

Minutes

MI CHOICE RENEWAL STAKEHOLDER MEETING

11/18/2011, 9-12 p.m. Capitol View

Application Process: (presented by Brian Barrie)

Policy's role is to interpret/liaison what needs to be done in the home and what Centers for Medicare and Medicaid Services (CMS) says what we should be doing. This may be the most difficult renewal process so far. As issues are discovered will need to figure how to tie those within our boundaries set by CMS. The Department of Community Health (DCH) wants input starting from the beginning of the renewal process and throughout. Workgroup to put together ideas for an internal review process by DCH management after approval sent out for public comment. Review comments and send to CMS, their 90 day review process starts. CMS then sends questions to the state to clarify, and the clock stops until DCH sends answers back to CMS.

CMS is looking closely at all federal waivers from all the waivers across the country. May have to go to different waiver structure to implement MI Choice program.

So far the waiver renewals have just tweaked initial waiver. During this process everything is going to be reevaluated to figure out what works, what doesn't and how can we make new ideas fit within the rules presented by CMS. Requested 1 year extension to add in integrated care program. If extension is approved we would continue with planned stakeholder meetings, and take hiatus until integrated care framework comes together. We would reconvene next fall and add in changes to accommodate for integrated care.

Assurances: (presented by Brian Barrie)

Each assurance has performance measures in the CMS application. Level Of Care Determination (LOCD) has to be done before MI Choice services can be administered. DCH can't deem anyone eligible until LOCD done, per CMS assurance.

(Appendices in application)

Over last few years, cost effectiveness has shrunk. Need to keep program costs below institutional care costs.

Appendix B: Slot- Unduplicated count for person enrolled in FY. Historically, MI Choice based on funding not actual slots. CMS is more concerned with slots and cost effectiveness, not how we allocate money to the Organized Health Care Delivery Systems (OHCDS).

FFP-Federal Financial Participation

IMD – Institute for Mental Disease

ICFMR – Institutional Care Facility for Mentally Retarded

Appendix G: Will have to discuss restraints because we state that we do not allow them. We will also have to discuss medication management. We checked box in the application that we do not do this. We have gone through policy and realize we have a huge gap here.

Appendix H: Quality improvement. A lot has changed with CMS and their requirements. Michigan does a lot already, but how this is defined in the waiver is our challenge.

Services and Provider Qualifications: (presented by Elizabeth Gallagher)

5 different categories of services that can be provided.

Statutory Services – Federal Government outlined definition and less flexibility with these services. With state specific services, CMS allows most flexibility. State specific services completely defined by the state to meet the states need. Do we have the right fit of services in the waiver? Should some be taken out or added in? Increase number of adults in program by implemented prevocational services.

Skilled Nursing is part-time or intermittent care.

Private Duty Nursing is continuous care.

Nursing part is going to be looked into thoroughly during renewal process.

Background checks should be looked into further, consider whether extra steps should be looked into. Do you stop when you find something that would prevent from hiring a worker or do you look into it more? Should electronic signatures be used?

Legally responsible person – Spouse or legal guardian

Quality Management: (presented by Heather Slawinski)

Must come up with performance measures to meet CMS assurances.

Quality Management Plan (QMP) – state does every 2 years and reports it to CMS.

Provides guidance to waiver agencies on what DCH focuses on and what waiver agencies can focus on.

Quality Indicators (QIs) – measurement that gives idea of what participant looks like and if something needs to be addressed.

Critical incidents will be reported on-line in near future.

Open Discussion:

- MI Choice recipients who want to volunteer to attend meetings, state has money to help with assisting their needs to attend.

- Brainstorm about MI Choice as is now, or as in integrated care?
- Look at waiver as it is now and will record categories related to Integrated Care
- LOCD being done before services are approved, when going between county lines and can't be reassessed until they are in their new location. (Inter Agency roles)
- Imminent Risk doesn't cover those with memory issues.
 - Need for a spend-down in MI Choice to allow for those with a little higher incomes.
- Income limits were set application option
- Nursing Home diversion policy, financial eligibility
- Medical Transportation transferred from Department of Human Services (DHS) to waiver program.
- Survey shows that a lot of workers are providing transportation without getting paid. Not just with Medical transportation but for all reasons
- Expand Capacity for Affordable Assisted Living
- Medicaid Eligibility issues, those with Medicaid Spend-down, and issues of not being in a nursing home while applying for Medicaid.
- Presumed eligibility – DHS policy versus contract policy
- Nursing Facility Level Of Care issues with people transitioning, people permanently in a temporary door.
- Pre-screening process on who is put on the waiting list
- Linking to other services, swapping from Medicare Skilled Services to MI Choice Services
- Individual's right to access MI Choice through diversion, and have imminent risk assessment done when the person requests. Same as with nursing facility transitions.
- Diversion issue – limitations on funding to people who are considered at risk for entering into nursing home. Department problem on how we fund Agencies with the diversion.
- Daily money management
- Including mental health as one of the statutory services.
- Assistive Technology Services expanded on
- Evidence based prevention programs
- Lack of statewide program in regards to statewide access.
- Training for Direct Care workers.
- Background checks – worker have the ability to say that's not me now.
- Medication administering by direct care staff overseen by Registered Nurse (RN), added to waiver as service.
- Licensed Practical Nurse do supervisory sites visits as opposed to RN.
- Supervisory visits for homemaking – please review.
- Monitored through Area Agencies on Aging, paying nurse to reassess – redundant and ridiculous
- Actual amount of money paid transition vs. diversion per day
- Waiting list – What determines when a person gets moved up.
- Any services that are under utilized? Can't it be redistributed to other services?
- Money locked in to waiver agency not locked in by service, needs to be looked at.

- Provider reviews – Medicare services at federal level look at reimbursement for people who don't improve, agencies are pushing those people off of Medicare sooner. Medicaid picking up some of Medicare services.
- Diversions not treated as transition. Those who don't have enough slots have to go to nursing home before being served.
- Enhanced dual eligible project – Medication management, limiting number of providers in home care while assuring choice. Quality and accountability would improve.
- Looking at funding, how slots are being deployed, highest number of need. Thinking about waiver providers who provide other services such as Community Mental Health services at once rather than having to have someone else come in. Limit the number of providers, allow for more eligibility of providing services from different programs utilizing same provider if possible. (Integrated Care)
- Nursing Facility Transitions (NFTs) have to be in nursing home for at least 90 days.
- Need exception request before providing assistance.
- Support brokerage under Self-Determination
- Marketing for nursing home residents about NFT program, barriers to what can and can't be said need to be removed.
- Waiver agencies are required to do Outreach, not "Marketing"
- Way to change amount of money they can have when they apply for diversions.
- There is not a cap on money for diversion. More of a DHS eligibility issue than a waiver issue.
- Meeting on Operating MI Choice in Assisted Living
- Expand Person-Centered Planning, and all person directed services change from Medical Model to Person-Centered Model.
- Use of Supports Coordination as a waiver service, currently as administration service
- Freedom of Choice