

**Unified Long Term Care System (ULTCS) Workgroup
Minutes
September 7, 2010**

MEMBERS PRESENT

Barbara E. Riley, Ohio Department of Aging, Chair
Bob Applebaum, Scripps at Miami University
Susan Ackerman, Center for Community Solutions
Kathleen Anderson, Ohio Council for Home Care & Hospice
Richard Browdie, Benjamin Rose Institute on Aging
Mary Butler, Ohio Statewide Independent Living Council
Andrew Capehart, Adult Protective Services
Mark Davis, Ohio Provider Resource Association
Doug Day, Ohio Department of Alcohol & Drug Addiction Services
Diane Dietz (for Pete VanRunkle), Ohio Health Care Association
Janet Grant, Ohio Association of Health Plans
Jodi Govern (for Rebecca Maust), Ohio Department of Health
Mallory Heidorn (for Senator Shannon Jones)
Roland Hornbostel, Ohio Department of Aging
Betsy Johson, National Alliance on Mental Illness of Ohio
Carolyn Knight, Ohio Developmental Disabilities Council
Christine Kozobarich (for Becky Williams), SEIU 1199
Beverley Laubert, State of Ohio Ombudsman
Peggy Lehner, Ohio House of Representatives
Amy McGee, Executive Medicaid Management Administration
Stephen Moore, Rehabilitation Services Commission
Christopher Murray, Ohio Academy of Nursing Homes
Steve Peishel, Office of Budget and Management
Tracy Plouck, ODJFS/Ohio Health Plans
Larke Recchie (for Joe Ruby), Ohio Association of Area Agencies on Aging
Bill Sundermeyer, AARP Ohio
Jean Thompson, Ohio Assisted Living Association
Gwen Toney (for Jeff Lycan), Ohio Home Hospice and Palliative Organization
Addie Whaley, Ohio Association of Adult Care Facilities

HANDOUTS

9/7/10 Agenda
Certificate of Need PowerPoint
Eligibility Subcommittee Recommendations and PowerPoint
Workforce Subcommittee Recommendations and PowerPoint
Integration & Care Management Subcommittee Recommendations and PowerPoint
Service Array Subcommittee Recommendations and PowerPoint
Balance and Funding Subcommittee Recommendations and PowerPoint
Front Door Phase 2 Schedule
Front Door Level of Care Short/Long Term Chart

WELCOME AND OPENING REMARKS

Barbara Riley opened the plenary meeting at 12:10 pm and called for introduction of ULTCS Workgroup members present. She directed the group to the ULTCS Mission and Vision posted on the ULTCS webpage to help refocus the work of the Stakeholder Workgroup. She announced that today's meeting would consist of hearing and discussing the full slate of short-term recommendations. The October meeting would then be a facilitated meeting where voting on the recommendations will occur.

STAKEHOLDER/PUBLIC COMMENT

N/A

CERTIFICATE OF NEED (CON) UPDATE

Jodi Govern from the Ohio Department of Health (ODH) presented a PowerPoint update on Certificate of Need progress. Recommendation #81 from the 2008 ULTCS Recommendations was to convene a Certificate of Need Study Committee. Since then Am. Sub. H.B. 1 established language for inter-county transfer of beds at regular intervals. In April 2010 a bed need map was published. In July entities responded to a competitive application. ODH hopes to wind up this initial process by April 2011. As a next step, ODH will convene stakeholders in January 2011 to discuss additional ways to incorporate the existence of home- and community-based services into the CON application review.

Comments:

- Since it had been used as one of the quality criteria, Beverley Laubert urged ODH to take note of the five-star rating being temporarily suspended in April 2011.
- Rich Browdie asked for details on Slide 4, the formula on which the numbers are based.
- Rep. Lehner asked about the legislative intent in reducing the occupancy rate per county from the proposed 90% to 85%. Per Diane Dietz it may have been done to allow flexibility of patient mix, especially with short-term beds included in the numbers.
- Janet Grant asked how Ohio's process compares to other states (with better balance). Jodi responded that some other states have CON but there is great variation, making it difficult to compare.

ELIGIBILITY RECOMMENDATIONS

Rick Tully spoke first about recommendations already implemented, those referred and then focused on those six being brought forward:

1. 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.
2. Eliminate face-to-face assessments: Eliminate the requirements for face-to-face interviews for initial applications for ABD Medicaid benefits.

3. 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.
4. 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.
5. Expand Assisted Living waiver eligibility: Apply the eligibility criteria and logic that is used in PASSPORT waiver to the Assisted Living waiver applications.
6. Expedite HCBS eligibility beyond PASSPORT: Utilize expedited/“presumptive” eligibility for home- and community-based services beyond PASSPORT.

Comments:

- Jean Thompson supported expansion of assisted living waiver eligibility, reminding people that previously consumers could not go from a hospital to an AL waiver program.
- Beverley Laubert asked about the cost of full implementation of personal need assistance.
- Diane Dietz asked that the Primary Entry Point (informed navigator portal) recommendation referred to the Front Door Subcommittee “land somewhere,” not necessarily with a subcommittee whose agenda is already packed with level of care and other priorities.

WORKFORCE RECOMMENDATIONS

Tiffany Dixon reiterated draft recommendations presented at the previous meeting, along with one new recommendation. She acknowledged that the group is working through inter-system language barriers toward meaningful systemic change. The first meeting of the university consortium is scheduled for September 22nd. The recommendations (that each have subrecommendations) are as follows:

7. Create a Direct Service Workforce Consortium.
8. 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.
9. 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.

10. 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.

Comments:

- Mark Davis emphasized the need for follow-through on the commissioned study by subsequently executing a strategy based on the data.
- Christine Kozobarich wanted to ensure that quality was emphasized throughout.
- Rep. Lehner asked about unionization of workforce, and Tiffany Dixon mentioned the summit being planned for late this year by the university consortium to include multiple stakeholders, both academic and non-academic, to discuss such issues

INTEGRATION & CARE MANAGEMENT RECOMMENDATIONS

Marc Molea spoke about four broad categories of recommendations categorized below:

11. Strategic Direction: Identify existing forums where state agencies and stakeholders can discuss issues and opportunities related to care integration and management.

12. 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.

13. Medical/Long-term Care Integration

- A. Provide care coordination of the Medicaid acute benefit for Medicaid HCBS waiver participants.
- B. Deploy Long-term Care Consultants 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.
- 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/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.

14. Identify and Support Shared Consumers: Identify shared consumers/members and provide long-term tools and short term education) to support coordination of services.
15. Behavioral Health: Identify, support and deploy evidence-based behavioral health screening tools/protocols and self-management interventions at transition points/critical pathways.

Comments:

- Bill Sundermeyer asked about the time period for examining recommendations with cost attached in time to build into budget formulation.
- Kathleen Anderson asked about the necessity of legislative authority to address dual eligibility recommendations. She added that home care is not included but would like to be, if appropriate.
- Gwen Toney stated that new consortia are being added without existing entities (home care and hospice) that are either being excluded or deprioritized.

SERVICE ARRAY RECOMMENDATIONS

Julie Evers spoke about the work begun, but not yet finished by her subcommittee. She described the group's first volley as focus on the recommendations having the greatest impact with little or no financial cost. They identified their recommendations for action under six general categories:

16. 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.

17. 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.

18. 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.

19. 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.

20. 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.

21. 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.

Comments:

- Janet Grant described the biggest barrier to discharge planning as time.
- Gwen Toney asked a more general question about what impacts additional funds.
- Roland Hornbostel asked if there was any way to combine recommendations and cited NCR's efforts to combine service coordination.
- Mary Butler provided a clarification on permanent supportive housing, stating that it does not have to be linked to housing.

BALANCE & FUNDING

Roland Hornbostel and Tracy Plouck presented the six Balance and Funding recommendations. Originally over 20 recommendations were under consideration. Several were forwarded to other subcommittees and several were considered longer term recommendations for continued discussion and work. Roland noted that implementation of all the recommendations provided by the subcommittees will help drive us toward the balance benchmarks set and that the balance goal was purposefully set to measure individuals, rather than funding..

- 22. 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 50/10.)*
- 23. 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.
- 24. 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.
- 25. 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.
- 26. 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 for housing and related supports for individuals with severe and persistent mental illness who would like to live in the community.
- 27. Provider Reimbursement Rates:** Establish appropriate reimbursement rates for all LTC providers sufficient to ensure sustained quality of care for all consumers.

Comments:

- Rep. Lehner asked about the national average relative to the balance benchmarks and Ohio. Roland stated that the national average is mostly measured in dollars. The Ohio Business Roundtable suggested that Ohio is roughly 20% off the national average.
- Roland Hornbostel reminded the group that the balance recommendation does not include the developmental disabilities population whose goal setting is being done separately through the Futures work.
- Janet Grant asked about statistics prior to 2007 numbers. Tracy Plouck stated that the old Olmstead reports cite HCBS vs. NF statistics.
- Mark Davis commented that the DD numbers for Ohio show that it is far better balanced than other states with 55,000 (of 80,000) served in home- and community-based settings and less than 10% served in ICFs. However, he went on to mention the low performance of the DD system in services with matched Medicaid, indicating that Ohio at one point ranked 47th.
- Susan Ackerman expressed support of the MH transition pilot, based on the continual movement by those with mental illness in and out of inpatient settings.
- Gwen Toney mentioned the DD rate methodology being used as a basis for other rate setting, e.g., individual providers and enhanced community living.

FRONT DOOR UPDATE

Erika Robbins shared the Phase 2 Schedule, as well as the Front Door's Level of Care Short/Long Term Chart to help define the work of the group now and into the future. She invited those who found something missing in the list to email her and/or to join the Front Door Workgroup. Front Door is working through rule language changes and then planning to reconvene on November 2nd.

NEXT STEPS/NEXT MEETING

Barbara Riley commented on obvious synergies between programs, agencies, and funding streams and urged ongoing connectivity rated to overlapping ideas and efforts. The ULTCS Stakeholder Workgroup will vote on the recommendations with immediate impact at its next meeting on October 21st. Any questions or comments on recommendations should be emailed through Mary Inbody at minbody@age.state.oh.us or directly to subcommittee chairs. It is anticipated that the Workgroup will arrive at consensus on the slated of recommendations on October 21st. Any subcommittee that needs space for a meeting prior to or following the October 21st plenary session should contact Mary Inbody.

Note that the November meeting is being cancelled due to a number of conflicts. The December meeting will be used to being moving toward the more long-term, visionary goals and recommendations.

ADJOURNMENT

Meeting adjourned at 3:03 pm.