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Unfinished Business:
Rebalancing Ohio's System of Long-Term Services and Supports for Elders and People with Physical Disabilities

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Please note that Roland Hornbostel's opinions are not necessarily those of The Center for Community Solutions.

Highlights:

- Despite recent progress toward achieving balance between long-term services and supports (LTSS) delivered in institutional settings and LTSS delivered in home- and community-based settings (HCBS), Ohio still lags behind other states.

- Achieving a balanced LTSS system is important for both fiscal and legal reasons – and "it's the right thing to do."

- Passage of the Affordable Care Act (ACA) includes important federal assistance for states in balancing their LTSS systems, including the Balancing Incentive Program, Money Follows the Person, Aging and Disability Resource Centers, and the Community First Choice Option.

- Am. Sub. H.B. 153 (the budget bill for the current two-year period) sets an aspirational goal of a 50/50 balance (institutional v. community-based LTSS as measured by the number of participants) for Ohioans age 60 and above, and a 60/40 balance for Ohioans under age 60 with physical disabilities. These should be regarded as intermediate range goals.

- Am. Sub. H.B. 153 consolidates funding for institutional and home- and community-based services in a single line item that allows for shifts in funding between settings based on consumer demand, rather than provider entitlement. The legislation also calls

for consolidation of Ohio's five Medicaid waiver programs serving Ohioans with disabilities into a single waiver.

- Decision making on LTSS systems reform has been consolidated in the Office of Health Transformation (OHT) which includes all key human service agencies in systems design.

- Ohioans may be institutionalized due to the lack of available, affordable, and accessible housing. The state must do a better job of "building the middle" between HCBS and institutional settings.

- Nursing homes have evolved as businesses since the early 1990s and now provide short-term rehabilitative care following hospitalization. They have dramatically increased services to younger Ohioans – including those with mental illness.

- Governor John Kasich's administration has proposed to the Center for Medicare and Medicaid Services that Ohio be allowed to integrate care for Ohioans fully eligible for both Medicare and Medicaid. A pilot program would be created in urban and suburban areas that would contract with managed care organizations to provide both acute care and LTSS for participants.

The Issue

Ohio's provision of long-term services and supports (LTSS) has always been heavily imbalanced in favor of costly institutional care (i.e., care delivered in a nursing home) and, in comparison with other states, has moved more slowly to "balance" or "rebalance" its LTSS system. In this brief, "long-term services and supports" includes services delivered in institutions and those delivered in home- and community-based settings to elders and adults with physical disabilities. Services to Ohioans with developmental disabilities and services targeted to children are not included in this analysis.

In part, this imbalance can be traced to the establishment of the original Medicaid program in 1965. Under federal Medicaid laws, nursing home care is an entitlement while other forms of community-based LTSS are "optional" or provided through Medicaid "waivers." In fact, it was not until 1981 that Medicaid law was amended to allow states to seek authority for home- and community-based services waivers that allowed states to serve a finite number of individuals in non-facility-based settings.

But why is this imbalance a problem? The reality is that nursing home care is expensive, especially on a per person basis, with the average daily Medicaid rate for an Ohio nursing home now at $167 per day. Community-based LTSS can be provided at less cost which means that an adequately funded, well-organized system of community-based LTSS will in the long run be more cost effective than the traditional nursing home- based system. Medicaid is one of the most expensive programs provided by Ohio for its citizens (estimated at almost $20 billion

dollars in SFY 2012). Just over one-third of that almost $20 billion dollars is spent in the provision of LTSS. So even if one does not know anyone who has entered a nursing home, or who has received Medicaid, as a taxpayer, one should insist that such a large expenditure be managed and spent as wisely as possible.

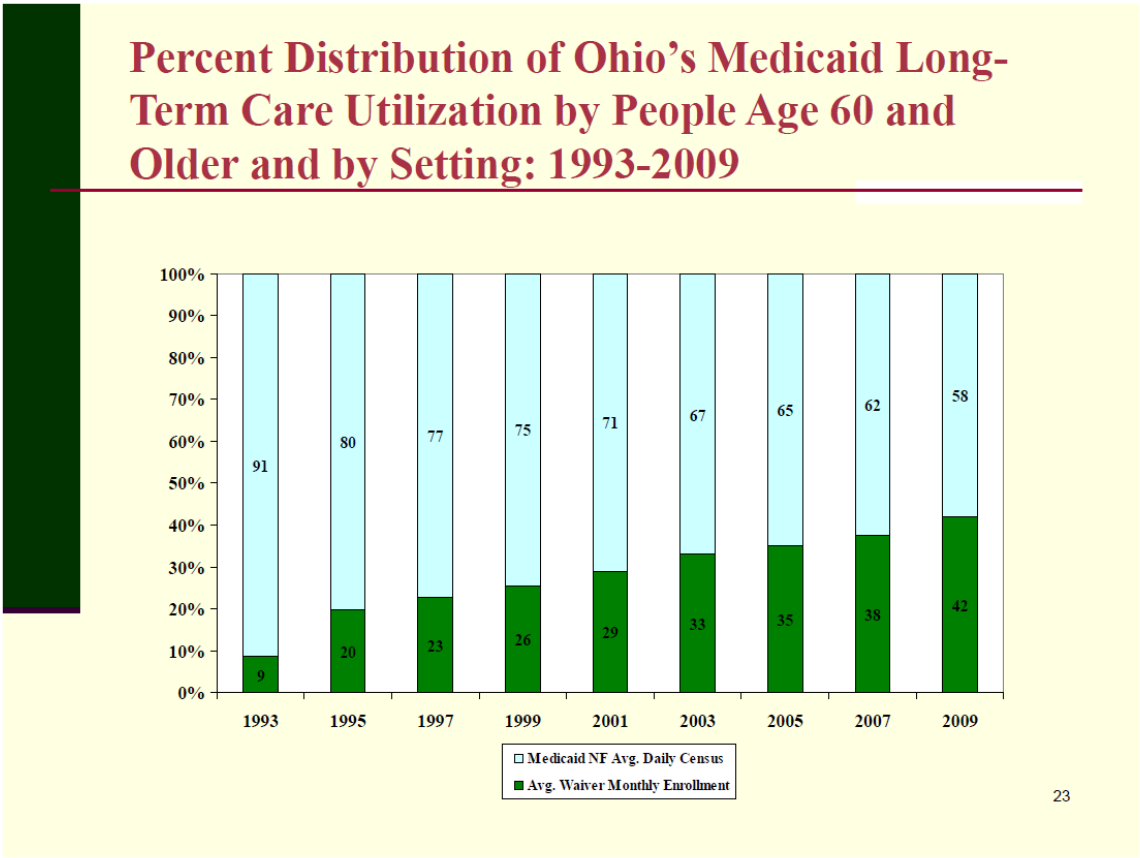
For those not impressed by the fiscal argument for community-based LTSS, it should also be pointed out that "it's the law!" The U.S. Supreme Court in its 1999 decision in *Olmstead v. L.C.* ruled that segregation of individuals in institutional settings was a violation of the Americans with Disabilities Act where the individual is able to live independently with supports and where the institutionalized individual desires to return to the community. This landmark ruling led states to scramble to create greater opportunities for community living by either creating new programs and services or expanding the availability of existing services. This has proven to be a wise legal strategy; since the *Olmstead* decision, more than 130 *Olmstead*-based cases have been filed against states to enforce the individual's right to community living.[1]

For those impressed by neither the fiscal nor the legal argument for community-based LTSS, the fact is that it's what the vast majority of Americans prefer. We all want to live our lives with dignity and as independently as we possibly can. So a strong moral argument can be made that community-based LTSS is simply the right thing to do. The convergence of these three supportive arguments has led every state to focus on building a community-based system of LTSS.

The federal government has also recognized the importance of achieving balance in state LTSS programs and services. The Affordable Care Act (ACA) creates an incentive program for states striving to achieve LTSS systems balance – the Balancing Incentive Program. States receive an enhanced federal match equal to either 5 percent or 2 percent of its home- and community-based LTSS expenditures. States spending less than 50 percent of their expenditures on home- and community-based LTSS expenditures (based on 2009 spending) qualify by agreeing to build single access points to LTSS (see discussion below), by creating a common assessment tool, and by agreeing to "conflict free" case management (this means that service provision and care management must be separate functions performed by separate entities). States, like Ohio, that spend between 25 percent and 50 percent of expenditures for HCBS (thereby qualifying for a 2 percent enhanced federal match) admitted to the incentive program agree to achieve a 50/50 LTSS spending balance by September 30, 2015. Currently, eight states have been approved for the incentive program. Ohio has prepared an application to the program but has not submitted it as of this writing. There is legitimate concern over whether the state has a realistic chance of achieving the spending balance in three years, given its current ranking (see below). On the other hand, the state could benefit by some $50 million annually in enhanced federal matching funds. If approved, these funds must be used by the state to enhance its community-based LTSS services. Other ACA options include the Community First Choice Option that provides states with a 6 percent increased federal match to provide community-based attendant services and supports to those who would otherwise be confined to a nursing home or other institution. In September, 2012, California became the first state to gain approval to offer this new option.

Ohio has made clear progress toward the goal of "allowing Ohioans the choice to live with dignity in settings they prefer."[2] In 1993, when Ohio first began tracking its success in providing community-based LTSS, $91 out of every $100 spent by Medicaid on LTSS were spent for nursing home care, and Ohio ranked in the bottom 10 percent of all states in providing community-based LTSS for its citizens. In 2010, Ohio spent 27.6 percent of all Medicaid funds for LTSS on community-based LTSS for older Ohioans and Ohioans with physical disabilities, and its ranking has improved to the middle of the pack (preliminary ranking is 24th for 2010, up from 33rd in the two preceding years).[3] Utilization of nursing home care by Ohioans age 60 and over has steadily declined since 1993 as documented by the Scripps Gerontology Center at Miami University.[4]

Figure 1: Percent Distribution of Ohio's Medicaid Long-term Care Utilization by People Age 60 and Older and by Setting: 1993-2009



Source: Scripps Gerontology Center - Miami University

"Balance" can be measured in one of two ways: (1) the proportion of *people* receiving services in home- and community-based settings, or (2) the total *spending* for HCBS services compared with

the cost of institutional services. National data, widely available, tend to focus almost exclusively on spending for services (which is how the rankings mentioned above are calculated). However, achieving balance using spending as a criterion is more difficult since the cost of facility-based services is higher than the cost for HCBS. This has led Ohio to focus on the number of people receiving LTSS in HCBS settings. In fact, the current biennium budget bill, Am. Sub. H.B. 153,[5] actually sets an aspirational goal for the current two-year period of a 50/50 balance for Ohioans age 60 and over and a 60/40 balance for younger Ohioans with disabilities (since the baseline for younger Ohioans had already reached the 50/50 balance before the new biennium began). The drawback in using a "people" measure is that national data do not exist for comparison purposes. AARP's Public Policy Institute recently attempted to come up with comparison data for a "people" measure. According to the AARP data, Ohio would rank 33rd in a measure of the proportion of older adults and adults with physical disabilities receiving HCBS.[6] However, the data are from 2008—much less current than available expenditure data. In addition, the Balancing Incentive Program, discussed previously, measures balance by overall spending on LTSS.

The aspirational goal in the budget bill is an intermediate goal, i.e., once achieved, a new aspirational goal should be set. We know that Ohio can do better. With states such as New Mexico and Oregon now devoting more than 60 percent of its LTSS funding for community services (a measure of spending), we can clearly do better than the current 27.6 percent. But how best to move forward?

A Roadmap to the Future

With so many states headed in the same direction to expand community-based LTSS, experts have been able to isolate and highlight key components of a truly transformed state LTSS system. In 2006, the federal Centers for Medicare and Medicaid Services (CMS) under a contract with Thomson Medstat (now Traven Health Analytics) developed and published a guide to assist states in profiling their LTSS systems. The profile highlighted the following characteristics of a transformed state system.

1. **Consolidated state agencies** – a single agency for both institutional and community services that coordinates policies and budgets to promote community options;
2. **Single access points** – a clearly identifiable organization managing access to a wide variety of community supports, ensuring people understand the full range of available options before receiving more restrictive services;
3. **Institution supply controls** – mechanisms such as Certificate of Need requirements that enable states to limit or reduce institutional beds;
4. **Transition from institutions** – outreach to identify residents who want to move and assistance with their transition to the community;
5. **A continuum of residential options** – availability of support services in a range of options from mainstream single-family homes and apartments to integrated group settings for people who need 24-hour supervision or support;

6. **HCBS infrastructure development** – recruitment and training to develop a sufficient supply of providers with the necessary skills and knowledge to encourage consumer independence;
7. **Participant direction** – people who receive HCBS having primary decision-making authority over their direct support workers and/or their budget for supports; and
8. **Quality management** – an effective system that: (a) measures whether the system achieves desired outcomes and meets program requirements and (b) identifies strategies for improvement.[7]

The remainder of this brief will discuss Ohio's progress toward these objectives.

Unifying Ohio's LTSS System – Budget and Decision Making Consolidation

As early as 2002, Ohio advocates were recommending a unified or consolidated approach to LTSS planning and service delivery. In 2005, the Ohio Commission to Reform Medicaid recommended unified budget and planning and consolidation of decision making responsibility.[8] In 2006, the Ohio Medicaid Administrative Study Council, formed to consider how best to establish a freestanding Medicaid agency, focused the work of a key subcommittee on how best to unify Ohio's LTSS budgeting process.[9]

These first two efforts were part of two larger efforts, and subcommittees and workgroups were not truly representative of all with an interest in LTSS. In 2007, a specific workgroup, the Unified Long-Term Care Budget Workgroup was created under the auspice of the Ohio Department of Aging. While the workgroup remains active today as the Unified Long-Term Care Systems Advisory Group under the auspice of the Office of Health Transformation, its focus and activity have shifted since its early recommendations dealing with an LTSS strategy for the state.[10]

Looking back over the last decade, Ohio's progress toward a better LTSS system has been steady. Governor John Kasich's administration's implementation of a new LTSS approach has accelerated the progress toward a new approach even faster than the original workgroup envisioned. For example, funding for nursing home care and community-based LTSS has been consolidated within the overall Medicaid budget of the Ohio Department of Job and Family Services (ODJFS); funding for community-based LTSS for elders has been moved from the budget of the Ohio Department of Aging (ODA) to ODJFS) in the 2012-2013 biennium – earlier than proposed by the ULTCB workgroup.

Major change like this does not come easily, and that is to be expected. For example, while the funding for ODA-operated programs such as PASSPORT, the assisted living waiver, and PACE have been moved to the overall Medicaid funding line in the ODJFS budget, the General Assembly still sets forth a total spending amount for these ODA-operated HCBS programs in Am. Sub. H.B. 153. Further, in the Mid-biennium Budget Review (MBR), nursing home advocates argued that "their" portion of LTSS spending was some $39 million less than anticipated and so reimbursement rates for nursing home care could be increased by $30

million. However, Governor Kasich exercised his line-item veto to eliminate this windfall for nursing homes. Such thinking, not uncommon in other states that have already undergone transformation of their LTSS systems, undermines the key reason for unifying the budget in the first place: the ability to move funding between service settings and programs as needed based on the demand for services and, once a unified system is producing desirable results, use the savings from a transformed system for other services that the government provides.

Unifying decision making authority in the Kasich administration has been accomplished through the creation of the Office of Health Transformation (OHT). While individual state agencies continue to play an important role in the delivery of LTSS, OHT has proven to be the venue in which major strategic and tactical decisions are made by the administration.

Creating Single Points of Access for Consumers

Decision making about the need for LTSS is incredibly difficult for consumers and their families. States offer a bewildering array of services and programs, often with different eligibility requirements. This confusing service array is compounded by the fact that most decisions about LTSS are made by families at a time of crisis. Despite campaigns like Ohio's Own Your Future, people simply do not want to think about the need for LTSS until they absolutely must.

For this reason, researchers and policymakers have suggested the creation of a single, highly visible portal for access to LTSS – a "one stop shop." This portal, to be effective, must be highly trustworthy, objective (i.e., not biased toward a particular program), and visible. It must have key functional elements such as the ability to determine eligibility for services in addition to information about available services. The dilemma is that, in a large state like Ohio, many portals to services already exist that are trusted by consumers. For example, older Ohioans typically seek services and advice from a strong network of Area Agencies on Aging. On the other hand, Ohioans with physical disabilities will most often seek access through a Center for Independent Living (though some rural areas of Ohio do not have CILs). An Ohioan with a need for behavioral health services will most often access that system through a county-based Alcohol, Drug Addition and Mental Health (ADAMH) board; and an Ohioan with a developmental disability will seek services through a county-based Developmental Disabilities (DD) board. And to complicate matters even further, all decisions about Medicaid financial eligibility are made by county JFS agencies. This makes it very difficult to set up physical access points for LTSS.

But there is another option. In our Internet age, it should be far more possible to set up *virtual* access points. Such an approach, referred to as "no wrong door," focuses on creating a seamless entry point for consumers regardless of how many agencies need to be involved during the consultation or eligibility determination process. The difficulty lies in creating the capacity to assist consumers with a variety of needs within the existing agency framework at a local level. This is where the Internet can be an important tool toward creating a mechanism to link disparate agencies and organizations together. Ideally such a virtual portal is accessible by

consumers to aid them in the decision making process. But technology is expensive and Ohio's efforts to date have been unsuccessful. The federal Affordable Care Act provides a small amount of funding to states to implement access points, either using a physical model approach or a "no wrong door" approach by making grants for Aging and Disability Resource Centers (Ohio calls this a "Network" rather than a "Center" to signify that Ohio is adopting a "no wrong door" system). However, the funding available through the ADRC grants is inadequate to the task outlined for the points of entry.

Institutional Supply Controls

The extent to which institutional supply controls is important to a transformed system of LTSS is somewhat more debatable than the first two. The theory behind controlling the number of institutional (nursing home) beds is that, if the bed is built, it will be filled. Therefore, it was common in the 1970s and early 1980s for states to control the number of nursing home beds by requiring a "Certificate of Need" (CON) review before the beds could be added. But is the adage really true? As the Scripps Gerontology Center has demonstrated, occupancy of nursing home beds in Ohio has always been significantly below capacity since the state began actively promoting HCBS options.[11] However, over time, the ongoing work by Scripps has demonstrated the adaptability of Ohio's nursing home industry. Put simply, Ohio's nursing homes aren't really nursing homes anymore. For example, beginning in the mid-1990s Ohio nursing homes saw increasing admissions of Medicare-eligible consumers for short-term, post-hospital rehabilitative care. It can be argued that this is a positive outcome of excess nursing home beds since nursing home care is less expensive than hospital care. On the other hand, Scripps has also documented the increased rates of admission for Ohioans *under* the age of 60. To the extent that these new admissions have behavioral health needs that nursing homes are too often ill-equipped to meet, this is a negative effect of having too many beds.[12]

So does Ohio have an institutional supply control? It does. In 1993, Ohio placed a moratorium on any CON that would add new nursing home beds. The problem is that by 1993, Ohio already had 20 percent more nursing home beds than the national average. Therefore, the moratorium institutionalized an overcapacity in the system. And there is some cost to the moratorium because the only way a nursing home provider can add new beds is by buying an existing provider's CON (at a cost of approximately $20,000 per bed acquired, though that depends heavily on what part of the state the expansion is occurring). The moratorium does protect the property rights of the individual nursing home owner by propping up the value of the home since the free market does not function in this environment; one simply cannot decide to open a new nursing home without buying the CON bed rights from another home. If this sounds like how public utilities operate, the reader is not incorrect.

Ohio is not the only state facing nursing home overcapacity. To the extent that policymakers believe overcapacity to be a problem, some programs in other states (e.g., Pennsylvania and Minnesota) have been created to, in effect, buy the excess beds back from existing nursing homes by auction, conversion to assisted living, or through an augment to the nursing home

reimbursement rate. However, in a state like Ohio that needs to devote available funding to invest in HCBS, a bed buyback program is unlikely to attract support.

The better alternative to having the state acquire excess capacity is to enhance its community services. As Figure 1 demonstrates, over time, the demand for nursing home beds by Ohioans age 60 and over has declined as the availability of programs such as PASSPORT expanded. A major reason for the admission to nursing homes of younger Ohioans with behavioral health needs is the lack of alternative community-based mental health services for these individuals. A carefully targeted investment in community services may end the "market" for nursing home beds to this population. But it won't be that simple.

Transition from Institutions—"Money Follows the Person"

An important strategy toward transforming a state's LTSS system is identifying current nursing home residents who wish to return to the community if they can be assured that services will be available to meet their needs. In 2005, CMS (the agency responsible for Medicare and Medicaid policy) created a new demonstration—Money Follows the Person (MFP)—that allowed individuals residing in nursing homes access to a greater array of state-designed services that would support the resident's return to community living. Ohio was one of the original states admitted to the demonstration, which has been extended and improved due to passage of the Affordable Care Act.

To be successful, a state must first have an effective targeting and outreach system to reach nursing home residents. The state must also have a sufficient array of services for residents that may go beyond the traditional personal care services delivered through programs like PASSPORT or the Home Care waiver for Ohioans under age 60. Thus the Ohio MFP program, called HOME Choice, offers coordinators and coaches to assist individuals making the transition from nursing home to community, home repair services, service animals, and computer equipment. But the biggest barrier to transition is that adequate housing must be found for the individual wishing to transition back to the community. This barrier has been highlighted by the national evaluator for MFP, Mathematica Policy Research, as the most significant reason that MFP has never been able to meet its predicted enrollment success.[13] Despite this, Mathematica points out that Ohio is one of two states to substantially meet its enrollment targets (the other is Texas). This fact may be an interesting coincidence, but both states had created a strategy that predates MFP that allowed nursing home residents to bypass waiting lists for existing HCBS programs (in Ohio, called Home First) which is critical in states with waiting lists for services. (While, as of this writing, there are no waiting lists for services to Ohioans over age 60, in the past, Ohio has resorted to waiting lists for PASSPORT at times where ODA's budget did not support natural enrollment growth for the program – hence, the creation of the Home First provision.) Texas has long had very lengthy waiting lists for HCBS. However, as Ohio does not currently have a waiting list for services for those age 60 and over, the Home First provisions in Ohio law are not triggered.

A Continuum of Residential Options

A transformed system utilizes an array of residential options from single-family homes to assisted living facilities that provide less medical services than the traditional nursing home. Ohio operates the third largest HCBS Medicaid waiver for Ohioans age 60 and over (PASSPORT) and a companion program (Ohio Home Care waiver) for those under age 60 with physical disabilities. In addition, Ohio also has a robust and growing assisted living Medicaid waiver program for those either unable or unwilling to remain in their own homes.

Residential alternative living is important for many Ohioans unable to live in the community without services designed to meet *unscheduled* needs for care. PASSPORT works best where services can be regularly scheduled since the service provider must travel to an individual's residence at a predetermined time. When these services need to be delivered on a less predictable schedule, an alternative residential/congregate setting is essential. Ohio has been challenged for decades with the need to create alternative care settings between an individual's own home and a nursing home (commonly referred to as "building the middle").

Creation of the assisted living waiver in 2006 was an important first step toward building the middle. However, an important limitation to the further advancement of assisted living in Ohio is that providers must first build facilities that qualify for licensing by the Ohio Department of Health as "residential care facilities." In Ohio's current economy, developers are not rushing to build new facilities, given that assisted living facilities must cater to privately paying residents. In fact, according to Scripps, occupancy rates in assisted living are even lower than nursing home occupancy rates.[14] For these reasons, Ohio will eventually run out of assisted living units that accept Medicaid reimbursement.

States that were pioneers in transforming their LTSS systems—such as Oregon and Washington—relied heavily on smaller residential facilities to provide family or "foster care." These efforts were funded through the two states' Medicaid HCBS waiver programs. While Ohio does license adult care facilities, these alternative settings have not been well-developed for a variety of factors related to low reimbursement rates (through the state's Residential State Supplement program which also severely restricts the number of participants) and concerns over the quality of services in these facilities.

One promising approach to the problem is the addition of a new service to PASSPORT – enhanced community living – that links publicly subsidized housing with service provision so that unmet service needs may be more flexibly met than in the existing PASSPORT model. However, it is too soon to tell whether this approach will work or will need to be modified.

HCBS Infrastructure Development

As HCBS expands, a legitimate concern is over the workforce necessary to provide services. This takes on two dimensions. First, does the state have enough workers to supply this new demand? Second, are the workers employed in HCBS settings trained adequately to provide the services consumers need in ways that match the consumer's desire for how these services

are provided? So far, as PASSPORT and Ohio Home Care have expanded, the supply of workers has also expanded. The number of workers appeared to be a much greater issue during the more robust economy (with lower unemployment in the state) in the late 1990s. However, training of workers remains an important issue. The state is attempting to address this issue through coordinated workforce development initiatives, funded in part by state earnings from the Money Follows the Person demonstration (MFP additional funds must be used to improve HCBS).

Participant Direction

The Participant Direction concept, fostered in large part by a Robert Wood Johnson-funded demonstration called "Cash and Counseling," refers to giving individual service recipients control over the workers that deliver services, an individual budget for such services, or both. In a participant-directed program, the consumer becomes the "employer of record" of the worker providing the services. The consumer hires the worker, trains the worker to specific service needs, and may even fire the worker for poor performance. The consumer may hire the worker of his or her choice – even a family member – with limited exceptions ("legally responsible" relatives such as spouses or parents of minor children). The state typically provides a "fiscal intermediary" to handle issues such as payroll and taxation. Case managers become counselors that provide guidance to the consumer, but the role is different than in traditional programs such as PASSPORT. The novelty of the Cash and Counseling demonstration required that a robust program evaluation be conducted.[15] Overall, the evaluation was extremely positive. Instances of abuse and exploitation of consumers was not greater for participants. Individuals with much greater levels of impairment could be safely served in the community. While LTSS service costs were higher for this consumer group (frankly due to the fact that if you hire a family member the worker is more likely to show up to provide the services – technically the proportion of services delivered v. those authorized was much higher), the rates of hospital use and nursing home use were smaller for the consumer group, leading to overall cost savings.

Ohio has carefully dipped its toe in the waters of participant direction by offering the Choices waiver for those ages 60 and over and through the addition of the SELF waiver for those with developmental disabilities on July 1, 2012. Choices is available only in certain regions of Ohio (Northwest Ohio and rural southern Ohio – Cash and Counseling had demonstrated that participant direction is a more significant option in rural areas) and has very limited enrollment numbers. More recently PASSPORT added a consumer-directed personal care option, but it is too soon to know the extent to which this option may be used. The Choices waiver has not been formally evaluated, but an early report on participant characteristics by Scripps suggested similar findings to that of the Cash and Counseling demonstration.[16] Within the Ohio Home Care waiver for Ohioans under age 60, ODJFS has allowed the use of individual providers, but many of the other elements for Cash and Counseling have not been adopted. In its proposal for an Integrated Care Delivery System (ICDS – see discussion below), Ohio has indicated that consumer direction will be a required element of the new system.

One of the provisions of the Affordable Care Act that Ohio has not, thus far, chosen to adopt is the Community First Choice Option, which would require Ohio to add HCBS attendant services to the state Medicaid plan. States that provide this new option would receive an additional 6 percent in federal matching funds for this service. Service design broadly follows the design of the Cash and Counseling demonstration, providing for consumer direction and control over service provision.[17] However, Ohio does not currently offer personal care as a state plan service (instead it is offered as an HCBS Medicaid waiver service through a program like PASSPORT which allows a state to control the number of individuals who receive the service). It has not been surprising that the early adopters of the Option are states that already offer personal care without a numerical restriction on total participants, such as California. For states offering personal care as a state plan option rather than as a waiver service, the Option provides additional federal funds for something they are already doing, albeit with revisions to ensure that the state's program is participant-directed.

Quality Management

Ensuring access to HCBS is, alone, not sufficient to truly transform a state's LTSS system. The services provided must be of high quality both to ensure positive health and quality-of-life outcomes and to ensure consumer confidence in the options for care and services. Defining "quality" in the LTSS context has proven elusive, but most experts agree that some mixture of consumer-derived measures (ask the customer or end user) and process and structural measures are necessary. The current approach to defining and measuring "quality" differs greatly between community-based LTSS and nursing home care. Nursing home quality has been measured historically through an "inspect and punish" model where the government (federal) has set very specific requirements that must be met and a series of penalties should the nursing home be found non-compliant with these requirements. The approach to community-based LTSS quality measurement is quite different. Instead of inspection and penalties, this approach focuses on problem identification and remediation, with providers and monitors working together toward common objectives.

Ohio has focused much of its recent effort on rewarding "culture change" in nursing homes, rewarding nursing homes for adopting person-centered care strategies that, if implemented, will create more homelike environments for residents. The Unified Long-Term Care System Advisory Group has highlighted 20 such strategies.[18] Strategies include performance on state-administered satisfaction surveys, consistent assignment of nursing home personnel, flexibility in dining and/or bathing, and others. A portion (better than 9 percent) of Medicaid nursing home reimbursement is set aside for those nursing homes meeting five or more of these strategies. It may not be a very high bar, but it is a beginning toward tying reimbursement to quality outcomes.

Ohio measures quality in community-based LTSS through its adoption of the "quality framework" developed by researchers at the University of Southern Maine for CMS.[19] As noted, the "framework" is focused on problem identification and remediation. In addition, some aspects of customer satisfaction are measured through a statewide survey in Ohio—but

more can and should be done to identify and support "quality" in home- and community-based services.

What's Next?

Ohio has made progress in transforming its LTSS system, but the Kasich administration now prepares to take on yet another challenge – integrating Medicare- and Medicaid-funded services for those Ohioans who are dually eligible for both programs. The original Unified Long-Term Care Budget Workgroup in 2007 briefly considered this idea but ultimately decided to focus exclusively on Medicaid-funded LTSS in its initial work. Governor Kasich's Office of Health Transformation, taking advantage of several new opportunities offered by passage of the Affordable Care Act, is quickly moving toward a new concept of integrated care for dually eligible individuals.

Historically, Medicare and Medicaid (despite similarly sounding names) have operated separately from one another, sometimes with competing objectives and outcomes. There has been little impetus to try to integrate the two programs because states have been unable to share in Medicare savings that accrue through implementation of program innovations. Even the Program of All-inclusive Care for the Elderly (PACE), which does integrate all acute care and LTSS for participants (who must qualify for nursing home placement),[20] does not share program savings.

Last summer, CMS offered new opportunities for states wishing to integrate their Medicaid programs with the federal Medicare program. For the first time, CMS has established a clear pathway that would allow participating states a chance to share in any Medicare savings created through an integrated program approach. Ohio has decided to take advantage of this opportunity and has applied to create an Integrated Care Delivery System (ICDS).[21] ICDS is, initially, a three-year pilot program operating mostly in urban and suburban Ohio counties that integrates Medicare- and Medicaid-funded supports – both acute care and LTSS. The ICDS pilot will serve approximately 115,000 dually eligible individuals, including many of those served in nursing homes or on HCBS programs such as PASSPORT. According to the Office of Health Transformation, full-benefit, dually eligible enrollees constitute just 9 percent of all Medicaid beneficiaries, yet this group accounts for 30 percent of total Medicaid spending.

The proposal divides the state into regions that will be served by two (or in the case of the Cleveland region, three) managed care organizations (MCOs) selected through a competitive procurement process. The MCO receives a capitated payment per enrollee and agrees to be "at risk" for any medical and LTSS costs exceeding the capitated payment. Dually eligible individuals in a demonstration region are required to receive Medicaid services through one of the selected MCOs; however, they may opt out of receiving Medicare services through the MCO since existing Medicare law does not permit mandatory enrollment.

If CMS approves the proposal, Ohio's demonstration would begin in 2013. Delaying implementation to later in 2013 would satisfy one of the concerns of advocates for those dually

eligible – that there will not be sufficient time to conduct a fair, open enrollment process for those covered by the demonstration. But other concerns remain: To what extent will participants be able to keep their current service providers? How will ICDS integrate with other initiatives currently underway? How will participant direction be specifically incorporated into the design and execution of the demonstration?

Finishing the "Business" —Transforming Ohio's LTSS System

As the title of this report suggests, while Ohio has made progress toward transforming its LTSS system, work remains to be done. In that spirit, the following recommendations are made for future consideration.

- Ohio has an admirable record in ensuring that all elders who qualify for ODA-administered waivers receive HCBS through programs such as PASSPORT, without resorting to waiting lists. Ohio should go the next step to ensure access for all younger Ohioans who qualify for HCBS so that consumers are not forced into institutional settings when a more appropriate and desirable community setting is available. The new ICDS proposal offers a "way forward" toward achieving this goal, but HCBS should be available regardless of where a consumer lives. Combining Ohio's five waivers serving elders and Ohioans with physical disabilities into a single Medicaid waiver, as envisioned by Am. Sub. H.B. 153, can achieve this goal for consumers not living in an ICDS region.

- Continue to "build the middle." Expanding housing options for Ohioans with disabilities, especially those with severe mental illness, should be a priority so that Ohioans are not unnecessarily forced into nursing homes due to lack of housing options.

- Carefully consider adopting the Community First Choice Option. Since presumably those dually Medicare and Medicaid eligible will already be entitled to receive personal care services as needed, arguments that a new state plan option would needlessly expand Ohio's Medicaid services are weaker than before. And adoption of the Option would move participant direction forward.

- Expand the concept of Aging and Disability Resource Networks. Ohio's aging and disability communities must work together to make ADRN more viable than it currently is. Ohio has acknowledged in its ICDS proposal the important role that ADRN can perform, but only if the ADRN is visible to consumers and their families and if professionals are trained to assist Ohioans with a wide variety of needs.

- Develop a formal evaluation of ICDS implementation. After all, ICDS is a three-year demonstration and will be available in only parts of the state. Other states have experiencing "growing pains" with similar systems (e.g., Kentucky) largely because MCOs lack experience with organizing and delivering LTSS. A formal evaluation can guide implementation and future expansion of this new concept.

- Make information about "quality" available to consumers and their support systems easily available. Ohio has been a true leader in making information about nursing homes and assisted living available over the Internet (through ltcohio.org), and this effort should be expanded to HCBS services.

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[1] The full *Olmstead* decision can be accessed at www.law.cornell.edu/supct/html/98-536.ZS.html
[2] Guiding Principle of Governor Kasich's Office of Health Transformation at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=C21EH6v1OYk%3d&tabid=84
[3] Steve Eiken, et. al. *Medicaid Expenditures for Long-Term Services and Supports: 2011 Update*. Traven Health Analytics (September 2011). Appendix A, Table AG.
[4] Shahla Mehdizadeh et al., *Coming of Age: Tracking the Progress and Challenges of Delivering Long-Term Services and Supports in Ohio.* Scripps Gerontology Center (June 2011), Miami University, p. 39.
[5] HB 153, Sec. 309.35.10
[6] Ari Houser, et. al. *Across the States 2012: Profiles of Long Term Services and Supports*. AARP Public Policy Institute (September 2012).
[7] Steve Eiken. *Technical Assistance Guide To Assessing a State Long-Term Care System*. Thomson Medstat (2006).
[8] Ohio Commission to Reform Medicaid. *Transforming Ohio Medicaid: Improving Health Quality and Value* (2005). p. 25.
[9] Ohio Medicaid Administrative Study Council. *Final Report and Recommendations* (2006). pp. 48ff.
[10] Recommendations from the Workgroup can be accessed at http://aging.ohio.gov/resources/publications/ULTCB_final_report.pdf
[11] Mehdizadeh, et. al., p. 12.
[12] Shahla Mehdizadeh and Robert Applebaum. *A Review of Nursing Home Resident Characteristics in Ohio: Tracking Changes from 1994-2004* . Scripps Gerontology Center, Miami University (2007).
[13] Carol Ervin, et al. *Money Follows the Person 2010 Annual Evaluation Report.* Mathematica Policy Research (2011).
[14] Mehdizedeh, et.al., p. 24.
[15] Randall Brown, et. al. *Cash and Counseling: Improving the Lives of Medicaid Beneficiaries Who Need Personal Care or Home and Community Based Services.* Mathematica Policy Research (2007).
[16] Suzanne Kunkel and Ian Nelson. *Profiles of Choices Consumers*. Scripps Gerontology Center, Miami University (2005).
[17] Community First Choice Option Final Rule 42 CFR Part 441, May 7, 2012.
[18] Unified Long-Term Care Systems Advisory Group, Nursing Facility Quality Measurement Subcommittee, Report to the Ohio General Assembly (September, 2011).
[19] For more on the CMS quality framework for home- and community-based services, see CMS's "Dear Medicaid Director" letter, February 17, 2004.
[20] Ohio currently supports two PACE sites – one in Cleveland and one in Cincinnati. PACE sites, because they are tied to specific geographic locations, typically serve a small number of enrollees and therefore states have been looking at other ways to foster integration between Medicare and Medicaid on a larger scale.
[21] Up-to-date materials for the ICDS demonstration can be accessed through www.healthtransformation.ohio.gov

Please note that Roland Hornbostel's opinions are not necessarily those of The Center for Community Solutions. Roland Hornbostel has been one of Ohio's leading policy professionals in the field of aging for over 30 years. As deputy director for policy and programs for the Ohio Department of Aging, Roland was responsible for the development of state government policies and programs for Ohio's older adults, representing the Department on interagency task forces coordinating health care and long-term care reform efforts for Ohio. One of the architects of Ohio's PASSPORT (home- and community based Medicaid waiver) program, he also managed Ohio's implementation of Older Americans Act and Long-Term Care Ombudsman programs. His publications have addressed Medicaid, long-term care, legal issues associated with dementia, and the impact on state policy of the U.S. Supreme Court decision in Olmstead v. L.C. He holds a Masters of Divinity from Christ Seminary in St. Louis, and a law degree from Cleveland's Marshall College of Law.

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