



Meeting Minutes



Detroit Long Term Care System Change Task Force Legislation & Regulations Subcommittee Meeting Minutes

Date: Thursday, January 15, 2009

Time: 10:30 a.m.

Place: Detroit Area Agency on Aging
Hildred Drew Dale Conference Center
1333 Brewery Park Boulevard, 1st Floor
Detroit, Michigan 48207

MEMBERS PRESENT

Eric Foster, Co-Chair
Tom Rau
Wanda Bailey Jenkins
David Stobb
Laurie Solotorow
Kendra Howard
Olivia Boykins
Mildred Madison
Marilyn Lawson
Martha Little
Kay Andrzejak

MEMBERS EXCUSED

Avis Holmes
Brenda Sowash
Dorothy Stone Montgomery

MEMBERS ABSENT

Bob Allison
Patricia Anderson
Faiz Esshaki, Co-Facilitator
Beverly Hamlar
Melissa Samuel
Margie Young

GUESTS

Erin George, Plante & Moran

STAFF

Gloria Hicks Long, Co-Facilitator

RECORDER

Leah Phippen

I. CALL TO ORDER/ WELCOME & INTRODUCTIONS

Meeting was called to order at 10:45 a.m.

Eric Foster asked members to state their names and agencies for the record.

II. CO CHAIR REMARKS

The Medicaid Eligibility workgroup met last week. The topic of Medicaid eligibility has been identified as a critical component in developing a policy recommendation as it related to shortening the time length of the process.

III. REVIEW AND APPROVAL OF MEETING MINUTES OF DECEMBER 10, 2009

Mr. Foster asked subcommittee members to review for approval, the meeting minutes of December 10, 2009. Wanda Bailey Jenkins made a motion to approve; seconded by Mildred Madison. Motion carried.

IV. MEDICAID ELIGIBILITY REPORT – PLANTE & MORAN

Laurie Solotorow distributed a draft of the initial work group report. The work group is comprised of members from two established providers who have facilities in Wayne County; members from Plante & Moran representatives from DAAA and the LTCC. A representative from DHS will be expected to participate in all subsequent meetings where appropriate. The purpose of the Medicaid Eligibility work group is to solicit feedback from providers and other stakeholders to better understand the challenges presented by the current Medicaid eligibility process. The workgroup's agenda addressed the following topics:

1. Problems encountered with Medicaid eligibility
 - a. Target groups/ populations that are most "troublesome"
The work group found that problems experienced are universal. Overall, the LTC population has a hard time understanding the application process because of its complexity. This is not specific to any given age group; residents and family members often receive conflicting or minimal information. Life insurance providers will not accept or release any information unless the requestor is the guardian, including DPOA's. Community Medicaid recipients are often harder to switch to facility Medicaid. On-site DHS specialists have a lack of customer service model and often give finite information, setting the client up for failure.
2. Issues resulting from the delay in approval
Some issues identified were increasing bad debt, the inability to recoup patient charges incurred during the approval period and increasing trend, within the last 6 to 9 months, in the number of residents who need Medicaid.
3. How LOC determination impacts the process
Approval is often delayed by the DHS budget completion. Providers believe that the process is not well understood by all members of the DHS. While the clinical level is done electronically and is relatively seamless, the financial level is often delayed by DHS.
4. Ideas to improve the system – Brainstorming session
 - a. Segregate the Medicaid process into short-term and long-term criteria to make the approval faster.
 - b. Waive patient pay amount until approval to allow short-term recipients to maintain their living expenses (mortgage, rent, etc.)
 - c. Better training for DHS workers in overall process
 - d. Better communication amongst DHS workers, specifically for recipients transferring from community to facility Medicaid.
 - e. More user-friendly Medicaid application
 - f. Impose a 90-day requirement for the level of care determination. If determination exceeds the 90-day limit, then the PPA is waived until the approval, and then resumed.
 - g. Better control/ regulation of Guardianship companies
 - h. Extend re-determination timeframe to 30 days rather than 5-10 days, so that there is sufficient turn-around time for the application once received by DHS.
 - i. Acknowledgement of addresses where re-determination information and/or document requests are sent (i.e. send to facility if address of record is a nursing facility).
 - j. Address the error rate reduction of 50% that inherently restricts approval of applications

Eric Foster referred to item 1c. and asked what would cause the challenge in transitioning a person from home healthcare to a skilled nursing home setting? Laurie stated that it was the complexity of the DHS process and the lack of skill and experience of DHS workers.

Tom Rau added that transitioning from community to facility Medicaid presented more “hoops” than new applicants transitioning from private pay to straight Medicaid. Liv Boykins asked the subcommittee if they noticed a disparity in the treatment of inner-city residents as it relates to state assistance.

Tom replied that in all of his experience, he has observed customer service attitude to play a big role in this issue. The expectations in customer service and overall attitude of the inner-city specialists are lacking. He noted that a specialist in a suburban community may be more willing to assist applicants; whereas, some urban community specialists would return the application unfinished for the applicant to figure out the problem. It could be a result of stress from larger caseloads.

Wanda Bailey Jenkins addressed Eric’s question when stating that community Medicaid has different eligibility factors than facility Medicaid. Wayne County has 17 different offices, whereas, the facility case would be at the Medical District. The community worker would have to apply budget changes and level of care changes in the computer before that case can be opened for the facility. Eric asked if it would be feasible to allow one particular worker to remain with a client throughout the entire transition to streamline that process. Also, understanding that there are some differences in benefit payments and regulations from community to facilities; are there ways to streamline some of the internal technical steps rather than operating as if two different insurance programs. Tom Rau stated that there are two different ways to qualify, one way for community and one way for facility. Kay Andrejak confirmed that there are two different eligibility processes; however, it is more stringent to qualify in the community. The income and asset requirements are more liberal in a nursing home environment. Wayne County’s challenge is with the structure of DHS. When notified that someone has moved into a facility is expected to stay over 30 days that case should be transferred from the community office to the specialized staff to ensure that the codes are in place so that the billing will go through as it should. The staff on community cases are not trained and don’t know the correct codes for billing. DHS staff members don’t always prioritize shipping a recipients’ file from one location to another. If someone qualifies in the community, unless there was a mistake on the front end, they should certainly qualify in a nursing facility. Kay explained that there is a complex coding system for different criteria such as people on Medicaid vs. Medicare, HMO, Hospice, Waiver, etc. that causes billing challenges. We may be able to encourage changes to this system to include a universal coding system to simplify the eligibility process and eliminate additional billing challenges. Tom agreed that changing the coding system is much better than trying to change the entire bureaucratic system.

Olivia asked Kay about the on-site staff option. She thought that it sounded like a sophisticated bribe. Kay explained that it is not intended for every facility. Some owners find it more efficient to go without it. Tom included that it is a “no brainer” to spend \$34,000 if it will generate millions. It also provides better service for residents.

Tom referenced work group agenda item 4b about not collecting patient pay amounts and commented that Michigan is the only state that doesn’t have a Medicaid recovery program where if someone dies with money or estate, then you can take that money and pay it back to Medicaid. Implementing this program would alleviate that issue and waiving patient pay would be unnecessary.

Gloria Hicks Long noted that one of our recommendations would be to implement a universal coding for the billing process.

Martha Little commented that case information should be electronic rather than kept in paper file format. This would alleviate the delay in transferring the client file between community and facility. She also asked what happened to the 45-day conjunction to make a decision in

eligibility. Kay stated that the state had set a goal for 30 days, but depending on the client criteria the process may be longer or shorter.

Martha added a comment with regard to medical review, that if medical reviews were conducted on-site wherever the resident is residing, it would also alleviate unnecessary file transfer.

Tom commented that there is no accountability for guardians. There should a certification or license requirement for guardians to ensure that they are maintaining the responsibility of the title. Liv added that Charles Dunn recommended the same idea, stating that it would create more jobs. Education would need to be implemented. Tom asked if guardians have to track resident funds. The subcommittee answered yes. He requested that a sub-group be pulled from this committee to focus on that issue. Gloria logged it as a potential recommendation for the subcommittee. Mildred Madison distributed a newspaper article on guardianship and contracts that allow relatives to be paid a salary for caring for the elderly. The contracts specify duties that the caregiver will be expected to perform. Marilyn Lawson commented that some consideration should be taken for increased living expenses due to good care of an elderly relative. Those funds paid should not be viewed as a salary, but rather an offset to increased bills such as heating costs, dietary needs, etc.

Eric concluded this agenda topic and asked members to take the information from the workgroup to come up with more ideas to present as possible policy recommendations.

V. REVIEW REVISED LETTER TO MICHIGAN CONGRESSIONAL DELEGATION

The letter will be reviewed at the next meeting.

VI. STATUS REPORT ON OTHER AAA'S – UCG

Kendra Howard reported that some of the other AAA's are experiencing some of the same issues that our urban communities are experiencing.

Tom commented that the rural communities do not have the same issues dealing with homelessness and disabled population. Eric reminded the subcommittee that the survey asked about the urban communities surrounding the other AAA's. Tom stated in his experience, he has observed that percentage-wise, Detroit has a higher number of disabled and homeless persons. Eric stated that the UCG would summarize the feedback from five of the six AAA's interviewed and present it to the subcommittee at the next meeting.

VII. PUBLIC POLICY PLATFORM DEVELOPMENT

Eric stated that the subcommittee would begin working on titling the different policy recommendations and apply to the Policy Recommendation Template that includes: Rationale, Regulation, Administrative Rule, Policy or Other Governing Laws Citations and the impact of proposed policy recommendation.

Gloria asked subcommittee members to note additional policy recommendations using this format and forward them to Leah Pippen or herself by Tuesday, January 20, 2009 to have them compiled and ready to present at the next meeting. Eric noted that the template is a living, breathing document.

Liv asked if the 85% rule removal would be an example of a good recommendation.

Erin noted that the Business & Economic Development Subcommittee was also recommending the same. Eric and Gloria encouraged any and all ideas even if duplicated in another subcommittee because all recommendations will be filtered through our subcommittee anyway.

VIII. LEGISLATION INPUT FROM OTHER TASK FORCE SUBCOMMITTEES

There is not input to report at this meeting.

IX. TASK FORCE POLICY REVIEW PROCESS/ TIMELINE

The policy recommendations are due to the Legislation & Regulations Subcommittee on January 30 for review by the Leadership/ Steering Subcommittee on February 6.

X. LEGISLATIVE PROCESS TRAINING UPDATE

The Legislative Process Training will be held on January 30, 2009. It will be open to members of all of the subcommittees of the Task Force, DAAA Staff and subcommittee members' administrators. The training is currently scheduled from 9:00 a.m. – 12:00 Noon

XI. SUBCOMMITTEE SCHEDULE MEETINGS FOR 2009

The Legislation & Regulations Subcommittee will meet on the following dates:

Thursday, January 22, 2009 – 10:30 a.m.

Thursday, February 12, 2009 – 10:30 a.m.

Thursday, February 26, 2009 – 10:30 a.m.

Thursday, March 12, 2009 – 10:30 a.m.

XII. AGENDA BUILDING FOR NEXT MEETING

Additional comments on Medicaid Eligibility Report
Building on Policy Recommendations Document

XIII. ADJOURNMENT

The meeting was adjourned at 12:10 p.m.

Respectfully Submitted by:

Leah Pippen

GHL/lp

Moving Towards Enhancing the Quality of Care