

Building a Cost-effective, Consumer-friendly Long-term Services and Supports System



**Final Report of the
Unified Long-Term Care Budget Workgroup**

May 30, 2008



Ohio Department of Aging

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Ted Strickland, Governor
Barbara E. Riley, Director

Dear Governor Strickland, Speaker Husted, President Harris, House Minority Leader Beatty, Senate Minority Leader Miller, Chair Jones and Members of the Joint Legislative Committee on Medicaid Technology and Reform:

I am very pleased to submit to you the final report and recommendations of the Unified Long Term Care Budget workgroup, as required by Am. Sub. H.B. 119 of the 127th General Assembly. The report is the culmination of 10 months of work involving over 300 individuals representing consumers, providers, advocates, state agencies, local entities, and interested stakeholders who served on the workgroup itself and its five subcommittees. In addition to the committee work, in order to assure that all interested parties had an opportunity to be informed and to be heard, we hosted community forums, presented at numerous conferences, held webinars, and created an extensive unified long term care budget web site with over 700 "subscribers".

Because of the broad representation of interested parties I believe we have been able to assemble a comprehensive report that addresses the legislatively required elements, and recommends many systemic changes designed to:

- Create a more cost effective and consumer based system;
- Achieve a better balance between institutional and home and community based care;
- Provide consumers with a choice of services designed to meet their needs and improve their quality of life; and
- Consolidate agency authority and long term care budgets.

I want to thank each of the workgroup members, with special thanks to Representatives Shannon Jones and Armand Budish, and Senators Thomas Niehaus and Capri Cafaro all of whom served on the workgroup. The product being presented to you represents a consensus report, and I want to acknowledge the work of our facilitator Maggie Lewis from the Commission on Dispute Resolution and Conflict Management who ably assisted us in our efforts. In order to address any questions or concerns you might have, I would like to request an opportunity to present the report to the committee in the near future as our recommendations include an aggressive implementation plan beginning in SFY 2009.

Thank you for the opportunity to work with an outstanding group of individuals who came together to work to improve our long term care system and better serve our consumers and Ohio's taxpayers.

Sincerely,

Barbara E. Riley
Director

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Executive Summary

Ohio is faced with a major challenge – one that only will continue to increase over time. How best to provide needed long-term services and supports to a growing population of Ohioans who need this support? A recent report from the Scripps Gerontology Center at Miami University estimates that the number of Ohioans of all ages that will need long-term services and supports will increase by 14% between now and 2020 (an increase of 43,600 consumers).

These demographic changes, in combination with continued growth in Ohio's Medicaid program, have serious implications for the state budget of 2020. Today, Ohio spends 24% of its General Revenue Fund (GRF) budget on Medicaid (the major funding source for long-term services and supports). If the state maintains the status quo – that is, its formal long-term supports are provided the same way, with the same programmatic structure, to the same proportion of Ohioans with disabilities, and Medicaid grows at a rate of 6% per year and overall state budget growth is 3.5% per year – then by 2020, Ohio will spend 32% of its *entire* GRF budget on Medicaid, according to Scripps. Between 2000 and 2006 Medicaid grew at a rate of 11.5% and if this higher rate of growth continued and the state budget continued to grow at 3.5%, by 2020 Medicaid would consume 68% of Ohio's entire GRF budget. It is clear that Ohio must change its current approach to delivering and funding long-term services and supports in order to meet the needs of our citizens and to manage our economic future.

It is important that a unified budget strategy not be perceived as a panacea for the challenge Ohio faces. Based on the experience of other states such as Oregon, Washington, Vermont and Wisconsin, a unified budget and budgeting process is a *tool* toward achieving policy goals. What Ohio lacks is a comprehensive *strategy* to address the future need of its citizens for long-term services and supports. In order to create an effective unified long-term care budget, it is essential simultaneously to build that strategy. This report of the Unified Long-Term Care Budget (ULTCB) workgroup sets forth an initial strategic framework upon which a comprehensive and cost effective system can be built.

Am. Sub. H.B. 119 created a unified budget workgroup chaired by the Director of the Department of Aging, Barbara E. Riley. The workgroup, consisting of consumer advocates, providers, and state policymakers, was to recommend a new budgeting process that:

- Provides consumers with a *choice* of services that meet the consumers needs and improve the consumer's quality of life;
- Provides an *array* of services that meet the consumer's needs throughout life;
- *Consolidates* policymaking authority and the associated budgets for long-term services and supports in a single entity (promotes *simplicity and flexibility*); and

- Assures a system that is *cost effective* and links disparate services across agencies and jurisdictions.

The workgroup was required to submit an implementation plan by June 1, 2008 (i.e., this final report) that incorporates:

- Recommendations regarding the *structure* of the unified long-term care budget;
- A plan outlining how funds can be transferred among involved agencies in a fiscally neutral manner;
- Identification of the resources needed to implement the unified budget in a multiphase approach starting in SFY 2009; and
- Success criteria and tools to measure progress.

The plan is to consider the recommendations of the Medicaid Administrative Study Council and the Ohio Commission to Reform Medicaid.

In order to focus on the goals and purposes articulated in Am. Sub. H.B. 119, the ULTCB workgroup adopted the following mission statement:

To create a budget for long-term care services and supports that unifies the budgeting process for facility-based and home-based services and that supports Ohio's ability to accurately forecast expenditures for these services in future years.

The workgroup also went on to adopt the following vision:

Ohio's budget for long-term services and supports will be: flexible to permit consumers to choose from a wide array of quality services based on their preferences and needs; transparent to policymakers; and a cost-effective solution to budgeting for the future service needs for Ohioans in need of long-term care who may eventually need Medicaid-funded supports.

The key concepts embedded in the mission and vision statements are *consumer choice*, *flexibility* and *transparency*. Consumer choice allows consumers to make informed choices among appropriate services and service settings. Flexibility is the creation of a budget structure that allows consumers to move among service settings and programs in a seamless fashion without regard to funding source. Transparency is the creation of a budget structure that informs key policymakers in the General Assembly of the use of funds for programs and services encompassing Ohio's long-term services and supports delivery system.

Successful implementation of a unified long-term care budgeting strategy promotes the following outcomes:

- A comprehensive strategy for how Ohio will provide long-term services and supports.
- A balanced system of long-term services and supports based on consumer choice. Medicaid spending for long-term services and supports will reflect a better balance between facility-based and home and community based services.
- Policymaking authority and associated budgets will be consolidated within a single entity to simplify the consumer's decision making and maximize the state's flexibility in meeting the consumer's needs.
- A transparent budget for long-term services and supports for policymakers.
- A seamless array of service delivery options.
- Consumers are satisfied with the services they receive and experience a higher quality of life.
- Ohioans are encouraged to plan ahead for future service and support needs as well as be better prepared to make informed decisions about their options.
- A cost-effective system that links disparate services across agencies and jurisdictions.
- Transparency and consistency in the rate setting process.
- Accurate expenditure forecasts for long-term services and supports in future years.

Initial decisions

The first question dealt with by the ULTCB workgroup was “who should be covered by the unified long-term care budget?” Should the budget cover only services received by elders? By adults with disabilities? By those of any age? The ULTCB workgroup ultimately decided on the inclusion of all Ohioans in need of long-term services and supports. The specific recommendation is that the budget be inclusive of all consumers with a *chronic* or *recurring* need for services, regardless of age or payer source.

Because the ULTCB workgroup is proposing a comprehensive solution that includes all Ohioans in need of these services, the workgroup conceived of this solution as consisting of four “phases.”

Phase One

The first phase of the unified budget is designed around the eligible population that becomes entitled to Medicaid-funded long-term services and supports by virtue of needing care equivalent to that provided by a Nursing Facility. Phase one covers both facility-based services and those provided in home and community based settings, including those Medicaid waiver programs operated by ODJFS and ODA.

Phase Two

In the second phase, this unified budget would include those Ohioans who need long-term services and supports, but do not access Medicaid waiver programs such as PASSPORT or Ohio Home Care. It is expected that this group will include primarily Ohioans with behavioral health needs. Consumers not receiving facility-based services would typically rely on traditional state plan Medicaid services offered on a recurring, long-term basis, which for this population may or may not be managed through the organized delivery system. Because service costs for this population will be more difficult to calculate and because the service delivery network for this population will need to be defined, despite the fact that in numbers, this is a smaller consumer group, creation of a unified budget will be more complex than for phase one. The county-based structure of the delivery system and the reliance on local funding that can differ by county, adds to this complexity.

Phase Three

In the third phase, a unified budget would be developed around consumers with care needs who historically have received services through the MRDD system. While in many respects, strategies for phase three are similar to those of phase one, the ODMRDD “futures” project, completed at the end of March, was an important precursor for this phase of the work.

Phase Four

The ULTCB workgroup recognized that not everyone receiving publicly funded long-term services and supports in Ohio receives those services through Medicaid-funded programs. Yet these non-Medicaid programs possess many of the same characteristics of Medicaid-funded programs and also are targeted to consumers with chronic or recurring needs for services. For example, Older Americans Act funds (federal), Senior Community Services funds (state), and county levy funded programs (local) provide services to consumers who do not meet Medicaid eligibility guidelines. The workgroup proposes the creation of a

phase four that would encompass those services and programs (while being clear that this is not recommending state control over local funding sources).

The next decision for the workgroup was to more precisely define “long-term care.” The ULTCB workgroup recommends that the definition of “long-term care” encompass all non-medical and some specific medical services that the consumer receives on an ongoing basis to meet recurring or continuing needs. While this would introduce a level of complexity to the budgeting process beyond simply adding up the costs of each program included in the unified budget, this reflects the intent of the workgroup to focus on the *service needs* of consumers rather than the specific *program* in which the consumer enrolls. Resolving this additional level of complexity allows the unified budget to focus on what consumers need and receive rather than focus on the programs and funding streams that have been created.

Budget Structure

Because the budget structure and the creation of a new unified management information system (MITS) are intertwined, the ULTCB workgroup recommends a five year plan for the creation of a unified budget in three stages over the current biennium and each of the next two biennia.

Am. Sub. H.B. 119 created new state “long-term care” lines in the budgets of ODJFS, ODA, ODMH, and ODMRDD. OBM, with the approval of the Controlling Board, is given authority in SFY 2009 to transfer funds from existing long-term services and supports programs to these new lines within a single agency’s budget and among agencies.

In the 2010/2011 biennium, the ULTCB workgroup recommends that funding be appropriated directly to these new lines rather than individual programs (e.g., ODA long-term services and supports rather than PASSPORT, Assisted Living, and PACE). This will allow greater flexibility within agency budgets to adjust program spending based on consumer demand while still retaining OBM’s ability to transfer funds among agencies.

For the 2012/2013 biennium, a single funding line for long-term services and supports is to be created in the ODJFS budget that will truly create a unified budget for these services. Implementing a single funding line will only operate efficiently with an integrated information technology system. Smooth and efficient implementation is contingent upon two factors:

1. Ohio has an integrated IT system that will support the integration of expenditure allocation and spending information for all long-term services and supports; and
2. State agencies, and their regional or local instrumentalities, are able to access this integrated IT system with appropriate levels of security built in to the system.

It is assumed that MITS will be this integrated system. In the event that MITS is not deployed to sister state agencies in time for the development of the 2012/2013 budget, the structure recommended for 2010/2011 would continue to be used until such time as MITS is deployed to the sister state agencies so as to not impede progress toward developing a unified budget.

Enhancing Consumer Access to Services

In addressing the problems consumers and their families have in accessing services through fragmented service delivery systems, states have historically used either a “single point of entry” (where all consumers accessing the system are directed to a single local source to access long-term services and supports) or a “no wrong door” system where consumers are assisted through the access process regardless of the point at which they encounter the system. The ULTCB workgroup recommends that rather than create a new and duplicative approach to the front door by creating a single point of entry, Ohio instead employ a “no wrong door” concept that builds on the strengths of Ohio’s county based system and existing infrastructure designed to serve people in their community. Access to this system should be available by phone, through face-to-face contact, and through the Internet.

These access points (i.e., the “Front Door” for consumers) should recognize the needs of all consumers rather than just those receiving services through the Medicaid program. Information and referral functionality should be broad enough to serve all consumers. In addition, by providing information to meet a broad range of needs, the “Front Door” can provide an important tool in encouraging and supporting planning for the future need for long term services and supports.

To ensure that local delivery systems work together to produce a seamless system for consumers, the ULTCB workgroup recommends that the Area Agencies on Aging be responsible for the development of regional collaboratives that include all of the present portals into the delivery system.

Technology should be utilized to create a common, secure, accessible electronic infrastructure to expand information sharing about consumers, in effect a virtual “front door.” This infrastructure should be seamless to consumers and providers.

To establish accountability at the state level responsible for the training and technical assistance of all “no wrong door” entry points, the ULTCB workgroup recommends that the Department of Aging and Department of Job and Family Services co-lead the team to develop the training and materials for use by all front door partners. This will require working with the affected sister state agencies in carrying out these responsibilities.

Eligibility criteria to access formal long-term services and supports funded by Medicaid

The ULTCB workgroup is recommending a number of long-term reforms that will need further exploration and may need to be linked to benefit design to ensure continuity of services to Ohio’s consumers. Changes to criteria have the potential to significantly

affect both individual consumers and the delivery system for long term services and supports. Any changes to existing rules and regulations should be data driven to the extent possible and based on analysis of utilization and assessment data. In addition, care should be taken to ensure that existing rules and regulations are not changed more quickly than the capacity to meet consumer needs is developed. Therefore, the workgroup recommends that mechanisms be developed to explore and evaluate each of these reforms and report to the Executive Medicaid Management Administration (EMMA) on their findings.

Financial eligibility processes and policies with respect to Medicaid-covered services in the delivery system for long term services and supports are a critical element in a consumer's ability to exercise meaningful choice. The ability to determine the eligibility for Medicaid funds and the policies used to make those determinations have been identified as barriers to obtaining services and exercising consumer choice to remain in the community in today's environment.

The recommendations for change relating to financial eligibility focused on four specific areas. These areas include:

- The timely processing for eligibility determinations,
- The requirements for documentation and face-to face-meetings,
- The need for education and training, and
- Policies affecting the financial eligibility determinations.

Unmet needs in community settings

The ULTCB workgroup recognizes that an inherent weakness in balancing Ohio's system of long-term services and supports is that key supports promoting the ability for consumers to live in the community simply may be unavailable. A "gap analysis" of Ohio's existing community-based long-term services and supports system suggests that issues exist in four specific areas.

- What are the gaps in service delivery that may result in institutional placement when it is not the consumer's preference?
- What provider requirements result in difficulty in obtaining needed long term services and supports when a consumer prefers a community setting?
- How can the delivery system for long term services and supports use informal supports to support a community setting? and
- How to ensure transportation as a critical element to community placement?

The ULTCB workgroup also recognizes that a special “gap” exists in housing and supportive services and accordingly asked stakeholders to develop recommendations designed to remedy this gap. The stakeholder group addressed five housing-related areas:

- Home maintenance, repair, and accessibility;
- Adult care facilities and adult foster homes;
- Assisted living and other supported housing;
- Service coordination; and
- Affordability of housing.

Consumer-directed supports

Participation in consumer directed care opportunities must be voluntary, flexible enough to meet the consumer's needs, and contingent upon whether the consumer and/or authorized representative can adequately direct his/her own care. The concept of "dignity of risk" and the consumer's right to make bad decisions is inherent in the concept of consumer direction and will need to be embraced in any consumer-directed care endeavors implemented by the state. For the latter to be possible, and to assure ongoing consumer participation, a comprehensive set of tools and resources must be created at the state level, and provided to interested consumers and/or their authorized representatives for the purpose of developing the skills necessary to direct their own care and services. Moreover, for consumer direction to be effective, it must be designed as simply as possible.

Every consumer should be able to direct as much of his/her care as he/she has the desire and ability to direct. To do so, the consumer should:

- Be able to communicate his/her specific needs to the provider.
- Possess the judgment and skills necessary to manage his/her specific needs.
- Select his/her team members and participate in the development of service plans and plans of care.
- Successfully complete training about how to hire, supervise, dismiss and evaluate a worker, complete/approve timesheets, and resolve conflicts, etc.
- Direct his/her care while staying within a budget or under a cost cap established for the consumer as part of the specific program in which he/she is enrolled.

- Work with his/her case manager to establish a back-up plan for situations in which the primary provider is unable to deliver services at the scheduled time.
- Play a major role in monitoring the provider to determine if care is being provided in accordance with the consumer's service plan and/or the consumer's plan of care as mutually agreed upon by the physician, the consumer and/or authorized representative and the provider.

Quality management/assurance

How best to assure the quality of long-term services and supports has been a longstanding and contentious issue for states. In Ohio, as in many other states, the quality approach adopted has relied heavily on an “inspect and punish” model in which a regular state survey emphasizing compliance dominates. There are serious limitations to this approach overall; when applied to home and community-based services the “inspection model” is even more problematic. The Centers for Medicare and Medicaid Services has identified this existing flaw in quality management systems and has offered a Quality Framework to states for their use in Medicaid waiver programs. As opposed to the “inspect and punish” model, the Quality Framework focuses on problem identification and remediation, directly enlisting the service provider in continuous quality improvement activities. The ULTCB workgroup recommends Ohio use the Quality Framework across all long-term care settings, acknowledging that it might not be possible to apply some parts of the matrix to individual independent providers (these are providers that are not affiliated with an agency) but in those cases apply the Quality Framework to the system of independent providers.

To better equip consumers to make meaningful choices based on objective and comprehensive data including customer satisfaction, the ULTCB workgroup recommends that Ohio expand the Long-Term Care Consumer Guide (populated with information about nursing facilities and residential care facilities) to provide consumers with information about an expanded array of provider types and develop methods of increasing public awareness of the availability of information.

Care management

The Unified Long Term Care Budget provides the opportunity to bring consistency and a standard purpose to care management.

Philosophically, the care management system should reflect a seamless and coordinated transition of the consumer through various stages of the care management process from access to assessment to care planning and service delivery. The process should facilitate integrated and comprehensive delivery of appropriate services in the appropriate setting. The care management process includes provisions for continuous monitoring of the consumer’s evolving needs and a timely response to same. The consumer’s strengths, special abilities, and cultural, social, health needs are given consideration in the whole-

person approach to care planning and service delivery. The delivery of high quality, efficient, timely consumer driven care which influences positive outcomes is critical.

A common definition for care management across systems and programs will further unite the long term care system and provide the framework and guiding principle for care management activities. The ULTCB workgroup recommends the following definition for care management:

Care Management is a holistic, collaborative, consumer-driven process for the provision of quality, culturally competent, health and supportive services through the effective and efficient use of available resources in order to maximize the individual consumer's quality of life based on his/her capacity and preferences.

The ULTCB workgroup recommends that this definition for care management be adopted and implemented for all consumers receiving long-term care services and supports.

Prioritized Recommendations

The unified long-term care budget workgroup has approved literally hundreds of recommendations from five subcommittees created to assist the workgroup in meeting its charge from the General Assembly. Given this volume, the workgroup believes it is essential to initially focus on a small number of priority recommendations. A more detailed project plan will be created and responsibility assigned to specific entities for each of the adopted recommendations to ensure that no particular recommendation will be lost in the process or sheer volume of the ongoing work.

Priorities for the near or short term: SFY 2009 (July 1, 2008 to June 30, 2009)

Priorities have been chosen for SFY 2009 with the understanding that implementation of these recommendations must be budget neutral. The phase (see page vi) to which the specific recommendation applies is noted.

- Decide on financing and service delivery structures (e.g. Medicaid waivers, state plan options, etc.) Phase 1, 2, and 3.
- Implement HOME Choice (Money Follows the Person) strategies, working with current nursing facility residents to offer them opportunities to return to community-based settings. Additional work will address and close loopholes that allow inappropriate placements. (Phase 1)
- Develop information and assistance tools (Internet based) for consumers to ease access at the "front door." (all phases)
- Establish interagency expenditure and caseload forecasting process. (Phase 1, 2, and 3).

- Implement State Profile Tool to benchmark Ohio’s progress in balancing its system in comparison with other states employing this process (all phases).
- Establish regional collaboratives to implement “No Wrong Door” successfully (all phases).
- Establish an ongoing stakeholder workgroup, facilitated by the Director of the Ohio Department of Aging. The ULTCB workgroup felt strongly that the process used to develop the recommendations in this report is the first time stakeholders have been involved in this comprehensive yet specific strategic planning process around the future delivery of long-term services and supports. The specific purpose of the workgroup is to further develop and assist in implementing these priority recommendations.
- Finalize work on phases 2, 3 and 4 for the Unified Budget.

Intermediate-term priorities – SFY 2010/2011 (July 1, 2009 to June 30, 2011)

- Modify the budget structure to create a single long-term services and supports funding line in the budgets of ODJFS, ODA, ODMRDD, ODMH and ODADAS. Phases 1, 2, and 3.
- Allow “Home First” enrollments into programs and services that have waiting lists currently (i.e., current nursing home residents bypass waiting lists). Phases 1, 2, and 3. “Home First” allows consumers currently receiving services in a facility-based setting such as a nursing facility to receive priority for home and community-based services. The concept was first employed in the last biennium to allow nursing facility residents on the waiting list for PASSPORT to move back home and receive PASSPORT services with the funding for those services transferred from the ODJFS budget.
- Extend care management to all consumers with need for long-term services and supports. Phase 1.
- Develop for each Ohio long-term services and supports program consumer-directed options from which consumers may choose. All Phases.
- Expand Ohio’s Long-Term Care Consumer Guide to provide information on long-term services and supports beyond nursing facilities and assisted living facilities. All phases.
- Create an informed navigator function to improve consumer access to services. This would be a specific charge to the regional collaboratives.

Long-term priorities – SFY 2012/2013 (July 1, 2011 to June 30, 2013)

- Employ a single unified IT system to support all state agencies and their local partners in carrying out their responsibilities to provide long-term services and supports. All phases.
- Create one single line in the ODJFS budget to unify all spending on long-term services and supports. Phase 1
- Finalize additional housing and supportive services options for Ohio (note that the planning for these is a short and intermediate-term activity). All phases.
- Establish incentives to encourage facilities to adapt to the new service delivery system (including implementation of a new Certificate of Need policy for nursing facilities). Phase 1.

1.0 Introduction

1.1 Why a unified budget for long-term services and supports?

Ohio is faced with a major challenge – one that only will continue to increase over time. How best to provide needed long-term services and supports to a growing population of Ohioans who need this support? In part, this increasing challenge results from the growing number of “Baby Boomers.” A recent report from the Scripps Gerontology Center at Miami University estimates that the number of Ohioans of all ages that will need long-term services and supports will increase by 14% between now and 2020 (an increase of 43,600 consumers).

The Scripps data first looks at Ohioans with severe disabilities that need long-term services and supports. The largest group is those with physical and/or cognitive disabilities. In 2005, 178,241 Ohioans had a severe physical or cognitive disability. By 2020 Scripps projects that this population group will grow to over 208,000. This reflects the increasing number of elders in Ohio as the result of the aging of the Baby Boom.

The second largest grouping of Ohioans with severe disabilities is those with chronic mental illness. In 2005, there were 89,673 Ohioans with chronic mental illness; by 2020, this cohort will grow to more than 101,000. The third grouping of Ohioans with severe disabilities is Ohioans with intellectual/developmental disabilities. This group numbered 36,597 in 2005 and will grow to over 38,000 by 2020.

Embedded in the demographic data is the fact that already *the fastest growing age group in Ohio is Ohioans over the age of 85*. It is this group where the prevalence of disability is the greatest (approximately 50% in this group have a long-term disability). By 2050, when the youngest of the Baby Boomers reach age 85, there will be more than one *million* Ohioans in this group. The 2005 census estimate is that currently there are 217,000 Ohioans in this age group.

These demographic changes, in combination with continued growth in Ohio’s Medicaid program, have serious implications for the state budget of 2020. Today, Ohio spends 24% of its General Revenue Fund (GRF) budget on Medicaid (the major funding source for long-term services and supports). If the state maintains the status quo – that is, its formal long-term supports are provided the same way, with the same programmatic structure, to the same proportion of Ohioans with disabilities, and Medicaid grows at a rate of 6% per year and overall state budget growth is 3.5% per year – then by 2020, Ohio will spend 32% of its *entire* GRF budget on Medicaid, according to Scripps. Between 2000 and 2006 Medicaid grew at a rate of 11.5% and if this higher rate of growth continued and the state budget continued to grow at 3.5%, by 2020 Medicaid would consume 68% of Ohio’s entire GRF budget. It is clear that Ohio must change its current approach to

delivering and funding long-term services and supports in order to meet the needs of our citizens and to manage our economic future.

However, it is important that a unified budget strategy not be perceived as a panacea for the challenge Ohio faces. Based on the experience of other states such as Oregon, Washington, Vermont and Wisconsin, a unified budget and budgeting process is a *tool* toward achieving policy goals. What Ohio lacks is a comprehensive *strategy* to address the future need of its citizens for long-term services and supports. In order to create an effective unified long-term care budget, it is essential to simultaneously build that strategy.

1.2 Precursors to the Unified Long-Term Care Budget Workgroup

Concerns about Ohio's long-term services and supports system have received considerable attention in the past decade. Four major studies have described the challenges associated with Ohio's system and have made recommendations that have led Ohio to the current unified budget initiative.

First, the need for a comprehensive strategic planning process that would engage all stakeholders – consumers, providers (both home and community based and facility-based), advocates, state agencies and their local instrumentalities – in shaping how Ohio can best meet the challenge to provide long-term services and supports in the future, was articulated by AARP Ohio in its 2002 report, *Long-Term Care in Ohio: Balancing the System*.

Second, the Ohio Commission to Reform Medicaid (OCRM) echoed this theme in its final report issued in January 2005 and recommended the creation of a unified long-term care budget, as well as the creation of a policy-coordinating entity:

Recommendation 4: Create a cost-efficient long-term care system with consolidated budgets, data collection and planning.

Action Step 1: Create a unified long-term care budget managed across all state and all local governmental agencies and service settings, and establish a single accountable head to provide leadership and direction for meeting the long-term care needs of Ohioans.

Rationale: A unified long-term care budget is necessary to provide a balanced long-term care system that improves the quality and reduces the duplication of services and cost.

Such a comprehensive budget will assist Ohio to meet the needs of persons requiring long-term care.

Experience in other states has demonstrated that unified budgets are a core component of successfully rebalancing a long-term care system, coordinating effectively with non-Medicaid services, and ensuring the redirection of existing long-term care resources within that same system. Oregon, Washington, and Vermont have each had great success

in controlling the costs of long-term care by creating unified budgets and expanding HCBS.

Impact: Potential administrative savings would result from increased efficiencies and quality of care improvement, cost reduction from better coordination of state long-term care policies and programs. A long-term care budget is necessary to achieve the growth rates set forth in these recommendations and maintain them over time.

Action Step 2: Establish a long-term care policy coordinating entity with authority that spans all state long-term care plans and programs.

Rationale: Establish a policy coordinating body comprised of state officials, providers, consumers, and advocates to review and discuss the ongoing efforts to re-balance the long-term care system. The entity will advise the appointed officials responsible for long-term care, the Governor, and the General Assembly on progress or recommend solutions to obstacles. The mission of this entity must be clear, and it should be chaired by the state official charged with overall implementation of the re-balancing effort. Initial work will focus on implementing the changes recommended in this report. Subsequent responsibility will include reviewing the results and evaluations of program and management initiatives; recommending subsequent initiatives; and recommending adaptations of policy in response to the continuing evolution of technology, federal policy, and consumer needs.

Impact: Potential administrative savings would result from increased efficiencies and quality of care improvement, resulting in cost reduction from better coordination of state long-term care policies and programs.

The Ohio Commission to Reform Medicaid also recommended that policymakers begin to conceive of Medicaid and the services it funds to be consumer-centric in nature as contrasted with the agency-centric or provider-centric models of the past. OCRM's recommendation included concepts that are key to developing both a comprehensive plan and a budgeting process for long-term services and supports.

- A unified budget is essential to Ohio's goal of creating a balanced system of long-term services and supports.
- There needs to be a policy-coordinating body that is broadly representative of all (consumers, advocates, providers, and state agencies) with an interest in how Ohio provides long-term services and supports.

Third, the Ohio Medicaid Administrative Study Council (OMASC), building on the work of the Commission to Reform Medicaid, articulated the following principles in its final report:

Unified ABD/Long-Term Care Budget Principles

To achieve the level of system change needed to address these issues, the Council recommends that several principles be adopted. If accepted, the consistent support of

policymakers and managers will be required to achieve and periodically adjust the relative balance between these principles:

1. Medicaid should provide coverage for a continuum of LTC services ranging from home based and community-based support to institutional care.
2. Consumer choice should play a prominent role in determining service settings.
3. Medicaid LTC services should be managed in a manner that is broadly supportive of informal care by family, friends and communities.
4. The public's interest in containing costs and assuring financial accountability should play a prominent role in setting parameters for service utilization, as well as in determining the terms and conditions of provider contracts.
5. To the extent that federal and state laws and regulations favor certain services or service settings over others, state law and regulation should seek to provide parity among service options for consumers.
6. The scope and management of a unified long-term care budget should be based on current and anticipated: (a) population demographics; (b) a generally accepted range of services; (c) service duration; and (d) prices.
7. Management of a unified LTC budget should account for the concurrent operation of several models of care and financial management (e.g., public/quasi-public case management, fee-for-service, managed care enrollment, and disease management).

To the earlier work of OCRM, the OMASC final report added some additional key principles:

- Medicaid should cover a “continuum” of long-term care services from home and community-based care to facility based care.
- Consumer choice should play a prominent role.
- Medicaid-funded services should support services provided by informal caregivers – families, friends, neighbors, and communities (in recognition of the fact that the majority of long-term services and supports in Ohio are provided by this informal network).
- Parity should be sought among the various service options available to consumers.

Fourth, concurrent with the release of the OMASC report at the end of 2006, the Auditor of State released her performance audit of the state's Medicaid program. In particular, to the concepts contributed by OCRM and OMASC, the audit stressed the need for Ohio to pursue greater options for consumer-directed services.

Governor Strickland has acted upon these recommendations by giving consumers more informed choices for services by directing the Ohio Department of Aging to end waiting lists for PASSPORT that existed in the last biennium and recommended that Ohio move toward a unified long-term care budget. Consequently, the Governor introduced and the

General Assembly enacted the unified long-term care budget workgroup in Am. Sub. H.B. 119 (the SFY 2008/2009 budget bill).

1.3 Statutory Authorization

Based on these earlier reports, Am. Sub. H.B. 119 created a unified budget workgroup chaired by the Director of the Department of Aging, Barbara E. Riley. The workgroup, consisting of consumer advocates, providers, and state policymakers, was to recommend a new budgeting process that:

- Provides consumers with a *choice* of services that meet the consumers needs and improve the consumer's quality of life;
- Provides an *array* of services that meet the consumer's needs throughout life;
- *Consolidates* policymaking authority and the associated budgets for long-term services and supports in a single entity (promotes *simplicity and flexibility*); and
- Assures a system that is *cost effective* and links disparate services across agencies and jurisdictions.

The workgroup is required to submit an implementation plan by June 1, 2008 (i.e., this final report) that incorporates:

- Recommendations regarding the *structure* of the unified long-term care budget;
- A plan outlining how funds can be transferred among involved agencies in a fiscally neutral manner;
- Identification of the resources needed to implement the unified budget in a multiphase approach starting in SFY 2009; and
- Success criteria and tools to measure progress.

The plan is to consider the recommendations of the Medicaid Administrative Study Council and the Ohio Commission to Reform Medicaid.

23 members of the unified long-term care budget (ULTCB) workgroup were appointed in August 2007 by the Governor and leadership of the General Assembly. The workgroup approved the creation of five subcommittees to make recommendations related to the statutory charge of the General Assembly. Over 300 Ohioans have participated in the work of those five subcommittees and their efforts will be further detailed below.

In addition to these public efforts, Ohio Department of Aging staff traveled throughout the state in August 2007 receiving input from more than 1000 Ohioans who attended ULTCB forums. During full workgroup meetings, a number of interested parties

appeared before the full workgroup to provide valuable and more detailed insights based on their own experience and programs. Finally, as the process neared its conclusion, ODA hosted a series of three webinars at which stakeholders were invited to provide feedback regarding the preliminary recommendations of the workgroup.

1.4 Creation and Role of the Executive Medicaid Management Administration

Am. Sub. H.B. 119 also references the Executive Medicaid Management Administration (EMMA), created by Governor Strickland through Executive Order 36S in December 2007. EMMA consists of eight state agencies (including Ohio's single state Medicaid agency – ODJFS) with responsibility for Medicaid funded programs or expenditures, including all of the agencies impacted by the unified long-term care budget. These agencies work in partnership through EMMA to unify and build consistency in Medicaid policy and harmonize operations in promotion of more efficient and effective delivery of services to Medicaid beneficiaries.

Under its charter, EMMA will focus on policy issues that 1) impact multiple agencies or populations served by multiple agencies, and 2) may result in a significant change in Medicaid policy, operations or expenditures. The Unified Long Term Care Budget clearly falls under this description. EMMA member agencies and staff have been active participants on both the full workgroup and its subcommittees since the workgroup was convened in August 2007, and are positioned to play the policy coordinating role envisioned by the statute creating the unified budget workgroup and the original recommendation of the OCRM.

ODJFS, both as the state Medicaid agency and a member of EMMA, will work collaboratively with the sister state agencies, through EMMA, and stakeholders to implement this strategy.

1.5 Relationship to HOME Choice (Ohio's Money Follows the Person Grant)

Ohio has received a grant from the Centers for Medicare and Medicaid Services to implement the Money Follows the Person (MFP) initiative. MFP is a demonstration grant that provides enhanced funding through the transitioning of Medicaid consumers from institutional to home and community based services (projected to be 2231 consumers over the demonstration period) on a reimbursement basis with a portion of this reimbursement reinvested in balancing the service delivery system to benefit all. Aside from the goal of transitioning 2231 individuals from institutional to home and community based services, the second goal of MFP is to bring more balance to Ohio's system of long-term services and supports.

Since both the HOME Choice program and the creation of the unified long-term care budget are complementary activities and thus have common objectives, the HOME Choice "balancing" workgroup also served as the "front door"/unmet need subcommittee for the Unified Long-Term Care Budget Workgroup.

1.6 Purpose and Goals of the Unified Long-Term Care Budget Workgroup

In order to focus on the goals and purposes articulated in Am. Sub. H.B. 119, the ULTCB workgroup adopted the following mission statement:

To create a budget for long-term care services and supports that unifies the budgeting process for facility-based and home-based services and that supports Ohio's ability to accurately forecast expenditures for these services in future years.

The workgroup also went on to adopt the following vision:

Ohio's budget for long-term services and supports will be: flexible to permit consumers to choose from a wide array of quality services based on their preferences and needs; transparent to policymakers; and a cost-effective solution to budgeting for the future service needs for Ohioans in need of long-term care who may eventually need Medicaid-funded supports.

The key concepts embedded in the mission and vision statements are *consumer choice*, *flexibility* and *transparency*. Consumer choice allows consumers to make informed choices among appropriate services and service settings. Flexibility is the creation of a budget structure that allows consumers to move among service settings and programs in a seamless fashion without regard to funding source. Transparency is the creation of a budget structure that informs key policymakers in the General Assembly of the use of funds for programs and services encompassing Ohio's long-term services and supports delivery system.

Successful implementation of a unified long-term care budgeting strategy promotes the following outcomes:

- A comprehensive strategy for how Ohio will provide long-term services and supports.
- A balanced system of long-term services and supports based on consumer choice. Medicaid spending for long-term services and supports will reflect a better balance between facility-based and home and community based services.
- Policymaking authority and associated budgets will be consolidated within a single entity to simplify the consumer's decision making and maximize the state's flexibility in meeting the consumer's needs.
- A transparent budget for long-term services and supports for policymakers.

- A seamless array of service delivery options.
- Consumers are satisfied with the services they receive and experience a higher quality of life.
- Ohioans are encouraged to plan ahead for future service and support needs as well as be better prepared to make informed decisions about their options.
- A cost-effective system that links disparate services across agencies and jurisdictions.
- Transparency and consistency in the rate setting process for providers.
- Accurate expenditure forecasts for long-term services and supports in future years.

1.7 Subcommittee Structure

Given the comprehensive nature of the statutory charge to the ULTCB workgroup, the workgroup's own mission and vision, and the relatively limited amount of time to complete its task, the ULTCB workgroup created five subcommittees.

Administration Subcommittee.

This subcommittee, chaired by the Office of Budget and Management, had three distinct charges. The first was to create a budgeting structure with specific line items that support a unified long-term care budget. The second was to recommend changes to the state's current information technology structure that is needed to support a unified budget in the future. It was expected that the work of the subcommittee would be heavily influenced by the proposed design of the new Medicaid Information Technology System (MITS) currently being implemented within the Department of Job and Family Services to replace the outmoded Medicaid Management Information System (MMIS). The third charge was the creation of performance metrics by which to measure Ohio's progress toward a more balanced system.

"Front Door" and "Unmet Needs" Subcommittee

This subcommittee, chaired jointly by ODJFS and ODA, jointly served both the "balancing" subcommittee of the HOME Choice (MFP) project as well as the ULTCB workgroup. The subcommittee was charged with recommending a plan for the design of the "front door" or access system by which Ohioans enter the long-term services and supports system, including access to trustworthy, reliable, and objective information about their options for long-term services and supports. The second charge to this subcommittee was to undertake a "gap analysis" of the current structure of available long-term services and supports to ascertain unmet needs that are not addressed by the current structure and to recommend necessary future changes.

Given the complexity of the “present state,” it is not surprising that the “front door”/unmet needs subcommittee ultimately developed its recommendations for improvement to Ohio’s “front door” access to long-term services and supports through seven separate stakeholder working groups, involving more than 100 individuals. They were as follows:

- “Structure” of the “front door.” How to best assist consumers in navigating a fragmented system,
- Transition between “post-acute” care to long-term services and support,
- “Criteria” for accessing long-term services and supports,
- Medicaid financial eligibility criteria,
- Gaps in Medicaid waiver and state plan services,
- Housing with supportive services, and
- Facility-based capacity issues

Consumer Direction Subcommittee

One common element of transformed long-term services and supports systems is that all contain elements of consumer direction that allow the consumer more control over the services received and allow for the consumer to substitute goods and services at the consumer’s discretion. Consumer direction has been proven to be one effective strategy to control overall service costs at the same time consumer quality of life and satisfaction are increased. The most rigorous evaluation of consumer direction models is the evaluation of the Robert Wood Johnson Cash and Counseling demonstration in Arkansas, New Jersey and Florida. (*Cash and Counseling: Improving the Lives of Medicaid Beneficiaries Who Need Personal Care or Home- and Community-Based Services, Final Report*, Mathematica Policy Research, Inc, August 2007). In addition, consumer direction is one strategy that states have employed to address the projected shortage of direct service workers. This subcommittee, chaired by ODJFS, was charged with recommending a plan to allow consumer direction for each long-term services and supports option.

Quality Management/Assurance Subcommittee

Not surprisingly, because Ohio has developed a system of long-term services and supports that has historically been based on the development of individual programs, each program has developed its own quality assurance mechanisms. This subcommittee, chaired by ODA, was charged to explore the degree to which quality assurance systems are integrated in a transformed long-term services and supports system and to recommend necessary improvements to the current system. The Centers for Medicare and Medicaid Services (CMS) “Quality Framework” provided a useful starting point for this work (see <http://www.cms.hhs.gov/HCBS/>).

Care Management Subcommittee

This subcommittee, chaired by ODA, was charged to make recommendations on the role of care management in a transformed system of long-term services and supports. Issues considered by this subcommittee include:

- Who would benefit from care management?
- What is the role of the care manager? (Gatekeeper, counselor, navigator, advocate, service authorizer, or some combination of all of these).
- How does the care management system for long-term services and supports integrate with existing managed care plans? This includes both Medicare managed care plans and the Medicaid ABD managed care plans.

2.0 Recommendations of the Unified Long-Term Care Budget Workgroup

The ULTCB workgroup first made two overarching recommendations that guided the entire effort: Who is covered by the unified budget; and what services are included in that budget?

2.1 Who is covered by the unified budget?

To answer this critical question, the ULTCB workgroup explored the current demographics of Ohioans served by the system as well as the future projections supplied by the Scripps Gerontology Center.

Equally important is the fact that Scripps has documented a shift over the last 12 years in the utilization of long-term services and supports. For example, the proportion of nursing facility residents who are younger (i.e., age 59 or less) has nearly tripled in twelve years. This fact argues for approaching the unified budget from an inclusive perspective.

Accordingly, the ULTCB workgroup ultimately decided on the inclusion of all Ohioans in need of long-term services and supports. Therefore, the workgroup recommends that the budget be inclusive of all consumers with a *chronic* or *recurring* need for services, regardless of age or payer source.

The need to be inclusive, while at the same time being mindful of the complexity involved illustrates the wisdom of the legislation which created the workgroup by suggesting a multi-phase approach in the development of a unified long-term care budget.

The ULTCB workgroup recommends the following multi-phase approach:

Phase One

The first phase of the unified budget is designed around the eligible population that becomes entitled to Medicaid-funded long-term services and supports by virtue of needing care equivalent to that provided by a Nursing Facility. Phase one covers both facility-based services and those provided in home and community based settings, including those Medicaid waiver programs operated by ODJFS and ODA.

Funding for the following programs and services, over time, are combined into a single, unified budget in phase one.

- Nursing facility services
- PASSPORT
- Choices
- Assisted Living Waiver
- Program of All-Inclusive Care for the Elderly (PACE)
- Ohio Home Care waiver
- Transitions “Carve Out” waiver

Phase Two

The second phase includes those Ohioans who need long-term services and supports and receive services and supports through non-waiver Medicaid services. It is expected that this group will include primarily Ohioans with behavioral health needs. Consumers not receiving facility-based services would typically rely on traditional state plan Medicaid services offered on a recurring, long-term basis, which for this population may or may not be managed through the organized delivery system. Despite the fact that phase two is a smaller consumer group, it is expected to be more complex than phase one due to the difficulty in calculating service costs and the need to define the service network. The county-based structure of the delivery system and the reliance on local funding that can differ by county, adds to this complexity.

Phase Three

In the third phase, a unified budget would be developed around consumers with care needs who historically have received services through the MRDD system.

In phase three, the following programs and services are combined.

- ICF-MR services
- Individual Options waiver
- Level One waiver
- Transitions MRDD waiver

The ULTCB workgroup posed this as a third phase because parallel in time to the work of this workgroup, ODMRDD was focused on its “futures” project (also mandated by Am. Sub. H.B. 119) which must be completed before meaningful work can begin on creating this phase of the unified budget. The “futures” project was finalized in March, 2008.

Phase Four

The ULTCB workgroup recognized that not everyone receiving publicly funded long-term services and supports in Ohio receives those services through Medicaid-funded programs. Yet these non-Medicaid programs possess many of the same characteristics of Medicaid-funded programs and also are targeted to consumers with a chronic or recurring need for services. For example, Older Americans Act funds (federal), Senior Community Services funds (state), and county levy funded programs (local) provide services to consumers who do not meet Medicaid eligibility guidelines. The workgroup proposes the creation of a phase four that would encompass those services and programs (while being clear that this is not recommending state control over local funding sources).

The concept of “phases” should be thought of as an organizational construct as opposed to an absolute construct. First, the concept of “phases” is often interpreted as linear in

nature. That is, phase one is completed before moving to phase two which is in turn completed prior to moving to phase three. This is not, strictly speaking, an accurate depiction of the workgroup’s recommendations. In fact, a number of the specific recommendations are designed to benefit consumers included in more than one phase and in some cases, the recommendations are meant to apply to all phases. A chart that depicts which phases each individual recommendation applies to is included as Appendix B.

Second, there is some natural overlap between the consumers included in one phase with consumers included in a different phase. For example, nursing facility residents with a primary need for behavioral health services could be included in phase one (because they currently reside in a nursing facility), but because of federal constraints¹ on Medicaid Home and Community-Based services (HCBS) waivers, assuming the consumer returns to the community, the community services would be provided either through phase two or phase four.

Recommendations – Who is Covered by the Unified Budget?

- 1. All Ohioans in need of long-term services and supports regardless of age, disability, or funding source for services.***
- 2. The scope of work should be divided into four phases:***
 - a. Phase 1 Nursing Facility and HCBS services predicated on Medicaid NF eligibility;***
 - b. Phase 2 Medicaid state plan services;***
 - c. Phase 3 MRDD services; and***
 - d. Phase 4 Non-Medicaid funded long-term services and supports***

2.2 What services are included in the budget?

A second key decision required the ULTCB workgroup to recommend a definition of “long-term care” with sufficient precision to facilitate the creation of a unified budget for these services. A traditional “textbook” definition of long-term care is suggested by the Centers for Medicare and Medicaid Services (the federal agency providing oversight to these funding sources):

[Long-term care is a variety of services](#) that includes medical and non-medical care to people who have a chronic illness or disability. Long-term care helps meet health or personal needs. . . Long-term care can be provided at home, in the community, in assisted living or in nursing homes.

¹ Historically, it has been difficult for states to qualify these services for Medicaid funding. By definition, CMS has limited services to those comparable to the services available in a facility-based setting that qualifies for Medicaid reimbursement (e.g., a nursing facility or ICF.MR). Facilities that have a large number of residents with behavioral health needs and who are between age 18 and 64 are classified as Institutions for the Mentally Disabled (IMDs) which do not qualify for Medicaid reimbursement.

Many have argued that today long-term “care” in reality is a complex array of services and supports experienced by consumers with long-term needs. In addition, the use of the term “chronic” may not encompass those consumers whose need for services and supports are episodic or cyclical in nature.

The ULTCB workgroup recommends that the definition of “long-term care” encompass all non-medical and some specific medical services that the consumer receives on an ongoing basis to meet recurring or continuing needs. While this definition introduces a level of complexity to the budgeting process beyond simply adding up the costs of each program included in the unified budget, it reflects the intent of the workgroup to focus on the *service needs* of consumers rather than the specific *program* in which the consumer enrolls.

In support of the proposal, consumers enrolled on Medicaid waivers benefit from having a case manager who assists consumers in understanding their options and authorizes a service plan for and with the consumer. Other services, purchased through non-waiver means, such as regular Medicaid state plan services currently are not included in this service plan and are not care managed. Services received through other funding sources are not even known. This fragmentation contributes to higher cost to the state and often lower quality for the consumer. It is also important to remember that some consumers receive Medicaid services ONLY through the traditional Medicaid state plan (e.g., consumers who need behavioral health supports).

Specific Phase One Services and Supports Included in the Unified Long-Term Care Budget²

Waiver Services

- Out of Home Respite
- Adult Day Health
- Supplemental Adaptive and Assistive Devices
- Personal Emergency Response Systems
- Home Modification and Environmental Accessibility Options
- Home and Personal Care
- Nursing Services
- Transportation
- Specialized Medical Equipment and Supplies
- Chore Services
- Social Work and Counseling
- Nutritional Consultation
- Home Delivered Meals and Alternative Meal Service
- Independent Living Assistance
- Assisted Living Services
- Community Transition Services

² These services are only specific to phase one and are included for illustration only. Work is still needed to determine the services included under phases two, three, and four.

State Plan

- Program of All-inclusive Care for the Elderly (PACE)
- Nursing Facility
- APN and CRNA
- Supplies and Medical Equipment
- Transportation
- Home Health
- Private Duty Nursing

Recommendation – What services are included in the budget?

3. “Long-term care” encompasses all non-medical and some specific medical services that the consumer receives.

2.3 Budget and Reporting Structure

Because the budget structure and the creation of a new unified management information system (the Medicaid Information Technology System or MITS) are intertwined, the workgroup recommends a five year plan for the creation of a unified budget in three stages: over the current biennium and each of the next two biennia.

Am. Sub. H.B. 119 created new state “long-term care” lines in the budgets of ODJFS, ODA, ODMH, and ODMRDD. OBM, with the approval of the Controlling Board, has authority in SFY 2009 to transfer funds from existing long-term services and supports programs to these new lines within a single agency’s budget and among agencies.

In the 2010/2011 biennium, the ULTCB workgroup recommends the appropriation of funding directly to these new lines rather than individual programs (e.g., ODA long-term services and supports rather than PASSPORT, Assisted Living, and PACE). This will allow greater flexibility within agency budgets to adjust program spending based on consumer demand and retains OBM’s ability to transfer funds among agencies. For example, in the current biennium, ODA has sufficient appropriation authority to meet the current level of consumer demand for the PASSPORT waiver, but has a waiting list for enrollment into the PACE program. The proposed budget structure for the 2010/2011 biennium would allow funds not needed for PASSPORT to be used flexibly to support the existing demand for PACE.

For the 2012/2013 biennium, a single funding line for long-term services and supports is to be created in the ODJFS budget that will truly create a unified budget for these services. Implementing a single funding line will only operate efficiently with an integrated information technology system. Smooth and efficient implementation is contingent upon two factors:

- Ohio has an integrated IT system that will support the integration of expenditure allocation and spending information for all long-term services and supports; and
- State agencies, and their regional or local instrumentalities, are able to access this integrated IT system with appropriate levels of security built in to the system.

It is assumed that MITS will be this integrated system. In the event that MITS is not deployed to sister state agencies in time for the development of the 2012/2013 budget, the structure recommended for 2010/2011 would continue to be used until such time as MITS is deployed to the sister state agencies so as to not impede progress toward developing a unified budget.

The ULTCB workgroup also recommends the creation of three different levels of reporting to support a unified budget: Performance, Decision-making, and Management reports.

At the highest level, *performance* reports are designed for the larger audience of key stakeholders. These include the Governor, members of the General Assembly, and key stakeholders. A performance report is required annually of the Directors of OBM and Aging by Am. Sub. H.B. 119. The purpose of an annual performance report is to update interested parties on implementation of the unified long-term care budget through all of its phases. That report will track performance of the unified long-term care budget, and the programs contained within that budget, against established performance measures utilizing an Ohio developed State Profile tool using the CMS sponsored Thomson/Medstat technical assistance guide (see Appendix D). For example, one performance measure might be the proportion of consumers who access facility based or home and community based services. Another might be a reduction in the amount spent “per member per month” (PMPM) for the population accessing long-term services and supports. The workgroup recommends quarterly update reports be provided to the Governor and members of the General Assembly.

Initially, data will be drawn from ODJFS’s Decision Support System (DSS), with some data from sister agencies. Eventually all necessary data will be derived directly from MITS.

Decision-making reports guide decision making within the administration. There are several different decisions that must be guided by these reports. First, decisions must be made on when and how to transfer funds from one appropriation line to another. Even after all budget lines are consolidated, decisions still must be made to distribute funds to specific services. While OBM has the statutory authority to move state funding flexibly among programs and agencies, an objective process needs to be established to inform these transfers.

To effectuate this process, the workgroup recommends creating a caseload forecasting group composed of staff from each of the affected agencies (i.e., those constituting

EMMA, including those agencies responsible for long-term services and supports and the Office of Budget and Management). This group would review monthly trends in service utilization.

Second, a series of decision making reports will be needed as Ohio's existing HCBS waivers come up for renewal. One important consideration of this process is the evaluation of the future financing and organizational structure of Ohio's system of long-term services and supports. In SFY 2009, EMMA will evaluate the options available to Ohio, based on the parameters of the types of Medicaid waivers authorized by federal law.

Third, decision making reports will guide the administration in setting budget priorities for future biennia in how best to distribute funds to differing types of long-term services and supports, based on consumer demand and need for these services.

Management reports inform: 1) budget development, 2) quarterly budget realignments, and 3) monthly tracking. These reports will contain more detail than the decision making reports and are designed to guide decision making by individual agencies on cash management strategies, allocation of funds and tracking of expenditures by specific programs.

Recommendations – Budget structure and reporting

- 4. The creation of a unified budget be accomplished in three stages: over the current biennium and each of the next two biennia.***
- 5. In SFY 2010/2011 funding be appropriated directly to new long-term care lines rather than individual programs.***
- 6. In SFY 2012/2013 a single funding line for long-term services and supports is created in the ODJFS budget.***
- 7. Create three different levels of reporting to support a unified budget: Performance, Decision-making, and Management reports.***
- 8. Quarterly update reports be provided to the Governor and members of the General Assembly.***

2.4 Provider rate setting

The administration subcommittee also discussed the issue of how rates are currently set for service providers and recommends that a transparent and equitable process be established to guide future rate-setting. The ULTCB workgroup recommends that to ensure consumers are provided access to necessary care and services and that these services are of high quality, a consistently applied, systematic, and transparent process to develop sound rates should be established. This is consistent with the recommendation of the Medicaid performance audit by the Auditor of State:

The State Medicaid agency should use recommended rate reimbursement criteria including ensuring that payment rates are high enough to encourage program participation by efficient providers, payment rates are low enough to minimize taxpayer burden and enable the provision of program services and enrollee coverage, and payment rates are appropriate to the overall market and individual submarkets to sustain program viability across and within a state's market area and to avoid under and over provision of care recognizing practice variation from one market to the next.

The Auditor of State went on to recommend that:

The state Medicaid agency should implement a regular process for the periodic evaluation of all Medicaid service rates and should examine each of its rate setting methodologies separately as it undertakes rate adjustment strategies. It is further necessary that in order to ease stakeholder concerns about the nature of timing of rate changes, the State Medicaid agency and the sub-recipient agencies should establish a more formal schedule of rate reviews and include ample opportunity for stakeholder comment.

The timing of this rate setting process should coincide with budget development for each succeeding biennium, i.e., the process should be implemented every two years.

Recommendation – provider rate setting

9. A consistently applied, systematic, and transparent process to review provider rates should be established.

2.5 Reinvesting savings.

The ULTCB workgroup recommends that all revenue savings achieved through the implementation of the unified budget be used to more expeditiously implement other recommendations contained in this final report that may not be revenue neutral but that contribute to an overall balanced long-term services and supports system for Ohio.

Recommendation – reinvesting savings

10. All revenue savings achieved through the implementation of the unified budget be used to more expeditiously implement other recommendations contained in this final report.

2.6 Special analysis in SFY 2010/2011 budget submission

Before each succeeding biennium, OBM is responsible for releasing an Executive Budget detailing the Governor's budget proposal to the General Assembly. Often the Executive Budget will contain several "special analyses" of key executive priorities. A special analysis discusses issues that impact the state's budget in greater detail. The special analysis is particularly effective in those cases where an issue affects more than one agency's budget and gives policymakers a better sense of how budget initiatives from multiple agencies are linked, as is true with the unified long-term care budget workgroup recommendations.

The workgroup recommends that OBM create a special analysis on long-term care to be delivered to the General Assembly as part of the Executive Budget submission for the next biennium.

Recommendation - special analysis in 2010/2011 budget submission

11. OBM should create a special analysis on long-term care to be delivered to the General Assembly as part of the Executive Budget submission for the next biennium.

2.7 Ongoing strategic planning process

The ULTCB workgroup recommends use of an Ohio developed State Profile Tool (SPT) using the CMS sponsored Thomson/Medstat technical assistance guide (see Appendix D) to establish performance metrics for a more balanced system of long-term services and supports. This will allow Ohio to benchmark its progress against that of other states that have chosen to use the SPT (11 states have completed or are in the process of completing the SPT)..

The SPT will be completed by early fall, 2008 to establish a baseline for measuring Ohio's future progress. Ohio's work to achieve balance is occurring through four distinct, but complementary initiatives; the development of the unified long-term care budget, the implementation of Ohio's Money Follows the Person grant, the Futures process led by ODMRDD, and the Transforming Systems Incentive Grant led by ODMH. Ohio will develop one statewide balancing plan comprised of the relevant strategies impacting balance within the long term services and supports delivery system. This plan will be monitored through the ODA led ULTCB workgroup.

The ULTCB workgroup recommends that their work be continued in future years and convened by the Director of ODA. This final report of the ULTCB workgroup is simply a plan. This plan should be regarded as a "living" document. Previously, Ohio has not engaged in a systematic process that engages all stakeholders in rigorous strategic and contingency planning to ensure that Ohio has a vision and concrete goals to guide the development of long-term services and supports that are truly focused on consumers and

their needs. Due to the complementary nature of the unified budget work and the balancing goal of the Money Follows the Person grant, a formal relationship will be established with the HOME Choice Consumer Council.

Recommendations – ongoing strategic planning process

- 12. Ohio should use the State Profile Tool (SPT) to measure the performance of the state in balancing its long-term supports system.*
- 13. The work of the Unified Long-Term Care Budget workgroup should be continued in future years and convened by the Director of ODA.*

2.8 Enhancing consumer access to services – the “front door” to long-term services and supports.

2.81 Background

As in most states, the development of long-term services and supports in Ohio has been incremental and driven by discrete funding sources. Population-specific programs were organized independently within separate service delivery systems. As a result, Ohio has *rational* programs and an *irrational* system, with gaps in the needed service array. This approach has allowed Ohio to treat nursing homes, ICF/MR facilities, assisted living, in-home services, supportive housing, and consumer directed services as separate program entities rather than components of an overall system.

Financing for services has also contributed to the fragmentation of the service delivery system. Funding comes from different state agency budgets (both federal and state funds) and, in Ohio, many service options are supported through the use of local property tax funding – all of which must be understood as a cohesive “whole” if Ohio is to succeed in creating a “front door” that is seamless, coordinated, flexible, choice-driven, and efficient for consumers to navigate. Information resources should include service options beyond those funded by Medicaid and should include tools to encourage and support advance planning for long-term services and supports. In this sense, the “front door” may be thought of, in reality, as a virtual entity rather than a physical place.

“Front door” activity is the activity prior to actual service assessment and delivery. It is after this “front door” process ceases and supports begin for the consumer, that the program or service delivery system will provide an assessment and may include a care management component.

Who assists consumers?

Throughout this report, a number of professional roles of individuals tasked to assist consumers are mentioned. In some cases, these are existing roles; in other cases, new roles are proposed by the ULTCB workgroup. What follows is a brief “glossary” of these professional roles:

Care manager/case manager – used interchangeably in this report, the care manager is responsible for working with consumers who qualify for a particular program to develop and implement a service plan that meets the needs of the consumer. The care manager may in some cases be responsible for authorizing services. Care management is prevalent in home and community-based services programs and managed care programs for the Aged, Blind and Disabled (ABD) or Covered Family and Children (CFC) Medicaid managed care plans. Presently, care management is treated as either a **service** or **administrative** function, depending on the program.

Service Coordinator - This concept is specific to certain residents in subsidized housing. The service coordinator acts a broker to other services for the residents, but does not authorize services or create care plans as would a care manager. While service coordinators already exist in some subsidized housing developments in Ohio, the workgroup is recommending that funding be provided for additional service coordinators.

Long-term care consultant – provides a free, in-person consultation with Ohioans of any age to assist them in determining their options for long-term services and supports. The consultation consists of a professional assessment as well as options counseling. This is an existing function of the PASSPORT program.

Transition coordination - This is a new **service** in Ohio, added by HOME Choice, Ohio’s Money Follows the Person grant. Transition coordinators assist consumers living in institutions to relocate to community settings. Transition coordination will be provided to HOME Choice participants by the Centers for Independent Living, the Regional Long-Term Care Ombudsman Programs, and other agencies.

Community support coach is a **service** provided for the purpose of guiding, educating and empowering HOME Choice participants, authorized representative and family members during the participant's transition from an institution into the community

Informed navigator function – assists consumers in navigating the administrative processes required to access a service or program. This function ceases when the consumer is enrolled in a service or program. At that point, the consumer may be assisted by a care manager. The establishment of the informed navigator function is recommended by the ULTCB workgroup. It is considered an **administrative** function.

Independent consumer advocate – the role of the independent advocate is to advocate for the consumer and it is important that this individual not be affiliated with an entity that is part of the traditional service delivery system. Independent advocates are also recommended by the ULTCB workgroup.

2.8.2 Addressing “Structure” through a “No Wrong Door” Model

In addressing the structure of their “front door”, states have historically used either a “single point of entry” (where all consumers accessing the system are directed to a single local source to access long-term services and supports) or a “no wrong door” system where consumers are assisted through the access process regardless of the point at which they encounter the system. The ULTCB workgroup recommends that Ohio - rather than create a new and duplicative approach to the front door by creating a single point of entry - instead employ a “no wrong door” concept that builds on the strengths of Ohio’s county based system and existing infrastructure designed to serve people in their community.

It is important that the “Front Door” recognize differences in individual situations and preferred methods of learning about and obtaining needed assistance. Entry into any part of the long term services delivery system should be seamless and available in a variety of ways. The workgroup recommends that access to the “Front Door” be available by telephone, through face-to face contact, and through the Internet.

The “Front Door” into Ohio’s delivery system for long term services and supports should recognize the needs of all consumers rather than just those receiving services through the Medicaid program. Information and referral functionality should be broad enough to serve all consumers. In addition, by providing information to meet a broad range of needs, the “Front Door” can provide an important tool in encouraging and supporting planning for long term care.

The “no wrong door” approach should be implemented in a way that ensures consumers can easily take next steps. Whenever possible, a “warm hand-off” (i.e. personal contact from the referral agency to the service-providing agency) should be used when a consumer is moving from an entry point to next steps to access services.

Marketing and education to ensure that the “Front Door” is recognized throughout the state as a valuable tool to plan for and access long term services and supports is vital to the success of the initiative in improving consumer access to meaningful choice. While communities will continue to employ multiple entry points, in order to maximize the return on investment of limited state funds into marketing, a primary point of entry for a community (or region) should be identified as the focus of statewide marketing efforts.

To ensure that Ohioans are given resources that encourage them to plan for the future need for long-term services and supports, the ULTCB workgroup also recommends that Ohio pursue a consumer education program designed to encourage individuals and their families to access resources relating to available long term services and supports before the need exists. This is an essential step in providing meaningful choice to Ohioans. As this report is written, Ohio is partnering with the federal Department of Health and Human Services to implement the Own Your Future campaign targeted at Ohio Baby Boomers to encourage them to plan better and sooner for the future need for long-term services and supports. In addition, Ohio has implemented a long-term care partnership program as mandated by Am. Sub H.B. 530 (126th General Assembly) that links the

purchase of private long-term care insurance to Medicaid financial eligibility criteria to encourage Ohioans to consider this type of insurance.

The workgroup recommends that additional training and resources on long-term services and supports planning be made available to three groups specifically mentioned by the subcommittee: discharge planners, key nursing facility personnel and court appointed guardians.

The ULTCB workgroup accepted the subcommittee's recommendation for a "no wrong door" model given the local (county or regional) structure of the current entry system to long-term services and supports. To ensure that there is an accountable system responsible to make sure that local delivery systems work together to produce a seamless system for consumers, the ULTCB workgroup recommends that the Area Agencies on Aging be responsible for the development of regional collaboratives throughout Ohio and for providing input to the development of and implementation of uniform criteria that takes as a starting point the criteria already developed by the "front door" subcommittee. The working assumption is that key systems will continue with their current role in the system (e.g., financial eligibility determinations continue to be a function of the county departments of job and family services; functional eligibility determination responsibilities remain as they are today). The goal of the collaborative is to improve the way the system works, not to realign the system as it currently exists.

This will require that the AAAs first identify key local entities through which consumers access long-term services and supports. At a minimum, the following partners would participate in these regional collaboratives:

- a. The County Department of Job and Family Services (CDJFS) (for Medicaid financial eligibility determination);
- b. County MR/DD Board
- c. County ADAMH (or equivalent) entities.
- d. Any operational Center for Independent Living serving the county or region.
- e. Any operational 2-1-1 provider serving the county or region.
- f. The Regional Long-Term Care Ombudsman program;
- g. The care management entity for the Ohio Home Care Waiver
- h. ABD managed care entities that are operating in the county or region to ensure transition coordination for consumers that move between the two systems; and

- i. Any other agency identified by the AAA as a primary partner agency. This includes key local hospital systems to ensure coordination between the post-acute and long-term services and supports systems.

The AAAs are recommended for this role because:

- The AAAs currently receive the greatest volume of requests related to long-term care due to their responsibilities for preadmission review, functional eligibility determinations, and long-term care consultations .
- AAAs are uniquely accountable to the state level (critical to ensure consistency). AAAs are creations of the Older Americans Act and are contractually bound through a three party agreement (the Departments of Aging and Job and Family Services are the other parties) that delineates the responsibilities for key “front door” activities.
- AAAs are skilled at identifying other non-Medicaid sources of long-term services and supports (consistent with phase four of the unified budget) because their responsibility is greater than for just Medicaid funded programs.

To ensure success of the regional collaboratives, each AAA will be responsible for:

- Ensuring that consumers receive consistent phone-based information and assistance;
- Working with the County Departments of Job and Family Services to improve timeliness in the determination of financial eligibility. Several ways have been suggested that could result in such improvement: colocation of eligibility determination workers, allowing AAA and county board staff to collect the paperwork and verifications necessary to determine financial eligibility, and creating a better electronic communications system between the agencies, among others;
- Working with local partners to build a system of “warm handoffs” (maintaining human contact) of both individuals and information when access to these systems is needed;
- Identifying “critical pathways” (i.e., entities such as hospitals, nursing facilities, and social service agencies) that serve as primary “feeders” into the long-term services and supports system and working with these “critical pathways” to develop specific mechanisms to create seamless transitions for consumers;
- Public education on long-term services and supports and outreach;
- Assisting Ohioans to plan for future long-term support needs;

- Education for trained personnel in relevant agencies who assist consumers;
- Developing an “informed navigator” function to assist consumers in accessing long-term services and supports and meeting eligibility requirements on a timelier basis.

Recognizing that for the foreseeable future most consumers will at most use Internet resources to supplement human contact by phone or in person, the ULTCB workgroup recommends the creation of an “informed navigator” function. An “informed navigator” is an individual familiar with all related systems and proficient in assisting a consumer in identifying needs, finding information and taking the next steps to access needed services. Each AAA should work within the framework of its regional collaborative to assure that every consumer experiences an entry point that is flexible and without barriers. Consistent with the Ohio “no wrong door” model, partners in the regional collaborative will provide input into the development and implementation of uniform statewide criteria.

Recommendations – enhancing consumer access to services

- 14. Employ a “no wrong door” concept that builds on the strengths of Ohio’s county based system and existing infrastructure designed to serve people in their community;*
- 15. Access to the “Front Door” should be available by telephone, through face-to face contact, and through the Internet;*
- 16. Recognize the needs of all consumers rather than just those receiving services through the Medicaid program;*
- 17. A “warm hand-off” (i.e. personal contact from the referral agency to the service-providing agency) should be used when a consumer is moving from an entry point to next steps to access services;*
- 18. A primary point of entry for a community (or region) should be identified as the focus of statewide marketing efforts;*
- 19. Ohio should pursue a consumer education program designed to encourage individuals and their families to access resources relating to available long term services and supports before the need exists;*
- 20. Additional training and resources on long-term services and supports planning should be made available to discharge planners, key nursing facility personnel and court appointed guardians;*
- 21. The Area Agencies on Aging be responsible for the development of regional collaboratives throughout Ohio and for providing input to the development of and implementation of uniform criteria that takes as a starting point the criteria already developed by the “front door” subcommittee;*
- 22. the AAAs should identify key local entities through which consumers access long-term services and supports to participate in the regional collaboratives; and*
- 23. Consumers should have access to an “informed navigator” function.*

2.9 The “Back Room” (technology and statewide policy that supports the “front door”)

There are two components to the “back room” responsibilities: development of an information technology portal that provides a strong foundation of choice-driven decision making, accountability, and increased efficiency across the long-term services and supports structure, and management processes that set forth policy and operations, including training and the development of a uniform assessment used by the “no wrong door” entry points. The ULTCB workgroup recommends that ODJFS have lead responsibility for the “Back Room” because of ODJFS’ role as the single state Medicaid agency and the ultimate technological solution proposed by the subcommittee builds upon the development and deployment of the MITS system. The ability to manage across the “boundaries” while maintaining accountability and managing cost depends on a strong IT component. ODJFS is responsible for developing the IT and management processes in coordination with current state agencies and other interested stakeholders.

Technology should be utilized to create a common, secure, accessible electronic infrastructure to expand information sharing about consumers, in effect a virtual “front door.” This infrastructure should be seamless to consumers and providers.

- Information sharing should only occur with the consumer’s consent.
- The Internet based system will provide access across the delivery system for long term services and supports.
- Technology should be used to ensure that information and referral services can be “logic driven” so that preliminary decisions regarding level of care can be reached, criteria to identify behavioral health needs can be utilized, and available options likely to meet a consumer’s needs can be identified.

This virtual “Front Door” supplements existing tools and is supported by business processes.

- The Internet-based system should integrate existing tools and systems that are successful in linking consumers to service delivery options. In the past, Ohio has created an array of such tools, but there is no one place currently where all information is integrated.
- The Internet based system should be designed so that it can be utilized by the consumer, the consumer’s representative, or consumer’s advocate in the setting most convenient for the individual.
- A “worksheet” function should be incorporated to assist consumers in the financial eligibility determination process. An online application for benefits should be created.
- Reporting functions should be built in to the system that can be integrated with the recommended decision making and management reporting systems.

The information technology should include functionality that is Internet based with a web portal including a consumer interface (e.g. search for providers, links to other websites like Benefits Bank) and the ability to process functional determinations in a “smart” manner to improve inter-rater reliability. In the short term (SFY 2009), while the suitability of MITS for this function is being researched, this virtual front door may be as simple as designing a single web page that contains all of the links to key tools for consumer and front door agency use (i.e., ConnectMeOhio, the Ohio housing locator, Network of Care, Benefits Bank, Benefits Checkup, and the Ohio Long-Term Care Consumer Guide). ODJFS project staff responsible for MITS has indicated that Ohio is on an aggressive timeline to meet a target for sister agency integration into MITS in 2012.

The ULTCB workgroup also recommends that a standardized screening and intake process should be implemented at all entry points into the delivery system for long term services and supports.

This screening and intake process should include the collection of a standardized data set that will be incorporated into processes used at all entry points into the system. The screening and intake process should include “tickler” functionality so that appropriate steps to check back with the consumer can be identified as appropriate. The value of a tickler system is to flag a future point in time when a consumer needs to make a decision about how he or she will receive long term care services and supports. At that point in time, he or she may need additional information about available options.

To establish accountability at the state level responsible for the training and technical assistance of all “no wrong door” entry points, the ULTCB workgroup recommends that the Department of Aging and Department of Job and Family Services co-lead the team to develop the training and materials for use by all front door partners. This will require working with the affected sister state agencies in carrying out these responsibilities.

Recommendations - technology and statewide policy that supports the “front door”

- 24. ODJFS should have lead responsibility for the “Back Room;”***
- 25. Technology should be utilized to create a common, secure, accessible electronic infrastructure to expand information sharing about consumers;***
- 26. The Internet-based system should integrate existing tools and systems that are successful in linking consumers to service delivery options;***
- 27. The Internet based system should be designed so that it can be utilized by the consumer, the consumer’s representative, or consumer’s advocate in the setting most convenient for the individual;***
- 28. A “worksheet” function should be incorporated to assist consumers in the financial eligibility determination process;***
- 29. An online application for benefits should be created;***
- 30. Reporting functions should be built in to the system that can be integrated with the recommended decision making and management reporting systems;***
- 31. A standardized screening and intake process should be implemented at all entry points into the delivery system for long term services and supports;***
- 32. The screening and intake process should include “tickler” functionality; and***
- 33. The Department of Aging and Department of Job and Family Services should co-lead the team to develop the training and materials for use by all front door partners.***

2.10 Easing the transition from acute care to long-term care

As issues relating to the “Front Door” into the system providing long term services and supports were identified and analyzed, the importance of addressing issues that arise at the point a consumer’s needs transition from acute care to long term services was

emphasized. The transition is often sudden and the consumer has little time to identify and evaluate options for services in order to make a meaningful choice. In many instances, those quick decisions have unintended consequences (e.g., loss of community housing) that may impact a consumer for the balance of the consumer's life.

The ULTCB workgroup recommends that the "Front Door" into the long term services delivery system be implemented to encourage advance planning and meaningful choice prior to a consumer's transitioning from acute care to long term services.

- Leverage the existing long term care consultation program through the Area Agencies on Aging.
- Ensure that information provided during a long term care consultation includes resources consumers can use to compare quality among providers.

An important role for the regional collaborative is to identify critical pathways (such as discharge planning) at the local or regional level. Each collaborative should develop strategies to focus on those pathways in a way that leverages existing relationships within each community. Staff from the Area Agencies on Aging should coordinate and collaborate with acute care providers from the point of admission to the hospital when a need for long-term care services is likely to occur by providing a Long Term Care Consultation visit in a timely manner.

The subcommittee also discussed the need to shorten the time between identification of a need for services and the actual initiation of those services similar to Pennsylvania's fast track eligibility determination and requirement that providers start services within 24 hours). Finally, this subcommittee, seconded by another subcommittee identified the barrier that is created by current prior authorization requirements on consumer choice and recommends potential policy changes as appropriate (see specific recommendation at 2.13 below.

Recommendations - Easing the transition from acute care to long-term care

- 34. Leverage the existing long term care consultation program through the Area Agencies on Aging to encourage advance planning and meaningful choice prior to a consumer's transitioning from acute care to long term services;***
- 35. Each regional collaborative (see recommendation 21) should develop strategies to focus on "critical pathways" (hospitals, skilled nursing facilities that provide short-term care) in a way that leverages existing relationships within each community; and***
- 36. Explore Pennsylvania's fast track eligibility determination process and requirement that providers start services within 24 hours of a referral.***

2.11 Eligibility criteria to access formal long-term services and supports funded by Medicaid

One of the primary functions of the “Front Door” for long term services and supports is to identify options that may meet a consumer’s needs in a way that provides meaningful choice. In order to provide meaningful choice, the criteria for different services and/or benefit packages are a critical element. As stakeholders examined the existing criteria for accessing institutional and waiver services, many options for reform that could contribute substantially to a balanced delivery system for long term services and supports were identified.

The workgroup is recommending a number of long-term reforms that will need further exploration and need to be linked to benefit design to ensure continuity of services to Ohio’s consumers. Changes to criteria have the potential to significantly affect both individual consumers and the delivery system for long term services and supports. Any changes to existing rules and regulations should be data driven to the extent possible and based on analysis of utilization and assessment data. In addition, care should be taken to ensure that existing rules and regulations are not changed more quickly than the capacity to meet consumer needs is developed. Therefore, the workgroup recommends that mechanisms be developed to explore and evaluate each of these reforms and report to EMMA on their findings. One workgroup of stakeholders has already been convened to discuss revisions to Ohio’s level of care and preadmission screening rules.

The relation between criteria and waiting lists is also a significant element in the efforts to develop a balanced delivery system for long term services and supports. Existing waiting lists in individual programs should be addressed with a state-level strategy of managing any waitlist. In addition, sufficient information should be collected about consumers on the waiting list to ensure that the state is able to maintain a meaningful waiting list that indicates unmet needs. Ohio will then be better able to manage its waiting lists through a comprehensive plan to ensure reasonable movement on the waiting list.

Specifically, the ULTCB workgroup recommends that the measurement of functional and medical needs both be included in the “level of care” criteria (which determine what services the consumer may be eligible for) including:

- Consider the implementation of specialized level of care criteria for some populations (e.g., children, TBI)
- Consider an extended transition period for any changes to level of care criteria to facilitate continued service to consumers already receiving long term services and supports through the Medicaid program.
- Replace the existing skilled and intermediate levels of care with a single nursing facility level of care. This would be consistent with federal requirements.

- To address issues that currently may result in inappropriate utilization of nursing facility services, analyze the current PASRR structure with particular attention to exemptions, categorical determinations, and specialized service determinations.
- To facilitate consumer choice, provide explicit authority for state agencies to initiate level of care and/or PASRR assessments if the provider fails to do so.
- To facilitate consumer choice, consider time limited level of care determinations across settings. For example, redeterminations might be made after the first nine months of services and annually thereafter. This will require a process to facilitate the transition of consumers among settings as changes in needs are identified through the reassessment.
- Evaluate the current requirement for face to face assessments. Identify the limited situations where a face-to-face assessment may not be necessary (e.g., a comatose consumer).
- Establish a time period (e.g., 60 days) where an assessment can be used as consumers move among settings.
- Consider a streamlined assessment process when consumers are moving between programs and/or settings. For example, this may constitute a process to validate existing level of care and PASRR assessments based on a record review when a consumer moves from a waiver to a nursing facility.

With so many differing local entities involved in these determinations, the ULTCB workgroup recommends the establishment of a quality assurance function with emphasis placed on documenting inter-rater reliability and training for personnel conducting assessments to ensure consistency and access across settings,.

Ohio should explore developing a tiered model of services (e.g., Vermont). This model will include an evaluation of each consumer's needs, assignment of a funding level based on those needs, and the flexibility to address changes in a consumer's needs. The vision behind a tiered model is to ensure maximum choice for consumers. This recommendation is not meant to specify **how** this should be achieved, but rather to emphasize that all potential options should be explored.

Recommendations - Eligibility criteria to access Medicaid-funded long-term services and supports

- 37. Existing waiting lists in individual programs should be addressed with a state-level strategy to ensure that waiting lists move with reasonable promptness;***
- 38. Sufficient information should be collected about consumers on the waiting list to ensure that the state is able to maintain a meaningful waiting list that indicates unmet needs;***
- 39. Ohio should convene a stakeholder group to analyze and explore changes to existing rules and processes regarding level of care and pre-admission screening and resident review (PASRR) for nursing facility admissions and NF-based waivers. This same issue will need to be addressed for phase three (MRDD) services and supports;***
- 40. The measurement of functional and medical needs both be included in the “level of care” criteria;***
- 41. Consider the implementation of specialized level of care criteria for some populations (e.g., children, TBI);***
- 42. Consider an extended transition period for any changes to level of care criteria to facilitate continued service to consumers already receiving long term services and supports through the Medicaid program;***
- 43. Replace the existing skilled and intermediate levels of care with a single nursing facility level of care;***
- 44. Provide explicit authority for state agencies to initiate level of care and/or PASRR assessments if the provider fails to do so;***
- 45. Consider time limited level of care determinations across settings;***
- 46. Evaluate the current requirement for face to face assessments, including determining whether such requirements should be retained;***
- 47. Establish a time period (e.g., 60 days) where an assessment can be used as consumers move among settings;***
- 48. Consider a streamlined assessment process when consumers are moving between programs and/or settings;***
- 49. Establish a quality assurance function with emphasis placed on documenting inter-rater reliability and training for personnel conducting assessments; and***
- 50. Explore developing a tiered model of services (e.g., Vermont).***

2.12 Financial Eligibility for Services and Supports

Financial eligibility processes and policies with respect to Medicaid covered services in the delivery system for long term services and supports are a critical element in a consumer’s ability to exercise meaningful choice. The ability to determine the eligibility for Medicaid funds and the policies used to make those determinations have been identified as barriers to obtaining services and exercising consumer choice to remain in the community in today’s environment.

The recommendations for change relating to financial eligibility focused on four specific areas. These areas include the timely processing for eligibility determinations, the requirements for documentation and face-to face-meetings, the need for education and training, and policies affecting the financial eligibility determinations.

Timely Processing

The timely processing of Medicaid financial eligibility applications is not a problem unique to Ohio. In fact, federal grants efforts in recent years have encouraged states to undertake measures that will streamline these applications. One of the key roles of the “informed navigator” function recommended by the ULTCB workgroup is to assist consumers through what can be an arduous and lengthy process. In Ohio, these applications are processed by the county departments of job and family services. Absent the time necessary for a detailed analysis of the current structure and potential alternatives, the workgroup adopted a series of recommendations to encourage process improvement. One workgroup member has proposed that a logical starting place for each regional collaborative is to map the current process with an eye toward reengineering it to eliminate duplicative steps and streamline others. The workgroup also recommends that expedited eligibility be considered for home and community-based services. Currently, the PASSPORT waiver is the only Medicaid waiver that in certain cases allows for services to begin to a consumer whose financial eligibility application is pending.³

Another recommendation is designed to deal with the consistency of eligibility determinations, given that those determinations are made by 88 county offices. The ULTCB workgroup recommends that ODJFS establish a “help desk” of key personnel who can assist in interpreting Medicaid’s often complex financial eligibility regulations.

Documentation and Face-to Face Requirements

Currently, consumers applying for Medicaid eligibility are required to have a “face to face” meeting with a caseworker at the local level. The ULTCB workgroup recommends that alternatives to this requirement be explored. The workgroup also recommended the colocation of financial and functional eligibility determination staffs (note that some counties in Ohio are already experimenting with this strategy). The workgroup also noted that software improvements to the virtual “front door” discussed above can be used to streamline documentation requirements.

³ As used in this section, some have referred to this process as “presumptive eligibility.” By federal Medicaid standards, presumptive eligibility is only allowed for pregnant women and children. The words, within the context of this report, are used to describe a historical process in the aging network whereby the state accepts some financial risk for allowing enrollment prior to an actual Medicaid eligibility determination.

Education and training materials

As noted earlier, marketing plans, mandated training for eligibility determiners and online distribution of materials and applications can improve the eligibility determination process. The ULTCB workgroup recommends implementation of a standardized orientation for all local staff regarding financial eligibility processing requirements that all staff must participate in (e.g., Minnesota has already developed mandatory training for workers).

Financial Eligibility Policy

The subcommittee considered a variety of changes to financial eligibility requirements to enhance a consumer's ability to choose freely among community-based and facility-based options. The subcommittee recognized that changing these requirements would have clear financial implications that will need to be considered, offset by adding additional opportunities for consumers to access less costly options over more costly options. Options recommended by the ULTCB workgroup for further exploration with a report to EMMA on findings are:

- Establishing an asset set-aside (perhaps 8-10k) for community living purposes so consumers can maintain/repair residence. Several states have recently implemented this change in recognition of the fact that to live in the community, consumers need to be able to maintain housing, for example, since Medicaid will only fund "room and board" in nursing facilities.
- If an individual in a waiver goes into a nursing facility, allow them to keep their institutional need standard income for a period of time (e.g., 6-13 months) to help pay for community expenses such as housing. The current requirement is that a nursing facility resident is entitled to a personal allowance of \$40 per month (\$30 if on SSI) and even though Ohio law now allows up to 13 months for a resident to sell the home, practicality suggests that this may not be financially feasible.
- Explore how CDJFS staff recalculate patient liability when individuals go from an HCBS to a NF (currently there appears to be inconsistencies across counties)
- Streamline the transition process between living/residence locations (e.g. HCBS and NF). Develop a "pending transition" code for CRIS-E that will support consumers moving from one location to another and addresses systems limitations that can delay a person moving/relocation and provider payment.
- Increase the personal needs allowance (PNA) across settings and programs.
- Research the possibility of counting judgments against a recipient such as child support, spousal support or a lien to pay a government agency (e.g. IRS) as an allowable deduction in order to offset the patient liability. (Example: A resident receives a \$1000/month pension check. There is a withholding of \$200 for

spousal support, the NF receives the \$800 that remains, but the full \$1000 is deducted from the facility's vendor payment).

Recommendations - Financial Eligibility for Services and Supports

- 51. encourage process improvements to improve the timeliness of financial eligibility processes (e.g., colocation of eligibility determiners, use of informed navigators – see recommendation 23;***
- 52. Expedited eligibility be should be utilized for home and community-based services beyond PASSPORT;***
- 53. ODJFS should establish a “help desk” of key personnel who can assist in interpreting Medicaid’s often complex financial eligibility regulations;***
- 54. Explore the following policy changes:***
 - a. Establishing an asset set-aside (perhaps 8-10k) for community living purposes***
 - b. Allow nursing home residents to keep their institutional need standard income for a period of time (e.g., 6-13 months) to help pay for community expenses such as housing;***
 - c. Allow retroactive Medicaid eligibility to be applied for home and community based and assisted living settings as it is for nursing facilities.***
 - d. Explore how CDJFS staff recalculates patient liability when individuals go from a community setting to a nursing facility;***
 - e. Develop a “pending transition” code for CRIS-E that will support consumers moving from one location to another;***
 - f. Increase the personal needs allowance (PNA) across settings and programs; and***
 - g. Research the possibility of counting judgments against a recipient such as child support, spousal support or a lien to pay a government agency (e.g. IRS) as an allowable deduction in order to offset the patient liability.***
 - h. Implement a standardized orientation for all local staff regarding financial eligibility processing requirements.***

2.13 Unmet Needs in Community Settings

The ULTCB workgroup recognizes that an inherent weakness in balancing Ohio's system of long-term services and supports is that key supports promoting the ability for consumers to live in the community simply may be unavailable. The “Front Door” subcommittee established a stakeholder workgroup to undertake a “gap analysis” of Ohio's community-based long-term services and supports. This stakeholder group was charged with providing comments/recommendations on four issues:

- 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?
- What provider requirements result in difficulty in obtaining needed long term services and supports when a consumer prefers a community setting?
- How can the delivery system for long term services and supports use informal supports to support a community setting? and
- How to ensure transportation as a critical element to community placement?

The ULTCB workgroup recommends consideration of the following additional services:

- 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 consumers to hire who they wish to provide their personal care services; provides them with a budget to purchase such services, oftentimes 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 consumers with one-time financial assistance to purchase items needed to set up a home in the community so that they 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 possibly should 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.
- The availability of transition coordination services as established in Ohio's HOME Choice demonstration should be expanded.
- Medication management and/or prescription coordination. The stakeholder group 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.

- In-home and institutional respite and/or sitter services under the State Plan should be made available.

The ULTCB workgroup recommends that some services that are currently limited in nature be expanded.

- Behavioral health services such as: evidenced based practices (e.g., ACT), crisis intervention, crisis stabilization units, and partial hospitalization programs for children and adolescents. Historically, it has been difficult for states to qualify these services for Medicaid funding. By definition, CMS has limited services to those comparable to the services available in a facility-based setting that qualifies for Medicaid reimbursement (e.g., a nursing facility or ICF.MR). By definition, facilities that have a large number of residents with behavioral health needs and who are between age 18 and 64 are classified as Institutions for the Mentally Disabled (IMDs) which do not qualify for Medicaid reimbursement.
- Program of All-inclusive Care for the Elderly (PACE) model. PACE is currently available in sites in Cincinnati and Cleveland.
- Expedited access to waivers for hospice consumers.
- Adult day services within the state plan. Currently this service is limited to Ohio's Medicaid waiver participants.
- 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, the stakeholder group also discussed existing barriers that would prevent expansion of services or development of any new service. Examples include:

- 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 reuse of adaptive and assistive devices and durable medical equipment.

- 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.

The stakeholder group addressed which provider requirements result in difficulty in obtaining needed long term services and supports when a consumer prefers a community setting in addition to the prior authorization system noted above. Provider specifications and requirements should be streamlined across delivery systems leading to decreased administrative burden and increased access to qualified providers, specifically:

- Develop universal and/or similar monitoring requirements established by the state agencies. (e.g., accepting reviews of other state agencies). This is also addressed by the quality assurance/quality management subcommittee below in 2.17.
- Develop qualification requirements for provider staff or independent providers across the state agencies for similar services. (e.g., standardized credentialing).
- Align Bureau of Criminal Identification and Investigation (BCII) background check requirements.
- Develop career lattices/professional development.
- Provide an automated billing system.

Although not specific to mandated provider requirements, the stakeholder group discussed at length the difficulty in finding and accessing qualified providers. In particular, the group 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 stakeholder group supports the recommendation presented to the ULTCB workgroup by the quality management/quality assurance subcommittee to establish a

comprehensive provider registry, ensuring it is user friendly and crosses all delivery systems.

Another provider related topic discussed, is the use of family members as service providers. This concept was further explored by the Consumer Direction subcommittee below (see 2.16), but the stakeholder group believes that barriers exist in the provider enrollment process that impede the ability of family members to be service providers.

The stakeholder group noted 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 ULTCB workgroup recommends 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 be less burdensome to support allowing family members to be paid providers.
- It was noted during the 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/payer sources for services and supports, both Medicaid and non-Medicaid. This needs to be initiated as early as possible. Ohio should 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.
- 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 stakeholder group discussed several new incentives to support informal caregivers as well:

- 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 as an alternative 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.

The stakeholder group identified transportation as a critical element in successful community placement. The group identified a number of challenges:

- No real regional or state policy directive for the delivery of transportation services by the county departments of jobs and family services (e.g., inter-county transportation and state-to-state transportation for needed and authorized services). Transportation policy should be coordinated at both the state and regional level. While good local models do exist, the “path of least resistance” is for each system to maintain its own vehicles and ridership policies.
- 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.

The ULTCB workgroup recommends the following strategies to improve access to transportation services:

- Transportation vouchers.
- Assisted or supported transportation.
- Bus passes for fixed route transport.
- County-wide coordination of transportation services with all transportation providers.
- Supplement available services with families, friends, neighbors and/or other 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.

Recommendations – unmet needs in community settings

55. The following additional services should be provided to close gaps in the system:

- a. Self-Directed Personal Assistant Services on the State Plan***
- b. The availability of transition coordination services as established in Ohio’s HOME Choice demonstration should be expanded.***
- c. Medication management and/or prescription coordination***
- d. In-home and institutional respite and/or sitter services under the State Plan***

56. The following services that are currently limited in nature should be expanded.

- e. Behavioral health services***
- f. Program of All-inclusive Care for the Elderly (PACE)***
- g. Expedited access to waivers for hospice consumers***
- h. Adult day services within the state plan***
- i. Specialty equipment and assistive devices***
- j. Extended State Plan nursing, physical therapy, speech therapy, and occupational therapy***

57. Barriers that would prevent expansion of services or development of any new service should be addressed:

- a. 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;**
- b. Regulations should be amended to permit the reuse of adaptive and assistive devices and durable medical equipment;**
- c. ‘Bridge Services’ should be available as a consumer transitions from a nursing facility to the community;**
- d. Establish a comprehensive provider registry, ensuring it is user friendly and crosses all delivery systems;**

58. “Informal supports” should be strengthened in Ohio:

- a. During the assessment process, assessors should identify all informal, unpaid supports in place;**
- b. Develop and/or revise provider qualifications to be less burdensome to support allowing family members to be paid providers;**
- c. Ohio should expand the capacity for, and broaden the scope of caregiver support groups, and the family resource center and long term care consultation concepts;**
- d. Expand access to legal services for the consumer’s informal support network;**
- e. Research the development of a state tax credit for families providing extraordinary care;**
- f. Research the expansion of the concept behind Health Savings Accounts to allow families to save money as an alternative to Medicaid;**
- g. Research the Community Living Assistance Services and Supports (CLASS) Act of 2007 which would create an insurance program for adults who become functionally disabled;**
- h. Reduction of estate recovery if family members provide gratis extraordinary care to the consumer;**
- i. Creating an emergency fund (one-time crisis-oriented) that would be available for family members to access to prevent admission to an institution;**
- j. Development of local-level co-ops of providers and consumers or informal supports that allow consumers/families access to additional back up coverage;**

- 59. Access to transportation services should be improved by increasing access to:**
- k. Transportation vouchers.**
 - l. Assisted or supported transportation.**
 - m. Bus passes for fixed route transport.**
- 60. Provider specifications and requirements should be streamlined across delivery systems leading to decreased administrative burden and increased access to qualified providers, specifically:**
- a. Develop universal and/or similar monitoring requirements established by the state agencies. (e.g., accepting reviews of other state agencies). This is also addressed by the quality assurance/quality management subcommittee below in 2.17.**
 - b. Develop qualification requirements for provider staff or independent providers across the state agencies for similar services. (e.g., standardized credentialing).**
 - c. Align Bureau of Criminal Identification and Investigation (BCII) background check requirements.**
 - d. Develop career lattices/professional development.**
 - e. Provide an automated billing system.**
- 61. County-wide coordination of transportation services with all transportation providers should be facilitated by state policy and by the regional collaboratives recommended in 21, above.**
- 62. Ohio should limit liability for volunteers or family members through the Volunteer Protection Act.**
- 63. Revise the provider specifications and requirements for non-medical transportation to increase potential pool of qualified providers.**

2.14 Housing with Supportive Services

The subcommittee recognizes that a special “gap” exists in housing and supportive services and accordingly asked a group of stakeholders to develop recommendations designed to remedy this gap. The stakeholder group addressed five housing-related areas: home maintenance, repair, and accessibility; adult care facilities and adult foster homes; assisted living and other supported housing; service coordination; and affordability of housing.

2.14.1 Home Maintenance, Repair and Accessibility

While Ohio Medicaid waivers provide for home modifications as necessary, the waiver programs do not address the cost of maintenance or repair. The ULTCB workgroup recommends that the state provide financial incentives to local governments to use a larger portion of their resources (federal Community Development Block Grant - CDBG and HOME funds) for home maintenance and repair. To increase the availability of accessibility modifications needed by consumers, the workgroup recommends that Medicaid rules be revised to reimburse providers for the cost of materials only in situations where the labor is donated by charitable or faith-based organizations. Because providers have large up-front expenses for the purchase of materials to make these

modifications, payment to providers should be expedited so that they do not have to wait until the job is completed for reimbursement of these expenses. The pool of professionals (currently limited to occupational and physical therapists) who can perform assessments and prescribe home modifications should be expanded.

The physical design of a home or apartment directly and profoundly affects the ability of its residents to function independently, particularly for people with disabilities or anyone who hopes to “age in place”. A well-designed, user-friendly living environment reduces the need for personal assistance with activities of daily living, reduces the risk of accidents and injury, and reduces the future need for expensive structural modifications. Ohio taxpayers spend more than \$3 million annually in Medicaid funds and MRDD capital funds to modify entrances and bathrooms in existing homes for people with disabilities. That figure does not include local government funds, Ohio Housing Trust Funds, local property tax levy services, charitable donations, or the cost to families. The average cost (nationally) of including one zero-step entrance when constructing a new home is \$150. Estimates of the average cost to Ohio taxpayers to add a ramp to an existing home ranges from \$2800 to \$5,000.

Therefore, the ULTCB workgroup recommends reducing the need for future taxpayer investment in home modifications by adding a “visitability” requirement to the Ohio Residential Code for all new construction of 1,2 & 3 family homes. “Visitability” generally includes, at a minimum, one zero step entrance into the home, and an accessible half bath on the first floor. State officials responsible for enforcement of accessible housing laws and codes should be encouraged to increase their efforts to enforce these codes. Education and training on accessibility laws and best practices should be provided to architecture students, builders, local plans examiners and code enforcement officials. Accessibility modifications should be included as part of the discharge plan for consumers leaving a nursing facility, and waiver funds should be authorized to enable home modifications to be completed prior to discharge from the nursing facility.

2.14.2 Adult Care Facilities and Adult Foster Homes

Adult care facilities (ACFs) and adult foster homes house between 1 and 16 individuals. Adult care facilities (3-16 beds) are licensed by the Ohio Department of Health. Adult foster homes (1-2 beds) are certified by the Area Agencies on Aging and are not required to be licensed. ACFs are an important component of the mental health system as over 50% of the residents of these facilities have some form of serious mental illness. A minimum amount of funding from the Residential State Supplement (RSS) program is used in these settings, but Medicaid funds are not currently available to these facilities in Ohio. ACFs and AFHs that provide a supportive, residential, family-like environment may be the preferred setting for some individuals who are unable or unwilling to live alone. There are few or no quality adult care facilities in many areas of the state. The quality of Ohio’s 651 Adult Care Facilities ranges widely. Although a significant number offer good care to their residents, others provide very little in the way of supportive services. For several decades, Ohio’s government policies, funding and priorities have

not supported the shared living model in general and group homes in particular. Since licensure began in November 1990, 993 licensed facilities have closed.

RSS clients require a protective level of care. Medicaid waiver clients must be assessed at a NF level of care. Therefore, RSS clients are by definition not eligible for Medicaid waivers. The ULTCB workgroup recommends that ways be identified to increase funding for high-quality adult care facilities and adult foster homes. This should include exploration of how to allow these providers to become personal care providers. In addition, Ohio should create a new state plan option (1915i, created by the Deficit Reduction Act) to offer Medicaid-funded services to the residents living in these settings.

Criteria should be developed to establish the quality threshold that these providers would be expected to meet in order to receive additional funding.

2.14.3 Assisted Living

Ohio currently offers an assisted living Medicaid waiver program. However, it has been underutilized by consumers for a variety of reasons. The Scripps Gerontology Center is currently evaluating the waiver program, but the ULTCB workgroup offers some concrete recommendations to improve the existing program.

- Expand eligibility for the program by the General Assembly to include consumers meeting level of care and income eligibility requirements who currently reside in the community.
- ODA should evaluate the personal needs allowance for waiver consumers (see recommendation 54e).
- Support amending federal law to waive Medicare Part D prescription drug co-payments as is currently the case for nursing facility residents.
- Allow retroactive Medicaid eligibility to be applied for residents in assisted living in the same fashion as it is for nursing facility residents.
- Create a state-funded room and board subsidy for couples and individuals who are low income but not eligible for SSI because Medicaid funds cannot be used to subsidize room and board in assisted living.
- Explore the impact of provider requirements to allow participation by older residential care facilities that currently do not qualify to participate in the assisted living waiver;

- Currently the state provides a tiered-rate system throughout Ohio. Explore more variability in how rates are set.⁴

The ULTCB workgroup also recommends that Ohio explore other supportive housing alternatives that have proven successful in other states. This is included as a deliverable in the current waiver evaluation by the Scripps Gerontology Center.

2.14.4 Service Coordination

Service coordination is a feature in some subsidized housing in Ohio already (some service coordinators are paid from federal funds; some receive a very minimal amount from the Ohio Housing Trust Fund. The service coordinator brokers services needed by the resident by providing low income renters with information and assistance to access other services and supports, leverages a multitude of public and private community resources, and reduces calls by tenants to emergency services. The service coordination concept fits well in a “no wrong door” system by linking tenants to the local service delivery network. The ULTCB workgroup recommends that resources be used to fund additional service coordinators. Pennsylvania in particular is examining how best to use service coordination to augment services and supports to tenants.

2.14.5 Affordability

The ULTCB workgroup recommends a tenant-based rental assistance program for HOME Choice participants since the availability of other rental assistance programs has been severely restricted by lack of federal funding. Past efforts to successfully transition nursing facility residents to community living have highlighted the critical importance of housing assistance for these consumers.

The workgroup also recommends that ODJFS fund a position within the Ohio Housing Finance Agency to facilitate cooperative efforts in housing and supportive services between these two key agencies.

⁴ ODA is currently in the process of contracting for an independent review of the rates it pays providers for PASSPORT and assisted living.

Recommendations - Housing with Supportive Services

- 64. The state should provide financial incentives to local governments to use a larger portion of their resources for home maintenance, accessibility modifications, and repair.***
- 65. Revise Medicaid rules to reimburse providers for the cost of materials only in situations where the labor is donated by charitable or faith-based organizations.***
- 66. Payment to providers for home modification services should be expedited so that they do not have to wait until the job is completed for reimbursement of these expenses.***
- 67. The pool of professionals who can perform assessments and prescribe home modifications should be expanded.***
- 68. Add a “visitability” requirement to the Ohio Residential Code for all new construction of 1,2 & 3 family homes***
- 69. State officials responsible for enforcement of accessible housing laws and codes should be encouraged to increase their efforts to enforce these codes.***
- 70. Education and training on accessibility laws and best practices should be provide to architecture students, builders, local plans examiners and code enforcement officials..***
- 71. Accessibility modifications should be included as part of the discharge plan for consumers leaving a nursing facility, and waiver funds should be authorized to enable home modifications to be completed prior to discharge from the nursing facility***
- 72. Specific improvements to Ohio’s assisted living Medicaid waiver program should be considered:***
 - a. Expand eligibility for the program to include consumers meeting level of care and income eligibility requirements who currently reside in the community.***
 - b. Support amending federal law to waive Medicare Part D prescription drug co-payments as is currently the case for nursing facility residents.***
 - c. Create a state-funded room and board subsidy for couples and individuals who are low income but not eligible for SSI because Medicaid funds cannot be used to subsidize room and board in assisted living.***
 - d. Explore the impact of provider requirements to allow participation by older residential care facilities that currently do not qualify to participate in the assisted living waiver;***
 - e. Explore more variability in how rates are set.***
- 73. Identify ways to increase funding for high-quality adult care facilities and adult foster homes.***
- 74. Explore how to allow these providers to become personal care providers. In addition, Ohio should create a new state plan option (1915i, created by the Deficit Reduction Act) to offer Medicaid-funded services to the residents living in these settings.***

- 75. Criteria should be developed to establish the quality threshold that these providers would be expected to meet in order to receive additional funding.*
- 76. Ohio should explore other supportive housing alternatives that have proven successful in other states.*
- 77. Resources should be used to fund additional service coordinators.*
- 78. Create a tenant-based rental assistance program for HOME Choice participants*
- 79. ODJFS should fund a position within the Ohio Housing Finance Agency*

2.15 Certificate of Need and nursing facility capacity

In order to accurately analyze the future of access, capacity, and unmet needs for Ohioans affected by the long term care delivery system, it is necessary to examine facility based capacity and related issues. These recommendations seek to improve the balance of long term care services and supports options for consumers, while ensuring access to quality facilities throughout the State of Ohio.

The Certificate of Need (CON) Program was implemented to ensure public access to quality, long-term care services by requiring review and approval of activities involving long-term care beds. Activities that require Certificate of Need review and approval include:

- The development of a new or replacement of an existing long-term care facility through the relocation of existing beds within the same county.
- The renovation of a long-term care facility with a capital expenditure of \$2 million or more.
- The relocation of existing long-term care beds from one site to another within the same county.

The current capacity of long-term care beds in Ohio is, in part, the result of a bed need formula contained in Rule 3701-12-23 of the Administrative Code. The bed need formula was initially developed in the 1980's and was applied biennially through June 30, 1993 to identify the bed need or excess for each county. During that time, a CON could be granted for the addition of new long-term care beds within a county where a bed need was identified. Since July 1, 1993, the Director of Health has been statutorily prohibited from projecting the need for long-term care beds and from accepting for review any CON application for an increase in long-term care beds that is not attributable to the relocation of existing beds within a county. The current moratorium on new long-term care beds is due to expire on June 30, 2009 (although historically it is renewed in each biennial budget). This set of recommendations is specific to nursing facilities because the future need for ICF/MR facilities is addressed by the MRDD "futures" report.

The ULTCB workgroup recommends that the current number of nursing facility beds in Ohio serve as an overall cap for the total number of nursing facility beds, given current occupancy rates. The Certificate of Need program should be maintained, but the Director of the Ohio Department of Health should convene a stakeholder group to review existing CON criteria, and consider the need for and impact of the movement of beds between counties (currently prohibited). This group should be convened immediately to consider short-term strategies and demonstrations that add flexibility to current requirements. Criteria should be adopted to ensure access to facility-based services for all populations including Ohioans living in inner cities and rural areas. As part of the process, the stakeholder group should consider whether the current law prohibiting the use of a long-term care bed need formula should be revisited.

Beyond CON, the workgroup recommends that Ohio explore the feasibility and appropriateness of implementing a nursing facility bed buyback or conversion program.

Recommendations - Certificate of Need and nursing facility capacity

- 80. The current number of nursing facility beds in Ohio serve as an overall cap for the total number of nursing facility beds.***
- 81. The Director of the Ohio Department of Health should convene a stakeholder group to review existing CON criteria, and consider the need for and impact of the movement of beds between counties.***
- 82. Criteria should be adopted to ensure access to facility-based services for all populations including Ohioans living in inner cities and rural areas.***
- 83. As part of the process, the stakeholder group should consider whether the current law prohibiting the use of a long-term care bed need formula should be revisited.***
- 84. Explore the feasibility and appropriateness of implementing a nursing facility bed buyback or conversion program***

2.16 Consumer Direction

Allowing consumers the maximum opportunity to self-direct their services is a policy of every state that has achieved a transformed long-term services and supports system.

The Consumer Direction subcommittee has a goal of incorporating consumer direction tenets into all facets of Ohio's long-term services and supports systems.

The subcommittee believes that participation in consumer directed care opportunities must be voluntary, flexible enough to meet the consumer's needs, and contingent upon whether the consumer and/or authorized representative can adequately direct his/her own care. The concept of "dignity of risk" and the consumer's right to make bad decisions is inherent in the concept of consumer direction and will need to be embraced in any consumer-directed care endeavors implemented by the state. For the latter to be possible, and to assure ongoing consumer participation, a comprehensive set of tools and resources

must be created at the state level, and provided to interested consumers and/or their authorized representatives for the purpose of developing the skills necessary to direct their own care and services. Moreover, for consumer direction to be effective, it must be designed as simply as possible.

Every consumer should be able to direct as much of his/her care as he/she has the desire and ability to direct. To do so, the consumer should:

- Be able to communicate his/her specific needs to the provider.
- Possess the judgment and skills necessary to manage his/her specific needs.
- Select his/her team members and participate in the development of service plans and plans of care.
- Successfully complete training about how to hire, supervise, dismiss and evaluate a worker, complete/approve timesheets, and resolve conflicts, etc.
- Direct his/her care while staying within a budget or under a cost cap established for the consumer as part of the specific program in which he/she is enrolled.
- Work with his/her case manager to establish a back-up plan for situations in which the primary provider is unable to deliver services at the scheduled time.
- Consumer direction and care management strategies should support consumer negotiated rates.
- Play a major role in monitoring the provider to determine if care is being provided in accordance with the consumer's service plan and/or the consumer's plan of care as mutually agreed upon by the physician, the consumer and/or authorized representative and the provider.

Additionally, the ULTCB workgroup recommends that consumers have greater choice regarding who they can choose to be their paid provider. Specifically, legally responsible family members (i.e., spouses and parents of minor children) should be permitted to be paid Medicaid providers of personal care services in the State's 1915(c) HCBS waivers. A number of other states are allowed to pay legally responsible family members to provide Medicaid services through 1115 waivers, and CMS recently approved a request by Minnesota to do the same as part of its 1915(c) waivers. In order for this to be allowed under a 1915(c) waiver, a State must provide a definition within the waiver application of what it considers to be "extraordinary care", i.e., care that is beyond what parents would normally do/would be expected to do for their child, or what spouses would be expected to do for each other. For parents of minors to participate, the service must be necessary to meet at least one assessed need that is identifiable when the child is determined waiver eligible. Legally responsible family members must meet all provider qualifications, conditions of participation and training standards as do all other providers.

The consumer may furnish or direct the training, and the provider must provide return demonstration of his/her competency.

The ULTCB workgroup also recommends that the state permit unused service dollars that are appropriated within the consumer's budget or cost cap to be used to purchase other needed services (i.e., home modifications, goods and services, etc.) while the consumer is enrolled in the program.

As a means of making consumer direction more widespread in the State of Ohio, the ULTCB workgroup also recommends:

- Develop and use innovative methods to pay for goods and services and other selected services (i.e., vouchers and/or debit cards, etc.).
- Establish and maintain a statewide registry of providers that lists providers' training, certification and/or approval, as well as information about qualifications, criminal record check requirements, monitoring and sanctioning, etc. The workgroup also recommends exploration of the potential use of the existing ODMR/DD registry of certified providers and/or the long term care consumer guide as the basis for the statewide provider registry system. Consumer input should be sought in developing the system.
- Review of Medicaid eligibility requirements in all existing Ohio waivers to assure consistent application, as appropriate, and to explore the expansion of opportunities for consumer eligibility (i.e., Medicaid buy-in, and allowing consumers to set aside patient liability for self-payment of goods and services, and rent assistance, etc.).
- Expand opportunities for consumer direction within the Medicaid state plan using the 1915(j) Medicaid state plan option for self-directed personal care assistance services (see recommendation 58a above).
- Expand person-centered care programs within nursing facilities.
- Expand opportunities for consumer direction through Ohio's current 1915(c) waivers, and/or implementation of new Medicaid waivers based upon consumer direction practices.
- Expand opportunities for consumer direction within non-Medicaid-funded programs funded or provided by other state and local entities (i.e., levies and grants, etc.).
- Provide access to an independent consumer-focused advocate that can assist consumers receiving long term care services and supports.

- Implement and coordinate quality assurance mechanisms across all systems for the purpose of minimizing unnecessary risks, providing quality services, monitoring consumer outcomes (and reporting negative outcomes) and assuring the consumer's health and welfare.

Regardless of whether or not care management is being provided to a consumer who is self-directing, and consistent with the ULTCB Care Management subcommittee's definition below, it is recommended that care management embrace person-centered planning as an integral component (i.e., the needs and preferences of the consumer and his/her family must be the primary consideration when developing the consumer's care plan). Care management must also include monitoring of and communication with the consumer and/or authorized representative to assure the consumer's health and welfare.

The ULTCB workgroup also recommends that HCBS waiver consumers who are self-directing be granted budget authority in which he/she is assigned a budget within which funds can be used to purchase needed waiver services identified during the assessment process. Consumers would be permitted to negotiate rates up to the Medicaid ceiling for these services and any savings accrued over the budget period could be carried over in order to afford the consumer the flexibility to purchase other needed services (i.e., home modifications, goods and services, etc.) while still enrolled in the program.

The Centers for Medicare and Medicaid Services, in its waiver application instructions, underscores that financial management services (FMS) are "a critical support" for consumer direction. 1915(c) waivers do not permit direct payment to consumers, whether for reimbursement of consumer expenses or to allow the consumer to directly pay his/her service provider. Instead, CMS requires that financial transactions be made through a fiscal intermediary. FMS entities generally function similar to a bank for the purpose of receiving and disbursing public funds, and tracking and reporting on the consumer's budgeted funds; process and pay invoices for goods and services in the consumer's approved care plan; prepare and distribute reports to the consumer and other approved entities; assist the consumer in verifying providers' legal work status; collect and process providers' timesheets; and operate a payroll service that includes appropriate withholdings, including taxes to be withheld. FMS entities are intended to assist the family or consumer to direct and manage their own care and services.

The ULTCB workgroup recommends that the State examine the various types of FMS entities used in the delivery of consumer-directed care around the country (and the legal implications of each) to (a) determine the model that is best suited to accommodate the needs of Ohio's long term care service and support system (i.e., vendor agent, agency with choice, etc.), and (b) ascertain the feasibility of allowing an FMS to execute Medicaid provider agreements as part of consumer direction, thus expediting the ability of the provider to furnish services to the consumer.

The workgroup also recommends that the State study and determine the various types of employer status available to the consumer (i.e., employer of record, co-employer of record and managing employer, etc.). Further, the state should explore and make a

recommendation to EMMA as to whether the concept of employer status should be uniformly applied across all long term care systems.

In addition, the ULTCB workgroup recommends that the State study the feasibility of utilizing organized health care delivery systems (OHCDS) as another means for offering opportunities for service delivery in the long term services and supports system and make a recommendation to EMMA as it makes decisions on future financing and delivery structures of Ohio's Medicaid programs. According to 42 CFR 447.10(b), an OHCDS is a public or private organization that operates under an agreement with the state Medicaid agency and provides at least one Medicaid service directly (i.e., using its own employees) and subcontracts with other qualified providers to furnish other services. When the OHCDS provides the service directly, it is reimbursed by the Medicaid agency; when a subcontractor provides the service, it is reimbursed by the OHCDS. Both the OHCDS and the subcontractors must meet all of the applicable provider requirements. Examples of OHCDS entities include, but are not limited to clinics, FMS entities, group practices and health maintenance organizations.

Additional recommendations from the ULTCB workgroup in regard to enhancing consumer direction include:

- Use Limited Medicaid Provider Agreements as a way to execute the purchase of goods and services (e.g., one-time agreements to purchase goods at retail establishments, etc.).
- Explore the legal implications of consumer direction (i.e., employer status, taxation, and unionization of independent, non-agency providers, etc.).
- Establish consumer protections that assure that providers cannot change timesheets after the consumer and/or authorized representative has signed them and before they are submitted for reimbursement.
- Establish safeguards against consumer and provider fraud.
- Assure uniform due process for consumers and providers alike.

Recommendations – Consumer Direction

- 85. Every consumer should be able to direct as much of his/her care as he/she has the desire and ability to direct.***
- 86. A comprehensive set of tools and resources must be created at the state level, and provided to interested consumers and/or their authorized representatives for the purpose of developing the skills necessary to direct their own care and services.***
- 87. Legally responsible family members (i.e., spouses and parents of minor children) should be permitted to be paid Medicaid providers of personal care services in the State's Medicaid waivers.***
- 88. Permit unused service dollars that are appropriated within the consumer's budget or cost cap to be used to purchase other needed services***
- 89. Consumer direction and care management strategies should support consumer negotiated rates.***
- 90. Develop and use innovative methods to pay for goods and services and other selected services (i.e., vouchers and/or debit cards, etc.).***
- 91. Establish and maintain a statewide registry of providers that lists providers' training, certification and/or approval, as well as information about qualifications, criminal record check requirements, monitoring and sanctioning..***
- 92. Review Medicaid eligibility requirements in all existing Ohio waivers to assure consistent application, as appropriate, and to explore the expansion of opportunities for consumer eligibility.***
- 93. Expand person-centered care programs within nursing facilities.***
- 94. Expand opportunities for consumer direction through Ohio's current 1915(c) waivers, and/or implementation of new Medicaid waivers based upon consumer direction practices.***
- 95. Expand opportunities for consumer direction within non-Medicaid-funded programs funded or provided by other state and local entities (i.e., levies and grants, etc.).***
- 96. Provide access to an independent consumer-focused advocate that can assist consumers receiving long term care services and supports.***
- 97. Implement and coordinate quality assurance mechanisms across all systems for the purpose of minimizing unnecessary risks, providing quality services, monitoring consumer outcomes (and reporting negative outcomes) and assuring the consumer's health and welfare.***

98. *Examine the various types of FMS entities used in the delivery of consumer-directed care to determine the model that is best suited to accommodate the needs of Ohio's long term care service and support system and ascertain the feasibility of allowing an FMS to execute Medicaid provider agreements to facilitate consumer direction.*
99. *Study and determine the various types of employer status available to the consumer (i.e., employer of record, including an exploration of the legal implications of consumer direction (i.e., employer status, taxation, and unionization of independent, non-agency providers, etc.).*
100. *Recommend to EMMA whether the concept of employer status should be uniformly applied across all long term care systems.*
101. *Recommend to EMMA the feasibility of utilizing organized health care delivery systems (OHCDS) .*
102. *Use Limited Medicaid Provider Agreements as a way to execute the purchase of goods and services (e.g., one-time agreements to purchase goods at retail establishments, etc.).*
103. *Establish consumer protections that assure that providers cannot change timesheets after the consumer and/or authorized representative has signed them and before they are submitted for reimbursement.*
104. *Establish safeguards against consumer and provider fraud.*
105. *Assure uniform due process for consumers and providers alike.*

2.17 Quality Management/Quality Assurance

As a guiding principle the subcommittee recommended that Ohio not add new levels of measurement where they currently exist (e.g., nursing homes complete the Minimum Data Set; home care agencies use the Outcome and Assessment Information Set) and be mindful of the cost and usefulness of data collected so as to not increase provider burden.

How best to assure the quality of long-term services and supports has been a longstanding and contentious issue for states. In Ohio, as in many other states, the quality approach adopted has relied heavily on an “inspect and punish” model in which a regular state survey emphasizing compliance dominates. There are serious limitations to this approach overall; when applied to home and community-based services the “inspection model” is even more problematic. The Centers for Medicare and Medicaid Services has realized this existing flaw in quality management systems and has offered a Quality Framework to states for their use in Medicaid waiver programs. As opposed to the “inspect and punish” model, the Quality Framework focuses on problem identification and remediation, directly enlisting the service provider in continuous quality improvement activities. The ULTCB workgroup recommends Ohio use the Quality Framework across all long-term care settings, acknowledging that it might not be possible to apply some parts of the matrix to individual independent providers (these are providers that are not affiliated with

an agency) but in those cases apply the Quality Framework to the system of independent providers.

Most commonly quality assurance approaches largely ignore consumers. Instead they rely on quantifiable indicators of quality that are easily measurable and documented, such as hours of worker training and case manager sign-off on plans of care. Although these indicators may provide useful information to prevent or correct adverse outcomes, consumer centered quality measures are necessary to gauge the success of the system in helping consumers achieve positive outcomes. Currently Ohio does measure customer satisfaction for some services and programs. For example, the Long-Term Care Consumer Guide measures customer satisfaction with nursing facilities and assisted living facilities. The ULTCB workgroup recommends that customer satisfaction measures be developed and implemented for other long-term services and supports as well.

- Apply consumer satisfaction across all long-term services and supports, using core questions and adding setting-specific questions.
- Develop a unified method of data collection related to satisfaction.
- Satisfaction should be measured by a third party (i.e., not the provider of service).
- In areas where satisfaction is not currently available as a measure of quality it should be developed.
- Satisfaction with smaller providers and consumer-directed services utilizing independent/individual providers should be available in aggregate form because confidentiality of responses cannot be ensured for a small number of consumers.
- Include all levels of service (e.g., home repair, homemaker, transportation in addition to nursing and personal care).

Another problem addressed by this subcommittee (and two others) is that access by consumers to good information that will help to improve the quality of services is quite limited. The ULTCB workgroup recommends that Ohio expand the Long-Term Care Consumer Guide to provide consumers with information about an expanded array of provider types and develop methods of increasing public awareness of the availability of information. This information would include customer satisfaction as noted in the preceding recommendation as well as regulatory data where available, and web-based feedback logs.

The ULTCB workgroup recommends that the historic reliance on structure and process requirements for providers be augmented with outcome measures that can be used across settings with specific application to the type of provider and in consideration of other factors such as consumer age groups. The workgroup also recommends financial incentives be based on quality and other measures such as providing services in hard-to-

serve areas or for hard-to-serve populations. Incentives should use measurable quality indicators or criteria pertinent to the provider type, similar to the nursing home quality incentive payment as outlined in 5101:3-3-58 of the Administrative Code. The incentive should be formulated as an add-on payment to reimbursement.

Recognizing that there are key differences between *quality* and *regulation*, the ULTCB workgroup recommends that Ohio identify provider types that are not regulated and explore whether licensing and periodic review would be appropriate as a means of demonstrating a *minimum* level of regulatory compliance.

Currently a service provider who wishes to provide services in more than one program is forced to go through multiple certification processes. For example, a PASSPORT provider already certified by ODA would also require certification from ODMRDD if the provider wishes to serve consumers in the Individual Options waiver. The ULTCB workgroup recommends the development of a reciprocal process across all systems that would recognize certification by another state agency, resulting in a more efficient and flexible environment for providers in addressing consumer need.

Recommendation - Quality Management/Quality Assurance

- 106. The state should not add new levels of measurement where they currently exist and should be mindful of the cost and usefulness of data collected so as to not increase provider burden.***
- 107. Use the CMS Quality Framework across all long-term care settings***
- 108. Develop and implement consumer satisfaction measures for additional long-term services and supports:***
 - a. Apply consumer satisfaction across all long-term services and supports, using core questions and adding setting-specific questions;***
 - b. Develop a unified method of data collection related to satisfaction;***
 - c. Satisfaction should be measured by a third party (i.e., not the provider of service);***
 - d. Satisfaction with smaller providers and consumer-directed services utilizing independent/individual providers should be available in aggregate form; and***
 - e. Include all levels of service (e.g., home repair, homemaker, transportation in addition to nursing and personal care).***
 - f. The virtual "front door" implemented to support consumer access to long-term services and supports should include the opportunity for consumers to provide feedback on the quality of the services they receive and a mechanism should be developed to respond to and resolve problems and issues along with consumers in a regulated timely manner.***
- 109. Expand the Long-Term Care Consumer Guide to provide consumers with information about an expanded array of provider types.***
- 110. Structure and process requirements for providers should be augmented with outcome measures.***
- 111. Develop financial incentives based on quality and other measures as an add-on payment to reimbursement.***
- 112. Identify provider types that are not regulated and explore whether licensing and periodic review would be appropriate as a means of demonstrating a minimum level of regulatory compliance.***
- 113. Develop a reciprocal process across all systems that would recognize certification by another state agency.***

2.18 Care Management

The current method of providing long term services and supports is fragmented and unique to each delivery system; so one can imagine that the framework for delivering care management is also unique and different to each system. The Unified Long Term Care Budget provides the opportunity to bring consistency and a standard purpose to care management. Current care management practices and definitions were discussed and

common goals and principles used for the foundation of building the care management component of the long term care system.⁵

Philosophically, the care management system should reflect a seamless and coordinated transition of the consumer through various stages of the care management process from access to assessment to care planning and service delivery. The process should facilitate integrated and comprehensive delivery of appropriate services in the appropriate setting.

The care management process includes provisions for continuous monitoring of the consumer's evolving needs and a timely response to same. The consumer's strengths, special abilities, and cultural, social, health needs are given consideration in the whole-person approach to care planning and service delivery. The delivery of high quality, efficient, timely consumer driven care which influences positive outcomes is critical.

A common definition for care management across systems and programs will further unite the long term care system and provide the framework and guiding principle for care management activities. The ULTCB workgroup recommends the following definition for care management:

Care Management is a holistic, collaborative, consumer-driven process for the provision of quality, culturally competent, health and supportive services through the effective and efficient use of available resources in order to maximize the individual consumer's quality of life based on his/her capacity and preferences.

The ULTCB workgroup recommends that this definition for care management be adopted and implemented for all consumers receiving long-term care services and supports. If necessary, change the definition of care management in waiver applications, the state plan, and any related administrative code rules.

The care manager, in a unified system of long-term services and supports, will wear many hats and fill many roles. Nationally the role of a care manager has evolved during the past two decades due in part to individuals with long-term care needs demanding more choice, control and authority in directing their own care and services. This movement towards consumer choice and direction will be supported by the care manager by focusing on managing the *services* and not managing the *individual*. Consumer choice and person centered planning should be the foundation from which care management activities occur.

Care management is not one strategy or approach; but reflects an array of approaches based on the consumer's capacity and the level of decision making, control and autonomy. The role of the care manager is guided by the purpose of care management which is to authorize and ensure the provision of quality, culturally competent, health and supportive services through the effective and efficient use of available resources in

⁵ The discussion of care management strategies may be impacted by new federal regulations governing Medicaid-funded targeted case management which were issued by CMS as an Interim Final Rule (IFR) on March 4, 2008. Because Congress may yet choose to delay the implementation of the rule (see H. 5613), the care management subcommittee did not consider the impact of the IFR.

order to maximize the individual consumer's quality of life based on his/her capacity and preferences (from the definition above). In doing so the care manager may take on the role of an advocate, coach, teacher, facilitator, broker, negotiator, counselor, coordinator, assessor, evaluator, gate keeper, record keeper and/or researcher.

The individual is linked with a care manager upon being determined eligible for long term services and supports. This is the demarcation point between where the informed navigator's role *ends* and where the care manager's role *begins*. The care manager will assist the individual through a variety of activities such as determining service needs through assessment, developing care plans, authorizing services, referring and linking to services and monitoring and follow up activities to ensure the individual's needs are being met, the individual is satisfied with the services and the individual continues to be eligible for services in the long term care system. The care manager will not assume a role as a direct service provider nor should the care management entity be permitted to provide any direct service. The ULTCB workgroup recommends that any potential conflict of interest within services covered by the unified budget be eliminated. This means that care management should not be provided by an entity/agency that is providing direct services.

The care manager's role must be adaptable to the variety of settings and programs providing long term care services and supports. This model of care management is based on the design of the current long term services and supports delivery system which consists of a community component (state plan – often through enrollment in an ABD managed care plan, Medicaid waivers, PACE and other sources) and institutional components. There needs to be acknowledgement that some delivery systems have certain responsibilities inherent to their system; for instance nursing facilities are required by federal law to develop a written plan of care which describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met; or the requirement for the PACE program to provide a benefit package for all participants, regardless of the source of payment, which includes all Medicare-covered items and services and all Medicaid-covered items and services, as specified in the state's approved Medicaid plan. Therefore the role of the care manager must also be flexible to accommodate the varying responsibilities of the distinct components of the delivery system.

For example, the role of a care manager for an individual enrolled on the PACE program may be limited to assessing continuing eligibility, ensuring the consumer is in the setting of his/her choice and facilitating changes to other long term service delivery systems at the consumer's request. The role of a care manager for an individual in an institutional setting will focus on assessing continuing eligibility, appropriateness/satisfaction of placement, discussion of community options, and the facilitation if the individual desire to transition to the community.

The care manager's role for individuals in a community setting would include the responsibility of ensuring access to and coordination of health and supportive services; coordinating and managing all the services, including state plan services, received within

the long term care system; assessing for continuing eligibility for long-term services and supports; and monitoring and follow up activity related to service needs.

With these concepts in mind the ULTCB workgroup recommends the following related to the role of the care manager:

- Coordinate and collaborate with all available funding sources;
- Assess ongoing eligibility for long term care services and supports;
- Assess service needs; authorize the long-term services and supports identified as part of the unified budget to meet those needs acknowledging that certain services (e.g., nursing facility, PACE, and ABD managed care plans) are fundamentally responsible for managing specific services and supports; and monitor the provision of quality, culturally competent health and supportive services;
- Use available resources efficiently and effectively; and
- Maximize the individual consumer's quality of life based on his/her capacity and preferences.

Every consumer receiving long-term services or supports would benefit from some level of care management. The minimal level of care management might be as simple as a periodic review of functional eligibility to validate the continuing eligibility for the services and supports provided. More intensive levels of care management may include activities such as developing care plans authorizing services, referring and linking to services, monitoring and follow up activities to ensure the consumer's needs are being met, that the consumer is satisfied with the services and that services are provided based on the consumer's needs and preferences. The ULTCB workgroup recommends that care managers be utilized for all long term services and supports whether provided in an institutional or community setting. The role of the care manager must be flexible to adapt to the unique characteristic of each delivery system. Protocols and standardized criteria should be developed to guide the degree of care management.

The last area considered by the Care Management subcommittee was how does the care management system for long-term services and supports integrate with existing managed care plans? This includes both Medicare managed care plans and the Medicaid ABD managed care plans.

House Bill 66 mandated the statewide expansion of the Medicaid managed care program for the entire Covered Families and Children (CFC) population and a portion of the Aged, Blind and Disabled (ABD) population. Excluded from the ABD population are individuals who are dually eligible (Medicare/Medicaid), children, waiver consumers, consumers in institutions and consumers with a Medicaid spend-down. At the same time Ohio experienced an emergence of Medicare Special Needs Plans.

Managed care plans share similar goals to the care management system for long term services and supports. Both value the right care in the right place, the least restrictive setting and care management as a central strategy for management and oversight of the delivery of cost effective, person centered, quality services.

Ohio's Medicaid managed care plans point out that they also provide some long term services and supports, as they have recently become responsible for the first two months of nursing facility services for their members, and provide services such as nursing and personal care typically associated with long term care needs. It is imperative that the diverse systems that play a role in the care management process develop a mechanism to enhance coordination for consumers and efficiently manage the cost of care.

In order to be effective the system must first be able to identify the common consumers and then have a structure from which to work. Because of the complex nuances of funding source standards, benefit/services coverage, eligibility, resources, etc., a comprehensive plan is required. This plan could lead to the design/execution of a Memorandum of Understanding (MOU) which defines the 'terms of engagement' between the managed care and long term care delivery systems including the development of a shared health care record, data sharing, end-to-end coordination, and monitoring.

The ULTCB workgroup also recommends that in order to encourage the ability of care managers to work across services, programs, and funding sources the potential of using computerized HIPAA compliant personal health care record be explored.

Recommendations – Care Management

- 114. Adopt the following definition for care management throughout the long-term services and supports system:
Care Management is a holistic, collaborative, consumer-driven process for the provision of quality, culturally competent, health and supportive services through the effective and efficient use of available resources in order to maximize the individual consumer’s quality of life based on his/her capacity and preferences.
This definition for care management should be adopted and implemented for all consumers receiving long-term care services and supports. If necessary, change the definition of care management in waiver applications, the state plan, and any related administrative code rules.***
- 115. Consumer choice and person centered planning should be the foundation from which care management activities occur.***
- 116. Eliminate any potential conflict of interest within services covered by the unified budget.***
- 117. Use care managers for all long term services and supports whether provided in an institutional or community setting.***
- 118. Protocols and standardized criteria should be developed to guide the degree of care management.***
- 119. Develop a mechanism between the managed care system and the long-term supports system to enhance coordination for consumers and efficiently manage the cost of care.***
- 120. Explore the potential of using computerized HIPAA compliant personal health care record.***

3.0 Prioritized Recommendations

The unified long-term care budget workgroup has approved literally hundreds of recommendations from five subcommittees created to assist the workgroup in meeting its charge from the General Assembly. Given this volume, the workgroup believes it is essential to initially focus on a small number of priority recommendations. A more detailed project plan will be created and responsibility assigned to specific entities for each of the adopted recommendations to ensure that no particular recommendation will be lost in the process or sheer volume of the ongoing work.

3.1 Priorities for the near or short term: SFY 2009 (July 1, 2008 to June 30, 2009)

Priorities have been chosen for SFY 2009 with the understanding that implementation of these recommendations must be budget neutral. The phase (see pp. 11-12) to which the specific recommendation applies is noted.

- Decide on financing and service delivery structures (e.g. Medicaid waivers, state plan options, etc.) Phase 1, 2, and 3.

The workgroup believes that, given the challenges that Ohio faces, to focus on budget structure only would be an inadequate response to these challenges. Rather, the state should move immediately to look at the structures that it currently employs to provide long-term services and supports for consumers. Just as the state should unify its budget, it should also move to consolidate the service delivery structure to the greatest extent possible within federal constraints. In the Deficit Reduction Act of 2005, Congress gave the states additional tools to address the long-term services and supports needs of their citizens. This report makes many recommendations to that end.

This is an opportune time to examine the service delivery structure because a number of Ohio's existing Medicaid waivers are due for federal renewal. These renewal processes provide the opportunity to examine changes to the underlying structure and/or the specific programs. The responsibility for implementing this recommendation lies with EMMA and its constituting agencies because it will involve multiple agencies and constituencies. As part of this work, EMMA will explore the feasibility of the creation of an "1115" waiver or other options that would provide Ohio with the ability to consolidate programs across systems and potentially to serve additional consumers or provide alternative services to consumers in a fashion that is more flexible than Ohio's current "1915c" waivers.

- Implement HOME Choice (Money Follows the Person) strategies, working with current nursing facility residents to offer them opportunities to return to community-based settings. Additional work will address and close loopholes that allow inappropriate placements. (Phase 1, 2, and 3.)

- Develop information and assistance tools (Internet based) for consumers to ease access at the “front door.” (all phases)
- Establish interagency expenditure and caseload forecasting process. (Phase 1, 2, and 3).
- Implement State Profile Tool to benchmark Ohio’s progress in balancing its system in comparison with other states employing this process (all phases).
- Establish regional collaboratives to implement “No Wrong Door” successfully (all phases).
- Establish an ongoing stakeholder workgroup, facilitated by the Director of the Ohio Department of Aging.

The current membership of the workgroup will be maintained, but subcommittees will be formed around discrete priority tasks. For example, separate subcommittees would be formed to finalize the plans for phases 2, 3 and 4. Another example is a subcommittee to create Ohio's State Profile Tool.

In addition, the stakeholder workgroup will build a formal connection to the HOME Choice Consumer Counsel created pursuant to Ohio’s Money Follows the Person grant due to the interconnection between the unified budgeting process and the balancing goal of the HOME Choice initiative.

- Finalize work on phases 2, 3 and 4 for the Unified Budget.

While in some cases the workgroup was able to determine which recommendations might benefit consumers beyond the initial phase, the workgroup recognizes that additional work needs to be accomplished. Key tasks to implement this recommendation include a decision as to whether the detailed recommendations need to be modified to accommodate subsequent phases (for example, now that the MRDD “futures” report has been issued, the 31 recommendations from that workgroup need to be compared with the recommendations from the ULTCB workgroup for congruity as part of phase three), and determining which specific services need to be added for phase two.

3.2 Intermediate-term priorities – SFY 2010/2011 (July 1, 2009 to June 30, 2011)

Some of these priorities will have cost implications which will need to be “scored” during the development of the budget (agency budgets are due to OBM by September 15, 2008 for the upcoming biennium).

- Modify the budget structure to create a single long-term services and supports funding line in the budgets of ODJFS, ODA, ODMRDD, ODMH and ODADAS. Phases 1, 2, and 3.

These new lines were created in Am. Sub. H.B. 119 for all of the agencies except ODADAS. The effect of this recommendation is to consolidate funding for individual long-term services and supports programs (e.g., PASSPORT, assisted living and PACE within ODA's budget) into a single line so that funding for these programs can be shifted depending on consumer demand.

- Allow "Home First" enrollments into programs and services that have waiting lists currently (i.e., current nursing home residents bypass waiting lists). Phase 1.

"Home First" allows consumers currently receiving services in a facility-based setting such as a nursing facility to receive priority for home and community-based services. The concept was first employed in the last biennium to allow nursing facility residents on the waiting list for PASSPORT to move back home and receive PASSPORT services with the funding for those services transferred from the ODJFS budget. In the current biennium, Am. Sub. H.B. 119 expanded the "Home First" concept to those waiting for the availability of the Residential State Supplement program. The goal of this recommendation is to extend the "Home First" option to other programs as well (e.g., the Ohio Home Care waiver) in an equitable fashion.

- Extend care management to all consumers with need for long-term services and supports. Phase 1.

For now, this recommendation is specific to phase one only. As further work occurs on phase 2, it may be desirable to expand care management for some phase 2 consumers to the extent that they are not already served through ABD managed care. Also services received by phase 1 consumers enrolled in Medicaid waiver programs but provided through the traditional state Medicaid plan (referred to as "card services") should be included in a consumer's overall plan of care consistent with the holistic definition of care management adopted by the care management subcommittee to the extent that these services are included in the list of state plan services considered to be "long-term services."

Care management for nursing facility residents is different from the way care management has traditionally been provided in Ohio's other programs in that the focus is not on service authorization and coordination as much as it is on transition coordination and assistance to consumers in accessing the most appropriate services consistent with the consumer's need and preferences. This recommendation is also responsive to concerns expressed in the OCRM final report that Ohio currently loses contact with consumers that enter nursing facilities.

- Develop for each Ohio long-term services and supports program consumer-directed options from which consumers may choose. All Phases.

Implementation of this recommendation is predicated on the short-term recommendation dealing with financing and service delivery structures. Options to be explored should include 1915j waivers, adding consumer directed options (individual budgeting, person

centered planning, “cash and counseling” models, etc.) to Ohio’s existing 1915c waivers, and other opportunities for consumer direction.

- Expand Ohio’s Long-Term Care Consumer Guide to provide information on long-term services and supports beyond nursing facilities and assisted living facilities. All phases.

Several subcommittees independently adopted this recommendation. At present, the Long-Term Care Consumer Guide provides extensive information, including the results of customer satisfaction surveys, for nursing facilities and residential care facilities only. The Consumer Guide is funded through assessments to these two specific provider types.

- Create an informed navigator function to improve consumer access to services and supports.
- Develop and implement a systematic and transparent process to review reimbursement rates during each biennium.

3.3 Long-term priorities – SFY 2012/2013 (July 1, 2011 to June 30, 2013)

As is true for the intermediate-term priorities, some of these priorities will have cost implications which will need to be “scored” during the development of the budget in late summer 2010. More specificity will be required before these cost implications can be determined.

- Employ a single unified IT system to support all state agencies and their local partners in carrying out their responsibilities to provide long-term services and supports. All phases.
- Create one single line in the ODJFS budget to unify all spending on long-term services and supports. Phase 1

Efficient implementation of this recommendation is contingent on the availability of a single, unified IT system as recommended above and a decision that all entities have an appropriate level of access to that system. Presently, the state agencies are exploring the suitability of MITS for this purpose. The target date for its use by sister state agencies is SFY 2012. In the event that this target date is adjusted, then the budget structure recommended for the SFY 2010/2011 biennium would continue to be used until a unified IT system is available so as to not impede progress toward developing a unified budget.

- Finalize additional housing and supportive services options for Ohio (note that the planning for these is a short and intermediate-term activity). All phases.

- Establish incentives to encourage facilities to adapt to the new service delivery system (including implementation of a new Certificate of Need policy for nursing facilities). Phase 1.

Appendix A – Statutory authority for the unified long-term care budget workgroup

SECTION 213.30. UNIFIED LONG-TERM CARE BUDGET WORKGROUP

(A) There is hereby created the Unified Long-Term Care Budget Workgroup. The Workgroup shall consist of the following members:

- (1) The Director of Aging;
- (2) Consumer advocates, representatives of the provider community, and state policy makers, appointed by the Governor;
- (3) Two members of the House of Representatives, one member from the majority party and one member from the minority party, appointed by the Speaker of the House of Representatives;
- (4) Two members of the Senate, one member from the majority party and one member from the minority party, appointed by the President of the Senate.

The Director of Aging shall serve as the chairperson of the Workgroup.

(B) The Workgroup shall develop a unified long-term care budget that facilitates the following:

- (1) Providing a consumer a choice of services that meet the consumer's health care needs and improve the consumer's quality of life;
- (2) Providing a continuum of services that meet the needs of a consumer throughout life;
- (3) Consolidating policymaking authority and the associated budgets in a single entity to simplify the consumer's decision making and maximize the state's flexibility in meeting the consumer's needs;
- (4) Assuring the state has a system that is cost effective and links disparate services across agencies and jurisdictions.

(C) The Workgroup shall submit a written implementation plan to the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, the Minority Leader of the Senate, and the members of the Joint Legislative Committee on Medicaid Technology and Reform not later than June 1, 2008. The plan shall incorporate the following:

- (1) Recommendations regarding the structure of the unified long-term care budget;
- (2) A plan outlining how funds can be transferred among involved agencies in a fiscally neutral manner;
- (3) Identification of the resources needed to implement the unified budget in a multiphase approach starting in fiscal year 2009;
- (4) Success criteria and tools to measure progress against the success criteria.

The plan shall consider the recommendations of the Medicaid Administrative Study Council and the Ohio Commission to Reform Medicaid.

(D) In support of the Unified Long-Term Care Budget the following shall be established in the General Revenue Fund:

(1) In the Department of Aging, 490-423, Long-Term Care Budget - State;

(2) In the Department of Job and Family Services, 600-435, Long-Term Care Budget - State;

(3) In the Department of Mental Retardation and Developmental Disabilities, 322-406, Long-Term Care Budget - State;

(4) In the Department of Mental Health, 335-411, Long-Term Care Budget - State.

(E) On an annual basis, the Directors of Aging and Budget and Management shall submit a written report to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, the Minority Leader of the Senate, and the members of the Joint Legislative Committee on Medicaid Technology and Reform describing the progress towards establishing, or if already established, the effectiveness of the unified long-term care budget.

(F) When the Governor creates the administration described in section 309.30.03 of this act for the Medicaid program, the Director of Budget and Management may do all of the following in support of the Workgroup's proposal:

(1) Transfer funds and appropriations currently appropriated to pay for Medicaid services to any appropriation item referenced in division (D) of this section;

(2) Transfer funds between appropriation items referenced in division (D) of this section;

(3) Develop a reporting mechanism to transparently show how the funds are being transferred and expended.

The Director shall obtain Controlling Board approval before transferring funds or appropriations under division (F) of this section.

(G) Before a proposal for a unified long-term care budget may be implemented, the Joint Legislative Committee on Medicaid Technology and Reform shall approve implementation of the proposal and submit the Committee's approval to the Governor.

Appendix B – Chart of recommendations by number

REC #	Recommendations	Goals/ Objectives										Phase				Priority			Respo nsible
Subcommittee (s)		Balanced System	Consumer Choice	Consolidation of policy making authority and associated budgets	Consistency in rate setting process	Seamless array of service delivery	Lead to a higher quality of life for consumer	Encourage Ohioans to plan ahead for future services and are prepared to make informed decisions	Cost effective system that links disparate services across agencies	Transparent Budget	Other	1	2	3	4	Short-term	Inter mediate-term	Long-term	Fed, State, Agency Admin
1		x					x				x				x				
2	The scope of work should be divided into four phases: a. Phase 1 Nursing Facility and HCBS services predicated on Medicaid NF eligibility; b. Phase 2 Medicaid state plan services; c. Phase 3 MRDD services; and d. Phase 4 Non-Medicaid funded long-term services and supports	x		x							x	x	x	x					State
3	Long-term care” encompasses all non-medical and some specific medical services that the consumer receives.																		Admin
4	Admin The creation of a unified budget be accomplished in three stages: over the current biennium and each of the next two biennia.	x	x						x		x	x	x			x			State
5	Admin In SFY 2010/2011 funding be appropriated directly to new long-term care lines rather than individual programs.	x	x						x		x	x	x			x			State
6	Admin In SFY 2012/2013 a single funding line for long-term services and supports is created in the ODJFS budget.	x	x						x		x	x	x				x		State
7	Admin Create three different levels of reporting to support a unified budget: Performance, Decision-making, and Management reports.			x					x		x	x	x		x				State
8	Quarterly update reports be provided to the Governor and members of the General Assembly									x	x	x	x	x	x				Admin / State

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			Balanced System	Consumer Choice	Consolidation of policy making authority and associated budgets	Consistency in rate setting process	Seamless array of service delivery	Lead to a higher quality of life for consumer	Encourage Ohioans to plan ahead for future services and are prepared to make informed decisions		Cost effective system that links disparate services across agencies	Transparent Budget	Other	1	2	3	4	Short-term	Intermedi-ate-term
	Subcommittee (s)																		Fed, State, Agency Admin
9	Admin	A consistently applied, systematic, and transparent process to develop sound provider rates should be established.			X	X						X	X	X			X		State
10	Admin	All revenue savings achieved through the implementation of the unified budget be used to more expeditiously implement other recommendations contained in this final report.	X																State
11	Admin	OBM should create a special analysis on long-term care to be delivered to the General Assembly as part of the Executive Budget submission for the next biennium.									X	X					X		State
12	Admin	Ohio should use the State Profile Tool (SPT) to measure the performance of the state in balancing its long-term supports system.	X								X		X	X	X	X			State
13	Admin	The work of the Unified Long-Term Care Budget workgroup should be continued in future years and convened by the Director of ODA.	X								X	X	X	X	X				State
14	FD Structure	Employ a "no wrong door" concept that builds on the strengths of Ohio's county based system and existing infrastructure designed to serve people in their community;	X	X									X	X	X	X		X	State
15		Access to the "Front Door" should be available by telephone, through face-to face contact, and through the Internet;						X	X	X	X							X	Admin
16	FD Structure	Recognize the needs of all consumers rather than just those receiving services through the Medicaid program;	X					X					X	X	X	X		X	Admin
17	FD Structure	A "warm hand-off" (i.e. personal contact from the referral agency to the service-providing agency) should be used when a consumer is		X				X					X	X	X	X		X	Admin

REC #	Recommendations	Goals/ Objectives	Phase	Priority	Responsible
Subcommittee (s)		Balanced System Consumer Choice Consolidation of policy making authority and associated budgets Consistency in rate setting process Seamless array of service delivery Lead to a higher quality of life for consumer Encourage Ohioans to plan ahead for future services and are prepared to make informed decisions Cost effective system that links disparate services across agencies Transparent Budget Other	1 2 3 4	Short-term Intermediary-term Long-term	Fed, State, Agency Admin
	moving from an entry point to next steps to access services.				
18	FD Structure/ Eligibility A primary point of entry for a community (or region) should be identified as the focus of statewide marketing efforts;	X	X X X X	X	Admin
19	FD Structure/ post-acute Ohio should pursue a consumer education program designed to encourage individuals and their families to access resources relating to available long term services and supports before the need exists;		X X X X	X	Admin
20	FD Structure/ cap Additional training and resources on long-term services and supports planning should be made available to discharge planners, key nursing facility personnel and court appointed guardians;		X X X X	X	Admin
21	FD Structure The Area Agencies on Aging be responsible for the development of regional collaboratives throughout Ohio and for providing input to the development of and implementation of uniform criteria that takes as a starting point the criteria already developed by the "front door" subcommittee;	X	X X X X	X	State
22	The AAAs should identify key local entities through which consumers access long-term services and supports to participate in the regional collaboratives; and		X X X X	X	

REC #		Recommendations	Goals/ Objectives										Phase				Priority			Respo nsible	
Subcommittee (s)			Balanced System	Consumer Choice	Consolidation of policy making authority and associated budgets	Consistency in rate setting process	Seamless array of service delivery	Lead to a higher quality of life for consumer	Encourage Ohioans to plan ahead for future services and are prepared to make informed decisions	Cost effective system that links disparate services across agencies	Transparent Budget	Other	1	2	3	4	Short-term	Inter mediate-term	Long-term	Fed, State, Agency Admin	
23	FD Structure/ Unmet needs	Consumers should have access to an "informed navigator."		X			X						X	X	X	X			X		State
24		ODJFS should have lead responsibility for the "Back Room;"			X	X					X		X	X	X	X			X		Admin
25	FD Structure	Technology should be utilized to create a common, secure, accessible electronic infrastructure to expand information sharing about consumers. This infrastructure should be seamless to consumers and providers.					X						X	X	X	X				X	State
26	FD Structure	The Internet-based system should integrate existing tools and systems that are successful in linking consumers to service delivery options;		X			X		X				X	X	X	X	X				Admin
27		The Internet based system should be designed so that it can be utilized by the consumer, the consumer's representative, or consumer's advocate in the setting most convenient for the individual;					X		X		X		X	X	X	X				X	Admin
28	FD Structure	A "worksheet" function should be incorporated to assist consumers in the financial eligibility determination process;			X						X		X	X	X		X				Admin
29	FD Eligibility	An online application for benefits should be created;	X	X			X				X		X	X	X				X		Admin
30	FD Structure	Reporting functions should be built in to the system that can be integrated with the recommended decision making and management reporting systems;	X								X		X	X	X	X				X	Admin

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Subcommittee (s)			Balanced System	Consumer Choice	Consolidation of policy making authority and associated budgets	Consistency in rate setting process	Seamless array of service delivery	Lead to a higher quality of life for consumer	Encourage Ohioans to plan ahead for future services and are prepared to make informed decisions	Cost effective system that links disparate services across agencies	Transparent Budget	Other	1	2	3	4	Short-term	Intermedi-ate-term	Long-term	Fed, State, Agency Admin
31	FD Structure	A standardized screening and intake process should be implemented at all entry points into the delivery system for long term services and supports;								X			X	X	X		X			Admin
32	FD Structure	The screening and intake process should include "tickler" functionality	X	X			X				X		X	X	X	X		X		Admin
33		The Department of Aging and Department of Job and Family Services should co-lead the team to develop the training and materials for use by all front door partners.					X		X				X	X	X	X		X		Admin
34	FD Post-Acute	Leverage the existing long term care consultation program through the Area Agencies on Aging to encourage advance planning and meaningful choice prior to a consumer's transitioning from acute care to long term services;	X				X	X	X	X			X				X			Admin
35	FD Post-Acute/Unmet needs	Each regional collaborative (see recommendation 21) should develop strategies to focus on "critical pathways" (hospitals, skilled nursing facilities that provide short-term care) in a way that leverages existing relationships within each community				X					X		X	X	X	X		X		Admin
36	FD Unmet Needs	Explore Pennsylvania's fast track eligibility determination process and requirement that providers start services within 24 hours of a referral.	X	X				X					X	X	X			X		State

REC #	Recommendations	Goals/ Objectives	Phase				Priority			Respo nsible						
			1	2	3	4	Short -term	Inter medi ate- term	Long -term							
Subcommittee (s)		Balanced System Consumer Choice Consolidation of policy making authority and associated budgets Consistency in rate setting process Seamless array of service delivery Lead to a higher quality of life for consumer Encourage Ohioans to plan ahead for future services and are prepared to make informed decisions Cost effective system that links disparate services across agencies Transparent Budget Other														
43		Replace the existing skilled and intermediate levels of care with a single nursing facility level of care;	X									X			State	
44		Provide explicit authority for state agencies to initiate level of care and/or PASRR assessments if the provider fails to do so;	X				X	X					X		State	
45		Consider time limited level of care determinations across settings;	X							X			X		State	
46	FD Eligibility	Evaluate the current requirement for face to face assessments, including determining whether such requirements should be retained;					X					X	X	X		State
47		Establish a time period (e.g., 60 days) where an assessment can be used as consumers move among settings;	X				X						X		State	
48		Consider a streamlined assessment process when consumers are moving between programs and/or settings;					X				X		X		State	
49	FD Criteria	Establish a quality assurance function with emphasis placed on documenting inter-rater reliability and training for personnel conducting assessments	X	X			X				X		X	X		Admin
50	FD Criteria	Explore developing a tiered model of services (e.g., Vermont).	X	X			X	X						X	State/ Fed	
51	FD Eligibility	Encourage process improvements to improve the timeliness of financial eligibility processes (e.g., colocation of eligibility determiners, use of informed navigators – see recommendation 23;	X	X			X				X		X	X		Admin
52	FD Eligibility	Expedited eligibility be should be utilized for home and community-based services beyond PASSPORT;	X		X							X				State

REC #	Recommendations	Goals/ Objectives	Phase				Priority			Respo nsible					
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Subcommittee (s)		Balanced System Consumer Choice Consolidation of policy making authority and associated budgets Consistency in rate setting process Seamless array of service delivery Lead to a higher quality of life for consumer Encourage Ohioans to plan ahead for future services and are prepared to make informed decisions Cost effective system that links disparate services across agencies Transparent Budget Other													
55.1	direction/ fd unmet needs The following additional services should be provided to close gaps in the system: a. Self-Directed Personal Assistant Services on the State Plan		X			X					X				State/ Fed
55.2	FD Unmet Needs The availability of transition coordination services as established in Ohio's HOME Choice demonstration should be expanded.	X	X								X	X	X		State
55.3	FD Unmet Needs Medication management and/or prescription coordination									X	X	X		X	State
55.4	FD Unmet Needs In-home and institutional respite and/or sitter services under the State Plan should be made available.									X	X	X		X	State
56.1	FD Unmet Needs The following services that are currently limited in nature should be expanded. a. Behavioral health services													X	State
56.2	FD Unmet Needs Program of All-inclusive Care for the Elderly (PACE) model		X											X	State
56.3	FD Unmet Needs Expansion of Expedited access to waivers for hospice consumers.		X											X	Admin
56.4	FD Unmet Needs Expansion of Adult day services within the state plan.	X												X	State

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Subcommittee (s)			Balanced System	Consumer Choice	Consolidation of policy making authority and associated budgets	Consistency in rate setting process	Seamless array of service delivery	Lead to a higher quality of life for consumer	Encourage Ohioans to plan ahead for future services and are prepared to make informed decisions	Cost effective system that links disparate services across agencies	Transparent Budget	Other	1	2	3	4	Short-term	Intermedi-ate-term	Long-term	Fed, State, Agency Admin
56.5	FD Unmet Needs	Specialty equipment and assistive devices	X					X					X	X	X			X		State
56.6	FD Unmet Needs	Extended State Plan nursing, physical therapy, speech therapy, and occupational therapy.						X						X				X		State
57.1		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;	X				X	X					X					X		State
57.2		Regulations should be amended to permit the reuse of adaptive and assistive devices and durable medical equipment;		X				X					X					X		State
57.3		'Bridge Services' should be available as a consumer transitions from a nursing facility to the community;	X	X			X	X					X					X		State
57.4		Establish a comprehensive provider registry, ensuring it is user friendly and crosses all delivery systems;		X				X		X			X					X		Admin / State
58.1	FD Unmet Needs	During the assessment process, assessors should identify all informal, unpaid supports in place					X		X	X			X		X			X		Admin
58.2	direction/ fd unmet needs	Develop and/or revise provider qualifications to be less burdensome to support allowing family members to be paid providers;		X				X					X	X	X	X			X	State

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Subcommittee (s)			Balanced System	Consumer Choice	Consolidation of policy making authority and associated budgets	Consistency in rate setting process	Seamless array of service delivery	Lead to a higher quality of life for consumer	Encourage Ohioans to plan ahead for future services and are prepared to make informed decisions	Cost effective system that links disparate services across agencies	Transparent Budget	Other	1	2	3	4	Short-term	Intermedi-ate-term	Long-term	Fed, State, Agency Admin
58.3	FD Unmet Needs	Ohio should expand the capacity for, and broaden the scope of caregiver support groups, and the family resource center and long term care consultation concepts;							X			X	X	X	X	X		X		Admin
58.4	FD Unmet Needs	Expand access to legal services for the consumer's informal support network;						X	X				X	X	X	X		X		State
58.5	FD Unmet Needs	Research the development of a state tax credit for families providing extraordinary care;						X		X		X	X	X	X	X			X	State
58.6	FD Unmet Needs	Research the expansion of the concept behind Health Savings Accounts to allow families to save money to offset costs to Medicaid.							X		X	X	X	X	X	X			X	fed
58.7	FD Unmet Needs	Research the Community Living Assistance Services and Supports (CLASS) Act of 2007 which would create an insurance program for adults who become functionally disabled							X		X	X	X	X	X	X		X		Fed
58.8	FD Unmet Needs	Creating an emergency fund (one-time crisis-oriented) that would be available for family members to access to prevent admission to an institution.						X			X	X	X	X	X	X		X		State
59.1	FD Unmet Needs	Recommended Transportation Incentives:Transportation vouchers.	X					X				X	X	X	X	X			X	State
59.2	FD Unmet Needs	Assisted or supported transportation.	X					X				X	X	X	X	X			X	State

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61.1	FD Unmet Needs	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.						X		X			X	X	X					State
61.8	FD Unmet Needs	Reduction of estate recovery if family members provide gratis extraordinary care to the consumer.	X								X		X	X	X			X		State/ Fed
62		Ohio should limit liability for volunteers or family members through the Volunteer Protection Act.	X	X				X		X			X				X			State
63		Revise the provider specifications and requirements for non-medical transportation to increase potential pool of qualified providers.	X	X									X				X			State
64	FD Housing	The state should provide financial incentives to local governments to use a larger portion of their resources for home maintenance and repair.	X	X				X					X	X	X		X			State
65	FD Housing	Revise Medicaid rules to reimburse providers for the cost of materials only in situations where the labor is donated by charitable or faith-based organizations.			X			X					X		X			X		State/ Fed
66	FD Housing	Payment to providers for home modification services should be expedited so that they do not have to wait until the job is completed for reimbursement of these expenses.				X							X		X		X			State
67	FD Housing	The pool of professionals who can perform assessments and prescribe home modifications should be expanded.			X						X		X		X		X			Admin
68	FD Housing	Add a "visitability" requirement to the Ohio Residential Code for all new construction of 1,2 & 3 family homes						X					X	X	X	X			X	State

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69	FD Housing	State officials responsible for enforcement of accessible housing laws and codes should be encouraged to increase their efforts to enforce these codes.			X			X				X	X	X	X	X		X		Admin
70	FD Housing	Education and training on accessibility laws and best practices should be provide to architecture students, builders, local plans examiners and code enforcement officials.			X			X				X	X	X	X	X		X		Admin
71	FD Housing	Accessibility modifications should be included as part of the discharge plan for consumers leaving a nursing facility, and waiver funds should be authorized to enable home modifications to be completed prior to discharge from the nursing facility			X			X					X		X				X	State
72.1	FD Housing	Specific improvements to Ohio's assisted living Medicaid waiver program should be considered: a. Expand eligibility for the program to include consumers meeting level of care and income eligibility requirements who currently reside in the community.	X				X	X					X					X		State
72.2	FD Housing	Support amending federal law to waive Medicare Part D prescription drug co-payments as is currently the case for nursing facility residents.					X	X					X				X			Fed
73	FD Housing	Identify ways to increase funding for high-quality adult care facilities and adult foster homes.				X					X	X	X						X	State/ Fed
74	FD Housing	Explore how to allow these providers to become personal care providers. In addition, Ohio should create a new state plan option (1915i, created by the Deficit Reduction Act) to offer Medicaid-funded services to the	X					X				X	X					X	X	State/ Fed

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80	FD CAP	The current number of nursing facility beds in Ohio should serve as an overall cap for nursing facility beds.	X	X									x				x			State
81	FD CAP	The Director of the Ohio Department of Health should convene a stakeholder group to review existing CON criteria, and consider the need for and impact of the movement of beds between counties.	x						x				x				x			Admin
82	FD CAP	Criteria should be adopted to ensure access to facility-based services for all populations including Ohioans living in inner cities and rural areas.	x										x				x			State
83	FD CAP	As part of the process, the stakeholder group should consider whether the current law prohibiting the use of a long-term care bed need formula should be revisited.	x										x						x	Admin
84	FD CAP	Explore the feasibility and appropriateness of implementing a nursing facility bed buyback or conversion program									x		x						x	State
85	directi on	Every consumer should be able to direct as much of his/her care as he/she has the desire and ability to direct.			x						x		x	x	x				x	Admin
86	directi on	A comprehensive set of tools and resources must be created at the state level, and provided to interested consumers and/or their authorized representatives for the purpose of developing the skills necessary to direct their own care and services.		x	x								x	x	x	x			x	Admin
87	directi on	Legally responsible family members (i.e., spouses and parents of minor children) should be permitted to be paid Medicaid providers of personal care services in the State's Medicaid waivers		x			x	x			x		x		x				x	Admin

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	Subcommittee (s)																		Fed, State, Agency Admin
88	direction/ funding	Permit unused service dollars that are appropriated within the consumer's budget or cost cap to be used to purchase other needed services	X	X											X				State
89	direction	Consumer direction and care management strategies should support consumer negotiated rates.				X									X				State
90	direction	Development and use of innovative methods to pay for goods and services and other selected services, e.g. vouchers and/or debit cards, etc			X						X	X	X				X		State
91	direction	Establish and maintain a statewide registry of providers that lists providers' training, certification and/or approval, as well as information about qualifications, criminal record check requirements, monitoring and sanctioning..		X	X						X	X	X			X			State
92	FD Eligibility	Review Medicaid eligibility requirements in all existing Ohio waivers to assure consistent application, as appropriate, and to explore the expansion of opportunities for consumer eligibility.	X	X								X	X	X				X	State/Fed
93	direction	Expansion of person-centered care programs within nursing facilities										X					X		State
94	direction	Expand opportunities for consumer direction through Ohio's current 1915(c) waivers, and/or implementation of new Medicaid waivers based upon consumer direction practices.		X								X		X		X			State/Fed
95	direction/ funding unmet needs	Expand opportunities for consumer direction within non-Medicaid-funded programs funded or provided by other state and local entities (i.e., levies and grants, etc.).		X								X	X	X	X		X		State

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108.3	Quality Satisfaction should be measured by a third party (i.e., not the provider of service).			X						X						Admin	
108.4	Quality Satisfaction with smaller providers and consumer-directed services utilizing independent/individual providers should be available in aggregate form			X						X	X	X	X		X		Admin
108.5	Quality Include all levels of service (e.g., home repair, homemaker, transportation in addition to nursing and personal care).		X	X						X	X	X	X		X		Admin
108.6	FD Structure The virtual "front door" implemented to support consumer access to long-term services and supports should include the opportunity for consumers to provide feedback on the quality of the services they receive and a mechanism should be developed to respond to and resolve problems and issues along with consumers in a regulated timely manner.									X	X	X	X		X		State
109	Quality/housing Expand the Long-Term Care Consumer Guide to provide consumers with information about an expanded array of provider types.		X					X		X	X	X	X		X		State
110	Quality Structure and process requirements for providers should be augmented with outcome measures.		X				X			X	X	X	X		X		Admin
111	Quality Develop financial incentives based on quality and other measures as an add-on payment to reimbursement.				X		X			X	X	X				X	State

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112	Quality	Identify provider types that are not regulated and explore whether licensing and periodic review would be appropriate as a means of demonstrating a minimum level of regulatory compliance.						X			X	X							X	State
113	Quality/Unmet needs	Develop a reciprocal process across all systems that would recognize certification by another state agency.		X							X	X	X	X			X			State
114	CARE	Adopt the following definition for care management throughout the long-term services and supports system: Care Management is a holistic, collaborative, consumer-driven process for the provision of quality, culturally competent, health and supportive services through the effective and efficient use of available resources in order to maximize the individual consumer's quality of life based on his/her capacity and preferences. This definition for care management should be adopted and implemented for all consumers receiving long-term care services and supports. If necessary, change the definition of care management in waiver applications, the state plan, and any related administrative code rules.		X			X	X				X	X	X	X		X			Admin
115	CARE / Direction	Consumer choice and person centered planning should be the foundation from which care management activities occur.		X			X	X				X	X	X	X		X			Admin

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19	FD Structure/post-acute	Ohio should pursue a consumer education program designed to encourage individuals and their families to access resources relating to available long term services and supports before the need exists;							x				x	x	x	x	x				Admin
20	FD Structure/cap	Additional training and resources on long-term services and supports planning should be made available to discharge planners, key nursing facility personnel and court appointed guardians;							x				x	x	x	x	x				Admin
24		ODJFS should have lead responsibility for the "Back Room;"			x	x					x		x	x	x	x		x			Admin
26	FD Structure	The Internet-based system should integrate existing tools and systems that are successful in linking consumers to service delivery options;		x			x		x				x	x	x	x	x				Admin
27		The Internet based system should be designed so that it can be utilized by the consumer, the consumer's representative, or consumer's advocate in the setting most convenient for the individual;					x		x		x		x	x	x	x			x		Admin
28	FD Structure	A "worksheet" function should be incorporated to assist consumers in the financial eligibility determination process;			x						x		x	x	x		x				Admin
29	FD Eligibility	An online application for benefits should be created;	x	x			x				x		x	x	x				x		Admin
30	FD Structure	Reporting functions should be built in to the system that can be integrated with the recommended decision making and management reporting systems;	x								x		x	x	x	x			x		Admin

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31	FD Structure	A standardized screening and intake process should be implemented at all entry points into the delivery system for long term services and supports;								X			X	X	X		X			Admin
32	FD Structure	The screening and intake process should include "tickler" functionality	X	X			X				X		X	X	X	X		X		Admin
33		The Department of Aging and Department of Job and Family Services should co-lead the team to develop the training and materials for use by all front door partners.					X			X			X	X	X	X		X		Admin
34	FD Post-Acute	Leverage the existing long term care consultation program through the Area Agencies on Aging to encourage advance planning and meaningful choice prior to a consumer's transitioning from acute care to long term services;	X				X	X	X	X			X				X			Admin
35	FD Post-Acute/Unmet needs	Each regional collaborative (see recommendation 21) should develop strategies to focus on "critical pathways" (hospitals, skilled nursing facilities that provide short-term care) in a way that leverages existing relationships within each community				X					X		X	X	X	X		X		Admin
39	FD Criteria	Ohio should convene a stakeholder group to analyze and explore changes to existing rules and processes regarding level of care and pre-admission screening and resident review (PASRR) for nursing facility admissions and NF-based waivers. This same issue will need to be addressed for phase three (MRDD) services and supports;	X	X	X		X	X		X			X	X	X		X			Admin

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79	ODJFS should fund a position within the Ohio Housing Finance Agency											X			Admin		
81	FD CAP The Director of the Ohio Department of Health should convene a stakeholder group to review existing CON criteria, and consider the need for and impact of the movement of beds between counties.	X										X			Admin		
83	FD CAP As part of the process, the stakeholder group should consider whether the current law prohibiting the use of a long-term care bed need formula should be revisited.	X										X			Admin		
85	directi on Every consumer should be able to direct as much of his/her care as he/she has the desire and ability to direct.			X								X	X	X		Admin	
86	directi on A comprehensive set of tools and resources must be created at the state level, and provided to interested consumers and/or their authorized representatives for the purpose of developing the skills necessary to direct their own care and services.		X	X								X	X	X	X		Admin
87	directi on Legally responsible family members (i.e., spouses and parents of minor children) should be permitted to be paid Medicaid providers of personal care services in the State's Medicaid waivers		X			X	X					X		X		Admin	
97	Qualit y Implement and coordinate quality assurance mechanisms across all systems for the purpose of minimizing unnecessary risks, providing quality services, monitoring consumer outcomes (and reporting negative outcomes) and assuring the consumer's health and welfare.			X								X	X	X	X		Admin

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99	direction	Study and determine the various types of employer status available to the consumer (i.e., employer of record, including an exploration of the legal implications of consumer direction (i.e., employer status, taxation, and unionization of independent, non-agency providers, etc.).		X	X								X		X			X		Admin
100	direction	Recommend to EMMA whether the concept of employer status should be uniformly applied across all long term care systems.						X			X	X	X	X			X		Admin	
107	Quality/housing/Unmet Needs / Direction	Use the CMS Quality Framework across all long-term care settings			X						X	X	X	X	X			X	Admin	
108.2	Quality	Develop a unified method of data collection related to satisfaction.			X						X	X	X	X	X		X		Admin	
108.3	Quality	Satisfaction should be measured by a third party (i.e., not the provider of service).			X						X	X	X	X	X		X		Admin	
108.4	Quality	Satisfaction with smaller providers and consumer-directed services utilizing independent/individual providers should be available in aggregate form			X						X	X	X	X	X		X		Admin	
108.5	Quality	Include all levels of service (e.g., home repair, homemaker, transportation in addition to nursing and personal care).	X	X							X	X	X	X	X		X		Admin	

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119	CARE	Develop a mechanism between the managed care system and the long-term supports system to enhance coordination for consumers and efficiently manage the cost of care.					x	x		x			x						x		Admin
120	CARE	Explore the potential of using computerized HIPAA compliant personal health care record.					x			x			x						x		Admin
8		Quarterly update reports be provided to the Governor and members of the General Assembly									x	x	x	x	x	x					Admin / State
57.4		Establish a comprehensive provider registry, ensuring it is user friendly and crosses all delivery systems;		x				x		x			x						x		Admin / State
42	FD Unmet Needs	Consider an extended transition period for any changes to level of care criteria to facilitate continued service to consumers already receiving long term services and supports through the Medicaid program;	x		x								x		x		x				Fed
58.6	FD Unmet Needs	Research the expansion of the concept behind Health Savings Accounts to allow families to save money to offset costs to Medicaid.								x		x	x	x	x				x		fed
58.7	FD Unmet Needs	Research the Community Living Assistance Services and Supports (CLASS) Act of 2007 which would create an insurance program for adults who become functionally disabled								x		x	x	x	x				x		Fed
72.2	FD Housing	Support amending federal law to waive Medicare Part D prescription drug co-payments as is currently the case for nursing facility residents.					x	x					x				x				Fed

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12	Admin	Ohio should use the State Profile Tool (SPT) to measure the performance of the state in balancing its long-term supports system.	X							X		X	X	X	X	X			State
13	Admin	The work of the Unified Long-Term Care Budget workgroup should be continued in future years and convened by the Director of ODA.	X							X	X	X	X	X	X				State
14	FD Structure	Employ a "no wrong door" concept that builds on the strengths of Ohio's county based system and existing infrastructure designed to serve people in their community;	X	X			X					X	X	X	X		X		State
21	FD Structure	The Area Agencies on Aging be responsible for the development of regional collaboratives throughout Ohio and for providing input to the development of and implementation of uniform criteria that takes as a starting point the criteria already developed by the "front door" subcommittee;	X		X							X	X	X	X	X			State
23	FD Structure/ Unmet needs	Consumers should have access to an "informed navigator."		X			X					X	X	X	X		X		State
25	FD Structure	Technology should be utilized to create a common, secure, accessible electronic infrastructure to expand information sharing about consumers. This infrastructure should be seamless to consumers and providers.					X					X	X	X	X			X	State
36	FD Unmet Needs	Explore Pennsylvania's fast track eligibility determination process and requirement that providers start services within 24 hours of a referral.	X	X				X				X	X	X			X		State

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55.3	FD Unmet Needs	Medication management and/or prescription coordination						X				X	X	X			X			State
55.4	FD Unmet Needs	In-home and institutional respite and/or sitter services under the State Plan should be made available.					X	X				X	X	X			X			State
56.1	FD Unmet Needs	The following services that are currently limited in nature should be expanded. a. Behavioral health services					X	X					X	X	X			X		State
56.2	FD Unmet Needs	Program of All-inclusive Care for the Elderly (PACE) model		X			X	X					X					X		State
56.4	FD Unmet Needs	Expansion of Adult day services within the state plan.	X				X	X						X				X		State
56.5	FD Unmet Needs	Specialty equipment and assistive devices	X					X					X	X	X			X		State
56.6	FD Unmet Needs	Extended State Plan nursing, physical therapy, speech therapy, and occupational therapy.						X						X				X		State
57.1		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;	X				X	X					X					X		State

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57.2		Regulations should be amended to permit the reuse of adaptive and assistive devices and durable medical equipment;		X								X			State	
57.3		'Bridge Services' should be available as a consumer transitions from a nursing facility to the community;	X	X			X	X					X		State	
58.2	direction/ fd unmet needs	Develop and/or revise provider qualifications to be less burdensome to support allowing family members to be paid providers;		X				X				X		X	State	
58.4	FD Unmet Needs	Expand access to legal services for the consumer's informal support network;						X	X			X		X	State	
58.5	FD Unmet Needs	Research the development of a state tax credit for families providing extraordinary care;						X			X	X	X	X		State
58.8	FD Unmet Needs	Creating an emergency fund (one-time crisis-oriented) that would be available for family members to access to prevent admission to an institution.						X				X	X	X		State
59.1	FD Unmet Needs	Recommended Transportation Incentives:Transportation vouchers.						X				X	X	X		State
59.2	FD Unmet Needs	Assisted or supported transportation.						X				X	X	X		State

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59.3	FD Unmet Needs Bus passes for fixed route transport.		X				X					X			State
60.2	Develop qualification requirements for provider staff or independent providers across the state agencies for similar services. (e.g., standardized credentialing).				X		X						X		State
60.3	Align Bureau of Criminal Identification and Investigation (BCII) background check requirements				X		X						X		State
61.1	FD Unmet Needs 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.						X					X			State
62	Ohio should limit liability for volunteers or family members through the Volunteer Protection Act.		X	X									X		State
63	Revise the provider specifications and requirements for non-medical transportation to increase potential pool of qualified providers.		X	X									X		State
64	FD Housing The state should provide financial incentives to local governments to use a larger portion of their resources for home maintenance and repair.		X	X									X		State
66	FD Housing Payment to providers for home modification services should be expedited so that they do not have to wait until the job is completed for reimbursement of these expenses.												X		State
68	FD Housing Add a "visitability" requirement to the Ohio Residential Code for all new construction of 1,2 & 3 family homes												X	X	State

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71	FD Housi ng Accessibility modifications should be included as part of the discharge plan for consumers leaving a nursing facility, and waiver funds should be authorized to enable home modifications to be completed prior to discharge from the nursing facility			X			X							X	State
72.1	FD Housi ng Specific improvements to Ohio's assisted living Medicaid waiver program should be considered: a. Expand eligibility for the program to include consumers meeting level of care and income eligibility requirements who currently reside in the community.	X				X	X							X	State
75	Criteria should be developed to establish the quality threshold that these providers would be expected to meet in order to receive additional funding.													X	State
75.3	FD Housi ng Create a state-funded room and board subsidy for couples and individuals who are low income but not eligible for SSI because Medicaid funds cannot be used to subsidize room and board in assisted living.													X	State
75.5	FD Housi ng Explore more variability in how rates are set.					X								X	State
77	Resources should be used to fund additional service coordinators.													X	State
78	Create a tenant-based rental assistance program for HOME Choice participants		X											X	State
80	FD CAP The current number of nursing facility beds in Ohio should serve as an overall cap for	X	X											X	State

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96	direction	Provide access to an independent consumer-focused advocate that can assist consumers receiving long term care services and supports.		X			X	X					X	X	X	X		X		State
98	direction	Examine the various types of FMS entities used in the delivery of consumer-directed care to determine the model that is best suited to accommodate the needs of Ohio's long term care service and support system and ascertain the feasibility of allowing an FMS to execute Medicaid provider agreements to facilitate consumer direction.		X	X						X		X		X			X		State
102	direction	Use Limited Medicaid Provider Agreements as a way to execute the purchase of goods and services (e.g., one-time agreements to purchase goods at retail establishments, etc.).									X		X	X	X			X		State
103		Establish consumer protections that assure that providers cannot change timesheets after the consumer and/or authorized representative has signed them and before they are submitted for reimbursement.						X			X							X		State
104	direction	Establish safeguards against consumer/provider fraud						X					X	X	X	X		X		State
105		Assure uniform due process for consumers and providers alike						X			X							X		State
106	Quality	The state should not add new levels of measurement where they currently exist and should be mindful of the cost and usefulness of data collected so as to not increase provider burden.			X						X		X	X	X	X			X	State
108.1	Quality	Develop and implement consumer satisfaction measures for additional long-term services and supports: a. Apply consumer satisfaction across all long-		X				X					X	X	X	X		X		State

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	Subcommittee (s)																		Fed, State, Agency Admin
117	CARE / Direction	Use care managers for all long term services and supports whether provided in an institutional or community setting.	X	X			X					X	X	X	X		X		State
50	FD Criteria	Explore developing a tiered model of services (e.g., Vermont).	X	X			X	X				X	X				X		State/ Fed
55.1	direction/ fd unmet needs	The following additional services should be provided to close gaps in the system: a. Self-Directed Personal Assistant Services on the State Plan		X			X					X	X	X		X			State/ Fed
61.8	FD Unmet Needs	Reduction of estate recovery if family members provide gratis extraordinary care to the consumer.	X								X	X	X				X		State/ Fed
65	FD Housing	Revise Medicaid rules to reimburse providers for the cost of materials only in situations where the labor is donated by charitable or faith-based organizations.			X			X				X		X			X		State/ Fed
73	FD Housing	Identify ways to increase funding for high-quality adult care facilities and adult foster homes.				X					X	X	X				X		State/ Fed
74	FD Housing	Explore how to allow these providers to become personal care providers. In addition, Ohio should create a new state plan option (1915i, created by the Deficit Reduction Act) to offer Medicaid-funded services to the residents living in these settings	X					X				X	X			X	X		State/ Fed
75.4	FD Housing	Explore the impact of provider requirements to allow participation by older residential care facilities that currently do not qualify to participate in the assisted living waiver;		X				X				X							State/ Fed

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92	FD Eligibility Review Medicaid eligibility requirements in all existing Ohio waivers to assure consistent application, as appropriate, and to explore the expansion of opportunities for consumer eligibility.	X	X					X	X	X			X	State/ Fed
94	direction Expand opportunities for consumer direction through Ohio's current 1915(c) waivers, and/or implementation of new Medicaid waivers based upon consumer direction practices.		X					X		X		X		State/ Fed
101	direction Recommend to EMMA the feasibility of utilizing organized health care delivery systems (OHCDS) .							X		X			X	State/ Fed

Appendix D – Links to Subcommittee Reports

The reports of each of the five subcommittees and the “front door” subcommittee’s stakeholder groups are available online at:

www.goldenbuckeye.com/ultcb

Appendix E - Unified Long-Term Care Budget – Workgroup Membership

Senator Capri Cafaro
Senator Tom Niehaus
Representative Shannon Jones
Representative Armand Budish

Barbara E. Riley
Ohio Department of Aging

Pari Sabety
Office of Budget and Management

Cristal Thomas
EMMA

John Corlett
ODJFS/OHP

John Martin/Tracy Plouck (moved to OBM)
ODMRDD

Angie Bergefurd
ODMH

Douglas L. Day
ODADAS

Becky Maust
ODH

Peg Ising/Anne Jewel
ODI

Brian Allen
Skilled Nursing Care Coalition

Jean Thompson
Ohio Assisted Living Association

Kathleen Anderson
Ohio Council for Home Care

Joe Ruby
Ohio Association of Area Agencies on Aging

William Sundermeyer
AARP Ohio

Shelley Papenfuse
Ohio Olmstead Task Force

Janet Grant – Care Source
Ohio Association of Health Plans

Jim Adams
Ohio Association of County Behavioral Health Authorities

Hubert Wirtz
Ohio Council of Behavioral Health Care Providers

Maureen Corcoran/Mark Davis
OPRA

Betsy Johnson
NAMI Ohio

Donna Conley
Ohio Citizen Advocates

Barry Jamieson
Ohio Association of County Boards of MRDD

Steve Mombach
Tri Health Senior Link

Robert Applebaum
Scripps Gerontology Center Miami University

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ODA – Project Manager

Maggie Lewis
Commission on Dispute Resolution and Conflict Management, Facilitator