



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

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Executive Director

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Ohio Association of  
Area Agencies on  
Aging (o4a)

Maureen Corcoran  
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RE: Medicaid Request for Information  
Ohio Medicaid Managed Care Program - Feedback from Individuals and Providers

Dear Director Corcoran:

The Area Agencies on Aging (AAA) are local leaders in aging and community living. We have a long history of connecting seniors to the services that they need to remain happy and healthy in their communities, which includes identifying social needs and connecting seniors with basic social supports such as food and housing supports.

The expansion of Medicaid to low income childless adults has provided the state with a financial incentive to take a longer-term approach to population health, particularly for the pre-Medicare population.

As the state considers changes to its traditional Medicaid Program, we would like to offer our lessons learned and strategies to improve the program for individuals with disabilities and pre-Medicare adults.

Below are some focus areas for consideration:

### **Care Coordination and Case Management**

The strategies used by the AAAs to successfully help people aging in place would work well for a number of younger individuals currently enrolled through the traditional Medicaid managed care program including those who are at risk of a long-term nursing home placement (e.g. pre-Medicare enrollees (55-64 age group), and individuals who are homeless, have severe and persistent behavioral health conditions, and/or high inpatient utilization). The AAAs are well-positioned to help ensure that this strategy is successful.

### **Recommendations:**

- **Integrated Care:** The state should maintain enrollment in managed care for ABD members who remain in a nursing home to ensure continued integration of care, incentivize maintaining aging in place, and to avoid adverse selection. Too often we are seeing nursing facilities push to discharge non-LTSS Medicaid recipients once the plan payment stops without adequate notice to ensure for a safe discharge.
  - Currently ABD members in nursing facilities are moved to fee for service after three months. This policy creates an incentive for institutionalization and is in

- At a minimum, the state should assign an independent case manager to any ABD member who has resided in a nursing home for more than 20 days to help the member evaluate his or her care options and, if needed, assist in transitioning to a Medicaid waiver.
- **Transition of care:** One of the most challenging and risky events in health care is when patients move from one setting or system to another, yet policy discussions rarely involve interactions between the acute and LTSS systems.
  - The state should incentivize collaboration and coordination between hospitals, post-acute care, and primary care providers to better support patient care and outcomes.
  - The state should develop roles and set expectations and facilitate collaboration among key partners (hospitals, payers, care managers) to improve transitions of care between facilities and from a facility to home.
  - AAAs are well positioned to assist the plans and providers with transitions of care as they have experience with evidenced-based care transition coaching.

### **Population Health**

The AAAs have long recognized and have worked to ameliorate the impact of non-clinical factors on patient health. As social determinants of health are integrated into the health care benefit, we want to ensure that the local organizations who have been providing these services have an opportunity to be successful in this new delivery system.

### **Recommendations:**

- **Social Determinants of Health:** The lack of basic social supports often drives poor health outcomes. If not identified early and addressed as part of a comprehensive care plan for high risk populations, consumers risk further degradation in health and the state faces higher costs. The State has an opportunity to create a strategy to address social needs and to select MCPs who will use local, community-based resources to carry out the necessary tactics. Part of the strategy should include:
  - Reliable, sustainable funding source that is eligible for a federal Medicaid match;
  - Identification of high-risk populations (e.g., high health care utilizers/high utilizers of multiple services, homeless, behavioral health conditions, jail transitions);
  - System wide tools deployed by PCMHs to assess needs and make referrals to community organizations;
  - Capacity building at the local level for community-based organizations (e.g. data and technology);
  - Community services provided by referral should be funded similar to the process used for supplemental benefits under Medicare Advantage; and
  - Direct services (i.e. intensive care coordination for high risk populations, access to flexible service funds to pay for nonmedical, one-time expenses).
- **Health Care Quality and Health Outcomes:** The state's current quality strategy for managed care is clinically based and does not adequately address strategies that improve health outcomes that facilitate aging in place throughout the lifetime.
  - Examples include fall prevention, transitions of care, integration with Medicare

- Performance based payments should reward improvements to cost and quality.
- Payment should incentivize coordination and collaboration between the acute and long-term care systems.

### **Data Sharing**

Good, timely, and actionable clinical and claims data is needed to drive decision making and ensure optimal care. The AAAs use data to identify care gaps, improve care transitions, refine internal work processes, identify areas for additional staff training, and to identify key partners in care (i.e. PCP). Currently, data is not shared consistently, access to clinical data is limited, and data quality varies.

#### ***Recommendations:***

- **Exchange of Clinical Data:** The state should take a leadership role in the integration of electronic medical records with the health information exchanges to ensure that actionable data is shared among key care partners.
  - Care plan and other key patient data should be shared among the patient's interdisciplinary care team.
- **Data Quality and Consistency:** Data quality is currently impeding greater progress on performance-based payments.
  - The state should develop clear standards and policies for data sharing.
  - A common template with consistent data definitions and formatting is needed to ensure that data is actionable without major manipulation. These should be uniform across all plans.
  - Increasing consistency and user friendliness across plans' IT infrastructure would be helpful. Currently, providers have to tailor their workflows for each plan's IT platform.
- **Increased Automation:** More processes need to be automated to maximize workflows and ensure patients get the care that they need.
  - Transfers, follow up, assessments, eligibility changes, and other key patient information should be shared automatically to ensure appropriate services are provided and to avoid gaps in care.
  - Notifications are needed to stop HCBS service when member in hospital and to ensure appropriate services are restored when the member is discharged.

### **Consumer Assistance**

Navigating the ins and outs of Medicaid and Medicare benefits and requirements can be overwhelming for recipients, and particularly challenging for those who are living with serious health conditions.

#### ***Recommendations:***

- **Maintenance of Eligibility:** The state's vision for better health for its Medicaid recipients cannot be achieved if consumers continue to churn in and out of the program. Many consumers experience gaps in coverage for technical reasons and not because they no longer meet the eligibility criteria for Medicaid. We recommend that the state better leverage managed care through its community partners to provide the outreach to consumers, particularly aged and disabled populations, to ensure that they do not slip through the cracks.

- **Appeals Process:** The state used to maintain a concurrent state and plan appeals process for consumers. Following adoption of the managed care mega rule, Ohio changed its process to require consumers to exhaust the plan process before filing an appeal with the state. The AAAs have found that many consumers have difficulty navigating the plan process. We would recommend that the state return to the concurrent process or create a neutral third party to serve as an advocate to help the consumer navigate the process.

Managed care has provided the AAAs with the opportunity to pilot a number of innovations with variation and at a pace that would not have been possible under the old fee for service delivery system. We look forward to refining our relationships and continuing to build on strategies to better care for our aging and disabled populations.

We would be remiss if we did not advocate that the state spearhead a Comprehensive Master Plan for Aging. Ohio's population continues to age and Ohio's current LTSS infrastructure including the future financing of LTSS is not adequate to meet the increasing demands. We need to examine all of our state policies and programs, not just long term care services and supports, with an age-friendly lens. For example, a Comprehensive Master Plan for Aging should take into consideration how to harness new technology to increase independence and make it easier for consumers to age in place and should include Medicare as well as Medicaid, in addition to other supports and services.

Thank you for the opportunity to provide comments on Ohio's Medicaid Managed Care procurement. If you have any questions, please do not hesitate to contact me.

Sincerely,

A handwritten signature in blue ink that reads "Larke Recchie". The signature is written in a cursive, flowing style.

Larke Recchie  
CEO