

Final Report
of
Workgroup C - Continuum of Care
to the
Medicaid Long Term Care Task Force

November 8, 2004

Report of Workgroup C – Continuum of Care
November 8, 2004

The membership of Workgroup C envisions for Michigan an accessible, integrated service system that assures those in need have an available range of options that allows them to live and receive services and supports where they choose. These services shall be accessed through a single point of entry and delivered in a manner that allows money to follow the person. That is, supports and services shall be connected to individuals rather than to providers or settings as is currently the case. This new element will allow free movement between and among services and settings as needs or consumer preferences change. Within an assessed level of need, individuals shall have a menu of services to choose from based on a person centered planning process. Services and supports shall be held to a standard of quality defined and measured first and foremost by consumers, as well as by regulators and payers.

The original charge to Workgroup C focused on Vision Statements 6 and 7 addressing nursing home quality and cost effectiveness, and availability of a full range of options in an accessible home and community-based service system. Workgroup and subcommittee deliberations resulted in development of new vision statements which reflect an intent to make a full array of services and supports available across an expanded choice of settings for all consumers who meet Medicaid eligibility criteria. These will be determined and delivered consistent with consumer preference as determined through a person-centered, informed choice process. Quality will be measured both in terms of consumer satisfaction and technical performance, by the individual receiving supports as well as surrogates (payers, regulators, caregivers, families, professionals, advocates).

The phrase “the consumer trumps all” describes the overriding principle of quality adopted. A quality long term care experience is an individual evaluation. While consumer assessment of the quality of their experience is key, the group also agreed that performance measures, regulatory assurance of health and safety standards, and state oversight are also critical elements of quality. Group members agreed that current federal nursing home regulations (the “OBRA” language) do actually promote a consumer-driven assessment of quality of care and quality of life for nursing home residents. However, group members identified problems with current enforcement and interpretation of this regulatory language.

The following core elements will form the basis of Michigan’s integrated system of care:

- A visible, accessible, single point of entry
- Service neutral screening, assessment, education and informed choice
- Money follows the person
- A consumer-chosen supports coordinator/facilitator that follows the consumer throughout a full range of service delivery systems, settings and options
- Self directed care as consumer desires, with assistance from others (families, friends, professionals) of their choosing
- Reimbursement based on individual acuity rather than a single flat rate for all

- Prevention and wellness as expected and reimbursed services
- Incentives for delivering what the consumer needs/desires, disincentives for under serving
- Use of technology to enhance efficiency and effectiveness of service delivery (communication, coordination, data sharing, tele-medicine)
- An independent external ombudsman to advocate on behalf of consumers
- A consumer bill of rights
- A quality management system embedded at the consumer, provider, and system levels

Working from the premise that Medicaid individuals should have full access to the same range of services, supports and settings available to the general public, Workgroup C recommends the following be included in Medicaid long term care benefit. This list is representative rather than exhaustive and reflects broad categories of services and supports. Additional detail about specific activities included within each broad category can be found in Attachment 3 (*Proposed LTC Continuum*). The workgroup is not wedded to any particular service delivery or financing structure as long as the full range of services and supports is accessible to individuals who need them and quality services are delivered.

| | |
|---|------------------------------|
| Adult Day Care | Home Modification / Repair |
| Ambulance | Homemaker |
| Assessment | Hospice |
| Assisted Living | Hospital Care |
| Assistive Technology | Immunizations |
| Behavioral Health | Laboratory Services |
| Case Coordination / Supports Facilitation | Medical Equipment/Supplies |
| Caregiver Education | Medication Management |
| Caregiver Support | Nursing Services |
| Chiropractic Services | Nursing Facility Services |
| Chore Services | Nutrition Services |
| Chronic Care Management | Personal Assistance Services |
| Counseling | Personal Emergency Response |
| Dental Services | Pharmacy |
| Diagnostic Services | Physician Services |
| Emergency Services | Podiatric Services |
| Employment Services | Prevention |
| Enhanced/Expanded State Plan Benefits | Psychiatric Services |
| Family Planning Services | Refugee Services |
| Financial Management | Rehabilitation Services |
| Fiscal Intermediary | Respite |
| Gap Filling Services | Shopping/Errands |
| Hearing & Speech Services | Supervision |

Supports Facilitation / Case Coordination
 Therapies
 Training
 Transition Services

Transportation
 Urgent Care Services
 Ventilator Services
 Vision Services

These services and supports can be delivered through a variety of structural and financing methodologies as described in Appendix B, Integrated Systems of Care - Basic Precepts of Common Models. Recommendations about establishment and implementation of specific service delivery models and their financing are deferred to Workgroup B.

There are several overarching systemic barriers that must be addressed to assure capacity exists to serve individuals in the setting of their choice and to deliver the authorized/needed services and supports.

| Barrier | Recommended Action |
|--|---|
| <p>1. Awareness of community-based long term care services and supports is limited.</p> <p>Our society puts no emphasis on helping people plan for potential future long-term care needs. Our pre-occupation with staying young makes us philosophically opposed to thinking about growing older, let alone thinking about the potential need for long term care services. This results in individuals and families waiting to consider long term care issues until very near or at the crisis point. Once at this crisis point, there is no place to go for objective, comprehensive information about available options. The lack of a visible entry point results in un-informed choices that may not be in the best interest of either the consumer or the payer. A strategic effort to help people plan for future needs and then receive assistance accessing desired service and support options will allow consumers to be served in the most affordable, least restrictive setting.</p> | <p>As recommended by Workgroup A, implement single point of entry to ensure consumers have opportunity to make informed choices prior to accessing long term care services.</p> <p>Within single point of entry, implement information & education campaign targeted to consumers, caregivers, and health care professionals.</p> |

| Barrier | Recommended Action |
|--|--|
| <p>2. Access to community-based long term care services and supports is limited.</p> <p>Michigan limits access to community-based services by placing caps on MI Choice waiver program enrollments and expenditures. Adult Home Help programs provides community-based long term care services and supports however that program has experienced limitations on services related to IADLs. Nursing facility enrollment and expenditures are not capped except by the availability of a Medicaid licensed bed and the willingness of a certified provider to admit a Medicaid recipient. Michigan policy establishes patient pay provisions for Medicaid coverage of nursing facility care. These provisions do not exist for home and community-based settings. Individuals with income in excess of 300% of SSI are ineligible for the MI Choice waiver and must receive long term care services in a nursing facility if financed by Medicaid.</p> | <p>Establish money follows the person principles that allow individuals to determine through an informed choice process where and how their long term care benefit will be used.</p> <p>Establish an equitable acuity based reimbursement system.</p> <p>Establish consistent patient pay provisions across all long term care settings.</p> |
| <p>3. Lack of Medicaid-financed community-based service delivery options.</p> <p>Michigan Medicaid policy does not allow residents of AFC or HFA homes who would otherwise qualify for adult home help and/or waiver services to receive those services in those settings. Currently MI Choice waiver services can be provided only in non-licensed settings. Not affording such a specialized service option for those who could appropriately reside in an AFC or HFA negates their use as a viable alternative to nursing facility placement.</p> | <p>Amend Medicaid policy to allow for the provision of specialized services and supports in licensed assisted living (i.e., AFC and HFA) facilities.</p> <p>Review and revise AFC and HFA regulations to include a legal definition of “assisted living” to ensure its viability as an alternative to nursing facility placement. This activity is referred to Workgroup G for consideration from a Regulatory and Legislative Reform perspective.</p> |

| Barrier | Recommended Action |
|---|---|
| <p>4. Long term care services are not person centered.</p> <p>Currently long term care services are delivered in medical model manner. Various federal and state required assessment processes and forms are filled out to determine medical needs, financial eligibility and other information focused on treatment and payment. As the authorizers of service and payment, professionals have the power to drive the care planning process. In some long term care settings, care conferences are often held without the presence of the person who is to receive the care. This may be more efficient and effective, but by making the consumer a passive receiver of care other problems, such as learned helplessness, depression caused by lack of control over one’s own life and other psychological and physiological problems requiring additional treatment. Experiencing health care problems does not automatically strip a person of control over their own life and our long term care service delivery needs to reflect this value.</p> | <p>Revise the nursing facility licensing and certification process to reflect a commitment to culture change, person centered care, gentle care and other innovative best practices.</p> <p>Work with Eden Alternative, Wellspring, Pioneer Organization movements and similar initiatives to integrate person centered culture change to nursing facility care.</p> <p>Revise health professional licensing and/or certification criteria to include culture change and other best practice training and CEU requirements.</p> <p>These activities are referred to Workgroup G for consideration from a regulatory and legislative reform perspective.</p> |
| <p>5. Current enforcement of regulatory requirements often blocks innovation and person-centered care.</p> <p>Current enforcement of regulations for nursing homes, adult foster care homes and homes for the aged sometimes gets in to way of providing care that improves the person’s quality of life and individual choice options. At the same time, unregulated settings do not offer protection or standards of rights, health and safety.</p> | <p>Review current regulations to identify person-centered language and promotion of individual choice.</p> <p>Review current enforcement protocols and practices in all regulated settings and revise to promote person-centered care and consumer assessment of quality.</p> |

6. VISION STATEMENT: ASSURES QUALITY IN MICHIGAN'S LONG TERM CARE SYSTEM

Good quality is defined and measured by the person receiving supports, and not through surrogates (payors, regulators, caregivers, families, professionals/advocates). The elements of quality are meaningful relationships, continuing of community involvement in the person's life, personal well-being, performance/customer satisfaction measures, the dignity of risk taking and the freedom to choose or refuse. Quality includes both technical performance (such as competent clinical care) and consumer experience/consumer satisfaction measures.

| | Objectives (Approach) | Target Date | Action Steps (Milestones/Goals/Objectives) | Barriers |
|----|---|----------------|--|----------|
| 6A | Align regulations, reimbursement and incentives to promote this vision of quality and move toward that alignment in all sectors of the long term care system. | | <ol style="list-style-type: none"> 1. Conduct a cabinet level review of ALL departments of state government to determine if and how each touches the long term care system. <ul style="list-style-type: none"> • What's on the books • How is it enforced • Impact on consumers 2. Have stakeholders from within Michigan and experts from outside Michigan analyze the Cabinet-level review and provide input on areas to address for alignment. 3. Develop and implement use of consumer experience/consumer satisfaction surveys and measurements. 4. Review and analyze current performance measures (both regulatory and non-regulatory). 5. Design performance measures that move Michigan's long term care system toward this vision of quality. | |

Several approaches assigned to the Workgroup C were not addressed, but rather considered by the Quality subcommittee to be components of an internal DCH/FIA work plan to improve and ensure quality in Medicaid-funded long term care programs. Those include:

- 6A - Convening quality improvement groups
- 6B - Integration of person centered culture change
- 6E - Revision of licensing and certification process to reflect commitment to culture change
- 6G - Revision of enforcement options to maximize support for quality of care
- 6H - Revision of nursing facility and AFC/HFA closure process/protocol.

It is recommended the approaches detailed below be considered from a regulatory perspective, and are respectfully passed on to Workgroup G for inclusion in their deliberations:

- 6C – Development of incentives for nursing facility involvement in the continuum of care
- 6F – Revision of health professional licensing and/or certification to include mandatory continuing education in culture change
- 6I – Dual certification for all Medicaid-certified nursing facility beds (policy change underway to achieve incrementally)

7. VISION STATEMENT: SUPPORTS IN MICHIGAN AN ACCESSIBLE, INTEGRATED SERVICE SYSTEM WHICH ASSURES THAT THOSE IN NEED OF SUPPORTS OR SERVICES HAVE A RANGE OF OPTIONS THAT ALLOW THEM TO LIVE WHERE THEY CHOOSE.

| | Objectives (Approach) | Target Date | Action Steps (Milestones/Goals/Objectives) | Barriers |
|----------|--|--|---|---|
| 7A | Identify a range of services and supports for inclusion in an integrated system of care. | Complete | 1. Develop succinct overview of the basic precepts of the most common models (see Attachment 1, <i>Integrated Systems of Care - Basic Precepts of Common Statewide Models</i>). | Multiple service delivery models (LTC only, LTC/primary care, LTC/primary care/acute care) and financing mechanisms (fee for service, managed/capitated, all inclusive, carve-out). Current system needs to be altered to achieve any of the potential statewide systems outlined in Attachment 1. |
| Complete | | 2. Determine core elements (see Attachment 2, <i>Core Elements of an Integrated System of Care</i>). | | |
| Complete | | 3. Determine services and supports to be included in integrated system of care (see Attachment 3, <i>Proposed Long Term Care Continuum</i>). | Service delivery fragmented. Lack of coordination between/among health and long term care service delivery systems. No incentives for systems to interact. | |
| | | 4. Develop new and innovative service delivery and setting options to optimize consumer choice. <ul style="list-style-type: none"> • Define and regulate "assisted living" in statute • Revise AFC and HFA rules/regulations to: <ul style="list-style-type: none"> o allow for the provision of home health care in AFCs and HFAs on an ongoing basis. o Establish HFA statute separate from the Public Health Code. | Lack of affordable setting options between own home and nursing facility. No spend-down provisions for licensed community-based settings. If over income only choice is nursing facility. Current regulations allow the provision of home health services in AFCs/HFAs only under special conditions, not on a continuous basis. HFAs are not regulated by DCH but current code includes them with the regulation of medical and nursing facilities and agencies. HFAs provide no medical or nursing functions. | |

| | Objectives (Approach) | Target Date | Action Steps (Milestones/Goals/Objectives) | Barriers |
|----|---|----------------|--|---|
| 7B | Identify gaps and strengths in services and supports on both a statewide and local basis. | | <ol style="list-style-type: none"> 1. Map consumer experience (movement) in the existing long term care system. 2. Collect and review existing gaps/ strengths analyses and long-term care planning documents as background. Evaluate problems. 3. Develop tool to aid in the assessment of availability and capacity of provider networks at the local (regional/ community) level. Include at a minimum: <ul style="list-style-type: none"> • aging/disability population analysis and projections • income and poverty analysis • county and local collaborative structures • housing for elderly, disabled, low income • community and residential direct care workforce • cultural competence of provider networks 4. Utilize regional/local planning bodies to: <ul style="list-style-type: none"> • conduct availability and capacity assessment of existing services and supports, settings, fund sources. • develop gaps and strengths analysis of service delivery network and financial resources • coordinate to maximize funding for services/supports and minimize funding for administrative activities. | <p>Insufficient licensed housing and quality direct care workforce available for low income consumers due to low level of pay for care.</p> <p>Turf issues, loss of control over funding.</p> |

| | Objectives (Approach) | Target Date | Action Steps (Milestones/Goals/Objectives) | Barriers |
|----|--|----------------|--|---|
| 7C | Design a continuum that integrates existing strengths in services and supports and fills gaps in a manner that promotes quality, choice, and cost effectiveness. | | <ol style="list-style-type: none"> 1. Design continuum that ensures availability of full range of health and long term care services and supports, including gap filling services, for long term care beneficiaries 2. Implement short-term steps that move toward achievement of long term goals. <ul style="list-style-type: none"> • change Medicaid eligibility <ul style="list-style-type: none"> ○ simplify eligibility, establish fast track determination, building on the presumptive eligibility experience within MI Choice waiver program. ○ allow protection of housing for up to 6 months to enable consumers to return to the community after stay in nursing facility • maximize federal match opportunities <ul style="list-style-type: none"> ○ expand quality assurance assessment program (QAAP) to include community-based care providers • maximize Medicare coverage of covered benefits for dual eligibles • identify funding for the provision of gap-filling services that are critical to maintaining independence and avoiding unnecessary institutionalization. | <p>Service delivery is fragmented. Lack of coordination between health and long term care, no incentive for systems to interact. Consumers in AFC and HFA settings lack access to the full range of health and long term care services and supports funded in nursing facilities, community-based waiver and adult home help programs.</p> <p>Staff shortages at FIA impact timeliness of financial eligibility determination.</p> <p>Currently AFC/HFA bed is not funded if a resident must even temporarily reside in a nursing facility. Consumer's home is not protected asset unless community spouse exists. Requires state manual policy revision. Potential financial impact.</p> <p>Federal regulations prohibit. Need approval from Secretary of HHS to implement.</p> <p>Lack of knowledge about Medicare benefits and appeal processes on part of beneficiaries and providers</p> <p>Medicaid funding currently does not follow the person from their home into AFC or HFA to prevent nursing facility placement.</p> |

| | Objectives (Approach) | Target Date | Action Steps (Milestones/Goals/Objectives) | Barriers |
|----|--|----------------|--|---|
| 7C | Design a continuum that integrates existing strengths in services and supports and fills gaps in a manner that promotes quality, choice, and cost effectiveness. | | Continued from previous page. 3. Through statute (executive order?), create a Type I agency within state government responsible for the planning, financing, delivery, and quality of long term care services and supports in Michigan. | Turf. Organizational opposition. Multiple state agencies have role/interest in various aspects of long term care. |

| | Objectives (Approach) | Target Date | Action Steps (Milestones/Goals/Objectives) | Barriers |
|----|---|----------------|--|--|
| 7D | Make necessary changes on the state and local levels to implement design. Ensure a high quality, integrated system is available statewide | Complete | <ol style="list-style-type: none"> 1. Make a single point of entry agency available to anyone needing LTC in Michigan. 2. Reform the certificate of need process so it responds to current demand and preferences of the populations being served and allows for new residential options. 3. Provide incentives to ensure providers comprehensively meet the needs of individuals who need LTC. 4. Implement acuity-based reimbursement for individuals receiving Medicaid-funded long term care services and supports. 5. Allocate Medicaid in a manner that ensures that money follows the person from one provider/setting to another. 6. Eliminate barriers/restrictions imposed by existing funding silos so individuals can choose the services, supports and settings they desire. 7. Develop a system of supports coordination to assist consumers to actualize their person centered plan. | <p>Lack of funding. Opposition to pooling of existing resources. Turf.</p> <p>Requires policy change. Difficult to implement.</p> <p>Current policy attaches benefits to providers/ settings rather than individuals.</p> <p>Long term care funding rolled into one line item still spent according to established budget targets which allocate insufficient resources to community-based care options.</p> |

| | Objectives (Approach) | Target Date | Action Steps (Milestones/Goals/Objectives) | Barriers |
|----|--|----------------|---|--|
| 7E | Educate consumers, advocates, providers and other professionals about the range of available services and supports and how to access them. | | <ol style="list-style-type: none"> 1. Reinstate and expand the long term care information and education campaign to raise awareness. Use existing research and teaching methodologies to develop educational tools to target specific audiences including consumers, families and health care professionals. 2. Develop tools that assist general public and health care professionals determine the various options for long term care and the appropriate services and setting to meet the client's needs and desires. <ul style="list-style-type: none"> • meaningful web-based long term care portal • electronic benefits application 3. Ensure adequate funding. <ul style="list-style-type: none"> • investigate availability of federal match for I&A/outreach activities related to identifying MA beneficiaries (they do this in Minnesota) | Lack of funding. Former campaigned focused on personal financing of long term care. Need to design and implement something specific for this purpose. Responsibility for development and implementation of information and education campaign are deferred to Workgroups E and A respectively. |

| | Objectives (Approach) | Target Date | Action Steps (Milestones/Goals/Objectives) | Barriers |
|----|---|----------------|--|----------|
| 7F | Track demographic and utilization data. Ensure ability to adjust benefits to reflect consumers' needs and preferences | | <ol style="list-style-type: none"> 1. On at least an annual basis, track rate of change and trends in Michigan among: <ol style="list-style-type: none"> a. age cohorts b. geographical regions c. risk factors predicting long term care service use <ol style="list-style-type: none"> i. poverty status ii. # adults with disabilities iii. living alone iv. health status v. age 2. Develop new data collection efforts related to: <ol style="list-style-type: none"> a. extent of informal support network (randomized statewide survey) b. specifics on consumer preferences for quality improvement (CMS participant experience survey where consumers interview consumers) c. self supports - what do consumers that "figure it out for themselves" do that allows them to survive and thrive | |

| | Objectives (Approach) | Target Date | Action Steps (Milestones/Goals/Objectives) | Barriers |
|----|--|----------------|--|----------|
| 7F | Track demographic and utilization data. Ensure ability to adjust benefits to reflect consumers' needs and preferences. | | <p>Continued from previous page.</p> <p>3. Establish state-level capability for ongoing analysis and forecasting for consideration during annual budget development process.</p> <ul style="list-style-type: none"> a. Annual review of demographic changes/consumer preference data. b. Annual distribution of key findings to legislators, policymakers, providers and others within the aging and disability networks. c. Coordinate public release of data. | |

Attachments
to the
Final Report
of
Workgroup C - Continuum of Care

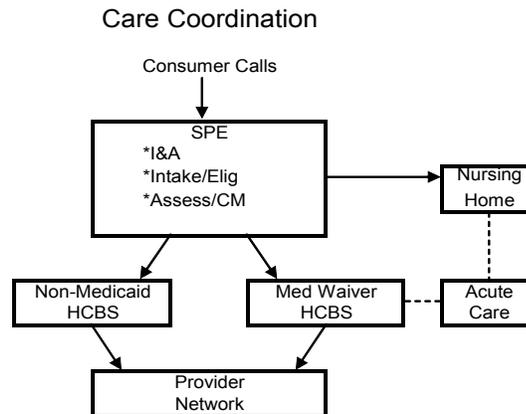
1. Basic Precepts of Common Statewide Models
2. Core Elements of an Integrated System of Care
3. Proposed LTC Continuum

November 8, 2004

Basic Precepts of Common Statewide Models

Michigan's current system would have to be altered to achieve any of these potential statewide systems. Following input from the CMS and NASHP, basic tenants of each are outlined for discussion purposes. All systems can be designed to accommodate the design principles of single point of entry, universal screening, consumer-directed care, and money following the person. Michigan may elect to demonstrate and track more than one system to determine effectiveness.

I. Care Coordination Model



Basic Approach:

- Incorporates Medicaid changes into broader system for full LTC population.
- Model allows combined SPE functions of intake, assessment & CM as long as entity is prohibited from provision of direct hands-on service delivery; requires 1915b waiver to limit number of SPEs established
- Builds on current waiver system with modifications to incorporate SPE; stronger consumer-directed care; physician linkages to integrate primary and acute care.

Integration Level/Characteristics:

- Directly integrates Medicaid HCBS with non-MA LTC systems [*Older Americans Act, key state plan services (home help), and key local resources*].
- Option of either authorizing or financially reimbursing institutional care through the SPE.
- Creates linkage through consumer's existing physician for coordination of primary & acute care
- Fosters competition at the provider [direct care] level; open enrollment for provider network

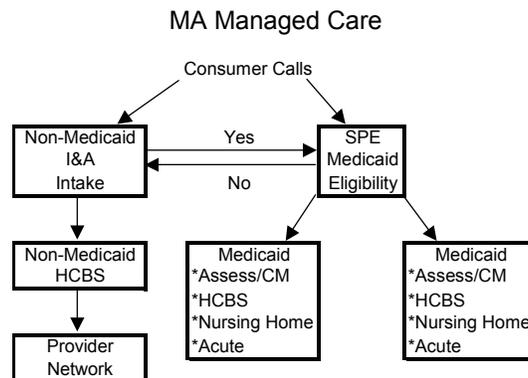
Basic system changes required for implementation:

- 1) Requires all SPEs to develop a voucher alternative to the care management purchasing structure that allows consumers capable of arranging their own service(s) to do so while still offering full care management to individuals who need it
- 2) Expands the direct purchase of service system to include assisted living and other LTC services (*Authorization rather than direct purchase of nursing home care is an option*)
- 3) Expands care management to include pre-admission discharge planning for individuals with scheduled hospitalizations
- 4) Requires communication linkages between CM and family/individual physicians to facilitate home-based follow-up of hospitalization and management of chronic illness

Conflict of Interest – Issues/Clarification

- CMS allows combined SPE functions of intake/assessment/CM as long as the SPE does not provide care plan services through MA
- Continued separation of intake/assessment/CM costs from service delivery costs within the SPE safeguards service dollars [unused service dollars returned to state] from profit taking
- SPE incentive to steer persons into home care controlled by family, state enforced monitoring and appeals process; eliminated if SPE also provides CM for institutional clientele as well as HCBS

II. Fully Integrated Managed Care Model - HCBS/Primary/Acute Care –



Basic Approach:

- Focuses on Medicaid only [HCBS, nursing home, acute care] similar to a block grant
- Requires separation of SPE intake/eligibility from assessment/CM/service functions
- Requires multiple (competing) MCOs at the local level; MCOs may provide ongoing service directly

Integration Level/Characteristics:

- Directly integrates Medicaid funding for providers of HCBS, nursing home, acute care; separating this system from non-Medicaid systems
- MCO is pre-paid service dollars; capitated rate; provides services directly
- Requires physicians to sign up with new system

Basic system changes required for implementation:

- 1) State must apply for a 1915 b or 1115 waiver for a Medicaid only entity
- 2) State must apply for a 222 waiver to incorporate Medicare into the structure
- 3) Requires separation of SPE functions of intake/eligibility from assessment/CM; creates separate funding structure for same
- 4) Fosters competition at the MCO level; requires competing MCOs

Conflict of Interest – Issues & Concerns

- CMS requires to separation of SPE functions of intake/eligibility from assessment/CM/service
- Opens service dollars to profit-taking and creates incentive for same
- MCO incentive towards profit taking controlled by state enforced monitoring and appeals process
- Role of service providers may be supplanted by MCO direct service

III. - HCBS & Nursing Home Managed Care Model

Two methodologies

1. Utilize structure of Care Coordination Model –

- Blend all nursing home and HCBS services into a blended capitated payment [using multiple acuity levels]; separating costs of intake/assessment/CM from service as currently exists
- SPE assumes risk for management of system.
- SPE maintains prohibition against direct service delivery; separation of SPE and direct service functions is maintained
- Profit taking not allowed for service delivery dollars

2. Utilize structure of MCO model –

- Separate cost structure for intake/assessment/CM and contract with SPE
- Blend all nursing home and HCBS services into a blended capitated payment [using multiple acuity levels] & contract with multiple MCOs
- Managed Care Organization (MCO) assumes risk for management of system
- MCO maintains right to provide direct service delivery & profit taking from same

LTC Task Force Workgroup C

Recommended Core Elements of an Integrated System of Care

- A visible, accessible, single point of entry
- Service neutral screening, assessment, education and informed choice
- Money follows the person
- A consumer-chosen supports coordinator/facilitator that follows consumers throughout a full range of service delivery systems, settings and options.
- Self directed care as consumer desires, with assistance from others (families, friends, professionals) of their choosing.
- Reimbursement based on individual acuity rather than one flat rate for all
- Prevention and wellness as expected and reimbursed services
- Incentives for delivering what the consumer desires, disincentives for underserving
- Use of technology to enhance efficiency and effectiveness of service delivery (communication, coordination, data sharing, tele-medicine)
- An independent external ombudsman to advocate on behalf of consumers
- A consumer bill of rights
- A quality management system embedded at the consumer, provider and system levels

Proposed LTC Continuum

Workgroup C recommends the following services and supports be available for consumers who meet financial and medical eligibility thresholds for the Medicaid long term care benefit. These may be delivered under a variety of service delivery and financing structures. Single supports facilitator assigned responsibility to coordinate linkage and delivery of services.

| | |
|---|--|
| Adult Day Care | |
| Ambulance | |
| Assessment | |
| Assisted Living | includes licensed AFCs/HFAs, services and room/board |
| Assistive Technology | includes any device that improves a person's functioning |
| Behavioral Health | |
| Case Coordination / Supports Facilitation | single coordinator across all settings |
| Caregiver Education | |
| Caregiver Support | |
| Chiropractic Services | |
| Chore Services | |
| Chronic Care Management | focus on consumers and all their needs rather than on medical diagnosis |
| Counseling | includes individual and family |
| Dental Services | |
| Diagnostic Services | |
| Emergency Services | |
| Employment Services | |
| Expanded State Plan Benefits | |
| Family Planning Services | |
| Financial Management | |
| Fiscal Intermediary | |
| Gap Filling Services | |
| Hearing & Speech Services | includes hearing aids |
| Home Modification / Repair | includes ramps |

| | |
|---|--|
| Homemaker | |
| Hospice | includes residential care (room and board) |
| Hospital Care | includes in-patient, out-patient |
| Immunizations | |
| Laboratory Services | |
| Medical Equipment/Supplies | |
| Medication Management | |
| Nursing Services | |
| Nursing Facility Services | includes innovative service delivery models |
| Nutrition Services | includes meal prep, home delivered meals, dietary services |
| Personal Assistance Services | includes personal care, supervision, attendant care |
| Personal Emergency Response | |
| Pharmacy | |
| Physician Services | includes visiting physician |
| Podiatric Services | |
| Prevention | includes primary and secondary, and wellness activities |
| Psychiatric Services | |
| Refugee Services | includes interpretive and cultural services |
| Rehabilitation Services | |
| Respite | in-home and out-of-home |
| Shopping/Errands | |
| Supervision | |
| Supports Facilitation / Case Coordination | single coordinator across all settings |
| Therapies | includes occupational, physical, speech, and maintenance therapies |
| Training | for consumers and caregivers |
| Transition Services | |
| Transportation | for medical and socialization purposes |
| Urgent Care Services | |
| Ventilator Services | |
| Vision Services | includes eyeglasses |

Addenda
to the
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of
Workgroup C - Continuum of Care

1. Assisted Living Subcommittee Report
2. Quality Subcommittee report
3. Workgroup Membership

November 8, 2004

Medicaid Long-Term Care Task Force Workgroup C – Assisted Living Subcommittee Report

September 29, 2004

Workgroup C Overall Value:

Creates an efficient, dynamic, and high quality continuum of long-term care and supports including in-home services, assisted living of various kinds, care and supports coordination, respite, congregative living, hospice, primary healthcare, chronic care management, and acute care hospital services.

Assisted Living Subcommittee Task:

Research regulatory issues and restrictions related to licensed and unlicensed assisted living.

Subcommittee members:

Andy Farmer, Mary Gear, Mike Head, David Herbel, Ed Kemp, Kay Miller, Marion Owen,
Bob Stein and Deborah Wood

To advance Workgroup C's Overall Value, particularly "an efficient, dynamic, and high quality continuum of long-term care...including...assisted living of various kinds"; the Assisted Living Subcommittee submits the following report.

Various issues have been discussed including the MI Choice Waiver Program (MCWP) and its applicable settings, definitions of "assisted living" and "continuous nursing care", present regulatory oversight concerning quality of care/services, whether we need more standards in place, etc.

If, under MCWP, Long-term Care services are to encourage "Person-centered Planning" and "Money Follows the Person", recipients should be able to select Adult Foster Care and Home for the Aged facilities. At present, they cannot. The MI Choice program is not an option under AFC or HFA).

In the past, there have been concerns that such a service option might well lead to people choosing the MI Choice waiver and leaving a home in the community for a segregated group living setting. However, *not* providing such a specialized service option for those who could reside in an AFC or HFA, so that they have no alternative to receiving care in a nursing facility, seems to negate the use of a viable alternative to nursing facilities.

Barriers to licensed assisted living facilities accepting the MI Choice Waiver Program (MCWP)

The Michigan government web site (http://www.michigan.gov/mdch/0,1607,7-132-2943_4857_5045-16263--,00.html#list) states: “Through this program (MCWP), eligible adults who meet income and asset criteria can receive Medicaid-covered services like those provided by nursing homes, but can stay in their own home or *another residential setting*.” (Emphasis added.)

The MCWP is intended to provide LTC services and supports for persons who are eligible for and in need of services furnished in a nursing facility, and who, without those services would need to receive care in a nursing facility. Presently, AFC and HFA licensed assisted living facilities may not receive payment for the provision of specialized LTC services and supports for persons eligible for the MCWP. If a resident of a licensed AFC or HFA facility needs specialized LTC services and supports, they cannot remain in that facility and have those services financed by the MCWP. If they need to access LTC services and supports because they are eligible for and otherwise in need of care in a nursing facility, they must move to their own home, a non-licensed setting, or to a nursing facility.

Recommended changes include:

- Submit an MCWP amendment to the Centers for Medicare & Medicaid Services (CMS) that would allow for the provision of specialized LTC services & supports in licensed assisted living (i.e. AFC and HFA) facilities. Such an amendment would describe what services and supports would be covered (e.g. bathing, medication management, extended supervision, protection, personal care, etc.) in addition to room and board.
- Review and revise AFC and HFA regulations to include a legal definition of “assisted living” and “continuous nursing care”, and to permit AFCs and HFAs to provide not only room and board (would need to be defined) but also personal and healthcare services. Also, are "assisted living" and "continuous nursing care" kinds of facilities or a set of services?

Assisted living is a marketing phrase and there is confusion as to what constitutes assisted living and how it differs from “continuous nursing care”. Though many nursing home residents may need periodic assistance from healthcare staff, they may not need “continuous nursing services”. Such residents may be better served by choosing a setting that has healthcare services available or by hiring a home health agency to provide services. There is no apparent reason why a facility could not provide room and board and offer personal and healthcare services while leaving the client free to choose another provider of those services. (Some committee members felt that neither phrase is legally definable).

- Evaluate the MCWP budget to determine if the funds available are sufficient to meaningfully provide for a covered service that offers specialized LTC services/supports in a licensed AFC of HFA, were the MCWP to be so amended.

Recommended changes - AFC and HFA Rules

- Differentiate HFA rules from other health facilities such as nursing homes. Presently, the statutes are mixed in with other health facilities such as nursing homes. Specifically, it should be separated out from PA 368, and into a statute of its own. This would also assist with its regulation and improve public understanding of that regulation.
- Define “Assisted Living” and “Continuous Nursing Care” so that government employees and the public more clearly understand the differences between the two, where each fits in the “continuum of long-term care”, and what needs to be licensed. (Some committee members thought that neither phrase is legally definable and if even if they were defined more barriers may be created.)

Though quality and licensing-vs.-non-licensing were discussed, there was no clear consensus on what was needed. One group felt that if “Money Follows the Person” and “Person-Centered Planning” services are implemented, individuals would “vote with their feet”, creating a free-market solution. Others felt we needed to consider licensing home health agencies or all facilities advertising themselves as assisted living, or at least register non-licensed assisted living facilities as explained on page 2 from the Michigan Department of Consumer and Industry Services 2001 “Response to the Assisted Living Task Force Report”.

**Workgroup C, Governor's Medicaid Long Term Care Task Force
Long Term Care Quality Subcommittee
Report 9/27/2004
Chair, Sarah Slocum**

**Good Quality is defined and measured by the person receiving supports, and not through surrogates like: payers, regulators, families or professionals/advocates.
Quality is:**

- **Relationships**
- **Continuity of Community involvement in the person's life**
- **Well-being**
- **Performance/Customer satisfaction measures**
- **Dignity of Risk Taking**
- **Freedom to Choose or Refuse**

And includes both high quality technical performance (such as competent clinical care) and consumer satisfaction measures.

1. Relationships – or Partnerships/Collaboration

Between the person receiving care and others includes:

- **Mutual Trust**
- **Mutual Respect**
- **Mutual Knowledge**
- **Continuity of caregiver**
- **Accountability – both parties demonstrate a commitment to the relationship, encourage each others' growth and wellbeing, and maintain appropriate boundaries**
- **Accountability for the caregiver – training, competence**
- **Accountability for the person receiving care – making sure the caregiver is paid, that benefits are up to date.**

2. Continuity of Community: (Susan Martin, lead)

**The resident, or person needing supports, continues their community connections through –
Individual definition/design of desired community**

Pre-LTC need, the system needs to encourage people to plan finances, living situations, etc. to try to avoid life disruption when care is needed

Campus approach to LTC, co-location of different types of providers/levels of services

Care coordinator/friend follows the person through any needed setting or service

Urban planning needs to include:

- **Community design elements (walkable communities, bikable communities)**
- **Transportation availability and accessibility**
- **Housing affordability, proximity to services and social functions, and accessibility**
- **Economic health of the community, jobs, infrastructure**

Weave community through all levels and settings of LTC

Rural issue – consider that distances between communities or services drives the need to move to new settings, away from familiar community.

3. Well-being: (Howard Schaefer, lead)

Physical: comfortable, safe, care needs met

Mental: strengths and independence maintained; support available when needed

Psychosocial: meaningful relationships, engaged in preferred pursuits; feeling valued;

able to care for others; feeling secure and able to cope.

Spiritual: at peace with self; access to chosen form of worship or practice

4. Performance/Satisfaction Measurement: (Reg Carter, lead)

Customer trumps everybody

- **Enforcement must support intent of OBRA (federal requirements), not used to limit personal control or choice by residents**

Are people (residents and families) satisfied?

Would you recommend this home/setting/service to others?

What were your original expectations of this home/setting/service and were they met/not met/ exceeded?

The loss of freedom and individual choice has a big impact on quality

For Performance measurement, need to measure Outcomes such as:

- **Satisfaction level**
- **Maintaining function and community**
- **Is this a life the person wants to live?**

5. Dignity of Risk Taking

Avoiding all risk prevents people from learning and from leading a life that is full and rich.

A network of supports and services makes risk possible by weaving a safety net that supports growth

Manage risk, not just avoid it. Provider and person manage risk together through a person-centered plan.

Need to assess the true cost of failure.

Provider has to take the risk of supporting the individual's risk/decision

Need clarity on who is choosing what risk, and taking responsibility.

6. Freedom to Choose or Refuse

Involves consequences and responsibilities

Consider implications for others

Is one of the core values in quality

Choice is not an event; it continues throughout the person's experience of long term care

Choice depends upon availability of options

Providers should provide as many options as possible to maximize real choice

Providers/caregivers/families have an obligation to search for ways to understand choices and preferences of all customers (e.g. those with dementia or other cognitive impairment).

Recommended Action Steps:

- 1. Cabinet level review of ALL parts of state government about how each entity touches the long term care system. Align regulations, reimbursement and incentives to promote this vision of quality and move toward that alignment.**
- 2. Have stakeholders from within Michigan and experts from outside Michigan review the Cabinet level review and give input on areas to address for alignment.**
- 3. Develop and use consumer satisfaction surveys and measurements.**

4. **Review and analyze current performance measures (regulatory and non-regulatory)**
5. **Design performance measures that move us toward this vision of quality.**

Subcommittee members in attendance during deliberations:

Reg Carter, HCAM
Andy Farmer, AARP
Ellen Speckman-Randall, MCSSA
Susan Martin, Rep. Rick Shaffer's office
Alison Hirschel, MPLP
Faiz Esshaki, DAAA
Sarah Slocum, SLTCO
Tony Wong, MACIL
Howard Schaefer, MSA
Jean Barnas, Alzheimer's Association
Hollis Turnham, Paraprofessional Healthcare Institute

| Workgroup C Membership | | Sharon Gire, Chair |
|-------------------------------|------------------|--|
| Mary | Alban | AAAAM |
| Pat | Anderson | HCAM |
| Gerald | Betters | Pinecrest Medical Care Facility |
| Peggy | Brey | Office of Services to the Aging |
| Reg | Carter | HCAM |
| Chris | Chesny | Mid-Michigan Visiting Nurses |
| Jane | Church | Office of Services to the Aging |
| Erin | Clark | Michigan Home Health Association |
| Mark | Cody | MPAS |
| Bob | Curtiss | Lutheran Social Services of Michigan |
| Nancy | Cusick, RN | A&D Home Health Care Inc. |
| Tom | Czerwinski | AAA Western Michigan |
| Kathy | Dodge | Macomb County Senior Citizen Services |
| Sara | Duris | Alzheimer's Association |
| Patrice | Eller | FIA |
| Andy | Farmer | AARP |
| John | Freeman | SEIU |
| Mary | Gear | MSA |
| Sharon | Gire | Director, Office of Services to the Aging |
| Vera | Graham | DDC - Saginaw |
| John | Grib | Senior Services Kalamazoo |
| Larry | Grinwis | The Ashland Group |
| Mike | Head | MDCH |
| Dave | Herbel | MAHSA |
| Gloria | Hicks-Long | DAAA |
| Alison | Hirschel | Michigan Poverty Law Program |
| Sara | Holmes | Alzheimer's Research Project |
| Lynn | Kellogg | Region IV AAA |
| Kathleen | Kirschenheiter | AAA 1-B |
| Susan | Martin | Office of State Representative Rick Shaffer |
| Yolanda | McKinney | Caring Hearts Home Care |
| Jenny | Mendez | Wayne State University, Institute of Gerontology |
| Maureen | Mickus | MSU |
| Kay | Miller | Presbyterian Villages of Michigan in Redford |
| Dan | Moran | DD Council |
| Diane | Ohanesian | Consumer |
| Marion | Owen | Tri-County Office on Aging |
| Sandra | Reminga | AAA 1-B |
| Bobbi | Simons, BSN/RN | Visiting Physician Association |
| Sarah | Slocum | State Long Term Care Ombudsman |
| Ellen | Speckman-Randall | MCMCF |
| Robert | Stein | Michigan Assisted Living Association |
| Hollis | Turnham | Paraprofessional Healthcare Institute |
| Tony | Wong | MACIL |