

The Working Group to Reinvent Medicaid  
Optional Working Session  
Thursday June 11, 2015  
1:30pm – 3:00pm  
CareNE – 45 Willard Ave  
Meeting Notes

**Attendees:** Donna Longshein, Deborah Burton, Nicholas Oliver, Louise Pavelle, Deb Faulkner, Deidre Gifford, Chuck Jones, Virginia Burke, Hugh Hall, Sam Salganik, Matt Trimble, Jim Nyberg, Matthew Harvey, Maureen Maignet, Joan Kwiatkowski, Kathy McKeon, Jackie Beshear, Diana Franchitto, Steve Horowitz, Roberta Merkle, Jennifer Reid, Jessica Mowry, Joan Wood, Lauren Lapolla, Sam Marullo, Secretary Roberts.

I. Call to order and Welcome: Dr. Wilson and Secretary Roberts welcomed everyone. Noted Dennis Keefe was unable to join due to a scheduling conflict, but offered his space for meeting today. The first real item on the agenda is Nancy Eldridge from Vermont's SASH program, who we will be calling at 1:45pm. Noted in the handouts today there is a summary from the LTC Work Stream around long term goals and ideas, also available on the website. (Working Group Member) Maureen Maignet compiled this list based on the discussions in the work stream meetings and comments forwarded to the larger Working Group and from other stakeholders. Maureen noted that she believes at least a quarter is showing up in some form in the Reinventing Medicaid first report. Will be great to hear about other states, and also think about what we will look to do in the long term.

II. Rebalancing Long Term Care: Successes in Other States:  
Vermont: Support and Services at Home (SASH).

Nancy Eldridge with SASH, calls in to speak about the program, speaks to slides sent to the group. (Presentation available on [reinventingmedicaid.ri.gov](http://reinventingmedicaid.ri.gov)) She will describe a bit about how the SASH program works, how it was set up, how it is funded and what that means for a SASH-like program from a Medicaid perspective.

Nancy Eldridge: Vermont began thinking about SASH after the first Medicaid assisted residence programs. Thought carefully about a different approach to serve everyone from high need, tier-three nursing home residents, to healthier elders. Strongly believe one of the places people shape behaviors and fix behaviors, is in the home – more about being in the home rather than “housing.” First slide gives a quick look at rationale for looking to a SASH approach. SASH intended to fill the “other” 140 hours for week, not benefiting from the choices for care services. When thinking about decentralization, the number of high quality housing already paid for principally by federal government that is heavily

regulated presented as a ready-made network and infrastructure of housing and, if layer in LTC services, they are about  $\frac{3}{4}$  of the way there given the existing facilities. SASH has 55 partner organizations that have signed on. Medicaid agency is where the medical home initiative sits in VT. Home Health signs an MOU, contributes a skilled nurse, area agencies on aging contribute a case manager on each team. We are at 138 affordable housing communities all over the state, tax credit deals, mobile home parks, and we offer to the residents in that community voluntary participation in SASH. We create panels of 100 participants and the team of partners just discussed then supports each panel. The team together talk about the highest need people on the panel and discusses the resources as a team effort. No targeting in SASH, create a population health pool of individuals ranging in health. When started, the program was initially a bit of a community organizer activity with intent towards creating a regional approach to make relationships cultivated locally with hospitals and providers. This has worked out really well, in practice and in terms of the involvement of the legislature.

Once a person volunteers to participate, we do a thorough assessment and a large data collection on the person in the apartment or home and entered right into Vermont central clinic registry that technically creates an integrated health record, though perhaps not as functional as we might like. Then do a person-centered interview to get at what motivates the individual. Develop a health living plan with participants, often with their family and friends, and then do a community health living plan. We can pull the data in the registry and create dashboards – pull data by address and can see what are the rates in that panel (rates of hypertension, or arthritis, etc) – develop interventions around five core areas. Funded through a capitated payment, \$700 per patient from Medicare. If we were to re-do this, or when we go back to CMS we will look for 20 hours per week per participant to assist with funding.

Thanks to data collection, for the 4% missing a primary care provider, we know who they are, where they live, and thus can offer assistance in assigning a primary care provider. Studies such as the HTN pilot show how successful being in the home and a part of the community can be in various health outcome areas. Data Build – designing buildings specifically for the elderly to keep them out of a nursing home, or support when return from the nursing home. Now can build in remote diagnostic capabilities to detect heat or coolant problems, for example. Many ways housing builds can partner with Medicaid department in helping to support care of populations. Geriatric tele-consults, or e-visits are new also. The VT legislature just passed a directive to Medicaid to reimburse for primary care provider visit regardless of the originating site. Conducting primary care visits virtually, through some new mobile units, to have an option of seeing a doctor through this technology to allow

patients to stay in their bed, or on their sofa. Reducing in person primary care visits, avoiding falls or catching illnesses in waiting rooms, etc. Excited about this, hoping Medicare will follow suit, but important to not force the elderly to go to a physician process when they are at their lowest ebb if technology is available to avoid that.

a. Questions:

- i. Secretary Roberts: What is SASH, when you say “we”, getting paid, who is that?

Nancy Eldridge: Cathedral Square is responsible for the implementation of the initiatives state wide. Our responsibility to ensure CMS is billed for the capitated payments and then organized. A series of MOUs to partner agencies and grant agreements to the housing partners. Dollars flow through the medical home. Every quarter we bill CMS, every quarter we expand the number of panels we have - we have been capped and reached our limit of 54 at this time. The dollars flow through community hospital and they send a check out to the six regional organizations.

- ii. Hugh Hall: How many patient participants in SASH?

Nancy Eldridge: Almost at 5000 right now, capped at 54 panels, so once we reach 5400 we are considered fully enrolled.

- iii. Deidre Gifford: Am I correct in assumption that the hospital you referred to is the community health team in Vermont parlance? I ask because under SIM grant we talk about community health teams, so are you in essence an arm of that?

Nancy Eldridge: Yes; dollars flow through the community hospital in happenstance, had to pick one as a point. CMS looks at the cost of the many community health teams attached to the hospitals and programs, and look at SASH as an extender to what that team can do. We do receive Medicaid funding, that pays for our operations essentially, pays for partner agencies to attend team meetings, used in part to purchase some technology, about a million a year and comes from the state MCO money or savings the state accrued, under savings.

- iv. Joan Kwiatkowski: Do you provide transportation as apart of that house? Also are your Medicaid service options different?

Nancy Eldridge: Transportation is something that the team cobbles together – we do not use the \$700 per person per year for anything other than the coordinator/staff function and wellness nurse quarter time function. We work hard to cobble together the resources available through the partner programs. We have participants who are Medicaid beneficiaries, non-duals, but Medicaid does not yet pay that capitated payment. So the way we fund them is by utilizing any other revenue stream that comes into the housing, and that can be anything from operating revenues to a HUD Ross grant, for

our whole goal here is to have a model that is ultimately payer agnostic and one that is applicable to a person of any age. The reason we are so Medicare focused is because the opportunity presented itself through the funding. We could have started it the other way around, but there was really no opportunity there. If we were to replicate this for example in RI or Minnesota, whatever the payer opportunities are will drive the financing of the model. In some cases that is private pay, commercial payer maybe ACO, maybe Medicaid/Medicare.

- v. Peter Andruszkiewicz: Is there a before and after picture of people served in their home now vs. post acute institutional care? Also other states claim that 95% of these want to be cared for in the home, do you have similar data?

Nancy Eldridge: The before and after is a bit difficult, as essentially talking about 5,000 people. Yes our efforts towards rebalancing have improved, but the hard thing would be to look at these people from a data perspective and state these 5000 people some percentage would have absolutely been in a nursing home absent SASH. We know the people so we cognitively know that is true, but hard to document at this time. To your second question we have done surveys with AARP, and definitely the preference is to stay home.

- vi. Jim Nyberg: Any regulatory barriers to paying directly for services such as care manager or nurse?

Nancy Eldridge: No regulatory barriers, one of the reasons the Medicare dollars funnel through a hospital is so that they are going to a "Medicare" agency. Our SASH coordinators are not medical providers; they are what I call at the federal level health care operators. The vast majority of the wellness nurses based in the housing are employees of either a hospital, FQHC, maybe health home agency, maybe community health team. We have not had regulatory barriers to implementation.

- vii. Sam Salganik: Who is eligible to participate?

Nancy Eldridge: If you are living in one of the 138 sites you can participate regardless of payer, regardless of health status. Beyond those properties we principally get a lot of referrals from partner agencies, in the case of people who live outside of the settings they must be Medicare beneficiaries.

- viii. Secretary Roberts: have you looked at total cost of care for people in SASH program, not just including services and supports that you are offering.

Nancy Eldridge: RTI is looking at all Medicare spending on the participants. Sec Roberts: do you look at Medicaid as well? NE: We have not, would love to do so, but not the scope of the RTI study. They produce these results, and hope be more and more inclusive. The first study did not include any community

participants; the reason being that control group was in upstate New York, in HUD assisted housing, felt they could not create an “apples to apples” control group using those participants.

- ix. Ira Wilson: You are leveraging in a creative way the fact that people are already aggregated in these publicly funded apartments/homes. Wondering if any of your participants live in single family homes?

Nancy Eldridge: CMS required that we offer this not only to people in our properties, but also outside. So about 27% live in single family homes and as we hope to get to a larger scale the beauty of the model is that you are not just leveraging that particular building, but creating these well staffed hubs that can cast a net across the larger community, particularly when we add family housing in. With 138 senior properties we have gone into many non-subsidized senior properties that exist. There are twice as many family housing areas. You will start to see a dotted map around the state where these hubs can help people in the single family homes. We have major isolation issues in our most rural parts of the state and it is important to get this out to them too. From a business model this is very efficient the larger you get, and in a state like Rhode Island you have such a great advantage with your smaller land mass. This model is best suited for an urban or dense population.

- x. Hugh Hall: What happens when you hit 5400 and 500 more people want to get in?

Nancy Eldridge: We are a SIM state as well as RI, we are probably going to be submitted a waiver to CMS part of the request will be to significantly increase that cap. We know that OMB has been pleased with our results and the medical home data and thus we think it is reasonable that they would want to increase that cap.

- xi. Ira Wilson: On behalf of the people here we want to thank you, for this clear and thoughtful presentation, Nancy.

I. Rebalancing the long term care system – Relevant Learnings from RI Data: Deb Faulkner [presentation available online at [reinventingmedicaid.ri.gov](http://reinventingmedicaid.ri.gov)]

a. Questions:

- i. Virginia Burke: The data on slide 13 is this current?

Deb Faulkner: No from 2008, but they stay pretty similar in a lot of different year increments. Worth updating but the story of folks coming in from non-Medicaid, become Medicaid eligible, makes programs cutting across payers even more critical.

- ii. Secretary Roberts: Did you do migration on anything other than finances?

Deb Faulkner: We did not but perhaps, Rick, you know?

Rick Jacobsen: Yes, the numbers weren't that high, back when we did it. Can go back and look for more information.

DHS Comment: Based on new applications we are seeing I would say these numbers have not changed in any significant way.

- iii. What is the general length once someone goes into a nursing home?

Rick Jacobsen: A bit of a bi-modal world, have many who are leaving in a short period of time, but after 45, 60, 90 days it is typically the life expectancy. Three and half to four years is national average, per Joan Kwiatkowski.

- iv. Ira Wilson: Vince Mor always says that once people get into a nursing home two things happen there is the physiology, but then also the social things. Sell their house. So let's imagine they improve, but then there is no where to go – these efforts in the first few weeks or months to help them go home is key. Very interesting, the work being done in the SASH, efforts to not get that negative cycle going.

- v. Linda Katz: We also had phase one of duals project, wondering if have data on that as we head into phase II on how well we have done to keep in the community and track?

Rick Jacobsen: I would like to say we have good data with history, but we don't.

Maureen Maignet: I believe that they are working on it and improving that.

Virginia Burke: I can say that the rate of transitions out of nursing home facilities was no change.

Linda Katz: Not so worried about that, but very interested in the data from keeping people going into the nursing home. What have been some of the issues that they face that we want to address in phase II.

Matt Trimble: Not just prevent, but delaying it overall.

Rick Jacobsen: One of the core metrics we are trying to catch. What percentage of people receiving long term services and supports in the next year are in nursing homes, what percentage of those who are "community well" are, a year later, in a nursing home. Has the intervention been able to slow that migration?

Matt Harvey: That's the data that SASH doesn't have yet either.

Virginia Burke: Pretty safe bet with the decrease in falls that the numbers have gone down.

Maureen Maigret: This just points out that we need to work on the front end approaches, so I took the opportunity to put together a dozen thoughts and approaches. [Document available on website].

Virginia Burke: Look to Minnesota from case data.

Maureen Maigret: Let's see that we can do better than we're doing.

- vi. Ira Wilson: One of the take home lessons is that this is infrastructure, we cannot just wish it.

Matthew Harvey: The agency that did this, they have senior housing all over VT, they contract too. We have a lot on our own.

Secretary Roberts: We have two organizations that oversee many; we have regulatory challenges about going into HUD financed housing. They are being smart to build on what they already have – how many thousand people are living in elderly subsidized housing, 15K? Our duals populations live there too.

Maureen Maigret: The regulations, you can not actually hire someone but can do a contractual arrangement.

Secretary Roberts: Then there is supportive housing regs that are still not done.

Kathy McKeon: How many people in there are already on a Medicaid LTC community waiver, do we have four different home care agencies passing each other in the elevator? Always run up against the issue of Medicaid requires choice, but we literally have enough Medicare LTC clients that could take one worker and do it. I know you can't now, but it makes sense. It seems as if there are other ways to do economies of scale things that are out there already. The other subsets are other people who have caregivers. They may come later to the formal services that people get, may fall into the nursing home if a caregiver cannot do it anymore. If not providing support in the community then losing an opportunity there.

- vii. Secretary Roberts: Other thing we haven't discussed is around dementia. We have little supportive services in the community, how to help those with dementia without physical frailty, who do not fall into qualification for other medicals assistance.

Maureen Maigret: I was asking Joan (Kwiatkowski) what we can do for those with mild cognitive impairment to allow them to stay in place. The issue is when the dementia gets in place that they need residential care.

Also, note adult day – difficult to ensure transportation, but helpful.

- viii. Louise Pavelle: We at NHP thought that leveraging the housing would make sense, so done some preliminary work with POA, ran some of our members against their addresses, clinical profiles, needs to intensive care management and have been analyzing their needs. We are in the process of doing that – only eight facilities but as a pilot – they were interested in looking at that.  
Secretary Roberts: Interesting to see any of the urban environments would do so.
  - ix. Deborah Burton: Housing issues be stated enough, individuals receiving Medicaid funding to reside in assisted living facilities, many of whom require a 30 day notice, unfunded someone who could leave if had funding to leave facility.
  - x. Hugh Hall: What are the next steps?  
Secretary Roberts: We are creating for the Governor a document that is a vision for where we want to go in health care broadly in initial steps, that are the right first steps. After that we will come back together around implementation. We have more and more things being created in terms of what has come out of the work streams, particular items to work through. What we are doing for July involves less specificity, not intended to have that detail, but critical to set up a structure of long term principals and goals, then work plans around issues raised, some that became budget initiatives to implement, but also things that have come up that make sense. Take a look at the New York website to see how a state has done this in the past – interesting reading for sure.
- II. Public Comment – no additional comment given at this time.
  - III. Adjourn – Thank you to all, wrap up – Maureen thanks Secretary for her leadership.