"People helping people help themselves"

Frank O'Bannon, Governor
State of Indiana

Indiana Family and Social Services Administration
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John Hamilton, Secretary

June 30, 2003

The Honorable Frank O'Bannon
Governor, State of Indiana
Indiana State House, Room 206
Indianapolis, IN 46204

Dear Governor O'Bannon:

On behalf of the Governor's Commission on Home and Community-Based Services, it is my pleasure to present you with this June 2003 Report.

The Commission evaluated and deliberated over many of the issues that affect the long-term care delivery system for persons who are elderly, persons with mental illness, persons with physical and developmental disabilities, and children at risk of institutionalization and their families. Our work was completed thanks to the tireless efforts of over 200 people, who served on one of five Task Forces and/or the Consumer Advisory Committee. These Task Force members included consumers, providers, government staff, experts in the private sector, and a very dedicated technical advisory and project support team.

From the beginning, our charge was to increase community capacity, to reduce or eliminate systems barriers to receiving services, and to support consumer choice. We took this assignment very seriously, and compiled a list of 28 new actions that, if pursued, will significantly improve the delivery of services to our most vulnerable Hoosiers and will help to finally and permanently shift the balance of Indiana's long-term care system to one that is more responsive to consumer needs and choice. These actions are included in the June 2003 Report and are accompanied by relevant supporting information and analyses.

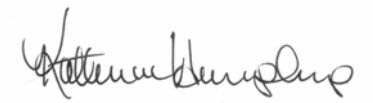
We greatly appreciate your interest in expanding and improving upon Indiana's services for persons who are in long-term care facilities or institutions or are at risk of institutionalization. We are especially grateful for the opportunity to assist you and your administration in developing strategies to address these important issues.

Please be assured that we have been acutely aware of the severe economic concerns that the state is currently facing, and we considered the limitations and opportunities created by these lean

times throughout our deliberations. The Commission worked closely with the Family and Social Services Administration, the Department of Workforce Development, the State Budget Agency, the Department of Transportation and other state agencies to understand issues critical to the development of consumer-focused, cost-effective community services. There are many opportunities for change and for improving the system. It is from that perspective that we have prepared this Report.

Thank you again for entrusting us with your confidence and for giving each of us an opportunity to assist Indiana in improving its long-term care delivery system. We look forward to convening one last time in December 2003 to evaluate the progress that has been made thus far on many of your priorities as well as the recommendations and actions that have been presented by the Commission.

Sincerely,



Katherine Humphreys
Chairperson
Governor's Commission on Home and Community-Based Services

Enclosure

Governor's Commission on Home and Community-Based Services

June 2003 Report

June 30, 2003

Acknowledgements

This June 2003 Report of the Governor's Commission on Home and Community-Based Services represents the cumulative work of a great many people, all of whom committed a great deal of time and energy to working through the many barriers and action steps needed to shift the balance of long-term care services in Indiana. This effort has been one of the most expansive efforts dedicated to long-term care in Indiana to date, bringing together highly regarded members of both the public and private sectors to contribute their skills and expertise in a forum that has never before been convened.

Governor's Commission on Home and Community-Based Services

The Commission members worked diligently to understand and work through the systemic barriers and action steps needed to shift the long-term care balance of services in Indiana. Commission members included: Mr. Bryan Blanchard; Ms. Sally Blankenship; Senator Billie Breaux; Representative Charlie Brown; Mr. Vincent Caponi; Representative Cleo Duncan; Ms. Nancy Griffin; the Honorable Allan Kauffman; Senator Connie Lawson; Mr. James Leich; Mr. Louis Martinez; Mr. James McCormick; Ms. Rose Meissner; Ms. Sharon Pierce; Dr. Stephen Rappaport; Reverend Roosevelt Sanders; Mr. William Sheldrake; Mr. Albert Tolbert; Ms. Karen Vaughn; Mr. Richard Wherry; and its chairperson, Ms. Katherine Humphreys.

Task Forces

The Commission convened five task forces to research and evaluate issues and then submit recommendations to the Commission for their review and consideration. These task forces met at least monthly, presented regularly at Commission meetings, and committed many hours to their research and discussions. We would especially like to acknowledge those persons who agreed to serve as chairpersons for these task forces.

- Children at-Risk: Mr. Denny Jones, Chair
- Community Personal Assistance and Support Services: Ms. Kathy Davis, Chair; Ms. Cris Fulford, Vice-Chair
- Housing: Mr. John Dickerson, Chair
- Transitions: Ms. Anne Jacoby, Chair
- Transportation and Employment: Mr. Curt Wiley, Chair

Consumer Advisory Committee

Absolutely essential to the Commission's work was the Consumer Advisory Committee, an advisory committee made up of a cross-disability group of consumers and advocates, representing persons who are elderly, persons with developmental disabilities, persons with physical disabilities, and persons with mental illness. They worked tirelessly to review and evaluate the recommendations and action steps developed by the task forces, and to provide advice and insight into the systemic barriers and sometimes overwhelming process and program obstacles as seen through the eyes of the consumer. We would like to extend special thanks to the Committee's Chairperson, Mr. Ed Bell.

Technical Advisory Group

A technical advisory group of staff from many different state agencies provided valuable expertise and support to the process. These staff included: Mr. John Hill, Mr. Roger Sell, Ms. Tammy Robinson, Mr. Doug Beebe, Mr. Bill Johnson, Ms. Wanda Williams, Ms. Ellen McClimans, Ms. Sandy Sleppy, Mr. Russell Brown, Ms. Joan Cochran, Ms. Linda Church, Ms. Evelyn Murphy, Ms. Katrina Stovall, Ms. Kristen Schunk, and Ms. Liz Carroll. In addition, special thanks goes to Ms. Venita Moore, Ms. Celia Leaird, Ms. Alison Becker, and Ms. Laura Butler who provided staff support to both the Commission and the Project Team on an ongoing basis and to Ms. Rosie Carney who supported the interests of persons with mental illness both through the technical advisory group and through many of the task force activities.

Technical Support

There was a number of consultant staff who provided technical support to the Commission, Task Forces, and Consumer Advisory Committee. These are the people who worked tirelessly "behind the scenes" to make sure that everything got done and that all deadlines were met. The technical support staff included: Ms. Judith Becherer; Ms. Donna Cameron; Ms. Melissa Dill; Ms. Elizabeth Galvin; Mr. Sanford Garner; Mr. Jim Hmurovich; Ms. Joelyn Malone; Ms. Mary Jo O'Brien; and Ms. Andrea Walsh. Special, special thanks goes to Ms. Julie Garrett, Ms. Debbie Austin, and Ms. Cindy Deakin, all three of whom worked many late and early hours to get the Commission and Task Force materials out to everyone on time. Their patience is greatly appreciated.

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Executive Summary

At the direction of Governor Frank O'Bannon, the Indiana Family and Social Services Administration has aggressively pursued reform for all of the at-risk populations for which it provides services. Despite this level of effort, Indiana continues to lag behind the rest of the country in providing a comprehensive array of long-term care services that includes not only the traditional healthcare service settings, but also affordable housing and sufficient in-home and community-based service options. This array of services is critical for facilitating consumer choice and independence, and promoting quality of care and quality of life for Hoosiers who are at risk for, or already in need of, long-term care services.

Persons who utilize long-term care services (regardless of funding source) include: the frail elderly; adults and children with physical disabilities; adults and children with developmental disabilities; adults and children with mental illness; and children and their families who are at risk of involvement in the child protective system, the juvenile justice system, or through academic failure in the education system.

There continues to exist a number of significant obstacles that make reform of Indiana's long-term care service delivery system in Indiana difficult to accomplish. Namely, affordable housing and community care services are extremely limited, making true consumer choice generally unavailable. Similarly, services and funding opportunities for children who are seriously emotionally disturbed or who are considered to be at risk of abuse, neglect, delinquency, developmental delay, developmental disability, or academic failure in Indiana are either not available, or are not managed consistently throughout each of Indiana's 92 counties.

To increase the momentum for expanding community capacity and consumer choice, the Indiana Family and Social Services Administration, in an unprecedented effort, teamed up with the U.S. Department of Health and Human Services to pursue innovation and to firmly establish lasting change. Three Federal grants, created in response to the landmark disability decision, *Olmstead v. L.C.*, were sought and subsequently awarded, to assist Indiana in once-and-for-all overcoming the long-standing barriers that have made reform so elusive in the past.

The three grants are as follows:

- *Real Systems Change Grant.* The purpose of this grant is to: establish a Commission that will provide a constant forum for interaction with consumers of long-term care services and their advocates; identify best practices and barriers to community integration and consumer control; provide oversight and monitoring; assist in the implementation of a series of mini-grants to local communities; and make further recommendations for policy and funding actions.

- *Nursing Home Transitions Grant.* The purpose of this grant is to: develop models for the diversion of persons from nursing home care and for the transition of nursing home residents back into the community; provide training, education, and outreach; collaborate with nursing home associations, housing partners, assisted living facilities, and community stakeholders; develop a team to design and facilitate the transition process; identify and select candidates to be transitioned and/or diverted; and evaluate and prepare reports.

- *Community Personal Assistance Services and Supports (CPASS) Grant.* The purpose of this grant is to: provide outreach and information about consumer-directed care services; develop a consumer-directed personal assistance services model and the supporting infrastructure; establish a fiscal intermediary structure for the attendant care workers; provide enhanced training; develop quality assurance, conflict resolution, and emergency assistance protocols; and develop a system for outcomes-based reporting.

At the lead in this effort, was the appointment by Governor O'Bannon of a bi-partisan, broad-based Commission, representing experts in fields that have never before been convened, to direct and coordinate the elements of long-term care in Indiana that have long been disconnected or altogether absent.

The Commission was funded primarily by the Real Systems Change Grant, but also receives funds from the Nursing Home Transitions and Community Personal Assistance Services and Supports grants for its role in coordinating all three initiatives; it used no state funds.

The Commission's primary purpose was to develop short- and long-term strategies to create or expand community options for persons at risk of being institutionalized, or for those currently in a nursing home or other institutional setting within Indiana's long-term care service delivery system. Its specific functions included: identification of the policy issues surrounding institutionalization; compilation of key statistics and other resource materials; identification of successful and innovative programs that break traditional housing and service barriers; solicitation of consumer perspective; and development of funding and policy strategies. Its work was intended to complement, and not duplicate, the valuable work already accomplished by so many others. The Commission met at least monthly since August 2002. It has produced an Interim Report presented to Governor O'Bannon in December 2002, and now this June 2003 report. The Commission will meet one last time in December 2003 to examine and evaluate progress made on both the short- and long-term recommendations presented in both reports, and to evaluate the progress made on systems change through the mini-grants and the impact that Senate Bill 493 (2003) has had on Indiana's home and community-based services system.

The Commission accomplished its work with the assistance of five special task forces that were assigned specific policy issues and a Consumer Advisory Committee that was specifically convened to research and evaluate the relevant policy issues, advise the Commission, and increase the scope and substance of Hoosier participation in formulating the solutions needed to break new ground in Indiana.

The Commission also worked with the Indiana Family and Social Services Administration to develop and award a number of mini-grants funded through the Real Systems Change Grant. These mini-grants were designed to create community partnerships, provide incentives for public/private partnerships, and serve to encourage innovation at the community level between community stakeholders.

There were two rounds of mini-grant solicitations: the first round of mini-grants was awarded in February to twelve different communities and totaled more than $430,000; and the second round of grants was awarded in May to eleven different communities and totaled more than $320,000. The grants were rated by a committee of staff of the Indiana Family and Social Services Administration and consumers from the Commission's Consumer Advisory Committee. Grants were considered if they fostered collaboration among community partnerships and totaled not more than $40,000 per grant. Innovation was favored over traditional, as was the development of

new capacity over simply expanding existing capacity. The focus was on maximizing and leveraging the funds by working to match other funding sources in the local communities.

The Commission determined in one of its early meetings that the original assignments and time-lines established for both the Commission and its task forces were not responsive enough to the urgency of many of the system problems and the opportunities presented by the upcoming legislative session. As a result, the Commission decided to deviate from its original workplan and instead refocus the task forces on identifying the most significant of the long-term care service delivery barriers and to develop comprehensive recommendations in response. Sixteen (16) individual recommendations were developed and presented in an Interim Report to the Governor in December 2002. The current status of each recommendation is included within this Report.

Since the publication of the Interim Report, the Governor's Commission on Home and Community-Based Services, its Task Forces, and the Consumer Advisory Committee have focused on the development and evaluation of a number of additional, but generally much more far-reaching actions. A number of new actions have been developed, all of which are absolutely essential to create the basic infrastructure, improve processes, and/or provide the services and supports needed to deliver quality services cost-effectively, while significantly enriching the lives of frail seniors, persons with mental illness and disabilities, and children and their families who are at risk.

The Commission recognizes that state resources (both in terms of funding and staff) are extremely limited, and that some actions are dependent upon the successful completion of others. Nevertheless, it believes strongly that now is the time to make significant and lasting change. The Commission therefore presents twenty-eight (28) new actions to serve as a blueprint for reform in Indiana. The actions are organized into four (4) categories: rebalancing the long-term care system; removal of barriers; community capacity; and children at-risk.

- Rebalancing the Long-Term Care System – This category includes ten (10) actions that are specifically targeted to those changes which will provide or build upon the community service infrastructure needed to support a large and ever-growing consumer population.

- Removal of Barriers – This category includes eight (8) actions that specifically focus on removal of key obstacles to expanding or improving community-based care.

- Community Capacity – This category includes eight (8) actions that specifically focus on opportunities to build upon or improve the services and supports that must be in place for consumers to live safely and successfully in a community-based setting.

- Children at-Risk – This category includes two (2) actions that are specifically targeted to improve and/or expand upon the service delivery system for children who are at risk and their families.

A master list and brief description of all twenty-eight (28) actions are attached at the end of this Executive Summary. They are sorted according to the categories identified above and include a brief description of the actions to be taken, identification of the agency or office responsible for taking the lead, and indication, if applicable, of legislative action that is required.

As the specific actions were developed, it became apparent that there were many issues that either fell outside the charge of the Commission, outside the charge of the individual task forces, or

required resources beyond the scope of this project and process. These issues, are, nevertheless substantive and must be addressed for meaningful systems changes to occur. They include: quality assurance; training and outreach; service access; interagency coordination; consumer choice; affordable and accessible housing; provider capacity; and Federal barriers.

In addition to the recommendations in the Interim Report and the actions in the June 2003 Report, there are a number of other steps that can be identified for action in the future. These steps or actions are not as easily defined, and cannot necessarily be assigned realistic timeframes and evaluation criteria because they depend on a set of unknowns. The unknowns include: the role of the Regional Planning Councils; quality assurance systems; Federal barrier changes; on-going evaluation through benchmarks and a Report Card; consumer participation; additional efforts through the New Freedom Initiatives; lessons learned from Best Practices; and structural support for Interagency coordination.

The Commission would be remiss if it failed to mention how much work remains to be done. Despite the activity and the level of progress that has been made by the Indiana Family and Social Services Administration and other state and local agencies over the past few years, Indiana continues to remain significantly behind most other states in re-focusing its scarce resources on more desirable, less costly community-based service delivery options. Spending priorities in Indiana continue to focus on institutional care, and progress in resolving many of the more complex service delivery problems such as caregiver support, eliminating process and system barriers, understanding the needs and desires of consumers, and shortage of caregivers, for example, has been frustratingly slow. Furthermore, the common framework for healthcare that is provided in traditional institutional settings and that favors medically cautious modes of care over care that relies upon consumer independence and freedom of choice continues to be extremely difficult to change.

The Commission accepts this current reality but commits itself to being part of the solution. It strongly advises the Governor, State Agencies, and the Indiana General Assembly to pursue each action aggressively and at the earliest opportunity possible. Each is critical in achieving the long-term care reform that has long been envisioned by the Governor, Indiana Hoosiers, and by so many others.

Master List of All 28 Actions Grouped by Category

Category: Rebalancing the Long-Term Care System

Lead Agency: Office of the Governor

Action: The Governor must direct the Indiana Family and Social Services Administration and other state agencies to pursue all grant opportunities made available through the President's New Freedom Initiative and all other grants that support Olmstead and the shift of the long-term care service delivery system.

Description of Action: The Governor will direct the State Agencies with aggressively pursuing the new Federal grant initiatives that provide states with the funds (at least $417 million in 2004 and another $1.68 billion for the next four years), expertise, and technical support to make significant and enduring reforms in the administrative infrastructure and delivery of housing and services to persons who depend upon public assistance. The grants are specifically targeted to expand community care options and to assist states in shifting the balance of care away from non-essential institutional care.

Action: The Governor should create a cross-disability consumer advisory council to advise him, the Indiana Family and Social Services Administration, and other state agencies on issues that facilitate continuing progress on *Olmstead* plan implementation and the movement of services toward home and community-based care. The Governor should strongly consider reappointing the members of the Commission's Consumer Advisory Committee, since they represent all target populations and have demonstrated strong understanding of the issues and the ability to collaborate well together.

Description of Action: The formal establishment of a cross-disability consumer advisory council will create a mechanism for consumer input that does not currently exist. Policies that directly and indirectly affect consumers are currently made with little or no consumer input, resulting in policies and process issues that may not address the needs, values, and priorities of consumers.

Lead Agency: Indiana Family and Social Services Administration

Action: Raise the monthly income eligibility standard for the Medicaid Aged and Disabled Waiver (and all other applicable waivers) to the federally-allowed limit of 300% (i.e., $1,656) of the Supplemental Security Income amount. This change will allow an individual to keep more of his/her income and still be eligible for Medicaid Waiver services. This Action is further supported by a similar provision included in Senate Bill 493 (2003).

Description of Action: The Indiana Family and Social Services Administration will revise eligibility criteria for the Medicaid Aged and Disabled Waiver to allow an individual to keep a greater portion of his/her income and still be eligible for the Waiver Program. This change will assist in eliminating the bias toward traditional nursing home care by making community-based services a true option for qualifying consumers.

Action: A targeted Medicaid Home and Community-Based Services Waiver for Adult Foster Care must be developed and implemented. This should be a new, separately-funded Medicaid Waiver Program that is specifically targeted to build capacity in this service area.

Description of Action: Foster care is essential for persons who are elderly and persons with disabilities who need a combination of residential care and services. Indiana does not currently offer this type of service, as a result, many individuals who can no longer remain at home, but who could thrive in an alternative setting, are forced to "choose" costly nursing home care.

Action: Adult day services should become a targeted service within Indiana's long-term care service delivery system, not only for consumers who receive public assistance, but also for consumers who are able to pay privately.

Description of Action: Adult day services are significantly under-utilized in Indiana and are not available in many parts of the State. This must be corrected, since adult day services fill an important place in the long-term care service delivery system. Namely, they provide a real non-institutional and cost-effective alternative for elderly and disabled persons whose primary caregivers are in need of respite or work outside the home.

Action: State and/or contractor staff must be integrated into the nursing home discharge process to ensure that consumers who are able to remain in their own homes/community setting can receive necessary services and/or support and monitor consumers who are placed in nursing homes for temporary care to ensure that they are successfully transitioned back into their own home or alternative community setting of their choice.

Description of Action: By integrating state/contracted staff into the nursing home discharge process, the State can ensure that consumers who can remain in their own homes/community setting can receive necessary services and/or support, and can monitor consumers who are placed in nursing homes for temporary care to ensure that they are successfully transitioned back into their own home or alternative community setting of their choice.

Action: Funding for public assistance programs should be transparent to the consumer and should follow the consumer to the service setting of his/her choice. This principle has been embodied within Senate Enrolled Act 493 (2003 Indiana General Assembly).

Description of Action: By allowing public funds to follow the client, the State will remove the long-standing bias that forces consumers to "choose" institutional service simply because there are no other funds available. This change will provide the financial and administrative means to consumers to apply a set amount of funding toward approved services that they need but in the setting (community or institutional) of their choice (This Action is already embodied in Senate Enrolled Act 493).

Action: The Indiana Family and Social Services Administration must dedicate and charge staff to fully and immediately develop the Medicaid Home and Community-Based Services Waiver for Assisted Living. Efforts must focus on recruiting and enrolling assisted living providers and developing a compatible consumer base.

Description of Action: There has been a lack of dedicated state staff to date to develop the assisted living program that has been in place since July 1, 2001. By refocusing on this priority program, the State will develop an essential residential care and services option for persons who can no longer live on their own but who do not need the intensive and costly level of care provided in a nursing home.

Action: The Indiana Family and Social Services Administration should establish a centralized Medicaid financial eligibility determination unit that is dedicated to Medicaid Waiver Program applicants. The purpose of this administrative change is to expedite the approval process for Medicaid Waiver applicants so that undesired institutionalizations may be avoided, and consumers are given the opportunity to receive services in their own homes and/or other community setting and to age in place for as long as possible.

Description of Action: The Medicaid Waiver application is so cumbersome and time-consuming that many persons who are elderly and physically disabled are institutionalized because they can no longer wait to receive the necessary services. By centralizing the financial eligibility determination process, approval time should be substantially reduced.

Action: Adult foster care should be added as a service component to Indiana's Medicaid Home and Community-Based Services Waiver for the Aged and Disabled.

Description of Action: In order to allow the Medicaid Aged and Disabled Waiver to have the most flexibility in serving consumers in all types of settings, the Waiver should be amended to include the opportunity for consumers to receive services in an adult foster care setting. This Action differs from the Action that requires the establishment of an Adult Foster Care Waiver because this waiver primarily serves persons who reside in their own homes, so the number of persons on the Aged and Disabled Waiver who will subsequently choose adult foster care services will be small.

Category: Removal of Barriers

Lead Agency: Indiana Family and Social Services Administration

Action: The Indiana Family and Social Services Administration should immediately evaluate and implement administrative process changes that will streamline and significantly reduce the time involved in determining Medicaid Waiver Program eligibility (focusing on development and approval of the individual plan of care/cost comparison budget and the level of care entry) and initiating services to no more than 20 days. The Agency should also implement a pilot program with the Medicaid Aged and Disabled Waiver that will transfer the daily management (other than the negotiation of rates and payment of vendors) of the program to the local level in order to reduce processing time.

Description of Action: The Medicaid Waiver application and approval process is extremely cumbersome and time-consuming. Therefore, it is necessary for the Indiana Family and Social Services Administration to immediately evaluate and modify the administrative process so that consumers receive approvals much more timely and services can be more quickly initiated. Additionally, a pilot program should be developed that allows as much

decision-making as possible to be performed at the local level to further reduce processing time and improve the eligibility decision-making process, and the quality of services.

Action: The Medicaid Waiver approval process should be modified to allow the cost comparison budget that is developed locally and early on in the approval process to serve as the initial waiver plan of care.

Description of Action: The Medicaid Waiver application and approval process is extremely cumbersome and time-consuming. By allowing the cost comparison budget to serve as the initial waiver plan of care, consumer services may be authorized and begun more quickly.

Action: State eligibility policy and/or administrative process for Medicaid and Social Security benefits should be modified to ensure that there is no lapse in coverage when a consumer transitions from an institution into the community or when a child ages out of foster care. There should also be developed an expedited process for persons who were not on Medicaid and/or who did not receive Social Security benefits at the time of admission to the state hospital to apply for and become approved for Medicaid and Social Security (when all eligibility requirements are met) prior to discharge in order to ensure that both Medicaid and Social Security benefits are available to the individual immediately upon discharge.

Description of Action: System, not program, limitations prevent qualified Medicaid and Social Security beneficiaries from receiving essential services (to which they are entitled) immediately upon discharge from a state hospital. There is an urgent need for these limitations to be resolved so that at-risk persons are not transitioned back into the community without the basic financial and healthcare supports needed to survive and succeed in the community.

Action: The Indiana Family and Social Services Administration must develop the infrastructure for a consumer-directed care program.

Description of Action: Unlike other states, Indiana does not have in place a consumer-directed care program that allows consumers to personally select, hire, and fire their own caregivers. This action establishes the infrastructure and mechanism necessary to implement this aspect of personal care assistance.

Action: Indiana's Residential Care Assistance Program policy should be modified to allow consumers to choose how their funding is used; i.e., to either live in a room and board assistance setting, or to use up to the same amount for temporary tenant-based rental assistance. If the consumer could choose to use these state funds as temporary tenant-based rental assistance until affordable housing such as a Section 8 Housing Certificate is applied for and obtained, the opportunities to live and perhaps work in the community are enhanced. Funding should follow the client regardless of living environment.

Description of Action: Indiana's Residential Care Assistance Program is very specific about how funds can be used. As a result, consumers may obtain housing only from certain providers. This policy limitation hinders consumer choice and independence and deprives consumers of some additional housing options that may better meet their needs and better serve the State's interests.

Action: Implement a Medicaid Home and Community-Based Services Waiver for persons with mental illness that includes people who are dually diagnosed (developmental disability and mental illness and/or mental illness and substance abuse) and support a number of complementary initiatives that are currently underway to further expand the community service alternatives for persons with mental illness.

Description of Action: Mental health services provided in a community setting have proven to represent a much more cost-effective, desirable, and successful alternative to care provided in traditional institutional settings. Nevertheless, Indiana has never had available the funds necessary to develop a sufficient number of community service alternatives to meet the needs of its low-income, mentally ill, and dually diagnosed populations. A Mental Illness Waiver targeted to persons with mental illness will help to bridge that gap.

Action: Medicare and Medicaid wheelchair and equipment coverage policy must be made more flexible to allow for a better evaluation of the consumer's needs, consideration of preventive care, and better coordination of vendors.

Description of Action: Adding flexibility to both the Medicaid and Medicare programs will assist the consumers in receiving the equipment that they need and will benefit both programs by improving the request and approval process. Common processing errors that currently occur in both programs cause consumers who are dependent upon wheelchair and other equipment and technology to suffer deteriorating health status, loss of employment and/or wages, and displacement from the community.

Lead Agency: Indiana Department of Workforce Development

Action: The Indiana Department of Workforce Development should explore the option to provide benefits to increase the number of and retention of personal care workers. This evaluation should be based on the best practices of other states, as well as the recommendations that were made in the 2002 Caregiver Commission Report.

Description of Action: It is possible that the provision of benefits will help to build up the personal care attendant provider base and retain them in employment. The need for personal care assistance is especially acute in rural areas and is expected to grow even greater in the future.

Category: Community Capacity

Lead Agency: Office of the Governor

Action: The Governor should appoint a Housing Task Force to focus on the housing issues of the elderly, disabled, and mentally ill populations. Membership should include: representatives of the housing industry, especially builders and contractors who have expertise and experience in new construction; consumers; advocacy groups; legislators; representatives of public/private funding sources; and service providers.

Description of Action: Housing issues for individuals who are elderly or who have disabilities, including mental illness, have not been sufficiently addressed, resulting in limited appropriate, affordable, and accessible housing stock for these populations. Establishment of

a Housing Task Force will facilitate a much-needed collaboration among housing and community program and services administrators, providers, and consumers to explore public-private partnerships that are needed to develop more housing options for the target populations.

Action: The Governor should work with the Indiana General Assembly to establish a real estate transaction fee to be assessed in the transfer of all commercial, farm, and residential real estate. The proposed fee per transaction would be dedicated to the Indiana Low Income Housing Trust Fund. If a local, low-income housing trust fund already exists within a community, one-half of the funds collected from the fee would be transferred to the local fund and one-half would go to the Indiana Low Income Housing Trust Fund for statewide application.

Description of Action: Indiana needs a dedicated state funding source to develop and support safe, affordable, and accessible housing for at-risk families and persons who are low-income, elderly, disabled, and/or mentally ill. Housing options are scarce, which has a significant, negative impact on the ability to provide services in the community. This will require legislative action.

Lead Agency: Indiana Family and Social Services Administration

Action: The current Vocational Rehabilitation Services rate (for supported employment and hourly-based placement) should be adjusted by utilizing a standard rate-setting methodology that includes an annual formula for inflationary increases. This methodology could include an hourly or results-based formula.

Description of Action: There is a shortage of vocational rehabilitation providers because of low statewide hourly rates. Current rates were established more than ten years ago, and were only adjusted one time after that.

Action: The Indiana Family and Social Services Administration should develop a standardized, state-wide rate ceiling for similar services provided. This should be established across all programs and be based on (or be responsive to) the actual cost of services being provided.

Description of Action: Availability and funding for community-based services is often inconsistent between programs even though the services needed are the same. This creates perverse incentives for providers and makes services difficult to obtain for some consumers.

Lead Agency: Indiana Department of Workforce Development

Action: A Business Leadership Network should be developed in Indiana to establish and further strengthen the link between business and employment at the local and state levels. Business Leadership Networks assist employers by exploring methods to more effectively recruit, market, and hire the talents of job applicants with disabilities. Business Leadership Networks have been developed across the country as part of an initiative started by the Office of Disability Employment Policy (ODEP) and supported by the U.S. Chamber of Commerce.

Description of Action: Formation of a Business Leadership Network in Indiana will potentially expand employment opportunities for individuals with disabilities and/or mental illness. A similar effort has been successfully replicated in 38 other states.

Action: Employment standards for staff qualifications, outcomes, and provision of services should be developed to ensure a level of professionalism in the delivery of employment services to individuals who are disabled and/or mentally ill. Vocational Rehabilitation Services should modify and require that all vendor/provider contracts include language that ensures compliance with the standards as they are developed.

Description of Action: Indiana needs state-wide employment standards for staff qualifications, outcomes, and provision of services. These standards will assist in resolving inconsistent and sometimes poorly-managed employment services for low-income consumers with disabilities and/or mental illness.

Lead Agency: Indiana Department of Transportation

Action: The statute that currently limits the service area of a Public Transportation Corporation (PTC) to its taxing district should be reviewed by the Indiana Office of the Attorney General, and, if necessary, amended by the Indiana General Assembly to allow for the provision of the most efficient and effective transportation options for all Hoosiers.

Description of Action: Public Transportation Corporations are currently limited to their taxing district, significantly hindering access to essential services for at-risk populations. Removal of this limitation will provide consumers with the transportation services that they need to access medical and social service appointments, employment opportunities, and shopping centers. This requires legislative action.

Action: Funding for public mass transit should be increased so that all citizens have access to adequate, affordable, accessible public transportation.

Description of Action: There is insufficient public mass transit available in Indiana, especially in rural communities. Dedicated funds need to be committed to make more and better transportation services available to consumers, particularly those who are elderly and have disabilities. This will require legislative action.

Category: Children at-Risk

Lead Agency: Indiana Family and Social Services Administration

Action: The Family and Social Services Administration should assist each Indiana community to implement an integrated and unified system of care that is organized to respond to the needs of children who are at-risk of long-term out of home placement. A system of care is a "comprehensive spectrum of services and supports that are organized into a coordinated network to meet the multiple and changing needs of individuals and their families".

Description of Action: Indiana Family and Social Services Administration will work with local communities to develop a comprehensive spectrum of services and supports for children that include case management and care coordination, early identification, and timely transitions to eliminate disruption in services.

Lead Agency: Office of the Governor

Action: The Governor must issue a clear statement that identifies an on-going commitment by the State of Indiana to early identification and assessment of children who need services, as well as a comprehensive prevention and early intervention strategy for Hoosier children.

Description of Action: The Governor will affirm the State's commitment to early identification and assessment of children who need services, and a comprehensive prevention and early intervention strategy for all children by charging the Indiana Family and Social Services Administration with several new responsibilities.

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Chapter 1. Introduction

Beginning in the early 1990's, Indiana's state government earnestly began to pursue a shift of long-term care service delivery away from the traditional, institutional settings of state-operated facilities, nursing homes, intermediate care facilities for the mentally retarded, and group homes, in favor of the then less-familiar community setting. It began with the controversial closing of Central State Hospital in 1992, which was later applauded for the significant, positive outcomes achieved for so many of its residents who were previously believed to be unable to function successfully in the community. It continued with the closing of New Castle State Developmental Center and the Northern Indiana State Developmental Center.

Many changes have occurred since that time. At the direction of Governor Frank O'Bannon, the Indiana Family and Social Services Administration has aggressively pursued reform for all of the at-risk populations for which it provides services. Medicaid community programs have been expanded, state-operated facilities have been closed, eligibility for the Medicaid disability program has been expanded, a prescription drug benefit has been developed, services for persons with mental illness have been expanded, and much more.

Despite this level of effort, however, Indiana continues to lag behind the rest of the country in providing a comprehensive array of long-term care services that includes not only the traditional healthcare service settings, but also affordable housing and sufficient in-home and community-based service options. A full array of services is needed in order to facilitate consumer choice and independence, and to promote quality of care and quality of life for Hoosiers who are at risk for, or already in need of, long-term care services. It is noteworthy that a nationally recognized consultant in the long-term care field recently predicted that, at current rates of growth and policy change, Indiana would not have a balanced long-term care system, where consumers have real choice in selecting community care settings, for another 30 to 40 years.[1]

Evidence of this service gap is the large proportion of Indiana's frail elderly and persons with disabilities who continue to remain in institutions**.** This imbalance was created by years of institutional bias, driven by both Federal and state regulation, and a general resistance to changing from what has been considered by many to be a very "safe" medical model of care to one that favors consumer choice and independence, and therefore includes some level of healthcare "risk".

There are a number of significant obstacles that make reform of its long-term care service delivery system in Indiana so difficult to accomplish. Affordable housing and community care services in Indiana are extremely limited, making true consumer choice generally unavailable. There is, in fact, no publicly-funded adult program in Indiana that operates without a waiting list for persons in need of that/those services. Specific examples of programs whose demand far exceeds the supply are: the state-funded CHOICE program; Medicaid Home and Community-Based Services Waivers; and Section 8 Housing. Moreover, even Medicaid disability benefits in Indiana are more difficult to obtain than in 48 other states, resulting in a disproportionately high number of chronically and seriously ill Indiana residents without any form of healthcare coverage.

Similarly, services and funding opportunities available for children who are seriously emotionally disturbed or who are considered to be at risk of abuse, neglect, delinquency, developmental delay, developmental disability, or academic failure in Indiana are not available or are not managed consistently in each of Indiana's 92 counties. As with many of Indiana's long-term care services for adults, children are often removed from their home environment to receive costly institutional

care, even though there are service funds available for treating children in the community. In contrast, Indiana has, in recent years, enjoyed national recognition for its leadership in enrolling children into the children's health insurance program (Hoosier Healthwise), its home visitation services (Healthy Families), and its early intervention services (First Steps). Each of these services promotes healthy child development, preventive or early intervention strategies to prevent long-term care of out-of-home placements and provision of services in the community. This recognition and success have not been as evident in maximizing Federal funding streams that would expand services in a cost effective manner to Hoosier children. The most notable of these are the Medicaid Rehabilitation Option and the Early and Periodic Screening, Diagnosis, and Treatment components of the Medicaid program. In each instance, under-utilization of these services is noted in some parts of the State. These Federal funds are available, but have not been pursued consistently by the State that could further promote community care services for at-risk children.

To increase the momentum for expanding community capacity and consumer choice, the Indiana Family and Social Services Administration, in an unprecedented effort, has teamed up with the U.S. Department of Health and Human Services to pursue innovation and to firmly establish lasting change. Three Federal grants were sought and subsequently awarded, to assist Indiana in once-and-for-all overcoming the long-standing barriers that have made reform so elusive in the past. At the lead in this effort, is the appointment by Governor O'Bannon of a bi-partisan, broad-based Commission, representing experts in fields that have never before been convened, to direct and coordinate the elements of long-term care in Indiana that have long been disconnected or altogether absent. A copy of Governor O'Bannon's Executive Order is included in the Appendices.

The Commission's work is intended to complement, and not duplicate, the valuable work already accomplished by so many others, such as the Senate Bill 317 Commission, the State-Operated Facilities Council, the Indiana Family and Social Services Administration's Long-Term Care Task Force, and the 2002 Commission on Caregivers. Specifically, the Governor's Commission on Home and Community-Based Service's work assignments focus on the "next steps" of building community capacity, eliminating barriers, and developing partnerships and systems that will support consumer choice. Their time-lines have been short, and their assignments daunting. Nevertheless, it is the belief and hope of many that the leadership of the Commission will create the impetus that is needed to finally tip the scales away from traditional modes of care and toward more responsive, consumer-driven, outcomes-oriented community care.

1.1 Background

The policy issues related to "long-term care" in Indiana cannot be fully understood without providing a definition of the term. In addition, while each state and program describes long-term care somewhat differently, all typically share the same common elements. One of the more comprehensive definitions[2] is as follows:

> "Long-term care is…a broad range of help with daily activities that chronically disabled individuals need for a prolonged period of time. These primarily low-tech services are designed to minimize, rehabilitate, or compensate for loss of independent physical or mental functioning. The services include assistance with basic activities of daily living (ADLs), such as bathing, dressing, eating, or other personal care. Services may also help with instrumental activities of daily living (IADLs), including household chores like meal preparation and cleaning; life management such as shopping, money management, and

> medication management; and transportation. The services include hands-on and standby or supervisory human assistance; assistive devices such as canes and walkers; and technology such as computerized medication reminders and emergency alert systems that warn family members and others when an elder with a disability fails to respond. They also include home modifications like building ramps and the installation of grab bars and door handles that are easy to use."

Persons who utilize long-term care services (regardless of funding source) include: the frail elderly; adults and children with physical disabilities; adults and children with developmental disabilities; adults and children with mental illness; and children and their families who are at risk of involvement in the child protective system, the juvenile justice system, or through academic failure in the education system.

Given the scope, variation, and funding source among long-term care services, it is difficult to estimate total expenditures for all services in Indiana. Indiana Medicaid expenditures alone for long-term care services totaled $1.81 billion in state fiscal year 2000[3]. Of that, approximately $773 million was spent on nursing home care, $289 million on institutional care for persons with developmental disabilities, and only $101 million on home and community-based services (waiver) care. Another $38 million was spent by Indiana's CHOICE program[4] to help people remain in the community. Perhaps more revealing, however, are the number of Medicaid recipients served by setting: namely 46,200 in nursing homes; 5,759 in intermediate care facilities for the developmentally disabled (state operated facility, large private facilities, and small group homes); and only 5,089 receiving community services through the Medicaid Home and Community-Based Services Waiver program.

The payment of services for abused, neglected, and delinquent children is paid through the 92 county family and children's funds, the revenue source of which is the county property tax. Due to significant local outcry because of the runaway costs of these funds throughout the State in the early 1990s, aggressive action was taken to constrain the growth of the local property tax rates. That provided an impetus for developing family-focused, community-based services, prevention programming, and increasing Federal reimbursement through the foster care placement programs. In state fiscal year 2000, over $27.5 million was expended in the Healthy Families home visitation program. To complement this very positive and beneficial effort to prevent abuse, neglect, and delinquency, the First Steps program expended over $42.5 million (also in state fiscal year 2000) to decrease, ameliorate, or early intervene when risk factors known to impact developmental delays or disabilities are identified in children ages 0-2. These efforts, while focused in the right direction, must be considered in the perspective of over $160 million spent in calendar year 2000 on private institutional placements for abused, neglected, and delinquent children, the amount of which does not include costs for children in state-operated facilities, correctional facilities or foster care. Foster care in the community for these children totaled almost $75 million in state fiscal year 2000, while in-home services for children in the child protective system, the juvenile justice system or for children who were at-risk of entering those systems approximated only $45 million. Clearly the direction is correct, but the effort is lagging behind the rest of the country, posing significant expense to both the child and the taxpayer. These figures do not include mental health services either at the community- or state-operated facility level.

Since the early 1980's, the Federal Centers for Medicare and Medicaid Services[5] have allowed states to use Medicaid funding to creatively design community-based programs that provide real alternatives to traditional forms of institutional care, such as nursing home, group home, intermediate care facility for the mentally retarded, and state-operated facilities (all of these are

typically defined as "institutional care" for purposes of the Medicaid Program). Many other states have embraced this flexibility wholeheartedly, having successfully shifted the long-term care service balance for their residents to one that favors more desirable and less-costly care in one's own home or other community setting over traditional and less-desirable institutional settings.

Across the country, consumer frustration with states' unwillingness, inability, and/or slow progress to embrace and develop viable and available community service options for its residents has been mounting in recent years. This frustration is evidenced by an increasing amount of litigation, which culminated in a key disability rights decision, *Olmstead v. L.C.*, issued on June 22, 1999 by the United States Supreme Court. A brief summary offered by the Center for Healthcare Strategies, Inc.[6] is provided below:

> *"The lawsuit, brought against the State of Georgia, questioned the state's continued institutionalization of two disabled individuals after physicians had determined that they were ready to return to the community. The Supreme Court described Georgia's action as "unjustified isolation", and determined that the state had violated these individuals' rights under the Americans with Disabilities Act (ADA).*
>
> *The Court explained that unjustified isolation was a form of discrimination. It reflected two judgments: First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life…Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.*
>
> *The Supreme Court was careful to say that the responsibility of states to provide healthcare in the community was "not boundless". States were not required to close institutions nor were they to use homeless shelters as community placements. Without imposing specific requirements, the Court said that if "…the state were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the state's endeavors to keep its institutions fully populated, the reasonable modifications standard [of the ADA] would be met." The Court specified that the state must provide community placement and services without displacing others on a waiting list for similar benefits and without unduly burdening the state's resources.*
>
> *Although the Olmstead decision confirmed the ADA's community integration mandate, the words "housing" or "supportive housing" do not appear in the decision. Instead, the Supreme Court used terms such as "community placements" and "less restrictive settings". Nonetheless, the Olmstead decision could have a profound impact on future state policies and approaches to provide community-based housing and support services for people with significant disabilities. As a result of the Olmstead decision, thousands of people currently living in "more restrictive settings" such as public institutions and nursing homes must be offered housing and community-based supports that are consistent with the integration mandate of the ADA."*

As described above, the *Olmstead* decision was a landmark for guiding the delivery of publicly-funded long-term care services, thereby further impressing upon states the need to respond to the decision quickly, clearly, and decisively.

1.2 The Indiana Family and Social Services Administration

Before and since the time that the *Olmstead* decision was rendered, the Indiana Family and Social Services Administration has engaged in a number of initiatives specifically targeted to increase community care options for individuals who depend upon public assistance for their services. These include, but are not limited to:

- *The Senate Bill 317 Task Force* – Appointed by Governor O'Bannon in 1997, this group was charged with developing a comprehensive plan for services for people with developmental disabilities, while assisting the Indiana Family and Social Services Administration in the simultaneous closure of two state-operated facilities.
- *The Governor's Council on State-Operated Care Facilities* – Created in 1999 in response to on-going concerns about the future of the nine (9) remaining state-operated care facilities for persons with developmental disabilities, Governor O'Bannon appointed a special council to develop a long-range plan to ensure the provision of high quality, cost-effective care in the nine facilities.
- *Long-Term Care Task Force* – In 2000, Governor O'Bannon appointed a task force to evaluate a number of long-term care issues and to oversee the development of the Medicaid Waiver application for assisted living and adult foster care that was mandated by House Enrolled Act 1197.
- *The Hoosier Rx Program* – Implemented in 2000, this program provides prescription drug assistance for low-income seniors. It is funded through Tobacco Settlement money.
- *House Enrolled Act 1767 Continuum of Care for the Elderly and Disabled* – Passed in 2001, this Act mandated the Indiana Family and Social Services Administration to develop a plan that would ensure that services provided under its programs match the needs of the individuals receiving the services. Additionally, it calls upon the agency to file a preliminary and final report.
- *House Enrolled Act 1950 Medicaid Buy-In* – Also passed in 2001, this Act provides for an expansion of the Medicaid disability program to include certain working individuals with disabilities as authorized by the Federal Ticket to Work and Work Incentives Improvement Act.

It is important to note that members of the Indiana General Assembly continue to have great interest in long-term care issues and continue to request information and action from the various agencies responsible for some part of the shift toward community-based care.

The Indiana Family and Social Services Administration has initiated and pursued numerous other policy changes and programs that have led to improved health outcomes and quality of life for many of Indiana's residents who depend upon public assistance for their healthcare and social needs. In addition, while limited by serious budget constraints in recent years, the Agency continues to actively and aggressively pursue program and system reforms that will collectively and significantly improve the long-term care service delivery system in Indiana.

Evidence of this commitment to change is the Agency's diligent pursuit and subsequent award of three grants offered by the Centers for Medicare and Medicaid Services within the U.S. Department of Health and Human Services. The three grants and a brief description of each are as follows:

- *Real Systems Change Grant*. The purpose of this grant is to: establish a Commission that will provide a constant forum for interaction with consumers of long-term care services and their advocates; identify best practices and barriers to community integration and consumer control; provide oversight and monitoring; assist in the implementation of a series of mini-grants to local communities; and make further recommendations for policy and funding actions.

- *Nursing Home Transitions Grant.* The purpose of this grant is to: develop models for the diversion of persons from nursing home care and for the transition of nursing home residents back into the community; provide training, education, and outreach; collaborate with nursing home associations, housing partners, assisted living facilities, and community stakeholders; develop a team to design and facilitate the transition process; identify and select candidates to be transitioned and/or diverted; and evaluate and prepare reports.

- *Community Personal Assistance Services and Supports (CPASS) Grant.* The purpose of this grant is to: provide outreach and information about consumer-directed care services; develop a consumer-directed personal assistance services model and the supporting infrastructure; establish a fiscal intermediary structure for attendant care workers; provide enhanced training; develop quality assurance, conflict resolution, and emergency assistance protocols; and develop a system for outcomes-based reporting.

1.3 Governor's Commission on Home and Community-Based Services

On July 30, 2002, Governor Frank O'Bannon made the announcement that he had formed the Governor's Commission on Home and Community-Based Care. It has been funded primarily by the Real Systems Change Grant, but also received funds from the Nursing Home Transitions and Community Personal Assistance Services and Supports grants for its role in coordinating all three initiatives; it has used no state funds.

The Commission is both broad-based and bi-partisan. It has twenty-one members, representing consumers, advocates, clergy, legislators, government, business, the service industry, public policy, education, and the medical and legal professions. Each member was selected for his/her unique perspective on the many issues and obstacles facing Indiana's frail seniors, children and adults with disabilities, persons with mental illness, and children and families who are considered to be at-risk. A complete list of Commission members can be found in the Appendices.

The purpose of the Commission was to develop short- and long-term strategies to create or expand community options for persons at risk of being institutionalized, or for those currently in a nursing home or other institutional setting within Indiana's long-term care service delivery system. Its specific functions include: identification of the policy issues surrounding institutionalization; compilation of key statistics and other resource materials; identification of successful and innovative programs that break traditional housing and service barriers; solicitation of consumer perspective; and development of funding and policy strategies.

While it has already been noted that there have been other efforts focused on the transition to community-based services, this is the first time that multiple agencies have focused their time and resources toward enhancing and expanding community services to support persons living in the community. Additionally, it is the first effort at developing cross disability community services.

The Commission has met at least monthly beginning in August 2002. It has produced an Interim Report presented to Governor O'Bannon in December 2002, and now this June 2003 report. The Commission will meet one last time in December 2003 to examine and evaluate progress made on both the short- and long-term recommendations presented in both reports, and to evaluate the progress made on systems change through the mini-grants and the impact that Senate Bill 493 (2003) has had on Indiana's home and community-based service system.

The Commission accomplished its work with the assistance of five special task forces that were assigned specific policy issues, and a Consumer Advisory Committee that was specifically designed to research and evaluate the relevant policy issues, advise the Commission, and increase the scope and substance of Hoosier participation to ensure that all with interest are involved in formulating the solutions needed to break new ground in Indiana. Each of the five task forces were devoted to specific policy areas of concern, while the committee was comprised solely of consumers and advocates with the express purpose of evaluating all task force work and advising the Commission. A complete listing of the task forces and the Consumer Advisory Committee, their specific purpose and function, and their membership can be found in the Appendices.

1.4 Mission Statement and Guiding Principles

At their first meeting, the Commission realized the importance of focusing on the assignments expressly presented them by Governor O'Bannon, and building upon and not duplicating the significant body of work already produced by numerous, preceding task forces and commissions. Moreover, they quickly came to appreciate the existing skepticism of many regarding the Commission and whether their work would, in fact, provoke lasting change and improvement in policy areas that have been frustratingly slow to evolve in Indiana.

In direct response to these challenges, the Commission resolved to develop recommendations that would transcend political interests and time-lines and that would complement (not duplicate) the continuing work of others, thereby creating an impetus for change that would be difficult to restrain.

The Commission's commitment is memorialized in a mission statement (Preamble) and five guiding principles, which were specifically developed to assist them in establishing clear and meaningful boundaries and direction for their work.

The Commission on Home and Community-Based Services exists to pursue common and aggressive actions that will facilitate immediate and lasting change in long-term care services in Indiana. The Commission's work is targeted to persons who already are, or who may sometime in the future depend upon long-term care services. The Commission will develop these recommended actions based upon a public policy that makes sense, is financially accountable, and promotes personal choice by the persons receiving or at risk of receiving these services. The Commission will build upon the good work already accomplished by other commissions and groups and will be guided by activities and implementation strategies that improve the lives of people currently affected by these services. Each recommended action is intended to help overcome the already well-known systemic barriers, current policies and procedures, and organizational practices that are obstacles to change.

Guiding Principle 1: Authority and Power of the Commission. The Commission recognizes that additional statutory or executive authority may be needed to implement the recommended activities and strategies that can improve service delivery for those persons who require or are at-risk of requiring long-term care services. However, the Commission also recognizes that true power comes in the ability to facilitate problem-solving in a meaningful and common-sense manner that transcends political, financial, and bureaucratic concerns. The Commission will articulate each strategy and recommended action step in a clear and concise manner that also identifies the consequences for refusing to enact the recommended action.

Guiding Principle 2: Accountability. The Commission will base its decisions upon information that is irrefutable so that a consensus can be achieved to bring about the systems change that is desired and that meets legal, financial, programmatic, and human expectations. Clear, measurable objectives will be identified, and timetables will be established that will form the basis of a three (3) to five (5) year action phase that is reasonable, realistic, and attainable. Any additional action phases will be a natural consequence of this initial phase, thereby reducing the likelihood of later modifying a longer-term strategy. The Commission understands the reality of budget constraints and will advocate current resource maximization that includes creative state plan amendments and waiver submissions prior to the development of any budgetary request.

Guiding Principle 3: Personal Choice. The Commission will identify strategies that promote the development of sufficient and quality care alternatives necessary to ensure true personal choice in all service settings.

Guiding Principle 4: Collaboration. Collaboration must exist throughout all levels of state and community agencies and organizations involved in services for long-term care. The Commission will serve as a "best practices and innovation" forum to ensure accurate information and education so training and organization culture changes can promote meaningful and real systems change. The Commission recognizes the importance and value of staff in each agency and organization involved in long-term care service delivery and endorses systems changes that allow staff to assist long-term care consumers to best meet their needs according to personal preferences.

Guiding Principle 5: Prevention and Early Intervention. The Commission is committed to the expansion of prevention and early intervention services that can decrease the incidence of causative factors that lead to a person's need for long-term care services.

1.5 Mini-Grants

As part of the Real Systems Change Grant funded by the Centers for Medicare and Medicaid Services, the Commission worked with the Indiana Family and Social Services Administration to develop and award a number of mini-grants. These mini-grants were designed to create community partnerships, provide incentives for public/private partnerships, and serve to encourage innovation at the community level between community stakeholders.

The mini-grants were directed to the three major goals of the Commission:

- To develop community capacity in the areas of community living arrangements, affordable housing, transportation, supported employment, and caregiver support.

- To develop systems that support consumer choice and consumer-directed care.
- To develop innovative systems that identify and propose solutions to eliminate barriers to service.

The Commission and the Indiana Family and Social Services Administration also accepted proposals that addressed other areas that proposed, supported, and validated enduring system changes. Grants were considered if they fostered collaboration among community partnerships. These were generally smaller-sized grants rather than larger grants and were a maximum of $40,000 per grant. Innovation was favored over traditional, and initiating new capacity was favored over simply expanding existing capacity. The focus was on maximizing and leveraging the funds by working to match other funding sources in the local communities.

There were two rounds of grant solicitations; one in December 2002, and one in March 2003. The first round of mini-grants was awarded in February to twelve different communities and totaled more than $430,000. The second round of grants was awarded in May to eleven different communities and totaled more than $320,000. The grants were rated by a committee of staff of the Indiana Family and Social Services Administration and consumers from the Consumer Advisory Committee.

Please see the Appendices for additional information on the mini-grants.

1.6 Commission Web Site and Reference Information

The Indiana Family and Social Services Administration has developed and maintains a web site expressly for the Governor's Commission on Home and Community-Based Services. This web site is: http://www.in.gov/fssa/community/ and includes viewing and downloading capability for the December 2002 Interim Report and this June 2003 report; meeting schedules, agenda and minutes; task force meetings and other information; information on the mini-grant solicitation; and other resource and informational material.

The Commission has also begun a reference and website list of relevant literature and other documents that have been published on one or more of the long-term care topics being researched and studied. This list can be found in the Appendices.

Chapter 2. Status of Recommendations Presented in the December 2002 Interim Report

During its first five meetings, the Governor's Commission on Home and Community-Based Services worked through a number of short-term actions that could be taken to begin the process for creating lasting systems change and community capacity. It was this "low hanging fruit" that formed the set of preliminary recommendations that were sent to the Governor in December 2002 for immediate implementation. All of these were identified as low-cost and/or administratively simple to execute but nonetheless important for promoting long-term care service delivery reform in Indiana.

All sixteen recommendations are restated below. Followed by each recommendation is a brief description of the most recently available status of implementation, any obstacles that have been encountered and additional steps needed to overcome the obstacles.

1. **Make financial eligibility for the Medicaid Aged and Disabled Waiver the same as for Medicaid-funded nursing home placements by implementing spousal impoverishment protections.** Targeted completion date: February 1, 2003.

   Status: Complete
   - Waiver approval received on February 24, 2003.
   - Waiver amendment effective date, January 1, 2003.
   - All county caseworkers have been notified of this change.
   - While the spousal impoverishment protection has been included in the Medicaid Aged and Disabled Waiver, work must still continue in ensuring uniform application by both Area Agency on Aging Case Managers and Division of Family and Children Field Staff.

2. **Raise the monthly eligibility standards for the Medicaid Aged and Disabled Waiver to 300% Supplemental Security Income amount. Complete a comprehensive fiscal impact analysis.** Targeted completion date: February 2003 for a comprehensive fiscal impact analysis.

   Status: Complete
   - A comprehensive fiscal impact analysis was completed in February 2003. Further refinement to the analysis was completed and presented to the Commission on March 27, 2003.
   - Funding has not yet been identified.
   - Senate Enrolled Act 493 mandates the implementation of 300% SSI, effective July 1, 2003.

3. **The Indiana Family and Social Services Administration should request approval from CMS to allow the certification and quality monitoring process that is currently in place for adult day services to serve as a substitute for state licensure**. Targeted completion date: January 15, 2003 for a written letter of request to be submitted to the Centers for Medicare and Medicaid Services.

   Status: Complete
   - A letter was submitted to CMS on February 14, 2003.
   - Follow-up questions were responded to on March 19, 2003.

- CMS responded to the Indiana Family and Social Services Administration's questions regarding clarification of "homebound status", relating to Medicare coverage of home health services provided to dually-eligible beneficiaries who are also attending adult day services.
- Division of Disability Aging and Rehabilitation Services certifies all adult day service providers for the waivers, which meets the Federal requirements and allows the providers to qualify for Medicare home healthcare services under the homebound provisions without having a state license.

4. **The Governor should re-appoint the Indiana Low-Income Housing Trust Fund Board to fulfill the original charge presented in 1988 to make recommendations regarding long-term funding sources to capitalize the housing trust fund and to serve as a focal point for creating affordable housing opportunities state-wide to help low-income and persons at risk remain in and/or return to the community.** Targeted completion date: appointment of the Board before April 1, 2003 and submission of the Board recommendations to the Governor by October 1, 2003.

5. **The Indiana Family and Social Services Administration is to develop, submit, and implement a Medicaid Home and Community-Based Waiver for children with serious emotional disturbance.** Targeted completion date: June 1, 2003.

   Status:
   - The Indiana Family and Social Services Administration is working to complete the waiver application, develop a provider base to provide waiver services, and complete a plan to administer the new waiver.
   - The application process is on schedule to be submitted to CMS in late June 2003. The waiver will provide an opportunity to braid funding from DMHA, DOC, DOE, and DFC to further develop and provide an intensive level of integrated comprehensive services and support for children with SED who meet an institutional level of care. Waiver services will be provided through developing local systems of care. New waiver services will include wraparound facilitation, respite, independent living skills, and family support.
   - A new position, Home and Community-Based Services/Seriously Emotionally Disturbed Manager, has been created. The position will be posted on June 23.
   - Workforce development is being addressed through initial meetings with a wide range of providers, families, and advocates.
   - During the first year of the model waiver, 50 youth will be served, growing to 200 within 3 years.
   - Administration of the waiver must consider certification and training of providers, implementing a uniform level of care determination process, managing waiver plans and budget, and implementing a quality improvement process.

6. **Expand access to Medicaid Rehabilitation Option funding to include state licensed, accredited, and/or certified child placement agencies.** Targeted completion date: July 30, 2003.

   Status:
   - Submission was made to CMS on December 27, 2002, retro-dated back to September 2002.
   - A teleconference with CMS revealed concerns with the residential treatment payment process and a need to revise the waiver submission. Revised state plan material has been

developed and is being finalized internally. The cover letter and revised plan amendment will be submitted to the Office of Medicaid Policy and Planning mid-June for submission to CMS.

7. **Maximize the use of the waiver granted by the Federal Government that promotes expansion and community-based services for children and utilize more fully the availability of the independent living funds authorized by Congress.** Targeted completion date: development of independent living guidelines by January 31, 2003; development of the administrative structure model by April 1, 2003; IV-E waiver with Adoption Assistance Program children beginning education by March 1, 2003.

   Status:
   - The Indiana Family and Social Services Administration continues to address both issues by modifying the child welfare policy manual. Staff have completed the first draft of the manual, addressing the requirements of the Independent Living Program. This material is planned for release beginning May 16, 2003. The material will also address all funding issues regarding potential match sources for the Federal dollars, as well as utilization of the IV-E waiver slots for children who would qualify for the Independent Living Program.
   - Program staff negotiated a $0.9 million match from public utility overcharge settlement agreement for IL room and board funds to permit full drawdown of Chafee Independent Living Program grant.
   - Independent Living Program contract amendments were finalized in May 2003, which includes the Proliance settlement funds as a state match to increase utilization of Federal funds. Amendments addressed energy education and the provision of room and board costs for children ages 18-21 (who were in foster care when they were 14 to 18) and who now need assistance.
   - The Independent Living Program Conference is scheduled for June 23 and June 30, 2003 for foster youth, foster parents, case managers, CASA volunteers, and service providers. The conference will provide important information about opportunities and assistance available to help teenage youth and is sponsored by the Indiana Family and Social Services Administration, Ball State University, and Prevent Child Abuse of Indiana.

8. **The State should revise, simplify, and make consistent the current waiver process and payment methodology for Medicaid transportation providers.** Targeted completion date: June 30, 2003.

   Status:
   - Based on feedback from the provider community about the current complexity for documentation and tracking of driver time and mileage, as well as concerns about the cost of transportation services, the Indiana Family and Social Services Administration's Bureau of Developmental Disabilities Services reviewed the procedures associated with Driver and Transportation Services.
   - In an effort to simplify transportation services, the following revisions will be made effective July 1, 2003. Specific actions taken are below:

     <u>Individuals in Residential Settings with 24 hours a day/7days a week</u>:
     Monthly Rate is $150 or $300 based on ability to transfer into a vehicle or need for accommodations.

     <u>Individuals in Residential Settings with LESS than 24 hours a day</u>:

$8.91 for the first round trip of the day up to 31 days a month.
$2.00 for the second round trip up to 31 days.

Individuals in Day Services Only:
$8.91 for the first round trip up to 23 days a month.
$2.00 for the second round trip up to 23 days a month.

- The Indiana Family and Social Services Administration is still working with EDS, the State's Medicaid contractor on developing/revising the waiver procedure codes. The Indiana Family and Social Services Administration believes that transportation has been revised and simplified. The new process will be more consistent for Medicaid transportation providers.

9. **The Medicaid Assisted Living Waiver for Persons Who Are Aged and Disabled should be quickly evaluated to identify the participation barriers and then be modified as necessary to successfully promote, develop, and support the Medicaid Assisted Living Waiver services to the fullest extent possible.** Targeted completion date: begin a comprehensive analysis of provider and consumer concerns and program barriers immediately; develop a comprehensive strategy for February 1, 2003; implement all changes by June 1, 2003.

Status:
- To date, there are 51 persons being served on this Waiver and there are 16 providers.
- Additional barriers that have been identified are Medicaid spenddown and the rate structure. The Office of Medicaid Policy and Planning and Division of Disability Aging and Rehabilitation Services are investigating the use of patient liability instead of spenddown (as is done in nursing facilities) since most assisted living providers are more familiar with this concept.
- The rate concerns are being addressed through planned provider education training and a reorganized and streamlined information and application packet.
- CMS reviewed this waiver May 11, 2003 through May 14, 2003. In general, the review was positive. Reviewers had a few positive comments and several recommendations. A formal report will be received in 60-90 days.
- EDS, the State's Medicaid contractor, is providing on-site assistance to AL providers on request, to assist with billing issues, and educating providers on how to work with spenddown and related billing issues.

10. **Fully define and develop the new congregate care option within the Aged and Disabled Waiver to ensure that this additional service and affordable housing component is viable and available.** Targeted completion date: develop a comprehensive strategy by February 1, 2003; implement all changes by June 1, 2003.

Status:
- A strategy was developed to include marketing the congregate care piece to providers of subsidized housing. The marketing plan will be completed by July 1, 2003.
- A provider training piece is being developed by the Bureau of Aging and IN-Home Services outreach unit to target specific providers and provider groups for training.
- A clarified definition of the service was developed to be included with the renewal documents for the Aged and Disabled Waiver.
- Approval from CMS is pending, and an effective date of July 1, 2003 is anticipated.

- There is a freeze on all Medicaid Waivers, so broad utilization of this service within the next year is not likely.

11. **The Indiana Family and Social Services Administration should immediately examine the barriers to timely Medicaid reimbursement of services provided by small providers and focus their educational outreach on these small community providers. The Indiana Family and Social Services Administration should also develop a streamlined payment process for small providers that will facilitate a timely and trouble-free payment. Waiver providers should be brought together to provide feedback on the changes that the Office of Medicaid Policy and Planning is making in response to new HIPAA requirements. The group should have broad-based representation**. Targeted completion date: implement changes by May 1, 2003.

    Status:
    - EDS, the State's Medicaid contractor, provides regularly scheduled training and will conduct focus training as needed and based on staffing availability with provider groups.
    - EDS will provide regularly-scheduled regional trainings for new and current providers and has provided on-site assistance as needed for particular providers (for example assisted living providers).
    - EDS is further developing a billing procedures manual for providers.
    - The Office of Medicaid Policy and Planning and Division of Disability Aging and Rehabilitation Services staff are developing a troubleshooting hierarchy process for case managers, providers, and waiver specialists to use in resolving level of care related billing issues.

12. **The Governor and the Indiana General Assembly should examine and assess existing legislation aimed at establishing Regional Transit Authorities (RTAs) across the State to all local taxing authority for the RTAs. A determination of the fiscal impact relative to expansion of services should be thoroughly examined as part of this assessment.** Targeted completion date: July 1, 2003.

    Status:
    - Representative Aguilera drafted HB 1665 for the benefit of the only current regional transportation authority in northwest Indiana. The bill would have granted a 1% increase in sales tax in Lake County, which would have raised approximately $6 million per year for the RTA. The bill was never given a hearing in the Ways and Means Committee and could not be revived in the Senate.
    - The RTA continues to exist, but it has no funding and therefore cannot accomplish much.

13. **The Department of Workforce Development should continue to maintain all resource centers with up-to-date, local employment opportunities and services. This information should be as "consumer-friendly" and comprehensive as possible and should include current resource materials prepared by partner agencies and organizations.** Targeted completion date: January 31, 2003.

    Status:
    - The Department of Workforce Development's Field Implementation staff has inventoried what is currently in place in the resource centers and has developed a comprehensive list. This was done with the help of local office staff and partner organizations.
    - A new guideline of minimum requirements has been drafted and will soon be shared with partner organizations for input.

- Progress has been slower than expected because the content hasn't been reviewed on a state-wide level in several years, so a more exhaustive approach has been preferred.
- The local Workforce Development office in at least one area has started monthly partner meetings, which are scheduled to continue every month to discuss how partners can help each other and how to access services. Shared trainings are being developed. Eligibility for each partner was discussed, as was the referral process.

14. **The Commission supports the application of a Real Systems Change mini-grant to focus on providing the administrative resources needed to facilitate and administer state-local application for all available Federal/state funds to support housing initiatives (i.e., Mainstream Vouchers - Section 8 vouchers for individuals with disabilities). If the project is not funded by a mini-grant, the Indiana Family and Social Services Administration should identify other resources to fund this project.** Targeted completion date: application for a mini-grant by April 1, 2003.

15. **All applicable Medicaid Home and Community-Based Services Waivers should include and implement the consumer-directed care service option.** Targeted completion date: implement by March 1, 2003.

    Status:
    - The Indiana Family and Social Services Administration waivers currently include a provision for self-directed care.
    - The Indiana Family and Social Services Administration is working with the CPASS taskforce to develop additional recommendations.
    - The Office of Medicaid Policy and Planning and EDS participated in a conference call with CPASS representatives to discuss payment mechanisms. The Indiana Family and Social Services Administration is working with the Department of Labor and Internal Revenue Service to finalize the process for enrollment and payment. This process, which includes training, enrollment, and fiscal intermediaries, is scheduled to be completed by July 31, 2003.
    - Drafts of the material have been completed by CPASS.
    - There are only minor obstacles regarding the lack of uniformity in the use of self-directed care in the CHOICE program. This issue will be addressed in the final documents from CPASS at the end of June 2003.

16. **The Indiana Family and Social Services Administration and the Indiana Department of Education should require inclusion of an age appropriate employment/vocational needs component as part of the person-centered plan/treatment plan/individual education program (IEP) for an individual receiving state funds or state-funded services, and/or services regulated by the State.** Targeted completion date: June 30, 2003.

    Status:
    - The rule that establishes an Individualized Support Plan (ISP) developed through the person-centered planning process, for all individuals receiving services through the Indiana Family and Social Services Administration's Bureau of Developmental Disabilities Section (BDDS) became effective May 21, 2003.
    - The use of the person-centered planning process will result in a more comprehensive view of the individual's needs; therefore, the Indiana Family and Social Services Administration will be looking at more vocational outcomes.
    - A pilot project with community rehabilitation programs is currently under consideration. A group consisting of providers, advocates, consumers, and the Indiana Family and

Social Services Administration staff are scheduled to meet June 12, 2003, to finalize payment points. A date to commence the pilot with two community rehabilitation programs from each of the five Vocational Rehabilitation (VR) regions will be identified by July 1, 2003, by the Deputy Director of Vocational Rehabilitation Services. The collaborative group has determined the essential elements of this process. This outcome-based system contains a strong person-centered planning component.

The Interim Report also briefly presented two (2) categories of additional recommendations that had not yet been developed. Nine (9) were considered to be additional short-term recommendations, and ten (10) were identified as long-term recommendations that required more complex and/or costly solutions. Most of the nineteen (19) recommendations were discussed extensively within the Task Forces during the months that followed the publication of the Interim Report in December 2002. Through these discussions, some of the recommendations were evaluated and then set aside, some were combined with other actions, some are included in the Issues and Going Forward chapters of this Report, and some were developed into the twenty-eight (28) new Actions that are presented in this Report.

Chapter 3. Presentation of New Actions

Since the publication of the Interim Report to the Governor in December 2002, the Governor's Commission on Home and Community-Based Services, its Task Forces, and the Consumer Advisory Committee have focused on the development and evaluation of a number of additional, but generally much more far-reaching actions. 28 new actions are now being presented; all of which are essential to create the basic infrastructure, improve processes, and/or provide the services and supports needed to provide quality community-based services cost-effectively, while significantly enriching the lives of frail seniors, persons with mental illness, persons with physical and/or developmental disabilities, and children at-risk.

The Commission selected four (4) broad categories for presentation of the twenty-eight (28) new actions. These include:

- Rebalancing the Long-Term Care System – This category includes ten (10) actions that are specifically targeted to those changes which will provide or build upon the community service infrastructure needed to support a large and growing consumer population.

- Removal of Barriers – This category includes eight (8) actions that specifically focus on removal of key obstacles to expanding or improving community-based care.

- Community Capacity – This category includes eight (8) actions that specifically focus on opportunities to build upon or improve the services and supports that must be in place for consumers to live safely and successfully in a community-based setting.

- Children at-Risk – This category includes two (2) actions that are specifically targeted to improve and/or expand upon the service delivery system for children who are at risk and their families.

All 28 actions are specifically described within this Chapter. Each is sorted by category and referenced according to the lead agency or office that has responsibility for evaluation and implementation. For an abbreviated summary of the Actions, please see the Master List of all 28 actions separated by category and presented at the end of the Executive Summary.

3.1 Category: Rebalancing the Long-Term Care System

The following ten (10) actions represent initiatives that are specifically targeted to those changes that will provide or build-upon the community service infrastructure needed to support a large and growing consumer population. Those agencies or offices identified as responsible for taking the lead include the Office of the Governor and the Indiana Family and Social Services Administration.

3.1.1 The following two (2) actions fall under the responsibility of the Office of the Governor

Problem: Like most other states, Indiana is experiencing a severe economic downturn, creating extreme funding deficiencies. As a result, funding for social service/public assistance programs is being carefully scrutinized in order to determine how best and where to target cost containment initiatives, all of which are expected to adversely impact consumers and public assistance providers. In seeming contrast, recent court actions, such as *Olmstead v. L.C.*, mandate that states develop initiatives and expand opportunities to provide consumers with real choice in the care and type of services available to meet his/her needs. Clearly, the objective is to shift the long-term care service delivery balance from traditional, institutional care to community-based care and allow consumers to age in place in the setting of his/her choice for as long as possible.

These two contrasting issues make it difficult for states to move forward with a long-term care vision. New initiatives that are anticipated to produce savings in the long-term, often require an initial funding investment that states are unable to afford in the current economic climate. As a result, long-term goals are compromised at the sake of short-term investments. Necessary policy and program changes, including some that are neither efficient nor effective, are delayed indefinitely.

Action: The Governor should direct the Indiana Family and Social Services Administration and other state agencies (i.e., the Department of Workforce Development, Housing, the Indiana Department of Transportation, and the Indiana State Department of Health) to aggressively pursue all Federal grant opportunities that will fund, in whole or in part, a shift in consumer services that will reflect consumer choice, independence, and quality of life and produce positive health outcomes and cost-effective policy initiatives.

Target Population. Those who would be affected by this change are all persons who are eligible for and receive public assistance.

Policy Outcomes. New Federal grant initiatives are expected to assist states in shifting the delivery of critical healthcare and housing services to its low-income, frail elderly, and disabled populations. Provider industries will change in response to consumer demand.

System Barriers. Funding for Federal grant initiatives may be limited in some way, requiring states to pick up a portion of the expense. This may be extremely difficult for states to do when experiencing severe budgetary constraints. Staffing new initiatives may also be difficult, when state staff is already dedicated to other projects and program initiatives. Time-consuming and costly computer system changes may be required.

Responsible Agency(ies) and Action Steps. The Office of the Governor, the Indiana Family and Social Services Administration, the Department of Workforce Development, Housing, the Indiana Department of Transportation, and the Indiana State Department of Health are responsible for researching, evaluating, and pursuing all grant initiatives and opportunities.

Action steps include:

- Research of current and new Federal grant initiatives.
- Evaluation of current and new grant initiatives current and new Federal grant initiatives.
- Coordination with other agencies and stakeholders as necessary.

- Development of written grant applications.
- Timely submission of grant application.
- Administration of grant awards.

Fiscal Impact. The cost of implementing this recommendation depends upon the Federal grant initiatives that are pursued. The state share will likely vary between no state investment, some/all administrative expense, and/or some/all service expense.

Targeted Completion Date. All grant opportunities should be researched and evaluated on a timely basis. Grant applications should be written and submitted on or prior to all published deadlines. Research of new and existing opportunities should be initiated immediately and should continue indefinitely.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of Federal grants for which Indiana is an active recipient.
- Increase in the number and scope of new community-based initiatives and program expansions.
- Increase in Federal funds for new community-based initiatives and program expansions.
- Verifiable compliance with the State's *Olmstead* Plan.

Problem: State, Federal, and local public assistance program policies that drive healthcare, housing, and other services are typically made with little or no consumer input. There is no formal mechanism, process, or consumer body that is regularly convened and relied upon to provide constructive input, education, and guidance to policymakers. As a result, critical consumer programs and services are heavily influenced by provider issues and government concerns, limitations, and priorities, which may not address the needs, values, and priorities of consumers.

Action: The Governor should create a cross-disability consumer advisory council to advise him, the Indiana Family and Social Services Administration and other state agencies on issues that facilitate continuing progress on the *Olmstead* plan implementation and the movement of services toward home and community-based care. The Governor should strongly consider reappointing the members of the Commission's Consumer Advisory Committee, since they represent all target populations and have demonstrated strong understanding of the issues and the ability to collaborate well together.

Target Population. Those who would be affected by this recommendation include consumers and advocates who represent persons who are frail and elderly, persons with physical and developmental disabilities, persons with mental illness and/or substance abuse, and children and their families who are at risk.

Policy Outcomes. Implementation of this recommendation will improve state policymaking by incorporating consumer input earlier and more accurately, thereby reducing the need for system re-evaluation and re-design. State compliance with its *Olmstead* goals and priorities will be achieved quicker and more effectively. Consumers will be given more "voice" in the programs and services upon which they depend. State and contract staff and providers will become more

aware of and knowledgeable of consumer needs, issues, and concerns, thereby improving the quality and delivery of publicly-funded services.

System Barriers. State and/or contract staff may be resistant to a consumer advisory process because of the number of stakeholder interests, boards, and other groups with and to whom they already must consult and/or respond. Consumer representatives may have transportation and mobility limitations that may impede their participation.

Responsible Agency(ies) and Action Steps. The Office of the Governor may establish this advisory council without administrative rule or state law. Action steps include:

- Appointment of members who represent all types of consumers in order to create a cross-disability forum.
- Designation of a council chairperson and/or state staff who will support the activities of the council.
- Identification of administrative resources that will fund the travel and meeting expenses of the members and the staff support.
- Development of a meeting protocol and feedback mechanism.
- Identification of mission statement, goals, and objectives.

Fiscal Impact. The cost of implementing this recommendation will consist of administrative expense associated with dedicated state staff time and travel time and expense of council members.

Targeted Completion Date. The council members should be appointed by September 30, 2003, with the first meeting scheduled before December 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Selection of dedicated, active Council members.
- The convening of regular and frequent meetings.
- Development of a full and meaningful agenda for those meetings.
- Decrease in the number and scope of project implementation and system and/or process modification errors.
- Improvement in consumer satisfaction with governmental services (typically documented through consumers surveys).

3.1.2 The following eight (8) actions fall under the responsibility of the Indiana Family and Social Services Administration

Problem: Federal regulation mandates that Indiana's Medicaid Home and Community-Based Services Waiver for the Aged and Disabled specifically targets persons who are in need of nursing home care. Yet even though the target population is the same, the financial criteria for Medicaid Waiver Program services is much more restrictive than for nursing home services. Specifically, the income of persons eligible for the Medicaid Waiver is limited to 100% of the Supplemental Security Income (SSI) amount, or $552. This means that if the individual's income exceeds $552 in any given month, (s)he loses Medicaid eligibility for services and must spenddown his/her income to the 100% SSI amount to regain eligibility. In contrast, an individual who has income above the 100% SSI amount ($552 monthly) does not lose his/her Medicaid eligibility for nursing home services. Rather, the income that is above the 100% SSI amount (less a monthly $52 personal needs allowance) may be applied directly to the cost of the nursing home care, and the individual continues to be eligible for Medicaid. This creates an "institutional bias" where the individual's only real choice is nursing home care. In other words, only individuals who have monthly incomes of $552 or less are eligible for Medicaid Waiver services, but incomes of $552 or less are not enough to cover living expenses. As a result, this current, very stringent income standard established for the Medicaid Aged and Disabled Waiver denies many persons who are frail and elderly or physically disabled from receiving critical services in their own homes.

The 300% SSI standard has already been adopted for consumers who receive services through the Medicaid Developmental Disabilities and Support Services Waiver programs.

Action: Raise the monthly income eligibility standard for the Medicaid Aged and Disabled Waiver (and all other applicable waivers) to the federally-allowed limit of 300% (i.e., $1,656) of the Supplemental Security Income amount. This change will allow an individual to keep more of his/her income and still be eligible for Medicaid Waiver services. This recommendation is further supported by a similar provision included in Senate Bill 493 (2003).

Target Population. Those who would be affected by this change are certain low-income persons who are frail and elderly and/or disabled, and who meet nursing home eligibility criteria, including: adults age 65 and over; physically disabled individuals of any age; and persons with developmental disabilities who have overriding medical needs.

Policy Outcomes. The implementation of this recommendation will establish policy consistency and equality between all Medicaid Waiver programs and Medicaid-funded nursing home services. It will help to eliminate institutional bias and effectively eliminates Medicaid spenddown for most individuals already receiving services through the Medicaid Aged and Disabled Waiver. It will establish a balance in Indiana's long-term care service delivery system by allowing all nursing home eligible persons the choice of receiving services in a nursing home or in their own homes or other community setting. It is also important to note that this policy change has already been made to two of Indiana's Medicaid waivers that serve persons with developmental disabilities. Finally, the adoption of this policy change will remove a significant and long-

standing barrier in providing and expanding community services for persons who are frail and elderly or physically disabled.

System Barriers. There are a number of major barriers that can be expected to significantly limit the impact of this recommendation and significantly delay the opportunity to reach the target for achieving program savings. These barriers are as follows:

- Consumers are often admitted to nursing homes directly from hospitals as part of their Medicare treatment protocol. Therefore, it is critical that these consumers are included in a targeted outreach effort and informed in a timely manner about their options to return to the community.
- The ability to serve consumers in alternative community settings is dependent upon the availability of Medicaid Waiver providers; Medicaid Waiver providers in Indiana are currently very few in number.
- There is no standard method for establishing competitive reimbursement rates for Medicaid Waiver providers.
- Processing time for Medicaid Waiver applications is very lengthy.
- The existing quality assurance process is very limited and cannot accommodate significant expansion in the number of people served in the community. Significant policy and program modifications are required, as well as a significant increase in state and local quality assurance staff.
- Affordable and accessible housing in Indiana is extremely limited, making the institutional bias very difficult to overcome.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning, the Division of Family and Children, and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for pursuing and implementing this change. The action steps include: developing the written policy; calculating a comprehensive and accurate fiscal impact; identifying any state match funds that may be needed; training staff involved with eligibility determinations; developing and implementing a viable plan that will begin responding to and resolving the systems barriers described above; and presenting that policy to the Centers for Medicare and Medicaid Services in the form of a written Medicaid amendment to the Aged and Disabled Waiver. Further, it is critical that the Indiana Family and Social Services Administration identify and pursue opportunities to partner with the business and local public community to resolve some of the identified systems barriers.

Fiscal Impact. The Office of Medicaid Policy and Planning performed a comprehensive fiscal impact analysis that evaluated a number of specific cost and program factors, including the following:

- Average per-person Medicaid and other state-funded (i.e., the CHOICE program) costs for all Aged and Disabled Waiver consumers, including the distribution of costs (ranging from high to low);
- Average per-person Medicaid and other state-funded (i.e., the CHOICE program) costs for nursing home consumers, including the distribution of costs and the effect of CMI scores on reimbursement;
- Aggregate Aged and Disabled Waiver and nursing home costs;
- Medicaid spenddown and patient liability; and
- Total funded waiver costs, including both used and unused waiver slots.

Results of this analysis revealed an *immediate* annual and on-going fiscal impact of raising the monthly income standard from 100% to 300% of SSI to be $2.7 million in state funds. Implementation of this policy should, however, reduce administrative costs associated with calculation and oversight of monthly Medicaid spenddown amounts for persons who are currently, or would otherwise be in spenddown status and eligible for and receiving waiver services.

The analysis also evaluated the *longer-term* program and cost effect on nursing home census, payment rates, and nursing home resident acuity. Specifically, the purpose of raising the monthly income standard for the Medicaid Aged and Disabled Waiver from 100% to 300% SSI is to immediately allow more persons to be able to afford to remain in the community and receive the less expensive healthcare provided through the Medicaid Waiver. The effect of this shift in services will serve to simultaneously reduce the number of nursing home admissions. Therefore, as more persons are diverted from nursing home care, total waiver expenditures will increase and total nursing home expenditures will decrease. Moreover, nursing home services will be appropriately directed to residents with higher acuity, generating higher per person nursing home payment rates but lower total nursing home expenditures (because of a lower resident census). The analysis further revealed that the total savings in nursing home expenditures will begin to exceed the start-up costs of implementing this policy change once approximately 1,000 persons have been diverted from nursing home care. As more persons are diverted, more savings will be generated. Therefore, the sooner this policy change is implemented, the less start-up costs the State will incur and the sooner the shift in services and expenditures can be achieved.

Finally, the analysis identified at least thirty-four (34) states that utilize the 300% SSI policy for its Aged and Disabled Waivers.

Targeted Completion Date. The Transitions Task Force originally recommended that monthly income standard for the Medicaid Aged and Disabled Waiver should be raised to 300% SSI by no later than July 1, 2004. In order to mitigate the immediate start-up expense associated with this policy change, this may, however, be accomplished by implementing an incremental series of changes; i.e., from 100% to 200% and then from 200% to 300%, provided that the 300% standard is adopted by no later than July 1, 2004.

Senate Enrolled Act 493 (2003), however, mandates the increase to 300% SSI, with an effective date of July 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the number of Medicaid recipients having spenddown status.
- Decrease in the institutionalization rates of Medicaid recipients who meet institutional level of care criteria.
- Decrease in nursing home resident census state-wide.
- Decrease in the number of Medicaid-eligible nursing home readmissions.

Problem: Adult foster care is an essential service within the array of long-term care services, since it provides both necessary healthcare services and affordable and accessible housing in an intimate community residential setting. For these and other reasons, foster care is an absolutely vital component of the child welfare system, yet it has never been fully developed, either privately or publicly, as a service option for Indiana's residents who are frail elderly or who have physical disabilities. Adult foster care is generally defined in Indiana as any family home or other facility in which residential care is provided in a home-like environment for compensation to three or fewer elderly persons or adults with physical and/or cognitive disabilities who are not related to the provider. Services include: personal care; homemaker; chore; attendant care and companion services; and medication oversight (to the extent permitted under State law).

Action: A targeted Medicaid Home and Community-Based Services Waiver for Adult Foster Care must be developed and implemented. This should be a new, separately funded Medicaid Waiver Program that is specifically targeted to build capacity in this service area.

Target Population. Those who would be affected by this change are certain low-income persons who are frail and elderly and/or disabled, and who meet nursing home eligibility criteria, including: adults age 65 and over; physically disabled individuals of any age; and developmentally disabled individuals who have overriding medical needs.

Policy Outcomes. The development of a new Medicaid Home and Community-Based Services Waiver for Adult Foster Care will complete the full array of service options necessary to provide cost-effective, community-based services to Indiana's low-income, elderly, and physically disabled residents. Adult foster care is a particularly important service option since it provides both healthcare and accessible and affordable housing, the latter of which is extremely limited in Indiana. This service will be available to persons who are nursing home eligible (as required by Federal law) but who prefer to receive services in a non-institutional community setting and for whom such services can be provided safely and cost-effectively. This service addition can be expected to provide a cost-effective community alternative to persons who may currently be excluded from other Medicaid Waiver Programs because their care is too costly to provide. A targeted Medicaid Waiver will allow an adult foster care provider base to be developed, and additional consumers to be served in a cost-effective, community setting.

System Barriers. Given the service and housing combination of adult foster care, a targeted quality assurance and monitoring protocol must be established and carefully maintained to ensure consumer safety, quality care, and provider compliance. Since Indiana does not recognize or license adult foster care services, provider training about Medicaid waivers (including, but not limited to, documentation and billing requirements) and service standards must be completed and carefully monitored. Specialized and frequent case management must occur to assure that the needs of adult foster care consumers are fully and continually met. Qualified state and/or contractor staff must be assigned to, and fully responsible for ensuring the safety and quality of life of consumers.

Computer system changes will be required and may be difficult or time-consuming to implement. State and/or contract staff will need to be dedicated to this service and fully trained.

Approval from the Centers for Medicare and Medicaid Services (CMS) is required in order to implement this new Waiver Program. Approval is not expected to be simple or quick, since a

number of states have failed Federal waiver audits of their adult foster care services due to poor quality of care, poor state oversight, and consumer safety issues. Therefore, it is reasonable to expect that CMS will scrutinize the quality assurance program for this new waiver.

State staff have been historically resistant to developing and administering another Medicaid Waiver Program.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for developing and implementing the new Adult Foster Care Waiver. The action steps include: developing the written policies; establishing provider certification standards; establishing a training curriculum for staff, consumers, and providers; establishing competitive reimbursement rates; identifying and implementing all necessary computer system changes; establishing a reliable quality assurance oversight and monitoring protocol; identifying new and dedicated state and/or contract staff to administer and oversee this service; and writing and submitting a waiver program application to the Centers for Medicare and Medicaid Services.

Fiscal Impact. Since this is a new Medicaid Waiver Program, new funding will be needed. The fiscal impact will be based on service utilization, and the design, development, administration, and oversight of the program. Additionally, the analysis should include a review of the short- and long-term effects of this program, including any projected savings that will occur over time. Implications for nursing home expenditures and resident census and acuity should also be considered. It is, however, essential to realize that failing to pursue adult foster care as a significant community care alternative has a cost as well; without this option, the lack of affordable, accessible housing will remain a significant barrier that severely limits the further development of community-based alternatives. It is precisely the adult foster care (and assisted living) service alternatives that provide the cost-effective combination of housing and services that allow consumers the option of safely remaining in the community to age in place for as long as possible. All states that offer extensive community-based programs depend heavily on both assisted living and adult foster care service programs.

Targeted Completion Date. The Indiana Family and Social Services Administration should develop a comprehensive fiscal impact analysis that consists of the following:

- The number of consumers to be served by the program, for each of the first two years;
- Detailed administrative costs related to program design and development (i.e., computer system; staffing; other);
- Expected service costs, including estimated provider rates, specialized case management, and direct state staff involvement; and
- Detailed administrative costs related to quality oversight and monitoring, including but not limited to: state and/or contractor staff; case management; long-term care ombudsman; program auditors; and adult protective services.

This fiscal impact analysis should be completed by no later than October 1, 2003.

As an accompaniment to the fiscal impact analysis, the Indiana Family and Social Services Administration must also complete a fully-developed implementation plan, that includes a detailed evaluation of a pilot program and a list of public/private cooperative opportunities that should be pursued. This shall also be due on October 1, 2003.

Finally, the new Medicaid Adult Foster Care Waiver should be implemented *as soon as possible but only after all funding has been identified and all action steps have been completed*.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:.

- Implementation of a targeted Adult Foster Care Medicaid Waiver Program.
- Development of an adult foster care consumer base, with the number of consumers increasing each quarter.
- Development of an adult foster care provider base, with the number of providers increasing each quarter.
- Increase in the number of quality assurance staff assigned to the adult foster care program.
- Minimal incidences of consumer dissatisfaction, abuse, and neglect.
- Development of rigorous quality assurance standards and evidence of strong oversight and on-going monitoring.

Problem: Adult day services (adult day care) are an integral community healthcare option within the long-term care service delivery system. They provide a regular, daily care alternative for the frail elderly and persons with disabilities that allows them to receive care and social interaction while allowing their primary caregivers to continue working outside the home or to receive necessary respite.

There are two primary issues in Indiana that hinder the success of adult day services as a viable community care alternative. First, adult day services currently have a very limited capacity. There are only 68 adult day centers, located mostly in urban areas and fully serving only 26 counties[7]. According to national research conducted by the Robert Wood Johnson Foundation, Indiana needs 119 more centers to fully meet Indiana's service needs. Second, the adult day service centers that Indiana does have are significantly under-utilized (48%). This is due to a lack of clear information and understanding about adult day services by consumers and referral sources. This under-utilization makes it difficult to recruit and retain providers. Clearly, there is a disconnect between the availability of the services and the referral of consumers to the services since national statistics indicate that Indiana has multiple under-served populations.

Action: Adult day services should become a targeted service within Indiana's long-term care service delivery system, not only for consumers who receive public assistance, but also for consumers who are able to pay privately. The targeting effort should include: development of educational materials and outreach to consumers and referral sources that clarify adult day services; development of enhanced orientation and training for adult day services staff to help them meet the complex needs of a "sicker" participant base; and exploration of successful models of rural home and community-based service delivery models for potential replication (e.g., Administration On Aging Alzheimer demonstration grants).

Target Population. Those who would be affected by this change are adults (both private pay and those who depend upon public assistance) who are frail and elderly and/or physically, developmentally, or mentally disabled and their caregivers.

Policy Outcomes. Implementation of this recommendation will help to grow a provider industry that can be expected to contribute significantly to Indiana's array of community-based services. Adult day services provide a real non-institutional and cost-effective[8] alternative for elderly and disabled persons whose primary caregivers who are in need of respite or who work outside the home. With medical monitoring, and by supporting the caregivers, adult day services provide vulnerable individuals with greater opportunity to receive necessary care and have social interaction intermittently, and thereby age in place in their home setting.

System Barriers. Implementation of this recommendation will likely result in some resistance from providers to increased staff time in orientation and training. In addition, there is currently no established state-wide educational process that fully presents the array of adult day services available to consumers. Lack of affordable, accessible transportation can be a significant barrier, particularly in rural areas when the consumer does not have family members or others available to assist them. Additionally, the CHOICE and Medicaid Programs have little experience with this provider group, therefore state and local staff may be unprepared in understanding and overcoming policy limitations and developing necessary outreach and timely and efficient reimbursement processes.

Responsible Agency(ies) and Action Steps. The Bureau of Aging and IN-Home Services, the Bureau of Developmental Disabilities Services, and the Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration are responsible for pursuing and implementing this change.

Action steps include:

- Development of a written marketing/development plan prepared by the adult day services trade association.
- Submission of that written plan to the Bureau of Aging and IN-Home Services for review and monitoring.
- Development of a written resource by the Bureau of Aging and IN-Home Services.
- Development of a state website dedicated to adult day services by the Bureau of Aging and IN-Home Services.
- Incorporation of adult day service description into regional and statewide training programs, including but not limited to: the Annual Governor's Conference on Aging; Area Agency on Aging training curricula for case managers and others; hospital discharge planning trainings; annual case management conference; nursing home associations' annual conferences; Indiana Medical Association curricula; and all service and information entry points for consumer.

Fiscal Impact. The administrative cost of implementing this recommendation is expected to be minimal, since this already falls under the administrative responsibilities assigned to the two bureaus. The cost implications of expanding adult day services within the CHOICE program and Medicaid Waiver Program should be budget-neutral in the short-term, since total funds are already allocated and this service will simply present another service option to consumers who have a limited budget. Savings are, however, possible in the longer-term since adult day services may delay or prevent an individual from seeking more costly nursing home and hospital services.

Targeted Completion Date. This initiative should be incorporated into existing training modules and consumer and provider outreach materials. Full implementation should occur no later than January 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of adult day service providers.
- Increase in the number of consumers who utilize adult day services.
- Increase in the overall utilization of adult day service providers.
- Decrease in institutionalization rates for consumers of adult day services.
- Decrease in acute care expenditures for consumers of adult day services.

Problem: The Indiana Medicaid Program's nursing home expenditures (approximately $800 million annually) continue to be significantly higher than other states (77% of all long-term care expenditures, compared to 57% nationally[9]). In contrast, Indiana's Medicaid Home and Community-Based Services Waiver Program expenditures total approximately $277 million[10]. In order to balance long-term care expenditures to better accommodate consumer choice in care and service delivery, Indiana must implement a diversion process that presents consumers with real alternatives to nursing home placement and/or supports them during a short stay in the nursing home for rehabilitation.

Indiana has been working toward this goal for a year. Even though there is progress, as of June 6, 2003, out of a goal of 1,000, there have been only 219[11] persons who have been successfully diverted. This slow progress can be attributed to a number of administrative and other barriers that include the following:

1.) Hospital discharge planners and social service designees are responsible for efficiently and expeditiously discharging hospital patients. They are familiar with nursing home level of care criteria and are generally able to transfer patients who are nursing home-eligible quickly and safely; they are not paid or assigned the responsibility to pursue the State's goal of diverting consumers from institutional care and doing an at-home evaluation or performing a case conference with the family.

2.) Nursing home social service designees face similar barriers; i.e., lack of training, lack of priority by management, and demands to keep beds filled.

Action: State and/or contractor staff must be integrated into the nursing home discharge process to ensure that consumers who can remain in their own homes/community setting can receive necessary services and/or support and monitor consumers who are placed in nursing homes for temporary care to ensure that they are successfully transitioned back into their own home or alternative community setting of their choice.

Target Population. Those persons who will be affected by this change are all acute care hospital and nursing home patients who are in the process of being discharged and who meeting nursing home level of care criteria.

Policy Outcomes. Implementation of this change will allow consumers the opportunity to understand their care choices, make informed choices, and receive on-going case management to support and monitor the care received. Undesirable institutionalization may be averted, thereby improving the consumer's opportunity to age in place in the setting of his/her choice, and

improving quality of life. Additional acute care episodes may be minimized and undesired institutionalization delayed or avoided altogether.

System Barriers. The barriers to implementing this action are as follows:

- If the state discontinues funding the regular Medicaid Aged and Disabled Waiver Program slots, there will be even fewer community service alternatives available for consumers who wish to avoid nursing home placement.
- The present system does not distinguish between an individual placed in a nursing home for rehabilitative services and one who needs rehabilitative services and then assistance in returning home. Without a case manager follow-up within the 100 days of nursing home care covered by the Federal Medicare Program, these individuals tend to remain in the nursing home indefinitely.
- There is an insufficient number of case managers available to follow the consumer to nursing home and facilitate transition back to the home or other community setting.
- Hospital discharge planning staff may not be able to assist with the additional responsibilities associated with a diversion initiative unless there is a financial incentive and/or legislation, rule, or other mandate that requires their participation.
- Individuals working within institutional settings (like acute care hospitals and nursing homes) may be uninformed about available community care service options and about the very different quality standards that apply to non-institutional settings.
- Legislation, rules, and/or mandates may prevent necessary access of the area agency on aging diversion staff to information related to the hospital discharge.
- Staff time to assess clients that choose to go to the nursing home or who do not qualify.
- It has not been determined how best to identify individuals that will have the potential of returning home after rehabilitation.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning and the Division of Disability, Aging and Rehabilitative Services within the Indiana Family and Social Services Administration are responsible for implementing this change.

Action steps include:

- Evaluation of successful program models used in other states (e.g., Illinois and Washington). The model should include universal pre-screening and funding for case managers employed by the State and/or its contractors to follow the consumer into the nursing facility.
- Completion of a fiscal impact analysis to determine the full administrative cost of implementing this diversion process.
- Development of policies, rules, and/or legislation needed to implement this recommendation.
- Development of simple, clear, and concise education and marketing tools, the target of whom will be hospital discharge planners, doctors, and nursing facilities.
- Define the process as a Universal Screening Process that encompasses nursing home placement, home and community-based services (the CHOICE program, Medicaid and private pay), and/or the opportunity to refuse all services.

The Universal Screening Process shall:

- Educate individuals at risk of nursing facility placement[12] and their families/caregivers about options for long-term care.
- Result in an improved quality of life and care for individuals by giving them the choice to receive care based on a person-centered plan.

- Reduce inappropriate nursing facility placement.

The process must include maximum of time to complete each step. For example, Illinois' time frames are:

- Universal Prescreening – within two (2) calendar days of referrals (date of referral is not counted as a day); perform this with a caregiver/family conference whenever possible.
- Case management follow-ups – in place within two (2) working days from the date of notification.
- Follow-up visit by the case manager after nursing facility placement – within 60 calendar days of placement.
- Post screening – completed within fifteen (15) calendar days of request.

Fiscal Impact. A fiscal impact analysis will need to be completed that includes adequate funds for staff and administrative functions such as marketing and educational funds. A staffing standard should be adopted; e.g., one FTE (full time equivalent) for every 60 attempted and 20 successful diversions. This program will be new, so further evaluation of the staff time needed to implement this program is also required.

Targeted Completion Date. A comprehensive fiscal impact analysis should be completed by September 30, 2003. This analysis should be accompanied by an implementation that includes potential funding source and a full phase-in plan. Rules should be pursued as soon as funds are identified; or if legislation is required, it should be pursued during the 2004 legislative session. This recommendation should be implemented beginning on July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the institutionalization rates for persons who meet institutional level of care criteria.
- Decrease in the utilization of acute care services for the same population.

Problem: In order to participate in the Medicaid Program, State Medicaid Agencies are required to fund institutional care for its beneficiaries, while community-based funds are not required. Similarly, other state and Federal public assistance programs establish criteria that limit funding in some way, often to the fiscal detriment of the State and the physical detriment of the consumer. The effect of these policies is to sustain a long-standing bias that favors institutional services over community-based services, even when the institutional services are more expensive and less desirable.

Action: Funding for public assistance programs should be transparent to the consumer and should follow the consumer to the service setting of his/her choice. This principle has been embodied within Senate Enrolled Act 493 (2003 Indiana General Assembly).

Target Population. Those who would be affected by this change are all low-income persons who are elderly, persons with disabilities, and person with mental illness who are eligible for and/or who receive public assistance.

Policy Outcomes. Implementation of this recommendation will allow for a greater number of Indiana's consumers to be served in cost-effective, community settings that reflect his/her choice in healthcare services. Providers will need to compete for consumers, thereby improving quality of care and consumer health outcomes. State program expenditures will need to be carefully monitored to ensure budgetary compliance. Resident census in institutional facilities (i.e., nursing facilities, intermediate care facilities for the mentally retarded/developmentally disabled; state hospitals) will decrease, while the acuity of the residents and the average facility reimbursement rates will increase. Similarly, the number of persons served in the community will increase, and it is likely that the acuity of those persons and the average cost of serving them in the community will also increase.

System Barriers. There will be a negative fiscal and economic impact on institutional providers, many of whom may appeal to the State and to the Legislature for relief. There may not be enough community-based services providers available to meet the needs of a growing consumer population. Quality assurance programs will need to be expanded in response to the growing shift of consumers away from institutional care and toward community-based care. Budget analysis and expenditure monitoring will be targeted to the expected and unanticipated effects of the policy change. There also needs to be consideration about how money is transferred when consumers leave one agency to begin services with another.

Responsible Agency(ies) and Action Steps. The Indiana Family and Social Services Administration and the State Budget Agency are responsible for implementing this policy change.

Action steps include:

- Review and evaluation of the administrative and funding limitations involved with the current fiscal administration of public assistance programs and this Action
- Review and evaluation of the projected economic effects on the institutional and community-based providers.
- Development of an implementation plan.

Fiscal Impact. The cost of implementing this depends upon the approach taken by the State. If existing funding is maintained and capped, then there would be no fiscal impact to the public assistance programs to implement this change. In contrast, however, the negative fiscal and economic impact on institutional providers is likely to be dramatic since more consumers are likely to choose community-based care if given the means to do so. If program funding is not capped or otherwise limited in some way, then there will be an undetermined increase in expenditures created by the addition into the public assistance system of new consumers (Woodwork Effect) who otherwise would have remained outside the system.

Targeted Completion Date. A comprehensive budgetary analysis should be developed by December 1, 2003. The change in administrative policy should occur on or before July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in resident census in institutional settings.
- Increase in the acuity of residents and the average reimbursement rate in institutional settings.
- Decrease in total institutional expenditures.
- Increase in the number of persons served by the Medicaid Waiver Program.

Problem: The Indiana Medicaid Home and Community-Based Services Assisted Living Waiver has been funded since July 1, 2001. Nevertheless, there are currently very few providers participating in the Waiver Program, despite available and dedicated funding. This problem is due to lack of dedicated state staff to develop the program (i.e., recruit providers; provide educational outreach and training, etc.), low or confusing reimbursement rates, administrative burdens and unfamiliar processes for small facility staff, and a lack of clear information and training for prospective providers.

Action: The Indiana Family and Social Services Administration must dedicate and charge staff to fully and immediately develop the Medicaid Home and Community-Based Services Waiver for Assisted Living. Efforts must focus on recruiting and enrolling assisted living providers and developing a compatible consumer base.

Target Population. Those who will be targeted in this policy directive are assisted living providers who are licensed in Indiana as a residential care facility and who qualify to participate in the Medicaid Waiver for Assisted Living. Those who will be affected by this initiative are certain low-income adults who are frail and elderly and/or disabled, and who meet nursing home eligible criteria, including: adults age 65 and over; adults with physical disabilities; and adults with developmental disabilities who have overriding medical needs.

Policy Outcomes. Evaluation and dedicated development of this Medicaid Waiver Program should result in the following: a significant increase in participating providers and consumers; an established program and administrative framework; good data collection; thorough and reliable quality monitoring and oversight; successful delivery of assisted living services; and a solid, interactive, and responsive partnership between assisted living providers and State Medicaid Waiver staff.

System Barriers. Difficulties associated with implementing this Action include: no dedicated state and local staff to communicate, design, modify, and develop a viable assisted living model; no current provider success to determine where policy changes are needed; poor information and provider training; lack of state understanding about the need for and value of a viable assisted living program; and communication and leadership problems associated with recent staff changes within the Indiana Family and Social Services Administration.

Responsible Agency(ies) and Action Steps. The Bureau of Aging and IN-Home Services and the Office of Medicaid Policy and Planning are responsible for implementing these initiatives. They must partner with the assisted living providers through the provider trade associations and the area agencies on aging.

The Bureau of Aging and IN-Home Services should provide a thorough, written plan for promoting and fully developing the Medicaid Assisted Living Waiver Program. It should include action steps that focus on building an assisted living provider base and must include, at a minimum:

- Streamlining the reimbursement methodology to include two or three reimbursement levels that directly relate to the levels of care currently permitted by residential care facility regulations.

- Developing a "pilot program" with one or two assisted living providers to modify the program, making it more user-friendly for providers and working out any challenges with the reporting/reimbursement process.
- Developing information that is brief and simple for providers who are new to the Medicaid System.
- Providing introductory seminars for interested providers.
- Providing educational training for providers who want to participate in the Medicaid Waiver Program.
- Establish a rapport and communication process with the area agencies on aging and the providers.
- Modify Medicaid financial eligibility policy to allow Medicaid spenddown to be treated as patient liability. Medicaid spenddown is a confusing and complicated process that would be replaced by a policy whereby the Medicaid Assisted Living Waiver resident pays her/his income liability directly to the provider; then Medicaid pays the difference.
- Developing and/or modifying the federally-required waiver program quality assurance protocol that complements the Indiana State Department of Health in its regulatory role for licensed residential care facility providers and meets the specific, individual needs of consumers who are served through this Medicaid Waiver Program.

The written plan should also include time-lines for program design, modification, and re-implementation, including the number and time-lines of consumers served.

Fiscal Impact. There should be no fiscal impact since the Medicaid Assisted Living Waiver was fully funded as a new program beginning in state fiscal year 2002 and included both administrative/staffing costs and service costs. There is, however, concern that the unused funding has been transferred elsewhere or reverted and that on-going funding may no longer exist.

Targeted Completion Date. Since this program is fully funded, this initiative should begin immediately. The written plan should be presented to the Commission by no later than December 1, 2003 with full implementation of the written plan beginning immediately thereafter.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Dramatic and continuous increase in the number of persons served by this Waiver.
- Dramatic and continuous increase in the number of participating assisted living providers.
- Decrease in institutionalization rates for persons served by this Waiver
- Decrease in utilization of acute care services by persons served by this Waiver

Problem: The Medicaid Home and Community-Based Services Waiver application and approval process is very complicated and time-consuming. By necessity, it includes two separate determinations: one for general Medicaid Program eligibility (which includes financial and, in some cases medical disability determination) with shared responsibility between the county office of Family and Children and the Office of Medicaid Policy and Planning; and the other for determining Medicaid Waiver Program eligibility (which includes level of care and plan of care/cost comparison budget), the responsibility of which is shared between the local area agency on aging, the Office of Medicaid Policy and Planning, and the Division of Disability, Aging and Rehabilitative Services. Although there are no time requirements for determining Medicaid Waiver Program eligibility, Federal regulation requires general Medicaid Program eligibility for individuals applying for Medicaid disability to be determined within 90 days from the date of the individual's application for Medicaid, and for other populations to be determined within 45 days from the date of application[13]. For many reasons, determining Medicaid eligibility more quickly is difficult to achieve.

Action: The Indiana Family and Social Services Administration should establish a centralized Medicaid financial eligibility determination unit that is dedicated to Medicaid Waiver Program applicants. The purpose of this administrative change is to expedite the approval process for Medicaid Waiver applicants so that undesired institutionalizations may be avoided, and consumers are given the opportunity to receive services in their own homes and/or other community setting and to age in place for as long as possible.

Target Population. Those who would be affected by this change are all persons who apply for Medicaid Home and Community-Based Services Waiver Programs.

Policy Outcomes. Implementation of this change will create administrative efficiencies in processing time, training, and information sharing. Those administrative efficiencies are expected to create more timely determinations of Medicaid program eligibility, thereby allowing necessary services to be provided more quickly. This change will reduce the likelihood that consumers who prefer home care will need to be institutionalized unnecessarily. Improvements in the administrative process can also be expected to positively impact Medicaid Waiver providers by reducing the time between when services are arranged and when they can be initiated (and paid).

System Barriers. There are a number of administrative process and computer system changes that are required. State resources may be limited, as well as dedicated space to house the centralized staff and function.

Responsible Agency(ies) and Action Steps. The Division of Family and Children and the Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration are responsible for implementing this change.

Action steps include:

- The Division of Family and Children must request approval of necessary staff by the Human Resources Division and State Personnel (Done).
- The Division of Family and Children must recruit, hire, and train staff (It may be necessary for staff to be phased-in over a period of time.).

- The Division of Family and Children and the Office of Medicaid Policy and Planning must identify space in the Central Office for staff.

Fiscal Impact. A fiscal impact analysis has already been completed by the Division of Family and Children as part of the request for approval.

Targeted Completion Date. This policy change should be implemented by December 31, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in processing time for Medicaid waiver applicants.
- Decrease in institutionalization rates for persons who meeting institutional level of care criteria.
- Decrease in institutionalization rates for persons receiving Medicaid waiver services.
- Increase in the number of participating waiver providers.

Problem: Adult foster care is a vital service within the array of long-term care services, yet it has not been fully developed, either privately or publicly, as a service option in Indiana. Adult foster care is generally defined in Indiana as any family home or other facility in which residential care is provided in a home-like environment for compensation to three or fewer elderly persons or adults with physical and/or cognitive disabilities who are not related to the provider. Services include: personal care; homemaker; chore; attendant care and companion services; and medication oversight (to the extent permitted under State law).

This option is already available, although not well-developed or highly utilized, through two of Indiana's Medicaid Home and Community-Based Services Waivers for persons with developmental disabilities.

Action: Adult foster care should be added as a service component to Indiana's Medicaid Home and Community-Based Services Waiver for the Aged and Disabled.

Target Population. Those who would be affected by this change are certain low-income persons who are frail and elderly and/or disabled, and who meet nursing home eligibility criteria, including: adults age 65 and over; physically disabled individuals of any age; and developmentally disabled individuals who have overriding medical needs.

Policy Outcomes. The addition of this service to the Medicaid Aged and Disabled Waiver will expand the full array of service options available to persons served by this waiver program. Adult foster care is a particularly important service option since it provides both healthcare and accessible and affordable housing, the latter of which is extremely limited in Indiana. This service will be available to persons who are nursing home eligible (as required by Federal law) but who prefer to receive services in a non-institutional community setting and for whom such services can be provided safely and cost-effectively. This service addition can be expected to provide a cost-effective community alternative to persons who may currently be excluded from the Medicaid Waiver Program because their care in a home setting is too costly to provide.

Utilization of the adult foster care service within the Medicaid Aged and Disabled Waiver is expected to be low, since the Medicaid Aged and Disabled Waiver primarily serves persons who receive care in their own homes, rather than persons who are seeking adult foster care.

System Barriers. Given the service and housing combination of adult foster care, a targeted quality assurance and monitoring protocol must be established and carefully maintained to ensure consumer safety, quality care, and provider compliance. Provider training and service standards must be established and carefully monitored; and specialized and frequent case management must occur. Qualified state and/or contractor staff must be assigned to, and fully responsible for ensuring the safety and quality of life of consumers.

Computer system changes will be required and may be difficult or time-consuming to implement. State and/or contracted quality assurance staff will need to be dedicated to this service and fully trained.

Finally, approval from the Centers for Medicare and Medicaid Services (CMS) is required to add this service to the Medicaid Aged and Disabled Waiver. This approval may not be simple or quick, since a number of states have failed waiver audits of their adult foster care services due to poor quality of care, poor state oversight, and consumer safety issues. Therefore, it is reasonable to expect that CMS will scrutinize the quality assurance program for this service.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning, and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for developing and implementing the new adult foster care service within the Medicaid Aged and Disabled Waiver. The action steps include: developing the written policies; establishing provider certification standards; establishing a training curriculum for staff, consumers, and providers; establishing competitive reimbursement rates; identifying and implementing all necessary computer system changes; establishing a reliable quality assurance oversight and monitoring protocol; identifying dedicated state staff to administer and oversee this service; and writing and submitting a waiver program amendment to the Centers for Medicare and Medicaid Services.

Fiscal Impact. There is no fiscal impact associated with the addition of the adult foster care service to the Aged and Disabled waiver, since the Medicaid Waiver Program budget and the number of persons receiving services is fixed for each year. There may, however, be some additional administrative costs associated with the development, implementation, and on-going quality monitoring of the adult foster care service.

Targeted Completion Date. The Indiana Family and Social Services Administration has already submitted the Medicaid Waiver Amendment to the Centers for Medicare and Medicaid Services and is currently awaiting approval. Nevertheless, in order to assure consumer safety and program success, the adult foster care service should be implemented *only after all action steps have been completed and by no later than October 1, 2003*.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of persons receiving adult foster care services through the Medicaid Home and Community-Based Services Waiver for the Aged and Disabled.
- Increase in the number of participating adult foster care providers for same.
- Decrease in institutionalization rates for persons served on the Waiver.

- Decrease in acute care service utilization for persons served on the Waiver.

3.2 Category: Removal of Barriers

The following eight (8) actions represent initiatives that specifically focus on removal of key obstacles to expanding or improving community-based care. Those agencies or offices identified as responsible for taking the lead include the Indiana Family and Social Services Administration and the Indiana Department of Workforce Development.

3.2.1 The following seven (7) actions fall under the responsibility of the Indiana Family and Social Services Administration

Problem: The Medicaid Home and Community-Based Services Waiver Program application and approval process is very complicated and time-consuming. Medicaid-eligible consumers throughout Indiana who apply for any of the Medicaid Waiver Programs often must wait months for their eligibility to be determined and approval of the individual care plan and budget[14]. Since Medicaid Waiver services cannot be provided until that approval is received (this includes approval of plan of care/cost comparison budget as well as Medicaid financial eligibility and level of care), Medicaid waiver applicants may experience deterioration in their condition and/or be institutionalized because they can no longer wait for the needed assistance to be provided in the community.

Action: The Indiana Family and Social Services Administration should immediately evaluate and implement administrative process changes that will streamline and significantly reduce the time involved in determining Medicaid Waiver Program eligibility (focusing on development and approval of the individual plan of care/cost comparison budget and the level of care entry) and initiating services to no more than 20 days. The Agency should also implement a pilot program with the Medicaid Aged and Disabled Waiver that will transfer the daily management (other than the negotiation of rates and payment of vendors) of the program to the local level in order to reduce processing time. This pilot should be carefully designed, monitored, and evaluated to determine whether state-wide implementation is desirable and feasible. It shall include: local approval of the individual care plan and budget; and local monitoring and quality assurance of waiver providers. (Please note that this Action does not intend for local monitoring and quality assurance to replace the federally-required quality, fiscal, and other oversight for which the Indiana Family and Social Services Administration is responsible.)

Target Population. Those who would be affected by this change are persons who are frail and elderly and/or disabled, and who meet nursing home eligibility criteria, including: adults age 65 and over; physically disabled individuals of any age; and persons with developmental disabilities who have overriding medical needs.

Policy Outcomes. Implementation of this Action should reduce the time it takes to complete the waiver approval process to no more than 20 days and allow consumers to access needed services. Examples of possible opportunities for improvement include: paperwork that is transferred multiple times between the same process points; the requirement of up-front, written doctor

approvals which are necessary but extremely time-consuming to obtain; and collection of detail on the cost comparison budget that is very difficult and time-consuming to develop.

With respect to the pilot program, clear outcome measures should be determined prior to the start of the pilot program. The pilot model needs to be established so that if it is successful, it can be replicated in a consistent manner across the State.

System Barriers. Administrative system barriers may include Medicaid and other computer system changes, and approval by the Centers for Medicare and Medicaid Services (CMS). At this time, the Office of Medicaid Policy and Planning does not support expansion of the pilot to authorize the local administrative unit to manage the waiver payment process for several reasons, including but not limited to: lack of consistency in rate structures or how rates are determined locally and widely varying rates for Medicaid waiver services and rates paid locally for similar services under Indiana's CHOICE program. These differences must be evaluated and resolved prior to any consideration of feasibility for a local administrative unit pilot of rate payment for waiver services.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for pursuing and implementing this pilot. Action steps include:

- Evaluating the Medicaid Waiver approval process and identifying opportunities for efficiency.
- If necessary, reviewing best practices of other states that have short application and approval processes.
- Training state staff and contractors on the process changes that will be made.
- Designing necessary computer system changes.
- Implementing all changes consistently and effectively.
- Establishing a comprehensive monitoring tool that will allow state and/or contract staff to identify the effects and overall success of the process modifications, and make any necessary adjustments quickly.
- Automation of level of care data entry process (between InSite and IndianaAIM); this has already been initiated.

For the pilot program:

- Identification of two local administrative units, one urban and one rural;
- Development of standards to measure the capacity of local agencies to administer the Medicaid Waiver Program locally;
- Evaluation of the accuracy of the software called InSite;
- Evaluation of the differences between the Medicaid Aged and Disabled Waiver and the CHOICE program (e.g., why do care plans from clients moved from the CHOICE program to the Medicaid Waiver increase);
- Evaluation of when it is not cost-effective to transfer a client from the CHOICE program to the Medicaid Waiver; and
- Development of a policy structure for local administrative units that will assure coordination with other agencies, such as the Bureau of Developmental Disabilities Services and independent case managers.

- Development of an outcomes measurement tool to evaluate the progress of the pilot to quantify any positive change and to assist in determining process improvements and state-wide applicability.

Fiscal Impact. The fiscal impact will consist of any computer and other administrative system changes associated with streamlining the approval process, and monitoring the pilot program.

Targeted Completion Date. Processing time for the Medicaid Waiver approval process should be modified and significantly reduced (by at least 50%) by no later than January 1, 2004 and by another 50% by December 31, 2004. Processing time should be reduced to 20 or fewer days by April 1, 2005. The pilot program should be designed and implemented by July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the period of time that eligible Medicaid waiver consumers must wait for services to be initiated.
- Decrease in the amount of time that Medicaid waiver providers receive payment.
- Increase in the number of participating Medicaid waiver providers.

Problem: Medicaid Home and Community-Based Services Waiver providers are not authorized to begin delivering services until a number of administrative steps have been completed. This administrative process is unnecessarily time-consuming and complicated, resulting in a significant delay between when Medicaid-eligible consumers are determined to be eligible for the waiver and the date that case managers are notified electronically that services may be initiated. The delay is often so great that some waiver providers are no longer available to serve the consumer when the waiver approval is finally received, or they decline to accept new waiver clients altogether. As a result, consumers may no longer be able to wait to receive the necessary care in the community, so they are unnecessarily institutionalized because nursing home services can be approved much quicker.

Action: The Medicaid Waiver approval process should be modified to allow the cost comparison budget that is developed locally and early on in the approval process to serve as the initial waiver plan of care. This approach is the same as that used in determining institutional eligibility and will reduce the time involved in the waiver approval process significantly. In addition, it will allow waiver providers to initiate and be paid for services much earlier (at the time that the cost comparison is developed). This approach has already been implemented successfully for the preadmission screening process with an error rate of less than 1% out of 4,000 decisions made locally[15].

Target Population. Those who would be affected by this change are persons who are frail and elderly and/or disabled, and who meet institutional eligibility criteria, including: adults age 65 and over; and physically and/or developmentally disabled individuals of any age.

Policy Outcomes. The implementation of this Action will allow Medicaid Waiver services to be initiated more quickly, thereby allowing more consumers to receive necessary care in the community setting of their choice with more providers willing to provide that care. It will help to eliminate institutional bias by allowing services to be arranged for and provided more quickly to consumers. Similarly, it will also assist in building the waiver provider base by allowing services

to be provided soon after the service plan is developed and by assuring more timely reimbursement.

System Barriers. There may be administrative or process obstacles involved with modification of the existing process, and there may be concerns that state staff have with accepting the cost comparison developed locally as the initial plan of care and the trigger for reimbursement. Historically, state staff have made a more restrictive interpretation of a Federal limitation that reimbursement can not be initiated prior to the approval of the initial plan of care.

Responsible Agency(ies) and Action Steps. The Office of Medicaid Policy and Planning and the Division of Disability, Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for pursuing and implementing this change. The action steps include: developing the written policy; modifying any necessary intake forms, modifying computer systems, training state staff about the process changes, developing informational outreach for consumers and providers, and requesting approval for the policy change to the Centers for Medicare and Medicaid Services in the form of a written Medicaid amendment to the Aged and Disabled Waiver.

Fiscal Impact. There is no administrative expense associated with this change. There may, however, be some administrative savings associated with increased efficiency in processing; i.e., fewer action steps for obtaining approval.

Targeted Completion Date. This policy change should be implemented by no later than July 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the period of time that eligible Medicaid waiver consumers must wait for services to be initiated.
- Decrease in the amount of time that Medicaid waiver providers receive payment.
- Increase in the number of participating Medicaid waiver providers.

Problem: Individuals with mental illness who are admitted to a state hospital are dis-enrolled from the Indiana Medicaid Program during their period of hospitalization because of limitations within the State's computer systems. The systems-related difficulties occur because Federal Medicaid regulation prohibits coverage of the hospital service, therefore states are responsible for paying the full costs. So, even though an individual does not lose his/her eligibility for Medicaid, his/her eligibility becomes temporarily "suspended" during the period of hospitalization in order to accommodate the shift in payment responsibility from Medicaid to the State. Similarly, children who are 18 – 21 and who age out of foster care often lose their Medicaid benefits unnecessarily because the case is not appropriately transferred to the new Medicaid category. When this dis-enrollment from Medicaid occurs, individuals who are discharged from the state hospital into the community and children who age out of foster care must wait an extended period of time for benefits to be re-instated. During that period, the individuals are denied vital pharmaceutical, treatment, and other healthcare services that are essential for successful transition (and sometimes even basic survival) into the community.

Unlike Medicaid, Federal law requires an individual's eligibility for Social Security benefits to be discontinued[16] during the period of institutionalization in a state hospital. To ensure successful transition back into the community, Federal law/regulation authorizes states to process the eligibility re-determination prior to the individual's discharge from the institution in order to ensure that benefits are available immediately upon the individual's discharge. Despite this Federal authorization, however, Indiana does not have a mechanism/policy in place to re-determine eligibility prior to discharge so that it coincides with an individual's discharge. As a result, the individual is denied the monetary assistance (to which (s)he is entitled) that is absolutely essential for covering basic housing, food, and other expenses.

Action: State eligibility policy and/or administrative process for Medicaid and Social Security benefits should be modified to ensure that there is no lapse in coverage when a consumer transitions from an institution into the community or when a child ages out of foster care. There should also be developed an expedited process for persons who were not on Medicaid and/or who did not receive Social Security benefits at the time of admission to the state hospital to apply for and become approved for Medicaid and Social Security (when all eligibility requirements are met) prior to discharge in order to ensure that both Medicaid and Social Security benefits are available to the individual immediately upon discharge.

Target Population. Those who would be affected by this change are all adults age 18 to 64 with serious mental illness who are admitted to a state mental hospital and who are eligible for Indiana Medicaid and/or Social Security benefits and all children ages 18-21 who age out of foster care.

Policy Outcomes. Implementation of this Action will provide a very fragile, at risk population (499 adults with mental illness during SFY 2002[17]) with the basic supports needed to survive and eventually succeed in, the transition from a state hospital to the community. This policy change will significantly and positively impact health outcomes, as well as mortality rates among this population. In short, implementation of this policy Action restores or expedites eligibility for two programs to which many individuals are entitled, but does so in a timely manner. The same is true for children who age out of foster care and who need continued Medicaid assistance.

System Barriers. Since both Medicaid and the Social Security eligibility determination process are operated as joint Federal/state programs that are administered according to each state's unique characteristics, laws, and regulations, program eligibility and administrative policies are not always consistently interpreted and applied among or even within states. Critical Medicaid and Social Security benefits that are not available during an inpatient hospital stay are often dropped during the hospital stay, either deliberately or unintentionally, making reinstatement of benefits unnecessarily burdensome and time-consuming. System changes may be required and may be complex to implement. Communication among state staff is poor, and care coordination for persons who are transitioning from an institutional back into the community is inadequate or non-existent. Previous housing arrangements may be lost, and may require extensive and time-consuming efforts to restore or identify new. Similarly, life-sustaining food and personal care items may not be accessible to consumers without the income received through the Social Security benefit. Consumers who depend upon essential drug and treatment protocols established prior to hospital discharge may experience serious and even life-threatening setbacks that reduce the likelihood of successful transition back to the community.

Responsible Agency(ies) and Action Steps. The Division of Mental Health and Addictions, the Division of Family and Children, the Office of Medicaid Policy and Planning, and the Disability Determination Bureau within the Indiana Family and Social Services Administration are responsible for evaluating and implementing this change.

Action steps include:

- Review and evaluation of existing policy.
- Determination of administrative and systems changes that are needed to implement the policy change.
- Development of an implementation plan with time-lines.
- Training of state staff.
- Implementation of a real-time quality assurance protocol to verify reinstated coverage/intended outcomes prior to and immediately after hospital discharge.

Fiscal Impact. The administrative cost of implementing this Action is expected to be minimal. There can, however, be expected a significant cost savings to the State related to decreased lengths of stays and decreased incidences of re-institutionalization in state hospitals, which are as prescribed by Federal law, paid with 100% state funds. Cost savings can also be expected by: providing preventive services that ameliorate the incidences of emergency room visits/acute care treatments; fewer and more efficient and effective case management services; and less expensive treatment and drug regimens that occur when consumer health status is stabilized.

Targeted Completion Date. This initiative should be pursued immediately with full resolution occurring by no later than October 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Verification that all Medicaid and Social Security beneficiaries are able to access services immediately upon discharge from a state hospital
- Decrease in the number of state hospital readmissions
- Increase in utilization of community-based services for Medicaid-eligible consumers immediately upon and for six months after discharge from a state hospital

Problem: Indiana does not have an enduring infrastructure to nurture and support consumer-directed personal assistance services.

Action 10: The Indiana Family and Social Services Administration must develop the infrastructure for a consumer-directed care program. At a minimum, this infrastructure shall include:

1.) Policies and procedures to implement fiscal intermediary services to support consumer- directed care that are standardized and available throughout Indiana. It must include sufficient start-up money to ensure an adequate cash flow.

2.) An easily accessible single source of information and education for consumers and their employees, caseworkers and providers regarding how to implement and sustain the provision of consumer-directed care

3.) A marketing plan that includes the publication of user-friendly information regarding the availability of consumer-directed services and the advantages and disadvantages of directing the individual's own care.

4.) A standardized training curriculum for all case managers in Indiana providing services to consumers eligible for consumer-directed care services and supports with training done within six months of implementation of the program. Training and educational opportunities should be offered at least semi-annually.

5.) A menu of standardized training and educational options to support the decision to access consumer-directed services and supports for all consumers and their employees. This should be done within 30 days of indicating an interest in the program.

6.) A statewide strategy, including the encouragement of public and private partner-ships, for increased recruitment, retention and training of individuals willing to provide services and supports to persons with disabilities.

Target Population. Consumers affected by this change include persons who are frail and elderly and/or with disabilities, who want to direct their own care in their own homes and in their own communities. Other persons who are affected by this change include persons already employed by consumers and persons who support the individual choices of consumers with disabilities and may be interested in becoming a personal care giver.

Policy Outcomes. Implementation of this Action can be expected to grow, the number of persons willing to become personal care attendants, as well as improve the employment retention rates for persons who already serve as personal care attendants. This increase in provider capacity will directly and positively impact consumers by introducing and/or extending the opportunity to remain in the community, decreasing unwanted institutionalizations (thereby further diminishing the longstanding institutional program and fiscal biases), increasing choice among available providers, and enhancing quality of life.

Responsible Agency(ies) and Action Steps: The Indiana Family and Social Services Administration is responsible for implementing this Action .

*Fiscal Impact***.** The fiscal impact is unknown until many of the action steps are completed. It is, however, important to determine both the short-term costs and the long-term costs and implications, since enhancement of the personal care provider pool can be reasonably expected

decrease institutional (both acute care hospital and nursing home) costs, thereby generating possibly significant savings over time.

Targeted Completion Date. January 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Development of a consumer base for participation in consumer-directed care with growth documented quarterly
- Development of a personal care attendant base for participation in consumer-directed care with growth documented quarterly
- Increase in retention time for personal care attendants
- Improved consumer satisfaction as documented through consumer surveys, provider retention, etc.
- Decrease in the institutionalization rate for the Medicaid Waiver population

Problem: Indiana's Residential Care Assistance Program (RCAP) assists persons who are elderly and/or who have mental illness in obtaining and funding safe and affordable housing[18]. This funding is, however, not flexible and requires consumers to obtain housing from only those providers who participate in the State's Room and Board Assistance (RBA) or Assistance to Residents in County Homes (ARCH) programs. This policy limitation hinders consumer choice and independence and deprives consumers of some additional housing options that may better meet their needs and better serve the State's interests. Additionally, since ARCH is a government-funded program, ARCH recipients are not allowed to be enrolled in Medicaid, so the State picks up 100% of all healthcare costs.

Action: Indiana's Residential Care Assistance Program policy should be modified to allow consumers to choose how their funding is used; i.e., to either live in a room and board assistance setting, or to use up to the same amount for temporary tenant-based rental assistance. If the consumer could choose to use these state funds as temporary tenant-based rental assistance until affordable housing such as a Section 8 Housing Certificate is applied for and obtained, the opportunities to live and perhaps work in the community are enhanced. Funding should follow the client regardless of living environment.

Target Population. Persons who would be affected by this change are low-income elderly and disabled adults who qualify for assistance under the State RCAP program.

Policy Outcomes. Implementation of this Action will introduce a much-needed flexibility to the RCAP program. If RCAP funds could be used to obtain temporary tenant-based rental assistance until a consumer can qualify for affordable housing options such as Section 8 Housing, then (s) he would move off the RCAP program, opening a new slot to assist another person. Not only could more individuals be served by the RCAP program, but also more could enjoy a more independent living situation within the community. Additional benefits may include increased consumer independence, community tax benefits if the consumer obtains employment, decreased risk of institutionalization, improvement in quality of life, and improved management and possible savings of state healthcare costs. Moreover, implementation of this Action may mitigate the likelihood that litigation related to unlawful segregation of persons with mental illness will by filed against the State.

System Barriers. Successful implementation of this Action will require a rule and/or statutory change, computer system changes, and administrative changes in procedures. Other barriers include: a lack of understanding about the characteristics of RBA clients (i.e., a mistaken belief that all persons receiving RBA need a high level of care); buy-in by state agencies, institutions, and case managers; resistance by RBA providers; lack of educational information for consumers *about* housing opportunities and state program purpose and policies; lack of reliable baseline data; lack of an appropriate system for measuring outcomes; lack of appropriate supports and oversight of consumers who participate in the RCAP/RBA program; and lack of an established partnership with housing providers to assure that consumers who are awaiting Section 8 Housing receive safe and appropriate temporary housing in the interim.

Responsible Agencies and Action Steps. The Division of Disability, Aging and Rehabilitation Services, the Division of Mental Health and Addictions, and the Division of Family and Children within the Indiana Family and Social Services Administration will be responsible for pursuing and implementing this change. Action steps include:

- Completion of a written review and evaluation of the RBA and RCAP programs.
- Promulgation of a rule change and/or pursuit of legislation to modify state statutes.
- Establishment of a collaborative partnership between responsible state agencies and housing providers (both RBA and new providers).
- Development of specific program criteria for RCAP.
- Development/modification of an effective data collection system that enables consumer information and funding to be readily identified and followed
- Development of benchmarks to measure outcomes.
- Modifications to the computer system.

*Fiscal Impact***.** The costs of implementing this action will likely consist of two main elements:

- Monthly savings for the State/Medicaid: If the same number of slots currently available are used as a reference, the State could save money by spending less for tenant-based rental assistance than what is currently being paid for all of the individual's community living needs. Currently, the State pays roughly $1,200 per person per month in the RBA program less the individual's contribution of SSI monies. In addition, the State pays $660 per person per month in the ARCH program. The State also pays full medical and healthcare expenses for individuals in the ARCH program. If ARCH individuals went to tenant-based rental assistance, the individual could enroll in Medicaid, and the State share would only be 38%, compared to 100%. An individual on either program would pay approximately $300 per month for rent with tenant-based rental assistance, and would save the State either $300 for ARCH or $800 per month for RBA. This could be used in the short-term to pay for the expenses of changing the system.

- Impact on Tenant Based Rental Slots: As individuals become eligible for affordable housing such as Section 8 Housing subsidy or Mainstream vouchers for persons with disabilities, the individual would no longer need/receive tenant-based rental assistance, thus opening up TBRA slots for others. The funds could then be used to support new persons coming into the system.

*Targeted Completion Date***.** This Action should be implemented by July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of persons served by the RCAP program
- Decrease in the average length of time per consumer RCAP program services are provided
- Increase in the utilization of temporary tenant-based rental assistance

Problem: The U.S. Surgeon General has estimated that 20% of the American population has some mental disorder in a given year, and about 5% of the population is considered to have a serious mental illness (SMI). Based on these figures, an estimated 305,000 people in Indiana are expected to experience some form of mental illness each year, 68,000 of which are likely to qualify for publicly-funded services.[19] Currently, the Indiana Division of Mental Health and Addiction serves 41,000 persons in state hospitals and in the community mental health system.[20]

Mental health services provided in a community setting have proven to represent a much more cost-effective, desirable, and successful alternative to care provided too many persons in traditional institutional settings. Nevertheless, Indiana has never had available the funds necessary to develop a sufficient number of community service alternatives to meet the needs of its low-income, mentally ill and dually diagnosed (mentally ill/developmentally disabled) populations. Moreover, although some persons with mental illness have a serious disability that renders them eligible for Medicaid and nursing home care, many do not. As a result, they are not eligible for services funded by a Medicaid home and community-based services waiver. Although Indiana funds many services through the community mental health system and Medicaid (through the Medicaid Rehabilitation Option), there continue to be a number of persons who are served in state hospitals who could successfully and cost-effectively be served in an alternative community setting if one were available (it is, however, also important to note that there are some persons for whom an institutional setting is the service of choice and/or where an individual's needs can best be met).

Action: Implement a Medicaid Home and Community-Based Services Waiver for persons with mental illness that includes people who are dually diagnosed (developmental disability and mental illness and/or mental illness and substance abuse) and support a number of complementary initiatives that are currently underway to further expand the community service alternatives for persons with mental illness.

Target Population. Those who would be affected by this change are certain low-income persons with mental illness and dual diagnosis (developmental disability and mental illness and/or mental illness and substance abuse) and who meet institutional eligibility criteria (i.e., state operated facilities, nursing homes, or intermediate care facilities for the mentally retarded).

Policy Outcomes. The development and implementation of a new Medicaid Home and Community-Based Services Waiver for Persons with Mental Illness will bolster the community-based service options already provided in Indiana and will help to prevent unnecessary institutionalization. More persons with mental illness can be served through the Medicaid Waiver and at less cost than in the equivalent institutional setting. Successful and consistent community treatment outcomes will positively influence overall healthcare costs, and the consumer's health, level of independence, employment retention, and quality of life. Institutional resident census may be decreased, and overall state institutional costs may be reduced.

System Barriers. The system barriers include: lack of information about how to access programs and funds among providers, consumers, and families; lack of affordable and accessible housing; lack of funding for supported employment and supportive housing; lack of available jobs and transportation; and lack of adequate personal care services provided in the individual's or family's home. Other barriers include: resistance from state staff to develop, implement and monitor the new waiver program; computer system changes that may be complex, costly and time-consuming; and lack of funding. Without additional resources, the Indiana Family and Social Services Administration may not have the staffing or expertise in development and oversight of an additional Medicaid Waiver Program, which by definition, carries with it separate administrative and Federal reporting responsibilities.

There are also a number of barriers related to Medicaid coverage of persons with mental illness. Federal regulations specify that Federal financial participation is only available in institutions for mental diseases (defined as institutions with more than 16 beds[21]) for individuals less than 21 years and 65 years or older. This creates a gap in funding for adults between the ages of 22 years and 65 years (See 42 CFR 441.11). Since, Medicaid home and community-based services waivers are specifically defined as a service option to be used in lieu of institutional care, Medicaid funding that is not available for certain populations (like persons with mental illness) in an institution can not be made available through a Medicaid waiver. Furthermore, in applying for a Medicaid waiver, the State needs to demonstrate cost-effectiveness by comparing costs for the population to be covered in the waiver to the costs of their care in an institution. Therefore, if Medicaid does not cover the costs of institutionalization, there is no cost comparison for the provision of services in the community.

It is also important to consider Medicaid eligibility in general. Individuals covered through the Medicaid program are (in broad categories), low-income families receiving cash assistance (TANF), pregnant women, children, and Aged, Blind and Disabled populations. Therefore, persons with mental illness who do not meet any of the Medicaid categorical eligibility criteria, would not be Medicaid-eligible, and would then also not be eligible for a Medicaid waiver program.

Responsible Agency(ies) and Action Steps. The Indiana Division of Mental Health and Addictions, the Division of Disability, Aging and Rehabilitative Services, and the Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration are responsible for developing and implementing the new Medicaid Waiver for Persons with Mental Illness. The action steps include:

- Evaluation of what services can be made available to address the needs of persons with mental illness and then determine what funding options can be available.
- Evaluation of Medicaid home and community-based services waivers and other Medicaid waivers for persons with mental illness already implemented in other states to determine the best model for Indiana to pursue. Currently, such waivers exist in the states of Colorado, Washington, California, Michigan, Utah, Texas, and Florida. Some of these waivers are 1915 (traditional model) and others are 1115 (demonstration). Each of these has demonstrated a cost savings.[22]
- Completion of a comprehensive fiscal impact analysis by population targeted and the model to be implemented based on research of the above action step. (This waiver will have very different costs depending on the needs of the population; i.e., whether they are dually diagnosed with mental illness/developmental disabilities or mental illness/substance abuse). Particular attention should be spent on the cost savings documented by other state waiver programs (i.e., Colorado).

- Completion of a fully-developed implementation plan, including development of appropriate Memoranda of Understanding between responsible state agencies for the new Medicaid Waiver, if appropriate.
- Depending upon the research performed above, the Medicaid Waiver should include services such as adult day care, alternative care facilities, electronic monitoring, home modifications, non-medical transportation, respite care, personal care, hearing-impaired services, and homemaker services.
- Submit the Medicaid Waiver application to the Centers for Medicare and Medicaid Services for review and approval.
- Determine whether rules will need to be promulgated.
- Promulgate rules as applicable.
- Ensure adequate quality assurance by investigating independent case management services for persons with serious mental illness.
- Secure State Medicaid Match required to support a waiver initiative for both waiver costs and medical (non-waiver) costs.
- Establish and monitor outcome measurements to quantify cost savings, as completed in other states with waivers for persons with mental illness.

Complementary initiatives that should be pursued are as follows:

1. The Division of Mental Health and Addiction should be encouraged to continue its development of a Medicaid Home and Community-Based Services Waiver for Children with Serious Emotional Disturbance, which will target 50 – 200 youth in the community who are or would otherwise be served in a state mental hospital.
2. The Indiana Medicaid Rehabilitation Option should be modified to include supported employment as a covered service. This policy change will assist in ensuring that people with serious mental illness are better supported in retaining community employment.
3. Vocational Rehabilitation Services should work in providing better information about supported employment, which are funded with non- Medicaid dollars and are currently underutilized.
4. The Indiana Family and Social Services Administration should research the educational benefits of the Texas Medication Algorithm, which provides an option to generic drug substitution, as well as, evidence-based practices for adults and children with mental illness and dual diagnosis. Information should be disseminated statewide.

Fiscal Impact. Since this is a new Medicaid Waiver Program, new funding will be needed for the initial implementation. The fiscal impact will be based on service utilization, and the design, development, administration, and oversight of the program. The cost could be considerably mitigated if state funds that are currently supporting other, related services, such as institutional care, were shifted to this program.

In the longer term, as the waiver program grows, there can be expected a cost savings that results from a significantly-decreased rate of institutionalization for these populations, as well as a decreased length of stay.

Targeted Completion Date. The Indiana Family and Social Services Administration should develop a comprehensive fiscal impact analysis that consists of the following:

- The number of consumers to be served by the program, for each of the first two years;
- Detailed administrative costs related to program design and development (i.e., computer system; staffing; other);

- Expected service costs (both waiver and medical services costs), including estimated provider rates, specialized case management, and direct state staff involvement; and
- Detailed administrative costs related to quality oversight and monitoring, including at minimum: state and/or contract staff; case management; long-term care ombudsman; program auditors; and adult protective services.
- The long-term effects of the shift from institutional care to community-based services; i.e., the estimated decrease in, and timing of, state hospital expenditures; when and by how much overall cost savings will occur.

Researching the desired model to be implemented in Indiana should be completed by September 1, 2003. The associated fiscal impact analysis should be completed by no later than November 1, 2003 and be presented at the final Commission meeting in December 2003. It should be accompanied by a comprehensive implementation plan, also due on November 1, 2003.

Finally, a new Medicaid Waiver for Persons with Mental Illness should be implemented *as soon as possible but only after all funding has been identified and all action steps have been completed*.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the institutionalization rates of persons with mental illness
- Increase in the number of persons with mental illness served in the community
- Decrease in the state hospital and acute care hospital readmission rates for persons with mental illness
- Reduction in total state hospital expenditures; increase in per person state hospital expenditures

Problem: Medicare and Medicaid beneficiaries have difficulty in obtaining approval for medically-necessary wheelchair and other durable medical equipment, assistive technology, and timely repair of existing equipment. There is generally no consideration for preventive care in the evaluation of medical necessity, which often leads to costly and painful health outcomes as well as potential limitations or loss of functional independence for the consumer. Written wheelchair and equipment policy generally appears to meet the needs of consumers but may not be implemented correctly or consistently by contracted, regional Medicare fiscal intermediaries or Indiana Medicaid's Fiscal Agent Contractor. Moreover, the consumer's needs are not well-evaluated and coordinated, which sometimes results in the purchase of expensive equipment that can not be used, returned, or replaced. Vendors are sometimes not monitored, and second opinions are not sought, both of which are especially critical since program policy imposes strict limits (time and quantity) on the acquisition of equipment for consumers. Because of these apparently process-related problems, consumers who are dependent upon wheelchair and other equipment and technology often suffer deteriorating health status, loss of employment and/or wages, and displacement from the community.

Action: Medicare and Medicaid wheelchair and equipment coverage policy must be made more flexible to allow for a better evaluation of the consumers needs, consideration of preventive care, and better coordination of vendors.

Target Population. Those who would be affected by this change are Medicare and Medicaid-eligible adults who are frail and elderly and/or have physical or developmental disabilities and/or have mental illness.

Policy Outcomes. Implementation of this Action will significantly increase the consumer's productivity, morale, and quality of life. Since mobility is a basic activity of daily living, consumers who are dependent upon wheelchairs must have safe, reliable, and comfortable wheelchair equipment to allow them to function in the most independent manner possible. Reductions in approval time and processing requirements for wheelchair repair and replacement will positively impact the consumer's general health status, ability to secure and retain outside employment, and overall ability to function. Additionally, better coordination and evaluation of the consumer's needs will reduce and/or eliminate unnecessary expense that occurs when inappropriate equipment is purchased or when policy does not permit a less expensive, more appropriate option.

System Barriers. Since Medicare is a Federal program that is operated by contracted, regional fiscal intermediaries, policies are not always consistently interpreted and applied. Similarly, the Indiana Medicaid Program relies upon a fiscal agent contractor to evaluate and authorize wheelchair and other equipment purchases. As a result, policy concerns expressed by consumers and government officials are not always properly routed and/or responded to, so policy change is very difficult to implement. In addition, consumer outreach is generally poor.

Responsible Agency(ies) and Action Steps. The Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services is responsible for implementing this policy change and/or reissuing wheelchair coverage policies to its Medicare fiscal intermediaries and consumers. The Office of Medicaid Policy and Planning within the Indiana Family and Social Services Administration is responsible for implementing this policy change within the Indiana Medicaid Program.

Action steps include:

- Review and evaluation of wheelchair coverage policies and processes administered by all Medicare fiscal intermediaries and the Indiana Medicaid Program.
- Determination of non-compliant Medicare fiscal intermediaries and policy/process problems within the Indiana Medicaid prior authorization process.
- Evaluation of wheelchair policy modifications necessary to provide preventive care and improve consumer service and health outcomes
- Determination of whether modification of regulations is necessary; drafting and promulgation of proposed regulatory changes
- Implementation of revised regulations, if necessary
- Implementation of policy and/or process changes
- Development of a consumer education protocol that will assist consumers in understanding coverage policies and changes as they occur

Fiscal Impact. The cost of implementing this Action is expected to be minimal, since it appears that Medicare and Medicaid wheelchair coverage policy already appears to meet the needs of consumers but is not being applied properly by the fiscal intermediaries or the Indiana Medicaid Program's fiscal agent contractor. There may, however, be some increase in administrative costs as consumer needs are more frequently evaluated.

Targeted Completion Date. This initiative should be pursued immediately with full resolution occurring by no later than July 1, 2004. If a change in regulation is required, than the proposed regulation should be published in the Federal Register by no later than December 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Decrease in the waiting time for wheelchair and other equipment approvals
- Reduction in processing requirements for equipment and equipment repair requests
- Decrease in total per person equipment expense over a period of time

3.2.2 The following action falls under the responsibility of the Indiana Department of Workforce Development

Problem: There are not enough individuals available who desire and are able to provide personal care attendant services and supports to consumers with disabilities who choose to direct their own care. This need for individuals is especially acute in rural areas. Once personal care attendants are trained and experienced, it is even more difficult to retain their employment. This acute need is expected to increase in the near future.

Action: The Indiana Department of Workforce Development should explore the option to provide benefits to increase the number of and retention of personal care workers. This evaluation should be based on the best practices of other states as well as the recommendations that were made in the 2002 Caregiver Commission Report.

Target Population. Consumers who are affected by this change include persons who are frail elderly and/or disabled. Potential caregivers who are affected by this change include individuals who live in the neighborhoods and communities of the persons needing these services; young adults in high schools and technical schools; and persons employed in low wage jobs without health insurance or other benefits.

*Policy Outcomes***.** Implementation of this Action can be expected to grow, possibly significantly, the number of persons willing to become personal care attendants as well as improve the employment retention rates for persons who already serve as personal care attendants. This increase in provider capacity will directly and positively impact consumers by introducing and/or extending the opportunity to remain in the community, decreasing unwanted institutionalizations (thereby further diminishing the longstanding institutional program and fiscal biases), increasing choice among available providers, and enhancing quality of life. In contrast, this change will likely adversely impact the employment and retention pool of lower-wage workers that are currently employed by home health agencies, nursing homes, and hospitals.

System Barriers. Since the State does not typically include benefits in the reimbursement mechanism for services, the implications of this change on other state programs are currently unknown. The fiscal impact may be significant. Benefits will need to be administered, and there may be no state mechanism currently in place to do so. Computer system modifications may be required. Legislation and/or rule promulgation will need to be drafted and pursued.

*Responsible Agency(ies) and Action Steps***.** The Indiana Department of Workforce Development is responsible for implementing this Action.

Action steps include:

- Identification of any personal care attendant benefits programs developed and implemented in other states.
- Evaluation of the administrative, policy and fiscal implications for Indiana.
- Identification of a benefits administrator and program oversight.
- Development of a benefit package.
- Consumer and provider marketing and outreach.

Fiscal Impact. The fiscal impact is unknown until many of the action steps are completed. It is, however, important to determine both the short-term costs and the long-term costs and implications, since enhancement of the personal care provider pool can be reasonably expected decrease institutional (both acute care hospital and nursing home) costs, thereby generating possibly significant savings over time.

*Targeted Completion Date***.** January 2005**.**

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of personal care attendants
- Increase in the employment retention rates for personal care attendants
- Increase in the number of persons receiving community-based services
- Decrease in the number of persons served in institutional settings
- Decrease in the institutional resident census

3.3 Category: Community Capacity

The following eight (8) actions represent initiatives that specifically focus on opportunities to build upon or improve the services and supports that must be in place for consumers to live safely and successfully in a community-based setting. Those agencies or offices identified as responsible for taking the lead include: the Office of the Governor; the Indiana Family and Social Services Administration; the Indiana Department of Workforce Development; and the Indiana Department of Transportation.

3.3.1 The following two (2) actions fall under the responsibility of the Office of the Governor

Problem: Housing issues for individuals who are elderly or who have disabilities, including mental illness, have not been sufficiently addressed, resulting in limited appropriate, affordable, and accessible housing stock for these populations.

Action: The Governor should appoint a Housing Task Force to focus on the housing issues of the elderly, disabled, and mentally ill populations. Membership should include: representatives of the housing industry, especially builders and contractors who have expertise and experience in new construction; consumers; advocacy groups; legislators; representatives of public/private funding sources; and service providers.

Target Population. Those who would be affected by this change are all low-income persons and families who are at risk, including the frail elderly, persons who are physically and/or developmentally disabled, and persons with mental illness.

Policy Outcomes. Establishment of a Housing Task Force will facilitate a much-needed collaboration among housing and community program and services administrators, providers, and consumers to explore public-private partnerships needed to develop more housing options for the elderly, disabled, and mentally ill populations. The Task Force will further assist the State in formalizing the critical link between availability of safe, affordable, and accessible housing with the community services needed to promote consumer choice and quality of life.

It is important to note that this proposed Housing Task Force differs from the Low Income Housing Trust Fund Advisory Committee (previously recommended to be re-appointed) in that the Committee's primary purpose is to make recommendations to the Housing Finance Authority regarding the identification of long-term sources to capitalize the housing trust fund, including: revenue from development ordinances, fees, or taxes; market-based or private revenue; and revenue generated from government programs, foundations, private individuals, or corporations.

In contrast, the purpose of this Housing Task Force would be as follows:

- To facilitate development of innovative housing options for the elderly, disabled, and mentally ill populations.
- To develop and define specific plan/expected outcomes for housing for these populations.
- To review all state housing plans/programs for duplication of efforts, fairness, and consistency in implementation.

- To serve as a policy and planning advisory group to the Governor on housing issues for these populations.
- To review and provide input into Indiana's State Consolidated Plan (SCP). Beginning in Fiscal Year 1995, the U.S. Department of Housing and Urban Development (HUD) required states and local communities to prepare a Consolidated Plan in order to receive Federal housing and community development funding. The Plan consolidates into a single document the previously separate planning and application requirements for Community Development Block Grants (CDBG), Emergency Shelter Grants (ESG), the HOME Investment Partnership Program and Housing Opportunities for People with AIDS (HOPWA) funding, and the Comprehensive Housing and Affordability Strategy (CHAS). Consolidated Plans must be prepared every five years; updates to the five-year Plan are required annually. The purpose of the Consolidated Plan is:

    1. To identify a state's housing and community development needs, priorities, goals, and strategies; and
    2. To stipulate how funds will be allocated to state housing and community development nonprofit organizations and local governments.

- To review allocation of Community Development Block Grant funds (In 2003, $5 million of $36 million went to housing).
- To develop guiding principles for the funding and operations of all publicly funded housing programs. Building on the framework already established by the Governor's Commission on Home and Community-Based Services Housing Task Force, the following principles should be considered:
    - Consumers should be encouraged and provided the option to own property or have leases in their own name.
    - Support services should be available and with the consumer's choice be coordinated between housing and service providers to assist individuals to remain in their own home.
    - To the extent possible, agencies providing housing shall make every effort to promote consumer choice in the provision of support services.
    - Sponsors are required to ensure that residents have access to any necessary supportive services but cannot require the acceptance of such as a condition of occupancy.
    - Housing should be integrated into the community.
    - Safe, clean, and affordable housing should be available and targeted to individuals with the lowest incomes.
    - Voluntary, 24 hours a day/7 days a week community-based support services should be available.
    - Consumers must be given real choice in the full range of housing options that are also available to individuals without disabilities.

System Barriers. Resistance from interested parties to forming "another" advisory group is likely. It should be noted that no current Governor-appointed advisory group for housing for these low-income, at risk populations is currently in place. The housing needs for these populations are often relegated to "add-on" task forces for other efforts.

Responsible Agency(ies) and Action Steps. The Office of the Governor is responsible for appointing the Task Force. Action steps include: appointing the Task force members; assigning priority to its function; issuing a written list of directive(s) for the Task force members, including expected outcomes with time-lines; developing a progress report expectation; and issuing one or more press releases.

Fiscal Impact. Dedicated funds will be required to staff and administratively support the Housing Task Force. The costs should be comparable to funds dedicated to support other Boards and similar bodies.

Targeted Completion Date. The Task Force should be appointed by no later than September 30, 2003. The first meeting should occur no later than November 1, 2003.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Selection of dedicated, active Task Force members
- The convening of regular and frequent meetings
- Development of a full and meaningful agenda for those meetings
- Development of a tangible and comprehensive housing plan for the State
- Increase in the number of new and expanded housing options for persons with low-income

Problem: Indiana does not have a dedicated state funding source to develop and support safe, affordable, and accessible housing for at risk families and persons who are low-income, elderly, disabled, and/or mentally ill. As a result, housing options are scarce. Of the few community services that are available, many are not geographically, physically, or financially accessible, so persons may be transient and reside in homeless shelters and go without care, or be unnecessarily institutionalized.

Action: The Governor should work with the Indiana General Assembly to establish a real estate transaction fee to be assessed in the transfer of all commercial, farm, and residential real estate. The proposed fee per transaction would be dedicated to the Indiana Low Income Housing Trust Fund. If a local, low-income housing trust fund already exists within a community, one-half of the funds collection from the fee would be transferred to the local fund and one-half would go to the Indiana Low Income Housing Trust Fund for statewide application.

*Target Populations***.** Those who would be affected by this change are all persons and families who are low income ($\leq$ 80 % Area Median Income), including those who are at risk, the frail elderly, persons with physical and/or developmental disabilities, and persons with mental illness.

Policy Outcomes. Implementation of this Action will create dedicated and expanded funding for low-income housing for persons and families who are at risk and persons of low income and who are elderly, disabled, and/or mentally ill. If directed and used properly, additional housing assistance will:

- Facilitate greater independence among consumers;
- Stimulate the housing market;
- Reduce family separation and disintegration;
- Reduce domestic violence/child abuse;
- Decrease dependence and utilization of institutional services;
- Decrease utilization of homeless shelters;
- Reduce incarceration of consumers;
- Increase employment;
- Improve health outcomes;

- Improve quality of life; and
- Assist in fulfilling the charge of the Low Income Housing Trust Fund Advisory Committee.
- Positive impact on property tax revenues

System Barriers. Given the current economic climate and the severe budget constraints that Indiana is experiencing, it will be difficult for legislators to realize the value and importance of imposing a fee and developing a new housing assistance program dedicated to persons with low-income. Success will require the thoughtful compilation of a great deal of information, including relevant data and statistics that profile the needs of the at risk populations, current service utilization and cost data, and that fully evaluates the short- and long-term implications of retaining the status quo and imposing a new fee. A new funding and accounting structure will need to be developed and administered. Management and oversight of the Indiana Low-Income Housing Trust Fund may need to be expanded and/or modified in some way. Potential opposition from certain interest groups is anticipated.

Responsible Agency(ies) and Action Steps. The Office of the Governor will need to take the lead (or assign it as appropriate) to develop and garner support for the imposition of this new transaction fee. Other action steps include, but are not limited to:

- Completion of a comprehensive written analysis (as described in Systems Barriers above) that fully profiles the needs of the at risk populations, the implications of imposing the tax, anticipated outcomes, and cost/fiscal effects to the State in both the short- and long-term.
- Evaluation of the Low-Income Housing Trust Fund composition, structure, management, oversight, and accountability.
- Development of an accounting process to collect the fee and distribute funds.
- Development of a protocol for how the funds will be distributed and used.

*Fiscal Impact***.** The fiscal impact of implementation of a real estate transaction fee has not been fully determined. If, for example the fee were $25 per transaction, based on a previous estimate of 200,000 real estate transactions per year, the fee could generate approximately $5,000,000 annually. Administrative costs would include costs associated with implementing and managing the funds created by this fee. The written analysis described in the Action Steps should include a complete evaluation of the short- and long-term costs and/or savings to the State.

Targeted Completion Date. The comprehensive written analysis of this new fee initiative should be completed by no later than January 1, 2004. Legislation should be pursued during the 2004 Legislative Session, and should become effective on July 1, 2004. The new fee should begin being assessed and collected by no later than September 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Successful legislation that imposes a real estate transaction fee
- Establishment of a collection and reporting mechanism for the fee
- Dedication of the fee to low-income housing
- Increase in the number of new housing initiatives
- Expansion in the number of existing housing programs/initiatives
- Increase in the number of low-income persons who receive housing assistance

3.3.2 The following two (2) actions fall under the responsibility of the Indiana Family and Social Services Administration

Problem: Statewide hourly rates for employment services provided through Indiana's Vocational Rehabilitation Program were established over ten years ago at $36.96 per hour. Since that time, only one rate adjustment has occurred, *and* vendors have had to absorb higher cost to retain and recruit qualified staff. Some agencies have stopped providing employment services due to increased cost and loss of large amounts of revenue-thus resulting in limited availability of timely employment services for those consumers in need.

Action: The current Vocational Rehabilitation Services rate (for supported employment and hourly-based placement) should be adjusted by utilizing a standard rate-setting methodology that includes an annual formula for inflationary increases. This methodology could include an hourly or results-based formula.*

Target Population. Those who would be affected by this change are providers/vendors of supported employment and placement services and consumers seeking employment. The eligibility criteria for vocational rehabilitation services are:

1. The applicant must have a physical or mental impairment;
2. The physical or mental impairment constitutes or results in a substantial impediment to employment;
3. The applicant requires vocational rehabilitation services to prepare for, secure, retain, or regain an employment outcome consistent with strengths, resources, priorities, concerns, abilities, capabilities, and career interests of the individual;
4. The applicant can benefit in terms of an employment outcome from vocational rehabilitation services.

Eligibility criteria for supported employment services are:

1. The applicant must meet three or more functional capacity areas and requires multiple vocational rehabilitation services over an extended period of time;
2. Competitive employment has not traditionally occurred or for whom competitive employment has been interrupted or intermittent;
3. The applicant will require intensive supported employment services from Vocational Rehabilitation Services with follow along services from the provider.

Policy Outcomes. By increasing the rate paid to providers/vendors to a competitive level, providers would be better able to attract skilled professionals that offer specialized employment services to individuals who have the most significant disabilities. Consumers would be better trained to secure and maintain employment in the community in integrated settings, would achieve greater independence, and would contribute to the common good of the community. Consumer reliance on public assistance may be reduced, health outcomes and quality of life will improve, and unnecessary institutionalization will be minimized or avoided altogether.

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* Note: The Results-Based Funding work group recommendations to move toward results-based funding may be implemented and would supercede this recommendation.

System Barriers. Depending on the amount of additional funds needed to support this rate increase, the Indiana Family and Social Services Administration may attempt to fund this rate increase in an undesirable way by reducing the number of persons served, rather than by seeking additional funds. Computer ***s***ystems will need to be modified to accommodate the new rates. Providers and consumers will need to be notified of the rate changes.

Responsible Agency(ies) and Action Steps. Vocational Rehabilitation Services, the Division of Disability Aging and Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for implementing these changes.

Other action steps include the following:

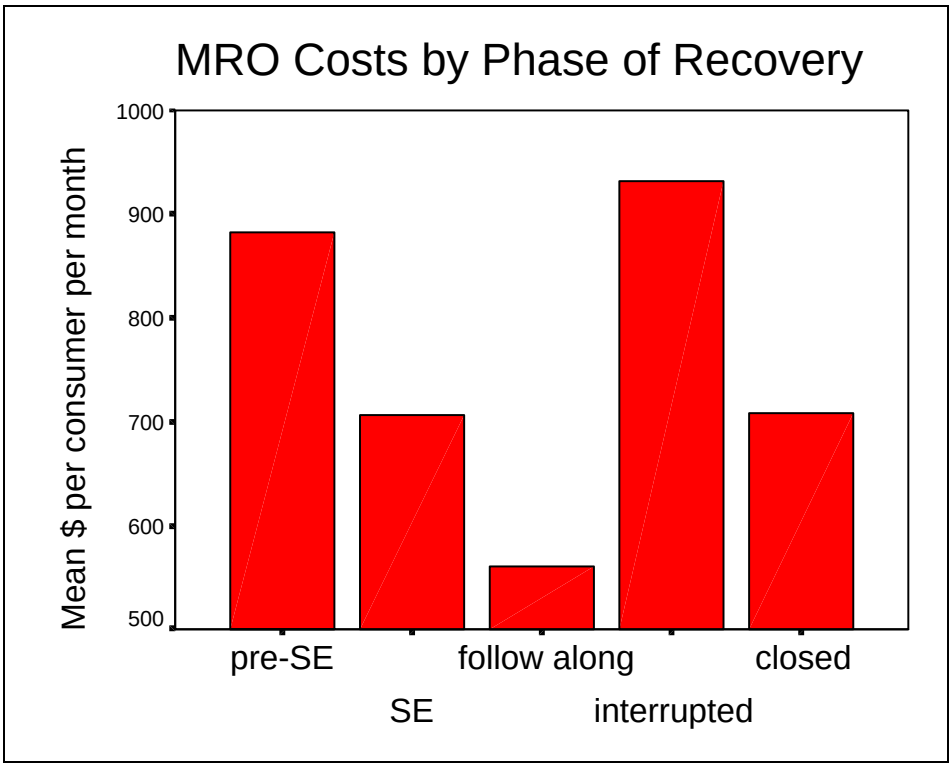
- The existing Results-Based Funding work group should complete work and make recommendations.
- Division of Disability Aging and Rehabilitation Services must complete a review and comparison of the current vocational rehabilitation rates to similar rates in other Indiana programs and/or to similar rates to programs in other states.
- Division of Disability Aging and Rehabilitation Services must determine further rate changes and implementation processes that are necessary to implement a standardized rate methodology
- Providers and consumers will need to be informed of the rate changes and any applicable changes in the billing process.
- Computer system modifications will need to be designed and implemented.

Fiscal Impact. The cost of implementing this change will depend upon the rate study findings and the impact of a rate change on other programs within Division of Disability Aging and Rehabilitation Services (i.e., BDDS) that purchase similar services and have the same eligibility criteria as vocational rehabilitation services. While initial start-up costs are certain, it is important to note that *for every dollar spent on vocational rehabilitation services, a consumer earns $13.00 in increased taxable earnings. The cost of vocational rehabilitation is paid back in taxes in two to four years.*[23] Increased employment may also have a positive impact on the tax base, Medicaid, residential programs, and the Medicaid Rehabilitation Option (MRO). Please see the graph provided below.[24] Finally, Indiana needs to continue to work with the state legislature to secure all of the available Federal funding for vocational rehabilitation services by providing the necessary state match (21.3%) to secure and draw down Federal funds.

Targeted Completion Date. The rate study should be completed by no later than January 1, 2004. Identification of funds should occur immediately thereafter, with changes in the rate methodology occurring by no later than July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number and type of specialized employment services.
- Increase in the retention rates of employed consumers.
- Increase in the number of consumers employed in integrated employment settings.
- Decrease in institutionalization rates of employed consumers.
- Increase in consumer satisfaction.



The above graph presents the mean dollars per month billed to Medicaid Rehab Option funds for SE consumers at Indiana mental health centers from 1997-2000, as a function of the stage of vocational recovery consumers were in. That is, in the 3 months prior to beginning SE, consumers averaged about $900 per consumer per month billed to MRO. During active SE (job development, initial months of work) consumers averaged about $700 per consumer per month billed to MRO. During follow-along (a stable phase of continued work) the average billed to MRO was about $550 per consumer per month. For those consumers whose vocational recovery was interrupted (due to relapse or other setback), there was an average of about $950 billed to MRO per consumer per month. Finally, consumers closed from all vocational support required about $700 of MRO-supported services per month.

Problem: Indiana uses multiple funding streams, including its CHOICE program, to provide services and supports to older Hoosiers and persons with disabilities who are at risk of losing their independence. Availability and funding for services is often inconsistent across programs even though the services needed are the same. Competition for individuals who provide these services also varies between some rural and urban areas.

Action: The Indiana Family and Social Services Administration should develop a standardized, statewide rate ceiling for similar services provided. This should be established across all programs and be based on (or be responsive to) the actual cost of services being provided.

Target Population. Those who would be affected by this change are persons who are frail and elderly and/or disabled and are at risk of losing their independence or are living in more restrictive settings but are able and willing to live independently.

Policy Outcomes. Implementation of this action will increase the number of providers willing to participate in the Medicaid waiver and other public assistance programs. This increase in the provider base will stimulate consumer choice of providers and should as a result improve service quality.

*System Barriers***.** There may be individual program and funding limitations established by statute and/or rule that make rate standardization with other programs difficult or impossible to implement without formal modification (either by legislation or through the rule promulgation process). Multiple computer systems will need to be modified, which may be complex and/or time-consuming. For community-based providers, there is no established method for collecting historical cost information and calculating payment rates based on cost, thereby a new methodology will need to be developed and implemented. Standardization of payment rates may require some rates to be lowered and some to be raised, especially given the current state budget limitations, which may generate provider objections. Evaluation and comparison of all similar services and corresponding payment rates may be resource-intensive for state staff and thereby generate resistance.

Responsible Agency(ies) and Action Steps. The Division of Disability, Aging and Rehabilitative Services, the Division of Mental Health and Addiction, the Office of Medicaid Policy and Planning, and the Division of Vocational Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for implementing this Action.

Action steps include:

- Identification of all state programs that have similar services.
- Evaluation of the payment rates for each service.
- Evaluation of any program limitations that prescribe payment levels (i.e., mandated in statute and/or rule).
- Development of a cost collection process and a payment methodology that uses provider costs to determine rates.
- If applicable, development of proposed legislation and/or promulgation of a rule change.
- Evaluation and modification of compute system changes.
- Coordination among all state agencies to establish initial standardized rates and to modify rates in all programs simultaneously as future changes occur.

- Educational outreach to providers and consumers.

Fiscal Impact. The administrative costs associated with this change will depend upon the computer system and process changes that are needed, as well as the staff and possibly contract resources that will be devoted to evaluation of multiple program services and payment rates and development and implementation of a cost collection/identification process and rate-setting methodology. Program costs will depend upon the availability of funds. If no new funds are made available, then rate standardization will create an undesired outcome by reducing all rates to that rate that represents the maximum allowed by the program; this will actually produce an undesired cost savings. If no new funds are made available but rules and other statutory limitations are modifications, then standardization could be implemented in a cost neutral way by raising some rates and lowering others.

Targeted Completion Date. January 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of participating providers.

3.3.3 The following two (2) actions fall under the responsibility of the Indiana Department of Workforce Development

Problem: Collaboration between employment initiatives and the private sector has been limited in the past. Indiana is lacking sufficient public/private sector partnerships and other collaborative employment initiatives that facilitate employment support for consumers in need of assistance in securing and maintaining gainful employment. As a result, consumers have limited opportunities to successfully work in integrated employment settings within the community.

Action: A Business Leadership Network should be developed in Indiana to establish and further strengthen the link between business and employment at the local and state levels. Business Leadership Networks assist employers by exploring methods to more effectively recruit, market and hire the talents of job applicants with disabilities. Business Leadership Networks have been developed across the country as part of an initiative started by the Office of Disability Employment Policy (ODEP) and supported by the U.S. Chamber of Commerce. Formation of a Business Leadership Network in Indiana will potentially expand employment opportunities for individuals with disabilities and/or mental illness. A similar effort has been successfully replicated in 38 other states.

Target Populations. Those persons affected by this change include individuals with a disability who are seeking employment.

Policy Outcomes. Implementation of this Action will expand awareness of the value of the available labor pool of individuals with a disability and/or mental illness, increase collaboration between providers/vendors and local/state employers, and increase employment outcomes for people with disabilities in unsubsidized employment. In addition, an expanded awareness of consumer needs on behalf of businesses and community employers would be facilitated.

System Barriers. Administrative considerations are the only significant barrier identified. Participation of local chambers of commerce and community business leaders will be required for the success of these networks.

Responsible Agency(ies) and Action Steps. The Indiana Department of Workforce Development, in cooperation with the State Human Resources Investment Council and the Division of Disability, Aging and Rehabilitation Services and the Vocational Rehabilitation Division within the Indiana Family and Social Services Administration are responsible for this Action. The specific action steps are currently dependent on grant funding. The intent of the grant as written is to "tie" funding to participation in the Workforce Investment Boards (WIBs). If grant funding is secured, a community business leader would need to be identified in order to proceed with development of the Business Leadership Network. There are Business Leadership Networks that have been established in Indianapolis and Evansville; both resources should be utilized when developing and implementing others.

Fiscal Impact. The costs associated with this Action are expected to be minimal and related only to administrative changes/activities (facilitation, start-up, etc.). The Indiana Department of Workforce Development is currently pursuing a Federal grant to support development of such a network and will seek alternate funding, possibly through expanded partnering in the business community, if the grant is not awarded.

Targeted Completion Date. This Action should be implemented by no later than January 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of participating local chambers of commerce and community business leaders
- Increase in employment and retention rates of persons who are disabled
- Increase in the number and type of employer/provider partnerships

Problem: Indiana has no state-wide employment standards for staff qualifications, outcomes, and provision of services. As a result, employment services for persons with disabilities and/or mental illness are inconsistent, staff training may be insufficient, and consumer outcomes are not always favorable. This lack of standards severely limits the consumer's opportunity to achieve maximum independence and quality of life. Without the necessary supports, successful, integrated employment becomes difficult and/or impossible to achieve. While CARF accreditation is required for all Vocational Rehabilitation Services (VRS) vendors/providers, the standards are not considered stringent enough to achieve the outcome of improved service to the client.

Action: Employment standards for staff qualifications, outcomes, and provision of services should be developed to ensure a level of professionalism in the delivery of employment services to individuals who are disabled and/or mentally ill. VRS should modify and require that all vendor/provider contracts include language that ensures compliance with the standards as they are developed.

Target Population. Those who are affected by this change are individuals who have a physical and/or developmental disability and/or mental illness.

Policy Outcomes. Professional development and standards compliance within all agencies offering employment services would enhance the quality of services delivered. Employment staff who are highly trained in the development and provision of employment services will have the skills necessary to facilitate the development of effective person-centered plans with consumers. The staff will also possess the sophisticated marketing skills and techniques necessary to develop job openings with employers. Working knowledge of the Americans with Disabilities Act, assistive technology, and reasonable accommodations will be enhanced, thus providing additional strategies when working with new employers.

System Barriers. Successful implementation of this recommendation will require identification of the agency responsible for oversight of standard implementation. There may be additional costs imposed upon vendors/providers. In addition, associations/advocacy groups might perceive the development of standards to be an encroachment on current professional educational/licensure requirements.

Responsible Agency(ies) and Action Steps. The Division of Disability, Aging and Rehabilitation Services and Vocational Rehabilitation Services within the Indiana Family and Social Services Administration are responsible for implementing this Action. Action steps include: the development of standards and an implementation process that includes all stakeholders; the promulgation of administrative rules; and collaboration with vendors/providers to provide education outreach and training.

Development of the standards will require a team of interagency partnerships with Vocational Rehabilitation Services, Department of Labor, Indiana Workforce Development, Department of Education, Division of Mental Health and Addictions, as well as other entities that have expertise in the area of employment (such as the Indiana Institute on Disability and Community, the Supported Employment Consultation and Training Center, Indiana Association of Rehabilitation Facilities (INARF), and the Indiana Council of Community Mental Health Centers). Upon completion of the standards, their incorporation into all contractual agreements/Purchase of Service Agreements offered by the State to vendors wishing to provide employment services should be required.

Fiscal Impact. Costs associated with this Action are expected to be primarily administrative in nature, and thereby minimal. A positive impact of this is that with increased skills, employment outcomes would be enhanced through a more effective job training experience. A favorable impact on job retention and employer satisfaction would be expected, thus minimizing the costs associated with retraining due to turnover.

Of note is concern that requiring high skill levels on behalf of vendors/providers may necessitate similar requirements in state agency staff. Consideration should be given to assure equity across state agencies relative to training and experience requirements for given state agency positions. For example, inequity in the Department of Workforce Development and Vocational Rehabilitation Services positions may create negative changes in the work environment at Work One Centers.

Finally, attention should be given to the need to manage costs by assuring that costs to small providers are not so prohibitive that competition is limited, thereby negatively impacting consumer choice.

Targeted Completion Date. Provider standards should be implemented by no later than July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Improvement in the quality of services provided (determined by surveys, etc.)
- Increase in the number and type of job opportunities for persons with disabilities

3.3.4 The following two (2) actions fall under the responsibility of the Indiana Department of Transportation

Problem: There are seven Public Transportation Corporations (PTCs) in Indiana that provide a combination of fixed route and demand-responsive, accessible transportation service to the general public. The seven PTCs are located in Bloomington, Fort Wayne, Gary, Indianapolis, Lafayette/West Lafayette, Muncie, and South Bend/Mishawaka. The PTCs are municipal corporations created by city council ordinances, and are governed by a board of directors appointed by the city councils and mayors of their respective urban areas.

The Office of the Attorney General has strictly interpreted the statute that establishes these entities (I.C. 36-9-4) and has determined that PTCs are not permitted to provide service outside of their taxing districts. Five PTCs have corporate boundaries that extend one mile outside the city limits plus one additional mile for every 50,000 in population, or major fraction thereof, in the municipality (IC 36-9-1-9(b)). The service district of the Indianapolis PTC (IndyGo) extends to the Marion County line. The service district of the Bloomington PTC (Bloomington Transit), and any other PTCs created after 1982, is limited to the city's corporate limits with no fringe. The Indiana Code was amended in 1982 and no PTCs have been created since then. This creates a problem because the PTCs are prohibited from providing consumers with transportation services needed to access medical and social service appointments and shopping centers that have moved out of the urban taxing district. This severely limits access to essential services for at-risk populations.

Action: The statute that currently limits the service area of a Public Transportation Corporation (PTC) to its taxing district should be reviewed by the Indiana Office of the Attorney General, and, if necessary, amended by the Indiana General Assembly to allow for the provision of the most efficient and effective transportation options for all Hoosiers.

Target Population. Those who would be affected by this change are all persons who utilize the services provided by PTCs, especially low-income persons who are elderly and/or have disabilities or mental illness. I.C. 36-9-4-10 specifies that a PTC is created by an ordinance of a municipal legislative body, or a city council. Current law does not allow for the creation of a PTC in a rural area.

Policy Outcomes. Implementation of this Action will allow public transportation providers to provide critical services to expanded areas within urban communities. This will improve access to both essential and non-essential services for all persons who use public transportation, but especially to low-income elderly and persons with disabilities and/or mental illness. Better

access to needed services will likely positively impact health outcomes of at-risk persons, since transportation will no longer be a barrier to receiving necessary healthcare, and it will improve the likelihood that at risk persons will seek and retain employment.

System Barriers. This change may provoke resistance from the private transportation industry and opposition from city businesses and residents against taxing and spending outside of their district. There are many private bus operators who object to any public operator providing service to anyone, anywhere, because they are using equipment that is subsidized with taxpayers' money and/or using tax funds to pay operating assistance. There have been intense discussions, lawsuits, and legal battles for decades over the issue of public operators providing charter service. The private charter operators object on the grounds that it is unfair competition. In some cases, it is legitimate competition, however, in many cases, the trips would never happen if the public operator did not provide the service because the requesting organization cannot afford the higher rates charged by the private operators.

It is possible that the Attorney General will not agree to a complete review of the statute, or that their review will continue to conclude that the service area is limited. If either of these outcomes occurs, then legislation to amend the statute should be drafted and pursued.

Responsible Agency(ies) and Action Steps. The Indiana Office of the Attorney General and the Indiana Department of Transportation (INDOT) share responsibility for implementing this Action . Action steps include:

- Request that the Attorney General review the previously-issued legal opinion regarding service area limits.
- Request that the Attorney General issue an opinion regarding the previous interpretation.
- If the Attorney General issues a revised opinion stating that the Public Transportation Corporations may go outside their taxing districts, then expanded transportation may occur immediately.
- If the Attorney General issues a revised opinion stating that the Public Transportation Corporations may not go outside their taxing districts, then INDOT will need to develop, promote, and pursue a legislative proposal to expand the service areas.
- Educational outreach and training of consumers and providers will be required.
- INDOT should examine the funding formula for rural transit providers to assure that access to public transportation for Hoosiers in rural and suburban areas is not diminished

Fiscal Impact. There is no anticipated fiscal impact associated with this Action . If the Attorney General decides that a PTC can go outside of their taxing district, increased expenses for the urban provider could occur. If there are rural providers close to the PTC, decreased income from fewer trips provided could also occur.

Cities might actually benefit from more service beyond its taxing district because city residents could access employment opportunities beyond their boundaries and then bring their salaries and their ability to pay taxes back into the city.

Targeted Completion Date. Should the Attorney General agree to review the relevant statute, the review should be completed by January 1, 2004. If necessary, legislation that amends the geographic service areas of the PTCs should be introduced during the 2004 legislative session, with an effective date no later than July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of persons with disabilities who utilize public transportation.
- Decrease in the number/percentage of missed healthcare appointments for persons with disabilities.
- Increase in the employment and employment retention rates of persons with disabilities.

Problem: There is insufficient public mass transit available in Indiana, especially in rural communities. This lack of available transportation services disproportionately impacts the low-income population, particularly persons who are elderly and persons with disabilities and/or mental illness. Transportation is essential for meeting basic healthcare, social, and employment needs. Lack of transportation is another barrier that contributes to institutional bias, since it significantly hinders an at-risk consumer's ability to receive necessary services and supports in the community.

Action: Funding for public mass transit should be increased so that all citizens have access to adequate, affordable, accessible public transportation.

Target Population. Those who would be affected by this change are all persons who utilize the services provided by public mass transit, especially low-income persons who are elderly and/or have disabilities or mental illness.

Policy Outcomes. Implementation of this Action will allow public transportation providers to provide critical services to expanded areas within Indiana. This will improve access to both essential and non-essential services for all persons who use public transportation, but especially to low-income elderly and persons with disabilities and/or mental illness. Better access to needed services will positively impact health outcomes of at risk persons, since transportation will no longer be a barrier to receiving necessary healthcare, and it will improve the likelihood that at risk persons will seek and retain employment.

System Barriers. Since Indiana has many rural communities, public mass transportation is not able to operate cost-effectively and efficiently. Therefore, innovative approaches to providing public transportation in these areas are essential. Public transportation in urban centers within the State need to be designed (or re-designed), implemented and monitored to assure adequate access to and safety of persons who are elderly and who have disabilities and/or mental illness. There is currently in place a moratorium for the funding of feasibility studies and operating assistance for new systems, therefore little evaluation of transportation systems has occurred. Nevertheless, the demand for service in areas without transit service and the demands to increase service in areas with limited transit service far exceed the limited growth of Federal funding and the stagnation of any growth in state funding over the last few years. The combination of inflation, no growth in funding, and the addition of 17 new systems over the last few years has had a negative impact on existing systems.

The Indiana Department of Transportation (INDOT) has traditionally been devoted to highway construction, and while it has greatly increased its interest and role in public transit, rail, and aviation, it is still dominated by highway interests. As a result, it is not likely that INDOT would take the lead in using any new gas tax revenues for public transportation.

Responsible Agency(ies) and Action Steps. The Indiana Department of Transportation is responsible for implementing this Action. Action steps will include:

- Completion of a study of the use of Surface Transportation Project (STP) funds, Congestion Mitigation & Air Quality (CMAQ), and other funds to determine how those funds can enhance public transportation. The study should include a comparison of Indiana to other states.
- As the gas and/or sales tax increases, INDOT should develop draft legislation that will increase the Public Mass Transportation Fund (PMTF) share.
- Communities with approved public transportation feasibility studies should receive start-up and operating assistance.
- Willing/interested communities without feasibility studies should be provided assistance by INDOT to complete feasibility studies.
- Regarding funding opportunities, increasing existing sources appears to be the most effective method in which to gain monies. At the state level, this could be achieved by either increasing the PMTF share of sales tax revenue, or by using part of gas tax increases to enhance the PMTF. A legislative proposal at the Federal level, known as the Transit Needs Adjustment Initiative, is underway that INDOT reportedly supports. It addresses equity in distribution of the share of Federal gas tax that goes to public transportation. It would guarantee a return of 95% and if passed, would mean an increase for Indiana. If it had been in effect in 2002, Indiana would have had a 68% increase in Federal funding for public transportation.

*Targeted Completion Date***.** INDOT should complete the study of possible funding sources by no later than January 1, 2004. If necessary, a legislative proposal should be drafted and pursued during the 2004 Legislative Session that will expand funding for public mass transit, with an effective date of no later than July 1, 2004.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

- Increase in the number of persons with disabilities who utilize public transportation.
- Decrease in the number/percentage of missed healthcare appointments for persons with disabilities.
- Increase in the employment and employment retention rates of persons with disabilities.

3.4 Category: Children at-Risk

The following two (2) actions represent changes that are specifically targeted to improve and/or expand upon the service delivery system for children who are at risk and their families. Those agencies or offices identified as responsible for taking the lead include the Indiana Family and Social Services Administration and the Office of the Governor.

3.4.1 The following action falls under the responsibility of the Indiana Family and Social Services Administration

Problem: Currently, fewer than 20% of Indiana children who are at risk (See attached graphic within this Action) of long-term, out-of-home placement are served by an organized and unified system of care. This creates an inconsistency in how children's needs are addressed by professionals within the various service systems in which children and their families are involved. Often children are involved in two or more of these public service systems, and children and their families experience complex, overlapping and even contradictory "treatment plans" that are physically, mentally and emotionally exhausting. In addition, the services provided to the child and family often do not meet their needs, are unnecessarily costly, and result in less than desirable, long-term outcomes.

Action: The Family and Social Services Administration should assist each Indiana community to implement an integrated and unified system of care that is organized to respond to the needs of children who are at-risk of long-term out of home placement.

A system of care is a "comprehensive spectrum of services and supports that are organized into a coordinated network to meet the multiple and changing needs of individuals and their families." The infrastructure would be designed in each community, but the core values and principles of a system of care that serve as the foundation of the network and service delivery would be consistent statewide. The system of care should be child and family focused, community-based, and culturally competent. Individualized care that matches the needs of the child and the family with services and supports would be provided in the least restrictive setting through a comprehensive array of services. Integrated across child service systems, services would include case management and care coordination, early identification and timely transitions to eliminate a break in services. Current individual systems of services must be coordinated and organized to promote this system of care concept. Whereas an overall policy direction and the expected outcomes for children and families served by the system of care should be established at the state level, the development and implementation of the system of care must be accomplished by and through the leadership and strengths of each local Indiana community. Services provided within the framework of an organized system of care must be based upon the specific strengths of the family and the child who is at-risk of out-of-home placement.

Target Population: Those who would be affected by this change are children and their families who may be "at-risk", "at imminent risk" or "in risk" status as illustrated in the attached diagram and definition of terms.

Policy Outcomes: A unified system of care is a common-sense approach to children's services that promotes the healthy development of a child's physical, mental, emotional, behavioral, and academic development. It suggests a new way of thinking about services and, when designed properly, consists of a comprehensive array of services that is organized into a coordinated network to meet the needs of children and their families. One of the unique hallmarks of the presence of a system of care is an integrated and single cross-agency service plan for each child and family. It includes a menu of home and community-based services, residential placement, and respite care and involves formal and informal supports and services that are chosen by the family, not simply through input, but by deliberate and informed decision-making. It is an approach that is child-centered, family-focused, community-based, and culturally competent with all services

individualized in the least restrictive environment. A system of care is not a process, a model, or a program. It is a framework that can be used by individual communities based upon that community's special needs, resources, collaborations, and existing service delivery systems to develop a full array of services to meet the needs of children and their families. The replication or transfer of a system of care from one community to another is impractical as a system of care must be developed within a consistent conceptual framework but specifically tailored to the unique qualities and strengths of individual communities. Information and education about the specific meaning of a system of care must be offered by the Family and Social Services Administration in conjunction with other state agency partners, and must precede local implementation

In addition to the outcomes described above, services provided within the scope of a system of care will:

- Decrease the number of costly long-term, out-of-home placements;
- Decrease the length of time a child is in out-of-home placements;
- Allow funds to be used more efficiently; and,
- Re-direct funds more toward prevention and early intervention services without endangering funding for current services and interventions.

System Barriers. Emphasizing the strengths of each Indiana community as well as the various existing service systems and organizing them into a meaningful array of services based upon the principles of a system of care can be the basis for overcoming any impending system barriers. Implementation of this Action will require the establishment of a partnership between the Indiana Family and Social Services Administration and a number of state agencies and entities, community leaders, and children's service providers. Strong leadership and commitment will be required to balance the interests of all parties, design a viable and fully-functional system of care and establish and implement a successful and fully-accountable evidence-based system approach. Changes in computer resources will be necessary, and multiple funding streams will need to be evaluated and carefully selected and utilized to maximize Federal reimbursements. State staff may have difficulty in promoting and accepting change. The affected population will have to be closely monitored to assure that they are not adversely impacted during periods of transition and system change. Educational and training protocols will need to be developed and implemented for all stakeholders.

Responsible Agency(ies) and Action Steps. The Indiana Family and Social Services Administration will take the lead on this initiative. Other primary stakeholders will include: the Indiana Department of Education; the Indiana Department of Health; the Indiana Judicial Conference; the Indiana Judicial Center; the Indiana Department of Correction; the Criminal Justice Institute; community leaders; and children's service providers. The state partners must model, promote, and enhance the coordinated approach expected of local collaborative efforts in order to meet the outcomes expected for children and families served by a system of care. It is imperative that an organized system of care is understood consistently through a clear communication of statewide policy and uniform training, is developed locally with a common shared vision, and that continuous quality improvement and evaluation is based upon impartial research. Existing appropriations must be fully maintained and the provision of services to "in-risk" and "at imminent risk" children must not be jeopardized, reduced, transferred or re-directed to pay for new systems development for earlier intervention or prevention services.

The policy direction for the development and implementation of an organized system of care must originate as a state priority initiated by the Governor. His vision must be communicated

clearly throughout state government and local communities so that the Governor's policy is consistently understood but implementation of the policy is managed locally within the framework of the policy by local juvenile justice, child development, academic, mental health and child welfare professionals in collaboration with families. The Governor also should establish a committee of appropriate agency heads to implement and be accountable for the system of care concept and to resolve inter-agency policy conflicts that will be identified as the system of care is implemented. The committee of agency heads should be responsible to provide statewide input into national strategies and discussions on systems of care, resolve emerging system development issues, provide promising practice information, offer technical assistance to local communities and provide the forum to determine what components of implementation should be consistent or standardized statewide and which should be left to the discretion of the local community. The inter-agency effort should have dedicated staff support to ensure effective policy analysis, data collection, and processing of policy changes and interpretations.

Other action steps that the Indiana Family and Social Services Administration must pursue are as follows:

- A plan must be developed that identifies time-lines, necessary actions, and responsible agencies for statewide implementation of the system of care concept;
- Memoranda of Agreement must be developed and implemented by state and local agencies that identify specific roles in the development, implementation and management of the system of care;
- Training must be developed that consistently communicates the definition and philosophy for a system of care and the implementation strategy for Indiana's system of care vision, both for families who are involved in public systems and for the workers providing and managing the services in the system. Training must help families understand the system of care concept so they are confident in the understanding of the concept and thereby building trust among the families, the service providers and the agencies involved in the system of care;
- System-of-care training must endorse and promote cross-training among appropriate agencies, including child welfare, juvenile justice, mental health, child development and schools;
- Development of fiscal policy that provides an incentive to courts, probation departments, child protective services, child development providers, educational professionals and service providers to maximize appropriate home-based and community services when appropriate and encourages the advancement of prevention and early intervention services, as well as continuous quality management;
- Development of consistent and coordinated needs and service assessments in the juvenile justice, child protective and educational systems that assess a child's safety, assess how well services are matched with the child's and family's needs that set the framework for a single coordinated plan that reduces the need or likelihood of long-term, out-of-home placement. Assessment practices avoid repeated interviews and surveys that yield limited additional information.
- Application for and full implementation of waivers from the Federal government must be pursued, implemented, and fully utilized, including the waivers for the IV-E program, the home and community-based services waiver and the Medicaid Rehabilitation Option (to eventually include not only partnerships with licensed child placement agencies, but also independent providers);
- Administrative funds and reimbursements through the IV-E program and other Federal programs must be maximized to provide the cash flow needed to bring about these systemic changes without increasing program budgets as current systems of services are developed into an organized and unified system of care;

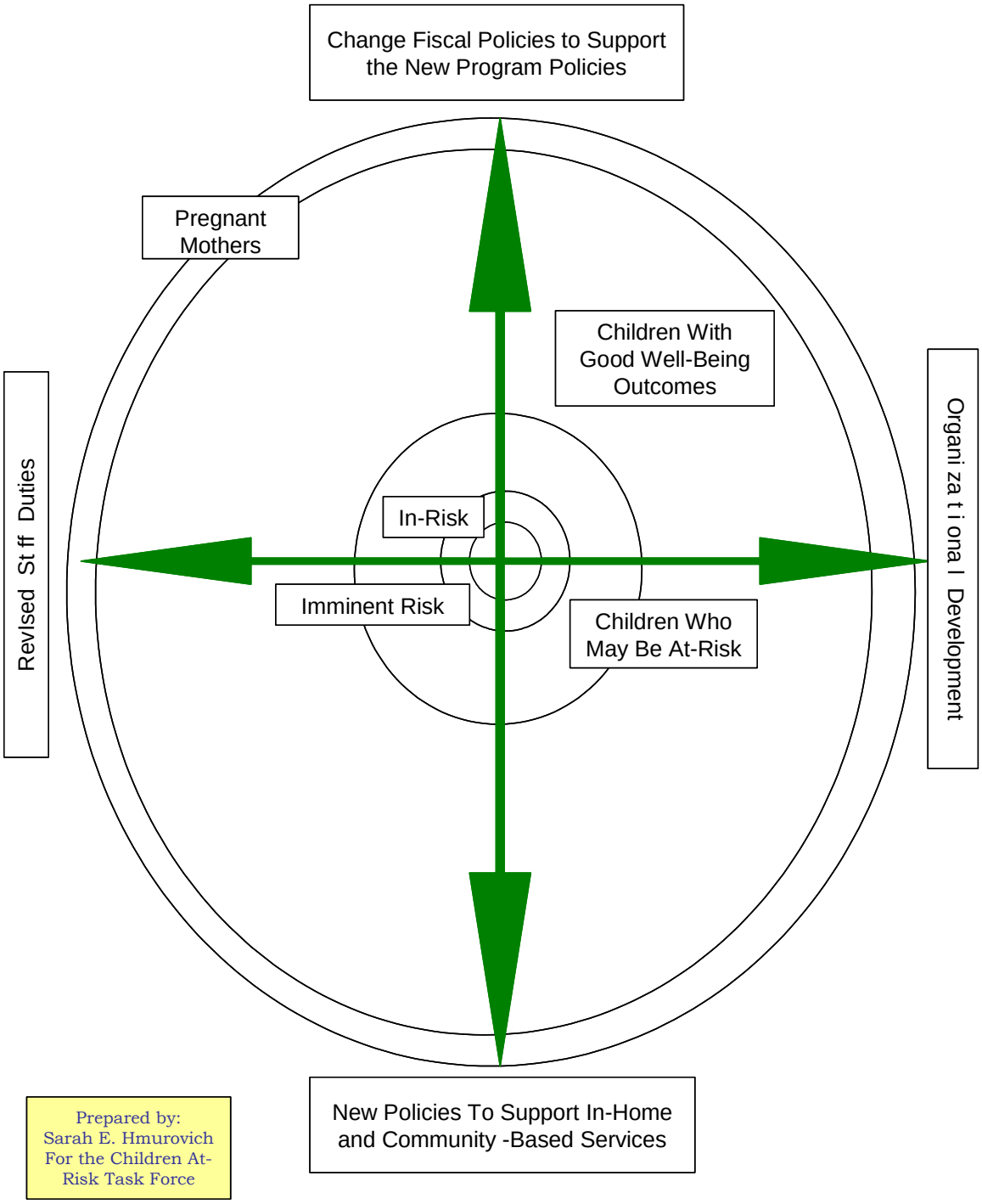
- Enhancement of automated information systems that serve children in the various service systems must be enhanced to provide better coordination of information and more efficient management of services for children in two or more of the systems;
- Consistent implementation of service, case management and eligibility definitions as well as policies concerning the management of information across state and local agencies;
- Collaboration and cooperation among the agency's three service divisions and with other state agencies that provide services to children including quality assurance reviews in the delivery and management of the services based upon recognized performance standards;
- Development and implementation of an automated accounting system that provides the controls and accountability expected by taxpayers for the expenditure of public funds and that provides a platform for state and local agencies to "pool", "braid" or "blend" local, state and Federal dollars, even those not commonly known or used, to maximize cost effectiveness;
- Codification of "best practices" that are available on a website and on-going communication and training processes must be established to provide technical assistance to communities as these organized systems of care are developed;
- Prioritization of evidence-based "best practice" standards so: 1) funds are not removed from other under-funded services; 2) dollars saved through efficiency and better management of services are re-directed to other needed child and family services; and, 3) some administrative savings are realized and used for third party evaluation of the new system to avoid unintended consequences;
- Development of Medicaid funding streams that can enhance appropriate services in schools, local health departments and health facilities;
- Promotion of community capacity in all areas of the state, specifically in the more rural areas that currently may have gaps in the full continuum of children's services.
- Expansion of university and internship programs for psychologists, social workers, educators and other service professionals in conjunction with institutions of higher education and the system of care philosophy should be included in the educational curricula of these professionals;
- Identification of expanded outcomes for the successful implementation of the system of care must be monitored and tracked on an on-going basis in an effort to identify appropriate agency and staff competencies and to serve as the impetus for continuous quality improvement. This will allow Indiana to measure its progress toward a fully integrated system of care;
- Evaluate outcome data against baseline data that is collected for June 30, 2003; and,
- Legislate and implement workload standards that provide adequate time for workers in mental health, child welfare, juvenile justice, schools, and developmental disability areas to work with children and their families.

Fiscal Impact: It is anticipated that the cost of this systems change can be managed within existing state and local budgets, provided: a) Federal program and administrative reimbursements and waiver approvals are maximized, b) thoughtful and deliberate efforts are managed to re-direct appropriate "high cost" out-of-home placements into safe and meaningful community and home based alternatives so as to create necessary cash flow, and c) duplication of efforts in eligibility determination and other administrative inefficiencies are eliminated.

Targeted Completion Date: Every child at-risk of a long-term out-of-home placement will be served by an organized system of care by June 30, 2007.

Benchmarks for Measuring Success. Please refer to the Benchmarks established for the Action listed in Section 3.4.2.

Defining the At-Risk Child



DEFINING THE AT-RISK CHILD

I. Pregnant Mothers (Prenatal) At-Risk Indicators
1) Tobacco use
2) Alcohol and drug use
3) Lack of healthcare visits in the first trimester
4) Nutrition/diet quality/food insecurity
5) Pregnancies too close together
6) Un-married teen pregnancy
7) Low Birth Weight
8) Housing stability
9) Employment stability

II. Child Well Being Outcomes
1) Living in financial security
2) Housing stability and security
3) Continuous healthcare
4) Nutrition quality/food security
5) Current immunizations
6) Regular well baby visits
7) A family which reads to the child
8) Affordable and quality childcare
9) Support from extended family or friends

III. Children Who May Be At-Risk:
1) TANF recipients
2) Food stamp recipients
3) Free and reduced school breakfast and lunch recipients
4) Baby born to a mother under 20 with no high school diploma
5) Sibling arrest
6) Sibling who is a victim of abuse or neglect
7) Stressfulness in the social environment
8) Parent-child separation
9) Lack of parent and child bonding
10) Family economic stress
11) Loss of insurance, insurance that does not cover a specific condition or insurance with high co-pays
12) Lack of access to healthcare
13) Criminal arrest in family
14) Parent incarcerated
15) Neighborhood disorganization (crime, gangs and drugs)
16) Parental abuse of drugs and alcohol
17) Children of parents with serious mental illness or developmental disabilities
18) Children with autism or serious emotional disorder

IV. Children At Imminent Risk:
1) Victim of abuse, neglect or other crime
2) Truancy and academic failure
3) Delinquent act
4) Child use of drugs or alcohol
5) Probation or parole violation
6) Children aging out of the foster care system

V. Children In-Risk:

1) Children in state operated facilities
2) Commitment to the Department of Correction
3) Children in-patients in private hospitals with private pay
4) Children in private detention and treatment centers
5) Parole Violators

VI. Organizational At-Risk Indicators:

1) Lack of appropriate workload standards
2) Absence of or inadequate staff orientation and training
3) Lack of child and family needs assessment
4) Lack of needed agreements among service providers
5) Inadequate public education and information and outreach
6) Inadequate funding to support service needs
7) Lack of clear agency policy and guidelines
8) Un-timely approval of provider certification or licensure
9) Inadequate provider reimbursement rates
10) Cumbersome process to receive provider payments
11) Insufficient cash flow to manage the agency
12) Un-timely payments to providers
13) Absence of a quality assurance process
14) Inadequate staff supervision
15) Low staff retention
16) Inadequate information system
17) Untimely eligibility determination
18) Inadequate or unresponsive appeal process
19) Inappropriate case management review process
20) Non-compliance with Federal and state program requirements, including inadequate record-keeping and adherence to financial criteria resulting in loss of funds
21) Lack of effective local interagency coordination
22) Lack of a person centered and family centered decision-making process

"The number of risk factors is more predictive of "at-risk" results than any one factor by itself or any combination of several.

3.4.2 The following action falls under the responsibility of the Office of the Governor

Problem: Most Hoosier children are born healthy and experience physical, mental, emotional, developmental, and academic outcomes, free from abuse, neglect, or involvement in the juvenile justice system. Hoosier children who do not experience these outcomes often enter a public system of services and may fail to reach their full potential. The number of children who could experience these well-being outcomes can be increased through the promotion of first trimester healthcare, on-going prenatal care, and needed support provided by healthcare and other service professionals. While the importance of these services is well-documented, budgetary constraints often limit scarce resources to be directed to older children who are involved in more intense or traumatic situations. This focus on the older child creates an on-going need for more costly services, because prevention or early intervention services were not available. Research indicates that the later the intervention, the greater the likelihood that the intervention will be less effective, and more costly.

Action: The Governor must issue a clear statement that identifies an on-going commitment by the State of Indiana to early identification and assessment of children who need services as well as a comprehensive prevention and early intervention strategy for Hoosier children. The Indiana Family and Social Services Administration should develop and implement a strategy to maximize the benefits available through the EPSDT component of Medicaid, and utilize the statutorily authorized Early Intervention Teams in each Indiana county as a local planning group to develop and implement community-based prevention and early intervention strategies that identify and assess children for needed services at age appropriate intervals and other appropriate times. The Indiana Family and Social Services Administration should provide the forum and infrastructure to determine the manner in which current funding for services can be maximized so as to expand and improve prevention and early intervention services. This strategy should promote: comprehensive (physical, nutrition and mental) care for the mother; child development information and education for parents; parenting support services to foster self-confidence and competence in parenting, on-going physical and mental healthcare for the mother and the newborn; developmental screens for children; risk assessments for families with children; aggressive enrollment of children into these needed services; implementation of an outreach plan that promotes access and utilization of these services; and maximization of Federal reimbursements for Medicaid eligible services.

Target Population. Those who would be affected by the preventive service Action s are pregnant women and children ages 0-5 years. Children ages 6 to 18 years would be most affected by early and on-going intervention services such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT).

Policy Outcomes. Prevention and early intervention services promote beneficial well-being outcomes for children. These services are almost always less expensive than out-of-home placement and provide greater choice for parents and families to receive services in their own home environment and in the community. The utilization of re-directed funds from higher cost alternatives to support these services would reduce or possibly eliminate the need for additional appropriations. Moreover, the existence of such a policy would encourage the reduction of

administrative costs, promote inter-agency collaboration and cooperation, and endorse the establishment of standards and automated information systems that would improve efficiency.

System Barriers. Multiple state agencies administer similar programs but in very different ways, without sharing common points of entry, standards of service, funding streams or policy orientations. Strong administrative leadership with support from the Governor's Office will be required to ensure that the interests of all stakeholders are carefully balanced. State agency staff may be resistant to designing and implementing necessary changes. Multiple computer systems changes will be required. The affected population will need to be carefully monitored during periods of transition to ensure that services are not interrupted or adversely impacted through unintended consequences. New educational and training modules will need to be developed. Medicaid Waiver amendments to the Federal government may be required to effectuate the changes, a third party evaluation must be initiated to ensure the changes meet the intended policy outcomes, and service delivery development must overcome the categorical program requirements of specific funding streams that result in "stovepipe" thinking.

Responsible Agency(ies) *and Action Steps:* The Governor should establish prevention and early intervention services as a necessary and critical component of a home and community-based service delivery system for children. The Indiana Family and Social Services Administration should be instructed to collaborate with the Indiana Department of Health, the Indiana Department of Correction, the Indiana Judicial Conference, the Indiana Judicial Center, and the Indiana Department of Education to develop a common policy that promotes the Governor's policy on prevention and early intervention. Common points of entry are developed and implemented most effectively through common intake formats and processes. Common standards of service must be established and implemented after a consistent and holistic service and needs assessment is performed. A state and local partnership should endorse the expansion, access, and utilization of First Steps, Healthy Families, Women, Infants and Children (WIC) Head Start, affordable and quality childcare and Hoosier Healthwise for all eligible families. Public information and outreach should make these services known to eligible families. The Indiana Family and Social Services Administration also should:

- Maximize the benefits available through the EPSDT component of Medicaid;
- Train all line workers and their supervisors on a holistic approach to prevention and early intervention services;
- Utilize the Early Intervention Team statute to serve as the initial community planning forum for the development and implementation of early identification and assessment of children, prevention and early intervention services;
- Collaborate with other state agencies both within and beyond the authority of the executive branch must be achieved that promotes the number one national education goal, that "children go to school ready to learn";
- Determine how funds from the Indiana Criminal Justice Institute, the Indiana Department of Correction, the Department of Health, local court systems, the Indiana Department of Education, and the Indiana Family and Social Services Administration can be maximized to serve children more effectively rather than by categorical funding stream requirements; and,
- Develop a monitoring system that tracks key indicators or benchmarks to measure the progress of this strategy commitment.

Fiscal Impact. This Action should be a component of the strategy to develop statewide access to unified systems of care for all children by June 30, 2007. In this manner, funds could be redirected to ensure that prevention and early intervention strategies can be implemented without jeopardizing current services and intervention for children at risk or currently in out of home

placements. Additional appropriations from the Federal government may be needed to expand certain services, but expansion of these services and state share for these services can be managed within approved budgets by monitoring utilization and constant tracking of existing appropriations.

Targeted Completion Date: The re-direction of priorities to early identification and assessment and prevention and early intervention strategies should be completed by December 31, 2008.

Benchmarks for Measuring Success. The following reflect some of the more significant indicators for evaluating progress attributable to this specific action:

Key Benchmarks - The percentage change in the number or amount of:

1. Children at "imminent risk" or "in-risk" served in a unified system of care.
2. Eligible children under 18 accessing EPSDT services.
3. Women receiving first trimester healthcare.
4. State and Federal funds used to support in-home and community-based services in comparison to all related expenditures.
5. Average length of time in long-term care facilities for children under 18 (or 21, depending on services)
6. Probation departments, child protective service offices, schools, and courts utilizing mental health pre-screening and/or family strength based assessment instruments.
7. Medical, dental, and mental health providers enrolled in the Medicaid program.
8. Expansion of Medicaid funding for services utilizing existing dollars for match.
9. Children's cases managed by the line workers in the child protective, juvenile justice, developmental disability, special education, and mental health systems.
10. Implementation of a comprehensive quality assurance system that references the system of care framework and addresses the quality of service provision, the timeliness of system response to client and agency needs, and an on-going cost-benefit analysis.
11. Children who are in out of home care that can move into their new "educational home" within an immediate timeframe and as agreed upon by child welfare, juvenile justice, mental health, child developmental, and education professionals.

Lead Benchmarks - The percentage change in the number or amount of:

1. Appropriately-aged children enrolled and using services offered by Healthy Families, First Steps, Women, Infant and Children (WIC), Head Start, Hoosier Healthwise and who transition to waivers with continuous services in a timely fashion.
2. Children under the age of 18 in institutions or children enrolled in special education.
3. Use of the IV-E waiver, the Home and Community-Based Services waiver, the Medicaid Rehabilitation Option and other funds that enhance healthy child development and that leverage additional Federal funds.
4. Number of local unified systems of care in Indiana, the number of Memoranda of Agreement signed by communities involved in these systems and the number of staff trained in the unified system of care concept.
5. Administrative funds directed to the development of the unified system of care infrastructure.
6. Number of service providers licensed, certified, or accredited by state and national standards.

Chapter 4. Issues

In reviewing the system and program issues and obstacles that were considered in the evaluation of the Actions presented in this Report, it became apparent that there were many issues that either fell outside the charge of the Commission and the individual task forces, or that required resources beyond the scope of this project and process. These issues are, however, both substantive and essential for fulfilling the goal to improve and expanded and community-based services in Indiana.

This section describes each of those essential issues and provides insight to the importance of each. It does not provide a specified set of actions, but rather serves to document that the Commission, the Task Forces, and the Consumer Advisory Committee understand the importance of each to overall system reform and feel compelled to communicate that to the Governor, the Legislature, and other stakeholders.

Those issues considered to be most essential are briefly described in this Chapter.

4.1 Quality Assurance

The shift away from traditional institutional modes of care to community-based services introduces many new opportunities for consumers and program administrators while simultaneously providing a whole host of quality assurance challenges. Unlike highly-regulated institutional care services, services provided in the community generally lack formal regulation and depend upon quality assurance protocols that are unique to each state. While states are given some Federal guidance regarding quality assurance expectations, they are also given wide latitude in their quality assurance methods. With respect to the Medicaid home and community-based services waiver programs, the Centers for Medicare and Medicaid Services require states to provide the following general assurances as a condition of waiver approval[25]:

- For the health and welfare of waiver participants;
- For plans of care responsive to waiver participant needs;
- That only qualified providers serve waiver participants;
- That the State conducts level of care need determinations consistent with the need for institutionalization;
- That the State Medicaid Agency retains administrative authority over the waiver program; and
- That the State provides financial accountability for the waiver.

Some examples of the unique challenges that quality assurance programs must take into account are:

- Direct oversight of the provisions of services may not be feasible where there are a large number of locations, some with as few as one person served.
- The type of direct oversight of service delivery found in institutions would be inconsistent with the spirit of the Medicaid Waiver Program itself, a program designed to allow people to avoid institutionalization.
- Structural characteristics of the current home and community-based healthcare sector such as limited opportunities for training and career advancement and the level of wages and benefits

provided staff in contracted programs may lead to high staff turnover or low staff awareness of home and community-based services program values.
- Because of the diversity of home and community-based services programs, a quality assurance program that is effective for one program may be unsuited for another.

Although the incorporation of a comprehensive and reliable quality assurance program into community-based services programs seems so obvious, many states and programs have, in fact, fared poorly in their program reviews. This poor performance can be attributed to many things, including: too-rapid growth in the program; lack of funding targeted to quality assurance; over-reliance on community care providers; lack of clear program definitions and quality expectations; lack of appropriate training, and lack of dedicated staffing.

It is for all these reasons that the Commission and the Task Forces wish to emphasize that *all Actions included in this June Report and the Interim Report presented in December 2002 must be accompanied by a full, appropriate, reliable, and on-going quality assurance protocol/process. This protocol/process must be fully established in both the design and implementation of each action. Moreover, successful implementation of each action is absolutely dependent upon a strong and reliable quality assurance component.*

4.2 Training and Outreach

Similar to quality assurance, each action presented by the Commission (and any significant policy change, for that matter) must be accompanied by a comprehensive and concise training and outreach plan. A sound training and outreach plan should have the following components:

- Formal, organized written and/or oral training for program staff.
- Formal, organized written and/or oral training for consumers and their families and caregivers.
- Formal, organized written and/or oral training for providers.
- Determination of and effective outreach for training location and dates.
- Determination of training frequency.
- A mechanism for updating the training materials in a timely manner, as needed.
- Some method for determining whether the training has been successful; i.e., training survey; outcomes analysis, error rates, etc.

Materials should be brief and easy to read, and the information should be accurate and complete. In addition, the Commission strongly advocates the use of web-based information to supplement (not substitute for) other written and oral outreach efforts.

4.3 Service Access

While it is obviously important for community-based services and processes to expand and improve to accommodate an increasing number of consumers and providers, it is no less essential that eligible persons are able to plan for and begin receiving services as quickly as possible. Depending upon the state, waiting lists may or may not be an acceptable method of managing program expenditures.

Through early Commission meetings, it became clear that there is not agreement about how "single point of entry" is defined. For example, it could mean any of the following:

- Consumers work with one (and only one) entity that determines eligibility, arranges for, and obtains necessary services;
- Consumers may choose from one of several entities that determines eligibility, arranges for, and obtains necessary services;
- Consumers may work with more than one entity to determine eligibility, arrange for, and obtain necessary services; but one application/intake form is used by all;
- Consumers may work with one entity, with eligibility determinations and other aspects of the process being determined by others "behind-the-scenes";
- Consumers may access one or more physical locations for the application process, eligibility determination, service planning, etc.;
- The physical location is wheelchair accessible and has adequate parking and a safe drop-off area.

Regardless of how access is defined, a successful program is one that is responsive to the needs of consumers and that includes physical environment considerations, easy-to-understand and complete application and information-collection forms, short processing times, and friendly and caring staff.

4.4 Interagency Coordination

Successful policy changes and community service program expansions depend upon strong communication between, and collaboration with, state agencies and program staff. Failure to have that foundation in place causes considerable consumer and provider upheaval and confusion, administrative inefficiencies, duplication of effort, and costly outcomes.

Poor coordination between state agencies and program staff may be attributed to: reluctance to relinquish decision-making authority; disagreements about philosophy, program, or process issues; resistance to policy changes; and differences in priority and/or level of commitment (agency investment).

Because this is an issue common to both government and the private sector, yet basic to the goal of improving systems and achieving significant and lasting efficiencies, each of the twenty-eight (28) new Actions presented by the Commission in this Report assumes that all program staff and other stakeholders understand the necessity and value in collaboration and consolidation of effort, and will commit themselves to resolving these long-standing interagency coordination barriers to the greatest extent possible.

4.5 Consumer Choice

The term "consumer choice" may have many meanings. It may refer to a consumer's ability to exercise free will when making decisions, or to a consumer's personal selection of a caregiver or service, or it may even refer to the establishment of a full array of services within a continuum of care so that all service options are available to the consumer should the need arise.

All of these meanings are incorporated within the twenty-eight (28) new Actions presented in this Report. It is the goal of the Commission to help the State to fill in the gaps within the existing array of services, promote greater consumer involvement in his/her care plan, and allow the consumer the opportunity to personally select, hire, and fire his/her own caregivers. In addition, while the primary objective of the Commission is to promote greater consumer choice and independence by expanding and improving the opportunities for consumers to receive care in a community-based setting whenever safe and feasible, it does not advocate in any way the elimination of institutional care as a valued and important service within the long-term care continuum.

Another similar, although somewhat different focus of the Commission, is to especially highlight the specific Action that promotes the establishment of a consumer advisory council. It is this Action especially that establishes a formal consumer advisory body that should assist the State on developing policy and program improvements and changes that will directly and indirectly affect the lives of consumers. This, too, may be considered an extension of the goal to promote greater consumer choice, since it seems reasonable and intuitive that policies, which are designed to serve and benefit consumers, should not be made without calling upon the persons most affected by those policies for input and confirmation. Longstanding models already exist with respect to collaborating with providers and incorporating their concerns and issues into the policymaking process, therefore, the formal establishment of consumer input in Indiana should be a logical extension of public policy development.

4.6 Affordable and Accessible Housing

It has been recorded many times in this document and within numerous publications generated by the state, local, and Federal governments that affordable and accessible housing is in very short supply. In fact, current data indicates that there are currently 3,700 households receiving housing assistance through Indiana's Housing Choice Voucher Program (Section 8), two-thirds of which have elderly or disabled members. This compares to a very high demand for this assistance with over 7,000 households on the pre-application list waiting for assistance[26]. It is for this reason that the issue of housing warrants special attention and cannot be fully resolved with the identification of a few critical actions.

Most notably, it is essential that all stakeholders understand that the lack of affordable and accessible housing has a chilling affect on achieving desired outcomes throughout the rest of the long-term care service delivery system. Namely, without affordable, accessible housing, the State will be extremely limited in its ability to de-institutionalize, and divert from institutional care, large numbers of people. This is because, while in institutions, consumers are receiving not only care, but also housing, both of which may be covered (and paid) by Medicare and/or Medicaid. In contrast, however, once consumers are discharged from an institutional setting, neither Medicare nor Medicaid is permitted to cover housing. Further, publicly-funded housing is in extremely short supply and has its own set of rules and restrictions. As a result, if development of new housing initiatives is not aggressively pursued, the State is likely to find itself in the position of having developed a plethora of new service options yet have no consumers to utilize them. Diverting people from institutional care poses less of a problem, since many of those consumers will continue to reside in their own homes, if given the opportunity. The problem with the diversion population does, however, present itself when the consumer can no longer live on his/her own and requires additional assistance that others cannot or will not provide.

It is for these and many other reasons, that the development of strong, effective, and large assisted living and adult foster care service programs becomes essential. These two programs offer both publicly-funded services and residential care, therefore investment in both resolves not only a service demand problem but also responds to the serious affordable, accessible housing shortage. It is important to note that the state leaders in community-based care throughout the country all have significant, viable, and flourishing assisted living and adult foster care programs. Without these two services, it is impossible for Indiana (or any state) to meet all of its home and community-based services goals.

4.7 Provider Capacity

Similar to the need for affordable, accessible housing is the need for a strong and reliable provider base. Without a solid provider base, Indiana cannot succeed in providing true consumer choice and will not succeed in shifting the long-term care service balance from traditional, institutional modes of care to community-based care.

Ensuring sufficient provider volume and quality requires the following basic elements:

- A formal provider recruitment strategy that includes outreach, training, follow-up, responsiveness, and access (to program staff).
- Clear provider guidelines and frequent performance feedback.
- Timely and well-understood payment processes.
- Reasonable rates that include regular inflationary increases.
- A rate structure that is based on both cost and competitive prices.
- A mechanism that provides retention assistance to institutional providers who wish to transition their services to those which are community-based.

While provider rate issues are currently targeted for budgetary discussions and possible reductions, it is extremely important to note that Indiana cannot make the shift to community-based services without investing in the provider base. Accomplishing true system reform will require some level of investment (a new expense) up front. If, however, that investment is carefully monitored, then savings in the longer-term, accompanied by a significant and cost-effective increase in the number of people served, can and should be expected. The Commission strongly encourages the Governor and State Agencies to refer to the Caregiver Commission Report (2002), which provides an excellent resource for provider issues and opportunities for resolution.

4.8 Federal Barriers

Many public assistance programs have a number of specific limitations or barriers that hinder their ability to meet consumer's needs. Some of these originate in the state or local administration and can be changed through the normal policy, rule, or legislative process. In contrast, Federal barriers are much more difficult to change for many reasons, including: the Federal government serves a much larger constituency; change is much more time-consuming and difficult to implement; unique state issues generate little interest nationally; consensus is more difficult to achieve; etc. One significant example of a Federal barrier that severely limits a state's ability to deliver cost-effective services is the prohibition of using Federal Medicaid matching funds for the costs of any Medicaid covered services furnished to an individual who is

under 65 years of age who resides in an institution for mental disease (IMD). This Federal policy creates a significant gap in funding and services for persons with mental illness that few states have effectively overcome.

Despite all of those reasons, recent and significant changes at the Federal level, delivered under the auspices of the *Olmstead* decision and the President's New Freedom Initiative, have created an impetus for change that the states have never before seen. As a result, it is imperative that Indiana work aggressively with other states (i.e., through the National Governor's Association, National State Medicaid Directors Association, etc.) to influence Federal policy, as well as to aggressively pursue any and all Federal grant initiatives that are available.

Indiana's efforts in pursuing Federal grant opportunities have, in the past, not always been stellar, so it is absolutely essential to the effort to expand and improve community-based services that the State invest and direct resources to these new opportunities. Not only does this present Indiana with the opportunity to leverage additional funds during extremely lean years, but it also improves the chances for Indiana and the other grantee states to collectively and effectively influence change at the Federal level.

Chapter 5. Going Forward

In addition to the recommendations presented in the Interim Report and the Actions prescribed in the June 2003 Report, a number of additional steps remain that will require definitive action in the future. These steps are not as easily defined, and may not be easily assigned timeframes and evaluation criteria since they depend upon a number of unknown factors. These unknowns include: changes in policy direction; changes in resource allocation; new or revised Federal mandates; or changes in staff capacity, organizational structures, and accountabilities.

Nevertheless, these actions can and must be defined in a way that provides the guideposts for continuing the direction, keeping the focus on systems change, and providing guidance for future leaders who will be responsible for completing the tasks.

The Going Forward actions are as follows.

5.1 The Role of the Regional Planning Councils

Meaningful change in system implementation will depend on an active and involved provider and advocacy base at the local level. Regional planning councils were first conceived by the State Operated Facilities Council and were intended to provide a forum and basis for creating this involvement. It is recommended that the eight (8) established Councils be charged with evaluating their current provider and community agency base to determine whether or not the existing capacity can accommodate the goal of serving all people in their setting of choice. If it does not exist, the Councils should assume the responsibility for defining more specific strategies for fulfilling this need.

It is further recommended that each Council evaluate its own unique response to the Actions presented in this report and the Caregiver Commission Report to determine what community resources can be generated, what strategies can be developed, and what support services can be modified to create meaningful and sustained systems change, one community at a time. Examples might include utilizing local philanthropic dollars for specific projects or petitioning the State for a demonstration project that coordinates services in a way to better serve people at risk of being institutionalized. It might also include involving a community hospital to strategically and systematically develop discharge-planning policies that support community options over a long-term care option.

5.2 Quality Assurance Systems

There must be a meaningful analysis of the quality assurance systems needed to provide a framework for community-based services, but also an adaptable implementation plan that will allow it to grow and improve as the services and consumer population expand. Clearly there will need to be a comparative evaluation of the quality assurance systems in place for the institutional service settings and the quality assurance systems that are expected and already in place for the community-based settings. The two have many differences, including: regulatory requirements; oversight responsibilities; reporting and accountability; philosophical approach; staff qualifications; and others.

There will need to be effective and routine collaboration between those government entities responsible for institutional oversight (e.g., the Indiana State Department of Health) and those responsible for community oversight (e.g., the Indiana Family and Social Services Administration) to ensure that there are no gaps in quality assurance activities and that standards are modified and evaluated commonly as the service delivery system becomes more balanced.

5.3 Federal Barrier Changes

Through the President's New Freedom Initiative, there will be continued emphasis on supporting states in developing community service options as an alternative to institutional care. In part because of the *Olmstead* Decision, the Federal government has recognized the inconsistencies of its own policies and funding streams that all too often create barriers for people who wish to live in the community with the appropriate support services. Indiana should capture the moment and pursue every opportunity to influence Federal policy changes whenever and wherever appropriate and possible.

5.4 On-going Evaluation through the Benchmarks and Report Card

As stated previously, the Governor's Commission on Home and Community-Based Services was created to examine, plan, and recommend short- and long-term actions that will significantly improve the system of long-term supports and services for persons who depend upon public assistance and who are disabled, who have mental illness, and who are at risk of institutionalization or are already institutionalized. These actions are absolutely essential for shifting the balance of publicly-funded care from traditional institutional modes of care to service settings and options that are community-based and more responsive to consumer choice, independence, and dignity.

For this effort to be sustained over time, it is imperative that the recommendations and actions developed by the Commission are tied to benchmarks designed to accurately describe and measure the change(s) and communicate progress to policy makers, decision makers, consumers, providers, and advocates.

Please note that the following benchmarks are intended to measure Indiana's *overall performance* in balancing the long-term care service delivery system over time; they are not intended to specifically measure the policy outcomes of individual recommendations and actions developed by the Commission.

1. Percent increase over time of Medicaid long-term care dollars spent on community-based services compared to institutional services.
2. Proportion and percent increase of Medicaid long-term care dollars spent on consumer directed care.
3. Percent decrease over time in the average number of days for eligibility approval for all Medicaid Home and Community-Based Services Waiver programs.
4. The percent increase over time in the number of persons receiving home and community-based services (both Medicaid and state-funded programs) compared to a percent decrease over time in the number of persons in institutions.
5. The number and percent increase over time in persons with mental illness who receive community and residential service supports compared to institutional services.

6. The number and percent increase over time of persons served by the Medicaid Assisted Living Waiver.
7. The number and percent increase over time of persons served in Adult Foster Care settings.
8. The number and percent increase over time of adult day service centers statewide.
9. The number of and percent increase over time in new housing initiatives.
10. The number and percent increase over time of persons served by existing housing initiatives.
11. Percent increase over time in the number of and geographic distribution of public transportation providers.
12. Percent increase over time in the utilization of specialized transportation services.
13. Percent increase over time in the number of and geographic distribution of public/private employment partnerships.
14. Percent increase over time in the employment rate for persons with disabilities.
15. Percent increase over time in the employment retention rate for persons with disabilities.
16. Percent increase over time in the number of integrated employment placements for persons with disabilities.
17. The number and percent increase over time of persons with disabilities who self direct their care.
18. The number and percent increase over time of eligible children under 18 years of age who access Medicaid-funded Early Prevention Screening and Diagnostic Treatment (EPSDT).
19. The number and percent decrease over time in the incidence of children with alcohol and/or drug abuse.
20. Percent increase over time in the number of children under 18 years of age who receive care in the community compared to the percent decrease over time in the number and length of stay of children under 18 years of age who receive care in institutions.
21. Percent increase over time in the number and incidence of children who are under 18 years of age and who receive successful community interventions that lead to a decreased number and incidence of children who enter the child protective or juvenile justice systems.
22. The number and percent increase over time in the utilization of a mental health pre-screening instrument and child and family strengths assessments by probation departments, children protective service offices, schools, and courts.

It will be incumbent upon each State Agency to establish the baseline data against which change to the system can be measured. Where it does not exist, the lead agency or office should take responsibility for developing it as a means of providing the necessary accountability for real systems change. It is further assumed that this report card will be adopted by key stakeholders as a means of holding specific state agencies and providers accountable for creating change.

States are typically not good at or accustomed to evaluating policy changes and new initiatives to determine the level of success of the initiative and to formally measure the outcomes. As a result, successes and failures are not well-documented, and opportunities to learn from mistakes are lost. Moreover, program and/or process problems are not modified when improvement opportunities are identified, so policies that do not make sense may remain in place for far too long.

To resolve this common problem, the Commission strongly recommends that the Actions presented in this report be regularly evaluated. Specific benchmarks for each Action have been developed, and are intended to accompany the general, overarching benchmarks described above to assist in determining the overall success of long-term care service reform.

5.5 Consumer Participation

While many services and programs are specifically targeted to consumers, their involvement in policy development, program design, and implementation is not typically sought. As a result, programs and policies are often unintentionally flawed in ways that are not readily apparent to the policymakers. To resolve this long-standing problem, the Commission believes strongly that consumers need to be incorporated into all aspects of service delivery. As the State shifts from an institutional focus of care to one that is driven by consumer choice and community partnership, it is the perfect time to fully incorporate consumers into the process. One way to do this is to convene a consumer advisory council to assure formal, regular inclusion of the consumer perspective into policy and program development. Another way is to solicit written input from consumers as draft policies and program manuals are developed. And yet another way is to develop regular and targeted consumer surveys to evaluate progress, identify system inefficiencies and flaws, and identify necessary program and/or policy modifications.

In the past, providers were the only or primary stakeholder that regularly communicated with state staff and/or were invited to participate in policy development. In addition, while the reasons for including providers are clear, it can be considered no longer acceptable or reasonable to exclude consumers from the process. Consumer issues demand consumer input, so a formal strategy for incorporating that perspective must be developed immediately and effectively administered.

5.6 Additional Efforts through the President's New Freedom Initiative

The President's New Freedom Initiative has already provided significant grant opportunities and funding to any willing state that is committed to pursuing reform in its long-term care service delivery systems.

This initiative continues to gain momentum and will soon present itself in a second round of grant opportunities available to the states. These new opportunities are specifically targeted to continue the work already undertaken through the first round of grants, as well as to introduce several new initiatives that will provide impetus to some consumer-driven programs that have not been widely implemented to date.

Not only do these grants help Indiana to further meet some of its longer-term goals, but they also provide a unique opportunity to generate new funds within a very challenging budgetary climate. The new initiatives highlight the possibilities for change and provoke states to seize those opportunities and pursue change when older, more costly and less desirable approaches can no longer be sustained. Further, valuable technical assistance is available and can provide guidance that can be specifically tailored to meet each state's needs.

Finally, it is important to note that budgetary constraints need not prevent the State from making progress, but instead can and should be (and has been in other states) a nesting ground for reform. The President's New Freedom Initiative was developed during a low economic period nationally and is specifically intended to help provide the momentum that states (and the Federal government) need to make the policy changes necessary to move public assistance programs forward. As a result, it is imperative that the State of Indiana pursue the additional grant opportunities that are available this year and in subsequent years. Indiana stakeholders and the Office of the Governor in particular should influence the congressional delegation to include

those resources in the President's proposed budget in the U.S. Department of Health and Human Services to be considered by Congress later this summer.

5.7 Lessons Learned from Best Practices

There is now considerable documentation that is available to states that conveys best state practices and provides program and process models that can be easily replicated. During this time when state resources have reached their limits, it is even more critical that staff time not be wasted in designing or implementing programs or policy changes for which successful models are available.

Examples of successes and failings should assist the State in targeting its efforts and avoiding costly design error and implementation flaws. It also places the State on a fast-track to obtain Federal approval on a new program or design that has already been approved somewhere else. Indiana should systematically review these efforts and evaluate the practicality and adaptability of the success that other states have in moving toward rebalancing their systems of care.

5.8 Structural Support for Interagency Coordination

While the shift from institutional care to community-based care has been extensively described in this report, it is especially important to note that success of that shift will depend upon a "meeting of the minds" between all state agencies involved in the process. This can be accomplished through the establishment of a formal mechanism that provides the structural support for interagency collaboration and coordination, which does not exist currently.

Success will depend upon collaborative planning, agreement on priorities, pooled resources, shared responsibility, and frank and open evaluation. Support for the interagency coordination will need to be provided from the "top down", with the decision-making occurring from the "bottom up", to the greatest extent possible. This will need to occur not only between the various divisions of the Indiana Family and Social Services Administration, but also between the agencies that are responsible for the services that will make the Actions presented in this report a reality throughout the State.

A significant opportunity exists in the potential coordination of Actions among two additional commissions that have been established by the Indiana General Assembly and the Governor. The Juvenile Justice Commission was established in April 2003 by Executive Order and has as its purpose, the study of laws and processes for children in need of services and the juvenile justice system. It is felt that the study of the whole system, rather than just components of the system, can best serve the interest of children and public safety. The Commission has met once, with three additional meetings planned. A key component of the Commission will be to study the similarities and critical juncture points in the child protective, education, and juvenile justice system to determine how information can be shared on children served by more than one system and how services for children and their families can be assessed and funded. Similarly, the passage of Senate Enrolled Act 62 (2003) establishes a commission to develop an implementation plan for the establishment of a continuum of services for children at-risk of abuse or neglect by their family. Both commissions will require the active involvement and the engagement of the education system to ensure and promote the ability of children to succeed with proper educational

skills. When considered in conjunction with the Action on the development of systems of care throughout Indiana, it is clear that educational attainment must remain a priority to help a child in any of the three service systems.

An opportunity also exists to promote integrated recommendations among the three commissions. The importance of prevention, early intervention services, and academic success can be enhanced by each of the two subsequent commissions to build upon and reflect the systems changes that are made in this Report. This may include a collection and coordination of all recommendations from each of the commissions into a single report for at-risk children.

Chapter 6. December 2003 Meeting

The Commission will conclude its work in December 2003. The final meeting of the Commission has several purposes:

- First, the Commission will receive a report on the mini-grants. Because many of the projects will have six months or less of operational activities, the grant report will be a status report covering grant progress, the impact the project is having on the community, the clients served, and reduction of barriers to service. In addition, the grant report will include information on any potential success in developing ongoing support for those projects that expect to be self-sufficient.

- Second, the Commission will receive a report on the progress in accomplishing the recommendations in both the Interim Report and the action in the June Report to the Governor. This report will detail all successes and accomplishments as well as any barriers to progress. It is assumed that where the barriers to progress are defined, the assigned agency will provide detail on any mid-course corrections.

- And finally, the Commission will receive a report on the progress in implementing Senate Enrolled Act 493. This legislation promises to have significant leverage on shifting the balance from institutional care to community-based care.

The strength of any initiative like that of the Commission on Home and Community-Based Services is in the implementation strategy. Without such a strategy, the recommendations and actions often get lost or at best, even if they are accomplished, the success is not always attributed to the original recommending body. This contributes to the frustration that many believe that blueprints for progress or Commission charters are not successful.

While the relationship between the work of the Commission and the work of the Regional Service Area Planning Groups is still unclear, it is assumed that if there is to be a connection of implementing specific Commission recommendations and actions through these groups, the Commission will be interested in hearing how this is to take place.

In conclusion, the December meeting will be primarily a meeting to learn what successes have been achieved by specific state agencies and through the mini-grant projects. In addition, the Commission will learn about decisions that have been made with respect to implementing the recommendations and actions at the community level.

Chapter 7. Conclusion

This June 2003 Report is submitted to Governor O'Bannon for review and consideration by the Governor's Commission on Home and Community-Based Services. It includes a brief background of the relevant long-term care service delivery system issues, identification of the target populations, an overview of three Federal grant initiatives, a status update of the sixteen (16) Action s presented in the December 2002 Interim Report, an analysis of several critical Actions that are essential for accomplishing substantial and lasting change in Indiana's long-term care service delivery system, a discussion of critical issues, and presentation of several issues that must be considered as the State moves forward.

The twenty-eight (28) new Actions presented in this June Report, and the sixteen (16) Action s included in the Commission's Interim Report presented in December 2002, provide a template for the State of Indiana to achieve the long-desired shift in the balance of long-term care services for persons who are elderly, persons who are physically disabled, persons who are developmentally disabled, persons with mental illness, and children and their families who are at risk.

Each Action has been carefully evaluated and vigorously debated, and stands out as a policy change that is essential for the successful transition from traditional, institutional care to care provided in a community setting. Most are not simple to implement and will require thoughtful and dedicated planning, but all are certain to help the State meet its many goals and objectives.

The Commission ends this Interim Report to the Governor by restating how appreciative it is of the trust and responsibility given it by Governor O'Bannon. The Commission is committed to embrace innovation and motivate solid and lasting change for Indiana's consumers of long-term care services. It is the Commission's goal to build upon the work of others by establishing partnerships between public and private, linking affordable housing and services, and creating a structure and process for consumer and provider outreach, all of which are vital for shifting the balance of Indiana's long-term care service delivery system.

Endnotes

[1] Dick Ladd, August 8, 2002 Presentation to the Governor's Commission on Home and Community-Based Services, Indianapolis, Indiana.

[2] "Long-Term Care for the Elderly with Disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century", Robyn I. Stone, pages 5-6, Milbank Memorial Fund, August 2000.

[3] OFFICE OF MEDICAID POLICY AND PLANNING Annual Report 2000, pages 10 – 11

[4] "Statewide IN-Home Services 2000 Annual Report, July 1, 1999 – June 30, 2000", page 9.

[5] The Centers for Medicare and Medicaid Services, or CMS, is part of the U.S. Department of Health and Human Services.

[6] "*Olmstead* and Supportive Housing: A Vision for the Future", CHCS Consumer Action Series, Ann O'Hara and Stephen Day, Technical Assistance Collaborative, Inc., December 2001, page 5.

[7] Robert Wood Johnson Foundation. "A National Study of Adult Day Services 2001-2002"

[8] According to the Robert Wood Johnson Foundation, consumers that can have their needs met in adult day services, do so at approximately a quarter of the cost of institutional care.

[9] Home and Community-Based Services Resource Network, www.hcbs.org.

[10] SFY 2003 data, "Expenditure Forecast: FY 2000 – FY 2005", Office of Medicaid Policy and Planning, April 10, 2003

[11] Office of Medicaid Policy and Planning, June 6, 2003.

[12] "At risk" is typically defined as someone who experiences three hospitalizations and/or inpatient nursing home/rehab services within a 12 month period.

[13] 42CFR435.911(a).

[14] According to an analysis completed by two area agencies on aging, approval for the Medicaid Aged and Disabled Waiver took an average of 107 days.

[15] Bureau of Aging and IN-Home Services, Indiana Family and Social Services Administration.

[16] The Kaiser Commission on Medicaid and the Uninsured, Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book", page 169.

[17] Indiana Division of Mental Health and Addiction Hospital DSS.

[18] The Division of Disability, and Rehabilitation Services reports that currently 70% of RBA recipients have mental illness.

[19] U.S. Department of Health and Human Services (1999)," Mental Health: A Report of the Surgeon General", Rockville, Maryland.

[20] Report from the Indiana Division of Mental Health and Addiction, 2002.

[21] 42 CFR 435.1009.

[22] Centers for Medicare and Medicaid Services website.

[23] Lee Moon, PhD., Indiana Vocational rehabilitation Services.

[24] David Perkins, PhD, Ball State University.

[25] "Quality Assurance in Home and Community-Based Services Waiver Programs: A Guide for States", December 2001, National Association of State Medicaid Directors.

[26] Governor's Commission on Home and Community-Based Services, Indiana Fact Book, May 21, 2003 version, page 38.

Appendices

A. Governor Frank O'Bannon's Executive Order

STATE OF INDIANA

EXECUTIVE DEPARTMENT
INDIANAPOLIS

EXECUTIVE ORDER 02-15

FOR: CREATION OF THE COMMISSION ON HOME AND COMMUNITY-BASED SERVICES

TO ALL TO WHOM THESE PRESENTS MAY COME, GREETINGS

Whereas, one of the most important responsibilities of state government is to ensure the health and safety of its most vulnerable citizens, including those citizens under its direct care; and

Whereas, over the last several years, Indiana has moved toward a system of integrated community-based services, and will continue to do so, but institutional care remains an important part of the continuum of state services; and

Whereas, there is a need to address the capacity of community-based services and expand relationships with providers, communities, advocates, and all stakeholders;

Whereas, there is a need to expand strategies that transition the current system of state operated care to community care; and

Whereas, there is a need to develop a comprehensive plan that supports the transition of the current system of state operated care to community care that encompasses previous planning efforts, specifically the work of the Governor's Council on State-operated Care Facilities completed November 30, 2000; and

Now, therefore, I, Frank O'Bannon, by virtue of the authority vested in me as Governor of the State of Indiana, do hereby order that:

1. The Commission on Home and Community-Based Services is created and established;

2. The Commission shall use all relevant state agency resources to complete its work;

3. The Commission shall assess the current capacity of services in the community;

4. The Commission shall identify aspects of current regulations and funding that support institutional care over community care;

5. The Commission shall use all previous efforts focused on increasing community capacity for persons at risk of being institutionalized;

6. The Commission shall work with individual communities, providers, and businesses across the state to address the gap in services in the community, thereby developing a plan to meet the needs for community transition. The plan will consider changes in the types of services provided and the delivery of those services;

7. The Commission shall consist of no more than 21 members, who shall be appointed by and serve at the pleasure of the Governor. The 21 members of the Commission will include four legislators representing both the House of Representatives and the State Senate, as recommended for service by the Speaker of the House and the President Pro Tem of the Senate.

8. The Commission shall submit an interim report in October 2002 and a final report no later than April 2003.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused to be affixed the Great Seal of Indiana on this 9th day of July 2002.

BY THE GOVERNOR: Frank O'Bannon
Governor of Indiana

ATTEST: Sue Anne Gilroy
Secretary of State

B. Governor's Commission on Home and Community-Based Services Membership Roster

Commission Members, TAG And Technical Support

Chairperson:

Katherine Humphreys

Members of the Governor's Commission on Home and Community Based Services:

Bryan Blanchard
President
Vincennes University

Sally Blankenship
Prosecutor
Ohio and Dearborn Circuit

Billie Breaux
State Senator

Charlie Brown
State Representative

Vincent Caponi
Chief Executive Officer
St. Vincent Hospital

Cleo Duncan
State Representative

Nancy Griffin
State Director
American Association of Retired Persons

Allan Kauffman
Mayor
Goshen, Indiana

Connie Lawson
State Senator

James Leich
President
Indiana Association of Homes
& Services for the Aging

Louis Martinez
President
Lake Area United Way

James McCormick
Assistant Executive Director
Dunn Mental Health Center

Rose Meissner
President
Community Foundation of St. Joseph County

Sharon Pierce
President and Chief Executive Officer
The Villages

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Roosevelt Sanders
Minister

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Kimberly Green
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John Hill
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Katherine Humphreys
Commission Chair

SueEllen Jackson-Bonner
Governor's Planning Council

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Venita Kumar
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Chuck Martindale
Indiana Department of Commerce

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Family and Social Services Administration

Chris Newman
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Vop Osili
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Karen Porter
Health Evolutions, Inc.

Andrea Walsh
Capitol Health Strategies

C. Five Task Forces

Children at Risk Task Force

Task Force Purpose: There are a variety of reasons that children reside in institutions: how the child is initially assessed (or not assessed); incompatible policies of various programs with diverse funding requirements; lack of coordination, communication, or training among states; and community agencies inadequate community support. Community support services cut across a number of state and local jurisdictions including the educational system, judicial system, human services systems, and family and children systems. The purpose of the Children at Risk Task Force is to develop short and long-term strategies for increasing community support services and to encourage integration of services for children who are at risk of being institutionalized into a broad-based spectrum of community services. The Children at Risk Task Force will also identify strategies that serve to prevent the development of risks that could eventually bring about the need for institutionalization.

Function: To examine and report to the Commission on:

- The benefits and limitations of the current system including: how it functions today; how it identifies and processes children; how parents obtain access to the system; how the system is funded; the policies that affect the various components of the system; and areas that should be highlighted because of their success or that need to be strengthened.
- The number of children currently in both public and private residential treatment centers.
- Examination of alternatives to residential care, including a review of how other states have addressed this issue.
- Determination of the barriers that prevent these children from being integrated or reintegrated into a community setting and recommendations for overcoming these barriers.
- Development of a plan that addresses the transitions throughout childhood and adulthood, including the challenges of multi-agency involvement.
- Development of a plan that provides for quality improvement and data to track the outcomes that are important to children and families.
- Develop potential recommendations in a report to be considered by the Commission that summarizes how the focus of the Children at Risk Task Force relates to the following agenda:
  - Current system barriers
  - Current best practices (what is going well in Indiana)
  - Incentives for change
  - Potential partnerships
  - Recommendations for system change
  - Evaluation criteria to measure effectiveness of change
  - Legislative recommendations
  - Budget recommendations

Children at Risk Task Force
Chair, Staff, and Members

Chairperson:

Denny Jones
Wishard Hospital

Staff Support:

Jim Hmurovich
Consultant

Members:

Rondle Anderson
Jennifer Asher
David Baker
Debbie Beckman
Sharon Bergman
Betty Bledsoe
Kerry Conway
Jim Dalton
Cathy Duchovic
Mary Edmonds
Tim Elliott
John Ellis
Teresa Hatten
John Hill
Glynn Hipp
Carol Hollinger
Janelle Hudson
Shannon Joerger
Wendy Jones
Drew Klatte
Beth Krouse
Jim McCormick
Janet McIntyre
Beverly Musseter
Shari Paige
Sharon Pierce
Knute Rotto
Lisa Sanders-Adams
Hannah Schertz
Sven Schumacher
Dave Sisk
Sandi Sleppy
Thomas Smith
Cyndy Stancliffe
Jodi Stuck
Rozella Stewart
Jim Vento
Betty Walton
Deborah Washburn

Community Personal Assistance and Support Services Task Force

Task Force Purpose: Many persons could live in their home if they could direct the support provided by a personal caregiver. The purpose of the Community Personal Assistance and Support Services Task Force is to examine the opportunities to expand community capacity and integration for persons at risk of being institutionalized by developing a personal assistance services and support systems model that allows for self-directed care.

Function: To examine and report to the Commission on:

- Innovative and exemplary self-directed care programs in Indiana and other states. The Community Personal Assistance and Support Services Task Force will make recommendations on the opportunities to replicate successful programs.
- Improvement of community-integrated personal assistance with respect to vouchers, provision of services in rural communities, and consumer preparation to transition into the community.
- Expansion of the design and delivery of community-integrated services, specifically as it relates to utilizing the strengths and resources of consumers and families, advocacy programs, alternative family placement/adoption, crisis intervention, and on-going caregiver training and support.
- Expansion of the design and delivery of community-integrated services, specifically as it relates to a fiscal intermediary or employers of record for non-traditional providers, development of provider capacity, refining the approval process, and identifying local solutions to workforce issues, including the use of public-private partnerships to develop fiscal intermediaries, employers of record, and on-going training.
- Develop short and long-term recommendations in a report to be considered by the Commission that - summarizes how the focus of the Community Personal Assistance and Support Services Task Force relates to the following agenda:
  - Current system barriers
  - Current best practices (what is going well in Indiana)
  - Incentives for change
  - Potential partnerships
  - Recommendations for system change
  - Evaluation criteria to measure effectiveness of change
  - Legislative recommendations
  - Budget recommendations

Community Personal Assistance and Support Services Task Force Chair, Staff, and Members

Chairpersons:

Kathy Davis
Controller
City of Indianapolis

Cris Fulford
Director, Executive and Government Affairs
ATTAIN, Inc.

Staff Support:

Mary Jo O'Brien
Capitol Health Strategies

Members:

Robert Agranoff
Don Baker
Linda Clouse
Elaine Cowen
Richard Daily
Melissa Durr
Deb Euler
Tammy Fish
Nancy Gemmer
Herbert Harris
Christina Helser
Bob Holda
Robert Hughes
Kim Lease
Jean MacDonald
Heather Marcharo
Selena Mault
David Scott
Richard Simers
Linda Simers
Monica Smith
Robert Smith
Jane Vanable
Mark Vinzant
Barb Woods

Housing Task Force

Task Force Purpose: Many individuals live in institutions because of inadequate and unavailable housing both in terms of quantity and quality. The purpose of the Housing Task Force is to coordinate existing resources and develop new housing solutions for persons at risk of being institutionalized.

Function: To examine and report to the Commission on:

- The housing needs of people who are at risk of being institutionalized.
- The alternative housing solutions within Indiana, including a review of how other states have dealt with this issue and what is currently available in Indiana.
- The potential of replicating successful programs through creative funding mechanisms.
- Develop potential recommendations in a report to be considered by the Commission that summarizes how the focus of the Housing Task Force relates to the following agenda:
  - Current system barriers
  - Current best practices (what is going well in Indiana)
  - Incentives for change
  - Potential partnerships
  - Recommendations for legislative and budget resources to support the system's change
  - Evaluation criteria to measure effectiveness of change
  - Legislative recommendations
  - Budget recommendations

Housing Task Force
Chair, Staff, and Members

Chairperson:

John Dickerson
Executive Director
ARC of Indiana

Staff Support:

Melissa Dill
Consultant
Health Evolutions, Inc.

Sanford Garner
A2SO4

Members:

Susan Albers
Bob Adsit
Sally Beckley
Jennifer Hoehm
Bill Boothe
Ron Brackin
Rosie Carney
Alison Cole
Bill Davis
Betty Dragoo
Joe Fahy
Maureen Felkey
Kay Fleck
Laura Frank
Pat Gamble Moore
Sherry Gray
Jim Hammond
Fred Hash
Kimberly Jarrett
James Jones
Deborah McCarty
Tina McIntosh
Linda Muckway
John Niederman
Juli Paini
Francis Sanford
Bill Shaw
Alan Spaulding
Michell Talbert
Mark Williamson

Transitions Task Force

Task Force Purpose: Many individuals are in nursing homes because of an inability to successfully finance and meet their medical needs in alternative, non-institutional settings. Others live in nursing homes because they do not have access to support services that would allow them to stay in their homes or because there is not a range of services to meet their needs. The purpose of the Transitions Task Force is to examine and document the opportunities for increasing community capacity and integration for persons in institutions or at risk of being institutionalized.

Function: To examine and report to the Commission on as follows:

- Estimate the number of people who are potentially at risk for being institutionalized or who could live in a less restrictive environment with a stronger support system.
- Review alternatives to nursing home care, including a review of how other states have dealt with this issue.
- Develop potential recommendations in a report to be considered by the Commission that summarizes how the focus of the Transitions Task Force relates to the following agenda:
  - Current system barriers
  - Current best practices (what is going well in Indiana)
  - Incentives for change
  - Potential partnerships
  - Recommendations for system change
  - Evaluation criteria to measure effectiveness of change
  - Legislative recommendations
  - Budget recommendations

Transitions Task Force
Chair, Staff and Members

Chairperson:

Anne Jacoby
Vice President, Vincennes University
Area 16 Agency on Aging/Generations

Staff Support:

Donna Cameron
Consultant
Health Evolutions, Inc.

Members:

Susan Albers
Judith Becherer
Nicki Bradley
John Cardwell
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Steve Cook
Bob Decker
Kim Dodson
Mark R. Graves
Melissa Durr
Ron Flickinger
Amy Flint
Arlene Franklin
Nancy Griffin
Jaris Hammond
Kristine Harlow
LaDonna Jenson
Bill Johnson
Karen Kissick
Dr. Mary Jane Koch
Faith Laird
Jim Leich
Sonja Long
Jean MacDonald
Steve Metcalf
Evelyn Murphy
Susan Rinne
Katherine Schmitt
David Scott
Paul Severance
Diann Shappell
Georgine Sutkowski
Melissa Van Houten
Jim VanDyke
Mary Louise Wesselman
Dr. David Wilcox
Patricia Wnek
Becky Zaseck

Transportation and Employment Task Force

Purpose: Many people are institutionalized because they do not have basic support systems to allow them to live in the community. Two important critical support services necessary for ensuring successful placement and retention in the community are transportation and employment. The purpose of the Transportation and Employment Task Force is to develop transportation and employment solutions for persons at risk of being institutionalized.

Function: To examine and report to the Commission on:

- Transportation and employment issues of people who are potentially at risk for being institutionalized or who are transitioning from an institutional setting.
- Alternative transportation and employment solutions, including a review of how other states have dealt with this issue and programs that are currently available in Indiana.
- The opportunity to form public-private partnerships with businesses, community teams and activities, and transportation.
- The opportunity to leverage and/or increase the amount of federal funding to support specialized transportation systems and supported employment.
- Creation of community infrastructure to support consumer-directed care, including the development of "best practices," consumer-directed transportation systems, and supported employment.
- Develop recommendations in a report to be considered by the Commission that summarizes how the focus of the Transportation and Employment Task Force relates to the following agenda:
  - Current system barriers
  - Current best practices (what is going well in Indiana)
  - Incentives for change
  - Potential partnerships
  - Recommendations for system change
  - Evaluation criteria to measure effectiveness of change
  - Legislative recommendations
  - Budget recommendations

Transportation and Employment Task Force Chair, Staff, and Members

Chairperson:

Curt Wiley
Fannie Mae – Indiana Partnership
Indianapolis, Indiana

Staff Support:

Melissa Dill
Consultant
Health Evolutions, Inc.

Members:

Ronda Ames
Bob Asher
Becky Banks
Dennis Born
Diane Cantrell
Valerie Cook
Jim Hammond
John Hill
Brian Jones
Betsy Kachmar
Dawn Layton
Gail Lee
Kent McDaniel
Steve O'Dore
Susan Preble
Lisa Rector
Pat Rogan
Gail Rubisch-Hawkey
Dorothy Schuerman
Sandra Seanor
Paul Shankland
Karen Swarts
Pat Vercauteren
John Watkins
Diane White
Dan Stewart

D. Consumer Advisory Committee

Consumer Advisory Committee

Purpose: Consumers have not always had support in providing important input in changing needed long-term care service delivery system's change issues. The members of the Consumer Advisory Committee (CAC) will provide serve in an advisory role to the Commission and its Task Forces to ensure that the perspectives and input of each of the target groups are represented appropriately in the recommendations of the Task Forces.

Function: To advise the Commission and five Task Forces and to:

- Provide support for the focus group input, ensuring that all stakeholder groups are represented.
- Develop a list of barriers and suggested solutions related to the systems being addressed by the Task Forces, including the following areas:
  - Nursing Home Transitions
  - Community Personal Assistance Services and Supports (PASS)
  - Children at Risk
  - Transportation and Employment
  - Housing
- Review and comment on all Task Force reports.
- Serve as a resource to the Commission by reviewing the interim and final reports to the Governor.

Consumer Advisory Committee
Chair, Staff, and Members

Chairperson:

Ed Bell
Executive Director
The Independent Living Center
Of Eastern Indiana

Staff Support:

Donna Cameron
Consultant
Health Evolutions, Inc.

Members:

Rosie Carney
Joe Daley
Richard Daley
Abby Flynn
Edna Fulk
Roy Garcia
Nikki Graham
Bob (John) Johnson
Kevin Kilty
Sharon Kozinsky
Veronica Macey
Melissa Madill
Marissa Manlove
Scott Sefton
Suzann Shackleton
David Thomas
Karen Vaughn
Betty Ware
Betty Williams

E. Real Systems Change Mini-Grants

"People helping people help themselves"

Frank O'Bannon, Governor
State of Indiana

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

NEWS RELEASE

For Immediate Release **Contact: Mary Beth Davis**
February 19, 2003 **davisMB@fssa.state.in.us (317) 233-4695**

Governor's Commission awards mini-grants for community partnerships

Funding directed toward alternatives to institutions for Hoosiers with limited options

INDIANAPOLIS – The Indiana Family and Social Services Administration and the Governor's Commission on Home and Community-Based Care today awarded 12 mini-grants totaling more than $430,000 to expand home and community-based services for the elderly and disabled.

The mini-grants – designed for Hoosiers at risk of being institutionalized or currently in an institution or nursing home -- help people with limited options live as independently as possible in their homes and communities.

Instead of distributing larger grants to a few communities, the Commission is geographically distributing a greater number of smaller grants throughout the state -- up to $40,000 each. The grants are awarded based on whether local proposals encourage innovation in the areas of community living arrangements, housing, transportation, supported employment, and caregiver support.

Grantees in the first round of awards include: a collaborative project with Richmond local government to provide better access to public transportation for the disabled in rural areas; retaining a case manager in South Bend to help with residential treatment for developmentally disabled ex-offenders transitioning back into the community; training and support for consumer directed care providers employed by aged and disabled Medicaid Waiver clients in Bloomington; and training materials for the transitional care of developmentally disabled and mentally ill in Logansport.

The mini-grants are supported by the Real Systems Change Grant, funded by the Centers for Medicare and Medicaid Services. The Governor's Commission aims to maximize the available funds by working with matching and other funding sources in local communities. Only grants that foster collaboration among community partnerships are considered. In fact, all grantees must provide a 10 percent match from a non-federal source, preferably from a community partnership or foundation.

"FSSA is committed to working closely with the Governor's Commission to provide quality services in the least restrictive settings possible," said FSSA Secretary John Hamilton. "The partnerships formed by these grants will help many families see their loved ones still fully participate in the community – and still receive quality care and supervision."

The Commission was created by Governor Frank O'Bannon to develop short and long-term strategies to create or expand community capacity for persons at risk of being institutionalized, or for those currently in an institution or nursing home, within Indiana's long-term care service delivery system. Kathryn Humphreys currently serves as chairperson.

A second round of grants will be awarded in the spring. For more information or mini-grant application materials, visit the Commission's home page at http://www.in.gov/fssa/community

REAL-SYSTEMS CHANGE GRANT RECIPIENTS

GRANT	DOLLAR AMOUNT	SERVED	PREMISE OF PROJECT
Evansville ARC Evansville IN	$40,000	Disabled. Individuals	Premise of this project is to ensure that the day after graduation is the same as the day before graduation for students with disabilities by receiving services from adult services agencies before they exit EVSC. Establish a Transition Coordinator position to work with EVSC school Corp. to ensure day-to-day transitioning for students with disabilities.
The Independent Living Center of Eastern Indiana Richmond, IN	$31,050	Disabled,/Rural areas min of 15 trips a week	ILCEIN will collaborate with government entities to create a consumer designed transportation network in partnership with public transportation services reaching into rural areas. Project will alleviate barriers to inclusive, community-based living lack of transportation and unreliable home health care. Anticipate project will become self-supporting.
Area 10 Agency on Aging Bloomington IN	$40,000	Elderly/disabled Up to 20 individuals for first training	Create a network offering training and ongoing support for consumer directed care providers employed by aged and disabled Medicaid Waiver clients. Will facilitate delivery of services under Medicaid Waiver by streamlining payment process. Will offer state-approved training meeting requirements for attendant care on basic First aid and CPR and instruction on Medicaid Waiver requirements. Once trained, Area 10 will assure that select providers receive regular payment for their services by acting as the fiscal agency for providers and consumers; Area 10 will review for quality of services, accuracy of reporting and consumer/provider relations.
The Villages of Indiana Bloomington IN	$40,000	Foster children/families	Will pilot and refine the direct entry of licensing data into the Indiana Child Welfare Tracking System (ICWIS). Will support DFC's quality licensing consultants by reducing the current 60-90-day processing period to 5 days. The States responsibility for ICWIS data entry for therapeutic foster family licensing will be shared with Indiana's private licensed child placing agencies. The Villages and Children's Bureau will pilot the date entry project and work together to develop an implementation manual for all LCPAs that will include processes and procedures and realistic benchmarks for quality of data entry. This project will eliminate a barrier to services for children in out-of-home placement through a public/private partnership between LCPAs and FSSA.
LifeStream Services, Inc. Yorktown, IN	$34,020	Long term care	Project is aimed at solving significant statewide issues affecting every in-home service provided through the In-Home Services program. Project will use telephone-based automated time and attendance system to increase the efficiency of long-term care system. Significantly change manner in which in-home services are documented, leading to significant savings and increased safety for clients.
LOGAN Community Resources,	$40,000	Ex-offenders	Project called "Criminal Justice Project" will advocate for adults with Dev. Disabilities

Inc. South Bend			who are involved in the criminal justice system. Will retain a case manager to help with areas of education, case management, social supports securing residential treatment during transition into the community.
Adult & Child Care Center, Inc. Indianapolis, IN	$39,639	30 consumers on ACT team	Will employ and train a Peer Support Specialist (PSS) on its existing community-based ACT team who will be an individual who is in recover from mental illness, and has the skills and desire to assist others in recovering. The PSS will receive extensive education and training on illness management and recovery from experienced IMR trainer, Veronica Macy, who is a consumer advocate who owns her own business, Recovery Network unlimited.
A.H. Ismail Center for Health, Exercise and Nutrition at Purdue University Lafayette	$39,835	Elderly	Will train supervisors from Area IV AA and In-Home Services as trainers for Home Support Exercise Program (HSEP) to frail older adults. Case management visits will identify individuals who can benefit for HSEP.
Woodlawn Center Logansport IN	$38,000	Dev. Disabled Mental illness	To develop, produce and distribute three model 15-min. training presentation to be available on video and CD describing the needs of persons with Dev. Dis and mental illness and are in transition to a less restrictive setting.
Indiana Canine Assistant & Adolescent Network, Inc. (ICANN) Indianapolis, Indiana	$21,000	Physically impaired individuals	Will raise and train service dogs to assist persons in Indiana who are living with physical disabilities to achieve greater independence in carrying out activities of daily living. 15 puppies will enter training 5 Dogs will enter advanced training, a minimum of two disabled persons will received ICAAN assistance dogs by April 2004.
Four Rivers Resource Services Linton, IN	$27,981	Disabled individuals needing transportation.	Ride Solution Barrier Removal Project will purchase a small, economical car and pay one year's salary to driver for this vehicle. Provide transportation for people with disabilities.
Rauch, Inc New Albany	$40,000	Blind & visually impaired	Will increase staff expertise through training; provide placement; provide equipment and software specific to the blind and visually impaired. The grant project will allow the development and coordination of a regional/mass training opportunity for a variety of audiences for the filed of serving the blind and visually impaired. Training categories include: etiquette training for personnel who are working with the blind; Assistive Technology for the computer from screen readers to refreshable Braille; office software used with Assistive Technology and workplace strategies in making a site accessible.

MINI-GRANT SECOND ROUND RECOMMENDATIONS

Agency Name	Population(s)	Location	Amount

1. Interfaith Hospitality Network Homeless Families MI Central $31,500
Service to approximately 50 families with a bio-psycho-social assessment, information and referral, case management and clinical services per the individual's family needs. Families with at-risk kids and MI are served.
Mr. Darnae' Scales, Executive Director
520 E. 12th St.
Indpls., IN46202
317-261-1562

2. Key Consumer Organization MI Central $22,027
To promote recovery for consumers with mental illness by providing Wellness Recover Action Plan (WRAP) training to 20 consumers who will use the training to train others. A resource guide to assist persons with mental illness to receive a post secondary education will be developed and shared with the MI population and service providers who work with that population.
Mr. David Thomas, Acting Executive Director
2506 Willowbrook Parkway. Suite 199
Indpls., IN 46205
317-205-2500

3. Indiana Housing Finance Authority DD, MI, Seniors Statewide 35,000
To create methods to permanently fund the Indiana Housing Trust Fund for the purpose of building housing capacity for persons with developmental and physical disabilities, mental illness, and senior citizens.
Ms. Jennifer Boehm, Director
Marketing and Public Affairs
30 South Meridian, 10th floor
Indpls., IN 46204
317-232-7777

4. Independent Residential Living 1st round DD/PD Central $33,300
To develop resources that enable home-owners with disabilities, particularly low to moderate income, elderly and rural persons, to access local services that provide needed home repairs/modifications so that these persons may remain in their own homes.
Mr. Michael Perigo, Resource Development Director
5971 West U.S. 52 #E
New Palestine, IN 46163
877-861-0032

5. Bowen Center, Kosciusko MI NC $24,550
To implement a community policing protocol and standard operating procedure to help meet the needs of mentally ill persons at risk of institutionalization by the establishment of a community coalition team consisting of consumers, families, community leaders, law enforcement, treatment providers, and not-for-profit community agencies. Therefore, when persons with MI interact with law enforcement during a crisis, the protocol can be followed and the risk of incarceration can be decreased.
Mr. Steve Swinehart, Kosciusko County Director
850 North Harrison St.
Warsaw, IN 46580
574-834-1415

6. Indiana Ascn. of Community Economic Development DD/PD Statewide $31,429
To implement a series of training and outreach activities that increase the availability of community based housing to persons with disabilities. 2 specific markets will be targeted: housing suppliers and housing consumers.
Ms. Christie L. Gillespie, Executive Director
324 West Morris Street #104
Indpls., IN 46225
317-423-1070

7. Indiana Chapter of Professional Case Managers Seniors/DD Statewide $31,428

To develop a case management training curriculum modules for professional case managers to be delivered across the state by certified trainers
Ms. Nancy Swaim
IN Chapter of Professional Case Managers
324 W. Morris, Suite #108
Indpls. IN 46225

8. Warsaw Community Schools DD kids (transition) NC $25,342

To develop a vocational program for "at-risk" and disabled students at the Alternative School. Vocational training can assist in transition to work for this population. This Alternative School currently offers only an educational component.
Mr. Tony England, Coordinator of Alternative Services
Warsaw Community Schools
PO Box 288
Warsaw, IN 46581
574-267-3238

9. Wabash Center DD/MI NC $27,921

To obtain overnight support by electronic monitoring from an off-site system that offers a quick response, if needed. Electronic monitoring is much less expensive than overnight staff costs.
Mr. Jeff Darling, President
2200Greenbush Street
PO Box 6449
Lafayette, IN 47903
765-423-5531

10. IARCCA At-risk kids(SED) Statewide $26,075

To develop a comprehensive training program that will educate providers on the Medicaid Rehabilitation Option as a resource for maximizing dollars to support a comprehensive array of services for children and families and promote capacity building.
Ms. Cathleen Graham, Executive Director
5519 E. 82nd, Suite A
Indpls, IN 46250
317-849-8497

11. Center for Behavioral Health DD including dual diag. South Central $31,428

To deliver additional components to the community's continuum designed specifically to meet the needs of adults with dual diagnosis to reduce costly medical visits and to increase autonomy and self-determination
Ms. Stephanie LaFontaine, Developmental Specialist
645 S. Rogers St
Bloomington, IN 47403
812-339-1691

TOTAL **$320,000**

F. Fact Book

Governor's Commission on Home and Community-Based Services

Fact Book

June 19, 2003

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INTRODUCTION

The Commission on Home and Community Based Services exists to pursue actions that will facilitate immediate and lasting change in the delivery of long-term care services in Indiana. The Commission's work is targeted to persons who are or may become dependent upon long-term care services. The Commission will recommend actions based upon a public policy that makes sense, is financially accountable, and promotes personal choice by the persons receiving, or at risk of receiving, long-term care services. The Commission will build upon the good work already accomplished by other commissions and groups and will be guided by activities and implementation strategies that improve the lives of people currently affected by these services. Each recommended action is intended to help overcome the well-known systemic barriers, current policies and procedures, and organizational practices that are obstacles to change.

ACKNOWLEDGMENTS

This report represents the culmination of several months of conceptualizing, data collection, and analysis. It could not have happened without the leadership of Katie Humphreys, and the support of Elizabeth Galvin, Katie Howard, Richard Deliberty, Tammy Robinson, Celia Leaird, Seth Frotman (Indiana University Law Student), Roger Sell, Wanda Williams, and the dedicated staff of the Family and Social Services Administration and Health Evolutions. We hope that the report contributes to policy decisions that will improve the lives and opportunities of those receiving, or at risk of receiving, long-term care services in Indiana.

SECTION I: THE POPULATIONS

Indiana's population by age group as compared to the United States population by age is demonstrated below.

Population Facts

	Indiana	USA
Population, 2001 estimate	6,114,745	284,796,887
Population, 2000	6,080,485	281,421,906
Population, percent change, 1990 to 2000	9.7%	13.1%
Persons under 5 years old, percent, 2000	7.0%	6.8%
Persons under 18 years old, percent, 2000	25.9%	25.7%
Persons over 18 years old and under 65	54.7%	55.1%
Persons 65 years old and over, percent, 2000	12.4%	12.4%
Persons at or below federal poverty levels, 2000	9.5%	12.4%

Source: iii

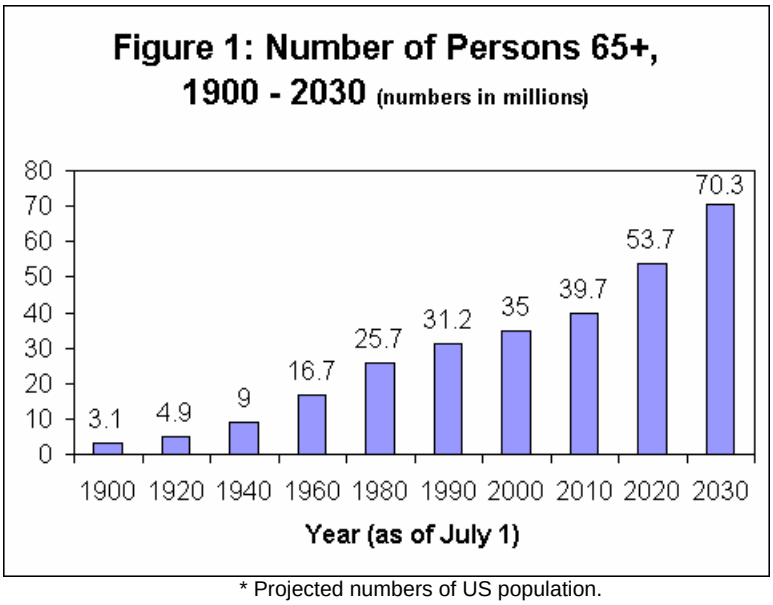
What Populations have the Task Forces Reviewed?

The Task Forces have looked at demographics and services for

- The elderly (age 65 and older)
- Persons with Developmental Disabilities
- Persons with mental illness
- Persons with physical disabilities
- Children who are at-risk

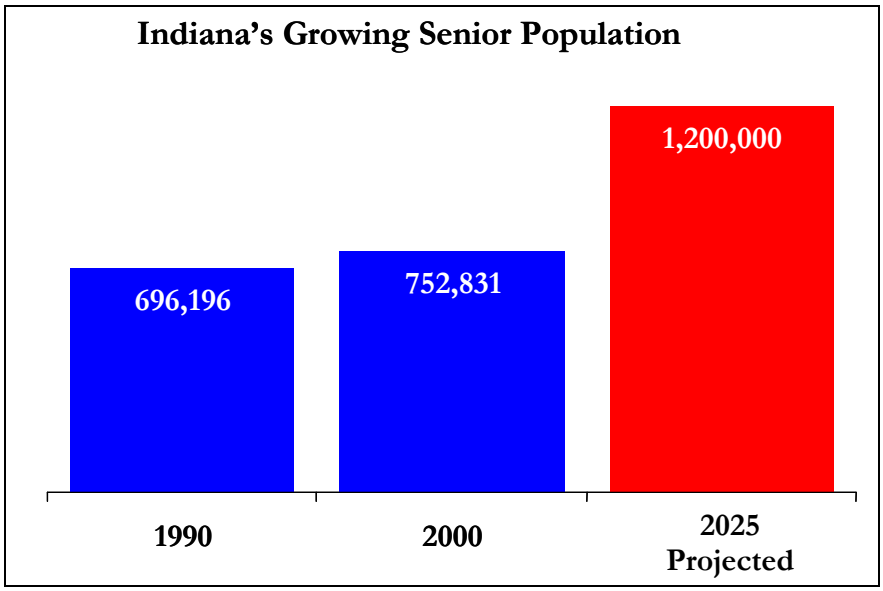
1. ***The Elderly***

"Seniors" are defined as persons who are age 65 or older. Population trends show that this segment of the population is growing rapidly. The 2000 U.S. Census counted 35 million people who are age 65 or older, a 12% increase from the 1990 census. It is estimated that the number of seniors will double by 2030. That estimate translates into 70 million seniors, representing 20% of the American population. In other words, one out of every five persons will be age 65 or older. Since the disabled are a large segment of the US population and disability often accompanies the aging process, clearly, the percentage of seniors nationwide with disabilities would be expected to increase proportionately. Estimates show that disabled seniors will account for 27% of the elderly population by the year 2020.



* Projected numbers of US population.

According to 2000 census figures, 12.4% of Indiana's population was 65 or older.[i] This translates into more than 752,000 persons, or one in every eight Hoosiers. According to data compiled by the Federal Administration on Aging, the senior population in Indiana increased by over 8% from the 1990 census.[ii] By 2025, Indiana's 65 and older population is expected to increase to over 1.2 million, making it the second-largest age category in the state with ratios mirroring the national estimates of nearly 20% of all Americans. For Indiana, however, this represents nearly a 60% increase from just the 2000 census figures over the next 25 years.



- **How many seniors are in need of care?**

Within this population group, it is estimated that at least 60 percent of people 75 and older will require some form of long-term care during the remainder of their life. In 2001, over 40,000 Hoosier seniors received care in a nursing home facility. Medicaid-eligible residents accounted for 2/3 of nursing home beds at a total cost to the taxpayers of $813 million. Although Indiana's 1999 nursing home bed ratio dramatically exceeded the national average at 83.8 beds per thousand seniors, (compared to a national average of 52.3), overall payments to nursing facilities decreased by 2.4% from 1995 to 2000.

Of Medicaid long-term care beneficiaries receiving services in 2000, approximately 75% received care in a nursing home, ICF/MR, or group home, while only 7.1% received long-term services through Medicaid waiver programs.

Medicare Enrollment *

As of July 1, 2001

	Total Population	Medicare -- All Beneficiaries		Disabled Beneficiaries		Aged Beneficiaries	
		Enrolled	%	Enrolled	%	Enrolled	%
United States	284,796,887	39,149,152	13.7%	5,405,700	1.9%	33,743,452	11.8%
Indiana	6,114,745	858,150	14.0%	120,335	2.0%	737,815	12.1%

* Enrollment is defined here as having coverage through Medicare Part A and/or Medicare Part B Supplemental.

How many seniors are below the Federal Poverty Limit (FPL)?

In 2001, national figures show that about 3.4 million elderly persons (10.1%) were below the FPL. These figures remained relatively constant after reaching a historic low in 1999. Another 2.2 million or 6.5% of the elderly were classified as "near-poor" with an income between the poverty level and 125% of this level.

According to data compiled by the Federal Administration on Aging which is calculated on the basis of the official poverty definitions for the years 1999-2001, nearly 8 percent of Indiana seniors aged 65 and older fall below the federal poverty level.[iii] Approximately 70,000 Hoosier seniors have monthly incomes less than $738 and annual incomes less than $8,860. This is somewhat lower than the national average of 9.9 percent.

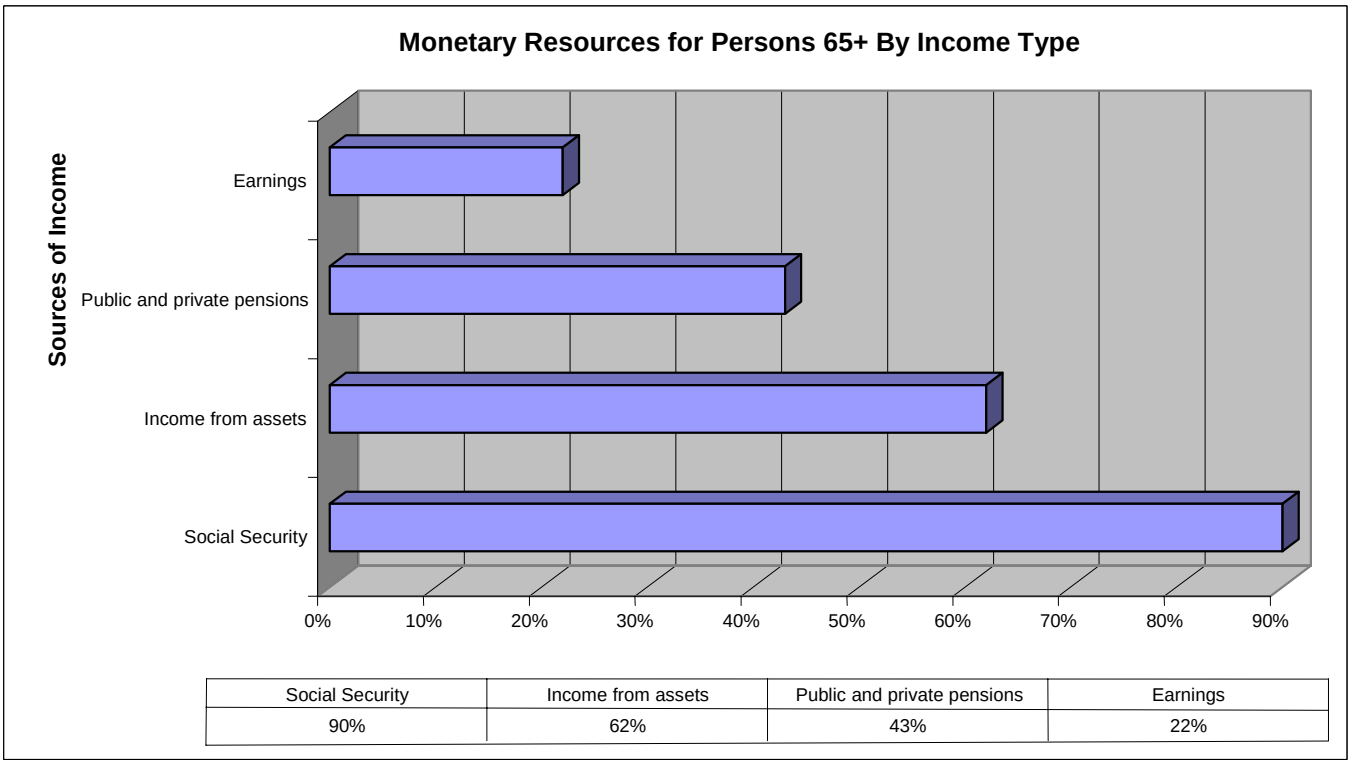
The federal poverty guidelines are calculated according to the following guidelines:

2002 HHS Poverty Guidelines	
Size of Family Unit	Contiguous States and D.C.
1	$8,860
2	11,940
3	15,020
4	18,100
5	21,180
6	24,260
7	27,340
8	34,420
For each additional person, add $3,080	

- **What is the major source of income for seniors?**

The Social Service Administration reported that the major sources of income for seniors in 2000 were the following:

- Social Security
- Income from assets
- Public and private pensions
- Earnings[iv]



2. ***Adults and Children with Developmental Disabilities***

- **Who are the Adults and Children with Developmental Disabilities?**

Developmental disabilities are severe, chronic disabilities attributable to mental and/or physical impairment (other than the sole diagnosis of mental illness), which manifest before age 22 and are likely to continue indefinitely. They result in substantial limitations in three or more of the following areas:

- Self-care
- Receptive and expressive language
- Learning
- Mobility
- Self-direction
- Capacity for independent living
- Economic self-sufficiency

Nearly four million Americans can be classified as developmentally disabled (MR/DD.) Approximately 3 percent (182,000) of Indiana's population have a developmental disability.[v] Indiana has 1,800 people with Developmental Disabilities living in a nursing home environment. Only four states have more.

In SFY 2000, of Indiana's 23,431 Medicaid enrollees with developmental disabilities and mental retardation, slightly more than 2% were served in state-operated facilities; 4 percent received care in ICF/MRs; and over 16% were served in a group home environment. The number of facility residents declined by nearly 50% in SFY 2000.

The numbers of MR/DD individuals currently receiving services identified by program areas are:

Service Setting	Clients	% of Total
Nursing Homes	4,396	33.5%
Group Homes	3,795	29.0%
Individuals on Individual Community Living Budgets (100% State funds)	3,315	25.3%
Large, Private ICFs/MR (11 Facilities)	832	6.3%
State Developmental Centers	608	4.6%
State Hospitals	160	1.2%
	13,106	**100.0%**

3. ***Adults and Children Who Are Mentally Ill***

- **Who are the Adults and Children who have mental illness?**

Mental illness is defined as those 18 years of age or older with a diagnosis of a major mental illness, severe disability, and no required duration (including those who have intermittent periods of serious mental illness over a long period of time.)

A serious emotional disturbance (SED) is defined as those under 18 years of age with a condition that results in improper behavior that interferes with the individual's ability to learn and function under normal circumstances. Children and adolescents with a SED have mental health problems that severely disrupt daily life at home, at school, and in the community.

Individuals with a serious mental illness often face insurmountable hurdles when attempting to enter the workforce. Some have educational gaps, concentration or endurance problems, and/or have medication-related side effects that make working difficult. There is an extremely high unemployment level among persons with mental illness, reaching as high as 85%.[vi]

Of the 44 million Americans who experience a mental disorder each year, nearly 1/3 are children.[vii] One in every five families is affected by a severe mental illness, such as bipolar disorder, schizophrenia, or major depression at some point. One in five American children and adolescents experience a behavioral, emotional, or mental health problem. One of every ten children or adolescent has mental illnesses severe enough to cause some level of impairment. Yet less than 20% of these young people ever receive needed treatment. [viii]

In Indiana, an estimated 270,000 adults (6% of the adult population) suffer from some form of mental illness.[ix] An additional 80,000 Hoosier children, ages 9 to 17, suffer from serious emotional disturbances**.** It is estimated that 223,000 Hoosiers have at least one co-occurring mental health and substance abuse disorder. The data also indicates that the severity of emotional and behavioral problems among adolescents is associated with increased likelihood of substance abuse. [x]

4. ***Adults and Children with Physical Disabilities***

Data regarding the disabled population is more limited than for other groups. Such is reflected in the following excerpts of a 1995 Department of Health & Human Services study [xi]. The survey cites several reasons for the lack of good data:

> While much is known about the frail elderly and their use of services, relatively little is known about other groups of persons with disabilities such as children, working age adults, and special populations (e.g., mentally ill, developmentally disabled) that cut across age groups.
>
> Numerous Federal surveys collect disability data on the working age population (aged 18-64), but except for the 1994/95 Disability Survey, none focus primarily on disability. That was not always the case. SSA conducted the Surveys of Disability and Work every few years beginning in the early 1960s in order to measure the extent of disability in the working age population and to examine the experience of disabled workers on SSDI and their families. The last Survey of Disability and Work was conducted in 1978 and there are no plans to repeat the survey. Nowadays, data sources include either special surveys on disability (like the 1994/95 Disability Survey) or the addition of disability questions on non-disability surveys.
>
> There are crucial but unresolved definitional and measurement issues among the working age population. No equivalent severity measures and survey questions have been developed for physical versus mental impairments. The standard functioning questions based on ADLs and IADLs often break down.
>
> A small but important segment of the working age population with disabilities are institutionalized (i.e., nursing homes, mental hospitals, prisons) or are homeless. Since few national surveys include this population and since the few surveys which focus on the institutionalized (i.e., the National Nursing Home Survey) have very small samples of the non-elderly, we know little about this group.

Disability Status of the Civilian Non-Institutional Population

	Indiana		U.S.	
	Number	%	Number	%
Population 5 years and over	**5,563,619**		**257,167,527**	
With a disability	1,054,757	19.0%	49,746,248	19.3%
Population 5 to 15 years	**972,185**		**45,133,667**	
With a disability	61,622	6.3%	2,614,919	5.8%
Sensory	9,746	1.0%	442,894	1.0%
Physical	9,891	1.0%	455,461	1.0%
Mental	50,918	5.2%	2,078,502	4.6%
Self-care	8,306	0.9%	419,018	0.9%
Population 16 to 64 years	**3,884,065**		**178,687,234**	
With a disability	691,505	17.8%	33,153,211	18.6%
Sensory	97,418	2.5%	4,123,902	2.3%
Physical	243,669	6.3%	11,150,365	6.2%
Mental	144,016	3.7%	6,764,439	3.8%
Self-care	63,617	1.6%	3,149,875	1.8%
Going outside the home	204,264	5.3%	11,414,508	6.4%
Employment disability	439,868	11.3%	21,287,570	11.9%
Population 65 years and over	**707,369**		**33,346,626**	
With a disability	301,630	42.6%	13,978,118	41.9%
Sensory	105,274	14.9%	4,738,479	14.2%
Physical	209,251	29.6%	9,545,680	28.6%
Mental	70,735	10.0%	3,592,912	10.8%
Self-care	64,661	9.1%	3,183,840	9.5%
Going outside the home	138,302	19.6%	6,795,517	20.4%
Population 18 to 34 years	**1,419,258**		**64,654,308**	
With a disability	191,349	13.5%	9,468,241	14.6%
Percent enrolled in college or graduate school		12.8%		14.5%
Percent not enrolled and with a bachelor's degree or higher		6.0%		7.9%
No disability	1,227,909	86.5%	55,186,067	85.4%
Percent enrolled in college or graduate school		21.0%		21.4%
Percent not enrolled and with a bachelor's degree or higher		14.4%		17.5%
Population 21 to 64 years	**3,434,336**		**159,131,544**	
With a disability	635,620	18.5%	30,553,796	19.2%
Percent employed		60.8%		56.6%
No disability	2,798,716	81.5%	128,577,748	80.8%
Percent employed		80.2%		77.2%

Source: U.S. Census Bureau, Census 2000 Summary File 3, Matrices P42, PCT26, PCT27, PCT28, PCT29, PCT30, PCT31, PCT32, and PCT33.

5. ***Children At-Risk***

- **Who are Children At-Risk?**

Approximately 26% (1.58 million) of Indiana's population are children 17 and younger.[xii] The Annie E. Casey Foundation defines the "at risk child" as a child who lives in a family with four or more of the following risk factors:[xiii]

- The child does not live with two parents;
- The head of household is a high school dropout;
- The family income is below poverty level;
- The child lives with underemployed parent(s);
- The family receives welfare benefits;
- The child does not have health insurance.

The Indiana Children At-Risk Task Force has identified additional indicators of children who may be at-risk.

Pre-natal at-risk indicators include:

- Smoking
- Alcohol and drug use
- Lack of health care visits in the first trimester
- Nutrition/diet quality/food insecurity
- Pregnancies too close together
- Teen pregnancy and unmarried teen pregnancy Low birth weight
- Housing instability and/or employment instability

Children who may be at risk are:

- Children in TANF families
- Children in Food Stamp families
- Children receiving free and reduced school breakfast and lunch programs
- Baby born to a mother under 20 with no high school degree
- Children whose sibling is arrested
- Children in a low family functioning
- Children whose sibling is a victim of abuse/neglect
- Children who experience stress in the social environment
- Children whose parents are separated, or whose parents are separated from them
- Children who have not bonded with parent(s)
- Children whose family experiences economic stress
- Children whose families have lost insurance
- Children whose families have insurance that does not cover a specific condition
- Children whose families have insurance with high co-pays
- Children with a lack of access to health care
- Children with a criminal arrest in the family
- Children with a parent who is incarcerated
- Children who live in neighborhoods with crime, gangs, and drugs
- Children whose parent(s) abuse drugs and alcohol
- Children of parents with serious mental illness or developmental disabilities
- Children with autism or serious emotional disorder

Children who are at imminent risk are:

- Victim(s) of abuse, neglect, or other crime
- Children who are truant and/or experience academic failure
- Children who commit delinquent acts
- Children who use drugs or alcohol
- Children who experience family economic stress
- Children who commit a parole or probation violation
- Children who age out of the foster care system

Children who are in risk are:

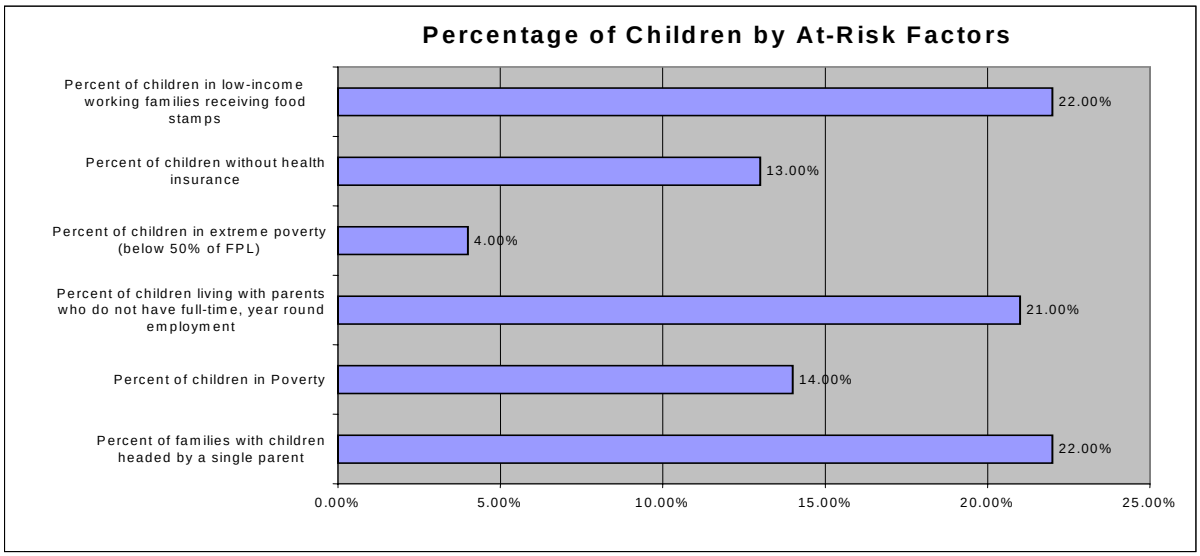
- Children in state-operated facilities
- Children who are committed to the Department of Correction
- Children in-patients in private hospitals with private pay
- Children in private detention and treatment centers
- Parole violators

It is pertinent to note that the number of risk factors is more predictive of "at risk" results than any one factor by itself or any combination of several factors.

2000 census data indicates that 11% (174,000) of Hoosier children live in poverty, compared with 16 % nationally, showing that Indiana fares better than many other states.

Nationally, 12% of all children could be classified as at-risk, a decrease of 1% from 1990. The table below reflects the occurrence of risk factors for children in the U.S.

According to data collected by the Annie E. Casey Foundation, 6% (95,000) of Hoosier children are at-risk.[xiv] Indiana decreased its number of at-risk children by half (12%-6%), marking the second largest improvement of any state during the years 1990-2000.



In addition to at-risk factors, the Children At-Risk Task Force identifies the following child well-being factors:

Children living in financial security
Children living in stable and secure housing situations
Children who have health care
Children who receive nutrition/diet quality/food security
Children whose immunizations are current
Children who have had well-baby visits
Children whose parents/families read to them
Children who receive affordable and quality childcare

It would be the desire of this commission to develop a web-site that links all the available data regarding at risk children in Indiana. This data should be organized by county.

SECTION II: SERVICES

This section seeks to define the services vital to the populations described in Section I. National and state data is included where possible.

1. ***Housing***

Of the 21.8 million households headed by older persons in 2001, 80% were homeowners while the remainder were renters. The median family income of older homeowners was $23,409 but only $12,233 for older renters. In 2001, 41% of older householders spent more than one-fourth of their income on housing costs, compared to 39% of for homeowners of all ages.

Nationally, there are 6.1 million very low to extremely low-income seniors with priority housing problems. It would take over 40,000 additional housing units a year just to maintain the current ratio of six seniors with unmet housing needs to each subsidized unit now occupied by a senior. It is estimated that there will be 9.5 million low to extremely low-income seniors in 2020. Assuming that only one-quarter of those seniors want to live in rent-assisted housing, it would be necessary to provide 140,000 units a year for the next 17 years.[xv]

According to the 2000 US Census, there are more than 2.5 million housing units in Indiana. About 196,000 were vacant and 71% of the housing units are owner-occupied. Affordable housing is an essential component of family and personal well-being; however, locating affordable housing may be easier said than done for a large part of Indiana's special populations. Over 28% of renters spend more than 35% of their income for rent alone. In Indiana, a full-time worker must earn $10.93 per hour to rent a modest two-bedroom home.

2. ***Transportation***

The inability to access affordable, reliable, and convenient transportation contributes to job loss and low job retention.[xvi] However, accessible transportation also impacts several other quality of life indicators such as political participation, access to entertainment, socialization, and religious attendance. Without transportation, Hoosier families are negatively impacted in most means that maintain self-sufficiency.

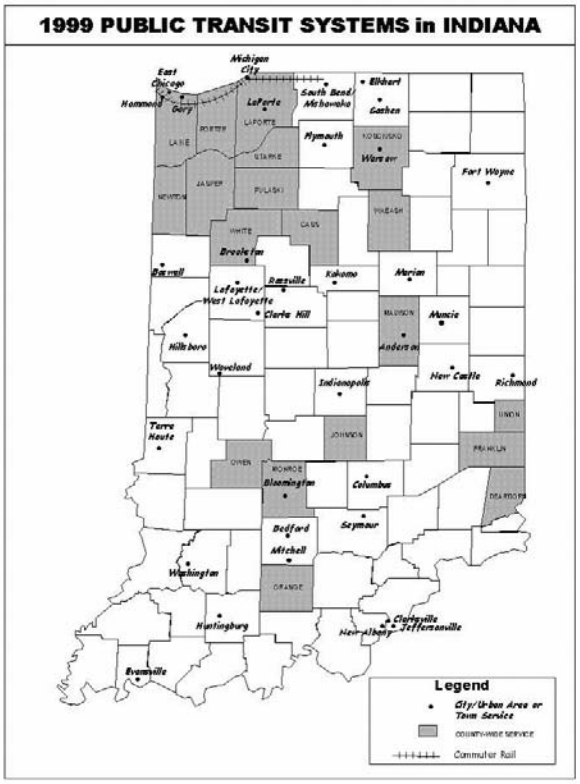
For the elderly and disabled population, the lack of available and convenient transportation can exacerbate isolation, as well as negatively impact their ability to access work opportunities, health

care, groceries, and other essential services. Medicaid-eligible individuals can access transportation through program covered health care services only.

In the year 2000, inaccessible and unavailable transportation remained an obstacle confronting persons with disabilities, hindering their ability to work and socialize outside the home. For every 10 disabled persons, 3 will have problems accessing adequate transportation. By contrast, only 1 out of 10 people without a disability have a problem with adequate transportation and of those experiencing difficulty, only 4% cite transportation as a major problem. The transportation gap between people with disabilities and people without disabilities has actually widened by 7 percentage points since 1998.[xvii]

Not surprisingly, inadequate transportation is an even greater obstacle for people with severe disabilities. People with a somewhat severe to very severe disability are more than three times as likely to view transportation as a problem (34% and 36% respectively) than people without disabilities (10%.) [xvii]

Income also seems to play a large role as people with annual household incomes of $15,000 or less, regardless of whether or not they are disabled, are much more likely to say transportation is a problem than people with annual household incomes of $50,000 or more. [xvii] Although Indiana has 44 public transit systems, 29 counties have no public transportation providers. [xvii]



3. ***Vocational Services***

People with disabilities are employed at lower rates that the general population. Moreover, the more severe the disability, the less likely a person is to be employed. The National Organization on Disability reports that only 32% of Americans with disabilities aged 18 to 64 are working compared to 81% of those without disabilities in this age category.[xviii] Two-thirds stated that they would rather be working.

Of those who reported encountering barriers, approximately 35% indicated that they could not afford training or educational programs or that they had been denied entrance into the programs. Only 9% replied that they faced discriminatory attitudes on the part of training staff.[xix]

According to Census 2000, more than 140,000 Indiana civilian non-institutionalized persons age 16 to 64 had an employment disability and were unemployed.[xx]

4. Community and Personal Assistance Support Services

The populations addressed within this data book obtain their health and personal assistance support services predominately through Medicaid funded programs. Although Medicaid eligibility standards are quite complex, in general it can said that eligibility requirements for Medicaid sponsored programs are as follows:

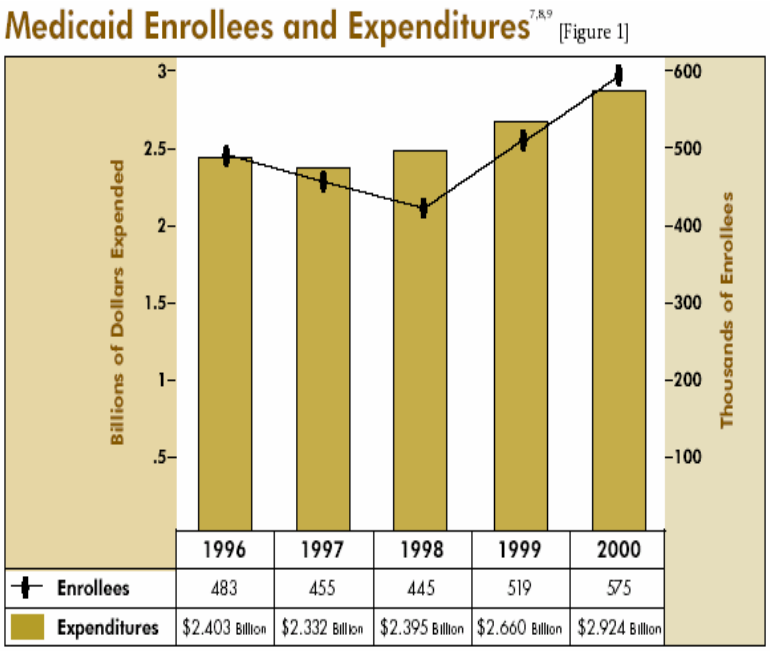
Members of Families with Children. Families meeting the income and resource standards for the Temporary Assistance to Needy Families (TANF) program are also eligible for Medicaid whether or not they actually receive TANF cash assistance.

Children and Pregnant Women Pregnant women and children under age nineteen with family incomes up to 150% of the federal poverty level are eligible for Medicaid. Prior to July 1, 1998, children from age one through age five were not eligible if their family incomes exceeded 133% of the federal poverty level and children aged 6 through 18 were not eligible if their family incomes exceeded 100% of the federal poverty level. The income standard and continuous coverage were adopted by the Indiana General Assembly in Public law 58-1998 which is “Phase I” of Indiana’s implementation of the federal Children’s Health Insurance Program.

Aged. Individuals aged sixty-five or older are eligible for Medicaid if they meet certain financial criteria. The financial criteria are more lenient if one spouse is in a nursing facility, while the other lives in the community. In addition, persons eligible for Medicare Part A may qualify to have Medicaid pay their Medicare premiums, co-payments and deductibles as a Qualified Medicare Beneficiary (QMB), a Qualifying Individual (QI), a Qualified Disabled and Working Individual, or a Specified Low Income Medicare Beneficiary (SLMB).

Blind and Disabled. The definition of “blind” for eligibility purposes is the same as the definition used by the federal Social Security Administration. To be eligible in the disability category, a disabled person must have a physical or mental impairment, disease or loss that appears reasonably certain to continue throughout four or more years of the individual’s life without significant improvement. The disability must also substantially impair his/her ability to perform labor or to engage in a useful occupation. Blind and disabled recipients may also be eligible for the Medicare-related programs described above, if they are eligible for Medicare.

The Medicaid program has grown substantially on a national and state level. The growth of the Indiana's Medicaid program is reflected in the increase in enrollees and expenditures:



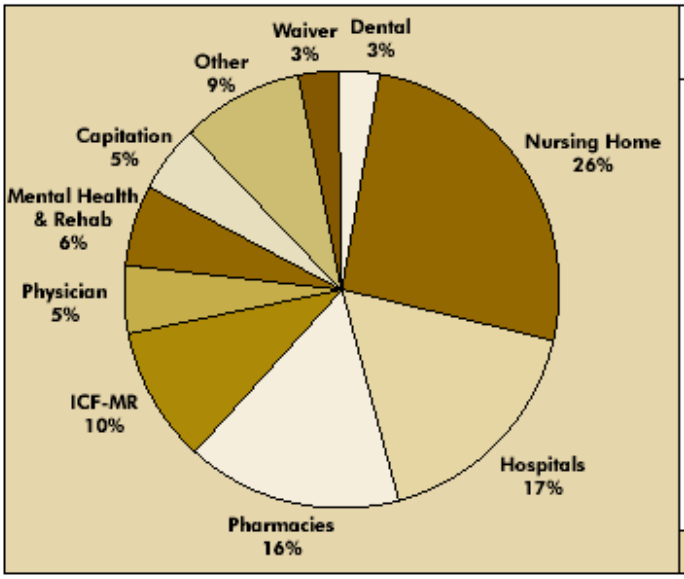
The increase in expenditures is closely related to the growth in services provided in institutional settings such as nursing homes and hospital. This trend is directly related to the growth of the population over the age of 85.

Although the aged, blind and disabled population accounts for only 25% of all Medicaid beneficiaries, they also account for 68.8% of all Medicaid-related spending during State Fiscal Year 2001. Conversely, low-income families that comprise 75% of the Medicaid-eligible population, actually, only account for 31.2% of all Medicaid expenditures. This is due to the fact that the aged, blind, and disabled categories utilize health-care services more intensely than the low-income segment of the Medicaid-eligible population.

Payments by aid group for SFY 2001 are indicated below:

Aid Group	Total Payments	% of Total Payments
Disabled	$1,210,316,030	37.2%
Aged	$1,000,948,966	30.8%
Child	$577,352,418	17.7%
Adult	$206,437,412	6.3%
Pregnant Women	$90,301,047	2.8%
CHIP I	$75,775,573	2.3%
Uncategorized	$58,389,807	1.8%
Blind	$26,019,796	0.8%
CHIP II	$7,565,864	0.2%
Total	**$3,253,106,913**	**100.0%**

Medicaid Expenditures by Provider Category [Figure 2]



Provider Category	Expenditures (in Millions)
Nursing Home	$ 773
Hospitals	498
Pharmacies	454
ICF-MR	289
Physician	156
Mental Health & Rehab	164
Capitation	145
Waiver	101
Dental	88
Other	256
Total	**$2,924**

Traditionally, the majority of older and disabled adults have lived in nursing homes and state supported institutions, many because no other alternatives have been available to them. Consumer preferences, the high cost of institutional care, and recent Supreme Court rulings (*L.C. & E.W. vs. Olmstead*) have slowly eroded such care restrictions. In an effort to assist seniors and persons with

disabilities in maintaining their independence and privacy, several in-home and community-based personal assistance support services have been incorporate as alternatives to institutionalization.

Community-based care originated as an outgrowth of the idea of meeting the needs of people with disabilities by emphasizing a presence in the community, health and safety, and self-determination. These programs provide high quality, cost effective, and accessible services that afford older persons and persons with disabilities the ability to maintain their independence and privacy by preserving the option to live independently in their own homes as long as possible. In-home services include home health services, homemaker services, attendant care, respite care, adult day services, transportation, home delivered meals, habilitation, therapies, as well as other appropriate services such as minor home modifications and adaptive aids. All of these services are available, including Medicaid waivers, through a case management driven system.

At present, it is estimated that more than 291,000 Hoosiers over age 65 experience some limitation in two or more “activities in daily living” such as bathing, dressing, or walking, and an additional 559,000 Hoosiers below age 65 who experience some limitations in these activities.[xxi]

5. *Institutional Services vs. Community Services*

The number of Hoosiers with disabilities and mental illnesses that are receiving home-based services or in services within the community has more than doubled while the number in a state-owned or private institution has been cut in half.

Although the predominate focus of community-based services rests on maximizing quality of life, there is no dispute that the cost of institutional care is higher than the cost of services provided in a community-based setting. One nationwide study calculated the cost of institutional care as more than six times the average cost of community-based care.

Indiana Nursing Home Facts

Average Medicaid Daily Rate	$102.08
Average Private Pay Daily Rate	$120.58
Number of Medicare Certified Beds	3,258
Number of Medicaid Certified Beds	14,421
Number of Dual Medicare/Medicaid Certified Beds	37,786
Number of Medicaid Home Health Agencies	140

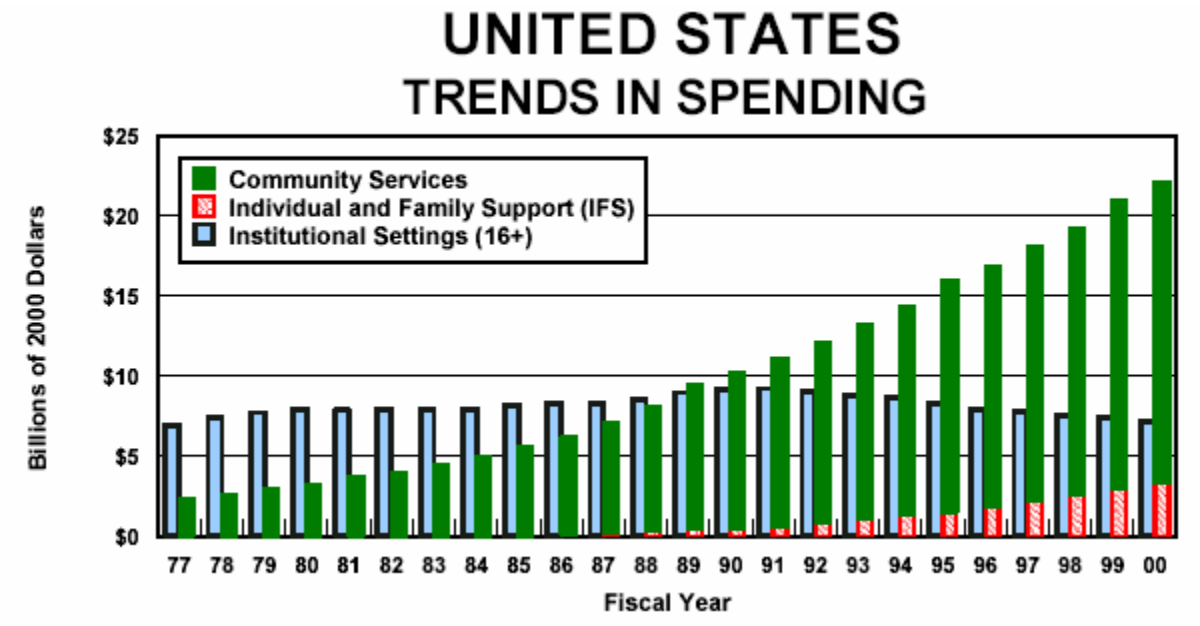
In-Home vs. Institutional Cost

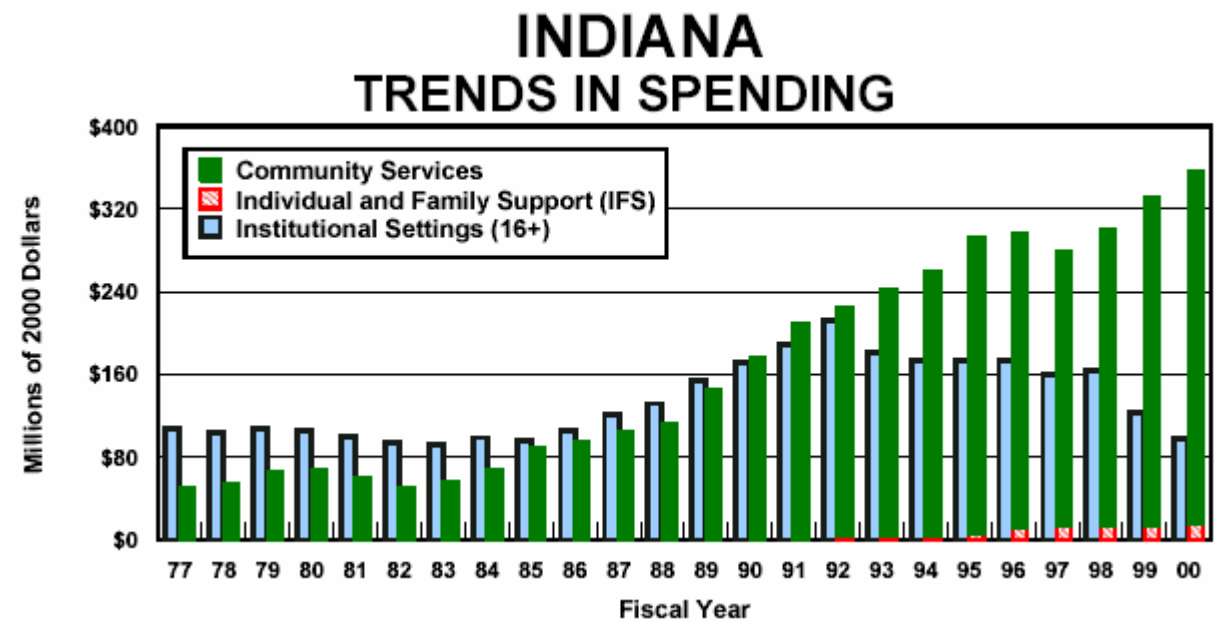
Average CHOICE and Aged and Disabled Medicaid Waiver Costs Compared to Medicaid Nursing Facility Case Mix Average Rate*

	Average CHOICE Cost	Average A&D Waiver Cost	Nursing Facility Case Mix Average Rate
DAILY	**Total**		
State Share	$19.82	$10.58	$38.20
Federal Share	-0-	$17.30	$ 62.42
TOTAL	$19.82	$27.88	$100.62
MONTHLY			
State Share	$602.86	$321.93	$1,161.92
Federal Share	-0-	$526.15	$1,898.61
TOTAL	$602.86	$848.08	$3,060.53
ANNUALLY			
State Share	$7,234.30	$3,863.17	$13,941.30
Federal Share	-0-	$6,313.79	$22,785.00
TOTAL	$7,234.30	$10,176.96	$36,726.30

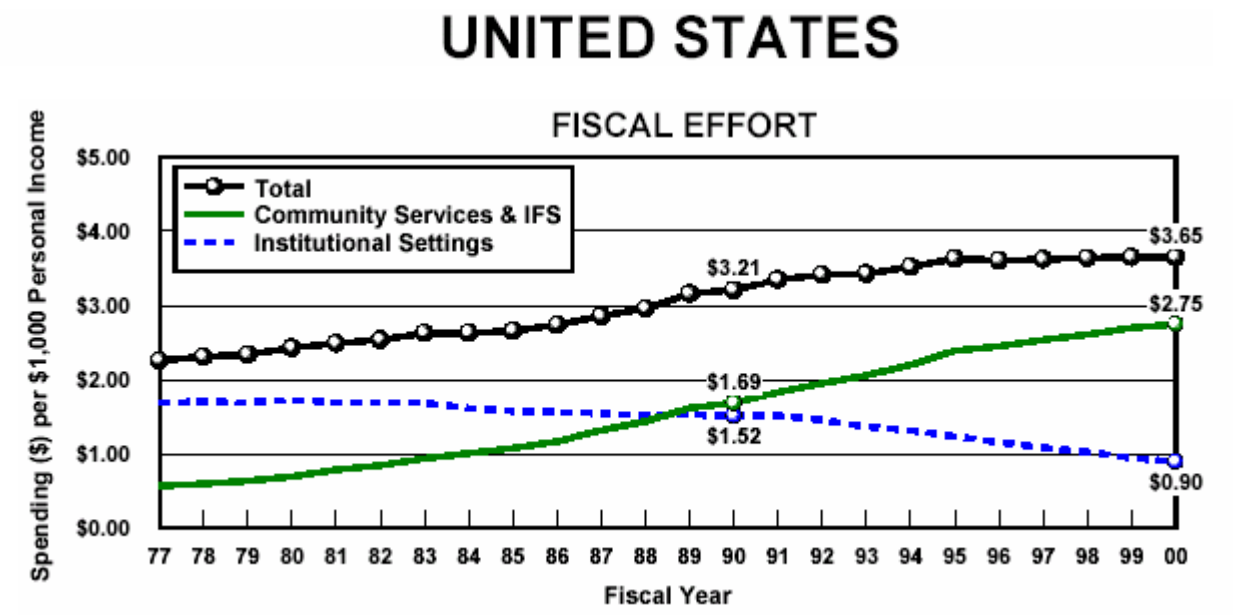
One rather dramatic example is the Muscatatuck State Development Center in Butlerville, Indiana, a state-owned institution that cares for its 177 residents on an annual operating budget of $56 million. These figures translate into a staggering cost of approximately $316,000 per person per year.

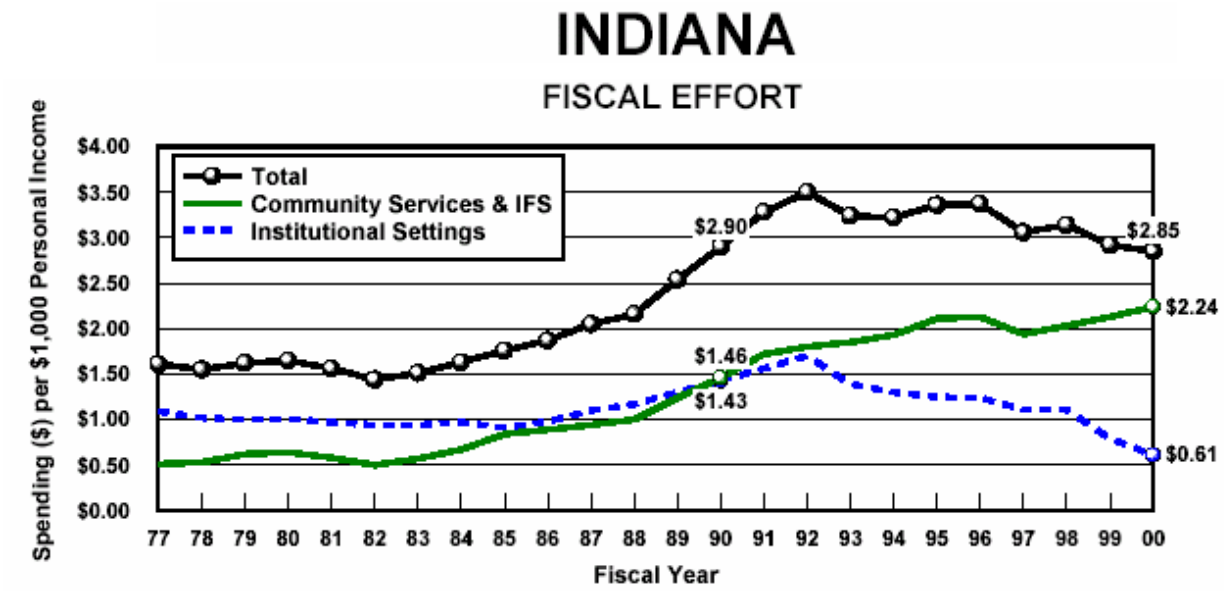
The next page of charts provides a comparison of programs as well as spending and funding sources for developmental disability programs across the United States.





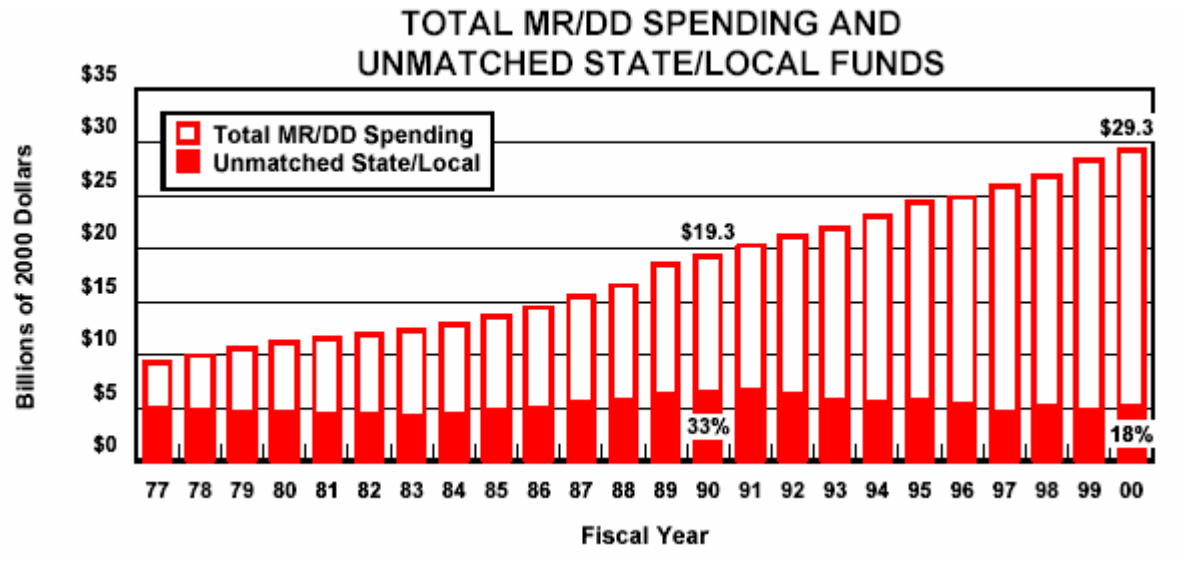
Indiana's shift in funding from institutional settings to community base services has been more dramatic than the national average. As reflected above, Indiana has increased spending for home and community-based services by 620% since 1982. Over the same period, the U.S. as a whole has increased spending for home and community-based services by only about 390%. Beginning in 1992, Indiana's funding for institutional settings began to decrease. From 1992 to 2000, the state reduced funding for institutional settings by 52%. For all states, the reduction over this period was only 16%.





The Coleman Institute for Cognitive Disabilities measures ***fiscal effort*** as the amount spent for services as a percentage of personal income. For community-based services, Indiana's increase in fiscal effort since 1980 has been slower than the national average. Indiana has increased from $0.70 per $1,000 of personal income in 1980 to $2.24 in 2000 – an increase of 220%. Over the same period, however the national average grew from $0.75 to $2.75, an increase of 266%. In 2000 dollars, Indiana's fiscal effort for community based services ($2.24 per $1,000 of personal income) represents about 81% of the national average of $2.75.

UNITED STATES



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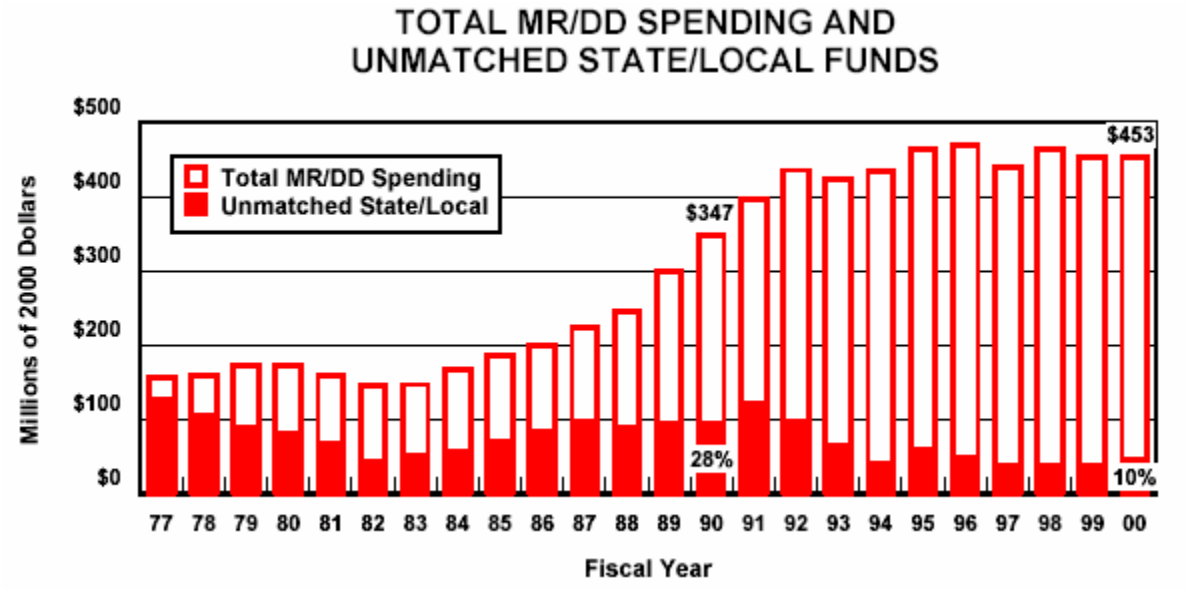
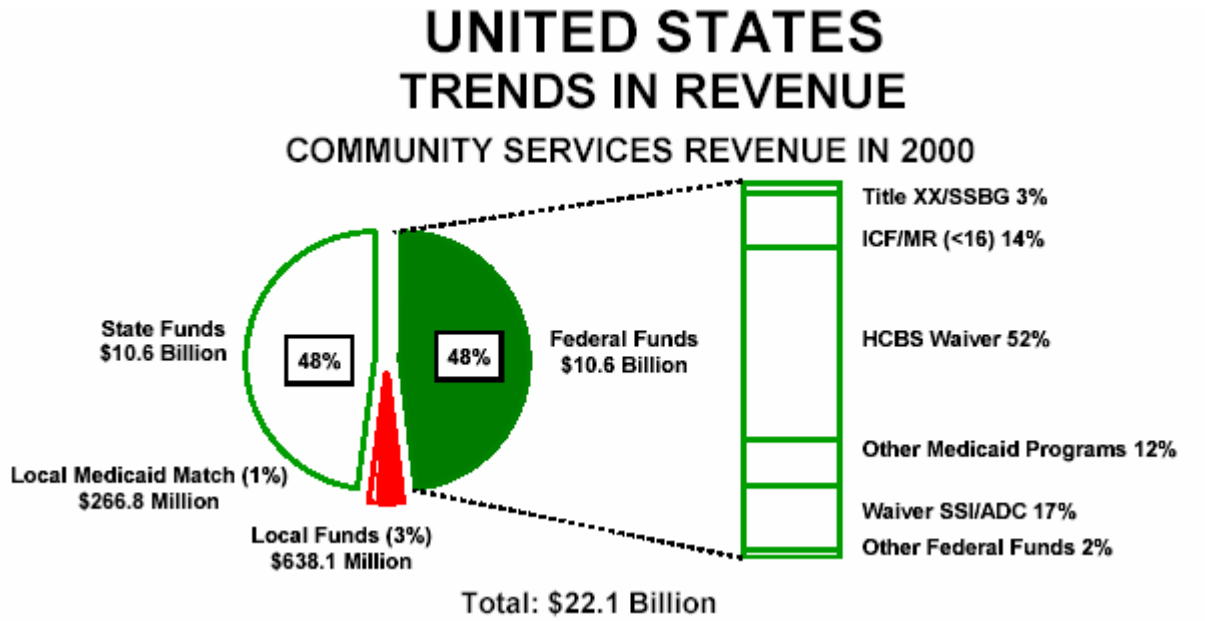
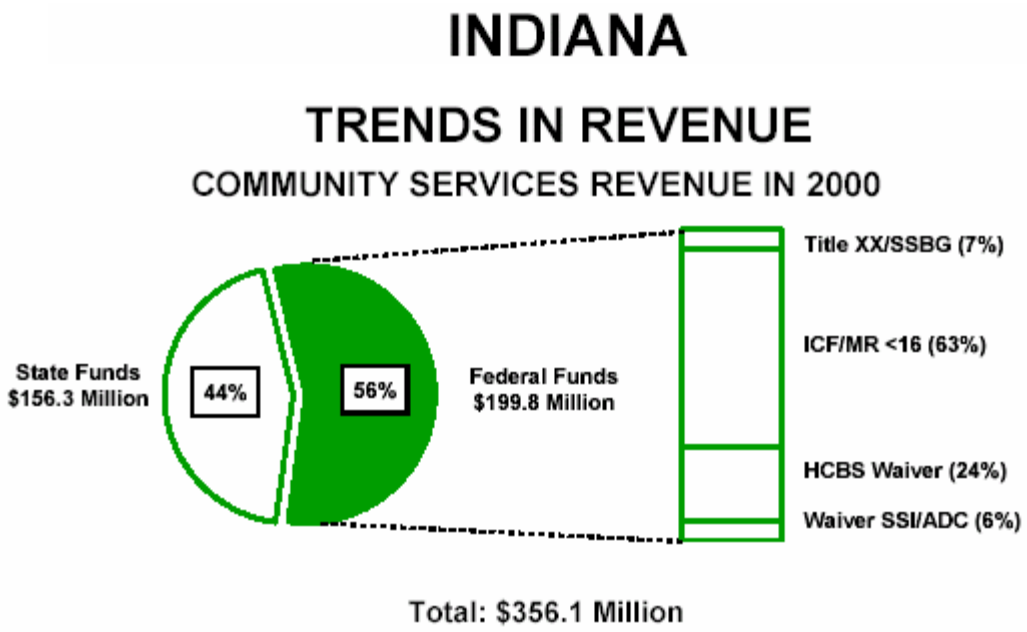


As shown in the chart above, Indiana began increasing spending for developmental disability (DD) services around 1982. In 2000 dollars, total state spending increased by 202% between 1982 and 2000. Over the same time period, the nation increased total spending for DD Services by about 144%.

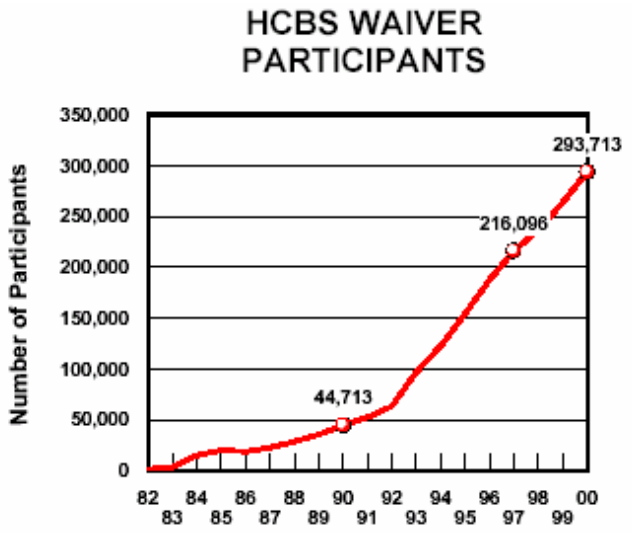
Another measure is the extent to which state and local funds are used to match, or leverage, federal funds. As of 2000, Indiana's level of unmatched spending was 10%. This compares to the national average of 18% for 2000. This leveraging effort is evident in the following charts as well.

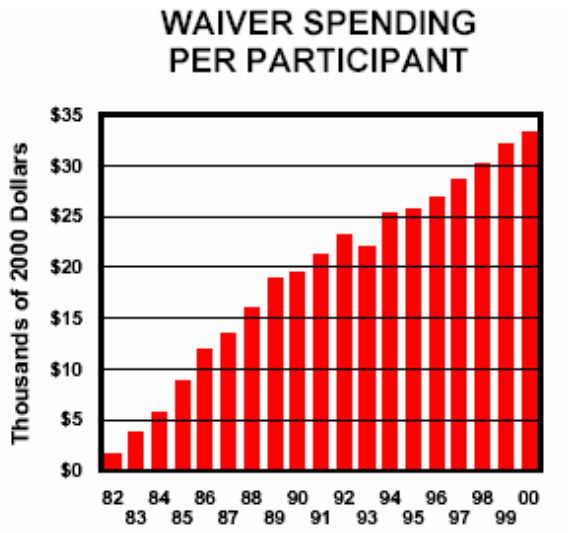


In SFY 2000, state and local funds represented 52% of all funds expended for community services in the United States. In the same year, Indiana utilized 44% state dollars for community services. Although Indiana lagged the national average for leveraged funding by 8%, the State still spent 7% more than the required Medicaid match.



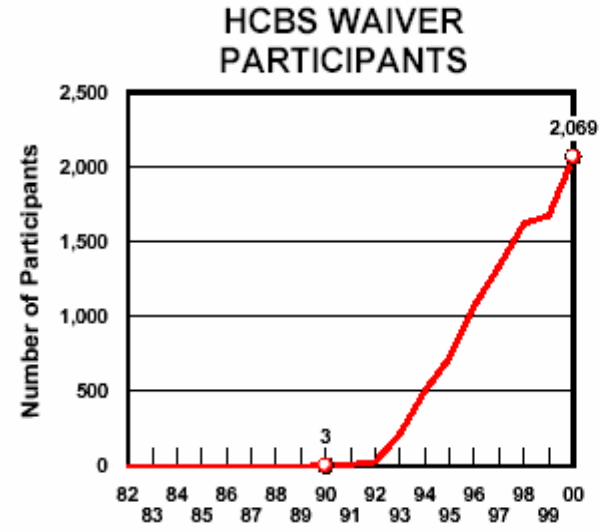
UNITED STATES

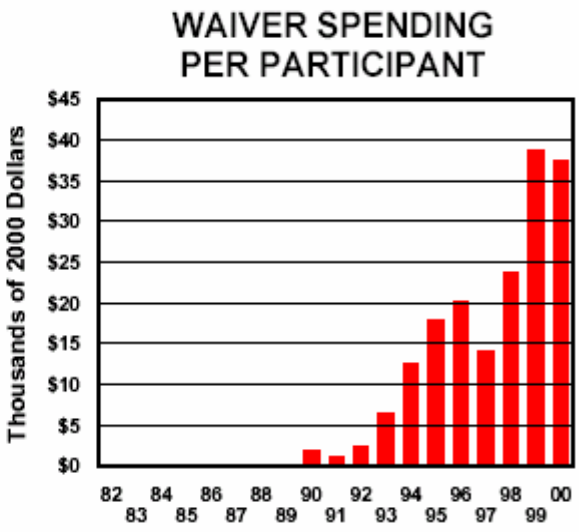




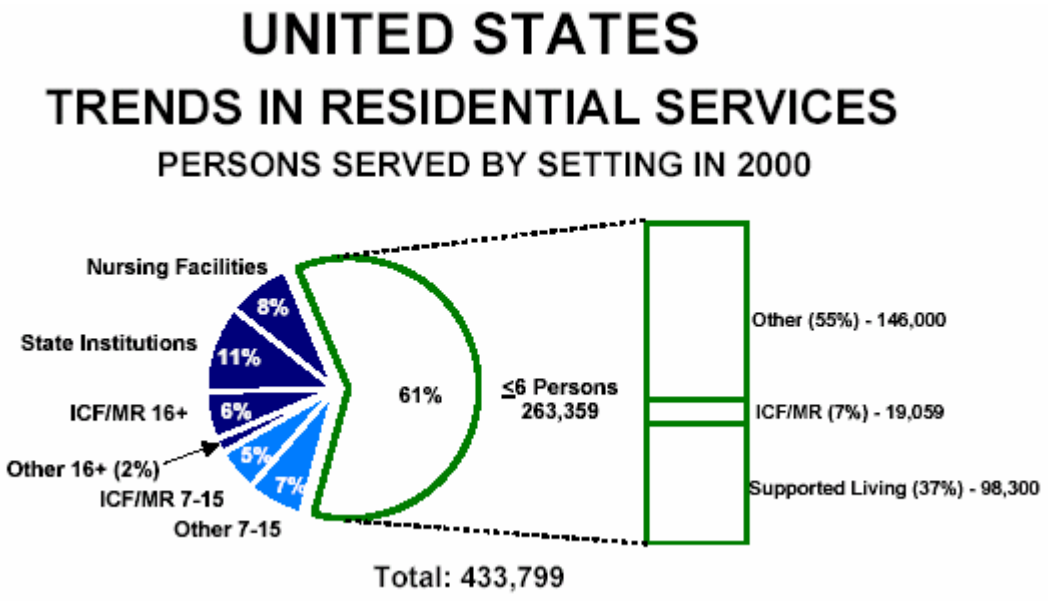
Although home and community-based waiver services grew from approximately $2000 per participant per year in 1982 to $33,000 by the year 2000, the number of participants increased from less than 100 nationwide to nearly 294,000 by 2000.

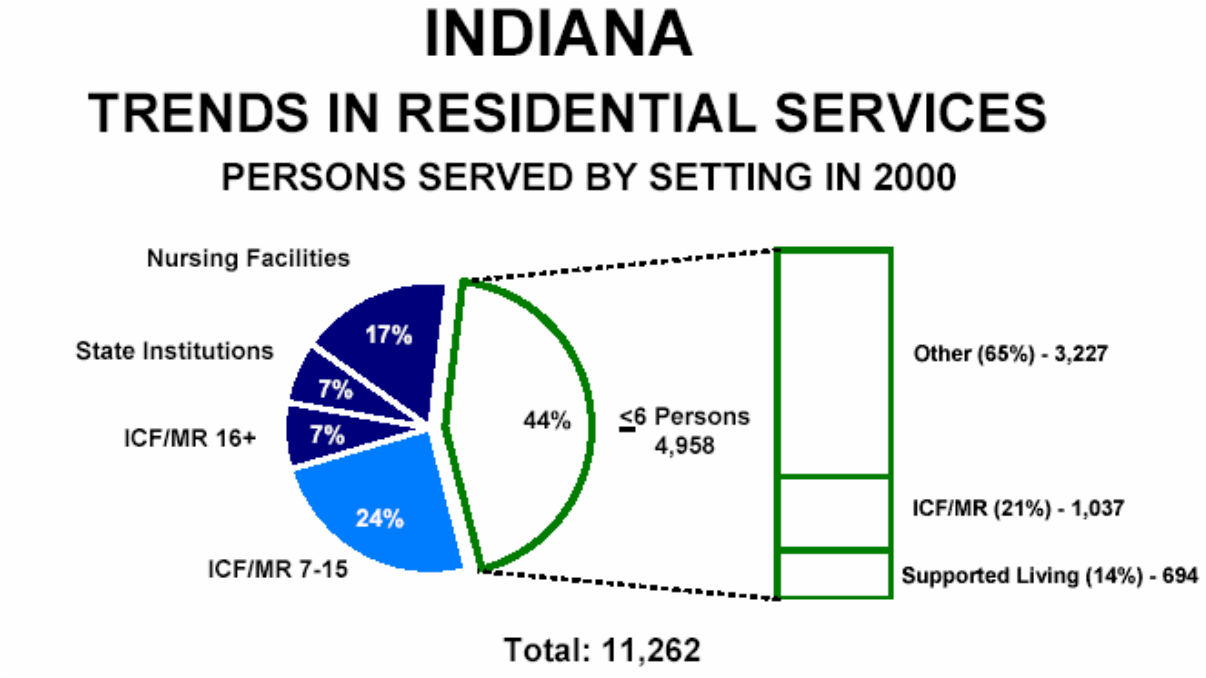
INDIANA





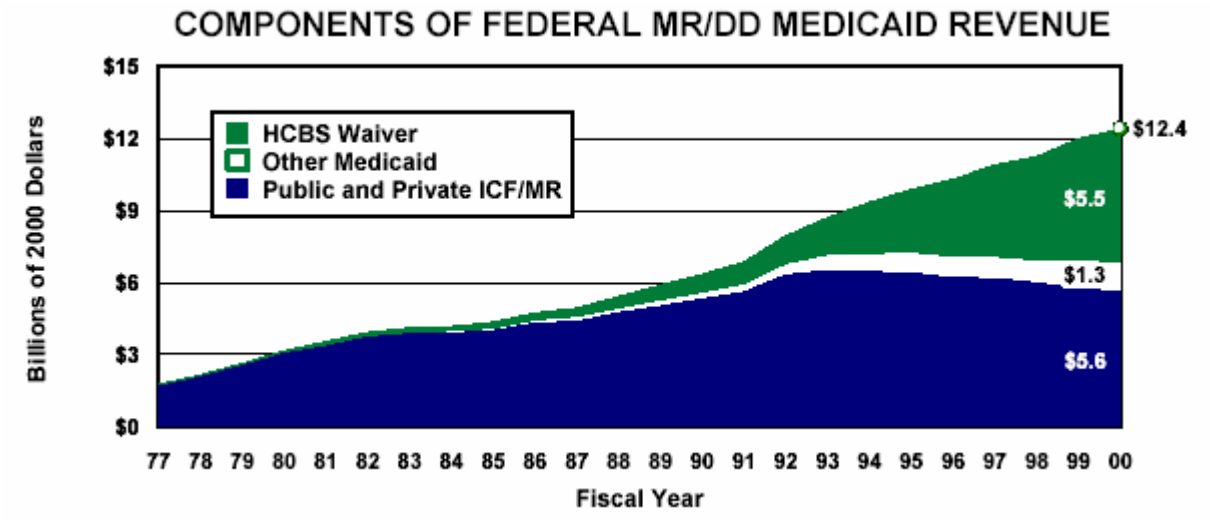
Indiana grew from spending approximately $1000 per waiver participant per year in 1990 to about $36,000 in 2000. Indiana's participant base also grew from a mere 3 waiver clients in 1990 to 2,069 by the year 2000. Although Indiana was slow to move toward providing waiver services and its growth inconsistent, overall its growth has kept pace with national trends.





In terms of serving individuals in smaller settings, Indiana lags behind other states. The 2000 national average for individuals with MRDD served in settings of six people or less was 61%. In Indiana, however, the rate was only 44%. It is desirable to serve individuals in the least restrictive setting as possible since this approach maintains a more “home-like” environment. For additional information, please reference the charts on page 27 and 28.

UNITED STATES



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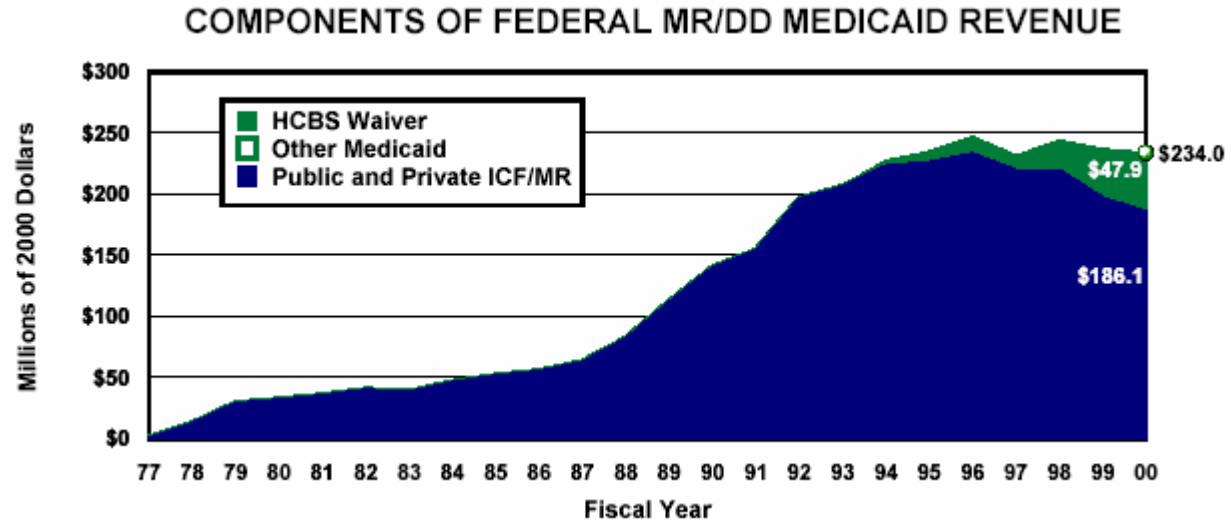


Trends in Persons Served By Setting -- Developmental Disabilities

Unites States

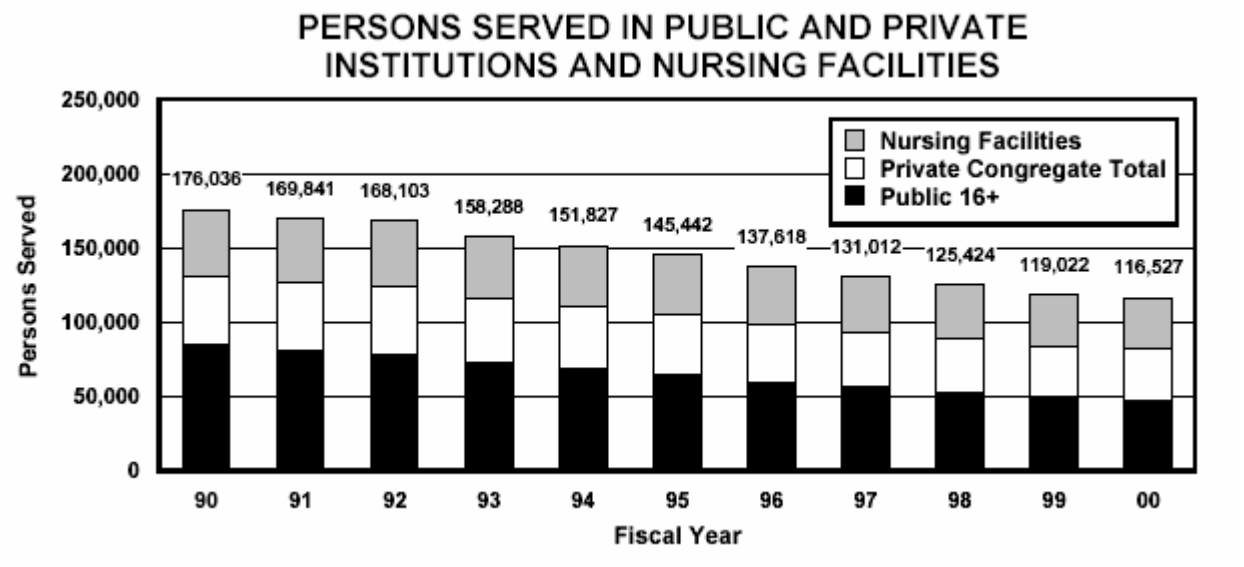
	1990	----	1995	1996	1997	1998	1999	2000	10-Year Change
TOTAL	**323,479**		**380,721**	**390,585**	**401,559**	**412,785**	**422,351**	**433,799**	**34.1%**
16+ PERSONS	**176,037**		**145,442**	**137,618**	**131,013**	**125,424**	**119,022**	**116,527**	**-33.8%**
Nursing Facilities	44,903		40,249	38,960	37,229	36,252	35,132	34,743	-22.6%
State Institutions	84,818		64,187	59,775	56,343	52,754	49,276	47,374	-44.1%
Private ICF/MR	32,926		30,752	28,777	27,744	27,271	26,218	26,107	-20.7%
Other Residential	13,389		10,255	10,106	9,696	9,147	8,396	8,303	-38.0%
7-15 PERSONS	**78,819**		**55,755**	**54,493**	**54,399**	**53,672**	**53,255**	**53,913**	**-31.6%**
Public ICF/MR	4,027		4,434	1,579	1,594	1,431	1,259	1,368	-66.0%
Private ICF/MR	21,008		23,197	23,443	22,949	22,813	21,818	21,927	4.4%
Other Residential	53,784		28,124	29,471	29,856	29,428	30,178	30,618	-43.1%
≤6 PERSONS	**68,623**		**179,524**	**198,475**	**216,148**	**233,689**	**250,074**	**263,359**	**283.8%**
Public ICF/MR	300		775	983	1,275	1,192	1,079	1,137	279.0%
Private ICF/MR	8,940		17,303	18,001	19,083	19,269	17,904	17,922	100.5%
Other Residential	59,383		161,446	179,491	195,790	213,228	231,091	244,300	311.4%

Indiana

	1990	----	1995	1996	1997	1998	1999	2000	10-Year Change
TOTAL	**9,659**		**10,152**	**10,297**	**10,643**	**11,199**	**11,671**	**11,262**	**16.6%**
16+ PERSONS	**5,132**		**4,507**	**4,313**	**4,009**	**4,177**	**3,961**	**3,550**	**-30.8%**
Nursing Facilities	2,370		2,057	2,057	1,823	2,000	2,200	1,933	-18.4%
State Institutions	1,983		1,299	1,261	1,191	1,182	926	782	-60.6%
Private ICF/MR	779		1,151	995	995	995	835	835	7.2%
Other Residential	0		0	0	0	0	0	0	n/a
7-15 PERSONS	**1,327**		**2,767**	**2,767**	**2,763**	**2,763**	**2,754**	**2,754**	**107.5%**
Public ICF/MR	0		0	0	0	0	0	0	n/a
Private ICF/MR	1,327		2,767	2,767	2,763	2,763	2,754	2,754	107.5%
Other Residential	0		0	0	0	0	0	0	n/a
<6 PERSONS	**3,200**		**2,878**	**3,217**	**3,871**	**4,259**	**4,956**	**4,958**	**54.9%**
Public ICF/MR	0		0	0	0	0	0	0	n/a
Private ICF/MR	2,000		1,028	1,028	1,032	1,032	1,037	1,037	-48.2%
Other Residential	1,200		1,850	2,189	2,839	3,227	3,919	3,921	226.8%

Source: State of the States in Developmental Disabilities, 2001,
Coleman Institute for Cognitive Disabilities and Department of Psychiatry, University of Colorado

UNITED STATES



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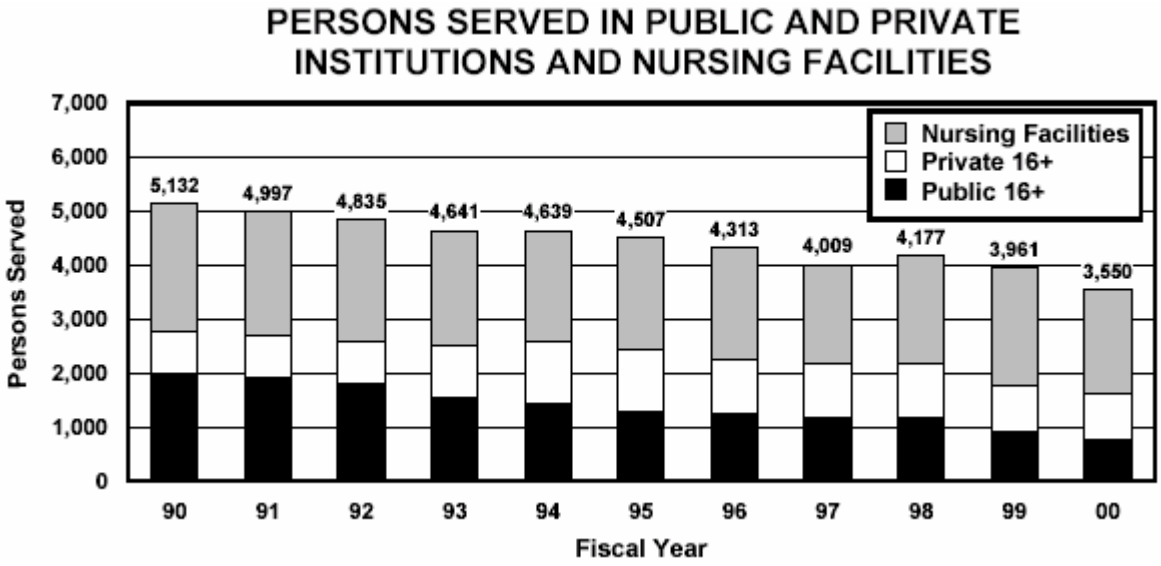

State	Fiscal Effort	Ranking
Rhode Island	$ 6.95	1
Maine	$ 6.53	2
New York	$ 5.99	3
North Dakota	$ 5.72	4
Vermont	$ 5.03	5
Minnesota	$ 5.03	6
D.C.	$ 4.61	7
Connecticut	$ 4.47	8
Wyoming	$ 4.25	9
West Virginia	$ 4.01	10
New Mexico	$ 3.98	11
Massachusetts	$ 3.81	12
Idaho	$ 3.81	13
South Dakota	$ 3.76	14
Kansas	$ 3.57	15
Oregon	$ 3.44	16
Alaska	$ 3.42	17
Ohio	$ 3.35	18
Oklahoma	$ 3.33	19
Montana	$ 3.32	20
New Hampshire	$ 3.30	21
Michigan	$ 3.29	22
Pennsylvania	$ 3.25	23
Wisconsin	$ 3.22	24
South Carolina	$ 3.16	25
Iowa	$ 3.07	26
North Carolina	$ 2.94	27
Louisiana	$ 2.82	28
Arizona	$ 2.76	29
Nebraska	$ 2.67	30
Missouri	$ 2.39	31
Arkansas	$ 2.31	32
California	$ 2.27	33
Indiana	**$ 2.24**	**34**
Utah	$ 2.23	35
Colorado	$ 2.22	36
Washington	$ 2.22	37
Maryland	$ 2.11	38
Tennessee	$ 1.99	39
Delaware	$ 1.99	40
New Jersey	$ 1.86	41
Illinois	$ 1.74	42
Texas	$ 1.73	43
Hawaii	$ 1.34	44
Virginia	$ 1.31	45
Alabama	$ 1.28	46
Mississippi	$ 1.24	47
Florida	$ 1.13	48
Kentucky	$ 1.07	49
Georgia	$ 1.06	50
Nevada	$ 0.72	51

Community Fiscal Effort and State Ranking, 2000

Note: Fiscal effort represents the proportion of total statewide personal income which is devoted to the financing of developmental disabilities community and Individual & Family Support services. Fiscal effort (Column 2) is expressed in $s per $1,000 of

Source: Braddock, Hemp, Rizzolo, Parish & Pomeranz. (2002). The State of the States in Developmental Disabilities: 2002 Study Summary. Boulder, CO: The Coleman Institute for Cognitive Disabilities and Department of Psychiatry.

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HCBS Waiver Federal/State Spending as a % of Total Mental Retardation/Developmental Disability Spending, 2000

	Rank (by waiver spending as % of total MR/DD spending)	State	Fed/State Waiver Funding	Number of Participants	Waiver Cost Per Participant	Waiver % of Total MR/DD Spending
	1	Vermont	$ 63,714,498	1,719	$37,065	80%
	2	New Hampshire	$ 99,742,724	2,638	$37,810	76%
	3	New Mexico	$ 110,293,519	2,160	$51,062	70%
	4	Rhode Island	$ 145,595,178	2,471	$58,922	68%
	5	Colorado	$ 203,772,399	5,799	$35,139	64%
	6	Arizona	$ 227,104,692	10,816	$20,998	62%
	7	Wyoming	$ 44,191,916	1,226	$36,046	60%
	8	Maine	$ 127,940,702	1,840	$69,533	59%
	9	South Dakota	$ 50,126,302	1,988	$25,214	57%
	10	Kansas	$ 169,359,274	5,500	$30,793	54%
	11	Oregon	$ 188,974,566	5,858	$32,259	53%
	12	West Virginia	$ 85,143,110	1,910	$44,578	53%
	13	Minnesota	$ 434,629,020	7,689	$56,526	53%
	14	Hawaii	$ 22,952,448	1,089	$21,077	50%
	15	Alaska	$ 31,112,865	681	$45,687	50%
	16	Nebraska	$ 84,264,420	2,320	$36,321	49%
	17	Alabama	$ 96,099,599	4,337	$22,158	48%
	18	Michigan	$ 468,386,750	8,300	$56,432	47%
	19	Maryland	$ 190,040,934	4,982	$38,146	44%
	20	Utah	$ 73,724,680	3,147	$23,427	44%
	21	Connecticut	$ 349,256,916	4,783	$73,020	44%
	22	Massachusetts	$ 465,896,852	11,360	$41,012	43%
	23	Oklahoma	$ 154,586,108	3,276	$47,187	43%
	24	Wisconsin	$ 292,877,847	8,865	$33,038	42%
	25	Pennsylvania	$ 660,766,466	15,943	$41,446	42%
	26	Montana	$ 33,564,652	1,276	$26,305	41%
	27	Tennessee	$ 188,112,207	4,318	$43,565	40%
	28	New York	$ 1,697,262,148	38,696	$43,861	40%
	29	Delaware	$ 31,502,716	489	$64,423	36%
	30	North Dakota	$ 39,537,856	1,923	$20,561	36%
	31	Missouri	$ 184,892,127	7,775	$23,780	35%
	32	Washington	$ 189,515,894	10,530	$17,998	35%
	33	Florida	$ 239,004,632	20,442	$11,692	33%
	34	Kentucky	$ 60,418,737	1,200	$50,349	32%
	35	Virginia	$ 144,459,211	4,698	$30,749	31%
	36	New Jersey	$ 296,254,000	6,894	$42,973	31%
	37	South Carolina	$ 113,050,202	4,489	$25,184	28%
	38	Georgia	$ 100,768,711	3,612	$27,898	26%
	39	Nevada	$ 13,150,358	950	$13,842	22%
	40	Iowa	$ 83,874,760	4,591	$18,269	21%
	41	North Carolina	$ 181,783,394	5,735	$31,697	21%
	42	Louisiana	$ 95,425,105	3,450	$27,659	19%
	43	California	$ 550,325,374	28,233	$19,492	18%
*	**44**	**Indiana**	**$ 77,731,833**	**2,069**	**$37,570**	**17%**
	45	Texas	$ 236,768,125	5,140	$46,064	16%
	46	Arkansas	$ 32,361,114	2,012	$16,084	13%
	47	Illinois	$ 148,731,384	7,400	$20,099	13%
	48	Ohio	$ 182,120,027	5,593	$32,562	12%
	49	Idaho	$ 14,883,847	653	$22,793	11%
	50	Mississippi	$ 4,421,843	848	$5,214	2%
		United States	**$ 9,780,474,043**	**293,713**	**$33,299**	**33%**

6. **Education**

Education is an important component of achieving and maintaining independence. In Indiana, 82% of the population age 25 or older has achieved at least a high school education. This can be compared to the national average of 80%.[xxii]

According to the National Organization on Disabilities, 22% of Americans with disabilities fail to complete high school as compared to only 9 % of students without a disability. It is also less likely for persons with disabilities to have graduated from college than their non-disabled counterparts. (12% versus 23%).

The degree of disability has a significant impact on educational achievement. Those with slight disabilities are more likely to complete high school (83%) and college (16%) than people with very severe disabilities (67% high school graduate; 9% college graduate), though they are still less likely to be high school and college graduates than people without disabilities (90% high school graduate; 23% college graduate).

Over the past 14 years, the educational gap has narrowed considerably between people with and without disabilities by 24 % in 1986 to 13% today. In 1986, almost 4 out of 10 people with disabilities (39%) failed to complete high school. Today, approximately 2 out of 10 people with disabilities (22%) have not completed high school.

The opposite is true when it comes to graduating from college. Since 1998, there appears to have been a decline from 30% to 26% among people with disabilities who have completed some college, and an even sharper decline from 19% to 12% for people with disabilities who graduated from college. [xvii]

SECTION III: DOORS TO SERVICES

This section of the Data Book is designed to illustrate how individuals access services in Indiana. The intent is to highlight the process of accessing services for the elderly, mentally ill, disabled, and/or children dependent on public services to access care.

1. ***Division of Family and Children County Offices***

The Local Office of the Division of Family and Children (DFC) is where applications are taken and submitted for assistance with the following services:

- TANF
- Food Stamps
- Medicaid
- SSI eligibility determination
- Hoosier Healthwise (Medicaid programs for children)
- IMPACT
- Child Support Services
- Family Protection and Preservation

There is an Office of Family and Children in all 92 Indiana Counties that administers Public Assistance Programs and Family Protection and Preservation Programs. A local office is available in the county seat and in various neighborhoods/townships when applying for benefits in larger communities. The application process originates in the local office. Once an application is filed with the local office, a caseworker is assigned and an appointment is set. The caseworker determines service need and financial eligibility based upon the information gathered in the application process. This process can be lengthy and may require more than one visit to the local office. The process can be particularly burdensome to one with limited mobility or lack of transportation. Locations of Family and Children local offices can be accessed at http://www.in.gov/fssa/children/dfc/directory/index.html or by phone at 317-232-4704.

2. ***Area Agencies On Aging***

Applications for the following services are made at one of Indiana's Area Agencies on Aging:

- Developmental Disability Waiver;
- Support services Waiver;
- Title V: Senior Employment;
- Pre-Admission Screening;
- Congregate Meals;
- CHOICE

Indiana's Area Agencies on Aging provide case management and information and referral to various services for persons who are aging or developmentally disabled. They can also assist the elderly client interested in employment or assistance with activities, parents of a child with a disability, or a community member suspecting abuse and neglect of a dependent adult.

They also serve as the single point of entry for the IN-Home Services Program. There are 16 AAA agencies throughout the state. One can determine the nearest location by reviewing the list at http://www.state.in.us/fssa/elderly/aaa/index.html, or by telephone at 1-800-986-3505.

3. ***Community Mental Health Centers (CMHCs)***

Applications for the following services are made at one of Indiana's Comprehensive Mental Health Centers:

- Medicaid Rehabilitation Option (MRO)
- Inpatient Services
- Residential Services
- Partial Hospitalization Services
- Outpatient Services
- Operate 72-hour Crisis Service
- Consultation-Education Services
- Community Support Program

Community Mental Health Centers (CMHCs) are providers of mental health services that operate on behalf of the Family and Social Services Administration Division of Mental Health and Addictions. There are thirty comprehensive mental health centers located throughout the state. http://www.in.gov/fssa/servicemental/faq/2cchild&adoles.html is the web address or one may call 1-800-901-1133 to find the nearest location.

4. ***Vocational Rehabilitation Offices***

Applications for these services can be made at one of Indiana's Vocational Rehabilitation Offices:

- Vocational Rehabilitation Services (VRS)
- Supported Employment (SE)
- Independent Living (IL) Services
- Assistive Technology through Awareness in Indiana (ATTAIN)

The Bureau of Vocational Rehabilitation provides quality, individualized services to enhance and support people with disabilities to prepare for, obtain or retain employment. Through active participation in their rehabilitation, people with disabilities can achieve a greater level of independence in both their work place and living environments.

Persons eligible for vocational rehabilitation services may include: persons who have a physical or mental impairment; persons whose impairment constitutes or results in a substantial impediment to employment; persons who can benefit in terms of an employment outcome from the provision of vocational rehabilitation services; and persons who require services to help prepare for gainful employment.

There are twenty-five area vocational rehabilitation offices divided into five regions. A complete list of offices is available at http://www.in.gov/fssa/servicedisabl/vr/offices.html or by calling 317-232-7000.

5. ***State-Wide Network of Rehabilitation Facilities Working in Conjunction with The Bureau of Developmental Disabilities***

Application for the following programs and related services are made at one of the local sites detailed below:

- Developmental Disability Day Services
- Autism Waiver
- Family Subsidy Program
- Case Management Services
- Diagnosis and Evaluations for Determine Status of Developmental Disability
- Traumatic Brain Injury Waiver
- Aged and Disabled Waiver
- Developmentally Delayed Waiver
- First Steps

The Bureau of Developmental Disabilities develops and administers a variety of services for people who have developmental disabilities. Services available for persons with disabilities are community-based residential alternatives to placement in state institutions and heath facilities. Programs support independent living in the least restrictive environment possible and are based on a person-centered planning process. Access is available through nine district agencies throughout the state. A complete list of offices is available at: http://www.in.gov/fssa/servicedisabl/field/index.html or by calling 1-800-545-7763.

SECTION IV: PROGRAMS

1. ***Housing***

A. Indiana's Housing Choice Voucher Program (Section 8)

Section 8 provides very low-income households with rental assistance. There are currently 3,700 households receiving housing assistance through this program. Two-thirds of those households have an elderly or disabled family member. However, demand is especially high for this program and there are over 7,000 households on the pre-application list waiting for assistance.[xxiii] In federal fiscal year 2001, Indiana received $17.4 million dollars in funding for the Section 8 program from the US Department of Housing and Urban Development (HUD).

B. Section 8 Family Self-Sufficiency Program (FSS)

Indiana's Housing Choice Voucher Program and Family Self-Sufficiency (FSS) Program, administered by DFC's Housing and Community Services Section provides rental voucher assistance in conjunction with public and private-sector services and resources that can help residents of assisted housing achieve economic independence. Use of housing as a stabilizing force permits the families to invest their energy into other sustaining efforts including employment, education, and job training that are necessary to achieve self-sufficiency.

To be eligible, families must be current voucher holders. Participants in the FSS Program are provided with an opportunity to save for the future through the FSS Escrow Account. Increases in the family's contribution for rent, due to increases in earned income, are credited to an interest bearing escrow account. After the family successfully completes the program, the escrow balance can be withdrawn by the family to be used in any manner. Most FSS Program participants have used the escrow monies to continue working, buy an automobile, or make a down payment on a home.

To date there have been 35 graduates of the program. The average escrow check amounts has ranged between $3,500 and $4,500. In the last 12 months, the FSS Program has awarded a total of $59,134.96 to participants who have successfully completed the program. Participating Community Action Agencies, under contract with the Division of Family and Children manage the program throughout the entire year.

C. The Family Unification Program (FUP)

The program provides housing assistance vouchers to families with children at-risk of an out-of-home placement due to lack of adequate housing. HUD provides Indiana with funding for the program. There are 200 housing units available statewide under this program. Currently, all units are full.

D. The Mainstream Program

A joint DDARS and DFC initiative, the project is designed to provide rental assistance vouchers to enable any person with a disability, regardless of age to rent affordable private housing. The Program targets very low-income, disables families who are on the Housing Choice Voucher waiting list of applicants. DDARS refers clients to the program, provides caseworker assistance to the eligible individuals in finding suitable housing, and provides on-going case management and

support. Mainstream Program recipients may live in mobile homes, apartments, doubles, single homes, etc. However, the program does not provide assistance to live in congregate settings such as nursing homes or schools.[xxiv]

2. ***Transportation***

In CY2001, INDOT awarded more than $1.7 million in capital grants to over 60 counties and 83 non-profit social service agencies for vehicles and related equipment repair to ensure services for the elderly and disabled. It is estimated that these grants result in over 500,000 one-way trips (statewide) each year[xxv].

Although Medicaid-funded transportation services are provided only to persons receiving Medicaid for use when receiving a Medicaid-approved medical service, Indiana spent $32,171,000 on Medicaid transportation services in SFY 2002. Even though these expenditures appear significant compared to other Indiana transportation programs, Medicaid transportation expenditures represent less than 1% of total Medicaid expenditures. xxxi

3. ***Vocational Services***

A. Vocational Rehabilitation Services (VRS)

Vocational Rehabilitation Services (VRS) is a State-Federal partnership program first established in 1920. The purpose of VRS is to assist eligible individuals with disabilities in achieving employment and independence. A major focus of the VRS program is to enable individual customers to have primary input into their own rehabilitation programs.

Eligibility for VRS is based on federal requirements. A person is eligible if he or she has a physical or mental impairment which is a substantial impediment to employment *and* he or she needs vocational rehabilitation services in order to enter, prepare for, engage in, or retain employment.

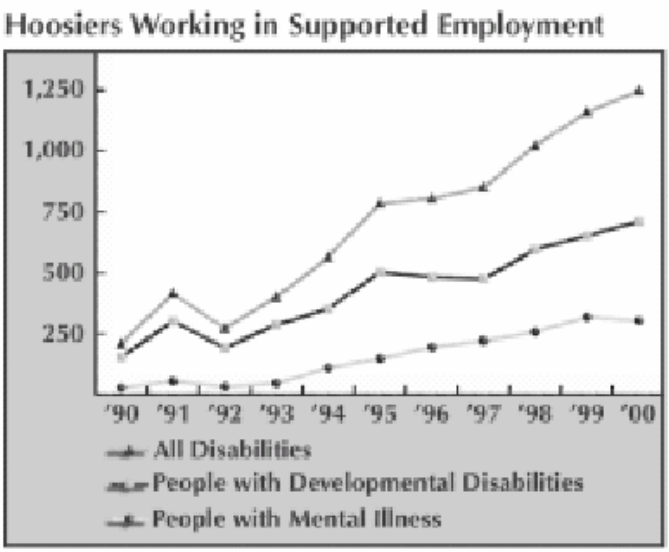
In SFY 1999, 4351 Indiana residents were placed in employment through FSSA's Vocational Rehabilitation program, up from 3,641 in FY 1995.[xxvi]

B. Supported Employment

Individuals with the most severe disabilities are placed in competitive jobs with qualified job coaches/trainers to provide individualized, ongoing support services needed for each individual to retain employment. The employer is contacted monthly and the employee is visited twice monthly to address any issues that may threaten the individual's ability to remain on the job.

DMHA provides the Office of Vocational Rehabilitation with funds to enable them to build supported employment programs. Currently, more than 26 community mental health centers offer supported employment programs throughout the state, a dramatic increase from the single CMHC offering such services in 1990. There are more than 700 people with Mental Illness in supported employment in Indiana at a cost of $1.1 million.

Since 1999, an average of 772 individuals has been enrolled in a supported employment programs each year.[xxvii] Researchers at Ball State University have been collecting data from supported employment programs throughout Indiana. Research shows that about 55 percent of those who enter a supported employment program will secure employment.[xxviii]

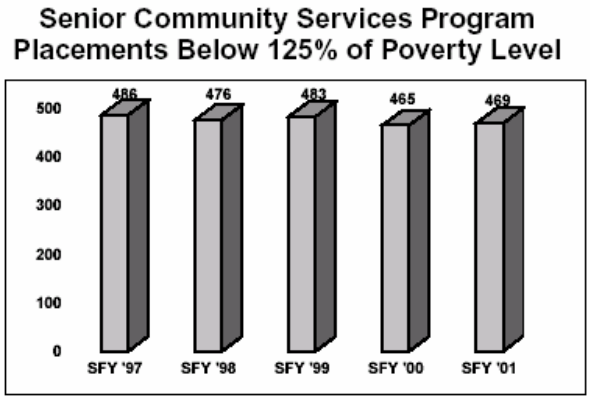


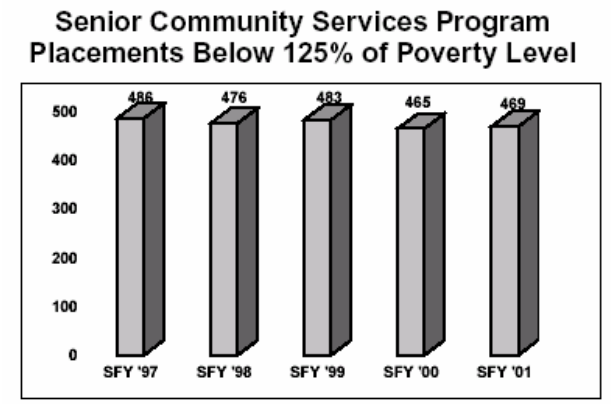
C. Senior Employment Program

The Older Americans Act of 1965, as amended, authorized the establishment of the Title V Community Service Employment Program. This program is commonly referred to as the Title V Senior Employment Program. The purpose of the Title V Senior Employment Program is to provide meaningful part-time work opportunities in community service for those 125% or below the federal poverty level and are 55 years of age or older with poor employment prospects (as defined under 42 U.S.C. 1397). The desired outcome of this program is to provide meaningful employment and training to low-income persons aged 55 years or older and who have poor employment prospects. Initially, the U.S. Department of Labor subsidizes wages.

In SFY 2001, the Title V Senior Employment Program served 469 Hoosiers. The majority of individuals served were women between 60 and 74 years of age. The U.S. Department of Labor has established a goal of placing 20% of the Title V clients in unsubsidized employment. Indiana exceeded this goal by placing 21.2% of the clients in unsubsidized employment.

The Title V program is funded primarily through the U.S. Department of Labor. Federal funds equaling $2,074,714 were expended in SFY 2001 and matched with $340,625 in state and local funding. In addition, administrative expenses were $68,979, matched with 90% federal dollars.





D. Impact

The Indiana Manpower and Comprehensive Training (IMPACT) Program provides services designed to help Food Stamp and TANF beneficiaries achieve economic self-sufficiency through education, training, job search and job placement activities.

The IMPACT program assists participants in meeting these goals through an approach that emphasizes job placement and job retention complemented by education and training activities. The participant's movement toward the goal is assisted by IMPACT case management, which coordinates an array of services, including education, training, job search, job placement, and social services offered by the Indiana Family and Social Services Administration through the Division of Family and Children and local providers.

IMPACT is Indiana's Welfare-to-Work program – a critical component of Indiana's welfare reform initiatives – which places an increasing emphasis on "work first." "Work first" means that individuals are expected to accept a job which can be secured with their existing education and skills.

Waivers from the U.S. Department of Health and Human Services and the U.S. Department of Agriculture provide "work pays" incentives to assist clients. Financial barriers to moving toward self-sufficiency have been reduced by Indiana's welfare reform initiatives. As an important link in the welfare reform program, IMPACT places and increasing priority on participants, retention, and wage gain with a "work first" focus along with a holistic approach to the whole family.

IMPACT is much more than a job training program, however, in that it seeks to address a broad range of barriers that clients may have in locating and maintaining employment.

From the time an individual applies for assistance, employment services are available and individuals are asked to begin their job search. For those not able to find a job right away, additional activities are provided. An assessment of the client's strengths and needs is completed and a case manager works with the client to develop an individualized plan for employment. The plan outlines the steps which will be taken for the client to become self-sufficient.

In addition to job search, the activities could include job readiness activities or an unpaid work experience at an agency. In addition to a work activity, appropriate vocational training or basic education classes might be included on the employment plan. The plan also includes supportive services such as transportation and child care.

To assist in this endeavor, the program has increased the provider contracts for job search, job readiness, job development, job placement and retention as well as providing services to the whole family and outreach to the faith-based community as service providers. Indiana was selected by the National Governor's Association as one of seven states selected to pilot workforce innovations for the incumbent worker in partnership with the Indiana Department of Workforce Development and the Indiana Economic Development Council.

State Fiscal Year	Job Placements
1993	3,982
1994	4,665
1995	9,483
1996	19,906
1997	27,349
1998	33,500
1999	25,382
2000	23,216

E. Temporary Assistance to Needy Families (TANF)

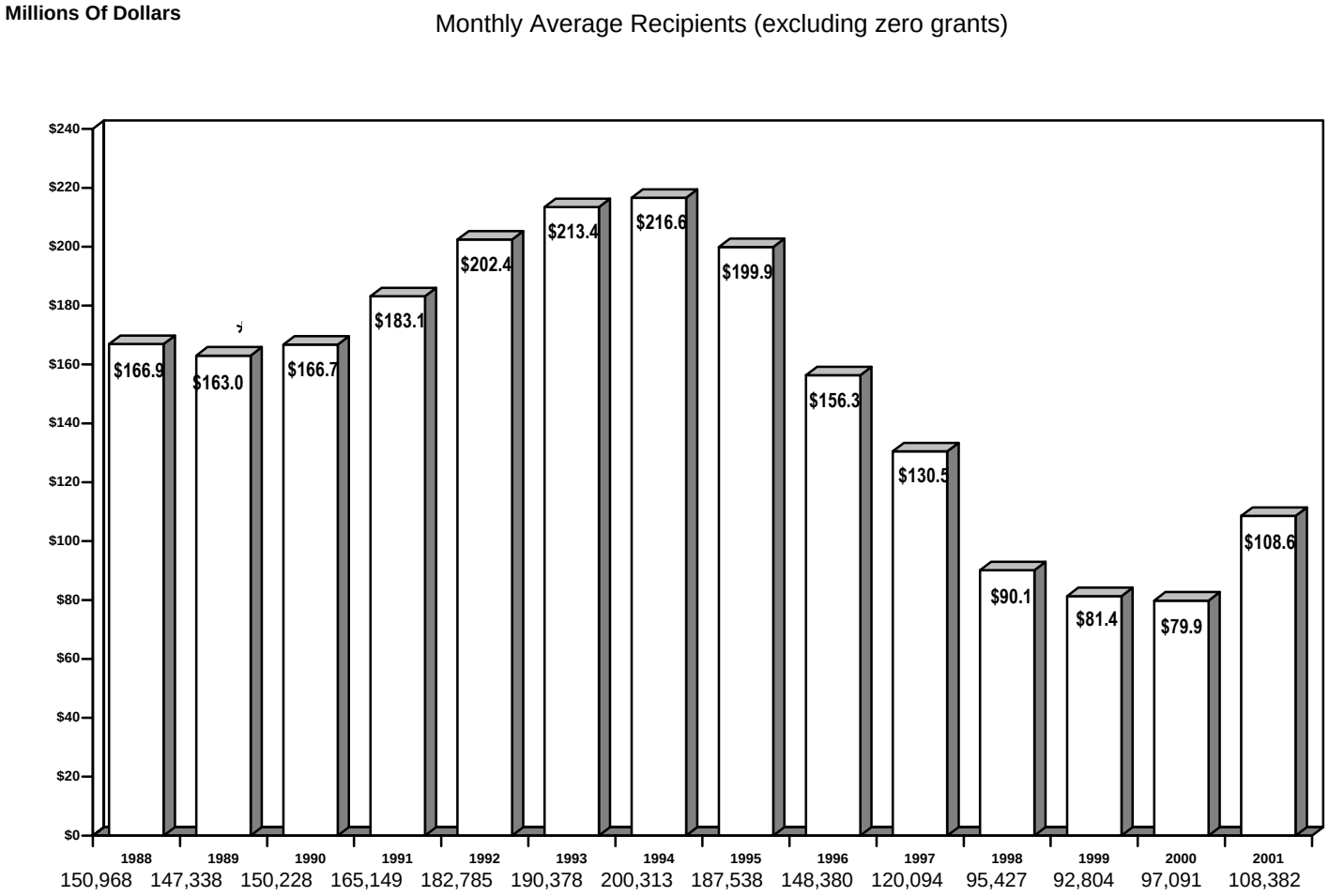
TANF is a program that provides cash assistance and social services to assist the family, helping them achieve economic self-sufficiency.

Although the TANF Block Grant provides the funding for varied social services and benefits to low-income families, the primary program funded by the block is the cash assistance program.

Indiana's cash assistance program is part of the State's Welfare Reform Demonstration Project. This demonstration includes the employment and training services provided to those families receiving cash assistance. Those assigned to the demonstration treatment group are required to cooperate with policies which address personal responsibility, child immunization and school attendance, maintenance of a safe and secure home, prohibition of substance abuse, and a 24-month time limit on cash assistance for those who are required to participate in employment activities. Additional provisions include more stringent penalties and employment incentives than the traditional AFDC Program. Those assigned to the control group are subject to the conditions of the former AFDC Program.

TANF beneficiaries include families with children under the age of 18, that are deprived of financial support from a parent by reason of death, absence from the home, unemployment, or physical or mental incapacity. Assets are both liquid and non-liquid. Therefore, an applicant may not have assets valued in excess of $1,000 at the time of application. Subsequent to application, the Treatment Group has an asset limit of $1500. In addition, individual members must provide their Social Security numbers and meet state residency and citizenship/alien requirements. Individual family members who do not meet exemption criteria must register for Indiana's Manpower Placement and Comprehensive Training (IMPACT) program, as well as cooperate with the Child Support Enforcement Program.

Temporary Assistance For Needy Families
Total TANF Regular Expenditures For
State Fiscal Years 1988 - 2001

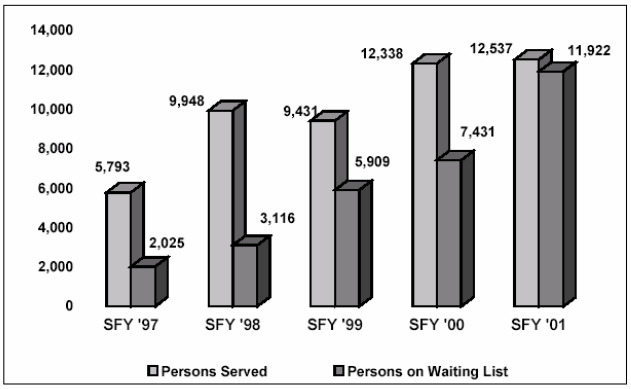


4. ***Community and Personal Assistance Support Services***

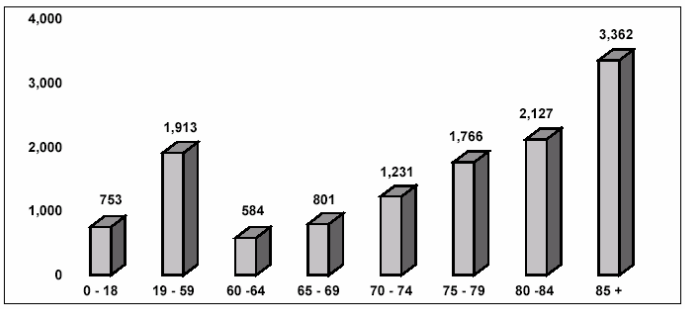
A. The Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) Program

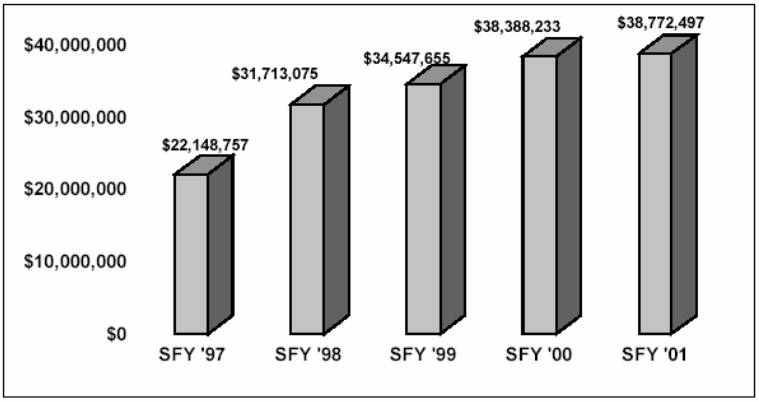
The CHOICE Program was established during the 1987 legislative session through House Enrolled Act (HEA) 1094 and began as a pilot program in Knox, Daviess, and Tippecanoe counties in 1988. The program went through several expansions that resulted in services being extended to all of Indiana's 92 counties by 1992. The program is available to person age 60 years of age and older, rform two or more activities of daily living as n Care Services Eligibility Screen. In SFY2001, a cost of $38.8M. This translates to roughly .000 persons, more than 7,000 remain on the

Persons Served by Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) vs. Persons on Waiting List



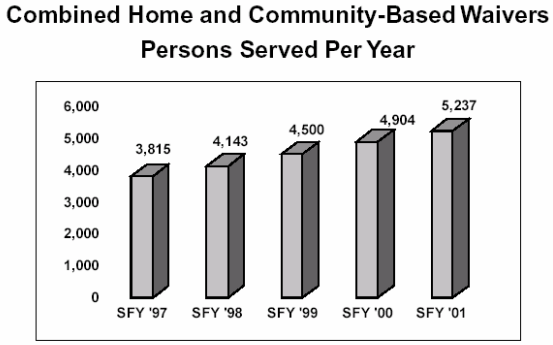
Ages of Persons Served by CHOICE in SFY 01

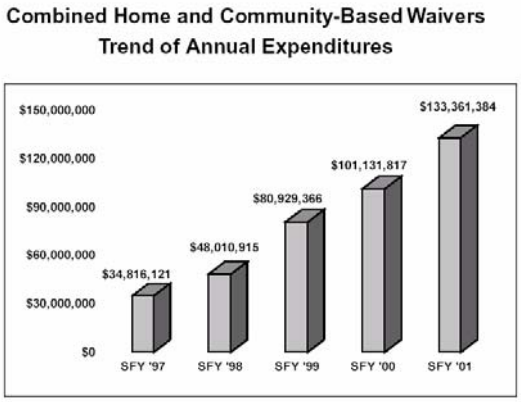




B. Waivers

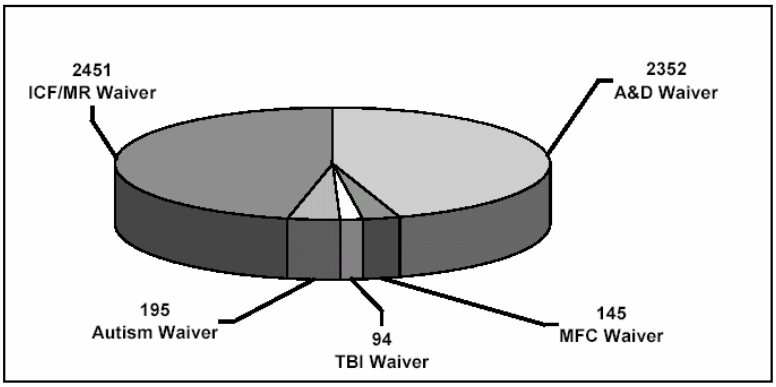
Medicaid waivers allow Indiana to provide a variety of in-home and community-based services to individuals who would otherwise require the level of care provided in an institutional setting. These



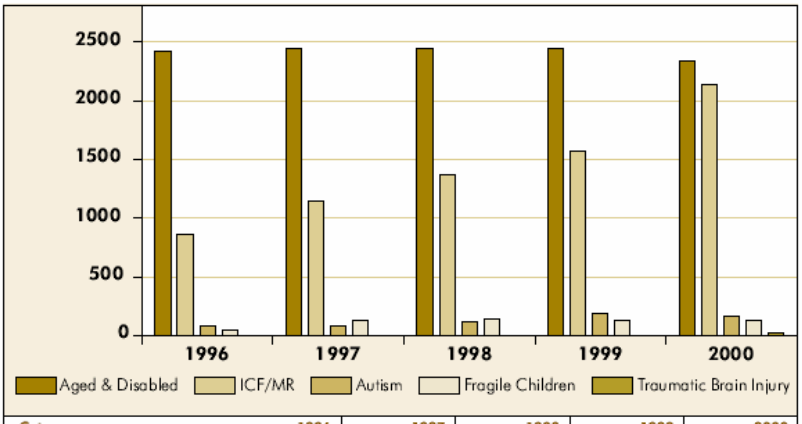


five Medicaid Waivers served a combined total of 5,237 individuals in SFY 2001 at a cost of $133.3 million.

By 2001, there were five Medicaid Waivers administered by DDARS allocated as such:



Waiver Recipients by Category [Figure 9]



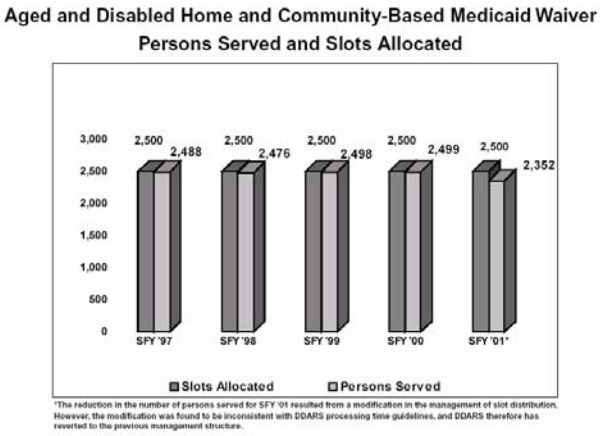
Category	1996	1997	1998	1999	2000
Aged & Disabled	2,422	2,448	2,445	2,447	2,343
ICF/MR	859	1,150	1,375	1,572	2,137
Autism	82	88	120	184	169
Fragile Children	50	129	138	134	134
Traumatic Brain Injury	-	-	-	-	28
Total	3,413	3,815	4,078	4,337	4,811

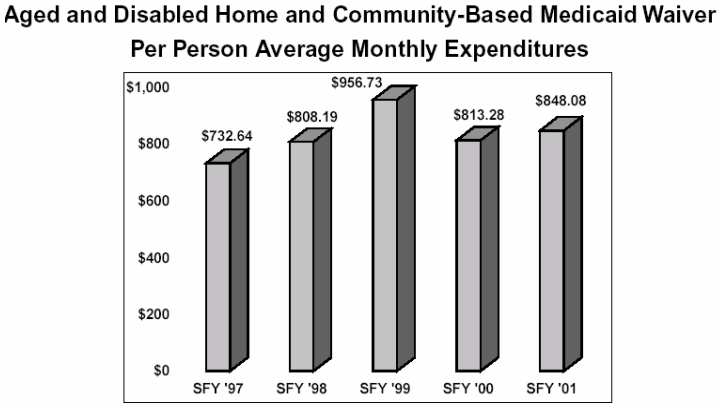
Waiver waiting lists at end of year SFY 2002
(www.in.gov/fssa/qtrreports.html)

Waiver Program	Waiting List as of 6/1/02
Aged and Disabled Waiver	2339
Autism Waiver	316
Developmental Disabilities Waiver	3473
Medically Fragile Children Waiver	222
Traumatic Brain Injury Waiver	80

i. Aged and Disabled Waiver

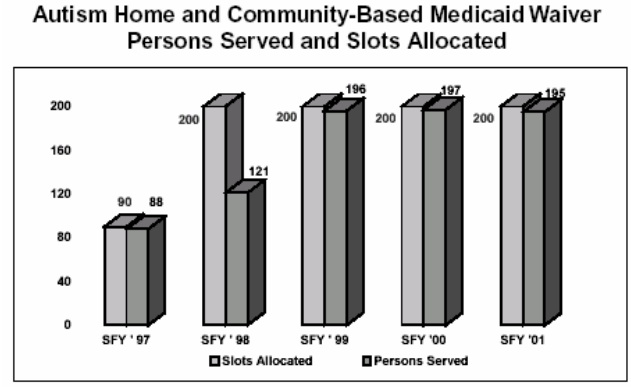
This waiver serves individuals who meet the Medicaid guidelines and either 65 years of age or have disabilities. Individuals served by this waiver must meet level of care standards of a skilled or intermediate nursing facility.

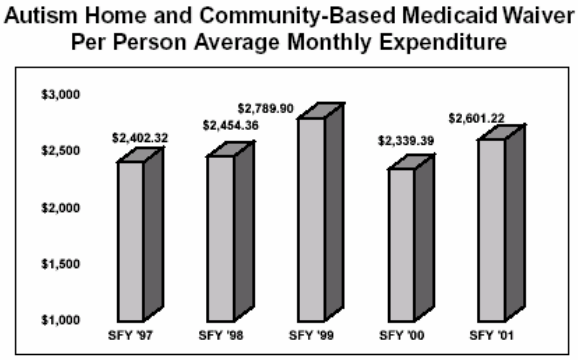




ii. Autism Waiver

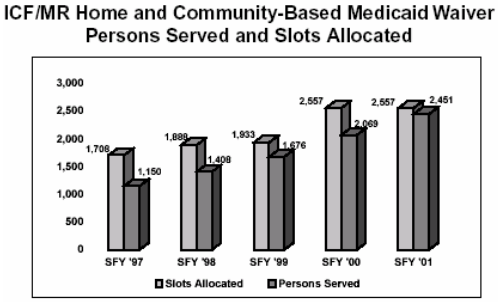
The autism waiver serves individuals with a diagnosis of autism who meet an intermediate care facility for mental retardation level of care.

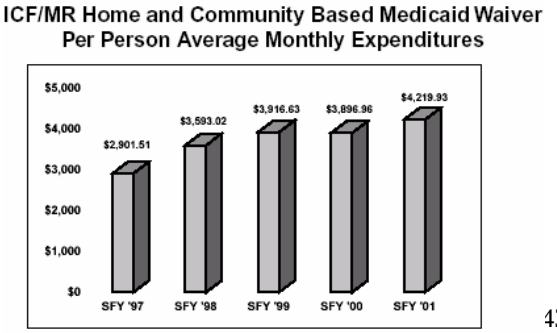




iii. Intermediate Care Facility for Mental Retardation (ICF/MR) Waiver

Serves individuals with developmental disabilities/mental retardation and other related conditions who meet intermediate facility for mental retardation level of care.





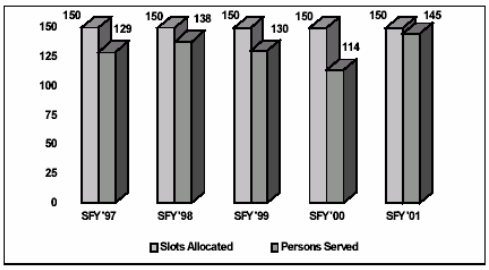
SFY 2000 Medicaid Payments for ICF/MR [Table 9]

	Number of Unduplicated Residents	Total Payments	Annual Cost Per Resident
Group Home ICF/MR	4,176	$199,873,533	$47,862
Large Private ICF/MR	1,064	$36,995,193	$34,770
State ICF/MR	523	$52,350,946	$100,097

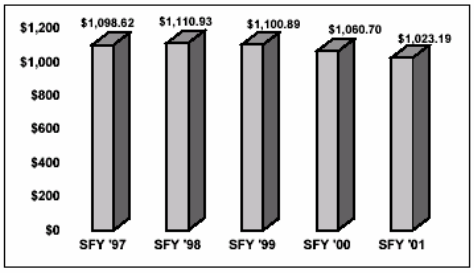
iv. ***Medically Fragile Children Waiver***

This waiver serves children under 18 years of age who are in need of significant medical services, including those who are technologically dependent. Beneficiaries of these services meet either skilled nursing facility level of care or hospital level of care.

Medically Fragile Children Home and Community-Based Medicaid Waiver
Persons Served and Slots Allocated



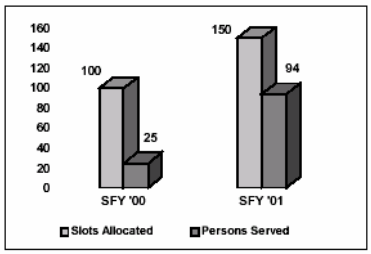
Medically Fragile Children Home and Community-Based Medicaid Waiver
Per Person Average Monthly Expenditures



v. ***Traumatic Brain Injury Waiver (TBI)***

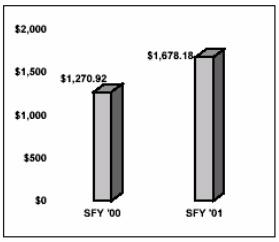
The TBI waiver serves persons who have suffered injuries to the brain including closed or open head injuries. Services under this waiver were implemented in March 2000.

Traumatic Brain Injury Home and Community-Based Medicaid Waiver
Persons Served and Slots Allocated



The Traumatic Brain Injury Home and Community-Based Waiver began services in March 2000, operating on a calendar year. Data for SFY '00 includes only a three month period.

Traumatic Brain Injury Home and Community-Based Medicaid Waiver
Per Person Average Monthly Expenditures

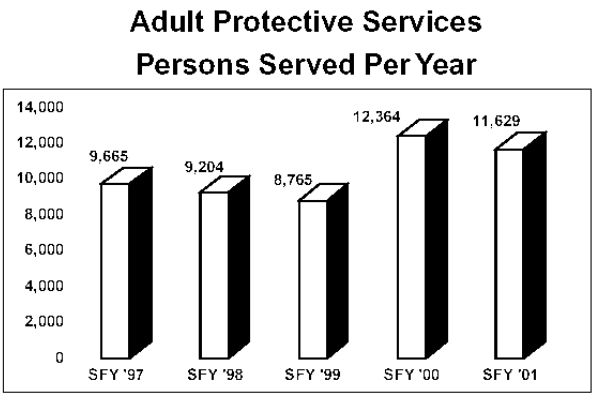


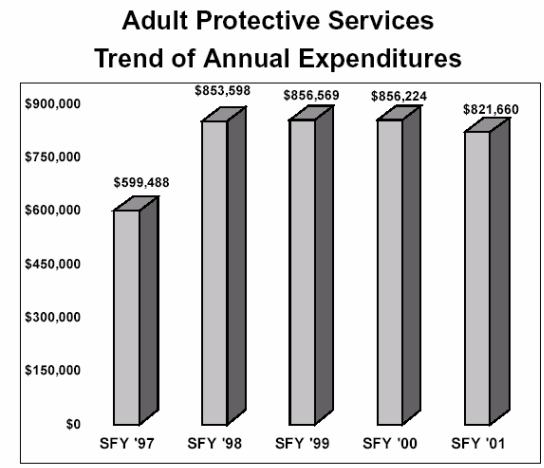
The Traumatic Brain Injury Home and Community-Based Waiver began services in March 2000, and therefore does not reflect a full year's expenditures. Data for SFY '01 includes a 12 month period and is an average of those 12 months.

B. Adult Protective Services

The purpose of the Adult Protective Services Program is to provide protection to adults who are endangered by abuse, neglect, or exploitation. The law defines “endangered adults” as individuals at least 18 years of age, incapable of caring for themselves, and being abused, neglected, or exploited.

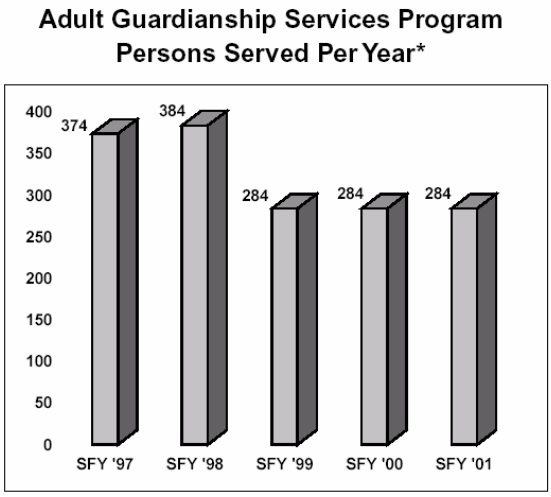
Adult Protective Services served 11,629 Hoosiers in State Fiscal Year 2001. Program expenditures for that period were $821,660.

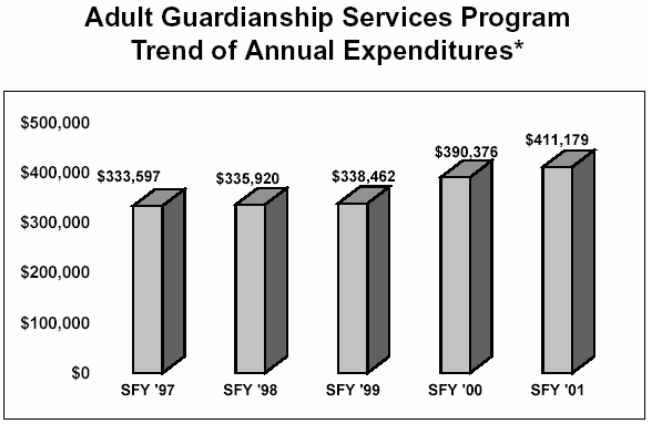




C. The Adult Guardianship (AGS) Program

This program was established to provide full guardianships, limited guardianships, and less restrictive alternative services to indigent, incapacitated, adults who are unable to care for themselves and/or manage their own affairs without assistance, or who have a developmental disability. The AGS Program served 284 individuals in SFY 2001. Total expenditures for that period were $335,920.





* Persons served per year reflects Adult Guardianship services that are funded with multiple resources, while trend of annual expenditures reflects only state funding. The reductions in persons served per year is primarily a function of changes in non-state funding, as state funding has increased in recent years.

D. Child Welfare Rehabilitation Option (CWRO)

The Child Welfare Rehabilitation Option is a new Medicaid waiver option that will provide clinical mental health services to individuals living in the community or in Residential Treatment Facilities who need aid intermittently or on a twenty-four hour a day basis for emotional disturbances or mental illness. Medicaid reimbursement will be available to current DFC licensed facilities and licensed child-placing agencies (LCPA). Indiana is requesting this option in order to leverage federal dollars. Currently, the costs of these services are being paid with 100% county funds. This waiver should be available sometime in CY 2003.

E. Child Support

The Bureau of Child Support assists Hoosier families and children by enforcing parental responsibility through collection of payments by non-custodial parents. The child support program provides a full range of child support services, including establishment of paternity, establishment and enforcement of child support orders, collection and distribution of child support payments, and location of absent parents.

Every child has the right to the care and support of both parents, regardless of whether or not the parents are married or both in the home. The child support program enforces this right. Child support services are offered through County Prosecutors Offices (one in each of the 92 Indiana counties.)

These services include:

- Locating absent parents
- Establishing paternity
- Establishing and enforcing support orders
- Establishing and enforcing medical support orders
- Collecting current and past due support payments
- Review and adjustment of current support orders

F. Food Stamps

Indiana's Food Stamp Program is designed to raise the nutritional level of low-income households by supplementing their available food purchasing dollars with food stamp benefits. Information regarding nutrition and budgeting is available to participants to assist in choosing a nutritionally sound diet with limited income. Program participants are entitled to use their food stamp benefits at the retailer of their choice and choose foods based on their own preferences. However, retailers must be federally approved to accept food stamp benefits. Non-food items may not be legally purchased with food stamp benefits.

The Food Stamp Program is administered through each state but benefits are funded solely by federal funds. Federal regulations which govern implementation of the program are developed by the United States Department of Agriculture, Food and Nutrition Services section pursuant to federal legislation. In Indiana, the Family and Social Services Administration is responsible for ensuring that these federal regulations are initially implemented and consistently applied in each county.

The local Office of the Division of Family and Children in each of the ninety-two Indiana counties has the responsibility for processing applications, certifying eligible applicants for participation, and issuing benefits.

In order to qualify for food stamp benefits, applicants/participants must meet both non-financial and financial requirements. Non-financial requirements include state residency, citizenship/alien status, work registration, and cooperation with the IMPACT Program. The financial criteria are income and asset limits. If an applicant is eligible based on the federally established financial and non-financial requirements, the allotment of food stamp benefits they receive is based on household size and net monthly income after all allowable deductions are subtracted.

The asset/resource limits are $2,000 per household except for households containing a member age 60 or older; then the limit is $3,000. Assets include bank accounts, cash, real estate, personal property, vehicles, etc. The household's home and surrounding lot, household good and personal belongings and life insurance policies are not counted as assets in the Food Stamp Program. All vehicles used for transportation were exempt effective March 1, 2002.

All households must pass a gross income test of 130 percent of the federal poverty level to qualify for benefits with the exception of those with elderly or disabled members. The gross income is determined by household size and based on the gross monthly income received by all household members.

Totals – Persons 331,206; Total dollars 297,964,712 (SFY 2001.)

G. Family Protection and Preservation

FSSA's Bureau of Family Protection and Preservation (BFPP) and The Division of Family and Children local officers serve children in the state who are at risk of abuse or neglect. The BFPP administers programs that provide child welfare and family services, child abuse prevention services, foster care, adoption, independent living, residential licensing and youth services. The BFPP provides child protection services to protect Indiana's children from further abuse or neglect and prevents, remedies, or assists in solving problems that may result in neglect, abuse, exploitation, or delinquency of children.

The Family Preservation Program carries out the Division's goal to prevent unnecessary separation of children from their families by identifying family problems while assisting families in resolving them.

The program also seeks to return children who have been removed from their homes to their families through the provision of services to the child and family problems while assisting families in resolving them.

The program also seeks to return children who have been removed from their homes to their families through the provision of services to the child and family when a court finds that reunification is in a child's best interest.

The Family Preservation Program provides services to prevent out-of-home placement or to reunify children and their families in cases of substantiated reports of child abuse or neglect. Program services offered to families include education, counseling, visitation, sexual abuse treatment, parent aides, homemaker services, and home-based family services.

Statistics show that approximately 12,500 children and their families are separated at any given time. The State of Indiana has developed a five-year plan for family preservation and support services with the help of local Step Ahead councils and local service needs assessments. Federal Title IVB Part II monies fund the five-year plan.

Children in Need of Services (CHINS) By Type of Placement

	Total CHINS	Foster Homes	Residential Care	Adoptive Homes	Own Home	Relative Home	Other
March 2003	10,793	4,320	1,391	0	2,968	909	1,205
March 2002	9,981	4,109	1,315	12	2,594	850	1,101
% Incr (Decr)	8.1	5.1	5.7	(100)	14.4	6.9	3.4

CY 2002 Identified CHINS Costs

(Family & Children Fund)

Foster Homes Relative	4,239,002
Foster Homes Non Relative	24,820,858
Therapeutic Foster Homes	42,488,278
Residential Facilities	101,635,371
Independent Living	367,603
Preservation Services	15,901,499
Misc. Cost	6,174,904
Total CHINS	**195,627,515**

As reflected in the table above, the cost of care for children in out-of-home placement is much greater than the cost of providing care to children at home. For example, in March 2002, nearly twice as many Children in Need of Services (CHINS) were being served in their own homes compared to being served in residential facilities. The annual cost for residential facilities care in 2002 was more than six times greater than that of preservation services.

Family preservation expenditures largely reflect the cost of home and community-based services to children and their families who are under the supervision of the local office of family and children (court) and have been placed in their own homes. However, some of these costs are spent on home and community-based services to families of children who have not yet been returned home. The purpose of these services is to prepare the family for the return of the child.

Child Welfare Expenditures, 2000 (Actual) to 2003 (Budgeted)

	2000	2001	2002	2003
Community Based				**Division**
Family & Children Fund - Cal. Year	**Actual**	**Actual**	**Final**	**Approved**
Foster Homes	34,617,916	32,222,819	37,579,584	35,575,384
Therapeutic Foster Homes	40,090,952	42,304,579	46,998,682	48,279,729
Independent Living	388,420	438,367	919,010	1,085,027
Preservation Services	34,886,060	38,283,145	42,480,974	42,879,185
MRO	783,373	1,060,782	2,088,999	2,248,177
Adoption Services	36,531,177	45,597,986	51,257,395	59,407,342
Child Welfare Services (CWS)	6,322,682	6,597,595	9,266,490	8,923,470
Destitute Children	20,063	11,696	Included in CWS	Included in CWS
Contracted with the State - FFY	**Actual**	**Actual**	**Actual**	**Budgeted**
IV-E, Independent Living	928,348	573,364	1,438,383	2,088,263 *
IV-B, Part I (Services Only)	$6,479,168	5,837,145	5,439,221	8,977,352 *
IV-B, Part II	3,449,171	3,410,345	2,674,202	7,819,282 *
Institutional Placements				**Division**
Family & Children Fund - Cal. Year	**Actual**	**Actual**	**Final**	**Approved**
Wards in Institutions	160,076,123	154,590,406	163,255,134	186,082,668
Prevention	**Actual**	**Actual**	**Actual**	**Budget**
Healthy Families	27,563,895	35,841,092	41,132,458	40,855,489
First Steps	31,428,952	54,078,028	58,930,670	63,729,758

* These budgeted amounts include prior-year carry forward.

H. First Steps Program

The First Steps Early Intervention System is Indiana's response to Part C of the Individuals with Disabilities Education Act. First Steps' broad definition of children with special needs, the exclusion of family income as consideration for eligibility, emphasis on family-focused intervention and efforts to provide services in the child's natural environment combine to create a successful program whose population consists of those most in need of early intervention.

First Steps is based in each of Indiana's 92 counties and is implemented by a Local Planning Coordination Council in each of them. In SFY 2001, 16,272 infants and toddlers received services through the First Steps System. The estimated number of First Steps population is 18,000 children.

The program is available to children from birth to three years old who:

- Are experiencing developmental delay;

- Have a diagnosed condition that has a high probability of resulting in a developmental delay; and/or
- Are at risk of having substantial developmental delay as a result of biological risk factors if early intervention services are not provided.

Services available include the following:

- Speech therapy
- Occupational therapy
- Physical Therapy
- Developmental Therapy
- Social Work
- Psychological service
- Nutrition
- Health
- Nursing
- Medical Diagnostics
- Audiology
- Vision Services
- Assistive Technology
- Service Coordination
- Transportation
- Family Training
- Counseling

SFY 2002 First Steps expenditures from all funding sources:

First Steps Early Intervention Services (Part C Grant 2001)	$7,830,010
Early Intervention (other sources)	$52,809,390

I. Healthy Families

Healthy Families Indiana is a primary prevention program. It is a voluntary home visiting program for new parents as well as strategy for strengthening families and promoting healthy child outcomes. A variety of services are provided including child development, access to health care and parent education. By working closely with hospital maternity wards, prenatal clinics, and other local agencies, the program systematically identifies, either before or immediately after birth, families who would benefit from education and support services and offer them home visitor services. In partnership with Healthy Families America, the national home visitation model, Healthy Families Indiana was launched in 1994. Prevent Child Abuse America and Healthy Families America credentialed Healthy Families Indiana as a multi-site system on September 25, 2001.

Indiana has the first Healthy Families program in the nation to support a state system with blended federal funds through the establishment of a Healthy Families Fund. Indiana is also the first state to establish formal linkages with the U.S. Justice Department.

At the state level, four revenue sources contribute to the overall funding: Children's Trust Fund, Indiana Criminal Justice Institute, FSSA Division of Mental Health and Addictions, and TANF funding through the FSSA Division of Family and Children.

The program is designed to strengthen families by reducing the incidence and possibility of child abuse and neglect, childhood health problems and juvenile delinquency. The goals of Healthy Families Indiana are to systematically identify overburdened families; promote healthy family functioning by teaching problem solving skills; reduce family stress; improve family support systems; promote positive parent/child interaction; promote health childhood development; prevent child abuse and neglect; and promote self sufficiency by linking families to existing community resources.

Healthy Families Indiana provides screening and assessment of families in targeted areas throughout the state. Service entry points include WIC programs, health clinics and local hospitals. Parents are screened using a validated, standardized instrument, and the Maternal Record Screen. Positive screens do not assess the risk of child abuse and neglect but do indicate a need to conduct a more in-depth discussion with the family.

Families with positive screens are then assessed using a standard validated instrument, the Kempe Family Stress Checklist which is scored using a standardized rating scale. Families with a score of 25 or higher are offered the opportunity to participate in a voluntary home visiting program tailored to their individual needs.

The 56 Healthy Families Indiana program sites provide services to families throughout the state. The number of families served has increased from 760 in 1994 to 21,401 in 2001. Healthy Families has grown from a $600,000 child abuse and neglect program in 1994 to $40.5 million in 2001. Funding is a combination of local, state, and federal dollars.

Descriptive data provided by Healthy Families Indiana sites during 2000 - 2001 have revealed the following results:

- Of the 4,000 families screened each month, 45% had a positive screen and nearly 20% had a positive assessment;
- 90% of the children had a regular primary health care provider and over 70% kept regularly scheduled well child visits;
- 75% received age appropriate Denver II Developmental Screenings and 80% were up to date on childhood immunizations;
- 3% of the families experienced a subsequent pregnancy;
- 28% of mothers who have not graduated from high school are enrolled in school or a GED program; and
- Over 98% of the families served in the largest Indiana site that had at least 24 home visits had no substantiated abuse or neglect while in the program despite the fact they were at higher risk.

J. Other Pertinent Services

- In State Fiscal Year 2001, more than 1.4 million congregate and 1.4 million home delivered meals were provided in Indiana.[xxix]

- Furthermore, $9 million was spent on Room and Board Assistance and $2.7 million was spent on Assistance to Residents of County Homes.

FY 2000 Profile of Indiana Older American Act Programs[xxx]		
Title III/VII Services	**60+ Persons Served**	**Service Units**
Personal Care	892	65,611
Homemaker	6,273	212,353
Chore	1,705	35,723
Home Delivered Meals	27,781	3,160,258
Adult Day Care/Health	457	150,196
Case Management	43,537	185,162
Congregate Meals	41,325	2,427,756
Nutrition Counseling	3,873	22,985
Assisted Transportation	7,673	187,633
Transportation		1,321,712
Legal Assistance		24,543
Nutrition Education		88,018
Information and Assistance		250,635
Outreach		527,357

SECTION V: GLOSSARY OF TERMS, ACRONYMS, AND RELEVANT AGENCIES

AAA

Area Agencies on Aging – (also known as Area Agencies or Triple A) Sixteen nonprofit agencies located throughout the state which provide services, and grant or contract with other public and private organizations to provide services, for older persons within their area. In Indiana, they are responsible for administering federal and state funding for community and in-home long term care services for the aged and disabled.

ACT

Assertive Community Treatment - a very intensive case management approach for high-risk individuals with severe mental illnesses. The model for ACT involves maintaining housing, living independently, home visits, and medication management assistance by trained staff.

ADA

Americans with Disabilities Act - Enacted July 26, 1990. The ADA prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation. It also mandates the establishment of TDD/telephone relay services.

ADLs

Activities of Daily Living – A measurement of a person's degree of independence in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. Also see "Custodial Care."

Adult Day Care or Adult Day Care Services

Care generally offered by a social service agency or nursing home, usually custodial care in nature. Similar in concept to children's day care centers but catering to adult needs and interests.

Adult Protective Services

Investigates and resolve reports of abuse, neglect, or exploitation, and to assist in obtaining protective services for endangered adults.

AOA

Administration on Aging – A federal agency under the U.S. Department of Health and Human Services. AOA provides home and community-based services to older persons through the programs funded under the Older Americans Act. Programs include home-delivered meal programs, nutrition services in congregate settings, transportation, adult day care, legal assistance, ombudsman services and health promotion programs.

Assisted Living Facility

Provides home and community services in a more home-like and comfortable environment than the typical nursing home setting. Services are designed around the resident's needs. Provides a combination of social interaction and privacy. Nursing staff provide nursing services in licensed assisted living facilities. These services are provided by a home care agency in unlicensed assisted living facilities.

Assistive Technology

Assistive technology device means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. Assistive technology service means any service that directly assists an individual with a disability in the selection, acquisition, or use of an assistive technology device.

Benefit Period

The period of time for which the insured is eligible to receive benefits or services under Medicare, Medicare Supplement, or a Long Term Care insurance policy.

Benefit Period under Medicare

The Medicare Part A benefit period begins upon entry to a qualified hospital, and ends when the patient has been out of a hospital (and not receiving Medicare benefits in a facility that primarily provides skilled nursing or rehabilitation services) for 60 consecutive days, including the day of discharge. The Part B benefit period is based on the calendar year.

Medicare Part A can cover inpatient hospital care, skilled nursing facility care, home health care and hospice care. Medicare Part B includes a wide range of services including outpatient hospital services (e.g. radiology and laboratory tests, therapy services, medical supplies, and durable medical equipment), physician services and home health care. In a skilled nursing facility (following a qualified hospital stay), Medicare Part A will pay in full for Day 1- 20 and for Days 21- 100 a co-insurance amount of $101.50 per day in 2002 is required. A beneficiary qualifies for a new 100-day benefit period when there are 60 days during which there has been no inpatient stay, no Medicare SNF stay, and no inpatient care for a continued skilled level of care. The Part B benefit period covers specific services based on the calendar year.

BI or TBI

Brain Injury or Traumatic Brain Injury– There are currently 5.3 million Americans living with a disability caused by brain injury. Brain injury is acquired damage to the brain, the result of either an external physical force or internal causes, which results in an impairment of cognitive, emotional, and/or physical functioning. It is not of a degenerative or congenital nature but caused by an external physical force or by internal damage such as anoxia (lack of oxygen), stroke, disease, or tumor. It may produce a diminished or altered state of consciousness, which results in impairment of "thinking processes" and physical abilities. These impairments may be either temporary or permanent, and cause partial or total functional disability or psychosocial maladjustment.

BAIHS

Bureau of Aging and In-Home Services- a part of Family and Social Services Administration/ DDARS. BAIHS administers four Medicaid waivers, CHOICE, and other home and community-based services for people who have disabilities or are aging.

BDDS

Bureau of Developmental Disabilities Services- a part of Family and Social Services Administration/ DDARS that administers developmental disabilities services programs, including three Medicaid waivers.

Case Manager

An individual qualified by training and/or experience to coordinate the overall medical, personal, and social service needs of the patient. Someone who coordinates/manages the patient's care or "case."

Case Management

The coordination and monitoring of treatment and services.

CHOICE

Community and Home Options to Institutional Care for the Elderly and Disabled – One of Indiana's in-home services programs administered by the sixteen Area Agencies on Aging.

CMHC

Community Mental Health Centers- state, local, or non-profit entities. They are contracted by the Indiana Division of Mental Health to provide a full range of mental health services within a designated geographical area. They also provide a "gatekeeper" function to monitor each individual from the time the individual was committed to a state institution administered by the division until the individual is discharged from the commitment. The provide services regardless of a client's ability to pay.

CMS

Centers for Medicare and Medicaid Services – A branch of the Department of Health and Human Services. This federal agency is responsible for administering the Medicare and Medicaid programs and approves all waivers and waiver amendments. Formerly HCFA (Health Care Financing Administration).

Convalescent Care/Rehabilitative Care

Non-acute care prescribed by a physician and received during the period of recovery from an illness or injury.

Conversion

For the purpose of the Medicaid waiver, the closing of a Medicaid funded facility or a portion of the facility, and the conversion of the facility's bed capacity to Medicaid waivers. The facility must have a closure or downsizing plan approved by the state in order to allow the funding to follow the person into the community. Also refers to the "systems change" of community rehabilitation programs from the provision of segregated services, i.e. sheltered workshops, to integrated services, i.e. supporting people in competitive employment in the community

CPS

Child Protective Services –Protects Indian's children from further abuse or neglect and prevents, remedies, or assists in solving problems that may result in abuse, neglect, exploitation, or delinquency of children.

Custodial Care

Care is considered custodial when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training. Example: help in walking, getting in and out of bed, bathing, dressing, eating, toileting, and taking medicine. (These may also be referred to as Activities of Daily Living or ADLs.)

CWRO

Child Welfare Rehabilitation Option – New Medicaid waiver option that will provide clinical mental health services to individuals living in the community or in Residential Treatment Facilities. Recipients will be those who need aid intermittently or on a twenty-four hour a day basis for emotional disturbances or mental illness. This option is being sought to leverage federal dollars to cover the cost of services that are currently being paid with 100% county funds. Waiver should be available sometime in CY 2003.

DAPW

Division of Public Works (http://www.in.gov/idoa/pwd/)- As a key branch of the Indiana Department of Administration (IDOA), the Public Works Division (DAPW) manages almost all of the building construction and maintenance projects for the State of Indiana. This includes evaluation of construction proposals for feasibility; designing the projects; advertising, public bids, and awarding construction; and managing these construction contracts through final completion. In past years, DAPW has administered more than 1000 design and construction projects annually, with an average estimated value in excess of $70,000,000.

DDARS

Division of Disability, Aging and Rehabilitative Services – a part of Family and Social Services Administration. Includes Bureau of Aging and In-Home Services, Bureau of Developmental Disabilities Services, Bureau of Rehabilitative Services, Bureau of Fiscal Services and the Bureau of Quality Improvement Services.

DD

Developmentally Disabled **-** A developmental disability is distinguished from other disabling conditions in that it occurs during the developmental years of an individual's life, usually before the

age of 18. Although the federal law does not define specific disabling conditions, persons with mental retardation or autism are generally developmentally disabled. Persons diagnosed as having a condition such as moderate or severe cerebral palsy may also be considered developmentally disabled. In addition, the 10- 15 percent of those persons with epilepsy who experience uncontrolled seizures also fit the definition of developmentally disabled.

DFC

Division of Family and Children – A state agency that strengthens families through services that focus on prevention, early intervention, self-sufficiency, family support and preservation. The division administers child welfare, Food Stamps, employment and training services for low-income clients, and Medicaid eligibility.

DHHS

Department of Health and Human Services – The federal agency that administers the Medicare Program through its divisions, the Social Security Administration and Centers for Medicare and Medicaid Services (CMS) – previously HCFA.

DME

Durable Medical Equipment – this is equipment which can: 1) withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) generally not useful to a person in the absence of an illness or injury; and 4) is appropriate for use in the home.

DMHA

***Division of Mental Health and Addiction* – Division of the Indiana Family and Social Services Administration.**

DOE

Department of Education

DOE/ DEL

The Division of Exceptional Learners, Indiana Department of Education- administers the Individuals with Disabilities Education Act (IDEA, P.L. 101-476), which applies to students with disabilities, ages 3 through 21, in Indiana. Included in this Act are students with autism, deaf-blindness, deafness, hearing impairments, mental impairments, multiple disabilities, orthopedic impairments, other health impairments, emotional handicaps, learning disabilities, communication disorders, traumatic brain injury, and visual impairments.

DOH or ISDH

Department of Health or Indiana State Department of Health (http://www.in.gov/isdh/index.htm) agency which serves to promote, protect, and provide for the public health of people in Indiana.

DOI

Department of Insurance (http://www.in.gov/idoi/)- agency which enforces statutes and regulations applicable to the operation of approximately 1,780 insurance companies, the issuance of insurance policies, the handling of complaints, and the dissemination of public insurance information. The Department, headed by a commissioner appointed by the governor, employs approximately 80 persons.

Deinstitutionalization

Policy which describes the provision of supportive care and treatment for medically and socially dependent individuals in the community rather than in an institutional setting.

Disability

Any limitation of physical, mental or social activity of an individual as compared with other individuals of similar age, sex, and occupation. Frequently refers to limitation of a person's usual major activities, most commonly vocation. There are varying types (functional, vocational, learning), degrees (partial,

total), and durations (temporary, permanent) of disability. Public programs often provide benefits for specific disabilities, such as total and permanent.

Dually Diagnosed

Dual Diagnosis is a term applied to the co-existence of the symptoms of both mental retardation and mental illness.

Endangered Adult

Individuals who are at least 18 years of age, incapable of caring for themselves, and being abused, neglected, or exploited.

FSSA

The Family and Social Services Administration (http://www.in.gov/fssa/)- an agency of the State of Indiana providing services to families who have issues associated with:

- low income,
- mental illness,
- addiction,
- mental retardation,
- a disability,
- aging, and
- children who are at risk for healthy development.

First Steps

A coordinated system of statewide local interagency councils whose mission it is to assure that all Indiana families with infants and toddlers experiencing developmental delays or disabilities have access to early intervention services close to home when they need them.

Group Home

A Group Home is a residential facility for a group that requires special care or supervision, such as children, mentally ill, senior citizens, or troubled teens or persons.

Health Professions Bureau

(http://www.in.gov/hpb/) Provides professional, quality support services to Indiana's health regulatory boards and committees, in furtherance of their responsibility to assure the safe and competent delivery of health care to the citizens of Indiana.

Healthy Families

A voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care, and parent education.

Home Health Care Agency

A home health care agency is a public or private agency that specializes in giving skilled nursing services, home health aides, and other therapeutic services, such as physical therapy, in the home.

Home Health Care

Health care services provided in the home on a part time basis for the treatment of an illness or injury. Medicare pays for home health care only if the type of care needed is skilled and required on an intermittent or part-time basis, and is intended to help people recover or improve from an illness or injury.

Hoosier Healthwise

A health insurance program for Indiana children, pregnant women, and low-income families. Health care is provided at little or no cost to Indiana families enrolled in the program.

HoosierRx

Indiana's prescription drug program for low-income seniors. Any eligible senior enrolled in the HoosierRx Program will receive 50% of the cost of their medications, up to a yearly benefit cap.

ICF/MR

Intermediate Care Facility for the Mentally Retarded– A facility in which individuals with developmental disabilities live together. There is 24-hour supervision by paid staff who provide assistance and training to help residents develop daily living skills, with programming for each individual's needs. These residences may be large, state or privately operated facilities, or group homes for 4 to 8 residents.

IDOL

Indiana Department of Labor (http://www.in.gov/labor/)- agency seeks to promote the welfare of Indiana's workforce by administering a variety of educational and compliance programs designed to provide the knowledge and tools necessary to guarantee workers' rights to safe, healthful, positive work environments, and the appropriate compensation for that work.

IHFA

Indiana Housing Finance Authority (http://www.in.gov/ihfa/)- created in 1978 by the Indiana General Assembly, it is a state-operated bank that finances residential mortgages and the development of rental housing. In addition, it is also a community development organization. IHFA provides affordable homes for Hoosiers, stimulates the construction industry and construction employment, and is financially self-sufficient. No state taxes are used for operating support of IHFA.

IHSS

In-Home Supportive Services –Non-medical services to help functionally impaired persons of all ages, with limited resources, stay at home. (For those who qualify, it is paid by Title XX of the Social Security Act.)

IMPACT

The Indiana Manpower & Comprehensive Training service- Provides job-related services to help TANF and Food Stamp recipients become economically self-sufficient.

INDOT

Indiana Department of Transportation (http://www.in.gov/dot/)- the agency's mission is to provide our customers the best transportation system that enhances mobility, stimulates economic growth, and integrates safety, efficiency and environmental sensitivity.

Independent Living Services

Promotes a philosophy of independent living including consumer control, peer support, self help, self determination, equal access, and individual and system advocacy, to maximize the integration and full inclusion of individuals with disabilities, community leadership, empowerment, independence, and productivity.

Institutionalization

Admission of an individual to an institution, such as a nursing home, for an extended period of time or indefinitely.

Intermediary or Fiscal Intermediary

An organization that handles Part A (*see definition*) claims submitted by hospitals, skilled nursing facilities, home health agencies, hospices, and other providers of services.

Intermittent Care

Not daily care, but care done on a part time basis.

IPAS

Indiana Protection and Advocacy Services (http://www.in.gov/ipas/)- Mission is "to protect and promote the rights of individuals with disabilities, through empowerment and advocacy."

- May be able to assist citizens of Indiana who have a disability and are either being denied a right or are being discriminated against because of that disability.
- Administers 6 Federally Mandated and Funded Programs for Indiana
  - Client Assistance Program (CAP)
  - Protection and Advocacy for Assistive Technology (PAAT)
  - Protection and Advocacy for Beneficiaries of Social Security (PABSS)
  - Protection and Advocacy for Individuals with Developmental Disabilities (PADD)
  - Protection and Advocacy for Individuals with Mental Illness (PAIMI)
  - Protection and Advocacy for Individual Rights (PAIR)
- Is an Independent State Agency which receives no state funding and is Independent from all service providers.
- As required by federal law and state law, must be and is independent of state governmental control.
- Is governed by the 13-member IPAS Commission which sets the agency's Priorities.
- Is advised on Mental Illness matters by a 10-member Advisory Council (MIAC).

Kids at Risk

Children who are "at risk" of failing to succeed in life because of the adversities of their young lives. Poverty, family discord, violence and abuse, substance abuse, and illness are among the hazards.

Lifetime Reserve Days

Sixty extra days provided by Medicare hospital insurance (Part A) that can be used in case of a long illness where the stay in the hospital is more that 90 days. Reserve days are not renewable – they can only be used once. A co-payment is required.

Long Term Care Insurance

A policy designed to help alleviate some of the costs associated with long term care, such as nursing home or home health care costs.

LTC

Long Term Care – the medical and social care given to individuals with impairments covering a long period of time. Long term care can consist of care in the home by family members, assisted with voluntary or employed help (such as provided by home healthcare agencies), adult day care, or care in institutions.

Medicaid

A federal-state partnership designed to ensure that the United States' aged, sick, and impoverished are cared for. This program, authorized by Title XIX of the Social Security Act, is a safety net that provides aid in the form of medical services to people who fall below the state-established poverty line. Subject to broad federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods for administering the program.

Medically Necessary

Medical necessity must be established (through diagnostic and/or other information presented on the claim under consideration) before Medicare or the insurance company will make payment

Medically Needy

Persons who are categorically eligible for Medicaid and whose income, less accumulated medical bills, is below state income limits for the Medicaid program (see Spend Down).

Medicare Part A

This provides either total or partial overage for hospital care, skilled nursing facility care, home health care services, and hospice services.

Medicare Part B

This covers a portion of the costs for doctors' care; physical, occupational and speech therapy sessions; ambulance services; prostheses; medical equipment; and home health services.

M.E.D. Works

Medicaid for Employees with Disabilities- allows disabled working individuals with incomes too high for regular Medicaid to be eligible for health coverage. M.E.D. Works members whose income is more than 150% of the federal poverty level will be charged a premium on a sliding-fee scale based on income. These individuals will receive the full-range of traditional Medicaid-covered services and will pay the same co-payments for certain services. This law was passed by the Indiana Legislature in 2001.

MI

Mental Illness - Mental illnesses are disorders of the brain that disrupt a person's thinking, feeling, moods, and ability to relate to others. Mental illnesses are disorders of the brain that often result in a diminished capacity for coping with the ordinary demands of life.

MR

Mentally Retarded – This is a disorder in which a person's overall intellectual functioning is well below average, with an intelligence quotient (IQ) around 70 or less. Individuals with mental retardation also have a significantly impaired ability to cope with common life demands and lack some daily living skills expected of people in their age group and culture. The impairment may interfere with learning, communication, self-care, independent living, social interaction, play, work, and safety. Mental retardation appears in childhood, before age 18 and affects approximately 1-2% of the population.

Nursing Home

A place where persons reside who need some level of medical assistance and/or assistance with activities of daily living. Not all nursing homes are Medicare or Medicaid approved/certified facilities.

Nursing Home Policy

Type of health insurance policy which generally pays indemnity benefits for medically necessary stays in nursing homes (sometimes referred to as Long Term Care policies).

OAA

Older Americans Act – Federal legislation enacted in 1965 to provide money for programs and direction for a multitude of services designed to enrich the lives of senior citizens. Example adequate housing, income, employment, nutrition, and health care.

OBRA

Omnibus Budget Reconciliation Act

Occupational Therapy

Therapy by means of work (i.e., arts and crafts) designed to divert the mind, to correct a particular physical defect, or to equip a handicapped patient with new skills.

OMPP

Office of Medicaid Policy and Planning– part of the Family and Social Services Administration. Determines level of care of Intermediate Care Facilities for the Mentally Retarded (ICF/MR), waivers, and nursing homes. It is responsible to CMS for oversight of the Medicaid waiver program.

Olmstead Decision

The Olmstead decision issued in 1999 interpreted Title II of the Americans with Disabilities Act (ADA) and its implementing regulation, requiring States to administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." Medicaid is the main resource in helping states to meet these goals. However, the scope of the ADA and the Olmstead decision are not limited to Medicaid beneficiaries or to services financed by the Medicaid program. The ADA and the Olmstead decision apply to all qualified individuals with disabilities regardless of age

Ombudsman

A "citizens' representative" who protects a person's rights through advocacy, providing information, and encouraging institutions or agencies to respect citizens' rights. Two programs: DD Ombudsman and Aging Ombudsman.

Per Diem

Per day, or a daily charge.

Personal Care

Assistance provided to people who need help with bathing, cooking, dressing, eating, grooming or personal hygiene. These service are not routinely paid for by either Medicare of Medicaid, but for those who qualify may be paid for by IHSS.

PPS

Prospective Payment System – Under PPS, nursing facilities are paid fixed amounts based on the Resource Utilization Group (RUG) for the person based on their relative staff and resource needed and acuity. In some cases, the Medicare payment will be more than the actual cost of providing services for that stay. In other cases, the payment will be less than the nursing facility's actual cost.

Provider

A generic term describing any individual, organization or company enrolled to provide services. Qualifications vary depending on the type of service provided.

Psychiatric Hospital Care

Medicare Part A can help pay for <u>no more than</u> 190 days of care in your lifetime in a participating psychiatric hospital.

Reasonable and Necessary Care

The amount and type of health services generally accepted by the health community as being required for the treatment of a specific disease or illness.

Rehabilitation

The coordinated use of medical, social, educational, and vocational measures for training or retraining individuals disable by disease or injury to the highest possible level of functional ability. Several different types of rehabilitation are distinguished: vocational, social, psychological, medical and educational.

RCAP

Residential Care Assistance Programs- State program that pays for care provided in licensed residential care facilities (assisted living) and in county homes for low income persons needing this level of care.

Respite Care

Short term care given to a person(s) with and illness or disability in the home, nursing home, or hospital; intended to give relief to the principal caretakers.

Sheltered Workshop

A segregated setting in which persons with disabilities who are not capable, temporarily or permanently, of competitive employment in the community are provided with vocational, pre-vocational, and habilitative services and experience.

Skilled Nursing Care

Care which can only be provided by or under the supervision of licensed nursing personnel.

Skilled Nursing Facility

A Medicare participating nursing facility which is staffed and equipped to furnish skilled nursing care, skilled rehabilitation services, and other related health services for which Medicare pays benefits.

Social Security Administration

This federal agency is responsible for the Medicare enrollment process, for determining Medicare eligibility, and for SSI and SSDI benefits.

Social Security Benefits

Benefits payable under Social Security programs, can be assigned to three general categories – retirement benefits, survivor benefits, and disability benefits.

Spend Down

1) A process of becoming eligible for Medicaid nursing home assistance by exhausting one's assets to pay for their care, until Medicaid asset eligibility is established. 2) A process of becoming eligible for Medicaid at home **or nursing home** assistance by paying for medical care out of one's own income, until Medicaid income eligibility is established. This occurs on a monthly basis, after asset eligibility is met on the 1st day of the month.

Spousal Impoverishment Provision

The community property and assets of a nursing home resident who is married may be divided to protect the property and assets of the spouse not in the nursing home.

State Budget Agency

(http://www.in.gov/sba/agencyinfo/)- the **a**gency's mission is to achieve excellence in fiscal decision making and fiscal results on behalf of the Governor and in support of the General Assembly. The State Budget Agency facilitates the processes of revenue forecasting, budget development, and budget implementation. The Budget Agency evaluates and communicates the fiscal and policy impacts of legislative proposals with the objective of assuring best information available to decision makers.

State Fiscal Year

The state fiscal year for the state of Indiana begins on July 1st and ends on June 30th of the next year.

Supported Employment

Individuals with the most severe disabilities are placed in competitive jobs with qualified job coaches/trainers to provide individualized, ongoing support services needed for each individual to retain employment. The employee is contacted monthly, either at or away from the workplace, to address any issues that may threaten the individual's ability to remain on the job.

Ticket to Work

The Ticket to Work and Work Incentives Improvement Act of 1999 provides States with three opportunities to assist disabled persons to maintain employment: grants to States to develop the administrative and internal structures in their Medicaid programs necessary to support people with disabilities who are employed; a demonstration to provide health care benefits to employed individuals with potentially disabling conditions; and two new opportunities to use federal matching funds for providing Medicaid benefits to working disabled.

Title XVIII

The portion of the Social Security Act which clearly defines the provisions of Medicare.

Title XIX

The portion of the Social Security Act which clearly defines the provisions of Medicaid.

Vocational Rehabilitation

Provides comprehensive, coordinated, effective, efficient, and accountable services needed by eligible individuals with disabilities to prepare for, enter, engage in, and retain employment consistent with each individual's strengths, resources, priorities, concerns, abilities, capabilities, and informed choice.

VRS

Vocational Rehabilitation Services- Vocational Rehabilitation Services (VRS) assists eligible people with disabilities to achieve employment and independence. VRS is committed to securing quality individualized services which enable individuals with disabilities, including individuals with the most severe disabilities, to pursue meaningful careers by obtaining gainful employment consistent with their abilities and capabilities.

VRS customers have the responsibility to participate in their own rehabilitation program, including making meaningful and informed choices about the selection of the employment outcome, vocational objectives, and vocational rehabilitation providers. Each VRS customer works in partnership with his or her vocational rehabilitation counselor who provides on-going rehabilitation counseling, case management, and follow up through each phase of the process of vocational rehabilitation.

To be eligible to participate in the VRS program, an individual must have a physical or mental disability, which results in a substantial impediment to employment, and the individual must require services to prepare for, enter into, engage in, or retain gainful employment. Services provided by VRS must be directly linked to an employment outcome, and must be necessary for an individual to perform the basic duties of a job.

Waiver

The Medicaid Wavier programs are funded with both State and Federal dollars. All waiver programs have been initiated by the Indiana General Assembly and approved by the CMS.

Eligibility for all waiver programs requires:

- The recipient must meet Medicaid guidelines.
- The recipient would require institutionalization in the absence of the waiver and/or other home-based services.
- The total aggregate Medicaid cost of serving the recipient(s) on the waiver (waiver cost plus other Medicaid services), cannot exceed the total aggregate cost to Medicaid for serving the recipient (s) in an appropriate institutional setting(s).

Current Indiana Waivers include:

- Aged and Disabled Waiver
- Autism Waiver
- DD Waiver
- Medically Fragile Children's Waiver
- Traumatic Brain Injury Waiver
- Assisted Living Waiver
- Support Services Waiver

Work One

Work One Centers are places that assist customers in finding workers or finding jobs. Partnering agencies are able to share information about customers that gives the Center a "single agency" appearance (although customers that want to work with a single agency can restrict information to that agency.)

SECTION VI: OTHER RESOURCES

The Indiana Governor's Planning Council
http://www.in.gov/gpcpd/

Administration on Aging, Department of Health and Human Services
http://www.aoa.dhhs.gov/

National Information Center for
Children and Youth with Disabilities
http://nichcy.org/index.html#about

State Agencies and Organizations

United States Senators
Honorable Richard G. Lugar (R)
United States Senate
306 Hart Senate Office Building
Washington, DC 20510-1401
(202) 224-4814
E-mail: senator_lugar@lugar.senate.gov
Web: www.senate.gov/~lugar/

Honorable Evan Bayh (D)
United States Senate
717 Hart Building
Washington, DC 20510
(202) 224-5623
(202) 228-1377 (fax)
Web: www.senate.gov/~bayh/

Governor
Honorable Frank O'Bannon
State House, Room 206
Indianapolis, IN 46204
(317) 232-4567
E-mail: fobannon@state.in.us
Web: www.ai.org/gov/index.html

State Department of Education: Special Education
Robert Marra, Associate Superintendent
Indiana Department of Education
State House, Room 229
Indianapolis, IN 46204-2798
(317) 232-0570
E-mail: rmarra@doe.state.in.us
Web: http://web.indstate.edu/soe/iseas/dse.html

Programs for Infants and Toddlers with Disabilities: Ages Birth through 2
J. Lanier DeGrella, Assistant Deputy Director
Indiana Family and Social Services Administration
Division of Family and Children
Bureau of Child Development
402 W. Washington Street, Room W-386
Indianapolis, IN 46204
(317) 233-9229

E-mail: jdegrella@fssa.state.in.us
Web: www.in.gov/fssa/first_step/

Programs for Children with Disabilities: Ages 3 through 5
Sheron Cochran, Preschool Coordinator
Division of Exceptional Learners
Indiana Department of Education
State House, Room 229
Indianapolis, IN 46204-2798
(317) 232-0567
E-mail: scochran@doe.state.in.us
Web: http://web.indstate.edu/soe/iseas/dse.html

State Vocational Rehabilitation Agency
Nancy Zemaitis, Interim Deputy Director
Vocational Rehabilitation Services
Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
402 W. Washington Street, Room W453
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-1319; (800) 545-7763, ext. 1319
E-mail: nzemaitis@fssa.state.in.us
Web: www.IN.gov/fssa/

Office of State Coordinator of Vocational Education for Students with Disabilities
Terry Fields, State Director
Vocational and Technical Education
Indiana Workforce Development
10 N. Senate Avenue, Room 212
Indianapolis, IN 46204-2277
(317) 232-1829
E-mail: tfields@dwd.state.in.us
Web: www.IN.gov/dwd/teched/

State Mental Health Agency
Janet Corson, Director
Division of Mental Health and Addiction
Family and Social Services Administration
402 W. Washington Street, Room W353
Indianapolis, IN 46204-2739
(317) 232-7845
E-mail: jcorson@fssa.state.in.us
Web: www.IN.gov/fssa

State Mental Health Representative for Children
Children's Services Bureau
Division of Mental Health and Addiction
Family and Social Services Administration
402 W. Washington Street, Room W353
Indianapolis, IN 46204-2739
(317) 232-7934
Web: www.IN.gov/fssa

State Developmental Disabilities Agency
Steven C. Cook, Director
Bureau of Developmental Disabilities

Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-7842

State Developmental Disabilities Planning Council
Suellen Jackson-Boner, Director
Governor's Planning Council for People with Disabilities
150 W. Market Street, Suite 628
Indianapolis, IN 46204
(317) 232-7770; (317) 232-7771 (TTY)
E-mail: gpcpd@gpcpd.org
Web: www.IN.gov/gpcpd

Protection and Advocacy Agency
Thomas Gallagher, Executive Director
Indiana Protection and Advocacy Services
4701 N. Keystone Avenue, Suite 222
Indianapolis, IN 46205
(317) 722-5555
(800) 622-4845; (800) 838-1131 (TTY)
E-mail: info@ipas.state.in.us
Web: www.IN.gov/ipas

Client Assistance Program
Contact Protection and Advocacy Agency listed above

Programs for Children with Special Health Care Needs
Children's Special Health Care Services
Indiana State Department of Health
2 N. Meridian Street, Section 7-B
Indianapolis, IN 46204
(317) 233-5578

State Agency for the Blind and Visually Impaired
Linda Quarles, Interim Deputy Director
Blind and Visually Impaired Services
Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
402 W. Washington Street, Room W-453
P. O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-1433; (877) 241-8144
(317) 232-1466 (TTY)
E-mail: lquarles@fssa.state.in.us
Web: www.state.in.us/fssa/servicedisabl/blind/index.html

Programs for Children and Youth who are Deaf or Hard of Hearing
James Van Manen, Deputy Director
Deaf and Hard of Hearing Services
Indiana Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
402 W. Washington Street , Room W-453
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-1143 (V/TTY); (800) 962-8408 (V/TTY in IN only)

Governor's Commission on Home and Community-Based Services
Fact Book

E-mail: jvanmanen@fssa.state.in.us
Web: www.IN.gov/fssa/dhhs

Regional ADA Technical Assistance Agency
Robin Jones, Project Director
Great Lakes Disability and Business Technical Assistance Center
University of Illinois/Chicago
Department on Disability and Human Development
1640 W. Roosevelt Road
Chicago, IL 60608
(312) 413-1407 (V/TTY); (800) 949-4232 (V/TTY)
E-mail: gldbtac@uic.edu
Web: www.adagreatlakes.org

University Centers for Excellence on Developmental Disabilities
(formerly University Affiliated Programs)
David M. Mank, Director
Indiana Institute on Disability and Community
2853 E. Tenth Street
Bloomington, IN 47408-2696
(812) 855-6508; (812) 855-9396 (TTY)
E-mail: uap@indiana.edu
Web: www.iidc.indiana.edu

John D. Rau, M.D., Director
Riley Child Development Center (RCDC)
Leadership Education in Neurodevelopmental Disabilities (LEND) Program
Indiana University School of Medicine
James Whitcomb Riley Hospital for Children
702 Barnhill Drive, Room 5837
Indianapolis, IN 46202-5225
(317) 274-8167
E-mail: jdrau@child-dev.com
Web: www.child-dev.com

Technology-Related Assistance
Cris Fulford, Executive Director
ATTAIN, Inc.
2346 S. Lynhurst Drive, Suite 507
Indianapolis, IN 46241
(317) 486-8808; (800) 528-8246 (in IN)
E-mail: attain@attaininc.org
Web: www.attaininc.org

State Mediation System
Sally Cook, Coordinator
Indiana Department of Education
Division of Exceptional Learners
State House, Room 229
Indianapolis, IN 46204
(317) 232-0580
E-mail: sacook@doe.state.in.us
Web: web.indstate.edu/soe/iseas/dse.html

Disability-Specific Organizations

Attention Deficit Disorder
To identify an ADD group in your state or locality, contact either:

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
8181 Professional Place, Suite 201
Landover, MD 20785
(301) 306-7070
(800) 233-4050 (Voice mail to request information packet)
E-mail: national@chadd.org
Web: www.chadd.org
National Attention Deficit Disorder Association (ADDA)
1788 Second Street, Suite 200
Highland Park, IL 60035
(847) 432-2332
E-mail: mail@add.org
Web: www.add.org

Autism

Cathy Pratt, Ph.D., Director
Indiana Resource Center for Autism (IRCA)
Indiana Institute on Disability and Community
2853 E. Tenth Street
Bloomington, IN 47408-2696
(812) 855-6508; (812) 855-9396 (TTY)
E-mail: prattc@Indiana.edu
Web: www.iidc.indiana.edu/

Brain Injury

John P. Young, Chairman, Board of Directors
Brain Injury Association of Indiana
1525 N. Ritter Avenue, Mikolon Building
Indianapolis, IN 46219
(317) 356-7722; (866) 854-4246
E-mail: BIAI@iquest.net
Web: www.biausa.org/indiana/bia.htm

Cerebral Palsy

Donna Roberts, Executive Director
United Cerebral Palsy Association of Greater Indiana, Inc.
615 N. Alabama Street, Room 322
Indianapolis, IN 46204
(317) 632-3561; (800) 723-7620
E-mail: ucpaindy@ucpaindy.org

Down Syndrome

Indiana Down Syndrome Foundation
233 McCrea Street, Suite 200
Indianapolis, IN 46225
(317) 216-6319; (888) 989-9255
E-mail: dsani@aol.com
Web: www.indianadsf.org

Deb Gavette, President
Down Syndrome Association of Northeast Indiana
P.O. Box 50305
Fort Wayne, IN 46815
(260) 471-9964; (877) 713-7264
E-mail: dsani4u@aol.com

Web: www.dsani.org

Epilepsy

Marge Frommeyer, Executive Director
Epilepsy Council of Greater Cincinnati, Inc.
(serving Clark, Floyd and South Eastern Counties)
3 Centennial Plaza, 895 Central Avenue
Cincinnati, OH 45202
(513) 721-2905
E-mail: ecgc@fuse.net
Web: www.ecgc.net

Learning Disabilities

Dawn Lytle, Indiana State President
Learning Disabilities Association of Indiana
P.O. Box 20584
Indianapolis, IN 46220
(800) 284-2519 (LD and ADD/HD Information Request Line)
E-mail: dlytle@kokomo.k12.in.us
Web: www.ldaamerica.org

Mental Health

Stephen McCaffrey, President
Mental Health Association in Indiana, Inc.
55 Monument Circle, Suite 455
Indianapolis, IN 46204
(317) 638-3501; (800) 555-6424 (in IN only)
E-mail: mha@mentalhealthassociation.com
Web: www.mentalhealthassociation.com

Pamela A. McConey, Executive Director
NAMI Indiana (National Alliance for the Mentally Ill, IN)
P.O. Box 22697
Indianapolis, IN 46222-0697
(317) 925-9399; (800) 677-6442
E-mail: nami-in@nami.org
Web: www.namiindiana.org

Mental Retardation

John Dickerson, Executive Director
The Arc of Indiana
22 E. Washington Street, Suite 210
Indianapolis, IN 46204
(317) 977-2375
E-mail: jdickerson@iquest.net
Web: www.arcind.org
Web: www.TheArcLink.org

Speech and Hearing

Michael Flahive, President
Indiana Speech-Language-Hearing Association
233 McCrea Street, Suite 200
Indianapolis, IN 46225
(317) 955-1063
E-mail: isha@in-motion.net

Web: www.islha.org

Spina Bifida

Spina Bifida Association of Northern Indiana
2421-01 Nappanee Street
Elkhart, IN 46517
(574) 295-3988; (866) 822-6499

Kim Zink, Coordinator
Wabash Valley Spina Bifida Support Group
P.O. Box 21
Farmersburg, IN 47850
(812) 696-2288
E-mail: spinabifida@earthlink.net
Web: www.homestead.com/planetzachary/main.html

Visual Impairments

Jay Stiteley, Director
American Foundation for the Blind-Midwest
401 N. Michigan Avenue, Suite 350
Chicago, IL 60611
(312) 396-4420
E-mail: chicago@afb.net
Web: www.afb.org

Organizations Especially for Parents

Parent Training and Information Center (PTI)
Richard Burden, Executive Director
IN*SOURCE
809 N. Michigan Street
South Bend, IN 46601-1036
(219) 234-7101 (V/TTY); (219) 239-7575 (TTY)
(800) 332-4433 (In IN)
E-mail: insource@insource.org
Web: www.insource.org

Parent-To-Parent
Donna Gore Olsen, Executive Director
Indiana Parent Information Network, Inc.
4755 Kingsway Drive, Suite 105-A
Indianapolis, IN 46205-1545
(317) 257-8683
E-mail: FamilyNetw@aol.com
Web: www.ai.org/ipin

Parent Teacher Association (PTA)
Mary Williams, President
Indiana Congress of Parents and Teachers, Inc.
2525 N. Shadeland Avenue, D-4
Indianapolis, IN 46219
(317) 357-5881
E-mail: in_office@pta.org
E-mail: pta@spitfire.net
Web: www.indianapta.org

Other Disability Organizations

Pat Bowers, Executive Director
Easter Seals Wayne/Union Counties
5632 U.S. Highway 40 East
P.O. Box 86
Centerville, IN 47330-0086
(765) 855-2482
E-mail: easterseals@juno.com

Jim Nulty, President
VSA arts of Indiana
Harrison Centre for the Arts
1505 N. Delaware Avenue
Indianapolis, IN 46202
(317) 974-4123; (317) 974-4117 (TTY)
E-mail: jnulty@vsai.org
Web: www.vsai.org

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[xxv] Brian Jones, INDOT

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G. Best Practices

Governor's Commission on Home and Community-Based Services

Best Practices

March 27, 2003

Overview

- There have been many successful Home and Community-Based initiatives in other states.
- This presentation is intended to summarize some of those initiatives that might be of interest to the Governor's Commission on Home and Community-Based Services.
- This presentation is not meant to be an exhaustive description of all programs. Rather, it should serve as a beginning point to this discussion.

Promising Practices in Home and Community Based Services

- The Centers for Medicare and Medicaid Services (CMS) has created a website (*www.com.gov/promisingpractices*) of Promising Practices reports on Home and Community-Based Services. Most reports are being developed by The MEDSTAT Group under contract with the Disabled and Elderly Health Programs Group within CMS.
- Some states are undertaking comprehensive reform of their entire system of home and community-based services. Others are identifying specific components as targets for incremental improvement. Thus, while some reports focus on "whole systems," most focus on discrete components that can be incorporated into an overall program design.

Topics

1. Coherent, Cost-Effective Administration and Financing
   - One-Stop Shopping and Person-Centered Service Delivery Systems
   - Assisting Individuals to Avoid or Move from Institutional Settings
2. Promoting Independence, Responsibility, and Participant-Driven Services
3. Assistance to Families and Community Caregivers
4. Access, Case Management, and Coordination
5. Accountability, Quality, and Fulfillment of Legal Obligations
6. Other Critical Supports for Community Inclusion and Participation

Coherent, Cost-Effective Administration and Financing

- Goals of these reform efforts might include:
  - Creating flexible long-term support payment mechanisms that follow individuals to their most appropriate and desired settings
  - Reducing institutional biases in Medicare and Medicaid
  - Developing individual program participation rules that eliminate eligibility cliffs and ensure equal treatment of similarly situated groups
- Also included in this category are promising practices that facilitate the active participation of older persons, people with disabilities, and other stakeholders in the design and administration of community long-term support systems.

Coherent, Cost-Effective Administration and Financing

- **Michigan:** Person-Centered Planning for People with Mental Illness, Addiction Disorders, and Developmental Disabilities
  - Michigan contracts with its Community Mental Health Services Programs as a health plan for services. To ensure access and improve choice, the contracts require local agencies to offer a wide array of services and use a person-centered planning process to determine a person's service plan.
- **California:** Comprehensive, Individualized Services for People with Serious Mental Illnesses Through a Single Provider
  - Village Integrated Service Agency provides coordinated, comprehensive services for people with mental illness.
- **New York:** Managed Long-Term Care Plan (MLTC) for Integrated Long-Term Care Services
  - The Visiting Nurse Service established a long-term care program for older people with disabilities (VNS CHOICE) as a part of New York's partially capitated MLTC program. The program has reduced hospital and nursing home use among participants and has low disenrollment.

One Stop Shopping and Person Centered Service Delivery Systems

- **Pennsylvania:** Transformation of Supports for People With Mental Retardation
  - Program emphasizes single entry points and person-centered services. Participants are offered a greater choice of supports, providers, and methods of service delivery, as well as better coordination with federal HCBS waivers.
- **Wisconsin:** Family Care
  - Aging and Disability Resource Centers provide a clearly identifiable single entry point for information, advice, and access to a wide range of community resources for older people and people with disabilities. Care Management Organizations (CMO) manage the Family Care benefit, consolidating funding from multiple program authorities into a single capitation payment to the CMO.

Assisting Individuals to Avoid or Move from Institutional Settings

- Many states have engaged in activities and developed programs that serve persons in the most appropriate community setting rather than in an institution.
- These programs and activities have included:
  - diversion programs to maintain people in the community
  - transition programs to actively move individuals from institutional settings to alternative community placements
  - program models in which the "money follows the person" to assure stability of community living

Assisting Individuals to Avoid or Move from Institutional Settings

- **Utah:** Informing Nursing Home Residents about Community Long-Term Care Options
  - Nursing home resident education project with the local Independent Living Centers and local Area Agencies on Aging about other long-term care options.
- **Colorado:** Community Options for People Discharged from Hospitals
  - The Fast Track program coordinates Medicaid HCBS waiver case managers and Medicaid financial eligibility staff at a major urban hospital to facilitate quick eligibility determination for hospital patients who need long-term care after discharge. Between March 1999 and June 2001, 149 people avoided likely nursing facility residency and successfully started receiving HCBS after a hospital discharge.

Assisting Individuals to Avoid or Move from Institutional Settings

- **Florida:** Providing Managed Care Organizations with Financial Incentives to Expand Community Care and Nursing Home Care
  - A managed long-term care pilot project encourages coordination of acute and long-term care services for people age 65 or older with disabilities. Participating HMOs must absorb the costs of lifetime nursing home care, if it is required for individuals enrolled in the pilot.
- ★ **New Jersey:** Information and Assistance to People in Nursing Facilities
  - Community Choice is one of the few permanent, state-operated nursing facility transition programs. Forty counselors provide information and assistance to nursing facility residents throughout the state. New Jersey established a fund for transition expenses for which no other funding source is available, such as furniture and housing deposits. Community Choice helped more than 3,400 people leave nursing facilities during state fiscal years 1998 through 2001.

Assisting Individuals to Avoid or Move from Institutional Settings

- **Texas:** Rider 37: Promoting Independence "Money Follows the Person"
  - With the passing of Rider 37, Medicaid funding may now follow an individual who moves from a nursing facility into the community. Since the Rider became effective in September 2001, over 950 Medicaid participants in Texas have transitioned from nursing facilities into their community, using their nursing facility funding.
- **Vermont:** Facilitating Nursing Facility to Community Transitions
  - The following efforts were made: a change in the waiting list policy for Vermont's largest Medicaid HCBS waiver for older people and people with physical disabilities, a statewide system of local Long-Term Care Community Coalitions to improve HCBS infrastructure, and a new Medicaid HCBS waiver for community residential options. These efforts resulted in a drop of Vermont's long-term care expenditures from 88 to 63% between 1996 and 2002.

Assisting Individuals to Avoid or Move from Institutional Settings

- ★ **Washington:** Facilitating Nursing Facility to Community Transitions
  - Nursing facility case managers help people obtain the housing and services necessary to leave a nursing facility. Washington also uses Medicaid post-eligibility treatment of income rules to allow Medicaid-eligible residents to keep more of their income to maintain their home or obtain and furnish a home after transition. The state also offers four funding sources for transitional services people may need when leaving a nursing facility. Over a five-year period, the number of nursing facility residents using Medicaid decreased 16%
- **Wisconsin:** Assistance to People Who Want To Leave Nursing Facilities
  - In 2001, 150 people were helped to leave nursing facilities who wanted to move into the community by targeting resources. The state set aside state and Medicaid HCBS waiver funds to pay for one-time transition expenses and for ongoing home and community-based services.

Promoting Independence, Responsibility, and Participant-Driven Services

- In some states, new design initiatives are being undertaken to make people the focus of funding and service planning, rather than each individual service and provider class.
- In some instances, attention is being focused on developing entirely new program infrastructures that support consumer-directed services, including:
  - Developing flexible home and community-based service funding
  - Assisting consumers in purchasing services through support brokerage and similar methods
  - Expanding the supply of accessible housing
  - Creating emergency back-up systems for personal assistance or other services
  - Assigning consumers the responsibility for developing their own service and budget plan

Promoting Independence, Responsibility, and Participant-Driven Services

- ★ **Arkansas:** Independent Choices - The Arkansas Cash and Counseling Demonstration
  - Demonstration project measures the impact of substituting a cash allowance for Medicaid services from provider agencies. People with disabilities are randomly assigned to two groups. The control group receives Medicaid personal care through a provider agency and the treatment group receives a monthly cash allowance and services to help them effectively use the allowance. Early data indicates treatment group participants have less nursing home utilization than control group participants.
- **Florida:** Cash Allowances and Support Services for People with Disabilities
  - Florida is the only state in this demonstration to serve both children and adults with disabilities.

Promoting Independence, Responsibility, and Participant-Driven Services

★ **New Jersey:** Personal Preference: The New Jersey Cash and Counseling Demonstration

- A preliminary study reported 86% of participants would recommend the cash allowance to others.

➢ **Alaska:** Program Changes Based on System's Principles

- Consumer directed personal care agencies train participants to direct their own services and perform fiscal responsibilities for people who employ their own personal assistants. Within the first four months, the program increased the number of participants hiring their own provider by 36%.

Promoting Independence, Responsibility, and Participant-Driven Services

★ **Oregon:** Maximizing Participant Control Over Services

- Independent Choices Program allows Medicaid-eligible individuals to pay cash directly to providers for personal care and related services. Under this five-year project, consumers receive a monthly cash amount and are fully responsible for the mechanics of payroll and budgeting for needed services. An independent evaluation of the pilot will examine, among other things, whether consumer satisfaction and sense of control have increased in comparison to traditional approaches.

➢ **Colorado:** Increasing Persons' Control Over Personal Attendants

- Participants in the Research and Demonstration Program, which began in 2002, can use money that otherwise would have been spent on Medicaid home health agency and personal care services to purchase in-home services from attendants they personally select, hire, and train.

Promoting Independence, Responsibility, and Participant-Driven Services

- **Michigan:** Person Centered Planning for People with Mental Illness, Addiction Disorders, and Developmental Disabilities
  - The State of Michigan combined several funding sources in its contracts with local community mental health agencies, which serve people with developmental disabilities, mental illness, and addiction disorders. To ensure access and improve choice, the contracts require local agencies to offer a wide array of services and use a person-centered planning process to determine a person's service plan.
- **Wyoming:** Individual Budgets for Medicaid Waiver Services
  - Individual budgets for HCBS waivers for people with developmental disabilities to improve equity among waiver participants and increase the authority of the consumer's service planning team. The state uses a statistical analysis of state historical data on individuals' needs and services to determine individual consumers' budgets.

Assistance to Families and Community Caregivers

- Most persons in need of long-term support receive their primary assistance with daily activities from their families, not from a paid service provider. Yet, until recently, public policies have not acknowledged or supported families in this important role.
- Public support for caregivers will include ways of equipping them with the information and skills needed to perform their role. These may include:
  - Providing consultation, peer support, and emergency help to deal with the psychological stress of caregiving
  - Help with transportation or/and respite services that will enable them to have temporary relief from the demands of their ongoing role

Assistance to Families and Community Caregivers

- **Massachusetts:** Facilitating Culturally Competent Self-Determination
  - Developed local, ethnic community governing boards to manage service delivery as a part of a self-determination initiative for people with developmental disabilities, taking advantage of relationships and cultural linkages to improve services for people with developmental disabilities in their own communities.
- **North Dakota:** Supporting Family Caregivers with Payment for Services Resource
  - State funds used to provide monthly payments to spouses and other relatives to care for low-income people with disabilities, including older people living at home.

Assistance to Families and Community Caregivers

- **Pennsylvania:** Counseling and Financial Assistance for Informal Caregivers
  - Family Caregiver Support Program uses funds to allow the caregiver to choose the services most needed to help care for an older relative at home and provide financial assistance with out-of-pocket expenses.
- **Utah:** Family-Directed Support Network for Families of People with Disabilities
  - The Family Council is an opportunity for families of individuals with disabilities to provide support, education, and resource information to one another. The Council is a state-wide family-directed support network available to all families of individuals with disabilities, including families who do not receive publicly funded services.

Assistance to Families and Community Caregivers

- **Washington:** Supporting Caregivers in Ethnically Diverse Communities
  - Working with local community organizations, the state used a combination of targeted outreach, community education, case manager advocates, and culturally sensitive diagnostic assessment proceeds to significantly expand caregiver supports for diverse populations.
- **Georgia:** Vouchers Caregivers Use to Pay for Services
  - Legacy Express provides vouchers to caregivers which may be spent on service options ranging from respite and medications to haircuts and lawn care. The objective is to give caregivers the authority and flexibility to select those service options that work best for them. Originally targeted at persons with Alzheimer's disease, the program has gradually been expanded to serve older people.

Access, Case Management, and Coordination

- "One-stop shopping" for coordinated information about a wide range of community long-term supports, as well as to help persons access economic assistance, housing, nutrition, and other public and private sources of support is being developed by some states.
- Other states have made improvements in the efficiency of program enrollment procedures. When consumers seek services from multiple programs, they often encounter duplicative paperwork, repeated requests for the same information, and a lack of attention paid to their specific expectations and preferences. Promising practices are streamlining these enrollment procedures and enhancing consumer-responsive problem solving on the part of service managers.

Access, Case Management, and Coordination

- **Illinois:** Simplified Access for HCBS Waiver and Older Americans Act Services
  - Local Case Coordination Units (CCUs) coordinate eligibility determination and case management for Medicaid waiver services, state-funded home and community-based services, and Older American Act services.
- ★ **New Jersey:** Single Access Point for Information on All Services for Older People
  - Established a single entry system for long-term supports and other services for older people, including a toll free number for information and services. The system is designed to prevent frustration of having to contact multiple offices in order to obtain information and services. The effectiveness of the system in each of New Jersey's 21 counties is evaluated through compliance with state protocols and consumer satisfaction scores.

Access, Case Management, and Coordination

- **Wisconsin:** One-Stop Shopping for Information and Service Access
  - Improved information, advice, and program enrollment for long-term supports for the aged and disabled through the Aging and Disability Resource Centers to the general public. The centers also give in-depth advice about long-term support options and provide a single entry point for persons seeking access to the state's home and community-based services programs, as well as to publicly financed care in nursing facilities, residential settings, and adult family homes.
- **Colorado:** Simplified Access to Nursing Home Alternatives
  - Established Single Entry Point Agencies (SEPs) that provide an access point for several publicly funded long-term supports for people with disabilities, including older people, people with physical disabilities, people living with AIDs, and people with brain injuries. Since SEPs have served the state, participation in community-based services have more than doubled while the number of nursing home residents has been stable.

Accountability, Quality, and Fulfillment of Legal Obligations

- Promising practices will also address ways to ensure that public programs are accountable for the quality of long-term supports provided to persons with disabilities. However, quality concerns are not limited to direct supports, but more broadly relate to the way persons are treated in all of their encounters with community long-term support systems.
- Promising practices in quality assurance and quality improvement will address ways that:
  - Quality is built into every component of a state's home and community-based services system
  - Frequent and accurate customer feedback and other information from the points of service delivery are used effectively to correct or prevent problems
  - Quality problems are systematically identified and remedied
  - The capacity to improve quality is built into the service delivery system

Accountability, Quality, and Fulfillment of Legal Obligations

★ **Minnesota:** Quality Measurement Involving Volunteer Reviewers
  - A quality assurance review process for services for people with developmental disabilities is replacing the state's licensing system on a trial basis. Volunteer reviewers evaluate all services for a person, working with the person and the individuals who provide the support, and identify exceptional practices and necessary improvements.

- **Ohio:** Increasing Timely Access to Services
  - Electronic communication between case managers and providers to streamline identification of service providers for program participants.
- **South Carolina:** Improving Responsiveness of Service Managers to Persons' Needs
  - Automated Case Management System (CMS) reminds case managers of needs identified in the assessment that may potentially be included in the service plan.

Other Critical Supports for Community Inclusion and Participation

- As the demand for community-based supports has increased, limitations in the amount, type, and scope of available supports have become more apparent. Promising practices include:
  - Expanding the supply of commonly provided services and developing new types of supports such as accessible housing or home modifications that have not been previously available.
  - Addressing how public programs can support persons of any age and disability to live and participate in the social and economic fabric of neighborhoods, businesses, and family life; particularly in regards to facilitating employment of persons with disabilities and enhancing the availability of transportation and personal assistance services.
  - Supporting individuals who are transitioning from institutional settings to the community and vise versa. Better linkages are being established to broaden community access to primary care physicians and specialty care for older people and people with disabilities.

Other Critical Supports for Community Inclusion and Participation

- **Iowa:** Training, Mentoring, and Increasing Awareness of Direct Support Professionals
  - Created the Certified Nursing Assistants (CNAs) Recruitment and Retention Project. This project focused on professionals in nursing facilities, but may be adapted to support home and community-based service providers. The project established training and mentoring for CNAs and increased awareness of their work.
- **Massachusetts:** Recruiting Direct Service Professionals in a Competitive Environment
  - The Massachusetts Department of Mental Retardation (DMR) and independent provider agencies joined forces to recruit direct support professionals for people with developmental disabilities. DMR and the program in the metro region identified 2,000 potential workers in its first 18 months of operation. Agencies hired more than 200 of these people.

Other Critical Supports for Community Inclusion and Participation

- **Several States:** Recruiting and Hiring Process to Identify Suitable Direct Support Workers
  - The Cooperative Healthcare Network (CHN), a national group of affiliated long-term care providers and training organizations, uses a standardized recruitment approach to attract and retain high quality service professionals through a targeted outreach and rigorous application process. Organized and supported by Paraprofessional Healthcare Institute (PHI), CHN employs over 900 direct care workers in home and community-based settings.
- **Virginia:** Improving Recruitment and Retention of Direct Support Workers
  - The Nursing Assistant Institute (NAI) programs improve the training and support that nursing assistants receive in order to increase recruitment, decrease turnover, and ultimately provide consumers with a stable workforce that is familiar with their healthcare needs.

Best Practices Highlighted

- **Transitions**
  - ★ New Jersey
  - ★ Washington
- **Money Follows the Person**
  - ★ Arkansas
  - ★ New Jersey
- **Consumer Directed Care**
  - ★ Oregon
- **Single Access Point**
  - ★ New Jersey
- **Quality**
  - ★ Minnesota

Additional Questions?

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H. Federal Barriers

Overview of Significant Federal Barriers to Advancing the Long Term Care Delivery System

Introduction

This paper is intended to provide a brief overview of significant Federal barriers that hinder or otherwise limit improvement in further developing the long-term care service delivery system and achieving full compliance with *Olmstead*. Many of the barriers were identified through President George W. Bush's New Freedom Initiative and already are supported by recommendations for improvement or full resolution by the federal agencies responsible for program implementation, operation and compliance. This list of barriers includes some of the more significant but is not intended to be comprehensive.

The barriers that exist under state law or regulation or are caused by system or process inefficiencies are not included in this overview.

In order to better understand the Federal barriers that have been identified, four primary Federal laws have been highlighted for reference below. These include: the Americans with Disabilities Act (ADA); the Civil Rights of Institutionalized Act (CRIPA); the Fair Housing Act; and the Social Security Act (SSA).

The Americans with Disabilities Act or ***ADA*** (42 U.S.C. 12101) broadly protects the rights of individuals with disabilities. The Civil Rights Division's Disability Rights Section is responsible for implementation of regulations and enforcement of Titles II and III of the ADA and for litigation of employment claims under Title I involving state governments. Title II applies to state and local government entities, and, in subtitle A, protects qualified individuals with disabilities from discrimination on the basis of disability in services, programs, and activities. Title III covers, among others, private businesses known as places of public accommodation, including among others, the offices of health care providers, child care centers, and a variety of community-based service providers. The Disability Rights Section is also responsible for coordination of Federal agencies' implementation of ***Section 504 of the Rehabilitation Act of 1973*** as amended (29 U.S.C. 794), which prohibits discrimination on the basis of disability in federally funded and federally conducted programs.[1]

The Civil Rights of Institutionalized Persons Act or ***CRIPA*** (42 U.S.C. 1997) concerns the rights of individuals who reside in institutions operated by or on behalf of a government. CRIPA authorizes the Department to initiate a civil action where there is reasonable cause to believe that a state or political subdivision of a state is engaged in a pattern or practice of subjecting institutionalized individuals to conditions that deprive them of the rights secured by the United States Constitution or Federal laws. The Civil Rights Division's Special Litigation Section enforces CRIPA and handles the majority of the Department's work under Olmstead. In its investigations of health care institutions, the Department collects evidence to determine whether there are violations of Federal statutes and regulations, including the ADA, Section 504 of the Rehabilitation Act, Title XIX of the Social Security Act, and various Medicaid programs.[2]

The Fair Housing Act or ***FHA*** (42 U.S.C. 3601) prohibits discrimination on the basis of disability in all types of housing transactions. The Civil Rights Division's Housing and Civil Enforcement Section shares responsibility for enforcing the FHA with the U.S. Department of Housing and Urban Development (HUD). Under the FHA's accessibility requirements, newly-constructed, multi-family housing must be accessible to and adaptable for use by individuals with disabilities. The FHA's accessibility requirements are more modest than those of the ADA, most notably with respect to spaces inside individual units where the FHA typically requires only that a space can be made usable by individuals with disabilities, including persons who use wheelchairs. The Department also works to ensure that zoning and other regulations concerning land-use are not employed to hinder the residential choices of individuals with disabilities; such hindrances include unnecessarily restricting communal or congregate-residential arrangements, such as group homes. These sorts of residential arrangements are frequently used for community placement of individuals with disabilities.[3]

The Social Security Act, or ***SSA***, and related laws establish a number of programs that: provide for the material needs of individuals and families; protect aged and disabled persons against the expenses of illnesses that may otherwise use up their savings; keep families together; and give children the chance to grow up healthy and secure.[4] The Act includes the following programs:

- Retirement insurance
- Survivors insurance
- Disability insurance
- Hospital and medical insurance for the aged, disabled, and those with end-stage renal disease
- Black lung benefits
- Supplemental Security Income
- Unemployment insurance; and
- Public assistance and welfare services, including:
  - Aid to needy families with children
  - Medical assistance (Medicaid)
  - Maternal and child health services
  - Child support enforcement
  - Family and child welfare services
  - Food stamps; and
  - Energy Assistance

The Ticket to Work and Work Incentives Improvement Act (TWIIA) of 1999 was enacted to allow individuals with disabilities to work. Title I of the Act provides access to employment training and placement services and Title II of the Act provides health care supports for working individuals with disabilities. Additionally, Title II establishes two optional Medicaid eligibility categories, extends the period of premium free Medicare Part A eligibility, and requires consumer protection for certain individuals with

Medigap coverage. These health care provisions are administered by the U.S. Department of Health and Human Services.

The Workforce Investment Act of 1998 (WIA) provides the framework for delivery of employment and training services at the state and local levels to both employers and job seekers, including dislocated workers, new entrants to the workforce, and people with disabilities. It creates "One Stop Centers" that are intended to make a comprehensive range of employment, training, and related services available in a local community. WIA also identifies multiple programs and agencies that are to be workforce system partners, both required and optional, which must coordinate their programs and services through the local One Stop Center System. State vocational rehabilitation programs are requried partners with local One Stop Centers and provide them with technical assistance.

Federal Barriers to Eligibility and Benefits

1. Institutional Bias

Medicaid

The Medicaid Program, which is a significant source of funding for long-term care provided to people with disabilities and the frail elderly, designates institutional care as an entitlement within the Program. What this means is that Federal law requires states to provide institutional care in order to participate in Medicaid, but does not do the same for care provided in the community, even though community care may be more desirable by consumers and less costly. The institutional bias is furthered by the fact that Medicaid pays for all room and board costs for consumers who receive nursing home, hospital, and intermediate care facility/mentally retarded (ICF/MF) services, while Medicaid funds can not be used to pay for room and board in the community. Therefore, in many cases Medicaid recipients can not afford to remain at home and instead must "choose" institutional care, even though it is more costly.

Further, according to a recent report prepared by the U.S. Department of Health and Human Services (HHS),

> "While Medicaid is a critical program and a significant source of funding for long-term care for people with disabilities, the rules for coverage, eligibility and administration favor spending on institutional care. The public input to HHS' self-evaluation emphasized that these rules result in a "bias" towards institutional care and often result in institutionalization of children, adults and seniors even when community care is less expensive and more appropriate for the individual. Historically, categorical eligibility and coverage rules have impeded state flexibility, frequently leaving consumers without real choice and the opportunity to direct their own care. Medicaid's structure and method of financing also results in differences in the services available to different populations. Of particular concern is the gap in home and community-based services for adults and children with mental illness and emotional disturbance."[5]

Medicare

Certain Medicare rules for home health care and durable medical equipment limit eligibility for benefits by creating very prescriptive requirements for consumers. An example of this is the definition of homebound, which strictly limits a consumer's ability to remain active in the community.

Another example of institutional bias is Medicare copayment policies with respect to mental health treatment.

Medicare coverage consists of two parts: Medicare Part A, which covers hospital-based mental health care, including room, meals, nursing and other related services and supplies; and Medicare Part B, which helps to cover outpatient mental health care, including lab tests and visits with doctors, psychologists, and social workers. Medicare Part B includes a copayment requirement that favors the institutional services: 50%

copayment for outpatient mental health care, compared to a 20% copayment for all other services.

Veterans Benefits

Similarly, the Veterans Health Administration currently has only statutory authority to pay for nursing home care. As a result, many veterans who could reside in a less restrictive environment are placed in nursing homes because they do not have the personal income to pay for assisted living or other forms of board and care.

2. Institutional Care for Mentally Ill Adults Age 21-65

An institution for mental disease, or IMD, is defined as a public or private facility with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases." This includes not just hospitals for individuals with mental illness but also nursing homes or other long-term care facilities that primarily serve such individuals. Federal Medicaid matching funds are not allowable for the costs of any Medicaid covered services furnished to an individual under 65 years of age who resides in an IMD.[6]

While individuals retain their Medicaid eligibility during a stay in an IMD or correctional facility, states often let such eligibility lapse if the institutional stay exceeds six months. The reason for this is that federal matching funds are not available for health care services provided to individuals during their residence in such institutions. Such lapses in eligibility create significant continuity of care problems when the individuals leave the institution for the community. This is particularly true for persons with a mental illness or HIV-AIDS who require a daily regimen of medically-monitored drugs that are critical to their health and daily functioning. States are unclear both about their responsibilities under the law and the current options for ensuring continuity of care.[7]

Similarly, persons who are residents in a public institutional for a full calendar month or longer, generally lose their Supplemental Security Income (SSI) benefits, making a return to the community very difficult financially. And for many, the SSI payments are the primary or only source of income for the individual.

3. Fragmentation of Federal Programs

The Federal government pays for services for people with a serious mental illness primarily through four programs: Medicaid; Medicare; Vocational Rehabilitation; and housing. Service access and delivery problems arise because none of these programs are particularly designed to promote a service delivery system that will produce good mental health care. Health outcomes are difficult to measure, care is largely uncoordinated, and no one is specifically designated to take responsibility for the care that is provided. Further, federal agencies are not typically skillful in promoting, developing and reproducing effective programs in communities.[8]

Moreover Medicaid, as the largest public payer for mental health care, does not reimburse for vocational training and support for individuals with a mental illness, even though many individuals with developmental disabilities receive the same services. Persons with mental illness are often referred to Vocational Rehabilitation, but their employment outcomes are very poor nationwide.[9]

Another example of problems created by the lack of coordination between federal programs is the link between disability payments paid by the Social Security Administration and health care eligibility through Medicaid. Because the Social Security payments are insufficient to cover both the costs of housing and medical, many people with mental illness are prevented from returning work because they will lose their eligibility for Medicaid.

> "The high costs of health care and the unavailability of employer-based health care for people with a "preexisting condition" means that thousands of people with a mental illness make a conscious choice to stay on disability assistance because it provides Medicaid coverage for their expensive medication and treatment needs."[10]

And finally, project-based and voucher housing programs are available to persons with disabilities but are very complicated and have long waiting lists. Even though the programs are subject to HUD guidelines, they may be administered by sub-grantees, have a different point of entry, and maintain their own waiting list.

Perhaps the best description of program fragmentation can be found in a recent report prepared by the U.S. Department of Health and Human Services,

> "Individuals with disabilities face barriers to community living because the right "mix" of services and supports is rarely provided in one package. Instead, individuals with disabilities, their families and caregivers frequently must put together services and supports from multiple service programs, each of which may have its own funding streams, eligibility requirements, policies, procedures, and service sites. The difficulty of negotiating these programs is compounded by lack of accurate information and assistance. Fragmentation and lack of coordination exists at all levels of government – both within individual agencies and across agencies. The lack of an agency focal point within HHS increases the challenge of adequate disability programmatic and policy coordination."[11]

Federal Barriers to Affordable, Accessible Housing

1. Private Housing Providers

HUD's Section 504 regulations treat private housing providers participating in the Section 8 housing voucher program as "contractors" rather than as "recipients" of federal financial assistance. As a result of this designation, these housing providers are not required to meet all requirements for assuring accessibility of their programs, services and activities, thereby further limiting the housing choices available to persons with disabilities. In addition, the entity that administers the voucher program is a recipient and must assure that private landlords participating in the program do not discriminate, must assist applicants in locating accessible units, request exceptions to the Fair Market Rents, and meet other requirements. Persons with disabilities nevertheless are often not aware of the requirements imposed on the recipient and might not know to request this type of assistance.

2. Consumer Education and Outreach

There are no consumer-friendly public documents or counseling programs staffed with persons who are familiar with fair housing laws like Section 504, the ADA and the Fair Housing Act. This is particular detrimental for persons with disabilities who are attempting to move out of institutions into the community. Many of these individuals may not be aware of discrimination or may not fully understand fair housing/Section 504 issues such as reasonable accommodation rights, eligibility for certain HUD programs, and overlapping accessibility requirements of the laws.

3. Homeownership

HUD's Section 504 regulations include a separate section on homeownership (24 CFR 8.29) that focuses on four programs that are no longer active. The regulation also includes requirements for new construction or alterations of any type of housing program. Some offices have, nevertheless, misinterpreted the regulations to require newly constructed or altered homeownership housing programs to comply with the section that covers the four now inactive programs, and not to the provisions in the regulations for new construction and alterations. As a result, some new housing homeownership programs developed under HUD's Hope VI and HOME programs do not meet the accessibility requirements in the regulations, further reducing the accessible housing stock available to persons leaving institutions.

4. Supportive Housing for Persons with Disabilities Program

There is a lack of flexibility within the Section 811 Supportive Housing for Persons with Disabilities Program to develop more integrated housing with less supportive services.

5. Housing Choice Voucher

Current legislation (Section 8 of the United States Housing Act) and HUD regulations (24 CFR Part 982) for the Housing Choice Voucher state that at the time a family initially receives tenant-based assistance, the total rent that the family may be required to pay may not exceed 40 percent of the family's adjusted annual income. This provision could cause families, including those that are disabled, to be unable to rent higher priced units in some communities.

In addition, many persons with disabilities receive only Supplemental Security Income (SSI) payments as income, which amounts to approximately $6,000 per year per person. Therefore, if given a voucher, a person with a disability may not have the personal funds needed to meet the normal expenses involved with moving into an apartment, such as security deposit, utility deposit, money to purchase furniture and other household items and supplies, etc.

And finally, some Public Housing Authorities (PHAs) are not sufficiently familiar with Housing Choice Voucher regulations at 24 CFR 982.303. These regulations allow the PHAs discretion to grant a family "one or more" extensions of the required initial term of at least 60 calendar days to lease an apartment. Moreover, if a disabled family requests an extension as a "reasonable accommodation", then the PHA must extend the voucher term up to the term "reasonably required for that purpose." This flexibility is necessary because it often takes a long period of time for a disabled family to locate an apartment, either because of the limitations of their disability or because of a lack of accessible housing in their communities.

And finally, some PHAs are not requesting an adequate number of vouchers to meet the housing needs of non-elderly disabled families affected by designated housing plans.[12]

6. Data and Reporting

The new version of Form HUD-50058, Family Report, makes improvements in the collection of data on families utilizing the voucher program but does not capture data related to the accessibility of units in privately-owned apartment buildings. Without this information, HUD still will not know to what extent disabled voucher families' needs for accessible units are being met in this program.

The form also does not indicate if the voucher is one that is targeted specifically to a person with a disability. Consequently, there is no way to know if these targeted vouchers specifically issued to a PHA for disabled families have been issued to such families. Further, there is no requirement that a PHA report on the number of "general purpose" vouchers that have been provided to disabled families.

Federal Barriers to Transportation

1. Curb Cuts (Curb Ramps)

Curb cuts are the sloping transitions between sidewalks and streets and roads that make independent movement easier for persons with mobility-related disabilities. Although curb cuts have been required in projects and programs that receive federal financial assistance since 1973, hundreds of thousands have not been built. Additionally, many curb cuts that have been built have not been properly maintained or were not built correctly[13].

Jurisdiction for curb cuts is generally assigned to two federal agencies: the Federal Department of Transportation (DOT) and the Federal Highway Administration (FHWA). The DOT generally has jurisdiction for curb cuts, which are specified in 49 CFR part 27, which implements Section 504 of the Rehabilitation Act (29 U.S.C.794). The FHWA has specific ADA policies for statewide planning in 23 CFR 450.220(a)(4), for metropolitan planning in 23 CFR 450.316(b)(3), and for the National Environmental Policy Act (NEPA) process in 23 CFR 771.105(f).

2. Limitations of the Americans with Disabilities Act (ADA)

The ADA only makes existing transportation accessible; it does not address the many transportation gaps that exist.

Paratransit is the parallel public transit system set up under the ADA to provide complementary, accessible transportation services to people with mobility impairments who live in areas served by fixed route public transit systems. It is enforced by the Federal Transit Authority.

Paratransit is very expensive and heavily subsidized. Problems include: illegal limits placed on quantity of services by transit providers; lack of timely service; and missed calls for pick-ups. Other concerns related to paratransit or fixed route transportation include: the functionality of working equipment; stop announcements; consumer securement; driver training; and scheduling.

Nearly 1,300 rural counties in the U.S. have no public transportation. Accessible rural public transportation systems are rare and costly to operate due to low usage and long distances traveled.[14]

Other programs offered through HUD and HHS do not require transit transfer locations to be provided in their projects, particularly in renovation and new construction. Therefore, the critical link for persons with disabilities between accessible housing, transportation and employment often does not exist because the program initiatives are not coordinated.

Federal Barriers Relating to Compliance

1. Housing Construction and Design

Section 504 of the Rehabilitation Act of 1973 and the Fair Housing Act of 1988 at the design review stage of construction of new public housing include requirements regarding the provision of accessible and adaptable residences for residents with physical disabilities. These requirements are not enforced, so non-compliance is usually discovered after the public housing project is built.

There is also widespread non-compliance with the FHA's new construction requirements for multi-family housing by both private and public providers. Much of this noncompliance can be attributed to a lack of knowledge about the requirements on the part of builders, architects, and engineers. Moreover, the systematic failure to build new housing in compliance with Federal accessibility requirements creates a situation where access is eventually achieved only through modifications or retrofits to existing housing.

While the incorporation of accessible or adaptable features in housing involves little if any cost at the design or the construction stage, retrofitting to bring non-compliant, multi-family housing and public housing into compliance with the FHA and Section 504 can be expensive and difficult. Similarly, many housing providers do not understand the FHA's prohibitions against discrimination on the basis of disability. These prohibitions include the obligation to provide reasonable accommodations for persons with disabilities or to allow such persons to make reasonable structural modifications to dwellings to improve accessibility.[15]

Even newly-constructed, multi-family housing that complies with FHA requirements is often not fully accessible to all persons with mobility disabilities, since the FHA requires only a modest level of accessibility or adaptability for persons who use wheelchairs. Also, the FHA only requires accessibility features in newly constructed multi-family housing with four or more units; therefore, most single-family housing developments built today do not provide any options for accessible single-family homes.

2. Discrimination

Many public housing authorities are not in compliance with the nondiscrimination requirements of the FHA and Section 504 of the Rehabilitation Act regarding access to public and/or Section 8 housing for persons with disabilities.

In communities where accessible housing does exist, some housing providers still have policies that exclude or place discriminatory conditions of residence on persons with disabilities. Examples include assisted living facilities with policies barring residents from using scooters or electric wheelchairs, or retirement communities that deny residence to person with certain types of visible disabilities.

And finally, in many communities across the country, there continues to be strong opposition by citizens and their elected officials to the location of group homes, assisted living facilities, and other facilities for persons with disabilities in residential settings. This community opposition often means that group homes are not built, thereby severely curtailing housing opportunities for persons with disabilities. Alternatively, such facilities are built in less desirable settings to avoid community opposition.

3. The Department of Justice's Authority under CRIPA is Limited

The Civil Rights of Institutionalized Persons Act (CRIPA) protects the rights of institutionalized people. Under CRIPA, the Department of Justice (DOJ) may initiate a civil action where there is reasonable cause to believe that a state is engaged in a pattern or practice of subjecting institutionalized individuals to conditions that deprive them of the rights secured by the United State Constitution or Federal laws.[16]

CRIPA only authorizes investigation of institutions where there are patterns or practices of violations of rights; thus DOJ has no jurisdiction to investigate individual Olmstead complaints under CRIPA.

The DOJ's ability to conduct CRIPA investigations is dependent on the cooperation of the jurisdiction being investigated; in cases where access is denied, the DOJ must initiate costly and time-consuming litigation.

CRIPA does not authorize the DOJ to investigate privately-run institutions; therefore, the individual does not have the same remedies available.

CRIPA does not authorize DOJ to follow individuals who have been deinstitutionalized as a result of DOJ intervention into the community to ensure that they are safe and receiving services that are appropriate to meet their needs.

Federal Barriers Relating to Employment

1. Workforce Development System

There is insufficient capacity of the workforce development system to provide meaningful opportunities to people with disabilities, including people with significant disabilities and high support needs who are transitioning to the community from institutional settings or are at risk of segregation. These services, while intended for all people, have not always been inclusive of or welcoming to people with disabilities. Furthermore, because people with disabilities have not been a part of the workforce system, there has been little conceptual framework on the part of those working within that system on how to provide effective services. This has created multiple access issues for people with disabilities, especially in relation to physical accessibility, customer relations, knowledge about promising practices, provision of accommodations, and effective strategies and services.[17]

Further, there are not enough customized employment opportunities available to assist people with disabilities in developing a viable work situation. Customized employment is intended to match the unique strengths, abilities, and interests of persons with disabilities with the specific needs of employers. This is another symptom of federal policies that do not go far enough to support integrated employment opportunities.

2. Entrepreneurship

Entrepreneurship is a critical next step in fully integrating persons with disabilities into the community. According to the U.S. Department of Labor, there are a broad range of obstacles, both within and outside the federal government confronting people with disabilities who are interested in self-employment and small business ownership. These obstacles include: lack of access to capital; lack of information on business planning; and federal program policies that actually discourage entrepreneurship. Coordination across multiple public and private initiatives is critical to creating real entrepreneurial opportunities.

3. One-Stop Center Employment Services

One-Stop Center employment services have not focused on the unique needs of persons with mental illness. This is an issue not only for persons with disabilities, but also for mental health providers who are not aware of the information available through local employment services offices or the new One-Stop Centers. This has, in part, resulted in a 70% to 85% national unemployment rate for persons with mental illness.[18]

Endnotes

[1] *Delivering on the Promise*, U.S. Department of Justice, Self-Evaluation to Promote Community Living for People with Disabilities, Final Report of the Attorney General.

[2] Ibid.

[3] Ibid.

[4] *The Social Security Handbook*, Social Security Administration, Section 100.Purposes of Social Security.

[5] *Delivering on the Promise*, U.S. Department of Health and Human Services Self-Evaluation to Promote Community Living for People with Disabilities, Report to the President on Executive Order 13217.

[6] The Kaiser Commission on Medicaid and the Uninsured, Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Resource Book", page 169.

[7] *Delivering on the Promise*, U.S. Department of Health and Human Services Self-Evaluation to Promote Community Living for People with Disabilities, Report to the President on Executive Order 13217.

[8] *Interim Report to The President*, The President's New Freedom Commission on Mental Health, October 29, 2002, page 4.

[9] *Interim Report to The President*, page 12.

[10] *Interim Report to The President*, page 13.

[11] *Delivering on the Promise*, U.S. Department of Health and Human Services Self-Evaluation to Promote Community Living for People with Disabilities, Report to the President on Executive Order 13217.

[12] *Delivering on the Promise*, U.S. Department of Housing and Urban Development, Self-Evaluation to Promote Community Living for People with Disabilities, Report to the President on Executive Order 13217.

[13] *Delivering on the Promise*, U.S. Department of Transportation Self-Evaluation to Promote Community Living for People with Disabilities, Report to the President on Executive Order 13217.

[14] Ibid.

[15]*Delivering on the Promise*, U.S. Department of Justice, Self-Evaluation to Promote Community Living for People with Disabilities, Final Report of the Attorney General.

[16] *Delivering on the Promise*, U.S. Department of Justice, Self-Evaluation to Promote Community Living for People with Disabilities, Final Report of the Attorney General.

[17] *Delivering on the Promise*, U.S. Department of Labor, Self-Evaluation to Promote Community Living for People with Disabilities, Final Report of the Attorney General.

[18] Ibid.

I. 300% SSI Analysis and Worksheet

Frank O'Bannon, Governor
State of Indiana

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

John Hamilton, Secretary

"People helping people help themselves"

MEMORANDUM

TO:	Governor's Commission on Home and Community-Based Services
FROM:	Evelyn Murphy, Director, Long Term Care /s/
RE:	Report on the fiscal impact of 300% SSI to Aged & Disabled Waiver program
DATE:	May 1, 2003
CC:	John Hamilton, Melanie Bella, Steve Cook, Doug Beebe, Andrew Stoner

Attached is the revised fiscal impact report requested by the Commission. The report explains a number of policy issues raised by the Commission, including spenddown, cost-effectiveness of waivers, and the impact of the income standard for Aged, Blind and Disabled Medicaid applicants. The following provides a summary of the revisions.

Clarification of application of 300% SSI
The 300% SSI income standard operates as an income cap. Therefore, individuals with income above 300% SSI have one of the following options: (1) not eligible for services because they could not afford the spenddown; or (2) eligible with a spenddown calculated on the basis of the 100% SSI standard. Of the 257 individual on the aged and disabled waiver with spenddown who were identified in the analysis, only 5 individual have income above the 300% SSI standard. (Their monthly income level was estimated by adding their spenddown amount and the 100% SSI standard of $552). Their monthly spenddown ranged between $1,215-$1,490. These individuals may opt to be on spenddown based on the 100% SSI standard if they have high medical expenses.

Immediate impact on Medicaid program
The initial analysis understated the immediate additional costs to the Medicaid program by applying the average additional Medicaid (waiver & medical) costs less CHOICE costs to all 257 individuals on the Aged & Disabled waiver on spenddown. The CHOICE reduction must be applied only to the 75 individuals for whom CHOICE paid the spenddown. The difference in additional Medicaid costs is as follows:

- Waiver and medical costs for 182 non-CHOICE A&D waiver recipients = $7,554 (state $)
- Waiver and medical costs for 75 A&D waiver recipients receiving CHOICE = $6,071

Impact on nursing facility reimbursement
In order for savings to accrue in the nursing facility system, there must be a resulting change in the mix of nursing facility residents as well as a change in resident days as follows:

- *The average case mix index for Medicaid residents in the nursing facility should increase*. This may result from a number of changes including but not limited to, individuals with low needs leaving the facility and receiving services in the community, low needs individuals who opt to stay in the community instead of entering the facility, other ongoing changes in nursing facility case mix. Note that changes in individual facility case mix index occur frequently (either upward or downward). Such changes are transmitted quarterly and the appropriate rate adjustment occurs on a quarterly basis. The analysis assumes that availability of community services for individuals with higher income (i.e., 300% SSI) will result in more lower needs residents leaving the facility and more lower needs residents choosing to stay in the community. This will leave mostly higher needs patients in the facility causing an increase the overall average case mix index resulting in an increased in the average daily rate for nursing facilities.

- *The total number of patient days should decrease.* The decrease in nursing facility days should reach a point at which, overall, total reimbursement for nursing facilities would decrease despite the increase in daily rate.

- In addition, the original analysis did not take into account the waiver of medical costs of individuals who choose to leave the facility and who must be served in the community.

It is difficult to estimate the length of time it will take for this change in nursing facility mix to occur even if the 300% SSI income level is adopted. Other factors that will affect this change include provider capacity to serve the increasing number of individuals in the community, availability of other community and social supports for individuals (e.g., housing, family), etc.. This change will be gradual and will likely not occur for a couple of years.

Overall fiscal impact
Overall, it is expected that the above revisions will result in an increase in the immediate total additional costs for individuals on the aged and disabled waiver, from the originally estimated $2.4 million (state $) to <u>$2.7 million (state $)</u> annually. It is also anticipated that there needs to be a more significant change in nursing facility resident mix as well as reduction in patient days to counter act the increase expenditures in community services which would not occur for some time. The longer the change takes the longer the State must incur the additional costs for waiver recipients. (See revised Appendix D, Tables 1 & 2).

As with the original report, this revised report does not provide any conclusions as to whether the State should adopt the 300% SSI standard for Aged, Blind and Disabled waiver recipients at this time. This decision needs to be made in the context of the overall Medicaid budget and other program changes that may be proposed.

REPORT TO THE GOVERNOR'S COMMISSION ON HOME AND COMMUNITY BASED SERVICES

ESTIMATING THE FISCAL IMPACT OF INCREASING INDIANA'S INCOME ELIGIBILITY STANDARD FOR THE MEDICAID AGED, BLIND AND DISABLED (A&D) WAIVER TO 300% OF THE SSI AMOUNT

May 1, 2003

ESTIMATING THE FISCAL IMPACT OF INCREASING INDIANA'S INCOME ELIGIBILITY STANDARD FOR THE MEDICAID AGED, BLIND AND DISABLED (A&D) WAIVER TO 300% OF THE SSI AMOUNT

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ESTIMATING THE FISCAL IMPACT OF INCREASING INDIANA'S INCOME ELIGIBILITY STANDARD FOR THE MEDICAID AGED AND DISABLED (A&D) WAIVER TO 300% OF THE SSI AMOUNT

I. INTRODUCTION

This report is in response to the recommendation by the Governor's Commission on Home and Community-Based Services (the Commission) to evaluate the fiscal impact of increasing the income standard for the Medicaid Aged & Disabled (A& D) Waiver to 300% of Social Security Income (SSI). The Commission requested consideration of specific factors that would influence the fiscal impact. The factors include: Medicaid spenddown and patient liability; use of Indiana's CHOICE Program funds; Medicaid waiver program utilization; cost-effectiveness of Medicaid waiver services; and impact of the proposed change on the nursing facility case mix reimbursement system. The Commission also requested a summary of other state Medicaid waiver income criteria and an explanation of the impact on resource and asset eligibility requirements.

II. POLICIES & PROGRAM SUMMARY

1. EXPLANATION OF THE RELATIONSHIP AND EFFECT OF ADOPTING 300% SSI ON THE MEDICAID RESOURCES AND ASSETS REQUIREMENTS FOR ELIGIBILITY

There is no relationship between the income standard and the asset/resource standard for Medicaid financial eligibility purposes. These are two distinct eligibility requirements and applicants must meet both income and asset/resource standards to meet the financial eligibility requirements for Medicaid.

Resources (commonly referred to as "assets") are defined by Medicaid rule as "real or personal property owned by the applicant or recipient and his spouse or parent(s)" that are available to the individual applicant or recipient.[1] It includes for example, financial instruments convertible to cash like stocks and bonds, and current market value of real estate. The resource/asset limit for Medicaid eligibility is $1,500 (single)/$2,250 (couple). Where the spousal impoverishment protection is available, the community spouse's resource limit is between $17,856 (min) and $89,280 (maximum). Spousal impoverishment protections apply to applicants of nursing facility services and the Medicaid Assisted Living waiver. In addition, on November 14, 2002 the OMPP requested approval from the Centers for Medicare and Medicaid Services (CMS) to extend the spousal impoverishment protection to Medicaid Aged & Disabled Waiver applicants. The OMPP is awaiting CMS's approval to this waiver amendment.

[1] 405 IAC 2-3-14.

Under Medicaid rules, the income standard for the Medicaid Aged, Blind and Disabled populations is the SSI standard of $552 (single) or $829 (couple).[2] Medicaid income standards are also sometimes characterized by percentage of poverty level as follows:

- For Federal Fiscal Year (FFY) 2003, 100% SSI monthly income standard is $552 (single)/$829 (couple).
- For FFY 2003, 100% Federal Poverty Level (FPL) is reported annually as $8,980 (single) and $12,120 (couple). This equates to monthly standards of about $748 (single)/$1,010(couple).
- Thus, the Medicaid income standard of $552 can be characterized in federal poverty level terms as equivalent to about 74% of FPL.
- The 300% SSI monthly income standard = $1,656.

Thus, the current monthly income standard for the Aged, Blind and Disabled populations is $552, which is equivalent to 100% SSI or 74% FPL.

2. POLICY DESCRIPTION OF MEDICAID SPENDDOWN

Indiana Medicaid rule states that "any otherwise eligible [Aged, Blind or Disabled] applicant or recipient whose countable income exceeds the applicable income limit . . .is eligible for medical assistance for that part of any month after his or her incurred medical expenses equal his or her excess income.[3]" The rule further goes on to say that the individual must provide to the county "for each month in which he or she requests medical assistance, documentary verification of his or her incurred medical expenses for which he or she is currently liable."

Medicaid eligibility is determined monthly (referred to as member months). Therefore, in any month during which the recipient's income exceeds the income limit, the recipient goes on "spenddown." Generally, there is little variability in spenddown for a recipient from month to month, so in most cases, the recipient must incur the same amount of excess income on medical expenses to meet his/her spenddown from month to month. An individual becomes eligible only once s(he) has incurred medical expenses equal to his/her spenddown amount. This can occur any day in a given month. Once the individual meets the spenddown amount, the Medicaid program will then begin paying for covered services.

<u>Example</u>: On March 1 Anne has income of $600, which exceeds the monthly income standard of $552 by $48 (i.e., $600-$552=$48). Anne has to incur medical expenses totaling $48 before Medicaid will begin paying for covered services.

Scenario #1: Anne goes to the ABC pharmacy on March 3rd and fills 3 prescriptions totaling $100. Anne has to take the receipt to her county caseworker

[2] 405 IAC 2-3-18(b).
[3] 405 IAC 2-3-10.

to show that she has in fact incurred medical expenses. On March 3rd, the day Anne met her spenddown, Medicaid will then pay $52 to the pharmacy (i.e., $100-$48 = $52).

Scenario #2: Anne has a nurse visit on March 3 to check her blood pressure, and she is charged $30 for the visit. Then on March 4th she goes to the pharmacy to pick up her prescription and is charged $100. On March 3, no Medicaid payment is made for the nurse visit since Anne still has $18 in spenddown left to meet (i.e., $48-$30=$18). But on March 4th, she meets her spenddown and Medicaid will pay the pharmacy the difference ($100-$18=$82).

3. IMPACT OF INCOME STANDARD ON ELIGIBILITY FOR MEDICAID WAIVER VS. NURSING FACILITY SERVICES FOR THE AGED, BLIND AND DISABLED POPULATIONS.

The policy question when dealing with the income standard for the Aged, Blind and Disabled populations who reside in the community is how much *reasonably* an individual needs on a monthly basis to be able to live in a community setting within the limits established for the Medicaid program by federal law or regulation. This helps determine the level at which the income standard should be established, taking into account the fiscal and program implications. The income standard can be set anywhere from some percent of the federal poverty level (FPL) up to 300% SSI (i.e.$1,656), which is the highest income standard allowable for the Medicaid Aged, Blind and Disabled populations. Thirty-four (34) states have adopted 300% of SSI as the income standard for the Medicaid Aged, Blind and Disabled population; four (4) an income standard between 100% and 300% of SSI.[4] Indiana is one of the few states that has not adopted this standard.

By recommending the "300% SSI" standard it may be inferred that the Governor's Commission on Home & Community-Based Services (hereafter the "Commission") believes that an individual needs at least around $1,656 on a monthly basis to be able remain at home.

3.1 Impact of Medicaid income standard for institutional vs. community services

The income standard for the Medicaid Aged, Blind and Disabled populations is the same whether the individual resides in the community or in the nursing facility. So comparing the income standard in the community to nursing facility is only meaningful to the extent that it raises the question of how much income an individual can keep without losing eligibility for Medicaid in one setting compared to the other.

There is, however, a significant difference in how income impacts services. An individual in a nursing facility has all of his/her needs met, including food,

[4] State Eligibility Summaries for Selected Aged, Blind and Disabled Groups. (See Appendix E)

shelter, and medical care. As such the only income the individual really needs is the personal needs allowance (currently at $52); any excess income (s)he has is applied to the cost of his/her care. The individual remains eligible for Medicaid and pays all excess income, called "patient liability," to the nursing facility. He/she does not lose Medicaid eligibility.

In comparison, the current income standard of $552 for persons who live in the community suggests that the individual only needs $552 to cover all expenses except medical (including food, clothing and shelter). Hence, any income over and above $552 must be spent-down (i.e., as medical expenses) before the individual becomes eligible for the Medicaid program. It is this scenario that raises the policy question stated above and that creates a bias in favor of nursing facility services.

The following two sections provide examples of how the Medicaid income standard, though the same for the nursing facility or for the Medicaid Aged and Disabled Waiver populations, significantly impacts eligibility determination for nursing facility vs. waiver services. Please note that income is treated differently at two levels; first, there is treatment of income for regular eligibility, and second there is post-eligibility income treatment. The examples below attempt to illustrate both. Please note that nothing in these examples address resource (asset) eligibility or income deductions or exclusions. These examples are purely intended to establish a common ground in understanding the income standard and its application for community (Medicaid Waiver) vs. institutional (nursing facility) applicants for Medicaid services.

3.1.1 Nursing facility eligibility

The regular Medicaid eligibility standard for a nursing facility applicant is the same as for the Medicaid Aged & Disabled Waiver applicant. The amount is equivalent to the SSI standard of $552/month. In determining *regular eligibility* for the nursing facility applicant, we look to see if the individual's medical expenses exceed the difference between the individual's income and $552; if so the individual is eligible.[5] So if the monthly income is $2000, then the calculation for *regular eligibility* is as follows:

$2,000-$552=$1,448 (if medical expenses exceed $1,448 monthly, the individual is eligible.

Once the individual enters the nursing home, even as private pay for a couple of months, the individual's medical expenses very quickly will exceed the $1,448. Assuming a cost of $100/day (as an example), the monthly cost of nursing home placement is $3,000 ($100 x 30 days). Note that most individuals enter the nursing home before Medicaid eligibility is determined, so in this example, it can be assumed that their medical expenses are equivalent to the estimated total

[5] 405 IAC 2-3-17 and 405 IAC 2-13-18(b).

nursing facility charge of about $3,000/month, and eligibility can be assumed at the beginning of the month.

During *post-eligibility*, the same individual above would pay all his/her income less personal needs allowance (i.e., $2000 - $52 PNA = $1,948) as patient liability to the nursing facility, and Medicaid pays the remainder due.[6] The individual continues to remain eligible for Medicaid.

3.1.2 Medicaid Waiver Recipient Eligibility (applicable to all Aged, Blind and Disabled aid categories who seek NF-level waiver services)

The income standard is the monthly SSI standard of $552. For *regular eligibility*, assuming the same monthly income of $2,000, this individual would not be eligible for Medicaid since:

$2,000 - $552 = $1448. The individual would have to spenddown $1,448 before meeting the Medicaid income eligibility threshhold.[7]

Each month thereafter (i.e., *post-eligibility*) this calculation will be made and if the individual has excess income over $552, the individual would have to spenddown the excess income. In determining whether the individual has met the spenddown, we would only look at *incurred medical expenses*; so the inference is that the individual would be able to live off of $552 each month for rent, food, shelter etc.

Based on the income standard alone, it is much more affordable for the individual to enter a nursing facility as Medicaid eligibility occurs much sooner.

4. DESCRIPTION OF HOW MEDICAID 1915C WAIVER PROGRAM COST-NEUTRALITY IS DETERMINED AND ASSURED

In order to be approved, federal Medicaid regulation requires, all Medicaid home and community-based (1915c) waivers to be cost-neutral. In other words, the average per person costs for the waiver cannot exceed the average per person costs in the equivalent institutional setting. The cost-effectiveness calculation is based on claims paid according to dates of service for each waiver year. For each waiver program, a State must provide a report (CMS-372) to CMS twice annually (based on waiver year). The initial report is due 6 months after the close of the waiver year. Since the initial report does not provide sufficient time to account for claims lag (especially since the report is by paid date), a second report, called the lag report, is due one year after the initial report (i.e., 18 months after the close of the waiver year).

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[6] 405 IAC 2-3-21.

[7] 405 IAC 2-3-10 spenddown.

The cost-neutrality formula is as follows:

$$D + D' <= G + G'$$

D, the average annual per capita waiver services expenditures =

$$\frac{\text{Total expenditures for approved waiver services}}{\text{Total unduplicated waiver recipients}}$$

D', the average annual per capita expenditures for all other Medicaid services provided to the waiver recipient =

$$\frac{\text{Total expenditures for medical services for waiver recipients (i.e., Services provided under the state plan such as pharmacy, acute care, home health)}}{\text{Total unduplicated waiver recipients}}$$

G, the average annual per capita institutional (ICF/MR or NF) services expenditures (excluding any patient liability) =

$$\frac{\text{Total expenditures for institutional services (ICF/MR or NF)}}{\text{Total unduplicated institutional recipients}}$$

G', the average annual per capita non-institutional (ICF/MR or NF) services expenditures for individuals in institutions =

$$\frac{\text{Total expenditures for non-institutional services (ICF/MR or NF) for the institutionalized recipients (e.g., pharmacy, acute care, non-routine DME)}}{\text{Total unduplicated institutional recipients}}$$

The cost-neutrality formula for SFY 2002 for Indiana Medicaid Aged and Disabled Waiver recipients is summarized in the chart below. These figures will be used as the baseline for determining the fiscal impact of raising the income standard to 300% SSI.

Per capita costs of Aged & Disabled Waiver recipient (excluding spenddown)	Per capita costs of nursing facility resident (excluding patient liability)
D + D' $7,583 + $12,297 = $19,880 $7,554 (state only $)	G + G' $20,727 + $ 5,136 = $25,863 $9,828 (state only $)

CAVEAT: Please note that these costs are based on SFY 2002 incurred data for the initial CMS372 report. These costs will increase as a result of claims lag as well as addition of new services to the Aged & Disabled waiver that occurred during the course of CY2002.

III. FISCAL IMPACT OF 300% SSI INCOME STANDARD

1. SUMMARY

The following is a general summary of how the fiscal impact of increasing the monthly income standard from the 100% SSI standard of $552 to the 300% SSI standard of $1,656 for the Medicaid Aged & Disabled Waiver applicants was determined.

(i) Identify the number of individuals currently receiving services under the Medicaid Aged & Disabled Waiver, their spenddown amount and the number of months during which they were on spenddown. This is important because increasing the income standard would eliminate excess income, thereby no longer requiring individuals to meet their spenddown. When such individuals no longer have a spenddown, Medicaid is responsible to pay for services.

(ii) Some Medicaid Aged & Disabled Waiver recipients on spenddown have all or a portion of their spenddown met with CHOICE funds. This is necessary in determining the additional State expenditures that would result from individuals no longer having a spenddown.

(iii) Determine the number of CHOICE clients who would become eligible for waiver services as a result of this change. CHOICE generally serves a group of individuals at higher income levels, who may also have limitations in 3 ADLs, and meet the Medicaid asset requirements. These individuals would become eligible for the waiver at the 300% SSI income standard.

(iv) Determine the impact that the income standard has on utilization of Medicaid State Plan services. This is an important consideration, as federal regulations require that Medicaid State Plan services be made available to all Medicaid waiver recipients.

(v) Determine the short and long-term impact of the increase in eligibility on utilization of nursing facility services. As more individuals are able to remain in the community, it is anticipated that the mix of nursing facility residents will eventually become more acute, which would likely result in an increase in the nursing facility's daily rate, and overall decrease in

patient days, and therefore, an overall decrease in nursing facility spending.

2. MEDICAID A&D WAIVER RECIPIENTS ON MEDICAID SPENDDOWN & CHOICE CLIENTS

2.1 Medicaid Spenddown amounts and number of months on spenddown

The following data is based on State Fiscal Year (SFY) 2002 paid claims data

- A total of 257 Medicaid Aged & Disabled Waiver recipients had a spenddown.
- The total spenddown amount for all 257 individuals was about $1.1 million.
- Their spenddown amount ranged from a low of $4 per month to $1,490 per month.
- The spenddown amount for each individual was not variable from month-to-month.
- The range of months during which these individuals were on spenddown was from 1 month to 12 months. The 257 recipients were on spenddown for a total of 1,942 member months. The mean member month during which an A&D waiver recipient was on spenddown in SFY 2002 was 7 months.

2.2 Medicaid Spenddown recipients & CHOICE

Increasing the income standard for the Medicaid Aged & Disabled waiver to 300% SSI has the following results: (1) current Aged & Disabled waiver recipients no longer have a spenddown; (2) some CHOICE clients who are otherwise eligible for the Medicaid waiver but for the current income standard would become eligible; and (3) Medicaid expenditures will increase due to the number of CHOICE clients moving to the Medicaid waiver and waiver recipients coming off spenddown.

2.2.1 Additional State expenditures resulting from removal of current Medicaid Aged & Disabled waiver recipients from spenddown

Of the 257 individuals on Medicaid spenddown, only 75 were receiving CHOICE funded services during the same period. Although specific data is not readily available to reach a conclusion, it can be assumed that CHOICE funds were utilized to pay for services to meet the individual's spenddown, if the services funded by CHOICE qualify as medical services for purposes of meeting the spenddown.

- The total spenddown amount for waiver recipients was $1.1 million.
- The amount of CHOICE funds paid for those 75 individuals was $196,026. The median CHOICE payment for the 75 individuals is $1,483.

- Assuming that all $196,026 was to assist the individual in meeting the spenddown, then CHOICE funds were used to meet part or all of the spenddown for 29% of all individuals on the Medicaid Aged &Disabled waiver who had a spenddown (i.e. 75/257).
- Furthermore, CHOICE funds were used to meet 18% ($196,026/$1.1million) of the total spenddown for all A&D waiver recipients.

During the time before individuals meet their spenddown, Medicaid does not cover the costs of waiver services or state plan services. Therefore the added cost to the Medicaid program is as follows:

Per capita State expenditures for waiver recipients less CHOICE funds currently spent on a Medicaid waiver recipient on spenddown (using the median)

$7,554 - $1,483 = $6, 071 (state $)

Total estimated additional State expenditures for individuals who were on CHOICE who would become eligible by virtue of the increase in income standard to 300% SSI resulting in zero spenddown for these individuals:

$6,071 x 75 = $455,325 (state $)

Total estimated additional State expenditures for all individuals who were not on CHOICE and would become eligible by virtue of the increase in income standard to 300% SSI resulting in zero spenddown for these individuals:

$7,554 x (257-75) = $1,374,828 (state $)

Total estimated additional State expenditures for all individuals who would become eligible by virtue of the increase in income standard to 300% SSI resulting in zero spenddown for these individuals:

$455,325 + $1,374,828= $1.83 million (state dollars)

2.2.2 Additional state expenditures from CHOICE clients becoming eligible for the Medicaid Aged & Disabled waiver

The number of CHOICE clients who would become eligible for the waiver is based on the total number of CHOICE clients with limitations in 3 or more activities of daily living (ADLs) whose income is at or above the 300% SSI standard (i.e., $1,656 monthly).

There are approximately 983 CHOICE clients with incomes at about 300% of SSI. The annualized CHOICE expenditures for these individuals is $4.7 million. Representation from the Indiana Association of Area Agencies on Aging states that 68% of the individuals on CHOICE with 3 ADLS and high-income levels

would be ineligible for Medicaid because their resources would exceed the Medicaid requirements.[8] The additional state costs resulting from CHOICE clients becoming eligible for the Medicaid Aged &Disabled waiver is as follows.

- Total number of CHOICE clients with 3 ADLs with income equivalent to 300% SSI is 314 (i.e., 32% x 983).
- Total annualized CHOICE expenditures for these clients is about $1.5 million {i.e., ($4.7 million/983) x 314}.
- Additional state expenditures for 314 individuals moving from CHOICE to the waiver less CHOICE expenditures is:

($7,554 x 314) - $1.5 million = <u>$0.9 million (state dollars)</u>

The increase in state expenditures is attributable to making all Medicaid State Plan services available to this population.

2.2.3 Estimated immediate costs, annually, to the Medicaid program of increasing the income standard to 300% SSI

The immediate costs to the Medicaid program is as follows:

$1.83 million + $0.9 million = <u>$2.7 million (state dollars)</u>

3. SHORT AND LONG TERM IMPACT ON CASE MIX SYSTEM AND NURSING FACILITY REIMBURSEMENT

In order to estimate the fiscal impact of increasing the income eligibility standard for the Aged and Disabled (A&D) Waiver to 300% of the SSI amount, it was assumed that some recipients who would have been admitted to a nursing facility due to their income, would instead choose to obtain services in the community under the Medicaid A&D waiver, and would remain at home. It was also assumed that certain individuals currently in nursing facilities might be able to return home or in other community settings due to the increased income standard. Based on ad hoc analysis of Indiana's nursing facility MDS (minimum data set) data, it was also assumed that recipients that would have thus been diverted from being admitted to a nursing facility or who would return to the community would classify in the lowest levels of the resident classification system (RUG-III), which are called "PA1" and "PB1." This is actually a very conservative approach, since a number of residents in higher levels may also be safely and cost-effectively served in the community if given the choice.

A model was developed to estimate the fiscal impact on Medicaid nursing facility expenditures based on the change in the overall case mix of the nursing facility population, and a decrease of 200, 500, 1000 and 1500 recipients from the nursing

[8] E-mail from Melissa Durr, Executive Director, IAAA dated February 12, 2003.

facility statewide. The Medicaid nursing facility budget would be impacted in two ways. First, since Indiana Medicaid reimburses nursing facilities under a "case mix" methodology,[9] by removing residents in the lowest levels of the RUG-III system (all other things alike), the average nursing facility case mix index will increase, thus appropriately increasing the average Medicaid daily rate per remaining nursing facility residents. This is summarized in the table below.

1. Estimated Increase in Nursing Facility Expenditures Due to Increasing Case Mix				
Reduction in low needs nursing facility residents	**200**	**500**	**1000**	**1500**
Avg. Current Direct Care Medicaid Rate	$51.25	$51.25	$51.25	$51.25
Increase in rate due to higher needs resident mix	+$.05	+$.12	+$.25	+$.39
Adjusted Medicaid Direct Care Rate	$51.30	$51.37	$51.50	$51.64
Estimated Annual Medicaid Days of Remaining Nursing Facility Recipients	9,981,600	9,954,000	9,908,000	9,862,000
Total Estimated Increase in Medicaid NF Expenditures	$483,720	$1,227,786	$2,519,227	$3,878,345
(State $)	$183,814	$466,559	$957,306	$1,473,771

Second, by reducing the overall number of residents from nursing facility admission, Medicaid will not incur nursing facility expenditures for those recipients. This is summarized in the table below.

2. Estimated Decrease in Nursing Facility Expenditures Due to Fewer Nursing Facility Recipients				
Reduction in nursing facility residents	**200**	**500**	**1000**	**1500**
Average Medicaid Rate (excluding client liability amount)	$79.70	$79.70	$79.70	$79.70
Total Estimated Annual Decrease in Medicaid	($5,817,735)	($14,544,338)	($29,088,675)	($43,633,013)
Nursing Facility Expenditures (State $)	($2,210,739)	($5,530,648)	($11,053,697)	($16,580,545)

[9] Case Mix reimbursement ties payment to the facility based on the level of resource needs of their residents. Higher needs or acuity residents generate higher reimbursement, and vice versa. The levels of case mix are based on individual resident assessment data that all facilities are required to submit called the "Minimum Data Set," or MDS.

Net savings that can be achieved by serving low needs individuals in the community instead of in the nursing facility as show on the table below.

3. Estimated Savings in Nursing Facility Expenditures				
Reduction in low needs nursing facility residents	**200**	**500**	**1,000**	**1,500**
Total annual estimated savings (state $)	($2,026,925)	($5,064,089)	($10,096,391)	($15,106,774)

The result of this analysis is as follows:

- The average Medicaid per person nursing facility reimbursement rate will *increase* as more elderly consumers are given the opportunity to receive services in the community. This increase in rates is appropriate, since nursing facilities would be serving persons with greater care needs.
- Total annual Medicaid nursing facility expenditures will, however, *decrease* over time, assuming fewer people are served in nursing facilities. This assumes actual reduction in total residents in the facility.
- Per person Medicaid A& D Waiver costs would not be expected to increase since existing medical criteria already requires the Waiver to serve persons with nursing facility level of care needs.
- Total Medicaid A & D Waiver expenditures will thus increase proportionately with the number of diverted persons added.

As a result, total annual Medicaid expenditures can therefore be expected to *decrease* by the difference between the annual nursing facility savings and the additional waiver expenditures incurred by the diverted consumers.

4. ESTIMATED COST (SAVINGS) TO THE MEDICAID PROGRAM TAKING INTO ACCOUNT THE COSTS OF SERVING MORE INDIVIDUALS IN THE COMMUNITY AT THE 300% INCOME STANDARD.

Individuals who are no longer served in the nursing facility due to nursing facility diversions or conversions must be served on the Aged & Disabled waiver. Therefore, the decrease in nursing facility expenditures must be balanced against a corresponding increase in individuals served on the Aged & Disabled waiver of $7,554 (state dollars) per person served on the waiver. The result is that there needs to be a significant change in nursing facility patient mix and total number of residents served in order to for the increase to 300% SSI to be cost neutral to the State. (See Appendix D). As a result, it is expected that the costs to the Medicaid program of increasing the income standard to 300% SSI would continue for some time.

5. CONCLUSION

The overall impact of increasing the income standard for Aged, Blind and Disabled populations on the Aged & Disabled Waiver is as follows:

- By increasing the income standard, individuals currently on the Aged & Disabled waiver with a spenddown will come off spenddown resulting in an *increase* in Medicaid expenditures for Aged & Disabled waiver recipients.
- Furthermore, Medicaid expenditures will *increase* due to eligible CHOICE recipients who would become eligible and be served on the Aged & Disabled waiver.
- The average Medicaid per person nursing facility reimbursement rate will *increase* as more elderly consumers are given the opportunity to receive services in the community. This increase in rates would be appropriate, assuming nursing facilities would be serving persons with greater care needs.
- Total annual Medicaid nursing facility expenditures will, however, *decrease* significantly over time, assuming fewer people receive services in nursing facilities. However this would also result in an *increase* in expenditures on the Aged & Disabled waiver as more individuals who otherwise would be in a nursing facility would be served on the waiver.
- **The long-term net result to the Medicaid program depends on the change in nursing facility patient mix and the reduction of total number of patients and overall patient days in the nursing facility**.

However, because the reduction in number of residents and patient days in nursing facilities, and CMI mix would only occur in the long term, **the immediate impact is an increase of $2.7 million (state dollars) annually** in Medicaid expenditures from the proposed change in income standard. Long-term, savings will accrue proportionally with the number of individuals who remain in the community instead of going into the nursing facility.

The following factors will also influence the actual fiscal costs/(savings) throughout this document:

- Currently the Aged & Disabled wait list is less than 100 individuals statewide. It is expected that without an increase in the total number of funded slots on the Aged and Disabled Waiver, there will be a significant increase in the waiting list since more individuals would apply due to the higher income standard.
- This fiscal analysis is based on SFY2002 dollars, number of recipients and utilization. The Medicaid budget projects a 2.5% increase (state and federal $) in overall nursing facility expenditures from SFY2003 to SFY2004. In addition, because a number of new services were added to the Aged Disabled

waiver in the last year, there is no meaningful historical information to estimate the impact on overall waiver expenditures.

Table 1. IMMEDIATE IMPACT ON MEDICAID

1. Additional cost of current A&D waiver spenddown recipients	
Average Medicaid cost (waiver & medical)	$7,554
x Total number of recipients (not on CHOICE) off spendown	182
Equals	$1,374,828
PLUS	
Average Medicaid cost (waiver & medical)	$7,554
Less average CHOICE (spenddown) cost	$1,483
Equals	$6,071
x Total number of recipients on CHOICE off spendown	75
Equals	$455,325
Total additional costs	**$1,830,153**
2. Additional cost of CHOICE recipients to A&D waiver	
Average Medicaid cost (waiver & medical)	$7,554
x Number of CHOICE recipients to A&D waiver	314
Equals	$2,371,956
Less total CHOICE costs for these recipients	$1,498,747
Total additional costs	**$873,209**
3. Total Estimated Costs of 300% SSI	**$2,703,362**

Table 2. LONG TERM IMPACT ON NURSING FACILITY REIMBURSEMENT

	Number of Residents 200	500	1000	1500
A. IMPACT ON NURSING FACILITY REIMBURSEMENT				
Estimated *increase* in Medicaid expenditures due to increasing case mix	$183,814	$466,559	$957,306	$1,473,771
Plus Estimated (*decrease)* in annual nursing facility expenditures due to fewer nursing facility residents & decreased Medicaid days	($2,210,739)	($5,526,848)	($11,053,697)	($16,580,545)
***Equals* Net costs or (savings)**	**($2,026,925)**	**($5,060,289)**	**($10,096,391)**	**($15,106,774)**
B. TOTAL COSTS OF SERVING FORMER NURSING FACILITY RESIDENTS ON WAIVER				
Number of recipients x Average Waiver & Medical Costs @ $7,554pp	**$1,510,800**	**$3,777,000**	**$7,554,000**	**$11,331,000**
C. OVERALL IMPACT OF INCREASE IN INCOME STANDARD TO 300% SSI				
Additional Medicaid costs for Waiver & Medical services for individuals of spendown and new eligibles (formerly on CHOICE)	$2,703,362	$2,703,362	$2,703,362	$2,703,362
Plus Additional Medicaid costs (Waiver & Medical) for former nursing facility recipients	$1,510,800	$3,777,000	$7,554,000	$11,331,000
Equals	$4,214,162	$6,480,362	$10,257,362	$14,034,362
Total costs (savings) in nursing facility reimbursement	($2,026,925)	($5,060,289)	($10,096,391)	($15,106,774)
Grand Total Estimated Costs or (Savings)	**$2,187,237**	**$1,420,073**	**$160,971**	**($1,072,412)**

J. References and Relevant Web Sites

References and Relevant Web Sites

Governor's Commission on Home and Community-Based Care – www.in.gov/fssa/community/

Indiana State Agencies and Programs

Addiction Services - http://www.in.gov/fssa/serviceaddict/index.html
Children's Assistance Programs - http://www.in.gov/fssa/children/index.html
Disability Resources - http://www.in.gov/ai/disability/index.html
Family Care Coordination - http://www.in.gov/isdh/programs/mch/fcc.htm
Governor's Planning Council for People with Disabilities - http://www.in.gov/gpcpd/
Hoosier Rx Program - http://www.in.gov/fssa/hoosierrx/index.html
Indiana Commission for Higher Education - http://www.che.state.in.us/
Indiana Department of Education - http://www.doe.state.in.us/
Indiana Department of Health - http://www.in.gov/isdh/index.htm
Indiana Department of Veterans Affairs - http://www.in.gov/veteran/
Indiana Department of Workforce Development - http://www.in.gov/dwd/
Indiana Family and Social Services Administration – http://www.in.gov/fssa/
Indiana Family Helpline - http://www.in.gov/isdh/programs/mch/ifh.htm
Indiana General Assembly - http://www.in.gov/legislative/legislators/
Indiana Housing Finance Authority - http://www.in.gov/ihfa/
Indiana Office of the Governor - http://www.in.gov/gov/
Indiana Office of Utility Consumer Counselor - http://www.in.gov/oucc/http://www.in.gov/oucc/
Indiana Medicaid Program - http://www.in.gov/fssa/servicedisabl/medicaid/index.html
Mental Health Services - http://www.in.gov/fssa/servicemental/index.html
Senior Health Insurance Information Program - http://www.in.gov/idoi/shiip/index.html
Temporary Assistance to Needy Families - http://www.in.gov/fssa/families/resources/index.html

Federal Agencies

Centers for Medicare and Medicaid Services – www.cms.hhs.gov/
Medicare Program Information - http://cms.hhs.gov/medicare/
Medicaid Program Information - http://cms.hhs.gov/medicaid/
State Children's Health Insurance Program - http://cms.hhs.gov/schip/
U.S. Department of Education - http://www.infoctr.edu/fwl/fedweb.exec.htm#doed
U.S. Department of Health and Human Services - http://www.infoctr.edu/fwl/fedweb.exec.htm#hhs
U.S. Department of Housing and Urban Development - http://www.infoctr.edu/fwl/fedweb.exec.htm#hud
U.S. Department of Labor - http://www.infoctr.edu/fwl/fedweb.exec.htm#labor
U.S. Department of Veteran Affairs - http://www.infoctr.edu/fwl/fedweb.exec.htm#va

Grant Opportunities

Robert Wood Johnson grant opportunity "Better Jobs, Better Care" – www.rwjf.org/newsEvents/mediaRelease.jsp?id=1035779539914
Real Choice Systems Change Grants for Community Living – www.cms.hhs.gov/newfreedom/default.asp.
Medicaid Infrastructure Grants – www.cms.hhs.gov/twwiia/default.asp.

References and Relevant Web Sites (Continued)

Reference Information

Indiana Long Term Care Facility Directory - http://www.in.gov/isdh/regsvcs/ltc/directory/index.htm
Indiana Nursing Home Report Card - http://www.in.gov/isdh/regsvcs/ltc/repcard/rptcrd1.htm
Indiana Family and Social Services Reports - http://www.in.gov/fssa/statistics/index.html
Indiana Services for Older Adults - http://www.in.gov/fssa/elderly/index.html
(Indiana) What to Do If You Lose Your Job - http://www.in.gov/dwd/jobseekers.shtm
List of Indiana human services assistance programs - http://www.in.gov/ai/social/programs.html
NPR Series on Housing (including nursing home transitions) – www.npr.org/news/specials/housingfirst/nprstories/020806.kansas/
HUD Draft Strategic Plan for FY 2003-2008 – www.hud.gov/initiatives/strategicplan/strategicfull.pdf
U.S.Department of Health and Human Services reference guide "Understanding Medicaid Home and Community Services: A Primer" – www.aspe.hhs.gov/daltcp/reports/primer.htm
Indiana workforce statistics - http://www.in.gov/dwd/inews/lmi.asp