

The goal of the Health and Long Term Care Integration Project is to plan, design and implement systems that integrate funding streams, and integrate acute/primary and long term care service delivery as an option for adults who are frail, vulnerable, chronically ill, physically disabled, and/or elderly.

Health and Long Term Care Integration Project
COMMUNITY ADVISORY COMMITTEE MEETING

Monday, June 5, 2006

9:30 a.m. – 3:30 p.m.

Skylight Conference Room, Waterbury

MINUTES

Present:

Advisory Committee Members: Susan Bandfield Abdo, Janice Clements, Peter Cobb, Janet Cramer, Larry Goetschius, Scott Goyette, Jeanne Hutchins, Jude Kantorowski (new member), Jackie Majoros, Maureen Mayo, Dennis McCullough, Harold Nadeau, Jill Olson, Lila Richardson, Mary Shriver, Lynn Whalen, Janet C. White, Jason Whitney.

Guests: Betsy Davis (PACE Vermont), Kathleen Dennette (Rate Setting), Patricia Elias (Rate Setting), Dody Fisher (Core Planning Team member), Susan Gordon (VT Association of Professional Caregivers), Fran Keeler (DAIL Division of Licensing and Protection), Deborah Lisi-Baker (Core Planning Team member), Chuck Rhynard (Central Vermont Council on Aging), Heather Shlosser (Core Planning Team member), and Julie Trotter (Core Planning Team member).

Presenters: John Baackes (Senior Whole Health, Massachusetts), Diane Flanders (Massachusetts Medicaid), and Richard Segan (Evercare, Massachusetts).

Staff: Michael Bailit (Facilitator), Patrick Flood (Commissioner, Department of Disabilities, Aging and Independent Living), Erica Garfin (Project Evaluation Consultant), Joan Haslett (Project Director), Cecile Sherburn (Project Assistant), and Theresa Wood (Deputy Commissioner, Division of Disability and Aging Services).

Agenda:

1. Welcome, Introductions, and Agenda Review
2. Presentations: Diane Flanders, John Baackes, and Richard Segan
3. Discussion regarding serving the nursing facility population in an Integrated Care model
4. Presentation and discussion regarding Community Feedback Partner input on the Draft Target Populations document
5. Review and discussion regarding Core Planning Team Covered Services Recommendations, including the Integrated Care Team
6. 2006 Work Plan Review and Next Meeting

Handouts:

1. Agenda
2. "Questions from Vermont: Nursing Homes and Integrated Organizations: Capitation of Medicaid and Medicare Reimbursement Model and the Impact on Nursing Homes"
3. "SCO: Senior Care Options: Bringing Medicare and MassHealth Together" (Diane Flanders' PowerPoint presentation slides)
4. "SWH: Senior Whole Health: Integration Care Community Advisory Committee" (John Baackes' PowerPoint presentation slides)
5. "Health and Long Term Care Integration Project: Community Feedback Partner Feedback on Options for Target Population Groups for Inclusion – June 1, 2006" (Erica Garfin's report)
6. "Health and Long-Term Care Integration Project: Services and Integrated Care Team – May 30, 2006 DRAFT" (draft proposed services document).

Note: Presenter Richard Segan did not provide handouts of his PowerPoint presentation; he will make them available at a later time and they will be distributed to all participants.

The meeting began at 9:35.

Welcome, Introductions and Agenda Review:

Jude Kantorowski was introduced as a new member of the Community Advisory Committee, representing the Vermont Association of Professional Care Providers (VAPCP).

Michael Bailit clarified that although Lynn Whalen has joined the Core Planning Team (CPT) as a consumer representative (following a lengthy selection process earlier in the spring), she remains a member of the Community Advisory Committee and has not resigned from that group, as was reported at the last CAC meeting. However, her role on the CPT is not to serve as a liaison between the CAC and the CPT but rather to represent consumers of services.

Michael explained that members of the Core Planning Team (CPT) and other interested persons were invited to attend this meeting of the Community Advisory Committee (CAC) in order to hear the presenters from Massachusetts. The point of the presentations was to obtain information on how the Massachusetts integrated care programs operate and the impact of their programs on nursing homes, and to address questions and concerns that have arisen within the CPT and the CAC as they consider whether to include in our target populations people who are currently living in nursing homes.

Questions from Vermont (from handout previously sent to the speakers by Joan Haslett) to be addressed regarding Nursing Homes & Integrated Organizations, specifically Capitation of Medicaid and Medicare Reimbursement Model and the Impact on Nursing Homes, include:

1. Is there any impact on the requirement for completion of an MDS assessment? Would it still be done by the nursing home staff or the Integrated Organization (IO)?
2. What are the licensure issues for care in nursing homes, i.e., who is ultimately responsible for the care provided – the nursing home or the IO?
3. Who makes decisions about care and services needed? For example, who decides if the resident needs hospitalization – the nursing facility or the IO who is paying the bill?
4. Would there be any effect on case mix scores when individuals switch from Fee-For-Service to this model, since residents enrolled in the IO would not be included in the case mix calculation?
5. Is there a minimum number of participants needed in a nursing home to make the model work for both the nursing home and the IO?
6. What are the value-added services to the nursing home and the participants through this model?
7. How does the interdisciplinary team of the IO relate to the nursing home staff?

1. Diane Flanders Presentation:

Diane is the Director of Coordinated Care Systems for the Massachusetts state Medicaid office which oversees the MassHealth Senior Care Options (SCO) program. John Baackes and Richard Segan represent two of the three SCOs with which the State of Massachusetts has contracted to provide these integrated services. The three SCOs each have 5-year contracts which expire at the end of 2008, at which time the state will go out to bid again.

Diane reviewed the objectives of the SCO program, milestones in the development of the program, the authority under which they operate, highlights to date, and benefits to all stakeholders (see handout). Highlights include:

- The Centralized Enrollee Record (CER) – this is not a participant’s full medical record but includes current information on a subset of the elements necessary for 24/7 response. For all three SCOs, this is now an electronic record.
- 24/7 access to the Nurse Case Manager, who has access to the CER.
- “Extra” benefits not routinely available in fee-for-service models (note the Vermont project is currently referring to these as “creative” or “flexible” benefits).
- Multiple rating categories – they have 24 different capitation rates, based on clinical level of need and setting of care. Some of the factors include:
 - the range of needs, from people deemed “the Community Well” to people residing in nursing facilities,
 - people who are “dually eligible” or those who are Medicaid eligible only, and
 - whether people reside in the greater Boston area or in the outlying, non-urban, more rural areas.

Diane noted that the long term care (LTC) providers, including nursing homes, were key stakeholders involved early on in the planning and development sessions. They convened an “advocates’ advisory group” which included the Massachusetts Extended Care Association and Home Health agencies as well as other agencies not traditionally

involved in services, such as AARP. The advocates were concerned that enrollees not be refused placement in a nursing facility when appropriate, and the providers were interested in the opportunities for new, creative uses of nursing facility beds as well as for the additional support and partnership that would occur in an integrated system of care.

The contracts with the SCOs specify they must provide coordination and expert care management across the continuum of LTC services, to ensure that people can go into a nursing home when it is appropriate and they want to do so. The Primary Care Team (PCT) remains responsible for arranging, delivering and monitoring LTC services while participants are in nursing homes, and will develop the Plan of Care (POC) with the nursing home staff. As people residing in nursing homes may need something that is not covered under traditional Medicaid/Medicare services, enrollment in the SCO provides opportunities for flexible, creative use of existing resources to meet individual needs.

2. John Baackes Presentation:

John Baackes presented information on Senior Whole Health (SWH), one of the 3 SCOs in Massachusetts (see handout) which pools the benefits of Medicare and Medicaid in one care management program. The model is a “proactive effort to stabilize the patient at an appropriate level of care.” He stressed that this approach does not – and is not expected to – save money in year one. Rather, over time it intends to slow the growth in nursing home costs and support people to stay at home if possible, and if they are in a nursing home, to stabilize and support them so they don’t need to go in and out of acute care hospitals.

SWH began operations in August of 2004 and is now enrolling approximately 150-200 people per month. Of the “dual eligibles” (people eligible for both Medicaid and Medicare) whom they serve, 2/3 are over 65 years old (“age dual”) and 1/3 are under 65 (“dual by disability”). He noted most enrollment is done “as a kitchen table sale” – especially when adult children are present. The adult children understand that the SCO will do the care coordination for their elder parent, which can be a good selling point when discussing nursing home care.

Currently only 7% of their enrollees are residing in a nursing facility for long term care, and about 1% are there for rehabilitation stays. They expect the number of nursing facility residents enrolled will increase over time because they are expanding their enrollment efforts in nursing facilities. They only enroll people in nursing facilities where the facility is already a contracted provider with SWH and where the patient’s primary care physician is also in the plan. If a resident in a participating nursing facility is interested in joining the SCO but their primary care physician is not in the network, SWH will invite the physician to join. After a certain number of residents in a given facility are enrolled in the plan, the facility can receive prospective payments instead of retroactive payments.

Each member receives an initial assessment, is assigned a Care Manager, and has an Individual Care Plan developed based on their needs. Because this model “stratifies [financial] risk” by using a rating category-based system to determine the capitation

payment for each individual, they reassess members periodically and if their functional status and/or needs have changed, they may be moved from one of the 24 capitation rate categories to another.

John described how the care management model works in nursing homes:

- SWH establishes rapport with the nursing home staff; nursing home staff calls SWH when there is a change in the patient's condition or an event.
- The SWH nurse performs rounds in the nursing home weekly or more frequently as appropriate.
- They review the chart and interview the patient and staff. When reviewing the chart the SWH nurse looks for opportunities to skill patients appropriately, which benefits both SWH and the nursing home.
- Care decisions are made by the nursing home staff.
- SWH can authorize outside care on site.
- Treat-in-place reimbursement rate is available to the nursing home.
- The care management nurse can handle family issues related to care outside the nursing home.

John stated that SWH would not be doing the nursing home component alone, nor would they attempt to implement the model without including the nursing home component.

3. Richard Segan Presentation:

Richard Segan is the Executive Director of Evercare New England, one of the 3 SCOs in Massachusetts. The Evercare mission is to optimize health and wellbeing of individuals who are aged, frail, or disabled. He noted that 66% of Medicare spending is for people with 5 or more medical conditions (i.e. "complex needs"). Evercare started in 1995 and today operates in over 150 nursing homes in Massachusetts and Rhode Island alone (and more elsewhere). Their goal is to enhance the quality of care in nursing home settings by offering care coordination and increasing access to primary care services by:

1. using "mid-level providers" - Nurse Practitioners - in the collaborative practice model, and
2. changing the financial incentives. This includes:
 - a. eliminating the "3-day hospital stay" requirement,
 - b. enhancing the primary care physician fee schedule to encourage nursing facility visits (i.e., paying primary care physicians for services they otherwise could not get paid for, like doing rounds with the Nurse Practitioner), and
 - c. developing special reimbursement codes which "recognize the value of communication between the primary care provider and the family" (e.g., paying for visits or phone calls with families).

Benefits to nursing home residents and their family members include that the enrollee's primary care is delivered more frequently and in response to clinical needs (not according to a regulatory schedule); coordinated care; increased communication with the family; an enhanced benefits package; and fewer hospitalizations and emergency room visits.

Benefits to the primary care physicians include better outcomes for patients/residents; more efficient practice patterns; enhanced reimbursement for routine and other visits; and compensation for services such as meetings with families.

Benefits to the nursing home are many. The SCO considers the nursing home to be an integral part of the care delivery system. Some of the benefits to the nursing home include improved access to primary care for residents; a greater focus on clinical geriatric issues; increased reimbursement for skilled services; and access to Nurse Practitioners as additional resources for nursing home staff education and collaboration. In addition to serving current residents, if the nursing home has a good short-term sub-acute system, the SCO can also refer patients to them instead of to a tertiary acute hospital.

Benefits to the state and to society include better outcomes at lower aggregate cost; the potential for lowering aggregate costs due to the investment in primary care and prevention and elimination of the 3-day hospital stay requirement; rational reallocation of scarce resources resulting in expanded benefits; and, for the state, integration assures no risk of cost-shifting from the federal government to the state.

As far as evidence for quality outcomes, the Evercare Demonstration project has been evaluated several times, and one study found a 50% reduction in hospital admissions and emergency room encounters, with no adverse outcomes for patients. While there has been some public concern that HMOs and capitation payments in general might result in less access to specialized services, this study found the opposite was true: more ready access to primary care produces better outcomes.

John stated that care coordination should be individualized, coordinated, comprehensive, and continuous, and that the Evercare model produces a win-win-win situation. He also noted that while his presentation has focused on nursing facilities in order to address our questions; in fact, institutional enrollment is not a key focus for Evercare's SCO contract; their focus is on providing all services in the community.

Discussion Regarding Serving the Nursing Facility Population in an Integrated Care Model, and Questions for Presenters:

There were questions about the applicability of the SCO model to serving nursing home residents in a rural state like Vermont. Providers must be willing to participate at the reimbursement levels offered. However, in many communities in Vermont there may only be one specialist (in a specific discipline) in the whole county, so if the specialist is not willing to participate, it won't work. Diane noted that they are excited about the SCOs being able to use "telemedicine," which is not allowed under fee-for-service, and thinks it holds promise for serving areas of the state where specialists may not be available.

Another question asked about the difference between the SCOs and PACE programs. Diane said they have 6 PACE programs and 11 PACE providers in Massachusetts, and that some of the PACE programs are part of organizations that are also doing SCO work. From the recipient's point of view, the differences are subtle. After screening, which is done by their AAAs, each person should get a menu of options of services to choose

from, and each program does its own marketing, all of which must be approved by both CMS and the State (to ensure accuracy).

The ratio of Nurse Practitioners to physicians varies by facility and by physician; Evercare does not specify a ratio. For best collaboration, an NP should work with 3-4 physicians.

The number of beds in a nursing home may determine whether this model will work: the speakers felt that if there are 60 beds, it will work; if only 20 beds, probably not. Mary Shriver noted that most nursing homes in Vermont are very small, and that only about 40 statewide would meet those Massachusetts "qualifications" (of size). Richard recommended she speak with the nursing home trade association of Massachusetts for more information, which she said she would do.

John noted that the model would not work financially with just a nursing facility population; you need to include all people who are dually eligible so that this risk pool is large enough. When asked if the SCO model would work without including the nursing facilities, Diane responded that they didn't know, but suspected it would not work. Since reimbursement is based partly on acuity level of enrollees, you need a risk pool that covers all levels of need. In Massachusetts the Medicaid reimbursement is currently about \$150 per person/per month, while the Medicare rate is over \$1200 per person/per month. By including the "Community Well" (or "Community Others") they have found that the model works financially, since mathematically you need both the low and high end users to make it work.

Where is the incentive to move people out of nursing facilities if the nursing facility rate is higher? When a person comes home from a nursing home, they continue at the nursing home rate for their first three months at home, in order to put the rest of services into place. However, the presenters noted that there is not a high rate of people returning home from nursing facilities, probably due to the reasons they went into the nursing facility in the first place.

Presentation of Feedback from Community Feedback Partners:

Erica Garfin presented the "Community Feedback Partner Feedback on Options for Target Population Groups for Inclusion" which summarizes the responses from the first round of information sharing with the Community Feedback Partners (CFPs). The feedback addressed:

- whether the CFPs agreed with the Core Planning Team's recommendations on whether or not to include each of the 4 groups as described in the Options for Target Populations document,
- their hopes and concerns for the project, and
- comments on the feedback process itself.

In addition, several CFPs recommended a few additional groups to be considered for inclusion in the target populations, including individuals ineligible for Medicare because they have never worked; these people are often described as being the most frail and having the fewest resources.

Continued Discussion of Target Populations:

Following Erica's presentation, there was much discussion over the possible inclusion of Group 2, people currently residing in nursing facilities, which was the main focus of the day's meeting, and the presentations from the consultants from Massachusetts. It was noted that one CFP felt they made their recommendation without adequate information about the tiered rate. Michael said that the message that he heard was that in order to make the new model financially viable, there must be a certain number of people enrolled. Therefore, including the nursing home population would increase the eligible population overall. One CAC member noted she previously heard the message "don't bite off more than you can chew" but today she heard "be sure to bite off enough" (referring to eligible populations). Concerns were also expressed that the project won't be sustained after the pilot stage. Another CAC member requested data on the population distribution in Vermont so that decisions don't get made that only work in Chittenden County (since in many parts of Vermont, poverty is more rural). Michael reported that in Minnesota, they contracted for services to first be provided in the city and then later expanded to rural areas, while in Arizona the RFP for bidders stipulated that they must serve everyone at the outset.

The Core Planning Team members present stated that after hearing the presentations by Diane, Robert and Richard, they felt the project should include everyone at the outset, including people in nursing homes, rather than starting with the minimum and hoping for a "trickle-in" effect. They also noted that if we include everyone from the beginning, we could end up having regional providers that together would provide coverage to the whole state.

Asked whether there is any patient satisfaction data available comparing people in nursing homes enrolled in the SCO with those in nursing homes who are not enrolled in the SCO, Diane replied that since perhaps 80% of their nursing home residents have cognitive impairments, they have not figured out how to do such patient surveys in a meaningful way.

Michael noted there is not yet enough data available on the integrated services model to make any comparisons between services provided by not-for-profit entities versus for-profits. He reminded us that the state can set many parameters through bidding process, including whether or not to restrict potential bidders to not-for-profit or for-profit entities.

There was an unanswered question as to who would bear the technological costs of 24/7 access to medical records.

Decision: By the end of the discussion the general consensus of the group was to move ahead with including the nursing home population as one of the target populations, although a few committee members stated that they remained undecided.

There were also a few requests from CAC members for additional information about the potential impact of including nursing home residents in the model. Next steps for obtaining the requested information include:

- Joan will get data on population distribution to look at any impact on program design.
- Mary Shriver (Vermont Health Care Association) will talk with the members of her group about their opinions, and will also contact the nursing home trade association in Massachusetts for more information on their experience with the SCOs, as was suggested by Richard Segan. Peter Cobb (from the Vermont Assembly of Home Health Agencies, Inc.) will talk with his peers in other states about their experiences.

Michael suggested that Mary and Peter also speak with association contacts in other states with similar programs (e.g., WI, MN).

Review and Discussion Regarding Core Planning Team Covered Services Recommendations, Including Integrated Care Team:

The group reviewed the May 30th draft of the “Services and Integrated Care Team” document which describes the interdisciplinary team and the proposed services to be delivered. In addition to Medicaid state plan services, Medicare services and 1115 Choices for Care Demonstration Waiver Services, the proposed services include:

- Integrated services, using an Interdisciplinary Care Team and a Centralized Enrollee Record;
- Health Promotion and Risk Management Services; and
- Creative (or Flexible) Services.

Discussion, questions and comments included:

- Comments on the document itself:
 - Language in the document overall should be more “consumer-centric.”
 - In the Interdisciplinary Care Team Responsibilities section, there should be a separate section entitled “Role of the Participant (or their designee)” inserted as section B between A. Team and C. Primary Care Provider sections. In this section, define the range of the role, the participant’s responsibilities, and their interface with the Team.
 - Define “designee” as “family or other concerned people” (note this is not the legal definition).
 - “Behavioral Health” is no longer the current nomenclature; return to using “Mental Health and Substance Abuse Services”
 - In the Social Worker section, the bullet on providing information about and assisting participants with housing issues is unclear – what is meant by “assist with” since other organizations do this work? Perhaps it should say “...information about access to... housing options...” There was also a request to add “transportation” to this item.
 - In the Health Promotion/Risk Management section, people suggested that nutrition and substance abuse be added to the list of risk factors. In

explaining why this list included some things and not others, Dody said the CPT chose items where a participant can be active in promoting her own health and modifying her own risk. An additional problem for people maintaining their own health is the challenge of keeping track of all the various medications some people must take, which can be quite complicated.

- The “Creative Services” section doesn’t include dental, vision or other services that a contractor might want to make available to all members; these would be considered “Supplemental” or “Extra” services (not in the traditional benefits package) and need their own separate category.
- Who is going to be keeping an eye on utilization? Who has an overall sense of what is being spent on each person? Dody responded that the Core Planning Team chose not to dictate a mechanism for this but rather to just provide a framework for the new system, and it would be up to the provider entity to figure out how best to be responsible for managing utilization.
- Will there be an issue of adequate office space for a social worker to be housed in a doctor’s office? Diane said the social workers don’t necessarily need a separate office space since they use technology and creative scheduling to accomplish their work. Many of their network primary care providers are in health centers or physicians in group practices, so they carve out a specific time to meet each week. She acknowledged, however, that this could be more challenging in a small, single-physician practice where designating an office space for the social worker, or even a separate meeting space, might be impractical.
- The Massachusetts information seemed to indicate the participant was not necessarily considered a member of the interdisciplinary team. CAC members want language added specifying that the consumer/participant must sign off on their Plan of Care and any changes thereto, to ensure Vermont’s system keeps the consumer at the center.
- Committee members stated that they want to offer people a choice of keeping their existing primary care physician, but the physician would have to be willing to work with the Social Worker and the RN. It’s possible that not all physicians will want to work as part of a team; those that choose to participate as providers must be willing to be an “equal-basis” team player. One solution would be to hire Nurse Practitioners (NPs) as the primary care provider on the teams. A well-trained, highly competent NP can be the intermediary with the physicians. It was suggested that perhaps the document should refer to “PCP or co-PCP” to allow for flexibility.
- In discussing the possible range of services, it was clarified that “traditional” Medicaid and Medicare services will be provided but the traditional limits and rules will not apply. However, there still needs to be an appeals process; Massachusetts uses the traditional Medicaid/Medicare appeals process. Diane noted that once the SCO is in place, the services are no longer “Medicaid/Medicare Services” but are now “SCO Services” and that instead of saying coverage will include services that are “medically necessary” they use

language that says they will provide “coverage that is equal to the equivalent of Medicare/Medicaid services.” She also said that they have a 3-way contract with Medicare; without such a contract, CMS would “have fits over” any service that is over and above the traditional services.

- Language: Michael defined the difference between “Creative” and “Extra” services: “Creative” services are individualized, case-specific services, while “Extra” services are those available to all participants as part of the benefits package.
- A committee member noted that the “Creative Services” section of the document sounds too professionally oriented; it needs to show the participant as an equal player.

Michael will write up for the Core Planning Team all the Community Advisory Committee feedback and input gleaned from today’s meeting regarding the proposed services document.

Work Plan Review and Next Meeting:

Timeline changes since the last meeting:

1. Stakeholders meeting: Some time during the next month, the State will send a document to the executive directors of the various stakeholder organizations/associations to:
 - describe to them where we are in the planning process,
 - give them a rough draft of documents produced to date,
 - invite them to scan their members for input, and
 - invite them to present to DAIL and OVHA their comments and feedback at a public hearing.
2. Second Feedback Loop: Erica Garfin will prepare and distribute the second feedback loop mailing to the Community Feedback Partners for their feedback on the proposed services document; responses will be due by late July. This is a change from the schedule she had previously sent them.
3. Request for Information: Joan will begin working on a Request for Information (RFI) document which will make our work to date available to potential bidders. She will specifically include certain questions raised by the Community Advisory Committee and the Core Planning Team and will ask potential bidders to address those concerns as well as to respond to the general concept of the project. By the end of the RFI process we will have an idea if anyone is interested and what type of organization(s) they are (e.g., for-profit, not-for-profit). Joan hopes to have the RFI issued by August 31st, with the responses due by September 30th.
4. August 8 Joint CAC/CPT Meeting: The Community Advisory Committee will join the Core Planning Team at their meeting scheduled for August 8th, to review the CFP feedback and the draft of the RFI. To accommodate the larger joint meeting, the meeting has been moved; see below.

NEXT MEETING:

August 8, 9:30 a.m. to 3:30 p.m., in the **Cyprian Learning Center, Hazen's Notch Room** (ground floor of the Osgood Building in the Waterbury Office Complex). As always, continental breakfast (9:00 a.m.) and lunch will be provided and a reminder will be sent; RSVP to Cecile by August 1st as to whether you will be able to attend.

Meeting adjourned at 3:30.

Minutes by Cecile Sherburn