

Unified Long-Term Care System Advisory Workgroup Minutes January 12, 2012

MEMBERS PRESENT

Kathleen Anderson, Ohio Council for Home Care and Hospice
Hon. Nickie Antonio, Ohio House of Representatives
Bob Applebaum, Scripps Gerontology Center at Miami University
Angie Bergefurd, Ohio Department of Mental Health
Mary Butler, Ohio Statewide Independent Living Council
Janet Grant, Ohio Association of Health Plans
Betsy Johnson, NAMI Ohio
Bonnie Kantor-Burman, Director, Ohio Department of Aging
Beverley Laubert, Ohio Department of Aging, SLTC Ombudsman
Jeff Lycan, Midwest Care Alliance
John McCarthy, ODJFS Office of Health Plans
Greg Moody, Governor's Office of Health Transformation
Christopher Murray, The Academy of Senior Health Sciences, Inc.
Katie Rogers for John Alfano, LeadingAge Ohio
Joe Ruby, Ohio Association of Area Agencies on Aging
Hon. Barbara Sears, Ohio House of Representatives
Jane Taylor and Joan Lawrence for Bill Sundermeyer, AARP Ohio
Jean Thompson, Ohio Assisted Living Association
Pete VanRunkle, Ohio Health Care Association
Steve Wermuth, Ohio Department of Health
Hugh Wirtz, Ohio Council of Behavioral Health and Family Service Providers

HANDOUTS

- ULTCS Meeting Agenda and ULTCS Advisory Workgroup Membership Roster (updated)
- Draft Model Design for an Integrated Care Delivery System (ICDS) in Ohio for Individuals Enrolled in Both Medicare and Medicaid
- Improving Care Coordination for "Dual-Eligibles"
- Developing Integrated Delivery Systems in Ohio Powerpoint handout
- Experienced Voices: What Do Dual Eligibles Want from Their Care? AARP Public Policy Institute Report
- Home Health and the Ohio Medicaid Budget (Tender Nursing Care – public comment)

WELCOME AND INTRODUCTIONS

Chair Bonnie Kantor-Burman welcomed the members of the Unified Long-term Care System Advisory Workgroup and a packed room of attendees.

OFFICE OF HEALTH TRANSFORMATION UPDATE

Greg Moody focused on the following three large initiatives of special interest to the group:

- The launching of the [health care payment reform initiative](#) on January 9th,
- The January 11th release of the [Medicaid Managed Care Procurement Request for Applications](#) (RFA), and

- The issuance of the [draft Integrated Care Delivery System concept paper](#) to be discussed later in the meeting.

John McCarthy added details about the RFA, including a timeline whereby applications are due March 19th, awards to be made April 9th, readiness reviews to be conducted April through July and provider agreements handled in August.

Greg pointed out that the RFA is one example of how HB 153 laid out the framework, while driving the system toward person-centered care, especially in three focus areas: 1) health homes, whose white paper was submitted to the federal government late last year; 2) dual eligibles initiative, and 3) single waiver. Both of the latter two are at the concept paper stage and undergoing stakeholder input before being submitted to the federal government.

At the last ULTCS meeting, members discussed the need for additional stakeholder opportunities. Monica Juenger was asked to describe the upcoming regional consumer engagement meetings for families and caregivers. The Olmstead Task Force is assisting, via a contract with Lewin, to provide facilitation and a survey tool. [Six regional meetings](#) are planned:

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| 1) Jan. 24 – Toledo | 4) Feb. 7 – Cleveland |
| 2) Jan. 31 – Columbus | 5) Feb. 14 – Athens |
| 3) Feb. 3 – Dayton | 6) Feb. 18 – Statewide consumer call |

SINGLE WAIVER UPDATE

Matt Hobbs provided an update on the single waiver. The stakeholder process began on November 9th. Part one included beginning to identify service package, gaps in services, what works/doesn't work – all to guide the overall development of the package. Part two included developing a draft concept paper that we hope to release to stakeholders by the January 26th single waiver stakeholder meeting. The planning and implementation timeline has been revised to ensure no disruption to consumers; the single waiver will follow the duals waiver which should be implemented in late 2012.

DUAL ELIGIBLES CONCEPT PAPER DISCUSSION

John McCarthy provided a PowerPoint handout about the dual eligible initiative to integrate services for beneficiaries who receive both Medicare and Medicaid services, being referred to as MMEs (Medicare and Medicaid Eligibles). He referenced the drastic increase in the 60+ population by 2020, pointing out that as people age, their health care costs increase. While Medicaid does a good job of paying for Medicaid services, it lacks coordination ---coordination in ensuring the consumer gets the appointments, arrives at the appointments and is linked to other service needs such as behavioral health needed to maintain and improve their overall health. He described the thought process around enrollee protections, person-centered care, eligible groups, enrollment and benefits. The next steps are to refine the concept based on feedback. The approach proposed is managed care which would necessitate a three-way agreement among CMS, Medicaid and the Medicaid provider. Based on this, it would need to be an 1115 waiver.

Greg Moody suggested that people take time to read the AARP Public Policy Report: *Experienced Voices: What Do Dual Eligibles Want from Their Care?*

Questions/Comments/Themes

- Pete Van Runkle asked about the process for others (provider representatives) to work on the project. John McCarthy sought to allay concerns expressed about a precipitous issuance of an RFP in “early” 2012.” John said that no draft RFP has been written yet; JFS just sent a contract to the Controlling Board to get some help with necessary steps. He anticipates an RFP process in June or July at this point, dovetailing with CMS conversations.
- Jeff Lycan spoke about consumer protection/quality measures and the need for public reporting (transparency) by the Integrated Care Delivery System (ICDS) for consumer choice.
- In the AARP report, Jeff Lycan noted the lack of access identified, especially in rural areas, partially around how dollars are directed to acute care and the potential for fewer hospital visits and fewer community providers on the prevention side.
- Jean Thompson applauded a system of 24/7 access and urged that the point of contact be a live person, especially for an elderly consumer. She commended the focus on consumers, but wants to see more particulars. She also mentioned concern over the limitations of primary care doctors’ willingness to take on new Medicaid patients.
- Hugh Wirtz suggested adding supplemental services specialists (PowerPoint slide 4) to support wellness efforts.
- Hugh Wirtz also asked about the network/array of services. John McCarthy responded that there is no carve-out, but how that interacts with mental health has not yet been decided. Behavioral health providers are seen as part of the network.
- In response to a question by Rep. Sears about HCBS eligibility requirements for those with NF level of care, John McCarthy stated that those already in the system would be “grandfathered” in, but with Money Follows the Person program, we are trying to see if they can be served in the community; there is no intent to take services away.
- Rep. Sears also expressed concern around ensuring fluency of services across different regions with centralized coordination, especially for those with a “whole host of needs.” John McCarthy responded that we are looking at a regional approach involving urban areas and smaller areas that don’t line up with the January 11th RFA that was issued.
- Rep. Sears also asked about overlaying identifiable resources, e.g., AAAs. Bonnie Kantor-Burman mentioned the new integration grant to help work with State Medicaid on coordination.
- Rep. Antonio asked for clarification on the consolidation of contracting. John McCarthy responded that we are moving from 38 to 12 (three different regions with four plans per region) in the current managed care contracts, separate from the duals proposal. There is no plan to roll the duals project into the RFA that was issued; the populations are totally separate.
- Rep. Antonio asked about the availability of dollars to “frontload” information for people. John McCarthy mentioned that other states have included an outreach/educational component to help people make choices.

- Bob Applebaum's issue related to the older population with service disabilities, half of whom are on Medicaid, with this population expected to triple, which the state can ill afford. Making Medicaid more efficient, while an admirable aim, doesn't erase the problem. In dual eligible managed care, there is no incentive to keep people OFF Medicaid rolls. We need to help people stay in the community, independent of Medicaid, mentioning the unique levy programs in Ohio with potential resources to help. Hugh Wirtz responded that the irony is that local resources are stretched further when they can get more people ON Medicaid rolls.
- Bob Applebaum believes that the whole system needs to change to make Medicaid the last place to go, not the first, or risk unsustainability. He added that allowing elders to opt out of Medicare makes sense, but defeats the purpose. The issue is having long-term care managing one piece and acute care managing another. John McCarthy asked for more input on this topic, but reminded him that CMS cannot do mandatory enrollment on Medicare.
- Rich Browdie suggested that the "strawman proposal may become a piñata." With so many areas and each with their own complexities, questions lead to more questions. We need to think about adequate number of lives as one issue. John McCarthy responded that there are 190,000 Ohio Medicaid consumers.
- Janet Grant focused on timing of implementation, suggesting that we take time to get this right so the consumer doesn't get lost. In Michigan, duals were enrolled in managed care effective December 1st, and it has been a nightmare.
- Janet Grant also asked how we are approaching special needs related to the CMS timeline. John McCarthy responded that we are trying to weave Ohio's efforts into the CMS timelines which should increase our chance of waiver approval; otherwise, it may take two years or more. Meanwhile, CMS is being as flexible as possible.
- Betsy Johnson asked about the value in holding consumer sessions now and then again in nine months out to see if it is working. She also asked if the consumer opts out, would that put them on fee for service for the Medicare pharmacy benefit? John McCarthy responded that they would still need Medicare Part D, but there is a difference inside the Advantage Plan, that still needs to be worked out. CMS believes that Medicare CMMI proposals around payment methodologies, e.g., home health, would be outside this initiative.
- Greg Moody announced that tomorrow (January 13th) the new OHT website is being launched and will include all areas, as well as how to submit comments on the concept paper electronically. The website will continue to be updated as new information comes available. He encouraged everyone to sign up for electronic updates.
- Joe Ruby said that most (85%) of his AAA's PASSPORT consumers are dual eligibles, and that PASSPORT infrastructure provides local guidance, mostly non-Medicaid, and for those who are Medicaid-eligible, it gets them to the right place. He stated the need for more home visits, possibly through the AAA structure and expressed his fear of dismantling an effective PASSPORT system. John McCarthy asked how we design this initiative to take this into account. One potential option might be to require contracting with PAAs, stressing that PAAs continue to be partners because of their history.
- Kathleen Anderson asked if acute care short term services integrated with LTC services needs to be added to the chart (PowerPoint slide 4).

- Kathleen Anderson said providers need the opportunity to come up with recommendations for credentialing, licensing, accreditation of providers, etc. and to talk about it as an industry. John agreed that we want those provider protections and encouraged more discussion on such topics as prompt payment.
- Jean Thompson mentioned the consumer appeal and grievance process, suggesting a parallel process be added for providers.
- Diane Dietz is interested in knowing when the Front Door workgroup will start working on Phase 3 level of care work. (It has not been determined at this time.)
- Mary Butler talked about the vital peer support work through the CILs.
- Jane Taylor suggested the need for better understanding of the structure to provide for consumer input. Greg Moody suggested utilizing a focus group type session to discuss barriers and opportunities for coordinated care, and then anticipate a second round of focus groups further down the road.
- Jean Thompson spoke about payment methodology whereby ICDSs are paid less than the Medicaid rate and then pay providers less, resulting in decreased access. John McCarthy responded that we are trying to build in the right incentives. We don't want ICDSs to just cut rates; we want better health outcomes and, where appropriate, to move people to or keep people in community settings.
- Jean Thompson suggested, using the example of generic vs. brand drugs, that services consumers are getting may not be at the level they need, but rather the level they want.
- Pete Van Runkle suggested that an artifact of the Medicare system, the minimum three-day hospital stay, is more costly. Through coordination, we could eliminate these kinds of rules and thereby cut costs. John McCarthy responded with concern over whose rules to use (Medicaid or Medicare), e.g., for payment methodologies. We cannot just run as two separate programs; we must figure out how to blend them.
- Chris Murray suggested that the language in the concept paper around the relationships of strategic partnerships is not very strong; it uses "expected", rather than "we will ensure..."

PUBLIC COMMENT

Maria Thacker, Administrator of Tender Nursing Care, provided handouts and spoke about her concerns as an advocate for the patients she serves, as a provider who cannot afford to contract with managed care, and as an employer who cannot afford to pay her employees a living wage. She spoke about closed networks, about the potential for managed care to increase nursing home placement and about the potential dismantling of PASSPORT.

Greg Moody thanked her for her courage in speaking up. John McCarthy thanked her for her good input in equipping him to go back to the health plan CEOs and pushing them to improve quality and changing the program for the better.

NEXT MEETING

Bonnie Kantor-Burman closed the meeting by thanking everyone for the valuable stakeholder input and reminding them of the next meeting scheduled for Thursday, March 8, 2012, 1:00 pm at the Lazarus Building, 50 W. Town Street, Conference Rooms C621 A/B. Meeting adjourned at 3:25 pm.