LONG TERM CARE IN OHIO:
BALANCING THE SYSTEM

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Executive Summary

This report is designed to identify the challenges facing long-term care in Ohio, and to develop recommendations to help Ohio achieve an effective, efficient consumer responsive system of long-term care.

The Ohio long-term care system faces several serious challenges. First, public expenditures do not match consumer demand. Second, consumers want to be able to design and shape the type of the assistance to be received. Third, financial pressures are substantial and will increase dramatically. Fourth, despite an interest in expanding community-based services, Ohio has a shortage of care workers. Fifth, long-term care in Ohio is fragmented and information on long-term care is difficult to access. Sixth, future demand for long-term care services is inevitable given demographic projections. Finally, although there is considerable agreement that the long-term care system in Ohio is broken, there is not a consensus on how to fix it.

Based on these challenges, we present the following objectives and recommendations.

- Establish a process to rethink and reengineer Ohio's long-term care system. We recommend the state enter into a system-wide planning process for long-term care in Ohio.

- Create a consumer-centered system and integrate consumer choice and control into Ohio's long-term care system. We recommend developing a consumer-centered model of long-term care, giving consumers better information, enhancing the role of case managers, and developing alternative quality measurements.

- Balance institutional and community-based long-term care services with consumer demand. We recommend restructuring long-term care in Ohio to match consumer demand, continuing the use of the Medicaid Waiver process, and supporting new initiatives to facilitate easier access to services.

- Support the new system with adequate public resources. We recommend altering the balance of public expenditures for long-term care, supporting local initiatives, and finding new sources of funds.

- Promote personal financial responsibility. We recommend exploring approaches to educating the public about the need and cost of long-term care and studying mechanisms to make long-term care insurance more affordable.

- Explore options for improving the linkages between acute and long-term care services.

- Expand efforts to support the long-term care workforce, both paid and unpaid caregivers

Background

Long-term care includes a range of services for individuals with disabilities provided in a variety of settings by a network of formal/paid and informal/unpaid caregivers. The accompanying sidebar presents an inventory of available long-term care services and settings. For any individual, personal resources, need, availability of informal supports, and access to affordable formal services will influence setting, caregivers, and services received.

The principal components of the formal long-term care system in Ohio are nursing home facilities, home health care agencies, and area agencies on aging. Ohio has 1,034 nursing facilities in operation, containing 95,701 beds. The State also has 27,443 licensed residential care beds (Applebaum and Mehdizadeh, 2001).

The typical nursing home in Ohio has between 90 and 100 beds. About three-quarters of the nursing facilities are proprietary in nature. The majority (90 percent) of these businesses are corporate entities. Most nursing facilities are located in urban areas and employ approximately 100 health care workers for every 100 nursing beds (Straker, Applebaum and Mehdizadeh, 1997). In some cases they are the largest employer in the area.

The Ohio Department of Health Annual Survey showed that in 1999 there were 333 Medicare certified home health agencies. About half of these agencies are free-standing proprietary providers, about one-quarter are hospital based, about one in five are private not-for-profit or public entities and just under 4% are nursing home based. There were also an estimated 190 private home health agencies that were identified in a 1997 Scripps survey (Straker and Applebaum, 1999). However, because Ohio is one of nine states that do not require

Long-Term Care Services

Personal Care
Home Health Care
Adult Day Care
Home-Delivered Meals
Nursing
Case Management
Social Services
Family Respite
Rehabilitation
Assistive Technology
Assisted Living Services

Long-Term Care Settings

Private Homes
Congregate Housing
Retirement Communities
Assisted Living
Adult Care Homes
Nursing Facilities

home health agencies to be licensed, a current number is not available.

A network of twelve regional area agencies on aging manage Ohio's PASSPORT program, which serves about 25,000 older Ohioans. These agencies perform a pre-admission review for all applicants to long-term care facilities and for in-home services as part of the PASSPORT program. These agencies use nurse/social work care managers to link older people who are Medicaid eligible and disabled enough to require a nursing home placement to an array of in-home services. To maintain accountability and independence, PASSPORT agencies arrange, monitor, and fund the needed services. However, all direct services are provided by community and institutional providers who contract with the program.

Long-term care is financed by both public and private resources. Ohio's Medicaid program alone spent over $2.8 billion on long-term care services for aged and disabled people in 2001. Individual and family contributions are equally important, with informal caregivers providing the vast majority of long-term care both nationally and in Ohio (Mehdizadeh & Atchley, 1992; Stone, 2000). Public and private long-term care expenditures in Ohio were estimated to be over $6.5 billion in 2000 (Burwell, 2000; AARP, 2000).

Long-Term Care and Ohio's Aging Population

Although long-term care policy cuts across the lifespan, the aging of our population creates unprecedented pressures for Ohio. This report focuses primarily on long-term care directed toward those aged 60 and above, but many of the issues are germane across the age spectrum.

The demand for long-term care is driven by the number of older persons and the disability rate of the population. Ohio currently has 1.57 million persons 65 and older. Most older Ohioans are healthy, but about three in ten (about 450,000 people) do experience a long-term disability. The number needing assistance is expected to increase significantly by 2050 when the 85 and over population will increase from 177,000 to over one million (Mehdizadeh, Kunkel, & Ritchey, 2001).

An ideal long-term care system would include a full spectrum of services, delivered in appropriate and desired settings, with adequate human and financial resources, and the capacity to meet demand. Ohio, like many other states, experiences a

series of limitations in the long-term care system. First, public expenditures do not match consumer demand. The vast majority of Ohio public expenditures for long-term care go to nursing homes, but nursing homes are not the setting of choice. Consumers consistently report wanting choice about the setting of their care. Second, consumers want to be able to design and shape the type of the assistance to be received. Third, despite an interest in expanding community-based services, Ohio has a shortage of care workers. Fourth, Ohio's long-term care system is fragmented and information on long-term care is difficult to access. Finally, future demand for long-term care services is inevitable given demographic projections, indicating that Ohio needs to develop a sound infrastructure as it prepares for the aging of the state.

Current expenditures, labor shortages, and projected increases in need for services mean that Ohio cannot successfully or feasibly meet future demand for long-term care by simply expanding the current system. Further, current expenditures, heavily weighted to institutional care, are out of balance with consumer preferences. This challenging scenario provides Ohio with the impetus to re-think its long-term care system.

Creating a Balanced Long-Term Care System for Ohio: Challenges and Contexts

Today there is unprecedented interest in creating long-term care systems that provide high quality services in the setting preferred by the consumer. This interest is reflected in recent national and state actions, such as the Olmstead decision and Ohio Access for People with Disabilities (2001), a report commissioned by Governor Taft. To change the current system so that it is more in line with this focus on options, high quality, and consumer preferences is no small task.

There are many challenges and some potentially conflicting agendas at work in the current system. Building a better system requires an analysis of these challenges and tensions, and a clear focus on bringing the system into balance. The current system is financially strained, institutionally biased, and plagued by labor shortages and concerns about quality. Solutions to these problems can only be considered in the context of a growing and shifting market. The new market is increasingly consumer-centered, requiring an expanded range of options available to meet consumer preferences, and

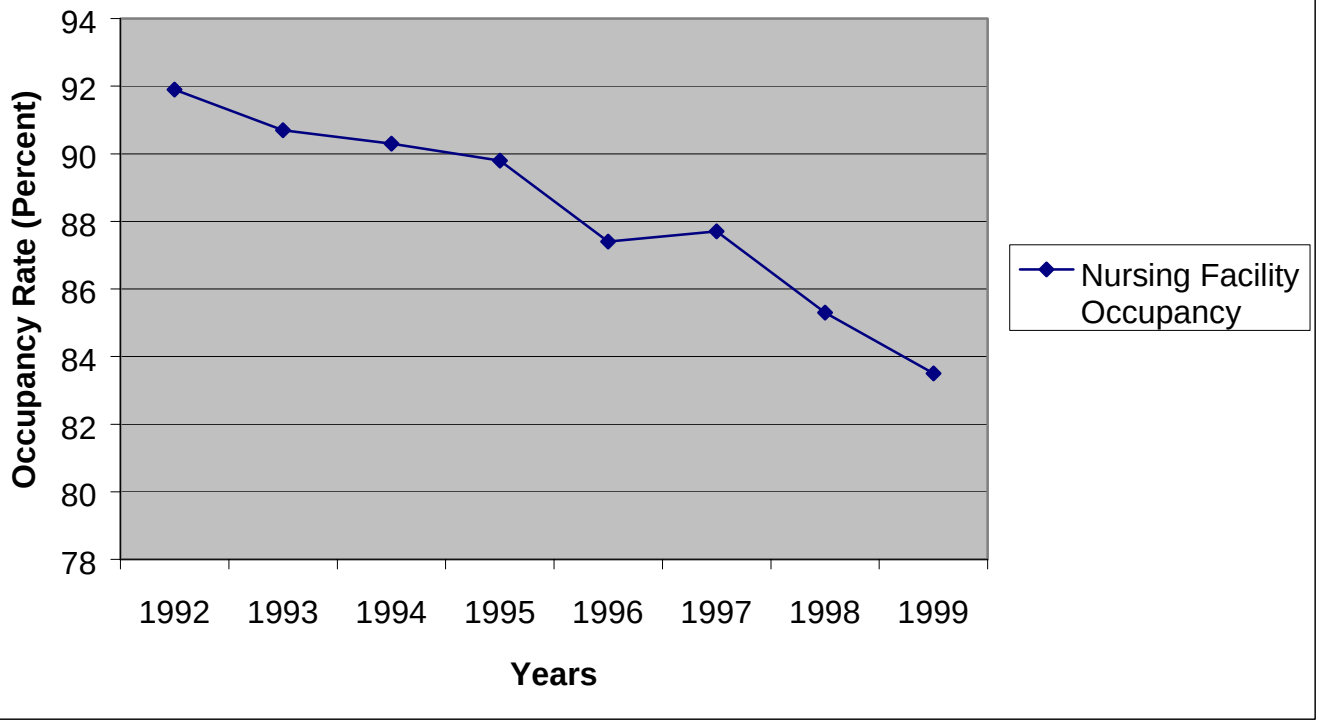
a broader understanding of how quality in long-term care is achieved.

This report is designed to analyze the challenges faced by the current system, to examine the context created by the shifting market, and to develop recommendations designed to help Ohio achieve an effective, efficient consumer responsive system of long-term care.

Shifting Markets: Creating Options and Involving Consumers: Increasing demand for long-term care and consumer preference for community-based services are two trends that will move with us into the 21st century (Stone, 2001). Ohio projections and utilization data support these conclusions. Between 2015 and 2050 the number of older Ohioans with a long-term disability will double in size from one-half million to one million (Mehdizadeh, Kunkel and Ritchey, 2001).

Utilization data from Ohio demonstrate increasing consumer preference for community-based services. At a time when the older population grew by four percent, in-home care supported by Medicaid and private funds doubled, and there was a dramatic increase in the number

Figure 1. Nursing Facility Occupancy 1992 - 1999



of local tax levies developed to support in-home services. During this same time period, Ohio also experienced a reduction in nursing facility occupancy rates. Figure 1 presents nursing facility occupancy from an eight-year longitudinal study funded by the Ohio Department on Aging and the Ohio Legislature. Over the past eight years, nursing facility occupancy rates have consistently decreased. Occupancy rates in Ohio nursing homes declined from just under 92% in 1993, to 83.5% in 1999. At the same time, nursing home expenditures in Ohio increased by 18 percent (Burwell, 2001).

Although nursing facility occupancy rates declined from 1992 to 1999, 2.2 billion dollars was allocated through Medicaid for nursing facilities in 2000, further indication that nursing homes continue to represent the majority of state long-term care expenditures (Burwell, 2000). Ohio, more so than many other states, has traditionally relied on nursing homes as a care option. For example, in the year 2000, Ohio had about 64 beds per 1,000 persons over age 65, compared to 52 per 1,000 for the nation as a whole. During the 1980's, Ohio's bed supply grew rapidly, with the number of beds increasing by 47%. Only ten other states had higher growth rates during this time period (Kane, Kane, and Ladd, 1998).

Another example of Ohio's emphasis on providing long-term care in nursing homes is its lack of support for alternate residential settings such as assisted living. Currently, Ohio does not support publicly funded assisted living. Further, Ohio has a waiting list for residential state supplement funds intended to allow persons 18 years and older to live in group homes such as residential care facilities.

The imbalance between nursing homes and home-based care that is characteristic of Ohio's system clearly does not match consumer preferences. Options and funding need to be brought into balance with consumer preferences. Ohio is, however, in the forefront of consumer direction as an innovative service delivery model in long-term care for older people. This approach, which acknowledges the consumer's right and ability to assess their own needs, determine how those needs can best be met, and assess the quality of the services they receive, is becoming increasingly prevalent in long-term services for older adults. Consumer–directed services incorporate consumer choice and control into the management of long-term care services (Scala & Mayberry, 1997).

Consumer-directed service is not one strategy, but represents a continuum of approaches from professionally managed services to an individual knowing what services they need and purchasing them themselves (Stone, 2000).

Today, different approaches to consumer-directed services are being tested both nationally and in Ohio. Nationally, Robert Wood Johnson launched two demonstration projects; "Cash and Counseling" and "Independent Choices". In Ohio, the Independent Choices initiative is testing the cost, quality, and effectiveness of consumer directed options within the PASSPORT program. With local funding, this same model is being tested for other older populations in one of Ohio's levy supported programs.

While there was initially some concern about consumer safety and potential fraud and abuse in consumer direction (Simon-Rusinowitz et al., 2000, Scala and Mayberry, 1997), there is a growing body of research that supports the benefits of consumer-directed services for those interested in this option. In a direct comparison of consumer-directed and professionally managed personal care services, consumer directed services had more positive outcomes in measures of satisfaction with services, feelings of empowerment, and quality of life (Doty et al., 1999). Other studies suggest that quality of care is not jeopardized when consumer-direction is chosen (Stone, 2000; Benjamin, 2000).

Financing: funding the options, controlling costs: Fundamental issues about who should pay for long-term care and what options should be funded have been debated for decades. In Ohio, the public system has generally funded institution-based care, and there is well-founded concern about how we can afford to continue to fund even that one option. To that end, cost containment strategies have been implemented. The greater challenge for the future is to consider funding strategies for a broader range of options, including home and community based services, assisted living, and consumer-directed services.

In recent years, increases in nursing home supply and costs combined with the growing older population in the state resulted in a series of legislative efforts designed to alter the delivery and financing of long-term care in Ohio. Through a continuous expansion of Ohio's participation in the Medicaid Home and Community-Based Waiver programs, the state has begun to shift some public long-

term care funding from an institutional to in-home care setting. Between 1995 and 2000, Ohio more than doubled its waiver expenditures, increasing from $195 million to over $433 million. Ohio's Aged and Disabled Waiver, PASSPORT, increased from $103 million in 1995 to $217 million in 2001 and served about 25,000 disabled older people over that one year time period.

Ohio has also expanded in-home services to middle income and less disabled older persons through a somewhat unique provision in state statute that allows counties to earmark property taxes to special services for older people. What started as an initiative to fund senior centers and specialized services in specific communities has grown to be a significant source of revenue for long-term care services for older persons who would not have access to services otherwise. Almost half of Ohio's counties rely on this approach to supplement aging services. Statewide, these levies contribute over $70 million annually.

Accompanying the home care expansion have been state efforts to control public expenditures in nursing homes. In 1993, the State enacted a moratorium that was to prevent the construction of a new nursing home bed if it would increase the total bed supply in the state. The State also passed a requirement that beginning in 1994 all applicants to Ohio nursing homes receive a pre-admission review before entry, and Medicaid recipients who do not meet nursing home eligibility criteria are not admitted. To help control expenditures the State also altered its method of nursing home reimbursement, shifting to a prospective payment system. In combination these efforts were designed to control Medicaid expenditures and improve the long-term care system in Ohio. Most recently, the Governor's Executive Budget for 2001 proposed to slow the rate of growth in nursing home spending by adding additional cost control strategies and eliminating outdated incentives that maintain excess nursing bed capacity.

Another strategy to reduce public expenditures for long-term care is integration with acute care. The primary goal of an integrated acute and long-term care is to provide a seamless system of health and social services at a lower cost (Davis, 2001). The potential for savings appears to be significant, especially if the state focused on the dual eligible population. The dual eligible population consists of low-income Medicare beneficiaries who are also eligible for Medicaid (Mehdizadeh, 2000). Dual eligible individuals use a

disproportionate share of health care services. National estimates indicate that the dual eligible individuals comprise 17 percent and 19 percent of the Medicare and Medicaid population, respectively and account for 28 percent and 35 percent of their budgets (Murray and Shatto, 1998).

There is a considerable difference of opinion on whether to integrate acute care and long-term care. Some believe that integrating acute and long-term care is impossible (Callahan et al, 1999). Others feel it is possible and could result in better coordination and integration of services and possibly lower costs (Stone, 2000, Callahan et.al, 1999).

There also is a difference of opinion on how to integrate acute and long-term care. The Federal government approved the use of the Program of All-Inclusive Care for the Elderly (PACE) model when it passed the Balanced Budget Act of 1997. PACE is a difficult model to implement and some question whether it is applicable and appropriate for large populations (Brown, 1999). Results from other demonstrations suggest that under the right conditions, the integration of acute and long-term care can achieve quality care in a cost-effective manner.

Up to this point the discussion of limited financial resources has focused on public expenditures. Increasing private revenue is another way to control public expenditures. Current sources of private funds are out-of-pocket reimbursement for long-term care and long-term care insurance. In 2000, about one-third of nursing home and home care expenditures were paid for out-of-pocket. In the same year, long-term care insurance paid for around 5% of the long-term care bill. Insurance currently pays for only a small portion of the total cost of long-term care, but it could become more important in the future (Weiner, 1996).

Building the Workforce: Workforce issues in long-term care are long standing. Several studies done during the mid 1990's warned us that the shortage of frontline workers could soon reach crisis proportions (Atchley, 1996). If the state were simply to continue its current configuration of long-term care services, it is projected that by 2010 an additional 9,000 full-time equivalents (FTEs) in nursing homes and 15,000 FTEs in home-based services would be needed (Even, Ghosal, and Kunkel, 1998). The prognosis for recruiting and retaining workers certainly represents a challenge for Ohio’s long-term care system.

Socio-demographic changes will also add to the challenge. Projections indicate a decrease in the availability of family members, friends, and neighbors who might provide the majority of long-term care. The pool of supporters may decline as a result of fewer children in the future, greater family mobility, and work force participation of women (Alecxih, 2001). Recent research estimated that the pool of potential caregivers could decline from eleven for each person to four by the year 2050 (Noelker, 2001). Thus the population in need of long-term care is increasing at the same time that the pool of potential caregivers is actually declining.

Building Access: Informed Consumers: Consumers need access to a full array of long-term care services. Barriers to receiving long-term care are having adequate information about services, accessibility, availability, and affordability.

In order for consumers to make critical long-term care decisions they need access to accurate information and trained professionals to assist them and their families. Ohio recognizes this as a problem and has taken steps such as CareChoice Ohio, a program that provides information about potential long-term care service options to older consumers and the newly developed "Long-Term Care Consumer Guide" (www.ltcohio.org) designed to provide consumers with better information when choosing a nursing home.

There is a void in long-term care services for those who are not eligible for existing programs and do not have the social, physical, or financial resources to meet their long-term care needs on their own. Services to this segment of the population simply are not available.

National and state reviews identify multiple funding sources, different rules and regulations, multiple access points, incremental adjustments to policy, and a general lack of interagency communication and coordination as principal causes for a fragmented long-term care system. Many consumers in need of services do not know where to turn for information and assistance.

Quality and Regulation: Both the nursing home and home care industry operate in a highly regulated market, an environment that heavily emphasizes health and safety. (Kapp, 1997). The rules and regulations long-term care providers have to follow do not address the importance of a meaningful quality of life. Regulations may also have the effect of restricting nursing homes and home care agencies from necessary innovation that responds to

consumer needs and demands. Providers choose to offer services that the government is willing to pay for and ultimately cannot compete with new products and services developed for segments of the market who have the ability to pay.

Throughout the last 25 years there has been constant criticism directed toward long-term care. Because the bulk of public dollars have been allocated to nursing homes, these providers have been the subject of the majority of complaints from regulatory agencies, the media, and the public at large. With the expansion of in-home services and assisted living facilities, the criticism has spread to other areas of long-term care.

Balancing health and safety concerns with choice and control desired by consumers is a significant challenge. Because the concerns about health and safety have so dominated the current regulatory approach, the needs of consumers have received little attention. Quality concerns are often met with increased paperwork compliance and additional structural requirements. All providers are treated essentially the same, whether they are strong or weak performers. Consumers, providers, funders, and regulators have all criticized the current approach to quality. As the system continues to expand, developing a sound quality system will be a critical challenge for Ohio and the nation.

Recommendations

As expenditures and concerns about quality have increased, so too have our regulatory efforts. Federal and state regulatory strategies have been consistently revised in an effort to improve the quality of services (IOM, 2001). Yet concerns about long-tem care quality remain an almost constant topic for policy makers and the public at large.

The Ohio Long-Term Care system faces serious challenges. Consumers are not always satisfied with the long-term care options available to them. The State is paying for a product that some need but few want. Financial pressures are substantial and will increase dramatically. Providers of long-term care acknowledge the need for

fundamental changes in the service delivery system. Regulators recognize major limitations in the delivery system and in the regulatory process. Although there is considerable agreement that the system is broken, there is not consensus on how to fix it. It is clear that the future demographic challenges are so great that the current system of long-term care will never provide quality services if it is not changed.

Based on a review of state and national research, we present a basic set of objectives to guide the development of a comprehensive system of long-term care in Ohio. These objectives will serve as the foundation for specific recommendations and action steps.

- ***Establish a process to rethink and reengineer Ohio's long-term care system.***

- ***Create a consumer- centered system and integrate consumer choice and control into Ohio's long-term care system.***

- ***Balance institutional and community-based long-term care services with consumer demand.***

- ***Support the new system with adequate public resources.***

- ***Promote personal financial responsibility.***

- ***Explore options for improving the linkages between acute and long-term care services.***

- ***Support the long-term care workforce, both paid and unpaid caregivers.***

Establish a process to rethink and reengineer the long-term care system. The long-term care challenges faced by states such as Ohio are daunting. An increasing population of our oldest citizens combined with issues about quality, choice, and financing of long-term care present a long list of policy issues to be considered. What should the state do to make sure that Ohioans receive good quality long-term care in a financially responsible manner?

- *The state must enter into a system-wide planning process.* Our current system of long-term care has its roots in the 1965 Medicaid legislation. At that time neither federal nor state officials

were concerned about long-term care. The legislation, however, created a structure that shaped the industry in the decades to follow. Ohio policy makers were never in a position to step back and ask the major questions: What is the best way to deliver and fund long-term care services in the state? What should the continuum of long-term care look like? How many nursing homes do we need? What type of residential care options should the state offer? What should the balance between in-home care, assisted living, and nursing homes look like?

Because each of the provider groups has their own vested interests, most of the debate at the state level involves advocacy for a specific service area, rather than a reflective look at the long-term care system as a whole. It's time to make a change. And, it's time to have the right people at the table to do it. Given the challenges associated with Ohio's long-term care system today and in the future, it is essential for Ohio policy makers to take a step back and gather consensus on a statewide long-term care strategy. Such an effort will involve bringing together policy makers, state and regional administrative staff, providers, consumers, researchers, and advocacy groups to develop a shared vision for Ohio. Although such a process would be challenging, the alternative -- not planning for an aging Ohio -- is even more difficult for the state in the long run.

Create a consumer-centered system and integrate consumer information choice and control into Ohio's long-term care system.

Like most of us, consumers of long-term care have different preferences about the type and nature of the services received. Although consumers vary on what type of service best constitutes quality, what they share is a common value about wanting to have their needs and preferences reflected in their care.

- *Develop a consumer-centered model of long-term care.* Research on long-term care shows that quality is maximized when the service delivery model gives consumers a range of options to choose from. A quality long-term care system starts with consumers having choice over the location in which they receive services, the type and amount of assistance received, and the mode of

service delivery. Consumers vary on the actual choices made, but what they hold in common is the desire to be involved in making the choice.

- *Give consumers and their families good information to make sound long-term care decisions.* Decisions about long-term care are often made in periods of stress. Due to the fragmented service delivery system, consumers consistently report not having knowledge about service options or about the quality of those options. The state's long-term care consumer guide is a direct response to concerns from consumers and their families when making a decision about nursing home selection.
- *Enhance the role of care managers.* As consumer direction becomes an option, the role of care managers continues to evolve. Clients with highly complex medical situations, little informal support, and high vulnerability need more case management intervention than a self-directed client. The State should continue its efforts to clarify the variable nature of case management intervention for consumers who fall along a continuum of need.
- *The State should develop quality measures that define quality from the consumer's perspective.* The approach to assuring quality in long-term care has emphasized health and safety as the primary outcomes. Although consumers certainly want to be safe, research highlights the important place of quality of life in long-term care. Being treated with respect and dignity, having choice over how and when services are delivered, and being able to exercise control over one's life have been reported as major factors effecting quality. The current regulatory system relies heavily on an annual inspection model, which emphasizes structural and procedural outcomes. Efforts to improve the survey and certification process and to provide more information to consumers represent state efforts to improve this process. However, federal constraints on Ohio's ability to develop new and improved quality systems for both residential and home care services are considerable. Participation in demonstration efforts to test alternative quality models should be explored at the state level.
- *The State should support integration of consumer-directed services in*

residential care and nursing facilities. Up to this point, state efforts to expand consumer-directed services have emphasized services in the community. Consumer-directed concepts can also be integrated into institutional long-term care. Principles of consumer choice and control can be applied in the residential care or nursing facility. As complex as it will be to change long-term care in the community, creating a more consumer centered service approach is even more difficult in the institutional setting. Institutional long-term care is heavily regulated. These rules and regulations have rewarded compliance with what the state and federal government want, not what is best for the residents of these facilities. They have created a culture that rewards compliance and restricts choice. But, there are states and individual providers involved in efforts to alter the institutional structure and operational and regulatory policies in an effort to enhance consumer choice, control and quality of life. Many of them are part of the Pioneer Network or Eden Alternative.

Balance institutional and community-based long-term care services with consumer demand. Key findings from our review of current practices and trends in long-term care in Ohio are: Ohio is experiencing a dramatic shift in the way long-term care is being delivered; Ohio is confronted with unprecedented demand; and, Ohio's long-term care service delivery system does not effectively match consumer needs and preferences with setting or services.

- *Restructure system to match consumer demand.* Trends like declining nursing home occupancy, significant increases in the demand for community-based alternatives, a mismatch between public expenditures and consumer demand, and excess capacity in residential care and nursing home facilities indicate that the Ohio long-term care system is out of balance.

  Different states have addressed this problem in different ways. Some, like South Dakota, just established certificate of need requirements and a moratorium on the expansion of nursing home beds (National Conference of State Legislatures, 1997). Ohio did this in 1993. Others are taking a more aggressive approach. For example, Minnesota recently passed legislation to help "right size" the nursing home

system (Minnesota Department of Human Services, 2002a and 2002b). The state has developed a planned nursing home closure process that provides incentives for closing beds in areas with excess capacity or in facilities too old to repair. They have also established two grant programs: planning grants to help nursing homes transition to new businesses; and demonstration grants to improve nursing home quality.

- *Continue to use the Medicaid Waiver process to expand home and community-based services and to modify system focus.* Ohio's long-term care system is out of balance. The projected increases in the size of the disabled older populations that will begin in 2015 will intensify this problem. One of the few mechanisms that the state has to re-shape the long-term care system is the Medicaid waiver program. Medicaid policy controls who gets services, where they receive them, and who can deliver them. Ohio's current Medicaid waiver does allow for a modest level of community-based services, but is not designed to meet the needs of a consumer centered service delivery system. Ohio's Medicaid waiver also does not allow for transitioning persons out of nursing homes. Recently, the Centers for Medicare and Medicaid Services (2002) granted states the authority to use waivers for this purpose. Ohio should consider submitting a waiver to help pay for the transition of persons from nursing homes back into the community.

  Offering housing and community-based supports is consistent with the Olmstead decision and consumer demand. Currently more than one-third of PASSPORT clients leaving the program end up in a nursing home. This typically occurs when the disability levels of the consumer out-pace the informal system's ability to promote care. Ohio should follow the lead of other states that use waivers to expand long-term care services, to add housing and care options such as assisted living, and to allow consumers to direct their own services. Affordable residential living options are a critical component of a sound system of long-term care. Reliance on the Medicaid waiver program is not without limitations. Strict financial and functional eligibility criteria allow only persons who are destitute and severely disabled to receive

long-term care services under this program. Although federal law allows states to increase the income eligibility requirements for home care recipients to 300% of the Supplemental Security Income program amount, the asset test is limited to $5000 or below. Ohio actually uses a lower asset test than required by the federal government ($1500), ensuring that only the lowest income Ohioans participate in the PASSPORT home care program.

The strict functional eligibility criterion means that only the most severely disabled Ohioans are eligible for home care. Older people who may need a lower amount of help, with such tasks as bathing or grocery shopping and cooking would not be eligible for the program. This is one of the reasons why Ohio counties have developed locally supported home care programs.

- *Established a "one-stop shopping" or "no wrong door" approach to facilitate easier access to services.* When an older person or their family need to access long-term care services, they often don't know where to go and/or which agency to talk to. Ohio's hot line and consumers guide to nursing homes is a good start, but Ohio consumers need more help. Ohio should follow through with the development of the proposed "no wrong door" approach to information and service. The goal of "one-stop shopping" and "no wrong door" approaches are to help prospective clients and their caregivers learn about their options and coordinate services from one agency to another.

- *Make care management available to everyone in need regardless of income, age, or service need.* Consumers who have the opportunity to access the system for information and assistance, regardless of circumstance, will be better prepared to make critical long-term care decisions. If a person has the ability to pay, they can pay on a sliding scale basis.

Support the New System with Adequate Public Resources. The vast majority of system recommendations have financial implications. To redesign the long-term care system, the state has to either increase or reallocate revenue.

- *Alter the balance of public expenditures for long-term care.* As mentioned earlier, the vast majority of public expenditures are allocated to services

delivered in nursing homes. Although there is certainly a need for nursing homes, the critical policy question is the optimum balance between the various components of the long-term care system. Given consumer demand and available financial resources, the state needs to create a balanced system. Because the institutional/community ratio is heavily weighted toward institutional expenditures, changing the balance in the system is difficult. Ohio, like most states, has limited opportunities to invest new revenues into the system. This means that efforts to shift the system's balance quickly becomes a zero-sum game, intensifying the political debate between the nursing home, assisted living, and home care constituencies.

- *Support local efforts for local tax levies.* Ohio's PASSPORT program, serving 25,000 older Ohioans with disability, represents a substantial investment by the state. Because of the strict financial and functional eligibility criteria, the majority of disabled older people, however, are not eligible for the program. In many states, general revenues are used for gap filling programs for individuals with higher income levels and less severe disability. Although Ohio has not taken this policy route, it has allowed local support for in-home services through the use of county property taxes. Almost half of Ohio's counties supplement aging services in this way. Such local initiatives raise community awareness about the resources available to help older Ohioans remain in their homes. The downside of the widespread use of this strategy is that it contributes to a more inequitable service system across the state. Some of the same issues that have been identified in the funding of schools will likely arise under this approach. There are strategies to overcome this problem, like the state matching property tax levies, up to a certain point. Such support allows counties to establish a comprehensive and workable local system. Exploring mechanisms to support such efforts would represent sound state policy.
- *Reallocate revenue generated from other sources.* An alternative to the local initiatives is a state supported expansion of in-home care. Expansion of state-funded aging services in other states has occurred with state and county general revenue funds, tobacco settlement

monies, property taxes, and state lottery funds. Long-term care programs that do not rely on Medicaid funding as heavily as Ohio are able to offer a wider range of services to a broader population of recipients (Summer, 2001).

Promote personal financial responsibility. Private funds support a small portion of the cost of long-term care. Ohio's long-term care system must rely more on private financial resources in the future.

- *Lower the cost of long-term care insurance.* One source of funds for long-term care is insurance. Ohio's Department of Insurance (1999) reports long-term care insurance sales through 1998 at just over 87,000 contracts. This level of sales represents only three (3) percent of the primary market. One of the reasons for low sales of long-term care insurance is the cost. To increase the number of Ohio residents who have long-term care insurance, the state needs to effectively lower the cost. There are several options that can be independently or collectively used to lower the cost of long-term care insurance. One option is to expand credits to individuals and employers for the purchase of long-term care insurance. Another option is to increase the group purchasing pool to reduce the cost of insurance for an individual. A third option is to develop long-term care group purchasing pools and/or create incentives for adding long-term care insurance to conventional acute care purchasing pools.
- *Educate the public about the cost of long-term care.* Most people do not plan to finance their long-term care because they are not aware of the need and cost. Many mistakenly believe that Medicare will cover their long-term care costs. The state should launch a campaign to educate the public about the need and costs of long-term care. One suggested strategy is to focus public education efforts on younger consumers who are not aware of the risks of long-term care (Davis, 2002).

Explore options for improving the linkage between acute and long-term care service. Stronger links between acute and long-term care have the potential to lower public and private expenditures for both levels of care, broaden the inventory of coordinated services, and improve the quality of care for disabled older persons. Years of experiments with integrating care models

have not produced the "right answer".

- *Evaluate efforts to integrate acute care in other states.* Triage, ACCESS, Community Care Organization, Social Health Maintenance Organizations (SHMOs), PACE, and SMHOII demonstrate years of attempts to integrate long-term care services and then long-term with acute care services. There is still no consensus on the potential for success and what model to use.

  The primary goals of integrating acute and longer-term care are to provide a seamless system of health and social services at a lower cost to the consumer and the state, better coordination of services, and a higher quality of care for older disabled persons (Davis, 2001, Callahan et al., 1999). No one approach has met all these objectives, but federal and state governments continue to look for the right mix of integration, finances, and services. There is no easy solution to the problems associated with integrating acute and long-term care. Even the PACE model, which is approved by the federal government, is at best difficult to implement and may not be appropriate for large populations (Brown, 1999).

  Despite uncertainty about the solution, there is agreement that the fragmentation between the two systems results in quality of care problems and in high expenditures for the state and federal government. A recent longitudinal study reported that Ohio Medicaid recipients with long-term care needs averaged $35,000 per year in Medicaid and Medicare health and long-term care expenditures (Mehdizadeh & Applebaum, 1999). With more than one-third of all Medicaid dollars allocated to this dual eligible population, it is essential to pay attention to this group. The state is encouraged to continue their exploration of creative ways to serve this important population.

Support the long-term care workforce, both paid and unpaid caregivers. A serious threat to long-term care is on the supply side of the equation: the availability of a sufficient number of workers. Ohio's long-term care system relies on two critical sources of workers: paid and unpaid caregivers. Recommendations to provide for an adequate supply of both groups of caregivers are:

- *Continue the work of the Governor's*

Summit on the Health Care Worker Shortage: The traditional labor force has already been described as hard to find and equally hard to keep. The task force on the worker shortage is an important step in Ohio's efforts to enhance the paid workforce. Agenda items such as: embracing the use of technology to reduce the need for humans to provide service, aligning state technical and vocational training programs with the needs of the long-term care industry, demonstrations of workforce efficiency, reviewing the scope of nursing practice, and finally oversight of wage and benefit issues to help to ensure a good workforce make an important contribution to the challenges faced by the state.

- *Provide social, instrumental, and financial support to informal caregivers.* Informal caregivers provide the vast majority of long-term care in Ohio. Many of the solutions being discussed to bolster the supply of formal health care workers have direct application to informal caregivers. Research findings indicate that interventions likely to get and keep an adequate supply of paid workers are effective in helping caregivers stay on the job (Noelker, 2001). Social supports such as caregiver groups, and respite or time away from care-related responsibilities have been identified as mechanisms to relieve caregiver strain, and help the support system maintain over a longer period of time. Instrumental supports like access to supplies, assistive equipment, and environmental modifications also contribute to the caregiver's ability to succeed.

  An issue that has received considerable attention in recent years involves payments for family, friends and neighbors who are care giving. States have used two major strategies in this area: compensation in the form of a tax credits or deductions; or a cash

payout to be used to hire a relative, friend, or neighbor. Using the tax code to support caregivers is a strategy that can provide useful support for higher income families, but is a limited benefit for lower income families.

Payment of informal caregivers has been used in a range of states over the past two decades. One of the largest tests of this approach is currently underway as part of the National Cash and Counseling Demonstration. In this program, Medicaid recipients are able to hire relatives, friends, and neighbors to deliver services. Demonstration results are not in, but experiences of family caregivers in other countries suggest that cash payments expand the labor pool, replenish financial resources depleted by care giving, and allow caregivers to adjust their work schedule to allow for caregiving (Tilley, Wiener, Cuellar, 2000).

Conclusion

Ohio's current system of long-term care does not provide consumers with adequate service choices. It emphasizes institutional care over in-home services and in both residential and community settings the system is not consumer-centered. The system is expensive, placing continued pressures on state government. The quality of the system has been the subject of constant criticism over the past three decades. Finally, the size of the older population experiencing a disability will more than double, at the same time that the number of informal caregivers will be reduced. Ohio must recognize these challenges today and create the necessary infrastructure to ensure a high quality, fiscally responsible, balanced system of long-term care for an aging Ohio.

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