

Unmet Needs in Community Settings (State Plan and Waivers)

The workgroup was charged with providing comments/recommendations on four issues: (1) When the existing array of long term services and supports available in the community is considered, what are the gaps that may result in institutional placement when it is not the consumer's preference?, (2) What provider requirements result in difficulty in obtaining needed long term services and supports when a consumer prefers a community setting?, (3) How can the delivery system for long term services and supports use informal supports to support a community setting?, and (4) Transportation is a critical element in successful community placement; what challenges exist today as consumers access transportation services and how can those challenges be addressed?

ISSUE #1

When the existing array of long term services and supports available in the community is considered, what are the gaps that may result in institutional placement when it is not the consumer's preference?

Recommended new services to address existing gaps:

- Self-Directed Personal Assistant Services on the State Plan (1915j option). (Not all consumers meet the additional functional eligibility criteria placed on waivers, nor do they wish to enroll on a waiver) This consumer-directed option allows an individual to hire who they wish to provide their personal care services; provides them with a budget to purchase such services, often times negotiating rates lower than the Medicaid ceiling; and builds upon the principles explored in the early Cash and Counseling demonstration waivers. This service has recently been suggested by the Centers for Medicare and Medicaid Services (CMS) as an option of the Deficit Reduction Act (DRA) that states should explore.
- Goods and Services (often called Transition Services in home and community-based services (HCBS) waivers). This service provides an individual with one-time financial assistance to purchase items needed to set up a home in the community so that he/she can move out of an institution. Transitions services will be a supplemental and demonstration service within the HOME Choice demonstration program; however, once the demonstration program ends, the service is no longer available. This service should be explored further so that it exists in some form after the HOME Choice demonstration program ends. Consideration should be given to expanding the service definition beyond what is provided in the CMS waiver template, and should also possibly be made available to consumers moving from the community to an institutional setting, e.g. consumer living in the home of a family member and then decides to move into an assistive living facility, still needing to have their own bed and other appropriate furniture or facility deposit.

- Medication management and/or prescription coordination. The workgroup felt strongly that physicians prescribe medications without necessarily knowing what other medications the individual is taking. Having a medication management service attached to the Medicaid medication formulary would educate and arm consumers with the information they need in order to obtain and safely take their medications. Additionally, medication management and/or prescription coordination could decrease potential contraindications between medications and may also decrease expenditures.
- Transition Coordination. Transition coordination services for persons moving out of institutional settings should be available beyond the restrictive timelines proposed by CMS' final interim rule. Ohio should advocate for changes to CMS' proposed case management rule, particularly as it relates to the restrictions placed upon transition coordination.
- Availability of care management for all Medicaid consumers to the degree that is needed and desired by each consumer. Navigating the long term services and supports system is difficult at best. Understanding what existing services are available and how to access them is a challenge for most, but when individuals do not have family members or friends to assist, they are often lost. Stakeholders expressed concern that parents and professionals alike do not understand what is available under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program (also known as Healthchek). Stakeholders expressed concern that many hospital discharge planners often do not understand Medicaid or the existing benefit packages, and how to assist the individual or family in accessing needed services. Care management would coordinate with existing community information systems – both general, such as 2-1-1 – and population-specific, such as the developing aging and disability network.
- In-home and institutional respite and/or sitter services under the State Plan should be made available.

Recommended expansion of the following existing services and/or programs:

- Behavioral health services such as: evidenced based practices (e.g., ACT), crisis intervention, crisis stabilization units, and partial hospitalization programs for children and adolescents.
- Program of All-inclusive Care for the Elderly (PACE) model.
- Expedited access to waivers for hospice consumers.
- Adult day services within the state plan.
- Transportation (See Issue 4).

- Specialty equipment and assistive devices; technology to assist the individual in the home environment; equipment to assist with medication administration; telemedicine; home modifications.
- Extended State Plan nursing, physical therapy, speech therapy, and occupational therapy.
- Consumer self-directed care options and available financial management services if needed.

Although the charge was to discuss service delivery gaps in this first issue, the workgroup also discussed existing barriers that would prevent expansion of services or development of any new service. Examples of these barriers:

- Prior authorization: having consumers wait for up to six months to obtain adaptive and assistive devices or durable medical equipment is unacceptable. The prior authorization (PA) system must be streamlined for timely authorization, made easier for the consumer and/or their family members or caregivers to access, and providers of the services must be educated on how to navigate the system. Additionally, regulations should be amended to permit the use of previously used adaptive and assistive devices and durable medical equipment.
- Reimbursement/rates.
- Medicaid eligibility: examples provided were implementation of the Medicaid buy-in program and developing a subsidy between eligibility periods (e.g., delivery of a Medicaid service the same day as discharge from a Medicaid reimbursed hospital or nursing facility (NF) stay). One stakeholder on the workgroup coined this concept as 'Bridge Services', similar to the concept of a bridge loan or bridge subsidy relative to the housing arena. Services that would provide coverage until deemed eligible for Medicaid services.
- Limitations within existing benefit packages: for example – current HCBS waivers offer services that may not, in fact, address the functional needs of the consumers enrolled – traumatic brain injury (TBI), autism, Alzheimer's to name a few. Functional needs do not always get captured by diagnosis, and functional evaluations do not always identify the most appropriate form of treatment/services.

ISSUE #2

What provider requirements result in difficulty in obtaining needed long term services and supports when a consumer prefers a community setting?

- Existing Prior Authorization (PA) system (this was also mentioned in Issue #1).

- Provider specifications and requirements should be streamlined across delivery systems leading to decreased administrative burden and increased access to qualified providers.
 - Universal and/or similar monitoring requirements established by the state agencies. (e.g., accepting reviews of other state agencies).
 - Qualification requirements for provider staff or independent providers across the state agencies for similar services. (e.g., standardized credentialing).
 - Bureau of Criminal Identification and Investigation (BCII) background check requirements.
 - Career lattices/professional development.
- Automated billing system.

Although not specific to mandated provider requirements, the workgroup discussed at length the difficulty in finding and accessing qualified providers. We discussed how difficult it is to find providers who have experience working with medically fragile/behaviorally challenged children; providers who are available to meet the individual's schedule and times of the day; provider skill sets, etc. Thus, the workgroup supports the recommendation presented to the Unified Long Term Care Budget Committee to establish a comprehensive provider registry, insuring it is user friendly and crosses all delivery systems.

Another provider related topic discussed, which will also be highlighted in Issue #3, is the use of family members as paid providers. It is believed that more family members would become paid providers if the Medicaid provider enrollment process was streamlined and easier to navigate. Consumers may prefer a family member over a complete stranger to provide their care. For many family members, they very well may be the most qualified to provide the care the consumer needs, but are reluctant to do so for a variety of reasons.

ISSUE #3

How can the delivery system for long term services and supports use informal supports to support a community setting?

The workgroup encourages the committee to recognize that for many delivery systems the use of the words 'informal supports' implies that the services and supports provided are unpaid; and that the 'informal supports' are family members. In fact, many family members are also paid providers who have either successfully navigated their way

through the Medicaid provider enrollment process or who have become employees of a home health agency. And, many 'informal supports' are not family members. Many 'informal supports' are neighbors, friends, church members, etc. With that said, **the workgroup recommends exploring the following:**

- During the assessment process, identify all informal, unpaid supports in place to determine what kind of formal, paid supports the consumer actually needs. This assessment could also identify what stressors are present that jeopardize those informal supports.
- Develop and/or revise provider qualifications to support allowing family members to be paid providers to be less burdensome.
- It was noted during our discussion that caregiver and/or family member education about the long term service and support system often assumes that the consumer, caregiver and/or family has had past involvement with Ohio's long term care delivery system. For some, this is not true and it should be recognized that families and consumers are in need of guidance in exploring all options/payor sources for services and supports, both Medicaid and non-Medicaid. This needs to be initiated as early as possible. Considerations:
 - Expand the capacity for, and broaden the scope of caregiver support groups, and the family resource center and long term care consultation concepts to offer basic information on all waivers, VA benefits for long term care, long-term care insurance, long-term care financial planning, information on private fee-for-service costs/providers, and other important benefits. Family resource centers and long term care consultants could also be components of the "front door."
 - Identify critical pathways for referrals and develop a process to initiate them at first point of consumer/caregiver/family contact.
 - Assign an ongoing advisor for the consumer/caregiver/family through linkages with services and supports.
- Educate the justice system on community options and available long term services and supports so that court appointed guardians do not place people in nursing homes or institutions as a means of first intervention if not warranted.
- Expand access to legal services for the consumer's informal support network, e.g. assisting with housing issues, wills, estate planning, asset management, disability determinations, appeals, etc.

The workgroup discussed several **new incentives** to support this issue as well. Please recognize there will be a fiscal impact with all new initiatives. The workgroup identified the following:

- In conjunction with the Ohio Department of Taxation, research the development of a state tax credit for families providing extraordinary care if they are not the paid Medicaid provider.
- Research the expansion of the concept behind Health Savings Accounts to allow families to save money to offset costs to Medicaid.
- Research the Community Living Assistance Services and Supports (CLASS) Act of 2007 currently pending before Congress and consider its potential impact on Ohio. If enacted, the CLASS Act will create an insurance program for adults who become functionally disabled. It will also allow families to save money for future needs without impact to financial eligibility.
- Reduction of estate recovery if family members provide gratis extraordinary care to the consumer.
- Creating an emergency fund (one-time crisis-oriented) that would be available for family members to access to prevent admission to an institution.
- Development of local-level co-ops of providers and consumers or informal supports that allow consumers/families access to additional back up coverage if they cannot find providers to cover the authorized hours.

ISSUE #4

Transportation is a critical element in successful community placement. What challenges exist today as consumers access transportation services and how can those challenges be addressed?

The workgroup acknowledges that the Office of Ohio Health Plans (OHP) has had a committee working on transportation services over the last year, and has produced a draft document with recommendations on how to move forward in the future. The workgroup asks that in addition to identifying the current challenges and possible incentives for this committee, that our identified challenges and incentives be forwarded to the chairperson of the OHP transportation committee.

Identified challenges:

- No real regional or state policy directive for the delivery of transportation services to the county departments of jobs and family services (e.g., inter-county transportation and state-to-state transportation for needed and authorized services).

- Differences between medical and non-medical transportation, and the disparity between how counties interpret and pay for services, and how counties prioritize the authorization of non-emergency transportation (NET).
- Accessible transportation. Stakeholders report that some transportation companies are eliminating their wheelchair transport due to the disparity between liability costs and reimbursement rates. In addition, some "accessible" transportation does not accommodate power chairs, scooters, large wheelchairs and other differently configured wheelchairs, etc.
- The differences between need and access; the disparity between what types of transportation services are needed versus what is available in distinct areas of the state.

Recommended Incentives:

- Transportation vouchers.
- Assisted or supported transportation.
- Bus passes for fixed route transport.
- County-wide coordination of transportation services with all transportation providers.
- Supplement families, friends, neighbors and/or informal supports to provide transportation without Medicaid provider agreement (e.g., gas cards as used on the employment side of Ohio Department of Job and Family Services (ODJFS) or possible state tax credit).
- Limiting liability for volunteers or family members reluctant to do transportation because of liability issues through the Volunteer Protection Act.
- Revise the provider specifications and requirements for non-medical transportation to increase potential pool of qualified providers.