GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

June 29, 2023

TO: Interested Party

RE: Consultation Summary Project MI Choice Renewal L 23-38

Thank you for your comment(s) to the Behavioral and Physical Health and Aging Services Administration relative to Consultation Summary Project MI Choice Renewal L 23-38. Your comment(s) has been considered in the preparation of the final publication, a copy of which is attached for your information.

Responses to specific comments are addressed below.

Comment: Waiver services are proposed to expand; however, additional payment should be proposed in the proposed renewal application.

Response: Thank you for your comment.

Comment: With all service expansions listed in this renewal, we would like the funding to be available to effectively deliver the service. We believe when the state implemented the non-emergency medical transportation service that funding was attached to that service. As there will not be historical data to look to for the costs of the service expansions, we would want to be prepared to cover the cost of any service expansion moving forward.

Response: Thank you for your comment.

Comment: We appreciate that the renewal application includes service expansions. For any new service expansion (such as assisting in hospitals with care, allowing spouses to provide paid care, and other items), we would like the changes to come with an implementation plan. We are hoping the plan would include clarity of rollout, services might be staged at certain time increments for rollout, and to consider piloting in a small fashion before network rollout. We also would like pilot data to ensure successful outcomes prior to these expansions being required to rollout statewide. We want to ensure there is data available to see if the service expansion or change is impactful to those we serve.

Response: Thank you for your comment. Additional policy and parameters will be developed and updated in the MDHHS Medicaid Provider Manual. However, all participants have different circumstances, and rollout must occur on a person-centered, case-by-case basis to meet the unique needs of each MI Choice participant.

Comment: Community health workers (CHW) will be allowed as an administrative expense. The waiver renewal should authorize AAAs to directly hire CHWs if not available in the community. Other entities, including health plans, are allowed to directly hire.

Response: MDHHS did not change the CHW service to an administrative expense. This change was not made because MDHHS did not want to jeopardize Federal Financial Participation by eliminating a service from the MI Choice waiver. Instead, MDHHS added the following language to the CHW provider qualifications "Trained waiver agency staff may be utilized if there were no other willing and qualified providers for the CHW service." Waiver agencies that cannot find qualified CHWs in the community that are willing to become a contracted network provider may ask for a provider network exception and if approved by MDHHS, hire the CHWs directly.

Comment: We appreciate that the CHW service may be allowed to be offered directly by the waiver agent under administrative expenses if there is not CHW availability in this area. We believe this service should be able to be offered by the Waiver Agents directly with the appropriate funding following as other entities such as health plans provide to participants.

Response: MDHHS did not change the CHW service to an administrative expense. This change was not made because MDHHS did not want to jeopardize Federal Financial Participation by eliminating a service from the MI Choice waiver. Instead, MDHHS added the following language to the CHW provider qualifications "Trained waiver agency staff may be utilized if there were no other willing and qualified providers for the CHW service." Waiver agencies that cannot find qualified CHWs in the community that are willing to become a contracted network provider may ask for a provider network exception and if approved by MDHHS, hire the CHWs directly.

Comment: The waiver renewal proposes to expand qualifications for supports coordinators to include licensed psychologists, OT, and PT in addition to social workers and registered nurses. We don't believe that those disciplines are relevant to supports coordination. MDHHS has presented

this as a remedy for the workforce shortage, but these are not easy disciplines to hire. CHWs and LPNs would be more relevant to supports coordination. We don't believe that psychologists/OT/PT are viable options.

In relation to expanding who can provide Supports Coordination to include licensed psychologists, OTs and PTs, we are uncertain this will assist the workforce recruitment challenges. While we agree that broadening the approach to who may offer or support the SC service could assist with recruitment of staff and serving participants, please consider disciplines such as LPNs, Human Service degreed individuals or other counseling licensed individuals with flexibilities. Possibly allowing the RN or the LSW being the primary and the other individual being the secondary on an assessment.

Response: MI Choice serves some of the most clinically complex and vulnerable adults at home. Licensed Practical Nurses, unlicensed individuals with Human Services degrees, and Community Health Workers do not have the qualifications to adequately address the medical and social issues faced by the population served. The service of Community Health Worker has been included in MI Choice since 2018 and is available to beneficiaries in need. Authorizing Community Health Worker services for MI Choice enrollees can help alleviate the demands on supports coordinators while assuring the enrollees have access to services and supports to meet their needs.

Comment: The proposed changes in performance measures are alarming. We request clarification regarding the proposed performance measures. We recommend restructuring quality payments to focus on improved performance rather than compliance with CQAR standards. Waiver agents strive to improve performance every day. Waiver agents will keep doing what MI Choice is known for -- person centered care. Performance guidance should be clear and streamlined to support person centered care and enhance efficiencies.

Response: Thank you for your comment. The table in Attachment A of this document compares the current performance measures with the performance measures included in the waiver renewal application. Of the original 39 measures, 14 (36%) were unchanged, 12 (31%) were deleted, the remaining 13 (33%) measures were modified to better align with current nomenclature, federal regulations, or to use better data sources. Three performance measures were added, providing a total of 30 performance

measures included in the renewal, a reduction of 23% in the number of performance measures.

Comment: Regarding the Quality Withhold change, we would like to see a commitment to ongoing beneficiary engagement in determining these criteria as well as evaluating performance. However, it is difficult to comment on this proposed change to focus on improved performance rather than compliance without a full review of the criteria that will be used to evaluate performance. Conceptually it makes sense, though we'd want to be sure this does not become a way for waiver agencies currently struggling with compliance to avoid penalties for noncompliance.

Response: Thank you for your comment.

Comment: Changes mentioned in reference to performance measures states performance measures will be focused more on improved performance, rather than compliance. With this change, we are requesting clarity and training with the performance measures themselves as a network or one to one with Waiver agents. We believe changes will be coming in relation to performance measures, restructuring quality payments, and monetary sanctions. Our agency continues to be on board with improving our performance daily. We want to keep doing what MI Choice is great at which is person centered care. We recommend that any changes to performance measures and reviews are streamlined and come with clear guidance or training prior to implementation (some efficiencies would be avoiding reporting the same information to multiple entities, having one consistent reviewer per agency, accreditations and other measures of quality are used to measure success).

Response: Thank you for your comment. MDHHS will keep waiver agencies informed of requirements and expectations.

Comment: We support proposed changes to authorize waiver agents to deliver assistive technology services directly.

Response: Thank you for your comment.

Comment: Regarding the separation of Assistive Technology from Specialized Medical Equipment and Supplies, this is an excellent change! The definition is expansive and person-centered, and it provides a great framework to allow participants to receive necessary equipment and supplies. We particularly like that the definition focuses on both the participant's function *and* decreasing social isolation.

Response: Thank you for your comment.

Comment: Can a spouse or legally responsible adult be hired through an agency via Agency with Choice? Or are they barred as caregivers no matter the self-determination arrangement?

Response: A spouse or legally responsible adult may be hired through a network provider agency through a traditional arrangement, but not through a self-determined arrangement such as Agency with Choice. As stated in the Community Living Supports service definition: “Spouses and legally responsible adults are allowed to be paid caregivers in limited situations. They must not be hired via the self-determination arrangements. These individuals must be hired by a home care agency that will provide supervision and oversight to ensure services are being delivered.”

Comment: The new language states: “Spouses and legally responsible adults are allowed to be paid caregivers in limited situations.” Is there any additional guidance regarding what those “limited situations” are?

Response: Thank you for your comment. Yes, additional policy will be forthcoming after the waiver renewal is approved by the Centers for Medicare and Medicaid Services (CMS).

Comment: Finally, we would like for spouses and legally responsible adults to be allowed to provide homemaking tasks that are for the sole benefit of the participant, or something along those lines. Or perhaps that is already possible, and these things would fall under “tasks not considered homemaking.” For example, we are thinking about a situation with a participant who suffers from incontinence: would all the work around stripping, changing, and laundering sheets be excluded homemaking tasks? Those kinds of tasks could really add up, and we’d hate to see spouses/legally responsible adults not get compensated for tasks that would be paid to an outside caregiver.

Response: Thank you for your comment.

Comment: Spouses and legally responsible individuals are authorized to provide CLS in limited situations. Will funding follow this enhancement?

Response: Because MI Choice is a managed care program, all rates developed must follow the actuarially sound requirements specified by CMS. Allowing spouses to be paid caregivers in and of itself may not warrant a change in

funding since some of these services may currently be provided by other paid caregivers and the costs are already included in the capitation rates.

Comment: Waiver agents request clarity around deciding between formal and informal care in these instances. What does limited situations mean?

Response: Thank you for your comment. Additional policy will be forthcoming after the waiver renewal is approved by the Centers for Medicare and Medicaid Services (CMS).

Comment: While we agree with expanding food services such as grocery delivery, we are uncertain of the impact of “meal kit” on those we serve. While this was allowed during the PHE, we believe it was minimally used during the pandemic. The expansion of grocery delivery is a more viable flexibility to meet the nutritional needs of participants.

We also appreciate the specific flexibilities offered for nutrition. We would recommend grocery delivery as the more viable service expansion than meal kits. We do not believe meal kits would be an ideal service for our participants. We believe current services with the addition of grocery delivery would contribute meeting the adequate nutritional needs of our participants.

Response: Thank you for your comment. Based on participant feedback, MDHHS has chosen to allow meal kits and payment of grocery delivery service fees to offer more options to participants.

Comment: Regarding Home Delivered Meals, these are great changes. The items you’re removing from the previous language will be very helpful to participants, particularly the requirement that the participant must be able to feed himself/herself. The inclusion of meal delivery kits and service/membership fees for grocery delivery services are also fantastic additions. Not only does this provide more diverse food options for participants, it also expands potential vendors for home delivered meals, which could help limit service disruption issues.

Response: Thank you for your comment.

Comment: We strongly suggest that the expansion of CLS provided in hospital settings is investigated to assure that there is data to support success for HCBS for participants. We recommend that this service expansion be a pilot program with clear guidance on how and when to deliver, as well as how to approach the hospital in relation to policy, legal responsibility, and

protocols. The system should be equitable for HCBS in this scenario, as this service expansion would only apply to MI Choice participants.

In relation to offering CLS in the hospital setting, we strongly suggest gaining data to support the success of this HCBS service delivery if this has not been collected already. If there is no data to support that this measure has positive outcomes, we recommend a small pilot of this service to collect outcomes.

Response: Thank you for your comment.

Comment: Regarding Community Living Supports in the hospital, another great addition!

Response: Thank you for your comment.

Comment: The proposed language looks good, though it may be helpful to include something that flags that the a-f list of circumstances is *not* an exhaustive list of situations where Community Living Support (CLS) could be provided in the hospital. The use of the word “may” in “Examples of the circumstances for which this could be allowed may be:” seems to make it clear that this is not an exhaustive list. However, many of the waiver agency staff in the waiver renewal stakeholder meetings expressed concern with the idea of providing CLS in hospitals in any capacity, and we worry that they might see this list and read the language as “Examples of the circumstances for which CLS is allowed are:.” A simple sentence such as “The examples provided below/above are not an exhaustive list of circumstances in which CLS can be provided to participants while in the hospital” would address this issue.

Response: Thank you for your comment. MDHHS will add that language.

Comment: Can there be clarification on how and when a video assessment can be done (assuming it is the participant's request). Both in a single SC approach and a team approach. Also, if a situation warrants a RN/SW approach for an existing participant, can this assessment be completed with 1 clinical SC being in person and the other clinical SC via video call remotely?

Response: Thank you for your comment. Additional policy will be forthcoming after the waiver renewal is approved by the Centers for Medicare and Medicaid Services (CMS).

Comment: Regarding subsequent reassessments, the proposed language reads "The initial iHC assessment is required to be conducted in-person. Reassessments are to be completed in-person unless the participant prefers to have the iHC completed virtually with camera on. Telephonic assessments are not allowed. If an individual is in a nursing facility that is out of service area, or transferring to a new waiver agency in a different service area, MDHHS will allow the assessment to be conducted virtually with video on." This provides nice flexibility for the participant and helps preserve some of PHE era policies that many participants may have grown accustomed to over the past few years.

Response: Thank you for your comment.

Comment: Regarding separation of Residential Services from Community Living Supports (CLS), the proposed language reads: "Residential Services are defined as: Personal care and supportive services (homemaker, chore, attendant services, meal preparation) that are furnished to waiver participants who reside in a setting that meets the home and community-based setting requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance (to the extent permitted under state law). Services that are provided by third parties must be coordinated with the assisted living provider." "CLS cannot be provided in residential settings such as Adult Foster Care, Homes for the Aged, or other assisted living facilities. Residential services must be used instead." Considering this, is the definition of Residential Services sufficient to cover all necessary services? For example, CLS includes "Dementia care, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's person-centered plan." Does the Residential Services definition allow for comparable services?

Response: Yes, the residential services definition allows for comparable services.

Comment: Could a participant potentially receive both Residential Services and CLS during "social and recreational programming" services that occur outside the facility?

Response: Yes, this is permissible.

Comment: Including evictions on the list is a great addition. Evictions are incredibly stressful and potentially traumatic events, and it is great to see them

acknowledged as such. One possible addition to this would be to add language about reporting eviction *notices* in addition to evictions. Simply going through the eviction process itself can be traumatic, even if the person ultimately is not evicted or finds alternative housing before the eviction. Including the eviction notice in the reporting process could also help prevent the eviction itself, or help make the process more manageable for the participant. To that end, we would like to see an additional requirement for the waiver agency to assist the participant in preventing the eviction.

Response: Thank you for your comment.

Comment: We also appreciate the more expansive and better detailed definition of Medication Errors. It is a good thing that it is not considered a medication error when an informed participant chooses to not take a medication or follow the prescribed course. That is their decision to make, and that choice did not need to be considered an error.

Response: Thank you for your comment.

Comment: Regarding the diversity, equity, and inclusion training, adding DEI training requirements is wonderful. And while we don't want MDHHS to have to identify a specific DEI training for waiver agents to complete, it would be nice to see *some* kind of standard attached to this. We all know there can be great trainings and there can be terrible trainings, and we would hate for these DEI trainings not to have their intended effect because waiver agencies satisfied the requirement with lackluster or ineffective options. Perhaps requiring that these be evidenced-based DEI trainings or something along those lines would help ensure these trainings are effective.

Response: Thank you for your comment. MDHHS agrees that DEI training must be effective. However, MDHHS is does not advocate a specific training, especially not within the waiver application. Were a specific training to be required, then become unavailable in the next five years, MDHHS would need to amend the waiver application. It is better to be generic in this requirement within the waiver application.

Comment: It would also be great to see MDHHS add reviews specific to DEI and offer targeted technical assistance to waiver agents who may need to approach participant interactions, assessments, and authorizations differently.

Response: Thank you for your comment.

Comment: Regarding retention payments, this commenter strongly supports retention payments and we were excited to hear the Department is still considering adding this benefit at a later date. Not only would these payments serve as an excellent retention tool, but they could also serve as a recruiting tool. If a participant seems likely to face future hospitalizations, retention payments could provide assurance to potential providers reluctant to work with such a participant. Knowing that a participant's hospitalization does not mean a potentially devastating interruption in pay could entice more providers to work with these participants. We understand that waiver agencies may view this as the provider getting paid to do "nothing." We obviously do not view it that way, but perhaps there are other flexibilities that would still allow the provider to serve the participant during this period. The care provider could do things like catch up on house cleaning, laundry, and shopping while the participant is in the hospital. Or perhaps they could accompany the participant in the hospital. Anything really that would allow the provider to keep working without any interruptions.

Response: Thank you for your comment.

Comment: Regarding Environmental Accessibility Adaptations, the definition includes the provision that, "The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate value." This definition also appears in the Medicaid Provider Manual. This represents discrimination against people living in poorer neighborhoods, as the identical adaptation could be approved in a neighborhood with higher property values. We previously discussed this issue with MDHHS staff in 2020 when MI Health Link considered adding duplicate language to its waiver renewal. The provision could also result in more State spending if the result is the beneficiary moving to a nursing facility. Broadly, we believe other language already in the definition addresses the issue this provision seeks to address. For example, existing language requires the provider to install the most cost-effective modification/adaptation and there is already a prohibition on adaptations or improvements that are of general utility but not of direct or remedial benefit to the participant. Therefore, we believe this provision is unnecessary, has unintended adverse consequences, and should be removed entirely.

Response: Thank you for your comment.

Comment: Regarding presumptive functional eligibility, we would like to see an option for presumptive functional eligibility for individuals aged 18-64 who want and need MI Choice services. It seems likely that individuals who qualify for nursing home level of care will also qualify when assessed through a disability determination. We are aware of cases in which MI Choice services have been delayed for weeks or longer because of time required to obtain a disability determination. It is unfortunate that individuals age 18-64 face a potential additional impediment to the prompt provision of services.

Response: Thank you for your comment.

Comment: Regarding MDHHS oversight of waiver agents, MDHHS needs the authority and capacity to impose a corrective action plan, monitor the waiver agent's compliance and impose penalties when a waiver agent's performance puts beneficiaries at risk. This could apply to broad operational issues (reports of longer than expected wait lists, refusals to put people on waitlists, inaccurate information about the number of hours a person trying to transition would get without an actual evaluation, assigning informal supports to do tasks they are unable to do in lieu of formal supports, consistently inaccurate denial notices) or individual beneficiaries who have complex and/or extensive needs and the service planning is adversarial. When an administrative appeal renders a decision that the appellant should be re-evaluated, the re-evaluation should not be done by the same waiver agent responsible for the service plan that is being appealed. The MDHHS Clinical Quality Assurance Team should be responsible for the re-evaluation and the team's decision should be binding on the waiver agent (with further appeal levels available to the beneficiary).

Response: Thank you for your comment.

Comment: What remedies exist when, for example, members of a specific community are not actually receiving services? It would be helpful to be able to utilize something like the Special Focus Facility designation that LARA uses for particularly troubled nursing homes to address these gaps in care for a specific waiver provider. If the model were similar to the Special Focus Facility designation, it would trigger more frequent oversight of the waiver agent, a public listing of the name of the troubled provider and how long it has been designated as a problem provider, and requirements that the waiver provider improve within a specific amount of time. When a waiver provider or agency has been designated or designation is being considered, the Department should explore:

How does this region or waiver agency compare to other regions in the state?
Can we identify the unique problems that exist in this region that led to gaps in services?
Can the state eventually impose civil monetary penalties?

Response: Thank you for your comment. CMS is requiring more scrutiny of managed care entity's provider networks. This additional scrutiny may address these concerns.

Comment: We suggest that the State take over the task of monitoring fiscal intermediaries, a change we believe the waiver providers would support. It would be very helpful to have an MDHHS staff person provide training and auditing for FIs especially since we understand there has been an increase in the number of entities providing this service. If the MDHHS staff person discovered systemic issues, they could be more efficiently shared and addressed than if each waiver provider was independently monitoring the FIs with whom they work. One of this commenter's recent cases supports the need for this kind of monitoring, as a fiscal intermediary incorrectly showed a negative balance of over $10,000 for the client's budget and originally sought to limit the participant's services. The fiscal intermediary eventually agreed to absorb those costs, but the case was concerning.

Response: Thank you for your comment.

Comment: President Biden and a number of states are pursuing measures to assure more transparency and accountability from the nursing home industry and this effort has received a great deal of public attention. We should demand the same from HCBS providers. Among the information that should be available to the state and the public are:

Payment rates to home care provider agencies?

What do waiver agents pay to agencies and SD workers.

Caseload statistics that will demonstrate which agencies have high caseloads. While we recognize that different providers have different staffing structures, there may be a way to both share more information and control for the different staffing arrangements.
The number of individuals who are actually being served, broken down county by county, with data that distinguishes between authorized and utilized hours. If a waiver provider is not serving anyone in Washtenaw

County, for example, because of a lack of caregivers, no individuals will be served until a new provider network is established even if hours of service have been authorized.

Response: Thank you for your comment. CMS is requiring more scrutiny of managed care entity's provider networks. This additional scrutiny may address these concerns.

Comment: Regarding the network adequacy and provider pool, currently, two waiver agents operating in the same service area can both cite the same providers when establishing the adequacy of their provider pool. Because both waiver agents serve separate groups of beneficiaries, this practice overstates the adequacy of the provider pool. MDHHS should use a process that compares the total number of beneficiaries served in the service area to the provider pool for that service area to determine if both waiver agents have adequate networks to serve all of their participants.

Response: Thank you for your comment. CMS is requiring more scrutiny of managed care entity's provider networks. This additional scrutiny may address these concerns.

Comment: The shortage of direct care workers, nurses and social workers compromises the waiver agents' ability to meet its contractual obligations and puts beneficiaries at risk. The waiver agents can spend more on staffing and those investments may be reflected in future PMPM rate increases. However, this option is wholly inadequate to address the growing worker crises in health care. MDHHS should modify the rate setting process to allow for immediate funding of compensation increases substantial enough to attract and retain workers in all essential roles.

Response: Thank you for your comment. CMS has very complex and comprehensive rules and regulations for setting actuarily sound capitation rates for all managed care programs which MDHHS follows.

Comment: Regarding a new competitive procurement process, we would like to see the state undergo a new competitive procurement process to select waiver agencies. It's our understanding that launching a new procurement process is not directly tied to the waiver renewal process. If it does not happen during this renewal application, we would like to see it explored in the future.

Response: Thank you for your comment.

Comment: On a similar note, we would like the state to reconsider the current waiver regions, or at least develop a process to open individual counties to other waiver agencies when the current agencies cannot adequately provide services.

Response: Thank you for your comment.

Comment: The new Ensuring Access to Medicaid Services proposed rule (CMS 2442-P) to the federal HCBS waiver requirements contains several items of great interest to advocates. These are still proposed rules, but it would be fantastic if the state would consider collecting this data now. In particular, there are two specific reporting requirements that would provide important data on services in the home. This data could help identify gaps in approved services vs. actual services provided, as well as gaps in care caused by shortages in the direct care workforce. The new proposed regulation at 42 CFR § 441.311(d)(2)(i) would require the state to report the average amount of time from when homemaker services, home health aide services, or personal care services are initially approved to when services begin for individuals newly approved to begin receiving services. The proposed regulation at 42 CFR § 441.311(d)(2)(ii) would require the state to report the percent of authorized hours for homemaker services, home health aide services, or personal care services that were actually provided within the past 12 months. Both of these regulations would identify when the waiver agency is not providing services, and if the data is reviewed on a rolling basis it could help pinpoint providers/regions that are struggling most.

Response: Thank you for your comment. MDHHS is aware of the proposed rules and when finalized will follow CMS guidance on adhering to the rules.

Thank you for your inquiry. We trust that previous responses addressed the concerns and questions noted. If you wish to comment further, send your comments to Heather Hill at mdhhs-michoice@michigan.gov.

Sincerely,

Meghan E. Groen, Director
Behavioral and Physical Health and Aging Services Administration