

## Overview of the Long-Term Services and Supports State Profile

In response to the advocacy of people with disabilities of all ages and their families, many states are balancing their long-term services and supports systems to assure choice, reduce institutionalization and increase opportunities for people to live in the community. As part of the balancing effort, some states - with the encouragement of Centers for Medicare & Medicaid Services - are developing a profile of their long-term services and supports system.

Each state's long-term services and supports system is shaped by factors that are unique to that state, including: the state's demographic makeup (e.g. the percentage of the population over or under age 65), historical service utilization patterns (e.g. proportion of the Medicaid budget spent on long-term services and supports), and its political and organizational structure (e.g., on what level services are administered - county, regional, state; community funding/supports).

A state long-term profile can:

- Provide policymakers and stakeholders with a high-level view of the long-term services and supports system, to ensure a common knowledge base;
- Identify opportunities for improved coordination – among long-term services and supports programs and with other health and social services;
- Acknowledge the success that has occurred;
- Identify service gaps; and
- Provide a framework for comparing balancing efforts across states.

The profile describes available home and community supports. It then presents demographic and utilization data to show the demand for and use of long-term supports. Finally, it describes the state's progress with respect to eight system components that have been identified by researchers as important for a balanced long-term services and supports system. They are:

1. **Consolidated state agencies** – a single agency for both institutional and community services that coordinates policies and budgets to promote community opportunities;
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. **Home and Community Based Services (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.

## Steps in the Development of a State Profile

- 1.) Determine available resources including the scope of the state profile (e.g. limit to only certain populations or choose to only profile a few system components instead of all 8).
- 2.) Describe the State's background and system administration including the role of individuals in need of long term supports and their families, local and state agencies, the legislature, advocates and providers. Describe the current long term supports system (program eligibility, funding, benefit design, services and operations). The description should include demographic and utilization data.
- 3.) Assess system components associated with balancing. The assessment should include the use of national, state and local data sources as well as interviews with individuals accessing services. Focus groups are encouraged.
- 4.) New Step - not in the Thomson Medstat Technical Assistance Guide. Ohio should develop a dashboard to measure progress over time so that the profile becomes a "living" document.

## Examples of Balancing Measures

### **General Balancing Measures**

- The ratio of HCBS waiver member months to NF/ICF-MR institutional member months.
- The percentage of institutional and non-institutional long term service and support expenditures that were expended for non-institutional long term care.
- An increase in the number of NF or ICF/MR beds that are closed.
- Enactment of statutory or administrative code rule changes supporting balancing.

### **Access**

- Percentage of individuals who sought access to long term care services through a single access point.
- Percentage of individuals with a primary care provider who lives within XX miles of their provider.

### **Housing**

- Percentage of PHAs who gave preference on their waiting list to anyone seeking to move from an institutional setting to the community.

### **Transportation**

- Percentage of consumers who reported having access to transportation to attend medical appointments.

### **Care Management**

- Percentage of transitioned individuals who were re-institutionalized in a NF or ICF/MR within 12 months of transition.

### **Employment**

- Percentage of transitioned individuals who participated in community employment roles.

### **Satisfaction**

- Percentage of individuals who expressed satisfaction with choices available and services chosen.