

**January 10, 2008**

**Testimony from the Montgomery County Frail Elderly Services Advisory Committee**

My name is Dr. Larry Lawhorne, and I am the Chairman of the Department of Geriatrics at the Wright State University Boonshoft School of Medicine in Dayton. I am also a member of the Montgomery County Frail Elderly Services Advisory Committee. On behalf of the committee, I want to thank you for the opportunity to bring to your attention 3 issues that have significant impact on the types and sites of services provided to frail older adults in Ohio. We hope that you will consider these issues as you address the goal of a unified long term care budget.

The issues are:

- ❖ The increasing role of Ohio's counties in the funding of services for frail elders.
- ❖ The savings for the state's Medicaid program because of county funding for alternative services that prevent or delay nursing facility placement.
- ❖ The consequences of the current asset limit for accessing Medicaid-funded community-based services such as PASSPORT.

Let's look at these issues one-by-one:

1. Counties are increasingly called upon to fill a gap that exists in funding services for the frail elderly in our communities. In part, this gap is due to a rapidly growing population of seniors needing help, but being unable to pass the strict level of care and Medicaid eligibility tests for the PASSPORT waiver. In 2003, Montgomery County passed its Human Services Levy<sup>1</sup> with the intention of providing dedicated funding for its frail elderly population for the first time. Using an innovative approach to leverage existing resources, the county collaborated with Area Agency on Aging (AAA) PSA-2, which was already the central access point for seniors in need of information, assessment, and/or services. This

collaboration enhanced the ability of the AAA PSA-2 to serve as the Medicaid-funded “front door” for seniors potentially needing services and to recommend appropriate options based on each individual’s eligibility. Many seniors were found to have meager resources but not meager enough to qualify for PASSPORT. Services for them were funded by the Human Services Levy. In Montgomery County, the Human Services Levy has allocated \$5.6 million annually since 2004 to provide care for poor frail elders who needed services but were ineligible for PASSPORT.

2. By providing the services just described, the need for nursing facility placement has been delayed or prevented altogether for a number of seniors in Montgomery County, thus saving Medicaid resources that otherwise would have been used for nursing facility care.
3. There is high demand for county funded community-based services in Ohio because of barriers in accessing Medicaid-funded programs such as PASSPORT for even the lowest income seniors. A fundamental barrier is the \$1,500 asset limit for a single individual. A number of other states have established higher asset limits. For example, Indiana has an asset limit of \$2,250, and Michigan, Pennsylvania, Kentucky, and Tennessee use \$2,000. The SSI asset limit is also \$2,000 for an individual. In addition, eligibility for PASSPORT waiver is too restrictive. Consumers must meet the same Level of Care criteria and Medicaid standards as those in the nursing home. Consumers in the community cannot maintain housing and associated expenses with the strict Medicaid asset limit of \$1,500. Consumers also have to be as frail, based on level of care needs, as those in the nursing home but with a cap for services of \$22,182, which is well below the amount needed to provide the 24-hour care received in a nursing home. Family and caregivers are left to pick up the remainder of care with no reimbursement. Raising the asset limit for seniors in need of LTC supports and services would pave the way for more comprehensive community-based services and bring in federal matching dollars.

In order to illustrate our 3 areas of concern, I would like to describe what happens with the approximately 350 consumers each month who are assessed by AAA PSA-2 and to tell you a story about a typical person whose services have been supported by the ComCare program<sup>2</sup> funded by the Human Services Tax Levy.

On average in 2007, 346 assessments were completed each month with 81 consumers (23%) found to be eligible for PASSPORT and 99 (29%) eligible for ComCare each month (See Figure 1). Of the 99 people who meet ComCare eligibility each month, 50 decline to enroll and 49 are placed on the ComCare waiting list, currently at 350 people, but growing. The attrition rate for ComCare is about 25 consumers per month allowing 25 people on the waiting list to enroll in ComCare. The typical consumer spends about 6 months on the ComCare waiting list. The 50 consumers who choose not to enroll in ComCare make that decision for a variety of reasons including concerns about the amount of the co-pay. While the co-pay is on a sliding scale, it is easy to see why there are concerns about it. Of the consumers who are now in ComCare, 80% have assets of less than \$5,000 and 12% have between \$5,000 and \$10,000 in assets...not much standing between them and Medicaid-funded nursing facility care if they cannot be maintained in the community.

Currently, funds from the Human Services Tax Levy support services for 750 of the 775 older adults enrolled in ComCare. Since the average length of stay in ComCare is approximately 17 months and since many of these ComCare consumers would otherwise be rapidly approaching nursing facility placement, we estimate that the program saves over \$41 million for Medicaid for each cohort of 750 ComCare enrollees.<sup>3</sup> Since the ComCare costs for providing services for these consumers is about \$ 4 million, you could

say that for every dollar that Montgomery County spends to support this group of poor, frail elders in the ComCare program, the state's Medicaid program has \$10 that can be allocated to other services. Given the property tax base that most counties use to fund services for the frail elderly, this is becoming increasingly burdensome. Consideration should be given to more equitable sharing of these costs by the state.

The ComCare story that I would like to tell you is about J.S. (not her real initials).<sup>4</sup> She was enrolled in ComCare in early 2004 at age 75 due to functional limitations related to chronic lung disease. Her husband had been dead for almost 20 years at the time she enrolled. She was living alone in an apartment in Dayton but had family in the Dayton area and had contact with them several times each week. In addition to chronic lung disease, she had high blood pressure, osteoporosis, and chronic dizziness. Not surprisingly, the two things that limited her function were lung disease and dizziness. Because of dizziness and osteoporosis, there was also major concern about falls and fractures. After a comprehensive assessment, she was found to have specific limitations in the areas of personal care, mobility, meal preparation, transportation, and safety...the latter related to fall risk. She was ineligible for PASSPORT but was eligible for ComCare and moved from the waiting list to enrollment in about 2 months. Personal care services, homemaker services, home-delivered meals, and an emergency response system were implemented as soon as she enrolled. Transportation to podiatry, her primary care provider, and her cardiologist was provided as well. Case management through AAA PSA-2 was ongoing. She had one hospitalization in 2006 and another in 2007 for complications related to lung disease but was able to return to her apartment

both times and resume ComCare services. She had several falls but none resulted in serious injuries. There was a continual decline in health status and depletion of her assets, but she experienced a smooth transition from ComCare to PASSPORT in September 2007 because of the availability and skill of her case manager. She remains in the same apartment that she was in when entering the ComCare program in 2004. It is very likely that the combination of in-home services, community-based care by her clinicians, and good case management by AAA PSA-2 has allowed her to do so well for so long.

In conclusion, what we have presented today is a general view of the effect of county-funded programs on the care of an increasing number of frail elderly in Montgomery County. We believe that the assumptions that we make are valid and generalizable. In addition, we believe that the property tax approach to fund this community-based care through the Human Services Levy will not be sustainable in the long run and that the state will need to contribute more to programs like ComCare. Our estimate of a savings of \$10 in nursing facility costs for each dollar spent on home-based services should be considered in your deliberations.

Our thoughts and best wishes are with you as you struggle with this very difficult task. We appreciate the complexities of determining the needs of Ohio's frail elders and balancing their needs with fiscal realities.

On behalf of the Montgomery County Frail Elderly Services Advisory Committee, I again thank you for the opportunity to testify before you. We wish you well in your important work.

**Footnotes:**

<sup>1</sup>The focus of Montgomery County's Frail Elderly Advisory Committee is on the senior community. The funding that is received by the Committee is allocated from a Unified Human Services Levy, which is unique to Montgomery County. The Human Service Levy consists of an "A" & "B" Levy of eight (8) years each, with staggered dates of duration. Voters approved a Replacement + 2 Mills "A" Levy in November 2007 that will provide an additional \$34.5 million beginning in 2008. The combined millage in 2008 totals 13.24 mills and will collect \$136.9 million beginning in 2008. All Human Service initiatives are funded from these dollars. The major agencies receiving funding are: ADAMHS - \$22.7 million, Children Services - \$23.1 million, Public Health - \$16.8 million, MR/DD - \$25.6 million, Frail Elderly - \$5.6 million, Indigent Ill Programs - \$5.9 million and other programs that total another \$13.7 million. The allocation process is beginning now to fund the additional dollars that will be collected.

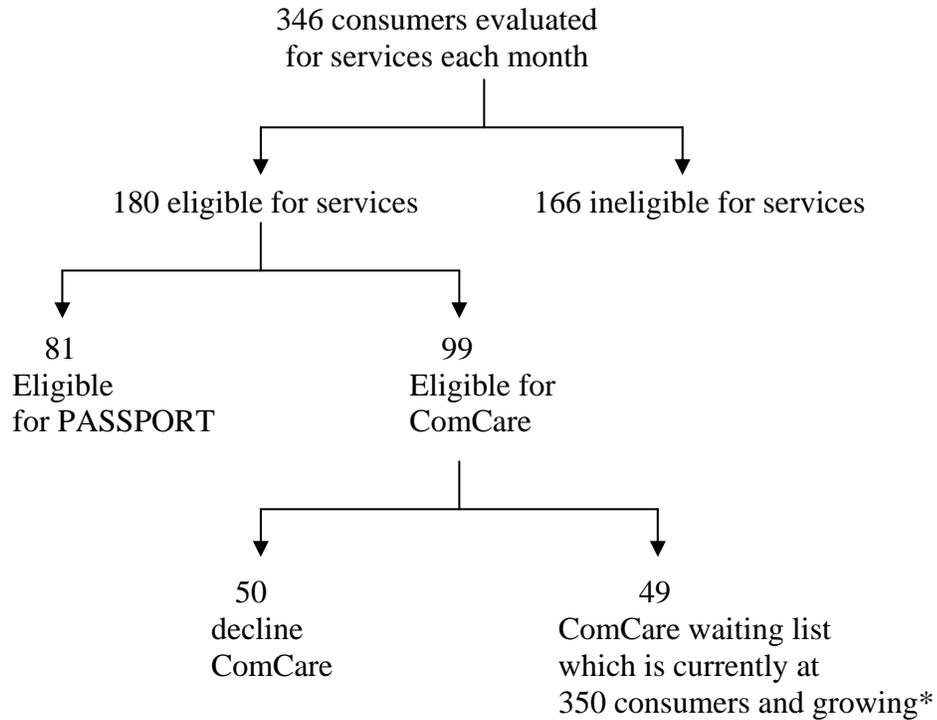
<sup>2</sup> ComCare is for seniors who need supervision or limited assistance to remain independent at home. It can also offer services to support those caring for a frail older person at home. Those who qualify for ComCare meet with a nurse or social worker to develop a plan of care that customizes services to assist them at home. Once enrolled, a case manager works with them to be sure needs are met with quality services, and that the plan of care is adjusted as needs change.

<sup>3</sup> Calculation based upon the observation that 438 of current ComCare enrollees meet the intermediate or nursing facility level of care required; therefore, 438 persons x 1.5 years

= 657 person-years x \$62,964 (Medicaid nursing facility standard for 1 year) =  
\$41,367,348.

<sup>4</sup>This is an actual case from ComCare files but identifiers have been deleted and / or modified to protect privacy.

Figure 1



\*Approximately 25 consumers per month move from the waiting list into ComCare. Consumers spend an average of 6 months on the waiting list before they move into ComCare.