

Michigan Medicaid Long Term Care Task Force

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MINUTES

Monday, November 8, 2004

State Capitol, Room 426

Lansing, Michigan

Members Present: S. Gire, R. Alcodray-Khalifa, J. Sutton, R. Carter, T. Czerwinski, D. Hoyle, S. Steinke, R. Chaney, G. Betters, M. Moers, T. Wong, J. Mendez, Y. McKinney, M. Hardy, M. Cody, Representative Shaffer, and Representative Gillard.

Members Absent: None

Other: Terri Ames for Senator Hammerstrom, Patrice Eller for M. Udow, J. Christensen for Janet Olszewski, and Amy Slonim, Michigan Public Health Institute, facilitator.

Call to Order: The sixth meeting of the Medicaid Long Term Care Task Force was called to order at approximately 10:00 a.m., by Chairman RoAnne Chaney. R. Chaney had two announcements: 1) The December 13th meeting will be held in the State Capitol, Room 426 and 2) the Task Force has added a second meeting in January, 2005. The second meeting will be held January 21, 2005, from 9:30am until 3:30pm. Information regarding meeting specifics will be sent out at a later date.

Review and Approval of Agenda: A motion to approve the agenda as presented was made by Representative Shaffer and seconded by T. Czerwinski. A voice vote was taken to approve the agenda. Motion passed.

Review and Approval of October 11 Minutes: There were a couple of changes in the minutes of October 11th. T. Wong brought to the Task Force's attention that at the October 11 meeting a question was raised regarding whether the SPE would incorporate CMH services. This question should be reflected in the minutes. Another question T. Wong raised in regard to that issue was that while private pay people would not be required to use the services of the SPE, if they decided to do so, why they should not be required to go through the assessment. Terri Ames, for Senator Hammerstrom, mentioned to the Task Force that Senator Hammerstrom had concerns about the minutes because there were a few instances where motions were made and seconded but the minutes didn't reflect if the motion had carried. There were some instances that the minutes reflected that some were carried and some were not. J. Hazewinkel indicated that a decision had been made by general consensus, therefore a vote was not reflected. This will be corrected. A motion to approve minutes with the recommended corrections was made by G. Betters and seconded by T. Czerwinski. The motion to approve corrected minutes carried.

Discussion and Vote on Workgroup F Report: Mark Cody asked for clarification of the legislative recommendations of the group. Workgroup G will work to recommend specific activity that can be used to implement recommendations that come out of Workgroup F. Specifically, he referred to page 4 of the recommendations of the report and asked for elaboration. RoAnne indicated that the workgroup felt that family caregivers needed support. The group did not go into specifics, but wanted to generally point out the need to support family caregivers. Mark wanted to know if this would be the model of child-care and child tax credit at the federal level. RoAnne agreed that this could be the case. Jenny had a question regarding the barriers noted on page 3. The ethnic groups that people come from should be noted. Marsha noted that the group discussed cultural sensitivity and awareness throughout the whole project. Jenny would still like the groups to be reflected in the report.

R. Carter asked if the group defined “unnecessary hospitalization and institutionalization.” R. Chaney indicated unnecessary hospitalization addresses preventable conditions. Preventing institutionalization is maintaining health so that people do not have to go to nursing homes. Unnecessary hospitalization also means providing home and community-based services so that the person does not have to go into a nursing home. R. Carter stated that if the state moves forward with this strategy it should analyze the outcomes of such interventions. R. Chaney indicated that it was clearer in hospitals. A large number of hospitalizations are preventable (close to 40%).

J. Christensen indicated that the Task Force might not want to talk about tax deductions, but instead think of tax incentives and other incentives. These changes would provide the legislative committee more flexibility. This change is on page 4, third column of the report. Tom asked for more clarification on goal one, page one. The goal is to develop or provide incentives for local collaboratives promoting healthy aging. T. Czerwinski asked what types of incentives the workgroup was looking for and if they were financial incentives. R. Chaney indicated that this was one that was more public health oriented goal and they were deliberately being very broad. T. Czerwinski also asked about local entities under operational steps. His question was what a local entity was. R. Chaney indicated that it was viewed as a collaborative effort and one entity would lead it. Under success measures, T. Czerwinski asked if there would be a contract between Community Health and the entity. R. Chaney agreed this could be the case. The purpose of the entity would be to help address issues related to aging for every person. Senator Cherry asked for clarification on local entities. She wanted to know if there would be just one entity or more than one. R. Chaney indicated that there could be many entities. They are trying to get a broad base on the local community to focus on healthy aging and people with chronic illness. R. Chaney commented that she appreciated reading Karen Schrock’s public comments in support of healthy aging for all people of all ages.

D. Hoyle is worried that the concept of Person Centered Planning (PCP) is not strong enough in the document. It needs to be mentioned earlier and more frequently. R. Chaney indicated that PCP is in the general principle language. D. Hoyle is worried that universities will continue to graduate people with no idea what PCP is, and that he believes PCP should be reflected throughout the language of the report.

J. Mendez asked about the time frame. She wanted to know who selects the pilot sites and asked for more information. R. Chaney referred her to page 1 and commented that the DCA workgroup would be in charge of this strategy. The group is looking to a statewide continuing group to work on this issue and determine the pilot sites. J. Mendez responded that the strategies and operational stats assessments don't make sense with what is on page 1. S. Steinke indicated that the group had several conversations on this issue and she clarified that the Department of Community Health is still the lead agency. Specifically the Public Health Administration within the Department of Community Health would be the appropriate lead because their expertise is more in pulling together the kinds of groups that design culturally competent and chronic care models. Public health already has a number of very good models in this area. J. Mendez indicated there are different issues involved, and the time frame and accomplishments are not clear. R. Chaney replied that the group had looked at some very specific models. There are not a lot of chronic care models out there, but the ones that get the most attention are by Wagner and ACO. They have some specific models around it. J. Mendez indicated that the success measures and the strategies don't "jive" together.

G. Betters asked if we could endorse a principle to look at the variety of chronic diseases and move forward instead of looking for too much specificity. R. Chaney indicated that she doesn't want to single out specific conditions as much as she wants to make sure that no one gets excluded. Once you specify conditions, you are automatically excluding other conditions not listed. The chronic care model looks at all of that. If you have one chronic condition, the tendency is to look only at the one condition and will ignore other conditions. This is a new way of looking at care. That is why we shifted to chronic care and not chronic disease. J. Mendez referred to page 7, and indicated that there was no strategy or measure that tells you that you are successful in medication usage. R. Chaney asked J. Mendez to make specific recommendations to make this report better. J. Mendez indicated that the ideas were related to training needs. They don't come back to the person with chronic care or illnesses. The measures are correct, but need to be explained to include issues that have been addressed in strategies.

R. Chaney referred to a vote and asked the Task Force not to get into major levels of detail. She wanted to know if the strategies and principles are in the right direction and whether the Task Force could live with them. The Task Force can "fine tune" the operational steps and outcome measures. J. Mendez indicated that she could live with the strategies as long as the Task Force is not saying that the outcome measures listed are not the only outcome measures. R. Chaney indicated that she agreed and they can go back and take care of any changes in operational steps and measures.

D. Hoyle indicated that he would like to see a goal on PCP and wanted to make sure that the workgroup would "fine tune" this area as well. R. Chaney indicated that it is a general theme and thought that there would be more of than in the outcome measures. D. Hoyle also added that professionals should be trained in this concept at the university level.

R. Carter referred to page 6; the first barrier is that most guidelines are not evidence-based. R. Chaney indicated that the two models get more into evidence-based guidelines. Historically the medical community has not done a lot of research in chronic care; therefore, there are not a lot of evidence-based guidelines out there. R. Carter on the acute side there is tons of guidelines that are often evidence-based. He didn't see a recommendation for changing that, but would think that one of the obvious things would be the development of evidence-based guidelines. R. Chaney referred to the two models that the workgroup is looking at are going in that directions, but needs to be strengthen that and link it to evidence-based. R. Carter indicated that eventually you need evidence-based guidelines for public presentations. R. Carter also asked that most preventative programs have a certain assumption about getting people to act differently. He wanted to know how [state government] will get people to act differently so they don't need care for chronic conditions. R. Chaney indicated that a big part of the Wagner model is self-management. R. Chaney believes that that is the only way to get people to act differently is if they are invested in their own health and don't subordinate themselves to the medical or academic community. Once you do that you start resisting. They are putting together evidence about self-management and doing studies on people who were labeled as non-compliant.

J. Christensen indicated that there is a considerable body of evidence in health promotion primary secondary prevention area that talks about how you can get people do to things differently. A lot of the information deals with social marketing, well rounded education program for the individual that actually raises the choices for the individual and powers them to act on their choices. Also there are issues related to policies in the environment where the individual lives. So if there are incentives, discounts, encouragement, or community support to do the right thing more people will reach out. What this recommendation suggests is that the group that reconvenes and designs pilots need to look at this body of literature, which he assumes that you asked public health to take the lead on this because of the experts can understand the behavioral changes in society. J. Mendez indicated that the flip side would be the licensing agents. J. Christensen responded by saying that he would label the licensing and regulatory arena, both profession and facility, on the policy side on how you get people change. J. Mendez indicated that the information from J. Christensen should be reflected and referred to page 4 in where the discussion talks about matrix, that some of that is acknowledged by the Task Force that is the responsibility of both entities rather than putting it on the academic part.

Senator Cherry indicated that under the "success and measures" section of the report part of the big things that the model projects will help you define what the actions are and they have substantive evaluation to them.

D. Hoyle indicated that the area of self-management would be a good spot to include person centered planning language. Since there has been success he would like to see PCP as high priority rather than a goal.

Senator Cherry suggested that the report as written is hard to follow and requested that the final report to have a new format that would be easier to read.

R. Carter indicated that one meeting does not seem like enough. If questions come up in the course of the discussion of the recommendations, there will not be sufficient time to seek additional information and clarification. R. Chaney agreed that the Task Force would need a second meeting in April.

R. Chaney clarified that at this time the Task Force needs to decide whether or not to endorse the general principles and main strategies reflected in the workgroup reports. They do not have to adopt operational details at this point.

Motion

D. Hoyle moved to accept the workgroups revised principle, goal statements, and general strategies. R. Alcodray-Khalifa seconded the motion.

Discussion

R. Carter requested clarification that by accepting the principles, the Task Force is accepting the workgroup report in order to continue moving the discussions forward. The details of the report are not to be considered an absolute, and the Task Force has the opportunity to make changes. Everything will be back on the table for final review and consideration in April when the Task Force makes its final recommendations. Amy Slonum clarified that the decision being made at this meeting is for the support of the general principles and recommendations. These preliminary recommendations will comprise the body of the total recommendations to be acted upon by the Task Force. The Task Force is approving the direction in which additional discussions and activities of the workgroups should take to develop other recommendations. These initial workgroup reports should be used as building blocks for subsequent workgroup discussions. Senator Cherry indicated that there would very likely be modifications made to preliminary recommendations as all seven workgroup reports come together to be given final consideration by the Task Force. J. Christensen talked about as a practical matter, this Task Force could have a meeting in April, look at the whole body of information that has been preliminarily approved and forwarded on and make changes to it in order to make all parts compatible with the overall direction and goals determined by the Task Force. It would not be entirely in good faith to approve it today with any reservations expecting that everything would be fully off the table. Therefore, if the Task Force approves the concept of the importance of the chronic care model for long-term care, by voting on it today the implication is that something similar to this recommendation would be included in the final report even though there may be some changes made to it.

Adoption

The Task Force accepted workgroup F revised principles, goal statements, and general strategies by a show of hands. The chair asked for abstentions or opposing positions; none being given, the motion passed.

Discussion and Vote on Workgroup A Report: S. Steinke spoke about workgroup A (SPE and PCP). She allowed the Task Force 3-5 minutes to review the material and was waiting for questions. M. Moers asked if SPE included people with mental illness, cognitive impairments, people generally served by a separate system. S. Steinke indicated that workgroup A has one more meeting to do some operational work, which is separate from the principles. The principles will help the workgroup look at building out the operational side. This question has to be revisited at the next meeting because there are significant boundaries between those systems. There are currently people in long-term care system who, don't receive mental health services at all and could use some. The goal is to increase the amount of care and services that they receive to fully function in the long-term system. R. Chaney referred to the Governor's charge, which states that people currently in mental health system, it is beyond the Task Force's chart. However, the Task Force could make a recommendation to the State of Michigan that that would be an ultimate goal and that they take a look at making it a SPE for everyone that gets long-term care services. D. Hoyle indicated that it is so far beyond the Task Force and it is so complicated. There is a reason why no other state has gone to it besides Arizona experiencing with it. He indicated that he don't think that the Task Force will have time to address the issue. The Task Force would have to change requirements at a federal level. D. Hoyle hesitates to make a recommendation if it will be that complicated to do. R. Chaney responded to D. Hoyle by saying that she wanted to make a recommendation to look at it for the future because there are problems with the mental health systems. D. Hoyle mentioned that he don't see PCP in the adopted principles. When it comes to determining how much money a person needs, PCP is a fabulous tool in determining. When you look at the services that come from PCP that would be away to look at what it will cost.

J. Mendez went back to Deana Mitchell's minority report and referred to item #2, that the Task Force includes proactive choice counseling for individuals. The SPE should not be the one that benefits, but it should be the person getting the service that benefits. Task Force needs to address concern. S. Steinke referred to the page 2 of the second report. Workgroup will build up more in terms of the protections.

Motion and Adoption

S. Steinke addressed D. Hoyle's concern about PCP. The workgroup will take an amendment to the report stating, "A SPE agency utilizes PCP principles and practices throughout its functions." **A motion to amend report was made by J. Christensen and seconded by J. Mendez. A voice vote was made and approved the amendment.**

G. Betters asked what the definition of a Medicaid provider is. His facility provides home and community-based waiver services and contract through AAA. AAA pays his facility to provide services. AAA is contracted with Medicaid to do that. S. Steinke agreed with G. Betters. A recommendation in the report from Workgroup A is to the financing workgroup that they look at how to separate those functions.

Senator Cherry asked for clarification a couple of items. SPE can be many because if you have a huge backlog of people not being served because they can't deal with the

amount of clients that are there. The resources have to be available so that the SPE does not limit people from getting service. Senator Cherry wanted to make sure that PCP is very strongly a part of the report. The Task Force has to look at ability to make it a good efficient system but also deals with the planning for each person.

M. Moers wanted to make sure that the Task Force remembered that they adopted PCP as the basic principle in which all of these concepts were developed. Can add to every issue, but PCP is included in the work that that workgroup has done.

S. Steinke agreed with M. Moers with the exception of Workgroup A since the specific charge was PCP it was more missing than being added.

P. Eller indicated that there was a suggestion that having SPE as a long-term goal and that the Task Force don't lose sight of this and how it should be addressed. She would like it incorporated in some way that the Task Force has SPE as a long-term goal in terms of how the systems work together. S. Steinke suggested that the workgroup could work on it on December 3rd. J. Christensen indicated that many comments have been received by the people in the mental health field. Many expressed concerns on both sides: 1) Will mental health experts be rolled into the SPE, 2) Are you going to put SPE up and they won't have access to services and why can't they have access to those services. It is an important issue that needs to be discussed. The Task Force is supportive of SPE of long-term care individuals. Whether or not that includes sub-categories of mental health individuals is a question that the mental health system, state long-term care system, and the LTC Task Force will need to answer after thoughtful discussion. If the suggestion is to put into the report there needs to be a dialog about the applicability of SPE for certain individuals served by the mental health system. J. Christensen believes that this would be the work of another Task Force.

D. Hoyle indicated that not just consumer on that side, but practitioners and everyone else including CMS and other people with some funding categories for a specific population should be coordinated. Have people come together to make sure it is coordinated. That could be a recommendation as a Task Force.

R. Alcodray-Khalifa suggested that the Task Force should not label it is a goal. It entails that the Task Force is going to take responsibility. Rather, this should be stated as a recommendation. That patient population does not get forgotten and that they have needs as well as the disabled communities. That recommendation should be given to the Governor.

R. Carter indicated that it wasn't clear that the recommendation is that the SPE speaks to a full array of items or customers that arrive at the front door. He thought that it should be customer-friendly. There needs to be clarification about why the Task Force is doing this. Is it meant to be all encompassing or meant to be only one of many doors that you need to enter in order to be aware of some subset.

S. Steinke indicated that it has been suggested to use the phrase “single coordinated agency” or a clearer term than single-point of entry. If long-term care services are needed a person would initially go through the system.

R. Chaney wanted to clarify that if a person with a developmental disability or mental illness goes to the SPE, only information and referral would be required.

Senator Cherry asked for clarification regarding a person going through SPE who might have mental health or developmental disabled issues along with other issues that require long-term care and how care managers would be involved.

J. Mendez was concerned with a comment that M. Cody made about assessment. She believes that the person at SPE would be appropriately trained to do assessments of people with mental health needs. (???) M. Cody replied by saying that the SPE would assist in the process of directing the individual to appropriate services or supports.

M. Moers asked about children and how their needs would be addressed through the SPE process. S. Steinke indicated that the children would be under a different system. M. Moers wanted clarification of who the workgroup was suggesting would utilize SPEs as her understanding is that they have previously indicated services would be available for people of all ages.

D. Hoyle indicated that children would be under Family Centered Planning rather than PCP.

S. Gire indicated that she would assume that the SPE would serve as an information, assistance, and referral center also because out there in the community people won't always be clear about who they should contact and she don't think that SPE should take place of the entry for all other human services. The community at large should know where they could go to the information needed.

Senator Cherry thinks that the SPE should be responsible for more than to just telling people where to go for services. The SPE should take a proactive role by helping them contact those agencies or facilitating the process.

R. Chaney responded to Senator Cherry by saying that as part of INR, she would like to see eventually is that INR has to be certified. There are some national standards and criteria for information and referral now that are very proactive.

T. Czerwinski mentioned that earlier in the discussion, G. Better asked for a definition of a Medicaid provider. Although S. Steinke talked about payment related definitions, T. Czerwinski stated that he is still not clear what that means. He wants to have it clearly stated what the SPE does and doesn't do. SPE performs care management. Care management under the waiver program arranges for services, reimburses for the services, monitors, and assesses the provider of the delivery of those services. He wanted to know if the SPE would perform the services he listed. S. Steinke indicated that SPE would

perform all services except payment of the bill. SPE would not be ordering services. They would authorize services and would work with you to choose your services.

M. Hardy asked if the SPE takes into consideration the kinds of checks and balances that arose in the minority report, because if SPE is going to provide all these services in case management, how does the Task Force ensure that there isn't a conflict of interest. S. Steinke indicated that in certain sections of the recommended principles the workgroup raised the issue regarding conflicts of interest. They are looking at a strenuous test to be met in terms of internal and external reviews and appeals process oversight by the state and options for external advocacy. These options would focus on the persons needs. T. Czerwinski asked about how the payment of bills eliminates the conflict of interest. S. Steinke replied by stating that if you take the conflict of interest out of the system, people have more of an assurance that if they qualify to meet the Medicaid standard to get paid as a Medicaid provider they will get their money on time and won't be dependent on developing a more political relationship with a SPE agency. T. Czerwinski indicated that he could discuss this further with S. Steinke at a later time.

Y. McKinney wanted to know the difference between the SPE and the current waiver program. R. Chaney replied by saying that the SPE would be much larger continuum that they would be referring people to. Currently the waiver program has a contract with specific providers. Under PCP consumers will be able to pick their own providers.

T. Czerwinski indicated that care management should be revisited in March or April.

Y. McKinney asked if a person goes to a SPE and needed services; the assessment is done, would they get a list of providers from the SPE office. S. Steinke indicated that it would be operationalized by having a group of Medicaid certified people, the SPE would help the patient figure out what they are looking for in services, do they want the SPE to pick for you, but the person can always change the provider.

Representative Gillard indicated that he understands the SPE as it is proposed, but the SPE needs to be separated from the providers.

Senator Cherry asked about how care management purchases services now for clients and SPE will not, in that process what kind of leverage will the SPE have if they are not controlling the dollars.

R. Chaney asked the Task Force if the principles and recommendations are things that they can live with.

Motion

A motion was made by T. Czerwinski to support the principles presented by workgroup A, seconded by M. Cody. R. Carter asked if R. Chaney is asking the Task Force to vote on the adopted features that need to be operationalized. R. Chaney clarified she is asking the Task Force to adopt the first five general principles as amended. R.

Chaney indicated that a vote would not be taken at this time because there are too many unanswered questions. The discussion will be continued in the afternoon.

Workgroup C Final Report to Task Force and Discussion: S. Gire, Chair of Workgroup C, reported to the Task Force. Workgroup C's responsibility is continuum of care. There are 43 members of the workgroup and 2 subcommittees that will have reports on the addendum. They have had 5 meetings that were all afternoons. In addition to the meetings, they have had email discussions and a very broad representation of providers, advocates, along with spirited deliberation around various issues. The workgroup has not yet completed its charge. They plan on meeting after input and voting next month to do final work in this area. Workgroup C's report started by developing a matrix of "what is"; not because that is what should be, but so that the group understood where they could begin their work. The result is a graphic representation of what they believe is wrong with the system. They had to continually remind themselves not to build a system based on what is but to be visionary. To do that, they revised their vision statement which now reflects a different focus. They identified barriers, action steps, defined a continuum of services and setting, and models that are used in different states for long-term care and continuum.

Jane Church followed up S Gire's presentation with a detailed review of the documents developed by the workgroup. The group's approach was not to concern themselves with how services would be delivered or paid for, but to develop ideals. The group defined what should be included in the LTC benefit.

Sarah Slocum, state long-term care ombudsmen, chaired the quality section of the report and asked to add her comments. She noted that the group included a broad array of viewpoints. Some questions have come up from the first written versions of the draft. The group did come up with a new vision statement, as what we are doing now does not result in a high level of quality from the perspective of consumers. Performance measures and health and safety factors will continue to be looked at. She noted that the group did not ditch current regulation or enforcement efforts.

R. Chaney suggested that further discussion regarding reports from Workgroups A and C continue at 2:45 p.m. Task Force members concurred and the meeting adjourned at 12:35 p.m. for lunch.

Re-convened by R. Chaney at 1:10 p.m.

Public Comment:

Dave Tyler, is a quadriplegic. His mother passed away in 1997. Between an FIA worker and his father, he ended up in a nursing home. He came to the meeting to discuss his experience with going through a disability network. He was given some brochures on how to get out of a nursing home. He was told that he was not feasible to be into his community. He hired Mark Cody to help him get out of the nursing home. He ended up living in Saginaw after his lawsuit. He got out of the nursing home in June of 2002. He

went on the HCBS waiver November 1, 2002. It took him about 2 ½ years to get out of the nursing home and live on his own. FIA takes over half of his checks through spend down which is too high. He has three months of rent paid, plus monthly utilities. By the end of the month he doesn't have much left for other needs. He had to have his own help aides lined up before he could be released from the hospital. The housing section 8 waiting list is too long. \$857 check spend down is \$479 rent is \$230 after utilities he gets \$50 per month.

Nadine Mitchum, chairperson for Michigan Campaign for Quality Care. She expressed a concern that the task force is spending most of its time on HCBS than on the plight of the 40,000+ in nursing home and the thousands more in assisted living. She asks that these other issues be given adequate consideration as well. Nadine's mom lived with her for 9 years. She was having trouble with stairs and moved her to the assisted living for 2 ½ years then nursing home 2 ½ years. She witnessed firsthand all of the abuse that happens in assisted living and more so in nursing homes. Assisted livings are not inspected often. The state has documentation of thousands of problems in nursing homes, just the tip of the iceberg. Some facilities are good and many workers are good and effective. Members of her group have joined because of the problems in nursing homes.

There are two important issues in addressing nursing home care. The single most important element of improving nursing home care is staffing. Michigan only requires 2.25 hours per person per day of care. A study showed that a minimum of 4.1 hours is needed for decent care. The second most important piece is effective enforcement. Surveyors are understaffed and overworked. Enforcement is not effective in preventing yo-yo compliance of providers. We need a system that is responsive to recipient concerns as it is already to providers.

She notes that the state must link its relevant departments to improve the LTC system. Add ombudsman to the state and local closure teams. She asks that we not neglect the urgent needs of residents as you pursue the goal of quality long-term care.

John Weir, Local LTC Ombudsman, I fight more for residents to be sent to hospitals that need care than ones that don't. People in nursing homes do not have the option of selecting their provider. Providers choose who they care for. People have to use nursing homes miles from home when there are open beds in their own communities. I like the idea of residents determining quality. I see people who are not taken care of who love where they live. Please look at our current system and pay close notice to the failings we have as we develop a new system. We need consumer choice and options for consumers to continue to receive services while they are appealing the quality of the services they receive.

Presentation: Home and Community-based Services Waiver Reimbursement;
discussion: R. Chaney introduced Tim McIntyre from Burnham Brook who discussed the MI Choice Waiver Process. A corrected version of the presentation was given to the Task Force. Burnham Brook is one the largest waiver providers in the State of Michigan. The stated intent of the waiver is to provide services for enable clients to remain at home

instead of in a nursing home. It is a 1915c, extends Medicaid funds to service community dwellers; adds care management and 13 home services to Medicaid benefits. There are two things that are waived under this waiver: 1) Financially eligibility limits, and 2) Lifts services restrictions and added 13 services to the plan. Eligibility is based on household income. This waiver alters community-based eligibility. The waiver was awarded to Michigan in 1992 and expanded in 1998. Most service areas now have more than one waiver agent. Currently there are 21 agents. The primary services in the waiver program include care management. The care management is evolving to adopt PCP as the process for individuals who choose this option. An important role for care management is advocacy. Participants must be age 65 or older; or between the age 18 and 64 meeting social security defined disability requirements. They also have to meet defined level of care criteria, financial eligibility requirements, which are 300% of SSI, and need at least 1 of 13 waiver services. The in-home services cost went from \$32/per day to \$34/ per day. The volume of participants has declined. The funding remains frozen.

Steve Bachleda, MSA, discussed a brief overview of MI Choice waiver reimbursement structure. Up until October 1st the state was paying \$32 per day for services, there is additional money that can be achieved. The first \$32 per day for services cost is covered 100% by the Medicaid program. Between \$32-\$34, Medicaid would cover 80% of that cost. Between \$34-\$36 Medicaid would cover 50% of the cost. A significant portion of the cost would have to be covered by the waiver agent. Up to \$96 there is no Medicaid reimbursement. Beginning November 1, 2004 the daily rate has been raised to \$34.

R. Carter asked about the \$32 cap. Steve Bachleda explained that up to \$32 or \$34 for the new year, Medicaid would cover 100% of the cost.

M. Cody asked how many MOU's are in effect. Mr. Schwartz noted this number at 117.

Jim Schwartz, MSA. He is responsible for day-to-day contractual, financial, and operations of the waiver. There is a fixed budget of 100 million for the last three years. In 1997, CMS had concerns about the reimbursement rate and how high cost individuals that wanted to get into the waiver would be reimbursed. There are provisions for high cost individuals, 6,899 participants currently.

S. Steinke asked what have the waiver budgets looked like since 1992. The waiver budget in 1998 was 80 million, 1999 was 126 million, 2000 was 150 million, and 2001-2004 is 100 million-fluctuation due to budget cuts.

M. Moers asked how the department comes up with the \$34. Steve Bachleda indicated that that is the map that they have for the moment and they have a built in process as they get the new eligibility tool in place. The cost per date will gradually rise.

R. Carter indicated that the administrative costs are outrageously high in Michigan. Jim commented by saying that they are looking at it. He further noted that the administrative cost includes care management, and that approximately 2/3 of the cost is actually for care management.

J. Christensen asked if there was any other states that fund home and community-based waivers the way that Michigan does, and if there were other states that could be looked at for actuarial models. Steve Bachleda indicated that he wasn't aware of any.

R. Carter wanted clarification about the Medicaid eligibility determination for the waiver participant from Tim McIntyre's presentation. The amount of income per month is 4 times the regular Medicaid participant. Tim McIntyre agreed with R. Carter. R. Carter points out that according to the data the waiver program is treating people with higher incomes. T. Czerwinski indicated that that was incorrect because that person may have also have a spend down. The spend down is the same as the traditional program. A person would have to spend all the way down to the \$375 to get into the waiver.

S. Steinke asked that they base the \$32 per day on historical data and as you are looking further out with the new level care screening tool you are basing the \$32 per day on the current client pool. Clearly you will have a higher level of acuity of persons and some will be knocked out from the lower acuity levels with created the balance. She wanted to know what steps are being taken to get a more accurate rate for treatment in the community. Steve Bachleda replied that they have projected the change. This year the rate will be minor. The \$34 will buy what the \$32 paid for the years before. There will be an inflation cost built in for next year.

Senator Cherry wanted to clarify that a rate was determined at some level that didn't have any basis on the service but it was what the state could afford.

Steve Fitton clarified that there was an analysis done in 1997-1998 that looked at the cost of population at that time. The \$32 per day was chosen as a number that most of the waiver agents were under at that time. He stressed that this was not simply a random number as some believe, but that it was based on actual cost information from previous years.

T. Czerwinski wanted to clarify that the average cost of the waiver agent is \$2-\$3 per day. After discussion it was clarified that administrative costs would be 7 to 8% of the total reimbursement.

R. Carter asked about the U of M screening tool. Tim indicated that U of M used the RUG system and threw those people out. Prior to that they did not qualify. S. Steinke asked R. Carter for him to check with his people to see what the change has been for them with the new screen.

Revisiting Workgroup A and Workgroup C Discussion: The Task Force decided to revisit the discussion for Workgroup A and Workgroup C in the roundtable discussion. S. Steinke addressed the Task Force to go back to the questions regarding Workgroup C. Representative Gillard talked about reimbursement based on individual acuity. He requested model regarding this issue and wanted them to be available to Workgroup G. Jane Church indicated that there is a system called a RUG system, which is the Resource

Utilization Groupings. This is used to establish the Medicare reimbursement. The systems that are in place in other states are based on those RUGS categories. The reimbursement for your care is based on how much it is projected to cost for alike group of people with the same needs you do. S. Steinke indicated that Steve Bachleda would be discussing this issue in December when they look at case mix reimbursement process.

T. Wong had an observation about the report. Whenever community-based is mentioned it should say home and community-based; and also whenever services is mentioned it should read services and supports.

S. Gire encouraged the Task Force to email her or Jane Church on any suggestions or comments that need to be changed.

R. Carter indicated that the group worked a lot time on the issue of quality, while recognizing that there were multiple definers of quality, and in the end the group voted unanimously that the customer's preference would always trump everyone else. The final say was with the client and not with others.

Jane Church indicated that if you email suggestions to her make sure that you use the email address of Churchja@michigan.gov.

S. Steinke took the Task Force back to Workgroup A regarding Senator Cherry's question and then the will look at approving the report presented.

J. Christensen answered Senator Cherry's question by saying that there were two parts to the question. The first part is what influence does the SPE or would the SPE under this purposed design have on influencing services if there is no financial connection. One is one of the requirements built in is that the SPE would have a monitoring function and quality assurance function so that it would be gathering information, some of the definition that were used client satisfaction, are people getting needs met, are services being delivered, etc. There is a though that the SPE would play a quality assurance function. It would not be the only entity in the system that would play the quality assurance function, the ombudsmen would play an appropriate role in assuring quality, the state would have some oversight responsibilities like licensing, and the Medicaid office would have some responsibility as well. The second side of it is what influence would SPE have on holding or adjusting rates for getting cost value for the services that are purchased. In that regard there were two thoughts in the SPE committee: 1) The more you involve the person in PCP and person-centered decision and the more you provide assistance to that individual the more likely you are getting more value for services. 2) Medicaid will undoubtedly come up with a rate structure with outliers and if people fall into them then Medicaid will be looking at it. From the statewide perspective we would be looking for the best available provider and the least cost.

S. Steinke went through the report point-by-point to make sure there were no objections to the report. As S. Steinke went through each point she asked the members to raise their hands if they had any objections. D. Hoyle asked about the principle called "Money

follows the person”. He asked that the last statement read care identified “by” the person instead of “for” the person. G. Betters objected to that because there would have to be a lot of regulation changes. S. Steinke suggested that they wrote as “pay for care identified specifically for the person and by the person”. J. Christensen suggested that the second sentence is not necessary since the first sentence identifies the thrust of the principle. The second sentence tries to explain something but doesn’t add to the first. S. Steinke asked the Task Force if that works. They agreed.

R. Carter indicated that he doesn’t like the idea of saying “yes” to something statewide without piloting. Piloting to him means that we try something, see if it works, and make adjustments after that based on whether it worked or not. The option still exists and the Task Force can say no.

J. Christensen agreed with R. Carter about piloting. When you undertake important policy decisions, you want to pilot it in some way to guide future steps. He believes that the Task Force can accept the language, but they should add that someone should undertake a careful evaluation after the early adopters are phased in so that a determination can be made to assure that desired results are being achieved.

D. Hoyle indicated that Workgroup C report discussed SPE. Being defined as a SPE and PCP workgroup we really were talking about SPE. Now to say lets see how SPE works is a step back. He would like to see the Task Force decide if they are going with SPE.

J. Christensen indicated that he wasn’t suggesting that the Task Force pilot. He was suggesting that the Task Force make a commitment to move forward to phase in implementation as it is stated in the recommendation, and to add the requirement for a status evaluation after the Task Force has completed 1/3 or 1/4 of implementation to give them guidance. If that evaluation comes back saying that it has been a disaster the Task Force would have a responsibility to say that they would have to make some changes.

S. Steinke read a revised version of the Phased Implementation statement. It reads as follows: *“We are supportive of a relatively short phased implementation period for SPE system. The end goal is SPE that is available to everyone in Michigan and the Department of the Community Health should under take a careful evaluation of early adopters to see if we are achieving anticipated results. It is anticipated that the information will be used to guide future implementation.”* S. Steinke asked Task Force to raise hands if revised statement is not acceptable. No hands were raised.

Senator Cherry indicated that the second feature should be shortened. The revised statement will read: *“The system needs to be based on a standard of criteria set by the State.”* M. Moers indicated that she would like to see consumers and activists in that statement. S. Steinke indicated that there is a recommendation in the operational areas regarding that issue.

R. Carter responded to the 5th feature of quality assurance. The recommendation regarding quality assurance, it isn't so much the inclusion of the measure of customer satisfaction but it is the priority place of that.

S. Steinke indicated that she was going to take everyone suggestions and change the statement to say that there should be a quality assurance function that emphasizes by is not limited to measures of consumer satisfaction. Senator Cherry indicated that the statement should specifically say that you are talking about the quality assurance of SPE. With the new suggestions the feature would read: The quality assurance function focused on SPE agency that emphasis but not limited to measures of consumer satisfaction.

D. Hoyle indicated that Case Coordination/Supports Coordination/Care Planning should be described in one term. S. Steinke agreed.

Senator Cherry wanted to know if there were other services that are providing to help in the long-term care continuum. We are not saying that FIA determines eligibility for those services. More appropriate to say that if the service is Medicaid funded, it should be FIA but for other services it maybe other agencies. M. Moers did not agree with saying the financial eligibility would be determined by FIA. S. Steinke revised to say: "Financial eligibility determination for Medicaid funded programs will be determined by the appropriate state agency."

Nursing home transition has been changed to read: "Transition coordination services."

Senator Cherry indicated that it started as "will"; now it is reading, "could". S. Steinke changed the wording to say "will be."

Motion & Adoption

A motion is needed to accept the preliminary report and the decision document for the retreat. **T. Czerwinski moved to take the previous motion off the table, D. Hoyle seconded. A voice vote was made to take the tabled motion off the table. The motion was approved.**

S. Steinke clarified the Task Force will entertain a motion to alter the original motion to be accepting the entire report or just the principles which was the original motion. **T. Czerwinski withdrew his original motion. D. Hoyle made a motion to accepting the full report, and seconded by M. Cody. A voice vote was made an approved. J. Christensen** wanted to clarify that this is just like the earlier motion in the other workgroup that the Task Force is accepting it in principle to empower the other workgroups in regulation and finance to move forward with it and the Task Force will take another look at it to see how it all fits together at the end of the process.

Next Meeting Date and Agenda Topics:

Workgroup B Steering Committee stayed after meeting.

The next meeting is scheduled for December 13, 2004. The meeting will be held at the State Capitol, Room 426.

A motion to adjourn the meeting was made by G. Betters, seconded by S. Gire, and passed.

The meeting adjourned at 3:32 p.m.