Health Care Reform and Long-Term Care

A STUDY OF IMPACT ON NURSING HOMES IN INDIAN COUNTRY

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Health Care Reform and Long-Term Care: A Study of Impact on Nursing Homes in Indian Country

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Executive Summary

Health care reform legislation, including the permanently reauthorized Indian Health Care Improvement Act (IHCIA), contains various provisions designed to increase access to and resources for long-term care in Indian Country and in the United States as a whole. To investigate the impacts of health care reform on long-term care in Indian Country, a qualitative study of nursing home (NH) administrators in Indian Country was conducted. The study included phone discussions with eight administrators from six different NHs.

Long-term care (LTC) is a critical need in Indian Country, because of a rapidly aging population with a prevalence of functional limitations and disability among older adults that is 14% points higher than the rate for the general U.S. population. Despite a high level of need for services, LTC access for American Indians and Alaska Natives remains problematic, with only 15 LTC facilities located in Indian Country. In addition, access to care can be complicated by geographic isolation, limited financial resources of American Indian and Alaska Native individuals, limited capacity of long-term services and supports (LTSS) programs, and a lack of culturally competent care.

Recognizing the unmet long-term care needs of Indian Country and the nation as a whole, provisions of the Affordable Care Act (ACA) on LTC address both NHs and home- and community-based services (HCBS). Requirements for NHs focus on:

- **increased protection of residents** through complaint processes and penalties, required notices of facility closure, and employee background checks;
- **increased transparency** through required disclosures of facility information, facility reporting on national websites, and increased consumer access to facility information and ratings;
- **training and staffing requirements**; and
- **quality of care measures**, including IT improvements and data collection infrastructure.

Health care reform provisions related to HCBS include:

- programs to support **transition from facility-based care to HCBS**;
- **incentives for states** to shift spending from facility-based care to HCBS; and
- **demonstration programs** to increase the provision of primary medical care to beneficiaries in their homes and to provide comprehensive community-based care.

Provisions in IHCIA also specifically address long-term care, including:

- **authorization for the Indian Health Service (IHS) to provide long-term care,** by explicitly including LTSS in the IHS scope of services and compact funding agreements with tribes;
- improvements to **reimbursement processes and resource sharing** with other federal programs; and

- **measures addressing provider shortages** through revised licensing requirements, scholarship and stipend programs, and increased training for behavioral health providers.

As a primary result of the study, NH administrators in Indian Country expressed limited awareness about ACA and IHCIA provisions that were anticipated to affect NHs, and reported that few of these impacts had yet been realized. One recommendation from interviewees was increased education for NH administrators and staff about relevant health care reform provisions, especially as health care reform implementation continues.

Regarding provisions targeting the quality of care in skilled nursing facilities, NH administrators reported that ACA requirements did not differ substantially from quality control and patient protections already in place.

Some NH administrators reported limited impact in the following areas:

- **Easier inclusion of LTC funding in IHS compacts**, based on the new IHS authority to fund LTC
- **Increased flexibility in hiring** based on revised licensing requirements for providers in tribal health facilities
- **Preparations for the development of quality assurance programs** and requirements

NH administrators also reported some interest in expanding the scope of their facility's services to include HCBS or Medicare-approved short-term rehabilitation services. In this area, NH administrators seemed motivated as much by a perception of community need for HCBS as by health care reform's intended shift from facility-based care to HCBS.

Overall, NH administrators in tribal communities are uncertain of how the ACA and IHCIA will impact their facilities and the long-term care needs of their communities, despite the fact some of these same administrators are using and benefiting from LTC provisions of health care reform. The findings of this report highlight a need to inform NH administrators in Indian Country about the ACA and IHCIA, through a focused and deliberate effort, to ensure these programs take full advantage of recent regulatory changes.

Introduction

Recent health care reform legislation, collectively referred to as the Affordable Care Act (ACA), includes several legislative components:

- the Patient Protection and Affordable Care Act (PPACA);
- the Health Care and Education Reconciliation Act of 2010, which amends PPACA; and
- the Indian Health Care Improvement Act (IHCIA), an act originally passed in 1976 and amended, reauthorized, and made permanent as part of the PPACA.

Collectively, this legislation forms the comprehensive health reform that was signed into law in early 2010, and it "includes the most significant improvements to the quality and safety of long-term care in the last 20 years" (Famlies USA, 2010). It also instates changes that are intended to improve the access to and quality of long-term care (LTC) delivered in institutions, beneficiaries' homes, and community settings.

ACA provisions are primarily aimed at expanding health care insurance, improving the quality and efficiency of care, increasing the health care workforce, and lowering health care costs. The ACA is also projected to impact institutional care facilities such as nursing homes (NHs).[1] The provisions are anticipated to affect the way that NHs bill third parties, recruit and train staff, make facility information accessible to potential residents or residents' family members, and more. Recent health care reform legislation also includes, primarily within IHCIA, a number of provisions aimed at changing the access to and quality of LTC specifically in Indian Country. However, the impact of health care reform on LTC facilities in Indian Country is not yet known.

For this reason, the Centers for Medicare & Medicaid Services (CMS) contracted with Kauffman & Associates, Inc. (KAI) to conduct a study of how NHs in Indian Country have been, or potentially will be, impacted by health care reform. To inform and create the framework for this study, KAI conducted an extensive literature and information review on the ACA's anticipated impacts on LTC in general, as well as its potential impacts on LTC and in Indian Country specifically. In the course of the information review, KAI examined in detail those ACA provisions applying to LTC, and provisions applying to health care delivery within the Indian health system. It should be noted that the provisions specific to the Indian health system originated primarily in the reauthorization of IHCIA, while provisions relevant to LTC came from throughout the ACA.

[1] ACA provisons address both skilled nursing facilities (SNFs), which are Medicare certified, and nursing facilities (NFs), which are commonly Medicaid certified. In this report, *nursing homes* (NHs) is used to refer broadly to institutional care facilities, including SNFs and NFs. Facilities are identified as SNFs or NFs only if policy or projected outcomes are anticipated to apply differently to certain facility types.

The first section of this report highlights key points drawn from the information review on the provisions of the ACA and their anticipated impacts upon LTC and LTC in Indian Country, including a section on the demographics for LTC in Indian Country. The second section of this report presents data and results from the study of the current impact of health care reform on LTC facilities in Indian Country as reported in interviews by administrators of NHs in Indian Country.

Part 1. Background: The Growing Need for LTC in Indian Country

Defining Long-Term Care

An understanding of how the ACA impacts LTC facilities in Indian Country should begin with, first, an understanding of what LTC is, and, second, an understanding of the relevant provisions from within the ACA. LTC, now increasingly also referred to as *long-term services and supports* (LTSS),[2] can be defined as a range of services and supports to assist and improve the quality of life for people with physical, cognitive, or mental disabilities who experience limitations in their abilities to conduct activities of daily life (ADLs). ADLs are defined on a state-by-state basis, but generally refer to the daily fundamental activities of self-care including bathing, dressing, eating, taking medications, and grooming. ADLs are used as a gauge for measuring the functional status of individuals and for determining the individual's need for LTSS. Another measure is a patient's capacity to conduct instrumental activities of daily life (IADLs). IADLs, while not necessary for fundamental functioning, are those activities that assist an individual to live independently, such as the ability to perform housework, shop, and manage transportation needs.

Table 1: Definition of long-term care/long-term services and supports

LTC/LTSS **(Long-term care, Long-term services and supports)**	A broad range of health and social services needed by people who are limited in their ability to perform self-care activities due to a physical, cognitive, or mental disability or condition that results in functional impairment and dependence on others for an extended period of time (Colello et al., 2012).

[2] The terms *long-term care* (LTC) and *long-term services and supports* (LTSS) are used synonymously in this report.

Long-term care can be provided in various settings, and the term includes both facility-based care and home-and community-based care. Table 2 defines and gives examples of these two types of LTC services. Comprehensive definitions of the various types of LTC care mentioned within these two categories are included in Appendix 2.

Table 2: Definitions and examples of facility-based long-term care and home- and community-based care services

Facility-Based Long-Term Care	Long-term services and supportsoffered in an institutional setting for the elderly and younger adults with physical, mental, or cognitive disabilities. LTC facilities can include a wide range of facilities such as: assisted living facilities,[3] nursing homes, board and care homes, and community care retirement communities.
Home- and Community-Based Services (HCBS)	A range of long-term care services that help persons with long-term care needs to remain in the home or community setting while maintaining the highest level of functioning and independence possible (Colello & Talaga, 2011, p.1). HCBS can include: home health aides, personal care, case management, private-duty nursing, assistive devices, adult day health care, respite care, meal delivery and rehabilitation. HCBS are offered in home and community settings including homes, apartments, and group homes

Demographics for Long-Term Care in Indian Country

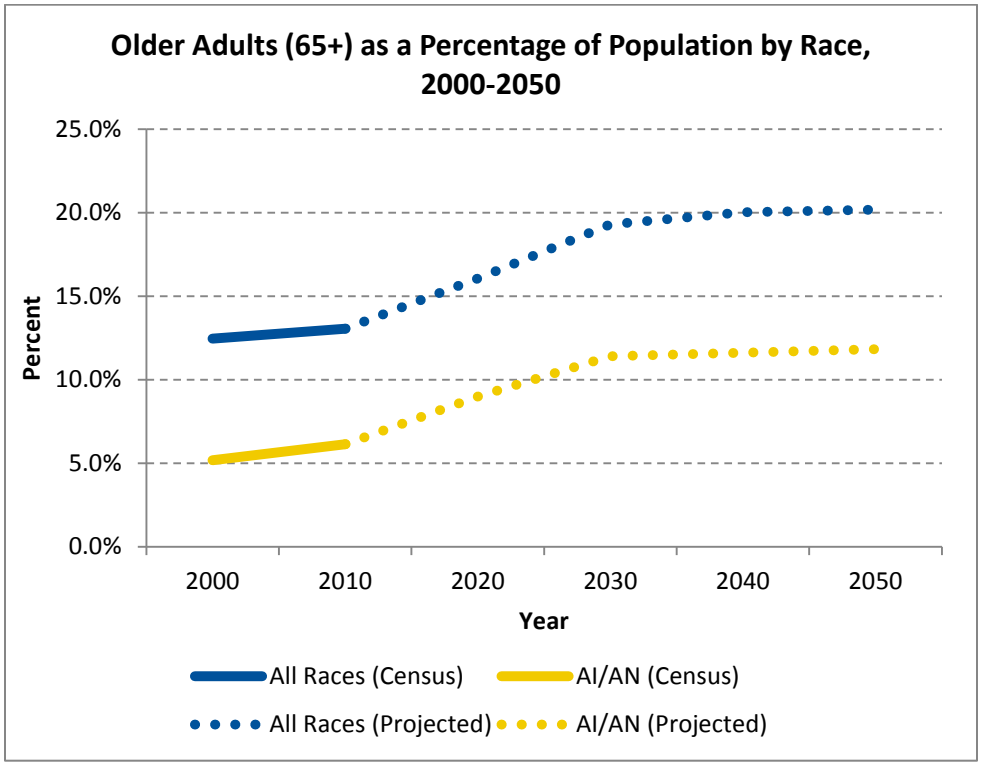
In the United States, the number of older adults 65 years or older increased by 14.8% (*n*=5.2 million) between 2000 and 2010. This growth of the overall older adult population is also evident in Indian Country. In fact, between 2000 and 2010, the number of American Indian and Alaska Native (AI/AN) older adults increased by 40.5%, a growth that is 2.7 times greater than that of the overall population of older adults over the same 10-year period (Administration on Aging, 2011).

According to U.S. Census Bureau population estimates reported by the Administration on Aging (2011), the elderly will not only increase in absolute terms (i.e., the number of persons 65 years

[3] Note that some states may consider assisted living facilities a community-based service rather than a facility-based service (Shelly Zylstra, personal communication 6/17/2013).

of age or older) but the elderly will also account for an increasingly large percentage of the population. This aging trend of the total national and AI/AN populations will continue into the future, as pictured in Figure 1. By 2050 it is projected that 20%, or one in five, Americans (*n*=48.3 million) will be 65 years of age or older, while approximately 12% of AI/AN individuals (*n*=445,000) will be 65 years of age or older.[4]

Figure 1. Older adults (65+) as percentage of population by race, 2000-2050



Source: U.S. Census Bureau, 2000 and 2010 Censuses, and 2008 National Population Projections

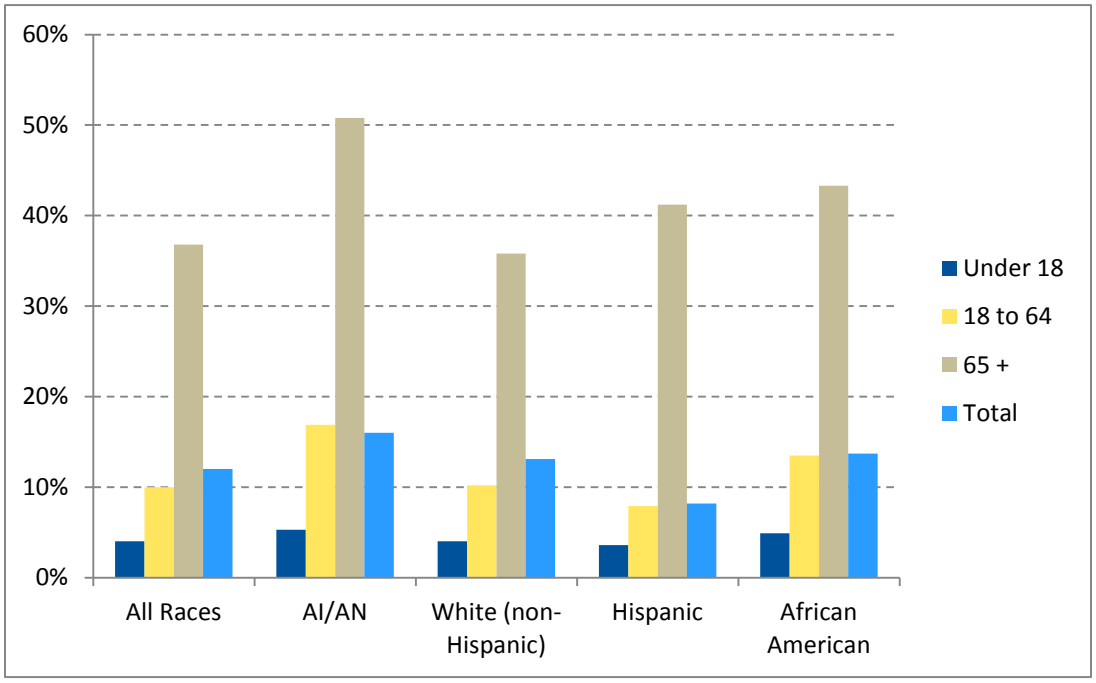
In addition to a growing older adult population, the AI/AN population is also impacted by higher rates of disabilities, especially functional disabilities[5] (Goins, Buchwald, & Guralnik, 2007, p. 692). Disabilities include physical, cognitive, mental, sensory, emotional, developmental, or some combination of these impairments. According to the American Community Survey's 2009-

[4] These numbers are based on the difference between the projected number of Persons 65 or older (from the total population and the AIAN population) in 2050 and the known number of Persons 65 or older (from the total population and the AIAN population) in 2010. Source: Administration of Aging. Population Projections by Race and Hispanic Origin for Persons 65 and older 2000 to 2050. http://aoa.gov/AoARoot/Aging_Statistics/future_growth/future_growth.aspx#hispanic

[5] A functional disability may be defined as a disability that causes difficulty in performing activities of daily living and routine social activities.

2011 data, AI/ANs have a greater percentage of persons with disabilities than African American, White (non-Hispanic), and Hispanic races in the United States (Administration on Aging, 2010). The percentage of AI/ANs aged 65 or over with a disability is 14% points higher than the disability rate of their same-aged counterparts of all races. In comparison to other populations in the United States, disability rates for AI/ANs are higher for amputation, blindness, end-stage renal disease, and cardiovascular disease, largely due to the high incidence of diabetes within the AI/AN population.[6]The elevated percentage of AI/AN people experiencing and reporting limitations to activities of daily life (ADLs) is a major predictor for the need for and subsequent use of LTC amongst the population of AI/AN people (Hassin & Shah, 2010, p. 5). Because of the combined factors of an aging population and high rates of disabilities, AI/ANs have an arguably greater need for LTC than other races in the United States.

Figure 2: Percentage of disability by age and race



Source: U.S. Census Bureau, 2009-2011 American Community Survey

The rapidly increasing nationwide need for LTC is causing a growing financial strain on state and federal Medicaid budgets, and it is increasing LTC spending. There is a considerable gap between the cost of facility-based ("institutional") LTC and that of LTC delivered through home- and community-based services (HCBS). Colello et al. (2012) explain that facility-based LTC costs more because it provides 24-hour skilled nursing care and includes the cost of room and board. Despite the high costs involved, there has been a clear bias, and a habitual practice, of

[6] Shelly Zylstra, Planning Unit Director of the Northwest Regional Council. (Personal communication June 2013).

providers assigning people in need of LTC to care from institutions rather than HCBS (Colello et al., 2012, p.13). In their analysis, long-term home-based care (including adult day health services, homemaker services, home health aide services, and more) was found to range between $15,900 and $18,200 a year, while facility-based LTC (including care received in assisted living, a semi-private room in a nursing home, or a private room in a nursing home) ranged between $39,600 and $81,000[7] (Colello et al., 2012, p. 5).

In response to the heightened need for long-term care services (due to the growing older adult population), and the higher cost of facility-based LTC, the ACA has implemented provisions that will encourage an increase of HCBS in order to decrease reliance on facility-based care. This process of moving away from facility-based care for LTC beneficiaries and toward home-based care is often referred to as *rebalancing* (Colello & Talaga, 2011). This rebalancing not only lowers the costs of LTC, but it also satisfies those LTC beneficiaries who want to remain in their homes and communities rather than receiving LTC in an institution. This shift toward HCBS predates the ACA, and the ACA should be seen as a continuation of the existing federal trend to shift spending from facility-based care to HCBS.

LTC in Indian Country: Availability and Key Access Barriers

According to a 2011 CMS report conducted by Kauffman & Associates, Inc., most tribes (of 209 surveyed) only had access to a few important long-term care services (Kauffman & Associates, Inc., 2011). Only 2-13% of tribes had access to assisted living, NHs, adult day care, and hospice care (compared to 84%-92% of tribes that had access to home-delivered meals and nutrition site programs). These results reflect the reality that access to LTC services has been very limited for AI/AN people in tribal communities. It is more common to have NFs in Indian Country than SNFs; SNFs are more costly to run and it is difficult to provide sufficient staff for 24-hour skilled nursing services in Indian Country. For additional explanations of service delivery methods for long-term care, see Appendix 1 on Long-Term Care Service Types.

Logistical, financial, and cultural factors have served as barriers to LTC for AI/ANs, especially geographic isolation, poverty, and the cultural perspective of caregivers (Jervis, Jackson, & Manson, 2002). Another barrier to access of LTC services is the shortage of administrative support (e.g., case managers, billers, access specialists) to help potential beneficiaries of LTC services navigate those LTC services that are available (Hassin & Shah, 2010). Prior to the ACA, Jervis et al. (2002) found that bureaucratic requirements and related issues such as the large amount of required paperwork served a major role in impeding access to LTC. Administrative support is further necessitated by the complicated state of LTSS funding in Indian Country, as there are multiple funding sources for tribal facilities, and reimbursement rates for services

[7] These estimated costs for facility-based LTC are reportedly low, at least in comparison to facility-based care in other states such as Alaska, per Turner Goins of the Center on Aging and Department of Community Medicine, West Virginia University (Personal communication, June 2013).

differ on a state-by-state basis. As these studies have demonstrated, a lack of sufficient administrative assistance for AI/AN people greatly challenges AI/AN access to LTC.

Anticipated Impacts of LTSS-Related Provisions in Indian Country

Three main areas of health reform legislation are anticipated to impact long-term care in Indian Country:

1. ACA provisions regarding NHs,
2. ACA provisions regarding HCBS, and
3. provisions of the Indian Health Care Improvement Act (IHCIA), as reauthorized by the ACA.

Generally speaking, the ACA provisions that have to do with NHs are aimed at improving the access to and quality of care delivered in NHs. The provisions pertaining to HCBS encourage states to shift long-term care spending from facility-based long-term care to home- and community-based care. Finally, the provisions from the reauthorized IHCIA address staff shortages and third-party reimbursements, approve the provision of and billing for LTC services, and increase facilities and resources through authorities to share with other government agencies and IHS or tribal health programs.

The ACA is divided into numbered sections, each of which describes a provision, or federally mandated requirement, to be implemented as part of health care reform. In this report, specific ACA sections are identified by number. See Appendix 2 for a comprehensive list of ACA and IHCIA sections related to long-term care.

The overview and analysis of ACA provisions contained in this report indicate that much of the impact of ACA provisions on LTC in Indian Country had yet to be realized, as of the summer of 2013. The Supreme Court ruled in favor of the ACA on June 28, 2012, and, since then, many of the provisions are still only in the beginning stages of implementation (Kaiser Family Foundation). Partly, ACA provisions were designed for multiphase implementation, with the bulk of policy becoming active in 2014. In addition, some provisions, such as Medicaid expansion and other demonstration programs, are optional for states to implement, and their impacts in Indian Country will depend on whether states in which particular tribes are located opt to take up these provisions. Furthermore, some provisions of the ACA and IHCIA are unfunded and need further appropriations to create meaningful change. Limited infrastructures of some tribal facilities are estimated to act as a constraining force, making implementation a challenging and time-consuming process.

Anticipated Impact of ACA Provisions on Nursing Homes

The provisions that pertain to institutional care facilities will apply to all NHs throughout the country—not specifically to facilities in Indian Country. The impacts for Indian Country facilities are anticipated to mirror the intended implications for NHs generally.

The anticipated impact of the ACA on NHs are numerous and include heightening the protection of and care given to nursing home residents, raising the accountability and transparency of nursing facility operations, and improving the training of personnel in the LTC workforce. The key anticipated impacts are outlined by provision number in Table 3. A more detailed description and projected impact of each mentioned provision can be referenced in Appendix 3. As indicated in Table 3, ACA policy is generally directed to both Medicare-certified SNFs and Medicaid-certified NFs. On occasion, provisions specifically identify one type of facility. For example, Provision 6104, on expenditure reporting, is targeted toward SNFs.

Table 3. Anticipated impact of ACA provisions on nursing homes

Anticipated Impact (Increase)	Provision Number	Description
Protection of NH Residents	6105	Creation of a standardized complaint form to be used by SNF and NF residents and their representatives
	6111	Penalty fees for SNFs and NFs reported to deliver substandard care
	6113	Requirement for SNFs and NFs to giving notice to residents prior to facility closure
	6201	More extensive background checks on staff (nurses *and* all other staff members that come into direct contact with residents)
Transparency of NHs	6101	SNFs and NFs must disclose information on owners and interested parties
	6106	SNFs and NFs must disclose the number of hours of care given per resident per day
	6107	SNFs and NFs will be rated using a 5-star rating system visible on a “Nursing Home Compare” website

Anticipated Impact (Increase)	Provision Number	Description
Consumer Access to Information on NHs	6103	Creation of the Nursing Home Compare website for consumers that includes Medicare and Medicaid-certified NHs
	6104	Requirement for SNFs to report expenditures (including expenditures for wages and benefits for direct care staff)
	6107	Consumers (patient families) will be able to view 5-star rating system of NHs
Training and Number of NH Staff	6102	Ethics training for staff of SNFs and NFs
	6121	Dementia and elder abuse prevention training for SNF and NF staff
	5302/5305abc/ 5307	Geriatrics training and availability of grants for professionals to teach and practice geriatric LTC
Quality of Care	6114	Demonstration projects to test out the use of IT to improve care at SNFs and NFs
	6201c	SNFs and NFs will be directed to create an infrastructure that aids the collection of data, the identification of problems, and creation of strategies to improve care

Anticipated Impact of ACA Provisions on HCBS

As with provisions targeting NHs, provisions that address HCBS do not specifically target Indian Country programs; rather, these provisions apply to HCBS programs across the nation. Consequently, the implications of ACA provisions for HCBS in Indian Country are expected to resemble the anticipated impacts for HCBS programs in the rest of the United States.

For example, the financial incentives that will be offered to states, through various ACA provisions, to shift LTC spending toward HCBS and away from facility-based LTC services should be equally felt in tribal communities as the rest of the country. As a result of these financial

incentives, over time, older AI/AN adults and persons with disabilities will likely increase their use of new options for receiving care in home and community settings. This substitution of facility-based care by HCBS is explained by the fact HCBS provides an attractive alternative to states, LTSS beneficiaries, and the families of individuals receiving long-term care. Specifically, states will spend fewer resources on LTSS, as the more cost-effective HCBS models satisfy demand for LTSS that previously would have been filled by long-term care facilities. In regard to LTSS beneficiaries and their families, HCBS will likely be viewed as a preferable form of LTSS, since AI/ANs who otherwise may have sought care from a LTC facility located far from home or in off-reservation settings can now remain in the tribal community.

With the new or enhanced programs such as the Money Follows the Person (MFP) and the Community-based Care Transitions (CCTP) programs that support the transition of LTC beneficiaries from facilities to home or community settings, patients or their families will likely opt for family members to be transitioned from LTC facilities to their communities to receive home-based care. Over time, if increased policy support and funding incentives make HCBS programs a more common and feasible alternative to facility-based care, then along with increasing HCBS programs' capacity, these shifts could potentially contribute to NHs, including those in Indian Country, facing lower occupancy rates. If rebalancing incentives toward HCBS prove successful over the long term, to the extent that more LTC clients are successfully transitioned into HCBS, NHs might find it advantageous to begin or continue providing shorter-term rehabilitation services in-facility to Medicare patients and out-of-facility services to Medicaid patients requiring HCBS, to offset revenue losses resulting from reduced demand for NH services.

The anticipated impacts of these provisions, for states that choose to implement them, are outlined by provision number in Table 4. For a more detailed description and impact of each mentioned provision, please see Appendix 2.

Table 4. Anticipated impact of provisions on HCBS

Anticipated Impact	Provision Number	Description
Help to transition beneficiaries from facility-based LTC to HCBS.	2403	The MFP program will (continue to) provide funding to enable beneficiary transitions.
	3026	The CCTP will provide funding to enable beneficiary transitions.

Encourage states to use LTC budget on HCBS instead of facility-based LTC	10202	Gives states incentives (an enhanced federal matching rate for a state's Medicaid spending) to shift LTC spending from facility-based care to HCBS.
	2401	The Community First Care Option also offers an enhanced federal matching rate to states that shift their Medicaid spending to HCBS.
	1915(i)	The 1915(i) option covers HCBS even for those beneficiaries who don't qualify for facility-based care.
Help keep beneficiaries in their homes, rather than in facilities	3024	The Independence at Home Program provides primary medical care to beneficiaries in their homes. This is expected to reduce the number of patients who are institutionalized unnecessarily due to transportation issues.
Encourage use of a comprehensive HCBS	2703	The Health Homes Option adds a comprehensive kind of community-based LTC care option for states.

Anticipated Impacts of IHCIA Provisions on LTC

Provisions of IHCIA have the potential to increase local care options and services, including those pertaining to LTC, through:

- augmenting the work force by authorizing (and providing potential scholarships or stipends to) IHS, tribally owned or operated health clinics, and urban Indian health programs (I/T/Us)[8] to recruit, train, and retain care providers at these facilities;
- increasing resources by formalizing the sharing of medical facilities, staff, and services between tribally operated facilities, IHS, and the Department of Veterans Affairs and Department of Defense (HHS, 2010);

[8] I/T/U is an abbreviation referring collectively to the three facility or program types that make up the Indian health care system: IHS facilities, tribally operated health facilities, and urban Indian health facilities.

- allowing IHS, tribal, and urban Indian health facilities to include LTSS services in their budget, contract, or compact funding agreements;
- allowing states to claim 100% Federal Medical Assistance Percentage (FMAP) for LTSS provided through IHS or tribal health programs; and
- facilitating the reimbursement process generally by affirming I/T/Us' ability to collect reimbursements from Medicare, Medicaid, and private health plans and ensuring that I/T/U facilities be treated as the equivalent of preferred providers under federal health plans.

These anticipated impacts are outlined, by provision number, in Table 5. For a more detailed description and impact of each mentioned provision, please see Appendix 2.

Table 5: Anticipated impact of IHCIA provisions on LTSS

Anticipated Impact	Provision Number	Description
Reduce provider shortages	123	Authorizes IHS to train and support alternative provider types, such as community health representatives and community health aides.
	124	Exempts tribes from paying provider registration and licensing fees imposed by a federal agency.
	106	Authorizes for the establishment of programs that will provide scholarships and stipends to draw professionals to IHS.
	221	Exempts health professionals employed by a tribal health program from that state's licensure requirements (as long as they are licensed in another state).
	705	Authorizes IHS to establish a mental health training program for AI/ANs to provide mental health care.

Anticipated Impact	Provision Number	Description
Potentially increase revenue for LTSS and facilitate the reimbursement process	201	Authorizes IHS to include LTC in their compact budget and include LTC in their scope of services.
	401	Affirms ability of tribally owned or operated facilities to collect reimbursements directly from federal health programs, such as Medicare, Medicaid, CHIP, or any other third-party payor.
	711	Potentially provides grant money for community-based behavioral health programs.
	408	Mandates that qualifying I/T/Us receive payment from federal health programs without discrimination (I/T/Us must be considered the equivalent of preferred providers for reimbursement purposes, so long as they meet generally applicable state or other requirements).
	206	Authorizes I/T/Us to collect reimbursements from liable third parties.
	207	Mandates that the receipt of third-party reimbursements will not lessen amount received in contract money allocations.
	402	Authorizes the use of IHS funds to purchase insurance for employees.

Anticipated Impact	Provision Number	Description
Increase other resources for LTSS programs	405	Authorizes facility and service sharing between IHS, tribally owned or operated facilities, and federal organizations like the Veterans Affairs and Department of Defense facilities and services.
	822	Authorizes facility and staff sharing between IHS and tribally owned or operated LTC facilities.
Reduce cost sharing	222	Mandates that patients cannot be held liable for payments and cost-sharing for authorized contract health services.
Potential construction of new health facilities	312/313	Provides authority for IHS to fund construction of new types of health care facilities using modular components, and authorizes IHS to fund new ways to provide health care in Indian communities such as mobile health stations. Construction of facilities is contingent on reallocation of existing funds or additional appropriations to IHS.
	509	Provides authority for IHS to fund urban facility renovations.

These projections were made with the awareness that appropriations will be necessary to support many of these provisions, especially those pertaining to training and staff incentives and using IHS funds for LTC. From the perspective of funding and resources, LTC is new program category that will compete with other budget lines for a portion of the existing pool of IHS funds, which are already widely regarded as inadequate to meet the system's needs. If additional appropriations are not provided, the impact of these provisions may be significantly reduced.

Despite the difficulties of ensuring adequate funding for LTC with limited IHS resources, the fact that IHCIA explicitly grants IHS the authority to fund LTC is still an important gain, for several reasons:

- This new authority creates the possibility that **future IHS appropriations can be allocated to LTC**.

- Including LTC as allowable services under IHS means that Indian Country **physicians offering LTC services are protected under the Federal Tort Claims Act** (FTCA). FTCA coverage would replace physicians' liability insurance, offering a substantial cost-savings to LTC programs.
- **Services provided under IHS authority also qualify for GSA purchasing**. Especially for pharmeceuticals, the option for government purchasing can offer substantial new savings for LTC programs.

While an increase in IHS appropriations to address LTSS needs seems unlikely in the near term, the ACA's expansion of the Medicaid eligibility to 133% of the federal poverty level, a central pillar of health care reform, creates another opportunity to finance LTSS needs in Indian Country. According to a recent analysis of AI/AN census data of states with IHS service units, tribally operated programs, or urban Indian health programs, nearly 500,000 uninsured AI/ANs will be eligible for Medicaid under the new eligibility definition (Fox, 2012). As the primary payer for LTSS, Medicaid coverage would increase access options for those uninsured AI/ANs currently in need of LTSS, in addition to providing access options for future LTSS needs of this same population. Higher rates of Medicaid enrollment would also allow LTSS beneficiaries, newly covered by Medicaid expansion, to access a greater network of primary and specialty medical services, since Medicaid-enrolled AI/ANs will no longer be limited to IHS care providers or constrained by the availability of Contract Health Service funding.

In addition to increasing individuals' options for care providers, Medicaid expansion has the potential to increase third-party reimbursements for I/T/U health programs and, in turn, allow I/T/U health programs to reallocate limited IHS funding to other areas of critical need, such as LTSS. Because Medicaid is the largest payer for LTSS, increasing the number of Medicaid beneficiaries by expanding Medicaid eligibility will likely create a valuable new pool of funding to supplement limited IHS and tribal resources in providing LTC in Indian Country.

Anticipated Obstacles to Implementing Provisions

The implementation of LTC services will likely vary considerably as a result of the diversity of LTSS needs and available resources of each of the 566 federally recognized tribes, in addition to the variability in how states structure Medicaid and LTSS waiver programs. Tribal facilities often differ from mainstream health care systems in available budget, populations served, and geographic location. Unlike non-tribal facilities, some tribally operated LTC programs receive financial support from the local tribal government, though the ability and willingness to provide financial assistance can vary widely among tribes. This, however, is not always the case; delivery of all types of health care in Indian Country is frequently constrained by a lack of resources and infrastructure. In this context, new national requirements for NHs have the potential to further burden already strained LTC program budgets in tribal communities. While new requirements such as staff training require a commitment of resources from any institution, I/T/Us might find themselves funding these requirements with a budget that is proportionally much smaller than that of most non-Indian health facilities.

Furthermore, new reporting requirements in the ACA may place significant pressure on tribal facilities' limited technological infrastructure. Electronic reporting, an activity necessary to implement several of the provisions above, requires appropriate computers and other hardware, software packages, and high-capacity Internet connectivity. While not every long-term care program in Indian Country will face health IT obstacles, those programs operating in rural and remote areas, where broadband Internet is generally not available, will likely face considerable challenges to acquiring and integrating advanced computer technology into health systems.

The ACA aims to provide some grants for NHs in the areas of background checks, training grants, and supplementary education programs. These resources have the potential to increase accountability and quality of care in Indian Country NHs. However, it was not yet known how many facilities will receive and benefit from these grants and how these grants would facilitate NHs, including those in Indian Country, to meet these new requirements. The potentially limited dispersion of grants was estimated to result in slower implementation of these provisions.

Part 2. The Impact of Health Care Reform on Nursing Homes in Indian Country: Administrator Phone-Interview Study Results

To investigate how ACA provisions have impacted long-term care facilities in Indian Country, this report includes the results of a qualitative study that gives voice to those "on the ground," addressing long-term care needs in tribal communities. Specifically, phone interviews with administrators at NHs in Indian Country were conducted to determine current and future anticipated impacts of health care reform provisions on NHs in Indian Country.

These phone discussions with NH administrators explored:

- how informed NH administrators were about relevant provisions in the ACA and IHCIA, as reauthorized within the ACA, and
- how NH administrators are dealing with, or anticipate they will deal with, these health care reform provisions.

Results: Main Themes

The early stage of implementation of the health care reform provisions played a large factor in the study results. Two main themes emerged during the phone interviews:

- administrators lacked comprehensive awareness of ACA provisions or their impacts at this point, and

- the provisions were not reported to have had a major impact on NHs.

The following sections describe the main thematic findings of this study: (1) various reported reasons for a lack of impact thus far, (2) the limited impacts that have been observed, and (3) anticipated future impacts of the reform provisions.

Noted Lack of Impact Brought About by ACA/IHCIA Provisions

Limited awareness

The most common theme raised by respondents was a lack of awareness of ACA and IHCIA provisions, especially IHCIA provisions. Most NH administrators were aware of health care reform, in a broad sense, but consistently reported that they were not aware of, nor had they received information about, provisions of the ACA and IHCIA relevant to NHs.

Administrators reported that they had not received information on ACA or IHCIA provisions related to NHs, even from expected sources, such as federal agency communications, health care conferences, or tribal information events. No respondents reported receiving emails or letters from CMS or IHS about health care reform provisions and their anticipated impacts on NHs. Even a facility administrator who attended a twice-yearly CMS health care association conference reported not encountering any information at the conference regarding the ACA and IHCIA. Another administrator attended an IHS event on the ACA and IHCIA that, in the administrator's opinion, indicated that (at least at that time) IHS had little information on how health care reform would impact LTC facilities. A different administrator reported that their tribe had advertised meetings on the impact of the ACA. In the one such meeting this respondent had attended, the information presented was "sketchy, if anything" and reflected only the "skeletal framework" of health care reform.

When asked about their level of knowledge of health care reform, one administrator commented that, to receive more detailed or actionable information, they would have to research it themselves:

> I'm not going to get the information [on ACA or IHCIA]. It's not going to be forwarded to me, I can tell you that. It would be something that I'm going to have to find out where some places are that I could start researching this.

Other administrators echoed the need or desire for more research on the topic, but few had conducted independent research; those who did commented that it had not yielded sufficiently clear or relevant information. More often, administrators said they neither had the direction nor the available time to conduct independent research on the new provisions.

A possible reason that NH administrators had not received sufficient information about health care reform provisions may be that CMS and IHS have yet to issue this information. Alternately, as several respondents suggested, guidance disseminated by federal agencies may not be reaching their intended audiences. As one administrator commented, "I personally haven't

received that information. If it's being lost someplace in the shuffle within the tribe, I don't know." A related factor is that a majority of the administrators contacted were either relatively new to the facility or to the administrator position. (Administrators reported having been in their current position from 7 months to 2 years.) In other cases, the administrators interviewed were actually interim or onsite administrators. In two cases, onsite administrators suspected that any potential communications about the ACA or IHCIA provisions were being sent to an offsite administrator.

As a final point, there was a notable lack of awareness of specific IHCIA provisions. This may be tied to the fact that at least three of the administrators were new to Indian Country and had not worked in a LTC facility in Indian Country before. In sum, because the majority of the administrators were not clear about the provisions themselves, they were unable to project a comprehensive understanding about the impact of these provisions on their facilities.

Lack of time to observe the impact of the provisions

Even for provisions that select administrators were aware of, administrators commented that it was simply too soon to have gained an adequate sense of their impact. Supporting this, one administrator stated,

> [A]s more of the ACA is implemented, then some of our first-hand experiences, some of what happens, is going to become more apparent. […] A lot of it right now is speculation, and a bunch of these pieces [of ACA legislation] don't hit for a little while longer.

Given more time, it is likely that impacts of the provisions on LTC programs in Indian Country will become more evident.

Lack of impact for individual provisions

The background research conducted for this study suggested that LTC facilities in Indian Country would now potentially have the ability to bill at a higher rate and would more easily be able to collect reimbursements from third parties. In addition, facilities were expected to be preparing for or implementing new requirements in training and quality assurance, and potentially experiencing the effects of additional state incentives to fund HCBS over facility-based LTC.

The phone-interview study, however, revealed that the impacts of individual provisions were less obvious and less wide-reaching than anticipated. Aside from one facility that had opened only 2 years before (and thus had no pre-ACA operations experience), the majority of the administrators shared the opinion that health care reform had not greatly impacted their facilities.

The following paragraphs include a variety of explanations that NH administrators gave as to why they felt that provisions—including those having to do with billing rates, reimbursements,

incentives for HCBS, and quality of care requirements at NHs—had had little to no impact thus far.

No appropriations for LTC. While the IHCIA gave new authority for IHS and tribally operated facilities to include LTC services in their compact funding and their list of offered services, administrators commented that this new authority was not accompanied by any funding. With no new funding available, respondents believed it is only in language, not practice, that facilities will be able to provide and fund LTC services. As one administrator commented, "The elder services and long-term care services is really an unfunded mandate in our viewpoint... [Congress has] authorized IHS to provide these services, but they haven't provided any funding."

While the new authority gives facilities more flexibility in how to use their funds, without additional appropriations, facilities would have to reallocate IHS funding from other areas of need in order to fund LTC.

No new use of an enhanced billing rate for IHS and tribal programs. Based on background research, KAI anticipated that LTC providers operating under IHS and tribally operated programs would now have the ability to bill Medicaid using an enhanced rate for LTC services. A subject matter specialist explained that these expectations were widespread: when IHS received the authority to include LTC in funded services, many believed that this new authority would be supported by the establishment of an IHS nursing home rate—a billing rate that would cover LTC services—in addition to the existing IHS encounter rates for hospital and outpatient, neither of which cover LTC.

Interviews revealed that this was not the case. Some administrators expressed confusion about whether a new rate, one that would cover outpatient rehabilitation or other LTC services, had been created. One administrator stated definitively, "I'm certain that IHS doesn't negotiate a long-term care bed rate with CMS. They just do inpatient and outpatient."

None of the interviewed NH administrators reported any change in billing rates. Only one administrator mentioned a potential change in rates. This administrator was in the process of negotiating with IHS and their state for an enhanced rate for LTC services, but had yet to hear any response from the state about whether this would happen. Another stated that they were not aware of, nor did they understand, the process of getting a rate different than the flat fee offered by their state.

The majority of the facilities expressed interest in a potential IHS rate for NH care. However, all respondents shared the sentiment that it would be difficult to determine such a rate, especially in deciding whether a federal NH care rate would be based on an estimated cost-of care or a daily rate.

Minimal impact from the federal push for HCBS. While ACA incentives encourage states to spend on HCBS over facility-based LTC, only two facilities interviewed indicated that they were investigating adding HCBS to the services they provide. One facility hoped to offer volunteer-based HCBS such as personal care, nursing care, or meal deliveries within the next year using

volunteers from their facility staff. The second facility affirmed that their tribe had been discussing the possibility of branching out into HBCS for the last 2 years. This facility also discussed a restorative program to help patients with mobility, enabling them to remain in their homes. The plans of these two facilities, however, were motivated less by ACA incentives, and more by the desire to offer all needed services to tribal members.

The remaining respondents expressed very little concern that the state incentives for HCBS would impact NH occupancy rates or would necessitate that NHs transition into HCBS. Multiple facilities reported that there was such a high demand for their current nursing home services that they did not foresee a reduction in this demand in the future. As one administrator described it, "That's really supply and demand, and we have a lot of demand for the services here, because we're the only game in the region." Additionally, some facilities worked closely with, or were at least in communication with, other service providers who already sufficiently addressed the HCBS needs of local older adults and adults with disabilities. Two administrators mentioned that their tribes already had a home care program that was organizing some degree of HCBS for tribal elders. Another mentioned that personal care services and a small degree of assisted living were already available in their area. One facility administrator commented that there were a number of HCBS providers in their area, including Title 6 caregiver services, basic nursing aides, some diabetes care conducted by nurses, basic homemaker services, community health resources (a part of IHS), congregate prepared meals in a senior center, and Meals on Wheels food deliveries to patients' homes. Given these reasons, most administrators did not envision a need to branch into HCBS themselves.

NH administrators also described barriers that they felt would prevent or discourage their facility from expanding into HCBS. Two facilities mentioned that even if there were an increased local demand for HCBS, or a state pressure to offer HCBS, they would not have the staff to support such an expansion of services. One administrator commented, "We don't have enough staff to provide those [HCBS] services. We've barely got enough nurses to meet our need here [at the nursing facility]." Another administrator spoke about HCBS as though it primarily included offering skilled nursing care in an individual's home, and did not express an understanding of the possibilities of offering personal care services that did not require registered nurses or stringent licensure processes to organize. In addition to these complications, one facility commented that HCBS presented an employment dilemma, because HCBS for individuals often only comprised a few hours of care per week. In this situation, the administrator explained, "you're trying to piece together hours to create a position [that is] meaningful employment for someone," which can be especially challenging in small villages. The same administrator also mentioned that the Medicaid rate did not appropriately cover the cost of HCBS services—another reason discouraging NHs from offering HCBS.

A different administrator predicted that the occupancy rates of NHs would not go down in the future, especially if NHs offered short-term rehabilitation and maintained a low hospital re-admittance rate—a key factor in determining whether or not a hospital will use a particular transitional care provider.

No impact by the Money Follows the Person (MFP) program. Overall, NH administrators were unfamiliar with the MFP program. Two facility administrators had never heard of the MFP program and expressed great interest in a program that would help transition patients from facilities to home and community care settings. A different administrator had heard of the MFP program but had simply not had any dealings with it at their facility. Another administrator reported that, in several states where they had worked, the MFP program had been used primarily for care for individuals with disabilities, but not for transitional care for elders—as they remarked, "money doesn't follow other people" who don't have a disability diagnosis.

One complicating factor for the MFP program is that, as one facility administrator pointed out, elders may not have a place to return to within their communities. In terms of the tribal-specific ACA-introduced MFP Tribal Initiative,[9] many facilities had not been impacted by this program for two reasons. First, only those states that had participated in the MFP program prior to the ACA could qualify for the MFP Tribal Initiative. Second, even for those facilities that had participated in the MFP program prior to health care reform, funding for the program had been indefinitely postponed.

No impact from the provisions aimed at quality of care delivered in NHs. Most facilities were unfamiliar with the ACA provisions for NHs. Many of the facilities interviewed were *nursing facilities* (institutions whose services do not including 24-hour skilled nursing care), as opposed to *skilled nursing facilities* (institutions providing 24-hour skilled nursing care onsite), and many nursing facilities felt that the ACA provisions related to institutional care did not technically apply to them as they would to SNFs. When further questioned, however, these NFs reported that they nevertheless already met many of the ACA provisions for institutional nursing care, even before the ACA provisions were released. For instance, two facilities were already (before the ACA) conducting extensive background checks for all direct and indirect staff members at their facility. Another facility also already conducted extensive background checks in addition to training modules for staff on dementia awareness and elder abuse prevention. Another administrator discussed how their facility participated in annual trainings both through their state's health care association and board of nursing. More than one facility was already offering a CMS-based elder abuse training module ("Hand in Hand") for their staff. One administrator was unsure if this was the same as the IHCIA-based trainings or not.

Administrators expressed confusion as to whether the use of loan-forgiveness grants was the same or different from the ACA/IHCIA-based financial incentives for recruiting and retaining staff. More than one administrator admitted that they were not aware of the IHCIA provisions pertaining to exemption from provider registration and licensure fees, and the exemption for in-state licensure (as long as the provider is licensed in another state). Most, however, anticipated that these new exemptions would be very helpful. Nearly all of the NH

[9] The MFP Tribal initiative is a funding program aimed to help AI/AN communities develop infrastructures to support community-based LTC services for AI/AN people.

administrators interviewed were also unaware of the provisions having to do with scholarships, stipends, and other incentives to recruit and retain (geriatric) LTC staff at tribal facilities.

Most of the administrators at NHs were aware of the upcoming Quality Assurance and Performance Improvement (QAPI) requirements. While many facilities had active quality assurance programs at their facilities, a number of the administrators were aware that CMS would be releasing new QAPI regulations, and some were already discussing these future QAPI developments. However, as one administrator commented, because CMS hasn't issued final regulations or specified a start date, "it's just been floating and waiting."

As an exception, one facility—whose management company possessed a QAPI division—had already been involved in some meetings, conference calls, and other preliminary preparations for their upcoming QAPI program.

No facilitation of the reimbursement process. The pre-study review of the new provisions suggested that health care reform would enable more facilities to recover reasonable charges from third parties (IHCIA Section 206), and that the process of receiving reimbursements should become easier (IHCIA Sections 401 and 408).

Despite the new ability to collect reimbursements directly from federal programs rather than having to go through the IHS (IHCIA 401) or the new law that states that I/T/U programs must be allowed to participate and be reimbursed by federal health care programs to the same extent as any other provider (IHCIA Section 408), no facilities had experienced a notably easier time receiving reimbursements from Medicaid. Three facility administrators expressed that they still felt they had to undergo the same kind of complicated negotiations for reimbursements from Medicaid as they had done before the ACA. One administrator, new to NHs, struggled to understand why particular claims were denied by Medicaid. One administrator commented that they did not experience difficulties getting reimbursements, but added that "it won't be any easier [due to the ACA]." Another mentioned that they did not currently experience difficulties with reimbursements, nor had they experienced notable difficulties prior to the ACA. Thus, at least at this time, the ACA was not felt to have facilitated the reimbursement process.

No impact because provision requirements are not new. As indicated under many topics above, NH administrators reported that numerous ACA requirements, including training, reimbursement, quality assurance, and others, described practices that are already largely in place in both skilled and non-skilled nursing facilities. As one administrator stated, "There are very few settings where the individual facility will not be doing something similar to what they're going to be required to do under the Affordable Care Act."

Rather than viewing ACA and IHCIA provisions as novel, it appears more accurate to view many of the provisions as pre-existing practices now put into law by the ACA. (The notable exception is the new IHS authority to include LTC in their scope of services.) The fact that so many ACA and IHCIA requirements and practices are already in place supports the larger finding that the

impact of health care reform provisions on NHs in Indian Country is less significant than anticipated.

No impact from Medicaid expansion yet. At the time of this study, the Health Insurance Marketplace had not yet opened, and the expansion of Medicaid eligibility to those below 138% of the federal poverty level had not yet occurred. Consequently, NH administrators were not yet able to adequately comment on how expanded Medicaid eligibility or the increased availability of private insurance would impact patient populations. One administrator was unsure about what Medicaid expansion entailed. In addition, some facilities interviewed were located in states that have already chosen not to participate in Medicaid expansion (e.g., Alaska, Nebraska).

Instead, the study asked administrators to project the potential future impacts of Medicaid expansion; these estimations are summarized below in the section on the future anticipated impacts of health care reform.

No new partnerships or sharing with other facilities. NH administrators reported minimal impact from the provisions helping to create new partnerships or facilitating the sharing of resources with other facilities or programs. The majority of facilities stated that they did not have any new partnerships and did not share staff, resources, or facilities with other organizations. One, however, did state that they had a Memorandum of Understanding between their facility and IHS for referral services such as physical therapy. This NH administrator communicated with other facilities in order to help relocate tribal members from distant facilities to the tribal NH, but this was in place prior to the reform provisions. Another administrator commented that their rural location discouraged partnering with other facilities, despite their potential interest in doing so. Finally, a facility administrator expressed a sincere interest in staff and information sharing between facilities, especially sharing of limited staff in rural areas, but was not aware if this was allowed by their state.

No impact in Indian Country; focus of provisions is off target. A major factor in the lack of impact observed by NH administrators on LTC facilities in Indian Country is that health care reform provisions focus primarily on expanding eligibility for Medicaid or private health insurance. However, in Indian Country, the main limiting factor in receiving care is not *eligibility* for care (by definition, all AI/AN people are eligible for care through IHS or tribal providers), but rather the *availability* of staff, funding, equipment, or other resources required to deliver care. One administrator explained,

> [The Affordable Care Act] mandates that insurance plans contain benefits that are either historically excluded or weren't necessarily available […but] that's not really an issue for the tribal members who are under Indian Health Service […] it's more that sometimes they're not available because of waiting lists or Contract Health, but it's not a matter of eligibility.

An important outcome of health care reform is an increase in opportunities for IHS and tribal programs to bill other payers, such as Medicaid, private insurance, and others. Interestingly, the

possibility of greater revenue for LTC programs through new payers—which could then increase program capacity to hire providers and purchase equipment—was not mentioned during these interviews.

Noted Impacts of Health Care Reform Provisions

The predominant finding was a less-than-anticipated reported impact of the health care reform provisions on NHs in Indian Country. However, NH administrators also mentioned a number of ways that ACA and IHCIA provisions *had* impacted LTC generally, or their NHs specifically. Below is a summary list of impacts or changes noted thus far.

- **New LTC authority.** While LTC facilities existed and were funded in Indian Country prior to health care reform, the new legal authority meant that facilities no longer needed to negotiate with IHS in order to add LTC services to IHS compacts. One administrator explained that, prior to IHCIA reauthorization,

  > we fuss[ed] around with language that talked about the medical services portion of elder care […] because they didn't want to cover any of the custodial requirements or services. But now […] clearly Congress has authorized IHS to provide long-term care services.

- **Diversify LTC facility scope of services.** Some facilities reported working to expand their scope of service to include shorter-term rehabilitation and post-hospital care services. One facility commented that they had already gone through three rounds of paperwork to get their Medicare certification, in order to take on more rehabilitation patients. It is not certain that this interest in Medicare certification is due to the health care reform provisions or simply due to the fact that Medicare reimbursements were higher than Medicaid rates.

- **Simplified/expedited hiring process.** One administrator noted that hiring had been simplified because tribal health providers were no longer required to be state licensed (as long as they were licensed in another state, per IHCIA 134). The facility experienced a wider hiring pool, an ability to fill positions in a timelier manner, and "more flexibility to bring on someone with an out of state license while they're getting their state license."

- **QAPI program development.** Most facilities were aware of the upcoming QAPI program regulations. One facility had already begun thinking about their upcoming QAPI program by having meetings and conference calls with other facilities and working on potential areas of focus in future QAPI regulations (such as fall prevention). This facility also mentioned the need for QAPI best models to emulate.

- **Inclusion of HCBS.** Several facilities are investigating a transition to providing increased HCBS. While the ACA incentivizes increased use of HCBS for LTC needs, it is uncertain whether these discussions to offer HCBS were caused by health care reform or simply by the desire to offer needed services within their communities.

Anticipated Future Impacts of the Health Care Provisions

Various impacts were noted by administrators as likely to occur in the future, as health care reform progresses. This section lists the projected future impacts mentioned in the interviews.

- **Increased knowledge of provisions and impacts.** Administrators anticipated that, as more health care reform provisions take effect, their impacts will become easier to identify. One administrator reported, "as more of the ACA is implemented, then some of our first-hand experiences [will] become more apparent, [even if this is] slightly after the fact." As administrators in key positions learn more about relevant provisions, either from experience or from information or education provided by other sources, they will be better positioned to take advantage of opportunities in the ACA and to make any needed adjustments to facility business models.

- **Leverage for state rate negotiation.** One administrator commented that the 100% Federal Medical Assistance Percentage (FMAP) to states provided for LTC offered in tribally operated facilities will, in the future, give facilities leverage when negotiating for state funding and state rates. This administrator hypothesized that this future potential enhancement of revenue from Medicaid would, in return, free up IHS money for other areas of need.

- **Increased billing to third parties.** With the expansion of Medicaid eligibility, administrators estimated that more people would become eligible, enabling LTC facilities to bill Medicaid more for services provided. Administrators hoped this would also result in more reimbursements to LTC facilities. Specifically, one administrator mentioned their hope that the greater number of Medicaid-eligible patients would result in more reimbursements that could be allocated to areas of critical need, such as major repairs, that currently pose a huge challenge.

- **Increased number of residents due to Medicaid eligibility expansion.** With expanded eligibility for Medicaid, administrators anticipated that more individuals would become eligible for care at LTC facilities, increasing occupancy rates.

- **Other revenue streams.** With AI/ANs able to purchase qualified health plans offered on the Health Exchange Marketplace, administrators commented that facilities would soon be able to bill health insurance plans, likely at a better rate than Medicaid. This potential new source of revenue could offset losses resulting from some states' low Medicaid reimbursement rates. This new billing capacity could supplement Medicaid and Medicare revenues. One administrator noted that if more AI/AN patients have additional insurance coverage, "when they come to the nursing home, they have additional resources they can potentially tap to help the facility maintain itself."

- **New protections.** Now that LTC is an authorized IHS service, LTC facilities operating under IHS or tribal health programs are now able to benefit from tort protections under the

Federal Torts Claim Act (FTCA). However, few facilities seemed aware of this; the one administrator who mentioned this explained that, at least in his case, there has been no response from the IHS to his inquiries about what these new protections might entail.

- **Enhanced QAPI programs and quality of care at SNFs.** Administrators anticipated that, in the future, QAPI programs would become more extensive, leading to further improvements in the quality of care at SNFs. As described above, much of this process is delayed until the new regulations are confirmed and released.

- **Ongoing Medicaid enrollment and eligibility complications or delays.** Several administrators projected that, whether states participate in Medicaid expansion or not, getting people enrolled in Medicaid will continue to be difficult. An administrator reported new patients who were left in a Medicaid-pending status for months, resulting in the facility having to cover the costs of services provided. As a result, facilities have become "leery of just admitting people on face value," assuming that Medicaid enrollment will follow. Instead, patients in a Medicaid-pending status may increasingly be turned away by facilities.

- **Increased number of LTC facilities and services.** Despite only two facilities projecting that they would branch out into HCBS, another administrator mentioned that in the long term, NHs would likely transition into Medicare short-term, post-hospital rehabilitation facilities and that assisted living and HCBS providers would increase in number. Instead of being directly related to health reform provisions for NHs, this prediction may be an indirect result of state incentives to increase Medicaid spending for HCBS.

Administrator Suggestions

The administrators made a number of suggestions for the future of LTC and the continued implementation of the LTC provisions. These suggestions spanned many topics and are listed below.

- **Education:** IHS should offer webinars to educate NH administrators on all health care reform provisions and their anticipated impacts.

- **Quality of life, not (only) quality of care:** LTC policy, and related grants, should focus on quality of life measures, along with quality of care. For instance, policy should be informed by other care providers, not only nurses, so as to not skew the reported priorities of LTC care providers. Furthermore, policies should reflect the importance of traditional foods and traditional medicine being offered in LTC facilities for AI/AN beneficiaries as this, more than the background checks and so on, impacts the residents' quality of life. LTC grants should also be awarded to facilities that have enhanced the quality of life of their residents, not only the quality of care delivered.

- **Funding:** IHS should use its budget to support LTC services.

- **New rate:** IHS should define an all-inclusive rate that can be used for facility-based care and HCBS.
- **Consultation:** Tribes and agencies should work together in implementing the health care reform provisions.
- **Enforcement:** New regulations of the ACA and IHCIA should be enforced or nothing will happen.
- **Tribal involvement in HCBS:** Tribes should operate a home health service program to support the needs of older adults and persons with disabilities who are outside of NH facilities.
- **Positive PR for NHs:** There should be positive PR for NHs that diminishes the public perception that NHs are places where people go to die. The public needs to be informed there are a number of supportive services offered within NHs that improve the quality of life of residents.
- **HCBS assessments:** Before patients are transitioned from facilities to home-based care, a thorough assessment needs to be conducted on the home of the patient to make sure it is safe and livable.
- **QAPI models:** NHs will need information on QAPI best practices and models that they can then emulate.

Conclusion

Due to rapid aging and high rates of disability, AI/AN populations in the United States have a great need for LTC. Health care reform includes a number of provisions aimed at LTC, and in some cases to LTC in Indian Country specifically. Preliminary research on the impact of ACA and IHCIA provisions on LTC in Indian Country reveal three main impacts:

1. Nursing homes (both skilled nursing facilities and non-skilled nursing facilities) will likely **maintain and improve their quality of care**, consistent with new ACA provisions aimed at NHs. In many cases, ACA requirements reflect quality of care standards that are already in place in Indian Country NHs.
2. LTC facilities **may be impacted by ACA incentives for states to fund HCBS** in lieu of facility-based LTC. While some NH administrators reported interest in expanding their services to include HCBS, or short-stay Medicare-reimbursable services, others did not foresee a decrease in demand for long-term, facility-based care. In addition, interest in HCBS and other diversified services seemed motivated by perception of community needs or reimbursement advantages, as much as by health care reform provisions.

3. Due to provisions of the IHCIA, LTC facilities in Indian Country will likely experience **improvements in facility and staff and resource sharing, and in staff recruitment and retention**. Improvements in reimbursement were predicted less widely. An important complicating factor in reimbursement practices is the lack of an IHS rate for LTC.

Despite these discernible early impacts of health care reform gathered from the study, a unifying factor across all interviewee responses was that administrators lacked information and awareness about health care reform provisions relevant to LTC, and that the health care reform provisions were perceived to have had little impact.

Data from the interviews provide a number of explanations for this lack of awareness and perceived impact.

1. Because health care reform is in the beginning stages, with many important features not becoming active until 2014, NH administrators reported that not enough time had elapsed for them to observe or experience impacts.
2. Despite a clear shared interest in learning about relevant provisions and their impacts on NHs, administrators reported lack of understanding about the provisions and lack of information or education received from outside sources.
3. There was a shared opinion among NH administrators that many of the actions put into law by ACA and IHCIA provisions described practices that were already in place in LTC facilities.
4. NH administrators expressed the opinion that the provisions needed further appropriations in order to implement.

The study results still provided valuable information about the current status of and impact of health care reform implementation. This study informs us that:

- As of June 2013 (when the interviews were conducted), **NH administrators are not sufficiently informed about ACA and IHCIA provisions related to LTC**, and thus are not positioned to take advantage of opportunities created by health care reform.
    - There is a lack of understanding about how ACA and IHCIA provisions differ from the status quo. Many provisions are perceived as mirroring practices that are already active in LTC facilities.
    - Administrators have not received information disseminated by federal agencies such as IHS and CMS. Barriers to receiving information had to do with information being directed to offsite NH personnel or other tribal agencies or officials. Administrators also lack of time to conduct sufficient independent research into the topic.
    - Beyond a lack of awareness of ACA provisions, there was significantly less awareness of the IHCIA provisions, which could be more instrumental for tribal facilities.

- **For LTC facilities in Indian Country, the current stage of implementation is one of education, not of putting the provisions into practice.** Administrators must be informed of, and understand, the provisions before they can incorporate these regulatory changes into their facilities.
    - NH administrators are interested to learn more about the relevant provisions through clear and directly applicable educational materials or webinars.
    - There is a great deal of turnover of NH administrators; interview responses suggest this may have to do with the amount of stress and responsibility involved in the position. This may complicate outreach, and should be kept in mind when placing new responsibilities on NH administrators.

Recommendations

The findings of this study suggest three key recommendations.

First, **the appropriate authority should organize outreach strategies** to ensure that pertinent information about the reform provisions pertaining to NHs directly is received by the administrators of such facilities. The lack of awareness amongst facilities in relation to health care reform, and the potential impact of reform on the facilities, could be combated in part by an effective CMS communication and awareness strategy targeted specifically at nursing home administrators and senior-level staff, with a strong emphasis on provisions relevant to them. Administrators could be informed through letters, emails, or conference sessions. Informative messages must be sent to all of the appropriate personnel at NHs, including both onsite and offsite administrators, where contact information is available.

Ideally, this communication and outreach strategy would be strongly tailored to Indian Country facilities, addressing the unique circumstances and challenges they face. A multifaceted strategic communication plan could consist of:

1. A culturally appropriate multimedia instructional kit for NH administrators and senior-level staff.
2. Culturally appropriate educational materials to advise NH administrators and senior level staff of nursing facility-specific provisions under health care reform and how best to use the relevant provisions to their advantage.
3. Coordinated consultation with NH administrators in Indian Country by a professional team of trained, educated, credible, and attentive communicators, to advise NHs of how to take advantage of opportunities created by health care reform.

In addition, it is recommended that CMS have a clear message and coordinated communications effort regarding LTSS-specific health care reform provisions and what these provisions mean for Indian Country. It is recommended that significant attention be placed to

educating LTSS administrators on the IHCIA provisions, as many administrators are unfamiliar with the IHCIA.

Second, **the appropriate authority should consider defining a national- or state-option all-inclusive rate for NHs specifically, or LTC more generally**. Communications with administrators suggests that such a rate would strengthen and potentially expand much needed LTC facilities and services, as well as providing significant clarification for reimbursement processes.

Third, it is recommended that an **additional study on impact should take place at a later time** when implementation is further along and the impacts of the various provisions have been more comprehensively observed and identified.

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Appendix 1. Long-Term Care Service Types

In descending order of availability in Indian Country, facility-based long-term care services include assisted living, nursing homes, board and care homes, and continuing care retirement communities.

Facility-Based Care Services

Assisted Living is designed to provide personal care and some nursing services to qualifying individuals who prefer to have their own apartment (in a community setting), yet live in an environment that provides assistance with meals, housekeeping and light personal care. This type of care is popular to build because assisted living facilities generally require less demanding certifications than NHs. HCBS may be provided as necessary as assistance needs increase. IHCIA now allows IHS medical staff to provide care in long-term care settings that will make the assisted living model more viable for tribes and villages wishing to keep their elders and members with disabilities near their home, family and community.

Nursing Homes (NHs), including skilled nursing facilities (SNFs), are the most identifiable location for LTSS and remain the Medicaid entitlement service for long-term care. They provide a wide range of services including assistance with ADLs and rehabilitation services for both long-term and short-term care. NHs can provide intensive care to individuals requiring full-time medical care, or rehabilitation services post-hospitalization. Since SNFs require 24-hour onsite medical assistance, rehabilitation professionals, extensive equipment, and are highly regulated, they are unusual to find in Indian Country. Fifteen tribal NHs are located in all of the US, and not all meet the requirements of SNFs. Thus, many elders and others requiring rehabilitation and extensive skilled care find themselves needing to move off the reservations to receive care.

Board and Care Homes (BCHs), also referred to as residential care facilities, group homes, adult family homes, or adult foster homes, are small facilities with 20 or fewer residents (states determine the number of beds in this model) that provide personal care and meals to residents. Medical attention is usually not provided on the premises. Clients living in BCHs under Medicaid receive additional support for other needs (medical, training, equipment) through the state Medicaid waiver. This allows clients to live in these facilities until the facility no longer believes they can care for the client, or until they pass away.

Continuing Care Retirement Communities (CCRCs) provide an array of care services within a community setting including independent living units, assisted living, specialized dementia care, hospice or skilled nursing care, depending on the needs of the individual.

Home- and Community-Based Care Services

Home Health Services provide medical services in the homes of individuals who have been deemed ‘homebound’ by physician’s orders and thus cannot travel to a medical institution for

routine health care. Home health Services are most often provided in the client's home after hospitalization to carry out physician goals and support healing and rehabilitation. Services include but are not limited to injections, IC therapy, wound are, occupational, physical and speech therapies, and client and caregiver training. They are designed to assist clients and families support clients to become independent and heal more quickly while avoiding costly extended hospitalizations. Home Health Services are generally paid privately or through Medicare Parts A and B. Home Health Services do not include personal care, housekeeping, meals or 24-hour care in the home. Home health does provide medical services in the homes of Home health care pertains to the provision of services such as skilled nursing care or licensed physical/speech therapies. Home Health Services require certification through a rigorous licensure process.

Personal Care Services are typically non-medical services aimed at supporting elders and people with disabilities to perform their ADLs and essential IADLs so that they can remain in their homes. Services in some locations allow patient-directed or nurse-delegated care to perform activities that are necessary and usually performed by a licensed medical provider. Examples include: catheter insertion medication administration and insulin injections. In some states, personal care services are provided only through homecare aides employed by homecare agencies. In other states, caregivers may be friends or family members (not spouses) who are familiar with the client and shares the same language and/or culture.

Adult Day Services are community-based services and provide a number of social and health support services in a congregate setting to adults with functional or cognitive disabilities for part of the day. Adult Day Services are usually of two kinds: Adult Day Care or Social Day Care. Services at Adult Day Care centers include nursing care, occupational, physical and speech therapies, recreational therapy, music therapy, and special dietary intervention. The staff at adult day care facilities includes nurses, social workers, activities professionals, and nursing assistants. The medical services they provide include administering of prescribed medications, emergency medical support, and daily health needs care such as diabetic care. Social Day Care primarily provides social interactions and support for clients, as well as a much-needed respite for family caregivers. Adult Day Services may be found in senior centers, assisted living facilities, nursing home facilities or in stand-alone community centers. These centers are usually connected with a clinic, hospital, or skilled nursing facility in order to meet the requirements for medical staff. Adult Day Adult Day Health Services usually require licensed staff and substantial licensure requirements to receive Medicaid payment.

Skilled Nursing Care is provided by license professional nurses for scheduled nursing tasks that do not need daily or unscheduled attention. Nurses come to the client homes to perform many of the tasks that would otherwise be provided in a hospital or nursing home.

Hospice Care, or palliative care, provides care for individuals at the end of their life. Hospice service—which encompasses nursing care, home health aides and homemaker services, and supplies—provides emotional and physical comfort and the treatment of illness is based on

managing symptoms, not providing a cure. To be reimbursed through Medicare, a primary payor for these services must be certified through a rigorous certification process.

Other HCBS include client and caregiver training services, home-delivered meals, transportation services and environmental modifications (such as home modifications like ramps).

Appendix 2. Lists of Relevant Provisions

ACA Provisions for Nursing Homes

Sections 5302, 5305(a & b), 5305(c), & 5507
These sections describe how ACA will impact LTC health workforce education and training. For instance, according these ACA provisions will include programs to augment the geriatric workforce mainly by offering appropriate medical training to those who provide geriatric care. Another aspect focuses on creating grants for health professionals to teach or practice in geriatric, LTC, or chronic care management. PHSA Sec. 855 includes new language traineeships for individuals preparing to undertake advanced degrees in geriatric nursing or nursing focused on geriatric care.

Section 6101. Disclosure of Owners and Other Parties
To meet accountability requirements, SNFs and NFs must disclose complete information regarding any individuals who could be considered to have ownership of, or control interests, in the facility. This helps to hold the appropriate person responsible in the case of misconduct in the facility.

Section 6102. Compliance and Ethics Requirements
ACA requires that SNFs and NFs implement compliance and ethics training programs.

Section 6103. Nursing Home Compare Medicare Website
To improve consumer access to quality information on NHs (including Medicare and Medicaid certified facilities) to LTC beneficiaries and their families, each state must have a comprehensive website which lists all NHs within the state including information about each facility, as well as complaint reports and results of inspections.

Section 6104. Reporting of Expenditures
In addition to reporting how much the SNF spends on the care of residents compared with other expenditures such as administration costs, SNFs must report direct care staff expenditures. The HHS Secretary will be required to create procedures that allow expenditure reports to be made easily available to interested persons.

Section 6105. Standardized Complaint Form
The Secretary must develop and disseminate a standardized complaint form and mode of responding to such complaints.

Section 6106. Ensuring Staffing Accountability
NFs must submit electronic data to the HHS Secretary pertaining to staff and staff positions, employee work categories, resident census data, information on staff turnover and duration, and the hours of care actually provided per resident per day by the care facility and its personnel.

Section 6107. GAO Study and Report on Five-Star Quality Rating System
The Government Accountability Office (GAO) is required to carry out a study and create a report for Congress on the CMS Five-Star Quality Rating System's application to NHs. This rating system (one star for low quality care and five stars for superior quality care) will appear on the Nursing Home Compare Medicare website and will be joined by other ratings pertaining to health inspections, staffing and quality measures.

Section 6111. Civil Money Penalties
This provision states that additional civil money penalties can be imposed on SNFs and NFs by the Secretary of State, if or when such a facility is found to provide sub-standard care.

Section 6113. Notification of Facility Closure
SNFs and NFs must give at least 60 days' notice before closing their facilities. States must approve a plan that assures safe transfer of residents from the closing facility to another appropriate facility.

Section 6114. Information Technology Demonstrations
The Secretary will conduct demonstration projects to develop best practices for the use of information technology to improve the care of residents.

Section 6121. Dementia and Abuse Prevention Training
The HHS Secretary is required to revise the training of nurse aides to include information about dementia and abuse prevention.

Section 6201. Background Checks on Employees of Long-Term Care Facilities
States can participate in a recently introduced nationwide grant program that expands funding for criminal background checks of SNF and NF employees including background checks for nursing aides and others who contact residents/patients.

Section 6201(c) Quality Assurance and Performance Improvement (QAPI) Program
This program, an ACA provision, aims to improve care delivered in nursing facilities by creating an infrastructure that supports a NH's internal capacities for data collection and analysis, while developing strategies that can identify the causes of both persistent and isolated problems and develop plans to prevent them (Abell, 2012). Part of the QAPI program focuses on collecting data on the ways NHs attempt to prevent hospitalizations of their patients.

ACA Provisions for Home- and Community-Based Services

Section 10202. Balancing Incentives Program.
This program offers incentives to those states that take measures to make HCBS, rather than NHs or other institutional care services, more accessible to individuals needing LTC.

Section 2401. Community First Choice Option.
This new option offers states an increase of 6 percentage points in their federal Medicaid matching rate for providing HCBS as alternatives to NHs or other institutional LTC services for people with Medicaid. Within Section 2401 is the amendment to Section 1915 of the Social Security Act that adds the 1915(i) State Plan Home and Community Based Services Option. Under 1915(i) states may now choose to accept individuals who receive HCBS as eligible under Medicaid, even if or when these individuals do not qualify for institutional care. Previously waivers only covered home care for those individuals who qualified for institutional care. 1915(i) gives states more flexibility to use Medicaid services in ways that accommodate the LTC needs of beneficiaries outside of institutional care facilities.

Section 2403. Money Follows the Person Program (MFP).
This program, which existed prior to, but was strengthened by the ACA, aids Medicaid-covered individuals who require LTSS in their transition from long-term care back to their homes and communities. MFP provides information and assistance to these beneficiaries. The program ensures that individuals receive long-term care from in-home assistance in order to complete activities of daily living including bathing, getting dressed, walking, preparing meals, and taking medications. A total of $2.25 billion in funding has been applied to extend and enhance this program through 2016.

Section 3024. Independence at Home Demonstration.
This option, created by the ACA, enables participating physician practices to provide primary care services to Medicare beneficiaries in their homes. Since complications in transporting beneficiaries to and from medical appointments are often a cause for placement in LTC institutions like NHs, providing at-home medical services curtails unnecessary movement of patients to LTC institutions. This option also encourages home-based care for the chronically ill (HHS, 2012).

Section 3026. Community-Based Care Transitions Program.
This program helps Medicare beneficiaries in the transition between hospital care and home care. There is, however, a limit on the length of time—100 days or less—that Medicare will provide services such as home aides. The Community-Based Transition Program was mandated and funded by the ACA. States that choose to participate in this or similar options receive a 6 percentage point increase in federal Medicaid matching funds for community-based attendant services and supports to beneficiaries who would otherwise be cared for in NHs or other institutions.

Section 2703. Health Home Option.
This option, established by the ACA, provides states with new Medicaid options to provide better coordinated and managed LTSS to beneficiaries with two or more, or severe, chronic conditions. Health Homes are person-centered systems of care that facilitate access to and coordination of primary and acute medical services, behavioral health care, and long-term community-based services and supports. Health home services include: comprehensive care

management, care coordination and health promotion, comprehensive transitional care from inpatient to other settings; individual and family support, referral to community and social support services, if relevant, and the use of health information technology to link services.

IHCIA Provisions

Section 123. Indian Health Demonstration Programs for Provider Shortages
This section authorizes Indian health programs to provide training and support for alternative provider types such as community health representatives and community aides, at least for demonstration programs.

Section 124. Exemption from Certain Fees
This section exempts tribes from paying registration, licensing and other fees imposed by federal agencies. Formerly, tribes had to pay registration fees to the Drug Enforcement Agency for all providers who could prescribe controlled substances. This extends federal exemptions from these fees to tribes.

Section 201. Authorizes Use of IHS Funding for LTC
IHS funds can now be used for new kinds of care including long-term care services.

Section 822. Facilities and Staff Sharing for LTSS Programs
This section authorizes the sharing of facilities and staff between IHS and tribally operated long-term care programs and, as in Section 201, authorizes hospice care, assisted living, long-term care, and home- and community-based care, creating the authority for the creation of new programs in AI/AN communities.

Section 206. Third-Party Reimbursement for I/T/U Facilities
This section authorizes IHS, tribal programs, and urban Indian entities to be reimbursed from third parties such as Medicaid, Medicare, and private health plans for reasonable charges billed for services provided to beneficiaries of these plans. It echoes the 1996 Memorandum of Agreement (MOA) between CMS and the IHS that authorized tribally owned and operated facilities to bill third parties. Before the MOA, only IHS facilities could do so. This section goes beyond the MOA by specifying that urban facilities can also recover costs from third parties and by clarifying that I/T/U facilities must be able to recover reasonable charge billed (or, if higher the highest amount a third party would pay for care and services from a non-governmental provider.)

Section 207. Crediting of Reimbursements
This section clarifies that reimbursements under various programs must be returned to the service unit or other health program that provided the service. Importantly, this section states that an I/T/U facility's receipt of third-party reimbursements will not result in the receipt of less contract funding for these facilities from the IHS. In other words, the IHS cannot offset the amounts given to urban facilities or tribally owned or operated facilities because of their receipt of third-party reimbursements.

Section 106. Health Provider Recruitment and Retention
This section focuses on modes of recruiting and retaining health care professionals to join Indian health programs in rural/remote areas by increasing scholarships and stipends to draw health care professionals to Indian health programs, as well as exempting these providers from meeting a particular state's licensing requirements as long as they have a license in another state.

Section 222. Contract Health Services (CHS) and Patient Liability for Payment
This section informs contract health providers that they have no recourse to hold patients liable for payment of any cost or charges, where the claim has been accepted by IHS. Section 135 states that contract-health-provider-referred patients cannot be billed for any deductibles or fees or co-pays for CHS-referred care.

Sections 312 & 313. Modular Health Care Facilities and Mobile Health Station Demonstrations
These sections direct IHS to establish demonstration programs that will provide funding to selected health care facilities to use modular health care facilities and for other select service units to purchase mobile stations to provide specialty health care services including dialysis.

Section 401. Reimbursements from Federal Health Programs
This section amends the law to allow tribally operated programs, including LTC programs, to directly collect reimbursements from Medicare, Medicaid and the Children's Health Insurance Program, for the services they provide.

Section 402. Purchasing Health Care Coverage for Beneficiaries
This section newly authorizes tribes, tribal organizations, and urban Indian organizations to purchase health benefits coverage for their beneficiaries using IHS-appropriated funds. Previously, these IHS funds would have been used to pay for the cost of providing care, either directly or through referral, rather than to insure AI/ANs.

Section 405. IHS, Tribal, and VA Cost- and Facilities-Sharing
This section authorizes the sharing of medical facilities and services between the IHS, tribes and tribal organizations, and the Department of Veterans Affairs (VA) and Department of Defense (DOD). IHS and Indian tribes or tribal organizations will be reimbursed by the VA or DOD where services are provided through IHS, the tribe, or a tribal organization to beneficiaries eligible for their services from VA or DOD.

Section 408. Participation in Federal Health Programs
This section addresses nondiscrimination under federal health care programs by providing that IHS, tribal, and urban Indian organization programs (assumed to include LTC programs) are eligible for participation in, and payment from, any federal health care program, pending they meet requirements for participation. It requires that I/T/U facilities be treated as the equivalent of preferred providers by these programs for the purposes of reimbursement.

Section 509. Urban Facilities Renovation

This section authorizes urban Indian health facilities to receive funding from IHS for construction or minor renovations of urban health facilities. This provision is estimated to also apply to urban LTC facilities if appropriations are made to implement it.

Appendix 3. Existing Nursing Homes in Indian Country

CMS Region 4

- Choctaw Residential Center. Philadelphia, MS. (Mississippi Band Choctaw Indianus).
- Tsali Care Center. Cherokee, NC. (Eastern Band of Cherokee Indians).

CMS Region 5

- Anna John Nursing Home. DePere, WI. (Oneida).
- Jourdain/Perpich Extended Care. Red Lake, MN. (Red Lake Band Chippewa Indians).

CMS Region 6

- Laguna Rainbow Nursing Facility. Laguna, NM. (Laguna Pueblo Indians).

CMS Region 7

- Carl T. Curtis Health Education Center. Macy, NE. (Omaha Tribe).

CMS Region 8

- Blackfeet Care Center. Blackfeet, MT. (Blackfeet Tribe).
- Morning Star Care Center. Ft. Washakie, WY. (Wind River Shoshone).
- White River Health Care Center. White River, SD. (Rosebud Sioux Tribe).

CMS Region 9

- Navajoland Nursing Homes, Inc. Chinle, AZ. (Navajo Nation).
- Archie Hendricks, Sr. Skilled Nursing Center. Sells, AZ. (Tohono O'odham Nation).
- Gila River Indian Care Center. Laveen, AZ. (Pima/Maricopa Indians).

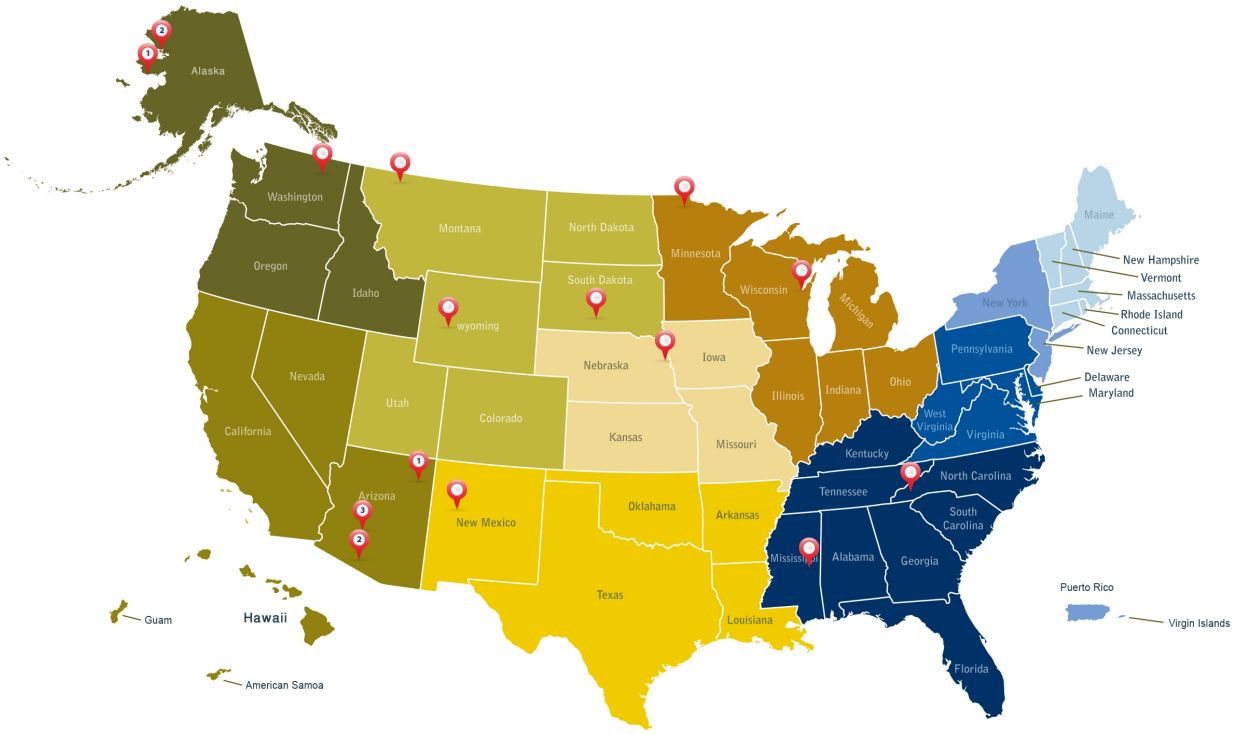
CMS Region 10

- Quyanna Care Center. Nome, AK. (Norton Sound Health Corp).
- Utuqqanat Inaat. Kotzebue, AK. (Manillaq Assoc of Elder Care).
- Colville Tribal Convalescent Center. Nespelem, WA. (Confederated Tribes of Colville).

Appendix 4. Nursing Home Phone Discussion Methodology

This study, conducted between May and June 2013, involved phone interviews with eight administrators at six long-term care facilities. To abide by the Paperwork Reduction Act, eight administrators were interviewed. The names of participating administrators will not be used to respect confidentiality. To support this research, phone consultations were also held with three experts on LTC and Indian Country. Sites were identified through review of a former inventory of nursing homes in Indian Country that identified fifteen known nursing homes in operation in Indian Country (KAI 2012). These fifteen nursing homes are indicated in Figure 4.

Figure 3. Nursing homes in Indian Country



REGION 1

REGION 2

REGION 3

REGION 4
Choctaw Residential Center.
Philadelphia, MS
(Mississippi Band of Choctaw Indians)
Tsali Care Center.
Cherokee, NC
(Eastern Band of Cherokee Indians)

REGION 5
Anna John Nursing Home.
Onieda, WI (Oneida Nation)
Jourdain/Perpich Extended Care Center.
Red Lake, MN (Red Lake Band of Chippewa Indians)

REGION 6
Laguna Rainbow Nursing Facility.
Laguna, NM (Laguna Pueblo Indians)

REGION 7
Carl T. Curtis Health Education Center.
Macy, NE (Omaha Tribe)

REGION 8
Blackfeet Care Center.
Browning, MT (Blackfeet Tribe)
Morning Star Care Center.
Ft. Washakie, WY (Wind River Shoshone)
White River Care Center.
White River, SD (Rosebud Sioux Tribe)

REGION 9
Navajoland Nursing Homes, Inc.
1. Chinle, AZ (Navajo Nation)
Archie Hendricks, Sr. Skilled Nursing Center.
2. Sells, AZ (Tohono O'odham Nation)
Gila River Nursing Home.
3. Laveen, AZ (Pima/Maricopa Indians)

REGION 10
Quyanna Care Center.
1. Nome, AK (Norton Sound Health Corp)
Maniilaq Association Utuqqnat Inaat Elder Care Facility.
2. Kotzebue, AK (Manillaq Association)
Colville Tribal Convalescent Center.
Nespelem, WA (Confederated Tribes of Colville)

To commence the study, a letter was emailed to all tribal leaders to inform them of the study. This letter was accompanied by a copy of the phone discussion instrument. A week later an email, accompanied by the discussion-guide instrument, was sent out to fourteen LTC administrators to seek their participation. Interviews were then scheduled with the five administrators who responded to our outreach. In two cases, the administrator asked to include another participant in our phone discussion, in one case this was a second administrator and in another case the additional interviewee was the Director of Nursing at the facility. Another round of phone outreach, conducted one month later secured two additional NH administrator participants. These discussions were held over the phone and did not include personal or confidential medical material. There was no request for IRB review from the contacted tribal leaders or NH administrators contacted. The NH administrators who participated in this study were located throughout the country in CMS regions 6-10 (AK, AZ, NE, NM, MT, & SD).

Six of the fourteen facilities that were contacted, participated in the study. Of these participating facilities, two were skilled nursing facilities (SNFs) and five were nursing facilities. Of the five NFs, two identified as 'nursing facilities', and three as 'nursing centers'). Phone discussions were guided through the use of an interview and discussion instrument called a 'phone discussion guide'. The phone discussion guide consisted of thirty-eight optional questions and prompts surrounding five main subject areas: facility background information, general impacts of the health care reform provisions, positive impacts of the health care reform provisions, challenging impacts of the health care reform provisions, and anticipated future impacts of the health care reform provisions. Specific topics covered included: the ACA, IHCIA, MFP program, HCBS, Medicaid expansion, partnerships, reimbursements, staff incentives and training, Medicare patients, and QAPI programs. This guide was reviewed by subject matter specialists prior to its use in this study.

Generally, participating administrators were asked to share their opinions and experiences regarding the impact of the recent health care reform policies on their LTC facilities. The telephonic interviews were semistructured; they were guided by the phone discussion guide, but allowed for interviewees to contribute points that pertained to the ACA/IHCIA provisions that were outside the scope or order of the discussion guide. All but one discussion took approximately an hour; the final interview was under thirty minutes due to the interviewees other time commitments. Each audio file was then transcribed, and the transcriptions were read for accuracy prior to coding the written transcripts into themes using manual methods and the qualitative research analysis software, Nvivo2.

Appendix 5. Limitations of Study

The study was limited by two main factors. First, the study was conducted early on in the implementation of the health care reform and thus the answers given were limited by the provisions that have been implemented and the degree to which NH administrator were aware of these relatively new provisions. Nevertheless, this study provided valuable information about the current status of health care reform implementation and impact. By way of a second limitation, it is possible that the study was limited by the fact that data was collected through phone interviews rather than in-person interviews. Due to minimized engagement, phone interviews, in contrast to in-person interviews, are often required to be shorter and more open-ended than in-person interviews. Thus, less material is typically covered in phone interviews than in in-person interviews. Additionally, interviews conducted over the phone miss cues such as facial expressions and body language that may help provide more comprehension of the questions and answers exchanged and further express emotional depth not captured in vocalized responses.

Fortunately, in the case of this study, the interviewed NH administrators were generous with their time; each contributing a full hour of thoughtful information and responses. Despite these stated limitations, this study yielded valuable information about the felt impact of health care reform on NHs in Indian Country, according to facility administrators.