

**ULTCS Workgroup  
Integration and Care Management Subcommittee  
July 28, 2010**

**MEMBERS PRESENT:**

Sande Johnson, ODA; Nilu Ekanayake, ODADAS; Beth Foster, OCHC; Diane Dietz, OHCA; Gwen Toney, OHPCO/OHCO; Christine Kozobarich, SEIU 1199; Joe Ruby, AAA 10B; Marc Molea, ODA, Subcommittee Co-Leader; Pam Scuellerman, Alzheimer's Association; Linda Ferrell, JFS/OHP; Janet Grant, CareSource; Sarah Curtin, HCCQC/ODI

**DISCUSSION:**

Marc and others reviewed the results of the July 23, 2010 Special Behavioral Health Integration Meeting. Several of the recommendations discussed at that meeting were sent to the I and CM subcommittee for review and others were referred on to the Service Array subcommittee.

Beth noted the behavioral health screenings provided by Home Health Agencies.

**Recommendations Review**

The subcommittee reviewed and discussed each of the 14 recommendations developed by the subcommittee, and, if necessary, made revisions. The authors of the recommendations provided clarifications.

We also tested for consensus whether members felt that each recommendation was ready to present to the ULTCS Work Group on August 2. All 14 recommendations received unanimous consensus to move forward.

**Next Steps**

It was determined that Marc would serve as the spokesperson for the subcommittee at the August 2 meeting with members providing clarifications if necessary.

After the August 2 meeting the subcommittee will revise and/or add to recommendations based on the feedback and discussion. Once recommendations are finalized the subcommittee will complete the matrix including identifying: Population Served, Change to Statute, Rule or Policy, Funding, Redeployment of Resources and Creation of Partnerships. The subcommittee also agreed to review and refine outcomes for each recommendation.

The subcommittee will consider adding a telemedicine recommendations based on recommendations from other subcommittees and the presentation at the next meeting.

**NEXT MEETING:**

- August 2, 2010, 12:00 – 3:00, Lazarus Building, 50 W. Town, Plenary Session: Rooms 621 A & B Room, Subcommittee: Room 601A (1:30 p.m.)

## **Integration & Care Management Subcommittee Recommendations**

### **Dual Eligible Integration**

1. Integrate the Medicaid acute benefit in dual Special Needs Plans (SNPs).
  - Dual eligible SNP members who have voluntarily selected the SNP.
  - 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 to set capitated rate.
  - Permissive enrollment statutory changes.
  - Streamline regulation to avoid dueling requirements.
2. Provide care coordination of the acute benefit for 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.
3. Outreach to duals on SNP option.
  - ODJFS mailing to duals to inform of SNP option.
  - ODJFS/ODA web site posting with SNP option.
4. Identify existing forums where state agencies and stakeholders can discuss issues and opportunities related to dual eligible integration, including, but not limited to:
  - consolidating and streamlining of current state/federal regulations;
  - potential federal demonstration programs; and
  - alternative Medicare and Medicaid Integration Options (e.g., Shared Savings Model, PACE, State as Integrated Entity).
5. Educate providers/case managers/consumers as to the requirements for Medicare, Medicaid and other programs (e.g., VA, behavioral health) so program benefits are used to the fullest extent.

### **Medical/Long Term Care Integration**

6. Deploy PASSPORT Long Term Care Consultants in hospitals on a statewide basis.
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 PASSPORT 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. Coordinate care planning for common members of Health Plans and Area Agency on Aging services funded by Medicaid waivers, Older Americans Act and senior services property tax levies.
  10. Include Long-term Care/AAA 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.
  11. Expand and sustain evidence-based disease self-management programs, including but not limited to Chronic Disease Self-Management Program, Diabetes Self-Management Program, and Matter of Balance.
    - Identify, deploy, and sustain evidence-based physical activity interventions (e.g., Enhanced Fitness, Active Living Everyday, Reducing Disability in Alzheimer’s Disease).
    - Deploy and sustain evidence-based disease self-management interventions aimed at meeting the needs of persons with severe and persistent mental illness and alcohol and drug addictions.
  12. Expand access to information, assistance/referral and AAA Long-Term Care Consultations through Aging and Disability Resource Centers.

### **Identify Shared Consumers**

13. Identify shared consumers/members (e.g., 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.

### **Behavioral Health**

14. Support use of evidence-based behavioral health screening tools and self-management interventions (e.g., Healthy IDEAS, Motivational Interviewing) at transition points (e.g., primary care practices, hospitals).