

Project Abstract

Ohio proposes a five-year MFP Rebalancing Demonstration to transition approximately 2,200 elders and people of all ages with disabilities from institutions to home and community based (HCB) alternatives. Ohio's MFP project will operate statewide to identify and serve Medicaid consumers with different care needs, but who have in common a minimum six month institutional length of stay, and the desire and capability to move from institutional to HCB settings with the right services and supports.

Ohio's MFP project will invigorate public and legislative debate regarding the right balance of Medicaid resources between institutional care and HCBS, and will examine the preadmission screening function for institutional entry. MFP will build on existing Medicaid HCBS waivers, state plan services and delivery systems, adding capacity and a coordinating "hub" for MFP participants. Ohio proposes to add HCB Demonstration and Supplemental Demonstration Services to facilitate a successful transition from institution to community. Examples include: independent living skills, peer support, benefits coordination, housing locator, service animals and home computers. Demonstration services will be phased out as people can be sustained through an HCBS waiver, Medicaid state plan, and other non-Medicaid services such as rent subsidies, food stamps, SSI/SSDI, etc. Ohio's MFP project will maintain and further expand opportunities for consumer directed care.

ODJFS, Ohio's single state Medicaid agency, will work in collaboration with Sister State Agencies, County MR/DD and behavioral health authorities, Area Agencies on Aging, institutional and HCB service providers, consumers, and a variety of advocacy organizations in the design, implementation and oversight of Ohio's MFP project.

Ohio's preliminary budget for the five-year MFP project is estimated to be \$65 million (state share) and \$157.9 million (federal share) for Qualified HCBS, HCB Demonstration, and Supplemental Demonstration Services and \$25.8 million for administrative activities (all funds).

Budget Narrative

NOTE: This narrative is also included in the Project Narrative, Part 3. Data to support the budget can be found in Appendix I.

This narrative defines the costs and methodology employed to determine the projected expenditures for each federal fiscal year of the project period. These projections are based on the projected number of MFP enrollees and the historical costs of HCBS waiver enrollees unique to each of Ohio's HCBS waiver programs. Historical HCBS waiver costs were utilized because Ohio will use the existing Ohio HCBS waiver structure to alleviate the need to transition consumers on day 366.

Ohio built the MFP program cost projection starting with the Qualified HCB services, adding the Demonstration services and finally adding the Supplemental Demonstration services. Ohio built a month-by-month phase-in schedule for each proposed enrollee beginning January 1, 2008 and extending through the September 30, 2011 project completion date. Projected costs were calculated by month using the number of projected enrollees utilizing each service each month and assuming a 30 day lag in payment to develop a total cost per federal fiscal year for the entire 5-year project.

Medicaid Administrative Costs: Average per member per month (PMPM) administrative costs for administrative case management for each HCBS waiver were calculated and multiplied by the number of projected MFP enrollees per federal fiscal year for each HCBS waiver program. The average cost of case management was inflated by 10% for MFP enrollees assuming increased activity with transition planning and inflated expenses of case management staff. Costs for administrative case management also include case management expenses provided by local entities and competitively bid

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statewide case management contracts. Administrative costs also include: required upgrades to information technology infrastructure; vendor contracts for consumer relocation referral and assistance; and, salaries, fringe benefits (including an annual 4% inflation factor beginning July of each year) and travel costs for state agency staff to implement MFP. The contract for information technology infrastructure contains a 10% increase each year to accommodate increased enrollment activity and Medicaid claims processing.

Qualified HCB Services: Ohio projected these costs by taking the total Medicaid expenditures per HCBS program PMPM for State Fiscal Year 2005 and inflating the costs by 3% per year to estimate the future costs for each program through the entire project period. The 3% growth rate is consistent with recent program growth. These PMPM projections were multiplied by the total member months based on the projected enrollment and setting to which the enrollee is likely to transition. Ohio then calculated the enhanced federal match based on the first 12 month enrollment period for each phased-in enrollee, taking into account that as MFP enrollees are phased-in, other MFP enrollees phase-out and revert back to the regular federal match rate.

HCB Demonstration Services: These services included two main categories: 1.) Services existing in one, but not all, Ohio HCBS waiver programs and 2.) New Ohio Medicaid services. The cost of services in #1 were calculated based on utilization rates and reimbursement costs as they exist within current waiver programs and projected forward, via the phased-in approach described above, for MFP enrollees who are assumed will use these services. For #2, Ohio obtained information from other State Medicaid programs and from Ohio Centers for Independent Living to gauge the cost and

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utilization for the Independent Living Skills, Benefits Coordination, and Peer Support. Projected costs and utilization assumptions were then added to MFP Qualified HCB service projections based again on the phased-in approach and enhanced federal match applied for the 12 month period per enrollee.

Supplemental Demonstration Services: Ohio proposes to add two services within this category: Home Computers, with adapted hardware and software to accommodate the communication needs of people with disabilities, and Service Animals. Ohio set per enrollee dollar caps for each and assumed utilization of each by 5% of all MFP participants each year. Some will use one or the other, some will use both and others will use neither. These costs were then phased into the MFP projected costs.

Part 1: Systems Assessment and Gap Analysis

Background

Ohio's development of long term care services and supports has occurred incrementally over many years and been driven by discrete systems and funding sources. Population-specific programs have been organized independently within separate state agencies and county/regional service delivery systems. As a result, Ohio's nursing facilities, ICFs/MR, assisted living, in-home services, supportive housing, and consumer directed services are operated as separate programs within Ohio's long term care system.

In February 2001, Governor Bob Taft and Ohio's state agencies responsible for long term care initiated systems-level change: *Ohio Access for People with Disabilities* (<http://www.ohioaccess.ohio.gov>). *Ohio Access* set a vision for the future of community-based services and supports emphasizing consumer choice, control, and autonomy. *Ohio Access* also reinvigorated dialogue with stakeholders at public forums and in system-specific commissions and committees. Governor Taft instructed the Cabinet directors of the Ohio Departments of Aging (ODA); Alcohol and Drug Addiction Services (ODADAS); Health (ODH); Job and Family Services (ODJFS); Mental Health (ODMH), and Mental Retardation and Developmental Disabilities (ODMR/DD) to use *Ohio Access* as the executive planning document for long term services and supports. He also instructed them to seek legislative support for *Ohio Access* principles, engage stakeholders to refine *Ohio Access* strategies, and implement *Ohio Access* strategies in future state budgets.

The 2004 updated version of *Ohio Access* reaffirmed Ohio's commitment to invest in home and community services and to contain cost growth in facility based institutions. It also recommended: preventing some causes of disability; providing supported employment, and

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focusing on behavioral health. Ongoing *Ohio Access* discussions involve key stakeholders primarily through the participation of the Ohio Olmstead Task Force, a broad based coalition of organizations representing people with disabilities.

As Ohio prepares its 2006 update to *Ohio Access*, it will continue to set a clear vision in which Ohio's seniors and people with disabilities may: 1) live with dignity in settings they prefer, 2) maximize their employment, self-care, interpersonal relationships, and community participation, and 3) have access to government programs which honor and support the role of families and friends who provide care.

1. Current Long Term Care Support Systems

Ohio faces many of the same challenges as other states in terms of achieving the right balance of funding and array of long term care services. According to the Scripps Gerontology Center and AARP, Ohio's number of nursing facility beds is higher than the national average. (Mehdizadeh & Applebaum, 2005; AARP 2005) With about 94,000 nursing facility beds, Ohio has a ratio of 64 beds per 1000 older adults, compared to the national average of 52 beds per 1000. Ohio administers eight home and community based services (HCBS) waivers serving about 58,000 older adults and people with disabilities. (See more detail in Part 1, Section 5). Ohio has about 375,000 additional Medicaid enrollees who are elderly or have disabilities who receive services via the Medicaid state plan from any of about 45,000 active Medicaid providers or through managed care arrangements to be implemented in early calendar 2007.

During the past decade, Ohio has enacted major legislative changes to its long term care service delivery system. In SFY 2004, Ohio's General Assembly and Governor Taft created the Ohio Commission to Reform Medicaid (OCRM) to recommend changes to Ohio's Medicaid program. *Recommendations from the Ohio Commission to Reform Medicaid* (OCRM) included

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a number of strategies to improve Ohio's delivery of long term services. (See Appendix B for more detail on OCRM recommendations and implementation status report). With the support of the Ohio General Assembly and Governor Taft, many of the Commission's recommendations have been accomplished, including:

- Creation of a Medicaid assisted living waiver which began operating July 1, 2006.
- Recommendation to convert the ICF/MR state plan service to a waiver. (This was changed subsequently to a smaller pilot project with voluntary participation by up to 200 consumers and providers. Stakeholders are meeting to create the pilot, but CMS approval has not yet been sought.)
- Creation of a Medicaid "cash and counseling" voucher for an additional 200 individuals. Ohio has begun design meetings and has initiated a vendor contract for technical assistance.
- Development of "Home First" (a Texas "Rider 37" strategy) for individuals on the wait list for PASSPORT, Ohio's 1915 C waiver for elders. As of September, 2006, 1265 nursing facility residents had been transferred into community settings and had begun receiving services from PASSPORT.
- Refinement of the assessment process for those seeking admission to nursing facilities. The focus has shifted from a functional eligibility determination to one of "long term care consultation." The consultation is targeted to Ohioans who are expected to "spend down" to Medicaid eligibility within six months of a nursing facility admission.
- Creation of a Medicaid Administrative Study Council to report on how Ohio can establish a separate Cabinet level agency to administer the Ohio Medicaid program. The

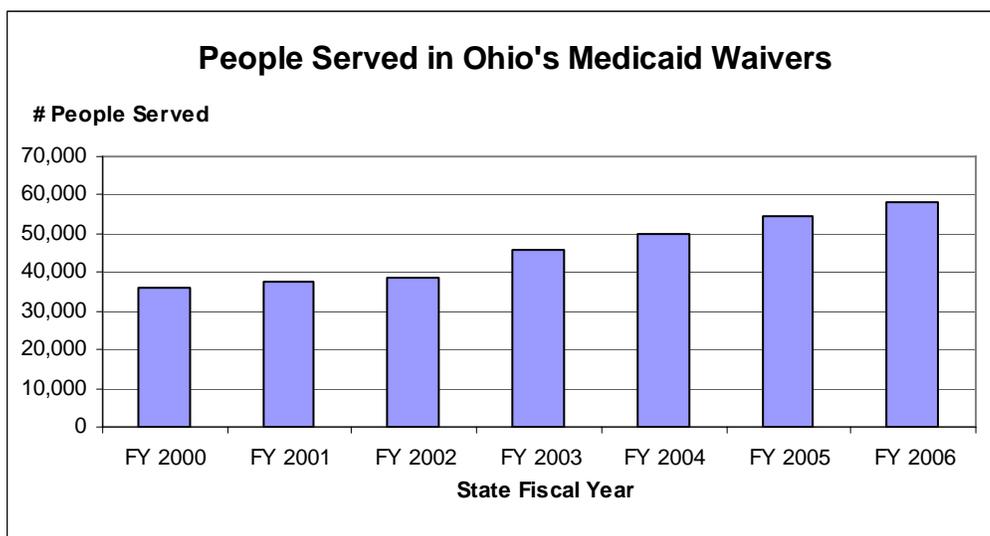
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report will also address issues related to the creation of a unified budget for long term services. The Council's final report is due by December 31, 2006.

2. Assessment of Rebalancing Resources

Increased Use of Medicaid Waivers

As recommended by the *Ohio Access* initiative, from 2001 – 2006, Ohio achieved a 55% increase in the number of people served by Medicaid home and community based waiver programs. In June 2006, 58,292 Ohioans were being served through one of eight home and community based waivers. (See chart below)



New Long Term Care Initiatives

Utilizing funding through Ohio's 2002 Real Choice Systems Change grant, Ohio developed an internet web portal for Ohioans with disabilities of all ages and their caregivers. ConnectMeOhio.org contains information on service providers and links to "BenefitsCheckup" (for financial eligibility information) and Ohio's innovative Long Term-Term Care Consumer Guide containing descriptive data, quality measures, and customer satisfaction ratings for nursing facilities and assisted living facilities. State agencies are developing a "housing annex"

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for ConnectMeOhio.org - an online directory of affordable and accessible housing for Ohioans with disabilities. The housing annex, developed with funding from the Ohio Housing Finance Agency and the 2002 Real Choice Systems Change grant, will be deployed by early calendar year 2007.

In 2005, Ohio was awarded an Aging and Disability Resource Center grant by CMS and the Federal Administration on Aging (AoA). A pilot project is being developed in Cuyahoga County (Cleveland) seeking to create a “seamless” access system for consumers. This pilot project will begin operation in October, 2006. Populations to be served include elders and younger adults with physical disabilities.

Ohio also received an Independence Plus Grant in 2003 to develop a new “self-determination” waiver in Ohio. State staff are currently developing policies in seven areas: 1) person-centered planning; 2) individual budgeting; 3) supports brokerage; 4) fiscal employer/agent; 5) participant protections; 6) quality assurance/improvement (coordinated with the QA/QI grant; and, 7) services and providers.

In SFY 2006, Ohio began several programs containing elements of “Money Follows the Person.” For example, Ohio’s “Home First” program transfers funding from the main Medicaid budget line item to the Ohio Department of Aging (ODA) for each individual transferred from a nursing facility to PASSPORT, which is funded within ODA’s budget. In July 2006 Ohio’s new assisted living waiver was also funded through a transfer of funds from the Medicaid agency to ODA. In the MR/DD system, Ohio has initiated a project to provide an opportunity for 48 individuals (44 have participated) to leave a Developmental Center and use the funds for a community option. Two additional “money follows the person” strategies were approved by the Ohio General Assembly but are not yet operational: 1) A voucher pilot program similar to “Cash

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and Counseling” targeted to consumers of any age who would otherwise be receiving services in a nursing facility, and 2) an “ICF-MR conversion” demonstration.

Housing Initiatives

In August 2004, Governor Bob Taft created the Ohio Interagency Council on Homelessness and Housing. Members include: the Ohio Housing Finance Agency (OHFA), and Ohio Department of Development, ODJFS, ODMH, ODA, ODMR/DD, the Ohio Olmstead Task Force, the Statewide Independent Living Council (SILC), Ohio Legal Rights Service, the Association of Community Development Corporations, and other housing related organizations. The Council’s Access Housing Work Group has developed recommendations to enable older Ohioans or people with disabilities to live in settings they prefer and to exercise choice in long term care services and supports. The work group has recommended changes in agency policies and procedures, model program designs, best practices, and streamlined service integration activities for people with disabilities. As noted above, Ohio is developing a statewide database of accessible and affordable housing as part of the ConnectMeOhio.org web portal.

3. Current Funding Mechanisms

Ohio is one of two states in the nation whose Medicaid reimbursement formula for nursing facilities and ICFs/MR is contained in great detail within state law. Historically, these funding formulas have been cost-reimbursed with statutory increases, resulting in rate increases greater than any other provider group within the Medicaid program.

Ohio’s 2006-2007 biennial budget made some significant progress when Governor Taft and the Ohio General Assembly approved a new price-based (vs. cost reimbursed) funding formula for nursing facilities. While still in statute, Ohio’s new nursing facility pricing system will allow market forces to work reflecting a competitive market price and eliminating

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regulatory barriers to competition.

In addition, the state's 2006-2007 biennium budget also demonstrated a commitment to HCBS by proposing a number of changes including:

- An eight percent increase (\$233 million) in state share funding for Ohio's PASSPORT waiver, allowing PASSPORT to serve over 31,000 older Ohioans in the biennium.
- A \$28 million increase for the Ohio Home Care waiver to serve 600 more adults < age 60.
- A \$4 million increase for Medicaid waivers to serve 1279 more individuals with MR/DD.
- An \$18 million (state share) in redirected Medicaid funding to develop an assisted living waiver.

4. Systems of Care, Waivers, and State Plan Amendments Supporting HCBS

Ohio's single state Medicaid agency, the Ohio Department of Job and Family Services, administers the Medicaid State Plan which includes mandatory home health services (nursing, aide, and skilled therapies) and optional private duty nursing services. ODJFS also manages Medicaid payments for nursing facilities and ICFs/MR and administers home and community-based services (HCBS) waivers. In addition to its oversight responsibility for all of Ohio's Medicaid waivers, ODJFS directly operates three of its own waiver programs: the Ohio Home Care waiver for Ohioans under age 60 with physical disabilities; the Transitions MR/DD waiver for certain Ohioans with an ICF/MR level of care, and the new Transitions Carve-Out waiver for Ohioans 60 years and older.

Because Ohio is a "home-rule" state, ODJFS contracts with 88 County Departments of Job and Family Services (CDJFS) to perform Medicaid eligibility determination functions. The CDJFSs also administer and perform eligibility and enrollment functions for other publicly funded programs such as food stamps, cash assistance, child care, child support, and child

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welfare. The various service delivery systems described below coordinate with CDJFSs for Medicaid eligibility determination and enrollment functions.

With oversight from ODJFS, a number of Cabinet level Sister State Agencies administer certain aspects of Medicaid HCBS through waivers or state plan services. Sister State Agencies have relationships with regional or county-based entities that either administer or directly provide Medicaid services to consumers. Medicaid financed long term care services and supports are organized for individuals age 60 plus; younger individuals with physical disabilities; individuals with mental health and addiction treatment needs; and individuals with mental retardation and developmental disabilities. Responsibility for serving these population groups resides with the respective Sister State Agencies.

The Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD) administers Medicaid and non-Medicaid funded programs for individuals with mental retardation and developmental disabilities. ODMR/DD provides institutional services through state operated developmental centers. ODMR/DD also licenses residential beds, including beds in private ICFs/MR. Through an interagency agreement with ODJFS, ODMR/DD also administers two HCBS Medicaid waivers: the Individual Options waiver, and the Level One waiver. Ohio's 88 County Boards of Mental Retardation and Developmental Disabilities (CBsMR/DD) serve as the point of access for these waiver services.

The Ohio Department of Aging (ODA) is responsible for services to Ohioans age 60 and over. As Ohio's State Unit on Aging, ODA is responsible to oversee the administration of the Older Americans Act. Under interagency agreement with ODJFS, ODA also manages Ohio's HCBS Medicaid waiver for those age 60 and over, the PASSPORT Waiver; the Choices Waiver (a separate 1915c waiver for PASSPORT participants who wish to self-direct their care), a new

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assisted living waiver; and Ohio's two Programs of All-Inclusive Care for the Elderly (PACE) sites. ODA also manages Ohio's Residential (Optional) State Supplement program for Ohioans age 18 and over. Under contract with ODA, Ohio's 13 Regional Area Agencies on Aging perform universal preadmission review for all nursing home applicants regardless of age or income. Applicants requiring further assessment (PASRR) for the presence of a mental illness or MR/DD are referred to one of the 88 CBsMR/DD or to an evaluator under contract with the Ohio Department of Mental Health (ODMH) to determine: 1) whether a person seeking admission to a nursing facility meets the level of care and 2) whether or not the person needs active treatment for MR/DD and/or mental illness.

The Ohio Department of Mental Health (ODMH) is responsible for both Medicaid and non-Medicaid funded services for individuals with mental health needs. Pursuant to Ohio's 1988 Mental Health Reform Act, the majority of state funding and responsibility for mental health services has been transferred from state institutions to 56 county Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards. (Six of the 56 boards are separate mental health or alcohol and drug services boards.) Similar to Ohio's county-based MR/DD system, authority for behavioral health care resides with these single and multi-county governmental entities.

ADAMHS Boards purchase services funded with Medicaid as well as local and state resources. In SFY 2004, ADAMHS Boards dedicated about \$86 million of their local tax levy dollars on Medicaid behavioral health services. Actual service delivery occurs through 450 service provider agencies in Ohio who hold provider contracts with the local Boards, and in some cases directly with ODJFS, for Medicaid services. County ADAMHS Boards also purchase psychiatric inpatient services at either state operated institutions or general hospitals.

The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) is the single

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state agency for substance abuse and addiction prevention, treatment and recovery support.

ODADAS is responsible for planning and coordinating those services statewide. In order to fulfill this responsibility, ODADAS develops and administers a comprehensive strategic plan, emphasizing abstinence as its primary goal. This plan highlights and communicates current and future initiatives aimed at enhancing access to quality, low cost prevention, treatment and recovery support services. ODADAS allocates federal and state funding to county ADAMHS boards. Each board plans and determines how to invest funds to meet their community's needs.

In SFY 2006, ODADAS's total funding (all sources) was \$177 million, the largest percent of which was from the Federal Substance Abuse Prevention and Treatment Block Grant. Medicaid represents about 33% of ODADAS's overall funding.

5. Current Expenditures

As has been true for many years, in SFY 2006, about three-quarters of Ohio's total Medicaid spending was for only about one-quarter of the enrollees, specifically those who are elderly or have chronic or disabling conditions. Ohio has about 94,000 nursing home beds, all of which will be Medicare and Medicaid certified effective January, 2007. Ohio has about 7500 ICF/MR beds in both private facilities and state run Developmental Centers. In SFY 2006, Ohio Medicaid spent \$2.65 billion for services to Medicaid consumers in NFs and another \$731 million for care in Ohio's ICFs/MR. On the HCBS waiver side, eight home and community-based Medicaid waivers are administered in Ohio by multiple state agencies. In state fiscal year 2005, Ohio Medicaid spent \$937 million on HCBS waivers to serve about 58,000 individuals on HCBS waivers. Ohio estimates that an additional 25,000 individuals are on waiting lists for HCBS services through one of Ohio's Medicaid waiver programs.

6. Current Efforts in Self-Direction

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A range of consumer-directed initiatives exist, or are being planned, for all of Ohio's HCBS waivers and programs. Ohio operates the "Choices" waiver (within PASSPORT) that allows consumers to select, hire, and fire their own direct service workers. "Choices" currently serves about 170 older people in central and rural southern Ohio counties. The state operates several other programs, such as the Alzheimer's respite project and the National Family Caregiver Support Program, that allow consumer-direction for a limited number of individuals in select regions of the state. In addition, Ohio is developing a 200 person "cash and counseling" voucher project to allow individuals to spend up to 70 percent of the cost of their care in an institutional setting.

The Ohio Home Care waiver allows consumers to select non-agency (independent) providers. Currently, provider agreements exist for approximately 6,000 non-agency providers including home health aides, RNs and LPNs. The state is planning to design and implement a Medicaid consumer-directed care waiver for Ohio Home Care Waiver enrollees. This model waiver will include delegated health-related activities and allow parents of minor individuals and spouses of individuals enrolled on the waiver to be paid providers. It will also include financial management services and other participant supports.

In 2002, Ohio implemented a statewide self-determination effort in conjunction with the county boards of MR/DD. A policy has been adopted for the use of public funds for self-direction including an approach encouraging each county to implement self determination procedures emphasizing a person-centered plan linked to an individual budget. Eighty-three of Ohio's 88 counties have implemented this process with more than 220 individuals. In 2003, Ohio received a CMS grant to develop an Independence Plus demonstration waiver.

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Development is in process.

Promoting recovery from the effects of mental illness is a fundamental goal of ODMH and the county ADAMHS Boards. To that end, Ohio's public mental health system has consistently convened consumer and family organizations, providers, and ADAMHS Boards to promote recovery, including strong components of self direction. Since Ohio's major mental health reform in the mid 1980's, ODMH and ADAMHS Boards have provided strong support for statewide and local consumer organizations and included consumers as voting members of the ADAMHS county governing boards. ODMH has established a center of excellence promoting recovery; funded "Bridges" training for consumers; and, developed and implemented a statewide "recovery" training curriculum for treatment professionals. Most recently, ODMH was awarded a Mental Health Transformations grant from the Federal Substance Abuse and Mental Health Services Agency (SAMHSA) and is incorporating principles of recovery and self direction as a fundamental part of its vision for the transformation of Ohio's mental health system.

7. Current Institutional Diversion/Transitions Programs and Processes

Ohio instituted a universal nursing home preadmission screening process in 1995 to assess the individual's need for a nursing facility level of care. This function is delegated to the Area Agencies on Aging who seek additional expertise (for PASRR) from the MR/DD and Mental Health systems regarding individuals who may need active treatment for mental illness or a developmental disability. In SFY 2006, ODA and the AAA's expanded their preadmission screening role to include diversionary preadmission counseling. In this way, they focus not just on assessing the level of care needed by an individual, but also on alternatives to institutional placement. As stated above, Ohio has also implemented "Home First" modeled after the Texas

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“Rider 37” to transfer certain nursing facility residents to PASSPORT.

In 2002, ODJFS was awarded a Nursing Facility Transitions grant by CMS and used this grant to establish the “Access Success” project for Medicaid enrollees who are able to leave a nursing facility but cannot afford the cost of returning to a community setting (modifications to their home, first month’s rent, etc). “Access Success” provides up to \$2,000 per person for transitional relocation expenses for NF residents who wish to live independently or with a family member. Since its implementation in 2004 until the end of the grant period in September, 2006, 117 people have been transferred (via contractual arrangements with two chapters of the Ohio Easter Seals and two Ohio Centers for Independent Living, as well as efforts within ODJFS) from a NF to their own home. Of these 117 individuals, 29% were enrolled in existing HCBS waivers, 43% only needed Medicaid services through the state plan, and the remaining 28% are no longer receiving any Medicaid services.

Although small in size, “Access Success” has become an important part of Ohio’s strategy to increase HCBS options for institutionalized Ohioans. Whether or not Ohio is awarded a Money Follows the Person grant, ODJFS plans to continue “Access Success” with state-only funds. If awarded an MFP grant, Ohio will use “Access Success” to serve any individuals who don’t meet the MFP participation criterion.

8. Addressing System Shortcomings and Gaps

Ohio faces a number of challenges in rebalancing its resources for long term services and supports. In SFY 2004 (the last year for which this rate was calculated) Ohio’s overall occupancy rate (including all payers) for nursing facilities was 87% and the Medicaid utilization rate was just under 67%. Ohio has about 13,000 empty nursing facility beds. Shifting resources between institutions and home and community-based services is a dominant political issue each

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budget year. Other challenges to Ohio's system include:

- Although Ohio allows the “banking” of unused nursing facility beds, there is no mechanism in place to permanently close them.
- Ohio lacks a state funded, in-home services program (for non-Medicaid enrollees)
- Ohio does not cover personal care services as a discreet optional service under Medicaid.
- Ohio's Medicaid financial eligibility is more restrictive (under Section 209B) than most other states regarding income and asset levels for ABD Medicaid eligibility.
- An estimated 25,000 older adults and people with disabilities are on waiting lists for HCBS waiver services through the Ohio's Home Care Waiver, with a wait list of 1,837; PASSPORT with a wait list of 1,330; and individuals of all ages with MR/DD with a combined wait list of 22,000 as reported by 88 County Boards of MR/DD.

Indeed, Ohio's growth in HCBS alternatives over the past 6 years has not been funded by reducing the number of Medicaid funded institutional beds or by redirecting Medicaid funding from institutions. Ohio's HCBS waiver expansions have required an influx of new local, state and federal Medicaid dollars focused specifically on expanding access to Medicaid waivers and state plan services. Consumer choice for HCBS alternatives is reflected in Ohio's reduced utilization of nursing facilities. In the period 1993 to 2003, occupancy rates in Ohio nursing facilities dropped from 92% to 87% (Applebaum & Mehdizadeh, 2005). Additionally, the number of individuals residing in state-operated developmental centers has dropped from 2,000 to 1,700 in the last five years, and two state operated developmental centers have been closed.

These facts show that Ohio's system of long term services and supports has begun to “rebalance” simply through strong consumer demand. However, Ohio's funding for LTC

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services has not yet been rebalanced since the majority of Medicaid dollars are still being spent on facility-based care. Ohio has many diverse stakeholder groups who actively participate in discussions related to public funding for long term care. The varying interests and policy suggestions of nursing facilities, ICFs/MR, service providers, consumer advocates, county governmental entities, and the state agencies themselves, has made change difficult.

Rebalancing Ohio's financing of LTC will require the active involvement of major stakeholders, including members of the Ohio General Assembly, and a mechanism to reach a compromise among key stakeholders.

Ohio will use the MFP Rebalancing Demonstration to help address these challenges by:

- Transitioning approximately 2200 people from institutional to HCBS waiver settings.
- Engaging key stakeholders in ongoing dialogue regarding issues such as how to recruit MFP participants; develop needed housing; implement supported employment; and how to approach the subject of institutional bed closure.
- Through *Ohio Access*, maintain continuous quality improvement of existing system components to address both participant choice and program effectiveness.

9. Program Collaboration

Governor Taft's "*Ohio Access Initiative*" is the vehicle that has cemented partnerships among Cabinet agencies and key stakeholders to work toward common goals concerning Ohio's long term services and supports system. At the state agency level, to date, these partnerships have been strategic and purposeful. The Governor's *Ohio Access* group includes the cabinet directors of all state agencies responsible for long term care services including the Office of Budget and Management and the Ohio Department of Health. The Governor's Executive Assistant for Human Services chairs these meetings.

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In addition to the state agency collaborations, the Ohio Olmstead Task Force (OOTF) is one of Ohio's greatest assets for implementing MFP. This task force has convened consumers and advocates of all ages and disabilities to support a common agenda – to make Ohio's system of long term services and supports responsive to consumers. The OOTF has been instrumental in developing Ohio's MFP grant proposal and has provided guidance on other “Real Choice Systems Change” grants proposed and/or received by Ohio. Members of the OOTF also provide ongoing oversight and recommend policy changes to Ohio's long term services and supports.

Ohio's MFP Rebalancing Demonstration will build on these existing partnerships by actively involving consumers and advocates, advocacy organizations such as AARP, the Arc of Ohio, and Centers for Independent Living. Ohio's MFP proposal will also seek the active participation of Ohio's providers including nursing facility providers and associations, ICF/MR providers and associations and HCBS providers whether agency-based or independent.

10. Quality Management

Ohio's long term care service delivery systems already have a number of quality approaches in place. Through a 2003 Real Choice Systems Change Quality Assurance and Quality Improvement in Home and Community-Based Services (QA/QI in HCBS) grant Ohio has implemented the following quality management strategies:

- ODMR/DD has begun developing and applying a quality framework (compatible with CMS's framework) to Ohio's service system for individuals with developmental disabilities. ODMR/DD has also developed a quality information management system and is training professionals and families in the basics of quality assurance as well as how to identify and address quality issues across the system.

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- Since 2003, ODJFS and ODA have utilized the CMS Quality Framework and the Participant Experience Survey questions in its quality assurance reviews. In 2004, ODJFS created a comprehensive quality management plan for the Medicaid waivers it manages based on the CMS Quality Framework. This plan includes outcomes, process measures and activities focused on customer satisfaction measurement as well as waiver assurance compliance. In addition, regional Quality Improvement Committees have been formed which include consumer representatives.
- The Ohio Department of Aging has used several grants from the Federal AoA to develop quality assurance and improvement systems for PASSPORT and Older Americans Act services. In fact, ODA, in conjunction with the Miami University Scripps Gerontology Center, has recently implemented a grant under the National Family Caregiver Support Program to develop and test an outcomes-based quality management system.
- The Ohio Department of Mental Health has developed and used the Ohio Consumer Outcomes to measure progress made by people being served by the public mental health system. In addition, Ohio's MH system has made a concerted effort to implement Evidence-Based Practices. ODMH, in partnership with several other organizations, has developed nine Coordinating Centers of Excellence to promote best practices. In addition, ODMH has promoted individualization and empowerment through the statewide use of consumer outcomes; use of a standardized electronic format for treatment planning and documentation, and, a statewide initiative called SOQIC (Solutions for Ohio's Quality Improvement and Compliance) dedicated to improving quality, reducing costs, and ensuring compliance with federal requirements.

Information processing and technology is essential in measuring quality and addressing

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deficiencies. Although Ohio's separate state agencies currently have individual information technology systems, the state has undertaken a multi-year planning and implementation process to completely reform Ohio's antiquated Medicaid Management Information System with a Medicaid Information Technology System (MITS). MITS, designed based on the Federal MITA architecture, will build on Ohio's existing Data Warehouse and Medstat Decision Support Systems to create a common Medicaid information technology system across agencies and overcome existing interoperability concerns among systems. (See more on this topic in Part Two, Element Nine).

11. Necessary Legislative Changes and Other Needed Changes

While much debate has occurred during the past ten years regarding the importance of increasing access to HCBS waivers as alternatives to institutions, consensus does not yet exist in Ohio regarding what constitutes "the right balance" of resources between institutional and HCBS, nor how such a "balance" can be accomplished. If Ohio receives an MFP grant, the Administration will urge policy makers and key stakeholders to engage in renewed debate on these issues, including:

- What is an adequate supply and distribution of institutional beds? Can funding for unutilized capacity in institutions really be transferred to HCBS settings? If so, using what mechanisms and policy changes, and within what timeframe?
- How do quality assurance mechanisms compare in HCBS settings and institutional facilities? How can government authorities measure and assure quality, health and safety in service arrangements that maximize personal choice and self-direction?
- Is there a significant difference in the quality and consumer health outcomes in agency-based service models vs. consumer-directed models?

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- How can new and expanded capacity for HCBS services and supports be configured to not increase Medicaid costs? Can some institutional costs be redirected so money can really follow a person out of an institution?

SFY 2007 is a year of political transition for Ohio. Governor Bob Taft is term limited and cannot seek re-election. However, both gubernatorial candidates have expressed support for reducing Ohio Medicaid spending on facility-based care and increasing spending on consumer directed alternatives. Therefore, we anticipate ongoing support for MFP regardless of who is elected Ohio's next Governor.

Part 2: Demonstration Design

1. Demonstration Design – Pre-Implementation Phase

Ohio proposes a five year MFP project targeting several different populations who have spent at least six months in a qualified institutional setting. These Medicaid eligible target populations include:

- People with mental retardation or other developmental disabilities;
- Adults and children (age 59 or younger) with physical, mental or emotional disabilities equivalent to the SSI definition (including traumatic brain injury);
- Elders age 60 plus;
- Individuals with mental illnesses living in NFs.

In anticipation of Ohio's receipt of an MFP grant, beginning in December, 2006, ODJFS staff will begin laying the groundwork for operational protocols that will later be submitted to CMS. A Project Director will be appointed and will begin drafting out a master work plan and implementation timeline for Ohio's MFP project. The Project Director will also begin identifying participants for the MFP Planning and Advisory Group and the Interagency Steering Committee. Finally, the Project Director will assure that Ohio's MFP project is reflected in Ohio's SFY 2008-2009 biennial budget submission for legislative introduction in March 2007.

Element 1: Trusted, Visible, and Reliable System for Information and Services

Ohio does not have a "single point of entry" for long term care services. Ohio's services and systems of care differ by age group and types of chronic disability. Long term care in Ohio is often population-specific and organized independently within separate Cabinet state agencies and local service delivery systems such as Area Agencies on Aging, County Boards of MR/DD and Alcohol Drug Addiction and Mental Health Services Boards. Nevertheless, when Medicaid

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pays for long term care, all service delivery systems are connected through ODJFS, Ohio's single state Medicaid agency.

Ohio does have a universal preadmission screening function at the "front door" for individuals seeking nursing facility care. This function, consisting of level of care assessments for those seeking Medicaid coverage, and preadmission screening and resident review (PASRR) for all individuals seeking entry into NFs. Currently, however, as noted earlier in this document, Ohio has chosen to delegate certain aspects of institutional assessment and placement to the service delivery system most relevant to the individual's primary diagnosis.

Because Ohio has various points of entry for long term care services and determination of need are performed by multiple agencies, a diffuse and sometimes disconnected system exists for preadmission screening and level of care determination. Scrutinizing "the front door" to Medicaid funded institutional care is an essential piece of rebalancing Ohio's long term care expenditures, and this activity helps to pave the way for money to follow the person when he or she leaves an institutional setting.

Ohio plans to address these challenges by creating a new full time position to redesign Ohio's existing NF and ICF/MR assessment and entry process. This person will lead a team of internal and external stakeholders (e.g., sister agencies, consumers, advocates, providers, local governments) to redesign preadmission activities including level of care activities for Medicaid long term care benefits including NFs, ICFs/MR, and waiver programs. Needed changes will be made to Ohio Administrative Code rules and interagency agreements between ODJFS and Sister state agencies as well as to contracts with any external vendors performing aspects of preadmission activities. ODJFS staff have already begun to review a variety of systems changes and moving away from a paper based system to one that is electronic and provides for central

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data collection. After implementation, ODJFS staff will have access to level of care and pre-admission screening information to use in program planning and in monitoring metrics, including: number of admissions, lengths of stay, and overall utilization within Ohio's institutional care settings.

In addition to scrutinizing "the institutional front door", Ohio's MFP project will develop a centralized "hub" for identification, tracking and referral of MFP participants for purposes of research, funding, and accountability and to ensure MFP participants are referred to the proper service delivery system to meet their individual needs. (A pictorial representation and more detailed description of this "hub" activity is included in Appendix G.) Ohio will develop more detailed descriptions and protocols for this "hub" function during the pre-implementation phase of the MFP grant.

As stated earlier, Ohio's MFP proposal will use existing health care and human services delivery systems as the fundamental support network for MFP participants. For example, existing 1915 C waivers and specialty state plan services managed by the Ohio Department of MR/DD and the County Boards of MR/DD will be the main supports for individuals with MR/DD. The Ohio Department of Aging and its Area Agencies on Aging who manage the PASSPORT and Assisted Living Waivers will serve this same function for elders. The Ohio Home Care Waiver will serve this capacity for adults and children with physical disabilities. For individuals with mental illnesses or addictions living in qualified institutions, the Ohio Departments of Mental Health and Alcohol and Drug Addiction Services and their county behavioral health authorities, Ohio's ADAMHS boards, will provide primary support and behavioral health treatment services.

Element 2: Screening, Identifying and Assessing Potential MFP Candidates

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In general, Ohio proposes to identify and assess MFP participants by utilizing the many existing resources within the long term care service delivery system. Identification of MFP participants will occur using a variety of informational sources including:

- Nursing Facility Minimum Data Set (MDS) questions Q1a, b and c which ask if an institutional resident wants to go home; if they have a family member or significant other who is supportive of them moving home; and, a prediction, performed by a medical professional, of their overall length of stay.
- Ohio's existing Data Warehouse and Medicaid Decision Support System (DSS) which can generate sophisticated individual claims level analyses of all Medicaid consumers. Preliminary data analyses have already been done to inform this grant submission, but regular updates will be performed to remain current with the "rolling six month" length of stay minimum criterion.
- Referrals from service providers and advocacy organizations including: facility social workers and discharge planners; nurse assessors and facility surveyors working for ODJFS and the Ohio Department of Health; the Office of the State Long Term Care Ombudsman (including 80 paid staff and 550 volunteers throughout Ohio); Centers for Independent Living; Area Agency on Aging staff who perform preadmission screening and long term care consultations; County Boards of MR/DD and County ADAMHS Boards.

Ohio's MFP project will build on "lessons learned" from its state-only funded project, Ohio "Access Success", which has been in existence, on a much smaller scale, since 2004. "Access Success" has successfully transitioned 117 people from nursing homes into home or community settings by providing critical one-time relocation services costing less than \$2,000. Since Ohio's MFP project will be quite a bit larger than "Access Success" in terms of people,

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dollars and services, Ohio proposes to purchase the services of one of more external vendors with expertise in the detailed work of transition planning for MFP individuals. Ohio utilized this strategy in “Access Success” via contracts with Easter Seals of Ohio and a pending contract with the Ohio Statewide Association of Independent Living Centers. Ohio will develop greater detail on this proposed use of external contractors as part of implementation planning.

Assessment of MFP participants with the highest probability of success will require individualized person-centered planning and attention to risk management. Ohio will build on the experience of other states regarding these types of projects and utilize technical assistance from resources such as the Independent Living Research Utilization and Ohio’s network of Centers for Independent Living.

To be successful, Ohio’s MFP project will add service capacity, in terms of increased “slots”, to existing 1915 C waivers. In addition, Ohio proposes that MFP participants will have access, through the category of HCB Demonstration Services, to all services currently covered within 1915 C waivers. Finally, Ohio proposes to create several new HCBS demonstration services and supplemental demonstration services. (More detail is included in Element 4 below).

Element 3: Mechanisms for Flexible Financing

Ohio proposes to utilize flexible financing for any individual identified who wishes to, and is capable of, successfully transitioning from an institutional to a community setting. In order to support this goal, Medicaid resources currently used to fund services for these individuals in institutional settings must be “freed up” to fund HCBS. This goal is consistent with the principles of *Ohio Access*. However achieving this goal will only be possible with the advocacy and partnership of both CMS and Ohio’s policy makers. As stated earlier, Ohio views MFP as added fuel to further advance the goals already underway. In this way, MFP will expand

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the capacity of existing waivers; create new services to support individuals transitioning to community settings; and provide incentives for Ohio's housing owners and financiers to create and maintain more accessible housing utilizing MFP resources to make home modifications. Enhanced matching funds will be applied to eligible services for MFP participants and those who are not MFP eligible will be served using existing financing mechanisms. In addition, Ohio plans to continue current state-only funding under the "Access Success" project to purchase relocation services and supports to individuals who are not eligible for MFP funding.

Ohio's MFP project will reinvigorate debate regarding the right balance of Medicaid funding for institutional versus HCBS. ODJFS and sister state agencies will raise the issue of redirecting resources from institutions, where consumer demand is decreasing, to more fully meet the increased consumer demand for home and community-based services.

Element 4: Availability of Supportive Services

Following CMS guidance, Ohio proposes to provide MFP participants with categories of service described below and in the Ohio Profile in Appendix D.

1. Qualified HCB Services will include all medically necessary services contained within Ohio's Medicaid state plan and specialty services available to participants in one of Ohio's HCBS waivers. These services will be continued, as medically necessary, for all eligible individuals during and after the conclusion of the MFP demonstration period. The only service contemplated for addition to Ohio's existing Qualified HCBS array is "Community Transition Service" which Ohio plans to add to all 1915 C waivers that don't currently include it. (However, until Ohio implements this change, "Community Transition Service" will be included as an HCB Demonstration Service for MFP.)

2. Ohio proposes to add **HCB Demonstration Services** that will be MFP population specific

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and time limited. They are:

- a) **Independent Living Skills** - Mobility training, financial management, community integration, self-advocacy, skills development;
- b) **Peer Support** - Caregiver support and services management; resource connection, transition planning and readiness;
- c) **Benefits Coordination** - Assessing potential eligibility and assisting with application for public and private benefits and programs available in the person's home community; and
- d) **Housing Locator Service** – A one time service capped at \$1000 per person, including activities including: identifying potential housing options that meet the individual needs and preferences of an MFP participant; investigating and arranging rental subsidies; Enrolling the individual on wait lists for publicly subsidized housing; developing a plan for visiting the housing and meeting the landlord; assessing the need for home modification and developing a plan for modification; conducting a final walk-through and “punch list” post construction to correct any problems before move in.

Due to the unique qualifications required to provide these services, the research and demonstration aspect of the MFP project, and the small number of MFP participants at any one time, Ohio proposes to provide these services by contracting with a limited number of select vendors. For purposes of administrative simplicity and programmatic integrity, Ohio proposes contracting with a few existing provider networks for these services.

Ohio also proposes to add within the HCB Demonstration category four services that already exist within one, but not all, of Ohio's 1915 C waivers. Ohio will attempt to enroll MFP participants into the waiver that most closely matches their service needs. However, this may not always be possible or the need may not be apparent at the time of enrollment.

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Therefore, Ohio proposes to include them as HCB Demonstration Services. They are: Day Habilitation; Supported Employment; Respite Care; Social work and Counseling; Nutrition consultation; and Extended Private Duty Nursing.

3. Ohio will also offer **Supplemental Demonstration Services** to MFP participants.

Currently, Ohio plans to offer the purchase of service animals and adapted home computers.

However other services may be added during the operational planning period.

4. Increasing the Supply of Affordable and Accessible Housing

As stated in the CMS' MFP guidance, affordable and accessible housing is critical to the success of rebalancing the delivery of long term care services. Ohio has begun conversations with colleagues in the Ohio Department of Development and the Ohio Housing Finance Agency (see support letters from each, attached) to assist with Ohio's MFP project. The following strategies are proposed to increase the availability of accessible, affordable housing for MFP participants:

- **Creating a "bridge" rent subsidy**, using non-MFP funding, to fill the gap while individuals wait for access to Section 8 or other publicly subsidized housing. We hope to fund this bridge subsidy with a combination of money from the Ohio Housing Finance Agency and any other Federal, state, local, or private funds that can be leveraged. The size of the fund, the dollar amount of subsidies, and the number of people it will support will depend on the amount of funding generated from these non-Medicaid sources. Payments from the "bridge subsidy" would end once an individual moves onto regular publicly subsidized housing or has sufficient income to be able to independently afford the cost of their housing. The subsidy funds may then be redirected toward another needy MFP participant.
- Engaging Ohio's local Public Housing Authorities to consider modifying their local preferences to ensure that MFP participants can have preferred status on the waiting list for

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Section 8 or Public Housing.

- Using MFP funding to make physical or technological home modifications or purchase adaptive equipment to facilitate sustained community living.
- Creating a comprehensive resource guide to public housing assistance for anyone assisting an MFP participant in seeking affordable, accessible housing. This information resource guide will include resources such as: 1) A description of the “ConnectMeOhio.org” web site and its soon to be developed Housing Annex; 2) A listing of Public Housing authorities by city and county, including contact names and information; 3) A listing of all Project Based Section 8 housing projects that have received funding for the accessible housing set-aside percentage; 4) A discussion guide for conversations with property owners/managers related to gaining access to subsidized housing and emphasizing the funding provided under MFP for home modifications.

Element 5: Community Workforce

Discussion regarding the availability of skilled and non-skilled home care workers is not new in Ohio. This concern has been a subject of ongoing work as part of the Governor’s *Ohio Access Initiative*. The adequacy of Ohio’s home health care workforce is an ongoing public policy issue that MFP alone cannot solve. The solution will require the broader attention of the Governor and Ohio’s General Assembly to a multifaceted strategy including education and training, development of a career path for these workers, and an adequate minimum wage both within Ohio and at the Federal level.

In the short term, Ohio Medicaid has created some needed HCBS provider capacity by expanding the number of independent providers available to Medicaid enrollees. However, with this expansion has also come a need for expanded quality oversight and investigation of this part

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of the work force. This would obviously need to continue under Ohio's MFP project. In addition, Ohio is already developing several self directed options (most associated with existing Medicaid waivers) which will allow family members or non-certified home care workers to perform Medicaid funded services and supports. Both of these strategies will help to increase the supply of home health care workers for MFP participants.

Element 6: Self Direction of Services

As noted in Part 1, Ohio has already or is developing a range of self directed options for home and community based care including the Choices waiver (within PASSPORT) for older adults; the use of non-agency providers within the Ohio Home Care waiver, the proposed self directed care waiver beginning with the 2008-2009 biennium; the 200 person "cash and counseling" voucher program; and, the MR/DD Independent Options waiver. These will be continued and expanded within the MFP project. In addition, Ohio proposes the concept of hiring a fiscal intermediary (FI) for MFP to fill several administrative roles including performing tasks needed for MFP (and potentially other Medicaid) consumers who wish to completely self direct their care. (More detail on the role of the Fiscal Intermediary is included in Part 3.)

Element 7: Transition Coordination

Successful transition of MFP participants will require individualized care planning and knowledge of the community resources available for the geographic region to which the person will be moving. Ohio will utilize relevant learning from our "Access Success" project and the experience of other states in the stages of assessment, pre-planning, actual relocation and follow up for all MFP participants.

Key Ohio stakeholders, including consumers and advocacy organizations, have advised that continuity in the person or team relating to the consumer during the transition planning and

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placement process will be critical to build trust and self-confidence, particularly among individuals who have been living in an institutional setting for a period of time. In addition, we have received input that transition planners need specific knowledge of the formal and informal community resources and supports for newly transitioned individuals. Ohio proposes to utilize a limited number of contractual entities located regionally to provide transitional planning and placement services. Protocols will be developed as part of the pre-implementation plan for transition and care planning that will build needed capacity, expertise and provide continuity until the person's care can be transferred to existing Qualified HCB Services (e.g. 1915 C waivers or state plan services).

Element 8: Quality Management

As described in Part 1, Ohio already has a number of quality processes in place or in development for its various home and community based services programs. More can be done, though, to develop a comprehensive and integrated quality management strategy across the long term care system. In Spring, 2006, ODJFS created an HCBS Quality Steering Committee to facilitate the improvement of quality of services provided to consumers while satisfying federal expectations and requirements. The Quality Steering Committee currently provides a forum for ODJFS and its sister agencies to:

- Identify core performance measures that are relevant to all systems,
- Examine performance across HCBS waivers and support implementation of best practices,
- Exchange resources, information and ideas,
- Facilitate the use of national technical assistance resources, and
- Ensure the existence of a full quality improvement cycle, including performance data.

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Because it is already focused on quality management within existing 1915 C waivers, the Quality Steering Committee will play a key role in building an MFP quality management strategy. (See more detail in the Implementation Phase, below)

Element 9: Health Information Technology

Ohio is undertaking a complete reformation of its 20 year-old Medicaid information technology system through the design and implementation of our MITS project which has received federal designation as an early adopter of the MITA architecture. Ohio is in the procurement stage for MITS, having completed extensive analyses of business processes and advanced planning documentation. Currently, competitively bid proposals are being reviewed. A vendor will be selected within the next few months to begin the on-site development.

In addition, Ohio has already developed a sophisticated Data Warehouse and Medicaid Decision Support System, both of which will soon be expanded to incorporate new data sources including those from other service delivery systems such as mental health, MR/DD and Public Health. During the development phase of Ohio's MITS, and expansions of the Data Warehouse and Decision Support System, ODJFS proposes to hire a vendor, the fiscal intermediary mentioned above and also in Part 3, to assist in collecting specific information needed to manage Ohio's MFP project, identify and track participants, and convert claims data to any format needed for billing or research purposes. The work of this fiscal intermediary will also be key to crossing the IT substructures of Ohio's multiple sister state agencies and their sub-recipients who administer portions of Ohio Medicaid's state plan services and 1915 C waivers.

In addition, Ohio has just submitted an application for a Medicaid Transformation grant that, if awarded, will allow Ohio to develop electronic medical records for Ohio Medicaid enrollees. Although the implementation of such technology is still a few years away, planning

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has already begun to reach this goal.

Element 10: Cultural Competence

Ohio's MFP proposal will address the racial, ethnic, and cultural values, preferences, and disparities that exist among MFP populations. Data collection for MFP participants will include race and gender demographics. In addition, emphasis will be placed on relocating the person in the geographic location he/she considers "home" in terms of life experience and informal supports. It will be important that city dwellers are able to return to the city, and those used to living in "the country" can return there. This will be a particular concern for Ohio's Appalachian population and will require additional planning during the MFP pre-implementation phase.

In addition, Ohio will extract data to determine the linguistic or translation needs of the participating MFP population utilizing data from the Ohio Medicaid Decision Support System. This information will be used to ensure home care providers meet existing requirements to assure linguistic access to Medicaid enrollees. Many Medicaid printed materials are already available in Spanish, and access to medical interpreters is available through the AT&T Language line.

Element 11: Interagency and Public / Private Partnerships

As stated above, Ohio has a strong history of interagency collaboration as part of the *Ohio Access* initiative and will build on this for MFP. Ohio's MFP planning process has already engaged the active participation of key stakeholders including public and private provider agencies; consumers and advocacy organizations; Sister State Agencies and their County or regional counterparts. This collaborative approach will expand in the pre-implementation and implementation phases of Ohio's MFP project. As noted above, ODJFS intends to convene an

MFP Planning and Advisory Group comprised of key stakeholders, including consumers and advocates, to advise and guide planning and implementation and to provide ongoing feedback throughout the five-year grant period. These partnerships existed prior to MFP and they will continue beyond Ohio's MFP grant.

2. Demonstration Design – The Implementation Phase

a) Populations to be served (See Also Ohio Profile in Appendix D)

As noted above, Ohio's five year MFP project will target multiple subpopulations for MFP, all of whom have had a minimum continuous length of stay of six months in some combination of hospital, nursing facility and/or ICF/MR. Ohio's MFP proposal will operate statewide. The location of an individual's placement will depend on their individual preference; the availability of accessible, affordable housing; supportive HCB services; and the location of their informal support systems. The importance of informal supports is a main reason why Ohio proposes to use the six month minimum length of stay for MFP participants. Ohio's experience with our "Access Success" project has shown that as institutional length of stay increases, the probability of having housing and informal support networks in place decreases, and so does the probability of successful transition to the community.

We expect some individuals will return to their own homes or the homes of family members or significant others. Some may need to find a new home or apartment and will benefit from HCB demonstration and supplemental demonstration services. Still others may need services appropriately delivered via assisted living, and so will be served in assisted living facilities that meet the MFP definition of qualified community facilities. Ohio's new assisted living law includes apartment that are operated by public housing authorities as eligible assisted

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living Medicaid waiver providers in Ohio. Assisted living participants who elect to be served in these apartments will have leases with the public housing authority that allow the consumer to exercise “total domain and control” over their living area.

Specific plans for how and when to phase in specific subpopulations will be established as part of the pre-implementation planning and will depend the alchemy of combining critical factors mentioned above including identification and recruitment of individuals; availability of needed services and support networks; and availability of affordable and accessible housing.

In addition, Ohio proposes to coordinate the placement of individuals in NFs or ICFs/MR in conjunction with establishing mechanisms to limit “backfilling” of vacated institutional beds and discussions related to the possibility of closing unutilized beds. Both of these topics will be essential to accomplish the core MFP goal of rebalancing Ohio’s Medicaid spending for long term care services. Linked to these proposals is also a proposal to redesign of Ohio’s institutional “front door” (See more on this topic in Part 2, Element 1).

At this point in time, Ohio does not propose a particular order of placement among MFP subpopulations. The order in which people are identified and transferred from institutions to HCB settings will depend on their individual circumstances, the readiness of their home of choice and the capability of their service delivery network. Below are some characteristics of various subpopulations which may affect their order of identification and placement.

Older Ohioans, age 60 plus will primarily be identified by the existing Aging Service Delivery Network in Ohio. This population will have the benefit of Ohio’s PASSPORT waiver, the largest and the oldest of our 1915 C waivers. This sub-population also has access to Ohio’s “Home First” door into the PASSPORT waiver and access to services via Ohio’s new Assisted Living Waiver. It is likely that fewer of these individuals will need subsidized housing, as many

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may have an already established home or informal support system to which they can return from an institution. However, home modifications may be frequently needed among this population.

Non-Elderly adults and children with chronic physical, developmental, or mental disabilities will be identified and transitioned as they and their supportive services are ready.

Some of these individuals will be eligible for Ohio's Home Care Waiver or the related "Transitions" waivers. Others will be eligible for one of the MR/DD waivers. Still others won't want or need the intensity of services provided via Medicaid waivers due to personal preference or the presence of informal supports. These individuals will simply be transitioned with Medicaid state plan services and MFP demonstration and supplemental services as needed.

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People with mental health or addiction treatment needs will likely have complex service needs due to the likelihood of “co-morbidities.” In addition, some of these individuals may no longer meet an institutional level of care upon their discharge and therefore not be eligible for placement into a Medicaid waiver. (Ohio has discussed the possibility of utilizing the DRA state plan option for this subpopulation pending the review of CMS’s final guidance.) Finally, identifying these individuals in institutional settings may also be more difficult. To that end, ODJFS will propose for the SFY 2008-09 biennium a targeted area review of NF residents in which Medicaid nurses will perform on site case reviews to locate residents with mental illnesses who might benefit from transitioning to a community setting.

Ohioans with MR/DD have a unique opportunity resulting from a recent agreement to settle Ohio’s 17 year old “Martin v. Taft” lawsuit. If endorsed and funded by the next Governor and General Assembly, the settlement will provide funding for an additional 1,500 Ohioans with MR/DD to be served through Medicaid-funded home and community based waivers. (Altogether, Ohio’s existing Individual Options and Level One waivers currently serve more than 15,000 individuals with home and community based services.) The coincidental timing of Money Follows the Person and the Martin settlement provide a unique opportunity to further expand the availability of HCBS for Ohioans of all ages with developmental disabilities.

Finally, Ohio’s state-only funded “Access Success” project will be offered for MFP participants do not want or are not eligible for Medicaid services beyond their institutional stay. “Access Success” will provide basic community transition services and refer or link them to other benefits or community resources for which they are eligible.

3. Anticipated requests for waivers or SPAs to operate MFP

Because Ohio proposes to use MFP to build on existing 1915C waivers, we do not anticipate requesting any new HCBS waivers. However, Ohio may need to amend existing waivers to accommodate the changes being proposed within MFP such as the addition of community transition services to waivers that currently lack them.

Ohio likely will not request waivers of statewideness or comparability since Ohio's MFP project will be implemented statewide via existing state plan and 1915 C waivers. However, Ohio does propose to utilize only a limited provider network for the new HCBS Demonstration services. In addition, depending on the types of additional self direction options planned for Ohio's MFP proposal, we may also request a waiver of some aspects of the provider agreement requirements for MFP providers and participants.

4. Methods to Increase Expenditures for HCBS

Ohio proposes to implement Money Follows the Person as a means to increase Medicaid spending for HCBS services and the number of institutionalized individuals receiving them while, at the same time, decreasing the utilization of institutional services in response to consumer demand.

Ohio's proposed "fiscal sizing" of the MFP project will depend on a combination of factors, all of which link to state biennial budget and legislative action for 2008-2009 and years beyond. However, for the purposes of this grant application, Ohio has projected MFP participation and costs as illustrated in the narrative in Part 3 and the accompanying data in Appendix I. In summary, Ohio projects that approximately 2,300 consumers will be successfully transitioned during the five year demonstration period. Budget projections assume a 3 percent inflationary increase in the per member per month (PM/PM) spending each year.

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MFP will enable Ohio to expand HCBS waivers beginning in SFY 2008 and 2009 and to further expand those waivers, as well as state plan services, in future years for individuals who wish to move from institutional to community settings. Given the current fiscal environment, it is unlikely that Ohio's Governor and General Assembly will be able to support a large increase in the state's Medicaid budget. Furthermore, Ohio recently enacted a State Appropriation Limitation (SAL), effective in SFY 2008, which will limit to 3.5% any growth in state general revenue fund expenditures in a single fiscal year. Because of the Medicaid entitlement, especially for a chronically disabled population, MFP related expansions will be an ongoing liability beyond the period of enhanced FMAP. Therefore, Ohio will use MFP as an opportunity to continue debate regarding how current resources spent on institutional care can be "rebalanced" in order to "follow" MFP participants as they transition back to the community. This realignment of current resources will be critical to the success of Ohio's MFP proposal and the state's ability to keep expenditures within the limitations set by the SAL.

5. Benchmarks to Measure Progress in Rebalancing

Ohio will empirically measure progress in rebalancing long term spending using the following benchmarks annually and cumulatively from FFY 2006 (pre-MFP grant) through FFY 2011 (year five of MFP):

- An increase in the number of individuals enrolled in Ohio's Medicaid waivers;
- An increase, beyond predicted normal program growth, in total Medicaid spending for waiver and state plan services, especially for MFP participants;
- An increase in the number of individuals transitioned from qualified institutions to qualified HCBS settings including waivers, Medicaid state plan, or non-Medicaid;
- A decrease in the number of Medicaid enrollees residing in NFs and ICFs/MR and a

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decrease in the number of Medicaid funded “bed days” utilized in each;

- An increase in the number of nursing facility or ICF/MR beds that are “closed” to new Medicaid residents; and
- Enactment and implementation of statutory or administrative code rule changes supporting Ohio’s rebalancing efforts.

6. Process, Strategies and Procedures to Target and Recruit MFP Participants

Potential MFP participants will be identified utilizing data from Ohio’s Medicaid decision support system and data warehouse, and when implemented, Ohio’s Medicaid Information Technology System (MITS). This will include data for all Medicaid enrollees who have had a continual length of stay in an institutional setting for at least six months during the five year MFP grant period. This data will be rerun quarterly to identify the changing potential MFP population throughout the grant period. Ohio will also use Minimum Data Set (MDS) questions Q1a and Q1b to identify those individuals who have stated a desire to move out of an institution and have a supportive family member. Question Q1c will also be used to provide another data element, a professional judgment of the person’s length of stay. These questions taken together in context should provide a starting point for searching for MFP participants.

MFP participants will be recruited by a wide variety of individuals and organizations that comprise Ohio’s existing LTC service delivery systems. This would include governmental entities such as the Sister State Agencies, Area Agencies on Aging, County MR/DD and ADAMHS Boards, the Office of the State Long Term Care Ombudsman, as well as service providers and consumer advocacy organizations such as Centers for Independent Living, the Arc of Ohio, Aging and Disability Resource Centers, and the like.

7. Cross Agency / Delivery System Collaboration

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Although ODJFS, Ohio's single state Medicaid agency, has taken the lead in developing Ohio's MFP grant application, ODJFS has sought broad involvement of all key stakeholders, including sister state agencies, county governmental entities, institutional and non-institutional service providers, consumers and consumer advocates representatives in the concept development and grant review process. (Appendix E contains a list of all organizations that participated in MFP planning meetings as well as notes from those meetings.) Since Ohio proposes to implement MFP within the existing LTC service delivery system infrastructure, it would be impossible for MFP to succeed without extensive collaboration from these key stakeholders. To facilitate this collaborative planning on an ongoing basis, Ohio will form an MFP Planning and Advisory Group, which will begin meeting as soon as Ohio is informed of its selection for MFP. This group will include representatives of all the stakeholder groups mentioned above to develop planning design and assist in the project's implementation over the five years. The MFP Planning and Advisory Group will use several work groups to research and plan specific aspects of MFP and to recommend needed changes and improvements. As stated earlier in references to the *Ohio Access Initiative*, convening key stakeholders regarding Ohio's long term care service delivery system is not new to Ohio. MFP will provide an opportunity to further expand the accomplishments of *Ohio Access*.

8. The Qualified HCBS Program Available to MFP Participants

Because Ohio proposes to use existing Medicaid waiver and state plan services as the foundation of qualified HCBS program for MFP participants, Ohio's Qualified HCB Services Program will be kept in place at the conclusion of the demonstration period. The only changes to existing service array are described in Part 1, Element 4 of this grant application and are included in the Ohio Profile Table in Appendix D. As required by the MFP Guidelines, these

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services will be available to MFP participants beginning on the first day the person moves from a qualified institution to a qualified HCBS setting. Some services, such as assessment and transition planning as part of the Case Management service, will begin before the person physically moves. Qualified HCB Services will be continued as long as the person continues to have a medical necessity for them and meets Medicaid eligibility criterion.

In addition to the existing state plan and waiver services, Ohio proposes to add HCB Demonstration Services which will be available to the individual throughout their first year in a community placement. Decisions regarding continuation of these services will be further developed in the pre-implementation planning process. In addition, Ohio proposes several Supplemental Demonstration Services to be provided on a one time or time limited basis.

Finally, although not funded by MFP, Ohio proposes housing supports including a “bridge” subsidy fund to supplement existing public housing subsidy programs and other strategies to expand access for MFP participants to accessible and affordable housing.

9. Description of Quality Management Strategy

Ohio’s MFP quality management strategy will be built on existing quality processes in place or in development for HCB services and programs. Ohio’s focus for MFP will be to integrate quality management across the multiple long term care service delivery systems. Ohio will utilize the newly created HCBS Quality Steering Committee (QSC) to guide the development of this comprehensive strategy during the pre-implementation phase of the demonstration. The QSC and MFP Planning and Advisory Group will jointly decide how to incorporate additional program perspectives and stakeholder representation. In addition, the QSC may use focus groups or other methods of gathering participant and provider input.

The Quality Steering Committee will begin its work by taking an inventory of existing

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HCBS program processes for assessment, discovery, remediation, and ongoing system improvements. This activity, during the pre-implementation phase, will identify existing best practices and areas of good practice as well as gaps which indicate needed improvement. The QSC will assist the MFP Interagency Steering Committee in developing quality indicators specific to MFP participants, such as preparedness for community placement, consumer satisfaction with HCBS placement, and quality measures for the new HCB Demonstration and Supplemental Demonstration Services. In addition, Ohio's quality strategy will incorporate mechanisms to measure the quality of state plan services for MFP participants who use them.

10. Summary of Ohio's Existing System for Continuous Quality Improvement

Ohio will build on existing quality improvement systems and practices to assure the health and safety of MFP participants. Currently three different levels of quality assurance reviews are in place: 1) ODJFS conducts reviews of each Medicaid-funded program, 2) all Sister State Agencies review activities of contracted agencies, local boards, and AAAs respectively; and 3) service providers are monitored through ongoing compliance reviews. Information gathered from the various quality assurance reviews, primarily areas of non-compliance, is reported back to the entity under review who must develop and submit a corrective action plan.

Each Ohio HCBS delivery system already has incident reporting and management processes in place. For example, both ODJFS and ODMR/DD have structured incident management systems to identify, investigate, and resolve incidents at the local and state levels.

11. Barriers to Flexible Use of Medicaid Funds and Strategies to Overcome Them

Ohio will raise this fundamental issue for discussion among the MFP Planning and Advisory Group members and within Ohio's the Executive and Legislative Branches of state

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government. Progress has already been accomplished with moving from a cost-based reimbursement to a pricing system for reimbursement of nursing facility care. Similar changes are proposed for ICFs/MR in the coming biennium. Ohio anticipates that over the five years of the MFP project, some shift in expenditures will occur as a result of “right sizing” institutional long term care resources so they more closely match consumer demand.

12. Enhancing Information Technology Systems to Identify MFP participants

Because Ohio is midway through the process of completely reinventing its Medicaid Information Technology (IT) system, Ohio is well positioned to meet the IT requirements of MFP and other initiatives requiring real time data analysis at the individual consumer and provider levels. While Ohio’s MITS will be implemented over the next three years, a number of tools are already available to provide more immediate access to data. Ohio’s existing Data Warehouse and Decision Support System can provide the most recent three years of Medicaid consumer and provider data including basic demographics, eligibility and enrollment, length of stay, diagnosis codes, Medicaid expenditure history via service level data, etc. Specific CMS questions are responded to in the following sections.

a) **Demographics Including Eligibility** – Ohio’s Decision Support System contains demographic data fields including: age, race, gender, residence by county and zip code, primary and secondary diagnosis, listing of all Medicaid providers and services provided by date, payment amounts, etc. In addition, Ohio’s Consumer Registry Information System, Enhanced (CRIS-E) which is managed and populated by county Departments of Job and Family Services, contains eligibility and enrollment information for Medicaid consumers.

b) **Financial information to substantiate enhanced FMAP** – Beginning in grant year one, Ohio will implement Medicaid information technology changes that will allow specific

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tracking of potential and actual MFP participants. Preliminarily, Ohio proposes to modify our existing Medicaid Management Information System (MMIS) to include an “MFP marker” as part of the recipient master file to facilitate empirical research, program integrity, and fiscal accountability. In this way, Ohio will be able to track all Medicaid enrollees eligible for enhanced matching funds. The long term strategy will include the integration of MFP tracking in the new Medicaid Information Technology System (MITS). More specifics on this will be developed as part of the pre-implementation planning process.

c) Assessment Data to Monitor Quality of Services Post Transition

Because Ohio proposes to utilize existing Medicaid waivers and state plan services, by and large, there won't be a need for quality monitoring outside of what currently exists for services provided to already participating individuals. The only exception may be for MFP participants who are receiving only state plan services or who leave Medicaid enrollment (voluntarily or because of a change in financial eligibility). These individuals will need additional quality monitoring in concert with existing activities. More details will be developed during the implementation planning.

Part 3: Preliminary Budget and Organizational Staffing Plan

1. Organizational Structure

The Ohio Department of Job and Family Services (ODJFS), Ohio's Single State Medicaid Agency, will be responsible for the MFP grant. Appendix F illustrates the major organizational relationships among ODJFS, Sister State Agencies and service delivery systems. Ohio proposes to use this existing infrastructure, with added supports, to implement the MFP grant. This grant submission has been developed through collaboration with the Ohio Departments of Aging; Alcohol and Drug Addiction Services; Health; Mental Health; Mental Retardation and Developmental Disabilities; and, the Office of Budget and Management. In this respect, Ohio's MFP proposal is a team effort to "rebalance" Ohio's system to better meet the needs of Ohioans with disabilities. Enrollment and coordination activities will occur at existing entry points in Ohio's system and are dependent on Ohio's local structure of PASSPORT Administrative Agencies, County Boards of MRDD, and county Alcohol, Drug Addiction and Mental Health Services Boards.

The ODJFS Office of Ohio Health Plans will assign a Project Director for MFP. Appendix F outlines the structure of the Medicaid Agency (ODJFS) and the location of the MFP Grant Project Director. Appendix F also shows the relationship between the Project Director, the Interagency Steering Committee, the MFP Planning and Advisory Group and proposed workgroups.

ODJFS proposes to develop a central referral and tracking system to manage a universal intake system necessary to assure consistent referral and data collection across the programs making up Ohio's long term care service system. See Appendix G for detail on the organizational relationship between the ODJFS central referral and tracking system and Ohio

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stakeholders.

1. Staffing Plan

Because Ohio proposes to build on existing infrastructure, the proposed staffing plan will utilize existing staff from each Sister State Agency with new and existing staff at ODJFS. Listed below is the **ODJFS proposed staffing plan** including the number and title of staff and the percentage of time dedicated to MFP activities.

- 1 new full time (100% dedicated to MFP) Medicaid Administrator titled “Project Director”
- 3 existing full time (50% of time for each staff dedicated to MFP) Medicaid Administrators titled “State Plan Policy Analyst” and “HCBS Waiver Policy Analyst”
- 1 existing full time (100% dedicated to MFP) Medicaid Administrator titled “Housing Coordinator”
- 1 new full time (25% of time dedicated to MFP) Medicaid Administrator titled “Long Term Care Pre-Admission Policy Manager”
- 3 new or existing full time (100% dedicated to MFP – positions to be determined during the pre-implementation phase) Medicaid Administrators to manage the central referral and tracking system.

Appendix H includes the position descriptions of each of the existing ODJFS staff and the roles/responsibilities of ODJFS staff who will assist with this project. Ohio’s MFP project will be directed by the Office of Ohio Health Plans within ODJFS. Biographical narratives of Ohio’s Medicaid Director and Assistant Deputy Director of Long Term Care Policy are also included in Appendix H.

Additional supports will come from Sister State Agencies currently operating Medicaid

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waivers and/or Sister State Agencies operating specialty state plan services, and other ODJFS staff not listed above.

Ohio will use the existing state and local long term care infrastructure to perform referral and enrollment activities. As the HCBS waiver programs grow through MFP, additional capacity at the State and local levels may result in additional administrative costs over time; these costs are included in the MFP projections.

Ohio will contract with three separate independent organizations (to be determined during the pre-implementation phase) to:

- A. Evaluate Ohio's Long Term Care Pre-Admission Process (25% dedicated to MFP);
- B. Manage the transition costs of individuals who do not meet the functional eligibility of an HCBS waiver (Ohio's Success Project – 100% dedicated to MFP); and,
- C. Interface with Medicaid on claims for individuals participating in the MFP Project including the role of fiscal intermediary for the Community Transitions service (100% dedicated to MFP).

3. Budget Presentation and Narrative

This narrative defines the costs and methodology employed to determine the projected expenditures for each federal fiscal year of the project period. These projections are based on the projected number of MFP enrollees and the historical costs of HCBS waiver enrollees unique to each of Ohio's HCBS waiver programs. Historical HCBS waiver costs were utilized because Ohio will use the existing Ohio HCBS waiver structure to alleviate the need to transition consumers on day 366.

Ohio built the MFP program cost projection starting with the Qualified HCB services, adding the Demonstration services and finally adding the Supplemental Demonstration services.

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Ohio built a month-by-month phase-in schedule for each proposed enrollee beginning January 1, 2008 and extending through the September 30, 2011 project completion date. Projected costs were calculated by month using the number of projected enrollees utilizing each service each month and assuming a 30 day lag in payment to develop a total cost per federal fiscal year for the entire 5-year project.

Medicaid Administrative Costs: Average per member per month (PMPM) administrative costs for administrative case management for each HCBS waiver were calculated and multiplied by the number of projected MFP enrollees per federal fiscal year for each HCBS waiver program. The average cost of case management was inflated by 10% for MFP enrollees assuming increased activity with transition planning and inflated expenses of case management staff. Costs for administrative case management also include case management expenses provided by local entities and competitively bid statewide case management contracts.

Administrative costs also include: required upgrades to information technology infrastructure; vendor contracts for consumer relocation referral and assistance; and, salaries, fringe benefits (including an annual 4% inflation factor beginning July of each year) and travel costs for state agency staff to implement MFP. The contract for information technology infrastructure contains a 10% increase each year to accommodate increased enrollment activity and Medicaid claims processing.

Qualified HCB Services: Ohio projected these costs by taking the total Medicaid expenditures per HCBS program PMPM for State Fiscal Year 2005 and inflating the costs by 3% per year to estimate the future costs for each program through the entire project period. The 3% growth rate is consistent with recent program growth. These PMPM projections were multiplied by the total member months based on the projected enrollment and setting to which the enrollee

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is likely to transition. Ohio then calculated the enhanced federal match based on the first 12 month enrollment period for each phased-in enrollee, taking into account that as MFP enrollees are phased-in, other MFP enrollees phase-out and revert back to the regular federal match rate.

HCB Demonstration Services: These services included two main categories:

1.) Services existing in one, but not all, Ohio HCBS waiver programs and 2.) New Ohio Medicaid services. The cost of services in #1 were calculated based on utilization rates and reimbursement costs as they exist within current waiver programs and projected forward, via the phased-in approach described above, for MFP enrollees who are assumed will use these services. For #2, Ohio obtained information from other State Medicaid programs and from Ohio Centers for Independent Living to gauge the cost and utilization for the Independent Living Skills, Benefits Coordination, and Peer Support. Projected costs and utilization assumptions were then added to MFP Qualified HCB service projections based again on the phased-in approach and enhanced federal match applied for the 12 month period per enrollee.

Supplemental Demonstration Services: Ohio proposes to add two services within this category: Home Computers, with adapted hardware and software to accommodate the communication needs of people with disabilities, and Service Animals. Ohio set per enrollee dollar caps for each and assumed utilization of each by 5% of all MFP participants each year. Some will use one or the other, some will use both and others will use neither. These costs were then phased into the MFP projected costs.

Part 4: Assurances

Informed Consent

Enrollment into Ohio's current home and community-based programs include processes for informing consumers that they may freely exercise their constitutional and federal/state statutory rights, including their right to choose HCBS as an alternative to institutional care. These processes vary slightly by waiver program. For example, when a consumer is enrolled into the Ohio Home Care Waiver, Ohio's contracted case management entity shares relevant Medicaid publications and a consumer handbook outlining the consumer's rights. Ohio plans to utilize similar processes for the MFP demonstration project, assuring that participants or their authorized representative have informed choice in selecting their community-based residence. In designing these processes, Ohio will look to its own processes as well as best practices from other states.

Public Process

Ohio's MFP proposal was developed with the active input of key stakeholders including consumers, advocacy organizations, institutional and HCBS service providers, county and regional entities and Sister State Agencies. Ohio convened two public stakeholder forums. The first occurred on August 28th in the early stages of developing Ohio's MFP proposal. The main purpose of this meeting was to obtain a list of critical issues that should be addressed in the drafting of Ohio's MFP proposal. A second stakeholder forum was held on 5th at which Ohio Medicaid staff presented in concept Ohio's MFP proposal and listened to feedback from stakeholders. In addition to these large meetings numerous smaller meetings and individual conversations occurred especially with consumer and advocacy organizations to better understand the demonstration services that were being suggested as most critical to assist

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individuals to make a successful transition from institutional to community settings.

On October 19th, a draft of the MFP proposal was sent out to all key stakeholders for their review and comment. Comments were collected, reviewed and incorporated into Ohio's final MFP grant application. See Appendix E for a list of participating stakeholder groups and notes from the two public stakeholder forums.

During the pre-implementation and implementation phases of the demonstration, Ohio plans to utilize an Interagency Steering Committee, including all state agencies that administer Medicaid funded long term care services, to monitor the overall MFP demonstration. Ohio will also form an MFP Planning & Advisory Group, comprised of a wide variety of key stakeholders, to develop the operational protocol for the demonstration and facilitate discussion of issues. Topic-specific work groups will be asked to debate complex and difficult issues, brainstorm ideas, and propose solutions and action steps. Specifically, work groups are planned for issues including housing, workforce development, IT and claims payment, access to services and self-direction, marketing and education, and rebalancing.

In addition, ODJFS will continue to meet monthly with the Ohio Olmstead Task Force to share information and solicit input on MFP. The 12 member committee is an important conduit for direct communication and involvement of consumers, caregivers and key stakeholders in the development of the structure, function, training components, oversight and administrative policies and procedures related to all home and community-based programs in Ohio. The OOTF has an Money Follows the Person Subcommittee to focus attention on activities and initiatives related to MFP.

Appendix F includes a demonstration organizational chart, which identifies the planned committees and groups.

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Maintenance of Effort Plan

As described earlier, Ohio intends to utilize its existing network of home and community-based service programs (waiver and state plan) to continue needed services for MFP participants after the first 365 days. Appendices I and J include tables and forms outlining Ohio's current and projected maintenance of effort of expenditures.

Reporting and Cooperation

If selected as an MFP grantee, Ohio looks forward to working with CMS staff and its contractors on this exciting demonstration. Ohio will produce and submit reports, following CMS specifications, to allow comparison of MFP efforts across the state and to provide data for an effective evaluation of the MFP demonstration. In addition, Ohio recognizes and will fully comply with the prohibited uses of grant funds outlined in Attachment 3 of the MFP Program Announcement.

Budget Narrative

NOTE: This narrative is also included in the Project Narrative, Part 3. Data to support the budget can be found in Appendix I.

This narrative defines the costs and methodology employed to determine the projected expenditures for each federal fiscal year of the project period. These projections are based on the projected number of MFP enrollees and the historical costs of HCBS waiver enrollees unique to each of Ohio's HCBS waiver programs. Historical HCBS waiver costs were utilized because Ohio will use the existing Ohio HCBS waiver structure to alleviate the need to transition consumers on day 366.

Ohio built the MFP program cost projection starting with the Qualified HCB services, adding the Demonstration services and finally adding the Supplemental Demonstration services. Ohio built a month-by-month phase-in schedule for each proposed enrollee beginning January 1, 2008 and extending through the September 30, 2011 project completion date. Projected costs were calculated by month using the number of projected enrollees utilizing each service each month and assuming a 30 day lag in payment to develop a total cost per federal fiscal year for the entire 5-year project.

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statewide case management contracts. Administrative costs also include: required upgrades to information technology infrastructure; vendor contracts for consumer relocation referral and assistance; and, salaries, fringe benefits (including an annual 4% inflation factor beginning July of each year) and travel costs for state agency staff to implement MFP. The contract for information technology infrastructure contains a 10% increase each year to accommodate increased enrollment activity and Medicaid claims processing.

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