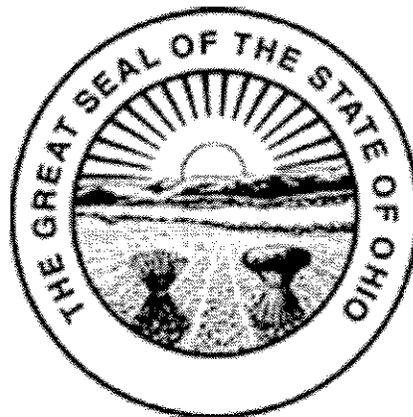


## Ohio MFP Table of Contents - Appendices

Appendix	Title/Contents
A	Ohio Access 2004: Governor Taft's Strategic Plan to Improve Long-Term Services and Supports for People with Disabilities
B	Ohio Commission to Reform Medicaid Report – Recommendations and Progress Report
C	Key Ohio Legislative Reforms (contained in the 2006-2007 state budget)
D	Ohio Profile and Project Summary
E	MFP Proposal Planning – Participation and Notes
F	Organizational Charts <ul style="list-style-type: none"> <li>• MFP Demonstration Organizational Chart</li> <li>• F-1: Ohio Medicaid – Major Organizational Relationships</li> <li>• F-2: ODJFS Table of Organization – Executive Offices</li> <li>• F-3: ODJFS TO – Ohio Health Plans – Deputy Director's Office</li> <li>• F-4: ODJFS TO – Ohio Health Plans – DDO/Long Term Care Policy</li> </ul>
G	MFP Central Referral and Tracking System – Organizational Relationships
H	Project Resumes and Position Descriptions <ul style="list-style-type: none"> <li>• Resume – Tracy Williams, ODJFS – State Medicaid Director</li> <li>• Resume and Position Description - Erika Robbins, ODJFS – Assistant Director for Long Term Care Policy</li> <li>• Position Description – MFP Project Director</li> <li>• Position Description – State Plan Policy Analyst</li> <li>• Position Description – HCBS Waiver Policy Analyst</li> <li>• Position Description – HCBS Waiver Policy Analyst</li> <li>• Position Description – Housing Coordinator</li> <li>• Position Description – LTC Pre-Admission Policy Manager</li> <li>• Position Description – Staff to support the ODJFS Central Referral &amp; Tracking System</li> </ul>
I	Budget and Maintenance of Effort Forms <ul style="list-style-type: none"> <li>• Demonstration of Funding Request</li> <li>• Maintenance of Effort - LTC Services Expenditure Percentages</li> <li>• Certification of MOE</li> <li>• MOE Narrative</li> <li>• MOE – State Plan Services</li> <li>• MOE – Waiver Services – by waiver</li> </ul>
J	Letters of Support

# 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**

---

## Contents

<b>I. Overview.....</b>	<b>1</b>
Who relies on long-term services and supports?	1
What are long-term services and supports?	2
Who provides long-term services and supports?	2
What is Olmstead?	3
What is the Ohio Olmstead Task Force?	4
What is Ohio Access?	4
<b>II. Progress Report, 2001-2003.....</b>	<b>7</b>
Increase Community Capacity	7
Prioritize Resources	10
Assure Quality and Accountability	12
<b>III. Current Challenges, January 2004.....</b>	<b>17</b>
Funding Constraints	17
Federal Policy Constraints	19
Local Resource Sustainability	20
<b>IV. Strategic Plan, 2004 and Beyond.....</b>	<b>23</b>
Vision and Goals	23
Performance Measures	23
Recommendations	24
<b>Appendices: Detailed Strategies</b>	
A. Give consumers meaningful choices	1
B. Focus on behavioral health	11
C. Improve quality and outcomes for individuals	17
D. Get the best possible value from taxpayer investments	21
E. Prevent the causes of disability	29
F. Support employment	33

*“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

## Overview

---

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.<sup>1</sup> The best estimates

---

<sup>1</sup> “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

## Overview

---

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.

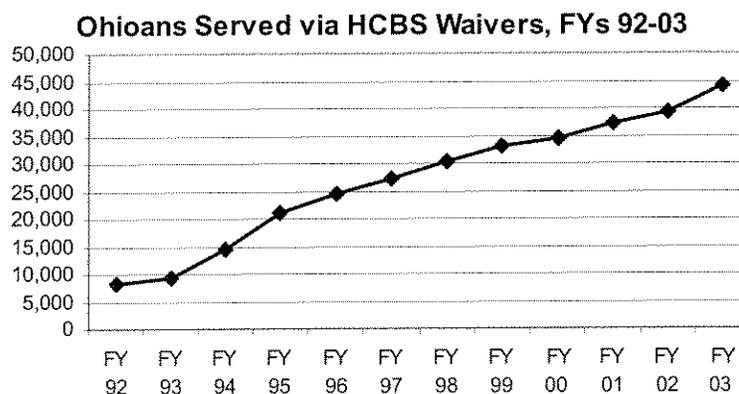
This section summarizes the impact of the original Ohio Access report. It documents the progress made under each priority between February 2001 and December 2003.

### 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.



## Progress Report, 2001-2003

---

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](http://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

## **Progress Report, 2001-2003**

---

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](http://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](http://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](http://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.<sup>1</sup> 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

---

<sup>1</sup> 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

## Ohio Access Strategic Plan, 2004 and Beyond

---

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 expenditures<sup>1</sup> 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.

---

<sup>1</sup> 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.<sup>1</sup> 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 equality, 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.

---

<sup>1</sup> 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](http://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](http://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 17<sup>th</sup> in 1981 to 34<sup>th</sup> 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 (IHCBS) 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 IHCBS 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.

## **Focus on Behavioral Health**

---

### **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](http://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.

## **Improve Quality and Outcomes for Individuals**

---

- 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

## **Improve Quality and Outcomes for Individuals**

---

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 anew 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.<sup>1</sup> 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

---

<sup>1</sup> 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).

---

## Get the Best Possible Value from Taxpayer Investments

---

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.

## **Get the Best Possible Value from Taxpayer Investments**

---

### **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).<sup>1</sup> The assumptions and costs associated with the ODDC model and the most conservative Lewin model are summarized below.<sup>2</sup>

<b>Medicaid Buy-In Cost Assumptions</b>		
	<b>ODDPC Model</b>	<b>Lewin most restrictive model</b>
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	1. Recommendation was that administration of \$2.5m and \$3m be given to JFS, but this was not passed by General Assembly  2. Buy-In for 12,542 people estimated <u>\$22.3 million</u> state funds by the Finance Committee	1. No administrative costs included  2. Buy-In in for 3,500 people estimated <u>\$8.2 million</u> state funds by Lewin

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

<sup>1</sup> 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.

<sup>2</sup> 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.

# Transforming Ohio Medicaid:

## Recommendations from the Ohio Commission to Reform Medicaid

### *A New Vision to Transform Ohio Medicaid*

The Commission recommends a dramatic transformation of the program - a transformation that requires a bold new vision and structure. The Commission proposes a vision that puts the consumer at the center of the transformation through choice, competition and individual responsibility. This vision dramatically increases the State of Ohio's massive health care buying power and expands its use of competitive selective contracting. It compels a systemwide commitment to care management initiatives designed to improve health while controlling Medicaid's major cost drivers - long-term care, hospitals, and pharmaceuticals.

A competitive Medicaid program operated with 21st century technology and knowledge management systems is the clear path to better services for consumers and smaller cost increases.

Medicaid Today		Ohio Medicaid Transformed
Focused on illness	→	Focused on prevention & wellness
Provider centered	→	Consumer centered
Price driven	→	Quality, outcome driven
Uncoordinated array of programs	→	Coordinated clear choices
Fragmented, dated information technology system	→	Connected, knowledge driven
Any willing provider	→	Competitive market place
"Blank check"	→	Contained within a budget

Ohio's Medicaid program is swamping the state budget, with expenditures increasing at twice the rate of the growth of state revenues. Despite past aggressive cost containment and budget strategies, this \$10.5 billion entitlement program comprised of state and federal dollars represents almost 40% of the state's general revenue fund spending and continues to grow.

In addition, a patchwork of activities has evolved over three decades since the creation of this important program, which has left Medicaid fraught with structural, policy and programmatic complexities and inefficiencies that do not always serve well the needs of the 1.7 million low-income and disabled Ohioans it serves.

The unsustainable rate of spending growth not only threatens the long-term viability of the program for the needy, but also threatens to crowd out funding for other essential state services including education, economic development, public safety, and transportation. The problem is not unique to Ohio; every state has experienced skyrocketing Medicaid costs that in some cases have brought the program to near bankruptcy in those states.

Governor Bob Taft and the Ohio General Assembly created the Ohio Commission to Reform Medicaid to address these issues and recommend strategies for reform. After a year of comprehensive study of Ohio's Medicaid program and review of initiatives in other states, the Commission believes that Ohio must take both short and long-term actions starting this coming fiscal year. As a first step, two general principles should be considered. First, Medicaid should consume no more of the state budget, in percentage terms than it currently consumes, and potentially less. This means that growth in its programs should not exceed the growth rate of state revenues, which historically has been on average 4.5%. Second, on a per recipient basis, average expenditure growth should not exceed the medical inflation rate. Had these principles been in effect, the historic average growth rate of Medicaid spending would have been cut in half to approximately 4%. Further, the Office of Budget and Management projected estimate for a 13% Medicaid growth rate in SFY 2006 would be reduced by more than two-thirds. The Commission believes that living within these constraints will only be achievable if steps are taken to eliminate inefficiencies and focus is placed on instituting cost effective care.

The Commission also identified a major impediment to achieving these ends: namely the lack of modern information systems to monitor and track detailed Medicaid expenditures across Medicaid's many programs and for gathering data on individual beneficiary activities over time. The Commission believes early attention to a comprehensive data management system is critical both to operation of the current program and to long term success of the structural, programmatic and administrative changes needed to transform the system. Although,

the Commission recommends that the state freeze or markedly constrain Medicaid spending for early impact this should not obscure the necessary investments such as information technology that will be needed.

To contain Medicaid spending to a sustainable level in the short term, the Commission recommends that the Governor and Legislature implement the following nine actions or tactics during the first six months of 2005, with particular attention to the passage of the SFY 2006-2007 biennial budget bill:

- \* Establish and adhere to a firm Medicaid budget target and specific mechanisms to enforce this target.
- \* Use selective contracting and other care management initiatives to better leverage the state's massive buying power to control and improve service quality.
- \* Eliminate Medicaid rates, such as nursing home reimbursement rates, in order to facilitate negotiation with Medicaid providers for competitive rates and improved quality.
- \* Implement short-term provider rate reductions or freezes, as appropriate, as a one-time move.
- \* Expand Ohio's estate recovery process to align with federal Medicaid estate recovery laws.
- \* Strengthen Medicaid audit processes to reduce Medicaid fraud, waste and abuse.
- \* Move Medicaid recipients into managed care arrangements unless medically inappropriate.
- \* Control pharmaceutical costs by formulary control and eliminate legislative and administrative barriers to competitive pricing.
- \* Apply for the 90% federal match to implement a statewide comprehensive technology system across all state agencies.

A list of short- and long-term recommendations is summarized below for the six areas of focus: Long-Term Care, Care Management, Pharmacy, Eligibility, Finance, and Structure and Management.

## Long-Term Care

**Recommendation 1:** Offer cost effective long-term care services to Medicaid eligible consumers and eliminate the established bias towards nursing homes.

**Action Step 1:** Remove the nursing home reimbursement formula from Ohio statute, and give the executive

branch authority to negotiate fair and reasonable rates that require nursing homes to achieve performance-based outcomes and objectives. This should happen in conjunction with the phase out of Certificate of Need.

**Action Step 2:** Phase out the current Certificate of Need for Ohio's nursing homes.

**Recommendation 2:** Ensure access to and information about long-term care service options and expand those options.

**Action Step 1:** Create a comprehensive pre-admission screening process for any Ohioan applying for Medicaid-funded long-term care, especially nursing facility.

**Action Step 2:** Establish Long-Term Care Resources Centers in each Area Agency on Aging service area.

**Action Step 3:** Offer assisted living as a Medicaid option. (See related recommendations in Care Management.)

**Action Step 4:** Increase the clinical capacity of home care options to care for consumers.

**Recommendation 3:** Encourage personal choice and responsibility for long-term care by modifying estate and asset recovery, as well as state funding policy.

**Action Step 1:** Modify Ohio's estate recovery process to the maximum extent allowed under federal Medicaid estate recovery law. In addition, use waivers to create incentives through an estate recovery model for consumers to select the lowest cost care options.

**Action Step 2:** Establish a long-term care "voucher system" (sometimes referred to as "Cash and Counseling") that would ensure that "money follows the person."

**Action Step 3:** Increase assets that may be retained by income-eligible Medicaid waiver applicants to avoid premature admission to an institutional setting.

**Action Step 4:** Remove bureaucratic obstacles to accessing Home and Community-Based Services as quickly as nursing facility care.

**Recommendation 4:** Create a cost-efficient long-term care system with consolidated budgets, data collection and planning.

**Action Step 1:** Create a unified long-term care budget managed across all state and all local governmental agencies and service settings, and establish a single accountable head to provide leadership and direction for meeting the long-term care needs of Ohioans.

**Action Step 2:** Establish a long-term care policy coordinating body with authority that spans all state long-term care plans and programs.

## Care Management

**Recommendation 1:** Establish a statewide care management program for all Medicaid recipients.

**Action Step 1:** Expand the current full-risk managed care program to all Medicaid-covered families and children enrollees throughout Ohio.

**Action Step 2:** Apply care management to the Aged, Blind and Disabled consumers as appropriate, recognizing established medical relationships within special needs populations such as those in intermediate care facilities for the mentally retarded, and the need for strategies which respond to consumers whose needs include medical management and coordination of supports for living in the community.

**Action Step 3:** Implement outcome-based protocols that offer incentives, including but not limited to financial incentives, to constrain cost and improve health status through patient education and compliance, deployment of community health education and outreach workers, and coordination with public and private social service organizations to support adherence to those protocols. During the 2006-2007 biennium, these should include at least the following circumstances: prenatal care beginning during the first trimester; diabetes; asthma; chronic obstructive

pulmonary disease; chronic heart failure; and delaying or preventing nursing home admissions.

**Action Step 4:** Improve Medicaid care management by increasing coordination between state agencies, adopting nationally recognized quality performance standards, and requiring managed care entities to purchase surety bonds to strengthen financial solvency.

**Action Step 5:** Establish a Managed Care Working Group (MCWG) including representatives from Medicaid care management plans, major health care and behavioral health professional and trade associations, consumer advocates, county agencies, and state agencies including the departments of Health, Insurance, Job and Family Services, Aging, Mental Health, Alcohol and Drug Addiction Services, Mental Retardation/Developmental Disabilities, and the Rehabilitation Services Commission.

**Recommendation 2:** Withhold payment of the hospital Graduate Medical Education (GME) Medicaid subsidy from those hospitals that fail to participate in expansion of care management.

This is the only recommendation on which Commissioners present at the December 13, 2004 meeting did not reach unanimous agreement. At the same time the full Commission discussed a proposal to similarly withhold monies from the Hospital Care Assurance Program (HCAP).

## Pharmacy

**Recommendation 1:** Secure the best prices for drugs (brand, generics and over-the-counter medications) through expansion of buying power and creation of a more competitive market for price negotiation.

**Action Step 1:** Consolidate all drug purchasing by the state and other Ohio public entities with Ohio Medicaid through administrative streamlining for the purposes of negotiating rebates and better overall prices for of individual drugs. At the same time, analyze the financial benefits of expanding the pool further through participation in newly emerging multi-state drug purchasing pools.

**Action Step 2:** Lift restrictions in the current rebate system, which exclude certain Medicaid purchases from negotiated cost recovery: these include mental health and HIV/AIDS drugs, physician office purchases, and purchases in the Disability Assistance Medical program.

**Action Step 3:** Create a transparent pharmacy program that allows for open, prospectively negotiated and publicly disclosed individual drug discounts, based on competitive pricing.

**Recommendation 2:** Restrict drugs eligible for payment under Medicaid program using a more limited formulary than currently in place, with preferred status going to similar, if not identical, lower cost drugs.

**Action Step 1:** Limit the number of preferred drugs to effective, lower cost products, and require documentation and prior authorization (PA) for off-formulary use.

**Action Step 2:** Regularly evaluate and promulgate evidence-based research on the use of prescription drug therapies, and utilize efforts such as prior authorization to ensure their practice.

**Action Step 3:** Set incremental time specific goals for increasing the use of generic as opposed to patented drugs as percent of all drug expenditures.

**Recommendation 3:** Reduce State expenditure at the point-of-purchase of Medicaid drugs.

**Action Step 1:** Bring Medicaid pharmacy reimbursement into parity with commercial insurers.

**Action Step 2:** Create a system of modest patient cost sharing for all drug purchases to align with other states' Medicaid programs.

**Action Step 3:** Implement a mail-order program for Chronic Care Maintenance Medications.

**Recommendation 4:** Establish systems to monitor cost effective management of drugs by Medicaid reimbursed prescribing physicians and health plans.

**Action Step 1:** Initiate Medication Therapy Management.

**Action Step 2:** Provide incentives for physicians and hospitals to move toward electronic prescribing supported by evidence-based research, practice guidelines and step therapy.

**Recommendation 5:** Limit state financial liability in the shift to Medicare Part D.

**Action Step 1:** Monitor the shift to the Medicare Part D formulary for the dual eligible population, operating on the general premise that Ohio should not provide additional subsidies for products covered in the Ohio formulary but not in the Federal schedule, but will consult with other states and with Medicare if clinically important differences become apparent.

## Eligibility

The Commission believes that Ohio's current Medicaid eligibility standards for low-income families and children, who represent 74% of the covered lives, but only 24% of costs, should be maintained. However, there are opportunities for strengthening Medicaid's role in supporting employment and for controlling the rate of growth in the covered aged, blind, and disabled (ABD) population.

**Recommendation 1:** Terminate, effective July 1, 2005, the duplicative disability determination process administered by the ODJFS Office of County Medical Services. Require ABD Medicaid applicants to apply first for federal Old Age, Survivors and Disability Insurance (OASDI) and Social Security Income (SSI), showing proof of such application, and base disability determination upon disability reviews conducted for the Social Security Administration (SSA) by the Bureau of Disability Determination Services at the Rehabilitation Services Commission (RSC).

**Recommendation 2:** Further develop data and policy alternatives for aligning ABD eligibility under Ohio's Medicaid State Plan with guidelines used by the vast majority of states.

**Recommendation 3:** Expand overall health care coverage through a better-defined relationship between Medicaid and employer-based health plans.

**Action Step 1:** Collect premiums from persons receiving transitional Medicaid benefits.

**Action Step 2:** Require certain employed Medicaid recipients to enroll in private insurance.

**Action Step 3:** Establish a Medicaid Buy-In Program for People with Disabilities after implementing Commission recommendations to control the rapid growth in Medicaid spending.

## Finance

**Recommendation 1:** Establish firm annual spending targets for Medicaid.

**Action Step 1:** Beginning with the SFY 2006-07 biennium, annual appropriations to the Ohio Department of Job and Family Services' 525 line-item account should be based upon actual spending for the most recent fiscal year for which data are available, adjusted for changes in the number of participants, health care costs, and state revenues.

**Action Step 2:** Provide program administrators flexibility and authority to manage costs within the budgeted amount. This would require repealing codified rates including nursing homes.

**Recommendation 2:** Freeze or limit institutional payment for the SFY 2006-2007 biennium.

**Action Step 1:** Freeze hospital inpatient rates at SFY 2005 levels.

**Action Step 2:** Reduce by up to 3% payment for nursing facilities and intermediate care facility/mental retardation (ICF/MR services), recognizing potential differences between the two in the final reduction determination.

**Recommendation 3:** Optimize cash flow by paying all bills no sooner than the end of the month, consistent with prompt pay laws.

**Recommendation 4:** Ensure Medicaid is the payer of last resort.

**Action Step:** Modify the current benefit coordination practices to ensure that Medicare and private sources are the first payers for all Medicaid eligible individuals.

**Recommendation 5:** Develop prospective diagnostic and risk-adjusted capitated rates, similar to that used by Medicare as opposed to the current Medicaid program that is cost-plus based.

## Structure and Management

**Recommendation 1:** Design and implement a comprehensive program of fiscal compliance audits and performance audits to improve effectiveness and overall operation of the Medicaid program.

**Action Step 1:** Provide the Auditor of State with statutory and independent budgetary authority to conduct performance audits of the Medicaid program and provider audits.

**Action Step 2:** Strengthen, formalize and validate audit-sampling techniques to determine levels of fraud, waste and abuse.

**Action Step 3:** Reposition the Surveillance Utilization Review Section (SURS), as an independent entity within ODJFS.

**Recommendation 2:** Update Ohio's Medicaid information systems and integrate financial and program management and patient care functions.

**Action Step 1:** Develop a comprehensive business case analysis for the entire Medicaid information technology system, consistent with Medicaid Information Technology Architecture (MITA) initiative by Centers for Medicare and Medicaid Services (CMS).

**Action Step 2:** Implement an Enterprise Data Warehouse System for the purposes of eliminating redundant reporting systems, exposing operational inefficiencies and modeling solutions.

**Action Step 3:** Establish a real-time, paperless, cost-claiming system and streamline and establish an integrated eligibility determination process for Medicaid and other services for needy Ohioans. Establish capacity for electronic prescribing, to include the Ohio formulary, patient records, and clinical decision support.

**Recommendation 3:** Restructure Ohio Medicaid through a multi-step process over the SFY 2006-2007 biennial budget.

**Action Step 1:** Appoint a Medicaid Transition Council to oversee the implementation plan to transform the Medicaid System through SFY 2007.

**Action Step 2:** Create a new Medicaid Department by July 1, 2007.

**Recommendation 4:** Leverage Ohio Medicaid's buying power through greater use of care management and selective contracting linked to quality performance.

**Recommendation 5:** Increase Medicaid's access to clinical and analytical resources for the improvement of health care delivery and financing through independent and cost-effective collaborations with the state's Academic Medical Centers (AMC).

## Conclusion

Medicaid must change. The costly and inefficient program requires decisive action that cannot be timid or tentative. The change must fundamentally transform relationship responsibilities and economic incentives.

The Commission's report summarizes its optimism that solutions do indeed exist. After a year of intense research, analysis, discussion and vision, the Commission is confident that its recommendations and implementation strategies will lead to a cost-effective transformation of Ohio's Medicaid program while continuing to provide health care to Ohio's most vulnerable citizens.

The Governor, General Assembly, providers and other stakeholders in the health care system must move forward with pragmatism, determination, and optimism to transform the program. The result will be a better quality Medicaid program with reduced, and ultimately, sustainable costs.

The time for transformation of Ohio's Medicaid program is now.

**Overview:  
Recommendations of the Ohio Commission to Reform Medicaid  
and Their Implementation Status by ODJFS, May, 2006**

**APPENDIX B-1**

OCRM Section	Description	Implementation Status in HB 66 or other	Description of Implementation Progress
LTC	Remove NF formula from statute	Partially	SFY 06 Rates frozen. New pricing system authorized for '07, work is progressing to implement on time and on budget
LTC	Phase out CON	Not Included	Not implemented, although discussed with NF Industry and ODH
LTC	Pre-admission screening	partially	Executive Budget proposed enhanced process by Ohio Dept of Aging
LTC	AAA's LTC resource centers	Not Included	ODA and ODMR/DD have obtained a grant to develop LTC resource centers
LTC	Assisted living waiver	In Development	Waiver has been Federally approved, implementation in process
LTC	Increase clinical capacity and flexibility of PASSPORT home care options	Not Included	All waiver consumers are entitled to the full array of state plan Medicaid services. A variety of waivers are available, some of which have nursing services across age groups and levels of care.
LTC	Estate recovery	In Development	Increase look-back to 5 years, extend to 13 months homestead exclusion & expand estate beyond probate. Other changes in Federal Deficit Reduction Act are in process.
LTC	LTC voucher	In Development	JFS and Aging are researching the best options around this initiative. Working with a consultant to develop waiver for submission by 12/2006
LTC	Increase waiver asset limit	Not Included	Not implemented - cost prohibitive
LTC	Consolidate LTC budgets	Not Included	Being studied by the Medicaid Admin Study Council
LTC	Create LTC policy body	Not Included	Being studied by the Medicaid Admin Study Council
Care Management	Expand CFC managed care	In Procurement	Statewide expansion on target; Procurement process via RFA completed; 8 plans selected & undergoing readiness review; Enrollment to begin summer, 2006 and completed by 12/06, enrolling 750,000 additional medicaid consumers
Care Management	ABD care management	In Development	Rate-setting completed. RFA nearly complete. Enrollment to begin fall, 2006. When complete, 126,000 ABD consumers.
Care Management	Monitor effectiveness of outcome based care management - CHAP	Not Included	Being discussed (among other topics) by Managed Care Working Group
Care Management	Improve HMO management, quality review & financial strength	partially	HB 66 included authority for ODI to increase standards for HMO actuarial soundness
Care Management	Establish Care Management Working Group (CMWG)	Done	JFS has formed group; 4 meetings held to date; Meetings are Ongoing
Care Management	Tie GME to managed care participation	Done	HB 66 tied direct GME to hospital managed care participation.
Pharmacy	Consolidate all state Rx spending and institute multi-state purchasing	Not Included	Rx consolidation studied for non-Medicaid state agencies; recommends use of ODMH Central Pharmacy
Pharmacy	Increase rebates	Done	Medicaid rebate revenue (Federal and Supplemental) is approximately 36% for SFY 2006
Pharmacy	Replace rebates with transparent system	Not Included	Will have to revisit rebates with implementation of Medicaid managed care and Medicare Part D
Pharmacy	Limit drugs to effective and low cost through a closed formulary	Not Included	Preferred Drug List is similar, but ODJFS is Federally prohibited from closing the formulary
Pharmacy	Use evidence based research, drug therapies -adopt Oregon Model	Not Included	Behavioral Health Quality Initiative measuring prescriber compliance with clinical quality guidelines and giving feedback
Pharmacy	Increase % of PDL generics	Ongoing	Ohio Medicaid already maximizes the cost and clinically effective use of generics.
Pharmacy	Bring pharmacy reimbursement into parity with commercial insurers	Done	HB 66 reduced retail pricing to WAC + 7% rather than WAC + 5%; pricing change has been implemented
Pharmacy	Consumer co-pay for all drugs	Done	\$2 co-pay for trade-name PDL drugs
Pharmacy	Implement mail order for chronic care maintenance drugs	Not Included	ODJFS is studying this option in view of changes from Medicare Part D and increased managed care enrollment.
Pharmacy	Implement medication therapy management	On-going	PACT program & Behavioral Health Quality Initiative
Pharmacy	Provide incentives for electronic prescribing	In Research	Language requires focus on top 10 prescribers (likely OB-Gyn) not those with the most prescribing problems
Pharmacy	Limit optional Medicaid drugs for Dual Eligibles (Medicare Part D)	Done	Policy implemented to continue limited Medicaid coverage for Part D enrollees
Eligibility	Maintain current eligibility for CFC population	Not Included	HB 66 reduced eligibility for working parents from 100% FPL to 90% FPL - implemented January, 2006
Eligibility	Move ABD determination to RSC	Not Included	Disability Determination Study Council report issued; recommendations being implemented
Eligibility	Study a switch from 209(b) to 1634	Not Included	Disability Determination Study Council report issued; recommendations being implemented.
Eligibility	Collect premiums for transitional benefits	Not Included	
Eligibility	Require enrollment in private insurance where applicable	Not Included	Federal Deficit Reduction Act provides some opportunities - under study
Eligibility	Medicaid "Ticket to Work" Buy-In	Not Included	Federal Deficit Reduction Act provides some opportunities - under study
Finance	Establish firm Medicaid spending targets	Included	Accomplished within existing Medicaid spending projection and budgeting process
Finance	Freeze Hosp rates, Reduce NF, ICF/MR by 3% then flat	Done	NF rates frozen (with Franchise Fee increase), ICF/MR rates frozen, Hospital rates frozen 1/1/06
Finance	"Optimize" payment schedule (delay payment cycle)	Not Included	
Finance	Medicare/Medicaid benefits coordination	Done & In Process	HB 66 enacted limitations on Medicaid payment of "crossover" claims for dual eligibles - implemented; Medicare/Medicaid ("Medi-Med") project underway
Finance	Switch to prospective payment for LTC & rehab hospital payments	Under study	ODJFS is monitoring significant Medicare payment changes and evaluating alternatives in the context of increased Medicaid managed care.
Structure & Management	Provide Auditor of State with full audit authority and funding	Included	AoS now has authority to initiate audits. JFS and AoS working to coordinate efforts.
Structure & Management	Additional Program Integrity Improvements	In process	Addressed in the JFS corrective action plan to the OIG report, see March, 2006 Update
Structure & Management	Update Ohio's Medicaid Information System	In process	Data warehouse study completed; recommendations under study. MITS RFP approved and to be made public ASAP
Structure & Management	Medicaid Transition Council	Formed	Medicaid Admin Study Council is appointed and at work; Recommendations due December, 2006
Structure & Management	Create Ohio Department of Medicaid	Under study	Being studied by the Medicaid Admin Study Council; Recommendations due December, 2006
Structure & Management	Selective contracting and Pay for Performance	In process	Pay for performance pilot in Development as a budget initiative; selective contracting part of managed care expansion
Structure & Management	Collaborate with state's academic medical centers	Not included	Already collaborate on research; Open to RFP response on Third Party Liability

**Notes:**  
OCRM stands for Ohio Commission to Reform Medicaid

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

#### *Assisted Living Medicaid waiver (Readiness Assessment 1, 8, 15, 17)*

Sec. 5111.89. (A) As used in sections 5111.89 to 5111.893 of the Revised Code:

"Assisted living program" means the medicaid waiver component for which the director of job and family services is authorized by this section to request a medicaid waiver.

"Assisted living services" means the following home and community-based services: personal care, homemaker, chore, attendant care, companion, medication oversight, and therapeutic social and recreational programming.

"County or district home" means a county or district home operated under Chapter 5155. of the Revised Code.

"Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

"Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

"Residential care facility" has the same meaning as in section 3721.01 of the Revised Code.

(B) The director of job and family services may submit a request to the United States secretary of health and human services under 42 U.S.C. 1396n to obtain a waiver of federal medicaid requirements that would otherwise be violated in the creation and implementation of a program under which assisted living services are provided to not more than one thousand eight hundred individuals who meet the program's eligibility requirements established under section 5111.891 of the Revised Code.

If the secretary approves the medicaid waiver requested under this section and the director of budget and management approves the contract, the department of job and family services shall enter into a contract with the department of aging under section 5111.91 of the Revised Code that provides for the department of aging to administer the assisted living program. The contract shall include an estimate of the program's costs.

The director of job and family services may adopt rules under section 5111.85 of the Revised Code regarding the assisted living program. The director of aging may adopt rules under Chapter 119. of the Revised Code regarding the program that the rules adopted by the director of job and family services authorize the director of aging to adopt.

Sec. 5111.891. To be eligible for the assisted living program, an individual must meet all of the following requirements:

(A) Need an intermediate level of care as determined under rule 5101:3-3-06 of the Administrative Code;

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(B) At the time the individual applies for the assisted living program, be one of the following:

(1) A nursing facility resident who is seeking to move to a residential care facility and would remain in a nursing facility for long term care if not for the assisted living program;

(2) A participant of any of the following medicaid waiver components who would move to a nursing facility if not for the assisted living program:

(a) The PASSPORT program created under section 173.40 of the Revised Code;

(b) The medicaid waiver component called the choices program that the department of aging administers;

(c) A medicaid waiver component that the department of job and family services administers.

(C) At the time the individual receives assisted living services under the assisted living program, reside in a residential care facility, including both of the following:

(1) A residential care facility that is owned or operated by a metropolitan housing authority that has a contract with the United States department of housing and urban development to receive an operating subsidy or rental assistance for the residents of the facility;

(2) A county or district home licensed as a residential care facility.

(D) Meet all other eligibility requirements for the assisted living program established in rules adopted under section 5111.85 of the Revised Code.

**Sec. 5111.892.** A residential care facility providing services covered by the assisted living program to an individual enrolled in the program shall have staff on-site twenty-four hours each day who are able to do all of the following:

(A) Meet the scheduled and unpredicted needs of the individuals enrolled in the assisted living program in a manner that promotes the individuals' dignity and independence;

(B) Provide supervision services for those individuals;

(C) Help keep the individuals safe and secure.

**Sec. 5111.893.** If the United States secretary of health and human services approves a medicaid waiver authorizing the assisted living program, the director of aging shall contract with a person or government entity to evaluate the program's cost effectiveness. The director shall provide the results of the evaluation to the governor, president and

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

minority leader of the senate, and speaker and minority leader of the house of representatives not later than June 30, 2007.

#### **\*SECTION 206.66.36. ASSISTED LIVING MEDICAID WAIVER PROGRAM**

(A) As used in this section, "Assisted Living Program" has the same meaning as in section 5111.89 of the Revised Code.

(B) After the Department of Job and Family Services enters into a contract with the Department of Aging under section 5111.91 of the Revised Code for the Department of Aging to administer the Assisted Living Program, the Director of Job and Family Services shall quarterly certify to the Director of Budget and Management the estimated costs of the Assisted Living Program for the upcoming quarter. The estimate shall include the state and federal share of the costs. On receipt of the certified estimated costs for an upcoming quarter, the Director of Budget and Management shall do all of the following:

(1) Transfer the state share of the amount of the estimated costs from GRF appropriation item 600-525, Health Care/Medicaid, to GRF appropriation item 490-422, Assisted Living;

(2) Transfer the federal share of the amount of the estimated costs from GRF appropriation item 600-525, Health Care/Medicaid, to Fund 3C4, appropriation item 490-622, Assisted Living - Federal;

(3) Increase the appropriation in JFS Fund 3G5, appropriation item 600-655, Interagency Reimbursement, by the federal share of the amount of the estimated costs.

(C) The funds that the Director of Budget and Management transfers and increases under this section are hereby appropriated.

#### ***PASSPORT "Home First" enrollment (Readiness Assessment 1, 8, 17)***

#### **SECTION 206.66.64. INDIVIDUALS MOVED FROM NURSING FACILITIES TO PASSPORT**

(A) As used in this section:

(1) "Area agency on aging" has the same meaning as in section 173.14 of the Revised Code.

(2) "Long-Term Care Consultation Program" means the program the Department of Aging is required to develop under section 173.42 of the Revised Code.

(3) "Long-Term Care Consultation Program administrator" or "administrator" means the Department of Aging or, if the Department contracts with an area agency on aging or

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

other entity to administer the Long-Term Care Consultation Program for a particular area, that agency or entity.

(4) "Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

(5) "PASSPORT program" means the program created under section 173.40 of the Revised Code.

(B) Each month during fiscal years 2006 and 2007, each area agency on aging shall determine whether individuals who reside in the area that the area agency on aging serves and are on a waiting list for the PASSPORT program have been admitted to a nursing facility. If an area agency on aging determines that such an individual has been admitted to a nursing facility, the agency shall notify the Long-Term Care Consultation Program administrator serving the area in which the individual resides about the determination. The administrator shall determine whether the PASSPORT program is appropriate for the individual and whether the individual would rather participate in the PASSPORT program than continue residing in the nursing facility. If the administrator determines that the PASSPORT program is appropriate for the individual and the individual would rather participate in the PASSPORT program than continue residing in the nursing facility, the administrator shall so notify the Department of Aging. On receipt of the notice from the administrator, the Department of Aging shall approve the enrollment of the individual in the PASSPORT program regardless of whether other individuals who are not in a nursing facility are ahead of the individual on the PASSPORT program's waiting list. Each quarter, the Department of Aging shall certify to the Director of Budget and Management the estimated increase in costs of the PASSPORT program for the individuals enrolled in the PASSPORT program pursuant to this section.

(C) On a quarterly basis, on receipt of the certified costs, the Director of Budget and Management shall do all of the following:

(1) Transfer the state share of the amount of the estimated costs from GRF appropriation item 600-525, Health Care/Medicaid, to GRF appropriation item 490-403, PASSPORT, for the remainder of the biennium;

(2) Increase the appropriation in Ohio Department of Aging Fund 3C4, appropriation item 490-607, PASSPORT, by the federal share of the amount of the estimated costs;

(3) Increase the appropriation in JFS Fund 3G5, appropriation item 600-655, Interagency Reimbursement, by the federal share of the amount of the estimated costs.

The funds that the Director of Budget and Management transfers and increases under this division are hereby appropriated.

(D) The individuals placed in the PASSPORT program pursuant to this section shall be in addition to the individuals placed in the PASSPORT program during fiscal years 2006 and 2007 based on the amount of money that is in GRF appropriation item 490-403,

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

PASSPORT; Fund 4J4, appropriation item 490-610, PASSPORT/Residential State Supplement; Fund 4U9, appropriation item 490-602, PASSPORT Fund; and Fund 3C4, appropriation item 490-607, PASSPORT, before any transfers to GRF appropriation item 490-403, PASSPORT, and Fund 3C4, appropriation item 490-607, PASSPORT, are made under this section.

(E) The Director of Job and Family Services shall do both of the following:

(1) Submit to the United States Secretary of Health and Human Services an amendment to the Medicaid waiver authorizing the PASSPORT program as necessary for the implementation of this section;

(2) By not later than December 31, 2006, submit to the General Assembly a report regarding the number of individuals placed in the PASSPORT program pursuant to this section and the costs incurred and savings achieved as a result of the individuals being placed in the PASSPORT program.

*Medicaid "voucher" pilot as amended by Am. Sub. SB 87 (Readiness Assessment 1, 8, 15, 17)*

**Sec. 5111.971.** (A) As used in this section, "long-term care medicaid waiver component" means any of the following:

(1) The PASSPORT program created under section 173.40 of the Revised Code;

(2) The medicaid waiver component called the choices program that the department of aging administers;

(3) A medicaid waiver component that the department of job and family services administers.

(B) The director of job and family services shall submit a request to the United States secretary of health and human services for a waiver of federal medicaid requirements that would be otherwise violated in the creation of a pilot program under which not more than two hundred individuals who meet the pilot program's eligibility requirements specified in division (D) of this section receive a spending authorization to pay for the cost of medically necessary ~~health-care~~ home and community-based services that the pilot program covers. The spending authorization shall be in an amount not exceeding seventy per cent of the average cost under the medicaid program for providing nursing facility services to an individual. An individual participating in the pilot program shall also receive necessary support services, including fiscal intermediary and other case management services, that the pilot program covers.

(C) If the United States secretary of health and human services approves the waiver submitted under division (B) of this section, the department of job and family services shall enter into a contract with the department of aging under section 5111.91 of the

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

Revised Code that provides for the department of aging to administer the pilot program that the waiver authorizes.

(D) To be eligible to participate in the pilot program created under division (B) of this section, an individual must meet all of the following requirements:

(1) Need an intermediate level of care as determined under rule 5101:3-3-06 of the Administrative Code or a skilled level of care as determined under rule 5101:3-3-05 of the Administrative Code;

(2) At the time the individual applies to participate in the pilot program, be one of the following:

(a) A nursing facility resident ~~who is seeking to move to a residential care facility or county or district home~~ and who would remain in a nursing facility if not for the pilot program;

(b) A participant of any long-term care medicaid waiver component who would move to a nursing facility if not for the pilot program.

(3) Meet all other eligibility requirements for the pilot program established in rules adopted under section 5111.85 of the Revised Code.

(E) The director of job and family services may adopt rules under section 5111.85 of the Revised Code as the director considers necessary to implement the pilot program created under division (B) of this section. The director of aging may adopt rules under Chapter 119. of the Revised Code as the director considers necessary for the pilot program's implementation. The rules may establish a list of medicaid-covered services not covered by the pilot program that an individual participating in the pilot program may not receive if the individual also receives medicaid-covered services outside of the pilot program.

#### **SECTION 206.66.38. MEDICAID PILOT PROGRAM**

Each quarter, the Department of Aging shall certify to the Director of Budget and Management the estimated costs of the Medicaid pilot program created under section 5111.971 of the Revised Code.

On a quarterly basis, on receipt of the certified costs, the Director of Budget and Management shall do all of the following:

(1) Transfer the state share of the amount of the estimated costs from the GRF appropriation item 600-525, Health Care/Medicaid, to GRF appropriation item 490-403, PASSPORT, for the remainder of the biennium;

(2) Increase the appropriation in Department of Aging Fund 3C4, appropriation item 490-607, PASSPORT, by the federal share of the amount of the estimated costs;

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(3) Reduce the federal share of GRF appropriation item 600-525, Health Care/Medicaid, by the federal share of the amount of the estimated costs;

(4) Increase the appropriation in Department of Job and Family Services Fund 3G5, appropriation item 600-655, Interagency Reimbursement, by the federal share of the amount of the estimated costs.

The funds that the Director of Budget and Management transfers and increases under this section are hereby appropriated.

#### *ICF/MR "conversion" pilot (Readiness Assessment 1, 8, 15, 17)*

Sec. 5111.88. (A) As used in sections 5111.88 to 5111.8812 of the Revised Code:

"Administrative agency" means the department of job and family services or, if the department assigns the day-to-day administration of the ICF/MR conversion pilot program to the department of mental retardation and developmental disabilities pursuant to section 5111.887 of the Revised Code, the department of mental retardation and developmental disabilities.

"ICF/MR conversion pilot program" means the medicaid waiver component authorized by a waiver sought under division (B)(1) of this section.

"ICF/MR services" means intermediate care facility for the mentally retarded services covered by the medicaid program that an intermediate care facility for the mentally retarded provides to a resident of the facility who is a medicaid recipient eligible for medicaid-covered intermediate care facility for the mentally retarded services.

"Intermediate care facility for the mentally retarded" has the same meaning as in section 5111.20 of the Revised Code.

"Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.

(B) By July 1, 2006, or as soon thereafter as practical, but not later than January 1, 2007, the director of job and family services shall, after consulting with and receiving input from the ICF/MR conversion advisory council, submit both of the following to the United States secretary of health and human services:

(1) An application for a waiver authorizing the ICF/MR conversion pilot program under which intermediate care facilities for the mentally retarded, other than such facilities operated by the department of mental retardation and developmental disabilities, may volunteer to convert from providing intermediate care facility for the mentally retarded services to providing home and community-based services and individuals with mental retardation or a developmental disability who are eligible for ICF/MR services may volunteer to receive instead home and community-based services;

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(2) An amendment to the state medicaid plan to authorize the director, beginning on the first day that the ICF/MR conversion pilot program begins implementation under section 5111.882 of the Revised Code and except as provided by section 5111.8811 of the Revised Code, to refuse to enter into or amend a medicaid provider agreement with the operator of an intermediate care facility for the mentally retarded if the provider agreement or amendment would authorize the operator to receive medicaid payments for more intermediate care facility for the mentally retarded beds than the operator receives on the day before that day.

(C) The director shall notify the governor, speaker and minority leader of the house of representatives, and president and minority leader of the senate when the director submits the application for the ICF/MR conversion pilot program under division (B)(1) of this section and the amendment to the state medicaid plan under division (B)(2) of this section. The director is not required to submit the application and the amendment at the same time.

**Sec. 5111.881.** (A) There is hereby created the ICF/MR conversion advisory council. The council shall consist of all of the following members:

(1) Two members of the house of representatives appointed by the speaker of the house of representatives, each from a different political party;

(2) Two members of the senate appointed by the president of the senate, each from a different political party;

(3) The director of job and family services or the director's designee;

(4) The director of mental retardation and developmental disabilities or the director's designee;

(5) One representative of each of the following organizations, appointed by the organization:

(a) Advocacy and protective services, incorporated;

(b) The arc of Ohio;

(c) The Ohio league for the mentally retarded;

(d) People first of Ohio;

(e) The Ohio association of county boards of mental retardation and developmental disabilities;

(f) The Ohio provider resource association;

(g) The Ohio health care association;

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(h) The Ohio legal rights service;

(i) The Ohio developmental disabilities council;

(j) The cerebral palsy association of Ohio.

(B) At least four members appointed to the ICF/MR conversion advisory council, other than the members appointed under division (A)(1) or (2) of this section, shall be either of the following:

(1) A family member of an individual who, at the time of the family member's appointment, is a resident of an intermediate care facility for the mentally retarded;

(2) An individual with mental retardation or a developmental disability.

(C) The speaker of the house of representatives and the president of the senate jointly shall appoint one of the members appointed under division (A)(1) or (2) of this section to serve as chair of the ICF/MR conversion advisory council.

(D) Members of the ICF/MR conversion advisory council shall receive no compensation for serving on the council.

(E) The ICF/MR conversion advisory council shall do all of the following:

(1) Consult with the director of job and family services before the director submits the application for the ICF/MR conversion pilot program and the amendment to the state medicaid plan under division (B) of section 5111.88 of the Revised Code;

(2) Consult with the administrative agency before the administrative agency makes adjustments to the program under division (F) of section 5111.882 of the Revised Code;

(3) Consult with the director of job and family services when the director adopts the rules for the program;

(4) Consult with the administrative agency when the administrative agency conducts the evaluation of the program and prepares the initial and final reports of the evaluation under section 5111.889 of the Revised Code.

(F) The ICF/MR conversion advisory council shall cease to exist on the issuance of the final report of the evaluation conducted under section 5111.889 of the Revised Code.

**Sec. 5111.882.** If the United States secretary of health and human services approves the waiver requested under division (B)(1) of section 5111.88 of the Revised Code, the administrative agency shall implement the ICF/MR conversion pilot program for not less than three years as follows:

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(A) Permit no more than two hundred individuals to participate in the program at one time;

(B) Select, from among volunteers only, enough intermediate care facilities for the mentally retarded to convert from providing ICF/MR services to providing home and community-based services as necessary to accommodate each individual participating in the program and ensure that the facilities selected for conversion cease, except as provided by section 5111.8811 of the Revised Code, to provide any ICF/MR services once the conversion takes place;

(C) Subject to division (A) of this section, permit individuals who reside in an intermediate care facility for the mentally retarded that converts to providing home and community-based services to choose whether to participate in the program or to transfer to another intermediate care facility for the mentally retarded that is not converting;

(D) Ensure that no individual receiving ICF/MR services on the effective date of this section suffers an interruption in medicaid-covered services that the individual is eligible to receive;

(E) Collect information as necessary for the evaluation required by section 5111.889 of the Revised Code;

(F) After consulting with the ICF/MR conversion advisory council, make adjustments to the program that the administrative agency and, if the administrative agency is not the department of job and family services, the department agree are both necessary for the program to be implemented more effectively and consistent with the terms of the waiver authorizing the program. No adjustment may be made that expands the size or scope of the program.

Sec. 5111.883. Each individual participating in the ICF/MR conversion pilot program shall receive home and community-based services pursuant to a written individual service plan that shall be created for the individual. The individual service plan shall provide for the individual to receive home and community-based services as necessary to meet the individual's health and welfare needs.

Sec. 5111.884. Each individual participating in the ICF/MR conversion pilot program has the right to choose the qualified and willing provider from which the individual will receive home and community-based services provided under the program.

Sec. 5111.885. The administrative agency shall inform each individual participating in the ICF/MR conversion pilot program of the individual's right to a state hearing under section 5101.35 of the Revised Code regarding a decision or order the administrative agency makes concerning the individual's participation in the program.

Sec. 5111.886. The department of mental retardation and developmental disabilities may not convert any of the intermediate care facilities for the mentally retarded that the

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

department operates to a provider of home and community-based services under the ICF/MR conversion pilot program.

**Sec. 5111.887.** (A) If the United States secretary of health and human services approves the waiver requested under division (B)(1) of section 5111.88 of the Revised Code, the department of job and family services may do both of the following:

(1) Contract with the department of mental retardation and developmental disabilities under section 5111.91 of the Revised Code to assign the day-to-day administration of the ICF/MR conversion pilot program to the department of mental retardation and developmental disabilities;

(2) Transfer funds to pay for the nonfederal share of the costs of the ICF/MR conversion pilot program to the department of mental retardation and developmental disabilities.

(B) If the department of job and family services takes both actions authorized by division (A) of this section, the department of mental retardation and developmental disabilities shall be responsible for paying the nonfederal share of the costs of the ICF/MR conversion pilot program.

**Sec. 5111.888.** The director of job and family services, in consultation with the ICF/MR conversion advisory council, shall adopt rules under section 5111.85 of the Revised Code as necessary to implement the ICF/MR conversion pilot program, including rules establishing both of the following:

(A) The type, amount, duration, and scope of home and community-based services provided under the program;

(B) The amount the program pays for the home and community-based services or the method by which the amount is determined.

**Sec. 5111.889.** (A) The administrative agency, in consultation with the ICF/MR conversion advisory council, shall conduct an evaluation of the ICF/MR conversion pilot program. All of the following shall be examined as part of the evaluation:

(1) The effectiveness of the home and community-based services provided under the program in meeting the health and welfare needs of the individuals participating in the program as identified in the individuals' written individual service plans;

(2) The satisfaction of the individuals participating in the program with the home and community-based services;

(3) The impact that the conversion from providing ICF/MR services to providing home and community-based services has on the intermediate care facilities for the mentally retarded that convert;

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(4) The program's cost effectiveness, including administrative cost effectiveness;

(5) Feedback about the program from the individuals participating in the program, such individuals' families and guardians, county boards of mental retardation and developmental disabilities, and providers of home and community-based services under the program;

(6) Other matters the administrative agency considers appropriate for evaluation.

(B) The administrative agency, in consultation with the ICF/MR conversion advisory council, shall prepare two reports of the evaluation conducted under this section. The initial report shall be finished not sooner than the last day of the ICF/MR conversion pilot program's first year of operation. The final report shall be finished not sooner than the last day of the program's second year of operation. The administrative agency shall provide a copy of each report to the governor, president and minority leader of the senate, and speaker and minority leader of the house of representatives.

Sec. 5111.8810. The ICF/MR conversion pilot program shall not be implemented statewide unless the general assembly enacts law authorizing the statewide implementation.

Sec. 5111.8811. An intermediate care facility for the mentally retarded that converts from providing ICF/MR services to providing home and community-based services under the ICF/MR conversion pilot program may reconvert to providing ICF/MR services after the program terminates unless either of the following is the case:

(A) The program, following the general assembly's enactment of law authorizing the program's statewide implementation, is implemented statewide;

(B) The facility no longer meets the requirements for certification as an intermediate care facility for the mentally retarded.

Sec. 5111.8812. (A) Subject to division (B) of this section and beginning not later than two and one-half years after the date the ICF/MR conversion pilot program terminates, the department of mental retardation and developmental disabilities shall be responsible for a portion of the nonfederal share of medicaid expenditures for ICF/MR services provided by an intermediate care facility for the mentally retarded that reconverts to providing ICF/MR services under section 5111.8811 of the Revised Code. The portion for which the department shall be responsible shall be the portion that the department and department of job and family services specify in an agreement.

(B) The department of mental retardation and developmental disabilities shall not be responsible for any portion of the nonfederal share of medicaid expenditures for ICF/MR services incurred for any beds of an intermediate care facility for the mentally retarded that are in excess of the number of beds the facility had while participating in the ICF/MR conversion pilot program.

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

#### *Creation of a cabinet level state Medicaid agency (Readiness Assessment 1, 17)*

#### **SECTION 206.66.52. LEGISLATIVE INTENT TO CREATE NEW MEDICAID DEPARTMENT**

It is the intent of the General Assembly that a new cabinet level department to administer the Medicaid program is to be established by July 1, 2007.

#### **SECTION 206.66.53. MEDICAID ADMINISTRATIVE STUDY COUNCIL**

(A) There is hereby created the Medicaid Administrative Study Council composed of the following:

- (1) One member of the Ohio Commission to Reform Medicaid, appointed by the Governor;
- (2) One member of the staff of the Governor's office, appointed by the Governor;
- (3) One individual with expertise in health-care finance, appointed by the Governor;
- (4) One individual with expertise in health-care management, appointed by the Governor;
- (5) One individual with expertise in health-care information technology, appointed by the Governor;
- (6) One individual with expertise in health insurance, appointed by the Governor;
- (7) One individual with expertise in health care quality assurance, appointed by the Governor;
- (8) Two individuals with expertise in organizational change representing the business community, one appointed by the President of the Senate and one appointed by the Speaker of the House of Representatives;
- (9) The Director of Budget and Management or the Director's designee;
- (10) The State Chief Information Officer or the Officer's designee;
- (11) The Administrator of Workers' Compensation or the Administrator's designee;
- (12) The following non-voting members:
  - (a) The Director of Job and Family Services or the Director's designee;
  - (b) The Director of Aging or the Director's designee;

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

- (c) The Director of Drug and Alcohol Addiction Services or the Director's designee;
- (d) The Director of Health or the Director's designee;
- (e) The Director of Mental Health or the Director's designee;
- (f) The Director of Mental Retardation and Developmental Disabilities or the Director's designee.

(B) The Governor shall appoint a member of the Council to serve as the chairperson of the Council.

(C) The Council shall study the administration of the Medicaid program. In conducting the study, the Council shall operate under the assumption that the General Assembly will enact by July 1, 2007, a law establishing a new cabinet level department to administer the program. The Council shall examine and consider all of the following as part of the study:

- (1) Structuring the program's administration in a manner that optimizes the program's fiscal and operational objectives;
- (2) Centralizing financing and information technology functions to coordinate the new department's activities with other state agencies, if any, that assist in the program's administration;
- (3) Creating a unified budget for Medicaid-funded long-term care services;
- (4) The fiscal and operating impact that a new administrative structure for the program would have on the Department of Job and Family Services and other state agencies that currently assist in the program's administration;
- (5) The role of government entities that administer the Medicaid program on the local level and the fiscal and operating impact that a new administrative structure for the program would have on those entities;
- (6) The recommendations of the Ohio Commission to Reform Medicaid.

(D) Beginning ninety days after the effective date of this section, the Council shall submit written, quarterly reports on the Council's progress to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The Council shall submit a final written report of its study to the Governor, the President of the Senate, and the Speaker of the House of Representatives not later than December 31, 2006. The final report shall include all of the following:

- (1) Recommendations regarding the scope and structure of the new department;

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(2) A business plan that directs the transition of the Medicaid program's administration from the Department of Job and Family Services and the other state agencies that assist the Department to the new department and addresses the transition's fiscal and operational impact;

(3) Identification of the resources needed to implement the business plan.

(E) The Council may hire staff, enter into contracts, and take other actions the Council deems necessary to fulfill its duties.

#### *Aging and Disability Resource Center (Readiness Assessment 4)*

#### **SECTION 203.21.09. AGING AND DISABILITY RESOURCE CENTERS**

The Department of Aging shall apply for the 2005 Aging and Disability Resource Center Grant Initiative of the Administration on Aging and the Centers for Medicare and Medicaid Services. If the application is accepted, the Department shall create an Aging and Disability Resource Center beginning in fiscal year 2006. The Department of Job and Family Services shall endorse the Department's application to the extent required by the invitation to apply.

#### *Long-Term Care Consultations Required (Readiness Assessment 4, 17)*

**173.42.** (A) As used in ~~sections 5101.75, 5101.751, 5101.752, 5101.753, and 5101.754 of the Revised Code~~ this section:

(1) ~~"Alternative source of long-term care" includes a residential care facility licensed under Chapter 3721. of the Revised Code, an adult care facility licensed under Chapter 3722. of the Revised Code, home and community-based services, and a nursing home licensed under Chapter 3721. of the Revised Code that is not a nursing facility~~ Area agency on aging" means a public or private nonprofit entity designated under section 173.011 of the Revised Code to administer programs on behalf of the department of aging.

(2) "Long-term care consultation" means the process used to provide services under the long-term care consultation program established pursuant to this section, including, but not limited to, such services as the provision of information about long-term care options and costs, the assessment of an individual's functional capabilities, and the conduct of all or part of the reviews, assessments, and determinations specified in sections 5111.202, 5111.204, 5119.061, and 5123.021 of the Revised Code and the rules adopted under those sections.

(3) "Medicaid" means the medical assistance program established under Chapter 5111. of the Revised Code.

(3)(4) "Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

~~(4)~~(5)"Representative" means a person acting on behalf of an applicant individual seeking a long-term care consultation, applying for admission to a nursing facility, or residing in a nursing facility. A representative may be a family member, attorney, hospital social worker, or any other person chosen to act on behalf of ~~an applicant~~ the individual.

~~(5)"Third party payment source" means a third party payer as defined in section 3901.38 of the Revised Code or medicaid.~~

~~(B) Effective July 1, 1994, the department of job and family services may assess a person applying or intending to apply for admission to a nursing facility who is not an applicant for or recipient of medicaid to determine whether the person is in need of nursing facility services and whether an alternative source of long-term care is more appropriate for the person in meeting the person's physical, mental, and psychosocial needs than admission to the facility to which the person has applied.~~

~~Each assessment shall be performed by the department or an agency designated by the department under section 5101.751 of the Revised Code and shall be based on information provided by the person or the person's representative. It shall consider the person's physical, mental, and psychosocial needs and the availability and effectiveness of informal support and care. The department or designated agency shall determine the person's physical, mental, and psychosocial needs by using, to the maximum extent appropriate, information from the resident assessment instrument specified in rules adopted by the department under division (A) of section 5111.231 of the Revised Code. The department or designated agency shall also use the criteria and procedures established in rules adopted by the department under division (I) of this section. Assessments may be performed only by persons~~ The department of aging shall develop a long-term care consultation program whereby individuals or their representatives are provided with long-term care consultations and receive through these professional consultations information about options available to meet long-term care needs and information about factors to consider in making long-term care decisions. The long-term care consultations provided under the program may be provided at any appropriate time, as permitted or required under this section and the rules adopted under it, including either prior to or after the individual who is the subject of a consultation has been admitted to a nursing facility.

~~(C) The long-term care consultation program shall be administered by the department of aging, except that the department may enter into a contract with an area agency on aging or other entity selected by the department under which the program for a particular area is administered by the area agency on aging or other entity pursuant to the contract.~~

~~(D) The long-term care consultations provided for purposes of the program shall be provided by individuals certified by the department under section 5101.752 173.43 of the Revised Code. The department or designated agency shall make a recommendation on the basis of the assessment and, not later than the time the assessment is required to be performed under division (D) of this section, give the person assessed written notice of the recommendation, which shall explain the basis for the recommendation. If the~~

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

~~department or designated agency determines pursuant to an assessment that an alternative source of long-term care is more appropriate for the person than admission to the facility to which the person has applied, the department or designated agency shall include in the notice possible sources of financial assistance for the alternative source of long-term care. If the department or designated agency has been informed that the person has a representative, it shall give the notice to the representative.~~

~~(C) A person~~ (E) The information provided through a long-term care consultation shall be appropriate to the individual's needs and situation and shall address all of the following:

(1) The availability of any long-term care options open to the individual;

(2) Sources and methods of both public and private payment for long-term care services;

(3) Factors to consider when choosing among the available programs, services, and benefits;

(4) Opportunities and methods for maximizing independence and self-reliance, including support services provided by the individual's family, friends, and community.

(F) An individual's long-term care consultation may include an assessment of the individual's functional capabilities. The consultation may incorporate portions of the determinations required under sections 5111.202, 5119.061, and 5123.021 of the Revised Code and may be provided concurrently with the assessment required under section 5111.204 of the Revised Code.

(G)(1) Unless an exemption specified in division (I) of this section is applicable, each individual in the following categories shall be provided with a long-term care consultation:

(a) Individuals who apply or indicate an intention to apply for admission to a nursing facility, regardless of the source of payment to be used for their care in a nursing facility;

(b) Nursing facility residents who apply or indicate an intention to apply for medicaid;

(c) Nursing facility residents who are likely to spend down their resources within six months after admission to a nursing facility to a level at which they are financially eligible for medicaid;

(d) Individuals who request a long-term care consultation.

(2) In addition to the individuals included in the categories specified in division (G)(1) of this section, long-term care consultations may be provided to nursing facility residents who have not applied and have not indicated an intention to apply for medicaid. The purpose of the consultations provided to these individuals shall be to determine continued

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

need for nursing facility services, to provide information on alternative services, and to make referrals to alternative services.

(H)(1) When a long-term care consultation is required to be provided pursuant to division (G)(1) of this section, the consultation shall be provided as follows or pursuant to division (H)(2) or (3) of this section:

(a) If the individual for whom the consultation is being provided has applied for medicaid and the consultation is being provided concurrently with the assessment required under section 5111.204 of the Revised Code, the consultation shall be completed in accordance with the applicable time frames specified in that section for providing a level of care determination based on the assessment.

(b) In all other cases, the consultation shall be provided not later than five calendar days after the department or the program administrator under contract with the department receives notice of the reason for which the consultation is required to be provided pursuant to division (G)(1) of this section.

(2) An individual or the individual's representative may request that a long-term care consultation be provided on a date that is later than the date required under division (H)(1)(a) or (b) of this section.

(3) If a long-term care consultation cannot be completed within the number of days required by division (H)(1) or (2) of this section, the department or the program administrator under contract with the department may do any of the following:

(a) Exempt the individual from the consultation pursuant to rules that may be adopted under division (L) of this section;

(b) In the case of an applicant for admission to a nursing facility, provide the consultation after the individual is admitted to the nursing facility;

(c) In the case of a resident of a nursing facility, provide the consultation as soon as practicable.

(I) An individual is not required to be assessed provided a long-term care consultation under ~~division (B)~~ of this section if any of the following apply:

(1) The circumstances individual or the individual's representative chooses to forego participation in the consultation pursuant to criteria specified by in rules adopted under division ~~(H)~~(L) of this section exist;

(2) The person individual is to receive care in a nursing facility under a contract for continuing care as defined in section 173.13 of the Revised Code;

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(3) The ~~person~~ individual has a contractual right to admission to a nursing facility operated as part of a system of continuing care in conjunction with one or more facilities that provide a less intensive level of services, including a residential care facility licensed under Chapter 3721. of the Revised Code, an ~~adult-care~~ adult care facility licensed under Chapter 3722. of the Revised Code, or an independent living arrangement;

(4) The ~~person~~ individual is to receive continual care in a home for the aged exempt from taxation under section 5701.13 of the Revised Code;

(5) ~~The person is to receive care in the nursing facility for not more than fourteen days in order to provide temporary relief to the person's primary caregiver and the nursing facility notifies the department of the person's admittance not later than twenty-four hours after admitting the person~~ individual is seeking admission to a facility that is not a nursing facility with a provider agreement under section 5111.22 of the Revised Code;

(6) The ~~person~~ individual is to be transferred from another nursing facility, ~~unless the nursing facility from which or to which the person is to be transferred determines that the person's medical condition has changed substantially since the person's admission to the nursing facility from which the person is to be transferred or a review is required by a third party payment source;~~

(7) The ~~person~~ individual is to be readmitted to a nursing facility following a period of hospitalization, ~~unless the hospital or nursing facility determines that the person's medical condition has changed substantially since the person's admission to the hospital, or a review is required by a third party payment source;~~

(8) ~~The department or designated agency fails to complete an assessment within the time required by division (D) or (E) of this section or determines after a partial assessment that the person should be exempt from the assessment~~ individual is exempted from the long-term care consultation requirement by the department or the program administrator pursuant to rules that may be adopted under division (L) of this section.

~~(D) The department or designated agency shall perform a complete assessment, or, if circumstances provided by rules adopted under division (I) of this section exist, a partial assessment, as follows:~~

~~(1) In the case of a hospitalized person applying or intending to apply to a nursing facility, not later than two working days after the person or the person's representative is notified that a bed is available in a nursing facility;~~

~~(2) In the case of an emergency as determined in accordance with rules adopted under division (I) of this section, not later than one working day after the person or the person's representative is notified that a bed is available in a nursing facility;~~

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

~~(3) In all other cases, not later than five calendar days after the person or the person's representative who submits the application is notified that a bed is available in a nursing facility.~~

~~(E) If the department or designated agency conducts a partial assessment under division (D) of this section, it shall complete the rest of the assessment not later than one hundred eighty days after the date the person is admitted to the nursing facility unless the assessment entity determines the person should be exempt from the assessment.~~

~~(F) A person assessed under this section or the person's representative may file a complaint with the department about the assessment process. The department shall work to resolve the complaint in accordance with rules adopted under division (I) of this section.~~

~~(G) A person~~ (J) At the conclusion of an individual's long-term care consultation, the department or the program administrator under contract with the department shall provide the individual or individual's representative with a written summary of options and resources available to meet the individual's needs. Even though the summary may specify that a source of long-term care other than care in a nursing facility is appropriate and available, the individual is not required to seek an alternative source of long-term care and may be admitted to or continue to reside in a nursing facility even though an alternative source of long-term care is available or the person is determined pursuant to an assessment under this section not to need nursing facility services.

~~(H)(K) No nursing facility for which an operator has a provider agreement with the department under section 5111.22 of the Revised Code shall admit or retain any person, other than a person exempt from the assessment requirement as provided by division (C) of this section, individual as a resident, unless the nursing facility has received evidence that a complete or partial assessment long-term care consultation has been completed for the individual or division (I) of this section is applicable to the individual.~~

~~(I)(L) The director of job and family services shall aging may adopt any rules in accordance with Chapter 119. of the Revised Code to implement and administer the director considers necessary for the implementation and administration of this section. The rules shall include be adopted in accordance with Chapter 119. of the Revised Code and may specify any or all of the following:~~

~~(1) The information a person being assessed or the person's representative must provide to enable the department or designated agency to do the assessment;~~

~~(2) Criteria to be used to determine whether a person is in need of nursing facility services;~~

~~(3) Criteria to be used to determine whether an alternative source of long-term care is appropriate for the person being assessed;~~

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

~~(4) Criteria and procedures to be used to determine a person's physical, mental, and psychosocial needs;~~

~~(5) Criteria to be used to determine the effectiveness and continued availability of a person's current source of informal support and care;~~

~~(6) Circumstances, in addition to those specified in division (C) of this section, under which a person is not required to be assessed;~~

~~(7) Circumstances under which the department or designated agency may perform a partial assessment under division (D) of this section;~~

~~(8) The method by which a situation will be determined to be an emergency for the purpose of division (D)(2) of this section;~~

~~(9) The method by which the department will attempt to resolve complaints filed under division (F) of this section Procedures for providing long-term care consultations pursuant to this section;~~

(2) Information to be provided through long-term care consultations regarding long-term care services that are available;

(3) Criteria under which an individual or the individual's representative may choose to forego participation in a long-term care consultation;

(4) Criteria for exempting individuals from the long-term care consultation requirement;

(5) Circumstances under which it may be appropriate to provide an individual's long-term care consultation after the individual's admission to a nursing facility rather than before admission;

(6) Criteria for identifying nursing facility residents who would benefit from the provision of a long-term care consultation.

~~(J)(M) The director of job and family services aging may fine a nursing facility an amount determined by rules the director shall adopt in accordance with Chapter 119. of the Revised Code in either of the following circumstances:~~

~~(1) The nursing facility fails to notify the department within the required time about an admission described in division (C)(5) of this section;~~

~~(2) The if the nursing facility admits or retains an individual, without evidence that a complete or partial assessment long-term care consultation has been conducted provided, a person other than a person exempt from the assessment requirement as provided required by division (C) of this section.~~

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

~~The director shall deposit~~ In accordance with section 5111.62 of the Revised Code, all fines collected under this division shall be deposited into the state treasury to the credit of the residents protection fund established by section 5111.62 of the Revised Code.

**Sec. 5101.752 173.43.** The department of job and family services aging shall certify registered nurses licensed under Chapter 4723. of the Revised Code and social workers and independent social workers licensed under Chapter 4757. of the Revised Code individuals who meet certification requirements established by rule to perform assessments under provide long-term care consultations for purposes of section 5101.75 or 5101.754 173.42 of the Revised Code. The director of job and family services aging shall adopt rules in accordance with Chapter 119. of the Revised Code governing the certification process and requirements. The rules shall specify the education, experience, or training in geriatric long-term care a person must have to qualify for certification.

**Sec. 5111.204.** (A) As used in this section ~~and in section 5111.205 of the Revised Code,~~ "representative" means a person acting on behalf of an applicant for or recipient of ~~medical assistance~~ medicaid. A representative may be a family member, attorney, hospital social worker, or any other person chosen to act on behalf of an applicant or recipient.

(B) The department of job and family services may require ~~an each~~ applicant for or recipient of ~~medical assistance~~ medicaid who applies or intends to apply for admission to a nursing facility or resides in a nursing facility to undergo an assessment to determine whether the applicant or recipient needs the level of care provided by a nursing facility. ~~To~~ The assessment may be performed concurrently with a long-term care consultation provided under section 173.42 of the Revised Code.

To the maximum extent possible, the assessment shall be based on information from the resident assessment instrument specified in rules adopted by the director of job and family services under division (A)(E) of section 5111.231 5111.232 of the Revised Code. The assessment shall also be based on criteria and procedures established in rules adopted under division (H)(F) of this section and information provided by the person being assessed or the person's representative. The

The department of job and family services, or if the assessment is performed by another an agency designated under contract with the department pursuant to division (G) of this section 5101.754 of the Revised Code, the agency, shall, not later than the time the assessment level of care determination based on the assessment is required to be performed-provided under division (C) of this section, give written notice of its conclusions and the basis for them to the person assessed and, if the department of job and family services or designated-entity agency under contract with the department has been informed that the person has a representative, to the representative.

(C) The department of job and family services or ~~designated~~ agency under contract with the department, whichever performs the assessment, shall ~~perform a complete assessment,~~ or, if circumstances provided by rules adopted under division (H) of this section exist, a

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

~~partial assessment, provide a level of care determination based on the assessment as follows:~~

(1) In the case of a person applying or intending to apply for admission to a nursing facility while hospitalized, not later than one of the following:

(a) One working day after the person or the person's representative submits ~~an~~ the application for admission to the nursing facility or notifies the department of the person's intention to apply and submits all information required for providing the level of care determination, as specified in rules adopted under division (F)(2) of this section;

(b) A later date requested by the person or the person's representative.

~~(2) In the case of an emergency as determined in accordance with rules adopted under division (H) of this section, not later than one calendar day after the person or the person's representative submits the application or notifies the department of the person's intention to apply.~~

~~(3) In all other cases a person applying or intending to apply for admission to a nursing facility who is not hospitalized, not later than one of the following:~~

(a) Five calendar days after the person or the person's representative submits the application or notifies the department of the person's intention to apply and submits all information required for providing the level of care determination, as specified in rules adopted under division (F)(2) of this section;

(b) A later date requested by the person or the person's representative.

~~(3) In the case of a person who resides in a nursing facility, not later than one of the following:~~

(a) Five calendar days after the person or the person's representative submits an application for medical assistance and submits all information required for providing the level of care determination, as specified in rules adopted under division (F)(2) of this section;

~~(b) A later date requested by the person or the person's representative.~~

~~(4) In the case of an emergency, as specified in rules adopted under division (F)(4) of this section, within the number of days specified in the rules.~~

~~(D) If the department of job and family services or designated agency conducts a partial assessment under division (C) of this section, it shall complete the rest of the assessment not later than one hundred eighty days after the date the person is admitted to the nursing facility unless the department or designated agency determines the person should be exempt from the assessment.~~

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

~~(E)~~ A person is not required to be assessed under this section if the circumstances specified by rule adopted under ~~division (H)~~ of this section exist or the department of job and family services or designated agency determines after a partial assessment that the person should be exempt from the assessment.

~~(F)~~ A person assessed under this section or the person's representative may appeal request a state hearing to dispute the conclusions reached by the department of job and family services or designated agency under contract with the department on the basis of the assessment. The appeal request for a state hearing shall be made in accordance with section 5101.35 of the Revised Code. The department of job and family services or designated agency, whichever performs the assessment, under contract with the department shall provide to the person or the person's representative and the nursing facility written notice of the person's right to appeal request a state hearing. The notice shall include an explanation of the procedure for filing an appeal requesting a state hearing. If a state hearing is requested, the state shall be represented in the hearing by the department of job and family services or the agency under contract with the department, whichever performed the assessment.

~~(G)~~(E) A nursing facility that admits or retains a person determined pursuant to an assessment required under ~~division (B) or (C)~~ of this section not to need the level of care provided by the nursing facility shall not be reimbursed under the ~~medical assistance~~ medicaid program for the person's care.

~~(H)~~(F) The director of job and family services shall adopt rules in accordance with Chapter 119. of the Revised Code to implement and administer this section. The rules shall include all of the following:

(1) Criteria and procedures to be used in determining whether admission to a nursing facility or continued stay in a nursing facility is appropriate for the person being assessed. ~~The criteria shall include consideration of whether the person is in need of any of the following:~~

~~(a) Nursing or rehabilitation services;~~

~~(b) Assistance with two or more of the activities of daily living;~~

~~(c) Continuous supervision to prevent harm to the person as a result of cognitive impairment;~~

(2) Information the person being assessed or the person's representative must provide to the department or designated agency under contract with the department for purposes of the assessment and providing a level of care determination based on the assessment;

(3) ~~Circumstances under which the department of job and family services or designated agency may perform a partial assessment under division (C) of this section;~~

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(4) Circumstances under which a person is not required to be assessed;

(4) Circumstances that constitute an emergency for purposes of division (C)(4) of this section and the number of days within which a level of care determination must be provided in the case of an emergency.

(G) Pursuant to section 5111.91 of the Revised Code, the department of job and family services may enter into contracts in the form of interagency agreements with one or more other state agencies to perform the assessments required under this section. The interagency agreements shall specify the responsibilities of each agency in the performance of the assessments.

#### *Long-Term Care Consumer Guide (Readiness Assessment 7)*

Sec. 173.45. As used in this section and in sections 173.46 to 173.49 of the Revised Code:

(A) "Long-term care facility" means a nursing home or residential care facility.

(B) "Nursing home" and "residential care facility" have the same meanings as in section 3721.01 of the Revised Code.

(C) "Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.

Sec. 173.46. (A) The department of aging shall develop and publish a guide to long-term care facilities for use by individuals considering long-term care facility admission and their families, friends, and advisors. The guide, which shall be titled the Ohio long-term care consumer guide, may be published in printed form or in electronic form for distribution over the internet. The guide may be developed as a continuation or modification of the guide published by the department prior to the effective date of this section under rules adopted under section 173.02 of the Revised Code.

(B) The Ohio long-term care consumer guide shall include information on each long-term care facility in this state. For each facility, the guide shall include the following information, as applicable to the facility:

(1) Information regarding the facility's compliance with state statutes and rules and federal statutes and regulations;

(2) Information generated by the centers for medicare and medicaid services of the United States department of health and human services from the quality measures developed as part of its nursing home quality initiative;

(3) Results of the customer satisfaction surveys conducted under section 173.47 of the Revised Code;

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(4) Any other information the department specifies in rules adopted under section 173.49 of the Revised Code.

Sec. 173.47. (A) For purposes of publishing the Ohio long-term care consumer guide, the department of aging shall conduct or provide for the conduct of an annual customer satisfaction survey of each long-term care facility. The results of the surveys may include information obtained from long-term care facility residents, their families, or both.

(B)(1) The department may charge fees for the conduct of annual customer satisfaction surveys. The department may contract with any person or government entity to collect the fees on its behalf. All fees collected under this section shall be deposited in accordance with section 173.48 of the Revised Code.

(2) The fees charged under this section shall not exceed the following amounts:

(a) Four hundred dollars for the customer satisfaction survey of a long-term care facility that is a nursing home;

(b) Three hundred dollars for the customer satisfaction survey pertaining to a long-term care facility that is a residential care facility.

(3) Fees paid by a long-term care facility that is a nursing facility shall be reimbursed through the medicaid program operated under Chapter 5111. of the Revised Code.

(C) Each long-term care facility shall cooperate in the conduct of its annual customer satisfaction survey.

Sec. 173.48. There is hereby created in the state treasury the long-term care consumer guide fund. Money collected from the fees charged for the conduct of customer satisfaction surveys under section 173.47 of the Revised Code shall be credited to the fund. The department of aging shall use money in the fund for costs associated with publishing the Ohio long-term care consumer guide, including, but not limited to, costs incurred in conducting or providing for the conduct of customer satisfaction surveys.

Sec. 173.49. The department of aging shall adopt rules as the department considers necessary to implement and administer sections 173.45 to 173.48 of the Revised Code. The rules shall be adopted under Chapter 119. of the Revised Code.

### *Ohio Access Success Project (NF Transitions – Readiness Assessment 11)*

#### SECTION 206.66.66. OHIO ACCESS SUCCESS PROJECT

Notwithstanding any limitations in sections 3721.51 and 3721.56 of the Revised Code, in each fiscal year, cash from Fund 4J5, Home and Community-Based Services for the Aged, in excess of the amounts needed for the transfers may be used by the Department of Job and Family Services for the following purposes: (A) up to \$1.0 million in each

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

fiscal year to fund the state share of audits of Medicaid cost reports filed with the Department of Job and Family Services by nursing facilities and intermediate care facilities for the mentally retarded; and (B) up to \$350,000 in fiscal year 2006 and up to \$350,000 in fiscal year 2007 to provide one-time transitional benefits under the Ohio Access Success Project that the Director of Job and Family Services may establish under section 5111.88 of the Revised Code.

#### *Ohio Home Care Waiver and Transitions waivers (Readiness Assessment 15)*

**Sec. 5111.97 5111.86.** (A) As used in this section:

- (1) "Hospital" has the same meaning as in section 3727.01 of the Revised Code.
- (2) "Medicaid waiver component" has the same meaning as in section 5111.85 of the Revised Code.
- (3) "Nursing facility" has the same meaning as in section 5111.20 of the Revised Code.
- (4) "Ohio home care program" means the program the department of job and family services administers that provides state plan services and medicaid waiver component services pursuant to rules adopted under sections 5111.01 and 5111.02 of the Revised Code and a medicaid waiver that went into effect July 1, 1998.

~~(B) The director of job and family services may submit a request~~ requests to the United States secretary of health and human services pursuant to section 1915 of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1396n, as amended, to obtain waivers of federal medicaid requirements that would otherwise be violated in the creation and implementation of two or more medicaid waiver components under which home and community-based services programs to replace the Ohio home care program being operated pursuant to rules adopted under sections 5111.01 and 5111.02 of the Revised Code and a medicaid waiver granted prior to the effective date of this section are provided to eligible individuals who need the level of care provided by a nursing facility or hospital. In the ~~request~~ requests, the director may specify the following:

- ~~(1) That one of the replacement programs will provide home and community-based services to individuals in need of nursing facility care, including individuals enrolled in the Ohio home care program;~~
- ~~(2) That the other replacement program will provide services to individuals in need of hospital care, including individuals enrolled in the Ohio home care program;~~
- ~~(3) That there will be a~~ The maximum number of individuals who may be enrolled in the replacement programs in addition to the number of individuals to be transferred from the Ohio home care program each of the medicaid waiver components included in the requests;

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

~~(4) That there will be a~~ (2) The maximum amount the department ~~replacement programs~~ ~~medicaid waiver components~~ may expend each year for each individual enrolled in the ~~replacement programs~~ ~~medicaid waiver components~~;

~~(5) That there will be a~~ (3) The maximum aggregate amount the department ~~replacement programs~~ ~~medicaid waiver components~~ may expend each year for all individuals enrolled in the ~~replacement programs~~ ~~medicaid waiver components~~;

~~(6)~~(4) Any other ~~requirement~~ ~~requirements~~ the director selects for the ~~replacement programs~~ ~~medicaid waiver components~~.

~~(B)~~(C) If the secretary ~~grants~~ ~~approves~~ the medicaid waivers requested ~~under this section~~, the director may create and implement the ~~replacement programs~~ ~~medicaid waiver components~~ in accordance with the provisions of the ~~approved~~ ~~wavers~~ ~~granted~~. The department of job and family services shall administer the ~~replacement programs~~ ~~medicaid waiver components~~.

~~As the replacement programs are implemented, the director shall reduce the maximum number of individuals who may be enrolled in the Ohio home care program by the number of individuals who are transferred to the replacement programs. When all individuals who are eligible to be transferred to the replacement programs have been transferred, the director may submit to the secretary an amendment to the state medicaid plan to provide for the elimination of the Ohio home care program.~~

After the first of any medicaid waiver components created under this section begins to enroll eligible individuals, the director may submit to the United States secretary of health and human services an amendment to a medicaid waiver component of the Ohio home care program authorizing the department to cease enrolling additional individuals in that medicaid waiver component of the Ohio home care program. If the secretary approves the amendment, the director may cease to enroll additional individuals in that medicaid waiver component of the Ohio home care program.

### *Medicaid Eligibility Reductions (Readiness Assessment 15)*

#### SECTION 206.66.39. MEDICAID ELIGIBILITY REDUCTIONS

The Director of Job and Family Services shall, not later than ninety days after the effective date of this section, submit to the United States Secretary of Health and Human Services an amendment to the state Medicaid plan to reduce to ninety per cent of the federal poverty guidelines the amount specified in division (A)(2) of section 5111.019 of the Revised Code as it existed immediately prior to the amendment made by this act. The reduction shall be implemented not earlier than ninety days after the effective date of this section and not later than the effective date of federal approval.

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

#### SECTION 206.66.44. MEDICAID COVERAGE OF DENTAL SERVICES

For fiscal years 2006 and 2007, the Medicaid program shall do the following:

(A) For Medicaid recipients under twenty-one years of age, the Medicaid program shall cover dental services. This section does not limit the ability of the Department of Job and Family Services to adopt, amend, or rescind rules applicable to dental services, including rules that limit or reduce covered services, reduce reimbursement levels, or subject covered services to co-payments.

(B) For Medicaid recipients twenty-one years of age or older, the Medicaid program shall cover dental services in an amount, duration, and scope specified in rules that the Director of Job and Family Services shall adopt under section 5111.02 of the Revised Code but shall be less in amount, duration, and scope than the Medicaid program covered those services immediately before the effective date of this amendment.

#### SECTION 206.66.45. MEDICAID COVERAGE OF VISION SERVICES

For fiscal years 2006 and 2007, the Medicaid program shall cover vision services. This section does not limit the ability of the Department of Job and Family Services to adopt, amend, or rescind rules applicable to vision services, including rules that limit or reduce covered services, reduce reimbursement levels, or subject covered services to copayments.

#### *Medicaid ABD Managed Care Expansion (Readiness Assessment 17)*

**Sec. 5111.16.** (A) As part of the medicaid program, the department of job and family services shall establish a care management system. The department shall submit, if necessary, applications to the United States department of health and human services for waivers of federal medicaid requirements that would otherwise be violated in the implementation of the system.

(B) The department shall implement the care management system in some or all counties and shall designate the medicaid recipients who are required or permitted to participate in the system. In the department's implementation of the system and designation of participants, all of the following apply:

(1) In the case of individuals who receive medicaid on the basis of being included in the category identified by the department as covered families and children, the department shall implement the care management system in all counties. All individuals included in the category shall be designated for participation, except for individuals included in one or more of the medicaid recipient groups specified in 42 C.F.R. 438.50(d). The department shall designate the participants not later than January 1, 2006. Beginning not later than December 31, 2006, the department shall ensure that all participants are enrolled in health insuring corporations under contract with the department pursuant to section 5111.17 of the Revised Code.

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(2) In the case of individuals who receive medicaid on the basis of being aged, blind, or disabled, as specified in division (A)(2) of section 5111.01 of the Revised Code, the department shall implement the care management system in all counties. All individuals included in the category shall be designated for participation, except for the individuals specified in divisions (B)(2)(a) to (e) of this section. Beginning not later than December 31, 2006, the department shall ensure that all participants are enrolled in health insuring corporations under contract with the department pursuant to section 5111.17 of the Revised Code.

In designating participants who receive medicaid on the basis of being aged, blind, or disabled, the department shall not include any of the following:

(a) Individuals who are under twenty-one years of age;

(b) Individuals who are institutionalized;

(c) Individuals who become eligible for medicaid by spending down their income or resources to a level that meets the medicaid program's financial eligibility requirements;

(d) Individuals who are dually eligible under the medicaid program and the medicare program established under Title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended;

(e) Individuals to the extent that they are receiving medicaid services through a medicaid waiver component, as defined in section 5111.85 of the Revised Code.

(3) Alcohol, drug addiction, and mental health services covered by medicaid shall not be included in any component of the care management system when the nonfederal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than the department of job and family services, but the recipients of those services may otherwise be designated for participation in the system.

~~(B)~~ Under the care management system ~~(C)~~ Subject to division (B) of this section, the department may do both of the following under the care management system:

(1) Require or permit participants in the system to obtain health care services from providers designated by the department;

~~(2) require~~ Require or permit participants in the system to obtain health care services through managed care organizations under contract with the department pursuant to section 5111.17 of the Revised Code.

~~(C)~~(D)(1) The department shall prepare an annual report on the care management system. The report shall address the department's ability to implement the system, including all of the following components:

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(a) The required designation of participants included in the category identified by the department as covered families and children;

(b) The required designation of participants included in the aged, blind, or disabled category of medicaid recipients;

(c) The conduct of the pilot program for chronically ill children established under section 5111.163 of the Revised Code;

(d) The use of any programs for enhanced care management.

(2) The department shall submit each annual report to the general assembly. The first report shall be submitted not later than October 1, 2007.

(E) The director of job and family services may adopt rules in accordance with Chapter 119. of the Revised Code to implement this section.

**Sec. 5111.161.** (A) There is hereby created the medicaid care management working group, consisting of the following members:

(1) Three individuals representing medicaid health insuring corporations, as defined in section 5111.176 of the Revised Code, one appointed by the president of the senate, one appointed by the speaker of the house of representatives, and one appointed by the governor;

(2) One individual representing programs that provide enhanced care management services, appointed by the governor;

(3) Four individuals representing health care professional and trade associations, appointed as follows:

(a) One representative of the American academy of pediatrics, appointed by the president of the senate;

(b) One representative of the American academy of family physicians, appointed by the speaker of the house of representatives;

(c) One representative of the Ohio state medical association, appointed by the president of the senate;

(d) One representative of the Ohio hospital association, appointed by the speaker of the house of representatives.

(4) One individual representing behavioral health professional and trade associations, appointed by the speaker of the house of representatives;

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

(5) Two individuals representing consumer advocates, one appointed by the president of the senate and one appointed by the speaker of the house of representatives;

(6) One individual representing county departments of job and family services, appointed by the president of the senate;

(7) Three individuals representing the business community, one appointed by the president of the senate, one appointed by the speaker of the house of representatives, and one appointed by the governor;

(8) The director of job and family services or the director's designee;

(9) The director of health or the director's designee;

(10) The director of aging or the director's designee.

(B) The members of the working group shall serve at the pleasure of their appointing authorities. Vacancies shall be filled in the manner provided for original appointments.

(C) The working group shall develop guidelines that the department of job and family services may consider when entering into contracts under section 5111.17 of the Revised Code with managed care organizations for purposes of the care management system established under section 5111.16 of the Revised Code. The working group shall consult regularly with the departments of insurance, alcohol and drug addiction services, mental health, and mental retardation and developmental disabilities and the rehabilitation services commission.

In developing the guidelines, the working group shall do all of the following:

(1) Examine the best practice standards used in managed care programs and other health care and related systems to maximize patient and provider satisfaction, maintain quality of care, and obtain cost-effectiveness;

(2) Consider the most effective means of facilitating the expansion of the care management system and increasing consistency within the system;

(3) Make recommendations for coordinating the regulatory relationships involved in the medicaid care management system;

(4) Make recommendations for improving the resolution of contracting issues among the providers involved in the care management system;

(5) Make recommendations that the department may consider when developing and implementing the financial incentive program under division (B) of section 5111.17 of the Revised Code to improve and reward positive health outcomes through managed care

## Appendix C

### Key Ohio Legislative Reforms from Amended Sub. H.B. 66 (2006-2007 budget bill)

contracts. In making these recommendations, the working group shall include all of the following:

(a) Standards and procedures by which care management contractors may receive financial incentives for positive health outcomes measured on an individual basis;

(b) Specific measures of positive health outcomes, particularly among individuals with high-risk health conditions;

(c) Criteria for determining what constitutes a completed health outcome;

(d) Methods of funding the program without requiring an increase in appropriations.

(D) The working group shall prepare an annual report on its activities and shall submit the report to the president of the senate, speaker of the house of representatives, and governor. The report shall include any findings and recommendations the working group considers relevant to its duties. The working group shall complete an initial report not later than December 31, 2005. Each year thereafter, the working group shall complete its annual report by the last day of December.

**APPENDIX D**  
**State Profile and Summary of Project**

**Name of State: Ohio**

**Primary Contact Name and Title: Erika Robbins, Assistant Deputy Director for LTC Policy**

**Year of Demonstration: Year 2 - FFY 2008**

<b>Populations to be transitioned (unduplicated count) – Year 2 (FFY2008)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD)</b>	<b>Physical Disability (PD)</b>	<b>Mental Illness (MI)</b>	<b>Dual Diagnosis:</b>
<b>Estimated number of individuals to be transitioned (unduplicated across populations)</b>	<b>260</b>	<b>112</b>	<b>17</b>	<b>8</b>	Co-morbidities may exist among <u>any</u> of the populations listed to the left
<b>Statewide (SW) or Not Statewide (NSW)</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	
<b>Qualified Institutional Settings</b>	Hospital NF ICF-MR	Hospital NF ICF-MR	Hospital NF ICF-MR	Hospital NF ICF-MR	
<b>Qualified Community Settings</b>	Home Apartment Community Residence	Home Apartment Community Residence	Home Apartment Community Residence	Home Apartment Community Residence	
<b>Qualified HCB Services</b>	<b><i>PASSPORT Waiver:</i></b> <ul style="list-style-type: none"> <li>• Homemaker/Personal Care</li> <li>• Adult Day Health</li> <li>• Environmental adaptations</li> <li>• Transportation</li> <li>• Personal emergency response systems</li> <li>• Specialized medical equip/supplies</li> <li>• Chore services</li> <li>• Social work &amp; counseling</li> <li>• Nutritional consultation</li> <li>• Home-delivered meals</li> <li>• Independent Living assistance</li> <li>• Community transition services (to be added to waiver)</li> </ul>	<b><i>Individual Options Waiver:</i></b> <ul style="list-style-type: none"> <li>• Respite Care</li> <li>• Supported employment</li> <li>• Environmental accessibility adaptations</li> <li>• Transportation</li> <li>• Specialized medical, adaptive equip/supplies</li> <li>• Homemaker/Personal Care</li> <li>• Social work</li> <li>• Home delivered meals</li> <li>• Interpreter</li> <li>• Nutrition</li> <li>• Day Habilitation</li> <li>• Community transition services (to be added to waiver)</li> </ul>	<b><i>Ohio Home Care Waiver:</i></b> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work</li> </ul>	<b><i>If applicable for the MFP participant, the relevant waiver/service listed under Elderly, MR/DD, or PD</i></b>  <b><i>Existing State Plan Services:</i></b> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological</li> </ul>	

**APPENDIX D**  
**State Profile and Summary of Project**

<b>Populations to be transitioned (unduplicated count) – Year 2 (FFY2008)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD)</b>	<b>Physical Disability (PD)</b>	<b>Mental Illness (MI)</b>	<b>Dual Diagnosis:</b>
	<p><b><i>Assisted Living Waiver:</i></b></p> <ul style="list-style-type: none"> <li>• Assisted living services</li> <li>• Community transition services</li> </ul> <p><b><i>Transitions Carve-Out Waiver:</i></b></p> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work Counseling (to be added to waiver)</li> <li>• Community transition services (to be added to waiver)</li> </ul> <p><b><i>Existing State Plan Services:</i></b></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health Assessment</li> </ul>	<p><b><i>Independence Plus:</i></b> Services yet to be determined</p> <p><b><i>Transitions MRDD Waiver:</i></b></p> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work Counseling (to be added to waiver)</li> <li>• Community transition services (to be added to waiver)</li> </ul> <p><b><i>Existing State Plan Services:</i></b></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health</li> </ul>	<p>Counseling (to be added to waiver)</p> <ul style="list-style-type: none"> <li>• Community transition services (to be added to waiver)</li> </ul> <p><b><i>Existing State Plan Services:</i></b></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health Assessment (non-physician)</li> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory</li> </ul>	<p>Management</p> <ul style="list-style-type: none"> <li>• Mental Health Assessment (non-physician)</li> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio's State Plan that are</li> </ul>	

**APPENDIX D**  
**State Profile and Summary of Project**

Populations to be transitioned (unduplicated count) – Year 2 (FFY2008)	Elderly	Mental Retardation/ Developmental Disability (MR/DD)	Physical Disability (PD)	Mental Illness (MI)	Dual Diagnosis:
	(non-physician) <ul style="list-style-type: none"> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio's State Plan that are not listed above</li> </ul>	Assessment (non-physician) <ul style="list-style-type: none"> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual)</li> <li>• Community Psychiatric Support Treatment (CPST) (group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Admin</li> <li>• PLUS all other mandatory and optional services included in Ohio's State Plan that are not listed above</li> </ul>	Detoxification <ul style="list-style-type: none"> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio's State Plan that are not listed above</li> </ul>	not listed above	
<b>HCB Demonstration Services</b>	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills	

**APPENDIX D  
State Profile and Summary of Project**

<b>Populations to be transitioned (unduplicated count) – Year 2 (FFY2008)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD)</b>	<b>Physical Disability (PD)</b>	<b>Mental Illness (MI)</b>	<b>Dual Diagnosis:</b>
	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Respite</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Day Habilitation</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Day Habilitation</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p>development</p> <p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Respite</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	
<b>Supplemental Demonstration Services</b>	Service animal Home computer	Service animal Home computer	Service animal Home computer	Service animal Home computer	

**APPENDIX D**  
**State Profile and Summary of Project**

**Name of State: Ohio**

**Primary Contact Name and Title: Erika Robbins, Assistant Deputy Director for LTC Policy**

**Year of Demonstration: Year 3 - FFY 2009**

<b>Populations to be transitioned (unduplicated count) – Year 3 (FFY2009)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD)</b>	<b>Physical Disability (PD)</b>	<b>Mental Illness (MI)</b>	<b>Dual Diagnosis:</b>
<b>Estimated number of individuals to be transitioned (unduplicated across populations)</b>	<b>380</b>	<b>164</b>	<b>32</b>	<b>12</b>	Co-morbidities may exist among <u>any</u> of the populations listed to the left
<b>Statewide (SW) or Not Statewide (NSW)</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	
<b>Qualified Institutional Settings</b>	Hospital NF ICF-MR	Hospital NF ICF-MR	Hospital NF ICF-MR	Hospital NF ICF-MR	
<b>Qualified Community Settings</b>	Home Apartment Community Residence	Home Apartment Community Residence	Home Apartment Community Residence	Home Apartment Community Residence	
<b>Qualified HCB Services</b>	<p><i>PASSPORT Waiver:</i></p> <ul style="list-style-type: none"> <li>• Homemaker/Personal Care</li> <li>• Adult Day Health</li> <li>• Environmental adaptations</li> <li>• Transportation</li> <li>• Personal emergency response systems</li> <li>• Specialized medical equip/supplies</li> <li>• Chore services</li> <li>• Social work &amp; counseling</li> <li>• Nutritional consultation</li> <li>• Home-delivered meals</li> <li>• Independent Living assistance</li> <li>• Community transition services (to be added to waiver)</li> </ul>	<p><i>Individual Options Waiver:</i></p> <ul style="list-style-type: none"> <li>• Respite Care</li> <li>• Supported employment</li> <li>• Environmental accessibility adaptations</li> <li>• Transportation</li> <li>• Specialized medical, adaptive equip/supplies</li> <li>• Homemaker/Personal Care</li> <li>• Social work</li> <li>• Home delivered meals</li> <li>• Interpreter</li> <li>• Nutrition</li> <li>• Day Habilitation</li> <li>• Community transition services (to be added to waiver)</li> </ul>	<p><i>Ohio Home Care Waiver:</i></p> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work</li> </ul>	<p><i>If applicable for the MFP participant, the relevant waiver/service listed under Elderly, MR/DD, or PD</i></p> <p><i>Existing State Plan Services:</i></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological</li> </ul>	

**APPENDIX D  
State Profile and Summary of Project**

<b>Populations to be transitioned (unduplicated count) – Year 3 (FFY2009)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD)</b>	<b>Physical Disability (PD)</b>	<b>Mental Illness (MI)</b>	<b>Dual Diagnosis:</b>
	<p><b><i>Assisted Living Waiver:</i></b></p> <ul style="list-style-type: none"> <li>• Assisted living services</li> <li>• Community transition services</li> </ul> <p><b><i>Transitions Carve-Out Waiver:</i></b></p> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work Counseling (to be added to waiver)</li> <li>• Community transition services (to be added to waiver)</li> </ul> <p><b><i>Existing State Plan Services:</i></b></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health Assessment</li> </ul>	<p><b><i>Independence Plus:</i></b> Services yet to be determined</p> <p><b><i>Transitions MRDD Waiver:</i></b></p> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work Counseling (to be added to waiver)</li> <li>• Community transition services (to be added to waiver)</li> </ul> <p><b><i>Existing State Plan Services:</i></b></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health</li> </ul>	<p>Counseling (to be added to waiver)</p> <ul style="list-style-type: none"> <li>• Community transition services (to be added to waiver)</li> </ul> <p><b><i>Existing State Plan Services:</i></b></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health Assessment (non-physician)</li> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory</li> </ul>	<p>Management</p> <ul style="list-style-type: none"> <li>• Mental Health Assessment (non-physician)</li> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio's State Plan that are</li> </ul>	

**APPENDIX D**  
**State Profile and Summary of Project**

Populations to be transitioned (unduplicated count) – Year 3 (FFY2009)	Elderly	Mental Retardation/ Developmental Disability (MR/DD)	Physical Disability (PD)	Mental Illness (MI)	Dual Diagnosis:
	<p>(non-physician)</p> <ul style="list-style-type: none"> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio’s State Plan that are not listed above</li> </ul>	<p>Assessment (non-physician)</p> <ul style="list-style-type: none"> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual)</li> <li>• Community Psychiatric Support Treatment (CPST) (group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Admin</li> <li>• PLUS all other mandatory and optional services included in Ohio’s State Plan that are not listed above</li> </ul>	<p>Detoxification</p> <ul style="list-style-type: none"> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio’s State Plan that are not listed above</li> </ul>	<p>not listed above</p>	
<b>HCB Demonstration Services</b>	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills	

**APPENDIX D  
State Profile and Summary of Project**

<b>Populations to be transitioned (unduplicated count) – Year 3 (FFY2009)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD)</b>	<b>Physical Disability (PD)</b>	<b>Mental Illness (MI)</b>	<b>Dual Diagnosis:</b>
	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Respite</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Day Habilitation</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Day Habilitation</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p>development</p> <p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Respite</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	
<b>Supplemental Demonstration Services</b>	Service animal Home computer	Service animal Home computer	Service animal Home computer	Service animal Home computer	

**APPENDIX D**  
**State Profile and Summary of Project**

**Name of State: Ohio**

**Primary Contact Name and Title: Erika Robbins, Assistant Deputy Director for LTC Policy**

**Year of Demonstration: Year 4 - FFY 2010**

<b>Populations to be transitioned (unduplicated count) – Year 4 (FFY2010)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD)</b>	<b>Physical Disability (PD)</b>	<b>Mental Illness (MI)</b>	<b>Dual Diagnosis:</b>
<b>Estimated number of individuals to be transitioned (unduplicated across populations)</b>	<b>388</b>	<b>148</b>	<b>45</b>	<b>17</b>	Co-morbidities may exist among <u>any</u> of the populations listed to the left
<b>Statewide (SW) or Not Statewide (NSW)</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	<b>SW</b>	
<b>Qualified Institutional Settings</b>	Hospital NF ICF-MR	Hospital NF ICF-MR	Hospital NF ICF-MR	Hospital NF ICF-MR	
<b>Qualified Community Settings</b>	Home Apartment Community Residence	Home Apartment Community Residence	Home Apartment Community Residence	Home Apartment Community Residence	
<b>Qualified HCB Services</b>	<b><i>PASSPORT Waiver:</i></b> <ul style="list-style-type: none"> <li>• Homemaker/Personal Care</li> <li>• Adult Day Health</li> <li>• Environmental adaptations</li> <li>• Transportation</li> <li>• Personal emergency response systems</li> <li>• Specialized medical equip/supplies</li> <li>• Chore services</li> <li>• Social work &amp; counseling</li> <li>• Nutritional consultation</li> <li>• Home-delivered meals</li> <li>• Independent Living assistance</li> <li>• Community transition services (to be added to waiver)</li> </ul>	<b><i>Individual Options Waiver:</i></b> <ul style="list-style-type: none"> <li>• Respite Care</li> <li>• Supported employment</li> <li>• Environmental accessibility adaptations</li> <li>• Transportation</li> <li>• Specialized medical, adaptive equip/supplies</li> <li>• Homemaker/Personal Care</li> <li>• Social work</li> <li>• Home delivered meals</li> <li>• Interpreter</li> <li>• Nutrition</li> <li>• Day Habilitation</li> <li>• Community transition services (to be added to waiver)</li> </ul>	<b><i>Ohio Home Care Waiver:</i></b> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work</li> </ul>	<b><i>If applicable for the MFP participant, the relevant waiver/service listed under Elderly, MR/DD, or PD</i></b>  <b><i>Existing State Plan Services:</i></b> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological</li> </ul>	

**APPENDIX D**  
**State Profile and Summary of Project**

<b>Populations to be transitioned (unduplicated count) – Year 4 (FFY2010)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD)</b>	<b>Physical Disability (PD)</b>	<b>Mental Illness (MI)</b>	<b>Dual Diagnosis:</b>
	<p><i>Assisted Living Waiver:</i></p> <ul style="list-style-type: none"> <li>• Assisted living services</li> <li>• Community transition services</li> </ul> <p><i>Transitions Carve-Out Waiver:</i></p> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work Counseling (to be added to waiver)</li> <li>• Community transition services (to be added to waiver)</li> </ul> <p><i>Existing State Plan Services:</i></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health Assessment</li> </ul>	<p><i>Independence Plus:</i> Services yet to be determined</p> <p><i>Transitions MRDD Waiver:</i></p> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work Counseling (to be added to waiver)</li> <li>• Community transition services (to be added to waiver)</li> </ul> <p><i>Existing State Plan Services:</i></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health</li> </ul>	<p>Counseling (to be added to waiver)</p> <ul style="list-style-type: none"> <li>• Community transition services (to be added to waiver)</li> </ul> <p><i>Existing State Plan Services:</i></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health Assessment (non-physician)</li> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory</li> </ul>	<p>Management</p> <ul style="list-style-type: none"> <li>• Mental Health Assessment (non-physician)</li> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio's State Plan that are</li> </ul>	

**APPENDIX D**  
**State Profile and Summary of Project**

<b>Populations to be transitioned (unduplicated count) – Year 4 (FFY2010)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD)</b>	<b>Physical Disability (PD)</b>	<b>Mental Illness (MI)</b>	<b>Dual Diagnosis:</b>
	<p>(non-physician)</p> <ul style="list-style-type: none"> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio's State Plan that are not listed above</li> </ul>	<p>Assessment (non-physician)</p> <ul style="list-style-type: none"> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual)</li> <li>• Community Psychiatric Support Treatment (CPST) (group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Admin</li> <li>• PLUS all other mandatory and optional services included in Ohio's State Plan that are not listed above</li> </ul>	<p>Detoxification</p> <ul style="list-style-type: none"> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio's State Plan that are not listed above</li> </ul>	<p>not listed above</p>	
<b>HCB Demonstration Services</b>	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills	

**APPENDIX D  
State Profile and Summary of Project**

<b>Populations to be transitioned (unduplicated count) – Year 4 (FFY2010)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD)</b>	<b>Physical Disability (PD)</b>	<b>Mental Illness (MI)</b>	<b>Dual Diagnosis:</b>
	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Respite</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Day Habilitation</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Day Habilitation</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p>development</p> <p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Respite</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	
<b>Supplemental Demonstration Services</b>	Service animal Home computer	Service animal Home computer	Service animal Home computer	Service animal Home computer	

**APPENDIX D**  
**State Profile and Summary of Project**

Name of State: Ohio

Primary Contact Name and Title: Erika Robbins, Assistant Deputy Director for LTC Policy

Year of Demonstration: Year 5 - FFY 2011

Populations to be transitioned (unduplicated count) – Year 5 (FFY2011)	Elderly	Mental Retardation/ Developmental Disability (MR/DD)	Physical Disability (PD)	Mental Illness (MI)	Dual Diagnosis:
Estimated number of individuals to be transitioned (unduplicated across populations)	400	160	64	24	Co-morbidities may exist among any of the populations listed to the left
Statewide (SW) or Not Statewide (NSW)	SW	SW	SW	SW	
Qualified Institutional Settings	Hospital NF ICF-MR	Hospital NF ICF-MR	Hospital NF ICF-MR	Hospital NF ICF-MR	
Qualified Community Settings	Home Apartment Community Residence	Home Apartment Community Residence	Home Apartment Community Residence	Home Apartment Community Residence	
Qualified HCB Services	<p><b>PASSPORT Waiver:</b></p> <ul style="list-style-type: none"> <li>• Homemaker/Personal Care</li> <li>• Adult Day Health</li> <li>• Environmental adaptations</li> <li>• Transportation</li> <li>• Personal emergency response systems</li> <li>• Specialized medical equip/supplies</li> <li>• Chore services</li> <li>• Social work &amp; counseling</li> <li>• Nutritional consultation</li> <li>• Home-delivered meals</li> <li>• Independent Living assistance</li> <li>• Community transition services (to be added to waiver)</li> </ul>	<p><b>Individual Options Waiver:</b></p> <ul style="list-style-type: none"> <li>• Respite Care</li> <li>• Supported employment</li> <li>• Environmental accessibility adaptations</li> <li>• Transportation</li> <li>• Specialized medical, adaptive equip/supplies</li> <li>• Homemaker/Personal Care</li> <li>• Social work</li> <li>• Home delivered meals</li> <li>• Interpreter</li> <li>• Nutrition</li> <li>• Day Habilitation</li> <li>• Community transition services (to be added to waiver)</li> </ul>	<p><b>Ohio Home Care Waiver:</b></p> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work</li> </ul>	<p><b>If applicable for the MFP participant, the relevant waiver/service listed under Elderly, MR/DD, or PD</b></p> <p><b>Existing State Plan Services:</b></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological</li> </ul>	

**APPENDIX D**  
**State Profile and Summary of Project**

Populations to be transitioned (unduplicated count) – Year 5 (FFY2011)	Elderly	Mental Retardation/ Developmental Disability (MR/DD)	Physical Disability (PD)	Mental Illness (MI)	Dual Diagnosis:
	<p><i>Assisted Living Waiver:</i></p> <ul style="list-style-type: none"> <li>• Assisted living services</li> <li>• Community transition services</li> </ul> <p><i>Transitions Carve-Out Waiver:</i></p> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work Counseling (to be added to waiver)</li> <li>• Community transition services (to be added to waiver)</li> </ul> <p><i>Existing State Plan Services:</i></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health Assessment</li> </ul>	<p><i>Independence Plus:</i></p> <p>Services yet to be determined</p> <p><i>Transitions MRDD Waiver:</i></p> <ul style="list-style-type: none"> <li>• Out of Home Respite</li> <li>• Adult Day Health Services</li> <li>• Supplemental Adaptive and Assistive Device</li> <li>• Supplemental Transportation</li> <li>• Emergency Response Services</li> <li>• Home Modification</li> <li>• Personal Care Aide</li> <li>• Waiver Nursing</li> <li>• Home Delivered Meals</li> <li>• Nutritional Counseling (to be added to waiver)</li> <li>• Social Work Counseling (to be added to waiver)</li> <li>• Community transition services (to be added to waiver)</li> </ul> <p><i>Existing State Plan Services:</i></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health</li> </ul>	<p>Counseling (to be added to waiver)</p> <ul style="list-style-type: none"> <li>• Community transition services (to be added to waiver)</li> </ul> <p><i>Existing State Plan Services:</i></p> <ul style="list-style-type: none"> <li>• Home Health Nursing</li> <li>• Private Duty Nursing</li> <li>• Home Health Aide</li> <li>• Skilled Therapies</li> <li>• Medical and Non-Medical Transportation</li> <li>• Pharmacological Management</li> <li>• Mental Health Assessment (non-physician)</li> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory</li> </ul>	<p>Management</p> <ul style="list-style-type: none"> <li>• Mental Health Assessment (non-physician)</li> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio's State Plan that are</li> </ul>	

**APPENDIX D**  
**State Profile and Summary of Project**

Populations to be transitioned (unduplicated count) – Year 5 (FFY2011)	Elderly	Mental Retardation/ Developmental Disability (MR/DD)	Physical Disability (PD)	Mental Illness (MI)	Dual Diagnosis:
	(non-physician) <ul style="list-style-type: none"> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual and group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio’s State Plan that are not listed above</li> </ul>	Assessment (non-physician) <ul style="list-style-type: none"> <li>• Psychiatric Diagnostic Interview (physician)</li> <li>• Counseling &amp; therapy (individual and group)</li> <li>• Crisis Intervention</li> <li>• Partial Hospitalization</li> <li>• Community Psychiatric Support Treatment (CPST) (individual)</li> <li>• Community Psychiatric Support Treatment (CPST) (group)</li> <li>• Alcohol/Drug Screening Analysis/ Lab Urinalysis</li> <li>• Assessment</li> <li>• Case Management</li> <li>• Group Counseling</li> <li>• Individual Counseling</li> <li>• Ambulatory Detoxification</li> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Admin</li> <li>• PLUS all other mandatory and optional services included in Ohio’s State Plan that are not listed above</li> </ul>	Detoxification <ul style="list-style-type: none"> <li>• Crisis Intervention</li> <li>• Intensive Outpatient</li> <li>• Medical/Somatic</li> <li>• Methadone Administration</li> <li>• PLUS all other mandatory and optional services included in Ohio’s State Plan that are not listed above</li> </ul>	not listed above	
<b>HCB Demonstration Services</b>	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills development	<i>Independent Living Skills:</i> mobility training, financial management, community integration, self-advocacy, skills	

**APPENDIX D**  
**State Profile and Summary of Project**

<b>Populations to be transitioned (unduplicated count) – Year 5 (FFY2011)</b>	<b>Elderly</b>	<b>Mental Retardation/ Developmental Disability (MR/DD)</b>	<b>Physical Disability (PD)</b>	<b>Mental Illness (MI)</b>	<b>Dual Diagnosis:</b>
	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Respite</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Day Habilitation</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Day Habilitation</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	<p>development</p> <p><i>Peer Support:</i> caregiver support and services management, resource connection, transition readiness</p> <p><i>Benefits Coordination</i></p> <p><i>Housing Locator Service</i></p> <p><i>Supported Employment</i></p> <p><i>Respite</i></p> <p><i>Social Work and Counseling</i></p> <p><i>Nutrition</i></p> <p><i>Nursing</i></p>	
<b>Supplemental Demonstration Services</b>	Service animal Home computer	Service animal Home computer	Service animal Home computer	Service animal Home computer	

## APPENDIX E

### Ohio MFP Key Stakeholders, Fall, 2006

<u>NAME</u>	<u>Organization</u>	<u>E-Mail Address</u>	<u>Attended 8.28.06?</u>	<u>Attended 10.05.06?</u>	<u>Attended Other?</u>
Alan Cochrun	Access Center for Independent Living	<a href="mailto:alan@acils.com">alan@acils.com</a>	x	x	x
Angie Bergefurd	Ohio Department of Mental Health	<a href="mailto:BergefurdA@mh.state.oh.us">BergefurdA@mh.state.oh.us</a>	x		x
Betsy Johnson	OH Assoc of County Behavioral Health Boards	<a href="mailto:bjohnson@oacbha.org">bjohnson@oacbha.org</a>	x	x	
Brenda Curtiss	Access Center for Independent Living	<a href="mailto:bcurtiss@ohiosilc.org">bcurtiss@ohiosilc.org</a>		x	
Carolyn Knight	Ohio Legal Rights Service	<a href="mailto:cknight@olrs.state.oh.us">cknight@olrs.state.oh.us</a>			
Christine Kozobarich	Universal Health Care Action Network of Ohio	<a href="mailto:ckozobarich@uhcanohio.org">ckozobarich@uhcanohio.org</a>			
Doug Devoe	Ohio Advocates for Mental Health	<a href="mailto:ddevoe@ohioadvocates.org">ddevoe@ohioadvocates.org</a>			
Dan Ohler	OH Assoc of County Boards of MRDD	<a href="mailto:dohler@oacbmrrd.org">dohler@oacbmrrd.org</a>	x		
Dave Zwyer	Ohio Developmental Disability Planning Council	<a href="mailto:David.zwyer@dmr.state.oh.us">David.zwyer@dmr.state.oh.us</a>		x	
Deborah Nebel, JD	LEAP	<a href="mailto:dnebel@leapinfo.org">dnebel@leapinfo.org</a>	x	x	
Donna Artis	Access Center for Independent Living	<a href="mailto:donna@acils.com">donna@acils.com</a>	x	x	
Doug Day	OH Dept of Alcohol and Drug Addiction Services	<a href="mailto:day@ada.state.oh.us">day@ada.state.oh.us</a>		x	x
Doug Garver	Ohio Housing Finance Agency	<a href="mailto:Dgarver@ohiohousing.org">Dgarver@ohiohousing.org</a>			
Gary Tonks	Arc of Ohio	<a href="mailto:Gary856@aol.com">Gary856@aol.com</a>			
Gary Collins	Assoc of OH Philanthropic Homes for the Aged	<a href="mailto:gcollins@aopha.org">gcollins@aopha.org</a>		x	
J. Thompson	Ohio Assisted Living	<a href="mailto:jthompson@ohioassistedliving.org">jthompson@ohioassistedliving.org</a>	x		
Jane Taylor	Ohio Association off Area Agencies on Aging	<a href="mailto:taylor@ohioaging.org">taylor@ohioaging.org</a>	x	x	
Jason Smith	Ohio Department of Aging	<a href="mailto:jsmith@age.state.oh.us">jsmith@age.state.oh.us</a>	x		
John Alfano	Assoc of OH Philanthropic Homes for the Aged	<a href="mailto:jalfano@aopha.org">jalfano@aopha.org</a>			
John Corlett	Community Solutions	<a href="mailto:Jcorlett@communitysolutions.com">Jcorlett@communitysolutions.com</a>			
Julie Johnson	Ohio Legal Rights Service	<a href="mailto:jjohnson@olrs.state.oh.us">jjohnson@olrs.state.oh.us</a>	x	x	
Kat Lyons	The Center for Independent Living Options, Inc.	<a href="mailto:klyons@cilo.net">klyons@cilo.net</a>	x		
Kathy Tefft-Keller	AARP	<a href="mailto:ktkeller@aarp.org">ktkeller@aarp.org</a>			
Laura Recchio	Consumer	<a href="mailto:Lrecchio@aol.com">Lrecchio@aol.com</a>			
Les Warner	OH Dept of Development	<a href="mailto:Lwarner@odod.state.oh.us">Lwarner@odod.state.oh.us</a>			x
Linda Lewis-Day	Ohio Department of MR/DD	<a href="mailto:Linda.lewis-day@dmr.state.oh.us">Linda.lewis-day@dmr.state.oh.us</a>			x
Lisa McDaniel	OH Dept of Development	<a href="mailto:LMcDaniel@odod.state.oh.us">LMcDaniel@odod.state.oh.us</a>			x
Loretta Adams	OH Job and Family Services Directors Assoc	<a href="mailto:ladams@oifsd.org">ladams@oifsd.org</a>			
Maria Matzik	Access Center for Independent Living	<a href="mailto:maria@acils.com">maria@acils.com</a>	x	x	
Mary Butler	Ohio Olmstead Task Force	<a href="mailto:mbutler@ohiosilc.org">mbutler@ohiosilc.org</a>	x	x	x
Maureen Corcoran	Ohio Private Residential Assoc	<a href="mailto:mcorcoran@opra.org">mcorcoran@opra.org</a>			
Molly Thomas	Services for Independent Living, Inc	<a href="mailto:Mthomas@sil-oh.org">Mthomas@sil-oh.org</a>	x		
Nancy Harry	Rehab. Services Commission	<a href="mailto:Nancy.Harry@rsc.state.oh.us">Nancy.Harry@rsc.state.oh.us</a>			

**APPENDIX E**

Pam Carter	Ohio Department of MR/DD	<a href="mailto:pam.carter@dmr.state.oh.us">pam.carter@dmr.state.oh.us</a>		
Pat Londergan	Ohio Department of Health	<a href="mailto:Pat.Londergan@odh.ohio.gov">Pat.Londergan@odh.ohio.gov</a>	x	x
Pat Luchkowsky	Easter Seals of Ohio	<a href="mailto:p.luchkowsky@Goodwilldayton.org">p.luchkowsky@Goodwilldayton.org</a>		
Pat McKnight	Dietetic Association	<a href="mailto:Mcknightp@aol.com">Mcknightp@aol.com</a>	x	x
Pete VanRunkle	Ohio Health Care Association	<a href="mailto:pvanrunkle@ohca.org">pvanrunkle@ohca.org</a>		x
Ron Hornbostel	Ohio Department of Aging	<a href="mailto:Rhornbostel@age.state.oh.us">Rhornbostel@age.state.oh.us</a>	x	x
Sam McCoy	Services for Aging	<a href="mailto:smccoy@services4aging.org">smccoy@services4aging.org</a>	x	
Sue Hetrick	The Ability Center-Toledo	<a href="mailto:shetrick@abilitycenter.org">shetrick@abilitycenter.org</a>	x	x
Susan Ackerman	Office of Budget and Management	<a href="mailto:Susan.ackerman@obm.state.oh.us">Susan.ackerman@obm.state.oh.us</a>		x
Suzanne Minnich	Traumatic Brain Injury Assoc	<a href="mailto:sminnich@biaoh.org">sminnich@biaoh.org</a>	x	x
Todd Bergdol	Ohio Health Care Association	<a href="mailto:Mbergdol@columbus.rr.com">Mbergdol@columbus.rr.com</a>		
V. Gresh	Ohio Academy of Nursing Homes	<a href="mailto:vgresh@oanh.org">vgresh@oanh.org</a>	x	
Deborah Leasure	Ohio Housing Finance Agency	<a href="mailto:dleasure@ohiohome.org">dleasure@ohiohome.org</a>	x	x
Bev Johnson	Cerebral Palsy Assoc	<a href="mailto:cerebralpalsyoh@sbcglobal.net">cerebralpalsyoh@sbcglobal.net</a>	x	x
Judy Patterson	OH Dept of Aging	<a href="mailto:jpatterson@age.state.oh.us">jpatterson@age.state.oh.us</a>	x	x
Judy Bird	Hannah News Service	<a href="mailto:jbird@hannah.com">jbird@hannah.com</a>	x	
Marc Levy	United Way of Dayton	<a href="mailto:MarcL@Dayton-unitedway.com">MarcL@Dayton-unitedway.com</a>		
Diane Luteran	Family and Children First of Montgomery Co	<a href="mailto:LuteranD@mcohio.org">LuteranD@mcohio.org</a>		

**ODJFS, Office of Ohio Health Plans****MONEY FOLLOWS THE PERSON  
STAKEHOLDERS FORUM  
AUGUST 28, 2006**

**The purpose of this forum was to gather information from our Stakeholders to inform the development of a proposal for the Grant opportunity “Money Follows the Person Demonstration Project” (MFP)**

Opening remarks, introductions and greetings were made by Mary Haller, ODJFS (Ohio Department of Job and Family Services) and the audience. Two participants were connected via speaker phone and Mary asked that audience members speak up so they could hear. Mary summarized the Program Announcement from CMS and noted that there is significant explanatory material on the CMS web site under the New Freedom Initiative.

[http://www.cms.hhs.gov/NewFreedomInitiative/02\\_WhatsNew.asp#TopOfPage](http://www.cms.hhs.gov/NewFreedomInitiative/02_WhatsNew.asp#TopOfPage)

This includes the program announcement as well as weekly answers to questions asked.

The Q & A updates are very informative.

Mary noted that this is not a traditional “grant” in that there is no cash award to grantees. Rather, the financing from CMS will come literally attached to each individual who moves from an institution into a qualified community setting. The funding is in the form of enhanced federal matching funds, estimated for Ohio to be at about 80% (versus the regular 58%). This enhanced funding is available beginning on the first day the person is moved out of an institutional setting for up to 12 months.

The enhanced funding is available to states for up to 5 years following their implementation date. States must submit by Nov 1, 2006 and will be awarded grants on or about Jan 1, 2007. States will have up to 12 months to develop an implementation plan. No enhanced match is available until after states have gotten approval for their implementation plan. However, regular FFP is available at existing matching rates of 58% for services and 50% for administrative activities.

**First presenter was Pat McKnight of the Ohio Dietetic Association:**

Pat started by thanking ODJFS for an opportunity to provide comments, discuss concerns and offer suggestions. One concern is in the development of services provided in the MFP grant is that beneficiaries need to continue to have access to quality nutritional care services. With respect to nutrition, there are two essential types of services that should be included: access to nutrition care services and access to safe and healthful food. Examples would be nutritional assessment, medical nutrition therapy, uniform standards, delivered meals and broader availability of services.

**Next presenter was Debra Nebel with LEAP:**

Debra mentions several issues and ideas for ODJFS to consider when writing our proposal. This should be open to all ages, all disabilities/diseases. A major issue is housing; this is critical. Debra

suggested talking with HUD and any other types of housing programs and try and get them on board. Timing and coordination are essential to match up waiver slots with housing. Sometimes consumers usually receive a waiver slot and have no housing or they have housing but no waiver slot. We need to be creative; this is a chance to build “bridge” services (transition) or maybe even add personal assistance services (non-medical services, basic living skills).

Debra asked the question “Do they have to be in the hospital 6 months?” Yes. But we think the 6 months can be cumulative of qualified institutions. E.G. a 2 month stay in the hospital and a 4 month stay in a nursing home. Need to confirm this with CMS. **(ODJFS action item)**

**Next presenter was Pat Luchkowsky with Easter Seals:**

Pat wanted to start with the mention of Ohio’s Success Project which successfully moves 56 people from nursing homes out into the community. She also wanted to share some of the results and lessons. One of the things she wanted to mention was the availability for consumers and others to receive information; she feels we need to market information more. “Connect me Ohio” is a good source but so many people are not aware of it or even know how to access it. During the Success project we went to 250 NF’s and spoke and gave information on the program. We also included them in the stakeholder planning.

**Some things that arose during Easter Seals work with the Success project included:**

1. Some people who came out of the NF did not meet Level of Care, and so were not eligible for waivers.
2. Wait list was not coordinated with aspects of the care plan.
3. Time needed = six month minimum to assure that some resources are in place.
4. Housing is a major barrier.
5. People needed time limited case management after relocation.

Suggestion that MFP be used to expand waiver slots. However, this could cause perverse incentives that would require people to enter a NF to get on a waiver.

Transportation is needed (Public or other) for medical appts, as well as groceries, errands and etc. Suggestion to use a consumer workbook so the plan is self directed and gives the consumer final say on the relocation plan. (Balance this against health/safety issues).

Relocation social worker will need to be very hands on - not typical case management. On average this person spent about 62 hours per person. The average cost for relocation was around \$2100.

**Next presenter was Maria Matsik** (via conference call). Maria spoke about the lack of home care providers available currently. This is of concern and should be addressed since MFP will add people back into the community. Currently there is a labor shortage among home care providers. ORC revisions allow individuals to hire non-licensed home care workers. We need a greater labor pool. In order to increase the number of providers, we need to offer livable wages, benefits, and try recruitment. Also there is a need for staff to back-up Independent Providers.

The nurse practice act allows some requirements to be delegated to non-RN’s. This happens in the MR/DD population, but Maria suggested it should be extended to other home care providers.

Suggestion that the JFS employment division emphasize the recruitment and training of home care assistants and create employment “ladders” so these people can progress to other jobs and education.

Direct care staff should have a universal criteria for certification/license across populations. We need money to train new caregivers in this job market especially the youth.

### **Notes from General Conversation – Flip Chart Notes**

- Public Housing Authorities – involve them and prioritize MFP participants
  - How? State Associations (there are 7 large ones), see also the
  - HUD website
- Poverty- Money to modify HUD homes. Renters can not get money for modification only owners can. Need Medicaid \$ to do this.
- Housing authorities have their own rules eg. Section 8 applications; prefer for wit lists
- Federal Rehab Act section 504(complaint driven) – 5% of stock. Modified for wheelchairs
- Income standard?
- People must be impoverished – Medicaid
- Dependency – unlearn institutional behavior
- Wait List will be a barrier
- “Bridge program” of rent subsidy NOT medicaid funded

### **Financial**

- Assessment of capacity of county system to accept money reasonability for these added individuals.

### **BREAK**

Focus of this discussion was to make suggestions for the MFP grant within topic areas of

1. who should be the targeted populations,
2. what should be the key services for these individuals, and
3. what should be the self direction models.

### **Targeted populations:**

- Meet LOC and want to leave the institution. (Look at the MDS question – do you want to leave?)
- Across populations - Elderly, MR/DD, Children, Adults, Physical disabled, people with mental illness.
- Measure potential success; look at availability of services (CIL model)
- MR – Link w/ conversion waiver
- Not provider driven – focus on people who want to leave
- Wait lists for various services- IO waiver and Ohio Home Care Waiver

**Key Services/ Individual housing**

- Pre-planning
- Assessment of services need/plan
- Housing – subsidized/accessible
- Subsidized utility services
- Skilled home healthcare/nursing (beyond state plan limit)
- Access to relocation funds
- Public Transportation & how to use it
- Securing social security benefits
- Food stamps
- Information and referral system – “who are you going to call”
- Banking – no/ low fees
- Payee services
- Local churches

**Self-Direction Models**

- Choice- more than one option for a service
- “Case management” vs. “Self direction”
- See State Medicaid Director letter of August 17, 2006 for models
- MR Independence Plus- but depend on availability of local match and not new people
- Would hope that in MFP, person has some ability to participate regardless of provider
- Make available a continuum of self direction
- Ohio Home Care waiver is developing a self direction component

**Real Choice System change**

- Focus is in development of infrastructure – Not funding services
- Ohio develop strategic plan for LTC
- Calls for engagement of stakeholders in a pre-planning process begin Oct.
- Focus on diversion from institutional care
- System-wide QA
- Person centered planning
- Unified budget for LTC – or at least a transportation one
- Build IT system for PASRR
- Staffing
- Consulting on strategic planning

**Ohio Department of Job and Family Services  
Money Follows the Person Grant Application  
Feedback from MFP Stakeholder Forum, October 5, 2006**

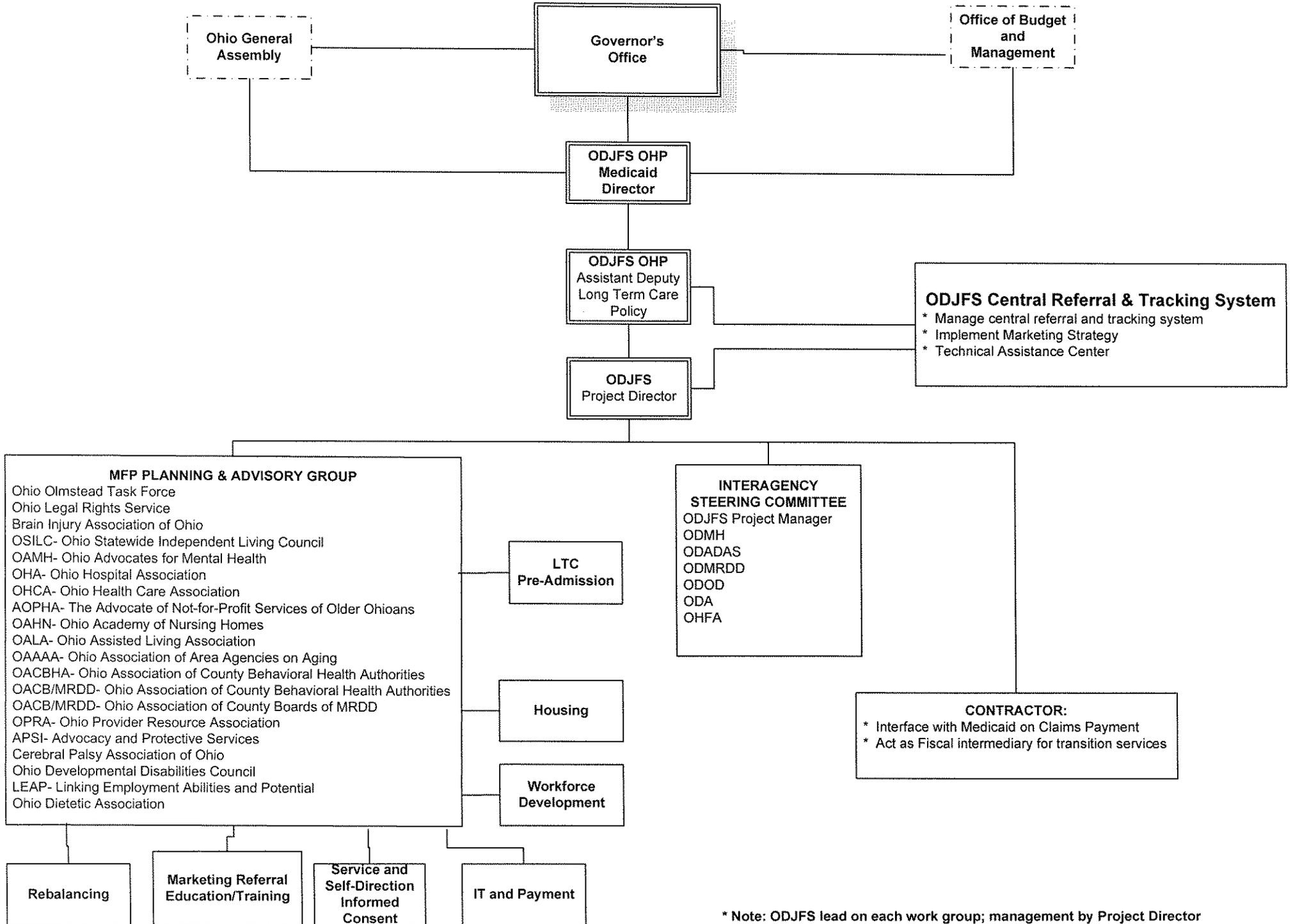
Flip chart notes:

- Add nutrition services to the array available to MFP participants.
- Will care coordination be ongoing or temporary? (will depend on the person's individual needs.)
- Emphasize the importance of assessment and care planning
- Facilitate personal choice, connection to informal supports and community.
- How is this different from Access Success? (Need to clarify this in the grant app)
- Clarify that the intent is to add capacity to existing waivers and the ABD population using core or state plan services
- Support is for 5 years, statewide, for multiple populations (clarify this)
- Transition planning is critical before the person moves. This needs to occur regardless of the FFP rate. Person performing transition planning should have familiarity with the community to which the person is moving. Continuity of this person (or team) is also important.
- What is the role of the AAA's? (envisioning that they would continue their current role of LYC counselors as well as performing LOC and administration of PASSPORT.
- Behavioral health services – FFP and Medicaid eligibility may differ depending on whether the person meets LOC. May be able to refinance some of the existing behavioral health services for people who meet the MFP criterion.
- Hold the bed open for the individual for some period of time? Pay facility at what rate? For what time period? Need to balance the amount of time bed is held with the principle/actuality of making the money follow the person. Hold bed open for 30 days in facilities with high occupancy. Pay as currently – 50% of per diem.
- Compromise suggested – close 1 bed for every two people who are moved. Difficulty is that beds have \$ value. Very tough policy issue. Hard to find the fairness to all concerned.
- Some institutions may need to close due to poor quality and certification violations.
- Also concerned about how to avoid backfilling of beds (more of a concern in the MR system than in NFs)
- # of people moved per year
- How to avoid a large state liability in the out years after the enhanced match is done? Can we realistically close beds? Bank beds? Difference between MR and NF systems?
- Ability to renegotiate the numbers with CMS as we get into planning.
- How to distinguish MFP placements; 1500 MR people on wait list with MF LOC and 6 month LOS; 20% of Home First placements have LOS > 6 mos)
- The experience for our state funded Access Success project has shown that the shorter the length of stay, the larger is the potential pool of participants. Thus, we predict that the CMS mandated six month length of stay will be a large barrier in terms of preventing a number of otherwise eligible people from participating.
- Access to accessible affordable housing is critically important to the success of MFP. Stakeholders had lengthy discussion on this topic and supported the idea of developing a

“Bridge” subsidy for rent until the person can be enrolled in a regular subsidy program via public housing authorities.

- Stakeholders also supported making available detailed information about where Section 8 vouchers have been funded for people with disabilities.
- Statewide Independent Living Council has a housing work group and a worker focused on this issue. Suggest that MFP work collaboratively with this person/group to exchange data and build on existing experience. SILC work group estimates that 1 in 5 people living in NFs are only there because they lack access to housing.
- Also important to work with the existing Ohio Interagency Council on Homelessness and Housing.
- ODADAS supportive of possibility of enhanced matching funds for addiction screening, intervention and treatment services people who meet the MFP criteria.
- Behavioral health boards are concerned about their ability to add too many people to their already overtaxed system without additional resources.
- Consumer advocates raised concern about characterizing MFP as a large source of Medicaid “savings.” Although there is hope that Ohio will achieve overall savings from rebalancing institutional to community costs, the most important feature to these stakeholders is the opportunity to broaden the choices available to consumers.
- Recruitment should be done primarily by those who already work with institutional residents, supplemented with work of advocacy organizations, family support networks, Centers for Independent Living, Ombudsmen, etc.
- Use existing educational resources, e.g. videos already made by CILs about leaving institutions, ala the Access Center in Toledo.
- Consider a mailing to all individuals living in institutions who meet the minimum length of stay alerting them to the opportunity provided by MFP and how to get more information.

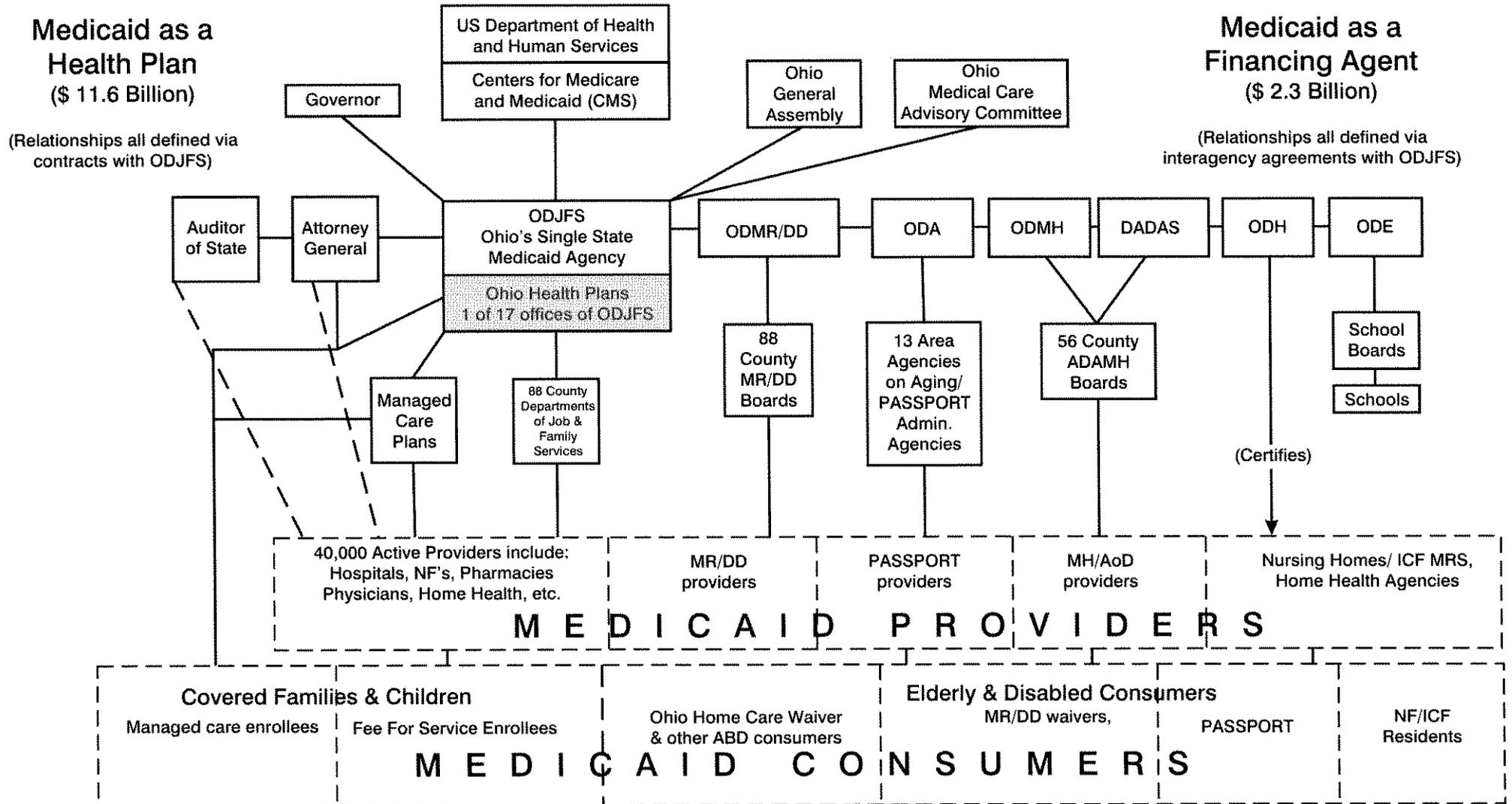
# APPENDIX F: Demonstration Organizational Chart



\* Note: ODJFS lead on each work group; management by Project Director Members to be determined following first planning group meeting

# APPENDIX F-1

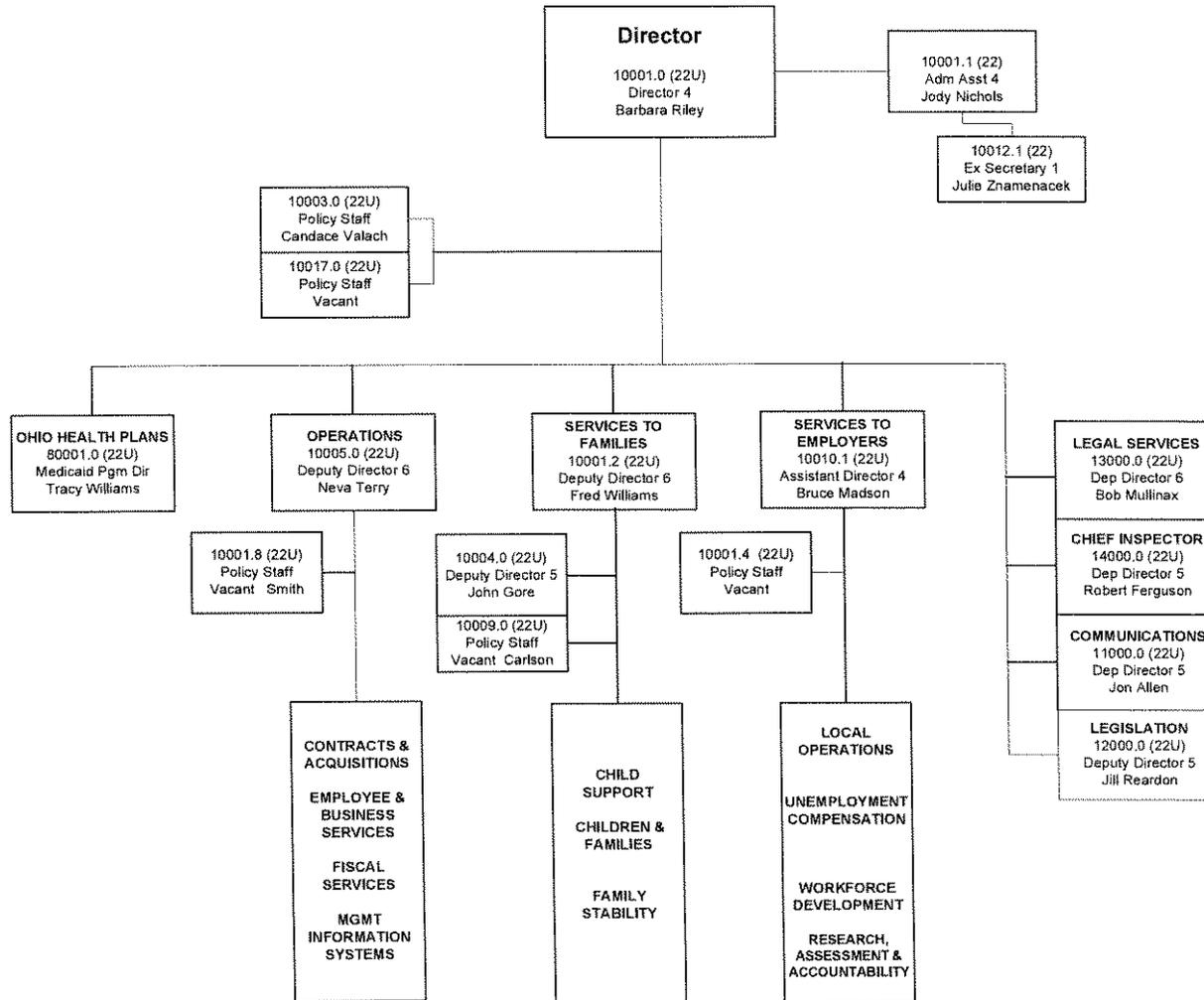
## Major Organizational Relationships of Ohio's Medicaid Program



# APPENDIX F-2

## ODJFS OFFICIAL TABLE OF ORGANIZATION EXECUTIVE OFFICES

CURRENT AS OF October 1, 2006  
LAST REVISION July 27, 2006



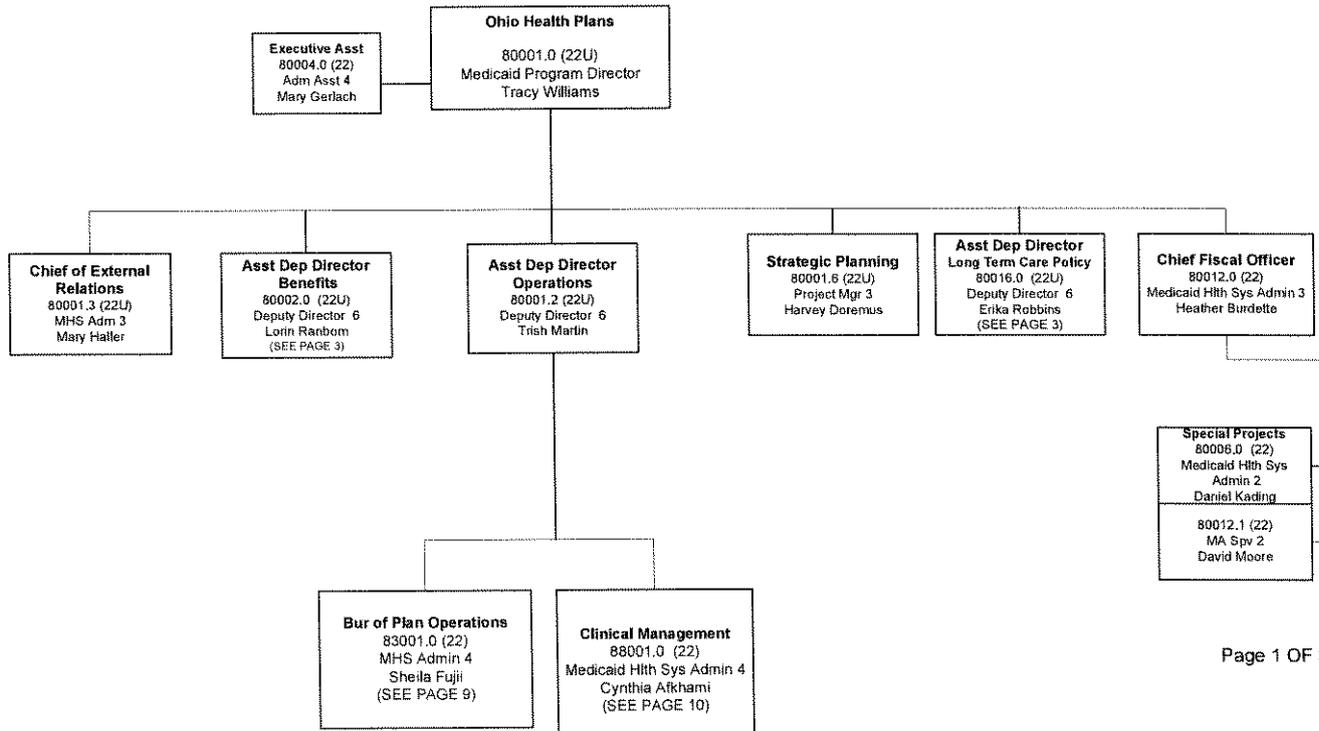
APPROVED:

KEITH NICHOLS, ASSISTANT DEPUTY DIRECTOR  
OFFICE OF EMPLOYEE & BUSINESS SERVICES

# APPENDIX F-3

ODJFS TABLE OF ORGANIZATION  
OHIO HEALTH PLANS  
DEPUTY DIRECTOR'S OFFICE

CURRENT AS OF October 1, 2006  
LAST REVISION: August 30, 2006



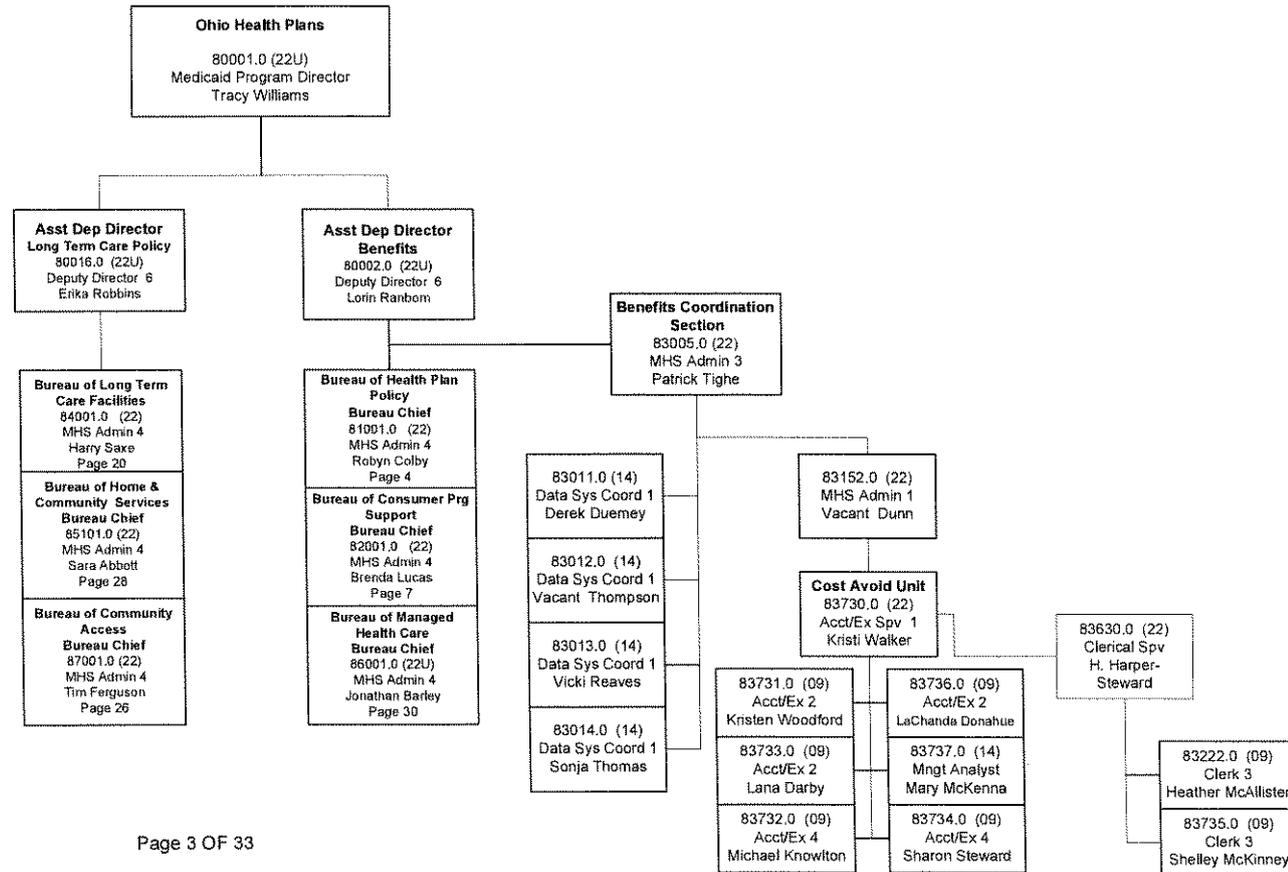
APPROVED:  
KEITH NICHOLS, ASSISTANT DEPUTY DIRECTOR,  
EMPLOYEE & BUSINESS SERVICES

# APPENDIX F-4

ODJFS TABLE OF ORGANIZATION  
OHIO HEALTH PLANS  
DEPUTY DIRECTOR'S OFFICE

CURRENT AS OF October 1, 2006  
LAST REVISION: September 29, 2006

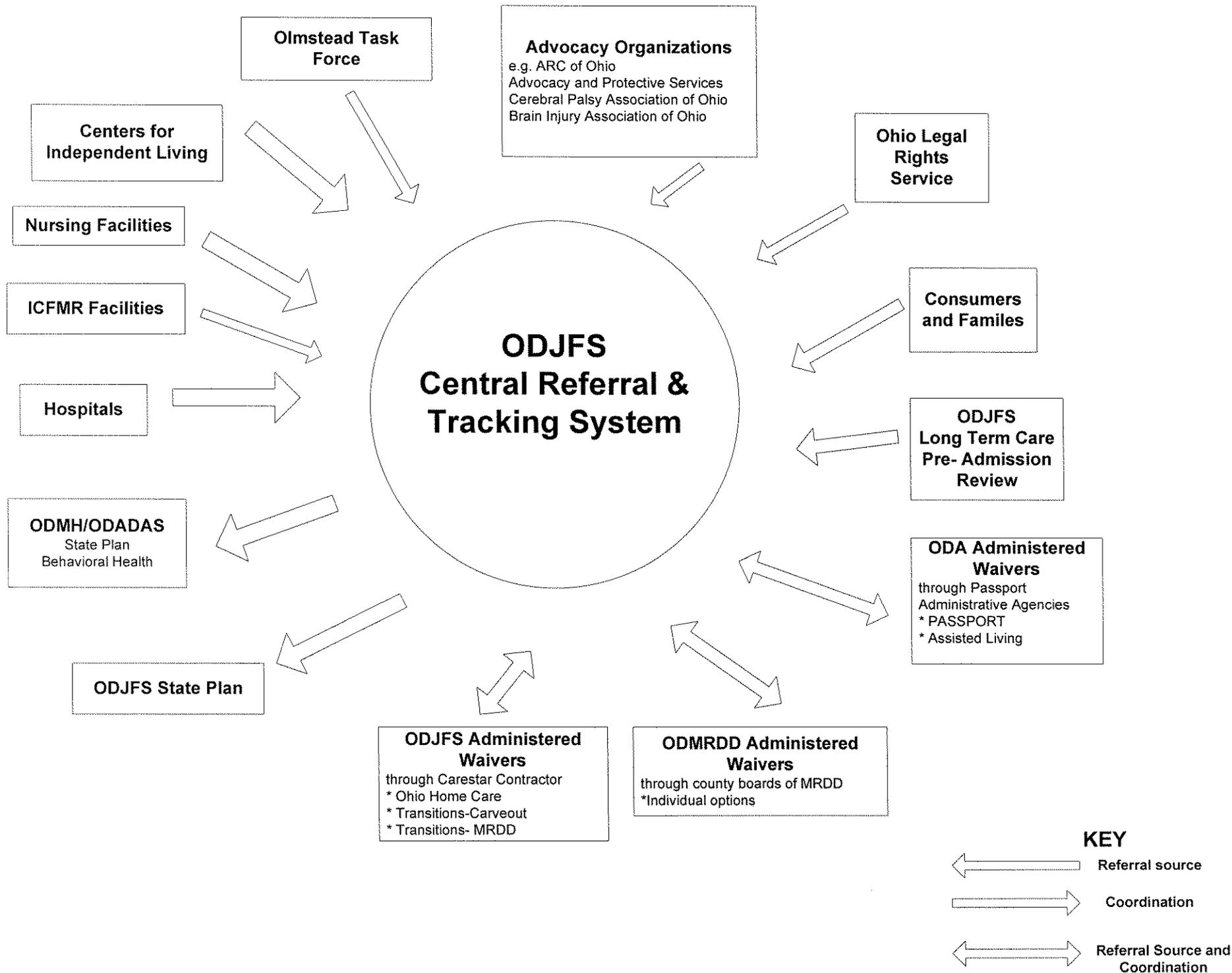
Page 3



APPROVED:

KEITH NICHOLS, ASSISTANT DEPUTY DIRECTOR,  
EMPLOYEE & BUSINESS SERVICES

# APPENDIX G: Central Referral and Tracking System-Organizational Relationships



## APPENDIX H

### Ohio MFP Resumes and Position Descriptions

This appendix includes the following:

- Resume – Tracy Williams, Ohio Medicaid Director
- Resume and Position Description – Erika Robbins, Assistant Deputy Director for LTC Policy
- Position Summary – MFP Project Director
- Position Description – State Plan Policy Analyst
- Position Description – HCBS Waiver Policy Analyst
- Position Description – HCBS Waiver Policy Analyst
- Position Description – Housing Coordinator
- Position Summary – LTC Pre-Admission Policy Manager
- Position Summary – Staff to support the ODJFS Central Referral & Tracking System

Tracy J. Williams is employed by the Ohio Department of Job and Family Services as the State Medicaid Director.

Ohio's Medicaid program purchases approximately \$13 billion in health care services for 2 million Ohioans. Ohio Medicaid provides health care services via contracts with 45,000 health care providers, including commercial managed care organizations; processes over 50 million claims each year; and provides financing for health care services delivered through Ohio's mental health, health, drug and alcohol treatment, aging and mental retardation & developmental disabilities systems.

Ms. Williams holds a Masters Degree in Public Administration from The Ohio State University and a Bachelor of Arts Degree in Political Science from Kent State University. From February 2004 to March 2006, Ms. Williams served as Chief Policy and Operations Officer for the Ohio Medicaid program. Prior to joining ODJFS, she served as the Senior Analyst for Health & Human Services at the Ohio Office of Budget and Management.

## Biographical Sketch

Erika C. Robbins

Erika C. Robbins is the Assistant Deputy Director of Long Term Care programs within the Ohio Department of Job and Family Services Office of Ohio Health Plans (Ohio's Single State Medicaid Agency). She is responsible for three bureaus critical to the long term care of Ohio's most vulnerable citizens. 1.) The Bureau of Community Access develops policy and oversees the provision of Medicaid waiver and State Plan services through coordination with other State agencies (The Departments of Mental Retardation and Developmental Disabilities, Aging, Health, Education, Mental Health and Alcohol and Drug Addiction Services). 2.) The Bureau of Home and Community Services administers three Medicaid home and community based waiver programs serving individuals with a nursing facility, hospital, or ICF/MR level of care. 3.) The Bureau of Long Term Care Facilities maintains reimbursement rates for nursing facilities and ICFs/MR, final settlements, administrative code rules, provider agreements, annual calendar cost reports, Medicaid state plans and estate recovery projects.

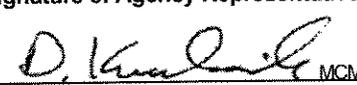
Erika has a Master's Degree in Applied Behavioral Science from Wright State University and a Bachelor's Degree in Psychology from Hanover College. She has over 15 years of experience working with individuals receiving long term care services; as a direct care worker, an advocate, a case manager, a policy developer, and a surveyor of quality care. She has conducted quality reviews of all Ohio HCBS waiver programs, Ohio's Level of Care and PASRR processes and has extensive experience with ICF/MR facility compliance. Over the last two years, she has worked with numerous individuals and families, stakeholder groups, State agencies, and the Centers for Medicare and Medicaid services in the development of programs designed to provide community options and choice to individuals with disabilities of all ages.

 <b>Position Description for Ohio Department Of Job &amp; Family Services</b>		<b>POSITION CONTROL NUMBER</b>  <b>80016.0 (22 U)</b>	
<b>PAYROLL NUMBER:</b> U 600-800		<b>AGENCY:</b> ODJFS	
<b>CLASS NUMBER:</b> 61316		<b>OFFICE:</b> OHIO HEALTH PLANS	
<b>CLASS TITLE:</b> DEPUTY DIRECTOR 6		<b>BUREAU:</b> LONG TERM CARE FACILITIES	
<b>WORKING TITLE:</b> ASST. DEPUTY DIRECTOR FOR LONG TERM CAR		<b>SECTION:</b> DEPUTY DIRECTOR'S OFFICE	
<b>APPT TYPE:</b> FULL TIME PERMANENT		<b>COUNTY OF EMPLOYMENT:</b> FRANKLIN	
<b>ACTION:</b> <input type="checkbox"/> New Position <input checked="" type="checkbox"/> Change <input type="checkbox"/> Renumber <input type="checkbox"/> Reclass			
<b>POSITION NO. AND TITLE OF IMMEDIATE SUPERVISOR:</b> 80001.0 MEDICAID PROGRAM DIRECTOR			
<b>NORMAL WORKING HOURS</b> (Explain unusual or rotating shift)		THIS POSITION IS OVERTIME EXEMPT.	
<b>FROM:</b> 08:00 AM <b>TO:</b> 05:00 PM			

%	Job Duties in Order of Importance	Minimum Acceptable Characteristics
35	Under administrative direction, assists Director, Assistant Director &/or Medicaid Program Director in defining agency goals & objectives; plans, directs & coordinates all policy level activities related to Medicaid health system services (i.e., long term care policy); provides policy guidance & strategic planning support to Director, Assistant Director &/or Medicaid Program Director on the development & implementation of various Medicaid &/or publicly financed long term care health services for consumers with disabilities, including but not limited to developmental disabilities (e.g., Medicaid Schools Program, Targeted Case management (TCM), home and community-based services waiver delivery systems, home care services, community mental health programs) based upon currently available health services research and analytical data; drafts & oversees development of administrative rules & legislation regarding Medicaid &/or publicly financed long term care health services for consumer with disabilities & evaluates program effectiveness in meeting established goals & objectives; represents &/or acts on behalf of Director, Assistant Director &/or Medicaid Program Director.	Knowledge of 1) social or behavior science; 2) business or public administration & management practices; 3) health care federal & state laws & regulations; 4) public medical assistance programs; 5) health services administration; 6) agency policies & procedures; 7) health care statistics, terminology & methods; 8) purchasing & payment practices of health care services 9) comprehensive health planning; 10) public budgeting & finance; 11) public relations. Ability to 12) analyze & apply multiple factors & present findings & conclusion; 13) develop analytical documents defining health services, developing/recommending policy positions &/or explaining impact of policy alternatives; 14) handle routine & sensitive inquiries & meetings as expert concerning availability of health care data & reports & presentations for policy & administrative decision making; 15) handle sensitive contacts & inquiries from public, consumers, providers & government officials in person, by telephone &/or in writing; 16) establish professional atmosphere as administrator.
25	Plans, directs & coordinates all long term care policy level activities to include impact from other public assistance &/or health related legislation &/or policies (i.e., policies or program issues that impact other state agencies & program areas); plans, directs & coordinates disability policy development & implementation in Medicaid health systems in response to various disability acts [e.g., Americans with Disabilities Act (ADA), Individuals with Disabilities Education act (IDEA)]; assures effective oversight of disability services administered by ODJFS & by recipients (e.g., County Boards of MRDD & Mental Health); assesses impact of state & national disability legislation on Medicaid health systems; provides oversight across bureaus on disability policy issues (e.g., coverage, federal compliance, funding), oversees multi-bureau (e.g., Long term Care Facilities, Home & Community Services; Community Access) performance reports & documentation.	Rank 2: Knowledge of: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11. Ability to 12, 13, 14, 15.
20	Supervises lower-level supervisory, managerial, professional, technical and/or administrative support staff (e.g., establishes goals & objectives; makes recommendations for hire; assigns work & provides direction; reviews work provides feedback).	Rank 3: Knowledge of 11, 17) employee training & development; 18) supervisory principles & techniques. Ability to 12, 16.
15	Acts as liaison with community, providers, legislative committees & other state &/or federal agencies; prepares & directs preparation of briefing documents; operates personal computer & applicable software to store, compute & retrieve data & to produce correspondence, reports & position papers; prepares &/or delivers speeches & presentations before state, national & professional organizations; testifies at legislative public hearings; advises deputy director/director various issues, problems.	Rank 4: Knowledge of 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 11. Skill in 19) operation of personal computer with applicable software applications (e.g., Word, Access, Excel). Ability to 12, 13, 14, 15, 16, 20) prepare & deliver speeches before specialized audiences.
5	Performs other related duties (e.g., conducts & attends staff meetings & trainings; travels to meeting sites; maintains records logs and files).	Rank 5: Knowledge of 1, 2, 11, 17, 18. Skill in 19. Ability to 12, 13, 14, 15, 16. *Developed after employment

**Additional Information**

THIS POSITION IS OVERTIME EXEMPT.  
 THIS POSITION IS UNCLASSIFIED PER 124.11 (A) (9), OHIO REVISED CODE.  
 TRAVEL REQUIRED, SOME WITH OVERNIGHT STAYS. MUST PROVIDE OWN TRANSPORTATION.  
 OR, IN ORDER TO OPERATE A STATE VEHICLE, YOU MUST HAVE A VALID DRIVER'S LICENSE FROM STATE OF RESIDENCE.

<b>List Position Numbers and Class Titles of positions directly supervised.</b> 84001.0, 87001.0 & 85101.0 – All Medicaid Health Systems Administrator 4's	<b>Signature of Agency Representative</b> 	<b>Date</b> 8/30/2006
	<b>D. KEITH NICHOLS</b> MCM	MCM /cos

**Job Duties for the Project Director of the MFP Grant  
(Position to be created and filled upon grant award)**

1. Coordinates all activities during the pre-implementation phase of the MFP Grant including the engagement of consumers, families, advocates, providers, local administrators, state agencies, the General Assembly
2. Develops a project plan with timelines, tasks (to include any changes to the State Plan and HCBS waivers) and responsibilities resulting in an operational protocol that meets the goals developed through the grant proposal and the steering and planning committees
3. Leads a team of internal and external stakeholders (e.g., sister agencies, advocates, providers, local governments, other bureaus) called the “MFP Planning and Advisory Group” to design an operational protocol for MFP
4. Organizes and leads the “Interagency Steering Committee” communicates ongoing with the Office of Budget and Management, the General Assembly, and the Governor’s Office
5. Organizes and leads the MFP Planning and Advisory Group and subcommittees (e.g. Rebalancing Initiatives, Workforce Development, Services including Self-Direction initiatives and Informed Consent, Marketing, Referral, Education/Training, IT and payment, and Housing)
6. Develops a plan of engagement to maximize stakeholder involvement and buy-in related to rebalancing efforts
7. Develops a communication strategy to inform and receive feedback on a regular basis from the Governor’s Office, the General Assembly and the Office of Budget and Management including the development of an annual report to the General Assembly on MFP progress
8. Develops a communication strategy that includes regular updates to stakeholders on progress and milestones during pre-implementation and through the operational protocol
9. Oversees the activities of the Long Term Care Planning Unit’s central referral and tracking system
10. Develops benchmarks and interfaces with CMS on the national evaluation
11. Collaborates ongoing with all levels of the MFP structure as well as CMS throughout the grant award
12. Communicates with the contractors (Long Term Care Pre-Admission Review, Success Ohio, and IT /Fiscal intermediary interface) involved in MFP
13. Coordinates all activities during the pre-implementation phase including activities related to #9, #10, #11, and #12 enumerated above.

 <b>Position Description for Ohio Department Of Job &amp; Family Services</b>		<b>POSITION CONTROL NUMBER</b>  <b>87230.0 (22)</b>
<b>PAYROLL NUMBER:</b> U 600-800	<b>AGENCY:</b> ODJFS	
<b>CLASS NUMBER:</b> 65296	<b>OFFICE:</b> OHIO HEALTH PLANS	
<b>CLASS TITLE:</b> MEDICAID HEALTH SYSTEMS ADMINISTRATOR 2	<b>BUREAU:</b> BUREAU OF COMMUNITY ACCESS	
<b>WORKING TITLE:</b>	<b>SECTION:</b> PROGRAM POLICY	
<b>APPT TYPE:</b> FULL TIME PERMANENT	<b>COUNTY OF EMPLOYMENT:</b> FRANKLIN	
<b>ACTION:</b> <input type="checkbox"/> New Position <input checked="" type="checkbox"/> Change <input type="checkbox"/> Renumber <input type="checkbox"/> Reclass		
<b>POSITION NO. AND TITLE OF IMMEDIATE SUPERVISOR:</b> 87110.0 MEDICAID HEALTH SYSTEMS ADMINISTRATOR 3		
<b>NORMAL WORKING HOURS</b> (Explain unusual or rotating shift)		
<b>FROM:</b> 08:00 AM <b>TO:</b> 05:00 PM	THIS POSITION IS OVERTIME EXEMPT.	

%	Job Duties in Order of Importance	Minimum Acceptable Characteristics
50	Under general direction, serves as agency manager of Medicaid Department of Aging interagency program(s) (i.e. PASSPORT Waiver, Preadmission Review, Core Services, PACE, Hospice) &/or initiatives that impact multiple components within one bureau (i.e., develops program rules, policies & procedures & prepares draft legislative language impacting service delivery within one bureau, conducts high-level analysis of proposed legislation, prepares proposals & recommendations & directs internal & external work teams); plans & evaluates implementation of policy for Covered Aging populations & Special Health Related Services delivery system (i.e., Basic Benefit plan & waiver services plan including psychiatric services, Community Alternative Financing System (CAFS), community mental health services, Medicaid outreach through public schools & Home & Community Base Services); Oversees, plans & coordinates inter-agency agreements & policy initiatives/ activities &/or policy development; directs and/or participates on intra- &/or interagency project teams (e.g., ODJFS, Departments of Mental Retardation & Developmental Disabilities, Education, Mental Health & Alcohol & Drug Addiction Services) in the development & implementation of strategic policies, procedures, goals & objectives governing core delivery system management functions (e.g., coverage, utilization & quality assurance of services) provided through care management networks of other state agencies & in developing special health related services delivery systems.	Knowledge of 1) social or behavioral science; 2) business or public administration & management practices; 3) health care federal & state laws & regulations; 4) public medical assistance programs; 5) agency policies & procedures; 6) health care statistics, terminology & methods; 7) purchasing & payment practices of health care services; 8) comprehensive health planning; 9) public budgeting & finance; 10) public relations; 11) employee training & development; 12) supervisory principles & techniques. Skill in 13) operating personal computer & applicable software applications. Ability to 14) analyze & apply multiple factors & present findings & conclusions; 15) prepare & oversee comprehensive & technical reports; 16) interpret social welfare information & technical materials in books, journals & manuals; 17) handle sensitive contacts & inquiries from public, consumers, providers & government officials in person, via telephone &/or written correspondence.
30	Acts as liaison with agency personnel &/or outside agencies (e.g., Executive Directors, Deputy Directors, Governor's Office), providers, advocates, beneficiaries &/or consumers; directs intra- & interagency project teams design & operate ongoing management & program evaluations for medical assistance community-based populations; provides technical direction & assistance to project teams to perform ongoing information & data collection & analysis of other states' health services delivery systems & funding alternatives for special health related services delivery systems; assists bureau in developing Medicaid reform initiatives (e.g., ODJFS, Departments of Mental Retardation & Developmental Disabilities, Education, Mental Health & Alcohol & Drug Addiction Services, Aging & other state & local departments which undertake reform); formulates health related policy; coordinates policy development & implementation across units &/or sections; assists high-level management in developing new &/or revising Medicaid programs; represents deputy director &/or director on programmatic related issues, meetings &/or conferences; directs preparation &/or prepares & reviews reports; responds to sensitive inquiries & contacts from public, providers & government officials & assists in development of goals & objectives.	Knowledge of 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. Skill in 13. Ability to 14, 15, 16, 17
15	Advises unit/section chief regarding various issues & problems; operates personal computer and software applications (e.g., Quattro Pro, GroupWise, Word Perfect, Word) to originate correspondence, reports, records, analysis & assessments; prepares & delivers speeches & presentations; assists in developing budgets.	Knowledge of 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. Skill in 13. Ability to 14, 15, 16, 17.
5	Performs other related duties (conducts & attends training sessions; conducts & attends staff meetings; travels to meeting sites; maintains logs, records & files).	Knowledge of 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. Skill in 13. Ability to 14, 15, 16, 17.

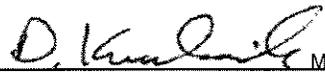
**Additional Information**

FLEXIBLE SCHEDULED REQUIRED WHICH INCLUDES EARLY MORNING HOURS AND SATURDAYS.

THIS POSITION IS OVERTIME EXEMPT.

TRAVEL REQUIRED, SOME WITH OVERNIGHT STAYS. MUST PROVIDE OWN TRANSPORTATION. OR, IN ORDER TO OPERATE A STATE VEHICLE, YOU MUST HAVE A VALID DRIVER'S LICENSE FROM STATE OF RESIDENCE.

\*Developed after employment

<b>List Position Numbers and Class Titles of positions directly supervised.</b> NONE	<b>Signature of Agency Representative</b> 	<b>Date</b> 9/25/2006
	<b>D. KEITH NICHOLS</b>	FW







**Job Duties of the ODJFS position on the Long Term Care Pre-Admission Plan (Position Description under development by the ODJFS Human Resources Office – position likely to be filled by mid-November 2006)**

1. Leads a team of internal and external stakeholders (e.g., sister agencies, advocates, providers, local governments, other bureaus) to redesign preadmission activities including level of care activities for Medicaid long term care benefits including nursing facilities, ICF/MRs, waiver programs, institutions.
2. Create, coordinate and monitor work teams with staff from other bureaus (e.g., BLTCF, BHCS and BCA) to redesign pre admission activities including level of care activities for Medicaid long term care benefits.
3. Develop, write and promulgate the OAC rules for pre-admission and level of care for nursing homes, ICF/MRs and community programs.
4. Write, develop and promulgate authorizing OAC rules for other agencies (ODA, ODMRDD, ODMH) to perform pre-admission activities
5. Coordinate level of care and pre-admission delegation of authority issues with other agencies (e.g., Aging, ODMRDD, ODMH)
6. Manage contracts with outside entities engaging in pre-admission screening.
7. Develop the interagency agreement (IAA) language with other agencies engaged in pre-admission activities
8. Develop plan around short and long term changes to improve access to long term care services.
9. Exchange information with, or participate on, OHP workgroups responsible for projects impacting access to long term care systems (e.g. MFP grant).
10. Develop and coordinate children's level of care issues across agencies (e.g., ODE, ODMRDD, ODMH) and bureaus (BHCS, BHPP, BCPS)
11. Coordinate pre-admission rules, policies and procedures around statewide access to all pre-admission activities including level of care, pre-admission resident review (PASRR) payment streams, coordination of care for other agencies including ODA, ODMH, ODMRDD.
12. Monitor and develop performance metrics on LOC rules and procedures to provide on going review and management
13. Perform impact analysis of the changes to pre-admission and level of care on other components of the Medicaid Program.
14. Provide technical assistance, outreach and training to other bureaus (BHPP, BCPS), agencies (ODMRDD, ODE, ODA), stakeholders (Area Agencies on Aging, OPRA) and providers (nursing homes, ICF/MRs) regarding new rules, procedures and policies related to preadmission and level of care.
15. Interact with the Centers for Medicare and Medicaid Services, legislators, legal staff, high level agency staff and the general public on preadmission activities.
16. Develop benchmarks and metrics for measuring effectiveness of polices and rules that are developed.
17. Coordinate system eligibility changes through MITS and BEN.

**Job Duties for staff to support the ODJFS Central Referral & Tracking System  
(3 existing or new FTE positions to be determined during pre-implementation  
phase)**

1. Develops and manages a universal intake unit for all MFP activity
2. Develops a mechanism to track MFP participants for CMS reporting, fiscal reporting, and evaluation purposes
3. Develops a mechanism to funnel MFP referrals received from referral sources to the appropriate coordination entry points
4. Interfaces with coordination entry points to assure access, timely enrollment, informed consent, tracking and connection with the IT/Fiscal Intermediary contractor
5. Provides information and tracks providers chosen by MFP to assure free choice and enhance claims payment processes
6. Develops a project plan for the unit with timelines, tasks and responsibilities that meets the goals developed through the grant proposal and the steering and planning committees
7. Implements marketing strategy developed via the Marketing, Referral and Education/Training subcommittee
8. Develops a education/training strategy in line with the recommendations from the Marketing, Referral, and Education/Training Subcommittee geared to participants and their families/friends, providers, case managers, and referral sources
9. Acts as a technical assistance center for MFP participants and their families/friends, case managers, referral sources, and providers

**Ohio MFP - Appendix I**  
Budget and Maintenance of Effort (MOE) Forms

<b>Money Follows the Person Demonstration Grant</b>						
<b><u>Budget Estimate Presentation</u></b>						
<b>Demonstration Funding Request – Federal Share</b>						
Fiscal Year	Qualified HCBS program services (demonstration share at enhanced FMAP) *of 80%	Demonstration HCBS services (demonstration share at enhanced FMAP) **of 80%	Supplemental Demonstration Service Costs (demonstration share at regular FMAP) ***of 60%	Administrative Costs and Evaluation Costs (at 50% admin FMAP rate)	State Proposed Evaluation Costs (at 50% admin FMAP rate)	Total FY Estimated Funding Request
2007	0	0	0	2,079,488	0	2,079,488
2008	4,545,101	2,139,161	187,920	2,493,488	0	9,365,670
2009	19,708,514	8,101,907	317,520	2,684,209	0	30,812,150
2010	21,485,269	8,604,958	321,840	2,742,299	0	33,154,366
2011	23,044,990	9,051,596	347,220	2,909,461	0	35,353,267
<b>TOTAL:</b>	<b>68,783,874</b>	<b>27,897,622</b>	<b>1,174,500</b>	<b>12,908,945</b>	<b>\$0</b>	<b>110,764,941</b>

Note: Funding in the above chart reflects the cost of qualified, demonstration, and supplemental services associated with the 12 month enhanced match period and does not include the match associated with continued service delivery at the regular FMAP for day 366 forward for each MFP enrollee.

Total federal expenditures for qualified services for the 5 year project period (including services from day 366 forward) = 125,669,911  
 Total federal expenditures for demonstration services for the 5 year project period (including services from day 366 forward) = 31,067,867  
 Total federal expenditures for supplemental services for the 5 year project period (including services from day 366 forward) = 1,174,500  
**Total federal expenditures for 5 year project period= \$157,912,278**

**Ohio MFP - Appendix I**  
Budget and Maintenance of Effort (MOE) Forms

<b>Money Follows the Person Demonstration Grant</b>						
<b><u>Budget Estimate Presentation</u></b>						
<b>Demonstration Funding Request – State Share</b>						
<b>Fiscal Year</b>	<b>Qualified HCBS program services (demonstration share at enhanced FMAP) *of 20%</b>	<b>Demonstration HCBS services (demonstration share at enhanced FMAP) **of 20%</b>	<b>Supplemental Demonstration Service Costs (demonstration share at regular FMAP) ***of 40%</b>	<b>Administrative Costs and Evaluation Costs (at 50% admin FMAP rate)</b>	<b>State Proposed Evaluation Costs (at 50% admin FMAP rate)</b>	<b>Total FY Estimated Funding Request</b>
2007	0	0	0	2,079,488	0	2,079,488
2008	1,136,275	534,790	125,280	2,493,488	0	4,289,833
2009	4,927,129	2,025,477	211,680	2,684,209	0	9,848,495
2010	5,371,317	2,151,239	214,560	2,742,298	0	10,479,414
2011	5,761,247	2,262,899	231,480	2,909,461	0	11,165,087
<b>TOTAL:</b>	<b>17,195,968</b>	<b>6,974,405</b>	<b>783,000</b>	<b>12,908,944</b>	<b>\$0</b>	<b>37,862,317</b>

Note: Funding in the above chart reflects the cost of qualified, demonstration, and supplemental services associated with the 12 month enhanced match period and does not include the match associated with continued service delivery at the regular FMAP for day 366 forward for each MFP enrollee.

Total state expenditures for qualified services for the 5 year project period (including services from day 366 forward) = 55,119,994  
 Total state expenditures for demonstration services for the 5 year project period (including services from day 366 forward) = 9,087,902  
 Total state expenditures for supplemental services for the 5 year project period (including services from day 366 forward) = 783,000  
**Total state expenditures for 5 year project period = \$64,990,896**

**Ohio MFP - Appendix I**  
Budget and Maintenance of Effort (MOE) Forms

<b>Money Follows the Person Demonstration Grant</b>		
<b><i>Maintenance of Effort – Long-Term Care Services</i></b>		
<b>Fiscal Year</b>	<b>% of Long Term-Care Institutional Expenditures</b>	<b>% of Long-Term Care HCBS Expenditures</b>
2005	46%	12%
2006	-----	-----
2007	-----	-----
2008	-----	-----
2009	-----	-----
2010	-----	-----
2011	-----	-----

Only fill in cells that are blank and available. Other cells will be filled-in in future years. Data should correspond to detailed MOE chart that will be posted on Oct 23.

Note: The above is based on the expenditures reflected in the MFP MOE forms (excludes physician services, prescription drugs, etc..)

Total expenditures = 7,044,117,242

Total Institutional expenditures (ICF/MR Public and Private, Nursing Facility) = 3,248,275,481

Total HCBS expenditures = 868,289,553

**CERTIFICATION REGARDING MAINTENANCE OF EFFORT**

In accordance with the applicable program statute(s) and regulation(s), the undersigned certifies that financial assistance provided by the Centers for Medicare and Medicaid Services, for the specified activities to be performed under the **Money Follows the Person Rebalancing Demonstration** Program by **the Ohio Department of Job and Family Services** (Applicant Organization) will be in addition to, and not in substitution for, comparable activities previously carried on without Federal assistance.

*Barbara E. Riley (HR)*

---

Signature of Authorized Certifying Official

**Director**

Title

**October 31, 2006**

Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES <b>STATE PLAN SERVICES ONLY</b> MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE FOR THE MEDICAL ASSISTANCE PROGRAM EXPENDITURES IN THIS QUARTER					
MEDICAL ASSISTANCE PAYMENTS	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE
		FMAP 59.68%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE	
		(a)	(b)	(c)	
1. INPATIENT HOSPITAL SERVICES					
A. Regular Payments	1,626,752,478	970,845,879			970,845,879
B. DSH Adjustment Payments	0	0			0
2. MENTAL HEALTH FACILITY SERVICES					
A. Regular Payments	322,452,214	192,439,481			192,439,481
B. DSH Adjustment Payments	0	0			0
3. NURSING FACILITY SERVICES	2,646,924,573	1,579,684,585			1,579,684,585
4. INTERMEDIATE CARE FACILITY SERVICES					
- MENTALLY RETARDED:					
A. PUBLIC PROVIDERS	590,553,203	352,442,152			352,442,152
B. PRIVATE PROVIDERS	394,797,705	235,615,270			235,615,270
5. CLINIC SERVICES*	80,706,386	48,165,571			48,165,571
6. TARGETED CASE MANAGEMENT FOR LONG TERM CARE*	0	0			0
7. PACE* (PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY)	17,797,633	10,621,627			10,621,627
8. REHABILITATION SERVICES*	0	0			0
9. HOME HEALTH SERVICES	153,140,637	91,394,332			91,394,332
10. HOSPICE*	112,809,943	67,324,974			67,324,974
11. PERSONAL CARE SERVICES	0	0			0
12. OTHER*	229,892,917	137,200,093			137,200,093

NOTE: \* indicates Optional Medicaid Plan Services. Please report if your State plans to provide these services for the MFP population.

**MFP MOE State Plan Services (Based on FORM CMS-64.9 BASE)**

**WAIVER SERVICES ONLY**

**MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE  
FOR THE MEDICAL ASSISTANCE PROGRAM  
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER**

MEDICAL ASSISTANCE PAYMENTS  TYPE OF WAIVER 1915C WAIVER NUMBER 0337	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP 59.68%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE		
	(a)	(b)	(c)	(d)	(e)	{f}
1. CASE MANAGEMENT						
2. HOMEMAKER SERVICES						
3. HOME HEALTH AIDE SERVICES	184,047,304	109,839,431			109,839,431	
4. PERSONAL CARE						
5. ADULT DAY HEALTH						
6. HABILITATION						
a. RESIDENTIAL HABILITATION						
b. DAY HABILITATION						
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))						
a. PREVOCAIONAL SERVICES						
b. SUPPORTED EMPLOYMENT						
c. EDUCATION						
8. RESPITE CARE	137,903	82,301			82,301	
9. DAY TREATMENT						
10. PARTIAL HOSPITALIZATION						
11. PSYCHOSOCIAL REHABILITATION						
12. CLINIC SERVICES						
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))						
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES						
15. OTHER*	38,661,973	23,073,465			23,073,465	

NOTE: \* Indicates Optional Wavier Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.  
Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.  
Alternate service titles should also be noted in the MFP MOE NARRATIVE.

**WAIVER SERVICES ONLY**

**MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE  
FOR THE MEDICAL ASSISTANCE PROGRAM  
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER**

MEDICAL ASSISTANCE PAYMENTS  TYPE OF WAIVER 1915C WAIVER NUMBER 0383	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP 59.68%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE		
	(a)	(b)	(c)	(d)	(e)	(f)
1. CASE MANAGEMENT						
2. HOMEMAKER SERVICES						
3. HOME HEALTH AIDE SERVICES	254,870	152,106			152,106	
4. PERSONAL CARE						
5. ADULT DAY HEALTH	1,068	637			637	
6. HABILITATION						
a. RESIDENTIAL HABILITATION						
b. DAY HABILITATION						
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))						
a. PREVOCAIONAL SERVICES						
b. SUPPORTED EMPLOYMENT						
c. EDUCATION						
8. RESPITE CARE	3,313	1,977			1,977	
9. DAY TREATMENT						
10. PARTIAL HOSPITALIZATION						
11. PSYCHOSOCIAL REHABILITATION						
12. CLINIC SERVICES						
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))						
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES						
15. OTHER*	20,684	12,344			12,344	

NOTE: \* Indicates Optional Wavier Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.  
Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.  
Alternate service titles should also be noted in the MFP MOE NARRATIVE.

**MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE  
FOR THE MEDICAL ASSISTANCE PROGRAM  
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER**

MEDICAL ASSISTANCE PAYMENTS  TYPE OF WAIVER 1915C WAIVER NUMBER 0198.90	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP 59.68%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE		
	(a)	(b)	(c)	(d)	(e)	(f)
1. CASE MANAGEMENT						
2. HOMEMAKER SERVICES	\$3,336,636	1,991,304			1,991,304	
3. HOME HEALTH AIDE SERVICES						
4. PERSONAL CARE	\$181,357,738	108,234,298			108,234,298	
5. ADULT DAY HEALTH	\$11,760,087	7,018,420			7,018,420	
6. HABILITATION						
a. RESIDENTIAL HABILITATION						
b. DAY HABILITATION						
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))						
a. PREVOCATIONAL SERVICES						
b. SUPPORTED EMPLOYMENT						
c. EDUCATION						
8. RESPITE CARE						
9. DAY TREATMENT						
10. PARTIAL HOSPITALIZATION						
11. PSYCHOSOCIAL REHABILITATION						
12. CLINIC SERVICES						
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))						
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES						
15. OTHER*	\$44,675,116	26,662,109			26,662,109	

NOTE: \* Indicates Optional Wavier Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.  
Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.  
Alternate service titles should also be noted in the MFP MOE NARRATIVE.

WAIVER SERVICES ONLY

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE  
FOR THE MEDICAL ASSISTANCE PROGRAM  
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER

MEDICAL ASSISTANCE PAYMENTS  TYPE OF WAIVER 1915C WAIVER NUMBER 40196	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP 59.68%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE		
	(a)	(b)	(c)	(d)	(e)	{f}
1. CASE MANAGEMENT						
2. HOMEMAKER SERVICES						
3. HOME HEALTH AIDE SERVICES	2,551,793	1,522,910			1,522,910	
4. PERSONAL CARE						
5. ADULT DAY HEALTH	92,024	54,920			54,920	
6. HABILITATION						
a. RESIDENTIAL HABILITATION						
b. DAY HABILITATION						
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))						
a. PREVOCAATIONAL SERVICES						
b. SUPPORTED EMPLOYMENT						
c. EDUCATION						
8. RESPITE CARE						
9. DAY TREATMENT						
10. PARTIAL HOSPITALIZATION						
11. PSYCHOSOCIAL REHABILITATION						
12. CLINIC SERVICES						
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))						
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES						
15. OTHER*	133,265	79,533			79,533	

NOTE: \* Indicates Optional Wavier Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.  
Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.  
Alternate service titles should also be noted in the MFP MOE NARRATIVE.

MFP MOE WAIVER (Based on FORM CMS 64.9P WAIVER)

WAIVER SERVICES ONLY

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE  
FOR THE MEDICAL ASSISTANCE PROGRAM  
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER

MEDICAL ASSISTANCE PAYMENTS  TYPE OF WAIVER 1915C WAIVER NUMBER 0231	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP 59.68%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE		
	(a)	(b)	(c)	(d)	(e)	(f)
1. CASE MANAGEMENT						
2. HOMEMAKER SERVICES	331,259,391	197,695,605			197,695,605	
3. HOME HEALTH AIDE SERVICES						
4. PERSONAL CARE						
5. ADULT DAY HEALTH						
6. HABILITATION						
a. RESIDENTIAL HABILITATION						
b. DAY HABILITATION	61,476,519	36,689,187			36,689,187	
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))						
a. PREVOCATIONAL SERVICES						
b. SUPPORTED EMPLOYMENT	490,612	292,797			292,797	
c. EDUCATION						
8. RESPITE CARE	375,287	223,971			223,971	
9. DAY TREATMENT						
10. PARTIAL HOSPITALIZATION						
11. PSYCHOSOCIAL REHABILITATION						
12. CLINIC SERVICES						
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))						
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES						
15. OTHER*	6,103,192	3,642,385			3,642,385	

NOTE: \* Indicates Optional Wavier Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.  
Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.  
Alternate service titles should also be noted in the MFP MOE NARRATIVE.

**WAIVER SERVICES ONLY**

**MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE  
FOR THE MEDICAL ASSISTANCE PROGRAM  
PRIOR PERIOD ADJUSTMENTS IN THIS QUARTER**

MEDICAL ASSISTANCE PAYMENTS  TYPE OF WAIVER 1915C WAIVER NUMBER 0380	TOTAL COMPUTABLE	FEDERAL SHARE			TOTAL FEDERAL SHARE	DEFERRAL OR C.I.N. NUMBER
		FMAP 59.68%	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE		
	(a)	(b)	(c)	(d)	(e)	{f}
1. CASE MANAGEMENT						
2. HOMEMAKER SERVICES	145,889	87,067			87,067	
3. HOME HEALTH AIDE SERVICES						
4. PERSONAL CARE						
5. ADULT DAY HEALTH						
6. HABILITATION						
a. RESIDENTIAL HABILITATION						
b. DAY HABILITATION	1,350,542	806,003			806,003	
7. EXPANDED HABILITATION SERVICES (42 CFR §440.180(c))						
a. PREVOCATIONAL SERVICES						
b. SUPPORTED EMPLOYMENT						
c. EDUCATION						
8. RESPITE CARE	27,578	16,459			16,459	
9. DAY TREATMENT						
10. PARTIAL HOSPITALIZATION						
11. PSYCHOSOCIAL REHABILITATION						
12. CLINIC SERVICES						
13. LIVE-IN CAREGIVER (42 CFR §441.303(f)(8))						
14. CAPITATED PAYMENTS FOR LONG TERM CARE SERVICES						
15. OTHER*	26,769	15,976			15,976	

NOTE: \* Indicates Optional Waiver Services offered by the State as provided under 42 CFR §440.180(b)(9) for long term care services.  
Please use the MFP MOE NARRATIVE to explain why the services listed in #14 is not part of services listed in numbers 1 through 13.  
Alternate service titles should also be noted in the MFP MOE NARRATIVE.





## **BRAIN INJURY ASSOCIATION OF OHIO**

---

1335 Dublin Rd. Suite 217D Columbus, OH 43215-1000 Phone 614-481-7100  
Fax: 614-481-7103 • e-mail: [help@biaoh.org](mailto:help@biaoh.org) • [www.biaoh.org](http://www.biaoh.org)  
Toll Free Helpline (In State) 1-866-OHIO-BIA (644-6242)

October 26, 2006

Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
Mail Stop C2-21-15  
7500 Security Boulevard  
Baltimore, Maryland 2124-1850

Dear Ms. Norris:

The Brain Injury Association of Ohio (BIAOH) is the state-wide, consumer-directed advocacy and education organization representing the estimated 227,000 Ohioans living with life-long disabilities due to brain injury (TBI). We are especially pleased to have offered input into the development of Ohio's Money-Follows-the-Person (MFP) grant application since Ohioans with brain injury do not at this time have a cabinet-level state agency responsible to identify their numbers, report or respond to their needs. And yet, through studies conducted by the Centers for Disease Control (CDC) in Atlanta, we know that traumatic brain injury is the fastest growing cause of disability!

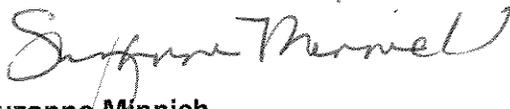
BIAOH, like other disability advocacy organizations, is committed to maximizing independence, productivity and integration of those we represent. We work to achieve this goal through support and encouragement to individuals, and through systems change initiatives such as this MFP grant. We believe we have a unique and important role to play in Ohio's success in rebalancing funds promoting choice and opportunities for safe, healthy and satisfying lives within individuals' homes and communities through our outreach and understanding of a heretofore largely neglected population. Additionally, we believe that our efforts, in collaboration with others, to develop a comprehensive service coordination system and fill gaps in services for Ohioans with brain injury complement and support the work outlined in Ohio's MFP grant.

BIAOH looks forward to collaborating with ODJFS, its sister agencies, and other advocacy organizations to successfully implement Ohio's MFP grant should it be funded. In particular, we believe the community of brain injury advocates could assist in the following ways:

- Involvement in “front door” issues such as refinement of the assessment process for those seeking admission to nursing facilities. (Note that Ohio’s Model TBI Program at the Ohio State University has a small contract to pilot TBI screening with Central Ohio’s Area Agency on Aging and the Mental Health system)
- Activation and further development of BIAOH’s blueprint for a comprehensive service coordination system for Ohioans with brain injury whose service linkage, information and support needs are not addressed in the current service delivery system. (Note BIAOH anticipates introduction of legislation proposed by Ohio Senator Steve Stivers to fortify and expand this system modeled after those established in other states.)
- Development of MFP referral and care planning protocols pertaining to individuals with brain injury to utilize the social and clinical expertise of professionals in existing service delivery systems.
- Involvement in Pre-Implementation Phase Planning, Quality Steering Committee & MFP Steering Committee
- Activation of BIAOH’s “informal and peer supports”
- Utilization of knowledge BIAOH staff gained through its ODJFS Ohio Access Success contract

In summary, BIAOH appreciates the opportunity to provide input into this landmark, systems change initiative. We offer our whole-hearted support, and sincere hope that we may assist ODJFS, its sister agencies, and collaborators reach the worthy goals and initiatives set forth in Ohio’s MFP grant.

Sincerely,



Suzanne Minnich  
Executive Director



## ***Ohio Brain Injury Advisory Committee***

400 East Campus View Blvd., SW5C, Columbus, OH 43235-4604  
(614) 438-1394 (V) (614) 438-1274 (FAX)

---

October 24, 2006

Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
Mail Stop C2-21-15  
7500 Security Boulevard  
Baltimore, Maryland 2124-1850

Dear Ms Norris:

On behalf of the Brain Injury Advisory Committee, we convey our support for Ohio's Money Follows the Person (MFP) Rebalancing Demonstration Grant submitted by the Ohio Department of Job and Family Services, Ohio's single state Medicaid agency.

Ohio proposes to use the MFP grant to further expand Governor Bob Taft's *Ohio Access Initiative* (<http://www.ohioaccess.ohio.gov>), a vision for the future of Ohio's community-based services and supports emphasizing consumer choice, control, and autonomy. Since 2001, the *Ohio Access Initiative* has driven the expansion of home and community based service (HCBS) options for elders and people with disabilities. However, despite these accomplishments, thousands of elderly and disabled Ohioans are on waiting lists for home and community based services through one of Ohio's Medicaid waivers. Ohio's Money Follows the Person initiative will add resources and leverage to move *Ohio Access* to the next level by supporting institutionalized individuals as they move back home. MFP will also provide an opportunity to further expand the vision of the *Ohio Access Initiative*.

Ohio's proposal will add needed capacity to existing Medicaid waivers and service delivery systems. MFP will also add some "post institutional" services to smooth the way for people who are returning home from an institution. Finally, Ohio's MFP proposal will focus on a variety of subpopulations who desire to move out of an institutional setting. In order to represent the interests of those diverse populations, ODJFS will convene a steering committee of key stakeholders to assist in planning and implementing the grant over the next five years.

Based on the State of Ohio's Needs and Resources Assessment conducted for the Brain Injury Advisory Committee, it was determined that individuals and families of persons with brain injury want a continuum of services and housing options outside the skilled facility settings. We are in support of the MFP grant that will allow individuals with brain injury who desire and have the capability to leave an institutional setting the opportunity to do so.

We support Ohio's Money Follows the Person proposal and urge CMS to select Ohio as a grantee.

Sincerely,

Julie Fasick-Valley, Chair  
Brain Injury Advisory Committee



Creating solutions,  
changing lives.

October 25, 2006

# Easter Seals of Ohio

Easter Seals creates solutions that change the lives of children and adults with disabilities, or other special needs, and their families.

Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
7500 Security Blvd.  
Baltimore, Maryland 2124-1850

Dear Ms. Norris,

On behalf of the seven Easter Seals organizations serving the citizens of Ohio, I offer our support for Ohio's Money Follows the Person (MFP) Rebalancing Demonstration Grant submitted by the Ohio Department of Job and Family Services, Ohio's single state Medicaid agency.

For too long now, Ohio has had a significant imbalance in how resources are spent on long-term care. This initiative should greatly enhance the development of rebalancing efforts as proposed by Governor Taft's strategic goals for long-term care in the *Ohio Access Initiative*. There continue to be thousands of people with disabilities and the elderly on waiting lists for community-based care, while at the same time there is a continued reduction in the number of Ohioans using facility-based care.

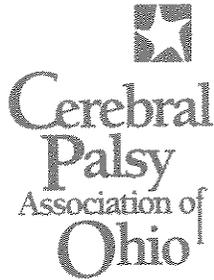
Easter Seals has actively participated in stakeholder planning meetings with the Ohio Department of Job and Family Services on the MFP Proposal. As the contract agency that developed, implemented and evaluated the CMS funded Nursing Facility Transition project, Ohio Access Success, Easter Seals is committed to advocating for more transition opportunities for people in institutional settings. We will continue to support this rebalancing initiative by participating on the MFP Steering Committee as it develops the state's operational plan and by educating members of the General Assembly about the findings of the Ohio Access Success project and the importance of rebalancing efforts.

We urge CMS to support Ohio's efforts in this very important endeavor. The quality of life of many Ohioans depends on it.

Sincerely,

  
Pat Luchkowsky, Director of Public Affairs  
Easter Seals of Ohio

Central & Southeast Ohio	Northeast Ohio	Northwestern Ohio	Southwestern Ohio	West Central Ohio	Youngstown Area, Ohio	Eastern Ohio
565 Children's Drive West P.O. Box 7166 Columbus, OH 43205 (614) 228-5523 (614) 228-8249 fax	1929-A East Royalton Road Cleveland, OH 44147 440-838-0990 440-838-8440 fax	1909 North Ridge Road #6 Lorain, OH 44055 440-277-7337 440-277-7339 fax	231 Clark Road Cincinnati, OH 45215 513-821-9890 513-821-9895 fax	1511 Kuntz Road Dayton, OH 45404 937-461-4800 937-461-2750 fax	299 Edwards Street Youngstown, OH 44502 330-743-1168 330-743-1616 fax	330 Fox Shannon Place #2 St. Clairsville, OH 43950 740-695-5979 740-695-6764 fax



October 30, 2006

Ms. Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
Mail Stop C2-21-15  
7500 Security Boulevard  
Baltimore, MD

Dear Ms. Norris:

On behalf of the Cerebral Palsy Association of Ohio, a statewide advocacy organization, I am pleased to write this letter in support of Ohio's Follow the Person (MFP) Rebalancing Demonstration Grant submitted by the Ohio Department of Job and Family Services.

Ohio proposes to use the MFP grant to further expand Governor Bob Taft's Ohio Access Initiative, a vision for the future of Ohio's community-based services and supports emphasizes consumer choice, control and autonomy. Since 2001, the Ohio Access Initiative has driven the expansion of home and community-based services for elders and people with disabilities. However, despite these accomplishments, thousand of Ohioans with disabilities are on waiting lists for home and community based services through one of Ohio's Medicaid waivers. Ohio's Money Follows the Person initiative will move this initiative another step by adding resources to support individuals with disabilities in moving from institutional settings to a home in the community and developing mechanisms to rebalance Ohio's long-term care system.

Ohio's proposal will add needed capacity to existing Medicaid waivers and service delivery systems. MFP will also add some post institutional services to smooth the way for people who are returning home from an institution. Finally, Ohio's MFP proposal will focus on a variety of populations who desire to leave an institution. In order to represent the interests of those diverse populations, ODJFS will convene a steering committee of key stakeholders to assist in planning and implementing the grant over the next five years.

The Cerebral Palsy Association of Ohio has actively participated in planning meetings for Ohio's Money Follows the Person proposal. ODJFS has gone above board to ensure that the voices of people with disabilities have been heard in this planning process. We will continue to support implementation of Ohio's MFP grant by participating in the Steering Committee, continuing to educate members of the Ohio General Assembly about the importance of alternatives to institutions, and educating people with disabilities about this exciting initiative.

We support Ohio's Money Follows the Person proposal and urge CMS to select Ohio as a grantee.

Sincerely,

A handwritten signature in cursive script that reads "Beverly A. Johnson". The signature is written in black ink and is positioned above the printed name and title.

Beverly A. Johnson  
Executive Director



Dedicated to human rights,  
personal dignity,  
community participation

October 25, 2006

Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
Mail Stop C3-21-15  
7500 Security Boulevard  
Baltimore, Maryland 2124-1850

Dear Mr. Norris:

The Arc of Ohio supports Ohio's Money Follows the Person (MFP) Rebalancing Demonstration Grant, submitted by our Department of Job and Family Services

The Arc has been a major player in the development and expansion of Ohio's community based service delivery system for individuals with mental retardation, other developmental disabilities and their families. As the state's oldest and largest advocacy organization, The Arc of Ohio and its member families, have a long history of moving Ohio from an institutionally based state to one which offers self determination and services within one's own home.

We will continue to participate in the implementation of Ohio's MFP grant and will work to make it a success.

We urge you to select Ohio as a grantee.

Sincerely,

A handwritten signature in black ink, appearing to read "Gary A. Tonks". The signature is written in a cursive style and is positioned above the typed name.

Gary A. Tonks  
Executive Director



October 20, 2006

Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
Mail Stop C2-21-15  
7500 Security Boulevard  
Baltimore, Maryland 2124-1850

Dear Ms Norris:

On behalf of the Access Center I wish to convey our support for Ohio's Money Follows the Person (MFP) Rebalancing Demonstration Grant submitted by the Ohio Department of Job and Family Services, Ohio's single state Medicaid agency.

Ohio proposes to use the MFP grant to further expand Governor Bob Taft's Ohio Access Initiative (<http://www.ohioaccess.ohio.gov>), a vision for the future of Ohio's community-based services and supports emphasizing consumer choice, control, and autonomy. Since 2001, the Ohio Access Initiative has driven the expansion of home and community based service (HCBS) options for elders and people with disabilities. However, despite these accomplishments, thousands of elderly and disabled Ohioans are on waiting lists for home and community based services through one of Ohio's Medicaid waivers. Ohio's Money Follows the Person initiative will add resources and leverage to move Ohio Access to the next level by supporting institutionalized individuals as they move back home. MFP will also provide an opportunity to further expand the vision of the Ohio Access Initiative.

Ohio's proposal will add needed capacity to existing Medicaid waivers and service delivery systems. MFP will also add some "post institutional" services to smooth the way for people who are returning home from an institution. Finally, Ohio's MFP proposal will focus on a variety of subpopulations who desire to move out of an institutional setting. In order to represent the interests of those diverse populations, ODJFS will convene a steering committee of key stakeholders to assist in planning and implementing the grant over the next five years.

The Access Center is a non-profit, non-residential center for independent living funded through Title VII of the Rehabilitation Act and whose board and staff are comprised entirely of people with disabilities. Our mission is to ensure that people with disabilities have complete access to the communities in which they wish to live. We do so through offering advocacy, information and referral, independent living skills training, peer support, our recycled durable medical equipment program and through assisting individuals transition from institutional settings to community living.

Our organization has actively participated in planning meetings for Ohio's Money Follows the Person proposal. We will continue to support its implementation by participating in the Steering Committee, educating members of the Ohio General Assembly about the importance of HCBS

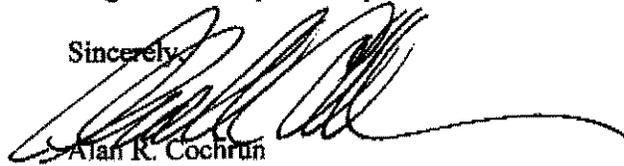
---

The Access Center for Independent Living, Inc.  
35 S Jefferson Street, Dayton, Ohio 45402  
(937) 341-5202v \* (936) 341-5217 FAX \* (937) 341-5218 TTY

alternatives, identifying and recruiting institutionalized individuals, enrolling MFP participants into existing waivers administered by our ODJFS, and providing support to individual MFP participants.

We support Ohio's Money Follows the Person proposal and urge CMS to select Ohio as a grantee. We look forward to continuing to work with ODJFS staff towards rebalancing Ohio's long term care system to provide sustainable, consumer centered choices in long term health care.

Sincerely,

A handwritten signature in black ink, appearing to read 'Alan R. Cochran', with a long horizontal flourish extending to the right.

Alan R. Cochran  
Executive Director



418 South Broad Street  
Lancaster, Ohio 43130

Voice / TTY: (740) 689-1494  
Toll Free: 1-888-957-6245  
Fax: (740) 689-1455  
Website: [www.socil.org](http://www.socil.org)

August 11, 2006

Mary A. Haller  
Chief, Stakeholder Relations  
ODJFS, Office of Ohio Health Plans  
Deputy Director's Office  
30 East Broad Street, 31<sup>st</sup> Floor  
Columbus, OH 43215

Dear Ms. Haller,

Please accept this as a letter of support for ODJFS application for the "Money Follows the Person" grant. As a Center for Independent Living we work with individuals with disabilities in Fairfield and Hocking Counties and know first hand their desire to transition from nursing homes to community life.

Ohio has had great success in serving people through Home and Community Based waivers but because they are optional programs they must constantly compete for long-term care funding with institutional care providers. The concept of enabling available funds to move with the individual gives individuals more choice over the location and type of services they receive. It also has the potential to save Ohio money because community based services are in the aggregate cheaper than institutionalized nursing home care.

State law already allows Medicaid dollars to follow persons 60 years and older who have been institutionalized in a nursing facility so that they can receive care and services in a home/community based setting. However, this provision does not apply to younger adults with disabilities. By Ohio applying and hopefully receiving the Money Follows the Person grant we will have an opportunity to provide community based services equally to individuals desiring this option.

If further information or assistance is needed in securing this grant please do not hesitate to call me at 740-689-1494.

Sincerely,

Pam Patula  
Executive Director

Independent Living Center of NCO, Inc.  
1 Marion Ave., Suite 115C  
Mansfield, OH 44903  
(419) 526-6770  
Ashland/Knox Outreach  
(740) 392-3191

October 20, 2006

Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
Mail Stop C2-21-15  
7500 Security Blvd.  
Baltimore, Maryland 2124-1850

Dear Ms. Norris:

On behalf of the Independent Living Center of N.C.O., Inc., convey our support for Ohio's Money Follows the Person (MFP) Rebalancing Demonstration Grant submitted by the Ohio Department of Job and Family Services, Ohio's single state Medicaid agency.

Ohio proposes to use the MFP grant to further expand Governor Bob Taft's Ohio Access Initiative, a vision for the future of Ohio's community-based services and supports emphasizing consumer choice, control and autonomy. Since 2001, the Ohio Access Initiative has driven the expansion of home and community based services (HCBS) options for elders and people with disabilities. However, despite these accomplishments, thousands of elderly and disabled Ohioans are on waiting lists for home and community based services through one of Ohio's Medicaid waivers. Ohio's Money Follows the Person initiative will add resources and leverage to move OHIO ACCESS to the next level by supporting institutionalized individuals as they move back home. MFP will also provide an opportunity to further expand the vision of the Ohio Access Initiative.

Ohio's proposal will add needed capacity to existing Medicaid waivers and service delivery systems. MFP will also add some "post institutional" services to smooth the way for people who are returning home from an institution. Finally, Ohio's MFP proposal will focus on a variety of subpopulations who desire to move out of an institutional setting. In order to represent the interests of those diverse populations, ODJFS will convene a steering committee of key stakeholders to assist in planning and implementing the grant over the next five years.

Our Organization will support its implementation by participating in the Steering Committee; identifying and recruiting institutionalized individuals and enrolling MFP participants into existing waivers administered by our agency.

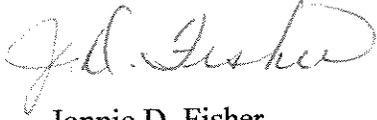


\*Supported By Crestline Area United Way & Shelby Area United Fund

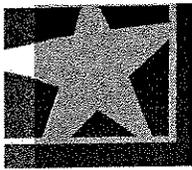
RICHLAND  
COUNTY  
FOUNDATION

We support Ohio's Money Follows the Person proposal and urge CMS to select Ohio as a grantee.

Sincerely,

A handwritten signature in cursive script, appearing to read "J.D. Fisher".

Jonnie D. Fisher  
Executive Director  
ILCNCO



PEOPLE  
WITH DISABILITIES  
MAKING  
INDEPENDENT LIVING  
A REALITY

## THE ABILITY CENTER

OF GREATER  
TOLEDO

5605 Monroe Street,  
Sylvania, Ohio 43560

419.885.5733 (V/TTY)  
419.882.4813 (Fax)  
866.885.5733 (Toll Free)

Website:  
[www.abilitycenter.org](http://www.abilitycenter.org)

DEFIANCE OFFICE:  
1935 E. Second Street  
Suite C  
Defiance, Ohio 43512  
419.782.5441 (V/TTY)  
419.782.9231 (Fax)  
877.209.8336 (Toll Free)

OTTAWA COUNTY  
OFFICE:  
400 West Third Street  
Port Clinton, Ohio 43452  
419.734.0330 (V/Fax)

BOARD OF TRUSTEES:  
Ned Neuhausel  
*Chairperson*

Nancy Atkins  
Dawn Christensen  
Melissa Emery  
Brian Fitch  
Rick Gray  
Pam Howell-Beach  
Jill Kopanis  
Sue Lovett  
Dr. Colleen Mandell  
Gary Mossburg  
Sean O'Mara  
Linda Peters  
Mark Stutler  
Cheryl Volk  
George Ward  
Daniel Wilkins

Timothy Harrington  
*Executive Director*

October 24, 2006

Ms. Mary Haller  
Chief of Stakeholder Relations  
ODJFS Office of Ohio Health Plans  
30 E. Broad St., 31<sup>st</sup> floor  
Columbus, Ohio 43215

Dear Ms. Haller,

The Ability Center of Greater Toledo supports Ohio's Money Follows the Person Demonstration Grant proposal submitted by the Ohio Department of Job and Family Services. Ohio's Access Initiative, which emphasizes community-based services and consumer choice and control, has increased long term care options for individuals with disabilities. Unfortunately tens of thousands of individuals are on waiting lists for such options and overall this Initiative has not shifted Ohio's dependence on facility based care for the elderly and those with disabilities. The institutional bias continues to take precedence in the state. The Demonstration Grant will give Ohio the opportunity to rebalance its long term care priorities to one where choice and consumer control are supported and community-based services are provided without question or delay.

The Ability Center has participated in planning meetings for the Money Follows the Person proposal with ODJFS. We have staff members who serve in leadership roles in the Ohio Olmstead Taskforce, referenced in the Grant Proposal as having significant influence in the grant's priorities. We hope to continue to have input, as stakeholders, in planning and implementing the grant over the next five years. The Ability Center is uniquely qualified to provide strategic input into nursing home transitions as we have assisted over 160 people in five years in doing so. We stand ready to support the implementation of the grant by providing our knowledge and experience as a resource. As a Center for Independent Living we are qualified and prepared to identify and provide Independent Skills training to individuals who are institutionalized. With staff positioned in Columbus to serve as a liaison to legislators regarding the needs of people with disabilities we will continually strive to educate members of the Ohio House and Senate about Money Follows the Person initiatives.

We urge CMS to approve Ohio's Money Follows the Person Proposal so that we might begin to change long term care from a focus on institutionalization to one of community and choice.

Sincerely

Tim Harrington  
Executive Director



PROVIDING: Advocacy • Peer Support • Independent Living Skills Training • Information and Referral

# LEAP

---

---

**Linking Employment, Abilities & Potential**

*Consumer-directed to ensure a society of equal opportunity for all persons, regardless of disability.*

October 26, 2006

Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
Mail Stop C2-21-15  
7500 Security Boulevard  
Baltimore, Maryland 2124-1850

Dear Ms Norris:

As the Executive Director of Linking Employment, Abilities & Potential (LEAP), I am writing to communicate our support for Ohio's Money Follows the Person (MFP) Rebalancing Demonstration Grant submitted by the Ohio Department of Job and Family Services. LEAP has been actively involved in providing stakeholder input throughout ODJFS' planning process, individually as an organization and collectively as a member of Ohio Olmstead Task Force's (OOTF) MFP Grant Subcommittee, which we currently chair. We agree with OOTF that Ohio's grant application represents an important step forward in rebalancing and addressing the institutional bias that continues to be a problem in Ohio.

As a Center for Independent Living that serves persons of all ages and cross-disabilities, it is essential that we continue to transform our long term care system of supports and services so that it serves all Ohioans. While strides have been made to provide a more comprehensive system for older adults and some younger persons with disabilities, there is still work to be done to end the institutional bias faced by the population that we serve. This is especially true for younger persons with disabilities who are not serviced through existing waiver programs which in Ohio are primarily age and disability/disease specific.

Ohio's proposal contains key elements that LEAP believes are essential to a successful MFP program and to the continued rebalancing of how Ohio spends its LTC dollars. These elements include:

- Commitment to serve all persons with disabilities who meet the program's eligibility requirements and who need the program in order to transition out of an institution. LEAP will continue throughout the planning and implementation process to emphasize the need to expand the availability of community supports and services more broadly, not on a specified demographic category or by a specific type of disability. Under existing waivers, the problem is especially acute for the MRDD population and for persons with disabilities between the ages of 22-59.

Attendant Training Office  
11607 Euclid Ave.  
Cleveland, OH 44106  
216.229.3029 Fax: 216.229.9640

LEAP  
1468 W. 25<sup>th</sup> St.  
Cleveland, OH 44113  
216.696.2716 Fax: 216.687.1453  
[www.leapinfo.org](http://www.leapinfo.org)

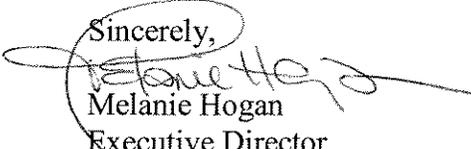
Lorain County Branch Office  
2100 North Ridge Rd.  
Elyria, OH 44035  
440.324.3444 Fax: 440.324.2112

- Emphasis on expanding consumer choice, consumer control and self-direction. Person centered planning needs to start while the individual is still in the institution, continuing throughout the transition to the community, and after the individual is established and receiving services in their home and community based setting. ODJFS' proposal recognizes the importance of post-transition planning. As a Center for Independent Living we realize that it is essential to provide peer support to assess and identify the full range of supportive services that will be needed and the availability of those supports in the community to assure a successful transition to the community.
- Recognition that there must be effective collaboration between ODJFS or their designees and that those relationships must be strengthened; with those who maintain and provide affordable and accessible housing for low income individuals, existing or MFP created Medicaid waiver service providers, and with existing or MFP created networks of formal and informal supports. LEAP believes that successful relocation is dependent upon the availability of community supports and the coordinated receipt of waiver services and housing.
- Inclusion and recognition of the need for additional services and supports to be in place to maximize self-sufficiency: personal care assistance, homemaker services, and adaptive technology. LEAP believes that if we are to rebalance and reverse Ohio's continuing institutional bias—we must creatively utilize all available Medicaid dollars, new MFP federal dollars and state dollars to address the issues that keep persons with disabilities institutionalized. LEAP will continue to advocate with our consumers for Ohio to address the lack of subsidized affordable, accessible housing and supportive housing; lack of reimbursement for Personal Assistance Services, and the lack of political will to use public monies to purchase services and supports that would build self-sufficiency and promote independent living in the community.
- Recognition of the need to include Peer Support, which is integral to LEAP's independent living philosophy, and to provide access to Independent Living Skills Training as essential services which should be provided through contracts reimbursable through the MFP project. LEAP believes that contracting with regional Centers for Independent Living and other qualified consumer-based organization would add extra value to the transition services offered through Ohio's MFP project.

In conclusion, LEAP has actively participated in the stakeholder meetings for Ohio's Money Follows the Person proposal. We will continue to support its implementation by: participating in ODJFS's MFP Steering Committee; educating members of the Ohio General Assembly and the Administration about the importance of HCBS alternatives and ways to rebalance how Ohio expends its LTC dollars through expanding Ohio's use of its version of the Texas "Rider 37" to allow persons under 60 to transition from NFs; and by identifying, advocating for and supporting institutionalized individuals to access Ohio's MFP program and transition back into the community.

LEAP is supportive of Ohio's Money Follows the Person proposal and we urge CMS to select Ohio as a grantee.

Sincerely,



Melanie Hogan

Executive Director

Linking Employment, Abilities and Potential (LEAP)



# Ohio Legal Rights Service

8 East Long Street, Suite 500, Columbus, Ohio 43215-2999

Telephone 614-466-7264  
TOLL FREE 1-800-282-9181  
TTY TOLL FREE 1-800-858-3542  
FAX 614-644-1888

October 26, 2006

Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
Mail Stop C2-21-15  
7500 Security Boulevard  
Baltimore, Maryland 2124-1850

Dear Ms Norris:

On behalf of Ohio Legal Rights Service (OLRS), I am writing to express support for Ohio's Money Follows the Person (MFP) Rebalancing Demonstration Grant submitted by the Ohio Department of Job and Family Services, Ohio's single state Medicaid agency. OLRS is an independent state agency and is Ohio's Protection and Advocacy agency for people with disabilities.

As the P&A for Ohio under the Developmental Disability Act, OLRS has long advocated for Ohio to address its dependence on institutional settings for the provision of services with individuals with disabilities. OLRS was pleased to participate in planning meetings for this grant proposal. OLRS believes that MFP is a significant opportunity for Ohio to address this imbalance, and to bring the promise of community integration, embodied in the Americans with Disabilities Act and upheld by the *Olmstead* decision, to reality in the lives of people with disabilities.

Ohio proposes to use the MFP grant to expand upon the *Ohio Access Initiative* - Ohio's *Olmstead* plan. *Ohio Access Initiative* lays out a vision for the future of Ohio's community-based services and supports that emphasizes consumer choice, control, and autonomy. The *Ohio Access Initiative* has driven the expansion of home and community based service (HCBS) options for elders and people with disabilities. However, thousands of elderly and disabled Ohioans continue on waiting lists for home and community based services through one of Ohio's Medicaid waivers.

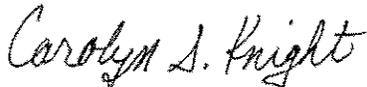
OLRS is pleased that Ohio's MFP proposal focuses on a variety of subpopulations who desire to move out of an institutional setting. Some of these subpopulations have not been previously addressed in Ohio's community based Medicaid programs, and we support Ohio's efforts to utilize this grant to consider the broad range of institutionalized individuals. Individuals who are already institutionalized also face significant barriers to community integration. Ohio's MFP initiative will add resources and leverage to move *Ohio Access* to the next level to support institutionalized individuals as they move back home. Ohio's proposal will add needed capacity to existing Medicaid waivers and service delivery systems. MFP will also add some "post institutional" services to smooth the way for people who are returning home from an institution.

OLRS looks forward to the opportunity to participate in the steering committee of key stakeholders to assist in planning and implementing the grant over the next five years. OLRs also supports Ohio's efforts through this grant to engage the broad spectrum of stakeholders in the serious and necessary discussions about how to truly allow "money to follow the person". OLRs looks forward to supporting those efforts, and participating in those discussions.

Finally, OLRs also represents the plaintiff class in the *Martin v. Taft* case, representing a plaintiff class of Ohioans with developmental disabilities "who are or will be in need of community housing and services which are normalized, home-like and integrated". That litigation is focused on ensuring that individuals with developmental disabilities who are institutionalized are provided the opportunity and the supports to move into the community. The parties recently reached a tentative settlement agreement which will in part ensure that a portion of the class that are now in ICFs/MR and nursing facilities will be able to move into HCBS waiver settings. The settlement should facilitate the identification of individuals who could be served through MFP. Conversely, this grant proposal will support the successful implementation of that settlement.

In closing, OLRs supports Ohio's Money Follows the Person proposal and urges CMS to select Ohio as a grantee.

Sincerely,

Handwritten signature of Carolyn S. Knight in cursive script.

Carolyn S. Knight  
Executive Director



October 27, 2006

Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
Mail Stop C2-21-15  
7500 Security Boulevard  
Baltimore, Maryland 2124-1850

Dear Ms Norris:

The Ohio Association of Area Agencies on Aging supports Ohio's Money Follows the Person (MFP) Rebalancing Demonstration Grant submitted by the Ohio Department of Job and Family Services, Ohio's single state Medicaid agency.

Ohio proposes to use the MFP grant to further expand Governor Bob Taft's *Ohio Access Initiative*. Ohio's aging network has played a critical role by operating locally many of the initiatives supported by *Ohio Access* such as PASSPORT (the home and community based waiver for older Ohioans); Assisted Living and Home First (both programs have relocated individuals from nursing homes); consumer-directed care; expanded consultations; and a care management system that provides assessment screening, assessments, pre-admission review and other functions. Despite these accomplishments, thousands of elderly and disabled Ohioans are on waiting lists for home and community based services through one of Ohio's Medicaid waivers. Currently 1330 wait for PASSPORT. Ohio's Money Follows the Person initiative will add resources and leverage to move *Ohio Access* to the next level by supporting institutionalized individuals and the barriers they face relocating to the community.

Ohio's proposal will add needed capacity to existing Medicaid waivers and service delivery systems such as PASSPORT and others. MFP will also add some "post institutional" services to smooth the way for people who are returning home from an institution. Finally, Ohio's MFP proposal will focus on a variety of subpopulations who desire to move out of an institutional setting. In order to represent the interests of those diverse populations, ODJFS will convene a steering committee of key stakeholders to assist in planning and implementing the grant over the next five years.

Our organization attended a planning meeting regarding the grant development and reviewed and commented on the draft proposal. We have a strong advocacy base and will work with all stakeholders and participate on the steering committee in order to realize the goals of Money Follows the Person - so that Ohio truly re-balances the resources to match the needs and desires of those in need of long-term care support.

Sincerely,

  
Jane Taylor  
Executive Director



Ohio Association of  
COUNTY  
BEHAVIORAL  
HEALTH  
AUTHORITIES

October 30, 2006

**Executive Council:**

**Karen J. Scherra**  
Clermont ADAMH  
President

**David A. Royer**  
Franklin ADAMH  
President-Elect  
Secretary

**William Mateer**  
Wayne & Holmes ADAMH  
Past President  
Treasurer

**Jody Demo-Hodgins**  
Crawford-Marion ADAMH

**William M. Denihan**  
Cuyahoga CMH

**William P. Harper**  
Lorain CMH

**Russell S. Kaye, PhD**  
Cuyahoga ADAS

**Sherry Knapp-Brown, PhD**  
Hamilton ADAS

**Ronald J. Rees, MPA**  
Washington ADAMH

**Michael A. Schoenhofer**  
Allen-Auglaize-Hardin ADAMH

**Precia Shenk Stuby**  
Hancock ADAMH

Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
Mail Stop C2-21-15  
7500 Security Boulevard  
Baltimore, Maryland

Dear Ms. Norris:

On behalf of the Ohio Association of County Behavioral Health Authorities, I wish to convey our support for Ohio's Money Follows the Person (MFP) Rebalancing Demonstration Grant submitted by the Ohio Department of Job and Family Services, Ohio's single state Medicaid agency.

Ohio proposes to use the MFP grant to further expand Governor Bob Taft's *Ohio Access Initiative* (<http://www.ohioaccess.ohio.gov>), a vision for the future of Ohio's community-based services and supports emphasizing consumer choice, control, and autonomy. Since 2001, the *Ohio Access Initiative* has driven the expansion of home and community based service (HCBS) options for elders and people with disabilities. However, despite these accomplishments, thousands of elderly and disabled Ohioans are on waiting lists for home and community based services through one of Ohio's Medicaid waivers. Ohio's Money Follows the Person initiative will add resources and leverage to move *Ohio Access* to the next level by supporting institutionalized individuals as they move back home. MFP will also provide an opportunity to further expand the vision of the *Ohio Access Initiative*.

Ohio's proposal will add needed capacity to existing Medicaid waivers and service delivery systems. MFP will also add some "post institutional" services to smooth the way for people who are returning home from an institution. Finally, Ohio's MFP proposal will focus on a variety of subpopulations who desire to move out of an institutional setting. In order to represent the interests of those diverse populations, ODJFS will convene a steering committee of key stakeholders to assist in planning and implementing the grant over the next five years.

Our organization has actively participated in planning meetings for Ohio's Money Follows the Person proposal. We will continue to support its implementation by *educating members of the Ohio General Assembly about the importance of HCBS alternatives*. We support Ohio's Money Follows the Person proposal and urge CMS to select Ohio as a grantee.

Sincerely,



Cheri L. Walter  
CEO

*Treatment Works People Rejoice*

33 North High Street • Suite 500 • Columbus, OH 43215 • Telephone: (614) 224-1111 • Fax: (614) 224-2642

Cheri L. Walter, Chief Executive Officer



---

An Affiliate of The American Dietetic Association

October 20, 2006

Judith Norris  
Centers for Medicare and Medicaid Services  
Office of Acquisition and Grant Management  
Mail Stop C2-21-15  
7500 Security Boulevard  
Baltimore, Maryland 2124-1850

Dear Ms Norris:

On behalf of The Ohio Dietetic Association, I convey our Association's support for Ohio's Money Follows the Person (MFP) Rebalancing Demonstration Grant submitted by the Ohio Department of Job and Family Services, Ohio's single state Medicaid agency.

Ohio proposes to use the MFP grant to further expand Governor Bob Taft's *Ohio Access Initiative* (<http://www.ohioaccess.ohio.gov>), a vision for the future of Ohio's community-based services and supports emphasizing consumer choice, control, and autonomy. Since 2001, the *Ohio Access Initiative* has driven the expansion of home and community based service (HCBS) options for elders and people with disabilities. However, despite these accomplishments, thousands of elderly and disabled Ohioans are on waiting lists for home and community based services through one of Ohio's Medicaid waivers. Ohio's Money Follows the Person initiative will add resources and leverage to move *Ohio Access* to the next level by supporting institutionalized individuals as they move back home. MFP will also provide an opportunity to further expand the vision of the *Ohio Access Initiative*.

Ohio's proposal will add needed capacity to existing Medicaid waivers and service delivery systems. MFP will also add some "post institutional" services to smooth the way for people who are returning home from an institution. Finally, Ohio's MFP proposal will focus on a variety of subpopulations who desire to move out of an institutional setting. In order to represent the interests of those diverse populations, ODJFS will convene a steering committee of key stakeholders to assist in planning and implementing the grant over the next five years.

Our Association has actively participated in planning meetings for Ohio's Money Follows the Person proposal. We will continue to support its implementation. We are especially committed to making sure that the participants have access to the quality nutrition care services available to those in long-term care institutions. We feel confident that the Ohio plan will provide for these services.

We support Ohio's Money Follows the Person proposal and urge CMS to select Ohio as a grantee.

Sincerely,

Mary Angela Miller  
President

34 N. HIGH STREET, NEW ALBANY, OHIO 43054-8507 USA 614/895/1253 FAX 614/895/3466  
[www.eatrightohio.org](http://www.eatrightohio.org) e-mail: [oda@eatrightohio.org](mailto:oda@eatrightohio.org)



# OALA OHIO ASSISTED LIVING ASSOCIATION

1335 Dublin Road, Suite 221-B, Columbus, Ohio 43215 (614) 481-1950 FAX (614) 481-1954

2006 / 2007

**Chairperson**

Beverly Donaldson  
*The Inns Management Group*

**Vice Chair**

Charles Latta  
*Sunrise Senior Living*

**Executive Director**

Jean B. Thompson

**Board of Trustees**

Ann Broderick  
*10 Wilmington Place*

Lloyd Chapman  
*Acquisition & Management Consultants, LLC*

Janet Feldkamp  
*Benesch, Friedlander, Coplan & Aronoff, LLP*

Lisa Fordyce  
*Summerville Senior Living*

Diane Goodwin  
*Legacy Health Services*

J. Michael Haemmerle  
*Abbington Communities*

Kathy Hunt  
*Elmwood Centers, Inc.*

Cindy Griffiths-Novak  
*The Belvedere of Westlake*

Joseph V. Gulling  
*Wallick Senior Housing, LLC*

Robin C. Miller  
*Asssted Living Concepts*

Judith Peoples  
*Good Neighbor Care*

M. George Rumman  
*Kingston HealthCare Company*

Gary L. Wade  
*AdCare Health Systems, Inc.*

Mari Warburton  
*M&M Healthcare, LLC*

OFFICE OF  
OHIO HEALTH PLANS

August 22, 2006

Mary A. Haller  
Chief, Stateholder Relations  
ODJFS, Office of Ohio Health Plans  
Deputy Director's Office  
30 East Broad Street, 31<sup>st</sup> Floor  
Columbus, OH 43215

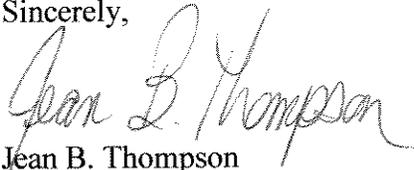
Dear Ms. Haller:

The Ohio Assisted Living Association supports Ohio's participation in the "Money Follows the Person" initiative.

Our Association has always supported consumer choice with regard to long term care. This initiative is financially prudent for the State, and allows for continued compliance with federal law requiring the least restrictive placement.

If there is anything further our Association can do to assist you, please don't hesitate to contact me.

Sincerely,

  
Jean B. Thompson  
Executive Director

**Leadership Council 2006**

**Platinum:**

*Benjamin Byers, Chancellor Health Partners • Judith Peoples, Good Neighbor Care*

*Beverly Donaldson, Inns Management Network Group • Mari Warburton, M&M Healthcare, LLC*

*Daniel Rath, Omnicare Pharmacies of Ohio • Lisa Fordyce, Summerville Senior Living • Chris Pfeifer, Sunrise Senior Living*

**Gold:**

*Joseph V. Gulling, Wallick Senior Housing, LLC*



what matters.™



United Way of the  
Greater Dayton Area

October 13, 2006

Ms. Mary Haller  
Chief, Stakeholder Relations  
Ohio Department of Job and Family Services  
Office of Ohio Health Plans, Deputy Director's Office  
30 E. Broad Street, 31<sup>st</sup> Floor  
Columbus, OH 43215

RE: ODJFS' application to the Centers for Medicaid and Medicare Services for a  
Money Follows the Person Grant for Ohio

Dear Ms. Haller

On behalf of the United Way of the Greater Dayton Area, I am writing to support the Ohio Department of Job and Family Services' application to the Centers for Medicare and Medicaid Services (CMS) for a federal grant to implement Money Follows the Person in Ohio for persons who are disabled and/or elderly.

We are strongly supportive of programs that allow for and support independence and do so with respect for those in need. This federal grant would facilitate consumer choice by eliminating government restrictions that prevent people from taking care of their own lives. This is an important step forward in helping people remain in our community rather than an institution.

We are supportive of the grant with the expectation that the State of Ohio not pass on the costs to the local community. Funds must follow the people by communities served.

We urge CMS' positive response on this important grant application.

Sincerely,

Marc R. Levy  
President and Chief Executive Officer

## OFFICE OF FAMILY AND CHILDREN FIRST

451 W. Third Street, 9th Floor  
Dayton, Ohio 45422-3100  
937-225-4695 - phone  
937-496-7714 - fax

[www.fcfc.montco.org](http://www.fcfc.montco.org)

COUNTY COMMISSIONERS  
Dixie J. Allen  
Charles J. Curran  
Deborah A. Lieberman

COUNTY ADMINISTRATOR  
Deborah A. Feldman

DEPARTMENT DIRECTOR  
Tom Kelley



October 13, 2006

Ms. Mary Haller  
Chief, Stakeholder Relations  
Ohio Department of Job and Family Services  
Office of Ohio Health Plans, Deputy Director's Office  
30 East Broad Street, 31<sup>st</sup> Floor  
Columbus, OH 43215

RE: ODJFS' application to the Centers for Medicaid and Medicare Services for a Money Follows the Person Grant for Ohio

Dear Ms. Haller:

On behalf of the Montgomery County Family and Children First Council, I am writing to support the Ohio Department of Job and Family Services' application to the Centers for Medicare and Medicaid Services (CMS) for a federal grant to implement Money Follows the Person in Ohio for persons who are disabled and/or elderly.

This federal grant would facilitate consumer choice by eliminating government restrictions that prevent people from taking charge of their own lives. Persons who are disabled or elderly value choosing their services, the service provider(s), and the setting in which those services are provided.

Our support for this concept assumes that Ohio will develop a system to cover these costs after the first year by allowing the Medicaid funds formerly spent on persons' institutional care to follow them to the community, rather than their having to wait for a "waiver slot". Limited local resources cannot be expected to pick up these costs.

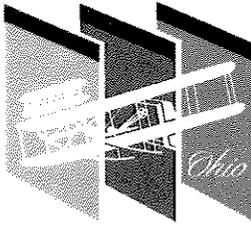
We look forward to CMS' positive response on this important grant application. Montgomery County would welcome a place on the state steering committee which will plan for implementation of the grant.

Sincerely,

A handwritten signature in black ink, appearing to read "Ned J. Sifferlen".

Ned J. Sifferlen, Ph.D., Chair  
Montgomery County Family and Children First Council

Cc: Montgomery County Office of Family & Children First – Tom Kelley and Diane Luteran  
Montgomery County Positive Living for Special Populations Community Outcome Team  
– Amy Luttrell and Dick DeLon, Champions



**MONTGOMERY**  
C O U N T Y

**OFFICE OF FAMILY AND CHILDREN FIRST**

451 W. Third Street, 9th Floor  
Dayton, Ohio 45422-3100  
937-225-4695 - phone  
937-496-7714 - fax

[www.fcfc.montco.org](http://www.fcfc.montco.org)

**COUNTY COMMISSIONERS**  
Dixie J. Allen  
Charles J. Curran  
Deborah A. Lieberman

**COUNTY ADMINISTRATOR**  
Deborah A. Feldman

**DEPARTMENT DIRECTOR**  
Tom Kelley

October 13, 2006

Ms. Mary Haller  
Chief, Stakeholder Relations  
Ohio Department of Job and Family Services  
Office of Ohio Health Plans, Deputy Director's Office  
30 East Broad Street, 31<sup>st</sup> Floor  
Columbus, OH 43215

RE: ODJFS' application to the Centers for Medicaid and Medicare Services for a Money Follows the Person Grant for Ohio

Dear Ms. Haller:

On behalf of the Montgomery County Family and Children First Council, I am writing to support the Ohio Department of Job and Family Services' application to the Centers for Medicare and Medicaid Services (CMS) for a federal grant to implement Money Follows the Person in Ohio for persons who are disabled and/or elderly.

This federal grant would facilitate consumer choice by eliminating government restrictions that prevent people from taking charge of their own lives. Persons who are disabled or elderly value choosing their services, the service provider(s), and the setting in which those services are provided.

Our support for this concept assumes that Ohio will develop a system to cover these costs after the first year by allowing the Medicaid funds formerly spent on persons' institutional care to follow them to the community, rather than their having to wait for a "waiver slot". Limited local resources cannot be expected to pick up these costs.

We look forward to CMS' positive response on this important grant application. Montgomery County would welcome a place on the state steering committee which will plan for implementation of the grant.

Sincerely,

Ned J. Sifferlen, Ph.D., Chair  
Montgomery County Family and Children First Council

Cc: Montgomery County Office of Family & Children First – Tom Kelley and Diane Luteran  
Montgomery County Positive Living for Special Populations Community Outcome Team  
– Amy Luttrell and Dick DeLon, Champions