HMA

HEALTH MANAGEMENT ASSOCIATES

Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) Program

PRESENTED TO

FAMILY AND SOCIAL SERVICES ADMINISTRATION, DIVISION OF AGING

AND

AARP INDIANA

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Executive Summary

The Indiana Family and Social Services Administration, Division of Aging (DA) and AARP Indiana engaged Health Management Associates (HMA) to review the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program to learn if the program is cost beneficial and if the assistance being provided to clients is achieving desired outcomes. HMA reviewed Indiana Code and Indiana Administrative Code; obtained information from the DA, Area Agencies on Aging (AAA), the state's InSite case management system, and the Medicaid Management Information System; and interviewed representatives from the DA, AAAs, AARP, and The Generations Project. Additionally, we reviewed similar state funded programs for comparison and interviewed representatives from those states.

The CHOICE program appears to play an important role serving individuals who need long-term care services and are at risk of losing their independence because they lack access to CHOICE funds and cannot enroll in the A&D waiver or are ineligible for Medicaid. However, we found that there are no standardized performance measures or outcomes established for the program without which it is very difficult to determine if the program is meeting its intended purpose. It is important to note that our efforts concentrated on CHOICE funding and that it is difficult, at best, to determine if any one funding source has resulted in a specific outcome.

The following conclusions and recommendations are highlighted as the result of review of the CHOICE program.

Conclusions

Administration

- Indiana Code requires that the Division of Aging administer the CHOICE program and develop and implement a process for the management and operation of the program locally through the AAAs based upon criteria developed by the division.[1] Thus there is authority to strengthen mechanisms for oversight and measurement to determine if the program is reaching its goals.
- There is a lack of consistency among the AAAs as to how the program is administered, based upon the differing policies such as for targeting individuals for services from the waiting list, eligibility determination, and care plan development .

Monitoring and Reporting

- The DA prepares an Annual CHOICE Report as required by Indiana Code; however, the report does not contain findings or recommendations to improve program performance or operational efficiencies for sustaining and achieving program goals.
- Data for this program are not centralized, may not be available or easily extracted for monitoring purposes. For example, as defined in law, an individual eligible for CHOICE is one who is at risk of losing the individual's independence if the individual is unable to perform two

[1] IC 12-10-10-6

or more ADLs. Some individuals are reported as having only one ADL impairment and may also have a severe medical condition, but available data do not provide information to correlate.

- The state does not have access to information which is controlled at the AAA level in the InSite system, nor does the state request regular data from the AAAs except for what is provided in the CHOICE Annual Report.
- AAAs indicated they are able to use CHOICE funding to provide services to intercede earlier and to forestall the placement of an individual into a nursing home while they might be waiting for services through the A&D Waiver or to help support families who keep loved ones at home. This anecdotal information is difficult to support due to lack of consistent outcome measures and availability of data. Some AAA CHOICE plans include reference to outcomes and benchmarks but none include specific outcomes or benchmarks. Additionally, it appears that the DA could do more to assimilate the information for reporting, funding, and policy decisions.
- The DA and the AAAs need better tools to measure success and outcomes of the program.
- Other than claims review and reviewing the annual CHOICE plans submitted by the AAAs, the DA does not regularly monitor AAA operations or CHOICE program outcomes. We also noted that while the DA sets CHOICE policy through Indiana Administrative Code and distributes policy through the CHOICE Program Manual, AAA implementation of the program is inconsistent.

Eligibility

- Some CHOICE recipients might qualify for the A & D Waiver but instead are utilizing CHOICE funds that do not draw federal matching funds. Approximately 37 percent of clients receive both Medicaid state plan services and CHOICE funded services and are obviously eligible financially for Medicaid. Additionally, the majority of individuals (60 percent) have three or more ADL impairments. To qualify for the A&D Waiver, individuals must meet financial criteria and functional criteria of a nursing home level of care, which can include three ADL impairments. It is possible that individuals served through CHOICE could qualify for the A&D Waiver, which is matched with federal funds at a rate of 67.16 percent for the federal fiscal year ending September 30, 2013. This will help provide more opportunity to serve individuals through the CHOICE program who are not eligible for Medicaid or Medicaid HCBS waiver services.
- It appears that the requirement for CHOICE applicants to first apply for Medicaid benefits is not meeting the intended goal for CHOICE to be the payer of last resort. The income limits for those in the special income group and spousal impoverishment provisions are not being considered for individuals seeking services funded by CHOICE. The spousal impoverishment provision allows the spouse who would not be receiving waiver services up to $115,920 (effective 1-1-13) in assets. Also parental income and resources are disregarded for children under 18.
- Since the A&D Waiver includes a provision that individuals transitioning off 100 percent state funded budget programs receive priority, the potential eligibility for the A&D Waiver is important.
- The majority of the individuals (90 percent) served through CHOICE reportedly have annual incomes of less than $25,000. This income level closely approximates individuals in the “special

income group" who may qualify financially for Home and Community-Based Medicaid Waiver services.

- Even though some individuals may be eligible for the A&D Waiver, they may be placed on a waiting list because of limited availability of funding for waiver slots.

Expenditures

- The current cap of $13,517 per quarter of CHOICE expenditures per individual exceeds nursing facility costs at certain levels.
- It is important to note that our efforts concentrated on CHOICE funding and that it is difficult, at best, to determine if any one funding source has resulted in a specific outcome.
- The average monthly cost for a client receiving services funded only through CHOICE is $650 per our analysis, which is similar to the average monthly cost reported in the FY 2011 Annual CHOICE report of $633. For a comparison of costs see Tables 8 through 10.
- For clients that receive services funded through a combination of CHOICE, Medicaid and the A&D Waiver, the cost to the state is more than if the client were served in the nursing home.

Recommendations

HMA recommends that the DA continue the CHOICE program as an integral part of the continuum of care for vulnerable individuals, in conjunction with other programs administered through funding from Medicaid, the Older Americans Act, and the Social Services Block Grant. The DA should modify their systems, procedures and guidelines to better attain the goals of the program through consistent quality, improved monitoring and reporting and by maximizing the number of clients served.

Consistent Quality

To ensure the highest quality possible is attained consistently throughout the state, actions can be taken, including:

- Develop a core standardized assessment instrument
- Apply consistent standards for targeting and prioritizing individuals to be served, for eligibility determination, and for outcomes, and reporting.
- Review AAA best practices for possible implementation system wide.

Monitoring and Reporting

Improvements can be made for the monitoring and reporting of program results, including:

- Install a case management and data reporting system that provides useful information not only for each of the AAAs, and is useful at the state level.
- The DA should obtain outcome measurement results by AAA either through standard reports in the software system or from AAAs.
- Provide easy access to cost sharing information electronically for review of amounts collected by each AAA.

- More specific data should be collected which provides functional eligibility information for individuals served through CHOICE.
- Review the CHOICE appropriation and compare it to the dollars expended solely for CHOICE clients (56.1 percent in 2011) to ensure that the funding is being applied as intended by the legislature.
- Rather than requiring a separate CHOICE Plan from each AAA, require the AAAs to include this plan information in their overall Area Plan and instead require a CHOICE annual report of outcomes and performance by each AAA.

Maximizing the Number of Persons Served

The DA should review and revise policies, rules and regulations, with input from AAAs, to help ensure that the maximum number of clients is served in the most efficient manner. These activities should include:

- Identify program goals that, if not met, have the greatest adverse impact on access to services, cost of care, and institutionalization.
- Revise the policy that all applicants apply for Medicaid. Currently, policy does not consider those who may qualify for the A&D Waiver through the special income group and spousal impoverishment provisions and as a result there may be A&D Waiver eligible individuals falling through the cracks. A revised policy may help serve more individuals through use of the A&D waiver services.
- Consider requiring annual verification of excess income or assets and a signed attestation of responsibility to seek Medicaid eligibility when income and assets reach Medicaid thresholds. Consider the special income and spousal impoverishment provisions. Maintain documentation in the individual's file.
- Consistent policies should be developed and applied for the cost sharing to maximize collection of funds for client services.
- Revise the waiting list policy for placement on the list to target individuals most at risk of losing their independence if not served in a timely manner, rather than on a first come, first serve basis.
- Revise the required level of 20 percent of CHOICE expenditures for individuals who are under the age of 60.
- Review the amount of the quarterly expenditure caps set by the DA for appropriateness.
- The program was originally designed before the implementation of the A&D Waiver, so review statutory requirements of the program such as requirements for ADL limitations. Consider raising functional criteria to three ADL impairments.

We would like to thank everyone who met with the HMA team and provided information for this report.

Introduction

The Indiana Family and Social Services Administration (FSSA), Division of Aging (DA) is responsible for administering the Community and Home Options to the Institutional Care for the Elderly and Disabled (CHOICE) Program.[2] The DA and AARP Indiana engaged Health Management Associates (HMA) to review CHOICE documentation and data and interview stakeholders to learn if the program is cost beneficial and if the assistance being provided to clients in the CHOICE program is achieving desired outcomes. To do this, HMA reviewed Indiana Code and Indiana Administrative Code; obtained information from the DA, Area Agencies on Aging (AAA), the state's InSite case management system, and the Medicaid Management Information System; and interviewed representatives from the DA, AAAs, AARP, and The Generations Project. Additionally, we reviewed similar state funded programs for comparison and interviewed representatives from those states.

Background

The CHOICE program was established during the 1987 legislative session through House Enrolled Act 1094 and began as a pilot program in Knox, Daviess, and Tippecanoe counties in 1988.[3] In 1990, the program expanded to 11 additional counties and by 1992, the program included services to all of Indiana's 92 counties.[4] The program provides case management services, assessment, and in-home and community services to individuals who are at least 60 years of age, or persons of any age (including children) who have a disability and who are found to be at risk of losing their independence. CHOICE services are offered to all eligible persons regardless of income, although cost sharing is applied to individuals who can pay all or a portion of the cost of CHOICE services rendered.[5]

CHOICE Program Goals

The purpose of CHOICE is to enable older adults or persons with disabilities to live independently in their own homes or in community-integrated settings through provision of home and community-based services. It is further intended to allow older adults ready access to community resources in order to improve the quality of life of families and children with an emphasis on seniors and persons with disabilities. The program is also intended to encourage more coordinated planning, to give increased attention to CHOICE participant views, to provide greater respect for participant preferences, and to value participant selection of providers as well as services. [6]

Program Administration

The DA is required to develop and implement a process for local management and operation of the program through Indiana's sixteen AAAs. It has established guidelines and procedures for the

[2] Ind. Code 12-10-10-6
[3] CHOICE Annual Report State Fiscal Year 2011, page 1
[4] Ibid.
[5] Indiana Division of Aging Operations Manual (Revised 2006), Section 5002.4
[6] DA Operations Manual, Section 5002

management of the CHOICE program for use by the AAAs. These guidelines and procedures are published in administrative rules and the DA's CHOICE Manual. A map of Indiana which displays the counties for each of the AAAs is provided in Attachment 1.

The DA enters into contracts for a two year term with the AAAs to administer CHOICE funds and perform local administrative functions,[7] including the following:

- Budgeting
- Case management
- Oversight
- Monitoring
- Quality assurance
- Submission of fiscal claims to the DA

AAAs also provide local administration for programs authorized under Title III of the Older Americans Act (OAA) and the Social Services Block Grant (SSBG) as well as for the Aged & Disabled Waiver. These programs provide sources of federal funding for in-home and community based services for populations similar to those served under the CHOICE program. Attachment 2 provides a comparison of the in-home and community based services available through Medicaid, Title III of the OAA, SSBG, and CHOICE. Attachment 3 compares the eligibility criteria for each of these programs.

The AAAs are required to submit a CHOICE plan to the DA annually that includes the following:[8]

- Referral and intake process including a description of how eligibility is determined
- Assessment process, format, and procedures
- Nursing home outreach methods
- Hiring practices
- Care plan development process
- Listing of all area and community support services
- Policies and procedures for case management and service coordination
- Policies and procedures for coordinating CHOICE with Medicaid HCBS waivers and other funding sources
- Quality assurance and quality improvement plan
- Description of internal methods for evaluating plans of care and monitoring the provision of services
- Description of processes and procedures for follow-up and incident reporting
- Policies and procedures for responding to mortality reviews conducted by FSSA
- Cost sharing plan including cost share collection procedures
- Complaint and appeal procedures
- Policies and procedures for waiting lists

[7] 455 IAC 1-5-3
[8] See 455 IAC 1-5-3(b) and CHOICE Manual, Revised September 2012

- Budget narrative
- Procedures for provider selection

The DA's CHOICE manual specifies the content and format for the AAAs' annual CHOICE plan.[9] The required sections are:

Section 1 – Intake and Referral Process
Section 2 – Assessment Process
Section 3 - Nursing Home Outreach*
Section 4 – Hiring Practices*
Section 5 – Care Plan Development Process*
Section 6 – Area and Community Support Services (list)*
Section 7 – Case Management and Service Coordination
Section 8 – Coordinating CHOICE with Other Funding Sources
Section 9 – QA/QI Plan
Section 10 – Plans of Care Evaluation and Monitoring
Section 11 – Follow up and Incident Reporting*
Section 12 – Mortality Reviews*
Section 13 – Cost Sharing
Section 14 – Complaint and Appeal Procedures*
Section 15 – Waiting List
Section 16 – Budget
Section 17 – Provider Selection*

*These sections were not reviewed.

All CHOICE plans for FY 2013 were reviewed. The plans varied in their level of detail as evidenced by the fact that the longest plan contained 74 pages and the shortest only 7. Most plans were between 20 and 30 pages long. Some of the AAAs maintain separate policies and procedures for the CHOICE program, while others incorporate them into their plans. When separate policies and procedures were provided, those were also reviewed.

Targeted Population

To be eligible for CHOICE program services, an individual must:

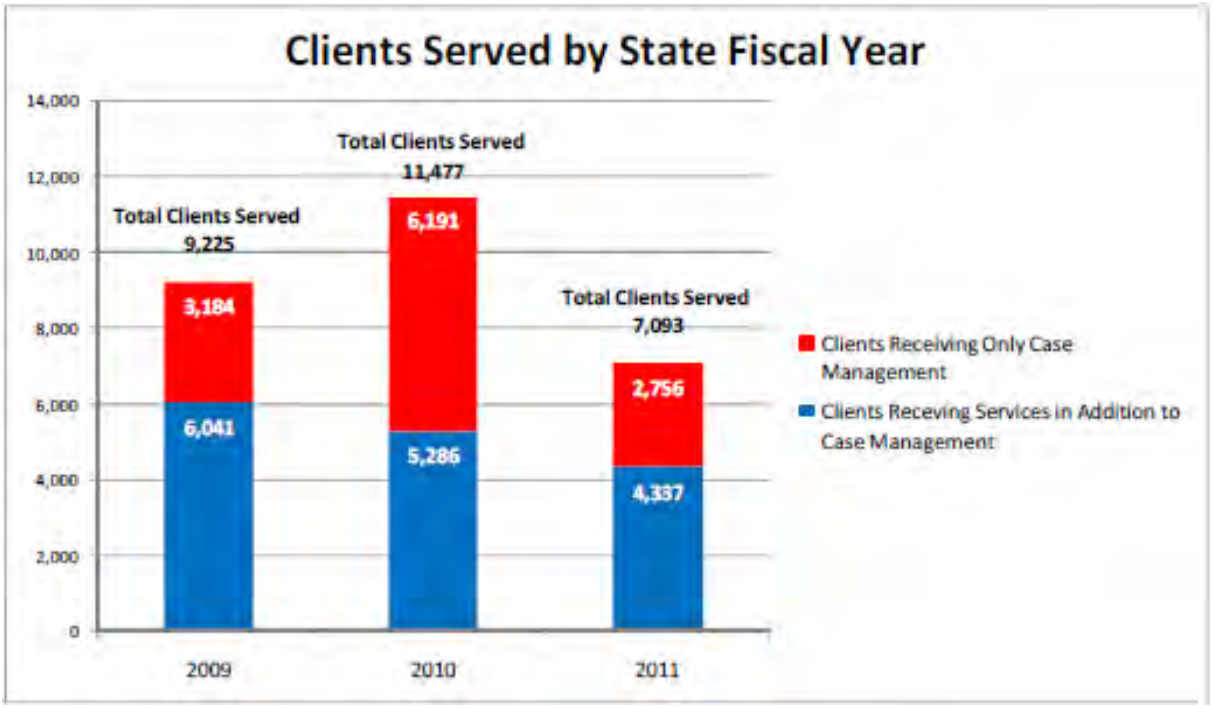
- Be a resident of the State of Indiana;
- Be 60 years of age or older or disabled;
- Not have assets exceeding the worth of five hundred thousand dollars, as determined by the Indiana Division of Aging; and
- Have an impairment that places the individual at risk of losing the individual's independence because the individual is unable to perform two or more activities of daily living (ADL).[10]

[9] CHOICE Manual, Section 10017.

Clients Served

The following graph (Figure 1) shows the number of clients served for the past three years.

Figure 1: CHOICE Clients Served 2009 - 2011[11]



Even though the funding for CHOICE did not change substantially between 2010 and 2011, there is a large reduction in the number of clients served. The decrease in the reported number of clients served may be due to the fact that, subsequent to March 2011, DA required that CHOICE clients have a care plan entered into the software system, InSite, rather than just a case note (documenting, for example, addition of the individual to the waiting lists). Prior to this time, any individual with a case note in the system was counted as a client, which likely overstated the actual number of clients served. Specifically, the category shaded in red included individuals in the system prior to March 2011 with only a case note.[12] According to state officials, for 2009, the smaller number of individuals shown in the "Only Case Management" category may be explained by a less extensive waiting list and thus fewer case notes documented in the systems.

As noted in the graph shaded in red, some clients received only case management. According to Indiana Code 12-10-10-1, case management means an administrative function conducted locally by an AAA that includes the following:

- Assessment of an individual to determine the individual's functional impairment level and corresponding need for services

[10] See Ind. Code 12-10-10-4

[11] Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) Annual Report State Fiscal Year 2011.

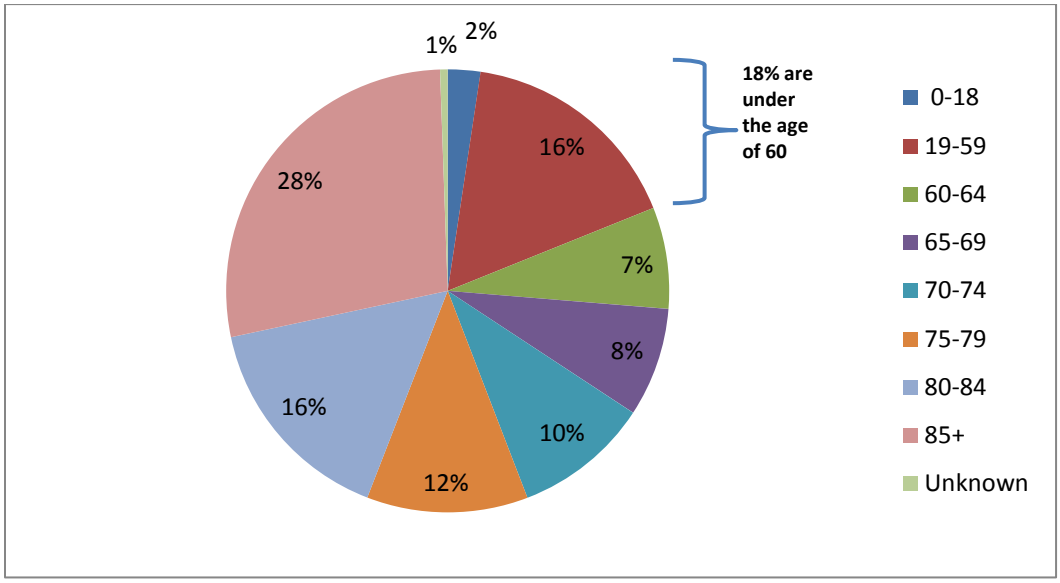
[12] Per discussions with DA officials.

- Development of a care plan addressing an eligible individual's needs
- Supervision of the implementation of appropriate and available services for an eligible individual
- Advocacy on behalf of an eligible individual's interests
- Monitoring the quality of community and home care services provided to an eligible individual
- Reassessment of the care plan to determine the continuing need and effectiveness of the community and home care services provided to an eligible individual
- Provision of information and referral services to individuals in need of community and home care services

For the state fiscal year (SFY) ended June 30, 2011, approximately 71 percent of the CHOICE clients were female.

The age of clients served is displayed in Figure 2. Eighty-two percent of clients were 60 years of age or older in SFY 2011.

Figure 2: CHOICE Clients Age Breakdown, SFY 2011[13]



Even though the functional eligibility criteria for CHOICE requires impairment of at least two ADLs, there are a small percentage of clients (4 percent) who reportedly have only one ADL impairment. Some of these individuals may also have a severe medical condition making them eligible for the CHOICE program, but it cannot be determined from available data.

[13] Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) Annual Report State Fiscal Year 2011.

Table 1: CHOICE Clients (Duplicated) Served by ADL Impairments SFY 2011[14]

	Clients Served	Percentage
1 ADL Impairment	328	4%
2 ADL Impairments	2268	29%
3 or More ADL Impairments	4626	60%
Severe Medical Conditions	507	7%
Total	7729	100%

Each of the AAAs provided income levels of the individuals served through CHOICE, displayed in Table 2. The majority of the individuals (90 percent) reportedly have annual incomes of less than $25,000. This income level closely approximates individuals in the "special income group" who may qualify financially for HCBS Medicaid Waiver services. The special income group includes individuals with income of up to 300 percent of the maximum Supplemental Security Income (SSI) benefit amount.[15] If income is above 300 SSI, an individual may still qualify with a spend down if the individual has a Qualified Income Trust, also known as a "Miller trust". Parental income and resources are disregarded for children under 18.

Furthermore, for financial qualification for Medicaid, assets (resources) are considered, but spousal impoverishment provisions apply. When a couple applies for Medicaid, an assessment of their resources is made. The couple's resources, regardless of ownership, are combined. The couple's home, household goods, an automobile and burial funds are not included in the couple's combined resources. The spousal impoverishment provision allows the spouse who would not be receiving waiver services up to $115,920 (effective 1-1-13) in assets.

[14] Ibid.
[15] Effective January 1, 2012 the limit is $2,094.00 per month or $25,128 annually. See http://member.indianamedicaid.com/am-i-eligible/eligibility-guide.aspx for additional information.

Table 2: Income Levels of CHOICE Clients Served SFY 2011

Area	$0 (No income data)	Under $25,000	$25,000 and above	Total Clients Served
1	62	579	32	673
2	5	277	20	302
3	7	216	11	234
4	2	166	6	174
5	2	176	12	190
6	21	510	39	570
7	9	138	6	153
8	31	772	67	870
9	12	133	6	151
10	6	126	3	135
11	2	179	18	199
12	3	294	12	309
13	2	292	14	308
14	3	110	8	121
15	7	299	45	351
16	5	276	15	296
Total	179	4,543	314	5,036[16]

Program Policies

Eligibility

Case managers at the AAA are primarily responsible for determining eligibility for CHOICE services. This takes place after AAA options counselors provide information about programs and benefits and then determine whether there is a need for referral to the case manager for an assessment at intake. At least two AAAs appear to triage individuals seeking services and identify whether an individual's needs should receive a high priority referral to the case manager at the intake stage.[17] A standard assessment instrument, known as the Long-Term Eligibility Screen (E-Screen, within the INSite case management software system), is used by all AAAs to determine whether an individual is at risk of losing independence. [18] Some AAAs also require certification from a physician that home care is safe and

[16] The total number of clients served in Table 2 differs from the numbers shown in Figure 1 and Table 1 because of the variance in the way that clients served was measured. Figure 1 includes individuals that may only have a case note and Table 1 is a duplicated count of clients served, whereas Table 2, above, is unduplicated and does not include clients with only a case note entered into the InSite system (see earlier discussion about the policy change effective March 2011).

[17] Areas 10 and 12. High priority can be indicated by application for nursing facility placement, significant change in client (or caregiver's) condition.

[18] See 455 IAC 1-5-5

feasible under certain circumstances such as when an applicant has a complex medical condition. The information collected through the E-Screen is used to develop a plan of care.

The E-screen is also used to determine eligibility for Medicaid nursing home services and for the Medicaid Aged and Disabled Waiver. While an in-depth review of the E-screen was not conducted as part of this review, this instrument does not appear to be structured in a manner that is conducive for the assessors, reviewers, or the state to easily extract functional data regarding eligibility for the Aged and Disabled Waiver, CHOICE, or nursing home placement. The E-screen is used to record the assessment of a person's medical conditions, rating of activities of daily living and presence of substantial mental health conditions. In particular, while at least 60 percent of CHOICE clients are identified as having at least three impairments of ADLs, an indicator that the individual may be eligible for the A&D Waiver, these particular ADL impairments may not be the same as those that qualify for A&D waiver eligibility. Based upon interviews with the AAAs, other factors are considered when determining appropriateness for CHOICE services such as age, family and environmental supports. It is our understanding that the DA is currently reviewing this assessment instrument as part of a larger effort to streamline processes and as part of their implementation of the Balancing Incentive Program.

In order to establish financial eligibility, CHOICE relies on the Medicaid application determination and verifications obtained from the Division of Family Resources (DFR), the agency that processes Medicaid applications. If the CHOICE applicant has had a Medicaid determination within the last 90 days, the CHOICE case manager obtains asset information collected by the DFR through the FSSA DA CHOICE representative. If the CHOICE applicant has not had a Medicaid eligibility determination completed within the last 90 days the CHOICE case manager helps the applicant file a Medicaid application. Under both scenarios, the CHOICE applicant completes and signs the CHOICE Asset Attestation form, attesting that the information obtained through the Medicaid eligibility determination process continues to accurately reflect assets. If the CHOICE applicant's financial situation has changed since the time of Medicaid application, the individual is referred to the DFR for a new Medicaid eligibility determination.[19] State policy requires the case manager to monitor the outcome of the Medicaid eligibility process. However, only four AAAs clearly indicated in their CHOICE Plans or policies that they obtain a copy of the Medicaid determination.[20]

Once an individual begins receiving CHOICE services, care plans are reviewed at least every 90 days. The review is conducted by the case manager during a face-to-face visit with the client. The case manager updates program eligibility information, the E-Screen, assessment information, and asset information. In addition, the continued need for CHOICE services is documented.

Cost Sharing

Cost sharing is not required for clients with income at or below 150 percent of the federal poverty level (FPL). However, for clients with incomes between 151 and 349 percent of the FPL, clients are charged for the cost of services on a sliding scale that increases by 0.5 percent for each 1 percent increase in the

[19] CHOICE Manual, Section 10004
[20] CHOICE Manual, Section 10010. Areas 8, 12, 13 and 16.

percent of poverty over 150 percent of the FPL.[21] Clients with incomes of 350 percent of the FPL or more or with assets in excess of $500,000 (no matter the income level) are responsible for 100 percent of the cost of CHOICE services.

AAAs are responsible for billing clients and collecting cost sharing amounts which they are able to use to help further support the CHOICE program. Bills are sent on a monthly basis for cost sharing amounts equal to or more than ten dollars. One AAA requires providers to collect cost share amounts directly from clients and reduces a provider's claims by the amount of cost sharing due. A client's failure to pay can result in termination of services. Some AAAs have policies that permit a waiver of cost sharing amounts for up to three months. One AAA indicated in its plan that FSSA may be asked to assume responsibility of the client's cost share in extenuating circumstances.[22]

The following table provides the cost share amounts collected by each AAA for the SFY 2011 and 2012, as reported by each AAA. Amounts collected vary considerably among the AAAs.

Table 3: Cost Share Collected by AAA[23]

AAA	2011	2012
1	$13,927	$3,769
2	$21,047	$19,614
3	Not Provided	Not Provided
4	$883	$142
5	$8,402	$11,175
6	$5,253	$5,816
7	$ 0	$ 0
8	$78,670	$52,837
9	$12,476	$10,250
10	Not Provided	Not Provided
11	$619	$2,809
12	$2,910	$1,967
13	$4,216	$4,847
14	$853	$804
15	$600	$508
16	$5,665	$3,583
Total	$155,522	$118,121

Payer of Last Resort

CHOICE is the funding of last resort for in-home and community-based services. If any older adult or person with disabilities applying for or receiving services through the CHOICE program is eligible for in-home and community-based services from sources other than CHOICE, they must be used prior to or in

[21] See Ind. Code 12-10-11-8(11)
[22] Area 10.
[23] Amounts collected provided by each AAA; this data is not collected at the state level.

place of CHOICE funding.[24] Other sources of funding may include Title III of the OAA, SSBG, Medicaid state plan or Medicaid HCBS waiver services, Veteran's Administration services, family supports, volunteer resources, other health insurance, or other support.

If an individual is eligible for Medicaid with a spend-down, expenditures for CHOICE services that are medical in nature may be used to meet the spend-down. CHOICE funds may also be used to fund services not available from Medicaid.[25]

Three AAAs indicate in their CHOICE plans that they do not use CHOICE funds to supplement Medicaid HCBS waiver services.[26] Seven AAAs allow CHOICE funds to be used to pay for services not available under the Medicaid HCBS waivers such as a medication dispensing unit.[27] At least one AAA requires case managers to monitor services for clients receiving funding from multiple sources to ensure there is no duplication (Area 9).

Funding Caps[28]

The DA has established a maximum level of CHOICE expenditures per individual. The current cap per quarter is $13,517. The cap is applied on a quarterly basis to coincide with the time period covered by the care plan. Home modifications are amortized over a twelve month period. Because CHOICE case management is considered an administrative function, it is excluded from the cap. This cap is approximately $150 per day, which exceeds nursing home costs at certain levels. See Attachment 6 for information on nursing home costs.

Two AAAs have established a monthly funding cap or a benchmark for services provided under Title III and SSBG, but there are no DA-established caps for these programs.[29]

Waiting Lists

The AAAs are responsible for maintaining waiting lists for clients seeking in-home and community based services under CHOICE, SSBG, and Title III programs living in their service area. The DA maintains waiting lists for the Medicaid Aged and Disabled (A&D) and Traumatic Brain Injury (TBI) waivers. The Indiana Association of Area Agencies on Aging (I4A) has developed a Waiting List Management Policy that establishes an operating procedure for moving individuals on and off the waiting list for CHOICE services. The DA requires the AAAs to follow the I4A policy although not all of them mention the policy in their waiting list procedures.[30]

Most AAAs prioritize individuals on the waiting list based on their date of application, but some of the CHOICE plans are silent on this point. Beyond that, there is variation among the AAAs for further

[24] DA Operations Manual, Section 5002.4
[25] CHOICE Manual, Section 10010
[26] Areas 4, 9 and 10
[27] Areas 5, 7, 11, 12, 13, 14 and 15.
[28] CHOICE Manual, Section 10008
[29] Area 5's cap is $500 for each program. Area 6 has a benchmark of $600 for each program as well as for local funding sources.
[30] CHOICE Manual, Section 10005

prioritizing who on the waiting list receives services first. One AAA prioritizes individuals 95 years of age or older. Three AAAs make exceptions to the date of application based on the following:

- County is underserved
- Active clients need additional services
- AAA is under serving persons under the age of 60 who have disabilities (e.g., the county is not using 20 percent of its CHOICE funding to serve this population)

Three AAAs permit individuals meeting one of the following criteria to receive higher priority for services:

- An individual is applying for nursing facility placement through the pre-admission screening program
- An individual has experienced a loss of a caregiver

One AAA uses a scoring system based on the individual's level of care (LOC) and access to financial resources in order to prioritize individuals based on greatest medical and socioeconomic needs.[31] The LOC score is derived from the E-Screen score, which is a combination of the assessed need for skilled care and ability to complete ADLs. This AAA has developed an Asset Planning Counseling (APC) worksheet to assess financial need. The case manager uses this tool to identify the applicant's financial holdings, monthly income, and monthly expenses. The APC score ranges between 0 and 5 with 5 indicating the greatest financial need due to a lack of resources to pay for services. The APC score is placed in front of the LOC score to create a three digit number. Individuals with higher scores have a higher priority for services. Individuals with the same scores are placed on the waiting list in chronological order by their date of application, with the earliest applications receiving highest priority.

Yet another AAA uses the ADRC Priority Tool to identify individuals with the greatest need for services.[32] This tool establishes a low, medium, or high priority based on a score derived from the answers to a series of questions about the client's living situation and need for assistance.

All AAAs following the I4A policy are required to have procedures in place for maintaining accurate information about individuals on the waiting list. These procedures include at least yearly updating of the following:

- Demographic information
- E-Screen and financial information
- Documentation of contact in case notes

If the AAA cannot reach an individual to update waiting list information, a letter is mailed to the individual. If there is no response within 30 days of the date the letter is mailed, the individual's name is removed from the waiting list. The AAA may use other methods to determine the individual's status

[31] SWIRCA & More (Area 16) CHOICE Plan, pp.23-24
[32] NWICA (Area 1) CHOICE Plan

such as consulting the Social Security death index, local newspaper obituaries and pre-admission screening applications.

See Attachment 4 for a table that lists all of the AAAs, the number of individuals on their waiting lists and their criteria for prioritization, if any.[33]

Funding and Expenditures

CHOICE is funded exclusively with state dollars, although state law permits federal social services block grant dollars to be used to fund CHOICE services that are not otherwise reimbursable under the Medicaid program.[34] At least 20 percent of AAA service dollars must be used to serve individuals under age 60 with disabilities.[35] As shown in the graph in Figure 2, only 18 percent of clients were under the age of 60; the actual dollars expended for these clients was not available.

Table 4 indicates how the CHOICE appropriation was earmarked for the SFYs ending June 30, 2009, 2010 and 2011.

Table 4: CHOICE Appropriations, SFY 2009, 2010 and 2011

	SFY 2009		SFY 2010		SFY 2011	
CHOICE	$33,424,487	68.50%	$32,161,716	66.00%	$27,333,208	56.10%
Aging and Disability Resource Center (ADRC)	$776,000	1.60%	$776,000	1.60%	$659,600	1.40%
DA Admin/Reserve	$1,665,156	3.40%	$2,927,927	6.00%	$7,872,835	16.10%
Amount Transferred to OMPP for A&D Direct Waiver Services	$12,900,000	26.50%	$12,900,000	26.50%	$12,900,000	26.50%
Total Appropriation	$48,765,643	100.00%	$48,765,643	100.00%	$48,765,643	100.00%

The funding for ADRC represents support for the Aging and Disabled Resource Centers that are administered by the AAA.

The DA Admin/Reserve is an amount that is held out of the current year appropriation at the request of the State Budget Agency as a mechanism for budget management. These dollars revert to the state budget at the end of the fiscal year. From 2009 through 2011, the Family and Social Services Agency was requested by the State Budget Agency to reserve a larger amount. In SFY 2012, the reserve from CHOICE is $2.3 million.[36]

The amount transferred to OMPP, as authorized legislatively,[37] is the amount used to draw federal matching funds for the Medicaid Aged and Disabled Waiver. For SFY 2012 and 2013, the amount

[33] Further information about the characteristics of those on the waiting list and data regarding reasons for termination from the waiting list was requested from the AAAs but was not available at the time for publication in this report

[34] Ind. Code 12-10-10-10

[35] DA Operations Manual, Section 2038 and CHOICE Manual, 2012 version, Section 1000.

[36] Per communication with Family and Social Services, Division of Aging

[37] House Enrolled Act No. 1001, for the biennial period 2011-2013

transferred is/will be $15 million and $18 million respectively.[38] These state general funds ($18 million) will generate $36.8 million of additional federal funding at the 2013 federal medical assistance percentage (FMAP) rate of .6716 for Indiana.

The balance of the CHOICE appropriation, $27,333,208 for SFY 2011, is allocated to each of the sixteen AAAs, consistent with how Older Americans Act funds are allocated and shown in Table 5.

Table 5: CHOICE Allocation to AAAs SFY 2011

Area	CHOICE Allocation	CHOICE Admin Allocation	CHOICE Case Management Allocation
1	$3,184,578	$382,149	$732,453
2	$2,731,280	$327,754	$628,194
3	$2,432,342	$291,881	$559,439
4	$1,336,719	$160,406	$307,445
5	$1,220,131	$146,416	$280,630
6	$2,116,573	$253,989	$486,812
7	$1,235,176	$148,221	$284,090
8	$5,181,774	$621,813	$1,191,808
9	$938,114	$112,574	$215,766
10	$476,543	$57,185	$109,605
11	$868,206	$104,185	$199,687
12	$733,880	$88,066	$168,792
13	$1,453,083	$174,010	$333,519
14	$979,771	$117,573	$225,347
15	$804,780	$96,574	$185,099
16	$1,640,258	$196,831	$377,259
Total	$27,333,208	$3,279,625	$6,285,948

Administrative expenses for CHOICE (including general and administrative expenses, Medicaid HCBS waiver administrative expenses and case management expenses) may not exceed 35 percent of the total CHOICE contract amount. The AAAs may not exceed 12 percent of the CHOICE contract amount for general and administrative expenses. The remaining 23 percent must be utilized for the provision of case management services pursuant to IC 12-10-10-1 and for Medicaid HCBS waiver administrative expenses. Case management, while considered "administrative" in the CHOICE program, provides a value to individuals in need of home and community-based services as well as to their families. Case management can offer assistance with identification and coordination of community resources, other

[38] The matching rate, known as the Federal Medical Assistance Percentage (FMAP) for Indiana was 66.96 and 67.16 percent during the federal fiscal year ended September 30, 2012 and 2013, respectively. Available at http://www.gpo.gov/fdsys/pkg/FR-2011-11-30/pdf/2011-30860.pdf

than those funded through government sources. The actual expenditures in 2011 for administration and case management are shown in Table 6.[39]

Table 6: 2011 CHOICE Expenditures for Administration and Case Management

	$ Expended	% to Total Expended
Administration	$2,408,269	9.0%
Case Management	$3,654,107	13.7%
Total	$6,062,375	22.7%

Actual expenditures for CHOICE by each of the AAAs for SFY 2011 was $26,655,298, or $674,910 less than the allocation. Table 7 compares the actual allocation to the expenditure.

Table 7: Comparison of CHOICE Allocation to CHOICE Expenditures by Area, SFY 2011

Area	CHOICE Allocation	CHOICE Expenditures	Difference
1	$3,184,578	$3,081,924	$102,654
2	$2,731,280	$2,731,280	$0
3	$2,432,342	$2,365,831	$66,511
4	$1,336,719	$1,308,044	$28,675
5	$1,220,131	$1,149,592	$70,539
6	$2,116,573	$2,029,767	$86,806
7	$1,235,176	$1,226,065	$9,111
8	$5,181,774	$4,883,168	$298,606
9	$938,114	$938,114	$0
10	$476,543	$476,543	$0
11	$868,206	$868,203	$3
12	$733,880	$733,880	$0
13	$1,453,083	$1,453,083	$0
14	$979,771	$979,771	$0
15	$804,780	$789,774	$15,006
16	$1,640,258	$1,640,258	$0
Total	**$27,333,208**	**$26,655,298**	**$677,910**

Cost Per Consumer

In order to analyze and compare costs of CHOICE funded services, several sources of data were used. Information was obtained from DA and the Office of Medicaid Policy and Planning in order to determine clients that received CHOICE funded services, as well as clients that received CHOICE funded services

[39] Per Annual Closeout Reports submitted by AAAs to DA.

along with Aged & Disabled Home and Community Based Waiver (A&D Waiver) funded services and Medicaid state plan funded services.

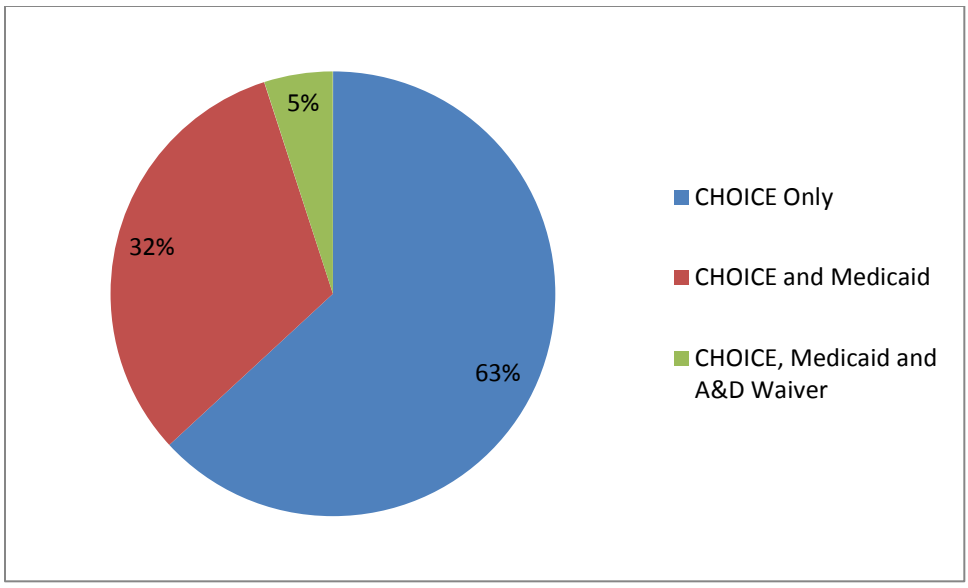
The DA generated two files of clients on a statewide basis for SFY 2009, 2010 and 2011:

- A list of clients ever eligible for CHOICE benefits; and
- A list of clients ever eligible to receive A&D waiver services.

These two files were used to extract Medicaid eligibility and claims payment data for these clients, summarized by month for SFY 2009, 2010 and 2011. The DA also generated a table by month and client of all CHOICE payments. The CHOICE payments in the table did not capture all the payments made due to the various ways in which claims are submitted by the AAAs to the DA. Therefore the total expenditures from Closeout Reports submitted by AAAs to the DA for SFY 2009, 2010 and 2011 were used in the calculation of costs. The data were analyzed to determine how many individuals who received CHOICE funded services also received services funded through Medicaid State Plan and the A&D Waiver. See Attachment 5 for further description.

Figure 3 below indicates the percentage of clients who received services funded through CHOICE and those that also received services through Medicaid State Plan and Medicaid A&D Waiver funding.

Figure 3: Percentage of Unduplicated Clients Served through CHOICE, Medicaid State Plan and/or A&D Waiver, SFY 2011



Individuals who received only CHOICE funded services (63 percent) were served for an average of 6.1 months in 2011. Individuals who received CHOICE and Medicaid funded services (32 percent) were served for an average of 5.6 months and those that were also receiving services through the A&D Waiver (5 percent) were for a shorter period of time, on average 3.8 months.

Even though services funded through CHOICE and the A&D Waiver are very similar, a portion (5 percent) of individuals served through the CHOICE program also received services through the A&D Waiver.

Interviews with AAAs indicated this may be due to the retroactive eligibility determination for Medicaid which permits payment for services to be made after a recipient is determined eligible for up to three months prior this date. Furthermore, about 33 percent of individuals receive CHOICE funded services as well as Medicaid state plan services. Medicaid state plan, or "traditional" Medicaid services, include inpatient, outpatient, and physician, as well as some home and community-based services such as home health.[40] The clients that receive both Medicaid state plan services and CHOICE funded services are obviously eligible financially for Medicaid but may not meet the functional criteria to meet nursing facility level of care which is required for A&D waiver funded services. Thus the need for CHOICE funded services. Available data do not provide the level of detail to determine the functional characteristics of individuals who are served through CHOICE while also receiving Medicaid state plan funded services.

The cost per client month was calculated for individuals that received CHOICE funded services. The cost per client month was calculated for individuals that received:

- CHOICE funded services (no Medicaid);
- CHOICE funded services as well as Medicaid; and
- CHOICE, Medicaid, and A&D Waiver funded services.

Table 8 shows the costs on a per month basis for each of the categories listed above and breaks out the federal and state portion (using the 2011 FMAP of 66.52 percent).

Table 8: Cost per Client Month for CHOICE Clients Served SFY 2011

	CHOICE Funds	Medicaid Funds	A&D Waiver Funds	Total Funds	State Portion	Federal Portion
CHOICE Only Clients	$650	$ -	$ -	$650	$650	$ -
CHOICE and Medicaid Clients	$515	$667	$ -	$1,182	$738	$444
CHOICE and Medicaid and A&D Waiver Clients	$423	$905	$1,102	$2,430	$1,095	$1,335

[40] For a more complete description, please see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html and http://member.indianamedicaid.com/programs--benefits/medicaid-programs.aspx for specific information for Indiana.

For comparison purposes, Table 9 displays the cost per client for individuals who receive A&D Waiver funded services along with Medicaid State Plan services and breaks out the federal and state portion (using the 2011 FMAP of 66.52 percent).

Table 9: Cost per Client Month for A&D Waiver Eligible Clients, Statewide SFY 2011

	A&D Waiver Funds	Medicaid Funds	Total	State Portion	Federal Portion
A&D Waiver and Medicaid	$1,132	$1,193	$2,325	$778	$1,547

Table 8 and Table 9 were produced to provide a comparison of costs for individuals served primarily through CHOICE to those served through the A&D Waiver.

The Medicaid costs for nursing facility residents were also obtained and reviewed. Indiana Medicaid reimburses nursing facilities using a case mix methodology system. A case mix system classifies individuals into groups that are homogeneous in their use of resources. Indiana uses the Resource Utilization Groups III (RUGs-III) to provide a means of allocating health care resources based on the variable costs of caring for individuals with different needs. For individuals served in a nursing facility identified in the RUG groupings "Reduced Physical Function," the nursing facility reimbursement rate ranged from a low of $92.30 per day or $2,769 per month to a high of $148.22 per day or $4,447 per month.[41] See Attachment 6 for the nursing facility rates.

Table 10 provides costs, broken out by state and federal sources (using the 2011 FMAP of 66.52 percent) for clients served in a nursing facility.

Table 10: Medicaid Reimbursement Costs for Nursing Facility Residents, by State and Federal Sources

	Medicaid State Plan		
	State	**Federal**	**Total**
Medicaid Reimbursement to Nursing Facility, at lowest rate[42] (excludes patient liability)	$927	$1,842	$2,769

For clients that receive services funded through a combination of CHOICE, Medicaid and the A&D Waiver, the cost to the state is more than if the client were served in the nursing home. It is very important to note that a simple comparison such as the one above does not consider the differences in the client's functional and medical status.

[41] Rates provided by Myers and Stauffer

[42] The costs for other Medicaid services, such as acute care are not included in these amounts.

Program Service Outcomes

Each CHOICE plan must include a Quality Assurance/Quality Improvement (QA/QI) plan. All of the reviewed CHOICE plans included a QA/QI plan. Most of the plans included one or more of the following methods for assessing quality:

- Completion of quarterly or monthly case management file/case record reviews to ensure documentation standards are met
- Completion of annual customer satisfaction surveys
- Completion of periodic (usually annual) provider audits
- Review and analysis of complaint/grievance procedures and complaint investigations

Some of the plans include a reference to outcomes and benchmarks, but none of them specify what outcomes are being measured or what benchmarks will be used for FY 2013. One plan indicated that "other data on monthly outcomes" is reported to the AAA President monthly for reporting to the Board (Area 3). Another indicated that outcomes are determined by the AAA based on ongoing review of effectiveness of services (Area 4). Area 5's plan identified a requirement that the AAA performs a Needs Assessment every two years and gives results to the Director for follow-up that needs to be addressed. Another AAA's plan states that benchmarks are established for client satisfaction, but does not specify what they are (Area 6). Area 13's plan states that all programs define their outputs, set goals and track results, but none of these are identified (Area 13). Area 14 and 15 both refer to service outcome measurement, stating that each client is reviewed quarterly for at least one result of service provisions. Both plans state that the outcomes are determined by AAA, but these are not specified.

One plan provided FY 2011 desired outcomes and results. Area 8 reported the following:[43]

> Outcome 1: Clients are diverted/converted from institutional placement with the provision of home care services.
>
> Results: The targets established by the AAA were met - Two hundred sixty persons were diverted from institutions and provided in-home services. Ten individuals were able to leave institutional settings (conversions) because of the provision of in-home services.
>
> Outcome 2: Services provided address needs identified during the assessment process.
>
> Results: Staff conducted peer review of files to determine whether services listed on the plan of care matched service needs described in the eligibility screen. Of the 133 files reviewed, 131 (98.5 percent) had services listed on the POC that matched services described in the eligibility screen.
>
> Outcome 3: Clients are satisfied with the services of the care manager.

[43] CICOA (Area 8) FY 2013 CHOICE Plan, Attachment V.

Results: The target for FY 2011 was more than 90 percent of respondents to the In-Home Services Client Satisfaction/Quality of Life Survey would be "very satisfied" for FY 2011. This target was exceeded. Responses to client satisfaction surveys indicated that 95.7 percent of respondents were "very satisfied" with care manager services.

Outcome 4: Client/caregiver's quality of life improved.

Results: The target for FY 2011 was 80 percent or more of respondents would report improvement in quality of life. Responses from the client satisfaction surveys indicated that 87.5 percent of respondents indicated that they definitely felt in-home services improved their quality of life.

Interviews with Area Agencies on Aging

As part of our analysis, HMA conducted nearly twenty interviews with key stakeholders across the state. These stakeholders included all AAA directors (or staff), advocacy organizations (such as AARP), and others.[44] Our purpose was to augment quantitative data (reported elsewhere in this report) with qualitative information and "real life" perspectives of cost-effectiveness and how CHOICE impacts vulnerable individuals and their caretakers and the well-being of communities across the state.

Twenty-five years since the initiation of CHOICE, stakeholders interviewed were unanimous in their support of the economic value of the CHOICE program in Indiana, passionate about its effect on people's lives, and deeply committed to partnering with Indiana state administration leaders to improve and strengthen the program so it can continue to serve elderly and disabled persons well in the years ahead.

Program Effectiveness

In several different ways, we asked about outcome measures, both from an individual and a cost point of view. How does the CHOICE program know whether it is achieving its goal? How is "risk of losing independence" measured from an operational perspective? What is the evidence that the burden of losing independence is mitigated by CHOICE program participation?

One set of responses highlighted the detailed CHOICE program guidelines that are followed by AAAs in administering the program at the local level. They stressed that "at risk of losing independence is a straightforward objective which is operationalized according to program guidelines."

- Detailed program guidelines specify CHOICE is intended for individuals who are "disabled due to a physical or mental impairment" and who are "at risk of losing independence."
- CHOICE services are provided to those who are determined to be functionally eligible, that is, to those who are unable to perform two or more ADLs as determined through an eligibility screen and by use of an approved assessment form and process.

[44] Interviews were conducted in person or by telephone during October and November 2012. Questions were approved by the IN Family and Social Services Administration. Confidentiality of individual responses was pledged.

- Thus, if all or nearly all of the individuals served by CHOICE have two or more ADL impairments and individuals remain able to live safely in the community for months or years until further health decline or change in family or environment, the program is meeting its legislative intent and regulatory objectives and is effective.

Nearly all AAA directors and staff stressed that while specific client outcomes are not scientifically measured, they "know" of the program's impact through professional observations, including home visits and interviews with family members and care providers. AAA staff, especially case managers, communicate regularly with clients, their families and health care providers to receive progress reports. Interviewees offered many examples of how vulnerable or physically unstable individuals had been facing the possibility of nursing home placement or hospitalization but were able to secure CHOICE services and, as a result, their personal well-being and living situation improved. One AAA noted, "many of our clients are under age 60 and have chronic medical conditions that put them at risk for institutionalization." From the perspective of many AAA leaders, the risk of nursing home placement is not just functionally based; the risk is very individualized and is related to a client's medical diagnosis (e.g. Alzheimer's), his/her family situation, and living environment. They emphasized that expert individual, family, and home assessments are critical in determining whether services should be authorized and at what level.

Other AAA leaders responded that "it is hard to prove a negative." Without a rigorous case control research study that compares specified outcomes over time between CHOICE participants and a comparable group of individuals on the CHOICE waiting lists -- such as number of falls, hospital emergency department use, hospital inpatient use, nursing facility admissions, and even death rate -- it is unlikely that CHOICE's effectiveness in preserving independence or delaying institutionalization can be statistically demonstrated.

Several AAA directors highlighted their observations that the CHOICE program yields economic benefits to communities across Indiana. They observed that supporting moderate income older or disabled individuals as they seek to live independently contributes more to the local tax base, local businesses, jobs, housing stability, and so forth; more so than if these individuals were institutionalized or isolated in significant physical or mental decline.

As we know from the literature, the availability of family support and caregiving for frail elders is a key driver in maintaining independence, but it comes at a substantial price to the caregivers themselves. The estimated economic contribution of family caregiving in Indiana was $9.4 million in 2009.[45] AAA and consumer stakeholders emphasized that the CHOICE program provides welcome support and respite for family caregivers who shoulder physically demanding, time consuming, stressful, and/or complex medical responsibilities caring for their beloved family members – and often over many years. CHOICE services augment family care and often make it possible for caretakers to continue working in income producing day jobs.

[45] Feinberg, Reinhard, Houser, and Choula. "Valuing the Invaluable: The Growing Contributions and Costs of Family Caregiving" (Washington, DC: AARP Public Policy Institute), 2011 Update.

Said one AAA leader, "There's no question about the cost-effectiveness of CHOICE program. Like a dam, it can hold you there (from falling into institutionalization)." Citing various Indiana state reports and budget graphs, stakeholders repeatedly asserted that CHOICE is cost-effective on a per client basis compared to the cost of nursing facility placement. This assertion is consistent with national research that generally estimates three persons with long-term care needs can be cared for in the community for every one person in a nursing home. Furthermore, shifting proportionately more public resources to home and community-based services from institutional settings can expand the reach of programs and result in serving a greater number of people with long-term care needs. To the extent that states provide home and community-based services instead of nursing facility services, this shift in service delivery can be both cost-effective and responsive to the preferences of potential customers.[46] By this measure, the CHOICE program is cost-effective.

Consumer Satisfaction

Consumer satisfaction is assessed at the local level by AAAs. "One immediate, but thankfully rare, feedback mechanism is we sure hear about it if something is wrong." If the AAA is called by an unhappy client, the case manager immediately follows up to address the complaint. Another avenue for securing consumer input is a consumer satisfaction survey of a small proportion of clients that is conducted each year by AAAs.[47] Some clients are also given an opportunity to participate in annual AAA Quality Improvement Program (QIP) efforts. Several AAAs highlighted that Annual Plans describe QIP projects they are initiating where, for a particular outcome measurement determined by the AAA based on its review of the effectiveness of CHOICE services, clients are evaluated regularly for at least one result. AAA directors also emphasized the importance of a 90-day client review. Each calendar quarter, CHOICE clients' progress and well-being is assessed by case managers, typically in a face-to-face manner along with a case record review. One AAA described its use of the ROMA outcome model that benchmarks its clients' outcomes to various attributes (thriving, safe, stable, vulnerable, and in crisis). Other quality assessment processes, such as annual service audits to verify service delivery to clients, were also mentioned by AAA directors.

Often ignored by public policy-makers, quality of life outcomes are important to individuals (and their families) when they experience functional limitations or declining health and receive long-term care services. In Indiana and across the United States, frail elderly adults and persons with disabilities – long-standing state taxpayers -- overwhelmingly prefer to live at home and in their communities rather than be institutionalized. Consumer stakeholders and all AAA directors highlighted the positive feedback and expressions of gratitude they routinely receive from CHOICE clients who are able to continue living safely at home because of the supportive services they receive from CHOICE. AAA directors stated their belief that, based on professional experience and organizational consumer satisfaction feedback, the CHOICE program is uniquely designed in a client-centered way to respond to individual functional needs and limitations within unique families and communities. Some suggested a perceived social benefit of

[46] Kassner, Reinhard, Fox-Grange et.al. *A Balancing Act: State Long-Term Care Reform*. (Washington, DC: Public Policy Institute), July 2008.

[47] Information from these consumer satisfaction surveys is placed in the InSite data system; stakeholders are generally unaware whether or how this feedback is used to drive CHOICE program improvement.

CHOICE – it fosters intergenerational families, enables the continuing participation in community life, and supports self-sufficiency, etc. Thus, from a quality of life perspective, stakeholders emphasized the CHOICE program is viewed by its customer base as both effective and cost effective. "The intrinsic value to quality of life that comes from programs like CHOICE is hard to measure."

Quality, Appropriateness, and Adequacy of CHOICE Services

The quality assurance and quality improvement material we reviewed from the CHOICE program seemed mostly to focus on adherence to processes specified in regulation.[48] To help answer the "effectiveness" question, we asked stakeholders about how they assessed quality in the CHOICE program. Are people getting what they need in terms of service delivery? Are they receiving enough of the right mix of services?

Stakeholders agreed that quality assurance is largely a local administrative function where QA and QIP activities are delineated in AAA Annual Plans. These include QIP new initiatives, customer satisfaction surveys, 90 day reviews of care plan and service delivery[49], and annual client reviews, where financial and functional eligibility is re-assessed – as described above. Many stakeholders expressed uncertainty about what, if anything, the state does with the information that agencies are required to submit. They were open to potential ideas for new tracking of CHOICE program outcomes (e.g. wellness measures, fall prevention, etc.). We learned it is nearly impossible to disentangle quality outcomes that CHOICE investments yield compared to other AAA service dollars because of how funds are managed across various long-term care program options (AOA Title III, SSBG, Medicaid A & D waiver, etc.). At the same time and based upon intimate knowledge of CHOICE program operations at the local level, stakeholders continued to emphasize their belief that the CHOICE program delivers quality services, even considering the constraints under which it operates.

Stakeholders emphasized that the services provided to clients are appropriate, by definition, as they are authorized based upon specified state guidelines and administrative processes. They stressed that service authorization is determined by experienced and dedicated staff on a case-by-case basis while considering all other available resources that might be used to provide assistance in the home. At the same time, they recognized that service levels might be altered in a manner that has nothing to do with a client's needs. On occasion, service levels are adjusted up- or down-wards as a result of changes in state CHOICE funding levels or the need to juggle end-of-year spending.

Stakeholders expressed various perspectives about the adequacy of services and expressed inconsistent views about extent of unmet need over the past few years. Whether limited state CHOICE funds are being allocated to provide services to those *most* in need is uncertain. During the interviews, some stakeholders mentioned the difficulty of serving some geographic pockets of the state (rural) and reaching certain minority or ethnic populations. Others mentioned the challenge of serving high needs clients, such as children with developmental disabilities, for long periods until Medicaid eligibility is established for them. Given state budget constraints, several questioned the wisdom of serving

[48] Outside of requiring certain quality processes, the State itself appears to do little monitoring of the CHOICE program and leaves it to local jurisdictions and agencies to assure quality and improve service delivery.
[49] According to at least one stakeholder, "a long review and mostly geared towards younger disabled clients."

individuals with two or more ADL impairments yet having no CHOICE funds available to serve potential clients in crisis or those with three or more ADL impairments. Finally, there was an uneven response to our queries about potential participants with high asset levels who might be able to privately purchase home care services instead of receiving CHOICE. Most AAAs stressed the moderate incomes of most individuals they serve. Thus, several said they paid little attention in their programs to asset levels ("we don't really know people's resources"), while a few others acknowledged the potential for more cost-sharing.

Stakeholders all specified that other potential payment sources must be exhausted before utilizing CHOICE funds. We were told that monthly fiscal analyses are completed and funding availability determined and shared with program managers so that potential clients, including those who are on waiting lists, could be targeted. Even as they repeated the state's guidelines, stakeholders expressed different views about how they prioritize service delivery.

- One AAA stakeholder observed that "there is always a reason that someone (an elder or family member) contacts us for services. "Something has happened." That something might be a recent hospitalization, a dangerous fall, or home situation that has caused concern. The call may also come when a family member has reached wits end in caring for a loved one (who may have dementia or Alzheimer's) and respite is sorely needed.
- One AAA director stressed the importance of "getting some services into a home as quickly as possible to help stabilize an unsafe situation." Thus, that agency does "triage services, based on funding available." Echoing that perspective was another AAA director who said, "We are really not allowed to triage services, but we do." She believes that authorization criteria must include information that "goes beyond ADLs;" for example, a person may have 3 or more ADL impairments but also have secure family and church support while another person with fewer impairments may be isolated and failing. Most concluded that service authorization is "very individual," and that advanced age is also something to consider. Said one AAA director, "it would be unlikely that a 96 year old person would be put on waiting list" for service.
- CHOICE services may also be initiated when the AAA knows of an individual through another service it sponsors (e.g senior center) and staff observe that the individual is failing in some way.

From the perspective of stakeholders, the question of adequacy of services is almost solely related to the state's budget authorization level for CHOICE. They express grave concerns that "with the aging of Indiana's population, family support [for frail elders] is not enough for long periods of time."

Other State Programs

As part of this project, HMA reviewed similar state funded programs in other states that deliver long-term services and supports to vulnerable seniors and persons with disabilities living in the community and who are at-risk for institutionalization. We reviewed the experiences in five states that sponsor

programs serving older adults or older adults and persons with physical disabilities that are state-funded and of a similar size and scope.[50]

We contacted and interviewed state officials in Florida, New Jersey, North Carolina, Pennsylvania and Washington to learn more about their programs' focus, outcomes, funding, administration, efficiencies, improvements, and recent policy choices.[51] These programs are summarized in Appendix 7.

Florida

The Community Care for the Elderly (CCE) Program is coordinated by the Department of Elder Affairs. The program provides community-based services organized in a continuum of care to help functionally impaired older adults live in the least restrictive yet most cost-effective environment suitable to their needs. Eligible clients may receive a wide range of goods and services. Primary consideration for services is given to elderly persons referred to Adult Protective Services (APS) and determined by APS to be victims of abuse, neglect, or exploitation who are in need of immediate services to prevent further harm.

- The FY 2011 appropriation is approximately $41.4 million for the CCE program.
- Administrative costs are calculated in a way that does not include case management, which is defined as services.
- Florida staff follow Medicaid HCBS waiver performance measures, which are primarily process-oriented; staff monitor the programs and how they meet process performance measures. Staff are developing some outcome measures but note that appropriate metrics are "difficult to determine" (e.g. does the provision of home delivered meals lead to reduced institutional placements?). Florida is "not there yet" with outcomes.
- Individuals can be on multiple state-funded or Medicaid waiver program waiting lists. In 2012, the eight HCBS state-funded and Medicaid waiver programs had a total of 46,000 elderly and disabled individuals on program waiting lists – often for more than one year. Individuals are screened before they are placed on a waiting list; and program staff review the lists at different intervals – at least annually. The waiting list is "budget driven".
- The Florida legislature is focused almost exclusively on cost containment. In this environment, administrative staff struggle to preserve home and community programs as these programs are "first on the block to be cut" even though staff recognize "the elderly prefer to age in place." Long-term care rebalancing is less a policy priority than "maximizing federal funds" through Medicaid; thus, Medicaid programs are less likely to be cut.

New Jersey

Jersey Assistance for Community Caregiving (JACC) provides a broad array of in-home services to enable individuals (60+ years) to remain in their homes and communities who are at risk of nursing facility placement and who meet income and resource requirements. The individual must have no other means

[50] Source: Cheek, Roherty, Finnan, et.al. *On the Verge: The Transformation of Long-term Services and Supports.* (Washington, DC: AARP Public Policy Institute), February 2012.
[51] The sentences, phrases, etc. in this section represent statements made by the state officials interviewed.

available to secure needed services and must have been determined to be clinically eligible for nursing facility care. All JACC participants receive Care Management services and a patient-centered package of supports. JACC services are limited to a maximum of $600 per month or $7,200 annually. Services are provided by qualified entities including participant-employed providers. JACC has some co-pay obligations.

- State-funded home and community-based programs in New Jersey are relatively small compared to Medicaid programs. Medicaid HCBS waiver programs totaled an estimated $200 million (with approximately $100 million of New Jersey funds). The JACC program spent an estimated $13 million this FY, with $10.5 of the total going to direct services; the remainder was allocated to care management and the third-party billing agent. Funding has remained flat for many years with "no expansion but no reduction either." A co-pay amount is billed by the third-party agent based on the client's income.
- The over-riding measure that is monitored for JACC is delay in institutional placement – how long is client able to stay out of a nursing facility? A report on the program is prepared for the Legislature each year. Complaints are also tracked; if a potential client runs into a problem with his/her eligibility, it is usually because the application is incomplete.
- New Jersey does not have a medically needy program of eligibility, thus, the JACC may be the only option available for many residents. "Some clients will never be eligible for Medicaid (pension or Social Security income level); some clients will always be on JACC; some only need a little bit of help." The state program is "easier to administer because there are no federal regulations and rules and decisions can be made without asking CMS." The state allows for presumptive eligibility of the JACC program (financial and clinical), which most counties have adopted; it is "rare" for these decisions to be overturned by the state. Completion of a Medicaid application is not required for JACC as "we know from their JACC applications that they are not eligible for Medicaid." Medicaid waiver services tend to cost more than $2,000 per month, while JACC allots about $600 per month.
- Each of the 21 counties (AAAs) maintains the waiting lists, the length of which varies dramatically. Each county receives an allocation of funds for client services and the county decides the level of services to provide. If a person is on the waiting list for more than one year, eligibility is re-determined.
- The state invested in an improved assessment tool "My Choice" which is used for nursing facility placement, JACC, and other programs. The state has "gotten away from ADLs (formerly 3 to qualify) and eliminated the bias of checked boxes." Instead, an algorithm determines eligibility based on many factors. The tool may be improved again to accommodate medication administration.

The Congregate Housing Services Program provides supportive services to frail and at-risk low-income elderly persons or adults with disabilities who reside in certain subsidized housing facilities and who are experiencing decreased energy and mobility but who retain the capacity and desire for as much self-management as possible. Services offered include daily meals provided in a group setting, housekeeping, personal assistance, and service coordination. Service subsidies (comparable to rent

subsidies) are available to assist tenants in certain income categories to meet the full cost of the program. This program combines shelter and services to help tenants avoid premature institutionalization. To participate in this program, a person must live in a building that has contracted with the State to provide a Congregate Housing Services Program. There are currently 36 grantees.

Anyone who resides in a housing unit that has received a New Jersey grant is eligible to receive services. Each site decides what services to provide (e.g. transportation, meals, housekeeping, shopping, etc.). The program is supported by the Casino Revenue Fund and is intended to provide for the physical and social needs of residents and extend the time they are able to live at home in the community for as long as possible. The program is informally monitored through anecdotal stories and a self-assessment tool. Staff believe the program's benefits are obvious in terms of delayed Medicaid spending (approximately $65,000/year nursing facility, $25-30,000 for assisted living compared with $1,000/year for Congregate Housing).

North Carolina

The North Carolina (NC) Home and Community Care Block Grant for Older Adults (HCCBG), established by statute in 1992, is administered by the Division of Aging. The HCCBG consolidates federal, state, and local resources into a "common funding stream" for services to older adults; federal AoA funds make up about 45 percent of HCCBG funding; state funding is appropriated by the General Assembly and AAAs fund county programs on aging through these grant agreements. The HCCBG works with 16 AAAs and 420 provider agencies across the state. The block grant gives County Commissioners great discretion and authority in planning, allocating and administering these aging funds which are intended to achieve the specified goals: promote the visibility and importance of aging programs locally; establish a single set of policies and procedures for HCBS provided with block grant funds; and provide for an equitable distribution of funds to counties consistent with the OAA. There is no income eligibility determination in the program; in the application, income is self-declared.

- North Carolina "overmatches" their state contribution to Older Americans Act (OAA) Title III funding to a level that is "far beyond" what is required. Combining OAA, SSBG, state and some county funds has contributed to program simplicity. "Multiple policies and pots of funding are not needed. There is one program manual." The only service that is capped is housing and home improvement ($700 per household). "State funds are now stagnant;" FY 2011 appropriations were approximately $40.9 million.
- Administrative costs "have never been calculated on a statewide basis," as the block grant is administered by the counties. Case management is considered a service, not an administrative cost.
- The purpose of this block grant mirrors one AoA Title III goal (e.g. reduce premature institutionalization). But the block grant does not target individuals most at risk of nursing facility placement; three frailty levels are served. "If a majority of clients served are at highest risk, then we know the program is meeting its goal." In addition, a weighted formula allocates funding to rural, low-income, and minority groups. The North Carolina information system can

track who is being served but it is unknown whether "premature institutionalization" has been prevented.

- The HCCBG is "completely separate from Community Care of North Carolina (CCNC)" the Medicaid medical home program. Payment rates are different between the programs – a set rate for Medicaid chore services but a rate competitively determined in the block grant program. Providers may or may not serve both Medicaid and block grant populations.
- During the 1990s, over 3,000 individuals were on a waiting list for this program; now the waiting list exceeds 18,000 individuals. The waiting lists are purged on an annual basis and they are monitored electronically.
- With North Carolina ranking 9th in its population of those over 60 years of age and voluntary contributions going down, staff are greatly concerned about how to meet the needs of a growing frail elderly population. "The need is there, but additional resources won't come" in these tough fiscal times. North Carolina staff believe that "we must change the whole thought process for clients who can pay for some of these services." Staff believe that public resources should support individuals at greatest need. "We also need to diversify funding sources. More is being asked of county governments and some are revolting."

Pennsylvania

Since 1985, the Attendant Care Program ("Act 150") provides personal assistance and support to individuals to enable them to live in their homes and communities rather than institutions. To be eligible for the program, a person must be aged 18-59 and have a physical disability, be mentally alert and able to direct his/her own services, and require assistance with activities of daily living. This program was designed to prevent individuals, such as those with spinal bifida and who have no intellectual disabilities, from "falling through the cracks. The program provides assistance with bathing, dressing, meal preparation, mobility, housekeeping, and other self-care and daily living functions.

The Attendant Care Program allows consumers to choose the model of service delivery they prefer: (1) under the agency model of service, services are performed by attendants employed by an agency; and (2) under the consumer employment model, individuals recruit, hire, train, and manage their own attendants. Services for the Attendant Care program are provided under the Act 150-Attendant Care Program and the Attendant Care Home and Community-Based Waiver. Medicaid eligible individuals who meet all program criteria are served in the Waiver Program. Individuals who are not Medicaid eligible are served in the Act 150-Attendant Care Program.

OPTIONS is an array of community-based long-term care provided locally by AAAs for the purpose of helping consumers function at the optimal level while remaining in the most appropriate setting, preferably their own home. This is accomplished through an extensive assessment of the applicant's condition and circumstance. The assessment determines eligibility, appropriateness, and – if all service slots are filled – the order of the applicant on a waiting list. Once this is completed the care manager, in conjunction with the consumer, matches the identified needs with the appropriate services. Examples of services which can be obtained are: home health, personal care, home support, medical equipment/supplies and adaptive devices, respite care, counseling, etc. Consumers who receive these

services are normally 60 years of age or older and experience some degree of frailty in their physical or mental health. They range in functional need from being eligible for a nursing facility to needing basic personal care services such as help around the home. There is no financial eligibility requirement for OPTIONS based services. However, consumers may be required to make a co-payment for services based on income.

- Funding for the Act 150 and OPTIONS state funded programs is provided through the Department of Aging. For the SFY 2013, funding for Act 150 is approximately $23.3 million and the funding for the OPTIONS program is $45.1 million. The state does not define an administrative percentage, but in general allows an administrative cost between 10-15 percent depending on service.
- The staff "don't know whether the program is meeting its goals." "We are struggling with that (uncertain performance) right now." The program now has waiting lists and "state money only goes so far."
- Since the 1990s, individuals who meet a specified clinical level of care criteria (nursing facility level of care) and financial eligibility have been transitioned to the Medicaid waiver and both programs are now run in parallel. This program is one of six HCBS waiver programs (three disability waivers, one aging, and one HIV). Given the construct of the Act 150 program (e.g. no cap on services), it may cost $20,000 per individual in a year in personal care and service coordination. With the possibility of a federal match in Medicaid, some believe that more individuals could be served through an improved and expanded Medicaid waiver program.
- Since 2009, there have been waiting lists for the program; there is little attrition; and "we haven't moved anyone in months" off the waiting list. Recent data analysis revealed that two-thirds of the individuals on the waiting list did not meet clinical eligibility guidelines but did meet financial requirements.
- "Act 150 has become an anomaly, the process to determine eligibility is antiquated, and there are too many decision-makers." Policy staff struggle whether "this program should be continued" or whether a Medicaid program such as 1915(j) would reach a broader group of people. However, Pennsylvania government is not inclined to move forward with a Community First Choice personal care option, and Act 150 is a "sacred cow" and "vocal advocates" forget that Medicaid waiver programs were developed to meet this need. Also, co-pay requirements for services are "ridiculously low" and far lower than the Seniors Options program, where seniors with income at 300 percent FPL pay the full amount for services. Horizontal equity is a problem when comparing all the HCBS programs for different populations.

Washington State

The Senior Citizens Services Act (SCSA), enacted in 1976, committed state monies to provide a range of community-based services for older adults to help them attain maximum independence and remain at home. Funded services include information and assistance, transportation, nutritious meals, caregiving support, direct services, training programs in counseling the elderly, and senior volunteer programs. Services are provided to individuals whose income is below 40 percent of the state's median income level. Administered by State Office on Aging in the Department of Social & Health Services, SCSA has

developed a coordinated system of social and health services for seniors and nurtured a network of community-based care. AAAs plan and implement services at the local level leveraging service dollars in different ways. These state and local monies are used as a match for local philanthropic grant funds.

Another program offered through the AAAs, the Family Caregiver Support Program, helps unpaid caregivers caring for an adult 18+ years find resources and receive training and respite. The program, begun in 2003, offers assistance, consultation, education and training, support groups, counseling, and respite services at little or no cost. The availability of services varies across communities.

- The SCSA's funding has been "fairly stable" over the years, but "took a 10 percent reduction a few years ago." In FY 2013, state funding totaled $8.4 million for SCSA, with $1.1 million for administrative costs. State funding for Family Caregiving totaled $11.3 million with $.5 million in administrative costs. This program enjoyed a modest expansion over two years. Care assessment and management is not an administrative expense, but a service; administrative expenses are considered "infrastructure needs." Cost sharing is important for adult day services, respite, and housekeeping but not for all services as there is no billing mechanism.
- SCSA program uses process measures, such as were funds spent on approved eligible persons and services and were funds spent on what the Legislature specified? Staff are "trying to do a better job telling the story" of how HCBS services are valued by clients and how state investments for these programs can be tied to longer term public savings. Staff have been focusing on improving performance metrics. "You have to personalize the program. Everyone has a story, but you need data, too." When the Family Caregiving program was expanded, researchers followed 1,500 participants to ascertain whether they were they diverted from Medicaid and whether the state received a positive return on its investment (ROI). Preliminary data suggest there was a "significant delay" in receipt of Medicaid but uncertain ROI in first year (because of federal Medicaid match).
- There are "not typically" waiting lists for these state-funded programs – only "once in a while" and "in specific service areas or geographical areas." There are about 20,000 individuals on the waiver and another 20,000 on the Medicaid state plan personal care program.
- With the aging of state residents, "we must find ways to support families." Staff are concerned about increasing vulnerability of some residents and believe that the $700/year investment in family caregivers absolutely "keeps people out of nursing facilities." The state is actively moving to decrease nursing facility placements (through Money Follows the Person). The state is also developing new services and programs and "continuing to assess gaps in community services," e.g., for those with significant behavior problems, housing, or traumatic brain injury. Key policy concerns include:
    - The need for better data; significant investments must be made and state leaders are "having a conversation."
    - Targeting to assure that the right individuals (most vulnerable) are being targeted for state-funded HCBS services, which can be a difficult undertaking.
    - The age wave starting to impact nursing facility utilization which, after a long downward trend, is beginning to creep up.

- The funding distribution between the elderly and disabled.

Lessons learned in the states we interviewed include the following.

- All states with whom we spoke acknowledged the serious state budget environment that confronted state-supported HCBS programs for the elderly and/or disabled. With legislators and executive staff focused on program cost containment even as demand for community-based home services is growing due to demographic changes, diminishing service alternatives, and family caregiver burn out, staff responsible for these programs generally expressed strong support for the "niche" these programs serve. State investments in these programs have held relatively steady during the past few years but all state staff expressed concern about ongoing risks to funding and battle fatigue while operating in a "cut, cut, cut" environment for several years. They all understand that their clients prefer to either age in place (elderly) or live independently in the community (disabled) and yet recognize "state funds only go so far."
- In response to state budget constraints, interviewees have been engaged with legislators and stakeholders in considering various alternative strategies. In some, there are serious policy discussions underway about the future of the state-funded community-based programs for which they are responsible. They are asking if the status quo is the optimum use of state resources and, if not, how the program should be modified, modernized, or altered to reach a broader audience or better targeted to those most in need. Some interviewees expressed frustration with the "sacred cow" perspective of some vocal stakeholders who seemed unwilling to consider program modifications that could strengthen home and community-based services for more individuals.
- The relationship between Medicaid waiver HCBS programs and state-funded HCBS programs is also under exploration in several states, as is the design of multiple and relatively small community-based programs that have evolved over the years. These special programs, including narrow Medicaid waiver HCBS programs, are often inefficient to administer and do not achieve optimum targeting or horizontal equity across populations in need of HCBS services. None of the state staff highlighted any requirement to apply for Medicaid as a condition of state program participation. Rather, they emphasized that the state programs were often designed for individuals "who would never qualify for Medicaid" either because the state did not have a Medically Needy program, or because individuals' income and assets were "just above" Medicaid thresholds, or because individual would not meet clinical guidelines for Medicaid waiver.
- The role of the state-funded programs in achieving long-term care system rebalancing was uneven. Most state staff acknowledged the state-funded programs were small and "first on the block to be cut" and that state fiscal goals is often to "maximize federal funds" through Medicaid.
- The question of whether state-funded HCBS programs are known to be reaching their objectives was answered differently by state staff. One state official was candid in her observation, "we really don't know if the program is reaching its goals." Other state staff emphasized the

importance of process measures, as outcomes were neither defined nor tracked. Another state official stressed "delay of institutionalization" – including delay of spending down to Medicaid -- is "*the* measure" that is most important in demonstrating whether the program is accomplishing its objectives; the state's data system supports such tracking and analysis. North Carolina, which "overmatches" state funds into a HCBS block grant to counties (including Title III and SSBG funds), focuses on meeting needs of rural, low-income, and minority residents and tracks frailty level.

- In Washington, a recent legislatively mandated study of an expanded state Family Caregiver Support Program was highlighted; it assessed whether the expansion reduced entry of clients into Medicaid long-term care and, if so, whether long-term care costs were reduced.[52] Preliminary results indicate a "significant delay" in the use Medicaid long-term care services and uncertain short-term savings due to the 50 percent federal Medicaid match.
- None of the states define "case management" as an administrative cost.
- Waiting lists for the state programs are uneven in their length, how they are monitored, and how individuals on the waiting list are prioritized for services.
- One state, New Jersey, highlighted its assessment tool, which is used by all programs, including for Medicaid nursing facility placement. This tool, NJ Choice, uses an algorithm to determine eligibility once information about ability to perform ADLs, IADLs, and many other factors are entered; the tool appears to limit bias and seems more sophisticated in terms of capturing relevant information to assure all programs are reaching targeted populations.

Conclusions

The CHOICE program appears to play an important role serving individuals who need long-term care services and are at risk of losing their independence because they lack access to CHOICE funds and cannot enroll in the A&D waiver or are ineligible for Medicaid. The DA, AAAs, and stakeholders are very committed to serving vulnerable individuals and the CHOICE program is generally an integral component to meeting this goal. However, we found that there are no standardized performance measures or outcomes established for the program without which it is very difficult to determine if the program is meeting its intended purpose. The following issues are highlighted as the result of review of the CHOICE program.

Administration

- Indiana Code requires that the Division of Aging administer the CHOICE program and develop and implement a process for the management and operation of the program locally through the AAAs based upon criteria developed by the division.[53] Thus there is authority to strengthen mechanisms for oversight and measurement to determine if the program is reaching its goals.

[52] M. Miller. *Did Expanding Eligibility for the Family Caregiver Support Program Pay for Itself by Reducing the Use of Medicaid- Paid Long-Term Care?* Olympia: Washington State Institute for Public Policy. November 2012.
[53] IC 12-10-10-6

- There is a lack of consistency among the AAAs as to how the program is administered, based upon the differing policies such as for targeting individuals for services from the waiting list, eligibility determination, and care plan development .

Monitoring and Reporting

- The DA prepares an Annual CHOICE Report as required by Indiana Code; however, the report does not contain findings or recommendations to improve program performance or operational efficiencies for sustaining and achieving program goals.
- Data for this program are not centralized, may not be available or easily extracted for monitoring purposes. For example, as defined in law, an individual eligible for CHOICE is one who is at risk of losing the individual's independence if the individual is unable to perform two or more ADLs. Some individuals are reported as having only one ADL impairment and may also have a severe medical condition, but available data do not provide information to correlate.
- The state does not have access to information which is controlled at the AAA level in the InSite system, nor does the state request regular data from the AAAs except for what is provided in the CHOICE Annual Report.
- AAAs indicated they are able to use CHOICE funding to provide services to intercede earlier and to forestall the placement of an individual into a nursing home while they might be waiting for services through the A&D Waiver or to help support families who keep loved ones at home. This anecdotal information is difficult to support due to lack of consistent outcome measures and availability of data. Some AAA CHOICE plans include reference to outcomes and benchmarks but none include specific outcomes or benchmarks. Additionally, it appears that the DA could do more to assimilate the information for reporting, funding, and policy decisions.
- The DA and the AAAs need better tools to measure success and outcomes of the program.
- Other than claims review and reviewing the annual CHOICE plans submitted by the AAAs, the DA does not regularly monitor AAA operations or CHOICE program outcomes. We also noted that while the DA sets CHOICE policy through Indiana Administrative Code and distributes policy through the CHOICE Program Manual, AAA implementation of the program is inconsistent.

Eligibility

- Some CHOICE recipients might qualify for the A & D Waiver but instead are utilizing CHOICE funds that do not draw federal matching funds. Approximately 37 percent of clients receive both Medicaid state plan services and CHOICE funded services and are obviously eligible financially for Medicaid. Additionally, the majority of individuals (60 percent) have three or more ADL impairments. To qualify for the A&D Waiver, individuals must meet financial criteria and functional criteria of a nursing home level of care, which can include three ADL impairments. It is possible that individuals served through CHOICE could qualify for the A&D Waiver, which is matched with federal funds at a rate of 67.16 percent for the federal fiscal year ending September 30, 2013. This will help provide more opportunity to serve individuals through the CHOICE program who are not eligible for Medicaid or Medicaid HCBS waiver services.
- It appears that the requirement for CHOICE applicants to first apply for Medicaid benefits is not meeting the intended goal for CHOICE to be the payer of last resort. The income limits for those

in the special income group and spousal impoverishment provisions are not being considered for individuals seeking services funded by CHOICE. The spousal impoverishment provision allows the spouse who would not be receiving waiver services up to $115,920 (effective 1-1-13) in assets. Also parental income and resources are disregarded for children under 18.

- Since the A&D Waiver includes a provision that individuals transitioning off 100 percent state funded budget programs receive priority, the potential eligibility for the A&D Waiver is important.
- The majority of the individuals (90 percent) served through CHOICE reportedly have annual incomes of less than $25,000. This income level closely approximates individuals in the "special income group" who may qualify financially for Home and Community-Based Medicaid Waiver services.
- Even though some individuals may be eligible for the A&D Waiver, they may be placed on a waiting list because of limited availability of funding for waiver slots.

Expenditures

- The current cap of $13,517 per quarter of CHOICE expenditures per individual exceeds nursing facility costs at certain levels.
- It is important to note that our efforts concentrated on CHOICE funding and that it is difficult, at best, to determine if any one funding source has resulted in a specific outcome.
- The average monthly cost for a client receiving services funded only through CHOICE is $650 per our analysis, which is similar to the average monthly cost reported in the FY 2011 Annual CHOICE report of $633. For a comparison of costs see Tables 8 through 10.
- For clients that receive services funded through a combination of CHOICE, Medicaid and the A&D Waiver, the cost to the state is more than if the client were served in the nursing home.

Recommendations

Based on our findings and conclusions, HMA recommends that the DA continue the CHOICE program as an integral part of the continuum of care for vulnerable individuals, in conjunction with other programs administered through funding from Medicaid, the Older Americans Act, and the Social Services Block Grant. The DA should modify their systems, procedures and guidelines to better attain the goals of the program through consistent quality, improved monitoring and reporting and by maximizing the number of clients served.

Consistent Quality

To ensure the highest quality possible is attained consistently throughout the state, actions can be taken, including the following:

- Develop a core standardized assessment instrument that meets the needs of the CHOICE program as well as other programs in concert with the activities for the Balancing Incentive Program.
- While variations in administration of the program are expected due to regional differences, consistent standards should be applied for targeting and prioritizing individuals to be served, for

eligibility determination, and for outcomes, and reporting. These elements should be monitored and managed to ensure efficient use of resources. In an effort to accomplish more consistency in operations and to measure effectiveness of the use of CHOICE funding, the following should be considered:

- The DA should, with input from the AAAs, develop consistent outcome measures, baseline data, and reporting frequency and mechanisms.
- Measures should focus on individuals most at risk of losing their independence. They should include characteristics, conditions and living situations that place individuals at greatest risk of nursing home admission, such as:
  - The percent of caregivers reporting that CHOICE services help them provide care longer.
  - The percent of clients served with three or more impairments in activities of daily living, by level and type of impairment. Note: this information is reported by the DA in the CHOICE Annual Report, but should be reported for each AAA and measured for improvement and trend.
  - The percent of clients served who live alone.
  - Percent with declining health, i.e., identified medical conditions.
- Measurement criteria should determine if participants have access to community resources and if participant preferences are respected in terms of selection of providers and services.
- Develop a standardized consumer survey that is conducted by an independent organization across all areas, rather than conducted by each AAA.

- Review AAA best practices for possible implementation system wide.

Monitoring and Reporting

Improvements can be made for the monitoring and reporting of program results including:

- Install a case management and data reporting system that provides useful information not only for each of the AAAs, and is useful at the state level. It is our understanding that the DA has been researching and planning to implement a new system for quite some time but has not been able to implement a system for a variety of reasons.
- The DA should obtain outcome measurement results by AAA either through standard reports in the software system or from AAAs.
- Provide easy access to cost sharing information electronically for review of amounts collected by each AAA.
- More specific data should be collected which provides functional eligibility information for individuals served on CHOICE. The use of a new, comprehensive assessment instrument and case management and data reporting system will help to facilitate this reporting.
- Review the CHOICE appropriation and compare it to the dollars expended solely for CHOICE clients (56.1 percent in 2011) to ensure that the funding is being applied as intended by the legislature. For example, funding for the ADRC is provided through CHOICE (see Table 4) which may help to divert individuals from being placed on any government funded program. It would

be worthwhile to review the expenditure of ADRC funding to determine if such outcomes are being realized and to determine if more or less funding from the CHOICE appropriation is appropriate for the ADRCs.

- Consider revising Indiana Code, rule, contracts, or policy to require a CHOICE Annual Report from each AAA, instead of a CHOICE Plan from each AAA. The report should include elements related to:
    - Performance outcomes and operational findings;
    - Information from consumer satisfaction surveys conducted by the AAAs ; and
    - Quality Assurance/Quality Improvement plans and results.

Maximizing the Number of Clients Served

The DA should review and revise policies, rules and regulations, with input from AAAs, to help ensure that the maximum number of clients is served in the most efficient manner. These activities should include:

- Identify program goals that, if not met, have the greatest adverse impact on access to services, cost of care, and institutionalization.
- Revise the policy that all applicants apply for Medicaid. Currently, policy does not consider those who may qualify for the A&D Waiver through the special income group and spousal impoverishment provisions and as a result there may be A&D Waiver eligible individuals falling through the cracks. A revised policy may help serve more individuals through use of the A&D waiver services.
- Consider a requirement of annual verification of excess income or assets and a signed attestation of responsibility to seek Medicaid eligibility when income and assets reach Medicaid thresholds. Consider the special income and spousal impoverishment provisions. Maintain documentation in the individual's file.
- Consistent policies should be developed and applied for the cost sharing to maximize collection of funds for client services.
- Revise the waiting list policy for placement on the list to target individuals most at risk of losing their independence if not served in a timely manner, rather than on a first come, first serve basis.
- Revise the required level of 20 percent of CHOICE expenditures for individuals who are under the age of 60. Through a careful assessment and targeting process, this 20 percent requirement may not be necessary.
- Review the amount of the quarterly expenditure caps set by the DA for appropriateness.
- The program was originally designed before the implementation of the A&D Waiver, so review statutory requirements of the program such as requirements for ADL limitations. Consider raising functional criteria to three ADL impairments.

Attachment 1: Indiana Area Agencies on Aging

Area 1
Northwest Indiana Community Action Corporation
5240 Fountain Drive
Crown Point, IN 46307
219.794.1829 OR 800.826.7871
TTY: 888.814.7597
FAX: 219.794.1860
Web Site: www.nwi-ca.com

Area 2
REAL Services, Inc.
1151 S. Michigan Street
South Bend, IN 46601-3427
574.284.2644 OR 800.552.7928
FAX: 574.284.2642
Web Site: www.realservicesinc.org

Area 3
Aging and In-Home Services of Northeast Indiana, Inc.
2927 Lake Avenue
Fort Wayne, IN 46805-5414
260.745.1200 OR 800.552.3662
FAX: 260.456.1066
Web Site: www.agingihs.org

Area 4
Area IV Agency on Aging & Community Action Programs, Inc.
660 N. 36th Street
Lafayette, IN 47903-4727
765.447.7683 OR 800.382.7556
TDD: 765.447.3307
FAX: 765.447.6862
Web Site: www.areaivagency.org

Area 5
Area Five Agency on Aging & Community Services, Inc.
1801 Smith Street, Suite 300
Logansport, IN 46947-1577
574.722.4451 OR 800.654.9421
FAX: 574.722.3447
Web Site: www.areafive.com

Area 6
LifeStream Services, Inc.
1701 Pilgrim Boulevard
Yorktown, IN 47396-0308
765.759.1121 OR 800.589.1121
TDD: 800.801.6606
FAX: 765.759.0060
Web Site: www.lifestreaminc.org

Area 7
Area 7 Agency on Aging and Disabled West Central Indiana Economic Development District, Inc.
1718 Wabash Avenue
Terre Haute, IN 47807
812.238.1561 OR 800.489.1561
TDD: 800.489.1561
FAX: 812.238.1564
Web Site: www.westcentralin.com

Area 8
CICOA Aging and In-Home Solutions
4755 Kingsway Drive, Suite 200
Indianapolis, IN 46205-1560
317.254.5465 OR 800.432.2422
TDD: 317.254.5497
FAX: 317.254.5494
Web Site: www.cicoa.org

Area 9
Area 9 In-Home & Community Service Agency
520 South 9th Street
Richmond, IN 47374
765.966.1795 OR 800.458.9345
FAX: 765.962.1190
Web Site: www.iue.edu/area9

Area 10
Area 10 Agency on Aging
630 W. Edgewood Drive
Ellettsville, IN 47429
812.876.3383 OR 800.844.1010
FAX: 812.876.9922
Web Site: www.area10.bloomington.in.us

Area 11
Aging & Community Services of South Central Indiana, Inc.
1531 13th Street, Suite G900
Columbus, IN 47201
812.372.6918 OR 866.644.6407
FAX: 812.372.7864
Web Site: www.agingandcommunityservices.org

Area 12
LifeTime Resources, Inc.
13091 Benedict Drive
Dillsboro, IN 47018
812.432.6200 OR 800.742.5001
FAX: 812.432.3822
Web Site: www.lifetime-resources.org

Area 13
Generations
Vincennes University Statewide Services
1019 N. 4th Street
Vincennes, IN 47591
812.888.5880 OR 800.742.9001
FAX: 812.888.4566
Web Site: www.generationsnetwork.org

Area 14
LifeSpan Resources, Inc.
33 State Street Third Floor
New Albany, IN 47151-0995
812.948.8330 OR 888.948.8330
TTY: 812.542.6895
FAX: 812.948.0147
Web Site: www.lsr14.org

Area 15
Hoosier Uplands / Area 15 Agency on Aging and Disability Services
521 West Main Street
Mitchell, IN 47446
812.849.4457 OR 800.333.2451
TDD: 800.743.3333
FAX: 812.849.4467
Web Site: www.hoosieruplands.org

Area 16
SWIRCA & More
16 W. Virginia Street
Evansville, IN 47737-3938
812.464.7800 OR 800.253.2188
FAX: 812.464.7843
Web Site: www.swirca.org

To contact your local Area Agency on Aging toll-free, call

1.800.986.3505

Attachment 2: Indiana FSSA Division of Aging HCBS Programs: Comparison of Services

Service	CHOICE	SSBG	A&D Waiver	OAA (Title III)
Adult Day Services	X	X	X	X
Adult Family Care			X	
Assisted Living			X	
Attendant Care	X	X	X	X
Behavior Management	X	X		
Case Management	X	X	X	X
Community Transition			$1,500 lifetime cap	
Congregate Meals	X			X
Counseling Support Groups	X			
Disease Prevention/Health Promotion[54]				X
Environmental Modifications	X	X	$500 annual limit for repair and service/$15,000 lifetime cap	X
Family Care Assistance		X		X
Family Care Information		X		X
Family Caregiver Counseling Support Groups				X
Gerontology Counseling	X	X		X
Habilitation Day Group	X	X		
Habilitation Day Individual	X	X		
Handy Chore	X	X		X
Health Care Coordination			X	
Homemaker	X	X	X	X
Home Health Aide	X	X		X
Home Delivered Meals	X	X	X	X
Individual Counseling Support	X	X		X
Information Assistance	X	X		X

[54] Includes health risk assessments, health screenings, and education programs provided through 16 Area Agencies on Aging in various locations including senior centers, congregate meal sites, senior high rises, retirement communities, home-delivered meals programs or other appropriate sites.

Service	CHOICE	SSBG	A&D Waiver	OAA (Title III)
Legal Assistance	X	X		X
Licensed Practical Nurse	X	X		X
Medication Management				X
Nutrition Counseling	X	X		X
Nutrition Education	X	X		X
Nutritional Supplements	X	X	$1,200 annual cap	
Occupational Therapy	X	X		
Ombudsman				X
Outreach	X	X		X
Personal Emergency Response Systems (PERS)	X	X	X	X
Pest Control	X	X	$600 annual cap	X
Physical Fitness		X		X
Physical Therapy	X	X		
Private Duty Nurse	X	X		
Private Hire Attendant Care	X		X	
Registered Nurse	X	X		
Residential Based Habilitation	X			
Respite	X	X	X	X
Specialized Medical Equipment & Supplies	X	X	$500 annual limit for repair and service	X
Speech Therapy	X	X		
Transportation	X	X	X	X
Vehicle Modifications	X	X	$500 annual limit for repairs/$15,000 lifetime cap	

Attachment 3: Indiana FSSA Division of Aging HCBS Programs: Eligibility and Cost Sharing Criteria

Criteria	CHOICE	SSBG	A&D Waiver	OAA (Title III)
Income standard	None, but cost sharing may apply	150% of FPL	300% of SSI	None
Resource standard	No more than $500,000 for no cost sharing	None	Spousal impoverishment provisions apply; parental income and assets disregarded for children under age 18	None
Age	At least 60 or any age for a person with a disability	At least 60 or any age for a person with a disability	65 or physically disabled	At least 60
Other eligibility criteria	• Unable to perform 2 or more ADLs • Medicaid denial or pending application	Documented service need; client with excess income who has a documented service need due to abuse, neglect, exploitation, risk of institutionalization, and/or pending discharge from the hospital or nursing facility, may qualify as a no means-test client	NF level of care (deficient in 3 or more ADLs)	Not applicable although priority is given to serving older adults in greatest economic or social need, or both, with attention to low-income minority older adults, and those residing in rural areas
Cost sharing	Income between 151-349% of FPL- sliding scale Income 350%+ FPL or assets in excess of $500K- 100% of cost	None	Spend-down may apply for income exceeding 300 percent of SSI	None

Attachment 4: CHOICE Waiting List

AAA	Number on Waiting List, Fall 2012	Waiting List Priority
1	Not provided	By date of entry to waiting list (unclear whether this is date of application or date application is returned and eligibility has been determined) and priority. Priority need for eligible consumer based on: • An individual applying for Nursing Facility placement through Pre-Admission Screening • Loss of caregiver • Individual determined eligible and meet the A&D Waiver guidelines (diversion or transition) • Those identified via the ADRC Priority Tool Process (high, medium, low) Maintaining equitable distribution of services in all areas can result in changes to waiting list standing to target underserved areas.
2	673	I4A Operating Procedures – Does not specify priority. Client placed on waiting list based on date of application (i.e., date of original call), but is not actually put on waiting list until application is returned. Priority need for eligible consumer based on: • Discharge from a hospital or acute care facility • Transition from a nursing home or rehab center (minimum of 30 day stay required to qualify) • Leaving a nursing facility due to bed closure or decertification; • Loss of a primary caregiver (loss due to death or long term incapacitation) • Transitioning to an assisted living, adult foster care, or congregate care setting from either an institution or the community • Transition from CHOICE to Medicaid waiver
3	596	I4A Operating Procedures By date of application with the following exceptions: • County is underserved • Active clients needing additional services • AAA is under serving persons under 60 with disabilities (not reaching 20%)
4	296	By date of application with the following exceptions: • County is underserved • Active clients needing additional services • AAA is under serving persons under 60 with disabilities (not reaching 20%) Maintains separate waiting list for elderly and disabled.
5	268	I4A Operating Procedures By date of application with the following exceptions: • Application for nursing facility placement with pre-admission screening and/or loss of a caregiver • A county is underserved • Active clients needing additional services

		• AAA is under serving aged or disabled • Budget (*unclear what this means*)
6	237	I4A Operating Procedures By date of application with the following exceptions: • Under or over-served county • Active client in need of one-time large expense or additional service
7	167	I4A Operating Procedures (does not specify priority)
8	1,032	By date of application signature, but individual 95 years of age or older and eligible will receive services immediately if funding is available. In addition, imminent placement in NF or emergency referrals receive priority
9	96	Priority not specified; placed on waiting list after all paperwork completed including Medicaid eligibility determination; waiting list maintained by ADRC coordinator
10	50	I4A Operating Procedures; By date of intake, with the following having priority need • An individual applying for Nursing Facility placement through Pre-Admission Screening • Loss of caregiver • High score on eligibility screen
11	180	By date of application by county. Priority is given to those requiring assistance with 3 or more ADLs as determined by the E-Screen
12	No waiting list according to CHOICE Plan	I4A Operating Procedures; limited exceptions to first come, first served (from 1999 policy): • Case Manager's ability to increase case load; funding could be shifted to the next client with an available case manager • No eligible client for the funding that is available; funding could be shifted to another demographic • Type and amount of requested service, i.e. if $300 per month is needed and only $200/month is available and partial service does not benefit the client. The next client with needs that can be met with the funds available may be selected. • Other extenuating circumstances with the approval of the Case Management Deputy Director Establishes waiting list for people under 60 when 20% of funding threshold is reached
13	257	I4A Operating Procedures; first come, first served based on referral date
14	420	By date of application
15	551	I4A Operating Procedures. Client placed on waiting list based on date of application (i.e., date of original call), but is not actually put on waiting list until application is returned
16	408	By date of application. Further prioritizes waiting list based on score derived from analysis of financial need and level of care

Attachment 5: CHOICE Data Description

HMA generated an unduplicated list of clients and, using data from OMPP, flagged all months for all clients as Medicaid eligible or not eligible. All months for all clients were flagged as HCBS waiver and CHOICE eligible or not eligible. Since monthly waiver eligibility data are not available, we used Medicaid payment data with a procedure modifier of "waiver" as a proxy, (i.e. a client with any waiver service in a month was flagged for that month as waiver eligible and those with no waiver service in a month were flagged for that month as not waiver eligible). Since monthly CHOICE eligibility data are also not available, we used a similar procedure to determine CHOICE eligibility, (i.e. a client with any CHOICE service in a month was flagged in that month as CHOICE eligible and those with no CHOICE service in a month were flagged for that month as not CHOICE eligible).

These two proxies tend to underestimate the number eligible for CHOICE and waiver services since those who were eligible but did not receive a service were not counted. This underestimation is negligible for the waivers, since, due to the nature of waiver services, anyone eligible will most likely receive services. But for CHOICE, the underestimation may not be negligible. It is possible for someone to be eligible for CHOICE services but not have a service in a given month. Further, even if a service was provided, the case manager may not have entered it into the database used to track services and care plans for CHOICE clients.

The Medicaid payment data were merged with the CHOICE payment data and duplicate records between the two Medicaid eligibility and payment files were eliminated. All Medicaid payments without a procedure modifier of waiver were flagged as regular (or state plan) Medicaid. Payments with a modifier of waiver were flagged as waiver. CHOICE payments were flagged as CHOICE. The CHOICE payments in payment database file did not include payments for all claims submitted for CHOICE services and therefore the expenditures reflected in the database were understated. To compensate for the understatement, the total amount of expenditures was used as reported from the Annual Closeout Reports provided by the AAAs and an adjustment factor was calculated.

The adjustment factor was calculated by dividing the actual expenditures by the database expenditures, so when generating tables for this report, each claim-level CHOICE payment in the database was multiplied by the adjustment factor. CHOICE payments in the database were adjusted using the adjustment factor shown in the table below.

Values	2011
Actual Expenditures	$26,655,298
Expenditures per Database	$20,666,142
Adjustment Factor	1.29

The unduplicated client list and eligibility flags were merged into an eligibility file and into a payment file.

Attachment 6: Nursing Facility Costs per Resident Day

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Summary by AAA Region and RUG-III Group

	AAA Region															
RUG	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
EXTENSIVE SERVICES																
SE3	248.10	264.45	251.43	257.19	237.73	239.15	232.47	257.86	221.53	251.28	245.88	231.18	239.24	259.27	220.26	247.36
SE2	218.39	232.26	221.26	225.52	209.08	209.76	204.10	226.14	194.65	219.83	216.09	202.61	209.90	227.93	193.38	217.24
SE1	193.84	205.67	196.33	199.35	185.42	185.49	180.66	199.94	172.44	193.84	191.47	179.02	185.66	202.04	171.18	192.36
REHABILITATION																
RAD	204.82	217.57	207.48	211.06	196.01	196.35	191.14	211.66	182.38	205.47	202.49	189.57	196.51	213.62	181.11	203.49
RAC	183.51	194.48	185.83	188.34	175.46	175.26	170.79	188.90	163.09	182.90	181.11	169.08	175.46	191.14	161.83	181.86
RAB	171.24	181.19	173.37	175.26	163.63	163.13	159.07	175.80	151.99	169.91	168.81	157.28	163.34	178.20	150.73	169.44
RAA	154.44	162.99	156.31	157.35	147.43	146.51	143.03	157.87	136.80	152.13	151.96	141.13	146.76	160.48	135.53	152.42
SPECIAL CARE																
SSC	187.38	198.68	189.77	192.47	179.19	179.10	174.49	193.04	166.60	187.01	185.00	172.81	179.29	195.23	165.33	185.81
SSB	177.69	188.18	179.93	182.14	169.85	169.51	165.24	182.70	157.83	176.75	175.28	163.49	169.72	185.01	156.57	175.99
SSA	171.88	181.88	174.03	175.94	164.25	163.76	159.69	176.49	152.57	170.59	169.45	157.90	163.98	178.88	151.31	170.09
CLINICALLY COMPLEX																
CC2	160.25	169.29	162.22	163.55	153.04	152.26	148.58	164.08	142.06	158.29	157.79	146.72	152.50	166.61	140.79	158.31
CC1	156.38	165.09	158.28	159.42	149.30	148.43	144.88	159.94	138.55	154.18	153.91	143.00	148.67	162.53	137.29	154.38
CB2	147.98	156.00	149.75	150.47	141.21	140.12	136.87	150.97	130.95	145.29	145.49	134.92	140.38	153.67	129.69	145.87
CB1	143.46	151.10	145.16	145.65	136.85	135.65	132.55	146.15	126.86	140.51	140.95	130.58	135.91	148.90	125.60	141.28
CA2	135.71	142.70	137.29	137.39	129.38	127.99	125.15	137.87	119.85	132.30	133.18	123.13	128.26	140.72	118.59	133.43
CA1	130.54	137.10	132.04	131.88	124.39	122.87	120.21	132.36	115.17	126.83	128.00	118.16	123.16	135.27	113.91	128.19
IMPAIRED COGNITION																
IB2	134.42	141.30	135.98	136.01	128.13	126.71	123.91	136.49	118.68	130.93	131.89	121.88	126.99	139.36	117.42	132.12
IB1	127.31	133.61	128.76	128.44	121.28	119.68	117.13	128.91	112.25	123.41	124.76	115.05	119.97	131.87	110.99	124.91
IA2	118.27	123.81	119.58	118.80	112.56	110.74	108.49	119.25	104.07	113.84	115.69	106.36	111.04	122.33	102.81	115.75
IA1	114.40	119.61	115.64	114.67	108.83	106.90	104.79	115.12	100.56	109.74	111.81	102.63	107.21	118.24	99.31	111.82

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CHOICE Program
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Summary by AAA Region and RUG-III Group

	AAA Region															
RUG	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
BEHAVIOR PROBLEMS																
BB2	131.84	138.50	133.35	133.26	125.64	124.15	121.45	133.73	116.34	128.20	129.30	119.40	124.43	136.64	115.08	129.50
BB1	124.08	130.11	125.48	124.99	118.17	116.49	114.04	125.46	109.33	119.99	121.52	111.95	116.78	128.46	108.07	121.64
BA2	117.63	123.11	118.92	118.11	111.94	110.10	107.88	118.56	103.48	113.15	115.05	105.74	110.40	121.65	102.23	115.09
BA1	109.23	114.01	110.39	109.16	103.85	101.79	99.86	109.60	95.89	104.27	106.63	97.66	102.11	112.79	94.63	106.58
REDUCED PHYSICAL FUNCTION																
PE2	142.82	150.40	144.51	144.96	136.23	135.01	131.93	145.46	126.28	139.82	140.31	129.96	135.28	148.22	125.02	140.63
PE1	136.36	143.40	137.95	138.08	130.00	128.62	125.76	138.56	120.43	132.98	133.83	123.75	128.90	141.40	119.17	134.08
PD2	137.00	144.10	138.60	138.76	130.62	129.26	126.38	139.25	121.02	133.67	134.48	124.37	129.54	142.09	119.76	134.74
PD1	130.54	137.10	132.04	131.88	124.39	122.87	120.21	132.36	115.17	126.83	128.00	118.16	123.16	135.27	113.91	128.19
PC2	127.96	134.31	129.42	129.13	121.90	120.32	117.74	129.60	112.84	124.10	125.41	115.67	120.61	132.55	111.58	125.57
PC1	123.44	129.41	124.83	124.31	117.55	115.85	113.43	124.77	108.74	119.31	120.88	111.33	116.14	127.78	107.49	120.98
PB2	121.50	127.31	122.86	122.24	115.68	113.93	111.58	122.70	106.99	117.26	118.93	109.46	114.23	125.73	105.73	119.02
PB1	116.98	122.41	118.27	117.42	111.32	109.46	107.26	117.87	102.90	112.47	114.40	105.12	109.76	120.97	101.64	114.44
PA2	110.52	115.41	111.71	110.54	105.09	103.07	101.09	110.98	97.06	105.63	107.92	98.91	103.39	114.15	95.80	107.69
PA1	106.65	111.22	107.77	106.41	101.36	99.24	97.39	106.84	93.55	101.53	104.04	95.18	99.56	110.07	92.30	103.96

Prepared by Myers and Stauffer LC

g:\proj\modl\choice\Summary by AAA and RUG Group

The analysis is based on the allowable costs of each nursing facility for the direct care, indirect care, administrative, capital and therapy cost components, as defined in the nursing facility reimbursement regulations at 405 IAC 1-14.6. The costs per patient day were inflated from the midpoint of the cost report period to 1/1/2013.
The direct care costs for each facility were case mix adjusted (normalized) using the facility's total case mix index for all residents, in order to determine each facility's direct care cost per case mix point. Capital costs were determined by including the fair rental value allowance (in lieu of interest, depreciation and rent), plus other capital related costs. Weighted medians were then calculated for each component for each AAA region. The normalized direct care median for each region was then multiplied by the case mix index for each of the 34 RUG-III groups, and summed with the indirect care, administrative, capital and therapy weighted median costs, to arrive at the weighted median cost per RUG-III group per AAA region.

Attachment 7: Other State-Only Funded Programs Similar to Indiana CHOICE

State	Total Population (and 65+ years)[55]	Program Name[56]	FY 2011 Appropriation[57] And Administrative Costs	Program Description	Program Purpose	Outcomes Measured by State? (Yes/No)	Co-Pay Required?	Waiting List? (Yes/No)
FL	19.1 million (17.6% 65+)	Community Care for the Elderly (CCE) http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2012/2012_SOPS_D_web.pdf	Per state published documents: funding is $40,479,617; administration is $35,000 to $70,000 per AAA if negotiated with the Department to competitively procure CCE services through a request for proposals. Pr state official,	Coordinated by the Department of Elder Affairs and AAAs administer funds at the local level. Provides a continuum of community-based services to help functionally impaired older live in the least restrictive yet most cost-effective environment suitable to their needs. Eligible clients receive a wide range of goods and services. Primary consideration for services is given to elderly persons referred to Adult Protective	Sponsor cost-effective ways to prevent, postpose or reduce inappropriate or unnecessary institutional placements among functionally impaired individuals 60 years of age and older.	Not specific to the CCE program. Client satisfaction surveys conducted and performance measures overall by AAA - Each measure includes information about clients served	Yes; based on a sliding scale; used to expand the availability of client services.	Yes; prioritized based on assessment

[55] U.S. Census Bureau, 2011 estimates from State and County Quick Facts.
[56] Source: Mollica, Simms-Kastelein, and Kassner. *State-Funded Home and Community-Based Services Programs for Older Adults* (Washington, DC: AARP Public Policy Institute), April 2009.
[57] Source: Walls, Gifford, Fox-Grage, et al. *Weathering the Storm: The Impact of the Great Recession on Long-term Care Services and Supports.* (Washington, DC: AARP Public Policy Institute), January 2011.

State	Total Population (and 65+ years)[55]	Program Name[56]	FY 2011 Appropriation[57] And Administrative Costs	Program Description	Program Purpose	Outcomes Measured by State? (Yes/No)	Co-Pay Required?	Waiting List? (Yes/No)
			total administrative funding is $714,745.	Services (APS) and determined by APS to be victims of abuse, neglect or exploitation who need immediate services to prevent further harm.		under one or more programs for which the AAAs are administratively involved.[58]		
NJ	8.8 million (13.7% 65+)	Jersey Assistance for Community Caregiving (JACC) http://www.state.nj.us/health/senior/jacc.shtml	Per state officials: $13 mil in direct services and $2.5 mil to case management & third party billing agent	ACC provides a broad array of in-home services for individuals (60+ years) at risk of nursing facility placement and who meet income and resource requirements. The individual has to have no other means available to secure needed services and must have been determined to be clinically eligible for nursing facility care. All JACC participants receive care	Deliver services to those 60+ who are clinically eligible for nursing facility level of care to delay or prevent institutionalization.	Yes (delay institution-alization)	JACC participants may contribute to the cost of their services. The co-pay obligation is based on countable income applied to a sliding	Yes

[58] http://elderaffairs.state.fl.us/doea/aaa_pm.php

State	Total Population (and 65+ years)[55]	Program Name[56]	FY 2011 Appropriation[57] And Administrative Costs	Program Description	Program Purpose	Outcomes Measured by State? (Yes/No)	Co-Pay Required?	Waiting List? (Yes/No)
				management. JACC services are limited to a maximum of $600 per month or $7,200 annually. Services are provided by qualified entities, including participant-employed providers.			scale. Co-pay is payable directly to the designated Billing Agent, which will bill the JACC participant.	
NC	9.6 million (13.2% 65+)	Home and Community Care Block Grant (HCCBG) http://www.ncdhhs.gov/aging/manual/hccbg/hccbg.htm	$40.9 million As the block grant is administered by the counties, the state does not calculate administrative	The NC Home and Community Care Block Grant for Older Adults, established by statute in 1992, is administered by the Division of Aging. The HCCBG consolidates federal, state, and local resources into a "common funding stream" which is allocated to counties for services to	Consolidate funding and enhance state support for coordinated community-based systems of care through county government so as to reduce	No, but there are service standards and each AAA is responsible for monitoring service using state	Yes	Yes

State	Total Population (and 65+ years)[55]	Program Name[56]	FY 2011 Appropriation[57] And Administrative Costs	Program Description	Program Purpose	Outcomes Measured by State? (Yes/No)	Co-Pay Required?	Waiting List? (Yes/No)
			costs.	older adults; OAA funds make up about 45% of HCCBG funding; state funding is appropriated by the General Assembly and AAAs fund county programs on aging through grant agreements. The block grant gives County Commissioners great discretion in allocating and administering these aging funds which are intended to achieve the specified goals: promote the visibility and importance of aging programs locally; establish a single set of policies and procedures for HCBS provided with block grant funds; and provide for an equitable distribution of funds to counties consistent	premature institutionalization.	developed tools		

State	Total Population (and 65+ years)[55]	Program Name[56]	FY 2011 Appropriation[57] And Administrative Costs	Program Description	Program Purpose	Outcomes Measured by State? (Yes/No)	Co-Pay Required?	Waiting List? (Yes/No)
				with the OAA. There are no income eligibility determinations to receive services.				
PA	12.7 million (15.6% 65+)	The Attendant Care Program ("Act 150") http://www.portal.state.pa.us/portal/server.pt?open=514&objID=733694&mode=2 ; also OPTIONS Program, Family Caregiver Support http://www.portal.state.pa.us/portal/server.pt?open=514&objID=616680&mode=2	Act 150 funding is approximately $23 million which includes $164,000 as private pay portion, OPTIONS program funding is approximately $45.1 million. Administrative portion for these programs ranges between 10-15% depending on	Since 1985, the Attendant Care Program ("Act 150") provides personal assistance and support to individuals to enable them t o live in their homes and communities rather than institutions. To be eligible, a person must be 18-59 years and have a physical disability, be mentally alert and able to direct his/her own services, and require assistance with activities of daily living. This program was designed to prevent individuals, such as those with spinal bifida and who have no intellectual	Provide services in homes and communities to enable individuals to live at home rather than in an institution.	No	Yes	Yes

State	Total Population (and 65+ years)[55]	Program Name[56]	FY 2011 Appropriation[57] And Administrative Costs	Program Description	Program Purpose	Outcomes Measured by State? (Yes/No)	Co-Pay Required?	Waiting List? (Yes/No)
			service.	disabilities, from "falling through the cracks." The program provides assistance with bathing, dressing, meal preparation, mobility, housekeeping and other self-care and daily living functions. The program allows individuals to choose the model of service delivery they prefer. The OPTIONS program is also a state-funded LTC program but for persons 60+ who are not eligible for Medicaid or not determined to be nursing facility clinically eligible. Services are administered through the AAAs and include: adult day, attendant, home health, meals,				

State	Total Population (and 65+ years)[55]	Program Name[56]	FY 2011 Appropriation[57] And Administrative Costs	Program Description	Program Purpose	Outcomes Measured by State? (Yes/No)	Co-Pay Required?	Waiting List? (Yes/No)
				transportation, assistive devices, respite, home modifications and guardianship. While there is no financial eligibility requirement, modest co-payment requirements based on income are assessed.				
WA	6.8 million (12.7% 65+)	Senior Services Citizens Act & Family Caregiver Support Program http://apps.leg.wa.gov/rcw/default.aspx?cite=74.38&full=true	Per state officials, the SSCA program received $8.4 million with $1.1 mil for administrative costs; and Family Caregiving totaled $11.3 mil with $.5 mil in administrative	The Senior Citizens Services Act (SCSA), enacted in 1976, committed state monies to provide a range of community-based services for older adults to help them attain maximum independence and remain at home. Services include: information and assistance; transportation; nutritious meals; caregiving support; direct services; training programs in counseling the	To develop coordinated system across state to facilitate maximum attainment of independence, especially for those without informal supports.	Yes	Yes, for some services	Yes, occasionally

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			costs. For SSSA the allowable amount of admin is up to 16.5%; under family caregivers admin limit is 10% (which matches the admin limits under the Older Americans Act.)	elderly; and senior volunteer programs. Services are provided to individuals whose income is <40% of the state's median income level. Administered by State Office on Aging in the Department of Social & Health Services, SCSA has developed a coordinated system of social and health services for seniors and nurtured a network of community-based care; Area Agencies on Aging plan and implement services at the local level, leveraging service dollars in innovative ways. These state and local monies are used as a match for local philanthropic grant funds. Offered through AAAs, the				

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				Family Caregiver Support Program helps unpaid caregivers caring for an adult 18+ years find resources and receive training and respite. The program, begun in 2003, offers assistance, consultation, education and training, support groups, counseling, and respite services at little or no cost. The availability of services varies across communities. As a single-services HCBS program, Volunteer Choice is offered through Compassion & Choices of Washington. It is a nonprofit organization that advocates for excellent end-of-life care, patient-centered care, and				

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				expanded choice at the end of life. It assists people with all aspects of end-of-life decision-making as they face incurable and terminal illness, pain, and suffering. It provides free end-of-life counseling and client support; encourages advance planning; and promotes the use of Physician Orders for Life-Sustaining Treatment (POLST) for those with serious illnesses.				