Ohio | Department of Aging

John Kasich, Governor
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OHIO HOUSE OF REPRESENTATIVES
FINANCE SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

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INTRODUCTION
A Transformational Moment

Good day, Chairman Sprague, Ranking Member Sykes and members of the House Health and Human Services Subcommittee. I am Bonnie Burman, director of the Ohio Department of Aging. Thank you for the opportunity to address you today and discuss how Governor Kasich's third executive budget will further position Ohio on the leading edge of innovation as we celebrate, embrace and serve our growing and changing aging population.

And growing and changing it is! In 1990, there were only nine Ohio counties where more than 20 percent of the population was age 60 or older. According to projections by the Scripps Gerontology Center at Miami University, by **2020 84 counties will have more than 20% of their population over age 60, and by 2030 in all 88 Ohio counties more than 20% of their population will be age 60 and older.** *(See figures 1-3 at the end of this document.)*

This dramatic population shift has far-reaching implications for families, the workforce, the economy and Ohio's long-term services and support system as well. And, of course, it has important implications for all of us here today. **I choose to view these trends as opportunities** – exciting ones that we can and should embrace in ways that will create better jobs and better lives for Ohioans of all ages.

Three key precepts underlie our approach to serving this growing cadre of elders. First, at the Ohio Department of Aging, we have a saying: **"The declinist view of aging has left the building!"** In its place, we embrace a developmental view of aging – one that recognizes that **we continue to grow, thrive and contribute as we age.** This approach will help us as a state engage our elders – and all generations – to create stronger communities, better job opportunities and a more responsive and cost-effective system of long-term services and supports.

Secondly, we now know that what we do to and for ourselves throughout our lifespans has a greater impact on our wellbeing as we age than genetics. Finally, we also know that as individuals' abilities change, there is ALWAYS something that can be done to keep them healthier, slow the rate of decline and, in general, help them live a more meaningful life. Building upon these three evidence-based precepts, our budget request and my testimony today focus on ways in which **we can, by working together, enhance wellbeing and prevent decline for Ohioans** even as abilities change.

New Vision, New Priorities, New Expectations

We are extremely fortunate that Governor Kasich, the Office of Health Transformation and the Ohio General Assembly have, over the last four years, helped us work more strategically in providing services for older Ohioans. This budget continues our work by focusing on two key strategies. First, we will work tirelessly to help Ohioans **age with the greatest wellbeing possible**. Second, when and if care is needed, we will work to ensure that each person is **cared for, and cared about, in the most responsive** manner. Most specifically, Ohioans should have access to the right care at the right time in the right place.

For both of these priorities we will be emphasizing:

- health, wellness and prevention;
- caregiver support; and
- a person-centered culture that moves from consumer choice to consumer voice.

Our mantra, very simply, is "Expect Excellence!" – Excellence not only in the services we provide, the policies we adopt and the care we promote, but excellence also in how we operate as a state agency. We will settle for nothing less than *satisfied stakeholders* (our taxpayers); *delighted customers*; *effective processes* and a *motivated, prepared workforce*.

Due to the growth and diversity of our aging population, we will not meet their needs by simply doing the same things better. Instead, we must do better things. Over the past four years, the Ohio Department of Aging has set the bar high regarding excellence in all that we do for our elders and Ohioans with disabilities. Organizationally, we are leaner, more efficient and better aligned to make the most of the resources available to us. For example:

- We have 23 percent fewer staff than we did in 2011, and the duties of the staff we have now are fully focused on the agency's mission and vision.
- We created the Elder Connections Division, which is working to strengthen our external private and public partnerships in health, wellness, prevention and caregiver support.
- We have transformed our approach to funding our state's area agencies on aging (AAAs) and have worked with them to ensure their area plans are aligned with our State Plan on Aging.

We have been and will continue to reallocate our funding and refocus our attention on programs and initiatives that promote health and wellness throughout the lifespan, minimize disability and maximize opportunities to contribute in very meaningful ways. We no longer measure our success by the number of consumers served or units of service provided, but rather on how those services and supports improve the lives of those we serve. In short, we have shifted from measuring and reporting inputs and outputs, to a laser focus on outcomes and impact.

The following four examples provide a window into how we are making an impact through innovation:

1. **We have taken on the declinist view of aging.** We strengthened our infrastructure for the evidence-based HEALTHY U Ohio chronic disease self-management program to meet and exceed our service goals and help more Ohioans live healthier, more active lives. We began to address the falls epidemic among older adults with the STEADY U Ohio initiative. And, we are strengthening partnerships with the Ohio Department of Health and state and local partners to help all Ohioans live "Well Beyond 60."

2. **We have unleashed the power of our Golden Buckeyes.** The Senior Community Service Employment Program is an integral piece of the state's new Unified Workforce Plan. We have strengthened our communities' ability to support family caregivers by linking caregiver support with health and wellness, and ensuring a trained workforce capable of providing quality

dementia and disability supports. We created connections in local school districts to help at-risk students succeed by linking the Retired Senior Volunteer Program with Project MORE, a proven tutoring and mentoring program. Further, we are working with state and local partners to provide more opportunities for adults to have a positive influence on our youth through the new Community Connectors program.

3. **We have made excellence the expectation in long-term care.** We raised the bar for quality in long-term care, first by restructuring nursing home payments to incentivize quality, person-centered care practices and policies, then by requiring and providing opportunities for facilities to participate in quality improvement projects. The Office of the State Long-Term Care Ombudsman plays a large role in the state's new managed care program for Medicare and Medicaid beneficiaries, MyCare Ohio, and is expanding its role as a an advocate for consumers of home care as well as facility-based care. The Ombudsman has also led efforts to make Music & Memory, an innovative approach to dementia care, accessible to every nursing home in the state.

4. **We have partnered to tackle tough issues.** Through our leadership role in the Governor's Cabinet Opiate Action Team, we have contributed to efforts to reduce the misuse and abuse of opiate pain killers, first with new emergency department guidelines, then by helping prescribers adopt new practices that identify potential issues and provide opportunities for physicians and patients to work together on effective pain management strategies. Similarly, we joined Ohio's fight against youth drug abuse by supporting the launch of the Start Talking! initiative. Through new and strengthened partnerships, we play a pivotal role in enhanced efforts to keep all Ohioans safe during natural disasters, severe weather and public health emergencies.

The proposals in this Executive Budget mark the continuing evolution of these efforts.

BUDGET PROPOSALS

Paying for Quality in Nursing Homes

In 2012, we continued our work to **raise the bar for quality in Ohio's nursing homes** by establishing incentive measures that made it clear that quality, person-centered care is the expectation in Ohio. Since then, two of the original quality measures have become requirements for licensure. In addition, we have implemented a program of quality improvement projects that help nursing homes achieve the new standards set before them. We continue to work with our sister agencies such as the Ohio Department of Health when it comes to licensure measures to improve quality.

The Executive Budget builds on the work of the previous four years and further strengthens the relationship between payment and quality by increasing nursing facility reimbursement $61 million over two years and requiring that all of the spending increase related to this rebasing ($84 million) be used to support a new quality framework. Under this framework, the current quality component is eliminated and nursing facilities are restored to 100 percent of their rate and full funding. The payment for quality will be replaced with a "Quality Reserve" that nursing facilities can earn back through

objective measures of quality care. The current list of 20 measures is replaced by five measures directly related to outcomes and Medicaid spending. Facilities will have to meet benchmarks for all five measures to receive the full quality payment or they will receive a fifth of their quality payment for each measure achieved.

We remain committed to the ideal that we will only pay for quality care, and the new measures are founded on evidence-based principles established by national leaders in long-term care quality improvement and culture change, including the National Consumer Voice for Quality Long-Term Care and the Advancing Excellence in America's Nursing Homes campaign (of which our own State Long-Term Care Ombudsman, Beverley Laubert, is a national leader), along with quality standards established by the Centers for Medicare and Medicaid Services (CMS).

Our expectations are that every nursing home in Ohio will:

1. Maintain an appropriate staffing ratio (for nurses and STNAs) to ensure that adequate staff are available at all times to meet the needs of residents;
2. Allow residents and staff to build beneficial relationships through consistent assignment so that staff get to know residents' needs and preferences and can provide better care;
3. Effectively prevent and treat pressure sores;
4. Ensure quality care to the level that prevents unnecessary re-hospitalization; and
5. Employ strategies to improve quality of life by limiting atypical antipsychotic medication use.

As you can see, the five measures include two staffing measures and three clinical measures. The administration is proposing staffing levels recommended by the National Consumer Voice for Quality Long Term Care, a national advocacy group representing nursing facility residents and their families. Consistent assignment of nurse aides is widely recognized as a key component of quality care for nursing facility residents and is a goal recognized and measured by the Advancing Excellence in America's Nursing Homes campaign.

Two of the clinical measures rely on quality measures established by CMS and are calculated using information from the Minimum Data Set (MDS). Those measures include the rate of pressure ulcers across the facility census (both long-stay and short-stay measures), and the rate of atypical antipsychotic use for both long-stay and short-stay residents. The third clinical measure is the rate of avoidable inpatient hospital admissions from nursing facilities and is the initial step in measuring potentially preventable events in Ohio's nursing facilities.

Do consumers know they have the right to expect these things of their care providers? We're working very hard to ensure that they do through increased public awareness and an increasingly important role for the State Long-Term Care Ombudsman. We will spend the first year of the biennium educating and training facility leaders and staff about these expectations and help them understand how they are directly aligned with quality care.

Long-Term Care Consumer Guide

For more than a decade, the Ohio Long-Term Care Consumer Guide website has provided valuable information to consumers and their families to help them make informed choices about where they receive long-term services and supports. Customer satisfaction is one of many important indicators of quality. In alternating years, our agency surveys residents and then family members for consumer satisfaction in the state's nursing homes. In even-numbered years, we survey residents of residential care facilities (assisted living) as well. We do not currently survey the family members of residents of residential care facilities.

These surveys are funded by fees paid by the facilities; we are asking in this budget for the fee to be increased from $300 to $350 per residential care facility to provide additional revenue to also survey family members of residential care facility residents. The surveys provide transparency for consumers and help them understand that **they have the right to expect excellence**. Further, the surveys give providers the opportunity to recognize potential areas for improvement in order to provide the highest quality of care. The Office of the State Long-Term Care Ombudsman provides technical assistance to facilities to help them improve their scores.

Improved Access to Reliable, Consistent Home Care

Ohio currently operates eight home and community-based services (HCBS) waiver programs that rely on direct care workers to provide home health care services. Together, these waivers provide more than 90,000 Ohioans with home and community-based services annually. In addition, another 32,000 seniors and individuals with disabilities gain access to HCBS services, including home health care, through the MyCare Ohio demonstration project. MyCare Ohio is available in 29 Ohio counties and serves individuals age 18 or older who are enrolled in both Medicare and Medicaid, and require a nursing facility level of care.

Over the past four years, the Kasich Administration, in collaboration with the legislature, has vigorously pursued – and achieved – balance in long-term care spending while transforming the lives of thousands of Ohioans. Just a decade earlier, many of these individuals would have had no choice but to receive care in institutional settings. This heightened focus on better choices has resulted in an increased demand for home and community-based services, and for home health care workers to provide care in those settings. In order for the Administration to continue its work in this respect, concerted efforts must be made to ensure the safety and comfort for those individuals who wish to receive care inside the home. The Executive Budget advances this objective through new initiatives that target provider competency and assure honesty in provider billing and services rendered.

While home health care services are critically important for a person to stay at home or in another community setting, home health care also presents a challenge in Medicaid related to fraud and abuse – particularly among independent providers who are not subject to the oversight of a home health care agency. From 2010-2014, the Medicaid Fraud Control Unit of the Ohio Attorney General's Office (MFCU) received 1,473 referrals for home health-related Medicaid fraud. Of those, 634 (~43 percent) were tied to independent providers. During the same period, MFCU indicted 535 home health

providers. Of those 535 fraud indictments, 335 (~63 percent) were for independent providers. From 2010-2014, 479 home health providers were criminally convicted, and independent providers accounted for 306 (~64 percent) of those convictions. During federal fiscal year 2014 (the most recent statistical data available), home health convictions accounted for 87 percent of all MFCU convictions.

In order to ensure programmatic oversight, decrease fraud and abuse and improve health outcomes for individuals, a majority of states – and the federal Medicare program – only do business through Medicaid with home health care agencies, not independent providers. The Executive Budget will transition Ohio Medicaid home and community based services to either care provided by a home health agency or the consumer self-directing their personal care as a strategy to improve the administrative oversight of the program, decrease programmatic fraud and abuse and improve health outcomes for individuals while working to preserve relationship-based care and caring.

This will be a gradual transition, occurring over the next four years. This will offer both individuals and providers ample time to prepare for changes to individuals' service and care plans that will occur on or before July 1, 2019. Ohio Medicaid will not take any new independent service providers after July 1, 2016, and by July 1, 2019 Ohio Medicaid will only accept claims submitted through home health agencies.

This change will impact more than 13,000 service contractors within seven HCBS waivers. These providers will be able to continue providing Medicaid-funded HCBS waiver services should they seek employment through an approved home health agency, or if they provide services to an individual who is using a self-directed option where the recipient is the employer of record.

Our PASSPORT waiver was built on the home-care agency model and does not use independent service providers. We have found that agencies add a level of oversight and share the financial burden of related costs, such as criminal background checks.

The goal, however, is **not to disrupt good relationships, but rather fortify them**. Ohio Medicaid and the related agencies will work with stakeholders to make the transition to the agency-only model as smooth as possible for our consumers and Ohio's direct care workforce.

The "self-directed or consumer-directed" option is available in three of Ohio's HCBS waiver programs (PASSPORT, SELF and MyCare Ohio). These options give the consumer more choice and control over the delivery of their home and community-based services. The State of Ohio will engage stakeholders to expand self-direction to all eligible Medicaid waiver programs. Under consumer direction:

- Case managers work with consumers to ensure that consumer-directed providers are certified and have, for example, a criminal background check.
- The consumer or his/her surrogate serves as the employer of record for the caregivers and has the authority to choose their provider, decide when and how services are delivered and may elect to maintain budget authority in regards to the care they receive.

Consumer direction is optional, voluntary and not appropriate for everyone. To participate, consumers must exhibit the capacity and ability to: advocate for themselves, know their rights, monitor quality, verbalize their desire to direct services, have open communication and use problem-solving skills.

More Flexibility for Providers of Care to Improve Quality

Our shared goal is to ensure that Ohioans have access to high quality care when they need it, in the settings they prefer. **As the health care industry in general evolves to include new care models, so must our programs and services.** Consider the changing role of our nurses: as advanced practice nurses are trusted with tasks once performed only by physicians, we must consider some of the roles that nurses currently fulfill that they may entrust to others, thus creating better jobs for them in our long-term services and supports system. Nurses are core to this system and addressing the anticipated growing nursing shortage in this system is important.

Currently, certified personnel in the developmental disability service system have the authority to perform specific health-related tasks and administer basic prescribed medications when the personnel are not otherwise authorized by state law to engage in those activities. These personnel also may perform additional health-related tasks and administer additional prescribed medications with nursing delegation. This successful program has operated in the developmental disability waivers since 2006 and we are proposing expanding this program to permit assistive personnel to provide services to individuals enrolled in home-and community-based waivers administered by the Departments of Medicaid and Aging.

Working with the Department of Developmental Disabilities, the Departments of Medicaid and Aging will develop a certification program to train assistive personnel to perform specific health-related tasks. The agencies will also maintain a registry of all assistive personnel and registered nurses who have received the training and been certified to delegate specific tasks. All rules addressing the certification of assistive personnel will be adopted in consultation with the State Board of Nursing, the Ohio Nurses Association and the State Long-Term Care Ombudsman. These services can provide greater flexibility to providers to best meet the needs of each specific consumer while improving efficiency and cost effectiveness. It also helps expand the career ladder for caregivers, creating better jobs and opportunities.

State-Funded Assisted Living and PASSPORT

It is a priority of this administration that **elders and people with disabilities are able to live with dignity in the settings they prefer**, especially in their own homes. To achieve this, we have to have a responsive long-term care system that provides the right care at the right time and in the right place. One way we do this is through our state funded Assisted Living and PASSPORT programs.

Ohio offers expedited access to long-term care waiver services and supports for individuals who are in the process of establishing Medicaid eligibility through the state-funded Assisted Living and PASSPORT waiver programs. For these individuals, an Area Agency on Aging or PASSPORT Administrative Agency determines through an in-person assessment whether or not the individual meets all of the non-

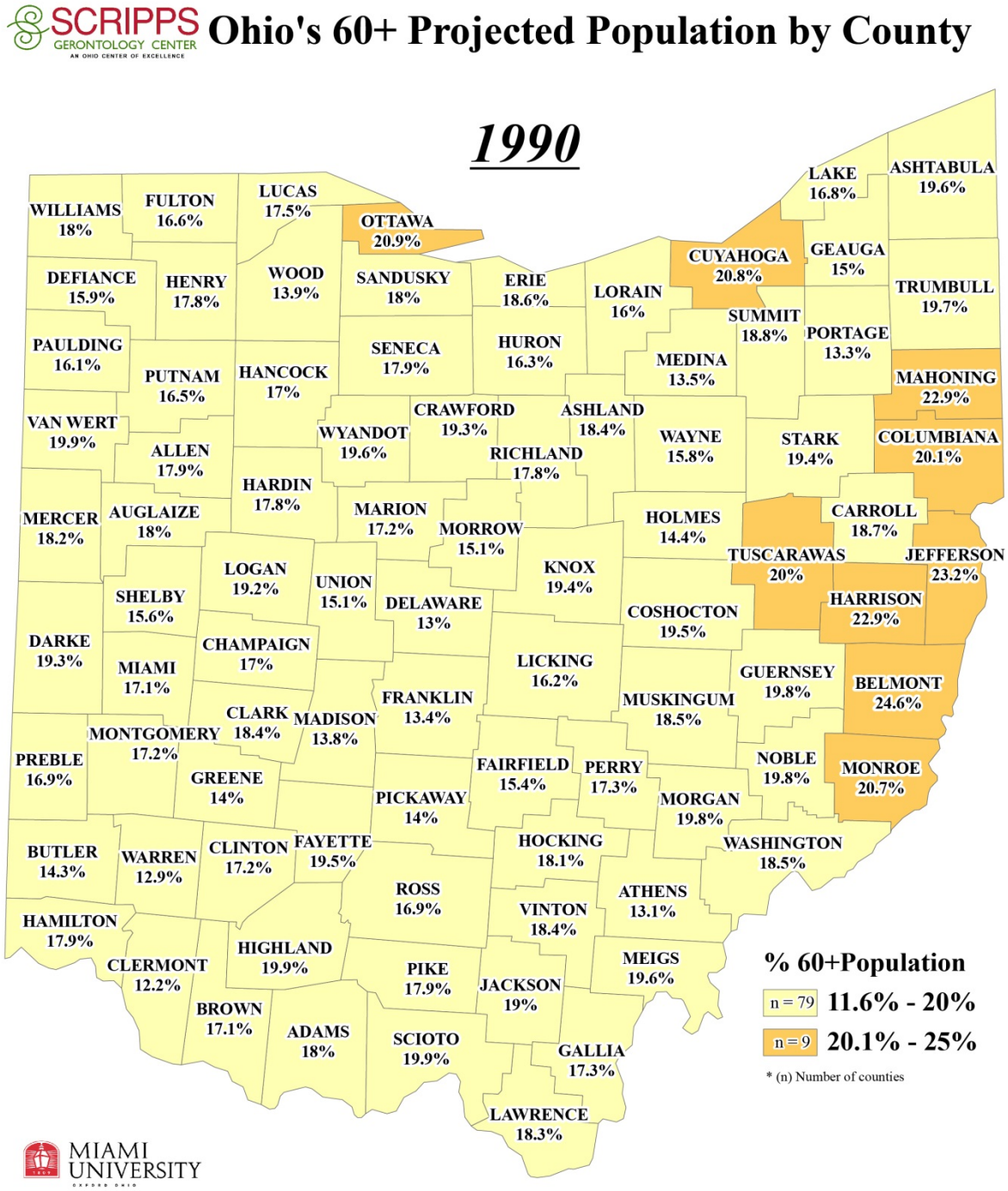
financial and financial eligibility criteria for enrollment in the state-funded program. Participation in this program is currently limited to 90 days while the individual's Medicaid application is being considered by the county department of job and family services. The suggested budget language makes changes to the statute authorizing the state-funded programs and will provide the Department of Aging with flexibility to use the rulemaking process to establish timeframes for an individual's participation in the state-funded PASSPORT and Assisted Living programs **that are responsive to consumers' needs**.

CONCLUSION

Together, we have made Ohio a better place for all Ohioans. The Ohio Department of Aging will continue to be fiscally responsible and innovative stewards of the resources our legislature and Ohio's taxpayers provide to us. Prevention, accountability and high-quality, person-centered approaches will continue to drive our decisions and our strategies. We will continue to seek and build relationships that ensure that every Ohioan in every county and community understands that aging is everybody's business.

I thank you for your continued partnership, vision and leadership in giving our elders opportunities to be respected members of society who continue to grow, thrive and contribute, while also ensuring that the care we promote produces the best outcomes. I and all the employees of the Ohio Department of Aging look forward to a continued productive relationship over the next four years.

Figure 1



Go to:
http://scripps.muohio.edu/content/maps-ohios-60-population-county-1990-2050 to download individual maps (PDF, J-PEG, TIFF formats available).

Note: % categories are based on the quintile points with adjustments; Color scheme based on Brewer (2000). www.colorbrewer2.org.
Citation: Yamashita, T. (2012). Maps of Ohio's 60+ Population by County 1990-2050. Scripps Gerontology Center, Miami University, Oxford, OH.
Data Sources: U.S. Census Bureau (2012). U.S. Census 1990 data.

Figure 2

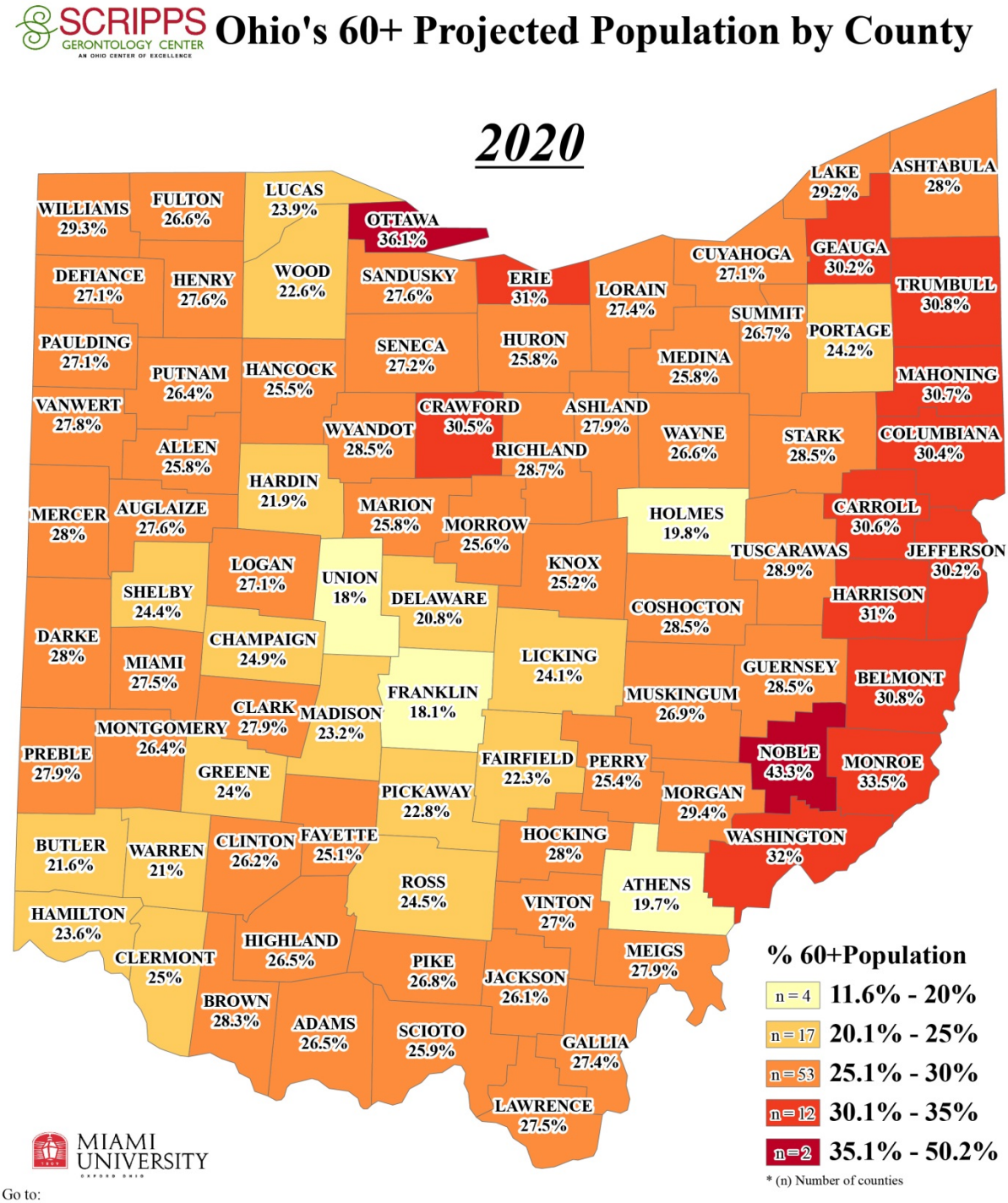


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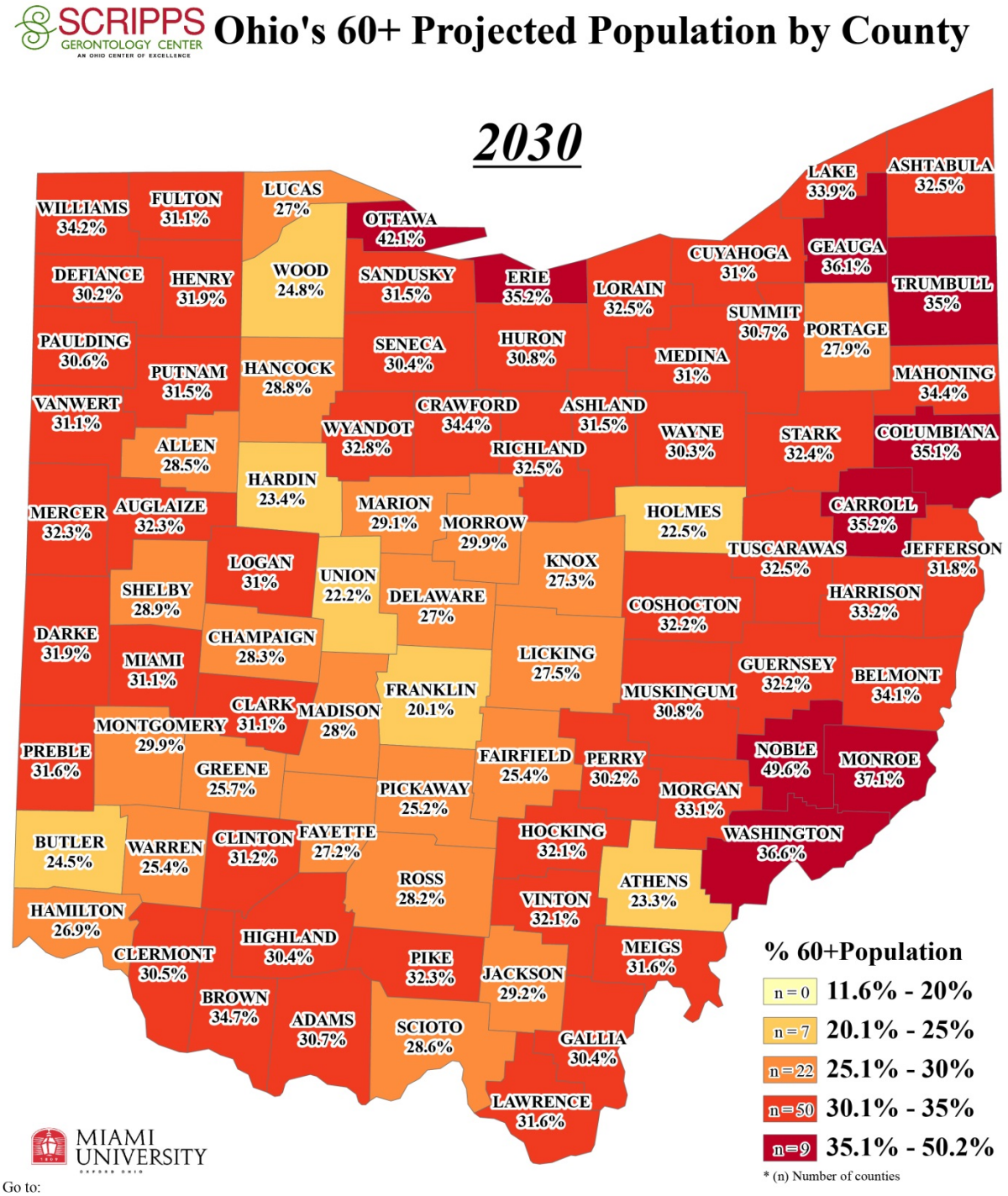
Figure 3



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