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LONG-TERM CARE SUPPORTS AND SERVICES
ADVISORY COMMISSION
February 25, 2008

EXECUTIVE COMMITTEE MINUTES 2/04/2008

PROPOSED 2008 LONG-TERM CARE COMMISSION
SCHEDULE OF MEETINGS

OLTCSS UPDATE

DCH/OLTCSS POWERPOINT PRESENTATION TO THE
DCH SENATE APPROPRIATIONS SUBCOMMITTEE
HEARING

EXCERPT FROM THE FISCAL YEAR 2009 DCH
EXECUTIVE BUDGET

HEALTH CARE ASSOCIATION OF MICHIGAN'S
TESTIMONY TO THE DCH SENATE APPROPRIATIONS
SUBCOMMITTEE HEARING

OLTCSS OPEN HOUSE FLYER

HEALTH POLICY FORUM NOTICE

LTC SUPPORTS AND SERVICES ADVISORY
COMMISSION OPERATIONAL GUIDELINES - REVISED
TO INCLUDE OPEN MEETINGS ACT SUMMARY

**LONG-TERM CARE SUPPORTS & SERVICES
ADVISORY COMMISSION
EXECUTIVE COMMITTEE
FEBRUARY 4, 2008
MINUTES**

ATTENDEES: RoAnne Chaney, Andrew Farmer, Jon Reardon, Hollis Turnham, Jackie Tichnell, Gloria Lanum, Jane Church

January Meeting - Farmer thanked and congratulated the workgroup chairs for a good meeting.

Re-appointments - There is currently one vacancy and four Commissioners to be re-appointed. (Turnham, Mania, Wilson, McKinney). No new information is available on the re-appointments.

Staffing of the Workgroups - There was much discussion regarding the participation of Commissioners on the workgroups and the need for additional staffing. Chaney and Slocum are still in need of Co-Chairs for their respective workgroups. Farmer did send the Consumer Task Force chair a request for consumer involvement on the Commission workgroups.

2008 Commission Meeting Schedule - The issue was discussed and it was decided that, at the next Commission meeting, Farmer would present the concept of a Commission meeting every other month with workgroup meetings on the off months. Issues discussed included:

- 2009 Commission meeting schedule
- Monthly Office updates
- Use of e-mails as alerts to Commissioners on the off months
- Loss of momentum in the off months

February Meeting - Tentative agenda items included:

- 2008 Commission meeting schedule
- Participation on the workgroups
- September hearing issues
- Healthcare ballot proposal

Executive Committee meeting was adjourned.

PROPOSED 2008 LTCSS ADVISORY COMMISSION SCHEDULE

March 24: Michigan's Healthcare Ballot Initiative

April – NO MEETING; Workgroups Time

May 19: Workforce Workgroup Recommendations
& SPE Demonstrations Review

June – NO MEETING; Workgroups Time

July 28

August – NO MEETING; Workgroups Time

September 22: Elections Impact A.M. Hearing (See Below) + Regular P.M. Meeting

October 27

November 24: SPE Demonstrations Review

December – NO MEETING; Workgroups Time

DRAFT SEPTEMBER HEARING FRAMING – NOT A “TOWN HALL”
September 22, 2008 LTCSS Advisory Commission Elections Impact Hearing:
What Are Voters Looking For in Long Term Care Reform?

- Testimony from voters on what voters want Presidential candidates to do about LTC.
- Testimony from voters on Michigan's Health Ballot Initiative: if it passes, what should the Governor and the Michigan Legislature do to assure healthcare is available and affordable for everyone?
- Presidential Campaign Representatives respond to T.F. Recommendations.

OFFICE OF LONG-TERM CARE SUPPORTS & SERVICES
Update for the Long-Term Care Supports and Services Advisory
Commission
February 25, 2008

BUDGET -

- FY 08 LTC appropriations is nearly \$2.0 billion
- FY 09 offers no opportunity to expand overall long-term care spending with general fund revenue
- Michigan's federal funding match rate from CMS has increased to 60%
- FY 09 Executive Recommendations include:
 - The redirection of resources based on projected savings during the fiscal year
 - Unified LTC appropriation to allow flexibility to reinvest a projected \$32.4 million gross nursing facility savings into community-based services on a real-time basis
 - "Rebalancing" by allowing expansions in certain community options that are offset by displacement in nursing facility care
- These recommendations will allow:
 - Expansion of PACE
 - Development of affordable assisted living
 - Development of specialized residential care
 - Expansion of funds for the MI Choice wait list
 - Assurance of payments for transitions from nursing facilities made under the DRA/MFP grant
- Intended outcomes:
 - Consumer choices may be better met through presentation of more care options
 - Consumers maintain desired quality of life by being able to choose better options
 - The LTC system is more responsive to a broader range of consumer needs
 - Best "fit" through Long-Term Care Connections options counseling and brokering of services
 - Care options are cost-effective
 - Capacity in all setting is more sufficient

- Budget neutrality is maintained in very tight economic times
- Source of Projected Savings:
 - Level-of-Care determinations through the Long-Term Care Connections is trending at a lower approval level
 - Declining nursing facility care - \$5.8 million
 - PACE population displacement - \$10.4 million
 - Transitions of nursing facility residents who do not require community-based services (other than a small proportion of Home Help) - \$15.9 million
 - Money Follows the Person grant - \$7.5 million for services using the enhanced match
 - Hold variable nursing facility cost increases closer to the market basket - \$31.3 million gross

GRANT UPDATES

1. Long-Term Care Connections (LTCC) Projects

- The level-of care determinations are being completed in a timely manner. Written agreements are in place between the LTCC, MI Choice waiver agents and nursing facilities. (UPCAP and Detroit AAA are at, or close to, having agreements with all the nursing homes in their catchment areas.) The Level-of-Care denial rate is 3%. The Options Counselors have increased their activities on exploring nursing facility diversion. There is a meeting with the computer personnel on adding the LTCCs to the LOC electronic system.

2. Long-Term Care Insurance Partnership program

- The workgroup continues to meet monthly with frequent phone calls with CHCS (funder). The group is working on the services package. The State Plan amendment for estate recovery was submitted to CMS December 28, 2007.

Prepaid LTC Health Plan

- HMA sent additional questions to the Medical Services Administration prior to the official data request for the feasibility study. Several workgroups are working on the details of this project. Staff is working on the site development in Detroit and the state infrastructure needed for the prepaid LTC health plan.

3. Deficit Reduction Act - Money Follows the Person grant

- The Project Director is currently working with a multitude of stakeholders and other DCH staff to develop an Operational Protocol. This Protocol must be approved by the Center for Medicare and Medicaid before Michigan can begin to access the \$67 million that was awarded by CMS. The Protocol must include:
 - A case study a person transitioning from a nursing facility back into the community,
 - At least five benchmarks, one of which must show increases in the number of individuals transitioned during the five year period of the grant, and the other which must demonstrate increases in the amount spent on home and community based services.
 - A description of the recruitment & enrollment plan
 - A description of informed consent & guardianship provisions
 - A description of the outreach/marketing/education plans
 - A description of stakeholder involvement
 - A list of benefits and services available
 - A description of opportunities for self-direction
 - A description of consumer supports including: 24/7 backup, consumer access to services, and continuity of care post-transition
 - A plan for assuring an adequate supply of housing
 - Organization & administration for the grant
 - A description of the quality management system
 - The state's evaluation & reporting systems
- Combined training for Long Term Care Connection, Waiver Agent, and Center for Independent Living staff is scheduled for mid-April. This educational event will facilitate regional coordination among the various components of the transition system, as they discuss how best to implement the nursing home transition program in their area of the state.

4. Self-Determination in Long-Term Care

- Three of the non-pioneer sites are enrolling persons in self-determination. More training of the waiver agents is planned.

5. Project Success - Technical Assistance for Training in Self-Determination

- Staff is also working with PHI on a small grant on consumers as employers. There is a train the trainer curriculum that will be presented to several two-person teams of consumer/care manager. Oakland AAA is the site for this project.

6. Medicaid Infrastructure Grant

- There are 1,053 consumers on Freedom to Work.
- Staff is working with Oakland, Detroit, Lifeways, Kalamazoo, and Kent County CMHs to recharge competitive supported employment in those areas. The CMHs have provided good responses and are eager to begin.
- Erin Riehle presented Project Search to over 100 CMH, hospital, ISD and provider staff. The statewide coordination for this project will be a challenge.

7. State Profile Grant

- Staff is meeting with the MPHI contract person for the half-time positions of State Profile grant manager

8. Choices for Diversion (Office of Services to the Aging Grant)

- This grant is to provide person-centered planning and self-determination for persons who are not eligible for Medicaid but do receive services from Title III (Older Americans Act). They are partnering with three Area Agencies on Aging - 1B (Oakland), TriCounty, and Grand Rapids (LTCC area). Their focus is on single points of entry. There are three planning groups: 1) targeting criteria, 2) training, and 3) standards.

Office Updates:

- DMB does have to approve level 14 or below positions. However, DCH is not going to fill 600 of their positions. Vacancies will be approved by DCH; the Office has submitted 10 for approval. The Quality Management Manager and DRA Specialist are the priorities. The Office has received approval to move forward to fill the remaining vacant positions for the Office.

- The Office has moved to Capitol View Building, 201 Townsend, Lansing.

Other

- The Participant Outcome Survey Measure project should be wrapped up tomorrow.
- There is a Senior Advocacy Event scheduled for June 11, 2008 on the Capitol lawn.
- There is a Self-Determination Leadership Seminar on March 11, at the Holiday Inn South.

DEPARTMENT OF COMMUNITY HEALTH

FY 09 Executive
Recommendation:
Overview of the Medicaid
Long-Term Care Budget

Senate Appropriations Subcommittee
February 21, 2008

Michael J. Head
Office of LTC Supports & Services

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FY 09 Long-Term Care
Executive Recommendation

- Unified LTC appropriation line to support flexibility in implementing services
- “Rebalance” with expansion of community care offset by lower Nursing Facility utilization
- Redirects resources based on savings to assist rebalancing

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What Is Rebalancing?

- Expanding and/or reinvesting to extend array of LTC options, to promote individual choice
- Most citizens prefer to obtain LTC assistance in their home and community as long as possible
- Federal mandates:
 - Centers for Medicare & Medicaid Services
 - Deficit Reduction Act
 - Olmstead Supreme Court Decision (1999)
 - President's 2002 New Freedom Initiative

3

FY 09 Proposed Budget - Elements

- \$32.4 million NF savings from:
 - Independent determination of functional eligibility
 - Low to no use of Medicaid LTC services for some individuals who transition from NFs back to home and community
 - Establishment of new PACE programs
- Allows funds for services:
 - Expanded PACE program
 - Develop Affordable Assisted Living model with MSHDA
 - Develop specialized residential care waiver option
 - Support expanded home care by reducing the MI Choice Waiver wait list

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FY 09 Additional LTC Budget Elements

- Funds to support nursing facility transition to home care with Money Follows the Person grant
 - Offers an enhanced federal match rate (80% federal) for “long-stayers” leaving NFs
 - “Long-stayers” = those in NF’s longer than 6 months
 - Enhanced funding is for one year per individual
- Support the continuation of four Single Point of Entry demonstration projects as required by PA 634 of 2006

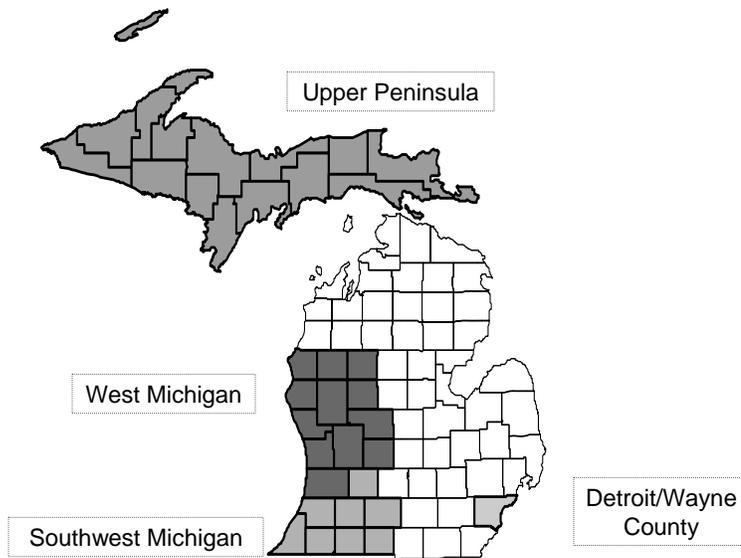
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Single Points of Entry

- Four demonstration sites covering 52% of population were initiated in FY 07
- Promote informed choice about options available to meet long-term care needs
- Streamline access to services; assist with use of individual resources
- Called “Michigan’s Long-Term Care Connections”
- P.A. 634 of 2006 governs structure & operations of SPEs

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SPE Regions



Public Act 634 of 2006

- For consumers in need of LTC services, the SPE must:
 - Assess eligibility for Medicaid long-term care programs
 - Assist with Medicaid financial eligibility determination
 - Assist in developing a long-term care support plans using a person-centered planning process
 - Authorize access to Medicaid programs
 - For which the consumer is eligible
 - As identified in the consumer's long term care supports plan.
 - Upon request, facilitate needed transition services for consumers living in long-term care settings

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SPE Activities: 2007- 08

Activity	Through January 2008
Information & Assistance	29,500
Options Counseling Cases	6,500
Assist transition from NF residence	100
Level of Care Determinations	3,000
Resource Data Base	3,500

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Program for All-Inclusive Care for the Elderly (PACE)

- PACE is managed health and long-term care for frail elders (Medicaid and Medicare)
- \$5.4 million to expand PACE into Muskegon and Calhoun counties
- Will serve 215 elders
- Adds to PACE option now available in Wayne and Kent counties

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Affordable Assisted Living (AAL)

- \$2.6 million to assure waiver services for ~ 100 people
- Partner project with MSHDA
- Allows “aging in place” for elders
 - When needs increase, waiver services maintain person in his/her apartment
 - Offers additional housing option for NF transitionees
- AAL can provide, if necessary, round-the-clock monitoring and assistance
- A “Housing with Services” model
- Six prototype projects are all within SPE areas
- SPE’s provide a “front door” for services access

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Specialized Residential Care

- \$14.1 million for developing a new waiver option
- 430 slots in licensed Adult Foster Care or Homes for the Aged
- For consumers needing 24 hr support and supervision which cannot be provided at home
- Adds home and community based services option that most states now have
- Targeted for development within SPE areas
- Can provide community option for those otherwise requiring NF care

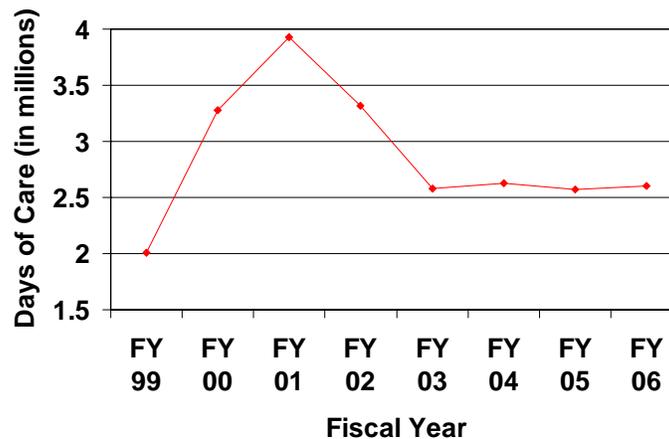
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MI Choice Waiver Wait List

- \$10 million to address ~15% of MI Choice Wait List population
- Supports ~ 485 new MI Choice participants
- Allows MI Choice Wait List to be reduced
- 12% of Wait List population die or enter a NF during their wait
- Expansion targeted:
 - One-half in SPE areas
 - One-half in non-SPE areas

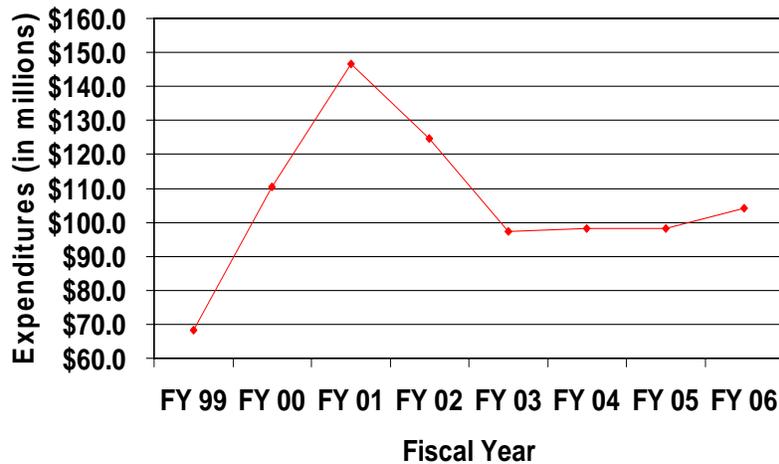
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MI Choice Days of Care Remain Steady



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MI Choice Expenditures Steady Since FY 03



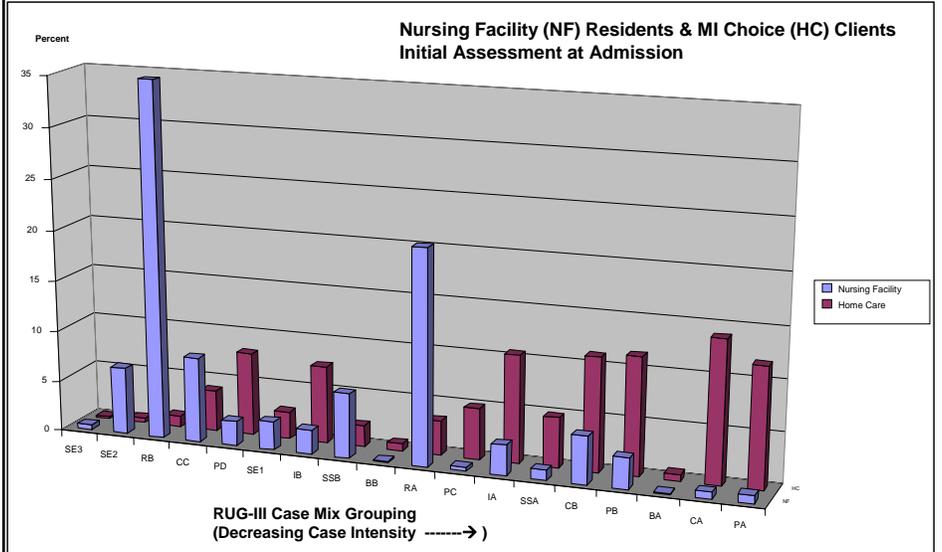
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The Medicaid LTC population in NFs and the MI Choice Waiver

- There are two NF populations
 - At admission: typically high care needs
 - Includes those on medical rehabilitation from hospital care
 - Another, after 4 – 6 months, which is longer-term with a different, less intensive mix of care needs
- The MI Choice population is not substantially different at admission and after six months
- At six months there is significant overlap between the proportion and intensity of need of NF and the MI Choice population

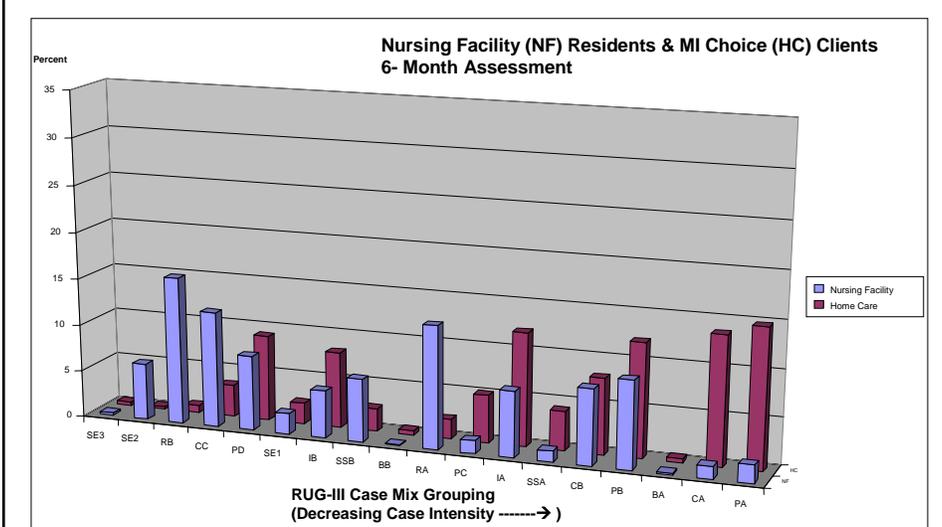
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Comparison of Nursing Facility and MI Choice Caseloads at Admission



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Comparison of Nursing Facility and MI Choice Caseloads After Six Months* in Program



* At six months, most NF residents are Medicaid paid care

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Projected Sources of Nursing Facility Savings To Be Reinvested

- LOC determination rate when conducted independently by SPE's is lowered, resulting in NF cost savings: \$5.8 million
- PACE expansion savings: \$10.4 million
- FY 08 & FY 09 transitions from NFs requiring minimal or no Medicaid LTC services: \$15.9 million

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Money Follows the Person CMS Grant

- Transition services for "long-stayers" – in residence at least 6 months
- MFP grant supports MI Choice services: transfer \$7.5 million to Waiver
- Projected reduction in NF services costs
- Based on NF transition trends and enhanced NF transition Pathway
- FY 09 target: 400 transitionees

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Limit Nursing Facility Variable Cost Component

- Limits the NF rate increases as past rate increases exceed inflation
- Holds annual variable rate increase closer to the CMS “Market Basket” index
- Reduced increase in cost: (\$31.3) million
- Fairness in rate increases compared to other providers

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Increase the Quality Assurance Assessment Retainer

- Proposed increases QAAP retained by state from \$39.9 to \$50.7 million
- Save \$10.7 million in general fund by increasing the retainer
- Would “lock in” retained revenue at 14.4%

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Medicaid NF Per Diem Rate Michigan Ranks Near Top of Neighboring States*

Rank	State	Rate	% of MI Rate
2	MI	119	100%
1	OH	\$144	121%
3	WS	110	(92%)
4	IN	103	(87%)
5	IL	\$ 90	(76%)

•Source: "Across the States, 2006 Supplement", based on 2002 Data

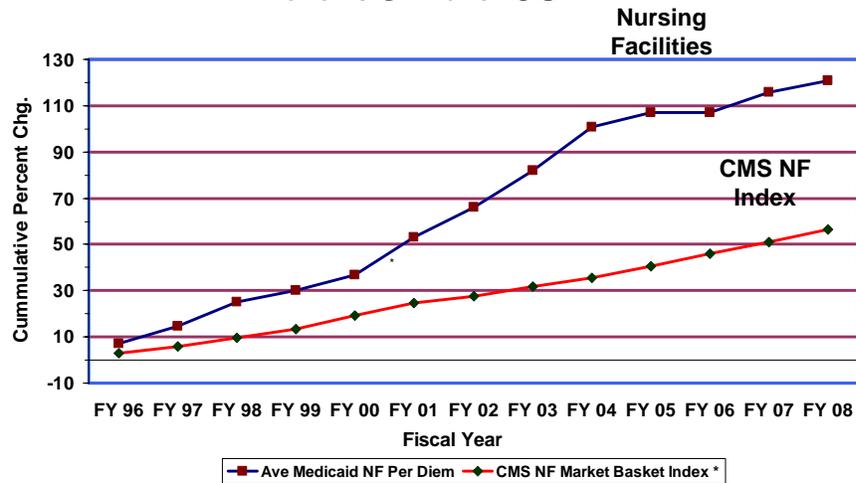
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NF Rates Have Increased At Rates Greater Than Inflation

- Reviewed cumulative rate increases for NF LOC providers since FY 96
- NF received an estimated cumulative increase of over 121% with QAAP included – over twice the rate of the CMS Global Insight Index thru FY 08

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Change in Nursing Facility Daily Payments Vs. CMS NF Market Basket Index FY 96 - FY 08

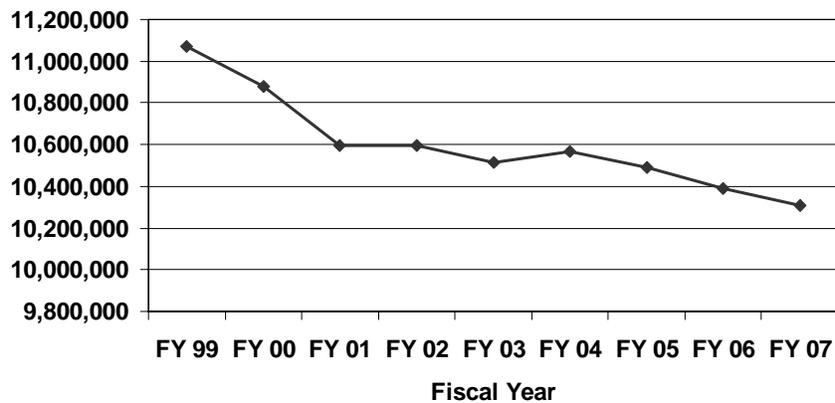


1995 as Base Year

* Source: Global Insight Health Care Cost Review

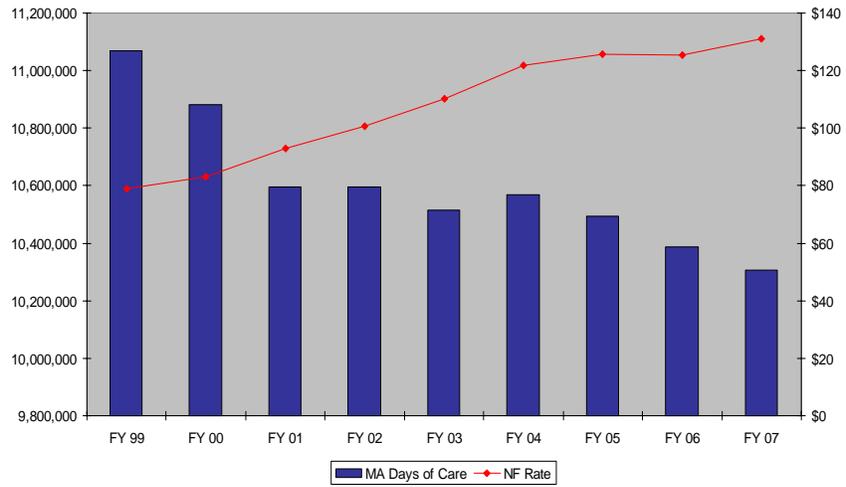
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Medicaid Paid Days of Nursing Facility Care



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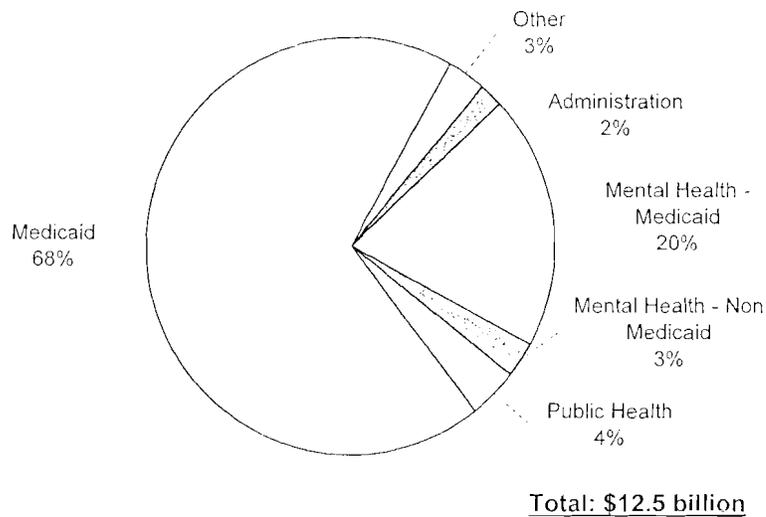
NF Days of Care Compared to Average NF Rate



Department of Community Health

The Department of Community Health (DCH) is responsible for health policy and management of the state's publicly funded health care systems. These programs include Medicaid health coverage for those with limited incomes; mental health services for people who have a mental illness or developmental disability; services for individuals who need substance abuse treatment; and services provided through local public health operations. The department also provides services to promote the independence and preserve the dignity of Michigan's elderly through the Office of Services to the Aging. *The Governor's proposed budget for fiscal year 2009 recommends total funding of \$12.5 billion, of which \$3.1 billion is general fund.*

Medicaid Makes Up Almost 90% of DCH Budget

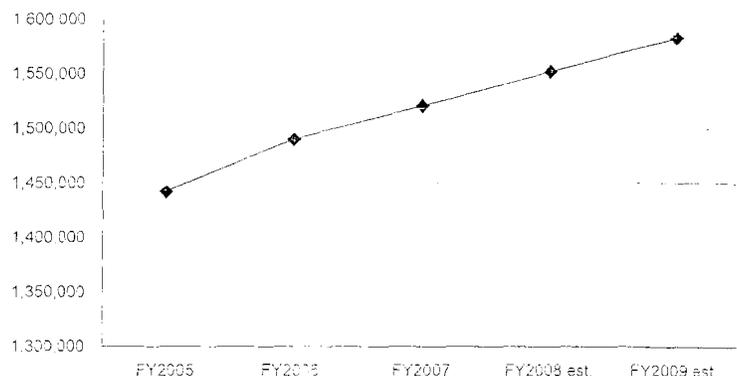


Highlights of Governor's Budget Recommendation for DCH

Medical Services

- Recommends \$6.5 billion for medical services and \$2.0 billion for the long term care portion of the Medicaid program, a 4.3 percent increase over fiscal year 2008. Medicaid provides health care services for one out of every 7 residents of the state.
- Adds \$125 million to the Medicaid budget for increases in the number of Medicaid recipients and increased utilization of services.
- Includes \$117 million to increase payment rates to HMO providers.
- Invests \$470 million in community-based long term care services.

Medicaid Serves Nearly 1.6 Million People



Mental Health Services

- Provides mental health funding of \$2.7 billion gross, \$1.2 billion general fund, that consists of:
 - \$2.4 billion to provide community mental health services, including \$59 million to increase provider payment rates;
 - Funding for psychiatric hospitals and centers of \$262 million; and
 - \$39 million to provide forensic mental health services to prisoners incarcerated in Department of Correction facilities, and \$2.3 million to initiate pilot mental health courts to provide treatment and services with the goal of diverting mentally ill individuals from the criminal justice system.
- Creates a centralized mental health managed care risk pool, saving \$7.3 million and maximizing use of available resources to support mental health services.

Other Medical Services

- Invests \$489 million for health and disease prevention programs, including \$50 million in grants to local public health departments.
- Supports Children's Special Health Care Services with \$212 million to provide medical care and treatment for children with special health care needs.
- Funds the Adult Benefit Waiver program at \$137 million to provide basic health coverage to 62,000 low-income adults each month.

Highlights of Fiscal Year 2008 Supplemental Recommendation

The Governor recommends a fiscal year 2008 supplemental of \$101.2 million that includes:

- \$60.8 million for an increase in the hospital quality assurance assessment program.
- \$40.4 million for supplemental physician payments made through health maintenance organizations.

Fiscal Year 2009 Governor's Recommendation
Department of Community Health
(\$ in Thousands)

	FY07 Appropriation*	FY08 Current Law*	FY09 Recommendation
GF/GP	\$2,937,585.8	\$3,122,814.7	\$3,086,105.8
All Funds	\$11,191,950.9	\$12,044,119.6	\$12,485,130.4
% Change - GF/GP		6.3%	-1.2%
% Change - All Funds		7.6%	3.7%

Programs	GF/GP	All Funds
Medicaid		
Medicaid Fee for Service	\$1,068,685.3	\$5,144,397.8
Medicaid Managed Care Services	\$371,069.7	\$3,018,727.4
Children's Special Health Care Services	\$100,251.1	\$211,793.0
Federal Medicare Pharmaceutical Program	\$178,055.8	\$178,055.8
Medicaid Adult Benefits Waiver	\$25,362.1	\$137,057.9
Mental Health - Medicaid	\$842,594.9	\$2,446,035.9
Mental Health - Non-Medicaid	\$314,199.7	\$314,199.7
Public Health	\$59,142.7	\$489,044.0
Administration	\$71,951.7	\$190,042.3
Other		
Office of Services to the Aging	\$33,848.0	\$94,381.8
Health Policy, Regulation & Professions	\$8,568.2	\$69,145.3
Information Technology Services	\$11,994.3	\$52,394.8
Crime Victim Services	\$0.0	\$27,725.4
Office of Drug Control Policy	\$382.3	\$12,129.3
Michigan First Healthcare Plan	\$0.0	\$100,000.0
* Adjusted for program transfers		
Total FY 2009 Recommendation	\$3,086,105.8	\$12,485,130.4

**HCAM Testimony
DCH Sub-Committee Hearing
February 21, 2008**

I want to thank Chairman Kahn and members of the sub-committee for the opportunity to speak with you today regarding the Department of Community Health Executive Budget Proposal.

I am Jon Reardon, Board Chairman for the Health Care Association of Michigan and 2nd generation owner of Hoyt Nursing and Rehab Centre in Saginaw, MI. HCAM is a statewide trade association representing proprietary, non-proprietary, county medical and hospital long term skilled nursing and rehabilitation facilities.

Our profession consists of 427 facilities employing over 40,000 dedicated workers caring for nearly 40,000 of Michigan's ill and infirmed elderly citizens every day of the year.

Before I discuss our specific concerns with the Executive Budget Proposal, I want to take a brief moment to clarify how we are currently funded through the Medicaid Program. The daily reimbursement rate for facilities set to be effective through fiscal year 2009 includes the "variable cost component" which is based upon the audited, allowable, actual cost of providing skilled nursing care during the year 2007. **There is no inflation factor to cover the two-year lag in recognizing increased operational costs incurred and facility investments to improve quality of care.**

It is important to clearly understand this, particularly in light of the Administrations budget proposal to once again significantly reduce our funding.

Specifically, the executive budget proposes to limit or cap the **“variable cost component”** increase for each nursing facility to 2.5%. This is a major change to the rate setting methodology after facilities have already invested in their operations through increased nursing staff hours and increases in staff wages and benefits. Labor costs comprise on average 65% of our daily costs in providing care. The proposed limit will reduce our funding by approximately \$31 million dollars. I have provided a graph showing our staffing hours which have been consistently increasing in response to the care needs of our residents and a break out of our variable costs.

The care needs of our ill and infirmed residents do not change as a result of this proposed cut, only our ability to meet these needs. The only way for facilities to react to such a massive cut of funding is reduced staffing and services. This is contrary to the push for increased quality care being demanded by the Centers for Medicare/Medicaid Services (CMS), the State Survey and Enforcement Agency and the various advocates for the elderly and disabled. This proposal would be permanently implemented through a change in Medicaid Policy and not the legislative process. We believe these decisions should be made by our elected officials, who through their positions are responsible for the well being of our elderly citizens.

The Administration is proposing that nursing facilities would now be required to pay for **employee background checks** as a cost of resident care. This is due to the expiration of a federal grant.

This is a perfect example of a forced cost increase now, which won't be paid for two years or at all if the Administrations proposal to limit the “variable cost component” to 2.5% is accepted. Should this proposal be accepted we are asking for an immediate “direct pass through” of funding to cover all costs related to employee background checks. Failing to do so creates another unfunded mandate.

Furthermore, this Administration proposes to increase the state retention amount from the **Nursing Facility Provider Tax Program, called the Quality Assurance Assessment Program.** Nursing facilities would be required to pay \$8 million more in taxes to allow for a higher federal match. The State will then increase its retention from \$39.9 million to \$50 million, resulting in a net \$4 million loss of revenue to nursing facilities. There is no way to sugar coat this, it is a tax increase that results in less funds for the provisions of patient care.

Lastly, this budget includes a shift of \$32 million from the nursing facility line item to the home and community-based line. The department asserts this shift is due to **decreased nursing facility utilization** through programs like the Nursing Facility Transition Initiative and the Single Point of Entry. Based on the limited amount of data available from the SPE program and other initiatives it is questionable how these savings can be determined or if they will materialize. Included with my testimony is a graph on the Medicaid Days of Care showing minimal caseload reductions.

Ultimately, if these projections are not met and there is a shortfall, we will still need to be funded our actual, audited allowable costs in providing skilled nursing care. Our concern is that we will again be cut through Executive Order or other means to balance the line item.

Last week the Director of Community Health in response to the Chairman's query said these proposals are designed to "limit the growth of Medicaid" but in fact they increase the growth of our costs and limit the funds available to provide required care and services. You have also heard the shift of funding from skilled nursing facilities to other array of services is a "rebalancing of resources." A true "rebalancing of resources" will be accomplished by the natural reduction in nursing home resident caseloads with the progression of residents to home and community based services. Moving \$32 million dollars from the nursing home line item based upon projections and not actual results is nothing more than "robbing Peter to pay Paul" and is not good public policy. It does not seem to us that these projections take into consideration the known increase in the future baby boomer population, of which a percentage will require skilled nursing care 24 hours a day.

Under all reasonable scenarios the need for 24-hour quality skilled nursing care will continue and remains a core government responsibility to its elderly citizens. As in any business or profession the ability to improve and meet the needs of its customer rests in its ability to invest in its human resources and operations. To that end we are asking for an investment of \$30 million dollars gross (\$12 million general fund) to be used as a "health care pass through". This will be used to provide health insurance to thousands of our dedicated workers, removing them from the uninsured and reducing Medicaid caseloads resulting in substantial savings to the State.

This investment will have an immediate positive impact by reducing employee turnover and increasing employee job satisfaction all which result in improved quality care.

Tying funding to an inflationary factor versus a recognition of actual historical costs will have a dyer effect by reducing care and services, which will limit our ability to invest in our human resources and improve our facility operations.

Thank you for the opportunity to speak. I would be glad to answer any questions.



WE MADE THE LEAP!!

From the Washington Square Building to the
Capitol View Building

***OFFICE OF LONG-TERM CARE
SUPPORTS AND SERVICES
MICHIGAN DEPARTMENT OF COMMUNITY HEALTH***

INVITES YOU TO JOIN US FOR A "LEAP-
DAY" OPEN HOUSE AT OUR NEW
LOCATION!!!

When: Friday, February 29, 2008 from
3:00 p.m. - 5:00 p.m.

Where: 1st Floor Capitol View Building
201 Townsend Street, Lansing

Light refreshments will be provided.



Michigan Health Policy Forum
SAVE THE DATE!

Kellogg Hotel and Conference Center
April 28, 2008
1 – 4:30 p.m.

Michigan Health Policy Forum

Is This Time Different? Prospects for Health Reform

Keynote Speaker
Alan Weil, Executive Director
National Academy for State Health Policy

Distribute widely
Registration is now open – Visit our website
<http://nursing.msu.edu/hpf>

**MICHIGAN LONG-TERM CARE
SUPPORTS & SERVICES
ADVISORY COMMISSION**

OPERATIONAL GUIDELINES

**Adopted
March 26, 2007**

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Broad Priorities, Agenda Setting & Planning

1. The Executive Order establishing the Commission and the Office has the implementation of the 2005 Governor's Medicaid Long Term Care Task Force Recommendations as central to their common Charge, so it these Recommendations which frame and guide all Commission priorities, agendas and planning.
2. Whereas the strength of the Task Force Recommendations, in both depth, integration and unanimous support stemmed directly from a statewide, widely-inclusive process of stakeholders, branches of State Government and the public, the Commission should endeavor to conduct its work in a manner consonant with the Task Force process model.
3. The Commission's engagement of statewide, widely inclusive groups of stakeholders, branches of State Government and the public should seek the consolidation of other public work in progress.
4. The Commission will establish workgroups and seek involvement from stakeholders, branches of State Government, the public, and the Commission.
5. These workgroups will scan the environment for both public and private work in progress that supports the actualization of the Task Force Report.
6. The workgroups will work in concert with the Office to develop strategies and advice for the use of public and private resources to address the needs and opportunities to do so.
7. The above process and its evolving structure serves as the Commission's primary policy, priority-setting and planning resource within the Task Force Recommendations; they function as the Commission's superstructure for ongoing public participation and communications in statewide education and planning.

8. Issues brought to the Commission's attention outside of this structure, whether brought by the Office, the Legislature, Public Comment, state or national events or the media should be reviewed by Commissioners and the Office (possibly Executive Committee members, if between meetings) for alignment with Task Force Recommendations; then if applicable referred to workgroups or other public individuals or bodies for development of a Commission response within its established priorities or recommend action through the reordering of priorities.

9. Planning cycles will be established and maintained for and between the Office and the Commission, and, between the Commission and what workgroups or other ongoing initiatives it undertakes. Plans for all these entities will address each of the Recommendations but may prioritize among them from year to year across the entities and subgroups so as to maximize the policy development and advocacy.

Meeting Protocols & Management

1. Commission meetings shall benchmark progress toward goals and objectives of the Commission, and the Office, for the full implementation of the Task Force Recommendations.
Commissioners and Office staff ought to be able to cite activities which serve and further such implementation at the end of each meeting – and name next steps and agenda for the next meeting to assure the Commission’s work remains on track.
2. Annual plans will map milestones of accomplishment across the yearly calendar of meetings to assure success and frame the agendas and outcomes of each meeting.
3. Annual plans will be shared with the Commission, its workgroups and the public as dynamic documents, having flexibility for adjustment of timetables according to progress or lack thereof. Revised timetables will be determined by the full Commission, either at meetings through its agenda or between meetings using the Executive Committee and/or e-mail to complete the work for distribution to workgroups and the public.
4. Annual Plans and agendas of full Commission meetings and workgroups shall be publicly posted and available at least one week before meetings, two weeks ahead is optimal. Background materials supplied to the Commission should also be posted and publicly available.
 - a. Agendas will be developed by the Chair with assistance from the Executive Committee and designated Office staff.
 - b. Minutes will be approved by the Chair with assistance from staff designated by the Office with assistance from the Executive Committee before being issued for full Commission Review and Approval.

- c. Fully Approved Commission Minutes will be publicly posted within 14 days after each Commission meeting.
5. Staffing support and assistance from the Office to the Commission will be in accordance with the Executive Order and with the Office Memorandum dated February 26, 2007 issued to the Commission at its Retreat gathering the same day. The Office Memorandum designates Gloria Lanum of the OLTCSS as the staff person Commissioners address questions and other needs related to Commission business and issues.
6. All Commissioners agree to review agendas, draft minutes and supporting materials before meetings to foster their active participation in discussions and decision-making.
7. Executive Committee meetings are convened at the pleasure of the Chair.
8. Commission members and workgroup volunteers will be encouraged to make donations of their personal, community and organizational resources at their disposal to enhance and leverage Commission and Office activities which enhance facilitation of the broader work. Such donations may include and are not limited to additional staffing, material, logistical support and coordination, meeting facilities, personal supports assistance and communications.
9. Annual planning by all Commission-related entities will target such logistical needs as part of operationalizing and sustaining their work. Office staff and the Commission Executive Committee will inventory these resource capacities, advertise specifically identified donation opportunities to the public; the Commission may delegate management of these logistics and their coordination to a special committee.
10. When the Commission or its Chair creates workgroups or committees, those workgroups or committees will receive a specific written charge of its role and responsibilities, membership,

with established deadlines for completion and submission to the full Commission for consideration. Findings or recommendations from workgroups or committees are not those of the Commission or the Chair.

- a. The ability of the Office to staff and support workgroups and committees is likely to be limited and will be determined by the Chair and the Office Director.
 - b. Meeting protocols for workgroups and committees will follow Commission protocols as closely as possible.
 - c. Effective communications between and among the Commission and its committees and workgroups will be sought.
11. Commission members must be present, physically or electronically, to vote. Commission members who are unable to be present may have a representative attend meetings to observe and listen to proceedings.
 12. Commission meetings will always include at least one time period for public comment. The Chair will manage that section of the agenda to encourage public input on all long-term care issues and to complete Commission business. (See Operational Guideline for Public Comment, page 6.)
 13. Commission meetings will include input from the Office.
 14. Commission decision-making processes are guided by the adopted “Consensus Defined” document (reprinted in full below). Any Commissioner who “blocks” a decision is obligated to explain his/her reasons for blocking Commission action at the time of voting. That same Commissioner is also obligated to work with the Chair or his/her designee to remove the “block” at the next Commission meeting.

CONSENSUS DEFINED

Excerpted from *True Consensus, False Consensus* by Bea Briggs, published in the Journal of Cooperative Living, Winter, 2001

The consensus process is a decision-making method based on values such as cooperation, trust, honesty, creativity, equality, and respect. Consensus goes beyond majority rule. It replaces traditional styles of top-down leadership with a model of shared power and responsibility.

The consensus process rests on the fundamental belief that each person/organization has a piece of the truth. Each member of the group must be listened to with respect. On the other hand, individuals/organizations cannot be permitted to dominate the group.

This is not to suggest that the consensus process presupposes or automatically confers complete peace and harmony within a group. In fact, in groups that are truly diverse, differences are both a sign of health and an invitation to creativity.

Consensus is not a panacea. It will not work in every situation. In order to invoke the power and magic of consensus, these main elements must be in place:

- Willingness to share power
- Informed commitment to the consensus process
- Common purpose
- Strong agendas
- Effective facilitation.

Procedure for Determining Consensus

In the consensus process, no votes are taken. Ideas or proposals are introduced, discussed, and eventually arrive at the point of decision. In making a decision, a participant in a consensus group has three options.

- To give consent. When everyone in the group (except those standing aside), says “yes” to a proposal, consensus is achieved. To give one’s

consent does not necessarily mean that one loves every aspect of the proposal, but it does mean that one is willing to support the decision and stand in solidarity with the group, despite one's disagreements.

- To stand aside. An individual stands aside when he or she cannot personally support a proposal, but feels it would be all right for the rest of the group to adopt it. Standing aside is a stance of principled non-participation, which absolves the individual from any responsibility for implementing the decision in question. Stand asides are recorded in the minutes of the meeting. If there are more than a few stand-asides on an issue, consensus has not been reached.
- To block. This step prevents the decision from going forward, at least for the time being. Blocking is a serious matter, to be done only when one truly believes that the pending proposal, if adopted, would violate the morals, ethics, or safety of the whole group. One probably has a lifetime limit of three to four blocks, so this right should be exercised with great care. If you frequently find yourself wanting to block, you may be in the wrong group.

Consensus decisions can only be changed by reaching another consensus.

Setting & Maintaining Short Term Public Policy Priorities

1. The Task Force Final Report Recommendations and their source material in the Task Force's Full Workgroup Reports, taken together, establish the ongoing framing through which current public issues are scrutinized for their relative importance and their sequencing for Commission attention and action.
2. Public issues can be named and brought to the attention of the Commission by anyone at anytime and conveyed by any means; if by the public, as part of Public Comment and/or Commission-related workgroups and other activities.
3. Public issues receive Commission priority from Commission deliberation and action, based primarily on:
 - Whether attention and action on the issue by the Commission addresses implementation of one or more Task Force Recommendations.
 - Commission decisions about priorities and actions should be based on which of those leverage a greater number of Recommendations' implementation; the greater number of Recommendations that are advanced – or impeded – by the issue, the greater priority that Issue should receive.
 - Additional scanning of public issues for their potential Commission priority should factor in the following measures:
 - ✓ which are most achievable
 - ✓ which make the biggest impact (affect more people, longer lasting)
 - ✓ which have the most positive outcome
 - ✓ even if relatively unimportant, which simply cannot wait

- ✓ which are totally obvious, regardless of subjectivity or objectivity
 - ✓ those not being addressed elsewhere or receive little ongoing attention
 - ✓ those on which there is higher awareness and support
 - ✓ sustainable resources are available to tackle it
 - ✓ gut instinct or intuition ~ “it just feels right”
4. Issues selected in this way for Commission Priority may be sequenced and staggered across monthly agendas and interim activities based on success rates, outcomes and available Office and Commission resources.
 5. The sequencing and staggering of Issues evolves into a longer range Commission Agenda and provides further basis for public advocacy planning and activities.
 6. Establishment of Commission workgroups and other initiatives expands the number of priorities the Commission can adopt and the potential resources available to sustain such work and advocacy.

Commission Responses to Public Comment

1. The Office of Long Term Care Supports & Services will provide, maintain and publicize contact mailing information for the public to send correspondence they wish addressed directly to the attention of Commission.
2. Any Commission member may receive public comment from any person in any form the person chooses, whether verbally, hand-written, typed, emailed or left in voicemail at any time in a given month and at Commission meetings, other public activities and other functions of Commission-related public committees, workgroups and presentations. Comments received by Commissioners between meetings should be forwarded to the Commission Secretary and the Chair; if received in writing, the recipient Commissioner should forward copies to the Commission Secretary and Chair, retaining the original until a formal written response has been mailed to the commenter.
3. Comments received between Commissions meetings will be reported by the Secretary (or in their absence, his or her Commission designee) as part of Public Comment at ensuing full Commission meetings.
4. The Public Comment portion of Commission agendas will include Commissioner questions of commenters present and Commission deliberation as needed and desired by Commissioners and Office staff.
5. Following Commission meeting adjournment, the Commission will respond promptly in writing to each comment received; the responsibility will fall primarily to the Commission Chair; he or she may ask a Commissioner, with experience and/or expertise particularly pertinent to the comment received, to draft a response and even voluntarily sign the given response on behalf of the Commission. Copies of comments and responses will be kept on

file by the Commission Secretary, with support and assistance from Office staff.

6. Written Commission responses to public comment should include as many of the following ingredients as pertinent and possible:
 - A brief recapitulation of the issues raised by the commenter.
 - A brief recapitulation of Commission questions, discussion and verbal reactions, if any.
 - A scan of federal and state laws, regulatory systems, programs and resources, including private resources, which are or might be pertinent to the issues raised and possibly appropriate to also respond; this should stem from Commission discussion wherein the Commission may choose to refer the commenter or, at the Commission's choosing, seek permission from the commenter to make related referrals of their comment as part of a Commission inquiry to the given agency(ies) or program(s); in the latter situation the Commission shares the third party's written response with the commenter while deliberating and deciding whether the agency response indicates needs for Commission advocacy action and/or policy development.
 - Every written Commission response ought end with advocacy action steps and discussion of further opportunities for commenters to become involved or increase their involvement in organizing in their communities and building broad movements for further reform of long term care, especially those with the greatest pertinence to their issues and their systemic, backdrop causes.
 - Each Commission written and verbal response conveys the utmost respect and deep appreciation for every commenter's efforts – sometimes at great personal cost and even risk – to make their voice heard.

7. A brief report and analysis of total public comment received by the Commission will be prepared each year by a subcommittee of Commissioners and Office staff as part of the annual report; other than issues, the summary should also include geographical and whatever known demographic characteristics of commenters as a group, and, possible learnings for improving the breadth, depth and public accessibility to participate in comment to the Commission.

Single Point Entry Demonstration Evaluation and Monitoring

1. Commissioners shall proactively assure their own learning needs and understanding of Task Force Recommendations, Executive Order Charges, the ensuing Request for Proposals process, State Law, local needs and developments relative to Single Point Entry and Demonstrations are addressed on an ongoing basis.
2. New Commissioners shall specifically request that the Office orient them to the specifics of each Demonstration Contract executed. The orientation will include but not be limited to apprising Commissioners of important distinctions and variances between the respective Demonstration Contracts and resulting individual contract expectations of the Office of each respective Demonstration Contractor. Updates shall be provided to all Commissioners if/when specific contracts are modified and/or Office expectations change on specific contractors. For the purposes of 2007, all Commissioners shall consider themselves and be regarded as new Commissioners.
3. At least twice each year the Commission shall request of the Office status updates on each of the Demonstration Contractor's contract compliance and activities. The status updates shall include but not be limited to:
 - Basic data on client (consumer, callers, etc.) profiles.
 - Numbers of clients being served.
 - SPE Service Delivery Staffing.
 - Client outcomes.
 - Public Education, Marketing and Outreach Plans, Activities (including events, products, tools and other deliverables).

- Governing Boards' and Consumer Advisory Board composition, status and activities.
 - Legal and financial status.
 - Community Needs Assessment tracking activities; detail on populations, unmet needs, unmet preferences and stakeholder capacity analyses on the local provider array.
 - Internal Contractor-specific quality improvement targeting and performance-tracking.
4. Commissioners may receive from any party, including SPE Demonstration Contractors, reports on SPE Demonstration activities directly to the Commission as part of Commission processes and opportunities for Public input and Comment.
 5. Direct Commissioner SPE Demonstration site visitation shall be facilitated at least once yearly by the Chair and the Office; the more Commissioners visiting more sites the better; Commissioner site visitation should attempt, as a minimum, direct contact with consumers using SPE services, as confidentially authorized by the given consumers; the use and release of specific consumer information gained by Commissioners by such contacts, if any, shall be defined, determined and authorization denied or withdrawn at the pleasure of each specific consumer at any time; as a rule, the purpose of such Commissioner-consumer contact is not to seek such personal information but to build and maintain each Commissioner's own sensitivity and awareness of consumer experience on thematic and systemic levels.
 6. The above Guidelines establish a floor of discernment for each Commissioner evaluate Task Force Recommendation on Single Point Entry and their implementation between and among each of the following: The Executive Order, the State Law, Demonstration Contractors' the Office's and Commission positions, actions and activity on record.

7. The primary Commissioner aids to this discernment are:
 - A. The Full Task Force Workgroup "A" Report document on Single Point Entry.
 - B. The full performance evaluation tool, process and document adopted by the Office following the Commission's recommendation for this.
 - C. What Commission workgroup(s) may be focusing on SPEs and the service capacities of the provider array.
 - D. Emerging Commission and public deliberations, plus local, state and national developments regarding SPEs and long term care reform.

8. Using the above, process of discernment of SPE evaluation and advocacy, the Commission's continuing recommendations in these areas should draw from at least two primary concerns:
 - redressing what distances exist and are growing, if any, between the original Task Force Recommendations for Single Point Entry versus what actually is being implemented at the State and local levels
 - what areas and operational issues of SPEs are not adequately addressed to begin with by the Task Force Recommendation, and Full Workgroup Report on SPE itself.

**LTC SUPPORTS AND SERVICES
ADVISORY COMMISSION
WORKGROUP CHARGES**

WORKGROUP ON FINANCE REFORM

Charge to Workgroup

- Review and monitor the implementation of recommendation # 9 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for improving the access to quality long-term care and supports through efficient long-term care finance reform.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that would adapt financing structures that maximize resources, promote consumer incentives and decrease fraud.
- Ensure all recommendations:
 - Involve consumers and broad public participation in planning.
 - Promote an array of long-term care services and supports.
 - Promote the concept of money (funding) following the person to wherever that person chooses to live.
 - Assure evaluation is addressed.
 - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 9: Adapt Financing Structures that Maximize Resources, Promote Consumer Incentives, and Decrease Fraud.

Strategies / Action Steps

1. Michigan should decouple its estate tax from the federal estate tax to make more revenue available.
2. Michigan should identify sources of non-federal tax revenue that are utilized to provide LTC and support services for Medicaid consumers, and create policies and procedures that will allow these funds to be used as local match to capture additional federal Medicaid dollars for long-term care and supports.
3. The Michigan Congressional Delegation should:
 - a. Advocate for the removal of the congressional barrier imposed on the development of Partnership program by states between Medicaid and long-term care insurance.
 - b. Strongly advocate that the federal government assume full responsibility for the health care needs of individuals who are dually eligible for Medicare and Medicaid.

- c. Urge the Congress to revise the current Federal Medical Assistance Percentage (FMAP) formula to a more just methodology using Total Taxable Resources or a similarly broader measure and to shorten the time frame from the data reporting period to the year of application.
4. Subject to appropriate reviews for actuarial soundness, overall state budget neutrality, and federal approvals, Michigan should establish a mandatory estate preservation program instead of establishing a traditional Medicaid Estate Recovery Program.
5. Legislation that promotes the purchase and retention of long-term care insurance policies and that addresses ratemaking requirements, insurance standards, consumer protections, and incentives for individuals and employers should be drafted, reviewed, introduced, and enacted after review by a representative group of consumers, advocates, and providers.
6. Three specific strategies aimed at increasing the number of people in Michigan who have long-term care insurance should be implemented: a) gain federal approval for the use of the Long-Term Care Insurance Partnership Programs.; b) expand the state employees' self-funded, long-term care insurance program; and c) examine the possibility of a state income tax credit for purchase and retention of long-term care insurance.
7. Tax credits and tax deductions for the purchase of long-term care insurance policies and for "out of pocket costs" for LTC should be considered.
8. A "special tax exemption" for taxpayers who provide primary care for an eligible parent or grandparent (and possibly others) should be explored. Based upon a \$1,800 exemption proposed in legislation introduced in 2005, the Senate Fiscal Agency estimates cost to the state in reduced revenue at less than \$1M.

As an initial step, Michigan should adopt a Case-Mix reimbursement system to fund LTC services and supports. This approach sets provider rates according to the acuity mix of the consumers served. The higher the acuity, the higher the rate paid to the provider due to the resources needed to care for the consumers. As the long-term care system evolves, other appropriate funding mechanisms should also be considered and adopted.

9. Michigan should encourage and strengthen local and regional programs that support caregivers in their care giving efforts.
10. An ongoing and centralized data collection process by DHS of trusts and annuities information should continue to be used to guide the need for state regulation.

11. There should be ongoing review and strengthening, along with strict and consistent enforcement, of laws and regulations governing the inappropriate use of trusts and annuities for Medicaid eligibility.
12. There must be more frequent, vigorous, and publicized prosecution of those who financially exploit vulnerable individuals.
13. State agencies should cooperate in discovering and combating Medicaid fraud, and recovering funds paid for inadequate care.
14. New legislation for the regulation by the state of “trust mills” and annuity companies should be enacted. This legislation should address the prevention of abusive sales tactics through the implementation of insurance industry regulations, registration of out-of-state companies, and prescreening of sales materials.
15. Appropriate state agencies should analyze and quantify the relationship between public and private resources, including both time and money, spent on LTC. This analysis should be used as a way to obtain a match for federal Medicaid dollars.
16. The state should study and pursue aggressive Medicare recovery efforts.
17. Medicaid eligibility policies should be amended to:
 - a. Permit use of patient pay amounts for past medical bills, including past nursing facility bills.
 - b. Require full certification of all Medicaid nursing facilities.
 - c. Require dual certification of all nursing facilities.
18. The task force recommends full funding for an external advocacy agency on behalf of consumers accessing the array of supports and services overseen by the SPE system. Based on a conservative figure, the total budget line for this item would be \$4.3 million. Of the increase, \$2 million would be to bring the State Long-Term Care Ombudsman program into compliance with national recommendations; \$2.3 million would go to the external advocacy organization outlined in Section 8 of the Model Act.

Benchmarks

1. Increased state and federal support will be available to implement Person-Centered Plans and consumer choice options.
2. A reduction of inappropriate asset and income sheltering will be achieved.
3. Improved federal-state funding partnership will be achieved.
4. An increase in the number of Michigan citizens with LTC insurance will be achieved.

5. An adequate allocation of finances and resources across the array of supports and services will reflect informed consumer choices in the delivery of LTC services and supports.

WORKGROUP ON PERSON-CENTERED PLANNING

Charge to Workgroup

- Review and monitor the implementation of recommendation # 1 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for the Person-Centered Planning process throughout the long-term care and supports system.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that will implement Person-Centered Planning across the array of long-term care and supports.
- Ensure all recommendations:
 - Involve consumers and broad public participation in planning.
 - Promote an array of long-term care services and supports.
 - Promote the concept of money (funding) following the person to wherever that person chooses to live.
 - Assure evaluation is addressed.
 - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 1: Require and Implement Person-Centered Planning Practices.

Strategies / Action Steps

The state should require and implement person-centered planning processes in statute and policy throughout the LTC system. As written in the Michigan Mental Health Code, “Person-centered planning” refers to “a process for planning and supporting the individual receiving services that builds upon the individual’s capacity to engage in activities that promote community life and that honors the individual’s preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.” MCLA 330.1700(g). The process begins as soon as the person enters the LTC system and continues as the person seeks changes. Person-centered planning is designed to allow people to maximize choice and control in their lives. A consumer-chosen supports coordinator/facilitator located at each SPE (see below) will help the consumer navigate through a full range of services, supports, settings, and options.

Strategies / Action Steps

1. Require implementation of person-centered planning in the provision of LTC services and supports. Include options for independent person-centered planning facilitation for all persons in the LTC system.
2. Revise health facility and professional licensing, certification criteria, and continuing education requirements to reflect a commitment to organizational culture change, person-centered processes, cultural competency, cultural sensitivity, and other best practices.
3. Require all Single Point of Entry agencies to establish and utilize person-centered planning in their operations. Review and refine practice guidelines and protocols as part of the first year evaluation of the SPE pilot projects.
4. Include person-centered planning principles in model legislation to amend the Public Health Code.
5. Early in the implementation process, ensure the provision of training on person-centered planning to long-term care providers, regulators, advocates, and consumer.
6. Require a continuous quality improvement process to ensure continuation and future refinement of person-centered planning in all parts of the system.

Benchmarks

1. Legislation requiring person-centered planning in the provision of LTC is passed in the current legislative session.
2. By January 1, 2006, the Department of Community Health, with the involvement of stakeholders, will establish in policy a person-centered planning protocol specific to LTC consumers.
3. Person-centered planning training is developed and provided to LTC providers, regulators, and advocates.
4. By October 1, 2006, each entity providing LTC services will have person-centered policies and training in place.
5. Regulatory survey and program monitoring processes are revised to include a review of the integration of person-centered planning in supports coordination activities.

WORKGROUP ON QUALITY

Charge to Workgroup

- Review and monitor the implementation of recommendation # 7 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for improving the access to a quality long-term care and supports system.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that will advance the establishment a new quality management system for the array of long-term care services and supports.
- Ensure all recommendations:
 - Involve consumers and broad public participation in planning.
 - Promote an array of long-term care services and supports.
 - Promote the concept of money (funding) following the person to wherever that person chooses to live.
 - Assure evaluation is addressed.
 - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 7: Establish a New Quality Management System. Align regulations, reimbursement, and incentives to promote this vision of quality and move toward that alignment in all sectors of the LTC system. Ensure that the consumer is the focus of quality assurance system.

Strategies / Action Steps

1. Develop and implement use of consumer experience/consumer satisfaction surveys and measurements.
2. Include a strong consumer advocacy component in the new system.
3. Review and analyze current performance measures (both regulatory and non-regulatory).
4. **Design performance measures that move Michigan's LTC system toward this vision of quality.**
5. **Invest quality management functions in a new Long-Term Care administration. The administration would improve quality by consolidating fragmented pieces of LTC, and defining and establishing broader accountability across the LTC array of services and supports. [Section 7 of the model Michigan Long-Term Care Consumer Choice and**

Quality Improvement Act in the appendix discusses some of the quality management functions in detail.]Raise Medicaid reimbursement rates and other incentives so that the LTC workforce receives compensation necessary to receive quality care as defined by the consumer.

Benchmarks

1. Consumer determination of quality is the priority quality measure.
2. Person-centered planning is implemented throughout the LTC system.
3. Oversight of QM is established within LTC Commission and LTC administration.

WORKGROUP ON WORKFORCE DEVELOPMENT

Charge to Workgroup

- Review and monitor the implementation of recommendation # 8 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for improving the access to a quality long-term care and supports workforce.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that would encourage more effective and the high quality provision of long-term direct care, services and support.
- Ensure all recommendations:
 - Involve consumers and broad public participation in planning.
 - Promote an array of long-term care services and supports.
 - Promote the concept of money (funding) following the person to wherever that person chooses to live.
 - Assure evaluation is addressed.
 - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 8: Michigan Should Build and Sustain Culturally Competent, Highly Valued, Competitively Compensated, and Knowledgeable LTC Workforce Teams that Provide High Quality Care within a Supportive Environment and are Responsive to Consumer Needs and Choices.

Strategies / Action Steps

1. Develop within the Michigan Works! Agencies (MWA) network, recruitment and screening protocols and campaigns that meet the needs of employers and job seekers.
2. Recast the state's Work First program to recruit, screen, train, and support individuals who demonstrate the desire, abilities, and commitment to work in LTC settings.
3. Develop recruitment campaigns to attract men, older workers, people of diverse cultural backgrounds, and people with disabilities to long-term care careers.
4. Mobilize state agencies' activities to include the research, exploration, explanation, and promotion of career opportunities in long-term care.
5. Improve and increase training opportunities for direct care workers to allow for enhanced skill development and employability.

6. Increase training opportunities for employers to improve supervision and create a positive work environment.
7. Reduce the rates of injury and exposure to hazardous materials to protect the current workforce and encourage new workers to join this workforce because of the sector's safety record.
8. Raise Medicaid reimbursement rates and other incentives so that the LTC workforce receives compensation necessary to receive quality care as defined by the consumer.
9. Expand the ability of all long-term care employers and their employees, particularly their part-time employees, to access affordable health care coverage for themselves and their families.
10. The Department of Human Services (DHS), Michigan Department of Community Health (MDCH), Michigan Office of Services to the Aging (OSA), Department of Labor and Economic Growth (DLEG) and other state agencies should work collaboratively to identify standards and benchmarks ensuring that direct care workers are key partners and team members in providing quality care and supports.
11. Develop health professional curricula and reform current practice patterns to reflect the changing needs of the population. Recognize the unique needs of the elderly; people with chronic health problems; people approaching end-of-life; people of all ages with disabilities; and those in need of rehabilitative and restorative services across LTC and acute care settings.
12. LTC administration will track employment trends, including turnover rates.

Benchmarks

1. Measurable increase in LTC employer use of MWA services and in LTC employer hiring of Work First participants.
2. More qualified Work First participants are recruited and successfully employed in the LTC industry, while continuing their education for entry into licensed occupations.
3. Higher compensation packages and increased training opportunities.
4. Continuously and incrementally reduced turnover rates over the next decade.
5. All people working in LTC have access to affordable health care coverage.
6. Increased use of creative management and workplace practices.
7. Use of data and consumer satisfaction to inform a system of services, state policies, and employer practices that result in consumer-driven outcomes.

8. Increased opportunities and incentives for LTC employers and their supervisory personnel to improve supervisory and leadership skills to create positive workplace environments and relationships to reduce turnover.

WORKGROUP ON PREVENTION

Charge to Workgroup

- Review and monitor the implementation of recommendation # 5 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for improving the quality of, and access to, prevention activities particularly in the area of informal caregiver support, healthy aging, and chronic care management.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that would encourage more effective provision of prevention activities particularly in the area of informal caregiver support, healthy aging, and chronic care management.
- Ensure all recommendations:
 - Involve consumers and broad public participation in planning.
 - Promote an array of long-term care services and supports.
 - Promote the concept of money (funding) following the person to wherever that person chooses to live.
 - Assure evaluation is addressed.
 - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 5: Support, implement, and sustain prevention activities through (1) community health principles, (2) caregiver support, and (3) injury control, chronic care management, and palliative care programs that enhance the quality of life, provide person-centered outcomes, and delay or prevent entry into the LTC system.

Strategies / Action Steps

Develop a DCH workgroup comprised of legislators, MSA, OSA, DHS, stakeholders / consumers, and others to oversee the collaborative process involving local public health entities engaged in prevention/chronic care. Under the direction of the DCH-led workgroup, local entities will:

1. Convene a broad-based coalition of aging, disability, and other organizations.
2. Review community resources and needs (including prevention, chronic care, and caregiver supports).

3. Identify existing local, culturally competent strategies to address prevention, chronic care needs, and substance abuse.
4. Develop and support programs to address prevention, chronic care, and caregiver supports.
5. Promote the use of culturally competent caregiver training on injury prevention, rights and benefits, and person-centered planning.
6. Develop wrap-around protocols for caregiver/consumer support needs.
7. Develop a public health caregiver support model.
8. Create initiatives and incentives to support caregivers.
9. Identify and promote the use of elements of established models for chronic care management and coordination (e.g., Wagner or ACOVE model).
10. Create incentives for implementing culturally competent chronic care models and protocols.
11. Develop and implement chronic care protocols, including, but not limited to:
 - a. medication usage.
 - b. identifying abuse and neglect, caregiver burnout/frustration.
 - c. caregiver safety and health.
12. Promote the use of Assistive Technology (AT) for consumers and direct care workers/caregivers as a prevention tool.
13. Investigate grant opportunities to pilot chronic care management models.

Benchmarks

1. Needs assessments are conducted and gap analysis reports are completed and reviewed.
2. Local and statewide groups complete plans to address local health and wellness gaps.
3. Executed contracts in place with local existing entities, which are broad-based (including the aging and disability community) to address gaps.
4. Completed workgroup report evaluating progress, outcomes, and identifying next steps.
5. Every local region has a program in place to train caregivers that is culturally competent to the needs and culture of the informal caregiver.
6. Consumer supports are increased and better utilized.
7. Caregiver needs screening incorporated into Medicaid-funded screening instruments.
8. Upon retrospective review, address caregiver needs.
9. Registries completed with processes in place for ongoing updates.
10. Legislative and administrative initiatives are in place and used.

11. Increase in the number of primary and LTC providers trained and adopting the best chronic care and culturally competent models.
12. Medical schools and nursing/ancillary healthcare programs expand their curricula to include chronic care.
13. Increased numbers of students graduating from schools with established chronic care curricula/programs.
14. Increased number of providers using screens and protocol-driven interventions.
15. Increased use of assistive technology as reflected in the person-centered plan.

WORKGROUP ON PUBLIC EDUCATION AND CONSUMER INVOLVEMENT

Charge to Workgroup

- Review and monitor the implementation of recommendation # 4 of the Medicaid Long-Term Care Task Force.
- Engage their members, volunteers, and constituencies in advocacy for the successful implementation of the Task Force recommendations.
- Assist the Commission in being an effective and visible consumer advocate for improving access to a quality array of long-term care, services, and supports.
- Present findings and recommendations regularly to the Commission for next steps and potential changes in policy that promote meaningful consumer participation and education.
- Ensure all recommendations:
 - Involve consumers and broad public participation in planning.
 - Promote an array of long-term care services and supports.
 - Promote the concept of money (funding) following the person to wherever that person chooses to live.
 - Assure evaluation is addressed.
 - Assure consistency with the overall commission process for statewide impact.

Background

Task Force Recommendation # 6: Promote Meaningful Consumer Participation and Education by Creating a Long-Term Care Commission and Informing the Public about the Available Array of Long-Term Care Options.

Strategies / Action Steps

Create a Michigan Long-Term Care Commission to provide meaningful consumer oversight and accountability to the state's reform and rebalancing of the long-term care system.

Recommended Actions

All stakeholders will have meaningful roles in the ongoing planning, design, implementation, and oversight efforts to achieve the recommendations of the Michigan Medicaid Long-Term Care Task Force and the long-term care efforts of the state. Consumers, families, and their representatives will be the principal participants.

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Educate consumers, families, service providers, and the general population about the array of long-term care options available so that consumers can make informed choices and plan for the future.

The goals of the public awareness and education campaign are:

1. Increase awareness of the SPE agencies through uniform “branding” of local agencies throughout the state (with uniform naming and logo, a single web site, and a geo-routed toll free number).
2. Increase awareness among consumers, prospective consumers, providers, faith-based communities, other community organizations, neighbors, friends, and family members of LTC services that consumers can choose from the array of LTC supports, determine their needs through the person-centered planning process, and have the option to control and direct their supports.
3. Authorize continuing education for professionals (including doctors, nurses, pharmacists, dentists, psychologists, administrators of LTC facilities, discharge planners, social workers, and certified nursing assistants) on the role of the SPE agency, the value of the person-centered planning process, the array of long-term supports available, and options for consumers to direct and control their supports. These professionals can direct individuals to the single point of entry and support them in making informed choices and planning for their future.
4. Assure that state employees involved in any aspect of LTC are provided mandatory training on the value of the person-centered planning process, the array of LTC supports available, and options for consumers to direct and control their supports.
5. Provide an orientation to legislators and their aides and officials in the executive branch on the value of person-centered planning, the array of long-term supports available, and options for consumers to direct and control their supports.
6. Create an educational program for children K-12 to learn about career opportunities in direct care and other aspects of LTC, and the components of the new LTC system (the array of long-term care supports available, the value of the person-centered planning process, and options for consumers to direct

and control their supports) so that children can share this information with their family members.

Strategies / Action Steps

1. Develop criteria for and authorize hiring of a social marketing firm to develop a marketing and public awareness campaign that includes the following components:
 - a. Uniform identity including name and logo for the single point of entry agencies;
 - i. Public awareness campaign that includes radio and television public service announcements, print ads, brochures, and other appropriate educational materials; and
 - ii. Local media and awareness tool kit that single point of entry agencies can use to outreach to and raise awareness among all stakeholders.
2. Develop criteria for and authorize hiring of a web design firm and an expert in creating materials for the targeted populations (e.g., seniors and people with a variety of disabilities) to design an informative, user friendly web site that can serve as a single point of information regarding LTC in Michigan. This web site will maintain the look, name, and logos developed for the marketing and public awareness campaign. The web site will include comprehensive information on LTC, have well-developed keywords and navigation capabilities, and be linked to major search engines and other relevant web sites in a way that makes them easily accessible.
3. Establish criteria for and authorize the development of curricula for education of professionals (including doctors, nurses, pharmacists, dentists, psychologists, administrators of LTC facilities, discharge planners, social workers, and certified nursing assistants) that can be included in academic programs and continuing education requirements for licensing and/or certification and will be implemented over time.
4. Establish criteria for and authorize development of a variety of training and educational materials targeted to the specific groups described above (state employees involved in long term care, legislators and their aides, and children K-12).

Benchmarks

1. Development of campaign materials including radio and television public service announcements, print ads, brochures, and other appropriate educational materials.
2. Dissemination of campaign materials:

- a. Measured by number of media placements and numbers of materials distributed.
- b. Measured by the impact as identified by consumers, family members, and professionals that interact with the Single Point of Entry agencies.
3. Development of curricula targeted to the identified professional and educational groups.
4. Implementation of curricula targeted to the identified professional and educational groups.
5. Measured by the number of individuals that complete a curriculum or other educational program.
6. Measured by the referrals to the SPE by the professionals.
7. Measured by consumer reporting of the content of the professional interaction (i.e., if and how the professional made a referral to the SPE and whether the professional described the potential for consumer choice and control).

OPEN MEETINGS ACT SUMMARY PA 267 OF 1976

The spirit of the Act is to make government open and accessible to the people.

The public's right to attend and participate in meetings of a public body is statutory. Provisions allow a person 1) to attend and record or telecast a meeting and 2) to speak during a public comment period under rules established by the public body.

The OMA mandates:

- that notice be given before a meeting is held,
- that minutes be prepared as a record of actions taken at the meeting
- that each meeting must include a public comment period
- when minutes must be available to the public
- that all decisions must be made in public.

Any person has a right to attend a meeting of any public body at any time unless the meeting is determined to fall under one of 10 statutory exceptions. Exceptions pertinent to the LTCSSAC:

- Social or chance gatherings not designed to subvert OMA
- Conferences
- Committees adopting non-policy resolutions “of tribute or memorial”

To determine if the OMA applies in a particular situation, you have to know whether 1) a **public body**, 2) is **meeting** to 3) **deliberate toward or make a decision** as each of those elements is defined by the OMA.

1) a public body - MCL 15.262(a) defines public body as “any state or local legislative or governing body, including a board, commissions, committee, subcommittee, authority or council that is empowered by state constitution, statute, charter, ordinance, resolution or rule to exercise governmental or proprietary authority or perform a governmental or proprietary function.” Any committee, subcommittee or other body that meets the definition of **public body** is subject to the OMA. **The LTC Supports and Services Advisory Commission meets the definition of a public body and is subject to the OMA.** Delegating authority for decision-making, deliberations to less than a

quorum or a single member of a public body (e.g., recommendation workgroups) does not avoid mandates of OMA.

- 2) **is meeting to** – MCL 15.262(b) defines a meeting as “the convening of a public body at which a quorum is present for the purpose of deliberating toward or rendering a decision on a public policy...” A regular meeting is on the schedule of meetings adopted by the body and posted within 10 days after the first meeting of the public body’s year. A special meeting is a meeting that is not in the schedule of regular meetings. A work session is defined as a meeting at which the body does not intend to vote on any business, but there is no such designation in the OMA. Work-group meetings being convened by various LTCSSAC members are not subject to the OMA, unless there would be a quorum of members of the LTC Advisory Commission present.
- 3) **deliberate toward or make decisions** – MCL 15.262(d) defines a decision as a determination, action, vote or disposition upon a motion, proposal, recommendation, resolution, order, ordinance, bill or measure on which a vote by members of a public body is required and by which a public body effectuates or formulates public policy.

What is a decision?

- Where a committee, subcommittee is empowered to act on matters in such a fashion as to deprive the full body of the opportunity to vote on the matter, the committee is exercising governmental authority that effectuates public policy and therefore is making a decision.