Comments on the Home and Community Based Services Report
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The Indiana Assisted Living Association, the Indiana Health Care Association / Indiana Center for Assisted Living, LeadingAge Indiana, and Hoosier Owners and Providers for the Elderly appreciates the opportunity to comment on the Home and Community Based Services Report published by the Division of Aging (DA) as required by P.L. 225-2017. Our membership includes assisted living providers (licensed and unlicensed), nursing homes and adult day care facilities. Some of the members participate in the current Medicaid waiver program, others do not. We have an interest in a system that functions well for Indiana and makes the best possible use of Medicaid funds.

We recognize the effort made by the DA to produce a report containing a great deal of information. Our brief comments are intended as a high level response to the report and its recommendations.

Twenty-four action steps are included in the report (page 7) with a table showing the high level goals each action step supports as well as key implementation considerations. We commend the DA for setting lofty goals but the report lacks specifics on when and how DA will obtain the resources to reach these goals. A key implementation consideration that was not sufficiently addressed is whether resources necessary to support the implementation currently exist or can be obtained.

We encourage the DA to prioritize and set realistic goals for itself. We recognize the report's goals are interrelated, but from a provider prospective, we believe the DA priorities should be:

1. Improve upon the technology and new systems you already have --Ensure technology is integrated and working successfully. Eliminate manual steps/bottle necks such as DA manual review of service plans.
2. Implementation of the settings rule, while rarely mentioned in this report, continues to be of concern for providers. A timeline for the development of clear criteria targeting the 2021 compliance date should be developed. DA needs to give itself sufficient time to prepare clear and consistent guidance to providers and to develop its survey process.
3. Improve the system for determining functional eligibility. While the report contains some good ideas, we also suggest:
    - Allow entities other than AAAs to apply to be the intake point for HCBS programs.
    - Allow providers to provide funding to the AAAs to support staff if the AAA cannot conduct its initial assessments timely.

- Contracts with the AAA should contain performance penalties for failure to comply with benchmarks.
- Allow assisted living providers to admit residents based on the provider's evaluation of functional and financial eligibility criteria and make payment retroactive to the date of the Medicaid application so long as person is deemed eligible on that date.
- Allow immediate temporary coverage for families in crisis through some type of presumptive eligibility.

4. Determine a rate methodology. That rate methodology should not be cost reconciliation and should include an inflationary index factor.
5. Add a new Medicaid waiver service option for congregate living for those individuals who are not at a nursing facility level of care but who are at risk of needing that service in the near future. This service option should be developed in such a way that the provider of housing can also provide medical and personal services.
6. Resolve issues surrounding DA's current interpretation of the settings rule. As we have previously communicated to the DA, we believe the DA's interpretation of the settings rule is incorrect in many respects.

   In particular, current and future providers of congregate housing and services are confused by the perceived conflict between providing medical and personal services in a licensed Residential Care Facility versus providing these services in an unlicensed "assisted living" or "independent living" community using a combination of unlicensed caregivers and licensed home health agencies. Medicaid and Medicaid waiver programs are designed to provide medical and personal services to help beneficiaries with daily living tasks. DA's insistence that these tasks should be separate from housing is not required by the settings rule nor does it make business sense for many providers.

Lastly, the report references per enrollee per month expenditures for nursing facility residents of $4,263 and for adult participant on the A&D waiver of $2,786. These figures were credited to Lewin analysis of Medicaid claims data. The report then references expenditure growth for Indiana's LTSS program, primarily based on those with nursing facility level of care, and presents a graphic (pg. 17) that represents a savings of $520.8 million dollars in 2023. This data comes from Milliman analysis.

We would like to better understand how the Lewin analysis of claims data, resulting in a $1,477 savings per member per month between institutional and community based care, relates to the Milliman analysis of future savings through implementation of the report's 24 recommendations. Prior analysis of savings generated by using more community based services has been performed by Milliman, not Lewin, and the last publicly available analysis we

have shows a per member per month cost of $4,204 for nursing facility residents and $3,288 for A&D waiver recipients, a savings of $916 per member per month.

We recognize there is a savings between institutional and community-based services in many circumstances. We want to be sure the analysis is correct and consistent so as to not over-promise savings.

We appreciate the opportunity to comment on the report and look forward to continuing to work collaborative with the DA on improving Indiana's current system of home and community based services.