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Program evaluation of PASSPORT:  
Ohio's home and community-based  
Medicaid waiver. Final report

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**Program Evaluation of PASSPORT:  
Ohio's Home and Community-Based  
Medicaid Waiver**

**Final Report**

Submitted to  
The Ohio Department of Aging  
May 15, 2007

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## **EXECUTIVE SUMMARY**

PASSPORT, Ohio's Home- and Community-Based Services (HCBS) waiver program for older people, provides in-home services to Medicaid consumers who would otherwise qualify for placement in a nursing home. The intent of the program is to support disabled community-dwelling older people in their efforts to remain at home for as long as is reasonably possible and to be fiscally responsible to Ohio taxpayers. PASSPORT services include personal care, homemaker, medical transportation, and home-delivered meals, emergency response systems, adult day services, chore, home medical equipment, minor home modification, independent living assistance, nutrition consultation, and social work counseling.

In the twenty plus years since it began as a regional demonstration program, the PASSPORT program has grown considerably in both size and scope. It is certainly the biggest waiver program in Ohio and one of the largest waiver programs in the United States. In SFY 2006, PASSPORT provided a variety services to nearly 35,000 Ohioans over age 60; the average daily census of the program was 26,000 clients. These services along with the informal/ unpaid care (which comes from a variety of family and community sources) have allowed many disabled Ohioans to remain in their communities longer than might otherwise have been possible.

The Ohio General Assembly called for an independent evaluation of the PASSPORT program. The Ohio Department of Aging, which administers the program pursuant to an agreement with the Ohio Department of Job and Family Services (Ohio's Medicaid agency), and an Advisory Council for the project specified the topics and questions to be addressed in the evaluation. Following are the key findings and recommendations related to those areas of investigation. These findings and recommendations are discussed briefly in this report, and in much more detail in the six topical reports that support this document.

## KEY FINDINGS

**The people getting PASSPORT services need them and are financially eligible for the program.** The majority of consumers met level of care eligibility by virtue of having either two ADL impairments or on the basis of multiple criteria. The remainder were eligible based on single criterion specified by program standards. The average gross monthly income of PASSPORT consumers was \$719, well below the allowable income of \$1,692. Only 69% of PASSPORT consumers had any assets; the average value of their assets was \$434.

**PASSPORT is less expensive than nursing home care.** The average yearly Medicaid expenditure for a nursing home resident was \$55,751, compared to \$23,702 for a PASSPORT client. The average per-person value of all non-Medicaid public assistance to PASSPORT consumers is \$2,830, compared to \$480 per year for nursing home residents. When Medicaid and other public costs are totaled, the cost of caring for a person in the community is a little less than one-half the cost of caring for a person in a nursing home.

**PASSPORT providers meet certification standards set for in the Ohio Administrative Code.** The PASSPORT Administrative Agencies use a pre-certification visit with providers to give technical assistance on the certification process, and to make sure that the provider is in compliance with standards. If a provider is out of compliance, the certification process does not move forward.

**On average, providers have been with the PASSPORT program for nine years or more.** About one-quarter of current PASSPORT providers have been in business five years or less. Current providers rate the likelihood of continuing with PASSPORT at 8.7 (on a scale of 1 to 10, with 10 being very likely). The major reason that providers discontinue involvement with PASSPORT is financial—low reimbursement rates, low numbers of referrals, or both.

**The initial and ongoing PASSPORT assessment process adequately captures consumer needs and contributes to an appropriate service plan. Case management and case management supervision are linchpins of the PASSPORT program.** The case management system is highly effective and widely praised by consumers and their caregivers.

**While there is consistent commitment to the principle of informed choice, there are several threats to consumers' exercise of informed choice.** Some of the factors inhibiting informed choice are the vulnerabilities that bring consumers to PASSPORT in the first place. Another threat is related to the lack of information available to consumers (such as provider quality).

**Delays in service onset were a problem in some cases.** Whether due to Medicaid eligibility determination or due to waiting lists (now obsolete), these delays put people at risk of declines in health and premature nursing home placement. Medicaid eligibility determination delays are variable by county and by workers within counties.



**Consumers seek a level of services that best meets their needs** and do not demand excessive services. Caregivers continue to provide essential care and support.

**PASSPORT has quality assurance processes in place and working to safeguard the health and welfare of participants.** The numerous quality assurance processes include annual structural compliance reviews of providers by the PAAs, monitoring of the PAAs by ODA and of ODA by ODJFS, incident reporting and follow-up, interviews and surveys with consumers, and PAA-specific quality assurance/quality management strategies. All of these processes center on the health and well-being of participants.

**ODA has undertaken a concerted effort to fully operationalize and implement the CMS Quality Framework.** ODA's adaptation of the CMS framework is the Quality Management and Improvement System (QMIS). Regularly scheduled teleconferences with PAA staff are a vehicle for communication about, refinement of, and implementation of the system. One of the challenges in implementing the quality management system is striking the appropriate balance between the effectiveness of standardization and the local responsiveness of PAA flexibility.

**The fiscal accountability of the PASSPORT program is ensured through multiple levels of monitoring and audits.** Providers, PAAs, and ODA fiscal processes and records are monitored routinely. Assessment of the fairness and adequacy of the contracting process revealed serious concerns about low reimbursement rates and rate setting that is not linked to quality.

**Overall, this evaluation found that PASSPORT is a cost-neutral, effectively targeted, quality-oriented, thoroughly monitored, consumer-responsive home care program.**

## **KEY RECOMMENDATIONS**

**Provider quality information could help to improve the program.** The need for information about provider quality was mentioned in many phases of this evaluation. Case managers and assessors reported frustration about their inability to give consumers information about providers. Providers were also interested in consumers having valid information about quality, and in the opportunity they themselves might have to learn about best practices. Consumers reported that they did not always feel fully informed as they were choosing their providers. The PASSPORT program should consider a systematic process for gathering and disseminating information about provider quality. All levels of stakeholders should be involved in the discussion about, and development of, this process.

**The barriers to informed choice in PASSPORT should be evaluated.** Even though there was widespread commitment to the principle of informed choice, there are barriers to achieving the goal. Lack of valid and reliable information that can be shared with consumers is a major barrier, as mentioned above. Other factors inhibiting informed choice are the vulnerabilities that bring consumers to PASSPORT in the first place, including the consumer's decision-making capacity. A careful evaluation of the goals and practices related to informed choice could strengthen the

PASSPORT program if appropriate changes are made. For example, the consumer's cognitive ability to make an informed decision should be explicitly assessed in the care planning process.

**Reimbursement rates should be reviewed.** At every level (state, PAA, provider), reimbursement rates were often mentioned as a problem. There was a great deal of consensus that reimbursement rates for PASSPORT providers need to be reviewed.

**PASSPORT faces a challenge in achieving balance between statewide standardization with PAA flexibility and autonomy.** This challenge became evident in several facets of the evaluation. With respect to the new quality management system (QMIS), standardized procedures for discovery, remediation, and improvement will yield a more comprehensive, manageable and efficient quality system; however, standardized processes might compete with the autonomy, responsiveness and local appropriateness of PAA practices. The current lack and potential value of standardization was also apparent with respect to selecting clients and informing providers prior to PAA review. Another example of this challenge is the independent relationships PAAs have with their providers. While autonomy here is crucial, some standardization (for example, of client record forms and employee timesheets) might benefit everyone.

**The non-selective provider approval process is disadvantageous to the program in many ways.** Consider requesting a waiver of the federal requirement that any willing provider which can meet the conditions of participation can become an approved PASSPORT provider.

**Medicaid eligibility determination sometimes causes delays in start of service, and these delays can put people at risk.** Financial eligibility determination can be delayed by the consumer (who must gather and produce a long list of personal and financial documents) or by the county DJFS. Regarding DJFS delays, it is apparent that the speed of Medicaid eligibility determination varies widely by county, and, within counties, it varies by worker. A careful evaluation of the Medicaid eligibility determination process might isolate and remedy the major causes of delay.

**The various consumer survey processes should be reviewed.** Consumers are surveyed and interviewed at several different points and for several different purposes. ODA, in close collaboration with the PAAs, might want to consider a streamlined, well-coordinated consumer survey process that yields representative, meaningful, and routinely utilized data on consumer outcomes as well as consumer satisfaction. At a minimum, a systematic review of current goals and practices regarding consumer surveys would be advisable.

**Data systems are fragmented.** PIMS is an effective billing system, and CRIS-E has extensive information about PASSPORT consumers. However, the lack of an integrated data system which includes information about consumers and all of their services was a hindrance in this project, and is a likely hindrance to ongoing review of the program.

## **INTRODUCTION**

In Am. Sub. H.B. 66 (the budget bill for the SFY 2006-2007 biennium), the Ohio General Assembly called for an independent evaluation of Ohio's Home- and Community-Based Services (HCBS) Medicaid waiver program for Ohioans age 60 and over. This program, PASSPORT (Preadmission Screening System Providing Options and Resources Today), is administered by the Ohio Department of Aging (ODA) pursuant to an interagency agreement with the state's Medicaid agency the Ohio Department of Job and Family Services (ODJFS).

PASSPORT provides home- and community-based services to low-income persons 60 years and over who are eligible for nursing home level of care. PASSPORT has allowed some of these consumers to remain in the community; for others, the waiver has deferred a move to a nursing home for a time. Services offered through this waiver include: personal care, homemaker services, transportation to medical appointments, home-delivered meals, emergency response systems, adult day services, chore, home medical equipment, minor home modification, independent living assistance, nutrition consultation, and social work counseling.

The goal for the PASSPORT evaluation is to determine whether the program is providing efficient and cost-neutral services as an alternative to facility-based long-term care, and to assess the extent to which the program complies with the assurances Ohio agreed to in its waiver application to the federal Centers for Medicare and Medicaid (CMS). To guide the work of the project, ODA and the PASSPORT Evaluation Advisory Council provided specific questions and topics to be covered in the evaluation. These topics and related research questions are:

### **Consumer Eligibility**

- Do PASSPORT consumers meet the financial and level-of-care eligibility requirements for participation in the Medicaid waiver program?
- What factors impact the length of stay in the PASSPORT program and what factors

lead to disenrollment to enter a nursing facility?

### **Cost Neutrality**

- Are the total Medicaid costs for PASSPORT consumers less than total Medicaid costs for nursing facility residents age 60 and over?
- How does the total public cost of maintaining PASSPORT consumers in the community compare with the total public cost of caring for nursing facility residents?

### **Assessment and Service Plan Development Process**

- What is the effectiveness of the PASSPORT assessment process in ensuring that PASSPORT consumers are supported in making informed choices about long-term care?
- Are the service plans developed for enrolled PASSPORT consumers based on the assessed needs of - and the informed choices made by - consumers?

### **Fiscal Accountability**

- Are Ohio's fiscal processes sufficient to ensure the fiscal accountability for funds expended through PASSPORT?

### **Provider Processes**

- Do PASSPORT service providers meet certification standards set forth in the Ohio Administrative Code?
- What is the tenure of most PASSPORT service providers and what factors impact it?

### **Quality Assurance/ Quality Framework**

- Does PASSPORT have quality assurance processes in place and working to safeguard the health and welfare of participants?
- How congruent are the existing PASSPORT quality assurance processes with the new CMS "Quality Framework" that Ohio will be required to fully implement by 2008?

Each of the preceding topics and questions will be addressed and answered in the pages of this report, following an overview of the PASSPORT program.

## **PASSPORT OVERVIEW**

### **History**

In 1981, Congress, in response to the perceived "institutional bias" of the Medicaid program, passed Public Law 97-35 (of the Omnibus Budget Reconciliation Act). This law

permits states to apply for special Home- and Community-Based Services (HCBS) waivers to provide in-home services to Medicaid-eligible consumers who would otherwise qualify for placement in an institutional setting, such as a hospital, nursing facility (NF), or intermediate care facility for the mentally retarded/ developmentally disabled (MR/DD). These Medicaid waivers are sometimes referred to in the literature as "2176" waivers (after the public law section that created them) and at other times as "1915c" waivers (after the codified section of the Social Security Act). The term 'waiver' is used under this law, since some Medicaid statutory limitations are dispensed with. Examples of the types of requirements that may be waived are: certain financial eligibility criteria; the imperative that services be comparable among beneficiaries; and the mandate that services be available statewide.

Since 1981, CMS has granted hundreds of waivers to states. Ohio's PASSPORT program is one such HCBS Medicaid waiver. Other state HCBS waivers are Choices and the Assisted Living Waivers, administered by ODA; the Ohio Home Care and Transition Waivers, administered by ODJFS; and the Individual Options and Level I Waivers, administered by the Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD).

PASSPORT is the oldest of Ohio's HCBS Medicaid waiver programs, dating to 1984 when it began operating as a demonstration program in two regions of the state - central Ohio and the rural Miami Valley. The program became available statewide in 1990. Today, PASSPORT provides HCBS services to an average daily census of more than 26,000 older Ohioans, making it one of the largest HCBS waivers in the United States (Mehdizadeh et. al., 2005).

PASSPORT'S approved slot number in SFY 2006 was 34,957 (that is, the number of unduplicated consumers served in any one year, as contrasted with the average daily census of

the program). The total budget for PASSPORT is just over \$345 million dollars in both state and federal funds for SFY 2006. Because PASSPORT is a Medicaid program, the federal government matches non-federal funds. State PASSPORT funds are derived from state General Revenue Funds; a franchise fee on nursing facility beds (\$1 per bed of the \$6.25 franchise fee goes to home care programs, especially PASSPORT); and a small amount of revenue is derived from off-track betting.

### **Dual Functions of the PASSPORT Program**

As the name implies, PASSPORT is more than an HCBS Medicaid waiver program. It also serves as an important gateway for Ohio's system of long-term care services and supports. All applicants to nursing facilities in Ohio, regardless of source of income, are required by federal law to be screened for mental retardation/ developmental disability or mental health needs (this process is referred to as the Preadmission Screen and Resident Review, or "PASRR") to determine the appropriateness of placement in a nursing facility. Individuals relying on Medicaid to pay for their nursing facility services are required to be reviewed for functional deficits, referred to as level of care review. In addition, PASSPORT provides in-person assessments upon request to those Ohioans exploring future needs for long-term care services and supports. PASSPORT also offers long-term care consultation services to consumers expected to spend down resources to Medicaid-eligibility levels within six months of admission to a nursing facility. This expanded role was implemented during the course of this evaluation.

PASSPORT also serves as the gateway to several other programs managed by ODA - the *Residential State Supplement (RSS)* and both the *Choices* and the *Assisted Living Waiver* programs. The *Choices Waiver* is a self-directed services waiver operated in central and southern Ohio for a subset of PASSPORT-eligible consumers.

## **PASSPORT Home Care Services and Utilization<sup>1</sup>**

In addition to its function as a point of entry along the pathways to long-term care, PASSPORT provides a wide array of HCBS services to eligible Ohioans. Most PASSPORT consumers receive personal care services, and personal care consumes the bulk of the program's budget. But many other services are also available, including: adult day services; home-delivered meals; homemaker; medical transportation; home medical equipment; emergency response systems; social work and nutritional counseling; minor home modification; chore; and independent living assistance. In addition to these Medicaid-waiver services, each PASSPORT consumer receives a Medicaid card with which to access other Medicaid-covered services. These traditional state-plan services are not case managed through PASSPORT.

PASSPORT has expanded considerably but participant characteristics have remained consistent for at least the past 12 years. PASSPORT enrollment has increased from 4,215 individuals in 1992 to 26,000 enrolled on any given day in 2006.

The majority of PASSPORT service dollars (75%) are allocated to personal care. Long-term residential settings also spend the majority of their resources on assisting residents with the tasks of daily living, such as dressing and bathing. About 11% of PASSPORT funds are allocated to home-delivered meals. Adult day services (4%), home medical equipment (3.3%), transportation (3%) and emergency response systems (2.2%) form a grouping of important, but limited, expenditure services.

A review of PASSPORT consumer characteristics indicates that almost four in ten PASSPORT participants are over age 80, with a mean age of 77. Most are female (79%), not married (80%), and living in their own homes (80%). While three-quarters of the participants are

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<sup>1</sup>From: Mehdizadeh, S., Applebaum, R., Nelson, I.M., Straker, J., Baker, H. (2007). The Changing Face of Long-Term Care: Ohio's Experience 1993-2005. Oxford, OH: Scripps Gerontology Center, Miami University (pg. 23-31).

white, the proportion of non-whites is twice as high for PASSPORT compared to nursing home residents.

PASSPORT participants average three limitations in the activities of daily living. Most (96%) are impaired in bathing, and three-quarters have mobility limitations. More than one-quarter report four or more ADL deficits, and almost six in ten have three or more limitations. Nine of ten report four or more impairments in the instrumental activities of daily living. About 10% are classified as needing 24-hour supervision, and 14% have problems with incontinence.

More than one-quarter had at least one hospital admission in the past year, with 6% having three or more. Eight percent had been admitted to a nursing home in the past year. As a result of their chronic conditions, PASSPORT consumers use a large number of prescription medications. More than 90% use three or more medications daily, and more than 40% use more than ten prescribed medications daily.

### **PASSPORT Eligibility**

To be eligible for PASSPORT, consumers must meet the following requirements:

1. Age 60+
2. Consumer agrees to participate in the waiver.
3. Consumer meets the requirements for a nursing home level of care (functional requirement).
4. Physician agrees with the service plan for the consumer.
5. Individual lives in an appropriate (i.e., non-institutional and unlicensed) care setting.
6. Care plan must not exceed the average cost of Medicaid services in a nursing facility (note that Ohio has a "cost cap" requirement that is set at 60% of the average cost of a nursing facility in SFY 2000 to ensure that the federal requirement for cost neutrality for HCBS Medicaid waivers is met).
7. Consumer must meet the financial criteria to be eligible for Medicaid:
  - a. PASSPORT uses a special income standard equivalent to 300% of the SSI standard of need;
  - b. PASSPORT uses the "spousal impoverishment" asset and income rules that apply to nursing facility residents;



- c. PASSPORT applicants are subject to the federal 60 month "look behind" period for the examination of asset transfers as are nursing facility applicants; and
  - d. PASSPORT consumers are subject to the estate recovery provisions of state and federal law as are nursing facility residents.
8. Consumer can be maintained safely in the community.
  9. Consumer's needs cannot be met by other resources.
  10. There is a PASSPORT "slot" available.

PASSPORT consumers are permitted to retain an income allowance that enables them to pay expenses that PASSPORT cannot pay. For example, room and board expenses are covered by Medicaid only when the consumer resides in an institution (i.e., a nursing facility).

In the past PASSPORT enrollment had been limited due to budgetary concerns. This created a waiting list of approximately 1,100 low-income seniors for PASSPORT by March 2007. On March 8, 2007, Ohio Governor Ted Strickland issued a directive ordering ODA to eliminate the waiting list by overriding the current budget limit.

The Home First Initiative allows nursing facility residents enrolling in PASSPORT to avoid being held on a waiting list and to be transitioned back into the community with the support of in-home care.

### **PASSPORT Administrative Structure**

ODA manages the PASSPORT program with the oversight of ODJFS, the state agency that administers Medicaid throughout Ohio. Within ODA, programmatic responsibilities are housed in ODA's Community Long Term Care Division (CLTCD).

ODA manages PASSPORT through its thirteen PASSPORT Administrative Agencies. These are Ohio's twelve designated regional Area Agencies on Aging and Catholic Social Services in Sidney. The PASSPORT Administrative Agencies (PAAs) enter into a "three-party" agreement with ODA and ODJFS sets performance requirements for PASSPORT. For example,

this agreement requires PAAs to maintain a consumer-to-case-manager ratio of 65:1. The PAA is responsible for preadmission reviews; assessment activities related to PASSPORT (and *Choices*, *RSS*, and the *Assisted Living Waiver* programs) or nursing facility admission; and ongoing case management for those enrolled in PASSPORT and the Assisted Living Waiver. Since the PAA is not permitted to provide home-care services to consumers, local service providers contract to provide personal care, adult day services, home-delivered meals and the other authorized PASSPORT home-care services. As of June 2006, there were 968 certified PASSPORT providers. Ohio does not have licensing requirements for home-care providers, but the state has created certification standards for PASSPORT providers. These standards were revised and filed in April 2006. Since PASSPORT is a 1915c Medicaid waiver, any willing provider that meets the certification standards can become a PASSPORT provider. Consumers are invited to choose among certified providers, but most consumers do not exercise this option. In cases where the consumer does not choose a provider, a provider is assigned based on cost and service provider capacity. ODA transfers money to the PAAs monthly and with those funds the PAAs pay service providers directly for services that are both authorized by a PAA case manager and delivered by the certified service provider. PAAs estimate their needs for the upcoming months; these advance payments are reconciled with actual expenses and this reconciliation provides the basis for the next monthly estimate of needed funds by the PAA.

The staff who perform the clinical functions at PAAs are professionally licensed personnel (i.e., registered nurses and social workers) who serve as screeners (performing preadmission review responsibilities), assessors (assessing eligibility- both financial and functional), and case managers.

## **PASSPORT Rates**

The PASSPORT rate structure has evolved over time based on three principal factors: 1. the geographic location of the service provider; 2. the type of service provided; and 3. macroeconomic factors affecting Ohio as a whole (i.e., recession and funding limitations). For services such as personal care and homemaker services, there is historic regional variation. For example, rates are higher in Cincinnati and Columbus than in Cleveland or Akron. On the other hand, rates for adult day services are based on two levels of service - enhanced and intensive - and these are statewide rates with no regional variation. Rates for services such as home medical equipment and minor home modifications are set on a "bid-per-job" basis, with the lowest and most responsive bidder selected. PASSPORT rates have not been increased since July 2000.

## **PASSPORT Monitoring and Quality Assurance Activities**

CMS has recently developed a new quality framework for HCBS Medicaid waivers, and Ohio is modifying its quality management activities for all its HCBS Medicaid waivers within the parameters set by the new quality framework.

In addition to oversight by CMS and ODJFS, ODA monitors its PAAs on a regular basis. PAAs receive an annual on-site monitoring visit to ensure the fiscal integrity of the PASSPORT program. In addition, a program review is done by ODA's CLTCD on a biannual basis. As part of the programmatic review, a sample of PASSPORT consumers is interviewed in-person to determine how well PASSPORT is meeting the needs of its consumers.

PASSPORT service providers are monitored on an annual basis by the PAAs through a structural compliance review (SCR) that measures adherence to state certification standards. Providers not meeting the standards can be sanctioned. Sanctions depend on the seriousness of the deficiency and range from requiring a plan of correction; suspending further PASSPORT referrals; or decertification of the provider from the PASSPORT program. In addition, each year

a sample of PASSPORT providers are subject to a unit of service review to ensure that the provider has delivered the billed services.

Other PASSPORT quality measures include an incident reporting system and an annual consumer-satisfaction survey. The incident-reporting system tracks adverse customer outcomes (and their resolutions). The consumer survey measures satisfaction and experience with individual service providers. The latest ODA consumer-satisfaction survey was completed in the fall of 2006, and the data are currently being analyzed.

### **PASSPORT Information Management System (PIMS)**

PIMS is a centralized data-collection and decision-support tool for PASSPORT. As an integral part of the flow of billing and payment, PIMS edits claims to ensure that the consumer is enrolled, the services have been pre-authorized, the units billed match that which is agreed to in the service plan, and the provider is certified as a Medicaid provider. In addition, PIMS limits provider payments to the rates that have been identified for each type of service. PIMS data, among other sources of secondary data, played an important role in this evaluation. Below we discuss the design and data collection strategies used on this evaluation.

### **METHODOLOGY**

The request for proposals to evaluate PASSPORT focused on six areas: *Consumer Eligibility; Cost Neutrality; Quality Assurance/ Quality Framework; Provider Processes; Assessment and Service Plan Development Process; and Fiscal Accountability*. These diverse areas required a group of evaluators with different core competencies. Consequently, we separated the evaluation into six different, but complementary, studies. Each study used different methods to gather data and matched Scripps research staff skills with an appropriate topical area.

We have summarized our approach to the PASSPORT Evaluation below. A much more detailed discussion of the PASSPORT Evaluation methods is present in each specific topical report.

The six studies overlap to some extent. *Consumer Eligibility* and *Cost Neutrality* rely heavily on existing data sets (PIMS, MDS, and CRIS-E) and related documentation. Secondary analysis of existing data played a significant role in determining all of the following: whether PASSPORT consumers met the financial eligibility criteria; factors that impact length of stay and disenrollment; total Medicaid costs; and the cost of maintaining PASSPORT consumers in the community. Central to the topical categories *Quality Assurance/ Quality Framework*, *Provider Processes* and *Assessment and Service Plan Development Process*, and, in part, *Fiscal Accountability* are administrators from PAAs, PASSPORT providers, ODA staff, clients, and families of consumers. We used focus groups, in-person interviews, observation, and surveys to gather new data for the evaluation. Since *Quality Assurance/ Quality Framework*, *Provider Processes*, and *Fiscal Accountability* are not completely separable, the most prudent approach to understanding the many mechanisms, motivations, processes, and relationships associated with PASSPORT - including its assessors, providers, clients, and families - involved collaborating on data collection where and when feasible and appropriate. Finally, in addition to interviewing PAA procurement staff and providers, the *Fiscal Accountability* study also relied on existing financial and administrative reports.

## **FINDINGS**

### **Consumer Eligibility**

*Do PASSPORT consumers meet the financial and nursing home level of care eligibility requirements for participation in the Medicaid waiver program?*

***Level of Care Requirements.*** We reviewed all 26,079 PASSPORT consumers who received services between October 1, 2004, and September 30, 2005, to verify consumer

eligibility for Intermediate Nursing Home Level of Care (ILOC) - as detailed in the Ohio Administrative Code (OAC): 5101:3-31-06, or skilled level of care (SLOC)—OAC:5101:3-31-05. We found that nearly all consumers in the study met ILOC by at least one of the criteria for eligibility. Eligibility determination was not possible for approximately 100 consumers because the assessment data entry was not complete. Except for a very small number (19) of consumers who were a few days short of the minimum age, all consumers in the study were age 60 or older. The per person cost of home and community-based services for PASSPORT consumers as a population was \$13,310 annually, well below the 60% per person, per year cost of nursing home care (\$29,343.72). Other findings regarding level of care eligibility of PASSPORT consumers are as follows:

- Most consumers had either at least two ADL impairments or had met nursing home level of care eligibility based on multiple criteria.
- 2.4% (614 consumers) met ILOC eligibility based on having one ADL impairment and needing hands-on assistance with the administration of medication.
- 1% (287 consumers) met ILOC eligibility based on having cognitive impairment or dementia.
- Less than 0.5% (11 consumers) met skilled level of care, or intermediate level of care, based on their unstable health conditions and need for skilled nursing care or skilled therapy.

***Financial Eligibility.*** Financial eligibility data for PASSPORT consumers are entered into a database called “CRIS-E” and updated monthly. In this study, we randomly selected 1,044 PASSPORT consumers across the state. Information on the 1,044 consumers was recorded from CRIS-E and evaluated in regard to Medicaid financial eligibility. This study found that all of the consumers in the sample met the financial eligibility standards by having less than the threshold

net monthly income level of \$1,692 (after accounting for all insurance premiums) and the asset level of \$1,500.

Rarely did anyone in this study have substantial interest income or dividends. The average gross monthly income of the PASSPORT consumers in the sample was \$719, compared to the allowable income of \$1,692 (the range of monthly income was \$13 to \$1990). Only 69% of the consumers had any assets with the most common asset being a savings and/or checking account. The average PASSPORT consumer's assets in the sample were valued at \$434.

Other findings are as follows:

- The most common source of income for the PASSPORT consumers in the sample was Social Security income (83% of consumers receive this form of income). The monthly amount ranged from \$50 to \$1,619; the average amount of Social Security income for the sample was \$683 a month.
- One in every seven (14.5%) PASSPORT consumers had Supplemental Security Income (SSI) as their only source of income. The average monthly income for these consumers was \$492.
- Occasionally, circumstances arise where a consumer's income in a given time period exceeds the maximum income eligibility level. In such situations, CRIS-E calculates the consumer's *liability* for that time period, which is usually a month. The liability is the amount that the consumer must pay toward the cost of her PASSPORT services. PASSPORT Administrative Agencies (PAAs) are responsible for collecting the consumers' liabilities and applying them toward their services. There was no one in the sample with liability.
- When a consumer is married and the spouse has some assets, ODJFS's Medicaid technicians use special worksheets to determine how much of the assets the spouse can retain. The final outcome of the worksheet analysis is reflected in the CRIS-E. We did not review the worksheet calculations or the spousal assets.

*What factors impact the length of stay on the PASSPORT program by consumers and what factors lead to disenrollment to enter a nursing facility?*

The reasons why some consumers stay in PASSPORT longer than others are complicated and unique. We have identified eighteen characteristics that may be helpful in predicting a consumer's length of stay in the program. The factors that contribute most to shorter stays are:

- Decline in caregiver ability to provide care,
- Consumer's need for twenty-four hour supervision,
- Presence of cancer.

On the other hand, the factors that contribute most to longer stays are consumer's impairment in bathing; impairment in laundry; and being age 70 or older.

Consumers left the PASSPORT program for a variety of reasons; 30% of those who left transferred to a nursing home. The factor that contributed most to consumers leaving the program and entering a nursing home was age, particularly for those over age 70. Consumers age 83 or older with Parkinson's disease or dementia were most likely to disenroll from the program and entered a nursing home.

### **Cost Neutrality**

*Are the total Medicaid costs for PASSPORT consumers less than total Medicaid costs for nursing facility residents age 60 and over?*

We examined Medicaid Administrative Claims data for Ohio nursing home residents and the state's PASSPORT program consumers to compare the costs of each type of service. To maximize comparability, the study restricted its scope to nursing home residents and PASSPORT clients age 60 and older who had received nursing home or PASSPORT Medicaid services for at least a year. In total, the study compared Medicaid costs related to 12,177 PASSPORT consumers and 6,029 nursing home residents.



Findings of this study are as follows:

- On average, total Medicaid costs for nursing homes residents residing in a facility for one year or longer were 2.3 times higher than for those receiving in-home services through PASSPORT. The average yearly total Medicaid expenditure for a nursing home resident was \$55,751 compared to \$23,702 for a PASSPORT consumer.
- The average yearly Medicaid health-care expenditures, excluding medications and services provided in the nursing home, for a nursing home resident was \$2,110; for a PASSPORT consumer, the cost was \$5,258.
- The average yearly Medicaid cost for long-term care supportive services for a nursing home resident was \$48,244; for a PASSPORT consumer, the cost was \$12,179 plus another \$1,194 for case management.
- The next major Medicaid expenditure category for both PASSPORT consumers and nursing home residents was medication. The medication expenditures for nursing home residents were \$5,400 per person, per year compared to \$5,070 for PASSPORT consumers.
- PASSPORT consumers, on average tend to be hospitalized more often and make use of emergency room and ambulance services more frequently than nursing home residents. The average cost of PASSPORT consumers' hospitalization was \$1,065 per person, per year, compared to \$289 for nursing home residents; the cost of emergency room services for PASSPORT consumers, reflected in outpatient hospital claims, was \$511 per person, per year, compared to \$157 for nursing home residents. Emergency room physician costs incurred by PASSPORT consumers, which are reflected in physician services, was \$692 per person, per year, compared to \$284 for nursing home residents. Yet, the total cost of inpatient, outpatient, and physician services only counts for 9% of total PASSPORT consumers' Medicaid expenditures.
- No association was found between the extent of nursing home resident's impairment and their total Medicaid expenditures. This is because nursing homes in Ohio are reimbursed based on a formula that takes into account the average care needs of the residents in the facility rather than each individual resident.
- PASSPORT consumers' Medicaid expenditures were related to their extent of impairment. Consumers with higher level of impairment used more services.

*How does the total public cost of maintaining PASSPORT consumers in the community on PASSPORT compare with the total public cost of caring for nursing facility residents?*

As it was not feasible to examine all sources of funding for all PASSPORT participants in this study, we used a stratified random sample of 1,044 PASSPORT clients for this area of

inquiry. We found that, aside from Medicaid, PASSPORT consumers are assisted by public funds from Supplemental Security Income (SSI); food stamps; government housing, energy assistance programs; and miscellaneous local services. Medicare expenditures were not examined in this evaluation because data were not available in a timely manner; and, both PASSPORT consumers and nursing home residents over age 65 are eligible for Medicare. However, since Medicaid was more often the co-payer for Medicare-reimbursed services such as inpatient and outpatient hospital and physician visits, and PASSPORT consumers, on average, use these services more frequently, it is reasonable to assume that PASSPORT consumers' Medicare expenditures are higher than those for the nursing home residents on Medicaid.

Findings related to these other sources of public funds are as follows:

- When all public costs are considered, including Medicaid, on average, the cost of caring for a person in the community is less than one-half the cost of caring for a person in a nursing home.
- On average, the value of the non-Medicaid public assistance and services that PASSPORT consumers received was \$2,830 per-year, compared to an average of \$480 per-year for some of the Medicaid-covered nursing home residents.
- Only one-third of PASSPORT consumers received SSI. The average SSI amount for these consumers was \$329 a month (\$3,948 a year), per person. The only non-Medicaid, public expenditure that nursing home residents have is SSI. Nursing home residents are entitled to only \$40 (\$480 a year) of their SSI each month, the rest is paid toward their nursing home care.
- Less than one-half (42%) of PASSPORT consumers received food stamps, ranging from a monthly amount of \$10 to \$149. The average amount for these consumers was \$49 a month (\$588 a year), per person.
- A little over one-third of PASSPORT clients received housing assistance. The average amount of subsidy for consumers who received such assistance was \$300 a month (\$3,600 a year), per person.
- Only 7.6% of the PASSPORT consumers in the study benefited from the Home Energy Assistance Program (HEAP). The average monthly assistance for those who received this benefit was \$12.50 a month (\$149 a year), per person.

- Less than 3% of PASSPORT consumers used Older Americans Act services (such as congregate meals, transportation, home repair, adult day care services, home making, and legal services and/or their caregivers received educational material from the National Family Caregiver Support Program). The PASSPORT Administrative Agencies were not able to provide a cost estimate, because these services were not under their jurisdiction.
- Less than 2% of consumers received housing repair or modification assistance from Ohio Department of Development housing trust fund. This assistance ranged from \$850 to \$5,000, per person. (Clients need to be home owners to receive this assistance, and in most cases this was a one-time-only service).
- A few PASSPORT consumers received reduced-rate public transportation (i.e., rides from certain local or county level programs). The number of clients and the amount of assistance was negligible.

**Recommendations from the cost neutrality and consumer eligibility studies:**

- For a variety of reasons including caregivers' concern about disclosing detailed personal information, the data screens related to caregivers in PIMS are not always complete. We recommend that ODA devise a way to assure caregivers of their privacy and confidentiality of their personal information then make completing the screens related to caregivers a required part of the assessment.
- Although the assessors and case managers must concentrate on determining LOC during the assessment process, other useful information is not always posted to PIMS such as whether the consumer has a health condition that does not influence his /her functional abilities. In the analysis, beyond determining level of care, we were limited by incomplete screens. We recommend that ODA require the assessors to complete all screens, within a certain time period. We also recognize that assessment is an ongoing process, and, as such, completed screens within a time limit might not always be feasible.
- For extracting information about other public assistance that PASSPORT consumers received we were faced with two challenges: a) there was not a single source that had all the information, therefore we had to identify each source and negotiate with different agencies or organizations for the information; b) the CRIS-E system, which identifies and determines the Medicaid client's financial eligibility, is not a user friendly system, and some of the work in determining eligibility was done behind the scenes on paper, which was inaccessible. Since older people with impairments are a vulnerable population with many limitations it would be to the consumers' advantage to have a single system that keeps track of all the programs and services in which they are enrolled. This reduces the need for repeated efforts by consumers to complete yet another application for a program. An integrated data system would also allow program staff as well as researchers to examine a variety of questions about the program, including the complete cost of caring for a person with disability in the community.

## **Provider Processes**

*Do PASSPORT service providers meet certification standards set forth in the Ohio Administrative Code?*

According to staff at the PAAs, the pre-certification visit is the most critical in ensuring that a provider understands the PASSPORT rules and has the processes and systems in place to meet the PASSPORT requirements. The PAA staff use the pre-certification visit as an opportunity to educate the provider about PASSPORT rules, annual compliance reviews, and other areas of the program. If a provider is out of compliance, the certification process does not move forward until the prospective provider has complied with the conditions of participation.

Once the provider meets the requirements for certification according to the PAA, that provider's information is forwarded to ODA. ODA verifies that the application is complete, that appropriate documentation is provided, and forwards the application to ODJFS for approval. ODJFS assigns a Medicaid provider number, verifies that none of the owners or board members of the provider agency are on the "Medicaid exclusion list" and approves the provider. The Medicaid exclusion list includes anyone convicted of fraud against the Medicaid or Medicare programs across the United States.

Our review showed that certification processes are consistent across PAAs and are consistent with the standards specified in rules. ODA's final authority to recommend certification provides further assurance that all documentation is provided and that processes are in place for providers to comply with the rules. We intended to include an audit of the elements required for certification by examining PIMS data, but since not all these data were available electronically, this part of the evaluation was unfeasible.

Another area of interest was based on concerns expressed by providers: i.e., whether the amount of time that the certification process takes was within guidelines as established in rules.

The attempt to examine this, however, was thwarted by incomplete certification data. Greater attention by PAAs in data entry is recommended so that future examinations of the timeliness and completeness of the certification process can be carried out.

PASSPORT has a number of quality assurance processes in place to ensure continuing provider compliance. These include an annual structural compliance review of providers by the PAAs. PAAs may also have additional processes. For example, some use provider-feedback logs to monitor complaints about providers. Some conduct their own surveys with consumers to gather information about provider service quality. At least one PAA uses a technical assistance model as part of its monitoring process, assisting providers in improving practices so that all become high quality. Over four-fifths of providers are monitored by multiple organizations. On average, these providers receive three monitoring visits per year.

Providers talked about how, ultimately, the individual worker IS the PASSPORT program. Client satisfaction and the quality of the service provided are, in the end, in the hands of the direct care worker. Providers and PAA staff talked about the level of trust required to allow individuals to go into the homes of frail elders, where only the consumer knows what actually occurs every day. To that end, providers and PAAs take hiring, training, and managing their workers very seriously.

While the current quality assurance processes are sufficient to provide safeguards to the health and welfare of participants, they do not provide all that is needed to ensure the actual quality of the PASSPORT program. A focus on consumer outcomes, such as satisfaction with services at the provider level, would assist the state in identifying high- and low-quality service providers. This in turn could be used to identify best practices, provide technical assistance and/or direct care worker training opportunities and improve care for all consumers statewide.

Some providers and PAAs also mentioned considerations of quality when referring clients to providers. If a client does not have a preference, or information about the providers to make a choice, then assigning providers based on lowest cost may not meet the needs of consumers for the highest quality service. Several providers wanted quality to become a component of the information that case managers can give to clients to assist them in making choices about providers.

*What is the tenure of PASSPORT service providers and what factors impact it?*

In order to determine what factors influenced providers to remain in the program, and what factors were problems, we conducted a mailed survey of active providers. In order to determine the reasons providers dropped out of PASSPORT we conducted a series of qualitative interviews via telephone with providers who became inactive between 2004 and summer 2006. We also conducted two focus groups with providers to determine what issues were important to them in order to develop a relevant mailed survey.

We limited our work with PASSPORT providers to five of the most widely used services: adult day service, home-delivered meals, transportation, homemaker and personal care. One-hundred and seventy-two providers who were still active in 2004-2006 had applied for PASSPORT certification prior to 2000. On average, as of July 1, 2006, these providers had been with PASSPORT for nine years. Given that the 2004-2006 list of providers included 801 provider offices under 633 main providers, the proportion of providers with long tenure is fairly high, at over one-quarter (27.2%). There may be more long-tenure providers since a large number of them had an application date of 6/30/2000. This date was entered in PIMS for providers that were transferred from the legacy information system. These providers were excluded from the analysis of provider tenure.

There are also a fairly significant number of short-term providers. Our mailed survey found 23.9% had been in business five years or less. Overall, current providers had been actively in business for an average of 19.1 years. Many were in the home care business long before the existence of PASSPORT.

Current providers indicated their likelihood of continuing as PASSPORT providers on a scale of 1 to 10, with 10 being very likely. On average, current providers reported an 8.7 on the 10-point scale. When asked if they would become a provider today if they were not already in the program, respondents were less positive, rating their likelihood at 7.6 on the 1 to 10 scale. Over 90% indicated they were satisfied or very satisfied with the PASSPORT program overall, as well as with communications with their PAAs. Despite complaints from the focus groups about multiple monitoring processes and time-consuming record keeping, over 90% were satisfied or very satisfied with the monitoring process. In open-ended comments, 46 providers raised issues regarding reimbursement rates. The next most prevalent comment was praise for the PASSPORT program as an important service for older Ohioans. The focus group participants also unanimously praised the program. There are strong indications that many providers participate out of a belief that PASSPORT is consistent with their mission and provides a needed community service.

Almost all inactive providers (16 of 19 interviewed) indicated a strong belief in the PASSPORT program as well. Most discontinued their service for financial reasons. The main financial problems were the low reimbursement rates or low numbers of client referrals. Current providers also mentioned client referral issues — when providers have too few clients, they cannot give employees enough work, contributing to higher turnover and lower quality care. Financial impacts often were borne by the workers in terms of lower pay and few benefits.

Mailed survey results indicate that among providers who rely solely on PASSPORT for funding, half provide a low amount of employee benefits and one-third are in the highest category of employee turnover. Financial issues were also related to maintaining their certification. The most common concern was the high cost of the required insurance. A certain level of client referrals is necessary in order to justify the expense of compliance with PASSPORT certification requirements.

PASSPORT providers (both active and inactive) also indicated that, to some extent, they see their employees as PASSPORT customers. They have a great deal of concern about employee morale, employee benefits and, in general, providing good jobs that will attract and keep good, reliable employees. In turn, they expect that good employees will provide good quality care for the older Ohioans served by PASSPORT. Workers in agencies that provide PASSPORT services are a sizable group. Among the nearly 50% of providers we heard from, nearly 20,000 full- and part-time employees (19,675) were reported. (The majority, 16,912, were direct service workers.). If a similar workforce exists among providers who did not respond, then nearly 40,000 workers, statewide, are employed by agencies that are affected by Ohio's PASSPORT program.

**Recommendations related to provider processes:**

- If the agency is monitored by Medicaid, Medicare, JCAHO, or another certifying organization, it seems that PASSPORT might consider waiving the PAA review. Currently, Medicare home health organizations can be accredited by JCAHO and also be in Medicare compliance with one monitoring visit from JCAHO. A similar strategy could be explored to reduce administrative costs for ODA, the PAAs, and PASSPORT providers.
- Each of the 13 PAAs builds independent relationships with their providers, but many providers operate in multiple PAAs. Some standardization could occur, without sacrificing the autonomy of the PAAs to manage providers as they see fit. For example, samples of PASSPORT client record forms, or employee timesheets that could be used by all PASSPORT providers would be helpful to ensure that provider records had all



required elements that would be examined in the monitoring visit.

- Making data about provider quality available would be beneficial for many reasons. For providers, information from consumers who have providers with very different practices regarding matching of workers and clients could illuminate whether there is one best practice regarding a consumer's relationship with their home care worker. Provider quality information will also assist consumers in making informed choices. Several providers wanted quality to be included in the information that case managers provided to consumers. They felt this would help them attract more clients, which in turn, would increase their revenue, increase the number of hours they could offer their workers, and ultimately allow them to provide even better service because of their ability to retain high quality employees
- The challenge for the PASSPORT program is to manage PASSPORT providers in such a way that high quality providers receive reimbursement rates that reflect the excellence of the care their workers provide and enough referrals to make the administrative challenges worthwhile.

### **Quality Assurance/ Quality Framework**

*Does PASSPORT have quality assurance processes in place and working to safeguard the health and welfare of participants?*

ODA and the PAAs have numerous quality assurance processes in place to safeguard the health and welfare of PASSPORT participants. There is a hierarchy of federal, state, and local monitoring of the PASSPORT program with regard to program operations and consumer experiences. (Parallel multi-level processes are in place for fiscal accountability and for provider quality monitoring). CMS regularly monitors the PASSPORT program at the state and PAA levels, including 10 to 15 interviews with consumers and/or providers once every five years (usually prior to waiver renewal). ODJFS reviews about 400 consumers and related providers every two years. ODA reviews each PAA once every two years, and can initiate a review of a PAA at anytime if there are significant issues raised from any of a number of sources, including complaints or negative events.

Specific quality assurance mechanisms include annual structural compliance reviews of

providers by the PAAs, monitoring of the PAAs by ODA, incident reporting, interviews and annual surveys with consumers, and PAA-specific quality assurance/quality management committees. As noted above, one PAA uses a provider quality feedback report and a technical assistance model as part of their monitoring process, assisting all providers in improving their services. The incident reporting system is designed to provide consumers with protection from harm; it is a highly formalized and important mechanism for identifying and remediating problems. Based on analysis of incident data, ODA provides training and technical assistance to assure that the incident reporting process is implemented in a standardized way across all PAAs, and that problems are addressed in a timely and effective way. In addition, consumers have several options for registering complaints and for filing formal grievances. Both ODA and the PAAs are involved in formal mechanisms for addressing complaints from consumers, their families, or any other concerned party

Overall, ODA and the PAAs are strongly committed to participant health and safety. This commitment is made evident through attempts to deal with individual incidents as they occur, but also through examination of trends and patterns that may suggest systemic solutions to any problems that arise. Current efforts involving the collection and analysis of more detailed data about correlates and consequences of falls, and the development of theft prevention program and training about falls prevention are examples of this commitment to understanding how to continually improve the ways in which PASSPORT can maintain the health and well-being of participants. PASSPORT providers play a central role in client health and safety, as discussed above.

*How congruent are the existing PASSPORT quality assurance processes with the new Centers for Medicare & Medicaid Services' (CMS) "Quality Framework" that Ohio will be required to fully implement by 2008?*

The PASSPORT program is already in compliance with the required waiver assurances that underlie the CMS Quality Framework, as documented in each of the topical reports. (The Quality Assurance/Quality Management report provides a table specifying how each topical report speaks to a particular waiver assurance). In keeping with the broader goals of the CMS framework, ODA has undertaken a concerted effort to fully operationalize and implement its own quality management system (QMIS: Quality Management and Improvement System). Regularly scheduled teleconferences with staff from the PAAs about QMIS are a central strategy for disseminating and refining ODA's vision for quality management. The teleconferences focus on the discovery, remediation, and improvements processes that are central to the quality management framework. The conferences are a forum for PAAs to discuss their current quality management practices, to hear from ODA about the values and practices that are part of the emerging quality framework, and to provide feedback to ODA about the system. These efforts reflect values that are consistent with the CMS Quality Framework, and with ODA's quality management goals: a strong focus on the consumer, use of data to improve the quality of the program, and provision of technical assistance to the PAAs in the service of continuous quality improvement. As with some of the other issues discussed in this report, one of the major challenges in implementing the CMS Quality Framework is striking the appropriate balance between the effectiveness of standardization and the local responsiveness of PAA flexibility.

Many of the focus areas within the CMS Quality Framework are discussed in other sections of this report. The major issue not covered elsewhere is "participant outcomes and satisfaction." PASSPORT consumers are surveyed or interviewed for several different purposes,

using several different instruments. A review of the goals and utility of the data that result from these parallel efforts might suggest ways to achieve greater coordination of efforts, greater depth of information, and more effective utilization of information for purposes of quality improvement. Currently, there are federal-, state-, and locally initiated efforts to gather information from consumers about their experiences. ODJFS conducts interviews with a sample of consumers as part of their monitoring of ODA. ODA works with the PAAs to take an in-depth look at consumer experiences, including interviews and a “walk through” of several clients, following them through each step of the PASSPORT system, as part of their biannual monitoring. ODA also conducts an annual survey with a large sample of participants; results from this survey are shared with the PAAs so that the PAAs can use the information in their quality management processes. Some PAAs conduct their own consumer surveys, but others do not. Among those that do collect their own data from consumers, there is variability in terms of how these data are used, ranging from internal quality monitoring to issuing provider-specific reports of quality.

**Recommendations related to quality assurance and quality management:**

- ODA, in collaboration with the PAAs, might want to consider a streamlined, well-coordinated consumer survey process that yields representative, meaningful, and routinely utilized data on consumer outcomes as well as consumer satisfaction. Certainly a systematic review of current goals and practices regarding consumer surveys would be advisable.
- Based on data from the 2005 and 2006 interviews with consumers (done as part of PAA monitoring), there is a high level of satisfaction with the program. The 2006 survey included some additional questions about informed choice. Even though the sample was small (N=78), the data suggest that consumers do not feel well-informed as they are choosing a provider. Only about half of the consumers who did not already have a preference for a particular provider felt that they got adequate information to make an informed choice. These data echo findings from some of the other topical studies. Consumers would like more information about the quality of the providers they might

choose to provide their services.

- PASSPORT is well on its way toward development and full implementation of a comprehensive quality management system (QMIS) that is congruent with the CMS Quality Framework model. One of the challenges in implementing this system will be balancing necessary standardization of discovery, remediation, and improvement processes with the effectiveness of local flexibility and autonomy in solving problems and improving quality. Achieving this balance is related to another challenge: ODA's dual roles of monitoring compliance, and providing technical assistance and support for continuous quality improvement.

### **Assessment and Service Plan Development Process**

We used a case study methodology to conduct an in-depth evaluation of the PASSPORT assessment and services experience of thirty individuals and their families. The cases were evenly distributed among “Newcomers” (new assessments), “Continuing” consumers, and “Disenrolled” consumers. When nearly all case studies had been completed, we conducted a focus group of 12 of the 13 PAA PASSPORT site directors or their designees. Case study data gathering included a combination of assessment observation, interviews, and consumer documentation review.

*Does the consumer exercise informed choice in the assessment, service planning, and service delivery experience?*

Our case studies revealed several threats to the exercise of informed choice, some inherent in the very vulnerabilities that bring consumers to PASSPORT in the first place. First, the consumer does not make decisions in isolation. Choice is negotiated among many individuals. Second, the consumer chooses among options identified and offered by others; others establish the range of choice, others delimit choice; others use language that is understandable or not to the consumer and his/her informal caregiver(s) in the decision-making process. Third, PASSPORT and other long-term care information itself is voluminous. The consumer and family have much information to “take in.” Fourth, the consumers (and

caregivers) are often limited in their capacity to negotiate options on equal footing with program professionals and workers. Finally, the negotiation of options may be conflictual, for example when the consumer and informal caregiver have competing preferences.

A major finding in this report is the significance of the role of professional discretion and judgment in the PASSPORT experience. Discretion is the decision making freedom left to the professional after all policies, rules, and regulations apply. The decisions made by professionals related to sharing and explaining information and negotiating a service plan have a significant impact on the consumer's informed choice throughout the PASSPORT experience. Good professional judgment is critical.

*Does the assessment process capture and accurately document the individual's needs, strengths, and resources?*

We observed that effective assessment is shared (uses multiple sources of input), ongoing (reflects changes over time), and developmental (builds upon itself to broaden and deepen knowledge over time). All three elements of effective assessment were found in our evaluation of the PASSPORT program. In all observed initial assessments and in the review of initial assessment documents of the other case studies, the assessment process appears to effectively capture and accurately document the individuals' needs and strengths, sufficient to develop and begin an appropriate service plan. We were struck by the variability among assessors in the level of attention to caregiver assessment. This is especially important given the level of interaction between caregivers, case managers, and providers.

In our assessment observations, we noted efforts of assessors to ensure informed choice in the face of threats identified above. In cases where the consumer's decision making capacity and assessment participation was impaired, the assessor communicated primarily with the

caregiver, involving the consumer as appropriate. In no cases did we observe inappropriate deferral to the caregiver in the assessment and informed choice process.

We were also interested in whether consumers were informed about their full range of long-term care options, including nursing home placement. Some assessors explicitly stated nursing home diversion or delay as the goal of the program but in no cases did assessors present the PASSPORT program as the only option for consumers. It is important to note that in some of the Continuing cases, case managers actively worked with consumers and their caregivers to keep the nursing home option open and always “on the table.” And, of course, several of the Disenrolled consumers left the PASSPORT program due to need for nursing home care, a process that was implemented with the counsel and assistance of case managers.

In all cases, the assessors worked to balance the consumer and caregiver needs and wants with a relatively conservative offer of PASSPORT resources. Assessors use discretion in the negotiation of the service plan. They decide how much service to offer or suggest and which of their own perspectives to share. The use of discretion requires strong assessment skills and good professional judgment, traits apparent in each of the assessors we observed.

We found that assessors and case managers are frustrated by their inability to provide the consumer information about the quality of the PASSPORT providers and thus to assure a quality service plan. Assessors and case managers are prohibited from providing information based on their own experiences with providers. As one PAA site director said, “There are no quality measures in any of the provider lists out there.”

#### *Financial Eligibility and Time of Onset of Services*

We examined whether PASSPORT consumers were enrolled in the program in a timely manner. Two things can significantly delay the onset of PASSPORT services: 1) the process of

Medicaid eligibility determination (made and renewed annually by the county DJFS) and 2) the PASSPORT waiting list. It appears that much of the waiting list time overlapped with county DJFS delays. Even though the waiting list has been eliminated (as of March 8, 2007), there are still delays to onset of services that can, in part, be attributed to delays in the Medicaid-eligibility determination process.

Medicaid eligibility determination can be delayed by the consumer (who must gather and produce a long list of personal and financial documents) or by the county DJFS. Regarding DJFS delays, it is apparent that the speed of Medicaid eligibility determination varies widely by county, and, within counties, it varies by worker. Among our thirty cases, the range of time between assessment and Medicaid eligibility determination was three days to three and one-half months, with a mean delay time of approximately 8.5 weeks for consumers who were not presumptively enrolled. PAA site directors reported average DJFS eligibility delays ranging from thirty days to three to four months; most participants estimated the average eligibility determination wait in their PAA areas to be forty-five to sixty days.

As stated earlier, the complexity of financial eligibility is another significant informed choice issue. Medicaid estate recovery is particularly complicated and although assessors provide basic information orally and in written materials, we did not observe the process of educating consumers in DJFS interviews; it would be helpful to examine the DJFS eligibility determination system and process in a future evaluation.

*Do both service plan and service implementation match the individual's assessed needs and strengths?*

Case managers are responsible for administering and monitoring the consumer's service plan; in that role, they are also responsible for the ongoing assessment of consumers. At the end



of September 2006, case managers had an average caseload of approximately 64 consumers. Case management and case management supervision are linchpins of the PASSPORT program and central to its success. We were impressed across the board with the responsiveness of case managers to their consumers' changing needs and circumstances.

We examined whether services match needs in terms of: 1) **type** (Is the consumer getting *what s/he* needs?) 2) **amount** (Not too much and not too little?) 3) **quality** (Do services meet standards of good practice and are consumers satisfied?) and 4) **impact** of services (How successful was PASSPORT at keeping care appropriately at home?).

PASSPORT consumers exercise choice regarding the type and amount of services they receive, within the guidance and approval of the program. PASSPORT consumers in our case studies actively sought a service plan that best matched their needs and did not insist on excessive services.

Most consumers received the type(s) of service(s) they needed; they had less say about the schedule of those services. Although most consumers and caregivers express basic satisfaction with their service plan, nearly all tell of occasional problems with the quality of service delivery. The quality of the PASSPORT program is only as good as the quality of the service providers, for the essence of the consumer's PASSPORT experience is the day-to-day receipt of services. Quality problems usually had to do with the unreliability or poor attitudes of direct service workers. For the most part, however, consumers were able to work with their case managers to solve quality and satisfaction issues, including changes in providers or workers.

Our case studies reveal consumers and caregivers strongly determined to keep care at home. The impact of PASSPORT on this effort is obvious. Those who disenrolled from the program in favor of nursing home placement did so after all efforts had been exhausted to sustain

care in the home. Consumers and caregivers we interviewed were effusive in their praise of the program; they expressed gratitude with descriptors such as “life savers,” a “blessing,” “I couldn’t have done this without them,” and “*Please*, don’t do away with the PASSPORT program.” One caregiver said, “I feel like I have been very blessed with the people they have surrounded me with.”

**Recommendations related to assessment and service plan development:**

- The size and level of demand of particular caseloads should be carefully monitored.
- Even though case managers work extremely closely with family caregivers, PASSPORT assessments are consumer-based rather than family-based. Caregiver assessment is minimal. The process and function of a family-based assessment is worthy of exploration
- Provider and worker quality is variable and consumers do not have adequate information about quality to make an informed choice about their service providers. Assessors and case managers cannot facilitate fully informed choice without adequate provider quality measures.
- Medicaid-eligibility delays in service onset are related in part to the volume of documentation demanded of consumers, but appear more often related to bureaucratic or worker delays at the CDJFS level. This serious issue requires systematic investigation.
- Our evaluation did not look at consumer/family informed choice in the Medicaid-eligibility process at the CDJFS agency level. Because of its complexities and its significant implications for families we believe the process merits evaluation.
- During the course of our evaluation we learned PASSPORT consumers who were enrolled via the Home First option had disenrolled in unanticipated numbers. We were unable to include this population in our assessment and services sample and believe an evaluation of the composition and fate of Home First enrollees to disenrollees should be conducted.
- Informed choice requires that consumers receive and comprehend the information necessary to make an informed decision, and that they be supported through the process of negotiating what may be difficult choices. A closer look at all of the necessary elements of informed choice, and the extent to which they are working effectively in PASSPORT, could strengthen the program. At a minimum, the consumer's cognitive ability to make an informed decision should be explicitly assessed during the process of care planning.

## **Fiscal Accountability**

*Are Ohio's fiscal processes (i.e. provider payment) sufficient to ensure the fiscal accountability for funds through PASSPORT?*

Fiscal accountability includes all the mechanisms and processes that assure that funds are managed properly and procurements are undertaken in a fair, open, and transparent manner.

Fiscal accountability is about finances, compliance and adherence to legal and administrative rules and regulation, and a fair balance among stakeholders. Accordingly, the results of this part of the PASSPORT evaluation are reported under these three headings: Financial Accountability, Accountability for Compliance, and Accountability for Fairness.

**Financial Accountability.** Overall, we find that the financial integrity of PASSPORT is well guarded by multiple levels (consumer, PIMS, case manager, case management visits, ODA, MMIS and CRIS-E) of adjudication and financial auditing. Our evaluation also underscores the value of ODA's PASSPORT Information Management System (PIMS), questions the Office of Research, Assessment and Accountability (ORAA) practices, and encourages ODJFS Bureau of Community Access to continue with the proposed change from a separate review of quality and finances to a more comprehensive waiver review.

PIMS is not without its shortcomings, particularly in management reporting, but it is an integral part of the flow of billing and payment. The integrity of PIMS is critical to the financial integrity of the PASSPORT program.

There is no question that ORAA audits are taking place in accordance with the rules and regulations. However, concerns arose regarding the validity of these audits based on time lag. Audits for FY 2001, 2002, and 2003 are performed between three and five years after the fiscal year is over. Insufficient controls or questionable practices undetected in that time period could result in significant financial liability.

In the past, the fiscal review of the PASSPORT program has not been tied to the ODJFS Bureau of Community Access Quality Assurance Survey process. However, recent changes have been made to the way ODJFS is reviewing waiver programs like PASSPORT. Last year, ODJFS introduced the concept of a Comprehensive Waiver Review. The new comprehensive review design was implemented as part of the comprehensive review of the Ohio Home Care Waiver Review and the Ohio Bureau of Community Access plans to use the same model for the review of the PASSPORT waiver in the future. This is a very positive step.

***Compliance Accountability.*** The methods used to ensure the integrity of the PASSPORT program are: PAA structural compliance review of every provider every year; ODA annual program review and fiscal monitoring; ODJFS Quality Assurance review of the PASSPORT; and CMS Management Review of the Ohio Home and Community-Based Services Waiver Program for Elderly and Disabled Individuals. A PAA structural compliance review and ODA annual program review were observed.

The structural compliance review is thorough, time- and human resource-intensive (before, during, and after the site visit), and completed according to rules and regulations. Structural compliance reviews vary across the State. One difference, for example, is how PAAs give providers the names of employees and consumers whose records will be reviewed. Some PAAs give the names of consumers to be reviewed prior to the actual visit. Others do not provide the names of selected consumers ahead of time. Still others use some combination of these two approaches, depending on whether the provider has more than one office and a decentralized record keeping system. All have the right to ask for additional records if findings suggest a trend or pattern of non-compliance to conditions of participation. If a provider has the names of consumers whose files will be the subject of review ahead of time, the provider has an

opportunity to check those records and the records of employees serving the consumer before the compliance review team gets to the providers office. Providers have a significant advantage when they know which records will be pulled. They could benefit from the situation by changing or correcting errors that would suggest the provider is not meeting PASSPORT conditions of participation.

While it may be that not notifying providers creates an undue burden on them, that seems to depend on the size of the provider and the location of consumer and employee records. If the reviewer wants to see a consumer's record that is at a satellite office, then it does create a burden. If the reviewer is at the provider's administrative office where records are kept, there is no burden. A compromise used by some PAAs is to ask for the consumer and employee records from satellite offices ahead of time and request other consumer records as part of the required entrance conference.

The compliance review is thorough, time- and human resource- intensive (before, during, and after the site visit), and completed according to rules and regulations. PAAs and others were asked how they felt about the program review process. Most thought it was helpful, and very professionally done. When issues are identified in the PAAs, ODA provides technical assistance and reaches out to the PAA to help resolve them. Interestingly, some of the PAAs expressed the same concerns about program review that providers and ODA expressed about Structural Compliance Review and Quality Assurance Review, respectively. All those reviewed feel monitoring focuses more on the technical features of service delivery, with a strong emphasis on rules and regulations instead of on higher-level management issues. Since successful program implementation is rooted in enhancing capacity and fostering group consensus via technical assistance and monitoring advice, it makes sense to move away from an unnecessary focus on

rules and regulations and to move toward management issues. For example, instead of focusing on rules associated with certain procedures time may be better spent distributing information about “best policies” in PASSPORT Administrative Agencies, discussing approaches to nurturing stronger working relationships with better and more responsive providers, and/or measuring and improving quality.

The ODJFS Bureau of Community Access also completes a Quality Assurance Survey to assess the following: self-reported consumer health and functioning; congruence of the care plan with consumer needs; home safety; knowledge of complaint processes; informal caregiver/direct care worker functions and training; and incident reporting practices. The last published Quality Assurance Review of the PASSPORT Waiver was in July 2002. ODJFS began its latest study in the fall of 2006. The results will not be available before the PASSPORT Evaluation is over.

According to Section 1915(c) of the Social Security Act, CMS is required to monitor Ohio’s implementation of the PASSPORT waiver program. This is usually completed in the fourth year after approval, or in the year before renewal. Ohio renews its PASSPORT waiver in 2008. CMS’ management review started on December 29, 2006.

This year CMS revamped its process for assessing and conducting ongoing quality monitoring activities for the Home and Community-Based Services Waiver Program. Now, CMS is asking Ohio to demonstrate that it has adequate mechanisms for finding and resolving problems on an ongoing basis. If Ohio provides evidence pertinent to level of care determinations, plans of care, qualified providers, health and welfare, and financial accountability, CMS may not need to do additional monitoring activities. This is a significant departure from past practices.

*Accountability for Fairness.* In addition to financial and compliance accountability, PASSPORT's management was examined in relation to the interests of all stakeholders. PASSPORT stakeholders include CMS, ODJFS, ODA, PAAs and their employees, providers and their employees, and consumers and their caregivers, all linked by a complex set of laws, regulations, and contracts.

ODJFS, ODA, and PAA staff interviews, and a survey of active providers and inactive providers, identified three major issues. The first issue is the inconsistency of the County Department of Jobs and Family Services as it relates to financial eligibility determination. In order to become eligible for enrollment in PASSPORT, a County Department of Jobs and Family Services (CDJFS) must determine the individual is financially eligible for Medicaid. Federal rules require the CDJFS makes the determination no later than 45 days after an individual's application is complete. In discussing waiting lists with PAA staff, most of the waiting list is comprised of individuals who are pending CDJFS financial eligibility determination. Our discussions with PAA staff also indicated that some of the PAAs have excellent relationships with their respective CDJFSs and experience fast financial eligibility determination turn-around times. For these, the quick turn-around seems to be related to the size and makeup of the county (rural or urban), having designated PASSPORT reviewers at the CDJFS, and/or a concerted effort to foster a strong working relationship between the PAA and CDJFS. For others with slower turn-around, PAA staff indicate causes for delays include employee turnover, conflicting Medicaid priorities, and the difficulty of navigating the system. Both groups also pointed out that the delay in a CDJFS financial eligibility determination is not always CDJFS's fault. At times there is resistance on the part of the consumer and/or caregivers to presenting the necessary documentation, and/or apathy on the part of individuals seeking assistance.

The final issues associated with stakeholder fairness are the quality and quantity of PASSPORT providers. Providers are the bread and butter of the PASSPORT program. In the 2004-2006, there were 968 certified PASSPORT providers. Provider surveys and discussions with PAA staff indicate providers, even those that have left the PASSPORT program, are committed to PASSPORT and know consumers are getting the services they need to stay at home. We are convinced that providers (though often are unhappy with the rates they receive for their services) go above and beyond program requirements to help consumer's access quality care. Despite this commitment, some providers cannot continue as PASSPORT providers because they are losing money and/or can not get enough referrals to make ends meet.

Comments from inactive providers surveyed for the PASSPORT Evaluation identify two main reasons for providers exiting the PASSPORT program: low reimbursement rates; and lack of referrals. One inactive provider said, "The reimbursement rate from PASSPORT wasn't enough, and between paying the employee on top of paying office staff, nurses, paperwork in general, bonding, insurance – we were in the hole".

On the surface, the driving force behind providers leaving the PASSPORT program appears to be reimbursement rates. PASSPORT rates and other reimbursement policies have not been adjusted since July 2000. However, the situation may be much more complicated. Many providers seem able to make ends meet fairly well. Otherwise, why would 91 percent of the providers surveyed be either 'very satisfied' or 'satisfied' with the PASSPORT program? And, why do the majority of these providers say they will very likely stay in the program?

Further, when asked, PAA staff say the formula for financial feasibility may include: reducing the number of PASSPORT consumers to be served; forming entirely different organizational structures to care for PASSPORT consumers (organizational structures that pay



lower wages, offer fewer [if any] non-statutory benefits, and no travel reimbursement); shifting costs from other programs, like levy supported programs, Medicare, other home care waiver programs, and private pay consumers; or refusing to participate in the PASSPORT program at all. PAA staff also said the lack of change in reimbursement has not left a void in the number of providers in the PASSPORT network. According to staff, large not-for-profit health care agencies are being replaced by small for-profits with less ability to respond to the services ordered by PASSPORT consumers. One PAA staff member said, “The pool of providers has changed over time.” Hence, we have a pool of less qualified (and less expensive) providers than we have had in the past.

PAA staff members are also frustrated with the number of providers. Federal law requires PASSPORT to approve any willing provider that can pass ODA’s Conditions for Participation. With the exception of some rural areas of the state - where certain types of providers are not available - most markets have responded with an ample supply of providers. Each one of these providers, regardless of size, is pre-certified, initially certified, and PAAs conduct annual monitoring of providers to ensure compliance as part of the structural compliance review. A significant amount of time and human resources is invested in certifying, monitoring, and providing technical assistance to each provider. PAA staff want to nurture strong working relationships with their better and more responsive providers, but do not have the time to do so. Another problem with the current number of providers is the impact on the number of referrals each provider receives. Just over half of the inactive providers surveyed mentioned they had so few PASSPORT consumers that it was not cost effective for them to continue providing PASSPORT services.

The protocol for PASSPORT referrals is to give the consumer enough information to make an informed choice. If the provider chosen by the consumer is not available, or if the consumer does not choose a provider, the consumer is referred to the provider with the lowest cost. According to PAA staff, low-cost selection occurs more often than not. Obviously, it pays to be the lowest cost provider in a PAA. Unfortunately, if a provider has a well-established and compensated work force, and is not chosen by the informed consumer, it likely will not get a referral. Consequently, more experienced providers may get fewer referrals, and their share of the market shrinks. A decrease in market share in a business that makes very little (if anything) off of each transaction is likely to fail. PASSPORT should consider changing the provider selection process to address these issues. Fewer providers may lower compliance and administrative costs, as well as allow for more opportunities for technical assistance, time to recruit additional providers in underserved areas, stronger PAA-provider relations, and opportunities to channel provider referrals to better providers. All of these could have an impact on the quality of the PASSPORT program.

**Recommendations related to fiscal accountability:**

- Improve the management reporting capacity of the PIMS system.
- When possible, complete the unit of service verification and the service delivery component of the structural compliance review at the same time.
- Encourage ODJFS to continue with its plan to change its quality assurance review to a full program evaluation of internal program management, including case management and adverse-incident management processes, quality assurance protocols, provider accountability, opportunities for consumer and stakeholder participation, and overall continuous quality improvement and fiscal integrity.
- Make every effort to reduce the time lag in ORAA audits.
- Change structural compliance review record request procedures to insure objectivity.
- During quality assurance reviews, at all levels, provide more technical assistance and monitoring advice to enhance the systems capacity and foster group consensus.
- Work with ODJFS to develop strategies to expedite Medicaid eligibility determinations.
- Request a waiver of the federal requirement that PASSPORT approve any willing provider that can meet PASSPORT's Conditions of Participation.

## **CONCLUSION**

ODA's goal for the PASSPORT evaluation was to determine if the PASSPORT program meets the assurances Ohio has made to the federal Centers for Medicare and Medicaid as promised in the most recently approved Medicaid-waiver application submitted by Ohio in July 2005. This summary report (and the six related topic reports) points out some of the positive and negative aspects of the PASSPORT program but, overall, underscores the effectiveness and importance of the program for older Ohio residents who meet the financial and level of care eligibility requirements. The PASSPORT program is meeting the assurances Ohio has made to the federal Centers for Medicare and Medicaid as promised in the most recently approved Medicaid waiver application.

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## GLOSSARY

**1915 (c) waiver** - Medicaid home and community-based services waivers that allow states to request waivers of certain federal requirements to allow development of HCBS treatment alternatives to institutional care so long as these alternatives cost no more than it would to provide the same care in an institutional setting.

### A

**AAA** (See Area Agency on Aging)

**Activities of Daily Living (ADL)** - Basic personal activities which include bathing, eating, dressing, mobility (ambulation), transferring from bed to chair, and toileting. See individual definition for each ADL.

**ADA** (See Americans with Disabilities Act)

**ADL** (See Activities of Daily Living)

**Adult day care** (See Adult day services)

**Adult day services**- Programs offering social and recreational activities, supervision, health services, and meals in a single setting to older adults with physical or cognitive disabilities. Typically open weekdays during standard business hours.

**Americans with Disabilities Act (ADA)**- Legislation enacted to establish a clear and comprehensive prohibition of discrimination on the basis of disability. Signed into law on July 26, 1990, the Americans with Disabilities Act is a wide-ranging legislation intended to make American society more accessible to people with disabilities.

**Area Agency on Aging (AAA)**- A local or regional agency (Ohio's 12 AAAs are composed of multiple county areas), funded under the federal Older Americans Act, that plans and coordinates various social and health service programs for persons 60 years of age or older. The national network of AAA offices consists of more than 600 approved agencies.

**Assessment**- One or more processes that are used to obtain information about an individual, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual requires waiver services as well as the development of the service plan.

### B

**Bathing**- One of the Activities of Daily Living (ADLs). The ability to wash oneself completely in a tub, a shower or by sponge bath, with or without the aid of equipment. These activities include getting a basin of water, managing faucets, getting in and out of a tub or shower, and reaching head and body parts for soaping, rinsing and drying.

## C

**Care/case management (CM)**- Offers a single point of entry to the aging services network. Care/case managers assess clients' needs, create service plans, and coordinate and monitor services; they may operate privately or may be employed by social service agencies or public programs. Typically case managers are nurses or social workers.

**Caregiver**- An informal caregiver is a person who provides support and assistance with various activities to a family member, friend, or neighbor. May provide emotional or financial support, as well as hands-on help with different tasks. Caregiving may also be done from a long distance. Formal caregivers are volunteers or paid care providers who are usually associated with an agency or social service system.

**Care plan**- (also called service plan or treatment plan) Written document which outlines the types and frequency of the long-term care services that a consumer receives. It may include treatment goals for the consumer for a specified time period.

**Case/care management**- (See Care/case management)

**Centers for Medicare & Medicaid Services (CMS)**- This federal organization oversees the Medicare and Medicaid programs. It also provides information to assist consumers in choosing a variety of types of service providers through its website at [www.medicare.gov](http://www.medicare.gov).

**Certification** - In Medicare and Medicaid, certification refers to approval for providers to participate in those programs. Licensed facilities or agencies might elect not to be Medicare- or Medicaid-certified if they planned to provide services only to private-paying residents. Requirements for certification are specified by the federal government for each type of Medicare and Medicaid provider.

**Chore services**- Help with chores such as home repairs, yard work, and heavy housecleaning.

**Chronic illness**- Long-term or permanent illness (e.g. diabetes, arthritis) which often results in some type of disability and which may require a person to seek help with various activities.

**CMS**- (See Centers for Medicare & Medicaid Services)

**CMS Quality Framework**- The CMS Quality Framework is a monitoring tool to evaluate a state's performance in meeting assurances and requirements for its waiver services. There are several areas of focus in the framework including participant access, participant-centered service planning and delivery, provider capacity and capabilities, participant safeguards, participant rights and responsibilities, participant outcomes and satisfaction, and system performance. These are to be reviewed as they relate to the overall quality management functions of design, discovery, remediation and improvement.

**Cognitive impairment**- (A deterioration or loss in intellectual capacity that results in impairment in some or all of the following: short and long-term memory, orientation to people, place, and time, deductive or abstract reasoning (including judgment), and ability to perform activities of daily living.

**Comprehensive assessment-** An organized process for gathering information to determine diagnosis and the types of services and/or medical care needed and to develop recommendations for services.

**Community-based services-** Services designed to help older and disabled people remain independent and in their own homes; can include senior centers, transportation, delivered meals or congregate meals site, visiting nurses or home health aides, adult day care, and homemaker services.

## D

**Deficiency-** A finding from a governmentally-administered inspection that a nursing home failed to meet one or more federal or state requirements.

**Dementia** – Term describing a group of diseases (including Alzheimer’s Disease) characterized by memory loss and other declines in mental functioning.

**Disability-** Limitation in physical, mental, or social activity. There are varying types (functional, occupational, learning), degrees (partial, total), and durations (temporary, permanent) of disability.

**Dressing-** One of the Activities of Daily Living (ADLs). The ability to put on and take off all garments and medically necessary braces, corsets, elastic stockings or garments or artificial limbs or splints usually worn and to fasten and unfasten them.

**Durable medical equipment-** (also called home medical equipment) - Equipment such as hospital beds, wheelchairs, and prosthetics used at home. May be covered by Medicaid, Medicare, or private insurance.

## E

**Eating-** One of the Activities of Daily Living (ADLs). The ability to consume food that has already been prepared and made available, with or without the use of adaptive utensils. Necessary skills include reaching for, picking up and grasping a utensil and cup; getting food on a utensil and bringing food, utensil and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meals. ‘Eating’ does not refer to the preparation of food.

**Emergency response systems (ERS)-** (also called personal emergency response systems) - A call button -- usually worn by the older individual -- which can be pushed to get help from family, friends, or emergency assistance in case of emergency. Can be purchased or rented.

**ERS** (See Emergency response systems)

**Estate recovery-** States are required by law to “recover” funds from certain deceased Medicaid recipients’ estates up to the amount spent by the state for all Medicaid services (e.g. nursing facility, home and community-based services, hospital, and prescription costs).

## H

**HCBS** (See Home & Community-Based Services)

**Home & Community-Based Services (HCBS)**- Non-medical services provided to older persons still living in their own homes. These services may include case management, meals, companions, housekeeping, adult day care, senior center and other services designed to keep people as independent as possible.

**Home and Community-Based Waivers** - Section 2176 of the Omnibus Reconciliation Act of 1987 permits states to offer, under a waiver, a wide array of home and community-based services that an individual may need to avoid institutionalization. Regulations to implement the act list the following services as community and home-based services which may be offered under the waiver program: case management, homemaker, home health aide, personal care, adult day health care, habilitation, respite care and other services.

**Home care / home care services**- Non-medical long-term care services received in a home. For example: homemaker, personal care, home-delivered meals, chore services, or emergency response systems.

**Home-delivered meals**- Sometimes referred to as “meals on wheels,” home delivered meals are delivered to homebound persons who are unable to prepare their own meals.

**Homemaker services**- Help with meal preparation, shopping, light housekeeping, and laundry.

**Home medical equipment**- (also called durable medical equipment) - Equipment such as hospital beds, wheelchairs, and prosthetics used at home. May be covered by Medicaid, Medicare, or private insurance.

**Home modification**- Adaptation and/or renovation to the living environment intended to increase ease of use, safety, security and independence.

**Home medical equipment** (See durable medical equipment)

## I

**IADL** (See Instrumental Activities of Daily Living)

**Impairment**- Any loss or abnormality of psychological, physiological, or anatomical function.

**Informal caregiver**- An informal caregiver is often a spouse, adult child or other relative who provides care for the care receiver, typically without pay.



**Instrumental Activities of Daily Living (IADL)**- Household/independent living tasks which include using the telephone, taking medications, money management, housework, meal preparation, laundry, and grocery shopping.

## L

**Length of stay (LOS)**- Length of stay is usually reported as the number of days a person lived in a facility or received services through a community-based program.

**Level of care (LOC)**- Amount of assistance required by consumers which may determine their eligibility for programs and services. Levels include: protective, intermediate, and skilled. In order to qualify for Medicaid nursing home or home & community-based services an individual must meet a nursing home level of care (either intermediate or skilled).

**LOC** (See Level of care)

**Long-term care (LTC)**- The broad spectrum of medical and support services provided to persons who have lost some or all capacity to function on their own due to a chronic illness or condition, and who are expected to need such services over a prolonged period of time. Long-term care can consist of care in the home by family members who are assisted with voluntary or employed help, adult day health care, or care in assisted living or skilled nursing facilities.

**LTC** (See Long-term care)

## M

**Meals-on-Wheels**- (See Home-delivered meals)

**Medicaid Waiver Programs**- Medicaid programs that provide alternatives to nursing home care. These programs have the potential to reduce overall Medicaid costs by providing services in innovative ways, or to groups of people not covered under the traditional Medicare program. These programs are approved on a demonstration basis, and generally have limited slots available.

## N

**National Family Caregiver Support Program (NFCSP)**- A federally-funded program enacted through the Older Americans Act Amendments of 2000 (Public Law 106-50). It helps states provide services to help family caregivers. The program calls for all states, working in partnership with local area agencies on aging and faith and community-service providers and tribes to offer direct services that best meet the range of caregivers' needs. These services include: Information to caregivers about available services; help to caregivers in gaining access to services; individual counseling, organization of support groups, and caregiver training; respite care; and supplemental services, on a limited basis, to complement the care provided by caregivers.

**Needs assessment**- An evaluation of physical and/or mental status by a health professional, usually a nurse. This assessment, together with the attending physician notes, determines the level of functional and cognitive incapacity of the patient, and is used to create a care plan and make decisions about the need for home health care, an assisted living facility, or a skilled nursing facility.

**NFCSP** (See National Family Caregiver Support Program)

**Nursing home-** Facilities licensed by the state to offer residents personal care as well as skilled nursing care on a 24 hour a day basis. Nursing homes provide nursing care, personal care, room and board, supervision, medication, therapies, and rehabilitation. Rooms are often shared, and communal dining is common.

**Nutrition services-** Include the following:

Home-delivered meals (also called meals-on-wheels) - hot, nutritious meals delivered to homebound older people on weekdays. Can accommodate special diets.

Congregate meals - hot, nutritious lunches served to older adults in group settings such as churches or synagogues, senior centers, schools, etc. Donations are requested, although not required. Subsidized with funds from the Older Americans Act.

## O

**OBRA** (See Omnibus Reconciliation Act of 1987)

**Older Americans Act-** Federal legislation that specifically addresses the needs of older adults in the United States. Provides some funding for aging services (such as home-delivered meals, congregate meals, senior centers, employment programs). Creates the structure of the federal Administration on Aging, State Units on Aging, and local agencies that oversee aging programs.

**Omnibus Reconciliation Act of 1987-** Changes to the Federal Social Security Act that significantly changed how nursing homes and home health agencies are regulated for Medicare and Medicaid certification.

## P

**PAAs** (See PASSPORT Administrative Agencies)

**PASRR-** (See Pre-admission review and see Pre-admission Screen)

**PASSPORT-** Ohio's home and community-based Medicaid waiver program for low-income persons age 60 and over. (PASSPORT stands for Pre-Admission Screening and Services Providing Options and Resources Today.)

**PASSPORT Administrative Agencies (PAAs)-** Organizations that handle the eligibility determination, assessment, and case management for the PASSPORT program. Generally housed at area agencies on aging in Ohio. The exception to this is Catholic Social Services in Sidney that serves as the PAA for Champaign, Darke, Logan, Preble, Miami, and Shelby counties.

**Personal care-** Assistance with activities of daily living as well as with self-administration of medications and preparation of special diets.

**Personal emergency response systems-** (See Emergency response systems)

**Pre-admission review-** Assessment required of all people living independently in the community who wish to enter a nursing home. This ensures that home and community-based long-term care options are presented to all older people who are able to take advantage of them.

**Pre-admission screen-** Older Ohioans requesting admission to a Medicaid-certified nursing facility must receive approval from their PASSPORT Administrative Agency before they may be admitted. This approval (the pre-admission screen) is a federal requirement to ensure that nursing home residents who need mental health services or specialized services for the mentally retarded or developmentally disabled are identified at admission.

**Provider-** Individual or organization that provides health care or long-term care services (e.g. doctors, hospital, physical therapists, home health aides, and more).

## Q

**Quality Framework** (See CMS Quality Framework)

**Quality of Care-** A measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer.

## R

**Residential State Supplement (RSS)-** State-funded program which gives cash assistance to older persons and to blind and disabled persons of all ages who are Supplemental Security Income (S.S.I.) recipients and who do not medically qualify for nursing home placement, but who live in other approved group living settings such as adult care homes and residential care facilities. There is an income eligibility requirement for receiving RSS.

**RSS** (See Residential State Supplement)

## S

**Service Plan** (See Care plan)

**Skilled care-** "Highest level" of care requiring skilled medical services (such as injections, catheterizations, and dressing changes) provided by medical professionals, including nurses, doctors, and physical therapists.

**Skilled nursing facility (SNF)-** Facility that is certified by Medicare to provide 24-hour residential nursing care and rehabilitation services in addition to other medical services.

**Social Security-** A federal program established in 1935 that includes a retirement income program, disability and survivors benefits, and health insurance through the Medicare program.

**Spousal impoverishment protection-** Federal regulations preserve some income and assets for the spouse of a nursing home resident whose stay is covered by Medicaid.

**SSI** (See Supplemental Security Income)

**Supplemental Security Income (SSI)**- Supplemental Security Income (SSI) is a federal supplemental income program for low-income elderly or disabled persons established in 1972. Many states supplement it with additional state SSI. In most states, SSI recipients are also automatically eligible for Medicaid.

## **T**

**Toileting**- One of the Activities of Daily Living (ADLs). The ability get to and from the toilet, get on and off the toilet, and maintain a reasonable level of personal hygiene for the body. Necessary activities include getting on and off a toilet or commode and emptying a commode, managing clothing and wiping and cleaning the body after toileting, and using and emptying a bed pan or urinal.

**Transferring**- (One of the Activities of Daily Living (ADLs). Moving from one position to another, like moving from a bed to a wheelchair or sofa or coming to a standing position. If a person can move with the help of equipment such as a cane, walker, crutches, grab bars or other support devices, then he or she is considered able to transfer positions.

**Transportation services** - (also called Escort services) - Provides transportation for older adults to services and appointments. May use bus, taxi, volunteer drivers, or van or ambulance services that can accommodate wheelchairs and persons with other special needs.

**Treatment plan** (See Care plan)