

# Unified Long-Term Care System Advisory Workgroup Minutes

## March 8, 2012

### MEMBERS PRESENT

John Alfano, LeadingAge Ohio  
Kathleen Anderson, Ohio Council for Home Care and Hospice  
Rich Browdie, Benjamin Rose Institute for Aging  
Mary Butler, Ohio Statewide Independent Living Council & Ohio Olmstead Task Force  
Jodi Govern for Steve Wermuth, Ohio Department of Health  
Janet Grant, Ohio Association of Health Plans  
Betsy Johnson, NAMI Ohio  
Bonnie Kantor-Burman, Director, Ohio Department of Aging  
John McCarthy, ODJFS Office of Health Plans  
Greg Moody, Governor's Office of Health Transformation  
Christopher Murray, The Academy of Senior Health Sciences, Inc.  
Tracy Plouck, Ohio Department of Mental Health  
Larke Recchie for Joe Ruby, Ohio Association of Area Agencies on Aging  
Katie Rogers for Jeff Lycan, Midwest Care Alliance  
Bill Sundermeyer and Joan Lawrence, AARP Ohio  
Jean Thompson, Ohio Assisted Living Association  
Pete VanRunkle, Ohio Health Care Association  
Hugh Wirtz, Ohio Council of Behavioral Health and Family Service Providers

### HANDOUTS

- ULTCS Meeting Agenda
- Modernize Eligibility Determination Systems
- Eligibility Modernization Timeframe
- Eligibility Modernization chart
- Balancing Incentive Payments Program
- Person-Centered Care Coalition poster

### WELCOME AND INTRODUCTIONS

Chair Bonnie Kantor-Burman welcomed the members of the Unified Long-term Care System Advisory Workgroup members and other attendees, both in person and by conference phone. She mentioned the person-centered care coalition posters and the 650-person conference occurring in Columbus today, thanking the three nursing home associations for their help.

### QUALITY INCENTIVE WEBSITE & TECHNICAL ASSISTANCE UPDATE

Bonnie announced that ODA has been working in partnership with ODH and ODJFS on the Quality Incentive website that is expected to be launched next week. Dusty Ellinger added that ODH is working to align its Technical Assistance Program (TAP) with the QI program to assist providers with the common goal of improving quality. Julie Evers said ODJFS-OHP is developing a web-based collection tool for 10 of 20 standards. It should be operational by the end of the month to begin collecting data for use in rate setting. Notification will go out when each component is available.

### BOARD OF EXAMINERS OF NURSING HOME ADMINISTRATORS (BENHA) UPDATE

Bonnie reported on the history and development of BENHA indicating that the field of long-term care has changed dramatically since BENHA was created. Given our move toward a unified LTC system, it seems timely to review the strategic goals for the board.

Jodi Govern provided additional structural information on BENHA. It is based in statute and its members are appointed by the Governor. It is housed within the Department of Health which provides administration and technical assistance. As a governmental licensing board, its licensure fees support the operations and staff costs.

Bonnie proposed that a fifth ULTCS subcommittee be formed for the following purpose:

*To seek stakeholder input regarding proposals for changes to the structure and affiliation of the Board of Examiners of Nursing Home Administrators, as well as potential expansion of the Board's authority and scope of practice to allow the Board to develop standards and a more inclusive curriculum appropriate for administrators of additional long-term care services and supports that places an emphasis on person-centered care.*

ODA will send out notification asking ULTCS Workgroup members to suggest a representative to work on this subcommittee. It is meant to be a short-term effort that is collaborative, inclusive and timely, with its work to be completed by late summer. Bonnie noted that the BENHA executive director and president are aware of this initiative and the BENHA Board has voted in support of it.

#### Questions & Comments:

- Kathleen Anderson requested that an orientation/refresher orientation on BENHA be provided.

#### **PASSPORT ADMINISTRATIVE AGENCY CONTRACT**

Bonnie announced that the PASSPORT Agreements with the 13 PAAs which went into effect in July 2011 were one-year contracts with the ability to extend them for the second year. ODA is sending out today, the offer to extend the contracts through 6/30/2013.

#### **INTEGRATED CARE DELIVERY SYSTEM (ICDS) DRAFT PROPOSAL**

Greg Moody described additional opportunities between now and March 27<sup>th</sup> for public comment on the ICDS proposal, describing this ULTCS Meeting as one of those opportunities, with other options posted on the OHT website. All comments are being reviewed for consideration in the final proposal. Greg asked ULTCS members to think about not just asking questions, but recommending answers to the questions they pose.

#### Questions & Comments:

- Pete VanRunkle asked when dual coverage starts. John McCarthy responded that in current managed care, there is a 30-day fee-for-service anticipated before enrollment starts.
- Larke Recchie asked what happens long term on the ICDS rollout. John McCarthy responded that the regions are being proposed for the three-year project, but the state is seeking feedback on what makes sense, e.g., to go statewide in year two which would necessitate a lot of infrastructure, especially in rural areas or wait till year three to go statewide, realizing that there is only one year remaining to get to the outcomes.
- Hugh Wirtz asked how we maintain clinical relationships, especially in team-based care, to maintain continuum of care and prevent gaps in benefit. John McCarthy suggested including a contract requirement to continue with the current provider for a specified length of time.

- Bill Sundermeyer asked about notification back to proposing entity on disposition of recommendation/idea. There is no plan to notify unless clarification is needed. Greg Moody said the final draft undergoes a 30-day federal comment period, and mentioned the two levels of detail: 1) what is built into the model, and 2) what appears in the contract.
- Jean Thompson asked about multiple programs operating during the transition. Since new enrollees are enrolled on their respective birthdays, any one provider may be involved in two programs, plus the waiver will continue to run in non-target areas. John McCarthy acknowledged both her statements. He reminded the group that the managed care company DOES NOT make these decisions; these are our decisions. He asked how we create a system that ensures quality of care. An 1115 waiver provides greater flexibility where we get to decide what the network is, but a larger network will cost more. He asked what measures/outcomes we should include in the contract, reminding them that we can also make changes to the contracts as we go along.
- Jean Thompson asked if providers had to accept everyone they were sent. John expressed support for choice, but mentioned that geography and distance also come into play to ensure an adequate provider network. He asked the group to think about how we should write that contract with managed care entities to ensure quality of care.
- Joan Lawrence asked what happens with PASSPORT programs. Greg Moody responded that, despite recent Dispatch article misstatement that ICDS plans are being required to contract with PAAs, that decision has not yet been made. The purpose of the stakeholder forums and hearings is to hear people declare how they want the system to work: what gets in as design feature or what principle should be incorporated into the detail of the contract.
- Hugh Wirtz mentioned a potential unintended conflict with behavioral health providers regarding clients who may also need wrap-around, non-Medicaid services, and the impact on providers' book of business. John McCarthy stated that all provider types need to take into consideration the ICDS proposal which is not just for Medicaid services.
- Mary Butler asked how ICDS measures outcomes for someone, for instance, who might not walk again. John McCarthy talked about big strides in measurement, e.g., fewer unnecessary trips to ER, diabetics' blood glucose levels or amputation rates. Such measures don't assume a "cure" but limit deterioration to what is reasonable. CMS wants to rebalance home- and community-based LTC and to prevent heart attacks. He added that HHS has a national Medicaid quality strategy that has been incorporated into the last part of the ICDS proposal.
- Betsy Johnson asked about cost savings being routed back into GRF or the behavioral health system. John McCarthy said the intent is to share cost savings with providers, but based on the current 6-7 percent growth, do we instead want to invest back into high quality services in order to lead to more savings? Greg Moody urged people not to miss the comment period. If the model is to generate savings, it makes sense to whoever is in that model to consider a pay-for-performance benefit, i.e., increasing capacity, rewarding outcomes and taxpayer stability – a model that can generate savings through innovation.
- Bill Sundermeyer recommended that "do not supplant resources" language be added.

- Rich Browdie asked how rates were being set for capitation. John McCarthy replied that we are talking with CMS actuaries to look at cost across settings, age bands and genders, and then looking at differences while balancing risk on covered lives to ensure incentive rates are built in.
- Kathleen Anderson asked if administrative rules were needed to enact ICDS. John McCarthy replied no; instead, requirements will be built into the contract.
- Mary Butler asked how to reward managed care organizations that take on someone who has a pre-existing condition, noting the potential for “cherry-picking.” John McCarthy answered that since there are only two plans for a given area, it will be easier to monitor. Rates are expected to be lower for lower needs, or built-in incentives for higher needs. Then, using performance-based measurement, a percentage can be withheld to be issued for high performance. In addition, penalties and/or taking dollars back from failure to perform are other tools.
- Jean Thompson asked if ICDS will serve as the front door for the January 2013 start-up. John McCarthy clarified that unlike Part D plans that can solicit individual’s business, once dual eligibility is determined, he/she will have the choice of two options for his/her respective region and if he/she does not choose, he/she will be auto-enrolled. Individuals who are enrolled will receive letters in October – December. Once enrolled in a plan (to start on 1/1/2013), a new care coordinator will reach out to them. We are still working on who the potential dual eligibles may reach out to when they get the initial letter.

### **BALANCED INCENTIVE PAYMENTS PROGRAM (BIPP) APPLICATION**

Greg Moody stated that the decision to apply for BIPP has not yet been finalized. Kim Donica reviewed the grant details. BIPP is an opportunity through the Affordable Care Act to receive enhanced federal Medicaid match for services identified in the handout she provided. Components include: a comprehensive no wrong door (for all ages and across the disabilities system), conflict-free case management, core standardized assessment (e.g., core data set to be used across systems to assess need for LTSS).

There are challenges:

- Any enhanced FMAP must be used for services, but infrastructural changes will be needed to comply.
- There are extensive reporting requirements, including a consumer satisfaction component.

There are also advantages:

- Enhanced match is approximately \$60 million per year.
- Some MFP Balancing funds are dedicated to this effort because we are already heading this way.
- If we fail to meet the 50/50 benchmark, there is no funding payback required, and if we reach the 50/50 benchmark early, we can continue to receive enhanced match through the grant term, as long as funds are available. To date only one other state has been approved, so funds will likely be available.
- States can start receiving the enhanced match during the first month of the first quarter after their application is approved.

### Questions & Comments:

- Larke reminded the group that PASSPORT has conflict-free case management. She asked about how to include the disability population's data. Kim responded that the appropriate firewalls already exist.
- Janet Grant mentioned capitated HCBS available that would have to meet the same requirements, including administrative requirements.
- Bill Sundermeyer asked if Assisted Living is considered institutional care. Per John McCarthy, institutional care includes nursing facilities, ICFs and hospitals. However, CMS has some draft rules that might alter that definition.
- In response to a question about time frame for a decision on the BIPP application, Greg said that it makes sense to use the same timeframe as the ICDS model (within the next month or so).

### **ELIGIBILITY MODERNIZATION**

Currently there are 150+ categories of Medicaid eligibility in the 88 counties. Most require an in-person visit to the county office. An individual may be admitted to a nursing facility and not know for 120 days if he/she is Medicaid-eligible. In 2014, under the Affordable Care Act, Medicaid eligibility will go to 200 percent FPL for children and 138 percent FPL (including a 5 percent hold harmless) for adults. Greg Moody announced that a new concept paper will be coming out within the next week on eligibility simplification. This creates an opportunity to simplify eligibility to two categories, one of which would be modified adjusted gross income.

Greg distributed a chart of "Potential Impact on Current Medicaid Enrollees," along with a timeframe and a document entitled, "Modernize Eligibility Determination Systems." In working to get an accounting of who would be impacted, the vast majority (roughly 95 percent) would automatically qualify based on income alone. Those who are currently eligible could be grandfathered in January 2014 when this provision kicks in while we determine what additional test we need to use to keep them from disenrolling.

### Questions & Comments:

- Janet Grant asked for more details about how many duals, SPMI, etc. John McCarthy responded that we have to get the data from CRIS-E and work backward, so it represents our best guess at present.
- Rich Browdie asked about how to speed the process of looking at assets, especially for older adults. Greg responded that under eligibility modernization, we would first look at income, which would handle the 95 percent. That would free up JFS staff at the county level to focus on the other 5 percent of tougher determinations.

### **NEXT MEETING**

The next meeting is scheduled for Thursday, May 10, 2012, 1:00 pm at the Vern Riffe Building, 77 S. High Street, 31<sup>st</sup> Floor. Meeting adjourned at 3:20 pm.