

Unified Long-Term Care Systems Workgroup Integration & Care Management Subcommittee Recommendations

Implementation Key: ☺ **Implement before the end of the 2012-13 Biennium**
↔ **Study, plan and/or partially implement in the 2012-13 Biennium**
◇ **Currently in-place at some level in Ohio**
∞ **Longer term implementation**

Strategic Direction

1. ☺ Identify existing forums where state agencies and stakeholders (e.g., providers, payers, consumers) can discuss issues and opportunities related to care integration and management, including, but not limited to:
 - Consolidating and streamlining of current state/federal regulations;
 - Identifying and applying for potential federal demonstration programs;
 - Evaluating alternative Medicare and Medicaid integration options (e.g., Medicaid HCBS capitation, Medicare Advantage Special Needs Plan, Shared Savings Model, PACE, State as Integrated Entity); and
 - Developing a plan outlining strategic direction by the end of SFY 2012.

Dual Eligible Integration

2. ↔ Integrate the Medicaid acute benefit in dual eligible Medicare Special Needs Plans (SNPs).
 - Supports dual eligible SNP members who have voluntarily selected the SNP for Medicare services.
 - Contract with SNPs that also are contracted as Medicaid managed care plans.
 - Expand current ODJFS SNP contract to manage acute benefit package for Medicaid (cost sharing and wrap around benefits).
 - State actuary sets capitated rate for Medicaid services.
 - Requires permissive enrollment statutory changes.
 - Streamline regulation to avoid dueling requirements.
3. ☺ ◇ Educate providers/case managers/consumers as to the requirements for Medicare, Medicaid and other programs (e.g., Veterans Administration, behavioral health) to ensure that program benefits are used to the fullest extent.
4. ☺ State agency (e.g., ODJFS, ODI, ODA) and advocacy/provider/payer organizations (e.g., AARP, MCO, Home Health) will work together to coordinate mailings and promotion (e.g., websites, ConnectMeOhio) aimed at informing dual eligibles of Medicare Special Needs Plans (SNP) option.

Medical/Long-Term Care Integration

5. ↔ Provide care coordination of the Medicaid acute benefit (e.g., inpatient care in hospitals, skilled nursing facility, hospice, home health care, doctors' services, outpatient care) for Medicaid HCBS waiver participants.
 - Eliminate the exclusion for waiver participants from Medicaid managed care.
 - Medicaid plans coordinate the acute benefit package within a risk adjusted capitated rate.
 - Waiver programs continue coordination of the long-term care services and supports benefit.
 - Effect a coordinated care agreement between the plan and waiver administrator.

6. 😊 ◇ Deploy Long-term Care Consultants¹ in hospitals, based on facility and patient characteristics (e.g., nursing facility admissions), to meet the needs of adults in need of long-term care supports and services (LTSS).
 - Cross train hospital discharge planners, especially in areas where demand does not warrant deployment of a Long-term Care Consultant, so they can provide person-centered discharge planning to patients and families in need of LTSS.

7. 😊 ◇ Develop area agency on aging/health care partnerships (e.g., hospital, patient-centered medical home, MCOs, community organizations) and train to implement evidence-based health coaching programs (e.g., Coleman Care Transitions Program, Guided Care Model).

8. 😊 ◇ Utilize and deploy existing resources such as Long-term Care Consultants in large Medicaid physician practices and patient-centered medical home to support patient access to available community-based programs and supports (e.g., self-management, transportation, home care).

9. 😊 ◇ Expand and sustain evidence-based disease self-management programs, including but not limited to Chronic Disease Self-Management Program (CDSMP), Diabetes Self-Management Program (DSMP), and Matter of Balance.
 - Partner with patient-centered medical homes, primary care practices, managed-care organizations and Medicaid to make CDSMP and DSMP available to their patients/members using the training infrastructure available through Ohio's aging network.
 - Identify, deploy, and sustain evidence-based physical activity interventions (e.g., Enhanced Fitness, Active Living Everyday).
 - Identify, deploy and sustain in-home evidence-based disease prevention interventions.
 - Deploy and sustain evidence-based disease self-management interventions aimed at meeting the needs of persons with severe and persistent mental illness and substance use disorders.

¹ Authorized as a service provided by ODA or its designee in ORC 173.42.

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10. ☺ ◇ Expand access to information, assistance/referral and Long-term Care Consultations through Aging and Disability Resource Networks (ADRN).
11. ☺ ◇ Include long-term care/area agency on aging representation in the IMPROVE (Implementing Medicaid Programs for the Reduction of Avoidable Visits to the Emergency Department), StAAR (State Action on Avoidable Rehospitalization) and Enhanced Primary Care Home initiatives.

Identify and Support Shared Consumers

12. ☺ ◇ Identify shared consumers/members (e.g., Medicaid waivers, Older Americans Act and senior services property tax levies, county behavioral health services, Medicaid waivers, MCOs, acute care and other long-term care) and provide long-term tools (e.g., health information technology) and short term education (e.g., confidentiality requirements) to support coordination of services.

Behavioral Health

13. ☺ ◇ Identify, support and deploy evidence-based behavioral health screening tools/protocols and self-management interventions (e.g., SBIRT/Screening, Brief Intervention, and Referral to Treatment, Healthy IDEAS, IMPACT, Motivational Interviewing) at transition points/critical pathways (e.g., primary care practices, hospitals, ADRN).