

Long Term Care Initiatives  
Reinventing Medicaid Implementation  
September 10, 2015 – 2:00pm  
Meeting Minutes

Attendees: Matt Harvey, Tanesha Richardson, Diana Beaton, Laurie Ellison, Jessica Mowry, Jim Nyberg, Matt Trimble, Michelle Lupoli, Paula Parker, Kathy Heren, Alison Croke, Erin Casey, Lauren Lapolla, Hugh Hall, Holly Garvey, Michelle Szylin, Mike Ryan, Jennifer Reid, Elizabeth Shelov, Ben Copple, Diana Franchitto, Vinnie Ward, Beth Marootian, Maureen Maigret, Emmanuel Falck, Ashley Sadler

**I. Welcome**

Matt Harvey welcomed folks to the group, and requested introductions around the table. See attendees list above.

**II. Reinventing Medicaid Act of 2015: A Review**

Matt Harvey explained that in the spring the Governor's Office charged Secretary Roberts with chairing the Working Group to Reinvent Medicaid. Public meetings, reports, final recommendations, budget recommendations. Submitted, amended by GA, passed into final budget 45- 52 initiatives (depending upon how tracked) that need to be implemented as a part of this Reinventing Medicaid work. Continued stakeholder engagement is critical to our success. The goals include working to pay for value, not volume; working to rebalance the system away from higher cost settings to lower cost setting, and to do all this in an open and transparent manner.

There are five Stakeholder groups at this time, this group focused on a long term care specifically, as so many of the initiatives touch the LTC system. The LTC stakeholder community is one of the more robust and helpful, and we wish to benefit from that engaged advocacy. There are group leads within the agency heading up each segment, and Holly Garvey is leading up this group.

**Questions:**

Hugh Hall: There is an outline of our charge, and I am wondering why the LTC recommendations from the previous work are not listed as factors yet?

Matt Harvey: Great question. Our initial priority is to implement those initiatives in the budget. We do also have a strategic charge to look towards the future group, and to achieve those longer-term goals we will have to develop and implement those that have not yet been committed to, many of which were discussed by the LTC work stream in the spring. This group will have a split mandate, to give feedback and guidance on the implementation work, and then following that, will work on the longer term goals.

Maureen Maigret: Has the Nursing Facility Incentive Program (NFIP) been discussed?

Matt Harvey: That is being focused on in a separate working group, which met first in late August, and is meeting going forward. Anyone requesting additional information on that work can contact Lauren Lapolla at [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov)

Jim Nyberg: I understand what you are talking about for budget line items, and then longer term. But what about items like expedited eligibility for adult day?

Matt Harvey: Actually that did make it in the budget, but fell under the eligibility and operations bucket rather than LTC. We don't have a specific stakeholder group to speak that bucket, but I can bring that to this group if there is interest in that.

Maureen Maigret: I think that would be very important.

Holly Garvey: An EOHHS policy team wrote the category 2 change on Institutional Highest levels of care and it has been submitted to CMS.

Kathy Heren: Wouldn't you want more input on that?

Matt Harvey: We can certainly express any opinions here to those working on that charge.

Kathy Heren: I am confused why you wouldn't want those who do the work to write on that program.

Matt Harvey: The Office of Medical Review is doing the work and they helped to write it, but it is a drafted policy; the policy has not yet been put in place and that will be posted for public comment.

Maureen Maigret: I think that is important to have community input.

Matt Harvey: This will involve a change not only to the 1115 waiver but also to the rules, both changes which feature public input and involvement.

Jim Nyberg: And while not as significant as levels of care, I would like a chance to revisit the conversation from a stakeholder perspective on expedited eligibility.

Maureen Maigret: I agree – need to make sure that access to care and home and community-based services are quick. Both those issues need to be discussed in depth.

Matt Harvey: Regarding levels of care, we are working to align with our neighboring states, three ADLS with the highest level, but will circulate what the draft looks like. On Expedited Eligibility, we've had a couple of internal conversations about it; want to be sure it is done thoughtfully with the Integrated Care Initiative (ICI) and the roll out of Phase II eligibility system. Want to be sure not going in the wrong directions. Do not have 100% clarity, but as we gain focus we can pull this group together.

Beth Marootian: I think this group would be valuable in setting priorities, knowing there is a long list of things to accomplish. Particularly a sequencing

need and prioritization.

Matt Harvey: I think that is a great idea. Very much want input on sequencing and dependencies, but to your point on prioritization - we don't have much of an option for things to do or not do.

Beth Marootian: I understand

Hugh Hall: Expedited eligibility for home care is very important, I just wouldn't want to limit it to home care.

Matt Harvey: Yes, it is expedited eligibility, or long term services and supports.

Vinnie Ward: When moving forward with the process of value based purchasing, I ask that the stakeholders be a part of these meetings. When Phase I was rolled out, we all met at RIPIN, and I asked where the combined rates are and there was a lack of awareness of combined rates. I don't want to see that happen in discussions of value based purchasing. Where can we be involved as home care agencies, how can we ensure we are part of the discussion?

Matt Harvey: That is an important point, and in addition to the work that this work group will do on this set of initiatives there are proposals on value based purchasing and long-term care in underway and this is where to hear about it. I know you will also hear about this at the EOHHS Task force, and that group will be a venue to talk about DSRIP initiatives more broadly. One thing we want to do is when we go to CMS and apply for DSRIP waiver and seeking federal funds for that, most other states that have done DSRIP waivers have focused on acute care hospitals. One thing we have been clear about is looking at DSRIP more broadly and pioneering in the way to use DSRIP funded programs to also support transformation in the LTC arena. We hear you, and if you do not feel that is happening, come to us and hold us accountable.

Maureen Maigret: Have you provided the NFIP the levels of care criteria that MA and CT follow?

Matt Harvey: I don't know what we have provided to whom, but we have those and can circulate to this group.

### **III. Long Term Care Initiatives: An Overview**

Holly Garvey reviewed the LTC initiatives in the budget that this group is focusing on. She advised that the initiatives in this bucket are looking to save about \$12million in all funds. Federal authority will be required for the majority of these initiatives. The presentation will focus on a high level overview of these initiatives.

Presentation slides available upon request via email to [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov)

#### **Comments, Questions:**

Beth Marootian: HCBS initiatives - Waiver criteria would be needed for all of

the initiatives?

Holly Garvey: Rules, federal authority, and systems would be addressed for the initiatives.

Maureen Maigret: Are any of those initiatives that have been included in the most recent 1115 waiver submission but were not approved?

Holly Garvey: The Home Stabilization initiative. The initiatives were reviewed against the current delivery system and where they available and where there were gaps. The initiatives seeks to address those gaps in services that were not present in any of the delivery system. BHDDH has recently received an award to help combat chronic homelessness and we have contact with them as a part of the conversation to see if their grant may be able to supplement some of the populations not eligible for Medicaid. Certainly we welcome input from any stakeholders, as there was a collaborative approach in developing it.

Matt Trimble: What types of services would be paid for through this?

Holly Garvey: Still hasn't been fleshed out – but things like tenancy services, how to teach someone to do certain activities to help them maintain stable housing. CMS recently issued a bulletin for certain housing stability services and we can share that with the group so you can see where we are talking on this. Care mentoring, coaching...etc.

Matt Trimble: How do these folks get on your radar screen?

Matt Harvey: This is why we have the conversation. Some are going to be Medicaid eligible; some coming out of a nursing homes, some kids, some adults who come to our attention with a behavioral health issue and come out of a hospital stay. Will be working with various community partners to discuss these.

Michelle Lupoli: Does that include caregiver support programs?

Holly Garvey: No, the home stabilization initiative would be for the individual.

Matt Trimble: I am missing if you look at finding homes for people in nursing homes, but in the community some don't have a home to go to.

Michelle Szylin: Part of the transition is help them find a home, and then work with them to teach the individual how to stay in the home.

Jennifer Reid: We have a housing initiative going on at the same time, increase housing in the community, for example.

Matt Harvey: You are right that is an issue, but once we can find them in a home setting it is in everyone's interest to help keep them there.

Holly Garvey: CMS has reported out on the importance of housing, and how that relates to stable health. Medicaid doesn't pay room and board, but can work to help them keep in the community. The intent is to make the services available to individuals at any age needing home stabilization services.

Kathy Heren: Many coming out of the programs that I deal with don't seem to

be good candidates.

Jennifer Reid: We do have some elders that are coming out of nursing facilities and do need these programs.

Maureen Maigret: Is an element of the program for home stabilization teach people how to manage the money, but offer financial management aid to those who may not have the mental capacity due to dementia or other reasons for that?

Matt Harvey: Not at this time, but a good thought.

Matt Trimble: Along the lines of this initiative, there was a suggestion to look at some of the nursing homes in this state that may have wings with beds that are out of service, and perhaps provide them with funds out of this to help provide housing. Where is the thought process on that?

Matt Harvey: We do not have a current initiative on that, but that does sound like the kind of thing that may be a good consideration for DSRIP funds.

Holly Garvey: We have permission to pilot the community supportive living change, which will be assisted living and supportive care residences.

Michelle Szylin: Anyone eligible can participate in the pilot, as enacted will be those in the ICI.

Matt Harvey: And this is a pilot, as we will need to assess for the General Assembly if cost effective.

Kathy Heren: As I recall, some of that was type of a room and board regulations?

Matt Harvey: The rules are drafted, which would enable us to be supportive of the pilot. We need to demonstrate to the General Assembly that it worked and saved money. The adult supportive care residence the rules are drafted, going through promulgation at the Department of Health. Then there are programs that allows Medicaid to provide these tiered system of payments for those in supportive care residences.

Maureen Maigret: Have you had discussions with the industry representatives to flesh out what the reimbursement would look like, and how many assisted living facilities might be interested in this?

Holly Garvey: I think that is what the next slide will show – this group is the venue for that.

Jim Nyberg: Not to jump around, but the rate initiative on Adult Day Services, I thought a similar group might meet on Adult Day?

Matt Harvey: There are a lot of specific, provider-specific working groups that we will need to be tied together. To the extent possible I would like to have those be tethered to this group and will undoubtedly have to have conversations with assisted living providers. On the assisted living topic, there are two things to do: define the rates and standards, and also increase the state's supplemental cash payment, and with those two things we have done a lot with SSA pushing that side along.

Holly Garvey: Right and I believe the way the language is written it has it laid out in the regulations.

Beth Marootian: Have those rules have been issued already, the changes the assisted living payments?

Kathy Heren: Not to the payment, just the assisted living rules.

Matt Harvey: There is a savings target, (\$1.5million general revenue).

Maureen Maigret: I read that, most likely, the assisted living piece would have to meet the new limited health service licensing criteria to probably get the higher level of reimbursement.

Jim Nyberg: As of last week no residence had applied for it yet, FYI.

Matt Trimble: The current service rate that many get today is low and hasn't changed in many years. If those were raised then that would open up assisted living work, if you open up those slots.

Matt Harvey: That is the theory of action.

Maureen Maigret: are you going to increase the basic rate?

Michelle Szylin: The rates will be different for this pilot; it is separated out. There will be a tiered rate in the pilot. If successful we can revisit.

Kathy Heren: If people participate in the pilot, and then you have to go to the General Assembly and the report demonstrates it is not cost effective, what happens to those in the pilot program?

Matt Harvey: That would be a question for the General Assembly. My hope is we will be successful.

Kathy Heren: From a business model some of the Assisted Living Providers may not want to take that chance.

Maureen Maigret: If none of the Assisted Living providers have applied for this license at this point, then what?

Michelle Szylin: They will be held to a higher standard, but they do not have to have that license. New standards will be written, and Medicaid would have to do a quality check.

Kathy Heren: Many of the assisted livings are getting away with too much and there is no quality check?

Michelle Szylin: Medicaid will put in a quality and oversight.

Maureen Maigret: I want to reinforce that looking at the current rate, if you increase that rate can you assess if that is helpful, then extend that out beyond the pilot.

Matt Harvey: I think that depends on what our tiers are.

Vinnie Ward: How do you save the \$3.3M all funds?

Matt Harvey: Move 90 people over 6 months from nursing homes to assisted living to achieve. I would like to get more than 90.

Laurie Ellison: Out of that wouldn't some be able to go back to their homes at some point?

Matt Harvey: Yes and that is even better, from a savings perspective. We want to build up a set of community-based capacities that do not exist and can think about these things all moving in the same directions. How many different kinds of settings and supports can we create and fund. Build momentum and that's the rebalancing.

Holly Garvey: I want to reiterate that this would be a part of the ICI, thus through nursing home transition.

Beth Marootian: A concern for nursing homes as well to raise community capacity, but as a health plan the flexibility to approach payment. Having the regulatory framework to do it is even more helpful.

Matt Trimble: You said the regulations have been developed for adult supportive care, what is the timeframe?

Betz Shelov: Between EOHHS & DOH we have drafted the first regulations and begun staff review on these regulations. Staff has until 9/14 to review, and then will be sent out for the public, best way to help us is to review the drafts. Calendar goal is January, but depends upon amount of community edits. The General Assembly passed the statute in 2009 to create this class of facility, so that the health department will license them as they do other facility types, and if you look at the act as enacted it very similarly mirrored the adult supportive care law. I think the General Assembly envisioned a smaller scope.

Kathy Heren: The assisted living people did not want the Assisted Living thing to look like the adult supportive care things. That was the intended.

Betz Shelov: That is helpful; adult supportive care only includes dementia and behavioral health. The statute permits the DOH to license facilities for dementia and behavioral health. Keep in mind when you look at the draft, DOH will promulgate, and their department focuses on health, safety & welfare, and Medicaid focuses on the money. When Michelle talks about the Medicaid oversight that is a provider agreement.

Kathy Heren: Conceptually this was to be similar to the old ICF2s, some oversight but not to the level of Assisted Living providers or nursing homes.

Betz Shelov: The statute does mirror assisted living, but the differences are there, just some confusion. There is a rule that we have to do a societal impact analysis of the office of regulatory reform. DOH is of the understanding we can send out to an informal community meeting, and thus can release prior to the ORR. We think with that plan is to send out to the community for an informal meeting.

Maureen Maigret: In the draft, could an existing entity like a nursing homes dedicate a small area that would accommodate 2-5 residences for this license?

Betz Shelov: No, you also have to have a license as a nursing facility, Assisted

Living provider, adult day or home health, and this license. I suspect that is a General Assembly check and balance.

Kathy Heren: The nursing homes could also benefit, for if have a closed wing, and could use the beds on that unit to meet that criteria. When it first began they were left out of that, thus...

Holly Garvey: Under the new CMS rules for HCBS, this would need to be approved by CMS under the heighten the scrutiny provision.

Michelle Szylin: That doesn't mean that they wouldn't qualify, but would have to have separate entrances, and separate staff.

Betz Shelov: The nice thing is that it has been a good collaboration between EOHHS & DOH, and hopefully many of these questions may be ironed out.

Maureen Maigret: What is the timeframe for putting the restructured payments in place for Assisted Living providers?

Holly Garvey: We are targeting January for a pilot start date for both.

Maureen Maigret: Will 4CP still exist?

Holly Garvey: The program will be redesigned, to meet a population that will not be enrolled in a health care model system.

Beth Marootian: Is 4CP the same as connect care choice?

Holly Garvey: They are two different programs, but have similar elements. The Connect Care Choice program has not already gone away. EOHHS used to have a program called connect care that was sunseted and is now known as connect care choice. When we added community partners, some individuals previously enrolled in connect care choice went over to community partners.

Kathy Heren: I know last year there was controversy over putting everyone into managed care?

Holly Garvey: That was in the budget proposal, but in the final General Assembly budget it was adjusted. We are seeking authority for mandatory managed care services from the feds but not for those not receiving LTSS.

Vinnie Ward: Have there been conversations with home care agencies who have already begun using Electronic Visit Verification?

Holly Garvey: They have done a body of research on this opportunity, and tried to line it up with the other initiatives that we are trying to move forward, and trying to bring all of those together. It is an oversight monitoring tool useful for the provider community and the state as well. We see it as a positive approach to ensure health and safety of our members.

Vinnie Ward: I have no issue if it works properly. I just know there are some agencies in the state have used it and you could use them as a resource to see how it is working.

Laurie Ellison: Do you envision all agencies using the same software?

Matt Harvey: I believe so.

Laurie Ellison: I bring it up as many agencies may use scheduling software, so you may want to have provider input on that end. I've heard need to be cautious when selecting, as some of the tasks are very specific, which may

meet the criteria of the state but may be an issue for those with different criteria for the provider.

Holly Garvey: Why don't I reach out to our lead who is on task for this project, to encourage another meeting on this conversation?

Vinnie Ward: A bit difficult as many use different software for scheduling. With mine you can use it do to billing, scheduling and payroll.

Laurie Ellison: That is how the visit is verified. Need to be mindful moving forward, not sure how would all work out but need to have input.

Holly Garvey: We will work with Bruce and Ralph to have that going forward.

Beth Marootian: You may want the health plan to know sooner rather than later if it is tied to payment.

Holly Garvey: We would certainly invite the health plans for that small group meeting as well.

#### **IV. Adult Supportive Care Residence: Capacity**

Given time constraints, group was requested to email lauren.lapolla@ohhs.ri.gov, for thoughts on this.

Maureen Maigret: Request a brief on the CMS Home Stabilization guidance. Michelle Szylin: I can send to Lauren who will distribute.

Jennifer Reid: Also can look to the exercise for MFP, as those were more stringent than these regulations.

Kathy Heren: I am concerned about CMS impeding this work.

Maureen Maigret: Final question, the state put out the Accountable Care Entity RFI, can those in the ICI be attributed to that Accountable Care entity?

Matt Harvey: I think probably, but it is an important question we need to answer. Many questions around attribution we need to think through, but very important.

Vinnie Ward: Final point for myself, right now I am turning away patients as I am at capacity. It is getting more and more difficult, as you make progress in making changes to bring costs down, please keep in mind we cannot find CNAs now that do not want to do that work. I have signs advertising CNAs everywhere, and they are not in home care. As you move forward please think about that, needs to be enough money in this fund to allow a home care agency to operate.

**V. Public Comment** – No additional comment offered at this time.

**VI. Adjourn** – A note about next meeting will follow shortly.