Coming of Age: Tracking the Progress and Challenges of Delivering Long-Term Services and Supports in Ohio

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EXECUTIVE SUMMARY

STUDY BACKGROUND AND HIGHLIGHTS

In 1993, the Ohio General Assembly had the foresight to recognize the growing importance of long-term care for the state, and this research study was launched. Since that time, with support from the legislature through the Ohio Long-Term Care Research Project and the Ohio Department of Aging, we have been able to track utilization trends for institutional and home and community-based services. Results show that over the 16 year time period of the study, Ohio has made considerable changes in its approach to delivering and funding long-term services. In 1993, more than nine of ten individuals age 60 and older receiving Medicaid long-term care did so in a nursing home setting. In 2009, more than four in ten older people on Medicaid received assistance in a non-institutional setting. Since 1997, the number of older people age 60 and over using nursing homes in Ohio has actually dropped by almost 7000, despite the fact that the older population has increased by 15%. While these shifts have been significant, Ohio's biggest challenges lie ahead of us, as the population age 60 and older will increase by 25% by 2020 and will nearly double in size by 2040. It is critical for Ohio to not only build on today's progress, but to create tomorrow's innovative system.

DEMOGRAPHICS AND COSTS

- Ohio's population age 60 and older (2 million strong) is the 7th highest in the nation.

- In 2009, more than 146,000 older Ohioans had severe disability and that number will increase by 16%, by 2020, and nearly double by 2040.

- In 2010, 315,000 Ohioans of all ages had severe disability, and that group will grow to 348,000 by 2020 (13% increase). Thirty-eight percent of these individuals rely on the Medicaid program.

- In 2009, Ohio spent $4.85 billion on Medicaid long-term care, including services for older people and Ohioans with developmental/or physical disabilities: $3.3 billion on institutional care (68%) and $1.55 billion on community-based services (32%). Ohio now ranks 40th highest among states in spending in their institutional/community ratio for individuals of all ages, but has improved from 47th in 2005. Ohio ranks 33rd in the institutional/community ratio for individuals age 60 and older.

- Ohio's Medicaid program spent more than $14 billion in 2010; about 36% of those funds went to long-term care. State Medicaid expenditures account for about one-quarter of Ohio's overall budget.

LONG-TERM CARE PROGRAMS

- Almost four in ten individuals with severe disability receive assistance only from family, or privately purchase care.

- Twenty-three percent of Ohioans with severe disability live in nursing homes.

- Twenty percent of Ohioans with severe disability receive in-home support through an array of Medicaid waiver programs, including: PASSPORT for older people, the Ohio Home Care programs for physically disabled individuals under 60, assisted living for individuals age 21 and older, and several waivers for individuals with intellectual disabilities.

- Ohio's PASSPORT Medicaid waiver program providing in-home services to individuals age 60 and over with severe disability has grown from an average monthly caseload of 15,000 in 1995 to 30,000 in 2010. Only two states have larger waivers for older adults, Washington and Texas.

- Ohio has 972 nursing homes with 96,000 licensed beds. Sixty-three percent of nursing home revenue comes from the Medicaid program.

- Between 1995 and 2009, Ohio quadrupled the number of residential care facility beds to 43,000. Ohio has 585 residential care facilities, and we classify 403 of these as assisted living residences. As of May 2011, 283 of these facilities were participating in the Assisted Living Waiver Program.

RESEARCH FINDINGS ON LONG-TERM CARE UTILIZATION IN OHIO

- Nursing homes have shifted their focus and now provide a combination of both long and short-term care. In 1992, Ohio nursing homes had 71,000 admissions, in 2009 that number had increased to 197,000. For the first time in two decades, in 2009 the number of admissions dipped slightly.

- The number of short-term Medicare admissions has been a major reason for the growth in nursing home admissions, going from 30,000 in 1992 to 126,500 in 2007. In 2009 Medicare admissions dropped to 109,000 (14% decrease).

- Many Ohioans use nursing homes for short stays; more than half spend three months or less and two-thirds are residents for less than six months.

- Nursing homes are serving a higher proportion of individuals under age 60, increasing to 12% in 2010, up from 4% in 1994. Almost 16% of Medicaid nursing home residents are under age 60.

- Ohio's nursing home diversion and transitions initiative served 3600 individuals between March 2010 and April 2011.

- Ohio's nursing home occupancy rate dropped to 84.7% in 2009, from 87.7% in 2007. The average daily census for private pay residents increased by 5%, Medicare decreased 9%, and the Medicaid average daily census dropped by 2%.

- Over the past 12 years (1997-2009) the average daily Medicaid census in nursing homes has dropped from 54,242 to 50,393 (7% decrease). The census for the over 60 Medicaid population has dropped by 14.5%, but has increased by 37% for those under age 60.

- In 2009, the average Medicaid nursing home reimbursement rate was $175 per day, (a drop from 2005 in today's dollars), private pay rates were $201 per day and Medicare was $399 per day, up from $363 in 2007.

- In 2009, residential care facility unit occupancy rates were 81%, a slight drop from 82% in 2007. The Assisted Living Waiver Program has grown to more than 2900 participants.

- Levels of disability vary across Ohio's Medicaid long-term care program participants. Nursing home residents average between four and five activity of daily living limitations, the Choices and Transitions Aging Carve-Out waivers average four activity limitations, PASSPORT averages three limitations, and PACE and the Assisted Living Waiver Program average between two and three activity limitations.

- Medicaid costs, after participant contributions, also vary by programs ranging from $1,067 per month for PASSPORT to $4,281 for nursing homes. PACE per member, per month amount was $2,643, a rate that covers both acute and the long-term care costs under Medicaid.

- Ohio has begun to change the long-term delivery system for older people with severe disability. In 1993, nine of ten older people supported by Medicaid were in nursing homes; by 2009, that proportion had dropped to 58%. The proportions have also changed for the under 60 population, dropping from 64% using nursing homes supported by Medicaid in 1997 to 51% in 2009. The under 60 ratio, however, has not changed much since 1999.

- Over the last 12 years, although the state has expanded the number of older people receiving in-home services, the Medicaid long-term care utilization rate has remained nearly constant. In 1997, Medicaid had a utilization rate of 31.8/1000 and in 2009 the rate was 32.5/1000 of persons over 60 using long-term services.

- In 1997, on average, 47,652 older Ohioans each day used Medicaid nursing home care. Comparatively, in 2009, 40,763 older Ohioans each day used Medicaid nursing home care. This means that each day Ohio's Medicaid nursing home population age 60 and over has been reduced by 6889 individuals (14.5% reduction). During this same period the overall population of Ohioans age 60 and older grew by 15% and Ohio increased its population 85 and above by almost 50,000.

- Between 1997 and 2009 the number of older Ohioans participating in Medicaid waiver programs increased from 14,168 to 30,388 (114% increase). The total number of individuals age 60 and older receiving Medicaid long-term services increased from 61,820 to 71,151 (15% increase). The overall population age 60 and older grew by 15% during this same time period, however, there was a significant shift in where individuals received services.

- An analysis of Medicaid costs indicates that this shift in utilization patterns for individuals age 60 and older results in Ohio's Medicaid long-term care expenditures in 2009 for this group ($2.64 billion) representing an estimated reduction from the 1997 Medicaid expenditures ($2.76 billion) by more than $100 million (calculated on 2009 dollar expenditure rates).

RECOMMENDATIONS

As an aging state, Ohio has begun to respond to today's concerns. This report has documented the considerable changes that Ohio has made over the last two decades. Since 1997, Ohio has altered how it delivers long-term services, particularly for individuals age 60 and older. Between 1997 and 2009 the population age 60 and older in Ohio rose by 15%; yet during that same time frame Medicaid nursing home use for older Ohioans dropped by 14.5%, and the number of home and community-based participants doubled. This change means that Ohio's Medicaid long-term services priced at today's rate for its older population are lower today than in 1997, despite increasing the number of people served each day by 9300. While this shift represents a major policy and program success in Ohio, the challenge of tomorrow generates the most important questions. Between now and 2040, when the baby boomers will be aging in full force, Ohio may double the population needing long-term services and supports. Growing the long-term care Medicaid budget proportionally to the increase in the older and disabled population, in combination with Medicaid's past inflationary increases, would have a staggering

effect on the state budget, easily doubling the proportion of state budget allocated to Medicaid (currently 25%). Given the pressures of education, economic development, infrastructure support and countless other demands on state government, such a scenario is not feasible.

States around the nation, confronted with similar problems, are now developing their responses. Although the perfect solution does not exist, there is a general consensus among long-term care experts about the steps necessary for states to meet these unprecedented challenges. Creating a system based on the principles of consumer choice, making sure individuals can choose their long-term service and support setting, is the hallmark of the expert advice. Translating this principle into action requires states to ensure that there is choice in the system and, thus, efforts such as Ohio's Unified Long-Term Systems Workgroup are critical to accomplishing these goals. The recommendations below represent ideas for Ohio as it continues to work toward long-term system reform.

(1) The demographic challenges of tomorrow are daunting. To respond to these changes, Ohio's system of long-term services and supports will need to be more efficient and effective. In our view, policy makers should consider four important areas in looking to the future. First, Ohio must place more emphasis on prevention and self-sufficiency. Today, about 49% of the 146,000 older people with severe disability rely on Medicaid. Estimates indicate that the sheer number of older people with severe disability could nearly double in size by 2040. Can policies and programs be developed to reduce the 49% participation rate through preventative activities? For example, programs being tested now to prevent falls that could result in lowering the rates of disability are the types of innovations that will need to be developed, tested and expanded. Second, efforts to improve technology to help serve the growing older population will be essential. Today communication devices are already being used to help assess and monitor services being received, both in the home and even in congregate settings. Current auto makers Toyota and Honda are even working on the development of personal care robots. While some innovations are a long way off, these are the types of technological changes that Ohio must be a part of in order to meet future state demand. Third, we need to continue to work to make our service system more efficient and effective. Whether it is through improved regulations, management practices, training of workers, or applying research evidence to enhance practice, the demographic pressures of tomorrow mean that an efficient and effective long-term services system will be essential. Finally, research results and practice experiences highlight the importance of families in providing long-term assistance. While families are providing more long-term services and supports today than ever in history, societal changes including work, mobility, and demographic mean that caregiving pressures have never been greater. Policies and programs that recognize these challenges and assist families will be critical as the older population with disability continues to grow.

(2) Given the changes described in this report, it is critical for Ohio to look carefully at utilization rates of the under 60 population and to formulate a strategy to respond to the needs of these individuals. This report indicates that Ohio has made important changes in how it delivers long-term services and supports to older individuals with severe disability. Over the last ten years, despite the increase in the number of those age 85 and above by 50,000, Ohio has seen a 14.5% reduction in Medicaid nursing home use by individuals age 60 and older. At the same time the state has experienced a 37% increase in the under 60 population using Medicaid nursing homes. We identified this trend in our 2009 report, and in the last two years the challenge has grown.

The increase in nursing home use by those under age 60 appears to be the result of several factors. First, the under 60 population has grown dramatically, as the bulk of the baby boomers are now between age 50 and 60. Second, the Ohio Home Care Waiver, which has grown slightly, has not been able to increase relative to the population changes now occurring. Third, evidence indicates that a portion of individuals under age 60 who are using nursing homes have lower levels of disability and in some instances the nursing home may not be the best care setting. We found that 17% of the under 60 population did not have any activity of daily living (ADL) impairments and 23% had zero or one ADL limitation. A more in-depth review indicates that a significant proportion of this population is experiencing behavioral health problems. The Ohio Home Care Waiver is designed to serve individuals with physical disability. Adults with chronic mental illness, in general, do not have access to home and community-based services, and in some instances, these individuals are ending up in Ohio nursing homes.

(3) Ohio has expanded its efforts to pursue nursing home diversion and transition and we recommend that such efforts be continued. A series of reforms including Home Choice, Home First and the Ohio Legislative Diversion and Transition Initiative, implemented for older people through the area agencies on aging, have begun to transform the long-term care delivery system. System changes, resulting in expanded efforts to work more directly with hospitals and nursing homes, appear to be having an impact on PASSPORT participants. For example, the proportion of individuals leaving PASSPORT for nursing home placement dropped from 38% in 2008 to 31% in 2010. During that same time period the proportion of those able to stay in the PASSPORT program until they died increased from 42% to 49%. These findings, combined with the reduced use of nursing homes by the older population, indicate that current program strategies are meeting state policy objectives. While such initiatives represent important

progress between now and 2020, the aging population will increase by 25%, and by 2040 the aging population will almost double. It will be critical for Ohio to build upon these efforts, but it must recognize that the pressures to reform the state's approach to delivering long-term services and supports will intensify in the future.

(4) The reduction in occupancy rates and the increase in the number of short stays in nursing homes provide another indicator of the dramatic changes experienced by the nursing home industry. Today's nursing home is a very different organizational entity than the facilities that were created during the 1960's and 1970's in response to a growing older population. At the time, Ohio and many other states thought they needed to create a nursing home industry to respond to the pending demographic changes that were going to result from increased life expectancy. Just as many of the health and long-term care delivery approaches of today were not yet on the policy radar screen, the emphasis on home and community-based alternatives was simply not considered an option. Today's circumstances mean that we have a transformed industry that is changing in focus, and that as a state we have more nursing home bed capacity than is necessary. It is critical for the state to determine the proper supply of beds and to work with the industry in reforming the focus of the industry. There will be a need for some type of nursing home in the future. The critical questions are what should the facilities of the future look like and what is the optimum capacity for the state? Because two-thirds of today's residents are supported by Medicaid, but 98% of nursing homes are non-governmental (either not-for-profit or proprietary), it is critical that the challenges faced by the industry be addressed through a public/private response.

(5) Finally, while Ohio has done a better job in its efforts to develop a long-term care data base to guide state policy decisions, there are gaps in the current approach. We recommend that Ohio have the same measures of program participant characteristics collected in a comparable way across programs and settings. Level of disability and costs vary considerably across long-term care programs and settings. While cost differentials are anticipated, it will be important for Ohio to have a better understanding of the program differences. However, without comparable data it is impossible to understand programmatic differences in costs and utilization.

BACKGROUND

While federal health reform has received the majority of national attention, another area of major importance, providing assistance to those individuals who need long-term services and supports, is an ever growing issue which falls primarily on the shoulders of the states. Although funded via the joint federal/state Medicaid program, it is the states that are responsible for overall program design and operations in the long-term services and supports arena. In most states, the initial long-term care strategy involved heavy investment in nursing homes. During the 1960's and 1970's, this was seen as a progressive move by states to ensure that older citizens had access to the needed care in a safe environment. As the older population increased in number, and issues of cost and quality began to permeate the nursing home industry, additional long-term service options were developed. As a result, states began to shift to other types of long-term care, such as in-home services, supportive housing, adult family care, and assisted living residences.

The tremendous growth in the older population, combined with the development of new options and a growing recognition that individuals with disability could live in a community environment, has changed how individuals use – and how states finance – long-term care. These changes have resulted in states now struggling with how to support a nursing home industry that they helped expand, while creating the array of service and support options that consumers are now requesting. In this report we track Ohio's progress over the last two decades as it has responded to the growing needs of the state. Ohio has made some important policy and programmatic changes that have improved its ability to meet the mounting challenges. This study documents these changes and highlights future areas for policy and programmatic consideration.

DEMOGRAPHICS

With more than 2 million individuals age 60 and over, Ohio ranks 7th in the nation in the sheer size of the population in this age category (U.S Census, 2011). In less than ten years, by 2020, the number of Ohioans age 60-plus will grow by 25%, and by 2040, the population age 60 and older will possibly double. Although the growth in our aging population is a marker of societal advancement, it is accompanied by serious challenges, especially in the area of long-term services and supports. About one in eight older Ohioans (about 264,000 people) experience a moderate or severe disability requiring long term assistance. Estimates indicate that the older population with severe disability (defined as individuals who meet the state's nursing home level-of-care criteria) will grow from 146,000 today to 170,000 by 2020 (16% increase), and by 2040 the number is estimated to nearly double. Looking at individuals across all age groups, we find that in 2009 there were about 309,000 Ohioans experiencing severe disability. A more extensive breakdown of the entire population with severe disability is provided in Table 1, where we find that 59% of this group includes adults with physical or cognitive disability, 12% are individuals with intellectual/developmental disability, and 29% experience severe mental illness.

Projections indicate that this number will grow to just over 348,000 by 2020 (Mehdizadeh, 2008). These demographic changes indicate that today's difficult issues are tomorrow's monumental challenges.

COSTS

With U.S. long-term care expenditures at $225 billion and growing, the cost of care is having a major impact on both individuals and government (Eiken, Sredl, Burwell, & Gold, 2010; MEDPAC, 2010). For individuals, long-term care is one of the leading causes of catastrophic expenses, with almost 20% of older people incurring more than $25,000 in out-of-pocket long-term care costs (Kemper, Komisar, & Alecxih, 2006). Nationally, estimates indicate that private out-of-pocket private insurance and long-term care expenditures topped $75 billion in 2010 (Kaye, Harrington, & LaPlante, 2010). The Medicaid program, the single largest funder of long-term care, spent $114 billion in that area in 2009. This represents about one-third of total Medicaid expenditures (Ohio LTC expenditures were about 36% of total Medicaid expenditures). Nationally, nursing homes and intermediate care facilities for those with intellectual/developmental disabilities represented $63 billion in expenditures, while the home and community-based waiver programs accounted for about $34 billion. An additional $12.5 billion was spent on the Medicaid personal care service option, which Ohio does not use. These patterns are a shift from ten years earlier, when nursing home expenditures were $44 billion, home and community-based waiver programs spent $8.2 billion, and $3.2 billion went to personal care (Burwell, 1999; Burwell, Sredl, & Eiken, 2008; Eiken, Sredl, Burwell, & Gold, 2010). Finally, the Medicare program covers a growing proportion of long-term care expenditures, accounting for more than 10% of total long-term care payments. Medicare's $25 billion expenditure represents a large increase from $11 billion spent in 1998 (AARP, 2000; MEDPAC, 2010).

Table 1
Ohio's Projected Population with Severe Disability by Type

Year	Total Population	Physical and/or Cognitive (59%)	Intellectual and/or Developmental (12%)	Severe Mental Illness (29%)	Total Population with Severe Disability
2005	11,464,045	178,241	36,597	89,673	304,511
2007	11,584,158	181,220	36,899	90,454	308,573
2010	11,764,330	185,672	37,352	91,626	314,650
2015	11,960,871	195,507	37,875	96,037	329,419
2020	12,177,862	208,154	38,485	101,490	348,129

Source: Reproduced from Mehdizadeh, S. (2008). *Disability in Ohio: Current and Future Demand for Services*. Oxford, OH: Scripps Gerontology Center, Miami University.

Ohio's long-term care expenditure patterns also show a heavy reliance on the Medicaid program, with total long-term care spending in this program topping $4.85 billion in 2009. The overall state cost of the Medicaid program is about one-quarter of the entire state budget, up from 21% ten years earlier. In 2009, Ohio spent $3.3 billion on institutional long-term care (68%) (nursing facilities and intermediate care facilities for individuals with intellectual/developmental disabilities) and $1.55 billion on community-based services (32%) (Mehdizadeh & Applebaum, 2011). Ohio's institutional Medicaid expenditures are 10 percentage points above the national average of 58%.

To better understand Ohio's spending patterns, it is important to separate out Medicaid services for those with intellectual/developmental disabilities and those with physical and cognitive disability. Institutional expenditures for individuals with intellectual/developmental disabilities were $744 million in 2009 (44%) compared to $934 million for community-based services (56%). For those with physical and cognitive disability, Ohio spent $2.54 billion on institutions (80%) compared to $634 million (20%) for community-based services. In 2004, Ohio had been ranked 47th among the states in its ratio of institutional to community-based expenditures for individuals of all ages and now ranks around 40th (Eiken, Sredl, Burwell, & Gold, 2010). Ohio ranks 33rd in its ratio of institutional/community-based expenditures for individuals age 60 and older.

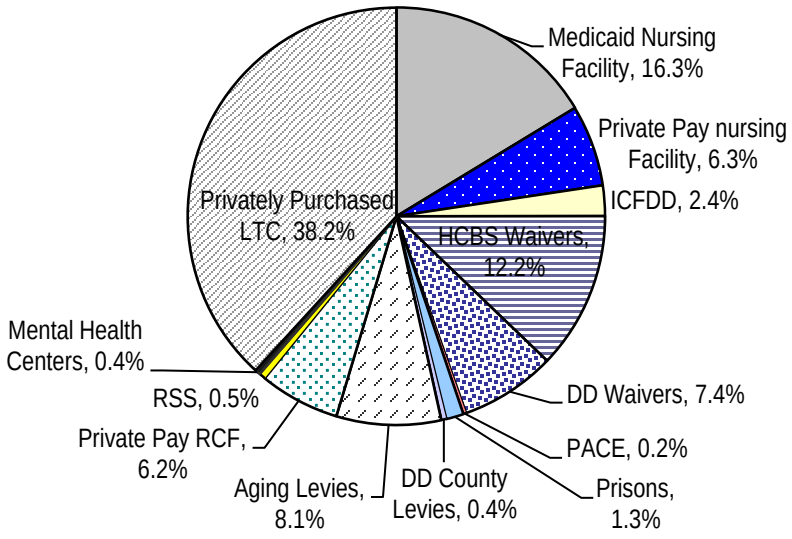
These numbers and other data presented throughout this report indicate that Ohio has begun to shift its long-term services and supports strategy. The state has continued to make programmatic changes in the long-term care delivery system. For example, Ohio's PASSPORT program has become one of the largest Medicaid waiver programs in the United States. PASSPORT has grown from an average monthly caseload of 19,500 older people with severe disability each day in 2004 to 30,000 in 2010. In 2006, Ohio became the 42nd state to operate an Assisted Living Medicaid Waiver Program. In 2009 that program had an average monthly caseload of 2000 and today serves almost 3000 individuals. Ohio has also received a Money Follows the Person (MFP) grant from the Centers for Medicare and Medicaid Services (CMS). Home Choice is designed to work with individuals transitioning from facility-based to community-based settings. Additionally, in the 2010/2011 biennial budget the general assembly asked the Ohio Department of Aging, through its network of Area Agencies on Aging, to develop a special program for nursing home diversion and transition to ensure appropriate use of Ohio's nursing homes. Between March of 2010, and May 1, 2011, more than 3600 Ohioans have been diverted or transitioned from nursing homes across the state (Applebaum, et al., 2011).

THE RANGE OF LONG-TERM SERVICE SETTINGS

To gain a better understanding of how long-term services and supports are delivered in the state, we review the range of settings and type of assistance used by individuals in Ohio who experience a severe disability. As shown in Figure 1, of the almost 309,000 Ohioans of all ages with severe disability, four in ten (38%) receive assistance from family or privately purchase

services, but do not receive publicly supported assistance. Less than one-quarter (22.6%) of those with severe disability reside in nursing homes and an additional 2.4% reside in institutions classified as Intermediate Care Facilities for people with intellectual or developmental disabilities (ICF/DD), which serve those with intellectual/developmental disabilities. Another 6% are living in residential care facilities. Sixteen percent of Ohioans with severe disability are supported by Medicaid in nursing homes. A growing number of Ohioans with severe disability (19.6%) are relying on Medicaid home and community-based waiver programs including 12% who are adults enrolled in PASSPORT, Choices, Assisted Living, Ohio Home Care, and Transitions Aging Carve-Out. An additional 7% of Ohioans were enrolled in the Medicaid waiver programs for individuals with intellectual/developmental disabilities. Finally, 8% of Ohioans with severe disability rely on county funded levy programs for assistance.

Figure 1
Proportion of Ohio's Population with Severe Disability
in Different Long-Term Care Settings (2009)



Source: Reproduced and updated from Medizadeh, S. (2008). *Disability in Ohio: Current and future demand for services.* Oxford, OH: Scripps Gerontology Center, Miami University.

This review finds that about 121,000 severely disabled Ohioans out of the state total of 309,000 (38%) relied on Medicaid for assistance with long term services and supports in 2009. In the following sections we provide an overview of the Medicaid programs designed to serve these individuals. The bulk of our analysis will focus on older adults, but in some cases we examine programs for individuals with physical or cognitive disabilities across the life span. In this report we do not include program data on individuals with intellectual/developmental

disabilities. Data show that individuals who experience severe disability receive assistance in their own homes, in the homes of friends and relatives, in adult care facilities, congregate housing, continuing care retirement communities, assisted living and other residential care facilities, and nursing homes. In the following sections we provide an overview of the long-term services and supports provided in the community and in residential care settings.

COMMUNITY

Most Ohioans with disability live in their own homes or in the home of a family member; in fact, more than two-thirds of individuals with severe disability in Ohio live in the community. Family and friends provide the majority of assistance to individuals living at home. National figures estimate that more than 80% of all long-term services and supports provided to older people are delivered by family and friends. More than seven years ago estimates valued informal care provided for older people in Ohio to be almost $12 billion annually, and while recent estimates are not available, the increase in the number of older people with disability in this time period indicates that this number is even higher today (Family Caregiver Alliance, 2004). For those Ohioans needing additional support, two major sources of formal in-home services are available: county property tax levies and Medicaid waiver programs.

County Levy Programs

Ohio counties are using a relatively unique approach to funding in-home services. Unlike the majority of states that have developed state-funded home care programs for individuals not eligible for the Medicaid waiver programs, Ohio is one of eight states that uses locally funded and managed programs to deliver in-home services. These programs are typically designed for individuals age 60 and over and are deemed important because Medicaid waiver programs are limited to people with severe disability and very low income. In Ohio, 69 of 88 counties have passed county-wide senior levies generating almost $140 million in 2009 to support services (Payne, Applebaum, & Straker, 2011). The county levies vary in size and scope with some, such as Hamilton and Franklin counties, generating more than $20 million annually, and others generating $50,000 per year or less. These programs typically focus on older people with moderate levels of disability and low-to-moderate incomes. In 2009, county levy programs served more than 100,000 older people in Ohio. We estimate that about 25,000 of these individuals were severely disabled.

Waiver Programs

Ohio has a series of Medicaid waiver programs serving adults with severe disability. The largest waiver program, PASSPORT, serves individuals 60 and older. The PASSPORT program is jointly administered at the state level by the Ohio Department of Job and Family Services (ODJFS), which is the single state Medicaid agency, and the Ohio Department of Aging, which is responsible for program operations. PASSPORT is operated on a regional level by Ohio's 12

area agencies on aging, and one private, non-profit human service organization. The administrative agencies use case managers to link an array of in-home services to the 30,000 older people who receive services through the PASSPORT program each day. An additional 3000 individuals are enrolled in the Assisted Living Waiver Program and receive case management services through the area agencies on aging. The regional agencies determine participant functional eligibility, assess consumer need, and arrange, monitor and fund services through their case management, fiscal, and quality assurance units. All of the direct services provided under PASSPORT are delivered by an array of approved community providers.

The Ohio Department of Aging also operates a companion waiver to PASSPORT, designed to allow older consumers the opportunity to self-direct their own services. The consumer essentially becomes the employer in this model and can hire, fire, and train their direct service workers. A financial management service manages payroll taxes for the consumer. The Choices waiver is also operated by the area agencies on aging, but it is not statewide at this point. Currently, the program is being implemented in Columbus, Rio Grande, Marietta, and Toledo and serves about 600 participants. The vast majority of the direct service workers in this program are family members (spouse excluded).

Table 2 provides an enrollment breakdown throughout 2010 for the 13 agencies operating PASSPORT, Choices and the Assisted Living Waiver Program at the regional level. Even though on any given day in 2010 these waivers served about 33,000 individuals, over the course of that year, PASSPORT, Choices, and the Assisted Living Waiver Program served almost 37,000 older Ohioans. By and large, the urban-based area agencies on aging, (Cleveland, Akron, Columbus, Dayton, and Cincinnati), report the largest number of program participants. The major exception to this pattern is the Rio Grande site. Although Rio Grande has about 4% of the state's severely disabled population, it accounts for 11% of the statewide caseload, and records a 73% annual service penetration rate. A number of factors can explain waiver participation rates, including the community economic profile, the presence or absence of county levy programs, and outreach and organizational approaches at each site. Overall, on a statewide basis, these three waivers annually serve about 25% of the older population with severe disability.

The state's other large community program for individuals with physical and cognitive limitations is the Ohio Home Care Waiver. This waiver program is managed at the state level by ODJFS and operated statewide by an independent case management agency, CareStar. In 2009, the program served 8535 participants. The program targets individuals under age 60, with 58% of enrollees between age 45 and 59. Nine percent of those served are under age 14. Technically, when individuals reach age 60 they are transferred to a companion waiver program called the Transitions Aging Carve-Out Waiver, which currently serves 1745 participants.

Ohio also has two sites that are part of a national initiative to integrate acute and long-term care through a managed care model. The Program of All-Inclusive Care for the Elderly (PACE) provides a service package that includes medical, social, and rehabilitative services.

Table 2
Distribution of PASSPORT, Choices, and
Assisted Living Consumers by Area Agency on Aging for Ohio, 2010

Area Agency on Aging (AAA)	Location	Estimated Total 60+ Population[1]	Estimated Population 60+[2] with Severe Physical and/or Cognitive Disability	Proportion of Ohio's Population 60+ with Severe Physical and/or Cognitive Disability	Number of PASSPORT/ Choices/ Assisted Living Consumers[3]	Proportion of PASSPORT/ Choices/ Assisted Living Consumers	PASSPORT/ Choices/AL Consumers as Percent of the Severely Disabled Population
1	Cincinnati	289,812	18,993	13.0	3142	8.5	16.5
2	Dayton	171,165	11,211	7.7	3652	9.9	32.6
3	Lima	72,241	4980	3.4	668	1.8	13.4
4	Toledo	182,040	12,071	8.2	2444	6.6	20.3
5	Mansfield	107,880	6961	4.8	2170	5.9	31.2
6	Columbus	272,820	16,732	11.4	4006	10.9	23.9
7	Rio Grande	87,343	5379	3.7	3937	10.7	73.2
8	Marietta	50,773	3158	2.2	899	2.4	28.5
9	Cambridge	104,770	6932	4.7	2138	5.8	30.8
10A	Cleveland	428,136	29,071	19.9	6688	18.2	23.0
10B	Akron	242,172	16,032	11.0	4277	11.6	26.7
11	Youngstown	150,726	10,254	7.0	1863	5.1	18.2
CSS*	Sidney	69,006	4411	3.0	954	2.6	21.6
	Total	2,228,884	146,184	100.0	36,838♦	100.0	25.2

* Catholic Social Services serves part of the Dayton region and is the only non area agency involved with the administration of PASSPORT services.
♦ Number of consumers who received services for part or the entire year.

Source: [1]U.S. Bureau of Census; U.S. Population Projections Detailed Data Files.
U.S. Census Bureau. American Fact finder: Basic Counts/Population. Retrieved on 4/20/2011 from
http://factfinder.census.gov/servlet/ACSSAFFPeople?_event=&geo_id=04000US39&_geoContext=01000US%7C04000US39%7C05000US39035&_street=&_county
[2]Mehdizadeh, S. (2008). *Disability in Ohio: Current and Future Demand for Services*. Oxford, OH: Scripps Gerontology Center, Miami University.
[3]PASSPORT Information Management System (PIMS).

Each PACE site has a team of doctors, nurses, social workers, and other health professionals who assess participants' needs, develop an integrated health plan and arrange and deliver the needed services. To be eligible for PACE, an individual must be at least age 55, meet the Medicaid nursing home level-of-care criteria, and be eligible for Medicaid or Medicare. There are two PACE sites in Ohio, TriHealth Senior Link in Cincinnati, serving Hamilton and parts of Butler, Clermont, and Warren counties, and the McGregor PACE Center for Senior Independence in Cleveland, serving Cuyahoga county residents. In 2009, a total of 815 individuals were served by PACE, with an average daily enrollment of 710.

RESIDENTIAL CARE

There is an array of residential care settings available to individuals with moderate and severe levels of disability. Adult foster homes, adult care facilities and residential care facilities most often serve residents with moderate levels of disability. In 2008, Ohio had 78 certified adult foster homes, and 652 adult care facilities (Brothers-McPhail & Mehdizadeh, 2009). Nursing homes and a portion of residential care facilities that are termed assisted living residences serve individuals with severe levels of disability.

Nursing Homes

Ohio has 972 nursing homes that contain 95,803 licensed beds (93,209 beds in service in 2009). The number of nursing home beds per 1,000 persons age 65 and older is 64, giving Ohio the 10th highest supply of beds per capita in the nation (Houser, Fox-Grage, & Gibson, 2009). The vast majority of nursing homes (908) are either freestanding or part of a continuing care retirement community. Forty-two facilities (4%) are part of hospital units and 22 (2%) are county homes (see Table 3). The number of hospital-based units dropped from 57 in 2007, recording 666 fewer beds in service in 2009. The average nursing home in Ohio has 98 beds, almost three-quarters (73.3%) are located in urban communities and are proprietary (74.3). About one in five (19%) are part of continuing care retirement communities.

A large part of the funding base for nursing homes is the Medicaid program, which provides 63% of total revenues. The average Medicaid rate in 2009 was $175 per day. Medicare accounts for 13% of funding, with an average reimbursement rate of $400 per day. Out-of-pocket costs, private insurance, and the Veterans Affairs comprised 23% of overall revenue. A private pay room was $220 per day for single occupancy and $201 per day for a shared room. The average private insurance rehabilitation reimbursement rate was $346 per day. Private long-term care insurance provides 1.4% of the total revenue. Nursing homes are licensed and inspected by the Ohio Department of Health (ODH) and the Medicaid payment system is administered by ODJFS.

Table 3
Ohio's Nursing Facility Characteristics, 2009

	All Nursing Facilities	County Homes	Hospital-Based Long-Term Care Unit
Number of Facilities	972	22	42
Licensed/Certified Nursing Facility Beds 12/31/09	95,803	2636	2379
Average Number of Beds Available Daily	93,209	2668	2217
Average Number of Licensed Beds	98	122	56
Location (percent)			
Urban	73.3	45.4	83.3
Rural	26.7	54.6	16.7
Ownership (percent)			
Proprietary	74.3	--	9.8
Not for Profit	23.2	--	82.9
Government	2.5	100.0	7.3
Average Daily Charge (dollars)			
Medicaid	$175	$166	$202
Medicare	$399	$377	$393
NF Private Pay (private room)	$220	$192	$433
NF Private Pay (shared room)	$201	$181	$436
Private Insurance (including Medicare Advantage)	$346	$349	$539
Revenue Sources (percent)			
Medicaid	63.0	49.6	41.6
Medicare	12.8	9.1	30.2
Private (self, others, and insurance)	22.8	40.8	23.3
Long-Term Care Insurance Only	1.4	0.5	4.9

Source: Biennial Survey of Long-Term Care Facilities, 2010.

Residential Care/Assisted Living Facilities

Residential care facilities provide personal care to 17 or more individuals, with a limit of 120 days of skilled nursing care in a year. In 2009, there were 585 residences containing 42,700 beds; up from 19,400 beds in 1997. The increase in the number of residential care facility beds is driven by growth in assisted living facilities. Because Ohio does not have a general definition of assisted living, we have applied the criteria that a facility must meet to participate in the Assisted Living Medicaid Waiver Program to systematically identify assisted living facilities. Requirements include such elements as a private bedroom and bathroom, locking door, 24-hour staffing, and the availability of a registered nurse. Based on our statewide survey, we estimate that 403 facilities appear to meet the state definition of assisted living. Currently, 283 facilities have been approved to participate in the Ohio Assisted Living Waiver Program, serving almost 3000 individuals age 21 and older.

Residential care facilities report an average of 73 beds and 54 units per residence (see Table 4). About three-quarters of facilities are located in urban areas, and one-third are part of a continuing care retirement community. There are a variety of room configurations that operate under the residential care licensure category, ranging from double occupancy with no private bathroom units, to two bedroom units with kitchen and sitting areas. As a result, the average monthly charge varies considerably, ranging from $900 to $8,200, depending on the type of unit. The overall statewide average was $3,300 per month.

Table 4
Comparison of the Characteristics of
Ohio's Residential Care Facilities

	All RCFs	RCF Only	Assisted Living
Number of Facilities	585	182	403
Total Licensed RCF beds	42,701	10,534	32,167
Total Number of Units	31,573	7978	23,595
Average Number of Beds	73	58	80
Average Number of Units	54	44	59
Average Monthly Rate	$3,304	$3,367	$3,277
Location (percent)			
Urban	76.2	77.5	75.9
Rural	23.8	22.5	24.1
Ownership (percent)			
Proprietary	71.7	74.6	70.4
Not for Profit	28.3	25.4	29.6
Part of CCRC (percent)	32.6	31.4	33.1

Source: Biennial Survey of Residential Care Facilities, 2010.

TRACKING LONG-TERM SERVICES AND SUPPORTS USE IN OHIO

Since 1993, with initial funding from the General Assembly and subsequent funding from the Ohio Department of Aging, we have tracked long-term care utilization in the state. Because long-term services and supports are provided in a range of settings with different funding sources, tracking use rates relies on a number of data sources. Information on nursing homes and residential care facilities comes from the biennial survey of facilities completed by Scripps every other year since 1999 and the Ohio Department of Health prior to that date. Response rates for our 2009 survey were high, with 92% of nursing homes and 86% of residential care facilities completing the survey, which is now done on-line. Data from the Medicaid Cost Report, completed by each facility and compiled and provided to us by ODJFS and the national Online Survey Certification and Reporting (OSCAR) generated by the Centers for Medicare and Medicaid Services (CMS), were used to supplement the facility survey. To track characteristics of nursing home residents, the study relies on the Nursing Home Minimum Data Set (MDS), completed by certified nursing homes when a resident is admitted, when a resident changes status, and for all residents at the end of each quarter. Data on PASSPORT, Choices, and the Assisted Living Waiver Program come from the PASSPORT Information Management System (PIMS). The two Ohio PACE sites provided participant assessment data directly to Scripps for analysis. Information for the Ohio Home Care Waiver and the Transitions Aging Carve-Out came from ODJFS (Medicaid Management Information System, Office of Ohio Health Plans, Bureau of Home & Community Services.) Medicaid cost data also came from ODJFS via the Decision Support System, Office of Ohio Health Plans.

NURSING FACILITY USE

The nature of nursing home use in Ohio has changed dramatically since we began tracking utilization rates in 1992. As shown in Table 5, while the number of beds in service has remained stable over the study time period (around 93,000), admissions have risen dramatically. In 1992, Ohio nursing homes recorded 71,000 admissions. From 1997 to 2007, the number of admissions had risen from 130,000 to 201,000 individuals (55% increase over the ten year period). In 2009, the number of admissions dipped slightly to 197,000 (2% decrease).

Until 2007 the increase had been driven by changes in Medicare admissions. In 1992, 30,000 of the admissions were “Medicare admits”; by 1997 that number had more than doubled to 80,000; and by 2007 there were 126,500 Medicare admissions (58% ten-year increase). For many, nursing homes have become a place for short-term rehabilitative care after an acute hospital admission. A major reason for this change has been the reduction in the average length of a hospital stay reimbursed by Medicare as a result of the prospective payment system. In 2009, the steady increase in Medicare admissions was reversed, dropping to 109,000 (14% decline). This reduction appears to be the result of four changes occurring in the system: (1) an increase in individuals under age 65 being admitted from hospitals to nursing homes, who are

Table 5
Ohio Nursing Facility Admissions, Discharges, and Occupancy Rates, 1992 – 2009

	1992	1997	1999	2001	2003	2005	2007	2009
Adjusted Nursing Facility Beds[a]								
Total beds	91,531	99,302	95,701	94,231	90,712	91,274	92,443	93,209
Medicaid certified	80,211	88,679	93,077	87,634	NA	87,090	90,559	90,876
Medicare certified	37,389	34,157	47,534	62,088	NA	86,701	91,659	91,928
Number of Admissions								
Total	70,879	129,778	149,838	149,905	168,924	190,150	200,954	197,233
Medicaid resident	17,968	19,063	28,150	24,442	NA	34,432	25,182	27,040
Medicare resident	30,359	80,006	78,856	90,693	NA	116,810	126,528	109,315
Occupancy Rate (Percent)[b]								
Total	91.9	87.7	83.5	83.2	84.7	86.4	87.7	84.7
Medicaid resident[c]	67.4	61.8	55.4	58.5	NA	58.8	56.9	55.4
Medicare resident[d]	9.9	20.9	12.8	11.8	NA	11.6	12.1	11.1

NA = Not available.

[a]Total beds include private, Medicaid, and Medicare certified beds. Because some beds are dually certified for Medicaid and Medicare, the individual categories cannot be summed. The total beds, Medicaid, and Medicare certified beds are adjusted to account for facilities that did not respond to the survey in each year.
[b]The occupancy rate since 1996 is based on facilities that did not have ICF/DD certified beds. In facilities with ICF-MR beds all beds are dually licensed, therefore it is impossible to separate Medicaid-DD residents from other residents.
[c]Medicaid certified beds occupied by residents with Medicaid as source of payment.
[d]Medicare certified beds occupied by residents with Medicare as source of payment.

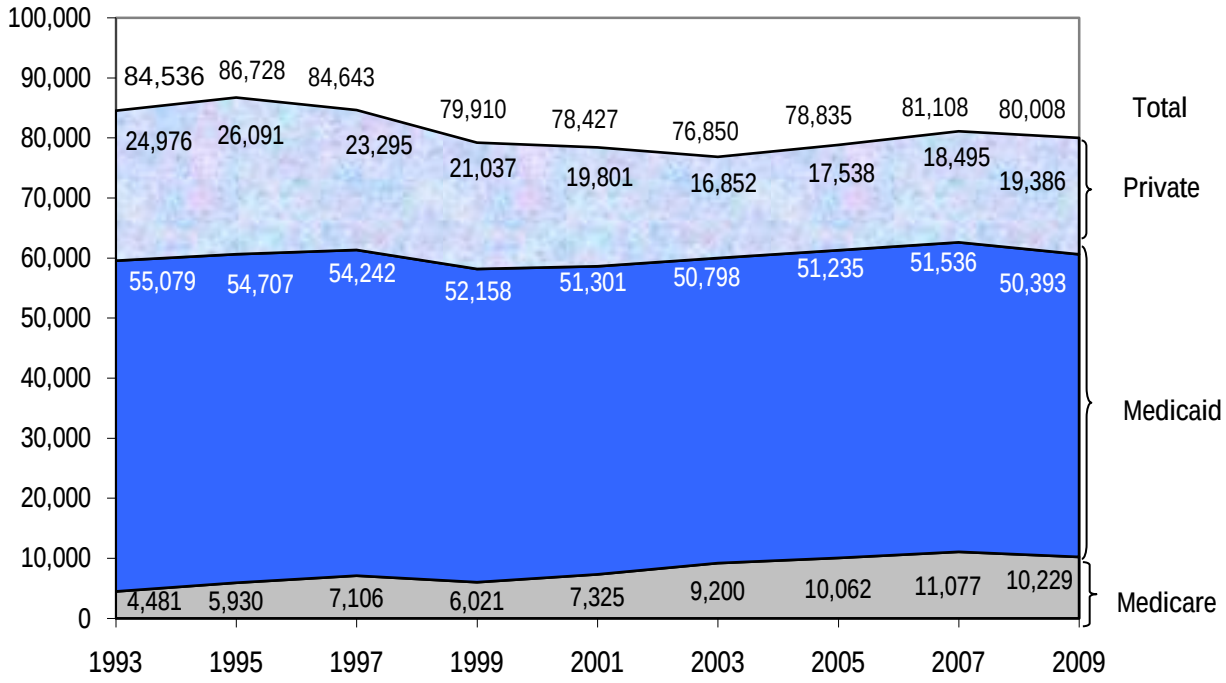
Source: Annual Survey of Long-Term Care Facilities. Ohio Department of Health 1992 - 1997, Annual and Biennial Survey of Long-Term Care Facilities, Ohio Department of Aging and Scripps Gerontology Center, 1999 - 2009.

reimbursed through private insurance, (2) a reduction in the Medicare hospital use for those age 65 and older in 2009 that was the lowest rate since 1990, meaning fewer overall nursing home referrals (Health Care Financing Review Statistical Supplement, 2010), (3) an increase in Medicare home health use post hospital discharge, such that some individuals are receiving rehabilitative care at home, rather than in a nursing home, and (4) a reduction in the number of hospital-based skilled nursing facilities and an increase in the number of long-term acute care hospitals (LTAC) in Ohio.

The question about how these use patterns affect Ohio nursing home occupancy rates is also presented in Table 5. Overall, occupancy rates in Ohio nursing homes decreased from 87.7% in 2007 to 84.7% in 2009. The reduced occupancy rate is a result of an increase in the number of beds actually in service in 2009 and a lower daily census. The total number of beds in service increased by 766, to 93,209 (.8% increase). As shown in Figure 2, the average daily nursing home census in 2009 was 80,008, a 1.4% decrease in the last two years. Individuals paying privately increased from 18,495 to 19,386 (4.8% increase), and the average number of residents each day reimbursed by Medicare decreased to 10,229 (7.7% decrease). The Medicaid census dropped by more than 1100 persons each day to 50,393 (2.2% decrease). The increase in private pay residents represents a continued reversal in the ten year drop in the private market that had occurred between 1995 and 2005 and is an indicator of a higher number of individuals under age 65 using nursing homes for rehabilitative care covered by private insurance.

In breaking down the Medicaid census by age we see a pattern showing a decrease in the over 60 Medicaid nursing home population and an increase in the under 60 group. Between 1997 and 2009, there was a 14.5% drop in overall daily census for the population age 60 and older; with the last two year time frame (2007 - 2009) showing a 6% decline. For the same 1997-2009 time frame the nursing home average daily census for those under age 60 increased by 37%; with the most recent two years (2007 - 2009) recording a 17% increase.

Figure 2
Average Daily Nursing Facility Census, 1993 - 2009



Source: Survey of Long-Term Care Facilities in Ohio, 1993-2009.

NURSING FACILITY RESIDENT CHARACTERISTICS AND COSTS

In this section we examine the characteristics of those using nursing homes and the costs of this care. More than half of nursing home residents are age 80 and above (55%), with almost one-in-five age 90 and older (see Table 6). Despite the concentration of residents in their eighties, as noted above, nursing homes today have a higher proportion of those under age 60 than in the past. For example, today 11.6% of all nursing home residents are under age 60; in 1994, the proportion was 4%. This increase was reported in our previous analysis as well, and is largely driven by utilization changes recorded in the Medicaid program, where 15.6% of those using the nursing home are under age 60. The proportion of residents under age 65 grew to more than 17%, up from 6.8% in 1994.

Nursing home residents continue to be primarily white women who are widowed, but the profile is changing (see Table 7). For example, today 67% of residents are women, down from 71% in 2004 and 74% in 1994. In 2010, 23% of residents were married, in comparison to 18% in 2004 and 15% in 1994. These demographic changes are very much related to the shift to short-term care for a growing number of individuals using Ohio nursing homes.

In looking at physical functioning as measured by the residents' ability to perform the activity tasks of daily living (ADL), we find that, on average, today's nursing home residents are

quite impaired, with 84% reporting four or more ADL impairments (see Table 8). Six in ten residents are reported to experience incontinence and cognitive impairment (55%). Residents are slightly more functionally impaired than in 1994, and slightly less impaired in the area of cognitive impairment, and thus, on balance, appear to be relatively consistent from a case mix standpoint over the study time period (Table 9). The proportion of residents reporting a limitation in the ADL item that measures bathing showed a drop from 85% in 2008 to 75% in 2010. This seems to be largely driven by Medicaid residents (73%).

Despite this high level of disability, 5.5% of residents, regardless of payer source, are classified as having no ADL impairments, and more than 9% have zero or one ADL limitation in 2010. A review of Medicaid residents showed 7.1% with zero ADL impairments and 11.7% with zero or one ADL impairment. In an earlier analysis we found that 4.4% of individuals residing in nursing homes and funded by Medicaid did not appear to meet the level-of-care criteria in 2004. This study found 3.9% of residents did not appear to meet level-of-care criteria in 2008. Because of the increase in the number of Medicaid residents under age 60, we examined this group in comparison to the nursing home population age 60 and older (see Table 10). More than four of five of the under age 60 group are between 45 and 59, reflecting the growth of the baby boomers into this age group. Unlike the traditional older resident population, this group has a much lower proportion of females (46% vs. 73%), and this group is more likely to be non-white (27% vs. 16%). This group is much more likely to have never been married in comparison to the over 60 group (56% vs. 14%).

Table 6
Comparison of the Demographic Characteristics of All Ohio Certified Nursing Facility Residents and Residents with Medicare and Medicaid as Source of Payment, 2009 – 2010

	All (Percentages)	Medicare (Percentages)	Medicaid (Percentages)
Age			
45 and under	2.2	1.0	3.2
46-59	9.4	4.9	12.4
60-64	5.6	3.3	6.2
65-69	7.0	8.0	7.1
70-74	8.9	11.3	8.5
75-79	12.1	14.9	11.2
80-84	17.4	21.0	16.2
85-89	19.5	21.0	17.9
90-94	12.6	11.2	11.8
95+	5.3	3.4	5.5
Average Age	78.2	79.6	76.7
Gender			
Female	66.9	64.5	68.7
Race			
White	86.1	90.0	82.2
Black	12.8	8.9	16.4
Other	1.1	1.1	1.4
Marital Status			
Never Married	15.5	8.6	20.5
Widowed/Divorced/Separated	61.3	59.4	64.3
Married	23.2	32.0	15.2
Resident Population Size*	105,039	14,017♦	59,006

*Data presented here reflect the characteristics of all residents, and those with Medicare and Medicaid (April – June 2009) as source of payment.

♦Some residents with Medicare as source of payment at the end of the quarter are not identifiable thus are excluded.

Source: MDS 2.0 April – June 2009 - 2010.

Table 7
Comparison of the Demographic Characteristics of Ohio's
Certified Nursing Facility Residents Over Time,
1994, 2004 – 2010

	1994 (Percentages)	2004 (Percentages)	2006 (Percentages)	2008 (Percentages)	2010 (Percentages)
Age					
45 and under	0.2	2.5	2.4	2.2	2.2
46-59	3.8	7.6	8.7	8.7	9.4
60-64	2.8	4.0	4.3	4.7	5.6
65-69	5.1	5.2	5.6	6.6	7.0
70-74	9.0	7.8	7.6	8.6	8.9
75-79	14.0	13.5	12.4	12.9	12.1
80-84	19.4	19.8	19.1	18.9	17.4
85-89	21.6	19.9	20.2	19.5	19.5
90+	24.1	19.7	19.7	17.9	17.9
Average Age	83.1	79.4	79.1	78.6	78.2
Gender					
Female	73.8	70.9	70.1	68.0	66.9
Race					
White	88.5	86.4	86.5	86.8	86.1
Marital Status					
Never Married	14.3	15.7	16.4	15.1	15.5
Widowed/Divorced/ Separated	70.6	66.1	65.2	62.7	61.3
Married	15.1	18.2	18.4	22.2	23.2
Population	81,414♦	73,900♦	73,869♦	94,016*	105,039*

♦Residents present at the end of the quarter specified below.

*Data presented here reflect the characteristics of all residents, who during the quarter specified below spent some time in a nursing facility.

Source: MDS Plus October-December 1994.
MDS 2.0 April – June 2004, 2008, and 2010.
MDS 2.0 July - September 2006.

Table 8
Comparison of the Functional Characteristics of All Ohio Certified Nursing Facility Residents and Residents with Medicare and Medicaid as Source of Payment, 2009 – 2010

	All (Percentages)	Medicare (Percentages)	Medicaid (Percentages)
Needs Assistance in Activities of Daily Living (ADL)[1]			
Bathing	75.4	87.4	73.0
Dressing	88.8	93.2	86.2
Mobility	85.8	94.3	80.7
Toileting	86.4	92.6	82.5
Eating	36.5	19.3	40.7
Grooming	86.4	87.2	86.0
Number of ADL Impairments[2]			
0	5.5	2.9	7.1
1	3.7	2.1	4.6
2	2.9	2.3	3.5
3	3.9	3.3	4.1
4 or more	84.0	89.4	80.7
Average Number of ADL Impairments	4.6	4.7	4.5
Incontinence[3]	60.6	37.9	67.6
Cognitive Impairment[4]	54.5	29.3	56.9
Average Case Mix Score	2.1	2.7	1.8
Resident Population Size*	105,039	14,017♦	59,006

*Data presented here reflect the characteristics of all residents, and those with Medicare and Medicaid (April – June 2009) as source of payment.

♦Some residents with Medicare as source of payment at the end of the quarter are not identifiable thus are excluded.

[1] "Needs assistance" includes limited assistance, extensive assistance, total dependence, and activity did not occur.
[2] From list above.
[3]"Occasionally, frequently, or multiple daily episodes."
[4]"Moderately" or "severely" impaired.

Source: MDS 2.0 April – June 2009 - 2010.

Table 9
Comparison of the Functional Characteristics of Ohio's
Certified Nursing Facility Residents Over Time,
1994, 2004 – 2010

	1994 (Percentages)	2004 (Percentages)	2006 (Percentages)	2008 (Percentages)	2010 (Percentages)
Needs Assistance in Activities of Daily Living[1]					
Bathing	94.0	93.6	93.1	85.1	75.4
Dressing	83.6	85.3	85.5	87.1	88.8
Mobility/Transfer♠	68.7	74.6	76.2	83.0	85.8
Toileting	75.1	80.1	80.9	83.8	86.4
Eating	38.5	32.5	31.4	30.5	36.5
Grooming	83.4	84.2	84.7	84.8	86.4
Number of ADL Impairments[2]					
0	5.1	5.4	5.2	6.1	5.5
1	7.2	6.1	6.1	4.4	3.7
2	4.9	3.9	4.0	3.5	2.9
3	7.7	5.4	5.2	4.5	3.9
4	75.1	79.2	79.5	81.5	84.0
Average Number of ADL Impairments	4.2	4.5	4.5	4.5	4.6
Incontinence[3]	59.4	60.9	61.0	56.2	60.6
Cognitively Impaired[4]	61.5	66.5	66.9	55.3	54.5
Average Case Mix Score	Not comparable	1.98	2.01	2.2	2.1
Population	81,414♦	73,900♦	73,869*	94,106*	105,039*

♦Residents present at the end of the quarter specified below.

*Data presented here reflect the characteristics of all residents, who during the quarter specified below spent some time in a nursing facility.

♠In 1994 and 2004 the ADL transferring, one of the components of mobility is reported.

[1]"Needs assistance" includes limited assistance, extensive assistance, total dependence, and activity did not occur.
[2] From list above.
[3]"Occasionally, frequently, or multiple daily episodes."
[4]"Moderately" or "severely" impaired.

Source: MDS Plus October-December 1994.
MDS 2.0 April – June 2004, 2008, and 2010.
MDS 2.0 July - September 2006.

Table 10
Comparison of the Demographic Characteristics of Certified Nursing Facility Medicaid Residents by Age Group, FY 2009

	Under 60 Years (Percentages)	60 Years and Older (Percentages)
Age		
Less than 18	0.2	--
18-30	3.4	--
31-44	15.0	--
45-59	81.4	--
60-64	--	7.3
65-69	--	8.4
70-74	--	10.1
75-79	--	13.3
80-84	--	19.2
85-89	--	21.2
90-94	--	13.9
95+		6.6
Average Age	50.3	81.6
Gender		
Female	45.7	73.0
Race		
White	73.2	84.2
Black	25.3	14.7
Other	1.5	1.1
Marital Status		
Never Married	55.7	14.3
Widowed/Divorced/Separated	33.2	69.7
Married	11.1	16.0
Medicaid Residents*	9229	49,777
Percent of Medicaid Residents	15.6	84.4

*The data present the characteristics of the Medicaid residents who spent some time in a nursing facility between April and June 2009.

Source: MDS 2.0 April – June 2009.

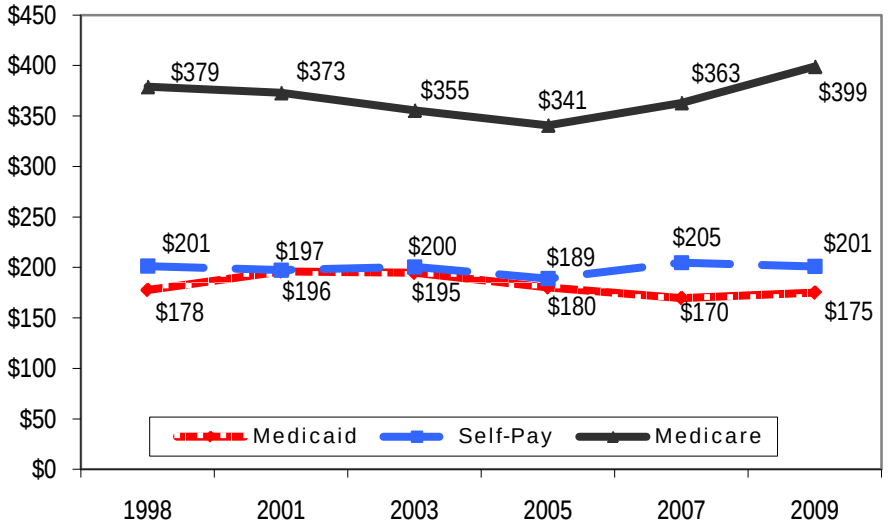
The analysis of the functional ability of the under 60 Medicaid group continues to raise questions about placement decisions. Seventeen percent of the under 60 group are reported to have no ADL limitations, and 23% have one or zero activity impairments (see Table 11). Across every major indicator these individuals appear to be considerably less impaired when compared to Medicaid residents age 60 and older. In comparing Medicaid residents who do not appear to meet level-of-care criteria, we find that while 3.2% of the 60 and older group did not appear to meet level-of-care criteria, the under 60 group included 9% in that category. These findings suggest that while the functional characteristics of older nursing home residents are increasing, the under 60 age group is a less functionally disabled population.

Costs

In this section we present nursing home costs over time in 2009 dollars, as adjusted for inflation. As shown in Figure 3, the average Medicaid reimbursement rate in 2009 was $175 per resident day, or just under $64,000 annually. The 2009 Medicaid rate represents no change when factoring in an increased franchise bed tax and an altered therapy reimbursement approach. The private pay rate was $201 per day, or $73,365 annually, and again does include the franchise bed tax. The Medicare rate, which is linked to resident rehabilitation and is for short-term care, is $399 per day, or $145,635 annually. The private pay insurance rate was $346 per day.

Overall, the historical analysis indicates that while Ohio Medicaid rates saw steady increases throughout the 1990's (increasing from $123 to $178 per day in today's dollars), since 2001, the reimbursement rate has actually gone down when adjusted for inflation. Ohio's 2007 nursing home Medicaid rate ranked 7th (in terms of reimbursement) nationally, but data are not yet available for the 2009 rate comparisons (Houser, et al., 2009).

Figure 3
Average Nursing Facility Per Diem by Source of Payment in 2009 Dollars, 1998 - 2009



Source: Survey of Long-Term Care Facilities in Ohio, 1998-2009.

Table 11
Comparison of the Functional Characteristics of Ohio's
Certified Nursing Facility Medicaid Residents by Age Group,
FY 2009

	Under 60 Years (Percentages)	60 Years and Older (Percentages)
Needs Assistance in Activities of Daily Living (ADL)[1]		
Bathing	56.5	76.0
Dressing	73.9	88.5
Mobility	68.8	82.9
Toileting	70.8	84.7
Eating	38.9	41.0
Grooming	75.6	87.9
Number of ADL Impairments[2]		
0	16.7	5.3
1	6.2	4.3
2	4.5	3.3
3	4.5	4.0
4 or more	68.1	83.1
Average Number of ADL Impairments	3.8	4.6
Incontinence[3]	53.7	70.2
Cognitive Impairment[4]	46.2	58.8
Medicaid Residents* (Number)	9229	49,777

*The data present the characteristics of all Medicaid residents who spent some time in a nursing facility between April and June 2009.

"Needs assistance" includes limited assistance, extensive assistance, total dependence, and activity did not occur.
[2] From list above.
[3]"Occasionally, frequently, or multiple daily episodes."
[4]"Moderately" or "severely" impaired.
[5]Case mix scores are used by Medicaid to determine reimbursement rates. A higher case mix score means that the resident has a higher level of impairment.

Source: MDS 2.0 April – June 2009.

RESIDENTIAL CARE FACILITY USE AND COST

Ohio has 585 residential care facilities that include about 31,600 units, with almost 43,000 licensed beds. The growth in licensed residential care facilities has been dramatic, doubling the number of facilities from 265, and quadrupling the number of beds (10,700 beds) between 1995 and 2009. Much of the growth has occurred as a result of the development of the assisted living industry. As noted earlier, we estimate that 403 facilities would meet the Medicaid waiver definition of an assisted living residence. As of May 2011, 283 of these facilities were participating in the Assisted Living Medicaid Waiver Program.

A review of residential care facility use patterns finds an overall unit occupancy rate of 80.9%; a slight drop from our 2007 survey (81.7%) (see Table 12). Because residential care facilities have more licensed beds than units, the bed occupancy rate is lower, at 64%. Since the overwhelming majority of assisted living residences are single room, we believe the unit rate is a better measure of utilization. Occupancy rates in residential care facilities appear to have been helped by the expansion of the Assisted Living Waiver program, which by the end of 2009 had grown to almost 2700 participants and today is approaching 3000.

Information on the characteristics of individuals who use residential care facilities is also presented. Unlike our nursing home data, which are based on individual records, these findings represent summary estimates provided by the facilities. To generate these numbers, facility respondents were asked to estimate how many of their current residents had a functional impairment in areas such as bathing, dressing and cognitive functioning. These findings indicate that about four in ten residents (43%) had two or more ADL limitations (see Table 13). About one-third receive skilled nursing care. Three in ten are reported to have a cognitive impairment (29%).

More detailed data are available on participants in the Assisted Living Medicaid Waiver Program (see Table 14). In 2010, the average age was 81 and almost half (46%) were 85 and older. Eight in ten were women, and the vast majority (92%), were not married. About nine in ten were impaired in bathing and participants averaged between two and three ADL impairments. Almost 40% of waiver participants needed supervision. These data indicate that the waiver participants are more disabled than the typical residential care facility resident.

Table 12
Comparison of Occupancy and Length of Stay in
Ohio's Residential Care Facilities, CY 2007 – 2009

	Overall (Percentages)		RCF Only (Percentages)		Assisted Living (Percentages)	
	2007	2009	2007	2009	2007	2009
Unit Occupancy	81.7	80.9	80.0	80.8	82.8	81.0
Bed Occupancy	66.1	64.3	65.9	67.5	66.7	62.8
Length of Stay	NA	952 days	NA	990 days	NA	936 days

Source: Biennial Survey of Residential Care Facilities, 2008 - 2010.

Table 13
Comparison of the Functional Characteristics of
Ohio's Residential Care Facilities Residents, CY 2009

	Overall (Percentages)* 2009	RCF Only (Percentages)* 2009	Assisted Living (Percentages)* 2009
Needs Assistance in Activities of Daily Living (ADL)			
Bathing	65.8	67.4	65.1
Dressing	49.8	49.7	49.8
Transferring	23.5	24.8	22.9
Toileting	33.5	35.1	32.9
Eating	8.0	9.0	7.6
Walking	21.2	21.6	21.0
With Two or More Activities	42.9	44.9	42.0
Medication Administration	77.3	82.5	75.1
Received Skilled Nursing Care	32.9	38.4	30.6
Behavior Problems	13.5	19.5	10.9
Cognitive Impairment	28.5	36.8	24.8

*Percentages are provided by facilities. The numbers are averaged for all facilities that provided a response to each question.

Source: Biennial Survey of Residential Care Facilities, 2010.

Table 14
Demographic and Functional Characteristics of
Enrollees in the Assisted Living Waiver Program,
FY 2008 - 2010

Characteristics	2008	2010 (Percent)
Age		
≤45	1.2	0.8
46-59	7.4	6.5
60-64	5.7	5.1
65-69	5.3	5.4
70-74	8.2	7.7
75-79	12.1	11.4
80-84	17.7	17.0
85-89	23.0	22.4
90-94	12.5	16.3
95+	6.9	7.4
Average Age	79.5	80.6
Gender		
Female	79.1	80.1
Male	20.9	19.9
Race		
White	88.0	88.6
Black	9.8	9.0
Other	2.2	2.4
Marital Status		
Non-Married	93.1	92.4
Married	6.9	7.6
ADL Impairment		
Bathing	91.8	87.5
Dressing	48.5	49.8
Mobility	72.4	72.6
Toileting	25.2	20.2
Eating	3.9	4.9
Grooming	22.7	20.6
Average Number of ADL Impairments	2.6	2.6
IADL Impairment		
Community Access	96.4	96.0
Environmental Management	99.7	98.2
Shopping	97.9	97.4
Meal Preparation	98.3	97.1
Laundry	94.3	95.3
Medication Administration	83.2	80.8
Needs Supervision		
24-hour	11.5	13.9
Partial time	27.8	23.4
Consumers Served	413	1943

[1]From the list above

Source: PASSPORT Information Management System (PIMS), 2008 and 2010.

PASSPORT USE AND COSTS

PASSPORT has become one of the largest aging/disabled Medicaid waiver programs in the United States, spending about $341 million in 2009. The program has expanded considerably, increasing from serving 4,200 individuals in 1992 to 15,000 in 1996, to 30,000 daily in 2010. Of the 74 different aging/disability waivers nationwide, only Washington and Texas have larger programs (Burwell, et al., 2008). To be eligible, applicants must meet the Medicaid nursing home eligibility criteria. Once PASSPORT applicants meet the economic and disability thresholds, the PASSPORT case managers, working in conjunction with participants and their families, develop a plan of care and arrange the necessary services. The administrative staff, case managers and other program professionals are responsible for monitoring and quality management activities.

PASSPORT case managers choose from an array of services such as personal care, adult day care, home delivered meals, respite care, and medical equipment. As shown in Table 15, more than 70% of all program service dollars statewide are allocated to personal care. Since individuals with severe chronic disability require assistance with the tasks of daily living, such as bathing and dressing, the heavy utilization of personal care services is common in programs of this nature. About 15% of program service dollars are allocated to home-delivered meals, an increase from 11% in 2008. That 86% of all services dollars are allocated to personal care and meals is an indicator of the basic assistance that PASSPORT participants rely upon. Adult day services accounted for 2.6% of total expenditures, an amount that has dropped from 5.9% in 2004. Finally emergency response systems, at 3.4%, almost doubled in the last two year time period.

Participant Characteristics

A review of PASSPORT participants is presented in Tables 16 and 17. Thirty-five percent of participants are age 80 and over, with a mean age of 76. PASSPORT participants are typically women (77%), and about one in five is married. Three in ten participants are non-white. More than four in five (84%) PASSPORT participants live in their own homes or apartments, the remainder generally live with a relative or friend. Despite overall stability in the PASSPORT population, we do see some interesting changes over the two decades. PASSPORT is serving a slightly younger population with the 60-64 age group increasing from 9.4% in 2000 to 12.9% in 2010. The proportion of participants under age 70 grew from 23.5% in 2000 to 30.2% in 2010. Over the last two decades the program has shifted slightly to serve a higher proportion of men (19.3% to 23.3%) and non-whites (26.9% to 31.6%).

Table 15
PASSPORT Expenditures by Type of Service,
FY 2004 – 2010

Type of Services	(Percentages) FY 2004	(Percentages) FY 2008	(Percentages) FY 2010
Personal Care	65.0	75.6	71.3
Home Delivered Meals	13.1	11.2	14.8
Adult Day Services	5.9	3.5	2.6
Transportation	3.4	3.8	3.5
Home Medical Equipment and Supplies	5.2	2.0	2.4
Homemaker Services	3.4	1.0	1.3
Emergency Response	2.3	1.9	3.4
Home Modification	0.8	0.7	0.6
Other	0.9	0.3	0.1

Source: PASSPORT Information Management System (PIMS) 2004 - 2010.

PASSPORT participants remain severely impaired, averaging three ADL impairments, with more than six in ten (62%) recording three or four ADL limitations. More than nine in ten (94%) are impaired in four or more instrumental activities of daily living, such as meal preparation and shopping. Four in ten participants need assistance with medications and one in five requires supervision. On both the average ADL and IADL measures, and on the items assessing supervision needed and medication administration, the profile is consistent over the study time period.

In reviewing health status, we find that one-quarter of consumers report circulatory disorders as a primary diagnosis (see Table 18). Problems with endocrine (14%), injuries (14%) musculoskeletal (13%), and respiratory systems (11%) are the primary categories. Additional health conditions include the nervous system (6%), cognitive disorders (8%), and an "other" category (10%). About one quarter had at least one hospital admission in the past year, and more than 9% had two or more admits in the past year. One in ten had at least one nursing home admission in the past year. The vast majority of participants take three or more prescription medications (95%), and 80% take six or more prescription drugs.

Table 16
Demographic Characteristics of PASSPORT Consumers,
FY 2000 – 2010

	FY 2000 (Percentages)[a]	FY 2004 (Percentages)[a]	FY 2008 (Percentages)[a]	FY 2010 (Percentages)[a]
Age				
60-64	9.4	10.8	9.8	12.9
65-69	14.1	16.2	16.5	17.3
70-74	18.3	17.8	18.1	18.0
75-79	20.2	20.3	17.6	16.8
80-84	17.2	17.3	17.4	16.1
85-89	12.7	10.8	12.8	11.9
90-94	6.1	5.4	5.7	5.2
95+	2.0	1.4	2.1	1.8
Average Age	76.5	76.4	76.5	75.6
Gender				
Female	80.7	79.8	78.2	76.7
Race				
White	73.1	76.6	71.3	68.4
Black	25.3	21.9	25.1	25.8
Other	1.6	1.5	3.6	5.8
Marital Status				
Never Married	5.8	6.3	7.7	8.9
Widowed	55.6	51.4	46.1	44.3
Divorced/Separated	20.6	23.0	26.6	27.5
Married	18.0	19.3	19.6	19.3
Usual Living Arrangement				
Own home/apartment	74.7	83.8	80.0	84.2
Relative or friend	21.4	15.7	16.3	15.0
Congregate housing for elderly/RCF	0.8	0.3	0.1	0.2
Nursing facility	2.3	--	2.7	0.4
Other	0.8	0.2	0.9	0.2
Number of Consumers Served♣	20,374	22,560	26,165	29,749

♣The number of consumers in 2000 - 2008 are those who had an active service plan and in 2010 is the average monthly caseload during the year.

[a] Percentages are adjusted to reflect only those consumers for whom information was available on each variable.

Source: PASSPORT Information Management System (PIMS).

Table 17
Functional Characteristics of PASSPORT Consumers,
FY 2000 – 2010

	FY 2000 (Percentages)[a]	FY 2004 (Percentages)[a]	FY 2008 (Percentages)[a]	FY 2010 (Percentages)[a]
Percentages with Impairment/Needing Hands-On Assistance in Activities of Daily Living (ADL)[c]				
Bathing	96.7	95.5	96.3	94.9
Dressing	63.1	61.7	60.4	60.0
Mobility[d]	74.5	78.4	81.6	81.9
Toileting	23.3	20.4	20.1	20.4
Eating	7.2	10.6	5.5	5.5
Grooming[e]	36.9	32.8	32.0	28.7
Number of ADL impairments*				
0	0.8	0.8	0.8	1.3
1	2.9	3.8	3.5	4.0
2	36.4	34.8	35.5	35.6
3	32.0	34.1	33.8	33.5
4 or more	27.9	26.5	26.4	25.6
Average Number of ADL Impairments	3.0	3.0	3.0	2.9
Percentage with Impairment in Instrumental Activities of Daily Living (IADL)				
Community access[f]	91.3	89.5	87.9	86.1
Environment management[g]	99.9	99.7	99.8	99.5
Shopping	97.7	97.6	97.1	96.6
Meal preparation	87.0	88.9	88.1	87.5
Laundry	96.7	96.2	95.9	95.2
Medication Administration	45.6	32.2	40.6	40.1
Number of IADL Impairments**				
0	0.0	0.1	0.0	0.0
1	0.0	0.1	0.1	0.2
2	0.4	0.3	0.5	0.8
3	3.8	3.7	4.2	4.9
4 or more	95.8	95.8	95.2	94.1
Average Number of IADL Impairments**	5.2	5.0	5.1	5.1
Supervision Needed[h]				
24-hour	NA	8.1	8.8	8.6
Partial time	NA	11.1	11.1	10.9
Number of Consumers Served♣	20,374	22,560	26,165	29,749

NA = Not available.

♣The number of consumers in 2000-2008 are those who had an active service plan and in 2010 is the average monthly caseload during the year.

*From list above. **From list above (including Medication Administration).

[a] Percentages are adjusted to reflect only those consumers for whom information was available on each variable.

[c] Impairment includes all who could not perform the activity by themselves or could with mechanical aid only.

[d] Needs hands-on assistance with at least one of the following three activities: *bed mobility*, *transfer* or *"locomotion."*

[e] Because of a rule change in 1994, the ability to perform grooming activity is measured differently, and it is not included in the comparison.

[f] Needing hands-on assistance with using a *telephone*, using *transportation*, or handling *legal or financial matters* constitutes impairment in community access.

[g] Needing hands on assistance with *house cleaning*, *yard work*, or *heavy chores* constitutes impairment in environmental management.

[h] Between June 2001 and September 2004 the Ohio Department of Aging gradually changed to a new PASSPORT information management system designed to keep track of PASSPORT consumers' characteristics and service utilization. Not all the information presented in this report was electronically available prior to this change, therefore some analysis is limited to the PASSPORT sites that changed to the new system prior to July, 2003.

Source: PASSPORT Information Management System (PIMS).

Table 18
Health Status of PASSPORT Consumers

	(Percentages)[a] October 2006		(Percentages)[a] FY 2008		(Percentages)[a] FY 2010	
Primary Diagnosis, Diseases of						
Circulatory System	30.4		29.3		25.4	
Endocrine, Nutritional, Metabolic Immunity	15.0		15.3		13.5	
Musculoskeletal System and Connective Tissue	14.8		15.7		12.6	
Respiratory System	11.0		10.2		11.4	
Injury and Poisoning	8.5		10.3		14.0	
Nervous System and Sense Organs	7.3		6.5		5.6	
Alzheimer's Disease		2.9		2.6		2.7
Parkinson's Disease		1.4		1.4		1.2
Other degenerative nervous system		3.0		2.5		1.7
Mental/Cognitive Disorders	6.2		5.5		7.6	
Dementia		4.1		3.9		5.6
Other mental disorders		2.1		1.6		2.1
Other	6.8		7.2		9.9	
Number of Hospital Admissions During Previous Year						
0	73.9		73.8		76.7	
1	14.7		15.1		14.0	
2	5.9		5.8		5.1	
3-5	4.6		4.5		3.9	
6 or more	0.9		0.8		0.3	
Number of Nursing Home Admissions During Previous Year						
0	92.0		91.1		91.4	
1	6.4		6.9		6.9	
2	1.2		1.5		1.3	
3 or more	0.4		0.4		0.4	
Number of Prescribed Medications						
0	5.7		1.0		2.2	
1-2	3.3		3.0		3.0	
3-5	13.0		12.4		12.4	
6-10	36.6		37.2		36.9	
11-15	27.2		29.1		29.2	
16-25	13.4		16.2		15.3	
More than 25	0.8		1.1		1.0	
Total Number of Medications (including over the counter medication)						
0	5.2		0.5		1.8	
1-2	2.3		1.9		2.1	
3-5	9.7		9.5		9.7	
6-10	33.8		33.3		33.6	
11-15	30.1		32.1		31.4	
16-25	17.6		20.9		19.8	
More than 25	1.3		1.8		1.6	
Number of Consumers Served	25,491		26,165		29,749	

*Data on Primary Diagnosis were classifiable only for 12% of the consumers. The results represent the data for only those consumers.

Source: PASSPORT Information Management System (PIMS) 2006 - 2010.

Because PASSPORT is such a large program, examining overall caseload averages could mask potential changes in the program that occur over time. To gain a better understanding of program changes, we also compare the characteristics of participants at admission over time. As shown in Tables 19 and 20, we do see some changes in new admissions over the years. Newly admitted participants are younger (22% age 60-64 compared to 12% in 2000), less likely to be female (75% vs. 78%), more likely to be never married (11% vs. 6%) and more likely to live in their own homes (83% vs. 78%). These individuals also are slightly less impaired on the ADL, IADL, and cognitive functioning measures.

To gain a better understanding of the changing age profile of PASSPORT participants, we compared PASSPORT's enrollment patterns with overall demographic changes in the state. The analysis was designed to assess how much the new use trends are affected by the increased number of boomers reaching age 60. Figure 4 provides a detailed overview of the PASSPORT enrollment patterns and state population changes. Overall PASSPORT enrollment has grown such that today 13 older people per 1000 individuals age 60 and older participate in the program. The data show that the increased enrollment of individuals under age 75 is not simply attributable to the boomer population increase. For example, in 1994 the rate of PASSPORT enrollment for those 60-64 was 1.4 per 1000 individuals age 60 and older. Today the 60-64 rate is 10.4/1000. The 65-74 group also increased, rising from 2.6/1000 in 1994 to 12.2/1000. PASSPORT participation rates dropped slightly for the 85 and older group, but, in combination with the participation rates of the Assisted Living Medicaid Waiver program, the rates are constant. This indicates that the increased enrollment of individuals under age 70 in to PASSPORT is not just a function of the boomer demographic changes. More study on this phenomenon is essential for state policy makers.

PASSPORT Disenrollment

Given the age and frailty level of participants, it is not surprising that the two major reasons for disenrollment are that the consumer dies (49%); or moves to a nursing home (31%) (see Table 21). Circumstances do change, such that in some instances participants are no longer financially eligible (5%), move out of state (4%), or leave the program for other reasons (11%), such as to move in with family members. A review of the disenrollment patterns for 2008 and 2010 show some significant changes. During this time period the proportion of participants leaving the program because of death increased from 42% to 49%, and the proportion admitted to nursing homes dropped from 38% to 31%. The PASSPORT program, through the area agencies on aging, has been involved in an extensive effort to help participants receive services at home for a longer period of time, even in the face of critical illness. The finding that a lower proportion of those leaving are being placed in nursing homes and that the program is providing an opportunity for participants to live out their lives at home is viewed as a positive outcome for the program.

Table 19
Comparison of the Demographic Characteristics
of PASSPORT New Enrollees* Over Time

	PASSPORT FY 2000 (Percentages)[a]	PASSPORT FY 2008 (Percentages)[a]	PASSPORT FY 2010 (Percentages)[a]
Age			
60-64	12.3	18.7	21.8
65-69	15.0	16.8	17.8
70-74	18.4	16.1	16.4
75-79	20.0	15.7	14.9
80-84	15.6	15.4	13.4
85-89	11.3	11.8	10.3
90-94	5.8	4.4	4.0
95+	1.6	1.1	1.4
Average Age	75.8	74.5	73.6
Gender			
Female	77.7	73.2	74.5
Race			
White	75.6	72.0	68.5
Black	21.9	24.6	25.5
Other	2.5	3.4	6.0
Marital Status			
Never Married	5.7	8.7	10.7
Widowed	52.6	41.7	40.2
Divorced/Separated	21.1	26.4	28.0
Married	20.6	23.2	21.1
Usual Living Arrangement			
Own home/ apartment	78.1	83.1	83.0
Relative or friend	20.3	16.0	15.8
Congregate housing for elderly/RCF	0.5	0.2	0.2
Nursing facility	0.9	0.5	0.9
Other	0.2	0.4	0.1
Number of Consumers Served*	3677	4027	4729

*The enrollees in the first six months of each year as indicated.

[a] Percentages are adjusted to reflect only those consumers for whom information was available on each variable.

Source: PASSPORT Information Management System (PIMS), 2000 - 2010.

Table 20
Comparison of the Functional Characteristics
of PASSPORT New Enrollees♣ Over Time

	PASSPORT FY 2000 (Percentages)[a]	PASSPORT FY 2008 (Percentages)[a]	PASSPORT FY 2010 (Percentages)[a]
Percentage with Impairment/Needing Hands-On Assistance in Activities of Daily Living (ADL)[c]			
Bathing	95.4	93.7	88.3
Dressing	59.3	58.1	56.3
Mobility[d]	78.6	80.8	77.4
Toileting	23.6	24.1	21.7
Eating	5.2	5.6	5.8
Grooming	30.2	26.2	21.3
Number of ADL Impairments			
0	1.1	1.2	5.0
1	4.0	5.2	7.3
2	37.1	37.5	33.8
3	32.2	30.0	29.9
4 or more	25.6	26.1	24.0
Average Number of ADL Impairments*	2.9	2.9	2.7
Percentage with Impairment in Instrumental Activities of Daily Living (IADL)			
Community access[f]	91.2	87.2	80.7
Environment management[g]	99.9	99.7	97.7
Shopping	97.6	97.0	95.1
Meal preparation	87.4	89.4	85.7
Laundry	95.5	94.9	92.5
Medication Administration	50.5	42.2	39.6
Number of IADL Impairments**			
0	0.0	0.0	0.1
1	0.0	0.2	0.7
2	0.5	0.7	1.5
3	4.1	4.3	6.2
4 or more	95.4	94.8	91.5
Average Number of IADL Impairments**	5.2	5.1	5.0
Supervision			
24-hour	NA	10.3	7.7
Part-time	NA	11.4	10.2
Number of Consumer Served	3677	4027	4729

♣The enrollees in the first six months of each year as indicated.

*From list above.

**From list above (including Medication Administration).

[a] Percentages are adjusted to reflect only those consumers for whom information was available on each variable.

[c] Impairment includes all who could not perform the activity by themselves or could with mechanical aid only.

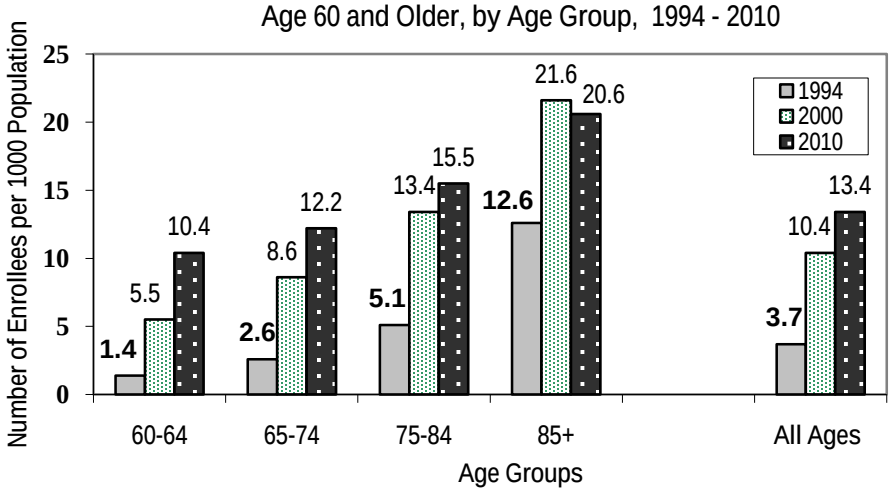
[d] Needs hands-on assistance with at least one of the following three activities: *bed mobility*, *transfer* or *"locomotion."*

[f] Needing hands-on assistance with using a *telephone*, using *transportation*, or handling *legal or financial matters* constitutes impairment in community access.

[g] Needing hands on assistance with *house cleaning*, *yard work*, or *heavy chores* constitutes impairment in environmental management.

Source: PASSPORT Information Management System (PIMS).

Figure 4
Number of New PASSPORT Enrollees per 1000 Older Population
Age 60 and Older, by Age Group, 1994 - 2010



Source: PASSPORT Information Management System (PIMS) 1994 - 2010.
Profile and Projections of the 60+ Population, Ohio. (2004). Oxford, OH: Scripps Gerontology Center, Miami University & U.S. Census Bureau.

Table 21
Reasons Consumers Were Disenrolled
from PASSPORT, FY 2008 – 2010

Reasons	2008 (Percentages)[a]	2010 (Percentages)[a]
Died	41.7	49.2
Admitted to Nursing Facility for 30+ Days	38.3	31.1
Admitted to Hospice Care	0.2	0.3
Admitted to Hospital for 30+ Days	1.1	0.9
Did Not Meet Financial Eligibility	3.7	4.9
Could Not Agree on a Plan of Care	1.2	0.9
Did Not Meet Level-of-care	1.7	0.7
No Longer Resides in Ohio	5.0	3.9
Other (including transfer to other waivers)	2.3	2.4
Voluntarily Withdrew from Program	4.6	5.7

[a] Percentages are adjusted to reflect only those consumers for whom information was available on each variable.

Source: PASSPORT Information Management System (PIMS) 2008 - 2010.

COMPARISON ACROSS MEDICAID LONG-TERM CARE PROGRAMS

In this section we present a comparison of the characteristics of participants in the array of long-term care Medicaid programs designed to assist older adults with physical and/or cognitive disability. All of the programs discussed were profiled earlier in the report. Each of these programs requires individuals to meet the nursing home level-of-care criteria, but age requirements vary. PASSPORT, Choices, and the Transitions Aging Carve-Out waiver programs require individuals to be age 60 and older. PACE has an age requirement of 55, and the Assisted Living Waiver Program uses an age 21 cut-off. Medicaid funded nursing homes do not have age restrictions.

There are some noteworthy age differences across programs (see Table 22). Assisted living (24%) and nursing homes (17%) serve the highest proportions of the oldest old, those over age 90. PACE, with an eligibility age of 55, has the highest proportion of younger participants. Almost half (47%) of PACE participants are below age 69, compared to about 30% of nursing homes, PASSPORT and Choices, and less than 20% for Assisted Living. Women are more likely to use long-term care services, but nursing homes (31%) serve the highest proportion of men. The racial profile of these programs also differs. The two residential settings, assisted living (11%) and nursing homes (18%), have the lowest proportion of non-whites. PASSPORT and Transitions Aging Carve-Out have about one-third non-white participants. Almost two-thirds of PACE participants are non-white.

Levels of impairment also vary by program (see Table 23). Medicaid nursing home residents record the highest levels of disability, averaging between four and five ADL limitations. Choices and the Transitions Aging Carve Out waiver participants average almost four ADL impairments, PASSPORT three ADL limitations, and PACE and assisted living waiver between two and three. Eighty-five percent of nursing home residents have three or more ADL impairments, as do 80% of participants in Choices and Transitions Aging Carve-Out. Six in ten PASSPORT participants (59%) have three or more ADL limitations. Half of PACE (51%) and assisted living waiver participants (48%) report three or more ADL impairments. Measures on need for supervision and cognitive impairment are not consistent across programs and settings, but these data suggest that nursing homes, assisted living, and the Choices waiver serve the highest proportion of individuals needing supervision or with cognitive impairment. These comparisons are important to study; however, measurement and data collection differences compromise our ability to understand variation across programs. The state should continue its efforts to collect and measure data comparably across programs and settings.

Table 22
Demographic Characteristics of Medicaid Waiver Consumers,
Medicaid Nursing Facility Residents, and PACE Program Participants, 2010

	PASSPORT[1]	Choices[1]	Assisted Living Waiver[1]	PACE[2]	Transitions Aging Carve-Out[3]	Medicaid Nursing Facility[4]
Age (Percent)						
<60	--	--	7.4	5.8	--	15.6
60-69	30.2	29.4	10.5	41.9	86.2	13.3
70-74	18.0	18.4	7.7	14.8	6.4	8.5
75-79	16.8	17.8	11.3	11.2	3.4	11.2
80-84	16.1	18.1	17.0	14.6	2.0	16.2
85-89	11.9	9.5	22.4	6.1	1.4	17.9
90-94	5.2	3.8	16.3	4.0	0.6	11.8
95+	1.8	3.0	7.4	1.6	0.0	5.5
Average Age	75.6	75.6	80.6	72.3	NA	76.7
Gender (Percent)						
Female	76.7	80.4	80.1	79.4	73.7	68.7
Race (Percent)						
White	68.4	83.1	88.6	35.8	66.5	82.2
Black	25.8	12.7	9.0	63.0	31.3	16.4
Other	5.8	4.2	2.4	1.2	2.2	1.4
Number of Consumers/Residents	29,749	608	2632	712	1703	59,006

NA = Not available

Source: [1]PASSPORT Information Management System (PIMS), 2010.
[2]Ohio has two PACE sites. TriHealth SeniorLink in the Cincinnati area, and McGregor PACE Center in the Cleveland area. Data is based on the initial and/or annual level-of-care assessments of the participants. Data presented here is based on 76% of the enrollees.
[3]Unpublished data for Calendar year FY 2010, Ohio Department of Job & Family Services, Ohio Health Plans, Bureau of Home and Community Services, Nov. 2010.
[4]Quarterly nursing facility. MDS, April - June, 2009.

Table 23
Functional Characteristics of Medicaid Waiver Consumers,
Medicaid Nursing Facility Residents, and PACE Program Participants, 2010

	PASSPORT[1]	Choices[1]	Assisted Living Waiver[1]	PACE[2]	Transitions Aging Carve-Out[3]	Medicaid Nursing Facility[4]
Percentage with Impairment/Needing Hands-On Assistance in Activities of Daily Living (ADL)[c] (Percent)						
Bathing	94.9	96.5	87.5	66.8	98.2	73.0
Dressing	60.0	77.9	49.8	63.0	94.5	86.2
Mobility[d]	81.9	74.8	75.6	86.9	87.8	80.7
Toileting	20.4	34.3	20.2	20.1	47.2	82.5
Eating	5.5	9.1	4.5	3.4	47.2	40.7
Grooming	28.7	68.2	20.6	11.9	29.4	86.0
Number of ADL Impairments						
0	1.3	0.1	3.6	3.1	0.4	7.1
1	4.0	2.0	13.6	22.4	1.0	4.6
2	35.6	19.3	35.0	23.5	12.1	3.5
3	33.5	27.5	27.3	32.4	34.4	4.1
4 or more	25.6	51.1	20.5	18.6	52.1	80.7
Average Number of ADL Impairments[*]	2.9	3.6	2.6	2.5	3.8	4.5
Supervision Needed						
24-Hour	8.6	16.1	13.9	16.5	NA	NA
Partial time	10.9	15.0	23.4	NA	NA	NA
Cognitive Impairment[i]	NA	NA	NA	NA	10.9	67.6
Per member, per month Medicaid[5] (Dollars)	$1,067	$1,500	$1,518	$2,643	$1,701	$4,281
Number of Consumers/Residents	29,749	608	2632	712	1703	59,006

NA = Not available
[*]From the list above
[i]Moderately or severely impaired in cognitive skills.

Source: [1]PASSPORT Information Management System (PIMS)
[2]Ohio has two PACE sites. TriHealth SeniorLink in the Cincinnati area, and McGregor PACE Center in the Cleveland area. Data is based on the initial and/or annual level-of-care assessments of the participants. Data presented here are based on 76% of the enrollees.
[3]Unpublished data for Calendar year 2010, Ohio Department of Job & Family Services, Ohio Health Plans, Bureau of Home and Community Services, Nov. 2010.
[4]Quarterly nursing facility. MDS April - June, 2009.
[5]The per member, per month data are based on FY 2009, Medicaid Decision Support System.

We also include comparative Medicaid cost data. Participant or resident contributions to the Medicaid program are accounted for in the average calculated cost. Again, comparisons should be made in the context of each program. For example, the Medicaid per member, per month cost for PACE ($2,643) is based on a rate that includes all of the acute and long-term services that are available under the Medicaid program. It is supplemented by a capitated Medicare rate for those eligible. Participant's average monthly long-term care Medicaid costs range from $1,067 in PASSPORT to $4,281 for nursing homes. Choices participants ($1,500) and Transitions Aging Carve-Out ($1,701) have higher monthly costs than PASSPORT, but serve a more impaired population.

LONG-TERM CARE SYSTEM LEVEL CHANGES

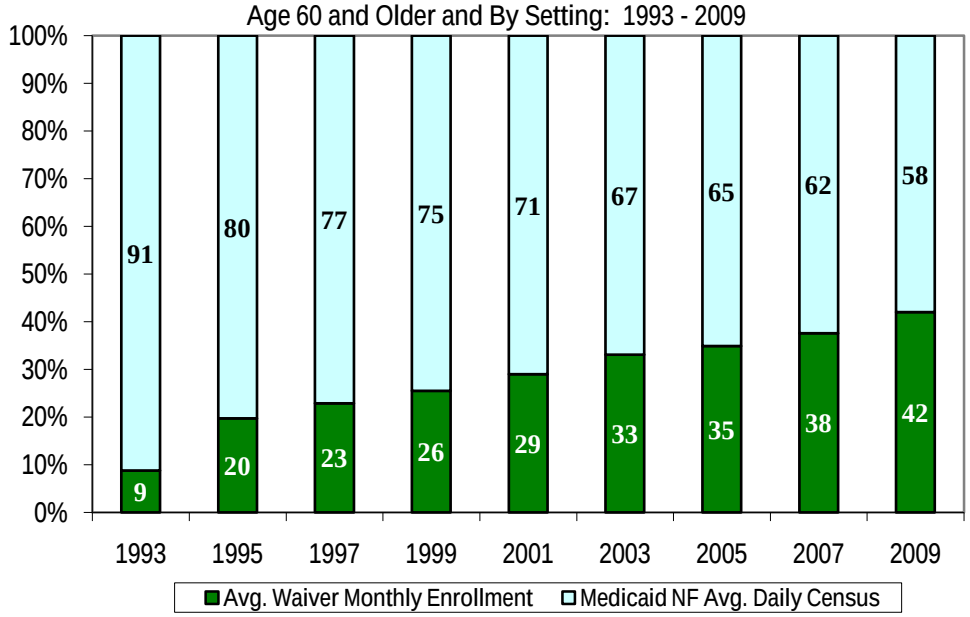
This report has documented some important changes in how long-term services are structured and financed in Ohio. In this section we examine two system level questions: (1) Has Ohio made progress in changing the balance in the system of long-term services and supports to respond to the growing number of individuals with severe disability? (2) Have changes in the system resulted in increased utilization and increased costs for the state?

System Balance

Over the past two decades Ohio has made progress in changing the long term care delivery system for its older population. As shown in Figure 5, in 1993, more than nine out of ten older Ohioans receiving Medicaid funded long-term care did so in the nursing home. That ratio has steadily changed over the past 17 years, and, in 2009, 58% of Medicaid long-term care recipients were served in nursing homes and 42% received home and community-based services. Because nursing home care is more expensive, this still means that, in 2009, more than 80% of long-term care Medicaid expenditures for older adults with disability went to nursing homes. Ohio's ranking in this category is now 33rd, with top ranked states such as New Mexico and Oregon spending 45% of funds on nursing homes and states such as Tennessee, Mississippi, North and South Dakota, and Utah spending more than 90% of their Medicaid funds on nursing homes. State efforts such as the expansion of PASSPORT, Home First, the Assisted Living Waiver Program, Home Choice, and the nursing home diversion and transition initiative have all contributed to these changing utilization patterns, but Ohio continues to serve a higher proportion of older individuals in nursing homes than the national average.

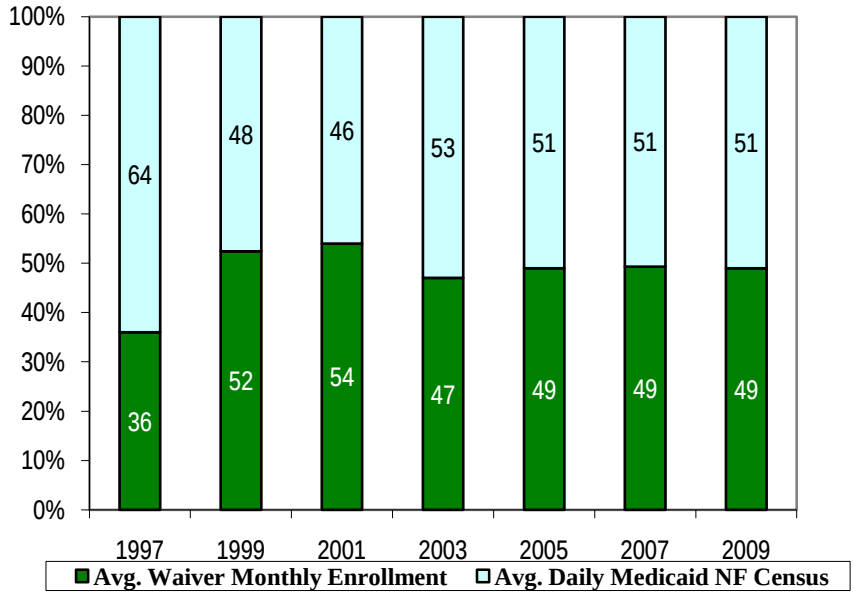
Utilization ratios for the under age 60 disabled population (excluding individuals with developmental disabilities) in Ohio have also changed in the last decade, but in a much less pronounced way. As shown in Figure 6, in 1997, 36% of individuals under age 60 receiving Medicaid long-term care services did so in a community setting. This 1997 ratio was more balanced than the spending patterns for older people. By 2005, the ratio had increased to 49% community-based services and 51% institutional care. Over the past four years the ratio has

Figure 5
Percent Distribution of Ohio's Medicaid Long-Term Care Utilization by People Age 60 and Older and By Setting: 1993 - 2009



Source: Medicaid Decision Support System (DSS): MDS; PASSPORT Information Management System (PIMS), 1993 - 2010.

Figure 6
Percent Distribution of Ohio's Medicaid Long-Term Care Utilization for People Under Age 60 by Setting: 1997 - 2009



Source: Medicaid Decision Support System (DSS): MDS; 1997 - 2009.

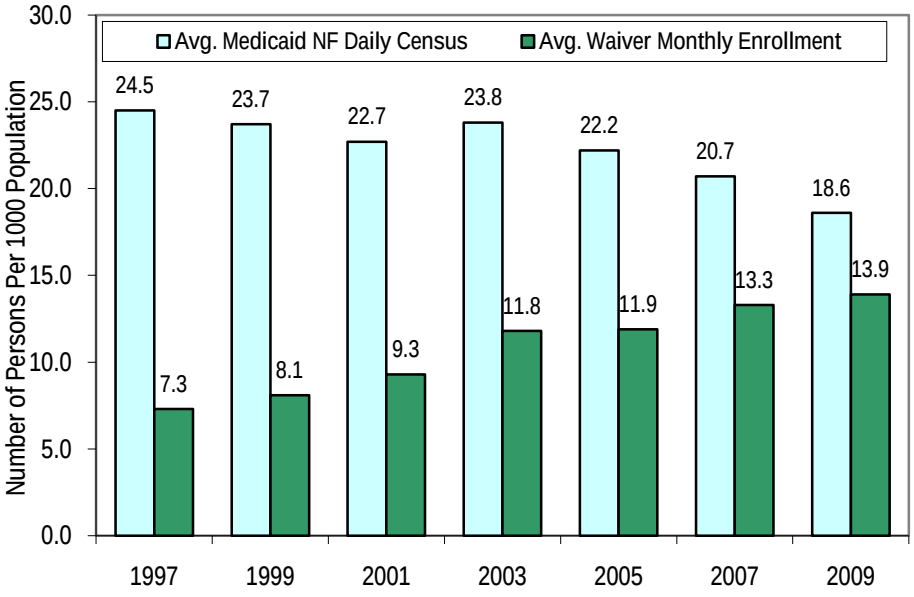
remained the same. Despite the fact that the Ohio Home Care waiver has increased by 9% since 2005, the increase in nursing home use by those under 60 over this same time period means that the ratio is unchanged.

Utilization Patterns

One of the questions raised by states as they have struggled to control growing Medicaid expenditures is: Will an expansion of Medicaid home and community-based services result in an increase in-home care program participants that is not off-set by reductions in nursing home use? To address this question, we present Medicaid nursing facility and home care utilization data between 1997 and 2009. Figure 7 shows the number of individuals age 60 and older receiving long-term services supported by Medicaid, as a proportion of the total population age 60 and older. In 1997, Medicaid had a long-term services utilization rate for the 60 and over population of 31.8/1000. At the time the nursing home use rate was 24.5/1000 and home care was 7.3/1000. Turning to 2009, we see that the overall utilization rate is 32.5/1000, almost unchanged in the 12 year time period. However, the nursing home use rate has dropped to 18.6/1000, and the home care rate has increased to 13.9/1000.

Over this 12 year (1997-2009) time period there has been a major expansion of PASSPORT and other waivers, but these data indicate that the overall long-term care utilization

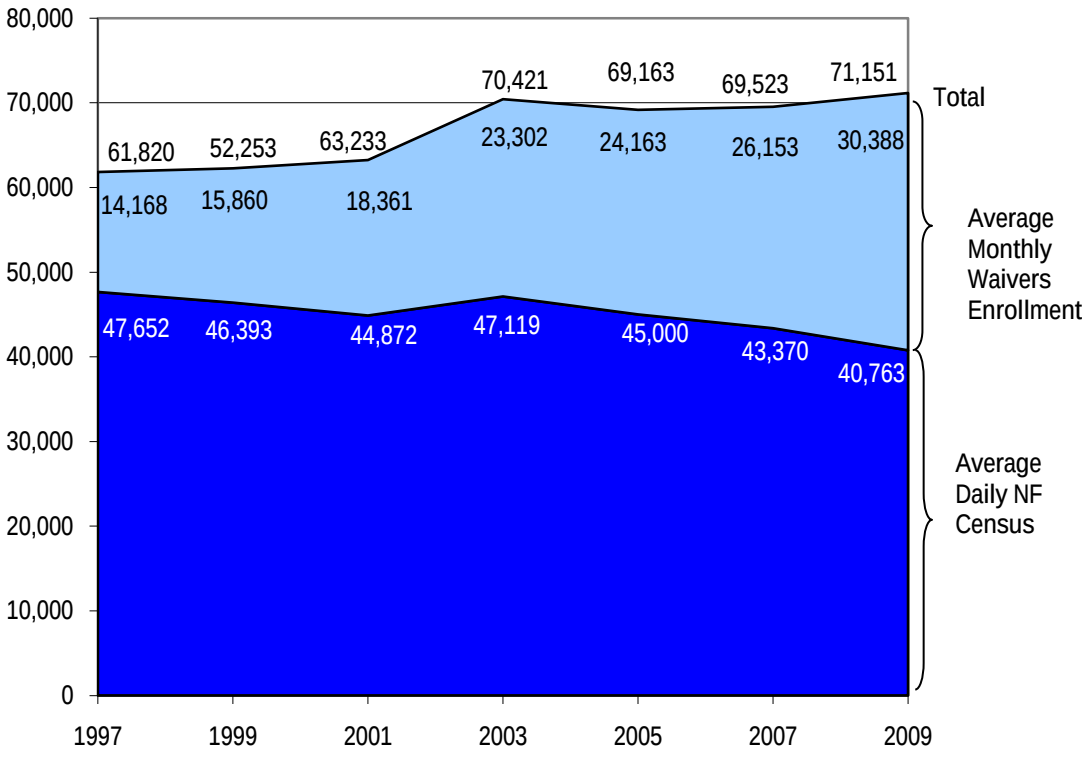
Figure 7
Number of People Age 60* and Older Residing in Nursing Facilities or Enrolled in a Waiver Program, 1995 - 2009



Source: Medicaid Decision Support System (DSS): MDS; PASSPORT Information Management System (PIMS), 1997 - 2009. U. S. Census Bureau.

rate has remained constant. For example, during this time period the older population grew by 14.7% and the number of individuals receiving long-term services paid for by Medicaid grew by 15%. This means that more people are receiving long-term care today than in 1997, but the utilization rates per 1000 older population are constant. What has changed is the setting where older people receive long-term services. As shown in Figure 8, in 1997, on average, on any given day, 47,652 older Ohioans were in nursing homes supported by Medicaid and 14,168 individuals were enrolled in the PASSPORT program, for a total of 61,820 individuals served. While a higher number of older people received long-term services in 2009 (71,151), the rates are the same. However, Ohio is serving about 7000 fewer older individuals in nursing homes and about 16,000 more individuals in home and community-based service programs.

Figure 8
Average Number of People Age 60 and Older Receiving Long-Term Services and Supports, Paid by Medicaid, Over Time, 1997 - 2009



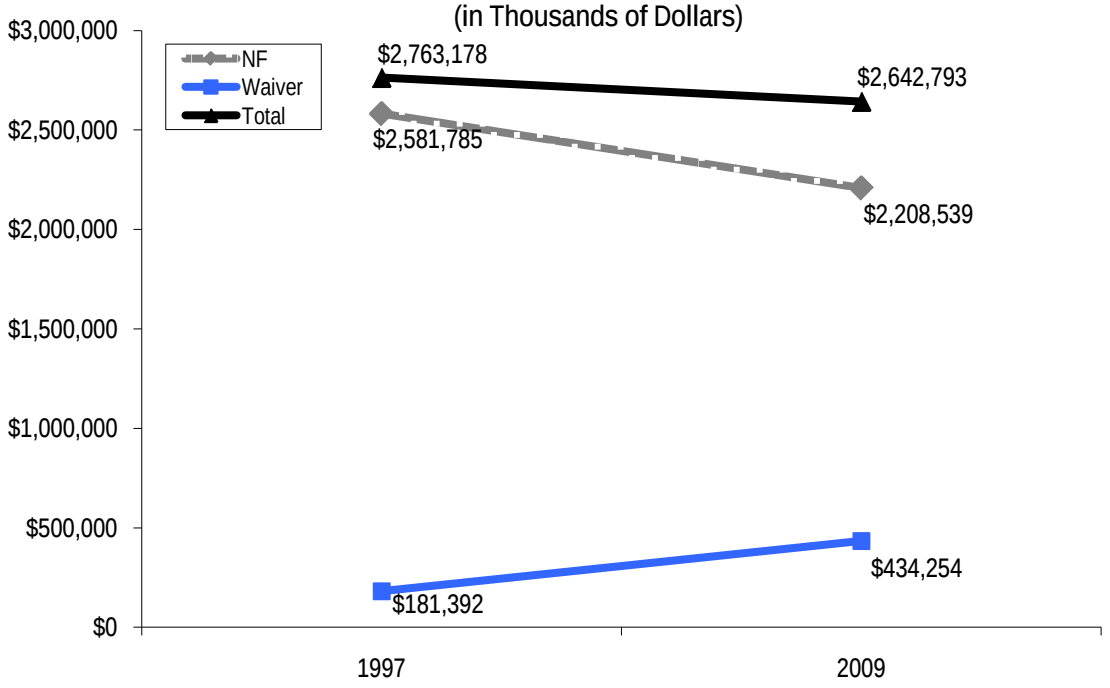
Source: Medicaid Decision Support System (DSS): MDS; PASSPORT Information Management System (PIMS), 1997 - 2009.

Costs

The final question in our analysis asks how have long-term service utilization changes affected distributing of Medicaid expenditures. To address this question, we compare the 1997 use patterns to 2009. To adjust for inflation, we calculated facility and community utilization patterns based on 2009 prices. As shown in Figure 9, the 1997 use patterns would have required

spending of $2.76 billion on Medicaid long-term care; with $2.58 billion on nursing homes and $181 million on home care. In 2009, actual Medicaid expenditures were $2.64 billion; with $2.2 billion on nursing homes and $434 million on home care. These findings indicate that, based on the policy and program changes that have been made since 1997, despite a nearly 15% increase in the over 60 population, we estimate that Ohio is spending less money today in real dollars on long-term services for individuals age 60 and older than it did in 1997. With projections indicating a possible doubling of the older population over the next 30 years, it will be critical for Ohio to use these policy lessons in preparation for the future demographic challenges ahead.

Figure 9
Comparison of Total Medicaid Expenditures on Services and Supports for People Age 60 and Older in 1997 and 2009 at 2009 Rates (in Thousands of Dollars)



Source: Mehdizadeh, S., and Applebaum, R. (2011). *Providing data to improve Ohio's long-term services and supports system*. Oxford, OH: Scripps Gerontology Center, Miami University.

STUDY BACKGROUND AND HIGHLIGHTS

In 1993, the Ohio General Assembly had the foresight to recognize the growing importance of long-term care for the state, and this research study was launched. Since that time, with support from the legislature through the Ohio Long-Term Care Research Project and the Ohio Department of Aging, we have been able to track utilization trends for institutional and home and community-based services. Results show that over the 16 year time period of the study, Ohio has made considerable changes in its approach to delivering and funding long-term services. In 1993, more than nine of ten individuals age 60 and older receiving Medicaid long-term care did so in a nursing home setting. In 2009, more than four in ten older people on Medicaid received assistance in a non-institutional setting. Since 1997, the number of older people age 60 and over using nursing homes in Ohio has actually dropped by almost 7000, despite the fact that the older population has increased by 15%. While these shifts have been significant, Ohio's biggest challenges lie ahead of us, as the population age 60 and older will increase by 25% by 2020 and will nearly double in size by 2040. It is critical for Ohio to not only build on today's progress, but to create tomorrow's innovative system.

DEMOGRAPHICS AND COSTS

- Ohio's population age 60 and older (2 million strong) is the 7th highest in the nation.

- In 2009, more than 146,000 older Ohioans had severe disability and that number will increase by 16%, by 2020, and nearly double by 2040.

- In 2010, 315,000 Ohioans of all ages had severe disability, and that group will grow to 348,000 by 2020 (13% increase). Thirty-eight percent of these individuals rely on the Medicaid program.

- In 2009, Ohio spent $4.85 billion on Medicaid long-term care, including services for older people and Ohioans with developmental/or physical disabilities: $3.3 billion on institutional care (68%) and $1.55 billion on community-based services (32%). Ohio now ranks 40th highest among states in spending in their institutional/community ratio for individuals of all ages, but has improved from 47th in 2005. Ohio ranks 33rd in the institutional/community ratio for individuals age 60 and older.

- Ohio's Medicaid program spent more than $14 billion in 2010; about 36% of those funds went to long-term care. State Medicaid expenditures account for about one-quarter of Ohio's overall budget.

LONG-TERM CARE PROGRAMS

- Almost four in ten individuals with severe disability receive assistance only from family, or privately purchase care.

- Twenty-three percent of Ohioans with severe disability live in nursing homes.

- Twenty percent of Ohioans with severe disability receive in-home support through an array of Medicaid waiver programs, including: PASSPORT for older people, the Ohio Home Care programs for physically disabled individuals under 60, assisted living for individuals age 21 and older, and several waivers for individuals with intellectual disabilities.

- Ohio's PASSPORT Medicaid waiver program providing in-home services to individuals age 60 and over with severe disability has grown from an average monthly caseload of 15,000 in 1995 to 30,000 in 2010. Only two states have larger waivers for older adults, Washington and Texas.

- Ohio has 972 nursing homes with 96,000 licensed beds. Sixty-three percent of nursing home revenue comes from the Medicaid program.

- Between 1995 and 2009, Ohio quadrupled the number of residential care facility beds to 43,000. Ohio has 585 residential care facilities, and we classify 403 of these as assisted living residences. As of May 2011, 283 of these facilities were participating in the Assisted Living Waiver Program.

RESEARCH FINDINGS ON LONG-TERM CARE UTILIZATION IN OHIO

- Nursing homes have shifted their focus and now provide a combination of both long and short-term care. In 1992, Ohio nursing homes had 71,000 admissions, in 2009 that number had increased to 197,000. For the first time in two decades, in 2009 the number of admissions dipped slightly.

- The number of short-term Medicare admissions has been a major reason for the growth in nursing home admissions, going from 30,000 in 1992 to 126,500 in 2007. In 2009 Medicare admissions dropped to 109,000 (14% decrease).

- Many Ohioans use nursing homes for short stays; more than half spend three months or less and two-thirds are residents for less than six months.

- Nursing homes are serving a higher proportion of individuals under age 60, increasing to 12% in 2010, up from 4% in 1994. Almost 16% of Medicaid nursing home residents are under age 60.

- Ohio's nursing home diversion and transitions initiative served 3600 individuals between March 2010 and April 2011.

- Ohio's nursing home occupancy rate dropped to 84.7% in 2009, from 87.7% in 2007. The average daily census for private pay residents increased by 5%, Medicare decreased 9%, and the Medicaid average daily census dropped by 2%.

- Over the past 12 years (1997-2009) the average daily Medicaid census in nursing homes has dropped from 54,242 to 50,393 (7% decrease). The census for the over 60 Medicaid population has dropped by 14.5%, but has increased by 37% for those under age 60.

- In 2009, the average Medicaid nursing home reimbursement rate was $175 per day, (a drop from 2005 in today's dollars), private pay rates were $201 per day and Medicare was $399 per day, up from $363 in 2007.

- In 2009, residential care facility unit occupancy rates were 81%, a slight drop from 82% in 2007. The Assisted Living Waiver Program has grown to more than 2900 participants.

- Levels of disability vary across Ohio's Medicaid long-term care program participants. Nursing home residents average between four and five activity of daily living limitations, the Choices and Transitions Aging Carve-Out waivers average four activity limitations, PASSPORT averages three limitations, and PACE and the Assisted Living Waiver Program average between two and three activity limitations.

- Medicaid costs, after participant contributions, also vary by programs ranging from $1,067 per month for PASSPORT to $4,281 for nursing homes. PACE per member, per month amount was $2,643, a rate that covers both acute and the long-term care costs under Medicaid.

- Ohio has begun to change the long-term delivery system for older people with severe disability. In 1993, nine of ten older people supported by Medicaid were in nursing homes; by 2009, that proportion had dropped to 58%. The proportions have also changed for the under 60 population, dropping from 64% using nursing homes supported by Medicaid in 1997 to 51% in 2009. The under 60 ratio, however, has not changed much since 1999.

- Over the last 12 years, although the state has expanded the number of older people receiving in-home services, the Medicaid long-term care utilization rate has remained nearly constant. In 1997, Medicaid had a utilization rate of 31.8/1000 and in 2009 the rate was 32.5/1000 of persons over 60 using long-term services.

- In 1997, on average, 47,652 older Ohioans each day used Medicaid nursing home care. Comparatively, in 2009, 40,763 older Ohioans each day used Medicaid nursing home care. This means that each day Ohio's Medicaid nursing home population age 60 and over has been reduced by 6889 individuals (14.5% reduction). During this same period the overall population of Ohioans age 60 and older grew by 15% and Ohio increased its population 85 and above by almost 50,000.

- Between 1997 and 2009 the number of older Ohioans participating in Medicaid waiver programs increased from 14,168 to 30,388 (114% increase). The total number of individuals age 60 and older receiving Medicaid long-term services increased from 61,820 to 71,151 (15% increase). The overall population age 60 and older grew by 15% during this same time period, however, there was a significant shift in where individuals received services.

- An analysis of Medicaid costs indicates that this shift in utilization patterns for individuals age 60 and older results in Ohio's Medicaid long-term care expenditures in 2009 for this group ($2.64 billion) representing an estimated reduction from the 1997 Medicaid expenditures ($2.76 billion) by more than $100 million (calculated on 2009 dollar expenditure rates).

RECOMMENDATIONS

As an aging state, Ohio has begun to respond to today's concerns. This report has documented the considerable changes that Ohio has made over the last two decades. Since 1997, Ohio has altered how it delivers long-term services, particularly for individuals age 60 and older. Between 1997 and 2009 the population age 60 and older in Ohio rose by 15%; yet during that same time frame Medicaid nursing home use for older Ohioans dropped by 14.5%, and the number of home and community-based participants doubled. This change means that Ohio's Medicaid long-term services priced at today's rate for its older population are lower today than in 1997, despite increasing the number of people served each day by 9300. While this shift represents a major policy and program success in Ohio, the challenge of tomorrow generates the most important questions. Between now and 2040, when the baby boomers will be aging in full force, Ohio may double the population needing long-term services and supports. Growing the long-term care Medicaid budget proportionally to the increase in the older and disabled population, in combination with Medicaid's past inflationary increases, would have a staggering effect on the state budget, easily doubling the proportion of state budget allocated to Medicaid (currently 25%). Given the pressures of education, economic development, infrastructure support and countless other demands on state government, such a scenario is not feasible.

States around the nation, confronted with similar problems, are now developing their responses. Although the perfect solution does not exist, there is a general consensus among long-term care experts about the steps necessary for states to meet these unprecedented challenges. Creating a system based on the principles of consumer choice, making sure individuals can

choose their long-term service and support setting, is the hallmark of the expert advice. Translating this principle into action requires states to ensure that there is choice in the system and, thus, efforts such as Ohio's Unified Long-Term Systems Workgroup are critical to accomplishing these goals. The recommendations below represent ideas for Ohio as it continues to work toward long-term system reform.

(1) The demographic challenges of tomorrow are daunting. To respond to these changes, Ohio's system of long-term services and supports will need to be more efficient and effective. In our view, policy makers should consider four important areas in looking to the future. First, Ohio must place more emphasis on prevention and self-sufficiency. Today, about 49% of the 146,000 older people with severe disability rely on Medicaid. Estimates indicate that the sheer number of older people with severe disability could nearly double in size by 2040. Can policies and programs be developed to reduce the 49% participation rate through preventative activities? For example, programs being tested now to prevent falls that could result in lowering the rates of disability are the types of innovations that will need to be developed, tested and expanded. Second, efforts to improve technology to help serve the growing older population will be essential. Today communication devices are already being used to help assess and monitor services being received, both in the home and even in congregate settings. Current auto makers Toyota and Honda are even working on the development of personal care robots. While some innovations are a long way off, these are the types of technological changes that Ohio must be a part of in order to meet future state demand. Third, we need to continue to work to make our service system more efficient and effective. Whether it is through improved regulations, management practices, training of workers, or applying research evidence to enhance practice, the demographic pressures of tomorrow mean that an efficient and effective long-term services system will be essential. Finally, research results and practice experiences highlight the importance of families in providing long-term assistance. While families are providing more long-term services and supports today than ever in history, societal changes including work, mobility, and demographic mean that caregiving pressures have never been greater. Policies and programs that recognize these challenges and assist families will be critical as the older population with disability continues to grow.

(2) Given the changes described in this report, it is critical for Ohio to look carefully at utilization rates of the under 60 population and to formulate a strategy to respond to the needs of these individuals. This report indicates that Ohio has made important changes in how it delivers long-term services and supports to older individuals with severe disability. Over the last ten years, despite the increase in the number of those age 85 and above by 50,000, Ohio has seen a 14.5% reduction in Medicaid nursing home use by individuals age 60 and older. At the same time the state has experienced a 37% increase in the under 60

population using Medicaid nursing homes. We identified this trend in our 2009 report, and in the last two years the challenge has grown.

The increase in nursing home use by those under age 60 appears to be the result of several factors. First, the under 60 population has grown dramatically, as the bulk of the baby boomers are now between age 50 and 60. Second, the Ohio Home Care Waiver, which has grown slightly, has not been able to increase relative to the population changes now occurring. Third, evidence indicates that a portion of individuals under age 60 who are using nursing homes have lower levels of disability and in some instances the nursing home may not be the best care setting. We found that 17% of the under 60 population did not have any activity of daily living (ADL) impairments and 23% had zero or one ADL limitation. A more in-depth review indicates that a significant proportion of this population is experiencing behavioral health problems. The Ohio Home Care Waiver is designed to serve individuals with physical disability. Adults with chronic mental illness, in general, do not have access to home and community-based services, and in some instances, these individuals are ending up in Ohio nursing homes.

(3) Ohio has expanded its efforts to pursue nursing home diversion and transition and we recommend that such efforts be continued. A series of reforms including Home Choice, Home First and the Ohio Legislative Diversion and Transition Initiative, implemented for older people through the area agencies on aging, have begun to transform the long-term care delivery system. System changes, resulting in expanded efforts to work more directly with hospitals and nursing homes, appear to be having an impact on PASSPORT participants. For example, the proportion of individuals leaving PASSPORT for nursing home placement dropped from 38% in 2008 to 31% in 2010. During that same time period the proportion of those able to stay in the PASSPORT program until they died increased from 42% to 49%. These findings, combined with the reduced use of nursing homes by the older population, indicate that current program strategies are meeting state policy objectives. While such initiatives represent important progress between now and 2020, the aging population will increase by 25%, and by 2040 the aging population will almost double. It will be critical for Ohio to build upon these efforts, but it must recognize that the pressures to reform the state's approach to delivering long-term services and supports will intensify in the future.

(4) The reduction in occupancy rates and the increase in the number of short stays in nursing homes provide another indicator of the dramatic changes experienced by the nursing home industry. Today's nursing home is a very different organizational entity than the facilities that were created during the 1960's and 1970's in response to a growing older population. At the time, Ohio

and many other states thought they needed to create a nursing home industry to respond to the pending demographic changes that were going to result from increased life expectancy. Just as many of the health and long-term care delivery approaches of today were not yet on the policy radar screen, the emphasis on home and community-based alternatives was simply not considered an option. Today's circumstances mean that we have a transformed industry that is changing in focus, and that as a state we have more nursing home bed capacity than is necessary. It is critical for the state to determine the proper supply of beds and to work with the industry in reforming the focus of the industry. There will be a need for some type of nursing home in the future. The critical questions are what should the facilities of the future look like and what is the optimum capacity for the state? Because two-thirds of today's residents are supported by Medicaid, but 98% of nursing homes are non-governmental (either not-for-profit or proprietary), it is critical that the challenges faced by the industry be addressed through a public/private response.

(5) Finally, while Ohio has done a better job in its efforts to develop a long-term care data base to guide state policy decisions, there are gaps in the current approach. We recommend that Ohio have the same measures of program participant characteristics collected in a comparable way across programs and settings. Level of disability and costs vary considerably across long-term care programs and settings. While cost differentials are anticipated, it will be important for Ohio to have a better understanding of the program differences. However, without comparable data it is impossible to understand programmatic differences in costs and utilization.

A Final Note: Ohio has a window of opportunity to address these challenges before the changes as a result of the baby boomers are upon us. Through its reform efforts Ohio has made important strides; however, the system changes required to respond to the demographic and financial challenges of the future suggest that the current reforms represent the start of a longer journey.

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