

Unified Long Term Care System (ULTCS) Workgroup
Short Term Recommendations
September 7, 2010

BALANCE & FUNDING RECOMMENDATIONS

1. Balance: To define the goal of balance for the home-/community-based services and nursing facility services as “Ohioans have access to the long-term services and supports they need in the setting of their choice.” Intermediate (three-year) performance indicators were also recommended:
 - *Adults with physical/cognitive disabilities, age 60 and older will reflect a 50/50 institutional/HCBS distribution. (In 2007 distribution was 60/40.)*
 - *Adults with physical/cognitive disabilities, age 59 and under will reflect a 40/60 institutional/HCBS distribution. (In 2007, distribution was 50/50.)*
2. Expand Home First: Apply the expanded Home First (HB 398) concepts of imminent risk of nursing facility placement to the Ohio Home Care waiver to prevent individuals from entering nursing homes unnecessarily.
3. Statewide ADRNs: Expand the role of AAAs as lead agencies in Aging & Disabilities Resource Networks (ADRN) through the following:
 - A. Secure funding through PPACA and Money Follows the Person to further ADRN expansion.
 - B. Determine how best to move Ohio’s ADRN effort forward and what leadership the state should provide to local ADRN efforts.
 - C. Create a subcommittee under Balance and Funding to further develop ADRN activities.
4. MH Transition Pilot: Support individuals with severe and persistent mental illness to relocate from nursing facilities to community settings and to be supported by the assistance of Medicaid and non-Medicaid services in those settings.
5. Affordable Housing Grantseeking Team: Individuals and associations represented on the Balance & Funding Subcommittee should commit an appropriate level of in-kind support toward an informal team to identify and pursue grant opportunities (e.g., HUD, OFHA, etc.) for housing and related supports for individuals with severe and persistent mental illness who would like to live in the community.
6. Provider Reimbursement Rates: Establish appropriate reimbursement rates for all LTC providers sufficient to ensure sustained quality of care for all consumers.

ELIGIBILITY RECOMMENDATIONS

7. Ensure financial eligibility timeliness: Establish a workgroup of participating state agencies and stakeholder organizations to provide input to ODJFS regarding monitoring and evaluation of county eligibility processing and efficiency to expedite the eligibility process; identify areas that could benefit from process improvement; and allow suggestions for consideration in the development of process improvement.
8. Eliminate face-to-face assessments: Eliminate the requirements for face-to-face interviews for initial applications for ABD Medicaid benefits.

9. Increase the personal needs allowance: Due to budget constraints, implement alternative action steps:
 - A. Assure lowest possible fees on PNA accounts;
 - B. Increase oversight of PNA account management;
 - C. Allow disregard of cash gifts up to the PNA maximum value;
 - D. Adjust resource limits to the Consumer Price Index;
 - E. Identify if a requested service item cost is less than the “comparable cost” item supplied by the facility.
10. Allow patient liability offsets: Identify possible offsets to patient liability related to judgments against a recipient that would impact recipients of long-term care services and that are allowable under federal law.
11. Expand Assisted Living waiver eligibility: Apply the eligibility criteria and logic that is used in PASSPORT waiver to the Assisted Living waiver applications.
12. Expedite HCBS eligibility beyond PASSPORT: Utilize expedited/”presumptive” eligibility for home- and community-based services beyond PASSPORT.

INTEGRATION & CARE MANAGEMENT RECOMMENDATIONS

13. Strategic Direction: Identify existing forums where state agencies and stakeholders can discuss issues and opportunities related to care integration and management.
14. Dual Eligible Integration
 - A. Integrate the Medicaid acute benefit with dual Special Needs Plans (SNPs)
 - B. Educate providers/case managers/consumers as to the requirements for Medicare, Medicaid and other programs to ensure that program benefits are used to the fullest extent.
 - C. Work together to coordinate mailings and promotion aimed at informing dual eligibles of the Medicare SMP option.
15. Medical/Long-term Care Integration
 - A. Provide care coordination of the Medicaid acute benefit for Medicaid HCBS waiver participants.
 - B. Deploy Long-term Care Consultants¹ in hospitals, based on facility and patient characteristics, to meet the needs of adults in need of long-term care supports and services.
 - C. Develop area agency on aging/health care partnerships and train to implement evidence-based health coaching programs.
 - D. Utilize and deploy existing resources such as Long-term Care Consultants in large Medicaid physician practices and patient-centered medical home to support patient access to available community-based programs and support.

¹ Authorized as a service provided by ODA or its designee in ORC 173.42.
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- E. Expand and sustain evidence-based disease self-management programs, including but not limited to Chronic Disease Self-Management Program (CDSMP), Diabetes Self-Management Program (DSMP), and Matter of Balance.
 - F. Expand access to information, assistance/referral and Long-term Care Consultations through Aging and Disability Resource Networks (ADRN).
 - G. Include long-term care/home-care/area agency on aging representation in the IMPROVE (Implementing Medicaid Programs for the Reduction of Avoidable Visits to the Emergency Department), StAAR (State Action on Avoidable Rehospitalization) and Enhanced Primary Care Home initiatives.
- 16. Identify and Support Shared Consumers:** Identify shared consumers/members and provide long-term tools and short term education) to support coordination of services.
- 17. Behavioral Health:** Identify, support and deploy evidence-based behavioral health screening tools/protocols and self-management interventions at transition points/critical pathways.

SERVICE ARRAY RECOMMENDATIONS

- 18. Discharge Planning:** Discharge planners in both nursing homes and hospitals need the knowledge and skills to assist consumers in choosing the settings and services that best meet their needs and support their goals.
- A. Develop a toolkit that can be used across settings to identify resources, both for services and information to support the consumers as they transition to the settings they choose with services to support their goals.
 - B. Develop tool to assist in determining the options that best meet each consumer's needs.
 - C. Develop resources accessible to consumers and their families which support their choices, their ability to access services that meet needs that change over time, and the role of informal caregivers in the delivery system for long term services and supports.
 - D. Create care support centers in hospitals where consumers and caregivers can utilize resources in accessible formats, including educational videos, print and online resources, and can connect with services and supports within their communities.
 - E. Explore the need for requirements for qualifications, certification, education and/or continuing education for discharge planners in hospitals and nursing homes.
- 19. Transportation:** Ensure consumer access to affordable, accessible transportation to support the choice of setting, consumer's participation in the community and access to health care.
- A. Explore legislative action to limit the liability of volunteer drivers in community transportation programs and develop legislation as determined to be appropriate.
 - B. Develop a health and human service transportation plan that ensures health and human services options are coordinated and addressed.

- C. Streamline state rules and regulations regarding service delivery and advocate for federal changes where barriers are identified so that funds can flow quickly to providers.
 - D. Create a comprehensive inventory of transportation service providers with an on-line service directory. Build on ongoing efforts at ODOT as appropriate.
 - E. Replicate local and regional models that have proven successful.
 - F. Explore reimbursement models that encourage group trips and ride sharing when appropriate to increase access to limited resources. The role of consumer choice and consumer direction should be considered as reimbursement models are explored.
 - G. Establish an Executive Council for Transportation Coordination reporting to the Governor, with representatives of state agencies, providers, consumers, and the General Assembly, charged with developing a plan to implement these recommendations across systems.
- 20. Housing:** Any toolkits or resources developed to assist consumers with disabilities in living in community settings should include materials to assist in accessing housing. Develop resources to provide accessibility modifications in rental housing.
- A. Increase capital and operating support for accessible housing to meet the needs of consumers accessing long term services and supports.
 - B. Provide priority access for consumers currently institutionalized and ready to transition to a community setting and to those consumers at risk of immediate institutionalization.
 - C. Expand Permanent Supportive Housing for individuals with disabilities as outlined in the Interagency Council on Homelessness and Affordable Housing Permanent Supportive Housing Policy Framework.
 - D. Increase capital and operating support for accessible housing to meet the needs of consumers accessing long term services and supports.
 - E. Provide priority access for consumers currently institutionalized and ready to transition to a community setting and to those consumers at risk of immediate institutionalization.
- 21. Service Coordination:**
- A. Investigate options for funding service coordination, including service coordinator grants and Ohio Housing Trust Funds.
 - B. Educate local entities about the ability to access funds for service coordination and the ways in which funds can be accessed.
- 22. Consumer Direction:** Continue to develop opportunities for self-direction in Ohio's delivery system for long term services and supports.
- A. As a long-term objective, cash and counseling programs should be explored as components of the delivery system for long term services and supports.
 - B. Build on the experience developed in Centers for Independent Living and through Home Choice by offering support coaching and independent living skills training to consumers who are not participants in that program. (Support coaching and

independent living skills training are core services mandated in federal law to be provided by every CIL in the country.)

- C. Build on efforts to develop local cooperatives that have taken place in some communities and that are being developed as a tool to achieve balance in the delivery system through the Home Choice project by developing tools to facilitate the development and operation of personal assistance cooperatives in communities throughout Ohio.

23. Telehealth:

- A. Create a telehealth task force comprised of public and private entities to eliminate regulatory barriers impeding the use of telehealth and to coordinate telehealth initiatives across systems and payers.
- B. Conduct pilot programs for the rendition of medical services using telemedicine that evaluate the management of, and treatment of patients with congestive heart failure, diabetes or diabetes related conditions.
- C. Establish reimbursement policies that require medical and other health care services rendered via telehealth to be reimbursable to the same extent such services would be reimbursed if rendered in person.

WORKFORCE RECOMMENDATIONS

- 24.** Create a Direct Service Workforce Consortium.
- 25.** Use the Consortium to develop a multifaceted communications strategy to help connect system stakeholders to resources, programs and data, and to link direct service workers with potential long-term care service and support provider employers.
- 26.** Conduct a long-term care system asset mapping process leading to the development of stackable long-term care certificates within Ohio's Health and Human Service Lattice.
- 27.** Commission a study to determine the relationships (including strengths and limitations) between existing reimbursement models and efficient care within public and private sector long-term service and support provider organizations.