

ICI Consumer Meeting
February 22, 2016
2:00pm – 3:30pm
Meeting Minutes

I. **Welcome**

Jennifer Bowdoin, working with EOHHS, welcomed everyone to the meeting. She advised that there is a brief agenda for today with updates, but invited all to ask questions as the meeting goes along.

II. **Ombudsman & ADRC SHIP Updates**

Jennifer Bowdoin: We received funding - \$460,000 over three years to implement the Ombudsman program for the ICI. The RFP has been posted to the Purchasing website, and there is a deadline of this Friday for questions to be submitted, with bids due March 15. I understand there have been some questions about the award amount which is not explicitly listed in the RFP. I will say there is the year one funding amount on CMS website; we will receive additional funding in years two and three that is consistent though not exact. If you have questions beyond that submit them through the RFP and we will turn them around as appropriate. We also have some funding to expand ship counseling in the community, Medicare Part D and Medicare plans. I Invite Paula Parker with the Division of Elderly Affairs to explain further.

Paula Parker: We have received a three year grant over three years and we have issued a sub-award to United Way of RI and they will be hiring three full time counselors who are going to be trained specifically in the integrated care initiative, thus the Neighborhood Health Plan Integrity product. They will have all the technical knowledge about benefits included in the program and a good understanding of other alternatives such as other Medicare and Medicaid products. We are going to be utilizing them in every phase of the demonstration as people are being enrolled during the first two phases of opt in, and then also passive enrollment. We want to be sure there is good messaging and media coverage about this initiative, and that we partner with the SHIP networks. We have currently about 25-30 partners across the state able to train the broader SHIP network about some of the finer points of the integrity product. Want elders to know they can get in person counseling in their community, or if they prefer phone counseling. We have asked EOHHS to get a differentiated list of where enrollees live by zip code so that resources are appropriately dispersed. We plan to co locate them, they will be mobile, there will also be a walk in option and our goal for anyone who has the opportunity to enroll fully understands the benefits of Integrity as well as other benefits to make an informed decision.

Jim Nyberg: So the training will not be just about Integrity?

Paula Parker: Correct. The purpose is to provide conflict free objective counseling for an informed choice. But right now no one in our network knows the fine point of integrity so will need to be trained to fully inform what will be offered under these programs. Three

years, so again not just during the initial enrollment and our SHIP counselors will serve as a resource. The folks that we are hiring will also be able to inform and direct people to the enrollment call in line. While our counselors cannot enroll anyone directly, they can give all the information.

Sam Salganik: Is there a relationship between Ombudsman and SHIP?

Paula Parker: Yes, and it will be made very clear which of the two is the right place to go for consumers.

Linda Katz: Just a thought in terms of the larger outreach plan, now that SHIP are coming on board, having that big picture, seems to bring that up again. We may need to redevelop the big picture work on this, and I encourage that we come around the table together to do that soon. I know we have that intention, but I want to be sure we work at it and follow through here.

Diana Beaton: Yes, absolutely that is the plan.

Paula Parker: And we have made the commitment to train not only our external counselors, but all state staff as well to be sure we are all fully informed. We will also be asking EOHHS to see if we can develop a quick sheet/fact sheet with the numbers of the SHIP counselors, or appropriate locations so that as enrollment letters go out, they can have that in the letter and be further reassured.

Jennifer Bowdoin: Important also to remember that enrollment is not just these first phases, but a consistent process with newly eligible. There is a lot of churn within the population, so important to keep working on this, to modify as we go, so we all know it is not a one and done program. We are focused on initial startup, and there are of course more things we will need to give more thought to.

Linda Katz: Perhaps if we talk about developing a little insert, if all thoughts on communicating could go to Diana, and then that could be shared to an interested marketing subgroup for e-review, and then keep trying to help this process go forward.

Jennifer Bowdoin: Another note about the Ombudsman – it had been asked at our last meeting if non-state employees can participate in the RFP review process. There is in fact precedent for this, so if you are interested in this let one of us know via email. A few requirements will be: a non-disclosure agreement, a conflict of interest form, and the understanding that there will be a quick turnaround. We do not know how many responses we will get but the turnaround will require a lot of work and dedication. Financial information would not be shared with non-state reviewers. That said anyone of interest can email Lauren Lapolla to be included.

III. **Contract Updates**

Jennifer Bowdoin: We have a contract that is 99% out of the federal and state review process. They have now made the contract available to Neighborhood Health Plan to review, who in a very short time may review provide additional questions, and if all goes well should have official sign off in March. Based on that timeline, which includes tight

technical details, we are looking at probably June 1 for the first effective dates. Letters out end of April, start to enroll in May. Due to CMS processes you need a significant amount of lead time from the time when the contract is signed to enrollment, hence that start date. It is never a done deal, CMS makes us promise to always state that as we discuss this, but right now still anticipating June 1.

Linda Katz: The conversion from InRhodes to UHIP in July, and outreach to consumers about what is coming down the pike...in getting people out of InRhodes and account set up in UHIP- can you talk somewhat about coordination and how those pieces fit together?

Jennifer Bowdoin: Yes, it is a big change. To some extent this program should not be affected very much. All of the enrollment in this program happens through our MMIS program, which is fairly downstream from the eligibility system itself. The planning is to make sure that the planning from RI Bridges to MMIS is happening correctly – if that functions as it is supposed to, then the enrollment actually happens.

Linda Katz: I am thinking also about the communication part, as we are developing materials and letters about ICI they will also get letters about RI Bridges and we will want to be careful that they [the consumer] are not overwhelmed and disregarding, or conflating the two.

Diana Beaton: There is an internal work group on communication plan for bridges, not at the deep dive point yet.

Linda Katz: Right – I think stakeholders need to loop us in there to be sure that we as an outsiders can take a look at all these notices and communications going out are streamlined and go from there.

Jennifer Bowdoin: We can get more specific information and present that in our March session.

Linda Katz: Many of us have asked for consumer and advocate testing of the system, and it may be interesting for folks around the table here who will see how it will work for those we interact with. If there is a way to set up consumer testing.

Jennifer Bowdoin: We can bring that back.

IV. **Other Items**

Jennifer Bowdoin: We have been talking quite a bit with a smaller group about transitioning this group into a consumer lead council which would provide feedback and recommendations to the Secretary, as well as functioning as a steering committee for the Ombudsman program. One thing that I keep going back to is how to get more consumers out to talk about this. We heard that there may have been a policy which prevented home care agencies from transporting members to non-medical appointments. While we are still trying to track that down, we don't want transportation to be a barrier to these meetings. If there are people who want to participate in meetings and who find that they are having barriers to participation please let us know and we will try to find a way to work on it. We will do whatever we can to make it doable to people to participate – whether it be technology, or interpreters etc. We want this to be a group that is open.

Nicholas Oliver: I can provide you that policy you referred to. Can you develop a one pager on what the council will look like so that we can recruit what the council will look like?

Jennifer Bowdoin: Yes, we have a charter that is in draft form. We are working internally and with advocates from the voices for better health to further flesh out some of the details. Not quite ready to make it available, but very close. It is a three page document that we will release in a final draft form to speak to the general information of what the group is and what the intent is. We also have a brief outreach letter we have been working on with advocates that we can send out to help recruit participants, which will also include an F.A.Q. document. There is also a brief nomination form. The intent is to have 15-21 members, at least half of whom are consumers. We will have a nomination form to let folks tell us more about themselves so as not to prevent a provider who may also be a caregiver from participating. We will work to select a group that has very strong consumer representation, look to all of you to help us get the word out. One thing that we want to do will be to schedule some information session so we can talk about what the council is and pre-emptively answer questions about the ICI as people are considering nominating themselves or others. EOHHS will appoint an interim chair and vice chair, and then once the group is going, we will have the council select their own chair and vice chair down the road, both of whom will have to be consumers. We are working now on training materials, particularly for consumers who may not have participated in a council before, we want them to feel educated and comfortable participating, as well as additional information about the demonstration itself, which will be iterative.

Jim Nyberg: To clarify would the council be in place of this?

Jennifer Bowdoin: This group will transition into that consumer council. It will still be a public meeting, but rather than us talking at you, they would set the agendas, invite people to speak to points they are concerned about, and a formal mechanism for communications back to EOHHS. I think there is still a need, in the short run for information sharing, to bring together some office hours particularly for providers who do not know what is going on, to have an opportunity to come and ask questions about things. If there are other things we need to do in addition, we are open.

Jim Nyberg: I appreciate the importance of consumer council, but as we go forward, I feel this is the only place that we as providers can provide our input on policy.

Jim McNulty: We agree, which is why 49% will also be providers or advocates etc.

Linda Katz: And that is to say a bit about what the agenda looks like, for I would expect that consumers would want to know about the impact on providers. Key to look at them together.

Jennifer Bowdoin: No shortage of need for communication around this, you are right.

Nicholas Oliver: In Massachusetts there is still a smaller mechanism like this group now that meets with their HHS at least quarterly to discuss many of the issues that we are talking here, and that is separate from the consumer advisory group. I echo Jim Nyberg's concerns.

Jim McNulty: I find that providers tend to have a lock on technical information. I will say I do not like reading Medicaid regulations, but to be effective as a part of the advisory group we need to have that information out there. If we are not aware of what they are we cannot do our jobs. We are all in it together, as Linda said, not just us and them.

Nicholas Oliver: The reality of Phase I when my providers' patients received the phase I letter none of them understood it. So initially many opted out – and I think that is part and parcel to why there is a big opt out of HCBS. Some folks asked their CNA or their provider what the letter meant; they talk to the person directly in front of them. Having a source of feedback is really important. The providers call their trade associations, not EOHHS. Providers are not the big bad guys in the room – we hear from patients, and that is not implicitly clear in the letters provided, and we are confident that will be the case for phase II.

Diana Beaton: CMS has given us what the letters look like, which we do not have much input on, but we can pass along. There are two for the passive enrollment group, and one of the other. We have the option to add in the FAQ, stuffers/inserts as Paula mentioned. We want to include the education and support materials. The first letter we have an in-house letter that is continued on from phase I and it goes to about 500 people a month and we are aware that did not work initially as it was a complicated roll out. If you would like to take a look at that, we can do so, so you can inform us if there is a need to adjust. We tried to segment for populations, as a dual w no LTC will have different FAQ then someone w LTC. It is complicated, and we are held to include information.

Nicholas Oliver: Yes we just don't want to produce any additional anxiety out there. They should reach the appropriate contact not just a provider who also doesn't know where to go.

Diana Beaton: We also want to try this time to have providers noticed about the letter before your population receives it. Have the outreach plan consider you all in.

Jennifer Bowdoin: We are at a point we can share the notices with everyone; we have about 19 notices at this time. We can send the opt in letter, and the passive notice(s) to you all. We will send those out, and the others we can make publically available on the website. We are putting together training materials as well, so if you have a population that in particular you want to know more about we can make that available to you. As far as the council goes, I am excited as I feel that we do not have a lot of interaction with consumers now, and we need that. I understand your pushback – but it will not be entirely consumers. Providers, trade associations etc. can be on the council itself, just not be in the chair or both vice chair roles. We will also have additional subcommittees, so if we feel like we need to meet on specific items, we can pull together a work group on that to resolve issues. And then, I mentioned having office hours for providers particularly to have information and questions answered on the demonstration. If there are other things we are missing I am open to other strategies. I am happy to meet if there are providers that would like to meet. If you feel there is a group that is neglected let us know. We are a bit removed over in hazard, so if we are neglecting something I hope you will let us know. If this newly restructured implementation council isn't doing the trick, then we can look at that and tweak as we get going.

Jim McNulty: Yes my concern is more along the lines of information asymmetry.

Sam Salganik: You mentioned that this new consumer council would act as steering committee to the new Ombudsman program, can you elaborate?

Jennifer Bowdoin: Yes, we are required to have a steering committee for the Ombudsman program and we felt it made sense to use this group as the same entity. We are still determining the details of that, but there is so much overlap that we would like to keep as combined as possible.

Bill Flynn: A lot of what we designed came from Massachusetts and that provision was there with appropriate confidentiality maintained, and the complaints or info to the Ombudsman is another resource to this council for information for what is happening out there. To some degree having a larger view of what is going on outside their own experience, more of that than an oversight committee for the Ombudsman.

Jennifer Bowdoin: Yes. The Ombudsman program should be one of our best gauges for how things are going on the ground. This should help bring things to live sooner than perhaps in other routes.

Jennifer Bowdoin: I think there is a lot of interest in how the program will be working and what I would like to do is develop a dashboard of metrics to see quick glance how are we doing. I think if we can all get comfortable with a relatively small set of information that can give us a quick view on how things are going, and then we have about ninety measures that Neighborhood Health Plan & the state will have to report on, which is a lot to wade through, if we can have a way to glance as a group to see how things are going, and shift the demonstration as needed/appropriate we can use that as an informing tool. Something we can work together to do over the next several months.

Ann Mulready: There are other initiatives happening in Medicaid that I cannot figure out how they will integrate with the ICI – i.e. integrated health homes for the SPMI population. It is mind boggling - there are so many new initiatives and how will they work together?

Jennifer Bowdoin: Yes, it makes all our heads spin too. There are very few things that are carved out of managed care in the state of RI – transportation, dental etc. – but pretty much everything else is in. When there is a reinventing initiative or something within the Medicaid program that affects the duals population and it is something that is an in plan benefit, the health plan is responsible for it. It should generally speaking work the same in FFS as with MCO, but for consumers it is a lot of change and hard to know what is affective what. IHH is an in plan benefit, and so consumers will have a choice about who will pay for their IHH, and who is overall responsible and accountable, but it does not affect their eligibility for it. If a person chose to not participate in the ICI, but still IHH, it does not affect their ability to use the IHH.

Linda Katz: It is the same with the accountable entity (AE) question. The AE is supposed to manage the care, so if I am a dual, will I be attributed through the pilot, and if so, what does that mean?

Jennifer Bowdoin: Currently no, and the reason is that Medicare is primary. Neighborhood Health Plan cannot attribute them to an AE as they do not have the Medicare claim. There is interest at EOHHS in putting duals who are in an integrated product into the AE, but that is a later phase than where we are. I do not think we are quite there yet in terms of the

time frame. There is an intent of moving them in, but we are no quite there.

Linda Katz: Underlying it all though is what does it mean for the consumer – what is the benefit for the consumer, given that the ICI is option. If we are trying to sell that to consumers, as we think there is a benefit, and if they can get the same sorts of services, then why should we push that? Perhaps that is a good conversation for this group at the next meeting.

Jennifer Bowdoin: One thing that may be helpful as not all Reinventing Medicaid initiatives impacts duals, is to outline which ones are brought into managed care, and impact duals, then those are handled by the MCO. It shouldn't work any differently for this product than it would for another. In terms of how it works, it should be consistent, but yes there is a lot of change her.

Linda Katz: Right, and then the state are re-procuring the managed care contracts, so that is potentially another area.

Jennifer Bowdoin: That will not affect duals though as RHO is not included in that re-procurement.

Ann Mulready: I need to understand the differences, but also if the consumer asks me, I don't know how to explain.

Jennifer Bowdoin: At the next meeting we will get a list of all Reinventing Medicaid initiatives, and if it will be in plan, and impacts duals, we can do a cross walk to see how they will work and impact populations.

Linda Katz: Right, but also may be helpful to think about someone with SPMI who may be in an IHH, applying for coverage and care what does it look like from the consumer perspective.

Jennifer Bowdoin: The benefit of this program is that it depends on where you are coming from how it will look. Having information for people in the community, fact sheets for each program etc. Let's work on those materials, we can send those around to review as developed to those who have volunteered to do so, and then from there see where we need to go.

V. Public Comment

No additional comment offered by the public at this time.

VI. Adjourn