

Michigan Medicaid Long Term Care Task Force

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****DRAFT MINUTES****

**Monday, December 13, 2004
State Capitol, Room 426
Lansing, Michigan**

Members Present: G. Betters, R. Carter, R. Chaney, S. Steinke, T. Wong, T. Czerwiniski, J. Sutton, Representative Shaffer, J. Olszewski, M. Cody, M. Moers, D. Hoyle, J. Mendez, M. Hardy, Y. McKiney, Senator Cherry, S. Gire, R. Alcodray-Khalifa.

Members Absent: Senator Hammerstrom

Other: Barbara Nelson for M. Udow, Kirsten Fisk for Representative Gillard and Amy Slonium, Michigan Public Health Institute, facilitator.

Call to Order: The seventh meeting of the Medicaid Long Term Care Task Force was called to order at approximately 10:13 a.m., by Chairperson RoAnne Chaney.

Review and Approval of Agenda: A motion to approve the agenda as presented was made by M. Cody, seconded by Representative Shaffer. A voice vote was made to approve agenda as written.

Review and Approval of November 8 Minutes: A motion to approve the November 8 minutes was made by G. Betters, seconded by M. Moers. A voice vote was made to approve minutes as written.

Updates on Other Workgroups:

Workgroup A, SPE (S. Steinke): The group met on December 3rd and they are working on objectives and clarifying what the Task Force voted on with making sure all the steps are included to be able to continue. The workgroup will meet in the first or second week of January.

Workgroup B, Finance (J. Olszewski): The workgroup has approximately 60 people who have signed up. There are four recommended outcomes that the group is charged with trying to get to. The group has to agree upon principles, components regarding financing of LTC, set of operational recommendations and ideal timelines for the state, a written rationale of the outcomes, and the presentation. Of the 60 people signed up, there are 11 that make up a steering committee. The 11 members are G. Betters, R. Carter, Senator Cherry, T. Czerwinski, D. Hoyle, M. Moers, Representative Shaffer, S. Steinke, J. Sutton, T. Wong and J. Olszewski as Chair of the workgroup. So far the workgroup has developed a work plan for the finance, which was adopted by the group on November 1st. The steering group has met 4 times and anticipates meeting 4 or 5 more times between now and early March. The full workgroup has met twice. They have additional meetings

scheduled in January, February, and March. The workgroup has created four subgroups to handle the amount of work. The subgroups will meet in December, January and then will present their information and potential recommendations to the full workgroup in early February. The subgroups are Single Point of Entry in Financing, Financial and other incentives in LTC, Funding Mechanisms, and Maximizing Resources. The group has a fifth topic which is Waivers, which will be addressed as a Medicaid staff assignment with them bringing information to the workgroup. No recommendations at this time.

Workgroup D, Workforce (Representative Shaffer): The workgroup has broken down into 5 subcommittees. Those subcommittees are workforce projections, culture change, compensation, retention, and recruitment programs. The workgroup has been meeting every other week to get updates on each subcommittee. The workgroup plans to present their report to the Task Force in January.

Workgroup E, Consumer Involvement (D. Hoyle): The workgroup has met and organized schedule to meet the February deadline. No report at this time. Expecting to be able to meet deadline.

Workgroup F, Chronic Care (R. Chaney): The Task Force has voted on the final recommendations, but had feedback on details and outcomes. R. Chaney will get with workgroup on the feedback, make suggestions, and bring the details back to the Task Force.

Workgroup G, Legislative and Regulatory reform (M. Cody): The workgroup has been meeting on a weekly basis. There are 25 members that make up the workgroup. The focus of Workgroup G is Legislative and Regulatory Issues. The workgroup has broken down into 5 subcommittees, which are single point of entry, entity status, vision, Medicaid eligibility, and licensing. The workgroup will be ready to report to the Task Force at the February meeting. The entity status is looking at assigning an office, which would have responsibility of LTC rather than spreading out to other offices or agencies. Vision is an idea of capturing a state law to what LTC will look at both immediately and in the future. Medicaid eligibility subcommittee has identified one issue that is a solid recommendation to the Task Force. The issue is the ability of people entering in a nursing home who will leave within 6 months to use their private pay payments to maintain a house in the community so that they will have a house to go back to. The licensing subcommittee is looking at assisted living licensing and what that should look like. The workgroup should be able to present at the February meeting.

Presentation: Case Mix Reimbursement: Steve Bachleda, MDCH presented information regarding Case Mix Reimbursement. Case Mix Reimbursement is payment based on resource utilization use of patients in a particular setting. The two most famous case mix reimbursements systems are the DRG system for hospitals and RUGS system for nursing home reimbursement. The presentation focused around the RUGS system and the 44 RUGS codes that are related to nursing home reimbursement. The codes are based on the resident assessment instrument. Case mix is currently used by Medicare for nursing facility reimbursement. This system or a variation of this system is also used by 26 states for Medicaid nursing facility reimbursement. Michigan does not currently use this system for Medicaid. We pay the same per diem to a nursing facility for every Medicaid patient in that facility. The advantage of case mix reimbursement is that the

purchaser and the provider accept a reimbursement level based on a price and not on actual cost. The risk to the purchaser is the price may be too high and the risk for the provider is the price may be too low.

J. Mendez requested information on how many other states use this system in home care and assisted living. Barbara Nelson requested information on the 26 states using this system. Is there any data that shows a positive or negative for them, and how long has each state been in this involvement?

Discussion and Action on Workgroup C Report: S. Gire opened the table for discussion of the report given to the Task Force in November. J. Mendez agrees with the outputs. Her problem occurs that when money follows the person and there are no services in the community there is a problem. D. Hoyle indicated that the phrase “continuum of care” has implications that he can’t buy into. The words “array of supports” would serve him better than a continuum of care. It has come to his attention that some people presume something under continuum of care that is different than a person choosing from an array of supports that they can obtain. S. Gire indicated that the workgroup should revisit this issue. R. Carter asked to clarify whether or not assisted living was Medicaid funded or not. S. Gire responded by saying that the workgroup needs to figure out how the funding mechanism needs to be modified to allow assisted living to be part of the array of supports that people have to choose from.

J. Olszewski asked the workgroup to asterisks services that are primary care or acute care with a note that the services are available in other populations as well but for purposes of this you want someone to coordinate the whole thing.

J. Mendez requested at January meeting the workgroup provide a diagram of single point of entry so that the Task Force is not confused by the three that are provided in the report. The suggestion was forwarded to Workgroup A.

S. Gire wanted to make sure that the Task Force realized that the models were just for discussion. They are not adopted at all.

Workgroup will be meeting in early January to take recommendations and issues raised.

R. Chaney wanted to vote on basic objectives. The basic objectives start on page 3 of the report. M. Moers motioned to accept the whole report, seconded by T. Czerwinski accepting principles. D. Hoyle indicated that some of the objectives belong to other workgroups. He opposes the motion because he would like to see the workgroup work with the suggestions that were made. M. Moers wanted to accept the report so that the Task Force could move on. Representative Shaffer agreed with D. Hoyle. He would like to see a more thoughtful study before they adopt the report.

Decision: Workgroup C General Principles Accepted

R. Chaney clarified M. Moers motion to accept the general principles of the report and not the specific details. T. Czerwinski seconded the motion. Voice vote approved the general principles of Workgroup C report.

Adjourned for lunch at 12:00 p.m.

Re-convened at 1:00 p.m.

Public Comment:

Gloria Hoolsma, Ruth Linneman, staff member for the National Multiple Sclerosis, is assisting her. Gloria described herself as MS society member who is 40 years old and has MS. She has a husband, Dan, and two children. She has difficulty breathing, seeing, and speaking. Also has limited use of her arms and cannot use her legs. About 12 years ago her immunizations were increased and she was forced to move in with her parents. Project Choices made it possible for her to have an aide in the morning. Gloria moved into her own apartment when she received the aide. Because of Project Choices her husband is able to work during the day knowing that his wife is being taken care of. Her children can be children instead of caregivers. Living at home she is able to attend school activities with her son. The aide also helps her attend her daughters' daytime activities. The aides make it possible for her to get the care that she needs. Project Choices makes it possible for her to take incoming calls to her house and she enjoys the freedom that she has. Without the help of Project Choices she probably would have put into a nursing home years ago.

David Benjamin, A & D Homecare. He is at the meeting to outline several factors that need to be considered by the LTC Task Force before it makes its recommendation to the Governor on the implementation of a single point of entry system. These concerns result from the Olmstead decision of 1999, which requires choice. Workgroup A's recommendation to the committee from October 5th & 6th decision document contains several problems which include the model proposed eliminates choice of providers for those receiving care management services. This model proposed limits the municipal choice and thereby reduces the opportunity for true person center planning. Advocacy for participant rights is irrelevant when choice is eliminated up front. Having two waiver agents in a region, as been an extremely affective means on raising the quality of service provision through competition and also has been an effective means of providing choices to consumers. Single point of entry system it is a fact that individual seeking answers on care availability need to receive their information from a locally available single point of entry provider not from someone outside the region. This is why it is necessary the 21 waiver agents should serve in the role of providing the single point of entry services. It is our position that the Task Force is not required to reinvent the wheel and that we have the solution at our fingertips with the MI Choice waiver program. The solution does not require large increases in state spending and could recreate single point of entry systems in the matter months rather than years. Referred the Task Force to the minority report, which was handed out at a previous meeting.

Anthony Andrews, Benton Harbor, Michigan. He described himself as a quadriplegic paralyzed from the neck down. He is paralyzed due to a tree trimming accident. Anthony walked out his front door one morning to go to work and he fell. He didn't get to see his home for a year later. His wife was working and took care of all the bills. His mother-in-law took care of his needs. She had an automobile accident and was unable to take care of him. During the care he was getting a social security check. Financial aid decided that because his wife lives in the home he shouldn't receive the social security check. He was using that check to pay his mother-in-law for the care that she was giving him. She depended on that money to handle her bills. Financial aid cut Anthony's check more than half. He is part of a program that helps design homes for people with disabilities. He does motivational speaking for kids. He believes people with disabilities need to get out and live.

Carol Newburry, from Kalamazoo. She is a member of the Michigan Campaign for Quality Care. Spoke to the Task Force about an important component of long-term care, nursing homes. In 2000, they placed her mother in a nursing home. She thought that putting her mother in a nursing home would be great. She would be taken care of. They were hoping to get her back on her feet and take her back home. She was in the first home for a month. The nursing home was unable to toilet her regularly so they had to buy her mother several outfits so that she could be changed 5 times in 24 hours. No one in the nursing home would answer lights, give her medicine at proper times, or answer pages. As a result of not getting proper medicines she would hallucinate, have nausea, vomiting, headaches, and slept a lot. She lived on liquid supplements and lost weight. A family member had to be present to make sure the nursing home would give her medicines on the correct schedule. The family changed nursing homes several times until they found one that was livable. She died in the nursing home in 2001. The state was notified about the first nursing home. They went into the nursing home finding several things wrong, were cited but this facility is no better today. Carol believes that the system provides no incentive for nursing homes, such as these to do better. They are cited over and over again for the same offences. The state agencies have bent over backwards trying to work with owners and operators of nursing homes. It has not worked. She believes that the state should focus on working for the consumer and the residents of long-term care. The state needs to strengthen and change the inspection process. No facility should be able to have citations over and over for the same deficiencies. Set standards and do not give in when they are not met. Give the consumers and the surveyors tools to improve this system.

Manfred Tatzmann, MDCH Traumatic Brain Injury (TBI) and Long-Term Care. People with TBI are at a severe disadvantage in the current public service system. In order to address this problem, the TBI Project supports a SPE system for LTC and recommends that the unique needs of individuals with TBI be included in the design of Michigan's Long-Term Care System. The LTC system needs to do the following: include appropriate services for individuals with TBI, especially those services that promote rehabilitation and supported independence within communities, serve people with TBI, agencies designated as SPE must be able to undertake screen and identify people with TBI, coordinate and advocate for services for people with TBI, be educated and

competent in dealing with people who have TBI. Serving people with TBI appropriately will pay off in the long run. People with TBI often benefit greatly from intensive early rehabilitation.

Michael Dabbs, President of the Brain Injury Association of Michigan. Also the immediate pass chairman of the Washtenaw Community Health Organization which is the CMHSP for Washtenaw, Livingston, Lenawee, and Monroe counties. He was at the meeting to make sure that the Task Force to be aware of the impact of TBI has on long-term care system. TBI has been described as an invisible disability from individuals with TBI. Most TBI's occur in age 19 or older. These individuals are often placed nursing homes or AFC setting with very limited or no rehabilitation offered. Staff is generally not familiar with the needs of a person with TBI, nor they trained on how to manage cognitive and behavioral issues. This problem can no longer be ignored for two reasons: 1) The number of people leaving the service will continue to grow across the public system, and 2) We no longer can afford to ignore the obvious cost implication to the Medicaid system and long-term care needs of this population.

Discussion of Remaining Task Force Schedule: The second meeting on January 21, 2005 will be about the “big picture.” Although not all of the workgroups will not be completed, four will be close to finished and the Task Force can start putting some things together. Amy Slonum, facilitator, outlined thee processes that the Executive Committee put together. The committee thought that it was important that the Task Force has the overriding basic elements that run through all of the workgroup reports set forth to look at the make sure that there is consistency and that all the building blocks were there and there was agreement on definitions. T. Czerwinski, Jane Church, J. Christensen, S. Steinke, and R. Chaney have agreed to create a diagram of the proposed system to help the Task Force see how the pieces described by the various workgroups will work together. This “system map” will includes paths for both people who are Medicaid eligible and those who are not. J. Mendez requested a diagram of SPE from Workgroup A be part of the discussion. J. Hazewinkel will collect key terms in a glossary for the discussion on January 21st to aid consistency between the various reports. He will also include the workgroup identification and the mission statement on future agendas.

S. Steinke revisited the thought of 3 meetings outside of Lansing. M. Moers indicated that it would be great, but there isn't enough time and there are other things to get done. G. Betters really need to be more focused before the Task Force meets outside of Lansing. D. Hoyle indicated that if we had more time it would be great, but we don't.

R. Chaney indicated that the Executive Committee decided that the Task Force would need an extension on the report. The Task Force will not be complete by April 1st. She suggested in the late February early March an extension be filed. Can revisit this discussion when the Task Force is clearer on the “big picture”. R. Chaney indicated that workgroups have votes be taken in April so soon after the first week of April a report could be issued. The Task Force was established in April, but not appointed until June. J. Mendez suggested that if a meeting is going to be cancelled could they be called before they drive into Lansing. She also suggested that a number is needed to call to find out if

the meetings have been cancelled. S. Steinke asked J. Christensen if Community Health could coordinate the calling the night before or giving out cell numbers for members to call to let them know they will be running late or not coming. J. Hazewinkel suggested calling his office number and he would have a message on his voicemail if the meeting were cancelled. He indicated that he would check his voicemail regularly to find out if someone isn't coming to the meeting. J. Hazewinkel's office number is (517) 432-7285.

Next Meeting Date and Agenda Topics: M. Cody indicated that one of the charges of the Task Force is quality issues, he thought that it would be instructive to the Task Force to hear from Walt Wheeler, head of surveyors, and Sara Slocum, Long-Term Care Ombudsman to discuss quality issues in nursing homes.

Executive Committee call was on the agenda for next week. Due to the committee meeting at lunch there will be no call. S. Steinke will schedule the next meeting.

The next meeting is scheduled for January 10, 2005. The meeting will be held at the Farnum Building.

A motion to adjourn the meeting was made by J. Mendez, seconded by M. Cody.

The meeting was adjourned at 2:10 p.m.