

Ohio Access

Governor Taft's Strategic Plan to Improve Long-Term Services and Supports for People with Disabilities



February 2004

An update to the original February 2001 report

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***“We are people who want the freedom to choose where, and with whom we live, in a place we can call our home, a place that is accessible to us, and that we can afford”
(Ohio Olmstead Task Force)***

Who Relies on Long Term Services and Supports?

According to the [2000 Census](#), one in five Americans has some level of disability and one in ten has a severe disability. This translates to 2.1 million Ohioans with some level of disability and 1.1 million with severe disability.

We all have a personal connection to the people behind these statistics. Many live with a disability or care for someone who does – we may ourselves be disabled, or we care for a loved one who is – a child with autism, a sibling with mental retardation, a spouse with muscular dystrophy, or a grandparent with Alzheimer’s disease. We often encounter disability without knowing it – a co-worker recovering from mental illness or a neighbor struggling with addiction. And all of us who take our health for granted must understand that disability can enter our life at any time – through accident, illness or age.

The exact number of Ohioans with a disability is unknown. Ohio’s human services departments have information about the number of people served through public programs, but it does not include the larger number of individuals who rely on services provided directly by family and friends or those receiving services paid by private insurance. The information below provides a snapshot of Ohioans with disabilities who rely on publicly funded services and supports.

- 72,000 people over age 64 with severe disability (they meet Medicaid requirements for nursing facility care) receive publicly funded services – 30 percent in home and community settings (21,000 people) and 70 percent in institutions (51,000 people).
- 189,690 adults under age 65 and 43,000 children under age 21 qualify for Medicaid based on disability. Many of these individuals (but not all) also receive non-Medicaid services from other state departments.
- 67,888 Ohioans with mental retardation or another developmental disability receive publicly funded services – 88 percent in home and community settings (57,000 people) and 12 percent ICFs/MR (7,500 people).
- 233,500 Ohioans receive publicly funded mental health services in community settings, including 64,943 severely mentally disabled adults and 41,688 emotionally disturbed children; only 412 Ohioans stay in public psychiatric facilities for more than one year.
- 93,000 people receive publicly funded alcohol and drug addiction services in community settings.

All of these individuals with a disability need some services or supports, and many receive services from more than one delivery system. Some people who might be eligible for publicly funded services do not receive them, and thus are not counted at all. Perhaps it is better that

the state does not have the data to organize people into these narrow categories. It emphasizes that every person has different needs, and that these may be more complicated than any one delivery system can accommodate. The point is to acknowledge every person with a disability as a full and equal participant in community life.

“[The life of my child with a disability was] defined by a label, by a label of disability, and the program he was supposed to fit into. My daughter [who did not have a disability] had no label, and a life defined by her own gifts and talents. And she fit life into what she wanted it to be.” (M.K.)

What Are Long Term Services and Supports?

Long-term services and supports include a variety of activities. It could be a neighbor preparing a home-cooked meal, a church van providing transportation to the doctor's office, or a nurse working in the home to provide skilled care. Additional examples include:

- Treatment, including medical, behavioral health, and rehabilitation programs;
- Help with daily activities, such as feeding, dressing, bathing, and helping a person who cannot walk or is incontinent;
- Care planning and case management;
- Income support through Social Security;
- Vocational and educational services, including supported employment and job training;
- Day programs, including activity centers, habilitation and adult skills programs;
- Facility based services;
- Transportation; and
- Other quality of life services, including leisure activities.

Most long-term services and supports are provided in home and community settings. Less than one percent of the total U.S. population—and less than four percent of the population that includes people with some level of disability—resides in a nursing facility or other long-term care institution (estimates based on the 2000 Census). The likelihood of receiving services in a home or community setting rather than a facility-based setting varies significantly by disabling condition. For example, almost all Ohioans with severe mental illness receive publicly-funded services and supports in the community, compared to only 30 percent of all seniors with a severe disability (70 percent reside in a nursing facility).

Who Provides Long Term Services and Supports?

Family members and friends provide the vast majority of long-term services and supports for people with disabilities. These informal caregivers offer their time, energy, companionship, and financial resources to help ensure the well-being of the people they care about. Although it is difficult to put a dollar value on this care, the Scripps Gerontology Center estimates that informal care provided to Ohio seniors was worth about \$5 billion in 1999.¹ The best estimates

¹ “The Value of Long-Term Care in Ohio: Public Dollars and Private Dedications,” S.A. Mehdizadeh and L.D. Murdoch, Scripps Gerontology Center, May 2003.

are that family caregivers provide approximately 60 percent of the care and support received by people with serious mental illness.

“I took really good care of my husband when he lived at home. This is not a patient, not an invalid, not a shut in, this is my husband.” (B.S.)

Many people with disabilities rely on service providers paid for by private insurance when their needs exceed the resources of family and friends. These providers include individuals who provide a specific service, like personal care or respite care; large companies that provide access to a network of various services; and facility-based service providers, including nursing facilities, intermediate care facilities for the mentally retarded (ICFs/MR) and state-run facilities such as inpatient psychiatric facilities and Mental Retardation and Developmental Disabilities (MR/DD) developmental centers.

When individual and family resources are not sufficient to ensure access to necessary services, a variety of government programs are available. Each state has a mix of programs and funding sources. The Medicaid program pays for many of these services in all states. Other funding sources include the federal Social Services Block Grant and Older Americans Act funds, state general revenue and county levies.

“I want to know why ... [it isn't] an ‘entitlement’ for people like myself to live in the community. If the regular Joe has a right to live in the community, then why don't I have that same right he has?” (J.K.)

People with disabilities face challenges related to the original design of federal programs like Medicaid. Under Medicaid, eligible people with disabilities are “entitled” to facility-based care—but home and community services are considered “optional.” States are required to apply for a “waiver” of the institutional requirement in order for federal dollars to follow people into home and community settings. [Section II](#) of this report summarizes how Ohio relies on Medicaid waiver programs to provide home and community based alternatives to facility based care, and [Section IV](#) describes the state's commitment to build on this strategy.

What Is Olmstead?

“The Olmstead decision is the difference between confinement and freedom. For some individuals...[who] believe the nursing home was and is their only option ... learning [about] ... Olmstead ... is the bittersweet moment of tears and laughter.” (D.L.)

Ohio's commitment to improve and expand home and community based long-term services and supports was reinforced in a 1999 U.S. Supreme Court decision, *LC. V. Olmstead*. In *Olmstead*, the Supreme Court said that unnecessary segregation of persons with disabilities is

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discrimination under the [Americans with Disabilities Act](#) (ADA), and that a state must provide community services to qualified individuals when:

- The state's treating professionals believe it is the most appropriate setting;
- The person (or authorized representative) chooses it; and
- The placement in the community can be reasonably accommodated taking into account the resources available to the state, including consideration of the needs of others.

A state can show that it is complying with the ADA if it has:

- A comprehensive, effective working plan for placing qualified persons with disabilities in less restrictive settings; and
- A waiting list, if needed, that moves at a reasonable pace.

What Is the Ohio Olmstead Task Force?

The [Ohio Olmstead Task Force](#) is a grass roots organization created by people with disabilities to make the Olmstead decision a reality in Ohio. On November 24, 2003, the Task Force hosted and Ohio Legal Rights Service sponsored a public forum to hear directly from Ohioans who rely on long-term services and supports. In a strong, unified, and unequivocal voice they said that the Olmstead vision must become a reality in Ohio.

Their words—which are quoted throughout this report—reflect the best qualities of citizenship: an understanding of the law, a desire to exercise rights, acceptance of personal responsibility, and contribution to society. And their words express the greatest goals of humanity: freedom, independence, individuality, acceptance, commitment to family and community, and the pursuit of dreams. In their own words:

- We are people who want the freedom to choose where, and with whom we live, in a place we can call our home, a place that is accessible to us, and that we can afford.
- We are people who want to choose who assists us to care for ourselves.
- We are people who want and benefit from family and community in our lives.
- We are people who want to work, and who want to be contributing members of our communities.
- We are people who want affordable health care for ourselves and for our families.
- We are people who want information and assistance on how to effectively access services.
- We are people who want access to our government and who want to be able to move about freely in public places in our communities.
- We are people who want Ohio to be the nation's leader in implementing the vision of Olmstead.

What Is Ohio Access?

Ohio Access is Ohio's Olmstead plan. It is the state's response to the voices for change—a strategic plan to improve long-term services and supports for people with disabilities. Governor Taft formalized the Ohio Access planning process in June 2000. From the outset, the Ohio

Access initiative has been consistent with the direction set by Olmstead. It is a call to action for all Ohio agencies that serve persons with disabilities:

- Aging ([ODA](#))
- Alcohol and Drug Addiction Services ([ODADAS](#))
- Budget and Management ([OBM](#))
- Health ([ODH](#))
- Job and Family Services, including Medicaid ([ODJFS](#))
- Mental Health ([ODMH](#)) and
- Mental Retardation and Developmental Disabilities ([ODMR/DD](#)).

This is the second Ohio Access report. The first [Ohio Access report](#) was released in February 2001 in response to Governor Taft's instructions to his cabinet to conduct a broad review of the state's existing system of services for people with disabilities, obtain feedback from the public, and make recommendations for improving these services.

Ohio has significantly improved long-term services and supports since 2001, and is in a better position today to do more. This report starts with a vision for Ohio in which every person with a disability lives with dignity in a setting they choose. It documents significant progress toward this vision over the past three years and lays out a clear plan for 2004 and beyond.

As you examine this report, you will encounter a number of facts that describe Ohio as of January 2004. These sections of the report are outdated already. However, you also will encounter values of lasting importance – opportunity, participation, independence, financial security, choice, and consumer direction. These are the ideas that make Ohio Access a living document, and motivate the Taft Administration's steadfast commitment to change.

Progress Report, 2001-2003

“The Administration has embraced the Olmstead decision and is actually listening to us. And I mean listening.” (M.B.)

[The original Ohio Access report](#), issued in February 2001, contained recommendations to improve Ohio’s long-term services and supports for people with disabilities. The recommendations were designed to support three guiding principles:

- Increase community capacity;
- Prioritize resources; and
- Assure quality and accountability.

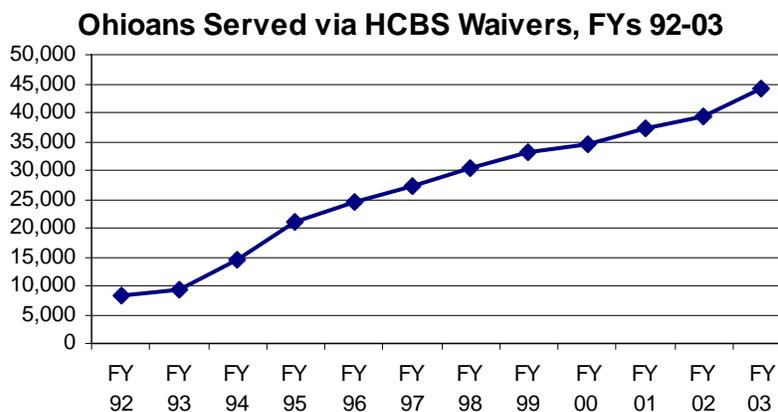
This section summarizes the impact of the original Ohio Access report. It documents the progress made under each priority between February 2001 and December 2003.

Increase Community Capacity

Ohio Access clearly demonstrates that publicly financed delivery systems must respond to individuals’ preferences about where they receive services and supports. Most people with a disability prefer to live at home for as long as possible, and consider facility-based services only as a last resort. Ohio Access respects an individual’s dignity and right to make this choice – and responds by creating more home and community based services (HCBS) and supports to meet the needs of people with disabilities.

✓ Expanded Home and Community Based Medicaid Waiver Programs

Ohio relies on [Medicaid home and community based waiver programs](#) to provide community alternatives for people with disabilities who otherwise face institutionalization. Ohio Access recommended serving more people through Medicaid waivers, as the chart below illustrates. As of June 2003, 42,468 Ohioans were being served via home and community based waivers. This represents a 19 percent increase since the original Ohio Access report was published in February 2001 and a 30 percent increase since Governor Taft took office in January 1999.



Ohio's commitment to expand home and community based Medicaid waiver programs encompasses multiple service delivery systems. Significant progress has been made over the past three years (SFY 2001-2003) to expand all of Ohio's existing waiver programs.

- [PASSPORT](#) – 24,891 Ohioans age 60 and over who otherwise would be eligible for Medicaid reimbursement in a nursing facility are at home today or in a community setting with support from ODA's PASSPORT program. The program has grown 10 percent over the past three years. There are no waiting lists, and future funding is expected to keep pace with increasing demand.
- [Home Care](#) and [Transitions](#) – 7,718 Ohioans under age 60 with disabilities or individuals who are medically fragile receive services through the ODJFS Ohio Home Care or Transitions Waiver programs. Home Care waiver services include home delivered meals, assistive living devices, out-of-home respite care, and adult day health services. A number of former Home Care consumers are now served on other, more appropriate waivers. Last year, 2,338 people moved to the new Transitions Waiver for people with an ICF/MR level of care, and 41 people moved to existing waiver programs, like Individual Options. Home Care now serves 5,380 people with no waiting list.
- [Individual Options and Residential Facilities](#) – 9,843 Ohioans with mental retardation or developmental disabilities receive services through the Individual Options (IO) waiver or the Residential Facilities Waiver (RFW) programs. MR/DD waiver programs have grown 76 percent since 2001, primarily as a result of MR/DD redesign (described below). However, despite the tremendous growth in these programs, services do not meet demand, and counties manage waiting lists for these programs.
- [PACE](#) – More than 480 Ohioans age 65 and older who are either “dually eligible” for Medicare and Medicaid or Medicaid eligible only receive comprehensive services through a Program of All-Inclusive Care for the Elderly (PACE). Ohio currently has two PACE Program sites in Cincinnati and Cleveland. Each site is authorized to serve up to 240 participants. ODJFS recently requested approval from the federal Center for Medicare and Medicaid Services (CMS) to expand each site to 290 participants, with a further commitment to expand to 440 participants.

✓ **Created (or Proposed) New Home and Community Medicaid Waiver Programs**

Ohio and most states want to be able to expand home and community based services without having to request federal permission to “waive” Medicaid's institutional entitlement. However, until Congress reforms Medicaid to give states more flexibility to design home and community based programs, Ohio will continue to rely on existing Medicaid waiver options to create new home and community based alternatives to institutional care.

- [Success Project](#) – ODJFS created a pilot program in the SFY 2002-2003 budget (it was continued in the SFY 2004-2005 budget) to assist up to 250 nursing home residents return to community living if they desire. Some people are medically able to leave facility-based care but simply cannot afford the one-time costs associated with moving back into a community setting (modifications to their home, first months

rent, etc.). Soon, the Success Project will provide services through Medicaid and will provide one-time financial assistance to cover relocation costs.

- [Choices](#) – ODA created the Choices Medicaid waiver program to give 200 PASSPORT consumers in central Ohio more direct control over their choice in service providers. ODA will use Choices to test how best to incorporate and promote consumer directed care for older persons in PASSPORT and other settings.
- [Level I](#) – ODMR/DD developed a new Level I Medicaid waiver program to provide opportunities for 6,000 individuals to remain in a home or community setting over the next three years.
- [ICF/MR Conversion](#) – ODJFS and ODMR/DD proposed removing intermediate care facility for the mentally retarded (ICF/MR) services from the state's Medicaid plan (thus eliminating the institutional entitlement) and replacing those services with a new waiver. At a minimum, the same number of people would have been served, but individuals would have been able to choose where they receive those services. Governor Taft included this proposal in his SFY 2004-2005 budget, but it was not adopted by the General Assembly. This proposal or a similar one will be offered by the Administration during the SFY 2006-2007 budget process.
- [Assisted Living](#) – Assisted Living is a popular choice among Ohioans who pay for their own care, but it is not currently available in Ohio through publicly-funded programs like Medicaid. Governor Taft's SFY 2004-2005 executive budget proposed creating a new Medicaid waiver for assisted living. Eligibility for the new waiver was to be limited to PASSPORT consumers who would otherwise have to move to a nursing facility because their need for services had become greater than their current environment could support, or seniors residing in nursing facilities who desire to live in a different setting and would be able to do so with a PASSPORT service package. Because the new waiver was designed to serve people already served by Medicaid, it would have required no new resources. Unfortunately, assisted living was eliminated by the General Assembly during its deliberations on the budget.

✓ **Chaired President Bush's New Freedom Commission on Mental Health**

President Bush appointed ODMH Director Mike Hogan to Chair the New Freedom Commission on Mental Health. The President charged the Commission to study the mental health service delivery system and to make recommendations that would enable adults with serious mental illnesses and children with serious emotional disturbances to live, work, learn, and participate fully in their communities. The Commission reported that recovery from mental illness is now a real possibility, but that for too many Americans the services and supports they need are fragmented, disconnected and often inadequate. The Commission proposed transforming the nation's approach to mental health care to support recovery, and established six goals for this purpose: Americans understand that mental health is fundamental to overall health; mental health care is consumer and family driven; disparities in mental health services are eliminated; early mental health screening, assessment, and referral to services are common practice; excellent mental health care is delivered and research is accelerated; and technology is used to access mental health information. The Commission's final report is available at www.MentalHealthCommission.gov.

Prioritize Resources

Ohio Access is realistic about balancing priorities within the limited resources of families, community organizations and government. Government agencies need to determine where resources are achievable and can make the most difference. An important part of this process involves seeking cost efficiencies and appropriateness of care, particularly in institutions, thereby making more dollars available where Ohioans prefer to live – in their own homes and communities.

✓ **Slowed the Rate of Growth in Spending on Nursing Facilities**

Public spending on nursing facilities continues to increase despite a declining demand for nursing facility services. Over the past 8 years, Medicaid spending on nursing facilities increased 61 percent while the number of people in nursing facilities declined 7 percent. Governor Taft recommended realigning nursing facility spending to match demand in his SFY 2000-2001 and SFY 2002-2003 budgets, but the General Assembly did not adopt these reforms. Governor Taft again proposed reimbursement changes in his SFY 2004-2005 budget and, given tremendous fiscal constraints, the General Assembly agreed to slow the rate of growth in public spending for nursing facilities to 3.2 percent in SFY 2004 (compared to a 7.7 percent increase that otherwise would have occurred per statute) and 1.0 percent in SFY 2005 (compared to 4.7 percent). As a result, the Ohio Medicaid program will spend approximately \$191 million more on nursing facilities over the SFY 2004-2005 biennium – but that is \$358 million less than Medicaid would have spent without this legislative intervention.

✓ **Completed a Fundamental Redesign of the MR/DD System**

The original Ohio Access report and Governor Taft's SFY 2002-2003 budget called for a fundamental redesign of the state's services and supports for people with mental retardation and developmental disabilities. Every decision in redesign is based on the principle of consumer self-determination – the idea that individuals and their families are in the best position to make critical decisions about what constitutes quality of life. The basic policy changes of redesign are complete, but details will continue to be implemented for years. Some of the tremendous accomplishments of the past three years are listed below.

- Refinanced existing county resources using Medicaid to draw down more than \$100 million in new federal funds annually.
- Increased the number of MR/DD home and community based Medicaid waivers (IO and RFW) by 76 percent over the past three years.
- Developed a new Level I Medicaid waiver program to provide opportunities for 6,000 additional individuals over the next three years to enable them to stay in a home or community setting.
- Provided \$14 million in state general revenue funds (GRF) for tax-poor counties to "jump start" Medicaid refinancing.
- Aligned funds from state (\$9.85 million), county (\$11 million), and federal (\$30 million) sources to increase rates for service providers to recruit and train direct care workers.
- Proposed removing ICF/MR services from the state's Medicaid plan (thus eliminating the institutional entitlement) and replacing those services with a new ICF/MR waiver.
- Substantially increased local investments in health and safety for consumers.

- Rewrote 53 state rules to strengthen consumer control. One example increased individuals' flexibility to self-administer their prescription medication.
- Supported the recommendations of an Executive Branch Committee that includes representatives of families, county boards, providers, and state agencies to coordinate the redesign effort.

✓ **Downsized MR/DD Developmental Centers**

ODMR/DD is committed to self-determination strategies for residents in developmental centers who want to leave the institution and live in a community setting. Over the past four decades, the number of residents in developmental centers decreased significantly from more than 10,000 people in 1963 to less than 2,000 people today. Over the past three years, the number of residents in developmental centers decreased 10 percent. Based on this trend, and in comparison to other states (Ohio has more state-run MR/DD institutions than all but one other state), ODMR/DD acted to close two of the state's twelve developmental centers.

✓ **Increased Medicaid Administrative Efficiencies**

Ohio's Medicaid program is a primary source of funding for long-term services and supports in multiple state agencies. Six state departments assist ODJFS in the administration of Ohio's \$9 billion dollar Medicaid program. ODJFS is working to improve Medicaid administrative efficiencies, and some recent examples are listed below.

- Restructured [Office of Ohio Health Plans](#) (Medicaid) to support Ohio Access activities. A new Bureau of Community Access provides assistance to other state agencies involved in Medicaid and monitors each agency's compliance with federal regulations.
- Implemented a Medicaid Decision Support System to increase Medicaid's ability to manage costs, improve program decision-making, and improve federal reporting.
- Modified state rules for Pre-Admission Screening and Resident Reviews (PASRR) to be clearer about responsibilities of nursing facilities and state agencies.
- Obtained federal approval to expedite the settlement of an outstanding backlog of audits, which will permit settlement payments to Community Alternative Funding System (CAFS) providers in the MR/DD system.

✓ **Created a Medicaid Business Plan for Behavioral Healthcare**

ODMH and ODADAS initiated, with ODJFS support, the development of a Medicaid business plan for behavioral healthcare to ensure that federal Medicaid fundamentals are applied consistently and on a statewide basis. Areas of focus include payment rates (fixed fee), reimbursement methodology, utilization review, and quality/performance requirements.

✓ **Used Federal Grants to Improve Access to Needed Services**

Ohio received seven federal grants worth \$3.5 million to manage Ohio Access activities. The grants were awarded by the federal Centers for Medicare and Medicaid Services (CMS) as an incentive for states to adopt policies and programs consistent with President Bush's New Freedom Initiative. Ohio was well prepared to win these grants, because the New Freedom Commission initiative is based on the same principles as Ohio Access (both are related to the Olmstead case.) ODA manages a Real Choice Systems Change Steering Committee to coordinate the grants described below. The Steering Committee includes representatives

from each department that received grants, project managers and two representatives from the consumer-led [Ohio Olmstead Task Force](#).

- ODJFS received a \$50,000 [Real Choice Systems Change “Starter”](#) grant to plan for future Real Choice Systems Change activities. These funds were used to involve the Ohio Olmstead Task Force in subsequent grant design and implementation.
- ODJFS received a \$500,000 [Medicaid Infrastructure](#) grant to explore ways through Medicaid to support individuals who seek to obtain or retain employment.
- ODJFS received a \$600,000 [Nursing Facility Transitions](#) grant to secure a vendor to design, implement, and evaluate the Ohio Access Success Project, which provides Medicaid-eligible nursing facility residents with one-time financial assistance of up to \$2,000 to relocate to community settings.
- ODJFS received a \$1.385 million grant to create a one-stop, on-line resource about services for people with disabilities. ODJFS contracted with ODA to create the site, which will be called [No Wrong Door Ohio](#). The grant also supports the ongoing work of the Ohio Olmstead Task Force and a housing coordination position at ODJFS.
- ODMR/DD received a \$500,000 [Independence Plus](#) grant to develop a new home and community based waiver for people who want to exert greater control over their lives.
- ODMR/DD received a \$500,000 [Quality Assurance](#) grant to design and implement a quality information management system that will develop computerized tools to facilitate the collection, organization, analysis of data, and provide valuable information to all systems users about the needs of individuals and support agencies.
- ODA received a \$75,000 grant to study the feasibility of adding [adult respite services](#) to PASSPORT.

In addition to the CMS grants, ODADAS received a much larger \$9 million, three-year federal [State Incentive Grant](#) from the Substance Abuse and Mental Health Services Administration to implement a comprehensive substance abuse prevention strategy. Most of the grant (\$2.55 million annually) will go directly to 20 county ADAMHS/ADAS boards to support evidence-based prevention planning processes and programs.

Assure Quality and Accountability

Ohio Access sets a clear expectation that all publicly financed service delivery systems must assure quality and fiscal accountability throughout the system. Responsibility must be clearly defined throughout the system in order to ensure continuous quality improvement, consumer health and safety, and compliance with state and federal program requirements.

✓ **Created a Long-Term Care Consumer Guide**

ODA created a comprehensive consumer guide to long-term care facilities at the direction of the General Assembly and with assistance from providers and consumers. The Long-Term Care Consumer Guide provides web-based information about nursing homes, including the results of ODH inspections, national quality indicators, and consumer satisfaction surveys. See: www.ltcoho.org

✓ **Conducted an Alcohol and Drug Addiction Services Shareholders' Process**

Governor Taft initiated an Alcohol and Drug Addiction Shareholders process to create a shared vision for Ohio's system of alcohol and drug addiction services, provide input about how to align the state's resources toward achieving the vision, and recommend short-term changes to improve the system. The Shareholders' process concluded with the department's implementation of regulatory relief and improved processes to engage county boards, service providers, and individuals served by the system.

✓ **Implemented the Technical Assistance Program for Nursing Facilities**

Facilities that are not performing well after being surveyed by the Ohio Department of Health can work with ODH staff to improve outcomes for their patients using proven curricula.

✓ **Took Steps to Address the Healthcare Workforce Shortage**

Ohio Access recognized that for people with disabilities to have meaningful choices of services and supports, the shortage of health care workers needed to be addressed. This is difficult to do – workforce shortage issues are linked to overall employment and economic conditions in Ohio – but several important steps were taken.

- Ohio Health Care Workforce Shortage Task Force – ODH convened a task force to review health care workforce shortage issues related to licensing standards, scopes of practice, technology to alleviate workload, recruitment and retention, and education. See: <http://www.odh.state.oh.us/ODHPrograms/HCFORCE/finalreport.pdf>.
- Ohio Health Care Workforce Advisory Council – ODA coordinates a Health Care Workforce Advisory Council through the Governor's Workforce Policy Board. The Council brings together consumers, providers, and state agencies to develop strategies to address critical shortages of healthcare workers. Additional information is available at: www.goldenbuckeye.com/wfadvisory.html.
- Regulatory Relief – ODH initiated several changes in state rules to address workforce shortage issues, including allowing nursing facilities to use feeding assistants rather than nurses to help residents eat and drink, and broadening the work experience that is acceptable for nurse aides to remain on the State Nurse Aide Registry.

✓ **Implemented a Behavioral Health Quality Agenda**

Ohio's behavioral health system leads the nation in assessing outcomes and using evidence-based services and supports. Over the past three years, the ODMH improved quality through its clinical quality agenda, regulatory relief and by addressing funding shortfalls that threatened access to acute hospital care.

- Clinical Quality Agenda – ODMH used data and quality improvement practices throughout the system to improve outcomes for consumers. The department created a statewide network to promote recovery, Centers of Excellence to promote evidence based practices, a consumer outcomes measurement system, technical assistance to improve cultural competence, and training in data-based performance improvement.
- Regulatory Relief – ODMH implemented new administrative rules to reduce barriers to provider efficiency while also increasing consumer protection. This strategy recognized national accreditation as meeting ODMH certification requirements, required that the majority of certified providers become nationally accredited before

2007, decreased duplicative documentation requirements (consistent with efforts to create a simplified quality- and recovery-oriented consumer record), and increased protection of vulnerable consumers by standardizing reports of significant incidents.

- Hospital Care – ODMH led the nation in deinstitutionalizing behavioral health care services nearly two decades ago and reduced the number of state owned inpatient psychiatric beds by 60% between 1990 and 1998. Today, Ohio's public psychiatric hospitals are full and private inpatient capacity is being eroded. During SFY 2002 it became clear that state resources were not sufficient to cover ODMH's acute psychiatric hospital capacity. ODMH requested, and the Governor and General Assembly added, \$23 million to avert hospital closures.

✓ **Achieved Quality Improvements Through MR/DD Redesign**

ODMR/DD redesign enabled state and local investments in the infrastructure to assure health and safety and to improve outcomes for people with disabilities whenever possible. As new federal dollars flowed into the system, ODMR/DD:

- Implemented an Abuser Registry to track people who are barred from employment as care providers for persons with MR/DD.
- Implemented a Major Unusual Incident (MUI) tracking system that received national attention from CMS as a "Promising Practice."
- Trained providers and administrators in every county to improve the MUI tracking.
- Required county boards of MR/DD to employ Investigative Agents who are separate from any service provision to investigate major unusual incidents.
- Completed statewide accreditation reviews for all county boards and quality assurance reviews for supported living and waiver providers.

✓ **Improved Programs to Identify and Treat Children with Disabilities**

ODH coordinates several programs that are designed to identify children with disabilities as early as possible and connect them to appropriate services and supports.

- Newborn Screening – ODH expanded the Newborn Metabolic Screening Program from 5 to 13 disorders. Parents have the option to screen their infant for an additional 16 disorders, for a total of 29 metabolic diseases. These are conditions that will cause developmental delay in infants if not treated immediately after birth.
- Help Me Grow – Identified 25,645 infants and toddlers eligible for the Help Me Grow program. Help Me Grow provides developmental screening and service coordination and ongoing services for infants and toddlers at risk for or with developmental delays and disabilities. It is administered through county family and children first councils to assist families with young children to connect with community resources they may need to help their child develop appropriately. While ODH is the lead agency, county boards of MR/DD are significant providers of these types of services. See: www.ohiohelpmegrow.org.
- Children with Medical Handicaps – ODH and ODMR/DD are developing common approaches to children whose families may seek services and supports from both agencies. This includes common outreach strategies, enrollment methods, tracking and recall systems, diagnostic criteria, and monitoring and quality assurance and as appropriate, enrolling them on MR/DD or ODJFS waivers.

✓ **Identified Transportation as a Priority**

Reliable and timely transportation is a challenge for individuals with disabilities in both urban and rural areas. Transportation is necessary to access employment, health care, social activities and a variety of other aspects of life. The Ohio Department of Transportation (ODOT) and the Federal Transit Administration have been working to address human services transportation issues for several years with a renewed emphasis in recent months. The Federal Transit Administration recently unveiled a program called "United We Ride" that coordinates transportation resources and maximizes them to avoid duplication of effort and expenditure. ODOT is examining how this initiative may be implemented in Ohio.

As detailed in this section, a great deal has been accomplished during the past three years. Thousands of Ohioans are receiving better services and supports today than ever before. However, these data confirm that much more remains to be accomplished. Although progress is being made, many needs are not yet being met. In the spirit of Olmstead, we are committed to meeting those needs, and that's the purpose of the updated Ohio Access report.

Current Challenges

“I am a registered nurse, so I thought, well, I know the system. But when [my adult son was injured] ... I needed every bit as much help as anyone else. It was unbelievable, some of the bridges that we had to cross.” (C.L.)

Improving the quality of life for people with disabilities – through higher levels of inclusion and involvement in work, social and community life – is a challenging task. We know that the lives of many Ohioans with disabilities have been enhanced in the past three years, but we can be sure that a much larger number of people with disabilities have not yet felt the benefits of the Ohio Access efforts.

There is still much ground to be covered and many advances to be made. But that is what the Ohio Access vision is all about and that is the undertaking that lies ahead.

It will not be easy. In fact, there will be significant challenges – most importantly limited funding, federal policy constraints and the task of sustaining critical health resources – that will stand in the way of continued progress. The following section creates a realistic picture of the challenges going into the SFY 2006-2007 budget.

Funding Constraints

Without question, resource availability remains the greatest ongoing challenge to fulfillment of the Ohio Access vision. Although the state’s revenues have rallied somewhat during the last few months, continuing national economic uncertainty and the proposed repeal of Ohio’s temporary sales tax will be critical questions as policymakers develop the next biennial budget. It is possible that the state’s next budget development process will be even more difficult than the last due to a combination of rising costs and sluggish or declining revenues.

The distribution of scarce resources is a related challenge. During SFY 2003, funding for primary and secondary education and Ohio’s Medicaid program comprised nearly half of Ohio’s annual spending. These two areas of government will continue to require the commitment of a substantial portion of the state’s available resources, thereby limiting the amounts available for new initiatives (including those within Ohio’s Medicaid health care delivery system) and the ongoing operational costs of the rest of state government.

Statutory requirements regarding Medicaid reimbursement for nursing facilities and ICFs/MR also prevent the state from providing the community-based capacity demanded by elders and people with disabilities because the first priority for new dollars are the institutional providers covered by statute. In the mental health delivery system, this was resolved by controlling institutionalization and by permitting resources to follow individuals from institutional settings to community settings. Ohio does not have a provision in law that allows money to follow the person from a facility-based setting to a community setting, although this does occur on a regular basis in the home and community based waiver programs. To assist with the closing of

Current Challenges

two Developmental Centers, ODMR/DD has instituted a policy to allow residents who choose to live in the community to allow the money for that individual to follow them. During the last two biennial budget development processes, Governor Taft proposed to slow or freeze the growth of reimbursement for nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) to redirect some new resources to expand community resources throughout the state. The Administration continues to believe that reimbursement reform is essential to community system growth as well as to slowing the overall rate of growth of the Medicaid program.

Inflation creates additional challenges for non-entitlement services and supports for elders and people with disabilities, including programs such as non-Medicaid behavioral health services, Alzheimer's respite services, Early Intervention for children, and human services subsidy payments to local governments. Even if budgets are not reduced, these programs are affected adversely by flat funding. The cost of providing these services is increasing each year, but the funding is not and there is no automatic rate adjustment such as in the nursing home reimbursement formula. As a result, state and local agencies must identify new resources or implement administrative efficiencies, create (or increase) waiting lists for services, narrow eligibility requirements in order to reduce the number of people receiving services and/or reduce the amount, duration or scope of the services that are being provided.

The failure to achieve real parity of private coverage for behavioral health has resulted in a greater reliance on publicly financed behavioral health services for individuals who do not qualify for Medicaid. "Medicaid crowd-out" is a term used by some local boards of MR/DD, mental health, and alcohol and drug addiction services to describe federal and state requirements that result in the obligation to fund Medicaid entitlement services for all eligible individuals prior to meeting any non-Medicaid payment obligations. In short, board systems address financial shortfalls by reducing or eliminating services provided to individuals who are ineligible for Medicaid. This is a particular challenge in Ohio's behavioral health system, where matching funds for community Medicaid benefits are the responsibility of local boards.

Given the fiscal challenges detailed above, resources from local levies are critical for the continued provision of many long-term services and supports. When authorized and renewed, levies provide valuable support for services to individuals who may be quite seriously ill but not Medicaid eligible, and for services Medicaid cannot reimburse, such as housing, employment supports, respite and prevention. Additionally, some parts of the Medicaid delivery system rely on local levies to help finance services. Unfortunately, in recent years voters in many board areas have decided against authorizing new or expanded levies for these and related purposes. For example, during the past ten years, only 3 out of 48 attempts to pass a new levy in the behavioral health system were successful.¹ Additionally, levy resources are not distributed based on statewide need but on local support. Most Appalachian counties do not have alcohol, drug addiction, and mental health levies although the need for care in these communities is high.

The Administration remains committed to the vision and goals of Ohio Access; however, the financial challenges detailed in this section will leave scarce resources to make significant new investments during the next biennium. To the extent possible, the SFY 2006-2007 Executive

¹ Source: Ohio Association of County Behavioral Health Authorities

Budget recommendations will prioritize resources in areas that will provide improved outcomes for the greatest number of Ohioans and focus on ways to provide Ohio Access agencies with flexibility to increase community capacity if that can be accomplished at no additional cost to taxpayers.

Federal Policy Constraints

The original Ohio Access report summarized how federal policy constrains Ohio's flexibility to implement new programs in home and community settings. Community services for people with disabilities are funded through a variety of federal, state and local sources, but it is federal Medicaid policy that shapes program design.

The federal Medicaid program has a long-established institutional bias, which makes it more difficult to serve eligible individuals in home and community settings. Eligible people with disabilities are "entitled" to facility-based care, but home and community services are "optional." States are required to apply for a "waiver" of the institutional requirement in order for federal dollars to follow people into home and community settings. Similarly, using managed care tools (e.g., controlling referral of individuals to expensive services, or capping the number of providers) requires obtaining a "waiver" of federal requirements.

Fragmentation in funding and policy exists among federal programs. There are a number of different programs and funding sources that are used to provide services to persons with disabilities, including Medicare, Medicaid, Supplemental Security Income, Food Stamps, Social Services Block Grant, the Ryan White Care Act, Maternal and Child Health Block Grant, and the Older Americans Act. This complexity makes it difficult to coordinate programs and funding and can be overwhelming for individuals to manage all of the benefits for which they are eligible. As an example, the President's New Freedom Commission on Mental Health reviewed federal programs that might fund services to a person with mental illness or their family, and found 42 such programs.

The federal Medicaid program is administratively cumbersome, particularly regarding Medicaid waiver authority. It takes a significant amount of staff time, in some cases months or years, to get approval from CMS for a Medicaid waiver. This has prompted states to call for an end to the current system of Medicaid waivers in favor of increased flexibility in state plan amendments to create flexibility without the bureaucratic limitations of the current system.

Three years after the original Ohio Access report was published, Ohio still faces all of the same federal constraints and Medicaid's institutional bias remains. During the intervening time period CMS has sent mixed messages by allowing some additional waiver flexibility and creating grants to encourage states to develop new home and community based alternatives to institutional care, while at the same time generally tightening CMS' interpretations about how Medicaid is to be managed by the states. As Ohio continues its discussions with CMS regarding federal interpretations of upper payment limits, payments to public providers, targeted case management and administrative claiming, the state remains well prepared to compete for the grants (because of Ohio Access). So far Ohio has received \$3,510,000 grant funding to support Ohio Access activities.

Current Challenges

Until Congress reforms Medicaid, Ohio will pursue available opportunities to improve services and supports for people with disabilities. In the short term, that involves pursuing federal grants that are strategic to changing the system and, over time, fundamentally altering the system to provide services and supports in home and community settings that most people prefer.

Local Resource Sustainability

Ohio's publicly funded mental health system is at a critical juncture today – a national model of community based care facing considerable resource challenges.

Compared with a decade ago, mental health services are more community based and locally managed than Ohio's other delivery systems. The Mental Health Act of 1988 enabled Ohio to reduce the size of its state hospital system so that funding could be used to provide more appropriate and cost-effective services in the community. Throughout the 1990s, state hospital downsizing and numerous state hospital closures resulted in a "devolved" system managed at the local level (including shared funding responsibility) and oriented strongly toward community care. The average daily inpatient census at state-owned psychiatric hospital facilities has decreased from 3,800 to 1,100 (71%) since 1988.

While this has been very good news for community based care, fiscal challenges now threaten the system's hard-fought progress. Hospital downsizing and consolidation has run its course as a source of new community funding. Local boards are experiencing significant financial stress from a combination of flat or reduced state and local revenue, inflationary growth, increased demand for services and escalating Medicaid match obligations. These factors reduce individuals' access to the array of safety net services they need in order to lead independent, productive lives. The problem is exacerbated by cutbacks in private sector mental health care and services paid through the mainstream Medicaid program. Particularly troubling is a pattern of closures in private hospital psychiatric units, with shorter lengths of stay and high levels of readmissions occurring after downsizing of public hospitals was completed. The burden on emergency rooms, community mental health agencies, local law enforcement, and nursing facilities is increasing. The community mental health system is caught in a vicious spiral, with increased demand, increased Medicaid match responsibilities, and decreased resources. Placing a priority on stabilizing mental health funding is necessary. Additionally, addressing Medicaid's impact on community mental health care is an urgent priority. As recommended by the President's New Freedom Commission on Mental Health, gaining federal flexibility (e.g., in Medicaid's requirements) may be necessary to prevent the elimination of mental health care for individuals with serious mental illness who are not eligible for Medicaid.

In the case of mental health, the cost of not providing treatment is often much greater to Ohio taxpayers than the cost of providing treatment, but these secondary costs are hidden:

- Severe, untreated mental illness often causes people to lose their job or never have the opportunity to pursue a career. Federal disability payments to people disabled by mental illness are estimated at \$850 million annually, far more than the General Fund budget of ODMH.
- Although most of the common crimes charged to person with mental illness are not violent crimes, persons with mental illness are overrepresented in jails and prisons, and responding

to minor disturbances by people with mental illness takes up a significant portion of police officers' time.

- Children with a serious emotional disturbance are less likely to be successful in school than all other categories of disability.
- Increasing numbers of individuals with mental illness are now receiving treatment in nursing facilities, particularly because of the scarcity of appropriate housing options for this population.

In addition to reducing inpatient costs, the successful provision of appropriate community based services ultimately saves taxpayer dollars by enhancing individuals' employment opportunities, reducing criminal activity, and increasing family reunification in the child welfare system. Reversing the decline in support for community behavioral health care and sustaining the minimal levels of public psychiatric acute hospital care remaining in Ohio is an urgent priority.

Strategic Plan, 2004 and Beyond

***“We are people who want to be the nation’s leader
in implementing the vision of Olmstead.”
(Ohio Olmstead Task Force)***

Ohio Access is a comprehensive working plan for improving long-term services and supports for people with disabilities. Over the past three years, Ohio Access has served as the primary blueprint for systems change in Ohio’s health and human services. During the past five months, the original 2001 plan was reviewed and modified with input from consumers, providers, and other interested parties. The Ohio departments contributing to this strategic plan include:

- Aging
- Alcohol and Drug Addiction Services
- Budget and Management
- Health
- Job and Family Services, including Medicaid
- Mental Health and
- Mental Retardation and Developmental Disabilities.

This section describes the updated strategic framework for Ohio Access, which includes a statewide vision and goals, performance measures, and recommendations to achieve success. Strategies are summarized here and described in detail in the appendices to this report.

Vision

Ohio Access sets a clear vision for Ohio in which:

- Ohio’s seniors and people with disabilities live with dignity in settings they prefer.
- They are able to maximize their employment, self-care, interpersonal relationships, and community participation.
- Government programs honor and support the role of families and friends who provide care.

Goals

Every strategy to achieve the vision must contribute to:

- Offering individuals meaningful choices.
- Aligning systems to improve quality and provide better outcomes for individuals.
- Getting the best possible value from taxpayer investments.

Performance Measures

The 2004 Ohio Access update includes a number of statewide measures to gauge Ohio’s *Olmstead*-related progress over time. As the specific strategies listed in this section are

implemented over the next few years, Ohioans will be able to refer to the four statewide measures listed below and see the extent to which aggregate progress has been made toward the goals across delivery systems. In some cases, the measures will enable Ohio to compare its progress to the progress of other states.

The following four statewide measures are tied to the goals of choice, quality, and value. State agencies are developing methods to collect baseline data for this analysis. While some delivery systems may interpret each measure somewhat differently depending on the needs of the consumers it serves, the main objective is to assess the state's current position relative to these measures and work to consistently improve choice, quality, and value.

- Ratio of people receiving Medicaid home and community based waiver services to people residing in Medicaid-reimbursed nursing facilities and ICFs/MR.
- Ratio of total public expenditures¹ for community based long-term services and supports to total public expenditures for institutional services.
- Per member per month (PMPM) rate of growth of total public expenditures for long-term services and supports.
- Ohio's ranking on various measures reported by other organizations, like the American Association of Retired Persons (AARP.)

"Any plan developed should consider consumer needs as an integrated challenge - not pitting younger people with disabilities against older people with disabilities." (R.H.)

Recommendations

The original Ohio Access report focused primarily on fiscal and policy issues in the health care arena. This report extends that focus to other services critical for a person to live with dignity in home and community settings, like housing, employment, transportation, education, and others. However, the strategies are first steps. The more fully developed strategies—and the majority of this report—continue to focus on improving health care services.

Many of the implementation plans contained in this report are subject to legislative approval via statutory change or the biennial budget process. The last budget proved that budget-related policy decisions are difficult and not without consequence. The next state budget will be introduced in the Ohio General Assembly in January 2005. It promises to be at least as difficult as the last. Updating Ohio Access now is intended to stimulate a policy conversation that builds support for its recommendations in time to be relevant for the next budget. The Administration acknowledges the General Assembly's challenge and is eager to engage members regarding the merits of Ohio Access initiatives, particularly because so many of these proposals respond to Ohioans' preferences for choice, quality, and getting the best possible value for taxpayers.

¹ All references to "total public expenditures" in this section exclude Medicare expenditures. Medicare is 100 percent federally funded and administered, and Ohio's budget policy decisions have virtually no bearing on Medicare expenditure growth.

The rest of this section outlines specific strategies for achieving the Ohio Access vision and goals. Specific strategies are bulleted under each recommendation, and described in detail in Appendices A - F.

“People should have a choice on where they live. You do. Isn’t it only fair?” (J.K.)

A. Give consumers meaningful choices

Ohio Access envisions a fundamental alteration in Ohio’s approach to long-term services and supports for people with disabilities. This transformation is necessary for seniors and people with disabilities to live with dignity in the settings they prefer and maximize their employment, self-care, interpersonal relationships, and community participation; and for government to honor and support the role of families and friends who provide care.

Progress toward this vision requires greater consumer participation and control in decisions about their care. It requires detaching funding from particular settings of care, and allowing those funds to follow people into the settings they choose. This concept is consistent with the Supreme Court’s *Olmstead* decision, and in most cases highly cost effective. In order to give consumers meaningful choices, the Ohio Access cabinet will work to:

- A.1 [Increase home and community based Medicaid waiver programs](#)
- A.2 [Provide information that consumers need](#)
- A.3 [Financially support consumer choice](#)
- A.4 [Support informal caregivers](#)

“Why can’t we ... be the first state in the union to follow through ... and not let the [President’s New Freedom Commission on Mental Health] gather dust in this state.” (J.C.)

B. Focus on Behavioral Health

Ohio’s “Behavioral Health” delivery system includes publicly funded mental health services and alcohol and drug addiction services. Many persons with serious behavioral health care needs experience long term but episodic illness. The episodic nature of their illness is quite different from the disability experienced by people with mental retardation, and many frail elderly persons. Acute care situations tend to be short (less than a week), but a small number of admissions for acute stabilization of psychosis or addiction last for weeks or even months because treatment proves elusive.

Approximately one in every ten Ohioans experiences behavioral health care needs at some point in life and, due to a lack of overall insurance or parity for behavioral healthcare, many people are unable to access the services and supports that they need via a private insurance plan. The publicly funded behavioral health system in Ohio functions as a safety net, providing acute care services and supports for indigent and working poor persons and virtually all long term care for persons with serious disorders, since private insurance often does not cover these services.

Ohio Access Strategic Plan, 2004 and Beyond

Ohio is recognized as having one of the strongest community behavioral health systems of any large state. It mirrors the state's general preference for local control with state direction and support and, through a local board system, allows for a unique level of local feedback and decision-making. Yet, that success is tempered by the reality of emerging crises in communities across Ohio.

The Ohio Access cabinet recommends focusing on behavioral health to:

- B.1 [Increase community based services](#)
- B.2 [Maintain public/private inpatient capacity](#)
- B.3 [Strengthen behavioral health Medicaid administrative processes](#)
- B.4 [Provide access to better care for children](#)
- B.5 [Implement the President's New Freedom Commission recommendations](#)

C. Improve Quality and Outcomes for Individuals

Ohio Access is clear that publicly funded long-term services and supports need to meet a high standard of quality. Historically, "quality" has been defined as the state's responsibility to ensure consumer safety. However, a new paradigm is emerging that expands the concept of quality to include consumer expectations about autonomy, self-direction, and choice. With these new conceptions of quality in mind, the Ohio Access cabinet will:

- C.1 [Measure service satisfaction and outcomes](#)
- C.2 [Address healthcare workforce shortage issues](#)
- C.3 [Enhance quality in nursing facilities](#)
- C.4 [Provide training for teachers who work with children with disabilities](#)

“Existing dollars could be used more effectively by allowing consumers to direct their abilities to purchase the services that they want and need.” (J.C.)

D. Get the Best Possible Value from Taxpayer Investments

Ohio Access envisions a fundamental alteration in Ohio's approach to long-term services and supports, focused first on providing meaningful choices for people with disabilities, but also ensuring that taxpayers get the best possible value for their investment. Fortunately, greater consumer choice often leads to improved outcomes and greater cost-effectiveness, which is critically important given constraints on public budgets. The level of reform that is necessary to realign long-term services and supports toward consumer choice and public value can only be accomplished through comprehensive planning, including a participatory stakeholder process and integration with Ohio's legislative process. In this spirit, the Ohio Access cabinet will:

- D.1 [Articulate clear principles for system design](#)
- D.2 [Involve consumers in planning and program design](#)
- D.3 [Coordinate across agencies](#)
- D.4 [Convene an Ohio Access housing task force](#)
- D.5 [Implement enhanced care management](#)
- D.6 [Stimulate demand for long-term care insurance](#)

E. Prevent the Causes of Disability

Disability can enter our life at any point – through accident, illness or age. In some cases, the causes of disability can be prevented. In order to improve the state's effectiveness in helping to prevent the causes of disability, the Ohio Access cabinet will:

- E.1 [Create a fetal alcohol syndrome prevention initiative](#)
- E.2 [Pilot community projects focused on prevention](#)
- E.3 [Expand early intervention for children](#)

“How long can we afford, as a state, to continue to relegate people with disabilities to not paying taxes, to not contributing to the economy of the state, to not buying goods and services that stimulate the economy?” (D.D.)

F. Support Employment

Most people with a disability between the ages of 21 and 64 work (77 percent according to the 2000 Census). Having a job and being economically self-sufficient are important aspects of personal independence and overall quality of life. However, many people with a disability who want to work are forced to make an economic decision not to because additional income would threaten their health care benefits. Federal welfare programs were reformed in the 1990s to support people who work, but Social Security disability programs and Medicaid were not. In order to support the critical link between work and self-sufficiency, the Ohio Access cabinet will:

- F.1 [Develop a Medicaid Buy-In program](#)
- F.2 [Implement Supported Employment in the Mental Health System](#)
- F.3 [Implement the U.S. Department of Labor Employment Navigator](#)

Enable Every Child to Succeed

Many of the strategies already listed benefit children. These strategies are listed here to emphasize the Taft Administration's highest priority to enable every child to succeed. Each strategy listed below is consistent with Family and Children First, Ohio's statewide initiative to streamline and coordinate services for families seeking assistance for their children.

- A.1 [Increase home and community based Medicaid waiver programs](#)
- A.2 [Provide information that consumers need](#)
- A.4 [Support informal caregivers](#)
- B.1 [Increase community based services for behavioral health](#)
- B.4 [Provide access to better care for children](#)
- B.5 [Implement the President's New Freedom Commission recommendations](#)
- C.1 [Measure service satisfaction and outcomes](#)
- C.4 [Provide training for teachers who work with children with disabilities](#)
- D.2 [Involve consumers in planning and program design](#)
- D.3 [Coordinate across agencies](#)
- E.1 [Create a fetal alcohol syndrome prevention initiative](#)
- E.3 [Expand early intervention for children](#)

Give Consumers Meaningful Choices

"Choice is important to the quality of life for Ohio's... citizens and as part of the solution to reduce the rising costs of long term care." (T.W.)

Ohio Access envisions a fundamental alteration in Ohio's approach to long-term services and supports for people with disabilities. This transformation is necessary for seniors and people with disabilities to live with dignity in the settings they prefer and maximize their employment, self-care, interpersonal relationships, and community participation; and for government to honor and support the role of families and friends who provide care.

Progress toward this vision requires greater consumer participation and control in decisions about their care. It requires detaching funding from particular settings of care, and allowing those funds to follow people into the settings they choose. This concept is consistent with the Supreme Court's *Olmstead* decision, and in most cases highly cost effective. In order to give consumers meaningful choices, the Ohio Access cabinet will work to:

- Increase home and community based Medicaid waiver programs;
- Provide information consumers need;
- Financially support consumer choice; and
- Support informal caregivers.

A.1 Increase Home and Community Based Medicaid Waiver Programs

The federal government allows states to seek Medicaid waivers, or exemptions, to provide long-term services and supports to people in community settings rather than in facility-based settings. The provision of these services reflects a valuable taxpayer investment because the federal government requires that the cost of waiver services be less than or equal to the cost of providing similar services in a facility-based setting.¹ Furthermore, many elders and people with disabilities want to live in their homes, and waiver programs provide that opportunity.

Ohio has obtained a number of federal waivers in recent years to provide home and community based services in a number of delivery systems. It is important to continue to expand upon this progress in several ways:

- Expand current waivers for eligible Ohioans;
- Redesign current waivers in order to increase quality, greater consumer direction and satisfaction, and the efficiency of service delivery; and
- Propose new waivers to help Ohioans to live as independently and productively as possible.

¹ The federal requirements regarding the expenditure "cap" may be aggregate or person-specific, depending on the waiver.

Give Consumers Meaningful Choices

This section discusses the Administration's plans for specific Medicaid waivers, both existing and proposed, during the next several years. Note that all strategies are subject to the availability of sufficient resources, and may need to be modified or prioritized to match budget realities.

The chart below contains an overview of Ohio's current and proposed Medicaid home and community based services (HCBS) waiver activities.

System	HCBS Waiver	Expand	Redesign	Propose
ODA	PASSPORT	SFYs 06-07		
ODMR/DD	Level One	SFYs 05-07		
ODJFS	Home Care: Transitions	SFYs 04-08		
ODJFS	Home Care Redesign		SFYs 04-08	
ODMR/DD	Individual Options and Level Three		SFYs 04-07	
ODMR/DD	Residential Facilities Waiver (RFW)		SFYs 04-08	
ODJFS	CAFS Skills Development and Supports		SFYs 04-05	
ODA	Choices for Elders		SFYs 04-05	
ODMR/DD	Independence Plus			SFYs 04-05
ODA	Assisted Living			SFYs 06-07
ODJFS	Early Intervention and Autism			SFYs 06-07
ODJFS	Cash and Counseling			SFYs 04-07
ODMR/DD	Community Access Model Waiver			SFYs 04-07
ODJFS	ICF/MR Conversion Waiver			SFYs 06-07

Expand Current Waivers

PASSPORT – A request was submitted to the federal government to extend this very successful waiver for elders for an additional five years. Additional expansion will depend on the availability of state GRF during the next biennium.

A.1.1 ODA will recommend PASSPORT funding levels in the SFY 2006-2007 budget that are sufficient to avoid waiting lists.

Level One – This waiver, offering limited support such as respite services and home modification for persons with cognitive disabilities and their families, is funded with a combination of federal, state, and local dollars. ODMR/DD developed this waiver in FY 2003 to provide 6,000 waiver slots over the next three years to individuals for whom \$5,000 per year in services and supports is enough for them to stay in a home or community setting.

A.1.2 By SFY 2006, ODMR/DD will release at least 1,000 additional Level One waiver slots to county boards of MR/DD, as funds are available to serve additional individuals.

Transitions – This waiver serves Ohioans who have developmental disabilities that qualify them for ICF/MR services. ODJFS created this no-growth waiver as an alternative to the Home Care waiver, and has been serving individuals since SFY 2003.

A.1.3 ODJFS will request federal permission to reassign additional slots individuals from the Home Care Waiver to the Transitions Waiver as Home Care is redesigned.

Redesign Current Waivers

Home Care and Core Plus – Ohio's Medicaid state plan includes the Home Care CORE and CORE Plus programs. CORE covers nursing and aide services for qualified beneficiaries up to 14 hours per week. CORE Plus is a state plan service that enables consumers to exceed CORE's 14-hour limitation on services. Due to the increasing utilization trends for CORE Plus, it is difficult for ODJFS to efficiently manage resources in this area of the Medicaid program.

Ohio's Home Care Waiver program is being redesigned at the same time as CORE Plus because both programs are critical to providing a safety net of services to individuals. Home Care is being restructured into several distinct waivers (Self-Directed Care, Community Resource, Sub-Acute) to better match available service levels and funding to individuals with high end needs, and to permit individuals with emergent needs to leave hospitals and access waiver services. One of the new waivers (Self-Directed Care) will permit consumers much more flexibility by providing a consumer directed design. The new waivers will improve clarity about available services and the specific program that best meets the individual's needs.

- A.1.4 ODJFS will work with other Ohio Access agencies to determine the number of affected consumers receiving Core Plus benefits as well as services through the MR/DD and Aging systems, and how these consumers will continue to receive such services.
- A.1.5 ODJFS will request additional Home Care and Transitions Waiver slots to accommodate CORE Plus customers who are eligible for these programs.
- A.1.6 ODJFS will develop and request the following from CMS: a Self-Directed Care Waiver in SFYs 2005-2006; a Community Resource Waiver from CMS in SFY 2006-2007; and Sub-Acute Waiver in SFY 2006-2007.
- A.1.7 ODJFS will transfer eligible adult CORE Plus consumers to other waiver programs before SFY 2008.

Individual Options (IO) and Level Three – The IO waiver serves approximately 7,000 Ohioans with developmental disabilities. Ohio recently received approval from CMS to serve an additional 2,000 individuals on the IO waiver. Reform efforts will result in two distinct waivers with different cost caps: a redesigned IO waiver which will serve individuals who rely on publicly funded services of approximately \$5,001 to \$79,500 per year, and the Level Three waiver, which will serve individuals with publicly funded service costs that exceed \$79,501 per year. Individuals will be assigned to one of these waivers based on an assessment of their need and existing amounts and types of support that they receive.

- A.1.8 IO will be renewed March 1, 2004. At that time, an individual cost cap will be equal to average cost of providing services to a person with similar needs in a licensed ICF/MR setting. Current waiver enrollees whose service costs are above the newly established cap will be grandfathered into IO in the first year. As Level Three is implemented, these consumers' needs will be evaluated to determine whether the Level Three waiver will meet their needs.
- A.1.9 ODMR/DD and ODJFS will establish timeframes for the Level Three waiver. ODMR/DD will involve County Boards, advocates, providers, and other stakeholders in the development of Level Three. ODMR/DD and ODJFS will submit a waiver proposal to CMS during SFY 2005.

Give Consumers Meaningful Choices

Residential Facilities Waiver (RFW) – This waiver serves approximately 2,500 Ohioans with developmental disabilities in licensed facility-based settings. RFW will be redesigned to enable money to follow the person, meaning that an RFW consumer can change service providers and retain their waiver “slot.” (Currently, the “slot” belongs to the licensed facility, not the individual receiving services.) This is consistent with the Ohio Access goal of offering individuals meaningful choices.

A.1.10 ODMR/DD and ODJFS will redesign RFW to enable money to follow the person and, by SFY 2008, move all RFW consumers to the IO waiver and eliminate RFW.

CAFS Skills Development and Supports – ODJFS and ODMR/DD are redesigning the Community Alternative Funding System (CAFS) state plan program to move some services onto ODMR/DD-operated waivers and to modify other services to better manage the program. These changes will make it easier for individuals and families to understand their options under CAFS and Medicaid. For example, CAFS covers skills development and supports provided through day services, but in order to access these services, a person must be enrolled in a Medicaid waiver. The redesign will make skills development and supports provided through day services available through waivers.

A.1.11 ODJFS and ODMR/DD will convert CAFS from a cost-based system to a fee schedule in SFY 2004.

A.1.12 ODJFS will work with ODMR/DD to move Skills Development and Support services to other ODMR/DD-operated waiver programs during SFY 2005.

Choices for Elders – Choices is a Medicaid model waiver that gives 200 PASSPORT-eligible consumers in central Ohio more direct control over service providers than currently allowed under PASSPORT. The Choices waiver is due to expire at the end of SFY 2004. ODA plans to expand this successful model to other Ohio counties, by converting the current model waiver to a home and community-based services waiver similar to PASSPORT.

A.1.13 ODJFS will seek federal permission on behalf of ODA in SFY 2004 to convert the Choices model waiver to a home and community-based (1915c) waiver that will serve approximately 350 people in SFY 2005.

Proposed New Waivers

Independence Plus for People with Developmental Disabilities – ODMR/DD received a three-year grant from the Centers for Medicare and Medicaid Services to develop an Independence Plus waiver. This waiver would enable individuals to self-direct some or all of their waiver services. Individuals would be assigned a “personal budget” based on an assessment of their medical need and existing amounts and types of support that they receive. After that, a “fiscal intermediary” would be appointed in order to provide assistance to consumers and their families as they choose specific services and providers.

A.1.14 ODMR/DD and ODJFS will develop an MR/DD Independence Plus waiver proposal and submit it to CMS in SFY 2005.

A.1.15 ODMR/DD will identify five counties to participate in the approved waiver and, if approved by CMS, implement in SFY 2005.

Assisted Living – Many elders do not need the more intensive medical services provided by nursing facilities, but lack the necessary informal supports that are essential to remain at home. Assisted living spans this gap, combining both supportive services and housing. Often it is the only alternative to nursing facility care for consumers who lack stable housing.

Ohio already has a well-developed assisted living market for private-paying individuals who need those services. Governor Taft's SFY 2004-2005 budget proposed expanding access to assisted living through a new Medicaid waiver program. Eligibility for the new waiver would have been limited to PASSPORT consumers who would otherwise have to move to a nursing facility because their need for services has become greater than their current environment can support, or seniors residing in nursing facilities who desire to live in a different setting and would be able to do so with a PASSPORT service package. Because the new waiver was designed to serve people already served by Medicaid, it would have required no new resources. The General Assembly rejected this proposal in its deliberations on the Governor's budget.

A.1.16 ODJFS will resubmit the Governor's SFY 2004 assisted living Medicaid waiver proposal (or a similar version) for consideration in the SFY 2006-2007 budget.

Early Intervention and Autism – ODMR/DD was granted permissive authority in the SFY 2004-2005 budget to apply to CMS (through ODFJS) for a home and community based waiver for either early intervention services or autism services, or both. The budget also created an Ohio Autism Task Force to make recommendations to the Governor and the General Assembly. The Administration will rely on the Task Force, which includes families of individuals who would potentially use the new waivers, in the development of an early intervention or autism waiver.

A.1.17 ODMR/DD will work with ODJFS and ODH, and in cooperation with the Ohio Autism Task Force, to develop recommendations for the SFY 2006-2007 budget about developing an early intervention waiver, autism waiver, or both.

Cash and Counseling – This initiative, related to Home Care reform, is a specific type of consumer directed care that provides a flexible monthly allowance (based on the consumer's care plan or on claims history) that consumers can use to hire their choice of workers, including family members, and purchase other goods and services. Cash and Counseling requires consumers to develop spending plans that show how they will use the allowance to meet their needs for supportive services. It also provides counseling to help consumers manage their allowance and their responsibilities as employers. Consumers who are unable or unwilling to manage their allowance themselves may choose another person, such as a family member, to help them or do it for them. These features make Cash and Counseling adaptable to consumers of all ages and with all types of impairments.

A.1.18 As part of the redesign of Ohio Home Care, ODJFS will apply for a grant from the Robert Wood Johnson Foundation in SFY 2004 to support the development of a self-directed care waiver.

Community Access Model Waiver – As the Apple Creek and Springview Developmental Centers close over the next two years, ODMR/DD remains committed to self-determination strategies for residents who want to leave these facilities and live in a community setting. The Community

Give Consumers Meaningful Choices

Access Model Waiver will enable ODMR/DD to support these individuals as they opt to leave Developmental Centers in favor of smaller community settings.

A.1.19 Pending federal approval, ODMR/DD will implement the waiver during SFY 2004, enrolling 55 people during the first full year of waiver operation and approximately 200 people by the end of the third year.

ICF/MR Conversion to Waiver – As was the case during the FY 2004-2005 budget development process, the Administration will seek to reform the Medicaid ICF/MR program during FYs 2006-2007. The goals are to enable consumers to receive services in cost-effective settings they prefer; to control expenditure growth in the long term; to mitigate the state's fiscal liability; and to achieve federal compliance.

Specifically, the Administration will propose to convert the state plan ICF/MR entitlement system to a home and community based waiver. This reform will enable the state to eliminate the State Plan option over time and increase control over the number of beds and costs in the system. This plan provides two critical tools for the state, as well as consumers: the flexibility of waiver slots, and a new waiver reimbursement system.

A.1.20 During the SFY 2006-2007 budget process the Administration will resubmit its proposal (or a similar version) to remove the ICF/MR program from the state plan and replace it with a waiver.

A.2 Provide Information Consumers Need

People with disabilities need timely, accurate, and complete information about available services in order to make informed decisions. In order to support the ability of consumers and their families to make meaningful choices, the Ohio Access cabinet will:

- Create a "No Wrong Door" website;
- Continue a long-term services and supports consumer guide;
- Redesign long-term services and supports consultations; and
- Expand the mental health network of care.

Create a "No Wrong Door" Website

Ohio's long-term services and supports are administered by several state agencies and, in some cases, multiple county boards. Individuals and families who need to access these services do not always know where to begin and the fragmented and sometimes contradictory information that is available to them can be the cause of enormous frustration. A project is already underway to assemble consistent, reliable, and up-to-date information about all of Ohio's services and supports for people with disabilities on one, easy-to-use website. No Wrong Door Ohio will include (but is not limited to) information about service providers, assistive technology, civil rights, community life, education, employment, financial benefits, health care, personal care, housing, transportation, and other resources. See: www.NoWrongDoorOhio.org.

A.2.1 ODA will select a contractor in March 2004 to develop and implement No Wrong Door Ohio for public use in July 2005.

Continue the Long-Term Services and Supports Consumer Guide

ODA operates a successful Long-Term Care Consumer Guide website that includes information about nursing facilities and other services for frail elders (See: www.ltcoho.org). The site will be expanded to include more specific information about home health services; supportive services such as transportation, homemaker assistance, and meals; and residential supports such as assisted living, adult foster homes, adult family homes, adult group homes, and nursing homes. To the extent available, data will include regulatory compliance information, quality measures derived from consumer assessments, satisfaction scores, and detailed information provided by service and support providers about specialization, policies, rates, and staffing. The consumer guide is available on the Internet and allows consumers to compare multiple providers. Consumers who do not have Internet access are able to access the consumer guide through ombudsmen, case managers, and other professionals who can conduct searches and comparisons on their behalf.

A.2.2 ODA will coordinate the Ohio Access agencies and others to expand the Long-Term Care Consumer Guide to include the functionality described above by June 2007.

Redesign Long Term Services and Supports Consultations

Many individuals face difficult decisions about their care without a full knowledge of available resources or the advice of others. Providing these individuals with the opportunity to discuss their situation with an expert improves the quality of their decisions and promotes better outcomes for individuals. Consultations can provide all individuals who are entering a nursing facility with the opportunity to meet with a professional consultant to discuss the options that are available to meet long-term care needs, including information about the full continuum of long-term services and supports, sources of public and private payment for services, factors to consider when making a decision, and opportunities to maximize independence and self-reliance.

A.2.3 ODA will implement a statewide consultation program in SFY 2004.

A.2.4 ODA and ODJFS will assess the current pre-admission review process for nursing facility admission in SFY 2004 and make legislative recommendations (if needed) to ensure that individuals receive the information they need to make choices about their care.

Expand the Mental Health Network of Care

The Network of Care is an Internet-based, consumer-friendly health resource, available at the local government level. It addresses system fragmentation by supporting the exchange of critical information among consumers, caregivers, case managers, local service providers, and county and state governments. The Network of Care integrates multiple information sources to create a one-stop resource for information, communication and advocacy. It offers consumers, families and caregivers a fast and accurate way of finding all services in a community from any computer with an internet connection. Individuals can also access databases about illnesses, treatments, programs, and legislation; use public and private communications mechanisms; and communicate concerns directly to policy makers.

The Network of Care technology was developed in California, featured as a model program by The President's New Freedom Commission on Mental Health, and will be evaluated as a pilot for select Ohio counties beginning in 2004. Since the original system development costs of \$2.5 million were borne by the State of California, Ohio's costs will only include adapting and applying the technology for our state.

Give Consumers Meaningful Choices

A.2.5 ODMH will pilot the Network of Care in select Ohio counties in SFY 2004 and, based on evaluation results, implement an expansion strategy in SFY 2005.

A.3 Financially Support Consumer Choice

Individuals want control over choices that impact their lives. Meaningful choices among long-term services and supports are nearly always linked to financial considerations—the types and quantities of services purchased, who provides the services, and in what setting. In order to increase independence and self-sufficiency for a number of Ohio's frail elders and people with disabilities, the Ohio Access cabinet will:

- Implement a cash and counseling program;
- Develop and implement an Independence Plus Waiver; and
- Provide institution to community support.

Implement a Cash and Counseling Program

About 1.2 million Americans receive disability-related supportive services at home through Medicaid state plan services or home and community based waiver programs. Under Medicaid state plan services, benefits are typically restricted to human assistance with personal care and homemaking provided by licensed agencies. Waiver programs offer additional services, but coverage is limited, with a case manager deciding whether or not services are needed. Increasingly, states are offering Medicaid beneficiaries and their families the opportunity to directly obtain services and supports from individual providers they choose. This alternative is called consumer directed care.

Cash and Counseling is a specific type of Medicaid funded consumer directed care. It provides a flexible monthly allowance (based on the consumer's care plan or on claims history) that consumers can use to hire their choice of workers, including family members, and purchase other goods and services. Cash and Counseling requires consumers to develop spending plans that show how they will use the allowance to meet their needs for supportive services. It also provides counseling to help consumers manage their allowance and their responsibilities as employers. Consumers who are unable or unwilling to manage their allowance themselves may choose another person, such as a family member, to help them or do it for them. These features make Cash and Counseling adaptable to consumers of all ages and with all types of impairments.

A [national evaluation of the first Medicaid cash and counseling pilot program](#) finds that participants are far more likely to receive the services authorized in their care plans than non-participants receiving traditional Medicaid personal care services because traditional agencies were not always able to provide services due to staffing shortages. Any additional costs were more than offset by the lower utilization of more expensive services (such as facility-based care) by participants.

The action step associated with Cash and Counseling is [A.1.18](#).

Provide Institution to Community Support

Federal Medicaid policy now permits states to assist individuals who want to leave institutional settings and return to their communities. States may provide limited payments for items typically not covered by Medicaid when individuals are leaving institutional settings, including one-time

costs such as rent deposits, utility deposits, and basic furniture. Soon, the Ohio Access Success Project, which was funded in the SFY 2004-2005 budget, will provide one-time financial assistance to cover relocation costs for people who are medically able to leave facility-based care but simply can't afford the one-time costs associated with moving.

- A.3.1 ODJFS will implement the Success Project in SFY 2004 and provide payment for transition services for up to 250 nursing facility residents during SFY 2004-2007.
- A.3.2 Upon federal approval, which is pending, ODJFS and ODMR/DD will immediately implement a Community Access Model Waiver, which includes payment for transition services, for up to 200 residents who want to leave state-run developmental centers or other ICFs/MR.

A.4 Support Informal Caregivers

Family caregivers provide the vast majority of the assistance that enables frail elders and people with disabilities to live independently in their homes and communities. In many cases, both the caregivers and care recipients are aging adults. Family caregivers face substantial stresses and burdens as a consequence of caregiving obligations. Because caregivers play such an important role, services that sustain a caregiver's role and maintain their emotional and physical health are an important component of any home and community-based care system.

The National Family Caregiver Support Program (NFCSP) provides funding for Ohio, which is added to funds from the State Alzheimer's Respite Program and local funds, to provide a package of services to support caregivers. These services include information about available services; assistance in gaining access to supportive services; individual counseling and training; respite care to provide temporary relief from caregiving; and supplemental services, on a limited basis, to complement the care provided by the caregiver.

- A.4.1 ODA will include caregiver resource information in the Long-Term Services and Supports Consumer Guide and No Wrong Door website, which will be available to the public in June 2005.
- A.4.2 ODA will work with Ohio's 12 Area Agencies on Aging to publicize the NFCSP program during SFY 2006-2007.

Focus on Behavioral Health

“Why can’t we ... be the first state in the union to follow through ... and not let the [President’s New Freedom Commission on Mental Health] gather dust in this state.” (J.C.)

Ohio’s behavioral health system includes publicly funded mental health services and alcohol and drug addiction services. Many persons with serious behavioral health care needs experience long term but episodic illness. The episodic nature of their illness is quite different from the disability experienced by people with mental retardation and many frail elderly persons. Acute care situations tend to be short (less than a week), but a small number of admissions for acute stabilization of psychosis or addiction last for weeks or even months because treatment proves elusive. The mixture of short-term and long-term treatments (e.g., medication, therapy) and supports (e.g., case management, supported housing) vary over time.

Approximately one in ten Ohioans experience behavioral health care needs at some point in life and, due to a lack of overall insurance or parity for behavioral healthcare, many people are unable to access the services and supports that they need via a private insurance plan. The publicly funded behavioral health system in Ohio functions as a safety net, providing acute care services and supports for indigent and working poor persons and virtually all long term care for persons with serious disorders, since private insurance often does not cover these services.

Ohio’s behavioral health system faces unique financing challenges. A longstanding federal policy excludes federal Medicaid reimbursement for inpatient psychiatric hospitalization for individuals aged 22 to 64. This means that, unlike other delivery systems related to Ohio Access, the behavioral health system is unable to use Medicaid home and community based waivers to “refinance” and generate additional federal funds for expanded services.

Ohio is recognized as having one of the strongest community behavioral health systems of any large state. It mirrors the state’s general preference for local control with state direction and, through a local board system, allows for a unique level of local feedback and decision-making. Yet, that success is tempered by the reality of emerging crises in communities across Ohio.

The Ohio Access cabinet recommends focusing on behavioral health to:

- Increase community based services;
- Maintain public/private inpatient capacity;
- Strengthen behavioral health Medicaid administrative processes;
- Provide access to better care for children; and
- Implement the President’s New Freedom Commission recommendations.

B.1 Increase Behavioral Health Community Based Services

Behavioral health community care is managed and governed by local Boards, many of which have multi-county jurisdiction, and most of which have combined responsibility for mental health and alcohol and drug services. Community care is provided by community agencies that are certified by ODMH and ODADAS and under contract with Boards. That system of community care is under extraordinary financial stress brought about by a number of factors, including:

- Erosion in the strength of state funding for the community system (Ohio's ranking among states in terms of per capita spending for mental health dropped from 17th in 1981 to 34th in 2000;
- Matching funds for Medicaid behavioral health benefits are provided by local boards using ODMH, ODADAS and local levy resources. Increasing Medicaid costs, coupled with below-inflation GRF revenue increases, are causing reductions in services for the many individuals who need services but are not Medicaid eligible;
- Reductions in private mental health spending, closure of private hospital psychiatric units, and a corresponding shift of costs to the public mental health system;
- The downsizing of state psychiatric hospitals has been completed, resulting in very low levels of institutional beds compared to other states and other long term care systems in Ohio. This means that savings in institutional costs are not available in behavioral health, as they may be in other systems, to cover the costs of current or expanded community care;
- Inability of boards to gain public support for new or increased levies; and
- Increased demand for behavioral health services.

The financial stress on the community system is most directly affecting poor adults who are seriously mentally disabled but not eligible for Medicaid. Without the support of the community system, these persons may fail at parenting, become homeless, enter the criminal justice system, or worse. They will face lives of despair and hopelessness. This is particularly tragic for people who, with proper treatment and supports, could be active and contributing members of society.

B.1.1 ODMH and ODADAS will seek additional funding in the SFY 2006-2007 budget to increase behavioral health community based services.

B.2 Maintain Public/Private Inpatient Capacity

Since 1997, Ohio's mental health inpatient system, both public and private, has lost 13 percent of its capacity to serve some of its most needy citizens. Many hospitals have "downsized" their psychiatric units and at least 22 have closed their units entirely. This downsizing followed the dramatic reduction in ODMH facilities in the mid 1990s, with five institutions closed, and a 60 percent reduction in ODMH beds from 1990 to 1998. The reasons behind this erosion of inpatient capacity are complex, but include a lack of adequate fiscal resources and reimbursement, reorganization and mergers of hospital systems, and shortages of skilled professionals including psychiatrists and registered nurses. These changes have intensified the pressures on an already fragile mental health system:

- Average length of stay decreased approximately 12 percent in private settings and eight percent in public settings from 1997 to 2002.
- The number of admissions and discharges increased 40 percent in private settings and 10 percent in public settings from 1997 to 2002.
- Total charges for inpatient services increased 12 percent from \$9,700 in 1993 to \$10,888 in 2001 while charges for all other major diagnostic categories increased nearly 55 percent over the same period.
- The number of patients admitted from overcrowded emergency departments increased 20 percent from 2000 to 2002.

B.2.1 ODMH will continue to monitor access and adequacy of hospital and community acute care in the public and private sectors, and recommend changes in policy, rates, or budgets as needed in order to sustain access to acute inpatient behavioral health services.

B.3 Strengthen Behavioral Health Medicaid Administrative Processes

The Medicaid benefit for community behavioral health in Ohio is managed by ODMH and ODADAS, with responsibility delegated from ODJFS. ODMH and ODADAS are committed to jointly improving administration of the Community Medicaid Behavioral Health Program at the state and local level. Each level of administration must perform essential activities to assure the community Medicaid behavioral health program meets consumer needs and complies with federal and state Medicaid requirements. The two departments, supported by ODJFS, developed a Medicaid Business Plan early in SFY 2004 that describes the scope and sequence of work necessary to achieve proper, efficient and statewide administration. The Plan addresses standardized Medicaid contracting, dispute resolution, auditing and compliance, rate setting, reimbursement and cost reconciliation, claims processing, clinical system improvement, implementation of Assertive Community Treatment (ACT) and Intensive Home and Community Based Services (IHCB) and Medicaid Administrative Claiming (MAC) for boards.

The purpose of the Medicaid Business Plan is to ensure consumer access to services, the quality of those services, and accountability at all levels of administration of the community Medicaid behavioral health program. By better defining and redesigning the reimbursement system to align with statewide Ohio Access principles, and by implementing tools to ensure quality of services and compliance with federal and state rules and regulations, the community Medicaid behavioral health program will achieve additional value from taxpayer investments. For example, the addition of ACT and IHCB services will enhance the options for evidence-based care available to individuals served by the community Medicaid behavioral health program.

- B.3.1 ODMH, ODADAS and ODJFS will standardize Medicaid payment contracts and uniform cost reporting, and add ACT and IHB as Medicaid reimbursable services in SFY 2005.
- B.3.2 ODMH, ODADAS and ODJFS will implement provider-specific fixed rates for community participating providers in SFY 2007.
- B.3.3 ODMH, ODADAS and ODJFS will implement other elements of the Medicaid Business Plan during SFY 2005-2008 and finish the project in SFY 2009.

B.4 Provide Access to Better Care for Children

Child and adolescent behavioral health problems are a significant issue in Ohio's child welfare system (with inadequate access a federally-cited deficiency), the major driver of school failure, a major challenge in juvenile justice, the leading problem in adolescent health, and a leading cause of death among teens.

Ohio is in a strong position to provide access to better care for children and adolescents with behavioral problems: Ohio's Healthy Youth Initiative involves schools to address behavior; evidence-based and best-practice models exist for making positive change; and technical assistance is available through the OSU Center for Learning Excellence, the Center for Innovative Practices, and School Success Networks. In addition, Ohio has several community-based planning processes in place to align these resources, including a comprehensive local planning process sponsored by Ohio Family and Children First called Partnerships for Success.

- B.4.1 ODMH and ODJFS will work with interested stakeholders in SFY 2004 to identify strategies to expand the supply of behavioral healthcare to priority populations.
- B.4.2 ODMH will implement Access to Better Care during SFY 2005 as an extension of Partnership for Success planning through the Ohio Family and Children First Initiative.

B.5 Implement The President's New Freedom Commission Recommendations

President Bush appointed ODMH Director Mike Hogan to Chair the New Freedom Commission on Mental Health. The Commission reported that recovery from mental illness is now a real possibility, but that for many Americans the services and supports they need are fragmented, disconnected, and often inadequate. The Commission proposed transforming the nation's approach to mental health care to support recovery (See: www.MentalHealthCommission.gov). ODMH with stakeholders will develop a comprehensive strategy to implement the Commission's recommendations, with emphasis on the following actions:

- Create a comprehensive state plan;
- Raise awareness to reduce stigma; and
- Make suicide prevention a priority.

Create a Comprehensive State Plan

The President's Commission recommended creating a comprehensive state mental health plan to reach beyond the traditional state mental health agency to address the full range of treatment and support service programs that consumers and families need. This approach is intended to overcome problems with fragmentation in the system, and to leverage resources across multiple agencies that administer state and federal dollars. Ohio is in a strong position to make quick progress: Ohio Access already coordinates activities across multiple state agencies; the Ohio Commission of Mental Health reported recommendations for system change in January 2001; and ODMH currently has initiatives underway to improve the quality of services for multi-need adolescents, adults with co-occurring mental illness and addiction or MRDD, adults with mental illness involved in the criminal justice system, and children with behavioral disorders in schools.

- B.5.1 ODMH will initiate a comprehensive planning process before January 2005.
- B.5.2 ODMH will release a comprehensive state mental health plan no later than SFY 2007.

Raise Awareness to Reduce Stigma

The Commission recommended raising awareness about mental illness as a strategy to reduce stigma, which discourages many people from seeking the services they need. Ohio is one of eight pilot states selected to participate in the Elimination of Barriers Initiative, a national anti-stigma effort sponsored by the federal Center for Mental Health Services (CMHS) in the Department of Health and Human Services Substance Abuse and Mental Health Services Administration. Reducing stigma in the general public and business community will increase employment and housing opportunities for people with mental illness and substance abuse disorders, and will enable consumers to participate more fully in the social fabric of their communities. CMHS is developing materials for three primary audiences: the general public through broadcast and print media public service announcements; the business community through educational materials for CEOs and managers with hiring responsibilities; and schools through resource kits for administrators and teachers.

- B.5.3 ODMH will coordinate distribution of “pilot” anti-stigma public service announcements and materials for the business community and schools in mid-2004 and cooperate in the federal evaluation of the program.
- B.5.4 ODMH will coordinate the distribution of final anti-stigma materials in September 2005.

Make Suicide Prevention a Priority

The Commission also addresses suicide prevention. Suicide is the second leading cause of death among people age 15-19, the third leading cause among persons age 10-14 and 20-24, and the eighth leading cause among males of all ages; and suicide risk for persons 80 or above is three to four times higher than for younger Ohioans. ODMH already has a plan for the prevention of suicide that includes improved tracking of suicides and attempted suicides, targeting intervention strategies to high-risk groups, encouraging communities to adopt prevention and response initiatives, implementing age-appropriate suicide prevention programs in schools, and evaluating the effectiveness of prevention programs.

- B.5.5 ODMH will join the National Violent Death Reporting System in SFY 2004.
- B.5.6 ODMH will implement age-appropriate suicide prevention programs in schools beginning in SFY 2004 using the department’s Red Flags and Teen Screen programs as models.

Improve Quality and Outcomes for Individuals

Ohio Access is clear that publicly funded long-term services and supports need to meet a high standard of quality. Historically, “quality” has been defined as the state’s responsibility to ensure consumer safety. However, a new paradigm is emerging that expands the concept of quality to include consumer expectations about autonomy, self-direction, and choice. With these new conceptions of quality in mind, the Ohio Access cabinet will:

- Measure service satisfaction and outcomes;
- Address healthcare workforce shortage issues;
- Enhance quality in nursing facilities; and
- Provide training for teachers who work with children with disabilities.

C.1 Measure Service Satisfaction and Outcomes

In order to meet a high standard of quality, it is necessary to measure customer satisfaction with services and outcomes. Satisfaction and outcome data allow state agencies and service providers to better understand and respond to the needs of consumers and engage in quality improvement on a continuous basis. It also aids in making decisions about how to allocate public resources and in ensuring accountability for how those resources are spent. Several state agencies have made important progress in this area.

ODMH has worked for nearly a decade to develop standardized quality measures and a statewide infrastructure for assessing consumer outcomes and satisfaction. Most providers are required to use the Ohio Mental Health Consumer Outcomes System, a set of surveys administered to consumers, family members and providers. The system measures actual outcomes for people who receive publicly funded services, including severity of symptoms, quality of life and empowerment, safety and health, and community functioning. The data are used for provider-level quality improvement and to benchmark performance. In addition, ODMH supports Consumer Quality Review Teams that measure consumer satisfaction with services.

ODADAS is implementing a statewide Outcome Framework Initiative to improve service delivery and determine the effectiveness of specific prevention and treatment approaches. The department will use this data to promote best practices and to guide decisions about resource allocation.

ODJFS and ODA are using the CMS-developed Participant Experience Survey to assess overall satisfaction with PASSPORT and the Ohio Home Care Waiver program. In addition, ODA has extensively tested a sophisticated new satisfaction instrument that measures consumer experience with the specific services they are receiving. ODA also conducts a more traditional consumer satisfaction survey by mail for PASSPORT.

C.1.1 ODMH will monitor and support statewide implementation of Consumer Outcomes System in SFY 2004, expand Consumer Quality Review Teams as funds allow, and identify a target audience and resources to support a satisfaction and outcome survey.

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- C.1.2 ODADAS will integrate its Outcome Framework Initiative into its resource allocation processes and community planning guidelines in SFY 2005.
- C.1.3 Each Ohio Access agency will be able to measure service satisfaction and outcomes in all of its long-term service and support programs by SFY 2008.
- C.1.4 ODMR/DD through the QA/QI grant will identify areas of improvement in effectiveness and efficiency specific to the management and delivery of services and supports to individuals with disabilities, as part of the design and development of the quality management information system.

C.2 Address Healthcare Workforce Shortage Issues

Many frail elders and people with disabilities rely on the availability of a trained, dependable direct care workforce in order to maximize their quality of life. A direct care workforce shortage has a detrimental effect on individuals' choices and quality of life, and the state's ability to expand home and community based services. It is essential that a direct support workforce is available and prepared to provide the types of services and supports that people with disabilities want and need to live successfully in their communities.

Ohio already has taken steps to address workforce shortage issues. The General Assembly required ODH to convene the Ohio Health Care Workforce Shortage Task Force to review health care workforce shortage issues related to licensing standards, scopes of practice, technology to alleviate workload, recruitment and retention, and education. ODA coordinates the Ohio Health Care Workforce Advisory Board in conjunction with the Governor's Workforce Policy Board to bring together consumers, providers, and state agencies to develop strategies to address health care workforce shortage issues. Consistent with earlier work in these two groups, the Ohio Access cabinet will:

- Focus on strategies to recruit and retain direct support workers; and
- Credential workers across systems.

"Choice isn't real without reliable, competent aides." (G.M.)

Focus on Strategies to Recruit and Retain Direct Support Workers

The shortage of direct support workers affects the entire health care system and is, in part, a result of Medicaid and Medicare policies that control reimbursement rates for services. However, the state and private sector can work together to develop strategies to improve the recruitment and retention of direct support workers. The following promising strategies are designed to have a positive impact on recruitment and retention of direct caregivers.

- C.2.1 The Ohio Healthcare Workforce Advisory Council under the leadership of ODA will implement a statewide public awareness campaign in SFY 2004 with funding from the Governor's Workforce Policy Board to promote the value of direct support workers in all settings (nursing homes, home care, day activity centers) and service recipient groups (frail elders, adults with physical disabilities or behavioral health needs, etc.)

Credential Workers Across Systems

Each service system has a different set of training requirements for direct support workers. Only the Ohio Department of Health has a required curriculum, test, and state registry for state tested

nursing assistants (STNAs) who work in nursing homes. While many required skills are consistent across systems, there is no “reciprocity” for training. The result is duplication of effort, added expense, and inconsistency. A statewide certification of direct support workers in the health and human services systems would provide a common starting place from which workers could advance into other health care professions. A statewide certification process would allow the state to collect data about certified workers and to track the types of settings they are working in, their average hours in a work week, their continuing education, length of time in a particular job, etc. Such a statewide process would also be advantageous for the direct support workers themselves as it would allow them access to employment in different systems. Another advantage of a statewide certification process is a recognition of the skills and abilities of workers and, over time, can increase esteem for the work they perform by the general public. Increased esteem and understanding can lead to improved wages, benefits, and opportunities for workers.

C 2.2 The Ohio Healthcare Workforce Advisory Council will convene an interagency workgroup in SFY 2004 to identify core skill competencies for direct support workers across work settings and client populations to serve as the foundation for developing a statewide credential process.

C.3 Enhance Quality in Nursing Facilities

Nursing facilities are an important and well-established service setting in Ohio’s continuum of long-term services and supports. It is critically important to sustain nursing facility capacity at an appropriate level, and to assure Ohioans that services in these settings are of the highest possible quality. Nursing facility regulations need to directly contribute to quality and patient outcomes or, if they do not, be reconsidered. State regulatory reform cannot be separated from federal requirements, and Ohio’s progress in this area will depend on federal support. The Ohio Access cabinet will:

- Expand technical assistance to improve quality;
- Modify regulations to support quality; and
- Develop a more efficient regulatory model.

Expand Assistance to Improve Quality

Ohio’s Technical Assistance Program (TAP) provides education to improve the quality of care within nursing facilities. TAP works directly with nursing facilities to implement programs that evidence shows improve quality. The program was only recently implemented but already has demonstrated quality improvement in the areas of self-care for seniors, functional improvement (activities of daily living), and preventing dehydration.

C.3.1 ODH will expand the TAP program to more nursing facilities during SFY 2006-2007 and enhance the program to include training sessions for implementing new practices.

Modify Regulations to Support Quality

Ohio has requested approval for a waiver from the federal Centers for Medicare and Medicaid Services (CMS) to change the way ODH surveys nursing facilities. Nursing facilities with good past surveys and complaint records and which are in the top ten percent of all facilities according to CMS Quality Indicators would receive an abbreviated survey. The resources freed up as a

Improve Quality and Outcomes for Individuals

result of conducting abbreviated surveys would be used to provide greater monitoring of facilities with a history of non-compliance. If the CMS waiver is not approved, Ohio will consider pursuing a waiver in federal statute.

- C.3.2 ODH will request a statutory waiver in SFY 2004 to conduct an abbreviated annual survey for the top ten percent of nursing facilities based on their performance the previous year.

Develop a More Efficient Regulatory Model

Over the long term, Ohio plans to develop and test an alternative regulatory model. A coalition of regulators, funders, providers, consumers, advocates and researchers will be formed to re-design the regulatory process. Examples of possible changes might include varying the size and frequency of survey visits, reducing the number of regulatory standards, incorporating improvement activities into the regulatory process, and linking reimbursement incentives to quality improvement. Ohio would need to seek a waiver from CMS in order to test the new model. If granted, volunteer nursing homes would be randomly assigned to test the new approach or to continue to be regulated under the traditional system. Resident and facility outcomes and costs would be compared for the two groups. The findings would then be used as a basis for regulatory reform in Ohio.

- C.3.3 ODH will initiate a research-based initiative with foundation funding to redesign the federal survey process to better focus patient outcomes, key processes, and a less predictable survey schedule.

C.4 Provide Training for Teachers Who Work with Children with Disabilities

Many children with disabilities are in mainstream educational settings. The opportunity for these children to maximize their personal development and involvement with peers is related to their teacher's knowledge and understanding about their disability. It is critically important to provide teachers with appropriate training for their interactions with children with disabilities. Increasing teacher knowledge creates more choice and opportunity in out-of-home educational settings for young children and their families.

ODH already is coordinating an interagency effort to improve teacher training. The plan is to assess training needs of teachers (pre-school to grade 12) and childcare providers and develop training opportunities for teachers and child care providers based upon needs assessment and environmental scans. This initiative requires input and resources from ODH, Education, ODMR/DD and ODMH, and state partnerships with the Ohio Head Start Association, Ohio Association for the Education of Young Children, Ohio School Nurses Association, Ohio Chapter of the American Academy of Pediatrics and Ohio Child Care Resource and Referral Association.

- C.4.1 ODH will convene a workgroup in SFY 2005 to assess the training needs of childcare providers and pre-school teachers related to children with disabilities and special health care needs and implement training opportunities statewide in SFY 2006.
- C.4.2 ODH will expand the scope of the workgroup (same as C.4.1 above) in SFY 2006 to assess the training needs of teachers K-12 related to children with disabilities and special health care needs and implement training opportunities statewide in SFY 2007.

Get the Best Possible Value from Taxpayer Investments

“Existing dollars could be used more effectively by allowing consumers to direct their abilities to purchase the services that they want and need.” (J.C.)

Ohio Access envisions a fundamental alteration in Ohio’s approach to long-term services and supports, focused first on providing meaningful choices for people with disabilities, but also ensuring that taxpayers get the best possible value for their investment. Fortunately, greater consumer choice often leads to improved outcomes and greater cost-effectiveness, which is critically important given constraints on public budgets. The level of reform that is necessary to realign long-term services and supports toward consumer choice and public value can only be accomplished through comprehensive planning, including a participatory stakeholder process and integration with Ohio’s legislative process. In this spirit, the Ohio Access cabinet will:

- Articulate clear principles for system design;
- Involve consumers in planning and program design;
- Coordinate across agencies;
- Convene an Ohio Access housing task force;
- Implement enhanced care management; and
- Stimulate demand for long-term care insurance.

D.1 Articulate Clear Principles for System Design

“Ohio must embrace and utilize ‘the money follows the person’ [philosophy] so that people with disabilities can more readily leave institutions and receive necessary services in their home.” (M.B.)

Comprehensive reform takes time and focus to accomplish. People are waiting for services now, so there is no time to waste on false promises that are abandoned later. It is important to set clear expectations from the outset of reform, and to articulate clear principles for system design that guide decision-making along the path toward complete reform.

Ohio Access always starts with a vision for Ohio in which seniors and people with disabilities live with dignity in settings they prefer; they are able to maximize their employment, self-care, interpersonal relationships, and community participation; and government programs honor and support the role of families and friends who provide care. These ideas take on very practical meaning when they are applied to the actual functioning of long-term services and supports. For example, they anticipate a system in which:

- Money follows people across all long-term care settings and services.
- People with disabilities control the resources they use to access services and supports.
- Public funds are allocated based on an individual’s need and personal resources, and the availability of public resources.

Get the Best Possible Value from Taxpayer Investments

- All Ohioans anticipate that they may some day need long-term services and supports and responsibly plan for that possibility.

Ohio has made progress toward achieving these principles for system design, particularly in behavioral healthcare (which is almost entirely community based) and MR/DD (which underwent a fundamental redesign during SFY 2002-2003). This entire report is devoted to making still more progress. Appendix A, in particular, outlines strategies to financially support consumer choice, provide information consumers need, expand home and community based Medicaid waiver services, and support informal caregivers.

Modernize and Simplify the Nursing Facility Reimbursement Formula

Ohio deviates from the system design principles listed above (and lags behind most other states) in its capacity to provide home and community based alternatives to nursing facilities. The nursing facility reimbursement formula is fixed in statute and, as a result, does not allow state policy to adapt to changes in consumer demand for long-term services and supports. As a first step, the nursing facility reimbursement formula needs to be modernized to:

- Simplify the reimbursement system;
- Reward providers of high quality long-term services and supports;
- Establish price competition to create efficient providers;
- Pursue regulatory reform;
- Maximize the reliability of the Medicaid funding base; and
- Control per member per month cost growth.

D.1.1 ODJFS, ODA and ODH will work with the Ohio General Assembly to recommend proposals for the SFY 2006-2007 budget (or before) to incorporate the outcomes listed above into the nursing facility reimbursement system.

The same principles for modernizing and simplifying the nursing facility reimbursement formula already are being implemented in other publicly funded long-term service and support systems.

D.1.2 ODJFS and ODMR/DD will implement a new reimbursement system for all ODMR/DD-administered waivers in SFY 2004.

D.1.3 ODJFS, ODMH and ODADAS will convert behavioral health care reimbursement systems during SFY 2006-2007.

D.2 Involve Consumers in Planning and Program Design

Ohio Access places a high priority on consumer participation in the process of planning and program design. The original Ohio Access report – and particularly its vision – emerged primarily from consumer voices.¹ The Ohio Access departments again sought consumer input in the development of this report, and particularly relied on the leadership of the Ohio Olmstead Task Force. The [Ohio Olmstead Task Force](#) includes consumers of long-term services and supports and advocates for frail elders and Ohioans with disabilities. The Task Force is consumer-led and

¹ Ohio Access principles were derived from consumer input received during the development of the ODMR/DD Vision Paper (1997-1999), the Ohio Commission on Mental Health report (1999), and regional Ohio Access public forums hosted by ODA and ODJFS (2000).

consumer-focused. It is the one forum where advocates for Ohio's elders, advocates for those with disabilities, and consumers of services come together to promote common objectives. The Ohio Access agencies support the Olmstead Task Force with information, participation in Task Force meetings when requested, and grant funds provide travel expenses and meeting accommodations to task force members.

“We can educate our legislators ... become their source of disability information.” (M.B.)

- D.2.1 ODA will ensure that federal grants related to Ohio Access are coordinated to provide ongoing financial support to the Ohio Olmstead Task Force.
- D.2.2 Each Ohio Access agency will broadly disseminate information about Ohio Access activities—and particularly this report—through existing advocacy networks.
- D.2.3 ODA will coordinate Ohio Access departments to provide consumer and advocate training about how to conduct effective legislative visits during SFYs 2004-2005.
- D.2.4 ODMR/DD will continue its self-determination initiative with a focus in 2004 of training individuals with MR/DD in self-advocacy.

D.3 Coordinate Across Agencies

Ohio Access is a blueprint for coordinating similar activities across multiple state departments. It sets a clear vision for the future and identifies specific strategies for change. Ohio Access is a dynamic process, not a static report, and requires continued focus in order to achieve the best value for Ohio's taxpayers. In this regard, the Ohio Access cabinet will:

- Plan for the future;
- Improve data collection;
- Maximize federal grant opportunities; and
- Involve more state agencies.

Plan for the Future

The facts described in this 2004 Ohio Access report will soon be outdated, but the spirit of the report will not. It is grounded in values of opportunity, participation, independence, financial security, choice and consumer direction that will endure even as particular circumstances change. Ohio's departments need to update their activities as well, always be clear about the priorities that unite our effort to improve services and supports for people with disabilities, and enlist the support of others to achieve these objectives.

- D.3.1 The Ohio Access cabinet will update the Ohio Access report every even-numbered year.
- D.3.2 The Governor's office will coordinate the Ohio Access cabinet to visit every state legislator during SFY 2004 to discuss Ohio Access principles and enlist support for its recommendations in the SFY 2006-2007 budget.
- D.3.3 The Governor's office will coordinate the Ohio Access cabinet to provide leadership and testimony in SFY 2004 to all legislative committees with responsibility for services and supports for people with disabilities.

Improve Data Collection

Data-informed analysis is critical to the development and modification of Ohio Access long-term services and supports delivery systems. Typically, each agency captures and uses its own data, but a new strategy recently undertaken by the Ohio Access agencies will capture the Medicaid covered utilization of a consumer across systems for a more accurate picture of the services and supports that people with disabilities rely on. Better data collection will permit planning for the full range of services and supports necessary to accomplish Ohio Access goals.

- D.3.4 ODJFS will immediately organize existing data to create a more complete picture of Ohio's long-term services and supports and work with Ohio Access agencies to refine data collection to be more useful in the development of the SFY 2006-2007 budget.
- D.3.5 Ohio Access departments will make recommendations in the SFY 2006-2007 budget for systems changes that are necessary to improve data collection.

Maximize Federal Grant Opportunities

President Bush's New Freedom Initiative has created new grant opportunities for states that want to expand home and community based services for people with disabilities. Ohio is well prepared to compete for these grants and already has received seven grants worth \$3.5 million to support Ohio Access. Ohio will continue to actively pursue federal grants—but it is important to be clear that the priority is to support Ohio Access, not to apply for every possible grant.

- D.3.6 The Ohio Access cabinet will coordinate decisions about federal grants that involve more than one state agency to implement, and identify a department leader for each grant.
- D.3.7 The Ohio Access departments will rely on input from the Ohio Olmstead Task Force to make decisions about which federal grants to pursue.

Involve More State Agencies

The original Ohio Access report focused primarily on medical treatment services. This report broadens that view to include other types of services and supports that are required for people to live in home and community settings. This is consistent with Olmstead planning guidance from CMS, which encourages states to include housing, transportation, employment, and education in state Olmstead plans. Access to affordable housing is particularly critical for people with disabilities to participate in community life, but housing services are scattered across multiple federal and state entities. An important first step toward addressing these issues is to involve more state departments in the Ohio Access planning effort.

- D.3.8 The Governor's Office will identify and involve other departments in Ohio Access planning, including Development, Education, Insurance, Minority Health Commission, Natural Resources, Rehabilitation and Corrections, Rehabilitation Services Commission, Taxation, Transportation, Worker's Compensation, and Youth Services (SFY 2004).
- D.3.9 The Ohio Access cabinet agencies and the Ohio Department of Transportation will renew focus on the Statewide Transportation Coordination Task Force in SFY 2004.

“In order for anyone with a disability to maintain [themselves] independently in the community ... [there must be] transportation; adequate, affordable, accessible transportation.” (K.L.)

D.4 Convene an Ohio Access Housing Task Force

Affordable housing is essential for people with disabilities who want to receive long-term services and supports at home. However, despite its importance, housing is among the most difficult of services to coordinate. There are multiple federal, state and local jurisdictions that are responsible for housing policy, and no single strategy for making affordable housing more accessible for people with disabilities. In addition, more than other services, the availability of affordable housing depends on private market forces and decisions made by private developers. Any coordinated strategy requires the alignment of government and private interests. Finally, because there has not been a coordinated affordable housing strategy to date, it is not clear what priorities need to be pursued first—is it additional housing? or is it supportive services in existing housing? and do the answers to these questions vary by population group?

The action steps below are intended to improve interagency coordination and identify future priorities for improving access to affordable housing for people with disabilities. There are many issues that Ohioans face in regard to affordable housing (homelessness, for example), but the emphasis here is narrow—developing “housing with supports” that enables Ohioans with disabilities to exercise true choice in long-term services and supports.

“It is in everyone’s best interest to help communities develop housing to fit [the needs of a person with a disability]... [Housing] is part of recovery.” (L.L.)

- D.4.1 The Governor’s Office will convene an interagency task force in SFY 2004 to survey the state’s current efforts to provide affordable housing for people with disabilities, receive input from consumers and advocacy organizations about expanding access to affordable housing, and develop recommendations for consideration in the SFY 2006-2007 budget.
- D.4.2 ODA and ODMH will jointly develop a coherent strategy for the Residential State Supplement program (RSS), which is currently closed to new participants and develop recommendations to the Ohio Access Housing Task Force for consideration in the SFY 2006-2007 budget.
- D.4.3 ODJFS will immediately hire a housing coordinator using resources from an existing federal grant to support the Ohio Access to Affordable Housing Task Force.
- D.4.4 ODMH will create a Mental Health Housing Leadership Institute in SFY 2005.
- D.4.5 OBM will evaluate Ohio’s capital investments in long-term care, and report recommendations to the Ohio Access Housing Task Force in SFY 2004.

D.5 Implement Enhanced Care Management

ODJFS has developed an enhanced care management (ECM) strategy to bring the benefits of enhanced care coordination, improved access to primary and preventive care, and expanded member services to additional Medicaid consumers who have chronic conditions. This strategy will prioritize individuals on Medicaid with chronic or critical health care conditions (the highest-cost users of Medicaid services) to improve cost predictability and administrative simplicity, assure the appropriate use of services and minimize preventable or unnecessary use of emergency care and inpatient services, and establish accountability for both access to care and quality of care.

Get the Best Possible Value from Taxpayer Investments

ODJFS will competitively select service providers to provide enhanced care management. Applicants will have experience in providing a comprehensive care management program, including: care coordination and case management; a nurse/health advice line; provider relations, education, and support; consumer information, education, and support; and accountability for access to and quality of care, as well as quantifiable return on investment. Selected applicants will be expected to promote the appropriate use of cost-effective medical care, pursue rapid quality improvement, and minimize preventable or unnecessary use of emergency care and inpatient services.

Other components of enhanced care management include the continuation and expansion of the risk-based managed care program for children and families covered by Medicaid; the ongoing use of pharmacy management, including cost sharing, for “fee-for-service” consumers; and activities to educate consumers regarding the use of their Medicaid benefits.

- D.5.1 ODFJS will competitively select qualified service providers and work to begin implementing the program in early SFY 2005.
- D.5.2 In SFY 2005 ODJFS will explore the feasibility of expanding ECM to Ohioans who are dually eligible for Medicare and Medicaid.
- D.5.3 ODJFS will report the extent to which ECM programs achieve the desired result of reducing per member rate of growth in cost of care for Ohio’s Medicaid fee-for-service aged, blind or disabled population (beginning in SFY 2006).

D.6 Stimulate Demand for Long-Term Care Insurance

Disability can enter our life at any point – through accident, illness and age. It is important that every Ohioan understand that he or she may some day need long-term services and supports, and responsibly plan for that possibility. According to the Center for Home Care Policy and Research, people who purchase long-term care insurance are much more likely to remain in community settings than those who have not purchased long-term care coverage, and less likely to require assistance from publicly-funded programs.

Unfortunately, the long-term care insurance market has been slow to develop, and many consumers are (with justification) skeptical about its value. However, as private insurers begin to cover *alternatives* to institutional care (as opposed to paying for care in an institution), the demand for these products is beginning to grow. If the state can further stimulate the demand for long-term care insurance, then it also might relieve pressure on publicly funded programs.

Ohio enacted a “long-term care partnership program” in 1993. Ohio’s program is the same as model programs in four other states that let participants shelter assets that would otherwise count toward establishing Medicaid eligibility in exchange for purchasing an approved long-term care insurance policy. However, before Ohio was able to implement its program, Congress blocked all but the original four states from implementing partnership programs. Recently, Congress reopened the debate about allowing additional partnership arrangements.

- D.6.1 ODA will immediately communicate Ohio’s support for repealing the federal prohibition on long-term care insurance partnerships to the state’s Congressional delegation.

Get the Best Possible Value from Taxpayer Investments

D.6.2 The Governor's office will convene an interagency task force to provide technical assistance related to other options to stimulate demand for long-term care insurance that are under consideration by the Nursing Facility Reimbursement Study Council.

Prevent the Causes of Disability

Disability can enter our life at any point – through accident, illness and age. In some cases, the causes of disability can be prevented. In order to improve the state's effectiveness in helping to prevent the causes of disability, the Ohio Access cabinet will:

- Create a fetal alcohol syndrome prevention initiative;
- Pilot community projects focused on prevention; and
- Expand early intervention for children.

E.1 Create a Fetal Alcohol Syndrome Prevention Initiative

Fetal Alcohol Syndrome (FAS) is considered the largest known cause of mental retardation and the most preventable birth defect. However, many Ohioans are not aware of the birth defect risks associated with alcohol consumption during pregnancy. ODADAS, ODH, and ODMR/DD are collaborating through the [Ohio Family and Children First](#) initiative to organize a conference to develop a statewide educational campaign to prevent FAS. The objective of the campaign is to reduce the number of children born with FAS.

- E.1.1 ODADAS will coordinate Ohio Access agencies and others to organize a September 2004 conference to develop a statewide educational campaign to prevent FAS.
- E.1.2 ODADAS will coordinate with Ohio Access agencies and others to implement a statewide educational campaign to prevent FAS during SFY 2006.

E.2 Pilot Community Projects Focused on Prevention

Prevention is universally hailed as a positive endeavor, but frequently pursued without focus or evaluation and, consequently, without results. ODH is developing a more focused approach to prioritize prevention strategies toward the causes of disability – illnesses and injuries that severely impair a person's ability to fully participate in community life and significantly add to the cost of public health care systems. The Ohio Access cabinet will pilot community programs to:

- Prevent falls;
- Prevent traumatic brain injury; and
- Prevent stroke.

Prevent Falls

As many as one out of three seniors in a community setting falls each year. Among people age 64 and older, falls are the leading cause of injury death, and the most common cause of non-fatal injuries and hospital admissions for trauma. Research indicates that reducing the risk factors associated with falls can significantly reduce the likelihood of a person actually falling. Effective programs include assessment of risk by health care providers, review of medications, exercise programs, behavioral recommendations, and environmental modifications.

Prevent the Causes of Disability

- E.2.1 ODH will adopt a standardized fall risk assessment in SFY 2004 to be used by health care providers, and provide continuing education courses beginning in SFY 2005 for physician and other health care professionals that include fall guidelines and information about referring at-risk seniors to effective fall prevention programs.
- E.2.2 ODH will work with the Ohio Department of Insurance in SFY 2005 to encourage insurance companies to cover prevention programs and services for falls.
- E.2.3 ODH will provide education and fall prevention services to older citizens and their caregivers through ODA and the Area Agencies on Aging.

Prevent Traumatic Brain Injury

Approximately 60,500 Ohioans suffer from traumatic brain injury (TBI) as a result of accidents and injuries. Falls account for nearly 70 percent of all traumatic brain injury among people age 45 and older. Individuals between age 14-24 and age 75 and older are significantly more at risk for traumatic brain injury than the population generally.

- E.2.4 ODH will work with Ohio Access agencies during SFY 2005 to develop a tracking system that links various data sets to increase understanding of the risk factors and magnitude of traumatic brain injury, develop a comprehensive state policy on decreasing the risk factors associated with traumatic brain injury, and implement a statewide program to raise awareness of traumatic brain injury and associated risk factors in SFY 2006.
- E.2.5 ODH will work with the Ohio Department of Insurance in SFY 2005 to encourage insurance companies to cover prevention and services for traumatic brain injury.
- E.2.6 ODH will collaborate with hospitals, professional associations and universities to provide training for health care providers relative to the risk factors and prevention strategies.

Prevent Stroke

Stroke is the third leading cause of death in Ohio and the leading cause of serious long-term disability. Significant, treatable conditions linked to stroke are high blood pressure and cigarette smoking. Programs aimed at reducing the incidence of stroke often focus on these two conditions and include broad-based public awareness programs directed toward the general public addressing the importance of blood pressure health.

- E.2.7 ODH will identify effective media messages to increase awareness in the general public about the need to control risk factors for stroke, coordinate a broad-based public awareness program regarding blood pressure, and support educational and informational initiatives for health care practitioners in training and in practice.
- E.2.8 ODH and the Tobacco Use Prevention and Control Foundation will continue current initiatives to reduce smoking.
- E.2.9 ODMR/DD will provide alerts to help people prevent and reduce the possibility of serious incidents from occurring. These alerts include topics such as feeding tubes, pneumonia, and seizure triggers.

E.3 Expand Early Intervention for Children

Ohio's Help Me Grow program is designed to identify children at the earliest possible age who may have a developmental delay or disability, and to connect families to appropriate services and supports. Help Me Grow served approximately 8,000 infants and toddlers with developmental

Prevent the Causes of Disability

disabilities in 2002. Less than 20 percent of those children were under age one, indicating an opportunity to improve the program to reach more children earlier.

ODH, Education, ODJFS, ODMR/DD and ODMH are collaborating through the Ohio Family and Children First Initiative to increase the Help Me Grow program's capacity to reach children earlier. This effort is designed to assist local communities in developing child find approaches in cooperation with health care and child care providers, and improve parent and public education strategies to identify more infants with developmental disabilities before age one.

In addition, state agencies will seek input and support from the Ohio Chapter of the American Academy of Pediatrics, Family Practice Association and the Ohio Child Care Resource and Referral Association.

- E.3.1 ODH will work with other Ohio Access agencies to assemble a workgroup that includes counties and others (Academy of Pediatrics, etc.) to develop strategies that will identify infants with developmental disabilities earlier and connect them to appropriate services.
- E.3.2 ODH will implement "Child Find" strategies in urban counties in SFY 2005 and statewide during SFY 2006-2007.

Support Employment

“How long can we afford, as a state, to continue to relegate people with disabilities to not paying taxes, to not contributing to the economy of the state, to not buying goods and services that stimulate the economy?” (D.D.)

Most people with a disability between the ages of 21 and 64 work (77 percent according to the 2000 Census). Having a job and being economically self-sufficient are important aspects of personal independence and overall quality of life. However, many people with a disability who want to work cannot because additional income would threaten their health care benefits. Federal welfare programs were reformed in the 1990s to support people who work, but Social Security disability programs and Medicaid were not. In order to support the critical link between work and self-sufficiency, the Ohio Access cabinet will:

- Develop a Medicaid Buy-In program;
- Implement Supported Employment in the Mental Health System; and
- Implement the U.S. Department of Labor Employment Navigator.

F.1 Develop a Medicaid Buy-In Program

Recipients of Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) risk losing Medicaid coverage, which is linked to their cash benefits, if they work. Eliminating barriers to health care and creating incentives to work can greatly improve financial independence and well being. To support this goal, Congress included a Medicaid Buy-In (MBI) option in the Balanced Budget Act of 1997 (BBA) and enacted the Ticket to Work Incentives Improvement Act (TWWIIA) in 1999. These laws authorized states to create MBI programs to extend Medicaid coverage to persons with disabilities who go to work.

“[My son needs] to find a job and buy in for his own Medicaid insurance. Otherwise ... it forces him into a spiral of poverty ... In order to get a job, support Medicaid Buy-In.” (C.L.)

States have a great deal of latitude about if and how to construct various MBI models for people with disabilities. There are several models that have been discussed in Ohio. Each of these models assumed that personal care services would be only those services currently covered on the Medicaid State Plan. One model was constructed using a contractor for the Ohio Developmental Disabilities Council (ODDC). The Ohio Senate Finance and Financial Institutions Committee also recommended this model. The ODDC model was presented with a number of variations, including different cost sharing and eligibility assumptions. Fully implemented, the ODDC model was predicted to serve 12,542 people and cost approximately \$22.3 million in new state dollars.

Support Employment

ODJFS contracted with The Lewin Group to further develop several aspects of MBI. Lewin presented five different models, the most conservative of which is described below. The Lewin models ranged from 3,451 to 9,056 participants with state funding ranging from \$8.2 million to \$29.6 million (\$20.3 million to \$74 million all funds).¹ The assumptions and costs associated with the ODDC model and the most conservative Lewin model are summarized below.²

Medicaid Buy-In Cost Assumptions		
	ODDPC Model	Lewin most restrictive model
Model		
1. Assets	1. \$10,000	1. \$2,000
2. Earned Income	2. \$20,000	2. \$10,000
3. Income standard	3. 250 percent	3. 200 percent
4. Premiums	4. 10 percent above 150 percent	4. Varies from 2.5 percent to 7.5 percent depending on family income
People to be served	12,542 (7,000 initially; 5,000 new to Medicaid)	3,500 (less than 2,000 new to Medicaid)
Cost of Buy In	<p>1. Recommendation was that administration of \$2.5m and \$3m be given to JFS, but this was not passed by General Assembly</p> <p>2. Buy-In for 12,542 people estimated <u>\$22.3 million</u> state funds by the Finance Committee</p>	<p>1. No administrative costs included</p> <p>2. Buy-In in for 3,500 people estimated <u>\$8.2 million</u> state funds by Lewin</p>

The Medicaid Buy-In proposals discussed above (including the ODDC model recommended by the Senate Finance Committee and the Olmstead Task Force) do not propose to add personal care to Ohio's Medicaid state plan. However, because this option is a priority for many individuals with a disability, it is important to address in this report.

Last year (SFY 2002) Ohio spent \$505.2 million on personal care services through Medicaid waiver programs (PASSPORT, IO, RFW, Choices, Home Care and Transitions). In fact, personal care is primarily what these waivers cover. Adding personal care to the state plan would make

¹ Average annual Medicaid costs for MBI program participants were assumed to be equal to the average annual Medicaid expenditure for non-institutionalized Medicaid enrollees with a basis of eligibility of "Disabled." The majority of these individuals are between the ages of 18 and 64, which is the target population used for the enrollment estimates. Per capita Medicaid spending data for this group was used as a proxy for the expected average spending for MBI enrollees. Spending data from FFY 2001 was trended forward two years based on historical annual growth in per capita Medicaid spending for the ABD population in Ohio.

² The total estimated costs in Table 1 do not include the cost of administrative activities to implement MBI, which ODJFS estimates would be an additional \$2.0 million in state funds for either model.

that service an entitlement, which means that Medicaid would be required to provide it (up to the specified limit) to any Medicaid recipient who meets the functional definition of need for the service. Once on the state plan, qualifying for this service would not be limited to people seeking to maintain or obtain employment (the purpose of Medicaid Buy-In). The cost to add personal care to the state plan is significant – one preliminary ODJFS estimate pegs this cost from \$171.7 million to \$194.1 million in state funds only to serve all Medicaid eligibles who would need personal care services. A new commitment of that magnitude, given the state's current fiscal constraints, is not realistic. More work would be needed to update and refine this estimate. However, providing personal care services through waiver programs will remain a high priority.

- F.1.1 ODJFS will develop a Medicaid Buy-In proposal for consideration in the SFY 2006-2007 budget; the proposal will address MBI model design (asset limits, premiums, etc.) and recommend a federal implementation vehicle (Ticket to Work Act, HIFA waiver, etc.); and the process will include active involvement of the Ohio Olmstead Task Force and others.

F.2 Implement Supported Employment in the Mental Health System

Supported Employment is an evidence-based practice that has been shown to improve employment outcomes for people with disabilities compared to traditional job and vocational approaches. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) offers grants to help local providers “install” a Supported Employment toolkit in their agencies. The objective of this initiative is to increase economic self-reliance for people with mental illness and improve their overall quality of life. Research shows that employed consumers experience reduced disability and move from being consumers of tax-financed services to becoming taxpayers. Access to Supported Employment also improves access to other choices related to work, including choice of type and location of housing, networks of acquaintances and friends, and type and location of service providers.

- F.2.1 ODMH will promote Supported Employment, establish four pilot sites during SFY 2004, and implement Supported Employment statewide during SFY 2006.
- F.2.2 ODMH will prioritize services to help consumers access income support and medical benefits through SSI/SSDI, Medicare, and Medicaid, and collaborate with ODJFS in the effort to expand Medicaid to support work.
- F.2.3 ODMH will promote the use of benefits counselors (advisers to consumers on navigating the complex world of health and income support benefits) to remove systemic barriers to employment for people with severe mental illness.
- F.2.4 ODMH will grow its partnership with the Ohio Rehabilitation Services Commission to improve consumer outcomes related to health and health care, economic independence, improved clinical outcomes, and meaningful participation in society.

F.3 Implement the U.S. Department of Labor Employment Navigator

The Disability Program Navigator helps people with disabilities “navigate” through the enormous challenges of seeking work. Complex rules surrounding entitlement programs, along with fear of losing cash assistance and health benefits, can often discourage people with disabilities from

Support Employment

working. U.S. DOL and the Social Security Administration established the Disability Program Navigator program to better inform beneficiaries and other individuals with disabilities about the work support programs now available at DOL-funded One-Stop Career Centers.

ODJFS is interested in applying for a DOL navigator grant at the next opportunity. The grant requires the state to work in collaboration with local One Stops and to use the grant to support, among other activities, hiring people in One Stops to assist people with disabilities to access programs that help them gain employment, or return to or retain a job.

F.3.1 ODFJS will immediately determine upcoming grant opportunities, promote the DOL Navigator initiative to all One Stops, and work directly with One Stops that are likely to be successful in pursuing this initiative.