Ohio Association of Area Agencies on Aging
Advocacy. Action. Answers on Aging.

Response to ODJFS RFI: Ohio Association of Area Agencies on Aging

Creation of an Integrated healthcare Delivery System for Medicare and Medicaid Eligible Beneficiaries: Addressing the needs of Ohio's Older Adults and Adults with Physical Disabilities

I. Description of Area Agencies on Aging, including services provided and population served

Aging & Disability Resource Networks (ADRNs) are the front door to long-term care in Ohio.. Area Agencies on Aging (AAAs) coordinate the community-based ADRNs and help older adults find the Long-term Services and Supports (LTSS) they need where they live. In FY 2010 we fielded more than 300,000 contacts from older adults, caregivers and others seeking information and assistance concerning Long-term Services and Supports (LTSS).

Each of Ohio's 12 AAAs serves as the PASSPORT Administrative Agency (PAA) in its multi-county region and has seamlessly integrated this role into the ADRNs. As AAA/PAAs we manage and coordinate care for 43,000 aging home and community based (HCBS) waiver consumers – 85% of whom are Medicare Medicaid Eligible (MME) individuals. Our role as AAAs enables us to plan, fund and coordinate services in our regions for nearly all older adult services including managing Long-term Services and Supports.

The AAA network is largely a private sector partner. Nearly all AAAs/PAAs are independent organizations. Our regional nature, coupled with our history of Medicaid cost-containment success, should allow for an immediate expansion of our role in the overall effort of modernizing Medicaid.

Ohio's AAAs deliver on the objectives of the Triple Aim:

Better Health: Improved health and wellness is achieved for our customers and consumers through the AAAs' role in providing:

- Evidence-based disease prevention
- Chronic disease self-management
- Medication management programs
- Evidence-based care transitions coaching
- Nutrition services and counseling
- Care coordination and planning
- Caregiver support and coaching

Our role in the initiatives above has already begun to transform what was once "case management" into our current function of care coordination. Our focus has shifted from simply authorizing long-term care services to improving health outcomes through health-focused care coordination. Many of these services are provided to both Medicaid and non-Medicaid populations across the state. AAAs coordinated non-Medicaid services such as adult day care, congregate and home delivered meals, homemaker and personal care services, and transportation for 231,169 older Ohioans last year. In

addition, through the PASSPORT program, 43,122 nursing home and Medicaid eligible frail individuals received services through care coordination.

Specifically, AAAs are developing and implementing evidence-based care transition models that improve health outcomes and prevent costly hospital readmissions and emergency department visits. Ohio's AAAs have more than 80 coaches statewide trained in the evidence-based Coleman Care Transition Intervention program (www.caretransitions.org). In many areas, AAA staff are already co-located at hospitals working in partnership with the discharge planning staff to ensure successful transitions across multiple care settings. Due to their demonstrated results in reducing hospital readmissions, several AAAs have applied for CMS funds from section 3026 of the Affordable Care Act of 2010 to provide the Care Transitions Intervention in their local hospitals.

Better Care: Aging and Disability Resource Networks provide ready access to the unbiased information individuals and their families need to make informed decisions about services. The resource centers also promote self-sufficiency by helping people maximize the use of their own resources and natural supports as effectively as possible. It is a model recognized by the federal government with continued funding including most recently, a competitive $2.3 million grant.

AAAs use person-centered care planning to help ensure that individuals can live in their setting of choice. AAAs coordinate consumers' care in settings that enhance their quality of life while they live with chronic conditions or disabilities, preventing unnecessary, higher-cost nursing facility admissions and returning cost efficiencies to the state budget.

Working with consumers and their families to develop the appropriate care plans are the heart of a person-centered approach. With the dual goal of serving consumers' needs while conserving resources, AAA care managers adjust care plans upward to avoid unnecessary nursing home placement or downward to contain costs if consumers' health or family supports improve.

Lower Costs: AAAs are proven performers in reducing Ohio's LTSS costs. Our success in this area results from 1) providing the less costly home and community-based care options that most people prefer, 2) connecting people to community resources that can delay enrollment in Medicaid, and 3) transitioning long-time nursing home residents back to the community. We are experts at coordinating community supports to keep seniors and people with disabilities in cost-effective home and community based care for as long as possible. We are on the ground in our communities, tapping into partnerships with hospitals, hospice programs, subsidized housing, food banks and homeless shelters, to name a few. AAAs are constantly building new partnerships and resources to meet changing needs and funding realities, utilizing volunteers and soliciting community donations for many of our programs. In many instances, these partnerships enhance public resources that are available including waiver services, thus lowering their cost to the state, and enhancing their effectiveness for consumers.

Our success in this area has been substantiated by Scripps Gerontology Center, who reported the use of Medicaid-funded nursing homes by Ohioans age 60 and older has dropped by 14.5 percent over the past 12 years, despite a 15 percent increase in the older population. In terms of cost savings, Ohio spent $121 million less on long-term care in 2009 than in 1997, despite the growth in population. The

enhanced value of the community supplied services and supports noted above goes uncounted, but is unquestionably substantial.

II. Proposed model for an integrated care delivery system + advantages of this model

Ohio's AAAs propose a hybrid system combining the best features of a Fee for Service (FFS) model and those of a capitated managed care integration model as outlined by the CMS July 8, 2011 State Medicaid Director letter.

This hybrid system would maintain a direct pay Long-term Services and Supports system (LTSS) which would be integrated and coordinated with a separate managed medical care system. The latter could include managed care organizations, accountable care organizations, primary care case management, and/or health homes, all or any of which the LTSS system could integrate with at specific mandated coordination points.

A hybrid preserves the unique strengths and service capacities of each of the parts, but integrates their services to save money and provide better care. In its November 2010 publication, Profiles of State Innovation: Roadmap for Improving Systems of Care for Dual Eligibles, the Center for Health Care Strategies, Inc., a nonprofit health policy resource center, recommends that states with strong medical care and LTSS systems should keep separate systems but bridge them to integrate services.

Ohio's existing LTSS system can be strengthened, rebalanced, and enhanced with innovations in its proposed new consolidated single waiver It is in the state's best interest to preserve that system as a separate but coordinated approach and assign the identification of consumers and care coordination responsibility to the ADRN. Advantages include:

- Savings from LTSS rebalancing would accrue to the state, not to a managed care entity enabling investments that would lead to further improvements in the system's performance;
- Savings would be realized sooner and more rapidly by building on the experience and strengths of the existing ADRN system rather than requiring a health plan or other entity to develop a new LTSS network;
- Reform efforts are more likely to succeed if the state recognizes that its medical care and long-term care systems are related but have different purposes and are used by patients and consumers in different ways.

In the case of the first advantage, cost savings for services traditionally paid by both Medicare and Medicaid, can be maximized by a managed care approach. But, because LTSS have very limited reimbursement by Medicare, it stands to reason that these services should continue to be paid by the state via Medicaid so that the cost savings of balancing could accrue to the state. A graduated shared savings model could be introduced between the LTSS system providers and the state, with savings reinvested in improved services and care delivery. The state could propose it receive shared savings from Medicare for care transitions work, CDSMP work and other interventions that save Medicare money because they are not strictly LTSS.

In addition, Ohio can generate savings more quickly by enhancing its existing ADRN system to increase the pace of rebalancing. For example, ADRNs only need authority from the state to expand the tools they already use so they can increase transitions out of costly nursing homes or avoid their

admissions altogether via earlier interventions and care management of nursing facility residents. This authority, combined with standardized assessment protocols and training, new practices related to varying care coordination strategies (currently constrained by state policy), and with more robust and varied waiver services, will result in more rapid rebalancing of LTSS spending in Ohio without requiring a health plan to develop a new LTSS network.

Finally, we believe successful reform is more likely if Ohio creates a system for MMEs that is properly designed and equipped to account for the differences in medical care and LTSS. Dually eligible individuals use LTSS need daily, not just episodic, assistance. Telephonic care management frequently cannot adequately address the challenges arising from the aging process, mental illness, family difficulties, and dementia that make it difficult for many MMEs to comply with medical treatments or advice without hands-on help, including in-home visits by a LTSS care manager. All PASSPORT in-home care consumers, for example, qualify for nursing home level-of-care, meaning they need help with at least two Activities of Daily Living.

Features of the hybrid system proposed by Ohio's Area Agencies on Aging include:

- **Mandated coordination with capitated managed health programs, behavioral health services and the LTSS system**
- **Standardized use of standardized assessment protocols and exchange of applicable health information across all participating medical care providers**
- **Care coordination including interfacing with medical care providers across all care settings**(home and community based services, nursing homes, assisted living, various types of supportive housing), including employment of strategies to use evidence-based strategies to increase the efficiency of care coordination itself
- **Earlier face-to-face interventions, education, and assistance** for consumers**,** including improved management of nursing home admissions
- **Expanded housing and consumer-directed options** for LTSS consumers within the combined waiver programs
- **Open enrollment for the combined waiver – no waiting lists**
- **Innovative interventions to lower costs and improve health outcomes**
- **Building on the existing strengths of Ohio's ADRN**
- **Increasing potential federal revenue to the state**

Detail for the features listed above:

- **Mandated coordination of capitated managed health programs, behavioral health services and the LTSS system**

Where acute care providers identify the highest-use/highest cost MME patients with potentially preventable and/or manageable high-cost services, they will collaborate with their Aging and Disability Resource Network to analyze how these patients intersect with behavioral health and LTSS. If a managed care plan were to choose to use their personnel instead of the acute care providers, the interface would be essentially the same. Together this team can develop a holistic,

person-centered care coordination plan that seeks the lowest cost setting for care. This model, organized regionally in alignment with Ohio's existing Planning and Service Areas, will open new avenues for sharing information and coordinating across disciplines, improving everyone's ability to provide consumers with opportunities for better health outcomes and cost efficient care.

Coordination between medical managed entities and ADRNs will save money through flexibility to create low cost interventions not allowed under current regulations, including eliminating unnecessary regulations and paperwork that burden the AAAs and providers in administering LTSS programs.

This model would allow current LTSS partnerships, agreements and proven programs to work with the acute care system. This is a unique opportunity to build on successful models of integration created among social / human services organizations and would be an excellent starting point to evaluate the impact of interventions and scalability.

Behavioral Health needs can be addressed from a medical perspective within the medical managed community. Social and community supports can be offered through the behavioral health community network providers. The ADRNss have established relationships in the community with behavioral health providers. Suggestions for integrating behavioral health services include:

- The use of predictive modeling to identify persons with needs for mental health services;
- Exploration of integrated mental health and health care management approaches to those identified with multiple needs or at risk for mental health institutional service use;
- Shared real-time data between mental health and physical health providers; and
- Advisory panels for integrative care collaboratives that include beneficiaries with serious mental illness and community mental health providers.

- **Care coordination across all care settings (home and community based services, nursing homes, assisted living, various types of supportive housing)**

AAAs can provide care coordination across the spectrum of settings for LTSS, including nursing homes, assisted living, in-home care and other supportive housing with service options introduced to expand nursing home alternatives. The AAAs offer proven, conflict-free care management across the state. The AAAs fill a gap in the current Medicaid managed care arena by providing comprehensive, conflict-free screening, assessment and in-home care management.

- **Earlier face-to-face interventions, education, and assistance for consumers, including improved management of nursing home admissions**

Ohio can learn from the experiences of states who have achieved more balance between nursing facilities and HCBS. Oregon HCBS/institutional ratio is almost the inverse of Ohio with 80% of Medicaid the elderly and physically disabled are served in HCBS and less than 20% in nursing facilities. An important component of their approach is early and consistent assessment, education and case management of nursing home residents. Ohio can adopt a similar approach requiring notification of all nursing home admissions, regardless of payer, and mandating an in-person visit. This would be an enhanced approach over the MDS 3.0 Section Q notification. In Oregon, AAA case managers are assigned a number of nursing homes where they see individuals upon admission and meet with nursing

home staff and family members with the intent of assisting individuals in returning to the community or living arrangement of their choice. Several surveys, including by AARP, indicate that more than 90% of individuals prefer home and community care.

- **Expanded housing and consumer-directed options for LTSS consumers within the combined waiver programs**

Some ADRNs have experience with the Choices model, a complete consumer-directed HCBS model including consumers as employers with a fiscal intermediary. We would recommend the Centers for Independent Living be engaged to provide voluntary training for consumers or designated representatives to act as employers.

Providing more housing options that build the middle continuum of care settings will address the needs of those who cannot be maintained at home but do not require a nursing home or assisted living facility. Options include enhanced relative care options and independent congregate housing where HCBS can be delivered by a single provider (In Oregon a considerable portion of Medicaid waiver HCBS is provided in Adult Foster Homes with up to five people whose average acuity levels are higher than those of residents in assisted living).

- **Innovative interventions to lower costs and improve care and health outcomes**

Examples include a hospital-based care transitions program where hospitals contribute funding for AAA Care Transition Intervention coaches. Early results from use of the evidence-based Coleman Care Transitions Intervention in local Ohio hospitals have shown marked improvement in the rate of hospital readmissions for consumers who use an AAA health coach.

According to a report of the Coleman Care Transitions Intervention [SM], patients who participated in the program were significantly less likely to be readmitted to the hospital, and the benefits were sustained for five months after the end of the one-month intervention. Anticipated cost savings over 12 months is $295,594 for a typical transitions coach panel of 350 chronically ill adults with an initial hospitalization. Patients who received this program were also more likely to achieve self-identified personal goals around symptom management and functional recovery.

Applied to MME consumers needing LTSS, an interface between these post-acute techniques and the on-going HCBS care coordination infrastructure will optimize the potential for stability and effective follow-through so critical to avoiding transition failures that frequently lead to re-hospitalizations and health deterioration that frequently leads to nursing home placement.

- **Keeping HCBS Medicaid waivers "open" without waiting lists.**

Ohio's aging waivers have achieved significant progress in diverting and transitioning people from nursing facilities to home and community options. The most progress has been made when the waivers remain open and a continuously viable option for Ohioans. Scripps Gerontology Center estimates that when a waiting list was lifted in 2007, Area Agencies on Aging saved the state $190 million on long-term care in that year alone. Closing enrollment impedes the progress of balancing and increases costs to the state.

- **Targeting "hot spots" in Health, LTSS, and behavioral health.**

Integrative care collaboratives can identify the highest risk/highest cost MMEs to target for intervention with managed health care in health homes, ACOS, or managed care organizations. These collaboratives could bring in expertise in care transitions, behavioral health and/or chronic disease management to mitigate the risk of poor health outcomes, hospitalization, rehospitalization or long term nursing home stays. As experienced in Ohio's HOME Choice program, the greatest cost savings are often with younger adults who do not need waiver services but lose housing and informal supports while in the nursing facility The MDS could be used to find some of those hot spots which could be weaved into the integrated care collaborative.

- **Building on the advantages of the current operation of the Aging and Disability Network include:**

Home visits: Through face-to-face assessments and care management, ADRN staff gain accurate accounts of health status and can respond to prevent or delay avoidable moves to high-cost care settings. For the frail elderly and other disabled individuals, in-person contact is frequently the most effective method for containing care costs. Under the system proposed here, when sufficient stability in a consumer's health care and support systems permits, less expensive evidence-based protocol guided telephone monitoring and coaching, can be employed to reduce costs, while retaining the ability to quickly engage in-person intervention when needed.

Community roots: A major strength of Area Agencies on Aging comes from the ability to leverage every available resource to provide the care older adults and their caregivers need to remain independent. We are rooted in our communities, tapping into local resources, supporting families in caring for their own, and establishing innovative partnerships with service providers. Given that Ohio's population of adults age 60+ will reach 4 million by 2040, our care-management expertise is imperative to the state's cost-containment strategies. Our latest innovation shows great promise in diverting individuals from nursing homes and returning long-time nursing home residents to the community. Preliminary research by the Scripps Gerontology Center shows that after six months, about two-thirds of individuals identified for diversion from nursing homes remained in the community and 53% of targeted nursing home residents returned home or to assisted living. At one-third the cost of nursing homes, independent living rapidly racks up savings. One frail senior saves the state an average of $3,000 for every month he or she uses in-home services instead of Medicaid-funded nursing home care.

Statewide coverage: Managed care companies gravitate toward urban areas where health care services are concentrated and easier to coordinate. In contrast, ADRNs reach into all 88 counties. They are already recognized as part of a community's fabric, well-trusted, and provide superior service in urban and rural areas, often developing and nurturing providers in underserved areas and monitoring quality regardless of provider type or location.

Leverage local dollars: In 72 Ohio counties, voters have long supported tax levies that expand services to older adults. Bringing in more than $136 million statewide every year, these ballot issues

augment limited state and federal funds needed for our aging population. As indicated above, many of these resources supplement Medicaid-reimbursed services and help to underwrite their infrastructures, thus lowering Medicaid costs. If voters believe that large managed care companies are taking over long-term care, communities will be less likely to raise local revenue for services such as in-home care and Ohio will lose needed local revenues and community support for residents in their communities.

- **Increasing potential federal revenue to the state.**

The federal government is providing opportunities such as the Balancing Incentive Payment Program (BIPP) to increase the amount of federal funds Ohio can receive by an increased Federal Medical Assistance Percentages (FMAP). The mandatory components of BIPP (no wrong door, standardized assessments, and conflict-free case management) go hand in hand with the proposed integration model in strengthening system design.

Based on the latest nationally reported data (2009), Ohio could receive $36,075,109 a year for 4 years (1,803,755,463 times 2%). However, this program began October 1, 2011 and will end September 30, 2015. Every day Ohio delays and does not receive CMS approval, it loses $98,836 a day based on 2009 expenditures (which are now likely higher).

III. How the hybrid model would meet needs of all MMEs

This hybrid model of MME integration could deliver care to a full range of dual eligibles with the following components:

- Initial comprehensive assessment and screening for risk, with care management for those at higher risk for poor outcomes, avoiding unnecessary emergency room, hospital and nursing home admissions
- A multidisciplinary team approach to care
- Individualized care planning
- High-tech solutions such as remote monitoring of people in their homes
- Comprehensive care management with a single point of contact
- Management of care transitions across different care settings and home
- Diverting and transitioning people from institutions, and
- Coordination with health home and/or medical home models.

The proposed hybrid model will address the needs of all MMEs including those with LTSS and behavioral health needs. Physical health needs, including prevention and acute care needs, could be addressed through a capitated managed model. ADRNs can manage high cost, high need MMEs, including those with chronic disease in need of LTSS. ADRNs can provide chronic disease self management programs for this population, further reducing costly acute care services such as emergency department visits and hospitalization.

IV. How the hybrid model would change provider behavior or service use while assuring cost savings and delivery of high-quality, patient-centered care

The ADRNs, in cooperation with the ODA and ODJFS, have developed responsive and appropriate networks within their local communities, including home health agencies, assisted living providers, consumer-directed providers, and many “nontraditional” providers. They offer relatively low-cost,

person-centered services that can often prevent high-cost outcomes such as emergency department visits, hospital stays, or nursing home stays.

Coordination of these diverse provider networks is not part of the expertise of medical management entities, medical providers, or hospitals. But mandated coordination with primary care practices and these diverse provider networks will encourage a more thorough examination of needs and addressing those needs at earlier stages.

V. How the hybrid model would change beneficiary behavior and service utilization, including improvements in self-management of chronic illness and ability to live more independently

The hybrid model will capitalize on earlier intervention in nursing facilities and hospitals with a proven system that uses low-cost LTSS assessors and care managers. With increased access to information and advice at critical junctions, consumers and their families can learn about lower-cost and preferred care settings in a timely way that allows them to plan for shorter hospital, post acute and/or nursing facility stays.

People overwhelmingly prefer independent living, but tend not to seek information or plan for this option until they experience health crises that force quick decisions about care settings. Intervention is often needed to prevent moves along the "path of least resistance," which is usually to a nursing home. Education and guidance presented at the time of these decisions can help them navigate the services they need to achieve independence.

Targeting key chronic conditions with prevention and self management programs at these critical junctures can improve health outcomes and prevent costly medical treatments. Medical providers can rely on experts in the field to assist consumers in accessing the daily custodial services they may need along with more essential non-medical services such as home modification, transportation, and nutritious meals.

The integrated model should be person-centered and take advantage of consumer direction as much as possible. The new consolidated single waiver should employ consumer direction components contained currently in the current Aging waiver, CHOICES and should when possible expand on it. Developing these same standards within the integrated environment as exists within the waiver environment will change beneficiary behavior to one of empowerment and independence. Choices and other cash and counseling models reflect that people get more care and greater satisfaction compared to traditional models, with people staying in HCBS longer and experiencing fewer nursing home stays. In addition, .Building the continuum of options out in the middle with other housing and services such as adult foster care earlier is critical to integration. The state may want to consider other state plan options like community first choice. The proposed hybrid integration model builds on work already underway at the state to develop a standard assessment tool and single entry no wrong door approach. Under Money Follows the Person system reform, and Unified Long Term Care System, there is a desire to create a virtual door that allows consumers to access benefits and services and to connect to assessment screening. In addition, discussion of CONNECTME OHIO enhancements are about enhancing the information source across the state – all of this changes beneficiary behavior by

providing a point of entry that is not only seamless, but easy to navigate which results in empowerment.

VI. Value of certain strategic partnerships

Strategic partnerships build on already developed key partnerships and affiliations. Using this approach avoids needing to start over from scratch. The ADRC and its related Administration on Aging initiatives are a firm foundation to build on. The state was recently awarded additional ADRC funds, demonstrating the federal government's commitment to this approach. Just in the last two weeks, Ohio was awarded a competitive AOA grant to expand Ohio's work "to accelerate development of comprehensive, integrated systems that can serve as models for other states. The models will demonstrate how to enhance state systems to provide consumers, including individuals with Alzheimer's disease or another dementia, or their caregivers with simplified, streamlined access to needed services." Ohio was one of four states to receive funding to help older adults and people with disabilities remain independent and healthy in their communities. The award declares "States are working with Area Agencies on Aging, Centers for Independent Living, Alzheimer's associations, health departments, and community-based organizations to increase access to evidence-based caregiver support programs and health and prevention programs. A goal of this effort is to identify persons with early signs of Alzheimer's disease and related disorders so their needs and the needs of their caregivers are addressed. The Administration on Aging is awarding each grantee a fully funded three-year cooperative agreement." Ohio has established these linkages and is seen as a model for further integration building on these partnerships and alliances.

ADRNs through the AAAs have also established working partnerships with hospitals, physician practices and nursing homes around the state in their 30 plus years of promoting home and community care. These relationships have often matured into formal partnerships allowing increased work in reducing hospital readmissions and promoting home and community care. The Affordable Care Act has enhanced the ability of AAAs to develop these partnerships. In Cincinnati, the AAA has linked with HealthBridge to provide real time information on ED and hospital stays, greatly expanding the impact of their care transitions work.

About the Ohio Association of Area Agencies on Aging | o4a

The Ohio Association of Area Agencies on Aging (o4a), a nonprofit organization, is a statewide network of agencies that provide services for older adults, their families and caregivers, as well as advocate on their behalf. The Association addresses issues that have an impact on the aging network, provides services to members, and serves as a collective voice for Ohio's Area Agencies on Aging (AAAs). Equal Opportunity Employer/Provider. For more information visit, www.ohioaging.org.

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