EOHHS Task Force
Meeting Minutes
November 23, 2015

Attendees: Nicholas Oliver, Allan Post, Maureen Maigret, Mary Calner, Ellen Brachy, Ann Mulready, Paula Parker, Anya Rader Wallack, Tom Izzo, Christine Gadbois, Holly Garvey, Michelle Szylin, Jim Nyberg, Craig O'Connor, Celia Pelkey, Deb Florio, Kathleen Kelly, Tom Cahill, Vivian Weissman, Michelle Brophy, Brenda Amodei, Lauren Pond, Theresa Jenner, Sharon, Michael Burk, Virginia Burke, Roberta Merkle, Tina Spears, Jennifer Bowdoin, Karen Beauchamp

I. **Welcome – Senator Izzo**

Senator Izzo welcomes new Medicaid Director Anya Rader Wallack and invited her to say a few words.

Medicaid Director Wallack: Many familiar faces here today, several new. I have lived in RI for 17 years, but mostly worked outside of the state. Prior to this position I was appointed as the head of Health Source RI, but the majority of my career has been focused on Medicaid policy. Always a learning curve on specifics of RI, and I look forward to working with all of you, and am happy to answer and questions, feel free to reach out for meetings through my assistant Leslie Smith. Thank you!

Kathleen Kelly: Could you quickly talk about any differences or similarities between RI and VT?
Anya Rader Wallack: I could speak about that in general, but the specifics of what is happening right here right now are what are most important. A lot of change in RI's Medicaid program right now is fairly and exciting around the country. Payments on value; innovation here. RI in the more general sense more similar to MA & VT in that they are waiver, tend to be progressive states, eligibility for coverage is pretty similar. I look forward to working in another progressive state using Medicaid as a tool to really help with health, not just the physical and mental health but also to use as a tool to improve the economic health in RI. Pulling on things I have learned in VT, but a lot we are innovating here and that is very exciting.

II. **Update: Drug Overdose Prevention Grant – Jennifer Koziol**

Jennifer Koziol, Department of Health, working with the Injury Prevention Program. Brief overview of the program.

Jennifer Koziol: This is a four-year CDC grant and it officially started September 1 2015, relatively competitive, with 32 states applying, 16 receiving funding. Awards $940,000 per year for four years and with this grant we will use funding to put towards funding staff who can be 100% dedicated to the drug overdose program. Will be hiring a project manager, an epidemiologist, an academic detailer and data manager – all have been posted and

interviews have begun. When writing the grant, CDC was somewhat restrictive in types of funding for what activates we could do. They were clear that we could not use funding to purchase naloxone – it must be focused on prevention. The bulk of the grant is focused on prescription drug monitoring program. There will be a strategy to get 100% of the subscribers registered. Make the prescription drug program easier to use.

There will be a lot of education for providers, onsite training, hosting a CME. Many of the activities we wrote into this grant overlay with the Governor's strategic plan to combat drug overdoses. A goal will also be to connect our information with neighboring states. Community intervention, including a drug overdose dashboard. Contracting with Providence Community Health Centers and anchor recovery centers. Peer recovery coaches; connected in EDs and Dept of Corrections. Contracting with Anchor to do targeted street outreach.

Ann Martino: We were going to request a Medicaid waiver for peer recovery specialists – did we do that?
Michelle Szylin: Yes, in process.
Jennifer Koziol: Yes, that's great.

Brenda Amodei: Would the peer outreach contact be reimbursed?
Jennifer Koziol: Right now there is no reimbursement for peer recovery coaches in RI.
Brenda Amodei: Is that up for comment?
Ann Martino: That is something to raise during the public comment process. That would be the forum to ask them, in our waiver request to the state.
Jennifer Koziol: Thanks. Back into community interventions, we will be working with URI School of Pharmacy to help normalize naloxone. Then we will also be looking at evaluating law, policies and regulations (reporting, evaluating access, and evaluating the good Samaritan law, but that sunsetted over the summer, so we are hoping to have then up again). Finally, looking to do a year one rapid response program a panel of experts to review up to 16 deaths, and put together a paper and then lay over with trends that we are seeing, and use the findings to turn it into a public marketing. If there are any ideas or chances for partnering we can let us know.

III. Ongoing Initiatives Update

a. Reinventing Medicaid Update

Deb Florio: there is a hand out of the Initiatives Dashboard. Red means things are risky, certain things not on schedule. Happy to report have gone down to just two items behind schedule, and those are the first two items on the dashboard – Assisted Living. Behind a little as it is a big initiative, with a waiver from SSA to ensure folks would have more income as well as being able to work with the Assisted Living provider community to bring more Assisted Living providers into the Medicaid world. This will be a big change gone up about $500 dollars, maybe not on the first, waiting for SSA to give us the final go. They have everything in place, need authorization from OMB. You have Category D, will be category F have to be in long term manage care to get this. This is exclusively for those who are long term care eligible.

Paula Parker: Will it start before the full integration?
Ann Martino: Yes. Anyone in Phase I can go in; have to be in the integrated care initiative, with a new set of certification standards, and that includes being able to provide advanced services, and at the highest level they would have to be able to perform dementia care. Certified by Medicaid, authorized under state wide. Certification standards are based on national standards.

Deb Florio: Plan is to share with industry leaders, want your feedback. It will be NHPRI doing the contracting as it will be for our managed care members. Many moving parts, very complicated, committed to working together.
Deb Florio: Continuing on with the dashboard, Electronic Visit Verification. That is in RFP status, hence why that is a bit behind. Otherwise we are moving right along very well. Overall I see this as initiatives driving together to really help move the system forward in a healthy way. Teams are meeting with teams. As an example, we have SPMI coordinated care. Those enrolled in NHP &United with SPMI, and all services coordinated and paid for through the plans, except we had the small number of services that were not paid. Now the whole continuum will be coordinated through the plans. That is one thing. Then also take the home stabilization and putting that underneath it, taking adult day and put that underneath it. Wrapping these programs around members to really help with the continuum of care. On the Kids side, we are re-organizing what we have the CEDARR family centers do. At the same time, we do the same thing for special needs kids putting all care in the plans for these kids. Care coordination in offices. Families have access to a CEDARR if they want, but if they don't they still have access to the services they may need. Meet the needs of the people we serve, not just meet the needs of providers, or just the plans. This are things helping to make the system work better for kids and families.

Virginia Burke: RICLAS initiative has significant savings attached to it. What is that?

Deb Florio: RICLAS is a type of group home. They are either run through a state employee or a private system. The state is trying to reorganize how those are utilized. What people have the most serious needs that we have to staff up at the most serious levels, to divert from ESH and use the state system for that. That reorganization makes a difference – only use a public system for the highest need population.

Maureen Maigret: A reference for state policy for telehealth, it says state policy complete. Where would one find that?
Ann Martino: This is a state plan amendment on that, not completely written just yet.
Deb Florio: It is a clinical policy, we can share it in draft with this group, under certain circumstances that it is better medicine to use telehealth (Skype etc.) There are more elaborate forms of telehealth as well, but we are saying it is acceptable.
Maureen Maigret: I raise that issue as some of us using geriatric competent care is that telehealth can be very successful, but at some point some of the home health agencies were using

Deb Florio: We are putting it into the health plan contract, any and all of those are open for negotiation now. We had to present to CMS; Medicare pays for some of those services. We are saying go forth and make policies, health plans, to reimburse for this.

Maureen Maigret: Adult day as noted here, it says submitted a SPA. Where is that?
Michelle Szylin: It should have been posted online last week – we will verify.

Maureen Maigret: Last question is expedited eligibility for LTSS – I have heard anecdotal reports on the process as it is going more slowly. Can you update?
Ann Martino: As a budget initiative a decision was made to put a hold on it given there are so many systems issues. However, as we will discuss later, there is a Lean initiative at DHS that has a goal to give updates on this.
Deb Florio: On the programmatic side we have put someone more in charge of organizing us in a way to have more authority around the efficient streamline. How many times touching this piece of paper, etc. The Secretary will have someone direct operations on the eligibility and enrollment side.

Ann Martino: As we streamline and update the rules, and get onto the UHIP system you will start to see more efficiency
Senator Izzo: Back to telehealth, if there are some providers who can do some things under Medicare for rules and procedures and then Medicaid follows the same thing…how is that meshing?
Deb Florio: Generally speaking what we would do is speak to Ann about rules, then start working on the systems stuff. Then we fix that, then we notify the providers. Then once those three steps are taken, we would watch. May have to tweak their contract a bit, but should not be overly burdensome.

Ann Mulready: Coordinated care management for SPMI, it says that the plan is improved and on target. Can you speak to that?
Deb Florio: Yes, there is a carve out of high level, high intensity behavioral services for SPMI. Those already in the plans, but had a piece carved out. As of 1/1/16 the plans will now expand their contracts to include providers who provide services for those with SPMI. We are going to continue to provide health home services; we are on target for the plans to take over payment of services on 1/1. We meet weekly on these. Have about 8K people with SPMI who receive these services, some on the FFS side we need to do the same thing for. All the members will receive a DLA a standardized assessment triaging people for their level of need. The on target here is that rates are set, attribution and allocation of members, health plans working with CMHOs, members will agree to be a part of the health home as they had before, the CMHOs will do the assessments on patients they will send through a portal, their member has agreed to participate. There was a lot of rockiness for awhile, but now we know this is happening, we are beyond the rockiness.

Jim Nyberg: Can you comment on the incentive programs and DSRIP?

Deb Florio: Yes, we are going to call the groups together soon, we wanted to bring the new Director up to speed, we have some new resources to plug into this effort.
Chris Gadbois: On adult day health does that include new certification for Alzheimer's?
Michelle Szylin: It is for assisted living, not for adult day health. There is a care level.
Chris Gadbois: Is SPMI similar to an initiative from a few years ago?
Deb Florio: Yes, and bringing it in plan, and as I understand it, in the re-vamping will have a health home with a bit more rigor, and the other services will be at an ACT level.

Chris Gadbois: The RICLAS question, is the savings just negotiating state workers contracts? Bc the acuity of referrals we are not seeing what you describe. Patients from Eleanor Slater Hospital we are still seeing at private homes. We haven't seen beds open up in RICLAS for them. Is the savings more on the waiver side?
Deb Florio: It could be – might be moving people about, it's a work in process, some of it caught up at DOA.

Unidentified Commenter: Adult supportive care residences. There was a DOH hearing on them awhile ago?
Ann Martino: Yes, the regulations are ready, and as soon as we have someone open it will move that along.
Unidentified Commenter: The hearing a few weeks ago demonstrated a willingness to change the regs to make it easier to operate.
Ann Martino: Right, now those are still being reviewed at the Office of Regulatory Reform (ORR.)

Senator Izzo: There is so much technical information that goes into this, we hear a lot about reinventing Medicaid, is there movement afoot to share with the general public so that they feel better about it.
Deb Florio That's a great point. A little early, and have been very busy standing this stuff up for Jan 1, and next on the agenda is to get performance metrics, evaluate that it is good, get what we think should do and report out what is working, what is not.

Senator Izzo: It is important for clients and recipients, even the broader public should have more information and feel better about the work we are doing. There is a new enthusiasm, but I think we need to work on that.
Deb Florio: Great ideas I agree.
Paula Parker: One last question, redesign medically needed program?
Ann Martino: There was originally a notion that you could redesign medically needed program so that people wouldn't be flexing on and off. There are some states that have done that, but it is expensive, and you need a large enough population to do it successfully and we do not have that.

b. **ICI Update: Jennifer Bowdoin**

Jennifer Bowdoin: We are handing out a document to you all now. Want to be sure that you all know how to get involved if you have an interest in this project on all levels. We

will certainly do outreach, but if you need information you know where to go. If you are not sure where to go, you can reach out to anyone on this list and they will help direct you.

We expect to have the contract back from CMS any day now, through another round of negotiations, then another review, and then to the health plans. It is a long, iterative process; we believe we are through most of the negotiations, but with three parties involved there are many steps. We will have a call center online to help enrollees, an Ombudsman program that we are out to RFP for; money from the ADRC SHIP grant. We think with combination of these three programs is to notify that modifying the Medicare financing model. We were concerned about the adequacy of the reimbursement model, a lot has to do with the Medicare methodology and CMS is modifying that – providing a better foundation to build off of and improve the success. Also working on some operational work being done; had good feedback with advocates on the notices.

Kathleen Kelly: I am confused. NHP has developed Integrity which is the Nursing Home product to serve Phase II ICI. So when you talk about going out and training providers, etc, will that be done in conjunction with NHP Integrity launch?
Jenn Bowdoin: Yes, absolutely. We will partner with NHP, have them take the lead on many trainings and we will take a supporting role.

Kathleen Kelly: Can this training be done on the integrity product done before the three way contract is signed?
Jenn Bowdoin: One thing that NHP is doing now will be building a network, they have to do that in order to pass readiness. And we do not think it would be fair for NHP to go out to providers to ask to agree without learning about the program. We expect that many of those activities are ramping up. What NHP can and cannot say is somewhat limited.

Kathleen Kelly: Can you tell me or point to a resource where the differences in requirements for Medicare provider, vs a LTS Medicaid provider.
Jenn Bowdoin: That's a great question – I think we need a crosswalk on that. We do not have anything internal, but I will connect with NHP to find out if they have one, and if not we will work together to create it.

Kathleen Kelly: Because Medicare in its purest form doesn't cover Assisted Living at all. Trying to see what would be new for Assisted Living providers.
Jenn Bowdoin: There are certain services which may overlap and that is where we will see a lot more of the change but we will work with you to get you the information you need to see how it will impact you.

IV. **Rules Update – Ann Martino**

Ann Martino: Most of you may have received a copy of the draft LTSS Rule with changes. Why the change: Overall we look at modernizing, updating, and revising. In July part of the

LTC app process will go through UHIP so need to make changes there. Also some Reinventing Medicaid initiatives that require updates and changes to rules. In addition the ACA really did change fundamentally what would be required. No longer need to be ABD, but rather functionally disabled. You will have afunctional clinical determination available to determine if eligible for LTC.

The draft rule sets the stage for things important within reinventing initiatives, for the nursing facility long term services and supports, relevant grandfather provisions. This rule also eliminates the distinctions between medically needed and categorically needed eligibility. The basis of eligibility does not matter, will receive the same services based on level of need. This is big as many of the home and community based programs were limited, and this is now available to those who need them. This rule also adds some of the new services created in association with Reinventing Medicaid: Home Stabilization, Community health Teams, Peer Supports. It introduces the concept of community support living program. This rule making process moves – many rules will be coming at you quickly at these task force meetings for input and comment and questions before it hits the longer arduous process of posting and reviewing through the rest of the state and ORR. At any point in time ORR can put the brakes on something, ask us to review again, and start over – so no certainty. They will come fast and furious, use this as an opportunity to have question s and comments, but hen have a chance in the formal process to formally request a hearing. When we talk about LTSS here, it is about anyone who gets LTSSS, not just the elderly. That said, let me throw it open to you to ask questions.

Maureen Maigret: First I want to commend you as this is long overdue. Having said that, can you talk about the process a bit more, as this a 60 something page document that this is new…
Ann Martino: The process of initiating rulemaking will begin on Dec 1. Before we can even post a notice we need approval from ORR. 15 days before beginning the process this has to go to ORR. We are hoping to get this to ORR on 12/01. When they authorize us to notice it could be much later.
Maureen Maigret: Is this the only interactive opportunity that we would have for interactive conversations?
Ann Martino: We can look to set those up if you feel we need more. The reason why we had such fast turn around here is the deadlines are being moved up and we are trying to meet the ORR standards. Before that process begins, please feel free to submit them to us via email. If you prefer one on one meetings, we can arrange those.

Maureen Maigret: There is a new category of worker known as the LTSS specialists?
Ann Martino: That is not a new category of workers, but in the past the world was simpler. Everyone was in DHS, there was field staff, there were people in office of Medical review, and rather than identify those groups individually, we are calling them all LTSS specialists. Other than the OMR nurses. Someone who is in EOHHS looking at environmental modifications; someone at DHS looking to see if can get authorized for another hour of adult day; those roles may shift. And what role DEA plays, all of that now is on the table. No

matter who you see will be someone who has been on board and has expertise and training. We are consolidating and referring to everyone who deals with our beneficiaries as LTSS workers.
Maureen Maigret: Change in nursing facility highest need criteria. I find it confusing, I submitted some comments on behalf of Senior Agenda on Cat 2 change, and we had suggested we stay with daily need not 24/7. I think it is confusing as I read this how many dependencies will they have.
Ann Martino: Need to need help in general with 6 ADLs of 9. The extent to which you need assistance is variable. And you need a clinical condition. That was submitted to the federal government. Three extensive assistance, total dependence with one, and limited assistance with two, and a clinical. If you have a functional disability you have to have one that is broader than indicated before.

Senator Izzo: Is this nursing home entry or LTC eligibility.
Ann Martino: We are talking about levels of need associated with the nursing facility level of care. Either need a high level of care, or the highest need for nursing home level of care. Under the terms and conditions of the waiver, we develop that. Nursing facilities are the most comprehensive at this time and the rule is clear on that.
Maureen Maigret: It is more restrictive than it has been, and if we do not have the capacity built up in the Assisted Living industry then we will have people trying to get into Nursing Facilities under the special exception.
Ann Martino: This was part of the discussion that the Reinventing Medicaid WG did look at – one of the reasons we have Assisted Living initiative and the home stabilization initiative was to address those concerns. We have done analysis with initial showing not much change. We can have something more at the next meeting to show you what the analysis will show on that.

Maureen Maigret: The recent Department of Health overview of the health system shows only have of Assisted Living meet the new HCB federal rule.
Ann Martino: The study you reference looked at the status quo. Given the low rate of payment for Assisted Living, you can understand why many Assisted Living wouldn't want to participate. Now we are planning to increase the reimbursements; we will be more consistent with the standards. We have also talked to folks at DEA about also redoing their standard so they are more consistent with HCB standards. Our preliminary talks with the feds show it will not be hard to get that model as not dually certified. Many Assisted Living we are talking about already have a much more modern approach in which if they do treat people with higher levels of acuity, go on the same side. Push the market there as well. That was a point of discussion, building capacity at home and community based residences. We will have the results of that analysis. Also recall these will not go forward on Jan 1 unless we get auth to do them on an emergency basis as ORR is already playing around with questions on net present value.

Unidentified Commenter: in order to make sure there is capacity in the community, programs such as the senior shared living program, rely upon the highest level of care, so

will this apply to just nursing home admissions or that whole level?
Ann Martino: In the quirky world of Medicaid there are three levels of care: nursing home level of care, institute level of care, and hospital level of care. In nursing facility level of care you need to have the highest need level of care for nursing home to get into the home. If you are in high need, then you are in the community. We are discussing a set of services designed to provide you with the care that you need. Feds are trying to expand the range of HCB areas. If you do not meet the highest level of care, you can still do shared living if you meet the high.

Michelle Szylin: If you meet highest level of care you get the payment, if you meet the high level of care you get that payment. It is just those who may have meet highest before may not now. But if that person is already there then grandfathered in.

Virginia Burke: On highest need – those six ADLS are they identified anywhere?
Ann Martino: Yes, in the hand out you have there, all nine are listed there.
Virginia Burke: It is a fairly dramatic change. The first model was on MA &CT – are there other states that are as stringent?
Ann Martino: Actually, we were an outlier on the nursing home work. And we can put something together for you to take a look at it.
Maureen Maigret: If a patient doesn't meet any of the requirements for number 1, then can make it for number 2, or number 3?
Ann Martino: Yes. There are many other ways to get in.
Maureen Maigret: Three may potentially be clients who are not the right fit for nursing homes?
Ann Martino: Many requirements that ensure that, for example, it is determined that the persons primary need is not psychological disabilities. That one may apply to someone with a TBI; or may be a child. Only really changed the first.

Maureen Maigret: Are respite services included? That has never been instituted for elders, only for children, so would respite be considered an informal support.
Michelle Szylin: It is a separate service. Informal supports refers to any other services someone may need outside services. Take all into consideration.
Ann Martino: The full scope of services that you see there should be available to anyone who meets the LTSS needs.

Maureen Maigret: What do you mean by mutually exclusive?
Ann Martino: About how you pay. If you are transitioning from a nursing home you may get transition services, home modification, all have different codes, and must be mutually exclusive. What is in a transition service is not the same as in a home stabilization service.
Maureen Maigret: So this definition of informal supports is more for a care plan?
Michelle Szylin: Yes

Maureen Maigret: You sent out the income eligibility criteria for various populations. Some have income at 133%FPL. We think the state should consider making the income eligibility

for the elders and disabled.
Ann Martino: As long as your income is below the cost of care, you are in. The amount of your income will not impact your ability to get LTS unless your income is in excess.

Maureen Maigret: Some states through disregards have increased that?
Ann Martino: Some states have income limits at 100% of FPL and then disregards to bring them up to 133% of that. Either eliminated Medically needy side. All there will be – SSI, low income, medically needed, Medicare premium payment program, and Sherlock. All others are consolidated into those categories.

Maureen Maigret: In the preventive level of care, preventive is for community MA people.
Ann Martino: However if you are in expansion you can become long term care eligible.

Senator Izzo: Due to time we may need to ask just one last question.
Maureen Maigret: Can you expand on the limits referred to for HCBS
Ann Martino: We do have limits within the context of the waiver. The waiver reads that you cannot have a waiting list for institutional care at the highest level. If you are at a high level, we can, and if you are at the preventive level we can. It is in the waiver and we kept it. There are limitations on the amount authorized to spend on home modifications. Nothing new there. The cost neutrality is now based on in the aggregate what the cost would be in a nursing facility. Against the actual institution.

Kathleen Kelly: You said we would see regulations fast and furious. Are we to assume that this document that you distributed for this meeting will be the base and then there are supplement documents?
Ann Martino: It is unlikely we will go into the details for ICI because the plan and contracts speak to that. On the LTS side we will do financial eligibility and streamline into four categories. All subject to the same resource limit. We will try to make it very hard for lawyers to charge potential beneficiaries exorbitant amount to help fill out an application. We will make it hard for nursing facilities who have an app pending to put up 30,000 or 40,000 before it's considered. You will see explicit changes ineligibility on the financial side in terms of access, because we have not changed the rule since 1994. If there are issues out there that you see, please bring them to our attention so that we can try to make the process easier and less onerous for beneficiaries.

V. **Public Comment** – No Additional comment made at this time.

VI. **Adjourn** – Next meeting December 14