ULTCS BALANCE AND FUNDING SUBCOMMITTEE
August 2, 2010 Meeting Notes

PRESENT

Co-chair Roland Hornbostel, ODA
Co-chair Tracy Plouck, ODJFS/OHP
Kathleen Anderson, OCHCH
Bob Applebaum & Shahla Mehdizadeh, Scripps
Angie Bergefurd, ODMH
Mary Butler, OSILC
Deanna Clifford, ODA
Doug Day, ODADAS
Chuck Demidovich, CCAO
Suzanne Dulaney, OACBHA
Frank Fleischer, OCAPS
Jodi Govern, ODH
Robin Harris, Governor's Office
Barry Jamieson, OSU
Carolyn Knight, DD Council
Beverley Laubert, State LTC Ombudsman
Joan Lawrence, AARP
Mike Luers, ODA
Jeff Lycan, OHPCO
Lynne Lyon, ODMH
Mike Moore, ODA
Grace Moran, ODA
Chris Murray, OANH
Steve Peishel, OBM
Larke Recchie, OAAAA
Sara Riegel, SEIU #1199
Erika Robbins, ODJFS
Bill Sundermeyer, AARP
Jean Thompson, OALA
Tim Tobin, OLRS
Pete Van Runkle, OHCA
Karla Warren, ODA

MATERIALS/HANDOUTS

July 20, 2010 Meeting Minutes
6 ADRN Recommendation

STATE PROFILE TOOL DEMONSTRATION

Bobby Applebaum and Shahla Mehdizadeh from Scripps gave a presentation of the State Profile Tool based on a sample of the first two of the eight indicators. Graphs compared Ohio statistics: to national figures, over time, across states and by age.

The term "facility-based" was defined as including nursing homes and ICFMRs as defined by CMS, compared to "home- and community-based services" (revised to "community-based waiver services").

A number of hurdles to developing the LTC profile were shared:

- Definition of long-term services and supports.
- Data limitations (e.g., bed tax).
- Data not always comparable and no data in some areas, especially non-Medicaid data
- People often fit into multiple data groups.

The goal is to have a set of data on the Web site by January, realizing that this is an evolutionary process that will continue to improve over time.

Shahla specified that managed care services are not included in this data.

SPT Comments
Jeff Lycan pointed out a concern about the resource limitations anticipated when the number of people to care for exceeds number of workers available.

Suzanne Dulaney asked about the timeframe for behavioral health. Jean Thompson asked about the definition of severe mental illness and mentioned that assisted living rules offer one definition. Addiction was stated as long-term by definition, but there are language definition concerns regarding "by episode" or "acuteness." Suzanne believes the SPT doesn't give a full picture of Medicaid. Erika Robbins asked that people be cautious about accurate titles and stated that footnotes try to frame the data sources.

Tracy Plouck suggested that the Balance and Funding Subcommittee be allowed to preview the measures. Bobby Applebaum will report back at the next meeting, but anticipates a preview site will be available by October or November.

Based on questions and comments, Scripps agreed to revise the presentation for distribution with the minutes and to be posted on the ULTCS Subcommittee page.

OALA NEW RECOMMENDATIONS
Jean Thompson was asked to describe her two additional recommendations (#22 and #23).

#22 – **Create incentives for assisted living providers to build in underserved areas/counties of Ohio.** (OALA-added 7/22/10)
Jean stated that this recommendation may be better served in Eligibility process group.

#23 – **Encourage maximum utilization and savings to the state through the AL Medicaid Waiver by offering a 4th tier or level reimbursement rate beyond the current maximum that would address "secure" unit placement for those with significant cognitive impairment.** (OALA-added 7/22/10)
Jean stated that this recommendation would address higher cost for higher need, but would necessitate program changes. Roland Hornbostel suggested a friendly amendment for ODA to review its three-tier approach that doesn't seem to be working properly.

Beverley Laubert suggested that as the population gets more complex, we should consider setting standards. Chuck Demidovich responded that implementing new standards would likewise increase operating costs.

> ***Action Step: Since these two recommendations seem to be eligibility-related, Roland agreed to talk with Rick Tully prior to the September meeting.***

RECOMMENDATIONS NEARING CONSENSUS
Recommendation #6: ***Expand the role of Area Agencies on Aging as Aging and Disabilities Resource Centers/Networks.***

Originally ODA had opted through its ADRN to work with younger population with physical disabilities, as opposed to Ohioans with developmental disabilities or Ohioans with behavioral health disabilities. Now ODA believes Ohio needs to expand to encompass all three disabilities populations.

Tracy Plouck affirmed that the ADRN handout is consistent with the recommendation.

Roland Hornbostel asked for comments on how to use the funding successfully and efficiently.

Chris Murray asked about the success of the Cleveland ODRN, to which Roland responded that there has never been robust enough data to accurately determine success.

Erika Robbins suggested an immediate action bullet for ADRNs to get a better understanding of what is happening, including funding, and how the state should move forward in leading local efforts. Larke Recchie added that Ohio should build on local expertise with overarching state direction.

Suzanne Dulaney asked about the ability of other entities to get the ADRN designation beyond the AAA, to which Larke Recchie responded that the beauty of the network is that a different entity could be funded following the no wrong door model.

Recommendation #16: ***Beginning October 1, 2010 and extending through June 30, 2013, individuals & associations represented on the ULTCB Balance & Funding Subcommittee should commit an appropriate level of in-kind support toward an informal team to identify and pursue grant opportunities for housing and related supports for individuals with severe & persistent mental illness who would like to live in the community in the event that sufficient supports are available. Partnerships with other entities could be developed as appropriate. This work should proceed regardless of whether any additional state support is made available via an operating or capital budget, with the goal of assisting to transition at least ___ people per year.***

> ***Action Step: Roland reiterated his request that Angie Bergefurd work with Tracy Plouck to wordsmith and refine the recommendation, especially regarding time commitment by agencies.***

Recommendation #1: ***Establish a benchmark for moving Ohio's balance between nursing facilities and HCBS from 59%/41% consumers and/or funding to 50%/50% in the next 3 years (aging/disabled population) and include the benchmark in the Olmstead Plan.***

Recommendation #15: ***By June 30, 2013, Ohio should show significant progress toward additional home & community opportunities in at least six of the eight areas of the State Profile Tool, using the SPT to measure that progress. Specific areas & goals will be determined during the course of the FY 12/13 biennial budget process.***

The group was reminded of the three options discussed previously for measuring balance:

- Counting funding
- Counting people
- Advancing on all (or a set number of) indicators (and doing trend analysis against Ohio data).

The two tabled recommendations, #1 and #15, were identified as alternative approaches to the same thing. Larke Recchie asked if significant progress is defined as moving forward on all indicators. Bobby Applebaum expressed willingness to lay out discussion parameters: money vs. people, three disability groups, in context of comparison to other states, and based on subpopulations.

Action Step: Roland agreed to flesh out more fully the agreed upon recommendations.

Action Step: Subcommittee members were asked to identify recommendations that they would be willing the flesh out, following the Workforce Subcommittee format:

- Recommendation
- Sub-recommendations
- Immediate Actions
- Short-term Actions
- Long-term Actions

Action Step: Mary Butler and Larke Recchie agreed to work on Recommendation #2.

Action Step: Chris Murray agreed to work on Recommendation #8.

Action Step: For any of the remaining recommendations (# 7, #18, #20, #21, #22, #23) to have the potential to be carried forward to the ULTCS Stakeholder Workgroup, new drafts following the format above need to be submitted to Mary Inbody by COB, Thursday, August 26th.

General Comment:
Bill Sundermeyer spoke of his recent personal experience in "helping his father die in the way he wanted to die," i.e., finding the person with the ability and credentials to get the data and the people willing to talk with him, share information and fight the system. For him the lesson was in the irrelevancy of most of our discussions when we should be focusing on how to make the system better, especially in next 12 months.

NEXT MEETING
There was consensus for the need for another meeting prior to September 7th in order to provide some drafts to present at the plenary meeting. It was decided to set the meeting for the week of August 30th at JFS with a conference call line.

Meeting adjourned at 3:55 pm.

(See attached table for complete list of recommendations and status. Shading denotes referral to another subcommittee.)

BALANCE & FUNDING SUBCOMMITTEE RECOMMENDATIONS STATUS SHEET

Item #	Recommendation (Updated8/10/2010)	Status	Approaching Consensus
1.	**Establish a benchmark for moving Ohio's balance between nursing facilities and HCBS from 59%/41% consumers and/or funding to 50%/50% in the next 3 years (aging/disabled population) and include the benchmark in the Olmstead Plan.** *(O4A and AARP, accord Applebaum)*		X???
2.	**Apply the expanded Home First (HB 398) concepts of imminent risk of NF placement to all of the HCBS waivers to prevent individuals from entering nursing homes unnecessarily.** *(O4A and AARP)*		
3.	**Allow individuals with mental illness who are inappropriately placed in nursing facilities to transition to community settings and for NF funds to follow them for community mental health services.** *(O4A and AARP)*		X???
4.	**Utilize Long-Term Care Consultations (assessors) from AAAs in hospitals, nursing facilities, and health care clinics with concentrated Medicaid chronic disease patients. This will prevent unnecessary nursing home placement.** *(O4A and AARP)*	**To Integration & Care Mgmt**	
5.	**Expand evidenced based disease self management programs to prevent or mitigate an increased need for long-term services and supports.** *(O4A and AARP)*	**To Integration & Care Mgmt**	
6.	**Expand the role of AAAs as Aging and Disability Resource Centers (or Networks).** *(O4A and AARP)*		X
7.	**Consider incentives for nursing homes to convert beds to assisted living or other HCBS options.** *(O4A and AARP)*		
8.	**Create an equitable, sustainable funding source across all providers where contribution levels are equated to expenditure levels and adjust accordingly.** *(OANH)*		
9.	**Create a prioritization policy that ensures available resources go to individuals with the greatest needs first.** *(OANH)*	**To Front Door**	
10.	**Develop uniform monitoring and reporting (e.g. quarterly assessments) across all systems and settings to be able to better disenroll individuals if their needs change and they fall down the priority list.** *(OANH)*	**To Front Door**	
11.	**Develop policies and programs that encourage the development and use of local resources for Medicaid eligible individuals (via federal match) for HCBS. (OANH)**	**To Front Door**	
12.	**Develop policies that ensure local non-Medicaid services are not available to individuals and that Medicaid is the last available resource for each service provided.** *(OANH)*	**To Front Door**	
13.	**Need for presumptive eligibility to allow expedited access to the waiver for those currently living in Assisted Living but running out of money.** Expedited access to the Assisted Living waiver is needed for those currently living in Assisted Living, but running out of money. Individuals can be forced to move to a more expensive setting while waiting for Medicaid approval (lag time up to 4-5 months). Since the level of care disability eligibility determination is made by the AAA, the delay appears to be with the financial eligibility determination at the County Department of Jobs and Family Services (and this time frame seems to vary between counties).	**To Eligibility**	

13. cont.	The timeliness of this decision is critical, since it is a "waiver" program. Under the waiver program, the AL facility is not reimbursed retrospectively for any time prior to the date of enrollment (even if the date the individual was eligible precedes the date that they were approved & enrolled. *Presumptive eligibility* is needed. This has been successfully implemented in other waiver programs (PASSPORT). *(OALA)*		
14.	**Need for access to Assisted Living for Medicaid eligible individuals not currently in a nursing home or on another waiver program.** Access to the AL waiver is now limited to those currently in a nursing home or other waiver programs. This prevents appropriate placement for other Medicaid eligible individuals into Assisted Living (which could prevent unnecessary nursing home placement). A change in the law is needed to allow access to this part of the continuum as appropriate, with the potential to increase quality of life and decrease overall system costs. OAC 5101:3-33-03 (B)(3). *(OALA)*	**To Eligibility**	
15.	**By June 30, 2013, Ohio should show significant progress toward additional home & community opportunities in at least six of the eight areas of the State Profile Tool, using the SPT to measure that progress. Specific areas & goals will be determined during the course of the FY 12/13 biennial budget process.** *(amended by OHP)*		**X???**
16.	**Beginning October 1, 2010 and extending through June 30, 2013, individuals & associations represented on the ULTCB Balance & Funding Subcommittee should commit an appropriate level of in-kind support toward an informal team to identify and pursue grant opportunities for housing and related supports for individuals with severe & persistent mental illness who would like to live in the community in the event that sufficient supports are available. Partnerships with other entities could be developed as appropriate. This work should proceed regardless of whether any additional state support is made available via an operating or capital budget, with the goal of assisting to transition at least ___ people per year.** *(OHP)*		**X**
17.	**Improve the wages and benefits of the direct care employees serving our LTC consumers.** *(AARP)*	**To Workforce?**	
18.	**Develop and implement an improved quality of care system which correlates the quality of care provided consumers directly to the reimbursements the provider receives.** *(AARP)*		
19.	**Explore partial and selective capitation mechanisms for non-institutional based services (as demonstrated by the Milwaukee family care model).** *(Benjamin Rose Institute on Aging)*	**To Integration & Care Mgmt**	
20.	**In an effort to ensure a sustainable continuum of long-term care service and support to serve Ohio's needs today and in the future, we must establish appropriate reimbursement rates for all long-term care providers sufficient to ensure quality of care for all consumers.** *(OHCA)*		
21.	**Provide for selective and strategic expansion of Personal Needs Allowance (PNA) supplement based on living arrangement and benefit to the state. (Benjamin Rose Institute on Aging)**		
22.	**Create incentives for assisted living providers to build in underserved areas/counties of Ohio.** *(OALA-added 7/22/10)*	**???**	
23.	**Encourage maximum utilization and savings to the state through the AL Medicaid Waiver by offering a 4th tier or level reimbursement rate beyond the current maximum that would address "secure" unit placement for those with significant cognitive impairment.** *(OALA-added 7/22/10)*	**???**	

Overview of Ohio's LTC Profile

- CMS Develops LTC Profile Tool to Track State Progress on System Balance --Unified Budget Group Requests Ohio Tool
- ODJFS Convenes Interagency Task Force to Determine Benchmarks. Decides on a Web version rather than written report
- ODJFS and Scripps have been working to populate data base- will build incrementally- launch starting January

Overview of the LTC Web Site

- Web includes general background on size of LTC population and costs in Ohio with data links
- Web includes detail about various populations needing long-term services and supports, with data links
- Web includes description of Ohio's benchmarks and then detailed link for each one

First Page of LTC Profile

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Ohio.gov | Profile of Ohio's System of Long Term Services and Supports

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- Balancing Ohio Home
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- Ohio Vision and Values
- Publicly Funded Long Term Services and Supports
- Strategic Initiatives
- Performance Indicators
- Acronyms
- Glossary
- Contact Us
- Customer Service Phone Numbers
- Feedback/

About Ohio's Long Term Services and Supports System Profile

Background

With 11.8 million people Ohio is the sixth most populated state in the nation. Estimates indicate that approximately 1.1 million Ohioans have a disability requiring long term services and supports, and 309,000 of these individuals are severely disabled. As in many states, the resources required to assist individuals who experience severe disability represent a substantial and growing budgetary challenge. Currently, Medicaid accounts for about 25% of state-only general revenue funds, and Medicaid long term care accounts for 36% of the total Medicaid budget. People with severe disability rely heavily on Medicaid (39%) and other public resources to pay for their care. Although Medicaid is a shared federal/state responsibility, it is the states that take the lead on system and program design, management, and overall strategy. Critics have suggested that states across the country have not provided the necessary array of long term

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About Ohio's Long-Term Services and Supports System Profile

Background

With 11.8 million people Ohio is the sixth most populated state in the nation. Estimates indicate that approximately 1.1 million Ohioans have a disability requiring long-term services and supports, and 317,000 of these individuals are ***severely*** disabled (Disability in Ohio: Managing the Projected Need for Long-Term Services and Supports).As in many states, the resources required to assist individuals who experience severe disability represent a substantial and growing budgetary challenge. Currently, Medicaid accounts for about 25% of state-only general revenue funds, and Medicaid long-term care accounts for 36% of the total Medicaid budget. People with severe disability rely heavily on Medicaid (39%) and other public resources to pay for their care. Although Medicaid is a shared federal/state responsibility, it is the states that take the lead on system and program design, management, and overall strategy. Critics have suggested that states across the country have not provided the necessary array of long-term services and supports needed to create a balanced long-term care system and as the population ages and the potential population in need of assistance grows, it will be critical for states to improve their systems of care.

Description of Interagency Team

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- Balancing Ohio Home
- Governor's Message
- Balancing Dashboard
- About Ohio's Profile
- Ohio Vision and Values
- Publicly Funded Long Term Services and Supports
- Strategic Initiatives
- Performance Indicators
- Acronyms
- Glossary
- Contact Us

- Customer Service Phone Numbers
- Feedback/ Case-Specific Concerns
- Recent Additions
- Site Index
- Site Map
- Acronyms
- External Link Disclaimer
- Help/FAQs

About Ohio's Profile

Ohio's long term services and supports system is shaped by factors that are unique to our 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 our political and organizational structure (e.g., on what level services are administered - county, regional, state; community funding/supports).

An interagency team convened to develop Ohio's Profile using the feedback and recommendations received through stakeholder participation in Ohio's multiple strategic initiatives.

The interagency team included the:

- **Ohio Department of Job and Family Services (ODJFS)**
- **Ohio Department of Aging (ODA)**
- **Ohio Department of Developmental Disabilities (ODODD)**
- **Ohio Department of Mental Health (ODMH)**
- **Ohio Department of Alcohol and Drug Addiction Services (ODADAS)**
- **Ohio Department of Health (ODH)**
- **Ohio Department of Education (ODE)**
- **Ohio Department of Development (ODOD)**
- **Ohio Housing Finance Agency (OHFA)**
- **Rehabilitation Services Commission (RSC)**
- **Ohio Department of Insurance (ODI)**

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Sample page-- glossary

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Profile of Ohio's System of Long Term Services and Supports

Balancing Ohio Home
Governor's Message
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About Ohio's Profile
Ohio Vision and Values
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Performance Indicators
Acronyms
Glossary
Contact Us
Customer Service Phone Numbers
Feedback/ Case-Specific Concerns
Recent Additions
Site Index
Site Map
Acronyms
External Link Disclaimer
Help/FAQs

Glossary

Activities of Daily Living (ADL) – Basic personal activities which include bathing, eating, dressing, mobility (ambulation), transferring from bed to chair, and toileting.

Administration on Aging (AoA) – Federal agency that oversees Older Americans Act programs. An agency of the U.S. Department of Health and Human Services. AOA works closely with its nationwide network of State and Area Agencies on Aging (AAA).

Adult care facility – Residential care homes classified as either an adult family home (3-5 residents) or an adult group home (6-16 residents). Skilled nursing services such as medication administration cannot be provided in adult care facilities. Many of Ohio's adult care facilities serve residents with mental or behavioral problems.

Adult day care (See Adult day services)

Adult day services – Programs offering social and recreational activities, supervision, health services, and meals in a single setting to older adults with physical or cognitive disabilities. Typically open weekdays during standard business hours.

Adult family home – An adult care facility that provides accommodations and support services for three to five unrelated adults and personal care services to at least three of those adults. Adult family homes obtain their license through the

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Ohio's Performance Indicators

1. Medicaid expenditures on facility- based care compared to home and community based services.
2. Number of persons served in Medicaid funded facilities compared to those served in their own homes and communities.
3. Per capita, per month Medicaid costs (acute and long-term care) for persons in facilities compared to those receiving services in their own homes or communities.
4. Occupancy rates for long-term care beds.
5. Availability of affordable housing for people with a disability
6. Workforce status of Ohioans with disability.
7. Status of services and supports for children with disability.
8. Waiting time for participation in programs for people with a disability.

Revised 8/4/10

Example of Benchmark

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state agencies responsible for long term services and supports, are designed to provide a brief overview of state progress, similar to the limited information available on the dashboard of an automobile. The indicators focus on long term services and supports that are paid for by public dollars. When possible, Ohio's data are compared with the other states. The web site allows users to click on each dashboard indicator for more detail on a specific performance item. Information will also be presented by age, and by the type of long term services and supports needed.

Ohio's Performance Indicators

(1) Medicaid expenditures on facility-based care compared to home and community based services.

- Ohio's Medicaid long term care expenditures on facility-based and home and community-based care
  - Comparing Ohio's Medicaid long term care expenditure patterns for facility-based and community-based care with national figures
  - Comparing Ohio's Medicaid long term care expenditures patterns for facility-based and community-based care over time
  - Comparing Ohio's Medicaid long term care expenditures patterns for facility-based and community-based care with other states
  - Comparing Ohio's Medicaid long term care expenditure patterns for facility-based and community-based care by age of consumers

(2) Number of persons served in Medicaid funded facilities compared to those

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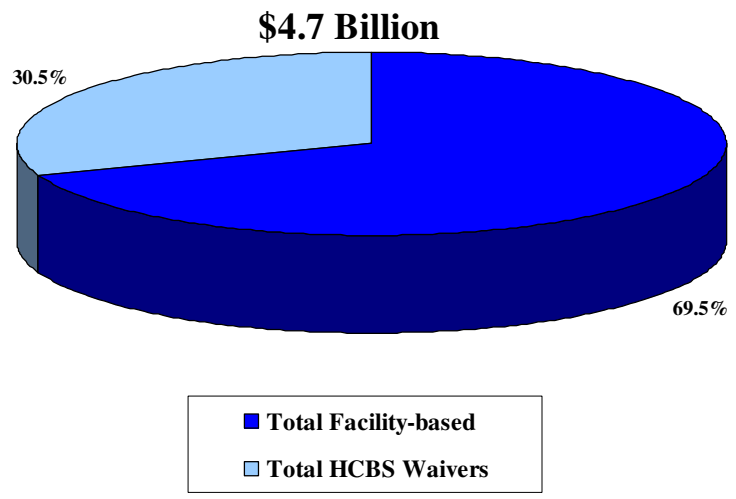
Medicaid Expenditures on Facility-Based Care Compared to Home and Community-Based Waiver Services.

In 2008, Ohio's total Medicaid expenditures for long-term care services and supports from all sources (federal, state and local contributions) were more than $4.7 billion dollars. About 70% of those dollars were spent on facility-based care (nursing home and Intermediate Care Facilities for people with intellectual or developmental disabilities) and 30% on home and community-based care.

Ohio's Total Medicaid Long-Term Care Expenditures for Facility-Based Care and Home and Community-Based Waivers 2008



Revised 8/4/10

Note 1:

The chart here presents total Medicaid expenditures (from state, federal and county contributions) for nursing home, ICF/MR and home and community-based waivers.

Note 2:

There are a number of individuals who live in the community and use private duty nursing, state plan home health, or mental health services. Those expenditures are not included here and throughout this presentation.

Note 3:

Although all Medicaid payments for facility-based care are included here, not all the care in a facility could be classified as long-term services and supports. Some individuals receive short-term acute and rehabilitative services in facilities.

Note 4:

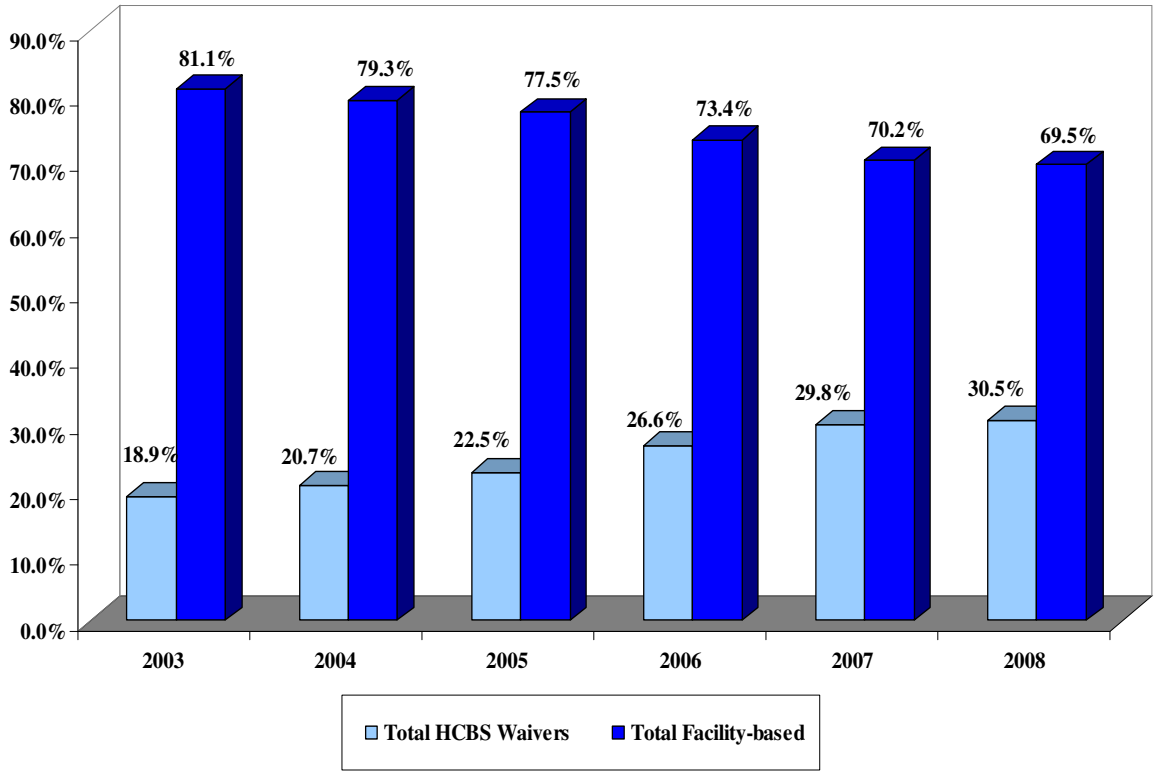
facility-based care expenditures for individuals enrolled in a Medicaid managed care are not included here.

Source: *Ohio Department of Job and Family Services. Medicaid Decision Support System*

Comparing Ohio's Medicaid Long-Term Care Expenditures Patterns for Facility-Based and Home and Community-Based Care Waivers Over Time

In the 5 years between 2003 and 2008, the proportion of Medicaid expenditures for home and community-based increased by more than 10 percentage points, from 18.9% to 30.5%.

Percent Distribution of Medicaid Long-Term Care Expenditures for Facity-Based Care and Home and Community-Based Waivers Over Time



Source: Ohio Department of Job and Family Services. Medicaid Decision Support System

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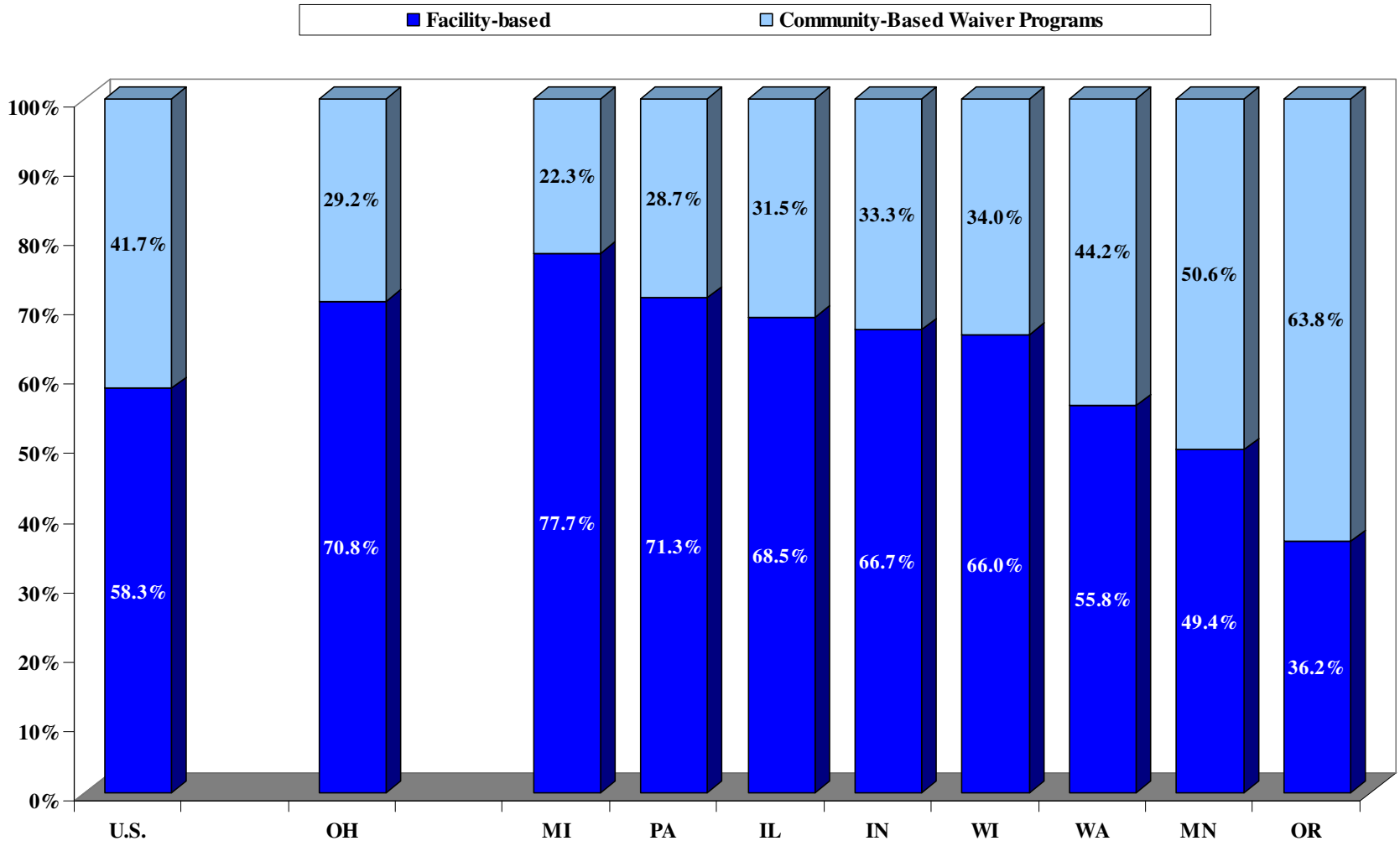
States Percent Distribution of Medicaid Long-Term Care Expenditures for Services and Supports by Setting, 2008



Note 1: Ohio had a franchise bed tax of $6.25 per bed in 2008. Not all states have a similar tax.

Note 2: The data presented here includes state and federal Medicaid dollars.

Source: Burwell, B., Sredl, K., & Eiken,S. (2008). *Medicaid long-term care expenditures in FY 2007*. Cambridge, MA: The Medstat Group.

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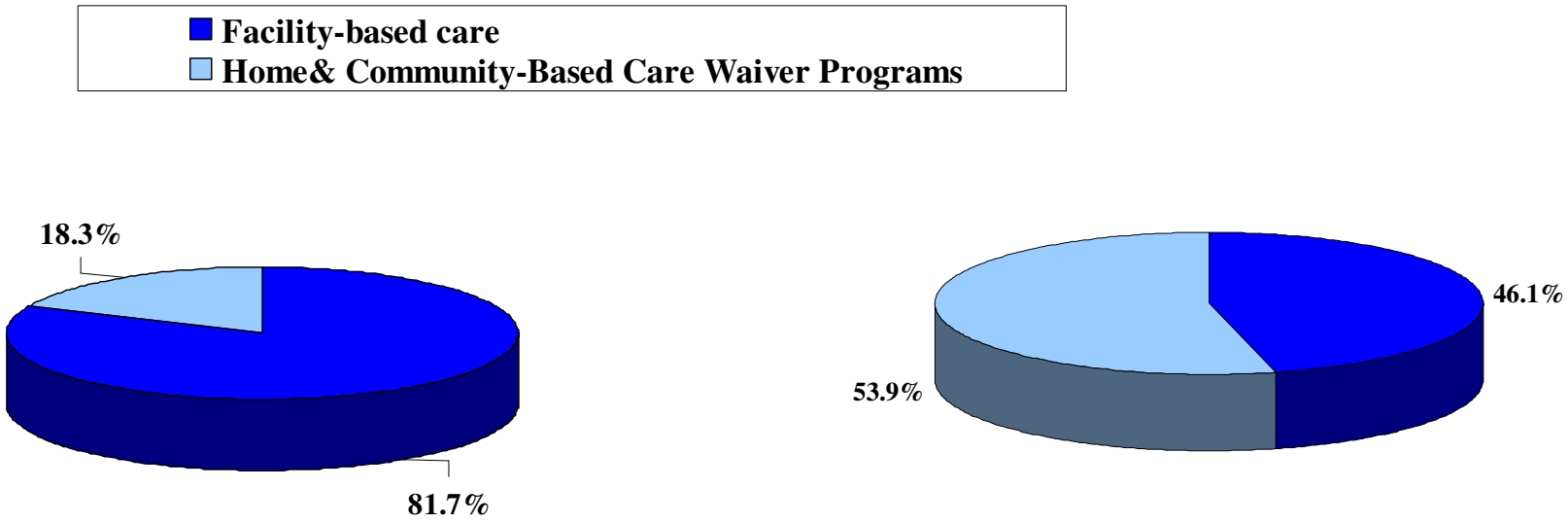
Medicaid Long-Term Care Expenditures by Disability and Setting, 2008



Individuals with Physical and/or Cognitive Disability

Individuals with Developmental and/or Intellectual Disability

Revised 8/4/10

Ohio's Medicaid Long-Term Care Expenditure Patterns for Facility-Based Care and Community-Based Care by Type of Disability

Through out this website, when it is possible, Medicaid expenditures and program and providers that serve the population with a disability are broken down by type of disability, irrespective of age:

- populations with physical and or cognitive disabilities;
- people with intellectual and or developmental disabilities;
- people with chronic diseases;
- people with severe mental illness
- People with substance abuse problems.

Revised 8/4/10

Population with Physical and/or Cognitive Disabilities

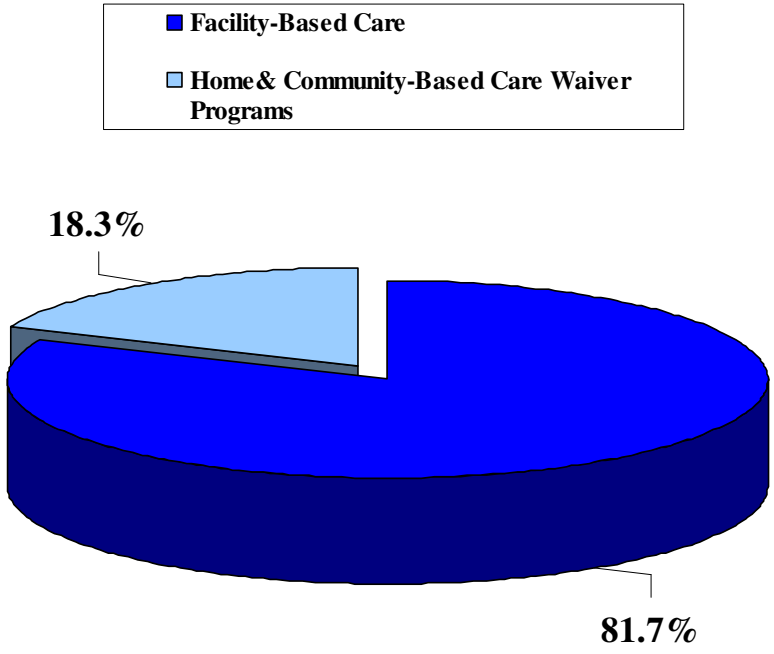
Although almost one out of every ten Ohioans has a disability, it is estimated that under 3% could be defined as severely disabled (Disability in Ohio: Current and Future Demand for Services). Throughout this website severe disability is defined to match Ohio's Medicaid eligibility criteria. Thus, a person meeting Intermediate Level of Care (ILOC) with no evidence of severe mental illness or intellectual and/or developmental disability, even if he/she has a diagnosis of dementia or Alzheimer's disease, he/she is classified as having a ***severe*** physical and/or cognitive disability.

The estimated number of people, of all ages, with severe physical and/or cognitive disability for 2009 was 182,500. People with disability rely on formal and informal sources for care and when it is possible use personal and family resources to pay for that care. 48% of the people with severe physical and/or cognitive disability received care paid for by Medicaid in 2009.

Medicaid Long-term Care Expenditures for People with Physical and/or Functional Disabilities

- Ohio's Medicaid long-term care expenditures *for people with physical and/or cognitive disabilities* using facility-based care and home and community-based waiver programs
- Comparing Ohio's Medicaid long-term care expenditures patterns *for people with physical and/or cognitive disabilities* using facility-based care and community-based waiver programs over time.
- Comparing Ohio's Medicaid long-term care expenditures patterns *for people with physical and/or cognitive disabilities* using facility-based care and community-based waiver programs with other states.
- Comparing Ohio's Medicaid long-term care expenditure patterns *for people with physical and/or cognitive disabilities* using facility-based and community-based waiver programs by age of consumers.

Medicaid Long-Term Care Expenditures for Individuals with Physical and/or Cognitive Disability, 2008



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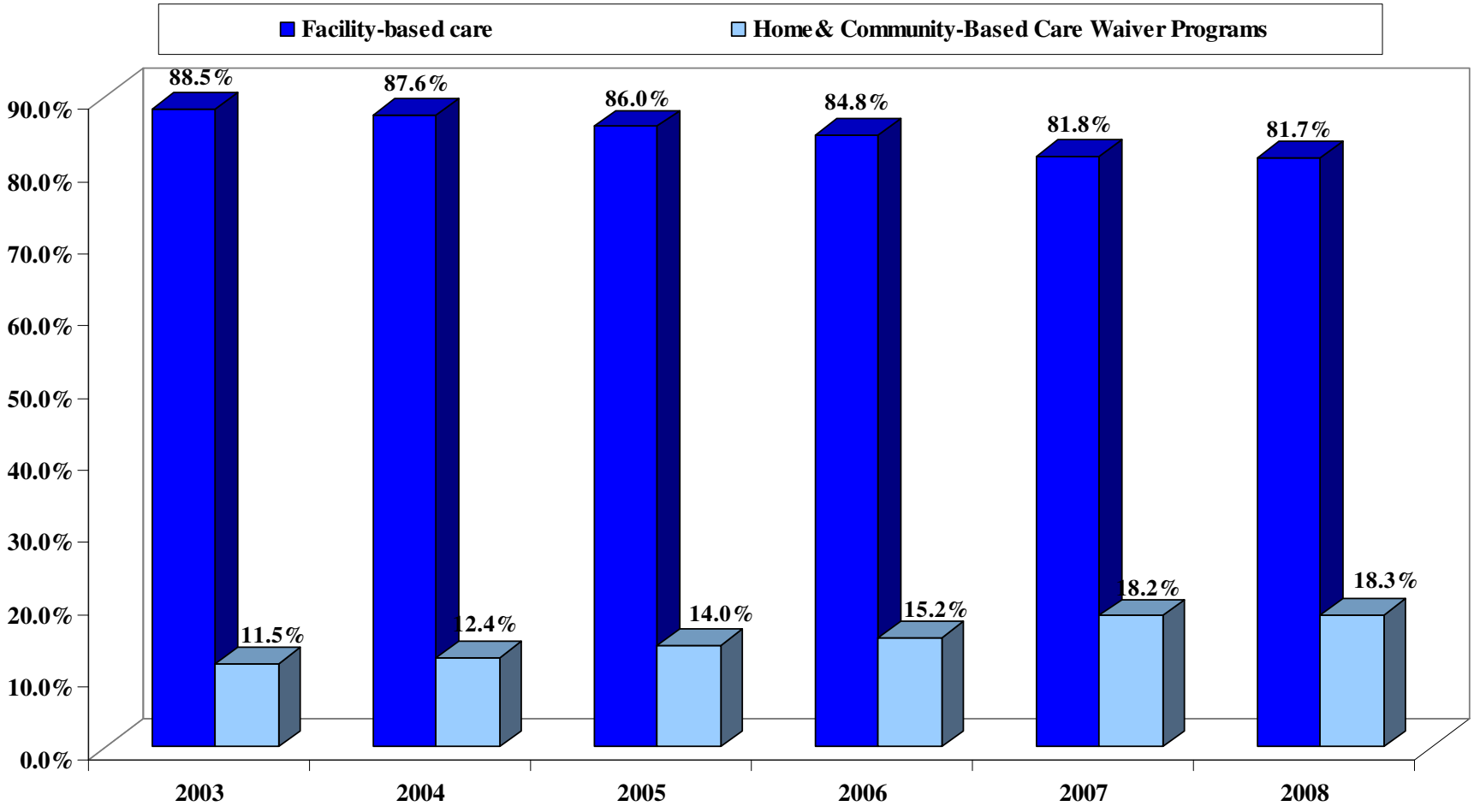
Percent Distribution of Medicaid Long-Term Care Expenditures for Services and Supports for People with Phyisical or Cognitive Disabilities using Facility-Based Care or Home and Community-Based Care Waivers Over Time



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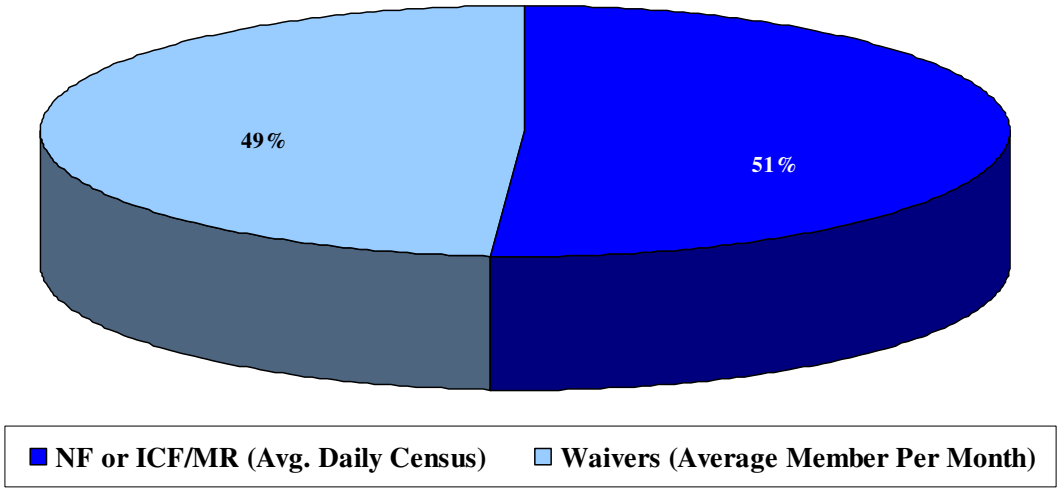
Benchmark # 2 Number of Persons Served in Facilities Compared to those Served in Their Own Homes and Communities.

- In this benchmark we will focus on people, rather than expenditures.
- We will present overall percentages for Ohio
- Data over time for past 5 years
- Data compared to other states
- Data broken down by target population

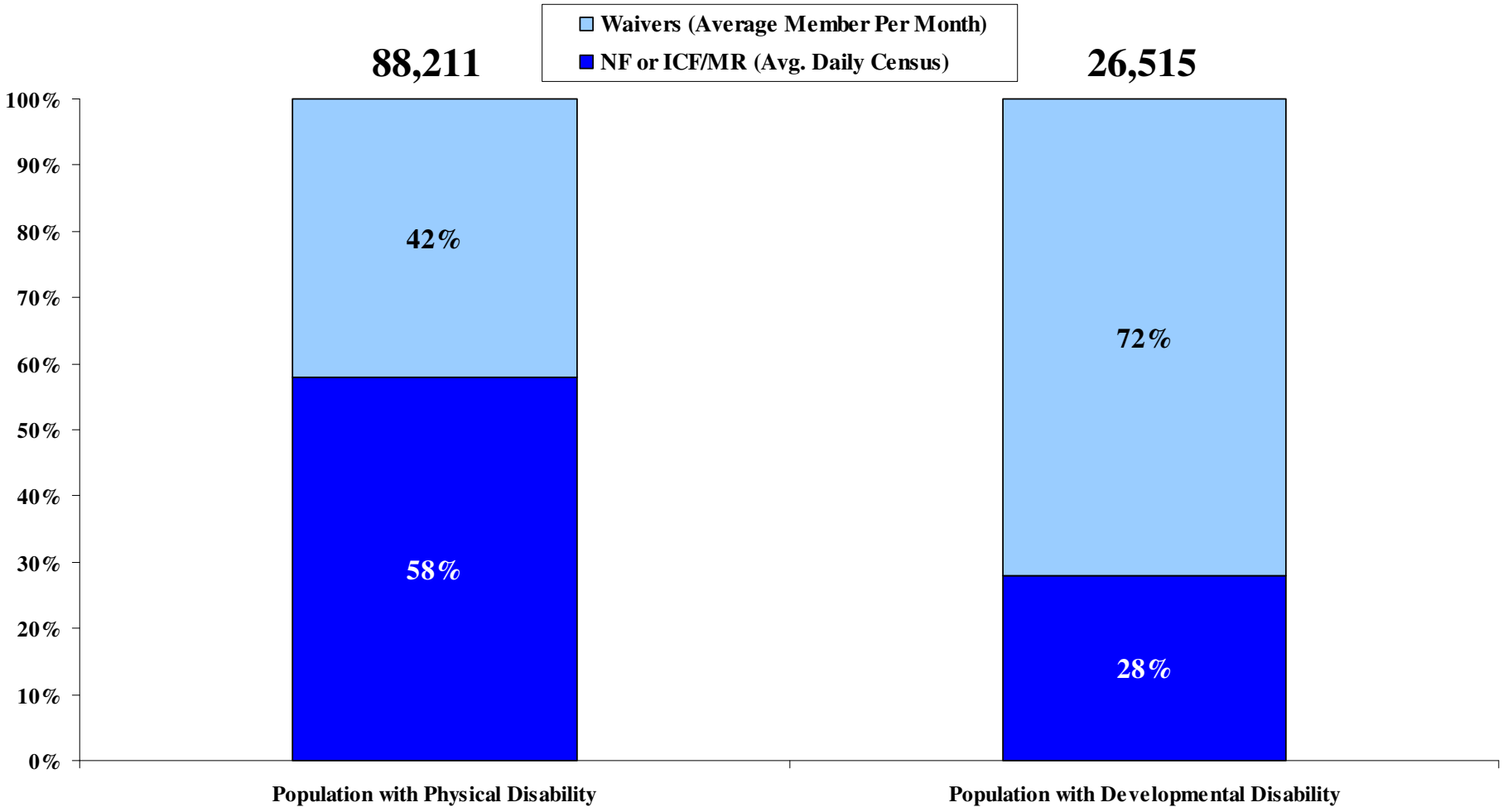
Medicaid Long-Term Care Utilization Consumers Using Facility-Based Care or Enrolled in One of the Home and Community-Based Waiver Programs, 2007

114,726 used LTC services on any given day



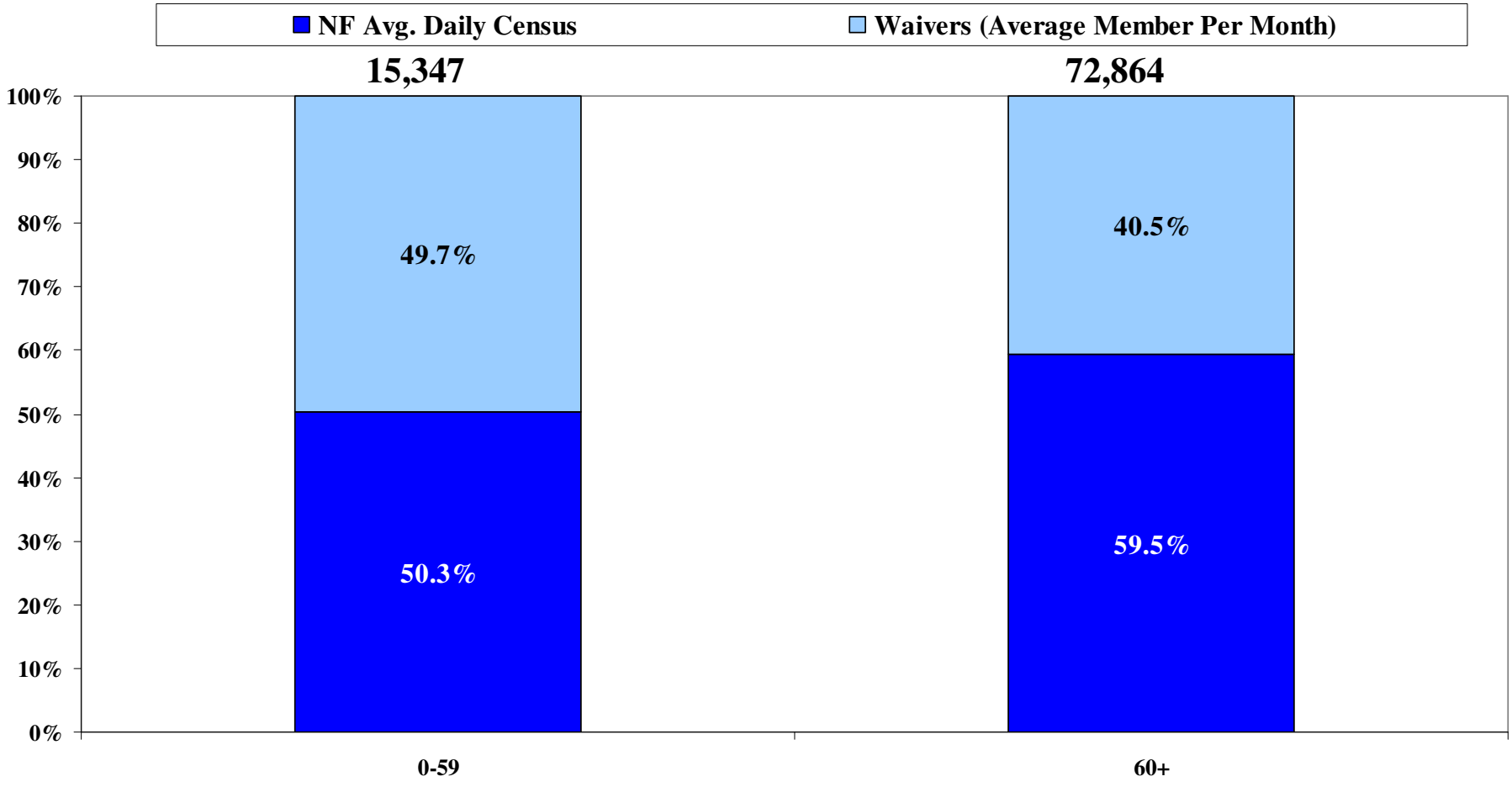
Revised 8/4/10

Percent Distribution of Medicaid Long-Term Care Utilization by Consumers with Physical & Developmental Disabilities and by Setting, 2007



Revised 8/4/10

Percent Distribution of Medicaid Long-Term Care Utilization by Consumers with Physical Disabilities, Age and Setting, 2007



Revised 8/4/10

Challenges for the LTC Profile

- Definitions of long term services and supports not so clear
- In some areas data don't exist (especially non-Medicaid)
- Data limitations such as bed tax, but national data include
- Data not always comparable—i.e. wait list
- Target population data useful, but a problem --people cut across groups

ULTCS Balance and Funding Subcommittee Recommendation

Expand the role of AAAs as lead agencies in Aging and Disability Resource Networks (ADRN)

Issue/background

Responding the acknowledged fragmentation that impedes access to services by consumers, in 2004, the Centers for Medicare and Medicaid Services (CMS) and the Administration on Aging developed the concept of an Aging and Disability Resource Center where consumers could experience seamless access to services. (Note that in Ohio we have used the term "Network" instead of "Center" to reflect both Ohio's "no wrong door" strategy to address issues of consumer access and to also reflect the fact that the Network is virtual instead of a physical location to which consumers must come in order to receive assistance.)

In Ohio, the Commission to Reform Medicaid recommended that ODA apply for the federal grant opportunity and ODA did so and was accepted for a grant in 2005. This grant (technically a "cooperative agreement" with both CMS and AoA for the first three years) allowed ODA to establish a pilot site in Cuyahoga County. The current ADRC grant in place in the state is supporting the work of the AAAs to build collaboration with partners at the regional level that will support the Aging and Disability Resource Network model.

Recent passage of the Patient Protection and Affordable Care Act (PPACA) by Congress incorporates the ADRN concept as a key component of health care reform in assisting consumers wishing to access key services. This summer, the Administration on Aging responded to the new emphasis in PPACA by issuing a request for proposals from states.

It should be noted that ADRN activity envisions assistance to consumers beyond accessing long-term services and supports to access other critical services such as employment assistance and housing assistance. Also, ADRN services are available to all consumers – not just those who qualify for Medicaid. For example, Ohio's existing long-term care consultation program is available to all Ohioans regardless of age or income.

Subrecommendations

- State agencies should work aggressively with AAAs to put the "D" in ADRN. The initial ADRN funding asked states to link its aging network to one of three disability networks – consumers with physical disabilities, consumers with developmental disabilities, or consumers with behavioral health needs. While Ohio had initially chosen to work with organizations representing consumers with physical disabilities, it is clear from PPACA that the eventual goal is for the ADRN to work cooperatively with organizations representing consumers with ANY disability.

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- Develop standardized criteria for a "fully functioning ADRN" and designate AAAs that either already meet the criteria or agree to a timeline by which criteria will be met as ADRNs. A statewide task force in 2005-2006 made a start at developing such criteria but these should be modified and augmented by the experience of other state networks. A subcommittee of the balance and funding subcommittee (in other words, the members of the subcommittee who are interested in this particular topic) would be created to guide this work.

- Creating tools for Ohio's ADRN. EMMA has been leading a process that would lead to the incorporation of robust provider information into Ohio's ConnectMeOhio website. This website was developed through Ohio's 2001 Real Choice Systems Change grant and while the website has good functionality it has suffered from a lack of actual provider data. The plan is to use MFP administrative funding available to the state to incorporate provider level data from state agency databases. In addition, tools available to the ADRN include Ohio's housing locator (funded by JFS, DOD, OHFA and the DD Council), the long-term care consumer guide (funded through an assessment on nursing facilities and residential care facilities), and the Benefits Bank.

Immediate Action

Secure funding through PPACA and MFP to further ADRN expansion.

Create a subcommittee of the balance and funding subcommittee to further develop ADRN activities.

Short-term Actions

To build linkages between the AAAs and the disability community (in particular the Centers for Independent Living) with a goal of putting the "D" in "ADRN."

To establish criteria for a fully functioning ADRN.

To designate AAAs meeting or agreeing to meet the criteria as ADRNs.

Long-Term Actions

To build networks that include Ohioans with developmental disabilities or behavioral health needs.

To track and respond to new opportunities and challenges presented by PPACA in the evolution of Ohio's ADRNs.

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