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Indiana's Efforts to Help Hoosiers Prevent Unwanted Nursing Home Residence

Susan C. Reinhard
Jennifer Farnham

This document was prepared by Susan C. Reinhard and Jennifer Farnham of the Rutgers Center for State Health Policy (CSHP)

Prepared for:

Rutgers Center for State Health Policy

Susan C. Reinhard & Marlene A. Walsh

Robert Mollica

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Rutgers Center for State Health Policy
55 Commercial Avenue, 3rd Floor
New Brunswick, NJ 08901-1340
Voice: 732-932-3105 - Fax: 732-932-0069
Website: www.cshp.rutgers.edu

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STATE POLICY IN PRACTICE……

Indiana's Efforts to Help Hoosiers Prevent Unwanted Nursing Home Residence

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Summary

Most states are developing nursing home transition programs to help older adults and persons with disabilities return to their homes and communities. Some are also developing nursing home diversion programs to help people on Medicaid avoid unwanted nursing home residence altogether. Indiana is doing both. ***Active, Healthy Aging*** is this state's general theme. This *Policy in Practice* brief describes Indiana's efforts to develop a new, comprehensive program that helps people in Indiana (the Hoosiers) avoid nursing home placement if possible and desirable. It also describes pilot programs to transition those who choose to enter a nursing home, but then want to return to their homes. It is intended to help state policy and program leaders, advocates, and providers learn from their peers and colleagues across the states. Similar briefs feature other states, such as Washington, New Jersey, and Minnesota.[1] They can be found at www.cshp.rutgers.edu and www.hcbs.org.

Major Points

- Since 2002, Indiana has diverted over 1,300 people from nursing homes and transitioned over 200 for a total estimated savings of over $17 million. After a year, less than 15 percent of those diverted or transitioned returned to a nursing home.

- Indiana's long-term care system, including care for the developmentally disabled, relies more on institutional care than many other states, but the movement toward home and community-based services is accelerating in this state. Indiana ranks third in the country with respect to increases in Medicaid home and community-based services (HCBS)

[1] Gillespie & Mollica (2005, June); Reinhard & Petlick (2005, December); Auerbach & Reinhard (2005, September).

spending in the 1998-2003 period, up 259 percent, as opposed to 83 percent for the rest of the country.[2]

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- Indiana's preadmission screening law provides a necessary but not sufficient condition for a successful diversion program. A proposed new law may strengthen its usefulness for counseling people about their options.

- Indiana will sustain its program by using Medicaid-targeted case management funds and by changing its diversion model from a first-come, first-served approach to a triage approach (the latter will allow leveraged savings).

- Indiana also plans to restructure service provider incentives to make sure that funds are spent efficiently.

Background

There are three general forces behind the national move from an over-reliance on institutional long-term care to more home and community-based care: 1) the higher cost of institutional care; 2) the preference of consumers for home and community-based care, reinforced legally with the 1999 *Olmstead* decision of the U.S. Supreme Court finding that unjustified institutionalization constitutes discrimination under the Americans with Disabilities Act (ADA); and 3) the aging of the population and corresponding increase in demand for long-term care services.

Like many other states, Indiana is responding to these forces in part by developing programs to help people avoid unwanted residence in a nursing home. Federal funds from the Centers for Medicare & Medicaid Services (CMS) helped fuel this effort in two ways. First, the 2001 *Real Choice* grant supported a Governor's Commission charged with identifying barriers to home and community-based services (HCBS) and transitions from institutions to the community. A consumer advisory committee of advocates and a diverse group of persons with disabilities guided this work.[3] Second, CMS awarded Indiana a Nursing Facility Transition grant in 2001 to fund partnering with locally-based organizations, such as independent living centers.

In addition to these grants, Indiana has been working with its area agencies on aging (AAAs) in several ways. The state enacted a preadmission screening law in1983[4] and contracts with the 16 AAAs to implement it. The AAAs are also a vital part of the state-funded HCBS program for seniors and people with disabilities, Community and Home Options to Institutional Care for the Elderly and Persons with Disabilities (CHOICE). A 2004 Aging and Disability Resource Center (ADRC) grant is focused on strengthening the AAA-based single entry point created in 1992 to facilitate one-stop entry into the long-term care system for older adults and people with disabilities.[5] Two of the major areas for systemic change are the determination of

[2] Gibson et al. (2004).
[3] Governor's Commission (2003).
[4] State of Indiana (2000), p. 1-3.

[5] Reinhard & Scala (2001); Reinhard & Mollica (2005).

financial eligibility[6] and counseling consumers about their long-term care options (known as "options counseling"). Since Indiana's AAAs already conduct nursing home preadmission screening, there is a strong potential to re-tool that process into a more robust nursing home transition program.[7] There is a legislative effort underway to change the focus of preadmission screening so that it is oriented toward informing people about their long-term care options[8] as opposed to only determining "level of care" for Medicaid eligibility.

Indiana has about six million residents, about 750,000 of whom are over the age of 65. Its demographic profile is similar to the country as a whole with respect to age, disability and poverty status, though its elderly population is not projected to grow as fast as the rest of the country. Indiana's long-term care profile is more weighted toward nursing facilities compared with many other states, ranking number three in 2003 with respect to the number of nursing facility beds per resident over age 65. However, Indiana's nursing facility residents and beds are also dropping faster than the national average.[9] Indiana had about 38,000 nursing home residents in 2004, of whom about 24,000 utilized Medicaid for their primary payment source.[10] By comparison, about 4,600 people received services through Indiana's Aged and Disabled Medicaid waiver program and 106 through its assisted living waiver.[11]

Preadmission Screening

Indiana's preadmission screening law provides a basic platform for options counseling and nursing home transition. The overall goal is "to determine whether there are community services available for individuals who need assistance with the tasks of daily living that would be more appropriate than care in a health facility and, if so, to deny permission to enter a health facility unless the individual is willing to forego eligibility for certain Medicaid reimbursement for a period of time beginning from the date of admission."[12] The law requires at least one screening team comprised of an individual's physician and one other person appointed by the AAA who must meet certain educational or experience requirements. This team makes a functional (level of care) eligibility determination, which is reviewed by the state's Office of Medicaid Policy and Planning. The state may make a final determination if the team disagrees or when a placement is denied, if the individual is eligible for Medicaid.

[6] Mollica & Gillespie (2003); Reinhard & Mollica (2005).
[7] Reinhard &Huhtala (2005).
[8] Known as "options counseling."
[9] Gibson et al. (2004).
[10] Harrington et al. (2005).
[11] Indiana Division of Disability, Aging, and Rehabilitative Services (2005).
[12] Indiana Division of Disability, Aging, and Rehabilitative Services (2001), Title 460 Indiana Administrative Code, Section 1-1-1.

The current state law includes certain provisions that permit individuals to enter a nursing home without options counseling. Aside from the preadmission screening team, it authorizes a designee who can authorize "temporary admission" to a nursing facility for up to 120 days. The designee may be the AAA staff member on the screening team, or a hospital discharge planner, most of whom are trained by the AAA to serve in this capacity.[13] Designees may authorize admission if services are not available in the community, or if they determine that the individual will be discharged from the nursing facility within 30 days of admission. In the latter case, the individual has an extended time period in which to gain approval for nursing facility admission. There is also an exception that the designee may admit an individual "before approval is granted if the designee determines that there will be serious harm to the physical or mental health of the individual if the individual is required to wait for approval."[14] A recent consultant report notes that "Once individuals stay in nursing facilities for 30-60 days, it becomes highly unlikely that they will leave, even if their needs change" because they have often lost their housing and other resources necessary for independent existence in the community.[15] Because of this, temporary admissions could become permanent.

State officials have identified that the preadmission screening process needs revision to move away from a sole focus on determining level of care needs and toward providing long-term care options counseling. There is an effort underway to make this change in the law. They also emphasized the need to re-evaluate nursing home residents to ensure that they meet level of care requirements on an ongoing basis.[16]

Nursing Home Diversion

Indiana developed a priority diversion program in 2003 for those needing urgent care. The goal is to move to a triage system as opposed to a first-come, first-serve system to leverage the savings from keeping people out of institutions.[17] To create the program, state staff worked with the AAAs, hospital discharge planners, state associations, administrators, and HCBS agencies. Initially, the state gave the AAAs $500 per successful diversion to fund a dedicated case manager in each AAA. These AAA case managers work with hospitals to identify those patients who are likely to enter nursing homes and provide them with information about HCBS. They inform nursing homes when a new admission will not be a long-term admission because the individual has been identified as a candidate for community care.[18] Currently, funding comes through Medicaid targeted case management funds.[19] .

Nursing Home Transition

In 2002, Indiana began the Nursing Facility Transition Program, which has been focused on developing model processes for transitioning individuals out of nursing homes to the community and diverting individuals from entering a nursing home. Initially the state contracted

[13] Casanova et al. (2005).
[14] Indiana Code (1997), Chapter 12, Section 12-10-12-31.
[15] Lewin (2005), p.45).
[16] Casanova et al. (2005).
[17] State of Indiana (2005b).
[18] Alexcih (2004), p.4.
[19] Casanova et al. (2005).

with an Independent Living Center; more recently they have focused on four AAAs and a consultant hired as project coordinator. The pilot project was finished in the Fall of 2005, and resulted in a best practices manual for ongoing use.[20]

Indiana's new administration is placing a strong emphasis on nursing home transition, with a primary goal to "transform long-term care from a real estate based model to a services based model."[21] Specifically, Indiana has set a strategic objective to reduce nursing home occupancy by 25 percent by state fiscal year 2009. Currently, there are about 29,000 nursing home residents on Medicaid in Indiana. They are working on a performance measurement system to effectively monitor the program.

Program Practices

Staffing

State staff ultimately oversee the process, but there are crucial staff at many sites and at many levels. The turnover of state staff overseeing the program has been identified as a barrier to implementation of the nursing home transition program.[22]

In July of 2005, the Family and Social Services Administration (FSSA) released a new agency plan transforming the agency structure to resemble a healthcare financing organization. Governor Mitch Daniels assumed the Governor's office in January of 2005 and announced a stronger focus on results and performance measurement. The Division of Aging is a newly created division within the FSSA and will be focused on improving access to an array of long-term care options--expanding HCBS capacity while closing nursing home beds, and increasing public awareness of long-term care (LTC) options. The ultimate goal will be a shift in emphasis from institutional settings toward HCBS in government spending.[23]

Although the state oversees waiver activity, Indiana has 16 local AAAs that serve as single entry points and as service providers for the aged and disabled waivers and the CHOICE program. These agencies are private, non-profit organizations that contract with the state.[24] As discussed earlier, they also play a key role in preadmission screening. The only prominent element they are not currently providing is the determination of financial eligibility. The state has noted significant variability among the AAAs with respect to service delivery, and this presents a challenge in terms of communication, coordination and monitoring activities. This is an important issue in considering how to expand the provision of services.[25] Compared to other states, Indiana offers a fairly narrow set of services that are defined in state statute, making change relatively difficult.[26]

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[20] Verma (2005).
[21] Hancock (2005).
[22] State of Indiana (2005a).
[23] Hancock (2005).
[24] Reinhard and Scala (2001).
[25] Lewin Group (2005).
[26] See Ibid., pp.39-40 for a list of services.

Financing

Preadmission screening

The state pays a fixed amount to the AAA agencies for each screening (around $130).

Transition case management

The Nursing Home Transition grant funded four AAA agencies to hire and supervise a dedicated case manager to assess transition possibilities in their area.[27] In addition, Medicaid Targeted Case Management funds are used for these efforts.[28] Now that the Nursing Home Transition grant is completed, case management activities will be funded solely through targeted case management.

The state is concerned that the current structure of case management payment leads to an inefficient use of funds—specifically, by capping eligible hours at a low rate. This policy encourages case managers to hire formal care at a higher cost rather than spending more time trying to work out informal care. This may also lead to reduced consumer satisfaction. Also, the current cap is per person, as opposed to an overall or aggregate dollar amount, which removes any incentive to serve more individuals.[29]

Transition assistance

Indiana is one of ten states to cover one-time community transition costs under its Aged and Disabled HCBS waiver.[30] It places a limit of $1,000 on waiver community transition services.

Home and Community Based Services (HCBS)

Indiana, along with many other states, continues to be challenged in building its HCBS infrastructure. In many cases, the services screened for in the preadmission screening process are not yet available in the community. For five of the eight HCBS waivers and the CHOICE program in Indiana, the waiting list of people interested in the program exceeds the people currently served by the program. In 2004, the nursing home population was over 38,000[31] while the aged and disabled waiver served about 4,600 and had 1,700 on the waiting list.[32] The Lewin Group identifies service provider capacity as a national challenge for states seeking to expand HCBS. With respect to Indiana, Lewin identified capacity of service providers (primarily due to low reimbursement rates) and also state staff capacity to oversee the program as a hurdle to

[27] Governor's Press Release (2004); Alexcih (2004).
[28] Lewin Group (2005).
[29] State of Indiana (2005b).
[30] Siebenaler et al. (2005), pp. 48-49.
[31] Harrington et al. (2005).
[32] Indiana DDARS (2005).

further expansion.[33] Nevertheless, Indiana has been successful in diverting over 1,300 people and transitioning over 200.

Program Results

The Overall Picture

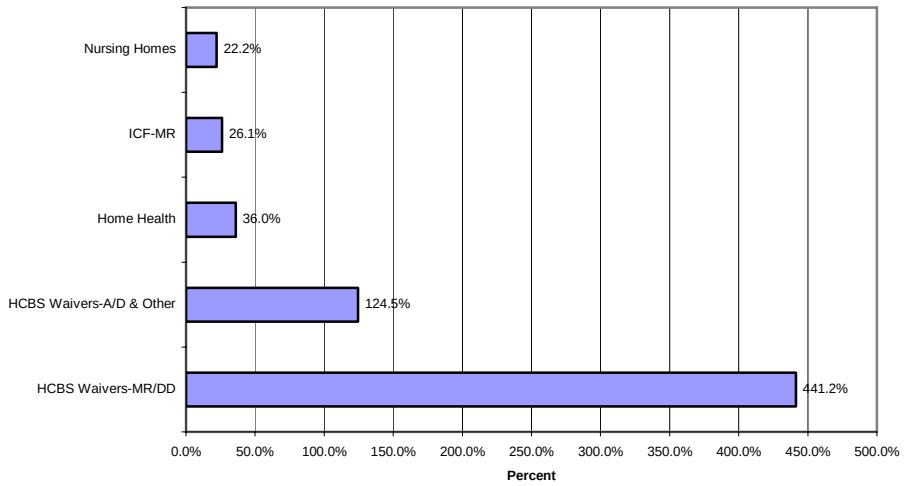
In 2003, as noted by the Governor's Commission on Home and Community-Based Services, Indiana lagged behind relative to other states in providing non-institutional options for long-term care[34]. Specifically, Indiana ranked third in the country in the nursing facility beds per 1,000 people aged 65 and over, and 39th in the country in terms of HCBS spending per capita.[35] However, Indiana is working to catch up. The same AARP report providing the previous rankings also shows that Indiana ranks third in the country with respect to the increase in Medicaid HCBS spending in the 1998-2003 period—up 259 percent, as opposed to 83 percent for the rest of the country.[36]

Indiana projects a shrinking share of the long term care budget for institutional care, from 63 percent in state fiscal year (SFY) 2002 to 48 percent in SFY2007 (state fiscal year is July through June). The long term care budget is projected to shrink as a percentage of the total Medicaid budget, from almost 36 percent in SFY2002 to about 32 percent in SFY2007. The total budget is projected to grow 7.6 percent a year, on average from SFY2002-2007; the long-term care budget is projected to grow only 4.6 percent per year during the same time.[37]

Figure 1 shows the increase in spending for several items in the long-term care budget from federal fiscal years (FFY) 1999 to 2004 (October through September). The largest increase was for HCBS waivers serving persons with mental retardation and developmental disabilities (MR/DD), up 441 percent. HCBS waivers for the aged and disabled (A/D) and other categories (e.g., traumatic brain injury) were also up steeply, at almost 125 percent. The smallest increase was for nursing homes, up 22 percent.

[33] Lewin Group (2005).
[34] Governor's Commission (2003).
[35] Gibson et al. (2004).
[36] Ibid.
[37] State of Indiana, Office of Medicaid Policy and Planning (2005, April).

Figure 1: Percent Change in Medicaid Spending, Indiana FFY1999-2004
Source: Burwell et al., May 11, 2005



As a share of the budget, nursing homes are still the largest item, ranging from 66 percent in 1999 to 54 percent in 2004. HCBS waivers for the mentally retarded and developmentally disabled have more than tripled, from almost 6 percent in 1999 to 21 percent in 2004. HCBS waivers for the aged, disabled, and other groups have grown from 1.4 percent to 2.1 percent. Nationally, this figure was about 5 percent in 2003.[38] See Figure 2 for an illustration.

Figure 2: Indiana Long Term Care Budget, FFY1999 to 2004
Source: Burwell et al., May 11, 2005

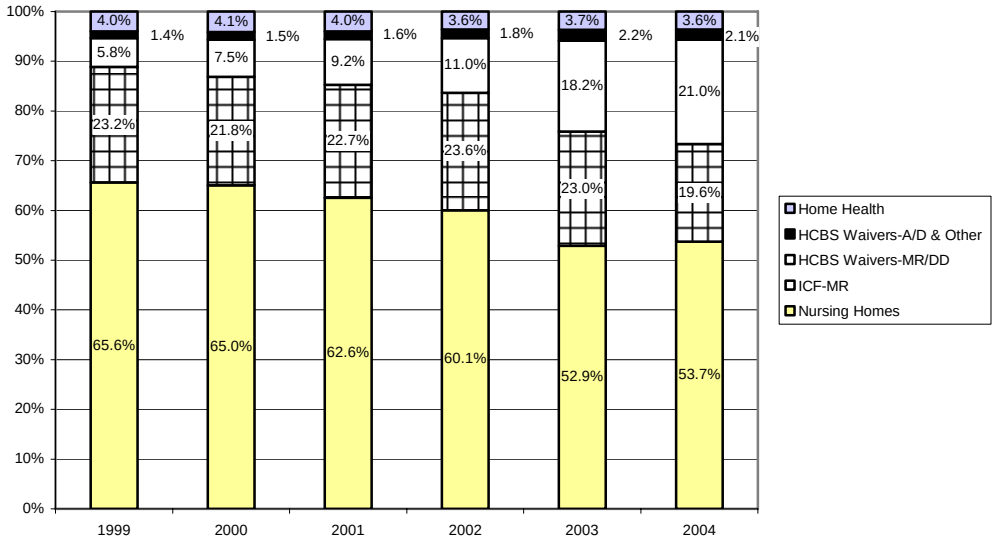
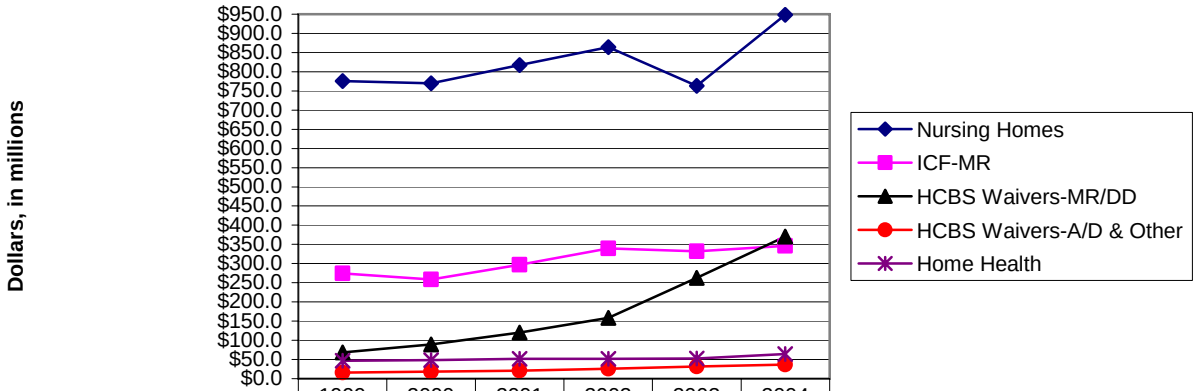


Figure 3 shows the levels of absolute spending for long term care budget items from FFY 1999 to 2004.

[38] Lewin Group (2005).

Figure 3: Medicaid Long Term Care Spending, in millions, Indiana FFY1999 to 2004
Source: Burwell et al., May 11, 2005



	1999	2000	2001	2002	2003	2004
Nursing Homes	$776.1	$770.0	$817.5	$864.3	$763.6	$948.1
ICF-MR	$274.5	$258.5	$296.8	$339.4	$331.7	$346.2
HCBS Waivers-MR/DD	$68.4	$88.9	$120.0	$158.3	$263.0	$370.1
HCBS Waivers-A/D & Other	$16.2	$18.0	$20.4	$25.7	$31.8	$36.4
Home Health	$47.0	$48.7	$51.9	$51.6	$52.9	$63.8

Savings from Nursing Home Diversions and Transitions

Milliman, Inc. estimate that the potential savings for one year is an average of $10,000 per person diverted (based on average 9.2 months duration) and an average of $9,000 per person transitioned (based on average 8.8 months duration). They expect the savings to be lower in the year following diversion or transition, but note that data are insufficient at this point to measure this.

Total savings from diversion and transition activities are estimated at $2.7 million in fiscal year 2003, $8.9 million in fiscal year 2004, and $5.5 million in the first half of fiscal year 2005 (see Table 1 for a breakdown).[39]

[39] Milliman, Inc. (2005).

Table 1: Number of Recipients and Savings (in millions) from Nursing Home Diversions and Transitions, FY2003 to FY2005

	FY2003		FY2004		FY2005		Total	
	New Recip.	Svgs.	New Recip.	Svgs.	New Recip.	Svgs.	New Recip.	Svgs.
Diversions	462	$2.7	583	$8.3	287	$4.7	1,332	$15.7
Transitions	3	$0.0	128	$0.6	94	$0.8	225	$1.5
Total	465	$2.7	711	$8.9	381	$5.5	1,557	$17.2

Source: Milliman Report
Note: FY2003 is from July 1, 2002 to June 30, 2003

The Lewin Group estimates that the savings are a bit lower. They put the difference in cost per person per month of waiver services versus institutional services as $955 for 2003, widening to more than $1,700 in 2015.[40]

Who is Diverted or Transitioned?

Those diverted or transitioned from nursing homes tended to be younger than the general nursing home population. About half those diverted or transitioned were over 65 years old, whereas 85 percent of nursing home residents were over 65 (see a detailed tabulation in Table 2 below).

Table 2: Age of Diversion/Transition/Nursing Home Population, July 2002 to December 2004, State of Indiana

	Diversion	Transition	Nursing Home
% over 65	49%	52%	85%
% under 55	27%	22%	10%
Average age	64	66	76
Recipients in December, 2004	815	160	25,702

Source: Milliman Report

Length of Diversion/Transition Services

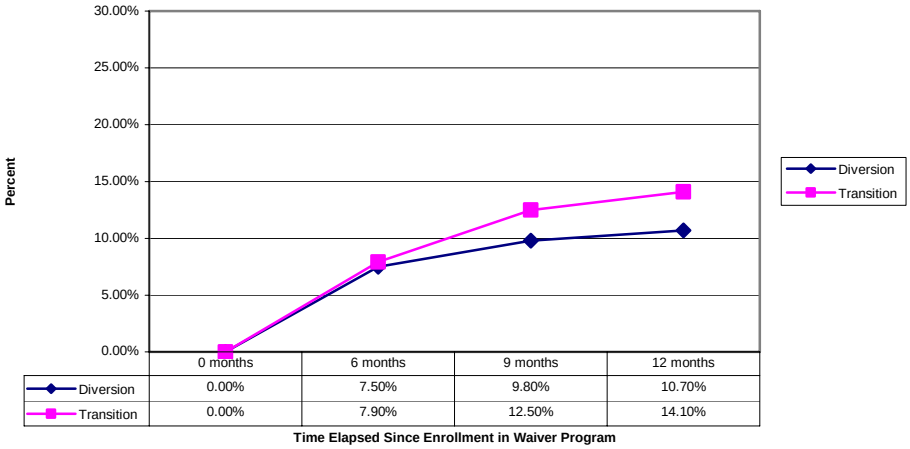
What happens to people receiving diversion or transition services? Specifically, how many of them go to a nursing home, and on what time scale? The data show that most people receiving diversion or transition waivers stay enrolled in the waiver program for at least nine months. As time progresses, some go to a nursing home. Figure 4 shows the percentage of people who receive nursing home services after having been previously diverted or transitioned.

[40] Lewin Group (2005).

After nine months, almost ten percent of those who had been diverted were receiving nursing home services. For those who had been transitioned, the figure was 12.5 percent.

Figure 4: Percent Receiving Nursing Home Services After Diversion or Transition

Source: Milliman Report, data from 7/1/02 to 3/31/05



	0 months	6 months	9 months	12 months
Diversion	0.00%	7.50%	9.80%	10.70%
Transition	0.00%	7.90%	12.50%	14.10%

Time Elapsed Since Enrollment in Waiver Program

Nursing Facility Transition Grant Results

According to grant reports, Indiana was able to integrate efforts for several of the federal grants it received to improve long-term care and felt that this was a large success.[41]

For the Nursing Facility Grant specifically, efforts were initially delayed because of staff turnover at the state level. However, a best-practices manual has been developed based on the combined experiences of four AAAs awarded funds under a pilot program.[42] A consultant coordinated their efforts and drafted the manual.[43] The manual outlines different ways of organizing nursing home transition efforts (for example, having a few staff dedicated solely to transition versus having all staff involved). The manual also offers many tips on client assessment and outreach to many different stakeholders (such as nursing homes, doctors, families, and community service providers, with sample forms and marketing materials.

The pilot program transitioned 110 people (81 women and 29 men) who had an average nursing home stay of 10 months (range was two weeks to almost 16 years). They were identified for transition by nursing home or AAA staff in almost 60 percent of cases, by family or themselves in about one-third of cases, and by preadmission screening or state data in the remaining cases (see Figure 5 for a complete listing).

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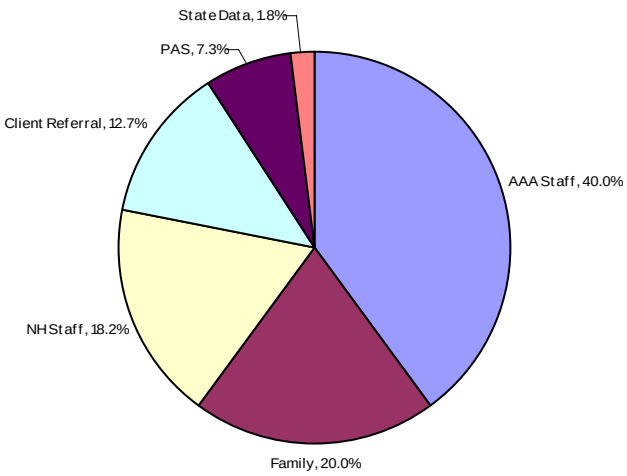
[41] State of Indiana (2005a).

[42] Several practices were taken from the following technical assistance document: Reinhard, S. & Gillespie, J. (2005, October). *Nursing Facility Transition Toolbox*. New Brunswick, New Jersey: Rutgers Center for State Health Policy and National Academy of State Health Policy. Available at: http://www.hcbs.org/files/80/3964/NFTToolbox10-12-05WEB.pdf

[43] Verma (2005).

Figure 5: How Transitioned Clients Identified

Source: Seema Verma Consulting, 2005



Almost 60 percent lived alone post-transition, while a little more than 30 percent lived with spouses or other family. The largest transition costs were for home modifications, medical equipment, furniture, rent and utility deposits. Costs were reported for 31 clients—the average cost per person over these 31 people was $800. Divided over the 110 clients (i.e., assuming 79 people had zero costs) the cost was $226 per person. The largest barriers to transition reported were medical care and support system concerns, followed by meals and home care/upkeep. These, together with the addition of medication management, became ongoing issues as well. Case management hours for transition issues ranged from one to 67, with an average of 14. Follow-up measures showed that after 60 days post-transition, almost 90 percent were still in the community. The top funding sources for care were personal and family resources, followed by Medicaid, Medicare, Social Services Block grants, the CHOICE program, Community donations and Title III of the Americans with Disabilities Act. About 90 percent of transitioned clients were receiving services under Medicaid waiver.[44]

Lessons Learned

Indiana officials indicate they could benefit from a change in their preadmission screening law to emphasize long-term care options counseling. This change will help maximize the use of federal and state funds to more efficiently identify people who need help to avoid unwanted nursing home placement.

[44] Verma (2005).

Conclusion

This brief summarizes Indiana's recent efforts to balance their long-term support system through more assertive outreach to consumers in their homes, in hospitals and in nursing homes. Estimated savings from nursing home diversion and transition are significant. Potential changes in the state's preadmission screening law may help advance options counseling and accelerate this pace of change.

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