



Department of
Aging

Ted Strickland, Governor
Barbara E. Riley, Director

**TESTIMONY BEFORE
THE OHIO HOUSE FINANCE AND APPROPRIATIONS
HUMAN SERVICES SUB-COMMITTEE**

Thursday, March 5, 2009

**DEPARTMENT OF AGING
Testimony HB 1
2010/2011 Biennial Budget**

**Presented by
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Budget Testimony for the Ohio Department of Aging
House Finance and Appropriations Committee
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Chair Brown, ranking member Burke and members of the Human Services Subcommittee of the House Finance and Appropriations Committee I am Barbara Riley, Director of the Ohio Department of Aging (ODA) and I want to thank you for the opportunity to present our SFY 2010/2011 budget proposal. The ODA is dedicated to assuring the delivery of high quality services that support independence and dignity for older Ohioans, adults with disabling conditions and their families and caregivers. This budget reflects an investment in those core values and services while operating within a tight budget environment.

Indeed, our work is increasingly critical as Ohio's elder population shows dramatic growth. Each month 12,000 Ohioans turn 60, resulting in a 33.2 percent growth in that age cohort from 2007-2020. Our fastest growing segment of the population is those 85 and older, with an estimated 1 million Ohioans 85 by 2050 compared to 217,462 in 2005. We also know a number of things about our aging population:

- we have fewer acute health conditions, but more chronic ones;
- we are wealthier, but more in debt than previous generations;
- half of those 85 and older experience some form of dementia;
- 16.5 percent of the 60-69 age group have 1 or more disabilities; and
- 51.6 percent of those ages 80 and older have one or more seriously disabling conditions.

With very limited resources, we must continue to serve frail and vulnerable Ohioans while retooling to address the changing needs and expectations of the burgeoning baby boom generation for themselves, their parents and their loved ones. The ODA must address the near-term needs while we prepare for the long-term demands.

Many of you are very familiar with ODA's flagship programs including the Golden Buckeye Card; Pre-Admission Screen System Providing Options and Resources Today (PASSPORT); Assisted Living; Program of All-Inclusive Care for the Elderly (PACE); the Long-term Care Ombudsman; and our Older American Act funded services, such as home delivered meals, congregate meals, homemaker services and the Senior

Community Services Employment Program (SCSEP). In 2008, an estimated 257,759 older Ohioans received services supported by Older Americans Act Title III, including:

Programs & Services	Consumers	Service Units
Home Delivered Meals	46,432	6,080,338 meals
Congregate Meals	66,132	2,412,928 meals
Personal Care and Homemaker Services	8,065	364,259 hours
Transportation	32,198	1,096,856 one-way trips
Caregiver Support including Respite	42,000	
Senior Community Service Employment Programs	3,488	
Adult Day Services	1,150	60,969 days
Chore	2,747	37,539 hours

As a service-focused, subsidy-based agency, it is challenging to reduce expenditures while retaining core services. ODA has a total biennial budget of \$1.3 billion (95 percent of which is Medicaid or federal funding) and operates with administrative costs of approximately 2.4 percent. Regardless, we have made a number of administrative savings, including: a five percent reduction in staff; reducing rental costs by nearly \$250,000 over the biennium; and reducing our total GRF administrative costs by 20 percent. Today, we are fortunate to have a unique opportunity to present a budget that not only sustains our most crucial programs, but includes a significant long-term care system reform and cost containment initiative.

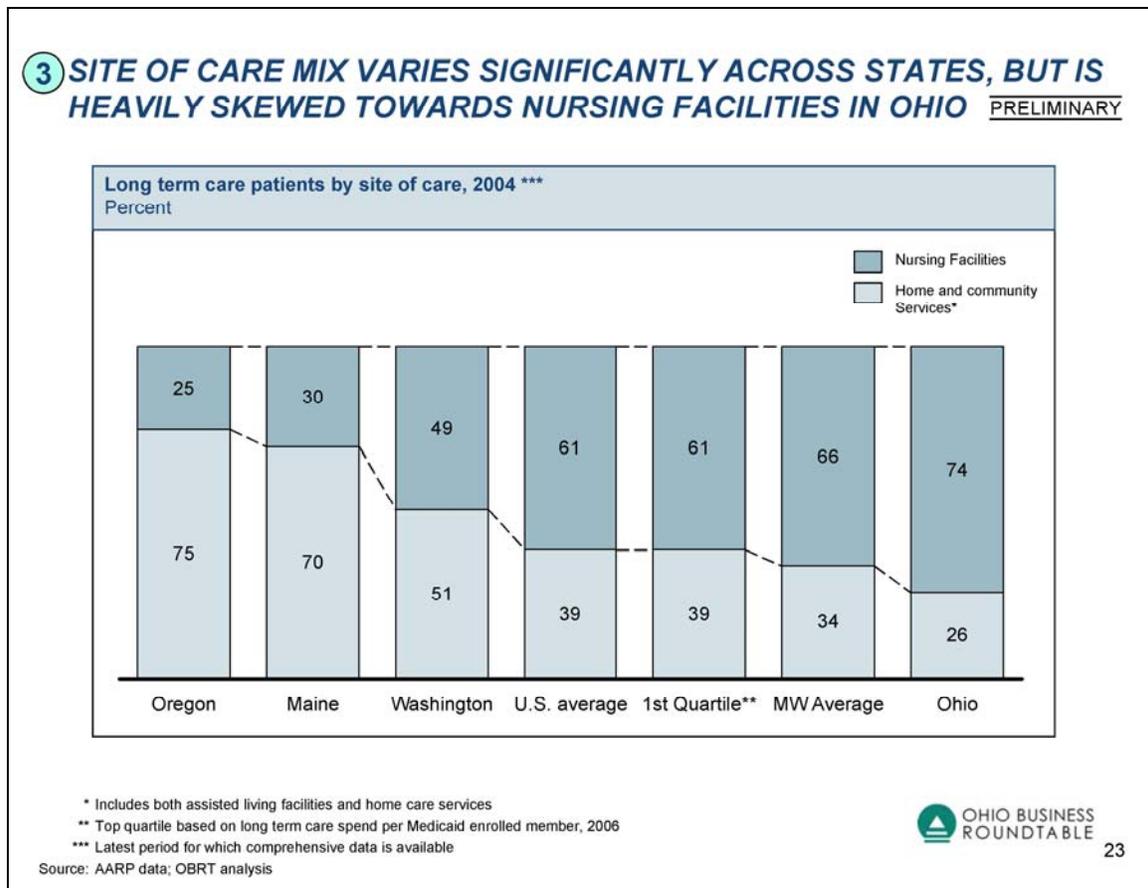
Unified Long-term Care Budget:

You may recall that in HB 119 the SFY 2008/2009 biennial budget, the Governor and General Assembly created a workgroup to make recommendations for the implementation of a Unified Long-term Care Budget (ULTCB). The 27 member workgroup, which included Senators Niehaus and Cafaro and Representatives Jones and Budish, formed subcommittees with more than 300 participants, representing all facets of

stakeholders, and by consensus issued a report with more than 120 recommendations. I am pleased to bring forward to you today the initial steps necessary to put those recommendations in place and create not only that unified budget, but also real long-term care system reform that will achieve better balance between home- and community-based services (HCBS) and institutional services. The premise of the ULTCB is that services are available to the consumer based on their need and their choice, not the funding stream.

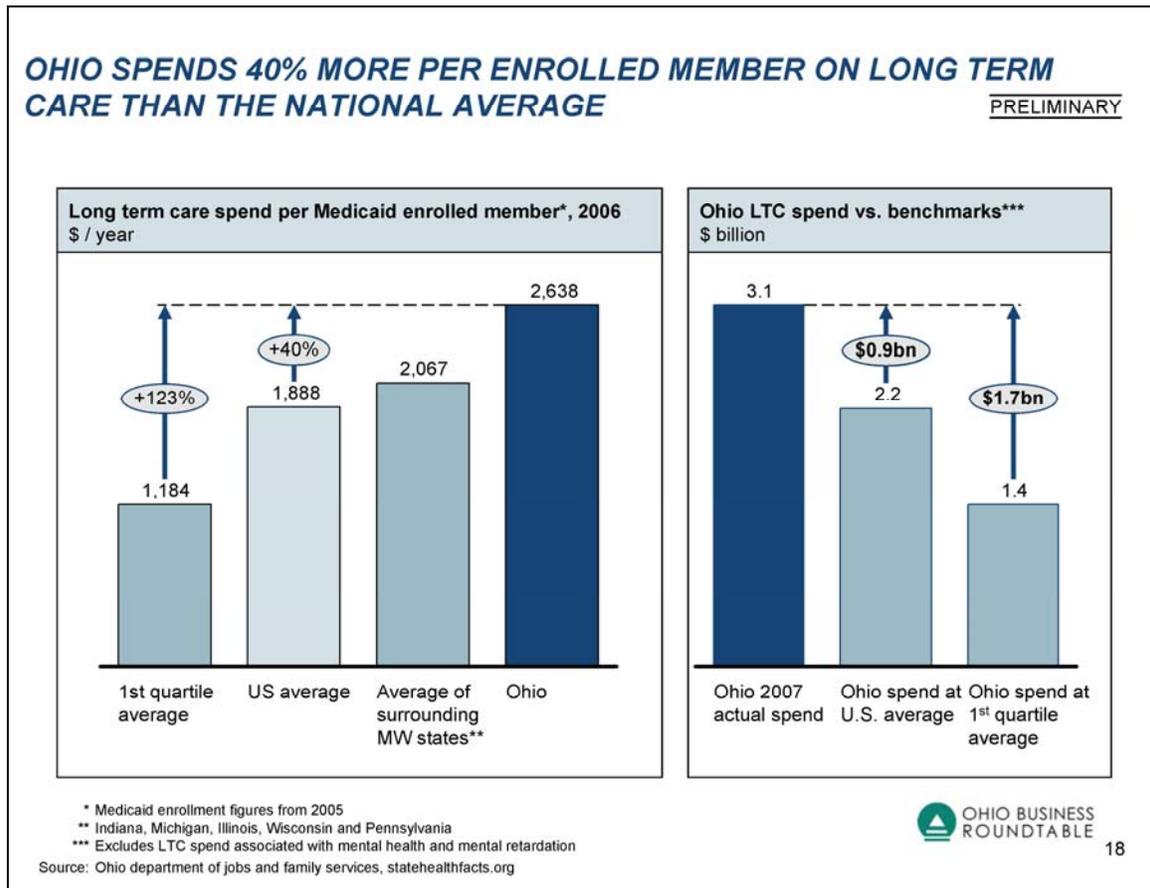
Why is this so important? First and foremost is the ability to improve quality of life, independence, well-being and choice for our consumers. When AARP conducted a recent survey in Ohio, 94 percent of the respondents indicated they would prefer to receive care in their own homes and communities. We know that health care outcomes are improved and that individuals are more satisfied when HCBS are made available.

But given our current economic circumstances, the cost containment side of the equation is vital. Ohio now ranks 39th in the nation on our expenditures for HCBS versus institutional care.



The Business Roundtable (BRT) has noted that if Ohio simply were to achieve the national average on what we spend for HCBS versus institutional services, we would realize a savings of \$900 million a year in Medicaid costs. Our current expenditure patterns are unsustainable and will drive Medicaid expenditures toward the proverbial train wreck.

“Between 2000 and 2006 the long-term care portion of the Medicaid budget grew at an average annual rate of 7.5 percent. If Medicaid long-term care expenditures continue to grow at that rate, by the year 2020 the total long-term care portion of Medicaid allocations, (from all sources) will grow to over \$13.2 billion (up from \$4.2 billion in 2006)” (Mehdizadeh, Scripps Gerontology Center, 2008)



This makes it abundantly clear that we must refocus our provision of services from the more expensive institutional care to the more cost effective and desirable HCBS. HB 1 begins that shift. The following illustrates the cost comparison for long-term care services:

Service/Program	Per Member Per Month Cost (includes state plan services)	State Share
PASSPORT	\$1,400	\$560
Assisted Living	\$2,106	\$842
PACE	\$2,774	\$1,110
NF	\$4,231	\$1,692

The most obvious line item change is the consolidation of our individual long-term care program line items into a single long-term care line. To support that single line item, ODA will explore combining our Medicaid programs into a single waiver. This would allow us to allocate services and service dollars based on need, not funding source, which has artificially driven service utilization over the years.

The foundation for the ULTC system underlying HB 1 includes:

- Full funding for PASSPORT enrollment so there are no waiting lists;
- Funding for Assisted Living and PACE to fully accommodate the slots currently approved by the Center for Medicare and Medicaid. (1,800 for AL and 880 for PACE);
- Moving 800 consumers, out of nursing facilities and into the community, if they are able and wish to do so;
- Diverting 1,445 individuals from nursing facility placement by using HCBS;
- Expanding opportunities for consumer self direction;
- Expanding the use of Home First to include the PACE program (this currently exists for PASSPORT, Assisted Living and the Residential State Supplement (RSS) programs);
- Creating a “no wrong door” approach for access to long-term care by using collaboration among local agencies facilitated by the Area Agencies on Aging;
- Expanding the Long-term Care Consumer Guide to include information on HCBS;

- Conducting follow up assessments for a subset of individuals receiving care in nursing facilities to determine whether they are interested in or have the capacity to move back into the community;
- Creating an ongoing quarterly caseload forecasting and expenditure review to monitor demand and funding, and if necessary, recommend to the Executive Medicaid Management Administration (EMMA) that a request be made to the Controlling Board to transfer funding;
- Expanding our long-term care service array to explore new service settings such as congregate/senior housing and/or adult foster care; and finally;
- Reconstituting the ULTC workgroup to pursue next steps.

How are we paying for this? In the recent federal stimulus package, the federal match rate for Ohio's Medicaid program was increased, and at ODA we are using that revenue to "front load" our ULTCB. This will allow us to fund our increased use of HCBS now, which over the next few years will result in a steady decline in our long-term care expenditure growth rate. This will allow us to continue to expand our lower-cost services for an ever expanding caseload well into the future while decreasing per member, per month, long-term care costs.

In addition, we will hold provider reimbursement rates at SFY 2009 levels; maintain Area Agency on Aging administrative costs at SFY 2009 levels; and provide case management so the per member per month costs for each of our service packages also are held constant at SFY 2009 levels.

Long-term Care Ombudsman:

The Office of the State Long-term Care Ombudsman, through state and regional staff plus over 500 volunteers, works to inform consumers regarding their right to expect quality care and responds to about 9,000 complaints a year. The budget includes \$600,000 per year from the Resident Protection Fund for the Office to tackle the difficult issue of involuntary discharge and proper nursing home discharge planning. We believe the ombudsman program is a crucial link in our efforts toward diversion and transition to HCBS.

Older Americans Act Programs:

Given Ohio’s fiscal climate, this budget does reflect reductions to other service areas by between 16 percent and 20 percent (after 2009 budget adjustments). As a result we estimate this potential decline in caseload:

Service	
Adult Day Care	31
Case Management	19
Chore	45
Counseling	1
Emergency Response System	8
Escort-Asst Transport	18
Home Delivered Meals	230
Home Maintenance	52
Home Medical Equipment	1
Homemaker	104
Personal Care	79
Protective Services	6
Transportation	812

At these funding levels, there is a possibility that we will be unable to comply with federal requirements for state maintenance of effort which could result in a proportional cut in our federal Older Americans Act funding. We will be working with other states, many of which are in a similar situation, to advocate for a waiver from the maintenance of effort requirements while states are in fiscal crisis.

However, there also is some good news as a result of Congress’ recent actions. Both nutrition and senior employment programs received additional funding and we believe we will receive additional dollars in Ohio as a result. We are still reviewing the

parameters being imposed with the funding but know it will not fully offset the impact of the necessary state level cuts. In addition, those funds must be spent quickly and may leave service gaps in the latter part of the biennium. The ODA is actively working with the Area Agencies on Aging, advocacy groups and our providers to identify potential efficiencies and ways to retain services and cut costs.

Senior Civic Engagement Initiative:

One of the efforts we are making to meet both the economic challenges Ohio now faces and the changing face of aging in Ohio is our Senior Civic Engagement Initiative (SCEI). Created by an Executive Order in May, 2008, this is a collaborative effort, led by the ODA, to enhance workforce development, volunteerism and life-long learning for Ohio's seniors.

One effect of our aging population is that all of the growth in Ohio's workforce in the next decade is in the 55 and over age group. We know that many of us do not choose to stop working at 55, and many more cannot afford to. We also know that our economy cannot absorb the costs if all those over 55 did leave the workplace, including the precipitous decline in income tax collection, the lost productivity and the societal costs. Therefore, we are working to build an environment where older workers can receive the training necessary to retain or attain today's jobs and where Ohio's businesses understand the value of older workers.

In addition, we are collaborating with the Ohio Community Service Council on maximizing the value of seniors as volunteers, and the value to seniors of volunteering. Finally, together with the Board of Regents and our colleges and universities we are creating life-long learning opportunities focused on both employment preparation and the benefits of exercising our brains, as well as our bodies, for the well being of our elders.

This effort and many of our others focus on active and healthy aging; a way of life that can prevent future reliance on long-term care and the Medicaid system.

Residential State Supplement:

This program essentially is a room and board stipend for individuals with disabling conditions who do not need a nursing home level of care. Currently, we serve more than 1,800 consumers, approximately 70 percent of whom have a mental health

diagnosis. This program does have a waiting list today, and as a result of the decreased level of funding, we project a decline from the current enrollment to 1,690 by the end of SFY 2011.

Given the behavioral health needs of this consumer group, we are working with the Department of Mental Health and Department of Health to determine how best to meet their needs.

Best Rx:

Best Rx is a prescription drug discount program put in place in 2005 to assist seniors or those with incomes at or below 300 percent of poverty with their prescription purchases. At the time it was created generics were less readily available, and there was no Medicare Part D prescription coverage, nor discount programs at Walmart, Kroger or Giant Eagle. Simply put, demand has never met expectations. Therefore, we are recommending the discontinuation of ODA's administration of the program as of January 1, 2010. Currently we are exploring if the program could be transitioned to a vendor. If this is not feasible, we will spend the next 10 months assisting the 20,000 consumers presently using the program to find the best prescription drug discounts available to meet their needs.

Before I conclude I would like to touch on how very valuable the newly created EMMA is. Through the joint efforts of the eight agency directors who share responsibility for administering Medicaid, we have begun to realize the efficiencies we all envisioned two years ago. I am greatly heartened by the open and cooperative nature of our communication, the willingness to share best practices, and the diligence of all involved to identify problems and look for creative solutions.

I want to thank you for your time and attention and I recognize that even though we are a small agency, we have brought forth a lot of information for you to digest. Perhaps that gives credence to the old adage "Good things come in small packages."

I will be happy to answer any questions you might have.