TESTIMONY REGARDING HEA 1493

July 18, 2017

Thank you for the opportunity to speak with you today. My name is Joan Cuson. I have been with the Area 2 Agency on Aging / REAL Services, for over 30 years. The last 12 years, I have served as the A2AA Director. Area 2 covers 5 diverse counties in Northern Indiana, Elkhart, Kosciusko, LaPorte, Marshall and St. Joseph.

I am also honored to serve on the CHOICE Board, and was a caregiver for my mother until her death. As a caregiver, I learned firsthand how what we do well, or what we fail to do, impacts the person.

In my 30 years with the A2AA, I have seen phenomenal change. Most of this change has been good, in that we were brought from a very simple organizational approach to one that can effectively compete with any for profit organization. Over the years we have learned to hone our business practices, look diligently for efficiencies, while still keeping our primary role (according to the Older American's Act) as an advocate for older adults. Our commitment to mission and service is what makes us unique. We recognize the importance of creating efficiencies as well as the need for quality - and are able to provide both.

The needs of caregivers has also changed over time. We see family who expect to remain involved in decision making but may be geographically removed from their loved one. We have families who understand the need to create processes that support the independence of their loved ones and who understand that unless there are changes, resources can only go so far. They also support protecting the viability of systems that will provide for their own care.

Several years ago, we were one of two pilot agencies that received a federal grant to develop a new service delivery system that would provide options counseling in a way that was person centered. What we developed was referred to as "CLP" or "CHOICE 2.0". At that time, there was no person centered model for aging. We developed that based on the population we know so well. What happened as a result of that pilot has promised to change the way Indiana approaches home and community based care and would be applicable to any funding source. This model was developed specifically to reduce costs, reduce or eliminate wait lists and insure a positive consumer experience. Our experience after two years with the pilot was a high satisfaction ranking, a care plan cost reduction of over 50% and the total elimination of a waiting list (from a high of 1600).

Key to our results was the initial investment in Options Counseling as a primary service. The needs of people are diverse. A true Person Center approach requires that you to meet the person where they are and serve them in a way that promotes the maximum independence and is meaningful to them. It is meaningful when they are the ones choosing from the options presented to them . Those options are comprehensive and began with identifying the unique needs of the individual.

Options counseling begins with a call to the Area Agency on Aging's ADRC, which Indiana has begun to invest in branding so that it is even more recognized as a destination for care.

Historically we our long term care system has been based on an initial determination of eligibility. Once eligibility is determined, there is a "menu" of services that open up and the service recipient is able to access many of those services.

In our initial visit, rather than determine eligibility, we determine need. In doing this, we keep the focus on only providing what is necessary, only for as long as it is necessary. Options counseling begins as an interactive evaluation of the individual's needs, both critical and non-critical. By that, I mean that we look at those issues that might actually place them at risk for losing their independence or risking institutionalization and insure that those needs are met as quickly as possible.

Non-critical needs are identified and recorded. The options counselor will work with the individual to identify ways that those needs may also be met. Often this results in the use of volunteer services, or relying on local community resources.

The initial assessment includes authorizing services in a new way. We ask the person what they are unable to do for themselves. Framing the discussion in this way, supports our approach to preserving independence by not "doing for" someone what they are able to do themselves. At the same time, we are able to hone the services provided which has resulted in reduced care plans.

Finally we approach Options Counseling with the intent of assisting for only as long as we are needed. This is explained at the onset. If the person is recovering from an illness, we authorize short term care plans for a specified period of time, rather than annually which is traditionally done. By integrating the option of short term care we have been able to serve more individuals as well as reduce costs.

Once need is identified, an Options Counselor will look more closely at how to provide for that need, which includes a robust discussion of finances and other supports.

When financial resources are known, the Options Counselor can have meaningful discussion with the client on what they need and who might pay for it. What we found through the pilot was:

- A willingness for families and the recipient themselves, to pay for the care.
- Other options that had not been considered, such as accessing local community resources, can meet the need.
- Working with families to coordinate care, can at times entirely eliminate the need for state funded care.
- By providing short term intervention the need for long term services can be eliminated. Rather than providing a weekly homemaker to do laundry, bring the washer and dryer into an accessible place where the client can avoid the risks associated with climbing basement stairs.
- Options Counselors are able to provide information on how to responsibly use resources.

By focusing on need before eligibility, we are able to identify other options to meet those needs, rather than relying on state funded services. If the needs are able to be addressed in other ways, people can be diverted from Medicaid entirely through a simple investment in options counseling.

In order to expand on Indiana's initial efforts, we would suggest the following:

- Provide presumptive eligibility for Medicaid Waivers, as Indiana has done for other vulnerable populations, like pregnant mothers. This would be the single most important step toward increasing accessibility in a way that might equal access to nursing home care.
- Insure that all systems, including technology and reimbursement, support a robust Options Counseling core service.
- Within the aging network, financial resources have been stated rather than verified. Those funding sources that are verified, such as Medicaid or Medicaid PA, are not integrated into other programs and therefore require additional effort on the part of the consumer by requiring multiple applications and eligibility determination. Sharing Medicaid income information would avoid this duplication.
- Include the funding of preventative services that support independence and build the individual's ability to remain safely at home for as long as possible. Preventative health services provide a real financial benefit to the state by prolonging a dependence on assistance as well as reducing health care costs.

There is no other provider better equipped to provide the options counseling service, then the Area Agencies on Aging. We are locally recognized and most times the first place an older adult or a person with physical disabilities will go. Options Counselors are specifically trained to deliver this service. Most importantly, we are unbiased in directing the individual to the care they need. We have no financial interest in the outcome of the options chosen by the individual.

A barrier to fully realizing the potential Indiana has to meet the needs of older adults is the current reimbursement rate for Medicaid services. Rates are well behind where they need to be, due in part to a lack of increase over the past several years. There is a critical need for an update now and a need to plan ongoing annual rate updates. Additional reimbursement issues have plagued us in our ability to staff client's care, some of which are:

1. Providers may not bill for travel time which results in service preference being given to Clients in urban areas while those in rural areas are left un or under staffed.
2. Due in large part to lower salaries and benefits, we experience high turnover in staffing.
3. Clients with high medical need are difficult to staff at the "standard" rate.
4. Clients who require specialized services, like children with complex medical needs are more difficult, if not impossible to staff.
5. As the employment market has rebounded, the ability to recruit and retain staff in any service area has become increasingly difficult.

6. In Care Management, providers are reimbursed $100. Per month for each client. This may create a need for providers to limit the amount of time spent with a client. For a $ 1,200. annual reimbursement rate, providers are required to see a client in their home at least four times a year. This reimbursement must cover travel time, documentation time, time spent processing paperwork, and managing and updating care plans. There is little time to spend on working with an individual in a way that might bring about improvement or increased independence. There is no time to invest in options counseling which could address complex care needs or to investigate other options such as local community resources.

We could greatly enhance our service provider network by doing some simple things.

- Insure quickest possible payment turn around.
- Provide adequate payment rates.
- Give the AAA's the ability to negotiate rates for those individuals who would be difficult or impossible to staff under standard payment rates.
- Remove the requirement that providers must be certified under Medicaid to provide CHOICE, Title III or SSBG funded services.

In closing, having worked in this field for over 30 years and planning my retirement soon, I would like to offer some observations, that are fully my own.

The Area Agencies on Aging are more complex than most realize. We have made amazing progress in proving our ability to positively impact health care. Through our work with transitions and our ability to improve communication and integration of care between medical and social providers, we have demonstrated a positive impact on health outcomes. Area Agencies can have a significant role in health care in the future.

As one who spent years developing the CLP model, it has tremendous implications. This model could reduce the cost of Medicaid PA services and save the state of Indiana tens of millions of dollars. Please give it consideration and support.

Invest in supporting a full range of services. There are no preferred services. People have to have access to whatever meets their needs and those needs are always changing. There should be no "push" for any one service over another. There is no service that is a panacea or that provides for everyone's needs. The answer is not in funding a specific service but through insuring access to the fullest most diverse provider network possible.

The answer is to invest in helping the person determine what is **necessary** so that they do for themselves for as long as possible, and be supported only when it is needed. If we do this well, we will be best able to provide for the aging wave that is already on us.

Given the financial benefits caregivers bring, greater then nursing home and long term care combined, we are shamefully remiss if we don't support what can be a very fragile network. When a caregiver is "done" the next option is likely to be a nursing home. Caregivers are what bring quality of life to their loved one. Not only is it a compassionate option it is a financially smart one.

Looking back at the care I provided to my mother, I can tell you that even those were the most difficult years of my life, they were also the most precious. I would not have given one of them up for anything. As I watched my mother struggle in a way that seemed cruel and senseless, it helped to believe that she was teaching me again, as she had all my life. My strength came from believing that our experience would somehow make a difference for others.

As a caregiver, and Margaret's daughter, I would ask that you please insure that we are doing all that we can do to help keep caregivers strong. If there is an additional effort that we need to be making that we have failed to make, it is this.

Thank you.