

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, April 24, 2006

9:30 a.m. – 3:30 p.m.

Skylight Conference Room, Waterbury

MINUTES

Present:

Advisory Committee Members: Peter Cobb, Janet Cramer, Larry Goetschius, Susan Gordon, Scott Goyette, Jeanne Hutchins, Maureen Mayo, Dennis McCullough, Harold Nadeau, Jill Olson, Lila Richardson, Darlene Saler, Mary Shriver, Julie Bushey Trevor, Janet C. White, Rebecca Worth,

Staff: Michael Bailit (facilitator), Joan Haslett (Project Director) and Cecile Sherburn (Project Assistant), and Theresa Wood (Deputy Commissioner, Division of Disability and Aging Services).

Guest: Bob Clark (observer, from the Senior Citizen Law Project in Rutland).

Presenting by telephone: Scott Wittman, Core Planning Team member, from Pacific Health Policy Group.

Agenda:

1. Welcome, Introductions, Agenda Review and Miscellaneous Updates
2. Presentation by Scott Wittman Regarding Current Medicaid Population
3. Discussion of Draft Target Populations Document
4. Introduction to Covered Services
5. Review of Final CPT Mission Statement and Guiding Principles
6. Decision Making Process Revisited
7. 2006 Work Plan Review & Next Meeting
8. Question Regarding Distribution of CPT Minutes and Attachments
9. Update on Other State Initiatives
10. Meeting Evaluation

Handouts:

1. Agenda
2. "Preliminary Review of Medicaid Data" OVHA/DDAIL (from Scott Whitman, dated April 24, 2006)
3. "Options for Target Population Groups Defined by Eligibility at Time of Enrollment" (revised 4/21/06)
4. "Vermont Health and Long-Term Care Integration Project: Introduction to Covered Services" Michael Bailit, April 12, 2006 (PowerPoint slides)

5. Approved Core Planning Team “Mission Statement and Guiding Principles” (April 4, 2006)
6. “Health and Long Term Care Integration Project Flow Chart” (dated 4/21/06)
7. “Health and LTC Integration Project Work Plan” (chart revised 4/19/06)
8. “New Planning Grants and Initiatives Related to the Health and Long Term Care Integration Project” (dated 4/13/06)
9. Acronyms chart (dated 4/21/06)

The meeting began at 9:30 a.m.

1. Introductions and Updates:

Dennis McCullough, MD, was introduced as a new Community Advisory Committee (CAC) member, representing physicians. Lynn Whalen has been selected as the consumer to be added to the Core Planning Team (CPT). Ginny Felice, CPT facilitator from Bailit Health Purchasing, will be leaving the project June 30, 2006. Evaluation Consultant Peter Youngbaer has taken another position and is being replaced by Erica Garfin.

The “formative evaluation process” was briefly described. Erica will be the point person for the evaluation process and the liaison with the Community Feedback Partners (CFPs). All of the Long Term Care Coalitions are interested in becoming CFPs, except for Connecticut Valley. In addition, several statewide organizations are interested.

2. Presentation by Scott Wittman Regarding Current Medicaid Population:

Scott Wittman explained (by telephone) the data in his handout. The Core Planning Team used these data in developing their recommendations for target populations. He noted the data are historical data from the Medicaid claims database and do not include Medicare costs. Because of the time lag in availability of Medicaid data, they also do not include any data on Choices for Care, which began on 10/1/05. The purpose of looking at these data is not to do future forecasting but rather to look at the various target populations being considered for inclusion in the new system model, to see the number of people and cost of claims for each group. After the conference call ended, the CAC agreed that they found Scott’s presentation and explanations helpful.

3. Summary of Discussion of Draft Target Populations Document:

General comments:

- A CAC member requested that the CPT generally provide the CAC with the criteria that it has employed to make its recommendations.
- Theresa Wood suggested that the document should footnote which populations are excluded (e.g. people on waivers for developmental disabilities or traumatic brain injury).

Comments regarding **Group 1**: *People eligible for Long Term Care (LTC) Medicaid only, or eligible for both Long Term Care Medicaid and Medicare, and who are living in the community at the time of enrollment*

- There was agreement with the CPT's recommendation to include this group.
- Where are the Medicaid-only demographic and cost data?
- Who exactly is included and excluded in this group? Can you enroll while an inpatient in a hospital? Are individuals in non-nursing facility (NF) institutions excluded? If someone enters a NF, for how long will they be remain in Group 1 for reimbursement purposes?
- While "enrolling individuals early" is listed as a 'pro', this really isn't so "early."
- Another pro is that there is potential for increasing provider accountability by including this group.
- How can "loss of control" be a weakness? Isn't the premise of the model that it will provide consumers with greater control? This needs to be clarified for consumer stakeholders.

Comments regarding **Group 2:** *People eligible for Long Term Care (LTC) Medicaid only, or eligible for both Long Term Care Medicaid and Medicare, and who are living in institutions at the time of enrollment*

- The CAC disagreed with the CPT recommendation and felt that this group needed additional study. The CAC recommended that organizations with experience serving individuals in nursing facilities be invited to address the CAC and CPT on the benefits of such an approach, and that Vermont nursing facilities managers be invited to attend the meeting.
- What is the rationale for enrolling this group?
- "This is where the money is" and savings could be achieved through improved care management and by helping people move out of NFs.
- Perhaps this group should be enrolled for the short-term only.
- Currently NFs are penalized if their occupancy is below 93% - this could impede efforts to help people transfer out.
- Theresa Wood suggested including Group 2 because they are already in Choices for Care and they should therefore be included in the Integration project for the sake of consistency.
- What does "massive undertaking for the entity with existing NF regulations" refer to?

Comments regarding **Group 3:** *People who are dually eligible (Community Medicaid and Medicare) who are living in the community and are not clinically eligible for Long Term Care Medicaid*

- Agreement with the CPT's recommendation to include this group.
- The Housing and Supportive Services Program experience has been that there are savings here.

Comments regarding **Group 4:** *People who are dually eligible (Community Medicaid and Medicare) and who have chronic conditions or risk factors for chronic conditions and live in the community*

- Agreement with the CPT's recommendation to exclude this as a *separate* group since it is actually a subset of Group 3 (and would thus be included).

- The CPT should study current chronic care initiatives in Vermont and the current CMS regional chronic care demonstrations (“Medicare Support”), as well as the VA’s approach and the CMS group practice demonstration, for which Dartmouth-Hitchcock is a participating site.

4. Summary of Discussion Regarding Introduction to Covered Services:

The CAC noted that if the contractor is to have the flexibility to cover alternative services, then it must have standards and criteria for deciding when to cover such services, and the onus will be upon the state to ensure that this responsibility is handled responsibly and equitably.

5. Discussion of Core Planning Team Mission Statement and Guiding Principles:

While the CAC understood that this document had been finalized, the members did suggest that future documents describing the Care Integration project do the following:

- use the term “Vermonters” instead of “consumers” wherever practical, and
- mention the family as a participant when describing the team approach.

6. Decision Making Process Revisited:

The Committee reviewed the handout which showed the workflow for document development, feedback and decision points in the development of this model. The draft documents developed by the Core Planning Team will go to both the Community Advisory Committee and the Community Feedback Partners for review and comment, and then will loop back to the CPT for editing and further refinement based on the feedback received. This process may repeat until a final draft version is sent to the Commissioner of Disabilities, Aging and Independent Living. Theresa Wood stressed that even at that point, no final decisions will have been made; if the Commissioner has suggestions, questions or wants something clarified, the document will come back to the CAC for further work.

Michael reminded the group that the process is iterative in that preliminary decisions made at each of the initial steps (identifying target audiences, services to be provided, and members of the interdisciplinary team) depend upon or impact on the others, so we will revisit earlier recommendations as new decisions and information help us refine the design. Also, in addition to obtaining feedback from the CAC and the Community Feedback Partners, the Commissioner will be assembling a group of physicians to provide feedback, and there will be public forums held, probably in the summer, to obtain public comment from all stakeholders and interested parties.

Erica Garfin, the new evaluation consultant, will attend the June 5th meeting of the CAC to report the feedback from the Community Feedback Partners on the first round of information distributed for their review and response, which will include the proposed target populations document discussed today.

7. 2006 Work Plan Review & Next Meeting:

The CPT will be looking next at other states’ experiences with integrated care models, after which they will put their recommendations in a document for the CAC to discuss at

its next meeting. The Advisory Committee decided to cancel the meeting tentatively scheduled for May 8th and so the next CAC meeting will be on June 5th. Agenda topics for that meeting will include the target populations, covered services, and options for the interdisciplinary team.

8. Question Regarding Distribution of CPT Minutes and Attachments:

There was a request from a CAC member to receive all the resource documents used by the CPT to inform their planning; some of the other members are interested as well. In the future these documents will be available on the yet-to-be-developed homepage for the grant on the DAIL website; until then, they can be sent as attachments (or links to other websites where they exist; e.g., other states' documents). It was also requested that DAIL include a list of the attachments in the text of the e-mail. Scott noted there is a way to send update notices when material is updated on the web; once the grant homepage is operational (DAIL's website is undergoing revision), perhaps DAIL could use that function to keep CAC members informed of revisions to working documents.

9. Update on Other State Initiatives:

A new chart of Vermont initiatives that are related to or similar to this Integration Project was distributed, as requested by the CAC. These initiatives and their responsible departments include:

- Department of Disabilities, Aging, and Independent Living (DAIL):
 - Choices for Care (1115 Waiver from the federal Center for Medicare and Medicaid Services - CMS)
 - PACE (Program for All-inclusive Care for the Elderly)
 - "Flexible Choices" (previously known as "Cash and Counseling")
 - Alzheimer's Disease Demonstration Grant to States (ADDGS)
 - Supportive Housing Grant (A Real Choice Systems Change Planning Grant from CMS)
 - The Health and Long Term Care Integration Project (A Real Choice Systems Change Planning Grant from CMS)
 - Quality Assurance and Quality Improvement (QA/QI) in Home and Community Based Services (A Real Choice Systems Change Planning Grant from CMS)
 - Aging and Disability Resource Center (ADRC) Grant (a planning grant from CMS and the Administration on Aging)
- Department of Health:
 - "Blueprint for Health" (funded by a legislative appropriation)
- Office of Vermont Health Access (OVHA):
 - "Global Commitment" (1115 Waiver from CMS)
 - Care Coordination Program

Joan offered to invite speakers from any or all of the various related initiatives to make presentations at future CAC meetings, for the CAC members who wish to learn more about them. She said that the Aging and Disabilities Resource Center (ADRC) grant staff

has already asked her for an opportunity to present to CAC. In addition, Joan said that she felt that it would be important for people working on this project to hear about the Quality Assurance/Quality Improvement grant, but not until we have gotten further down the road in our planning. The CAC members said they would also like to hear about the OVHA Care Coordination project. Presentations will be scheduled for future meetings, as time allows.

10. Meeting Evaluation:

The group agreed the meeting format worked well and had no suggestions for improvement.

NEXT MEETING:

Monday, June 5th, 9:30 - 3:30 in the Skylight Conference Room.

Meeting adjourned at 3:15 p.m.

Minutes by Cecile Sherburn