

1 STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

2 OFFICE OF HEALTH AND HUMAN SERVICES

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6 PUBLIC MEETING: INTEGRATION
7 OF CARE AND FINANCING FOR
8 MEDICAID-ONLY AND
9 MEDICARE/MEDICAID ELIGIBLE
10 (MME)

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14 R.I. COUNCIL OF COMMUNITY
15 MENTAL HEALTH ORGANIZATIONS
16 40 SHARPE DRIVE
17 CRANSTON, RHODE ISLAND
18 JULY 25, 2012
19 9:00 A.M.

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24 BEFORE: MICHELLE SZYLIN, CHIEF, FAMILY HEALTH
25 SYSTEMS
26 ROBIN ETCHINGHAM, ASSISTANT ADMINISTRATOR
27 KATHLEEN McKEON, FACILITATOR

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1 (MEETING COMMENCED AT 9:07 A.M.)

2 MS. ETCHINGHAM: Good morning,

3 everyone. It's five past 9:00, so we are going

4 to get started just to keep everyone on the

5 schedule. I would like to welcome everyone.

6 This is our first meeting of the Integrated

7 Care Group that is addressing outreach and

8 information, and we are all glad that you took

9 the time to make it, to help us work on looking

10 at this issue.

11 I'm Robin Etchingham, and I'm

12 from the Executive OFFICE of Health and Human

13 Service. With me today is Michelle Szylin,
14 also from the Executive Office of Health and
15 Human Service. Kathy McKeon is working with
16 us, and she is going to be the community
17 facilitator. She is from the Office of
18 Community Services and Catholic Charities from
19 the Diocese of Providence.

20 What we would like to do is go
21 around the room and have you introduce yourself
22 and also give a little bit of your interest in
23 attending these group meetings. So, also in
24 the audience we have helping with the

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1 presentation is Alison Croke, who's also
2 working with our office, the Executive Office
3 of Health and Human Service. Diana Beaten
4 (phonetic) is here from the same office. Holly

5 Garvy -- I think I have everyone. Oh, Kristin
6 Jordan. So, we have quite a few people from
7 our office also attending today.

8 So, if we could start going
9 around the room and start with Alison.

10 MS. CROKE: Okay. My name is
11 Alison Croke. I'm working with DOHHS, and I'm
12 working on this initiative on one of the
13 models, the capitative part.

14 MS. BEATEN: My name is Diana
15 Beaten, and I work with Health and Human
16 Services, and I mostly focus on communications.

17
18 MS. GARVY: Good morning. Holly
19 Garvy. Also working with the Executive Office
20 of Health and Human Services, part of the Xerox
21 State Health Care Team that's working with the
22 Medicaid Program. As Alison said, this program
23 has two models of care, and I work with the
24 enhanced PCCM model.

1 MS. SERVACKS: I'm Elisa
2 Servacks (phonetic), and I'm Medicare and
3 Xerox, assist with dual integrations
4 specifically the PCCM model.

5 MR. KENNEDY: Jordan Kennedy,
6 also working on Medicaid and Xerox and working
7 with Alison on the capitative model.

8 MS. GORMAN: I'm Cathy Gorman, a
9 former DH person, social worker, and associated
10 with the Older Women's Policy Group, which is a
11 component of the Senior Agenda Consortium.

12 MS. MARTIN: I'm Donna Martin.
13 I'm the director for Community Provider
14 Network, which is a state-wide association for
15 organizations that support adults with
16 developmental disabilities, and I'm here
17 because there are some significant implications
18 for that population in this project.

19 MS. PRATT: I'm Gail Patry with

20 Health Centers Advisers, and we run a
21 beneficiary protective program on behalf of the
22 beneficiaries.

23 MS. FORCIER: I'm Cindy Forcier
24 with the PACE Organization of Rhode Island. 99

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1 percent of our population are eligibles.

2 MS. MAREISH: Rebecca Mareish
3 from Care Link, and we are a membership
4 organization of adult day health centers,
5 assisted living, nursing homes and senior, and
6 PACE Organization of Rhode Island is one of our
7 members. We are very interested.

8 MR. NYBERG: Good morning. Jim
9 Nyberg, Leading Age, Rhode Island. We are a
10 trade organization of representative nonprofit
11 home-care providers across the spectrum, and we

12 are interested in this in terms of how it
13 affects our providers and the people they care
14 for.

15 MR. VARADIAN: Michael Varadian,
16 executive director for operations and policy at
17 the Department of Behavioral Health Care
18 Developmental Disabilities and Hospitals.

19 MS. COLE: I'm Jane Cole, at
20 BHDH as well, and I work in DD and behavioral
21 health.

22 MS. BROTHERS: Good morning.
23 I'm Bettina Brothers. I'm working with the
24 Rhode Island Parent Information Network. I'm

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1 one of the peer advocates for the Community of
2 Care Programs, and I represent the care choice
3 piece, and I'm here to learn more about what's

4 going down the pike.

5 MS. SHAFRIN: Lisa Shafrin
6 (phonetic) from Rhode Island Parent Information
7 Network.

8 MS. CARPENTER: Marie Carpenter,
9 the director of Elderly Care for the American
10 Baptist Churches of Rhode Island, and also, the
11 vice-president of the Rhode Island State
12 Council of Churches.

13 MS. KATZ: I'm Linda Katz, the
14 policy director at the Economic Practice
15 Institute and interested in everything.

16 VOICE: Everything.

17 MS. KATZ: I just like going to
18 meetings. Don't write that. No, we do a
19 policy advocacy on behalf of
20 low-and-moderate-income individuals, so I'm
21 interested in this new system that we are
22 looking at.

23 MR. PARISEAU: Good morning.
24 I'm Ken Pariseau from the Neighborhood Health

1 Plan and Neighborhood is a managed-care
2 organization, and we are interested in being
3 one of the entities on the capitative model.

4 MS. SZYLIN: Good morning. I am
5 Michelle Szylin, and I work for DOHHS in the
6 Medicaid division, and I'm going to talk about
7 our common vision and our mission that was
8 developed for the integrated care initiative.
9 So, as you know, OHHS has been working on this
10 initiative for quite sometime, and we have had
11 two public meetings to talk about what the plan
12 is going to be; and there are two documents
13 that have been posted on the EOHHS web site,
14 which I'm sure you are all familiar with. One
15 is a report to the General Assembly, and one is
16 a report, a demonstration proposal to CMS.

17 So, if you haven't seen those
18 documents, they are posted on the web site, and

19 feel free to print those down and read them.

20 They may be lengthy, but...

21 Currently we have two internal
22 groups running at OHHS. One is working on the
23 MCO capitative model and one on the enhanced
24 PCCM model, and we have a large group where the

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1 two groups come together and discuss what's
2 happening.

3 We are trying to come up with
4 common goals and common visions and missions,
5 and we meet every two weeks. The large group
6 meets every two weeks. So, the common vision
7 that we have come up with for all models is the
8 State of Rhode Island will have an integrated
9 health care system for Medicaid only and
10 Medicaid-Medicare eligible, MME, members that

11 will achieve improved health and well being,
12 better health care and lower costs.

13 Our common mission is to
14 transform the delivery system through
15 purchasing, purchase-centered, comprehensive,
16 coordinated, quality health and care and
17 support services that promote and enhance the
18 ability of Medicaid-only and MME members to
19 maintain a high quality of life and live
20 independently in the community.

21 So, today, OHHS is committed in
22 getting feedback from all of our stakeholders,
23 and so we have developed three work groups.
24 One on quality, one on services and supports,

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1 and one on outreach and information. Today
2 you're here on outreach and information, and

3 you may have actually signed up to participate
4 in all three work groups, which is great. This
5 work group will meet three times. And Kathy
6 McKeon has agreed to facilitate this work
7 group, and she is going to be talking about
8 what our work group goals are.

9 MR. McKEON: I'm going to stand
10 up over here because I can't see you, so you
11 can't see me if I sit down; and I apologies for
12 having to leave the room there, but I just
13 wanted to introduce myself a little bit in the
14 sense that I -- I don't know. I'm kind of like
15 the one that doesn't fit in here in this team.
16 I work for the Catholic Diocese of Providence,
17 and I work in the Catholic Charities area. At
18 Catholic Charities we do a lot of work with
19 low-income people. One of our largest programs
20 is with elderly service and we provide respite
21 care to families, a lot of referrals to older
22 people.

23 So, we are, through Catholic
24 Charities, very much a social services agency

1 as well as the Catholic Charities of
2 Providence. In my previous life, I worked for
3 31 years at the state Department of Elderly
4 Affairs, now the Division on Aging. I'm fairly
5 fluent in this language that you hear thrown
6 around here today.

7 And really, what my role is here
8 is to facilitate this group but to also maybe
9 bring some other people to the table in the
10 next couple of meetings who work on the ground
11 with seniors, who can talk about some of the
12 real issues we need to keep in mind as far as
13 getting the message across to people,
14 simplifying somehow the message, making what
15 happens clearer to them, easier to maneuver.

16 This outreach and information
17 group, I think, is extremely important to this

18 initiative, because it's going to involve,
19 first of all, a big change; and any time there
20 is a big change to a large group of people,
21 there's, you need to really plan fully and
22 thoughtfully talk about how can we make this
23 easiest and most successful for them.
24 What we will do here is, and I'm

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1 going to refer to the screen you have up there.
2 We are looking for this group to provide
3 recommendations for appropriate outreach
4 information strategies for the members who will
5 be enrolled in either of the two models that
6 people have been talking about. And at this
7 point, if you're not really into the two models
8 or know the details, it's not so much important
9 as that you know it's Medicaid people only and

10 Medicaid-Medicare people, what we used to call
11 the duals, and now MMEs. And it means that
12 they will be getting information talking about
13 this change and change to them, what to do
14 about it.

15 So, we want to really focus the
16 comments in this work group today and over the
17 next two meetings on the format issues, things
18 that people can tell us about how we should do
19 this. If other issues do come up, or as we are
20 talking about education and information, you
21 think of another area that, you know, oh, that
22 service you definitely would be included in
23 this, there's a very easy and helpful way to
24 e-mail a special e-mail address that's been set

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2 integration, and it's on your handout, also on
3 that slide.

4 So, I would encourage you to do
5 that, and then there will be some things that
6 you bring up that we don't have answers to yet.
7 This is a work in progress. Things are being
8 worked out, so there are not all the answers to
9 many of the questions that you would bring up;
10 but they will be held in a parking-lot list
11 people want to know about or need to know about
12 down the line.

13 So, as Michelle mentioned,
14 we will meet three times. Later on we will
15 mention the dates. They are included in your
16 handout. Today you're going to get an overview
17 of what this initiative is, who it impacts, and
18 then we are going to open up the room to
19 discussion around, you know, what's the first
20 kind of thing that comes off the top of your
21 head around education and information as we
22 move forward.

23 MS. CROKE: Thanks, everyone.
24 I'm going to stand up, too, despite my heels.

1 I'm really five-foot three. Again, my name is
2 Alison Croke. I'm with the Xerox State Health
3 Care Team working with DOHHS to develop these
4 programs that we are going to talk about today.

5 So, I was asked to come and talk to you all a
6 little bit about what the system looks like
7 today and what it is we are trying to design so
8 that the system looks a certain way in 2013 and
9 looks even a different way in 2014.

10 So, we are going to look at the
11 next couple of slides, but I think most folks
12 are aware that for clients who are on Medicaid
13 and also clients who are Medicaid and Medicare
14 eligible, which is the new term we are using,
15 MME, the system is very fragmented. People get
16 their specialty care, their primary care and

17 hospital care from one system. They get
18 long-term services and supports and sometimes
19 prescription drugs from a totally different
20 system, and never do the two systems
21 necessarily talk to each other in a very
22 coordinated way.

23 So, when people ask what is the
24 problem, what is it that we are trying to

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1 achieve, for clients on Medicare and Medicaid,
2 the problem is, to anyone who works with them,
3 the systems are very fragmented and not
4 coordinated. One of our goals really is to
5 improve that coordination and decrease that
6 fragmentation. We also wanted to develop a
7 personal center of system care. Too often
8 whoever is paying the bill is the one making

9 the decision. So, we would like the person to
10 be at the center of everything that we are
11 designing.

12 We also want to measure what it
13 is we are doing with putting quality measures
14 in place. What are the things that we should
15 be monitoring and looking it. There's a whole
16 other model that focuses on that. As Michelle
17 said, some of you signed up for that one. This
18 group won't focus on that, but this, it is an
19 important element.

20 So, the first slide talks a
21 little bit about what we want the system to
22 look like in 2013. So, today, first of all,
23 let's talk what the system looks like today.
24 Today we have adults on Medicaid and only on

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1 Medicaid, and they are enrolled in either
2 Connect Care Choice or Rhody Health Partners.
3 We have about 1700 Medicaid-only clients that
4 are enrolled in Connect Care Choice; and to be
5 enrolled in Connect Care Choice, you have to be
6 receiving your primary care from one of 17
7 primary care practices around the state.

8 We have also, in addition to
9 that, 13,500 Medicaid-only clients that are
10 enrolled in Rhody Health Partners; and in that
11 program, we contract with our two managed care
12 organizations, United Health Care and
13 Neighborhood Health Care of Rhode Island.
14 Those delivery systems are mandatory for
15 Medicaid-only adults, so they have to be
16 enrolled in either Connect Care Choice or Rhody
17 Health Partners.

18 One thing that is not included
19 in either of those two programs right now are
20 strong linkages to the long-term care system.
21 We are using the term long-term care supports.
22 For example, if someone is a permanent nursing
23 home resident, they are not enrolled in either

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1 today. If they are currently in either of
2 those two programs and they enter a nursing
3 home, after 30 days, they disenroll them from
4 those programs. There is not a strong
5 connection to the long-term care system.

6 There's already fragmentation in
7 that system for people who are Medicaid only.
8 One of the things we are talking for 2013 for
9 Medicaid-only clients is that if they are
10 receiving long-term services and supports, they
11 would be either in the Enhanced Connect Care
12 Choice Program or they would be in the
13 Integrated Medicaid-funded MCO, which is a
14 somewhat awkward thing to say. We don't have a
15 name. Maybe we will call it Rhody Health Care

16 Plus. We will come up with something.
17 Enhances Connected Choice will be -- I'm
18 talking about Medicaid-only clients, and I will
19 talk about people who are eligible in a minute.

20 In 2013, people, if they are in
21 Rhody Health Partners or Connect Care Choice,
22 once they become eligible for long-term
23 services or supports, they would be either be
24 in the Enhanced Connect Care Choice model or

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1 the Integrated Medicaid MCO.

2 Today, if you're dual eligible,
3 Medicare-Medicare, you're not in either Connect
4 Care Choice or Rhody Health Partners. You're
5 in the Medicaid fee for service system and
6 you're in the Medicaid system. You could be on
7 the Medicare Advantage Plan. You could be in

8 Medicare fee for service. Today we have
9 about -- in the number changes every day when
10 we look at data, it's kind of a moving target,
11 but there are about 30,000 people who are dual
12 eligible in Rhode Island, and most of them are
13 not in Medicare Advantage, but there are about,
14 according to our data, about 5,000 people,
15 depending on the day you look at it, about
16 5,000 that are in a Medicare Advantage Plan.

17 So, for those people right now,
18 the system is extremely fragmented. So, in
19 2013, what the system will look like for those
20 clients, if you're dual eligible and you're
21 in -- regardless of whether you're getting
22 long-term services and supports, you will be in
23 the Enhanced Connect Care model or the
24 Integrated Medicaid MCO model. The difference

1 is the Medicare benefit will still be outside
2 of that. There will be much stronger linkages
3 with Medicare, but the benefit is not paid for
4 by Medicare. Those services covered by
5 Medicare will still be covered by Medicare, but
6 plus clients, who are eligible, will be either
7 enrolled into Connect Care Choice or Integrated
8 MCO for all of their Medicaid services.

9 There are some things that
10 Medicaid pays for that's outside of long-term
11 services supports. Things like vision,
12 transportation. Medicaid pays for dental
13 benefits, although limited. There are some
14 things that in 2013 will remain outside of the
15 two models, and that's intensive behavioral
16 health care for people who have severe mental
17 illness and the long-term illness supports for
18 people in the DD system.

19 VOICE: Can we ask questions
20 now?

21 MS. CROKE: Yes.

22 VOICE: Just to clarify, in

23 2013, a dual eligible, whether they are in a
24 nursing home, or say, in assistant living on a

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1 waiver, they will be in Enhanced Connect or the
2 MCO?

3 MS. CROKE: That's correct, for
4 just their Medicaid benefits. And nursing home
5 is a Medicaid health benefit.

6 VOICE: Thank you.

7 MS. CROKE: All right. So, any
8 other questions about that right now?

9 VOICE: So, the transportation,
10 dental and vision, are you still deciding
11 what's going to happen to that?

12 MS. CROKE: We are still
13 deciding, but transportation is a complicated
14 issue. Vision would be most likely included in

15 the benefit package of management organization
16 at work, discussing internally whether or not a
17 dental benefit would be included. It's a huge
18 area of unmet need, dental benefits for all
19 Medicaid and especially for people low-income
20 elderly and the disabled.

21 VOICE: Those would apply to the
22 Integrated MCO as well as the Connect Care
23 Choice?

24 MS. CROKE: In the Connect Care

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1 model, the State will contract with the
2 coordinated care entity. The benefits will
3 still be with a fee-for-service system, but the
4 coordinated care entity would be responsible
5 for care management and care coordination. We
6 are looking at creating a community-health

7 team, which would be a workforce of
8 para-professionals or community health workers
9 that would help people coordinate their care
10 and all the coordination between their primary
11 care, their long-term services and supports.
12 Really a coordination contract. Those benefits
13 still remain reimbursement through the
14 fee-for-service system.

15 VOICE: How would it work for
16 people, again, which have variations of case
17 management, say the case management agencies
18 that do the care coordination?

19 MS. CROKE: That's a good point.
20 I'm not putting you in the parking lot. Not
21 yet. But that is an issue that we are working
22 through entirely. So, we are still in the
23 design phase. We say 2013. We are looking to
24 do a competitive procurement for these two

1 models in the fall of 2013 -- 2012, excuse me.
2 In the fall of 2012, September, rough time
3 frame, and we would have these programs
4 enrolling folks in the first quarter of
5 calendar year 2013.

6 VOICE: I'm just a little
7 confused by the MME and Medicaid-only across
8 there. I thought that what was happening in
9 2013 is that the Medicaid-only folks would
10 have, would be in that integrated Medicaid?

11 MS. CROKE: That's a bit of an
12 error in the slide. So, in the integrated
13 Medicaid fund at MCO, the Medicaid-only clients
14 receiving LTSS would be involved in that MCO as
15 well as MMEs.

16 VOICE: So, under where it says
17 MME, on the far right, that should only say MM
18 only?

19 MS. CROKE: Yes, MM only
20 receiving LTSS.

21 VOICE: MM only, they can be

22 under the Enhanced Connect Care Choice?

23 MS. CROKE: That's correct.

24 VOICE: That doesn't include

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1 the MME, the Medicaid portion of the MME, so
2 people duly eligible the Medicaid portion for
3 them, also, correct in '13?

4 MS. CROKE: For either Enhanced
5 Connect Choice, that's for Medicaid-only
6 clients and MMEs.

7 VOICE: So, for a person who
8 goes into a home and is a paying customer and
9 then when the assets are, you know, are gone
10 and goes onto Medicaid, will this be an
11 automatic thing that will happen? The
12 enrollment will just automatically happen?

13 MS. CROKE: That's some of what

14 you're going to talk about in this group is how
15 that message will be communicated to clients.
16 We are going to talk about that. Other
17 questions about 2013? Okay. So, then in 2014,
18 we would have still the Enhanced Connect Care
19 Choice model for Medicaid only, and MM's. We
20 have PACE. We have PACE in both years,
21 2013-2014. PACE continues, and the intention
22 is to have growth in the PACE model. And
23 that's primarily for MMEs and the Integrated
24 Medicare and Medicaid funded MCO then replaces

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1 Rhody Health Partners and the Medicaid-only MCO
2 that you saw on the slide that was for 2013.
3 So, this is a three-way contract
4 with CMS, the State and the managed-care
5 organizations. So, on the track where we are

6 procuring for the 2013 model that we spoke
7 about in the last slide, we are also in
8 negotiations at this point with CMS to discuss
9 whether or not the State would enter into this
10 three-way contract. So, primarily this group
11 and the three work groups that we have
12 established we are going to focus on what's
13 happening in 2013-2014 is that much further
14 away, and it's really still in discussion with
15 CMS. Negotiations is even too strong of a
16 word. Discussions is probably the better word
17 to use. There are other states that are
18 entering into this three-way contract with CMS.
19 Massachusetts is entering into it for 2013.
20 We, as Michelle mentioned, submitted a
21 demonstration proposal to CMS asking for 2014.
22 But there has been some recent testimony in
23 front of Congress regarding this initiative,
24 the integration of Medicaid and Medicare. We

1 are not sure how that will impact what we are
2 doing and all the other states are doing, so
3 but, the goal would be, if everything, all
4 plans align well, we will have Medicare and
5 Medicaid funding integrated into a managed care
6 organization, and those all those benefits
7 coordinated by one entity and paid for by one
8 organization.

9 VOICE: I just want to make
10 sure I have this. I think this is, what we are
11 doing in 2013 is going to be, will really be
12 the delivery system for 2014, and all that
13 would happen in 2014 is the money, the
14 financing changes, but that really --

15 MS. CROKE: All that would
16 happen?

17 VOICE: Well, I know it's a big
18 "all," but, am I missing anything in terms of
19 once we put 2013 in place that's sort of it in
20 terms of the impact for clients and providers?

21 MS. CROKE: One of the reasons
22 that we are taking the actions that we are
23 taking for 2013 is to set us up so that when
24 2014 happens it's a little more seamless for

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1 people.

2 VOICE: Thanks.

3 MS. CROKE: Any more questions
4 about 2014? Okay. All right. So, one of the
5 first things that we do when we start to design
6 new programs is we take a look at the data and
7 we take a look at it again, and we take a look
8 at it 20 or 50 more times. So, you're going to
9 have a data presentation, I believe, at our
10 third meeting from Rick Jacobsen. But I was
11 asked to come with a little bit of a preview.

12 I'm giving you a little bit of

13 background data to provide context for what
14 you're going to talk about. Some of the
15 presentations that you will see have different
16 numbers now than the one you're looking at
17 right now. We have calendar year 2010. We
18 have fiscal year 2010. This is fiscal year
19 2011 data. For example, if you went to a
20 meeting yesterday and you have different
21 numbers, that's okay. That was a different
22 year. This is the year 2011 data. We have
23 divided the groups, all dual eligibles. These
24 are full duals. I mean people on Medicare Part

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1 A, B and D, also receive Medicaid benefits.
2 There are some people for which the State pays
3 a Medicare clients Part B premium. They are
4 not considered full dual eligibles because they

5 don't get the Medicaid benefit. This is just
6 full duals, and the majority of duals are full
7 duals.

8 You can see that long-term care
9 there's about 5,877, we use the term average
10 eligibles. The difference between average
11 eligibles and unique users is unique users
12 counts every individual person, whereas average
13 eligibles is an average.

14 Someone could have been in a
15 State facility year 2011 in a nursing home for
16 100 days and another person in for 365 days.
17 So, that's where the average eligibles takes an
18 average of that. On average, on any given day,
19 there are 5,877 in the bucket that we call
20 long-term care. That would be people living in
21 an institution. They are in a nursing home.
22 They may be receiving Hospice in a nursing
23 home, and they are also in any other kind of
24 institution. I believe Eleanor Slater Hospital

1 is part of these numbers. So, that's about 21
2 percent of the population, but close to 80
3 percent of the expenditures, that money that
4 Medicaid spends on services.

5 Then we have clients that are in
6 the MRDD system, so these are clients that are
7 on the MRDD waiver, 2317. Clients with severe
8 persistent mental illness, 2058. Then we have
9 a category called waiver, so these are clients
10 who receive long-term services and supports
11 living in the community. They may be in
12 assistant living. They may be living at home.
13 They may be living in, you know, with a family
14 member, but they are living in the community.
15 They are not in an institution. And then we
16 have a bucket called community, which is
17 everybody else. These are dual eligibles.
18 They are not in the long-term care system.
19 They are not receiving nursing home services or

20 any home supports that would be considered
21 long-term care.

22 So, that's close to 14,000,
23 which brings us to our total average eligibles.
24 Close to 28,000. Unique individuals closer to

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1 33,000. So, this is just a further breakdown
2 to show you where, for people who are in an
3 institution where, where are they. So, most of
4 them are nursing homes. Some are receiving
5 Hospice in the nursing home. 290 individuals
6 in Slater, Eleanor Slater, and 21 folks in
7 Tavares. Tavares is usually a pediatric
8 facility but there are some of our clients that
9 age in place, so they have turned 21 and they
10 have stayed living in Tavares. Some folks you
11 will see living in Tavares.

12 We went from having several
13 waivers to the one global waiver, but we still
14 break it out by programs, so we have the aged
15 and disabled program, almost 1600 folks.
16 Personal choice, and the HAB Program and then
17 assisted living. Some other data that --

18 VOICE: Assisted living, is
19 that, there's two different waivers. It looks
20 like there might be one of them. Isn't there
21 Rhode Island Housing and the DDA waiver?

22 MS. CROKE: You may be right.
23 We can take that back. When Rick comes to your
24 third meeting, he will get into a lot more

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1 detail, but you could be correct.

2 VOICE: That's also a State
3 facility 2008 snapshot.

4 MS. CROKE: Just to make sure
5 everybody is awake, right? All right. So, one
6 other thing I wanted to mention. We are also
7 taking a look -- and Rick will get into more
8 detail about this at the third meeting -- we
9 are also taking a look at the types of chronic
10 conditions people have, so we are trying to
11 look at more diagnostic information. So, what
12 we find is that the two groups, folks living in
13 an institution and folks living at home are
14 very similar in many ways. On average, about
15 76 percent of them have between two and five --
16 there are people that have between five and 12.
17 It's a smaller percentage. I wanted to give
18 you information about the number of chronic
19 conditions. There's a very high prevalence of
20 behavioral health conditions, so, with their
21 chronic illness and the top two behavioral
22 health conditions, first, is mood disorders,
23 depression, which doesn't surprise you, and the
24 second is dementia.

1 And so that, we take a look at
2 this data as we are doing program design and
3 development, because what we find will help
4 drive some of the policy decisions we make or
5 the programmatic decisions we make when we are
6 developing the two programs. So, unless
7 there's more questions --

8 VOICE: Alison, just to clarify
9 this group that we are looking at,
10 communication, so what's the financing part of
11 this group? I guess that term I'm confused.

12 MS. CROKE: What's the what?

13 VOICE: Wasn't there a
14 financing component for this group?

15 MS. CROKE: Well, the overall
16 project is the integration of care and finance.
17 That's what we are working on. So, what we
18 have done is taken that large initiative and

19 divided it into three topic areas where we
20 would like to see guidance. I'm sure that's
21 very disappointing. We won't be talking about
22 Medicaid financing.

23 VOICE: It's part of the
24 communication. We always try to understand

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1 where people are in order to help them get to
2 where they need to be.

3 MS. CROKE: Yes.

4 McKEON: Okay. Well, at this
5 point, I would like to remind you there's very
6 strong coffee in the back. So, if you feel you
7 need a cup, help yourself. As I'm sitting
8 there listening, I'm delighted that the
9 Stenographer doesn't come from a background in
10 OHHS or any of these letters, because, as you

11 listen, you can tell that we speak a whole
12 different language at this level. And you
13 know, some of us more ingrained in it than
14 others, and it a necessary part of living in
15 the bureaucracy that we live in and getting
16 things done; but unfortunately, sometimes it
17 does trickle its way down; and I know that
18 there are -- you know, you look at letters.
19 I'm sure you all looked at letters. If you
20 have ever been a care giver or had an elderly
21 parent, aunt, uncle, says read this, and tell
22 me what it says. That it is very difficult to
23 get the message across without using some of
24 this stuff that doesn't necessarily mean a lot

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1 to people, without giving too much information.
2 And quite honestly, the other thing that

3 happens is that government agencies require
4 that certain information be given out so that
5 people are fully informed. My dad, who has
6 since passed away, used to say to me, what do I
7 need to know this for? Why are they telling me
8 all of this? Just tell me, are they going to
9 pay the bill or not. So, you have to really
10 kind of get that balance between giving people
11 what they really need to know in a way that
12 they can understand it but also to make it as
13 simple as possible so they are not afraid of
14 it, they don't ignore it, they don't throw it
15 in the trash. You know, those kind of things
16 that go on.

17 So, we are going to move into
18 the, it's all about you, part of the meeting
19 now for all of you sitting out there. We have
20 given you a little bit of background on what
21 the initiative is doing. For those of us who
22 have been in this field for a long time, that
23 disconnect between Medicare and Medicaid has
24 caused years and years of problems for people

1 who are what they call the dual eligibles.
2 Because, truly, it has put them in a position
3 of having to manage two payment systems for
4 themselves, and it is confusing and
5 counter-productive to have integrated care.

6 So, in the long run, once we all
7 live through this, it's going to be a good
8 thing. Having said that, we want to make sure
9 that we can get all the input from you that we
10 can so that the request for proposals that goes
11 out to agencies to manage this can have some
12 good specifics in there about education and
13 information and how it needs to be done; and
14 we, also, want to be able to inform the initial
15 change in enrollment process so that it's as
16 smooth as humanly possible.

17 So, we have our first topics to

18 consider. Based on your experience from where
19 you sit from what you see every day, what may
20 potential members be concerned about? And what
21 I would say, I'm going to open this up for
22 discussion, but any one of those points that's
23 on our first line if you want to speak to.
24 Either what would people be concerned about.

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1 What should we think about in terms of the
2 initial enrollment? How should we inform
3 members? Should there be frequently asked
4 questions? And then the initial enrollment
5 versus ongoing. What might be different
6 strategies? So, help us out. Jim?

7 VOICE: I think one of the big
8 ones is consumer choice, in terms of things
9 they might be concerned about. If you're dual

10 eligible or MME say in a nursing home or
11 assisted living on a waiver, it sounds like if
12 you're enrolled in the Connect Care Choice,
13 it's still an open network; but if you're
14 enrolled in a managed care organization and
15 there is a more restricted network, that could
16 affect essentially where you live. When you
17 think about managed care, you sometimes can't
18 see the doctor. That's annoying. These
19 people, it could affect their home,
20 essentially. I would say to have as much
21 consumer choice as possible in regards to where
22 they end up.

23 MS. McKEON: And to be able to
24 verbalize the difference between the two

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1 choices, and in terms of what it might mean to

2 my care. I think that's important. It's one
3 thing to say you have a choice between this
4 model and that model. It's another thing to
5 give examples of how might this be different
6 than the other one.

7 VOICE: As mentioned before, do
8 you have to move all a sudden. That can be
9 very disruptive.

10 MS. McKEON: Very good point.

11 VOICE: And not just for the
12 resident but also for the families, because
13 they are going to do the same thing. They are
14 going to ask the same questions that your
15 father used to ask. Does it make any
16 difference who's going to pay the bill? That's
17 going to be part of it as well.

18 MS. McKEON: Yes.

19 VOICE: I mean we also need to
20 keep in mind that this is also making a big
21 change for people who are Medicaid only. We
22 are going to be requiring people Medicaid only
23 now their long-term services and support are
24 going to be in a managed care environment. So,

1 basic, the simple language that we use. We
2 need to have -- we really should be vetting
3 with people who are maybe low literacy,
4 low-income folks to know that we are getting
5 the information right. Obviously, languages
6 other than English. I think that people will
7 be concerned am I going to be able to keep my
8 same doctor, right? So, in explaining the opt
9 out, I mean I will just go on record saying I
10 would hope that we do an opt in as opposed to
11 an opt out, but I know that's not the topic
12 here. So, those are some. And long things,
13 frequently asked questions don't work. I think
14 short pieces of information, and with a good
15 roll-out plan so people are getting information
16 in advance.

17 The other thing we should keep
18 in mind is there's a lot of outreach with the
19 State's engagement with the Affordable Care Act
20 going into effect in 2013, so there's another
21 outreach initiative going on. There's also an
22 outreach initiative from DHS under the Ford
23 Grant. So, I think we need to make sure that
24 somehow all of this is coordinated, because

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1 there's a lot of health care change going on in
2 the state all at once effecting people on
3 Medicaid.

4 VOICE: Do we know how much
5 continuity there will be possible, how many
6 providers will be participating in one way or
7 another so that people don't have to disrupt
8 relationships with existing physicians and care

9 providers, and do we know how broad the
10 networks are going to be, and well, maybe that
11 has something to do with contracting, too.
12 Accessible, different facilities and locations
13 will be as we go forward?

14 MS. McKEON: I think since they
15 are in the process, and correct me if I'm
16 wrong, but since they are in the process now of
17 defining that request for proposals and that
18 bidding document, that's a very important thing
19 to include as a, either as a standard or a
20 quality measure is the broadness of the network
21 so that's an important thing.

22 VOICE: I was going to say what
23 we have done with our other MCO contracts and
24 what we will do with our, with our enhance

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1 PCCM, which is part of the fee-for-service
2 world, but we have done broad readiness reviews
3 and we will have standards within the contracts
4 that will have different network requirements,
5 and the plans have demonstrated in the past,
6 were different program initiatives that we have
7 implemented their readiness, that their
8 networks are sufficient and robust, and you
9 will meet all the requirements that we have
10 laid out in the different contracts, and I
11 think that there is a strong willingness, even
12 as we advance to 2014, that in those
13 conversations with CMS, you know, robust
14 networks are critically important. We have
15 done different, other program initiatives is
16 that we have transition timelines within those
17 different agreements that set forth existing
18 relationships that are, in effect, maintaining
19 those relationships for a period of time as to
20 ensure that there's continuity of care, and
21 that's part of the whole consumer protection
22 that we really are very closely looking at and
23 making sure that whatever we put out is going

24 to make sure that we meet those.

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1 So, any specific pieces of
2 information that this group can help with our
3 communications and our contract standards will
4 really be important.

5 VOICE: I think, on that note,
6 the proposal for CMS could stay, expected to
7 maintain existing relationships with care
8 providers for six months. And one of our
9 comments is that maybe that should be extended.
10 Six months might be a short time. Particularly
11 in the area of long-term area.

12 VOICE: With the PACE Program,
13 some of our potential participants, they
14 qualify but with a cost share, and that could
15 vary between 200 to 1500. So, we my think 200

16 is the low cost share; but for the person,
17 that's not affordable. So, will cost shares
18 apply to other programs; and if they cannot
19 afford the cost share, what happens?

20 MS. McKEON: Cost share is
21 something that really affects the long-term
22 care side of this equation. And it's a very,
23 very important issue because many people who
24 have worked with people in the community know

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1 that people have declined Medicaid long-term
2 care specifically because it doesn't give them
3 enough spending money to cover expenses
4 wherever they are in their housing and their
5 lives. Is this something that has been worked
6 out already?

7 VOICE: No. It has not been,

8 and that is a parking lot issue.

9 MS. McKEON: Clearly, and I
10 hope, you know, the notes reflect this, that
11 that is something that is a real consumer issue
12 for people in long-term care, that, you know,
13 we think that because we have Social Security,
14 we have X, and then we are 75, 80 years old,
15 and we don't have a lot of other expenses, but
16 you know, no different than the rest of us,
17 some people still have credit card bills
18 they're paying off, and some people have
19 mortgages, and some people have sons and
20 daughters that they are going to be supporting
21 until the day they die.

22 These things affect how people
23 look at what they spend money on. Though we
24 may say \$200 a month for this package is a

1 wonderful bargain, it may not be possible.

2 VOICE: Just to speak to what
3 other people have already mentioned, we also
4 find in the PACE Program a barrier, not only
5 the physician, not wanting to change the
6 physician, but, also, the CNA coming to their
7 home. They know their birthdays. They buy
8 them Christmas presents. That relationship is
9 important for their overall well being.

10 MS. McKEON: You make a good
11 point.

12 VOICE: This is going in the
13 parking lot with Jim. When the State put out
14 the RFP for Rite Care and Rhody last time, it
15 issued, I think it was an RFI first, and the
16 community was able to comment on that, and I
17 would hope that that process is used again;
18 because I think it was very helpful for
19 everybody to be able to see the whole package
20 and to be able to comment on that rather than
21 give no input on different pieces.

22 Just also in terms of the

23 information out, I think using examples is
24 really helpful. You know, a lot of times we

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1 write outreach material that says, now, you're
2 care will be integrated, but instead giving
3 some examples of this is how you're accessing
4 services now and this is what it will mean in
5 the future, and certainly, showing the
6 positives of how that can help somebody.

7 MS. McKEON: I would like to ask
8 somebody from the OHHS side to just explain a
9 little bit about opt out and opt in, what's the
10 difference and why are we talking about opt
11 out. Who shall I throw that to?

12 VOICE: I will take that. So,
13 as part of an enrollment strategy, what we did
14 when we enrolled adults with disabilities into

15 our Connect Care Choice and our Rhody Health
16 Partners delivery systems, we did an opt out;
17 and what that was is that we, for the enhanced
18 PCCM Connect Care Choice Program, we looked at,
19 because there are, that program has
20 participating providers within the community
21 who meet the Connect Care Choice practice
22 standards for advanced patient centered,
23 medical home and that practice has a nurse care
24 manager integrated into the practice.

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1 So, right now, within that
2 practice model, there are 17 practice sites, so
3 what we have done when we were looking at the
4 initial roll-out of those programs, is we
5 identified individuals who currently had
6 experience within those, those practice sites,

7 and we identified those individuals as being
8 opted -- they had the opt-out opportunity; so,
9 they were currently receiving care at that
10 practice. If they wanted to switch delivery
11 systems, they could switch delivery systems,
12 and if you will, change to one of the Rhody
13 Health Partners MCO contractors, which would be
14 Neighborhood Health Plan of Rhode Island or
15 United Health Care.

16 Part of the challenge is to make
17 sure that there's enough enrollment in the
18 practice sites to make it, if you will, a
19 viable business model for the different health
20 plans; and what we are looking to is to enhance
21 the PCCM model is the contracted coordinated
22 entity.

23 That was the strategy that we
24 used that folks would have a choice between the

1 two delivery systems that will try to best
2 match those individuals currently receiving
3 care to ensure continuity, and but also, give
4 folks the opportunity to change, if they would
5 like.

6 MS. McKEON: Holly, if I'm
7 understanding this correctly, with the 17
8 health homes identified --

9 VOICE: Connected choice
10 practices.

11 MS. McKEON: Connected choice
12 practices. People who were in one, you
13 basically said to them, you are already here
14 and we are leaving you there unless you decide
15 to tell us otherwise?

16 VOICE: Tell us otherwise, and
17 if you would like to, your choices would then
18 be to select either Neighborhood Health Plan of
19 Rhode Island or United Health Care.

20 MS. McKEON: Now, this
21 up-and-coming process is going to be

22 significantly different in the, I think, in the
23 sense that, first of all, it's an enormous
24 number compared to what you're working with;

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1 but also, is it likely, or am I understanding
2 it correctly, that most of these people will
3 probably not be in the spot where you would say
4 to them we are leaving you where you are?

5 VOICE: I think, you know, we
6 are still doing some analytics on sort of where
7 people are. We, and you know, again, I will
8 kind of defer back. We have some information
9 and our best information on the Medicare data
10 side, and so that's, you know, we are still
11 working with that. But what we are trying to
12 do is identify, you know, we are, it's still
13 sort of in the planning stages, and we are, you

14 know, doing those looks. But what we would
15 like to be able to do is try to identify,
16 again, the same process. Identify folks who
17 currently receive care in an existing practice
18 site. Because, you know, we would like to make
19 sure that there's continuity of care. I would
20 also like to point out we did just do an open
21 enrollment for Rhody Health Partners and
22 Connect Care Choice, so that, you know, we are
23 trying to also maintain that we have done that
24 enrollment process. Those individuals, if they

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1 wanted to make a selection for a new plan, they
2 were able to do that; and those enrollments
3 were effective July 1st of this -- well, this
4 month, the beginning of the month.

5 MS. McKEON: Now, an opt in

6 would be a letter saying, by a certain date,
7 you know, as an existing Medicare-Medicaid,
8 whatever, customer, you have two choices, and
9 we need you to tell us what that is. Is that
10 more of the opt in kind of process?

11 VOICE: Yes.

12 MS. McKEON: You're looking at
13 the opt out for what reason?

14 VOICE: Well, I think, you
15 know, sometimes, you know, we need to, we need
16 to enroll folks into the managed-care programs,
17 and we need to be able to, you know, as I said,
18 it's trying to get a business model moving
19 forward. Right now we have mandatory
20 enrollment for Medicaid in these programs, and
21 this is going to be mandatory enrollment for
22 their Medicaid benefit. Their Medicare benefit
23 for 2013 will not be a managed enrollment. And
24 CMS has been abundantly clear about that; but

1 for their Medicaid benefit, it will be
2 mandatory enrollment.

3 VOICE: I thought it was, by
4 not being mandatory enrollment, they could
5 still be automatically enrolled with the opt
6 out. Is that the plan? It won't be an opt in?
7 It will be still be an opt out?

8 VOICE: We are looking at an
9 opt out.

10 MS. McKEON: So, part of the
11 challenge is going to be that when people get
12 this letter, you're speaking specifically to
13 their Medicaid benefit and not their
14 Medicare --

15 VOICE: Correct, for 2013.

16 MS. McKEON: 2013.

17 VOICE: So, I'm still a little
18 confused in terms of opt out. So, there's
19 30,000 MMEs right who will be told that you
20 are, you are now in a managed care plan for

21 your Medicaid benefit. Will they be told, will
22 they then be given a choice to say, as of this
23 date, you need to pick either being in a PCCM
24 or one of whichever MCO's are available?

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1 VOICE: Right.

2 VOICE: If they don't pick,
3 they will be assigned?

4 VOICE: Yes.

5 VOICE: As opposed to a letter,
6 here is your opportunity to have better health
7 care for yourself and integrated health care
8 services. You can now pick one of these plans
9 to enroll in.

10 VOICE: Right. That would be
11 an opt-in model.

12 MS. McKEON: So, if I can just

13 interpret, so that the positive aspect of that
14 other approach is something that, although it
15 doesn't, it doesn't, in one letter, give you
16 the right to automatically enroll if you don't
17 hear back, it does present the whole thing in a
18 more positive light? It's saying to the
19 person, whoopy, you qualify for three prizes,
20 and you get to pick the one you want; and I
21 understand, I understand exactly where you're
22 coming from in terms of getting the job done
23 within a certain point of time. But having
24 lived through open enrollment through Medicare

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1 and staff and all of that, there are lots of
2 people who really need somebody to sit down and
3 explain this.

4 VOICE: Right. I think one of

5 the things that we would hope that we could get
6 from the conversations that we are having this
7 morning and the future ones is how do we best
8 do that. How do we best engage folks? You
9 know, we have heard in a number of different
10 forums different ideas, but we really, you
11 know, this is the direction that we are, you
12 know, planning on; and so, we would really need
13 some help in trying to move that forward.

14 VOICE: From the health plan
15 perspective, I mean an equally positive
16 congratulations message can go out. You know,
17 on this date, congratulations, you're now
18 enrolled in United Health Plan. You're now
19 enrolled in Neighborhood Health Plan. As a
20 result of this enrollment, you now have access
21 to all of these services. All these issues,
22 all these problems that you have had in the
23 past around accessing services will now be
24 facilitated by this health plan. So, I mean

1 one can have an equally positive message for
2 the opt-out program, also. Into Holly's point
3 about the business case for the health plan,
4 really, I mean, the advantage of the opt in is
5 attempting to create enough critical mass in a
6 health plan or a managed-care entity so that
7 when you begin to think about the service
8 delivery system problems and you begin to talk
9 about building new services and filling in the
10 gaps and increasing the, decreasing
11 fragmentation and increasing integration, I
12 mean in order for a managed entity to do that
13 that, there has to be enough members pulling in
14 premium dollars to be able to then go out to a
15 provider, go to the agency and say, Jim, it
16 seems like in our delivery service system we
17 have these gaps. Will you work with us? Will
18 you help us build these new services? That's
19 tax money. I think the advantage of the opt

20 in, which has been successful with Rhody, the
21 advantage is it creates enough of a mass to
22 then begin to drive your service delivery
23 system.

24 MS. McKEON: The opt out.

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1 VOICE: Yes, the opt out.

2 MS. McKEON: That's a valid
3 point, because for this to be successful, that
4 economy and scaling has to be considered.

5 VOICE: Thinking back to
6 information for people, right, obviously, if
7 it's, even if it's opt out, people are going to
8 need to make a choice between the plans or
9 PCCM, right, so, really good information about
10 what are the different things that people will
11 be thinking about in terms of making that

12 choice. Maybe if we look at some of the way
13 that Medicare has, you know, been able to
14 compare plans and decide what you want. A lot
15 of that is also being built for the new
16 exchange in terms of thinking through. What's
17 important to people as they choose health
18 plans, and obviously, with this, it's not only
19 your primary care but also the long-term
20 services and supports and working together to
21 think about sort of a matrix that will help
22 people make those decisions, and also, have
23 in-person support in the same way to have the
24 SHIP program to help people walk through some

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1 of that.

2 MS. ETCHINGHAM: One of the
3 things that we did when we rolled out Rhody

4 before it came out, and well before anyone was,
5 you know, sent the letter that they were
6 enrolled with the opt-out option, was we had a
7 lot of, we went out a lot of evenings to local
8 places where that population would be, and we
9 had presentations. So, we really tried to get
10 the public to understand what they were going
11 to receive and what the changes were going to
12 be and what their advantages were, and we
13 presented most models so we were at senior
14 centers and we went all over in the community
15 and we did it in the evening. So, it wasn't
16 just work hours that we went out there, and we
17 also set up an information line so that when
18 people had a question, there was a direct line
19 that could answer their questions, and it
20 wasn't a general line that wasn't familiar with
21 the new product coming out.

22 So, there was a lot of work done
23 up front, and that would be the same practice
24 was to look at what was the advantages of doing

1 that up front. That way you have less
2 questions, and then we could talk to them one
3 on one right there at the site; and you know,
4 and really it worked out very well when we went
5 out there that way.

6 MS. McKEON: Certainly, we have
7 Cathy Taylor sitting with us today from the
8 Division of Elderly Affairs. There is a
9 network out there with the Point, a central
10 phone number to call. Regional point agencies
11 around the state as well as case managers and a
12 network of people out there working with part
13 of this population. PACE already working with
14 part of this population, so my feeling is that
15 the more we can preempt a generic letter
16 arriving at people's homes that they don't want
17 to deal with or understand, the better off we
18 will be. Some of these people are known to us

19 and they have people that they are already
20 working with.

21 VOICE: I was just going to
22 follow up with that. And we can roll a partner
23 out in a really formal way with the SHIP
24 counselors and with the points. There's a lot

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1 of work being done in EOHHS around really
2 beefing up our options counseling. So, helping
3 people understand what the best insurance
4 products and long-term services and supports
5 are for them individually.

6 And so, you know, I think that's
7 something that we can build out in the roll-out
8 of this, so individuals who have questions can
9 have somebody go out and sit down with them and
10 figure out in an unconflicted way what really

11 is the best thing for them so they aren't

12 confused.

13 VOICE: So, for the
14 Medicaid-only population, who are already in
15 Connect Care Choice or Rhody, they would just
16 be informed that their long-term services and
17 supports are now going to be rolled in to their
18 existing provider, and do they have a choice --
19 will they have a choice, at that point, to say
20 I want to switch to one of, you know, from an
21 MCO to the primary care case management?

22 VOICE: So, I would put that on
23 the parking lot list. We are talking about the
24 enrollment strategy, but we are, we certainly

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1 haven't finalized all the details of that yet.

2 VOICE: I think there's

3 different issues for the Medicaid-only
4 population who are already in, you know,
5 receiving their primary and acute care through
6 one of those delivery systems, and now we are
7 rolling their long-term services and supports
8 into that.

9 VOICE: I think we are talking
10 about roughly 28,000 people, and this is to
11 start in January; so, this seems like it would
12 be a pretty massive education and awareness
13 campaign in a short time. To the extent I
14 think there's a coordinated plan to make sure
15 we are not missing types of populations, would
16 be key. This would be a big undertaking, and I
17 imagine there is not much money for it, unlike
18 the glory days of Medicare Part D.

19 MS. McKEON: One of the things
20 that I think is helpful, and one of the things
21 that I always bring to the table is the
22 non-traditional way of reaching people like
23 church bulletins, and there is a big chunk of
24 Medicaid-Medicare people, who are not in

1 long-term care, who are, you know, not going to
2 be connected with the case manager, who maybe
3 don't, who are only 69 years old and who are
4 still working, and don't, you know, know
5 somebody that's going to answer these questions
6 for them; so I think, you know, to the extent
7 that we can use non-traditional ways of just
8 letting people know, and one of the things
9 that, you know, I think that happens with the
10 Medicare open enrollment is people have come to
11 know what that is. Even if you're not in
12 Medicare or you have a parent or you're just
13 somebody that watches television or reads the
14 newspaper, most people know there's such a
15 thing as Medicare open enrollment. If you're
16 on Medicare, this is the time to a look at the
17 plans and make a choice. I don't know if it

18 can be considered a Medicaid open enrollment or
19 something, but something to brand it so that it
20 begins to look, sound and feel as one thing
21 with a little bit of coming attraction type
22 stuff with it is very helpful with something
23 like this, particularly for care givers.
24 My soap box is there are many,

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1 many, many people out there who have someone in
2 their lives that they talk to about these
3 things and to get them to see this in public
4 information is important. They are going to
5 say, did you get something in the mail about
6 your Medicaid, whatever. And they are on the
7 lookout.
8 VOICE: I wonder if there is a
9 way to get on the good side of the Journal like

10 to get positive presses from the Journal.

11 MS. McKEON: You're talking to
12 someone from the Diocese of Providence, so I
13 can't answer that question. Swipe that from
14 the record.

15 VOICE: Often the Journal is
16 always looking more for the controversial
17 circumstances. Maybe there is a way to make
18 connections with the health care reporter and
19 say this is a new initiative that's coming up.
20 I still get the Journal. I don't think a lot
21 of younger people do. People of our age do,
22 and that might be a good way to get
23 information.

24 VOICE: Kathy, a couple of

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1 things. What we hear from the beneficiaries a

2 lot is even kind of more basic than a lot of
3 the things we are talking about here, and that
4 neither many of them or their care givers
5 understand where the line in the sand is
6 between Medicare and Medicaid, so I think that
7 whatever information that goes out has to do a
8 little, this is not your Medicare benefit but
9 something that works with your Medicare
10 benefit.

11 I think the second point I
12 wanted to make was along the same lines of what
13 you were talking about about educating their
14 care givers. The other thing we deal with
15 substantially is the misinformation being
16 provided to the beneficiaries by health care
17 providers, and we are working right now with
18 DEA and the Point on educating physicians,
19 nurses, et cetera, providers, on the services
20 available at the Point, and I think that
21 whatever information campaign goes out to the
22 consumers has to concurrently go out to the
23 people that they are going to ask.

24 MS. McKEON: Absolutely.

1 VOICE: I think, in the absence
2 of good information, they just make stuff up.

3 VOICE: They are very creative.

4 MS. McKEON: In that case, they
5 go with what they heard over breakfast. I
6 don't want to neglect that provider, doctor's
7 office aspect of this, because that is
8 certainly part of the outreach and information
9 education that has to be done around this; and
10 I agree with you sooner rather than later, so
11 they are also in the position of knowing the
12 answers and being able to answer some questions
13 or provide materials or whatever else.

14 VOICE: I would just sort of
15 kind of go back to what Robin had said earlier.
16 When we had rolled out Connect Care Choice and

17 Rhody Health Partners, Robin had alluded to the
18 fact we had done an awful lot of presentations
19 at a lot of different venues, but we did
20 specifically work with hospitals, any
21 situations, discharge planners, hospitals; but
22 as part of your thinking and part of the
23 strategy that we are looking at, we would like
24 to have a very focused conversation with

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1 physicians and with, you know, the actual
2 doctors, so that we can make sure that they are
3 informed and then opportunities to be able to
4 maybe provide more information to some of their
5 office staff but just so we are making sure
6 that we have got that broad, if you will, you
7 know, information campaign.

8 MS. McKEON: Jim?

9 VOICE: And just to add to also
10 to include long-term care providers, actually
11 for dual eligibles, whether they are nursing
12 home residents, the family trust, the providers
13 to make sure to get accurate information, even
14 though they have a vested interest in some of
15 the outcomes, but make sure they are informed.

16 MS. ETCHINGHAM: One of the
17 things we had done in our presentations we
18 always gave them the information that if there
19 was anyone that wanted -- we had done some
20 outreach that was done to everyone in a
21 postcard; and if any group at all wanted any
22 kind of presentation, they could call us up,
23 but we had also done nursing homes, went to
24 nursing homes. I went to home health agencies

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1 so it was pretty wide. We had kind of a
2 presentation that was given to providers, and
3 there was a presentation that we gave to the
4 general public; so, we had two types of
5 presentations that we were running at the time.

6 VOICE: And the associations
7 like mine and the other ones they can certainly
8 help.

9 MS. ETCHINGHAM: That's exactly
10 what we did for one of them.

11 VOICE: This also may be parking
12 lot, but thinking about ongoing information, I
13 think about notices to people of particular
14 decisions. Maybe it would be good to set up a
15 group that looks at what are the notices that
16 people are going to get if they are denied a
17 service, particularly the Medicare-Medicaid
18 kind of, you know, you're not getting this
19 benefit because, and the confusion that may
20 happen because it was a Medicare versus a
21 Medicaid service.

22 VOICE: That's a really good
23 point, because especially with both, for 2013,

24 the, you will not be actually integrated with

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1 the Medicare benefit. It's going to be
2 coordinated; so, if the Medicare rules will
3 apply, and those can be different than the
4 Medicaid rules --

5 VOICE: How does the Medicaid
6 notice explain the Medicare side and vice
7 versa.

8 VOICE: Thank you. That's an
9 excellent point.

10 MS. McKEON: The other thing I
11 want to mention, at this point, is that this is
12 probably the third initiative that I have done
13 outreach and information and that kind of focus
14 group kind of thing. So, one of the things we
15 suggested when we did money follows the person,

16 information and outreach, is that OHHS, DEA,
17 all have access to List Serve, a group of
18 people who are willing to have their e-mails
19 listed to comment on things like here's a draft
20 of a letter that's going to go out to this
21 group about such and such. By such and such a
22 date, give us any input you have. You can read
23 it, comment, ignore it or whatever. The people
24 on that last initiative all agreed to do that,

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1 so I'm going to give you people the chance to
2 opt out. We have your e-mail addresses. If,
3 for some reason, you don't think you could do
4 that or wouldn't want to do that, let somebody
5 know, but I think that it is very, very helpful
6 when people come together like this. There's
7 so many details that are going to happen over

8 the next months, years, whatever on this; and I
9 know, from when I worked at DEA, that there
10 were times when I had like two days to finish a
11 letter. I would think, gosh, I wish I had time
12 to ask who's going to be reading this or
13 interpret it to someone. So, the more names
14 out there you don't know what you might pick up
15 that somebody in the office didn't. That's one
16 of the ways to keep this going.

17 VOICE: I was going to add to
18 Linda's comment. I think that notices around
19 decisions, but also it gets into the
20 predecisions, so DOH has got to get involved,
21 because it really does -- the UR stuff is
22 driven by DOH as well as NCQA, so it's
23 complicated around notices, so it's a really
24 good point.

1 VOICE: I think much of this is
2 complicated. Even explaining the PACE model to
3 consumers and families is complicated. So, we
4 need to do outreach to people who service that
5 point, trust, source of information. We know
6 you're busy. We don't want you to become an
7 expert. This is a resource. Just hand it to
8 the person. Let them call. So, they don't
9 feel the need to be educated and up to speed.
10 Give them the information to central resource
11 people is fluid in it.

12 MS. McKEON: That's more
13 important.

14 VOICE: That's a great point.
15 The PACE model is complicated to us because we
16 have to understand all the parts that go into
17 it. For the consumer, it's supposed to be the
18 simplest possible model. I think what has to
19 go out is these changes are really good for you
20 because all these things that were hard and
21 complicated and nasty and disruptive are going
22 to be smoothed out. So, I think that is the

23 piece that goes to the consumer.

24 VOICE: You have to keep in

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1 mind the consumer, even though we think it's
2 complicated, that's their world. They live in
3 it. The language, we have to be mindful of
4 that. They are accustomed to that. Saying
5 there's something better they are going to be
6 cynical. I like what I have. I like my
7 doctor. It works for them. Even though, as an
8 outsider looking in, we can see there's
9 improvements in the system, it's working for
10 them.

11 MS. McKEON: Sometimes it's
12 working for them because they have gotten used
13 to it. It's not so much they expect it. This
14 is what I know. This is what I know. It's

15 that change thing for everybody. One of the
16 things that I think is one of the best selling
17 points of this concept is that not today and
18 not tomorrow but over time, you know, those
19 three medical cards that you run around with
20 could eventually be one. You could have one
21 card and not have to deal with who's paying for
22 this because somebody else is going to figure
23 that out, and I think a lot of people
24 understand that. Which card is it. You know,

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1 I see them at the pharmacy. Out comes the
2 wallet, and it goes on the thing, and which one
3 do you want. If we can simplify that for
4 people, sometimes they can see that down the
5 line as a good thing. Change is difficult and
6 this is a big change. So, it's going to be

7 hard for everybody.

8 One thing I want to mention, and

9 not that I'm cutting off the discussion, but we

10 do have, at the end of your handout, two

11 additional dates to meet; and the next one is a

12 little bit of lead time, August 10 -- I'm

13 sorry, put the glasses on -- August 16. The

14 reason we are doing that is because if you look

15 around, we have mentioned people and

16 organizations and groups that aren't at the

17 table to talk about information and outreach

18 that would be no-brainers, like the Point and

19 SHIP volunteers and case managers and that kind

20 of thing. So, what we have decided to do is

21 put together a panel of four or five people

22 representing those people who work on the

23 ground, so to speak, every day with big chunks

24 of this population.

1 We are going to have them come
2 on the 16th. They are going to briefly speak
3 about what they do and what they see the issues
4 are. And we are going to open it up to the big
5 group again to dialogue. They will bring to
6 the table additional information and different
7 ways of looking at things, and so that will be
8 our agenda for the 16th.

9 And then our wrap-up meeting,
10 the 21st, will really be trying to synthesize
11 what we talked about over the previous two
12 meetings and come up with some specific
13 recommendations that they can go back to --

14 VOICE: And the data
15 presentation --

16 MS. McKEON: There will be a
17 more indepth presentation on the data what we
18 know about these people and how we can inform
19 going forward. I'm encouraging all of you to
20 continue with the process if you make the next
21 two meetings, but I just wanted you to have

22 some sense of what it will look like for the

23 next two.

24 Also, there's that e-mail

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1 address that if you're thinking about something

2 at two in the morning, you can't sleep, you

3 don't have to save it for the next time we

4 meet. You dash that off.

5 VOICE: Do we still have a

6 meeting on the 31st?

7 MS. McKEON: No. Oh, thank you

8 for mentioning that. Originally the 31st was

9 thrown out as a date for this group. The 31st

10 is a state-wide SHIP training. Many of the

11 people we were looking at inviting to the next

12 meeting were involved in that. SHIP is Senior

13 Health Insurance Program, in case anybody

14 doesn't know that. Since that was a big
15 training date for the 31st, we took that off
16 the table; and we have added these two in, and
17 they are both here in this building and in this
18 room, as a matter of fact, and both of them
19 9:00 to 11:00. So, I'm hoping for as many of
20 you as possible. We will continue our
21 discussion. Yes?

22 VOICE: Is there a plan to post
23 the minutes from all three of the work groups
24 so we can see what the other work groups are

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1 doing?

2 VOICE: Yes. Yes. And then
3 all the presentations. Our plan is to be as
4 seamless as possible and get as much
5 information up as we can. We recognize that,

6 you know, folks' time is really critical plus
7 in the summer folks are taking vacation; and I
8 know a lot of people are very much interested.
9 We have gotten really a tremendous response to
10 this initiative. So, we want to make sure that
11 we are getting all the information up and
12 available for folks to look at. So, as soon as
13 it's available, we will post.

14 VOICE: When the original
15 bulletin came out, I know there were a lot of
16 questions and comments submitted during the
17 comment period. You're going to respond to
18 them? Is there a time when that report will be
19 out?

20 VOICE: Thank you. We had 75
21 questions. They were under the final review,
22 and so I will say that there were some
23 vacations, but so I will circle back and we
24 will try to get those posted, if we can, this

1 week. If not, maybe next.

2 VOICE: I'm sure it's a big

3 undertaking.

4 VOICE: It was. Thank you,

5 Jim.

6 MS. McKEON: Other comments,

7 suggestions for us? Other people you can think

8 of who you might want to invite, bring to the

9 next meeting or suggest that they come, it's

10 fine. Do you guys want to have an e-mail on

11 that if someone new wants to group? They can

12 e-mail the main e-mail address. Very good.

13 Everybody can think of at least one person --

14 if you've got an aunt or uncle who's 80 on this

15 program, bring them along.

16 We have also talked about

17 smaller focused groups of current

18 beneficiaries, getting people together who are

19 the people who will get the letter and the

20 people who will have to respond to that kind of

21 thing. You know, just to maybe have something
22 concrete to show them and say how can we make
23 this better. I think that's going to be very
24 important. It's not an easy thing to do.

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1 People are -- every time I get a phone call at
2 my house and somebody wants me to do a survey,
3 I say, oh, I'm so sorry, but I don't have time
4 right now. Everybody feels the same way. If
5 we can identify some consumers that are willing
6 to sit down -- Marie, maybe you can help us
7 with that through some of the churches, too, we
8 can get some groups together.

9 VOICE: I wanted to ask maybe
10 to have on the panel to include some of the
11 cultural groups, the language groups that we
12 serve.

13 MS. McKEON: One of the people
14 that will be on the panel, I hope, is Louis
15 Casino, is a Hispanic outreach person in my
16 office. He was involved in the SHIP training,
17 so he couldn't be valuable. But I have asked
18 him to participate. He's been with us three
19 years and has some incredible stories to tell
20 about people who are so isolated because of
21 their language and how very easily it is for
22 people to get off track when they don't speak
23 English and have anyone to go to so that's an
24 important point.

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1 VOICE: We have a chaplain at
2 Rhode Island Hospital who is Haitian, and we
3 have several Haitian churches that -- that
4 would be a good way to get that information

5 out.

6 MS. McKEON: Great.

7 VOICE: Those are the kind of
8 things we need to develop a list of who are,
9 what are the best contacts and kind of build on
10 that to roll out a marketing plan for this.

11 MS. McKEON: Even to let them
12 know this is going on. This is basically what
13 it's all about, and this is who somebody can
14 call, and there will be the availability for
15 multiple languages for them to ask the
16 questions. You know, key people like that are
17 someone that the people asks the question.
18 They trust them. They share the language.
19 They can say while my mother was in the
20 hospital, she got this, and what am I supposed
21 to do, and I would do the same.

22 VOICE: Yes, and this guy would
23 be very comfortable with the medical portion of
24 it.

1 MS. McKEON: Okay. Other
2 thoughts? As I said, please e-mail them in.
3 Random thoughts at two in the morning are
4 always good. OHHS group, anything else you
5 want to add, ask?

6 (PAUSE)

7 MS. McKEON: We are good.
8 We will look at this. An hour and a half. We
9 are good. Thank you all very much. This was
10 excellent.

11 (HEARING ADJOURNED AT 10:29
12 A.M.)

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1 C-E-R-T-I-F-I-C-A-T-E

2

3 I, MARY ELLEN HALL, Notary Public, do
4 hereby certify that I reported in shorthand the
5 foregoing proceedings, and that the foregoing
6 transcript contains a true, accurate, and
7 complete record of the proceedings at the
8 above-entitled meeting.

9 IN WITNESS WHEREOF, I have hereunto set
10 my hand and seal this 31st day of July, 2012.

7

8

9 MARY ELLEN HALL, NOTARY PUBLIC/
10 CERTIFIED COURT REPORTER

11

12 IN RE: Integration of Care and Financing

13 DATE: July 25, 2012

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