

Michigan Medicaid Long Term Care Task Force

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MINUTES

(as corrected after the 11/8/04 meeting)

Monday, October 11, 2004

House Office Building

Mackinac Room

Lansing, Michigan

Members Present: J. Sutton, J. Mendez, Representative Shaffer, G. Betters, R. Carter, T. Czerwinski, S. Steinke, D. Hoyle, T. Wong, M. Cody, M. Moers, S. Gire, Y. McKinney, J. Olszewski, R. Alcodray-Khalifa

Members Absent: Senator Cherry, Senator Hammerstrom, and M. Hardy.

Other: Linda Potter representing RoAnne Chaney, Kirsten Fisk representing Representative Gillard, Betty Nelson representing M. Udow, and Amy Slonim, Michigan Public Health Institute, facilitator.

Call to Order: The fifth meeting of the Medicaid Long Term Care Task Force was called to order at approximately 10:00 a.m., by Vice-Chair, Susan Steinke.

Review and Approval of Agenda: S. Steinke suggested a change in Workgroup A and Workgroup F reports. The change was made to allow questions from audience after the Task Force has their questions answered. A motion to approve agenda was made by D. Hoyle and seconded by M. Cody. Also due to time, S. Steinke suggested that Workgroup F move to 2:45 p.m. A motion to revise agenda was made by J. Mendez, seconded by J. Olszewski, and carried by voice vote.

Review and Approval of September 13 Minutes: A motion to support the September 13, 2004, minutes, as presented, was made by S. Gire, and seconded by Representative Schaffer. The motion was approved by voice vote.

Proposed Process for Workgroup Recommendations and Discussion: The issue is that the Task Force needs a clear decision making process for the adoption of final recommendations and it needs to be rearticulated. At the September 13th meeting there were questions on how the Task Force would adopt or work with recommendations from the workgroups as they are represented to the Task Force. The issue was addressed during the Executive Committee conference call. The committee came to agreement on the following: The LTC Task Force will operate using an consensus-based process for reviewing the reports, taking action, and making final decisions. Each workgroup will present its final report including suggested recommendations to the LTC Task Force within the charge given to the group within the report format requested of the group. The

LTC Task Force members will have to opportunity to discuss and consider the workgroups suggested recommendations at the time the final workgroup is presented. If the LTC Task Force finds the workgroups' suggested recommendations acceptable, these recommendations will be placed on the agenda for the subsequent LTC Task Force meeting. At the subsequent meeting, the LTC Task Force members will have the opportunity for final discussion and will then make a decision regarding acceptance of the workgroup recommendations. These accepted recommendations will then become preliminary recommendations for the full LTC Task Force. Preliminary recommendations can then be used to service the framework for activities, discussions, and decisions of the remaining workgroups. Preliminary recommendations adopted by the LTC Task Force will service the basis for the final report, and upon completion of all workgroup activities and adoption of LTC Task Force preliminary recommendations a final report will be drafted and placed on the agenda for the April meeting of Task Force. This draft report will include all of the adopted preliminary recommendations as a single package for the final review discussion and decision making of the full Long Term Task Force. Upon the approval of the members during this final meeting all adopted preliminary recommendations will become final recommendations of the LTC Task Force will be presented as such to all those required pursuant to Executive Order 2004-1.

S. Steinke clarified that according the Executive Order the Task Force cannot call anything a final recommendation until a final report is issued. Also, the Task Force needs to come to decision on how they are going to use the workgroup reports.

A few suggestions were made by Task Force members on how to use the reports. R. Carter suggested that the Task Force should expedite all workgroups to report. He believes that the only way to make a decision is to have the whole picture.

S. Steinke indicated that in January most workgroup reports would be in. Workgroup B would not be able to present a final report by January.

R. Alcodray-Khalifa suggested that a second meeting of the LTC Task Force be scheduled in January to take a look at the "bigger picture". This will provide members the opportunity to thoroughly review recommendations in their entirety, and allow adequate discussion of the issues presented.

S. Steinke suggested to LTC Task Force member to get their not available dates for January to J. Hazewinkel by October 15th. Volunteers task force members can work with the executive committee on the structure of this second meeting so that the LTC Task Force members can have the kind of conversation/discussion necessary.

A motion to approve the definition of consensus, and the decision-making process proposed by the executive committee was made by T. Czerwinski and seconded by R. Alcodray-Khalifa. The consensus process was approved by voice vote.

D. Hoyle states that each group needs to report to the Task Force to get feedback. He believes that decisions should be made as the Task Force meets so that they don't have to make all the decisions at one time.

Jan Christensen stated that what some of the issues the Task Force is discussing relate to implementation planning, as previously noted by several members of the Task Force. The Task Force may make some broad recommendations to the Michigan Department of Community Health about the direction in which the state should be going. However, it is then helpful to have additional background and some implementation documents to address questions such as what it might cost, what legislative changes might be necessary, and what level of effort might be needed from all affected parties to achieve that. Once MDCH has some preliminary recommendations, it is possible to begin doing some internal work. This work can address issues such as what does it actually mean to implement that, how would you go about it, and put some additional detail together which would then would be available to the Task Force. Task Force members could review this additional information before ending its deliberation so that the Task Force can make final decisions regarding the overall Task Force report and its final recommendations.

S. Steinke asked for a vote to approve implementation-planning going on as workgroup recommendations are approved. This is so that other workgroups to use the information from approved preliminary approvals of the former workgroups gone before them. D. Hoyle doesn't see a reason for formal vote because he is hoping that other groups will give reports for feedback.

Workgroup A Second Report to Task Force and Discussion: Presented by D. Hoyle, Sara Slocum, and Ellen Sugrue. A retreat was held at the Michigan Home Health Association to come up with the second draft of the report. Workgroup A used the consensus process to develop some of the preliminary recommendations. The workgroup split into small groups to report out and a consensus was reached from the small groups. An additional meeting that will need to take place is to discuss those things that come up in the process that the group was not able to discuss during the retreat. Information and referral was identified as a critical component of the single point of entry. It would be available to all consumers, caregiver, and family members. The workgroup reached consensus on financial eligibility determination; the group agreed that the Family Independence Agency would continue to actually perform the financial eligibility. The SPE agencies will have a supportive role in the process. The workgroup envisioned that the single point of entry could offer assistance and support for consumers so that "clean applications" could be submitted much more frequently. The group recognized the staffing problems and some of delays that have happened and some of the processes that are going on at FIA currently. They wanted to make sure that it was recognized and dealt with constructively through a supportive process at the SPE while keeping the actual determination separate and remaining at FIA. It was noted that nursing home transition will be a function of the SPE agency. The service offers choice to current nursing home residents. It involves consumers in decision-making about their own lives, and facilitates a smooth transition into their own community. Workgroup A thought that SPE are

ideally suited for implementing this program and will learn from the experience in the pilots that existed in Grand Rapids and Detroit. Data will be available at the end of December on the Grand Rapids and Detroit projects. The case coordination, support coordination, and/or care planning issue were a function that the group determined should be contained into the SPE. Person center planning being an important element of what is being discussed the group came to the option of independent facilitation. The reason being: 1) not every support coordinator is skilled at facilitation of person center planning and 2) there are sometimes suspicions that people from the system doing person center planning versus independent facilitation isn't quite fair. The advocacy piece that can come from outside facilitation really provides another option for people to make sure that they are not stuck with professional recommendations but in fact have options that are more person centered. The facilitation being done by a person whether paid or unpaid outside of the system is one that the workgroup agreed on. The last meeting will include the feedback from the Task Force.

Jan Christensen spoke to the Task Force about previous discussions about the SPE and the mandatory provision for publicly funded programs. He does not believe that the discussion went beyond the publicly funded program of Medicaid. This is an issue that the workgroup should take a look at. The solution to the question is to require a mandatory offer for everyone else who is using privately funds. This can assure that the hospital discharge program that that hospital discharge planner can advise individuals that the single point of entry agency can answers questions such as what is available, how they can assist the individual consumer, what they think might be in a person's best interest as opposed to mandating where to seek services, or advising consumers that they can't use public dollars to get into a long-term care setting. After much discussion, and looking at the pros and cons of both sides the workgroup came to a conclusion that going through the single point of entry should be mandatory for all publicly funded persons, and that the single point of entry be a mandatory offering for everyone else.

M. Cody asked why the group suggested that the financial eligibility determination should be retained at FIA. S. Steinke indicated that it is a federal law that the state has to do it. M. Cody indicated that the MSA could choose who does the financial eligibility. T. Wong asked whether the SPE would incorporate CMH services. Also, if private paying individuals choose to use the SPE, would the assessment tool be required for them? S. Steinke is going to look into these issues and get back with the Task Force.

R. Alcodray-Khalifa suggested that the State of Michigan create a videotape to show services to people. Also she suggested providing bilingual brochures to go along with these videos.

Betty Nelson suggested that these people be well aware of what happens so that they are not working into a panic state. She suggested using cable TV to show individuals their options.

S. Steinke indicated that the preliminary report from Workgroup A is eligible to be voted on because it was presented in September. The Task Force must decide if they want to

vote to approve the report or wait until November. A motion to wait until November was made by R. Carter and seconded by T. Czerwinski. Motion carried by voice vote.

Interim Report Discussion: J. Hazewinkel presented a preliminary draft of the report to the Task Force. The preliminary draft is not yet available to the public, as Task Force members must first review it and offer changes. The report is a progress report of the activities of the Task Force to date, and includes a brief forward written by the Chair, a list of members, recap of the Executive Order, mention of the activities and meetings that have taken place with the workgroups, summary of presentations given at the meetings, and a chart of workgroups which shows the values that each group is working with. As part of the preliminary findings, a copy of the vision statement, which was adopted in August, was included. It will be noted that the workgroup A and F reports are scheduled for today's meeting. It was requested that the Task Force members review the report and reply to John Hazewinkel with any suggestions, comments, or changes by Friday, October 15th. A copy of the draft report will then be posted on the website. Task Force members want to emphasize that the public is aware that this report is an interim report and that a final report is "a work in progress".

S. Gire stated that Workgroup C has made significant changes to their report, and notes that it needs to be clearly marked as a draft that does not reflect final workgroup recommendations or positions.

R. Carter suggests not including attachments, appendices, and preliminary reports from Workgroup A and F because the Task Force has yet to make decisions on those items. Including draft documents with the report may be misconstrued as representing final decisions which would not be the case.

S. Gire suggested stopping on page 6 of the interim report and add 3 workgroups who have been in the process, have been addressing specifics in the vision and values statements, and some specific strategies to achieve those ends so that it is clear that if someone looks at initial charge that they don't feel that the Task Force has been working on the same thing over and over.

M. Moers believes that the Governor should be aware of what the Task Force and workgroups are working with right now.

S. Gire agreed with M. Moers, and also identifies the organization affiliations too, so that it is clear that it is a very broad based effort, and the 21 Task Force members are getting additional input from behind the Task Force. They additional people should be recognized.

The appendices will include the 3 workgroups that have met thus far.

Task Force requested that the interim report not to be posted until Monday, October 18, 2004, so that their comments be included on the report that is put on the website.

Changes given to J. Hazewinkel at the meeting will be made and sent out to Task Force members on October 12, 2004.

Other workgroups:

Workgroup C Report: S. Gire, Chairperson of Workgroup C presented the update. Workgroup C has had 5 meetings. The original workgroup was about 46 people. They have averaged about 32 people due to others changing groups because they could not make all meetings. During the meetings they have divided into smaller groups in the process and have rewritten the visions and values statement. They rewrote the visions and values statement not to change their goals but to clarify what they think needs to be done. Additionally, the group has developed strategies, which is part of the charge from R. Chaney. On each strategy, they have asked R. Chaney to approve sending three items from Vision and Value statement 5 into Workgroup C because they relate to continuum. They are working on two subcommittee levels: 1) Quality issues regarding long-term care. Sara Slocum is the chairperson for that subcommittee. 2) Assisted Living issues funding, regulation, etc, and Kay Miller is chairing that subcommittee. The workgroup has also worked through a proposed list of services for the continuum and what the court elements ought to include. S. Gire has suggested to the group that they should try to schedule two meetings in the month of October. The group will be ready to report to the Task Force in November.

Schedules and updates for B, D, E, G

Workgroup E, chaired by D. Hoyle, will begin meetings at the end of November.

Workgroup B, chaired by J. Olszewski.

Workgroup D, chaired by Representative Shaffer. The group has identified 6 meetings beginning Thursday, October 14th. The meetings will be held in 426 of the Capital Building. The members participating in Workgroup D should have received an email with the meeting dates and the overall charge is for the workgroup.

Workgroup G, chaired by M. Cody. Meetings start on Wednesday, November 3, 2004. The group is still looking for meeting space. They have an attorney who will be a facilitator.

The meeting adjourned for lunch at 12:20 p.m.

The vice-chairperson re-convened the Task Force at 1:05 p.m.

Public Comment:

Andy Farmer, AARP, Stakeholder document presentation. At the first Task Force meeting they offered public comment in the form of summary document of the overall work of the AARP stakeholder group that has already submitted materials to the members. The summary document mentioned and other documents of the 3 workgroups of that stakeholder organization would be forthcoming. The other 3 are: 1) SPE, 2) Home and community-based services, and 3) Workforce. The summary document given to the Task Force is about the subcommittee Home and community-based services. The document consists of the statement of principles and action items.

Bud Kraft, Michigan Developmental and Disability Council. He had a few comments about information discussed previously by the Task Force. He heard previously that the community and mental health service system would be delivering services to persons with developmental disabilities. Would like to remind the Task Force that there are many people with developmental disabilities who are not in the service system. They are with their families or other support systems. Bud believes that there is a difference if someone is in the system, already you can see why those individuals wouldn't come through the SPE. If they were in the system then it would be not necessary, but if they are in the system and wanted to change and come out of the community mental health system then he thinks that the Task Force should look at the opportunities for the individuals to come there and get the information referral to do that. He thinks that the Task Force should look at MI Choice, Home Help, Section Aide, Meals on Wheels (if old enough), so that they can receive those services. Bud wanted to clarify if the AAA's would be excluded from the SPE. S. Steinke indicated that the AAA's would be able to apply in the process just like anyone else would.

Karen Schrock, from the Adult Well-being Services. She was attending the LTC Task Force meeting to talk about the interest in promoting basic public health principles in the deliberations in long-term care. Also, to make sure that the current community-based providers, providing services, which reduce the need for long-term care in the institutional sense become part of the Task Force implementations strategies. Karen was a part of workgroup C and appreciated the opportunity, but caregiver support is critical. Many families that they serve would not put their loved ones in institutional settings for long-term care if they got adequate support. The second issue that was mentioned was health promotion and prevention. Health promotion and education are not normally focused on the older adult population. Part of the strategy needs to be looking at how we can more effectively educate our senior adults about health and avoid some of the health problems that lead to the need for long-term care. There is very limited focus on the prevention for older adults and even less emphasis for people with developmental disabilities. Karen was at the meeting to advocate for provision of preventive services to these groups as a way of improving the quality of their lives and reducing long-term care costs. Prevention does work for aging adults as well as for people who have other disabilities and we need to make sure that provisions for them are included in the Task Force strategies.

Ann Holtzworth, speaking on behalf of those who receive home help services. She was diagnosed with juvenile rheumatoid arthritis at 19 months old. Ann received home help services through project choices, which is a waiver funded through the Tri-County Office on Aging. Aides come into her home 3 times a day to help her with personal care, activities, and daily living tasks such as, transferring, bathing, dressing, meal preparation, and light house keeping. Many people have told her that many legislators and people in government are of the opinion that people with severe, chronic disabilities would receive care from family members if we did not have programs such as project choices and various other home help programs. In Ann's case that is a false assumption. The only remaining member of her immediate family is her brother who lives in the Lansing area and will be 70 years old in January. Without the home help services she would have no alternative other than to go into a long-term care facility. Thanks to the home help program, she has been living in her own apartment for six years by herself. As long as these services are adequately funded, she will be able to continue living on her own.

Colleen Clansey, reading on behalf of Lauren Segal. Lauren has had MS for 27 years. She cannot move at all from the neck down, can barely see or speak. She is wanted to tell the Task Force how she has been able to stay in her own home. Lauren is 54 years old. When she was 31 years old her neurologist told her that she would have to live the rest of her life in a nursing home or with her parents because she could no longer transfer herself; so she tried living in a nursing home. Many of the other residents who were not old, were mentally ill, and were unable to communicate. After 2 months she decided that it was no way for a human being to live. Her grandfather was nice enough to give her the money she needed to move out. Her neurologist told her probably it would be too hard for her to set up help at home. She would have to be on the phone all the time. He did not mention how important it would be for Lauren to be connected to her community and it has been. In the last 20 years Lauren has been involved in 2 theater groups, Barrier Free Theater and Diversability Theater, which she helped found. Diversability Theater performed many of her poems. She wrote a calendar of poems. Her poetry has been published all over including the Ann Arbor News. Lauren has co-authored two books: 1) Unexpected Journeys, which has been published, and 2) Mysterious Path, which has not yet been published. She has attended the MS support group nearly every week for 19 years. She has written 3 letters to the editor of the Ann Arbor News, also has had the opportunity to develop a 20-year personal friendship with the editor. Her care has become more and more specialized as the disease progresses. She cannot speak. Her personal assistant reads her lips very well. The personal assistant has been with Lauren for 6 years. She cannot move. She requires range of motion exercises twice a day. If she misses them her limbs stiffen up. Her PA has never missed a day unless she found a sub. Lauren has been hospitalized for three days in the last 10 years with pneumonia; her personal assistant was with her everyday. It would be a disaster if she missed a meal, which includes her fluids because she would be likely to get a urinary tract infection. She has a computer that enables her to write with her chin. It has a chin lever electrically connected to a speech synthesizer connected to the computer. The computer also controls the TV, radio, and CD player adding to her independence. Lauren writes for 5 to 6 hours per day. She pays rent with SSI, a federal program with partial state subsidy from MSHDA. She pays for food with food stamps, a federal program, and Medicaid a state

program. Family Independence Agency, as state agency, is paying for most of her help. Part of the reimbursement for living with her is rent and food so it is federal. She combines resources so federal money is used. Lauren also uses local resources like the Ann Arbor bus system. 20 years ago, she was told the safe way to organize her life was to live in a nursing home. It is not true today. Hospitalization is expensive for the state and so is changing a feeding tube. You have to take the ambulance and go the ER for the three hours. Lauren uses the local subsidized handicap equipped bus to go to her Medicaid approved doctor for five minutes. Feeding tubes wear out about every 7 months or so. Nursing homes are her greatest fear. The decision to stay in your home gives you a chance to be productive. A nursing home is a hopeless solution to a tough problem. The decision in the ability to stay in your own home with a realistic plan indicates hope.

Dave Tyler, quadriplegic since October 31, 1988. He was involved in a hit-and-run accident. Dave suffered severe injuries; the hospital told him that no one would be able to touch him. His paralysis was that he would be on oxygen for the rest of his life and would not be able to do anything for himself. He would need 24 hour care. At first, FIA was sending workers out, but that wasn't working too well. They left it up to him to find his own workers. Dave lived 10 years in Swartz Creek. In 1997, his mother passed away. His father wasn't sure what he was going to do with him. The FIA worker told his father to put him into a nursing home. After Dave healed up, he was placed in a nursing home for three years. While in the nursing home he received a brochure from the disability network, housing program. He contacted the disability network and they advised him on how to get out of the nursing home. Genesee County told Dave they didn't have anymore waiver programs to live independent. A&B out of Saginaw helped him get out of the nursing home. Since November 1st 2002 he has been living independently.

Presentation: Rate Setting for Nursing Homes and the Waiver Program: S. Steinke introduced Deputy Director Paul Reinhart from the Medicaid agency. Paul introduced the staff from Medicaid who spoke about the rates setting for nursing homes and the waiver program. John Donaldson presented the rates on nursing homes. The current methodology that Medicaid is using to set rates for long-term care providers was established in 1982 by a task force composed of members from the legislative area, the department, providers, and other interested individuals. They specified two groups. The group one is free standing nursing homes. There are currently 399 of those who are enrolled in the Medicaid program. There are another 40 to 45 facilities that currently do not participate in the program. The second group was hospital long-term care and county medical care facilities. There are 25 hospital long-term care units that are privately owned, 5 hospital long-term care units that are County owned, and then 38 county medical care facilities. When Medicaid figures the rate setting, they calculate the rates to coincide with the states fiscal year. The bases for these rates are the individual facilities annual cost reports that they have to submit to the department. Medicaid uses calendar year 2003 cost reports to set the rates beginning October 1, 2004. The rate itself is made up of 3 components: 1) variable piece, 2) plant piece, and 3) add-ons to the rate. Mr.

Donaldson provided a comprehensive description of what may be included in these components.

There are limitations placed on how Medicaid reimburses. The first add-on that applies to both the medical care facility, hospitals, and nursing homes was a federally mandate in 1987, which required that nurse aides be competency evaluated, trained, and tested. On the interim, Medicaid provides reimbursement up to \$.80 per day if historically the facility has incurred that cost. If a facility has incurred more than \$.80 per day, Medicaid retrospectively sell that period after they file their cost report. For a facility that is historically not incurred \$.80 per day, Medicaid will pay them whatever they incurred historically for that cost. The other add-on is the quality assurance supplement, known as the QAAP tax. It came into law with PA 303 of 2002. Basically Medicaid is founding the state funds with a tax on the non-governmental nursing homes and hospital long-term care units to provide them with an inflationary increase with the cost base Medicaid uses. The county owned facilities also receive the quality assurance supplement from July of 2002 to September of 2003. There has not been an appropriation for them to receive it going forward. The county owned facility has received the proportion-shared pool, where Medicaid transfers money to the facilities; they keep a portion of the money, and then transfer a piece of the money back to Medicaid. Medicaid is able to claim federal monies on that and that helps cover the cost of rate increases that is provided to long-term care providers. In county owned facilities there is a maintenance of effort. Originally it was in the PA 408 of 1984 that usually a law that ends in five years, that has been renewed every five years, the current act expires on December 31, 2007. It relates to the county facilities variable rate and how much there variable cost of increase. They need to pay back a portion of that to the department for every Medicaid day of care rendered.

S. Steinke has indicated that the Medicaid office had prepared to present rates on home and community-based waiver, but due to time they would have to present those rates at the November meeting.

Real Choice Systems Change/Cash and Counseling Grant: S. Steinke introduced Mike Head, Michigan Department Community Health, Consumer Directed Home and Community-based Services. He is speaking about a number of grants that the State of Michigan is working on and what they have received through the Real Choice System grant process. There are about five grants that they have that are coordinated through his office. The office of Consumer Directed Home and Community-based Services represents a commitment to the department to try and pursue arrangements for services that support both mental health and long-term care that try not only be based on a person center planning approach but also aim to provide option for people to control and direct services themselves. One of things discussed is the cash and counseling project to get a better sense of what it is the office is interested in doing to try to infuse into the long-term care system model that has actually been central to the home help program. The Real Choice System Change is a term that comes from CMS. CMS got an appropriation from Congress about four years ago and has maintained it each year. It is aimed at trying to promote implementation of the *Olmstead* Supreme Court decision. The Real Choice Systems Change initiative is aimed at trying to counter what is known as the

“institutional bias” in the Medicaid program and also to promote consumer choice and direction over home and community-based services. The focus of the program is on supporting beneficiary participation, choice, and control to live a real life in the community. The Real Choice Systems Change grant process consumer advocate involvement must be the driving factor. The State of Michigan has had four grants issued since 2001. The grants are: 1) Personal assistance services support grant, 2) Real Choice Systems Change Multi-Project grant, 3) Money follows the person rebalancing initiative, 4) Independence plus initiative.

Workgroup F Final Report to Task Force and Discussion: S. Steinke presented a report on Workgroup F, which are Chronic Care and Caregiver Support. Workgroup F has rewritten its originally assigned “vision and value statement” principle. The workgroup decided to change some of the words in the principle because adopting the term “chronic care” versus “chronic disease” is to reflect the pointed focus on the person and all there needs rather than a focus on a medical diagnosis. It prevents the group on focusing on just one disease and ignoring comorbidity, which happens when you have more than one chronic care condition. Also the group decided to add the words “implement” and “sustain” to the value statement to emphasize the potential power and lasting impact of the adoption of this principle. Finally, they expanded the outcomes listed in the principle to include: enhance the quality of life, provide person center outcomes, and prevent unnecessary hospitalization or institutionalization.

Workgroup F referred some items to Workgroup B and Workgroup G. Since many people report of denials of service due to technicalities on long-term care policies, there needs to be consumer protection on such policies for them to effective. Workgroup F recommended to Workgroup G that there are many issues of the assisted living including consumer protection, education, and spousal impoverishment. The recommendations for Workgroup C are to develop more senior centers and adult day centers as forms of respite support for caregivers and consumers.

S. Steinke indicated that Task Force members are vote on it in November. If members have any changes they should let Marsha or Susan know by October 29, 2004.

Task Force Member discussion and roundtable:

M. Moers stated that all members should pat themselves on the back for all the hard work and that the Task Force has a good start.

M. Cody echoed what M. Moers stated. M. Cody indicated that the Task Force members had a good discussion on Single Point of Entry (SPE) and all of the other information.

T. Wong indicated that he is pleased with the progress being made.

S. Steinke thanked members and workgroup volunteers for their hard work.

Next meeting date and agenda topics:

Agenda items are: 1) Visiting home and community-based rate setting, 2) Case mix reimbursement, 3) Comparability between the home and community-based waiver and the nursing homes and the cost effectiveness, what is assumed in that?

The next meeting will be held on November 8, 2004 in room 426 of the Capitol. (Members of the Executive Committee were asked to remain for short time after adjournment to set a time and date for them to meet.)

A motion to adjourn was made by R. Alcodry-Khalifa, seconded by M. Cody. The meeting adjourned at 3:05 p.m.