

What is Long-Term Care?

Background

An overly simple traditional “textbook” definition of long-term care is suggested by CMS:

[Long-term care is a variety of services](#) that includes medical and non-medical care to people who have a chronic illness or disability. Long-term care helps meet health or personal needs. . . Long-term care can be provided at home, in the community, in assisted living or in nursing homes.

Many would argue that today long-term “care” in reality is a complex array of services and supports experienced by consumers with long-term needs. In addition, the use of the term “chronic” may not encompass those consumers whose need for services and supports are episodic or cyclical in nature.

In Ohio, like most states, the array of long-term services and supports evolved over time. Different programs were created for different policy objectives – all of which made good sense at the time they were developed. The result is that Ohio has *rational* programs, but an *irrational* delivery system that is often overwhelming to consumers and has lacked a cohesive policy focus. To many, asked to define long-term services and supports, the answer is a specific program: PASSPORT, Individual Options, Nursing Home care, assisted living, Ohio Home Care, and so on. But to allow the *program* to create the *definition* obscures the fact that consumers of each of these services also receive medical and non-medical services through other mechanisms – Medicare, Medicaid traditional state plan services, informal unpaid care, just to mention three.

A second issue for the workgroup to consider is that by convenience, the discourse around long-term services and supports tends to focus on Medicaid-funded long-term care services. Should that be the sole focus of the workgroup? Or do we mean to include other sources of funding? Are we just talking about state and federal funding or do we address local funding as well?

Linking Non-Medical and Medical Services

We propose that the definition of “long-term care” encompass all medical and non-medical services that the consumer receives. Admittedly, this would introduce a level of complexity to the budgeting process beyond simply adding up the costs of each program included in the unified budget because we must then determine what additional services long term care consumers receive. But resolving this additional level of complexity allows us to keep the unified budget focused on what consumers need and receive rather than focused on the programs that have been created.

In support of the proposal, consumers enrolled on Medicaid waivers benefit from having a case manager who assists consumers in understanding their options and authorizes a service plan for and with the consumer. Other services, purchased through non-waiver means, such as regular

Medicaid state plan services currently are not included in this service plan and are not care managed. Services received through other funding sources are not even known. This fragmentation contributes to higher cost to the state and often lower quality for the consumer. It is also important to remember that some consumers receive Medicaid services ONLY through the traditional Medicaid state plan (e.g., consumers who need behavioral health supports).

Should a unified budget consider funding other than Medicaid?

The first reaction is often “yes” because we want to be holistic if we are designing a system based on what consumers need and receive. But the difficulty here is one of proportion. That is, Medicaid funding predominates among all funding sources (acknowledging that informal, non-publicly funded long-term care dwarves even Medicaid spending). The 2004 *Ohio Access* report (available online through the ODA website) illustrates that for sister state agencies such as ODA and ODMRDD, Medicaid funding now predominates (e.g., 80% of ODA’s funding comes from Medicaid sources). The state contributes relatively small amounts of its GRF beyond Medicaid for long-term services and supports. Federal funding through the Older Americans Act, Title XX, Substance Abuse Prevention, and Treatment and other sources does not significantly increase the amount of spending on long-term services and supports either. Our recommendation for the subcommittee workgroups is to *consider* these non-Medicaid funding sources in their recommendations (e.g., the “front door” should not be focused solely on Medicaid-funded programs; care management should not just focus on Medicaid waiver services); but the ultimate unified budget itself would *not* include non-Medicaid sources in the line items that are created.

By limiting the ULTCB to Medicaid only funding, the funding streams that would fall outside the ULTCB would include OAA, Title XX, SAPT, local levy dollars, and various state line items. In some instances this would mean that a service provided by a Medicaid program would be included, while the same service provided by another source to the same or similar consumer (such as adult day care, transportation, etc) would not be included. We recommend that the administration committee conduct a review to identify overlaps or similar issues and determine whether a future integration of such funds into the ULTCB would be appropriate.