CHRT

ANALYSIS: PHASE III

Michigan Medicaid Long-Term Services and Supports

Final Report

DEC 14, 2018

In brief

In the FY2017-2018 state budget, the Michigan Legislature asked the Michigan Department of Health and Human Services (MDHHS) to explore the implementation of managed long-term services and supports (MLTSS) in the state. To do so, MDHHS is working with the Center for Health and Research Transformation (CHRT), Health Policy Matters (HPM), and Public Sector Consultants (PSC) to conduct an analysis of the state's current long-term services and supports (LTSS) system and to analyze a variety of options for expansion of managed LTSS.

Managed LTSS is a relatively new concept–one that has yet to develop an extensive evidence base to demonstrate effectiveness. However, there are a number of programs across the country. Some have shown positive results–for example, increasing access to home- and community-based services, reducing hospitalizations and emergency department use, and improving consumer quality of life–while others have shown more mixed results.[1] Even with mixed state experiences, CHRT/HPM believes that transitioning to a more managed LTSS system is still worth exploring because of the potential to achieve MDHHS' key goals: access to high-quality services in the setting of one's choice, better integration of LTSS with physical and behavioral health care, improved person-centered care coordination, and the ability for individuals to live independently in their homes and communities.

Based on our research, CHRT/HPM concludes that the MI Health Link program could be a logical platform to adapt for a future MLTSS program because it has the infrastructure required to better integrate physical health care, behavioral health care, and LTSS. However, changes to the current program need to be made and it is too early to have the data necessary to ascertain MI Health Link's success or drive decisions about whether it should be the framework for a future MLTSS program. In the absence of complete data, CHRT/HPM does not recommend a particular model at this time, but instead offers several MLTSS options for MDHHS to consider (Figure 1). This report also highlights concrete opportunities for improvement–such as conflict-free options counseling, person-centered planning, and integrated care management–that are prerequisites for a transition to MLTSS.

CHRT/HPM recommends an overall timeline (Figure 2) of five years as a starting point to guide MDHHS' next steps for global LTSS improvements and MLTSS planning. The first step is for MDHHS to extend the MI Health Link demonstration for an additional three years beyond the 2020 end date. This will allow time for the incoming

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Editor's note: See endnotes for all references; see appendix for all figures.

administration to fully transition, gather and analyze additional data, and implement the global opportunities for improvement discussed in this report. The evaluation of MI Health Link conducted by Research Triangle Institute (RTI) is expected in 2021, which will give MDHHS more information to evaluate the success of this current integrated program. Years four and five of this timeline allow for an MLTSS planning and development process that is in line with federal guidelines.

This report includes an executive summary of findings and provides a full description of the MLTSS options and timeline. This is followed by an in-depth explanation of the global and programmatic opportunities for improvement identified through this study, an overview of the current quality measures across LTSS programs, a summary of key stakeholder feedback on the opportunities for improvement and proposed MLTSS models, and a landscape analysis of the current Medicaid LTSS programs.

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Figure 1: Continuum of MLTSS Options

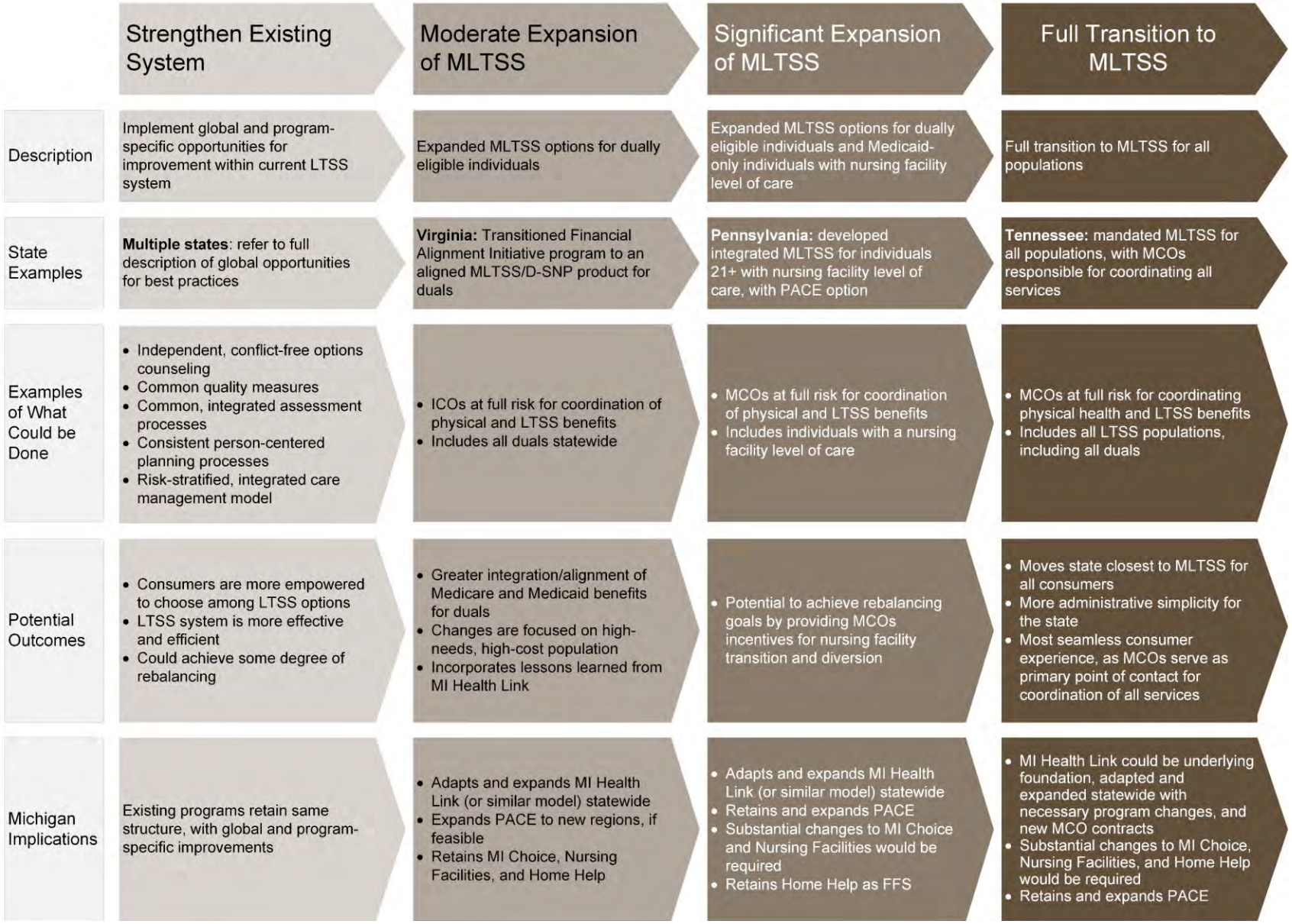
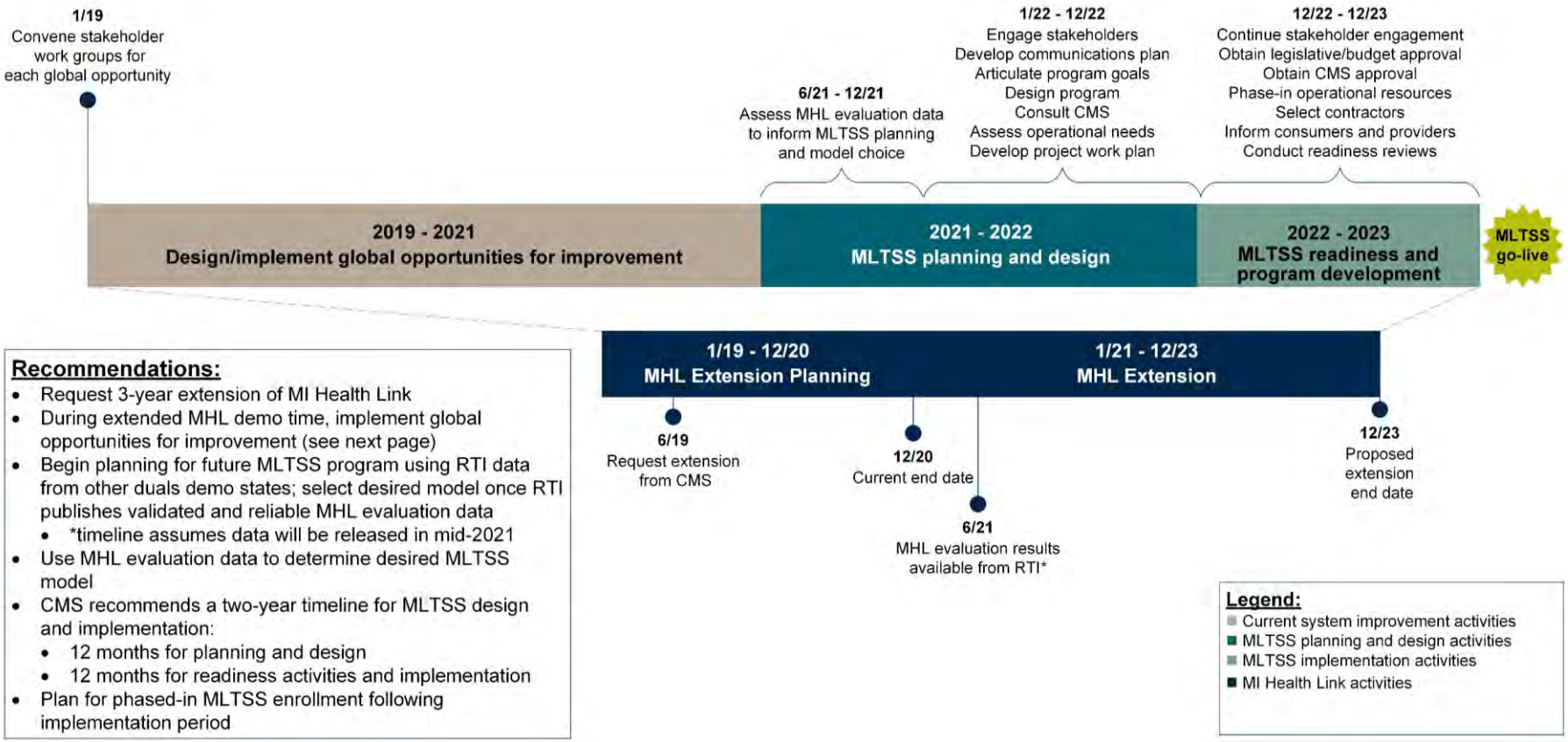
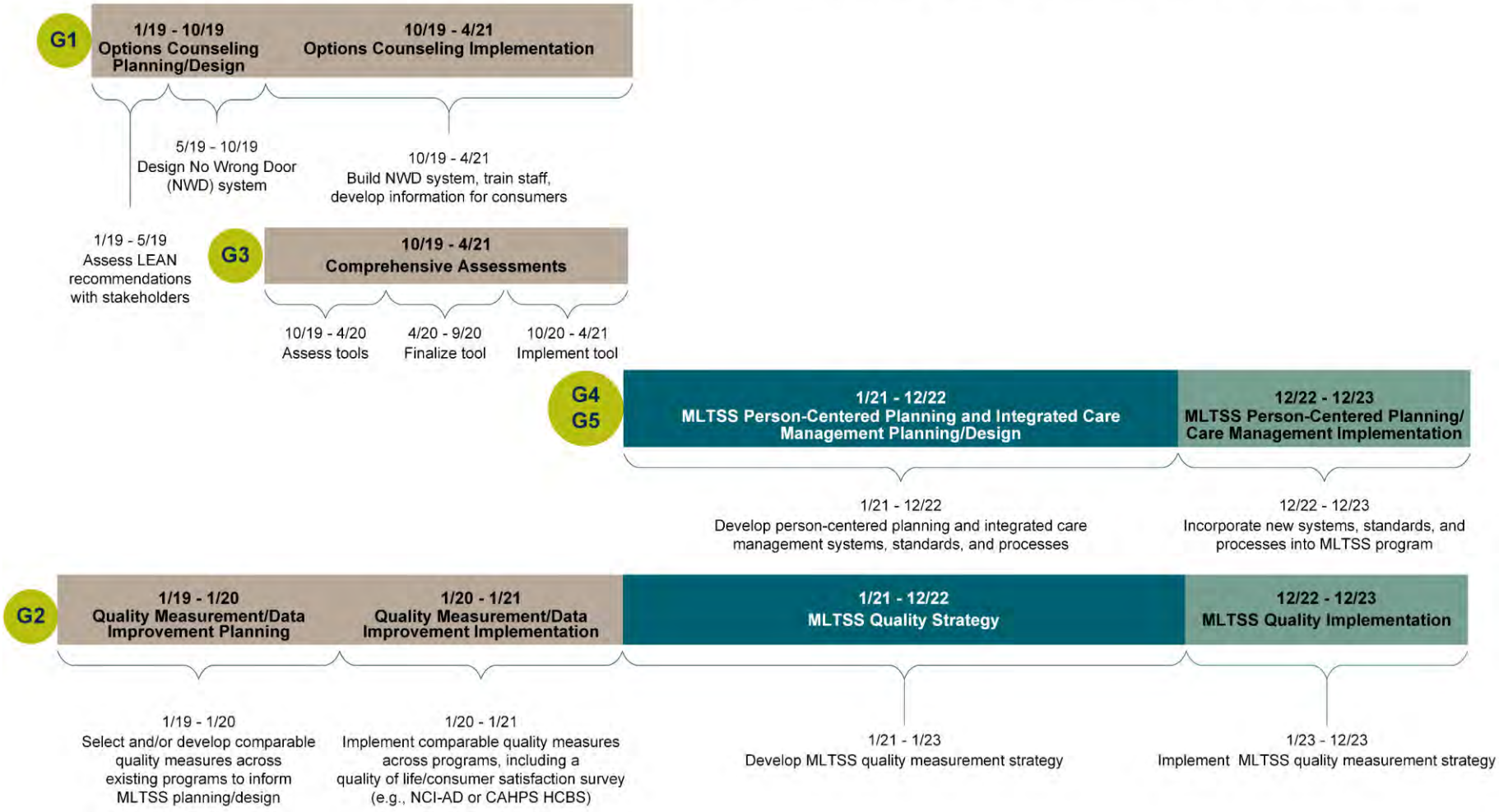


Figure 2: Proposed Timelines for LTSS Opportunities for Improvement and MLTSS Design/Implementation



Proposed Timelines to Implement LTSS Opportunities for Improvement and Incorporate Improvements into MLTSS Design/Implementation



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I. Executive Summary

Introduction

MDHHS has been working with the Center for Health and Research Transformation (CHRT), Health Policy Matters (HPM), and Public Sector Consultants (PSC) to begin to explore pathways to move toward a more managed system of long-term services and supports (MLTSS). The Department proposed goals and value statements to guide the MLTSS design process, in alignment with federal requirements surrounding MLTSS. The Department's overarching goal: *To establish a person-centered, quality-driven approach to developing an MLTSS program that supports consumers in the least restrictive setting, consistent with consumer needs and preferences.*

MDHHS's early objectives were to:

- Increase informed consumer choice
- Promote person-centeredness, choice, and self-determination
- Increase access to, and quality of, managed LTSS
- Hold providers accountable for quality of care
- Maximize access and anticipate and accommodate future demand
- Reduce avoidable acute care services, such as emergency department (ED) utilization, hospitalization, or hospital readmissions
- Integrate physical and behavioral health services to the greatest extent possible

CHRT, HPM and PSC engaged in a series of analyses to identify how MDHHS could move toward these goals and objectives while improving service delivery for individuals who require LTSS. Following is a description of each of the components of the work, followed by recommendations regarding next steps.

Essential Elements of MLTSS

In 2013, the Centers for Medicare and Medicaid Services (CMS) issued guidance to states that outlines essential elements of MLTSS. This guidance describes ten key principles to help drive states' planning, design, and implementation processes for the development of a robust MLTSS approach.

- Ensure adequate planning and transition strategies
- Engage stakeholders effectively and early
- Provide MLTSS in an integrated setting
- Align payment structures with MLTSS programmatic goals that support the Triple Aim
- Support consumers with options counseling and enrollment/disenrollment resources
- Follow person-centered processes
- Offer comprehensive, integrated services that incorporate coordination and referrals
- Ensure qualified providers as well as network adequacy and continuity of care requirements
- Include participant protections safeguards, and oversight of services
- Focus on quality of care and life across physical health, behavioral health, and LTSS

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Lessons from Other States

As of 2017, 24 states operated MLTSS programs.[2] Most of these programs are relatively recent, with 13 states receiving CMS approval from 2011-2015. Massachusetts and Rhode Island are seeking to utilize Delivery System Reform Incentive Payments (DSRIP) waivers to obtain funding from CMS to enhance program infrastructure and quality, including for LTSS programs. The trend toward full integration of physical, behavioral, and LTSS and psychosocial supports is noteworthy nationally within Medicaid Managed Care Organization (MMCO) programs and within MLTSS programs. In Phase I of this project, CHRT/HPM gathered research and best practices on MLTSS in selected states, illustrated below.

	OVERALL MLTSS APPROACH	APPLICABILITY TO MICHIGAN
Tennessee	Mandatory MLTSS was implemented under an 1115 Demonstration Waiver for older adults and individuals with disabilities as part of a well-established MMCO program with fully-integrated LTSS and BH services. The I/DD population is carved- out and served through a 1915 (c) waiver within a structured, fully-integrated approach.	MI also has a well-established MMCO program under an existing 1115 waiver (for expansion enrollees) and 1915 (b) waiver. The MCO market strength, the duals demonstration and other LTSS programs will all contribute to success in MLTSS, as well as the overlap between Medicare Advantage and Medicaid plans.
Minnesota	Older adults: MN's set of mandatory MLTSS programs for older adults was implemented on a staggered statewide basis in the early 1980s under an 1115 waiver and was later moved to a 1915 combination waiver. One program (MSHO) fully integrates Medicare and Medicaid services and one (MSC+) integrates Medicaid covered servicesonly. Individuals with disabilities: Special Needs BasicCare (SNBC) is a voluntary managed care program for adults with disabilities (age 18-64) with an opt-out process. 50% of the population receives integrated care through SNBC. The I/DD population is carved out of MLTSS, where the I/DD population receives services under waivers with a long wait list.	Older adults: MSHO and MSC+ were carefully constructed with significant consumer and stakeholder input. MN employed separate stakeholder processes for older adults, individuals with disabilities, and individuals with I/DD. MN Senior Health Options (MSHO) and MN Senior Care+ (MSC+) employ quality metrics that could benefit MI. Individuals with disabilities: This voluntary program captures significant enrollment and has satisfied members. MN has a highly positive relationship with consumers and advocates; the structure of the program and the process by which it operates deserves further review.
Pennsylvania	PA's new managed care delivery system for older adults and individuals with disabilities includes integrated LTSS and BH services. The mandatory Community HealthChoices (CHC) program is being implemented on a staggered statewide basis. BH services are coordinated by BH- MCOs and County BH agencies. PA consolidated all programs with the exception of the ICF/DD program.	PA consolidated waiver services into a new MLTSS program with integration across all services, in collaboration with county BH agencies and BH-MCOs. PA employed a best practice stakeholder process that we recommend for MI, where the decision to move to a managed system was presented with defined, fleshed-out options to stakeholders for their input.

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Global Opportunities: Strengthening Existing Programs

CHRT/HPM completed a review of the national MLTSS landscape and best practice states, and went on to study MI's existing LTSS and MLTSS programs. Our reviews focused on workflows across key functions including eligibility and enrollment, assessment of person-centered needs, care planning processes and implementation of care management services. MDHHS agreed that these processes represent the essence of person-centered planning.

CHRT/HPM conducted detailed reviews of processes associated with these topics for each MLTSS and LTSS program within MDHHS, identifying many programmatic strengths. The team also identified global opportunities to improve the delivery of LTSS across multiple programs. *In considering global opportunities for improvement, MDHHS and the consulting team recognized the importance of addressing such opportunities for improvement as a pre-requisite for developing a viable MLTSS program.*

Following are global opportunities for improvement and recommendations that MDHHS should address before it moves toward a more quality-driven MLTSS approach. In addition, program-specific opportunities for improvement are presented later in this report.

Finding 1: Consumer counseling services are not consistent across programs or independent of service provision; consumers often receive information from whichever program they speak to first without information regarding all available LTSS options. Currently, options counseling (i.e., the Freedom of Choice Form) generally occurs after an individual is deemed eligible for a specific program, and it is unlikely that a consumer would choose to pursue a different LTSS program, even if it may better fit their needs. Lessons from MI's prior experience with Single Point of Entry and ADRCs should be used to inform these efforts.

Recommendation 1: Create an independent, conflict-free options counseling center to provide information to individuals seeking LTSS and to more quickly direct consumers to appropriate services.

Finding 2: Quality metrics are not aligned across programs. Improved quality data could facilitate choice for consumers as well as evaluation and programmatic performance improvement for providers.

Recommendation 2: Identify appropriate goals and structure for LTSS quality measurement, including the adoption of a core set of common quality measures across programs that can inform consumer choice and facilitate evaluation and improvement of program performance.

Finding 3: Initial and comprehensive assessments across programs vary significantly, both with regard to content and process. This is especially true in MI Health Link, where contracted Integrated Care Organizations (ICOs) each have unique assessments, making comparisons regarding population characteristics and performance outcomes difficult to achieve.

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Recommendation 3: Create common processes for initial and comprehensive assessments with standardized, interoperable electronic documentation. Design decision tree-based assessments where consumers' answers will direct them to subsequent questions and drill-downs depending on their needs, preferences, and program-specific requirements.

- Utilize a lower-cost resource, such as an options counselor or certified social worker (vs. a registered nurse), to conduct the initial assessment at the outset of the enrollment process to stratify the population and identify specific LTSS options for which a consumer may be eligible. Then, conduct a uniform assessment on high risk individuals either by telephone or in person for the highest risk consumers in the program (e.g., top 5% who generate approximately 50% of total cost).
- Automate care plans with data elements from the comprehensive assessments.

Finding 4: Person-centered planning could be enhanced with a consistent application of person-centered planning core values documented through a centralized approach and portability across programs.

Recommendation 4: Create a more consistent person-centered planning process that includes standardized training and expectations for all case managers and providers of LTSS with centralized, electronic documentation for assessments, care plans, care plan revisions, admission/discharge/transfer (ADT) notifications, etc.
Finding 5: Care integration can offer the promise of improved quality and cost-effectiveness, especially for consumers with highly complex needs.

Recommendation 5: Create a more integrated approach to care delivery across all programs that offer LTSS. Adopt a common, stratified care management model for all LTSS programs for consumers who require a nursing facility level of care, with the goal of integrating care. Integrate physical health, LTSS, and psychosocial supports fully. Consider integrating behavioral health (BH) incrementally.
Finding 6: Consumers can benefit from planned transitions from one LTSS program to another. Thoughtful Transitions of Care can contribute to better quality care and more cost-effective care--from one program to another and from one setting to another.

Recommendation 6. Create processes to help ease consumer transitions from one program to another (e.g., the MDHHS policy to allow LOCDs to follow a person across programs).

Listening to Stakeholders: Summary of Feedback

MDHHS employs stakeholder feedback as a guiding component of efforts to improve the quality and cost-effectiveness of LTSS delivery in Michigan. As part of Phase 2 of this work, PSC conducted nine focus groups with LTSS consumers and in some instances, their caregivers, including LTSS consumers residing in nursing homes and in the community. PSC engaged consumers with a variety of needs including individuals with intellectual and developmental disabilities (I/DD), individuals with serious mental illness (SMI), and individuals with various disabilities. PSC also conducted 27 interviews with LTSS providers and other key stakeholders. In Phase 3, PSC conducted a survey and interviews with key LTSS stakeholders, including representatives of managed care organizations (MCOs), LTSS providers, nursing facilities, Area Agencies on Aging, community mental health, organizations representing recipients of services and supports, and the state long-term care ombudsman office. Key findings from the Phase 2 and 3 interviews and focus groups are highlighted below.

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What's Working Well?

The MI Choice Waiver Program is widely praised for the choice and flexibility it affords customers where services are available and accessible, despite its long wait lists and a fragmented LTSS market. PACE (Programs of All-inclusive Care for the Elderly) is praised by most stakeholder groups as a model for integrated care that successfully addresses many of the issues raised by providers and customers in other segments of the LTSS system. Nursing home availability is excellent, according to interviewees, as is the ability of nursing homes to transition residents to home- and community-based care.

Lessons Learned from MI Health Link

Most stakeholders view MI Health Link as a good concept but are critical of the effort to move managed LTSS to health plans which, they believe, prioritized cutting costs over improving quality of care. Many providers questioned whether health plan management of LTSS was an effective means to either end. Following the Section 298 efforts to shift administration of behavioral healthcare to health plans, many stakeholders felt the state lacked transparency and were mistrustful of MI Health Link as a result. Regarding MI Health Link, stakeholders, including health plans, expressed:

- The need for clearly defined goals and roles. Without these, many stakeholders felt the program required significant improvements related to clarity of tasks and goals, program administration, and coordination of care.
- Stakeholders felt that MI Health Link's passive enrollment communications focused more on why consumers might opt-out of the program rather than why consumers might choose to participate in it. They believe these communications need to be reviewed by a communications specialist to enhance the program's success.
- Many stakeholders expressed that there is an opportunity to improve support for informal caregivers and address workforce shortages in the acute care market, and shared concerns regarding the adequacy of capitation rates.

Opportunities for Improvement

Stakeholders agree that informal caregivers are crucial to the LTSS system, but that they lack adequate information, training, and support. While caregivers provide most of their loved ones' care and/or care coordination, few know which services are available or how to obtain them. Consumers and caregivers report that home and community-based care was more difficult to access, relative to nursing home care, and they believe this phenomenon is due to worker shortages and fragmented service delivery. For example, focus group participants reported that home care providers only offer a single service, where a consumer may require multiple services.

Availability of LTSS is siloed by demographics, geography, and care coordinating agencies. While needs differ across customer group (e.g., older adults vs. people with developmental disabilities), defining services according to customer groups can mask similarities in functional needs. Services and supports differ from region to region and between urban and rural communities. Specific types of services (e.g., behavioral health, environmental modifications, and supports) are often provided by separate agencies. Available choices are not always easily accessible, due to a program's limited target population or service territory, or the need to seek multiple services and supports individually from different providers. High-cost institutional care is the easiest type of LTSS to access, even for those who don't need or desire it. As a result, many customers who are eligible for and desire home- and community-based care cannot gain access to such services.

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Stakeholders were generally supportive of the recommendations to strengthen the existing LTSS system, and said they should also be addressed to improve MI Health Link, if it is adapted and/or expanded to additional areas of the state. Stakeholders believed that any expansion of MLTSS should be accompanied by conflict-free options counseling, standardization of quality measures for comparability across programs, and consistent processes for assessments, person-centered planning, and care management.

Expanding Managed Long-Term Services and Supports

Stakeholders said that any expansion of MLTSS should be considered with proper due diligence and with a data-driven decision-making process. Stakeholders provided a number of ideas for the state to consider as it continues its MLTSS research and planning efforts, including recommendations regarding competitive bidding, enrollment mechanisms, care coordination, network adequacy, support for caregivers, incentivizing access to HCBS, and beneficiary protections and communication. While many stakeholders focused these comments on the MI Health Link demonstration, due to its ability to be adapted for an MLTSS model in the future, some stakeholders recommended pursuing alternative approaches to MLTSS.

Landscape Analysis: Summary of Findings

CHRT/HPM conducted a descriptive analysis of Michigan's major Medicaid LTSS programs for MDHHS to consider in weighing the implications associated with a move toward greater MLTSS. The analysis in this report focuses on the five major Medicaid programs that provide LTSS: Home Help, MI Health Link, MI Choice, PACE, and nursing facilities. Key findings from the landscape analysis are included below.

- In FY2017, individuals receiving Medicaid LTSS comprised just 5 percent of total Medicaid enrollment, yet they accounted for 23 percent of total Medicaid expenditures.
- In FY2017, 82 percent of individuals enrolled in Medicaid LTSS programs were dually eligible for Medicare and Medicaid. All Medicaid LTSS programs have between 90 and 100 percent dually eligible enrollees, except Home Help with 60 percent.
- In 33 of Michigan's 83 counties, 25 percent or less of individuals with a nursing facility level of care received LTSS in a home- or community-based setting in FY2017.
- For programs serving individuals with a nursing facility level of care, nursing facility and MI Choice enrollees had similarly high hospital admission rates in FY2017. However, MI Choice enrollees had approximately a 50 percent lower readmission rate than those in nursing facilities.

Next Steps in Michigan: Options and Recommended Decision Points

We recommend that MDHHS implement the global opportunities outlined above across LTSS programs in the short-term to create a strong foundation for an eventual transition to greater use of MLTSS. We further recommend that MDHHS:

- Apply for an extension of the MI Health Link demonstration in order to gather more data on the program and implement the global improvement opportunities outlined above
- Implement program-specific recommendations once the global infrastructure opportunities have been addressed, including necessary improvements to MI Health Link

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- Review and analyze the MI Health Link evaluation (expected in 2021 from RTI), which would allow adequate time to plan and implement a new MLTSS program

This section contains a description of potential models to expand MLTSS, a recommended timeline to pursue the global opportunities for improvement and begin MLTSS planning and design, and recommended next steps for MLTSS planning and design.

Continuum of MLTSS Options

To develop options for MLTSS expansion in Michigan, CHRT/HPM analyzed processes and data on current Medicaid LTSS programs and identified best practices in states that have pursued similar MLTSS models. PSC gathered views from stakeholders on strengths and weaknesses in the current system. We considered options that build on strengths in the current system – including a longstanding history of managed care for physical health benefits, existing MLTSS options with MI Health Link, MI Choice, and PACE, and lessons learned from MI Health Link implementation. MDHHS could choose to implement one specific option, or the options could build on each other.

As MDHHS considers options to expand MLTSS, we recommend the Department engage in the following activities to support program design:

- Evaluate MI Health Link based on data from RTI's evaluation of the program to leverage opportunities to pursue a data-driven MLTSS program that takes advantage of lessons learned in MI Health Link
- Begin to plan MLTSS using CHRT/HPM's proposed design process, including:
    - Develop the overall program design, based on data-driven analysis and best practices nationally, given the importance of thoughtful and incremental planning to achieve full implementation
    - Determine the optimal waiver authority
    - Identify appropriate covered populations for inclusion in the program design
    - Determine the appropriate geography scope and timing of implementation statewide
    - Finalize the program design and all key elements
- Consider implementing services for older adults and individuals with physical disabilities first, followed by incremental approaches to developing an MLTSS program for individuals with significant behavioral health needs and individuals with intellectual or developmental disabilities (I/DD)
- Recognizing the natural overlap between behavioral health and LTSS, consider creating a separate plan for the I/DD population (either leaving them out of MLTSS, or delaying implementation and working with stakeholders to create a plan that is specific for that population)

II. Options, Proposed Timeline, and Recommended Next Steps for MLTSS Development

CHRT/HPM recommends that MDHHS implement the global opportunities outlined above across LTSS programs in the short-term to create a strong foundation for an eventual transition to greater implementation of MLTSS. CHRT/HPM further recommends that MDHHS implement program-specific recommendations simultaneously or once the global infrastructure opportunities have been addressed.

Additionally, CHRT/HPM recommends MDHHS apply for an extension of the MI Health Link demonstration in order to make necessary program improvements, review and analyze the MI Health Link evaluation (expected in 2021 from RTI), and allow time to plan and implement a new MLTSS program. This section contains a description of potential models to expand MLTSS, a recommended timeline to pursue the global opportunities for improvement and begin MLTSS planning and design, and recommended next steps for MLTSS planning and design.

Continuum of MLTSS Options

The new MLTSS program could follow one of several model options. CHRT/HPM developed two continua illustrating these options: the first, which provides more details on potential MLTSS structures, was developed for MDHHS staff and is included in this section; the second was adapted for an external stakeholder audience and is included in Section V of this report. Written descriptions of each option are included below.

MLTSS Options: CHRT/HPM has identified four potential options for MDHHS to consider as the state moves toward a more managed LTSS system. To develop these options, CHRT/HPM analyzed processes and data on current Medicaid LTSS programs, PSC gathered views from stakeholders on strengths and weaknesses in the current system, and CHRT/HPM identified best practices in states that have pursued similar MLTSS models. CHRT/HPM considered options that build on strengths in the current system – including a longstanding history of managed care for physical health benefits; existing MLTSS options with MI Health Link, MI Choice, and PACE; and lessons learned from MI Health Link implementation. MDHHS could choose to implement one specific option, or the options could build on each other.

The four proposed options below have a number of benefits. They can allow more consumers to remain in their homes and communities; provide greater integration of physical health and LTSS benefits; enhance quality and cost-effectiveness; and allow for the incorporation of value-based payment strategies to incentivize innovation. The range of options are also varied in scope. The proposed options align with similar efforts in other comparable states, allowing MDHHS to leverage other states' experiences in program design, development, and implementation. There is flexibility in each element of each model, and MDHHS could choose an approach that mixes elements of different models. For example, Illinois includes LTSS in its broad Medicaid Managed Care program, but has two separate MLTSS programs (a duals demonstration and an MLTSS program for those who opt-out of the demonstration) for dually eligible individuals.

Option 1: Strengthen the existing system
MDHHS would implement the global and program-specific opportunities for improvement recommended by CHRT/HPM, and would seek a three-year extension of the MI Health Link demonstration to allow more time for program improvement, data collection, and evaluation of program outcomes. We recommend MDHHS pursue this

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option before moving forward with any MLTSS options. This would allow the Department to ensure the quality and completeness of MI Health Link data so that pilot experience can inform decision-making about MLTSS. A detailed timeline of this option is included in this report.

Option 2: Moderate expansion of MLTSS

Following implementation of Option 1, including implementing the opportunities for improvement and the MI Health Link demonstration extension, MDHHS would develop a statewide MLTSS product for dually eligible individuals. This could take the form of an adapted and expanded MI Health Link program (depending on federal willingness to grant an extension). This option would retain the current program array for Medicaid-only consumers with minimal disruption to the current system. Implementing MLTSS for duals can integrate physical health and LTSS benefits for the high-cost, high-needs populations, potentially resulting in greater coordination and quality. Implementing this option would affect duals receiving LTSS (approximately 106,591 duals in FY2017). Ohio has gone this route, and is currently in the process of requesting an extension of its duals demonstration through 2022. Ohio plans to use the extended timeline to evaluate lessons learned and focus on improvements to its My Care Ohio program.[3] The state has established a committee to look at the value of implementing MLTSS based on My Care data and data from other states.

Option 3: Significant expansion of MLTSS

Following implementation of Option 1, including implementing the opportunities for improvement and the MI Health Link demonstration extension, MDHHS would develop a statewide MLTSS product for dual eligibles plus Medicaid-only individuals who require a nursing facility level of care. This is similar to Option 2, but would cover a slightly larger population. This could be adapted from the general structure and most successful elements of the MI Health Link program, or could use another vehicle. It could include transition of the current MI Health Link, MI Choice, and nursing facility programs into one consolidated program for dual eligibles and Medicaid-only LTSS consumers with a nursing facility level of care. MCO contracts could include incentives for greater provision of home and community-based services. Implementing this option would affect duals receiving LTSS (approximately 106,591 in FY2017) and Medicaid-only individuals at a nursing facility level of care (approximately 3,295 in FY2017). Pennsylvania has gone this route. The state developed an integrated MLTSS program for dual eligibles and individuals ages 21+ with nursing facility level of care. Though Pennsylvania did not have a duals demonstration, they relied on their experience with managed care and lessons from other MLTSS states. Please see two programmatic options below.

Option 4: Full transition to MLTSS

Following implementation of option 1, including implementing the opportunities for improvement and the MI Health Link demonstration extension, MDHHS would develop an MLTSS program for all populations receiving LTSS including dual eligibles. MCOs would be at full risk for coordinating physical health and LTSS benefits. While it would be the most impactful to the current system, this option allows for the possibility of more administrative simplicity and a more seamless experience for consumers with one entity serving as primary point of contact for coordination of care. With the appropriate oversight and accountability for the MCOs, it has the potential to improve person-centered care coordination and positively impact health outcomes. This option could affect the 130,529 individuals enrolled in Medicaid LTSS.

Option 3/4a. Program adapted from MI Health Link: depending on evaluation results for MI Health Link, and assuming CMS allows expansion of MI Health Link, MDHHS would

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need to review current contracts to adopt needed program changes, and develop separate contracts for Medicaid-only LTSS enrollees.

Option 3/4b. Program built on D-SNP: for dual eligibles in Virginia, the Medicaid plan coordinates Medicare benefits through the member's Medicare plan. Members have the choice to select the health plan's companion D-SNP, Medicare fee-for-service, or a different Medicare Advantage Plan.

Recommended Timeline and Next Steps for Global Opportunities for Improvement and MLTSS Planning and Design

Based on analyses of existing program data and processes, and reviews of LTSS and MLTSS best practices from other states, CHRT/HPM recommends the following timeline as a starting point to guide MDHHS' next steps for global LTSS improvements and MLTSS planning. Timelines are based on guidance from CMS[4] and learnings from other states, though MDHHS decisions will impact the timing of specific elements listed here. A visual depiction of these timelines follows the description below.

MI Health Link

CHRT/HPM recommends requesting a three-year extension for the MI Health Link program in order to continue to improve the program while designing a future MLTSS product. The currently scheduled end date for MI Health Link is December 31, 2020. With a new gubernatorial administration, new legislative session, and potentially new MDHHS leadership transition at the beginning of 2019, we anticipate some delay in MDHHS' decision-making processes regarding next steps for MLTSS expansion. With these leadership changes, it is unlikely that the state could accomplish a meaningful MLTSS planning, design, and development process between now and the scheduled end date of MI Health Link.

Any decisions on expansion of MLTSS in Michigan should be based on evidence of the effectiveness of current programs, which requires reliable utilization data. A lack of validated encounter data for MI Health Link is another reason to consider extending the program beyond 2020. A well-informed MLTSS planning and design process would rely on quality and utilization data from MI Health Link to identify successful elements of the program that could be adapted for future MLTSS expansion. However, at this point in time there do not appear to be sufficient data available to the state to support this activity. Extending the demonstration would allow for more time to collect, validate, and analyze program data. At the very least, Michigan data from RTI's evaluation of the FAI demonstration could be available to the state by mid-2021, and this data could be used to inform MLTSS planning.

Finally, substantial state resources would be required to implement and sustain an MLTSS program, potentially incorporate the MI Health Link program, and simultaneously implement the global opportunities for LTSS improvement identified in Phase 3.

With these situational factors in mind, Michigan could follow the lead of several other states that have recently requested an extension of their duals demonstration programs. For example, Ohio's demonstration, My Care Ohio, is slated to end on December 31, 2019. Until 2018, the state had planned to develop a separate MLTSS program. However, in 2018 the Ohio Legislature called for a committee to study the value of MLTSS and the successes and challenges of the My Care Ohio program before moving forward with any expansion of MLTSS in the state. As a result, in mid-2018 Ohio requested a three-year

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extension of the program from CMS. This extension provides extra time for the legislative committee to study MLTSS and for the state to collect additional data on the My Care Ohio program.

If Michigan were to follow a similar schedule to that of Ohio, MDHHS should request an extension of the MI Health Link program from CMS no later than mid-2019 to allow time for CMS to review and approve the request. A three-year extension, similar to Ohio's request, would move the targeted end date of the program to December 31, 2023. This would allow more time for MDHHS to implement global and program-specific opportunities for improvement and to engage in a robust MLTSS planning, design, and development process prior to the end of the demonstration.

Global Opportunities for Improvement

Assuming MDHHS opts to extend the MI Health Link demonstration, CHRT/HPM recommends the Department focus on implementing opportunities for improvement within the existing system from 2019 to approximately mid-2021 (or when the RTI data is made available). There are several opportunities for improvement in the existing LTSS system – namely, options counseling, comprehensive assessments, and comparable quality measures – that will need to be in place as a foundation for MLTSS. In addition to recommending high-level timelines for each of these opportunities, we also recommend the Department convene work groups of internal and external stakeholders to inform the implementation of each global opportunity.

G1: Options Counseling

The Balancing Incentive Program, the source for many of the current best practices in options counseling and No Wrong Door (NWD) systems, recommends a timeline of approximately 18 to 24 months for planning, design, and development of an options counseling system, depending on the degree to which initial assessments are automated within the system.[5] MDHHS may not need a full 24 months to develop such a system. A LEAN design team is currently in the process of developing recommendations for the Department on options counseling, so some initial research and design work is already underway. We recommend the Department begin its options counseling process by assessing the recommendations of the LEAN Design Team with a working group of internal and external stakeholders. Those recommendations can be used to inform the design of a new No Wrong Door system, which is approximately a six-month process. Next, the Balancing Incentive Program recommends an 18-month process to select a vendor, build the system, train system staff, and develop educational materials for consumers. If MDHHS follows this general timeline, the Department could expect to target April 2021 as a "go-live" date for a new options counseling system.

G2: Quality Measurement and Data Improvement

Currently, there are few comparable quality measures across existing Medicaid LTSS programs. While each program generally has a quality measurement strategy and reports on a variety of measures, there is an opportunity to standardize a set of measures across programs to make it easier for consumers and other stakeholders to compare program performance. The MLTSS Quality Subgroup asked each of the five major Medicaid LTSS programs about each program's capacity to report on a set of validated CMS MLTSS quality measures. This activity found that each LTSS program varies in its capacity to report on the selected measures, and there is a lack of common quality measurement across existing programs.

CHRT/HPM recommends the Department pursue opportunities to standardize quality measurement and improve data collection across existing programs in order to develop a standard baseline for MLTSS quality measurement and allow for robust comparisons of

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performance across programs. These opportunities include selecting and implementing comparable quality measures across existing programs. In particular, the state could benefit from fielding a quality of life/consumer satisfaction survey across programs, such as the National Core Indicators-Aging and Disability Survey, or the CAHPS HCBS Survey. Collecting standardized information from consumers about their experience with LTSS programs can help inform MLTSS planning and design.

G3: Comprehensive Assessments

Improvements to processes for initial and comprehensive assessments within LTSS should be pursued in tandem with options counseling, and common assessment processes should be in place before a new options counseling system goes live. The process to review current MDHHS assessment tools, select and finalize a new tool, and implement the tool should take approximately one year from start to finish. We recommend the state plan approximately six months to develop a detailed assessment of all the tools currently in use in LTSS programs, as well as commercially available comprehensive LTSS assessment tools. Selecting and finalizing a comprehensive assessment tool will take another six months. The state should plan for an additional six months to implement the new assessment tool, including any necessary changes to the state's data systems.[6] From start to finish, this will take a total of approximately 18 months to implement.

G4, G5: Person-Centered Planning and Integrated Care Management Processes

There is an opportunity for MDHHS to develop standardized processes for person-centered care planning and integrated care management within LTSS. Recognizing that another LEAN design team is currently developing a set of recommendations for person-centered planning within the existing program structure, it may make sense for the Department to incorporate these two areas of improvement in the MLTSS planning and design process. Person-centered planning and care management are elements in current LTSS programs, though they are generally not standardized across programs. MLTSS development provides an opportunity for the state to develop an overarching person-centered planning and care management strategy for consumers receiving LTSS.

MLTSS Planning, Design, and Development

The Centers for Medicare and Medicaid Services (CMS) recommend a two-year timeline for MLTSS planning, design, and development.[7] According to 2013 guidance, states should plan, at a minimum, a one-year planning/design phase and a one-year program development/implementation phase culminating with the beginning of enrollment in MLTSS.

In the planning phase, CMS recommends states conduct the following activities:

- Engage internal and external stakeholders (this is already underway in Michigan)
- Develop communications plan (already beginning with the development of MDHHS' MLTSS website)
- Articulate program goals (already underway internally with some principles shared externally)
- Design program, including decisions on target population, covered services, care coordination, geographic scope, risk arrangement, payment method, waiver authority, and role of current LTSS providers/organizations (see below for more detailed description of program design steps) Consult CMS on waiver authority options
- Assess operational needs, including for contract management, quality

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measurement, rate setting, data systems, enrollment processes, and fiscal and service impacts
- Develop detailed work plan for implementation

In the first phase of this project, CHRT/HPM recommended several program design steps MDHHS should focus on to define a desired structure for MLTSS. Recommended program design steps are described below.

Develop Overall Program Design and Requirements

- Identify priorities for the MLTSS sub-populations using stakeholder input
- Develop standards and metrics associated with MLTSS care delivery using stakeholder input
- Conduct a gap analysis to determine MCO ability to meet MLTSS requirements, as defined by MDHHS and stakeholders
- Identify infrastructure needs to design and implement an MLTSS program
- Identify barriers to success and strategies to overcome such barriers

Select Waiver Authority

- Conduct a detailed analysis of potential MLTSS authorities under which to develop program, with pros and cons
- Review DSRIP waiver as a potential option
- Select waiver vehicle and begin waiver application process with CMS

Determine Covered Populations

- Work with stakeholders to review and agree on distinct consumer needs by sub-population with stakeholders
- Review CMS requirements for coverage of each sub-population
- Analyze and determine adequacy and best use of current programs by sub-population
- Review implications for change from the current approach to MLTSS by sub-population
- Determine strategy for covered sub-populations and how to best meet consumer needs

Define Geographic Scope

- Analyze population densities, state bandwidth, network adequacy, rural and urban mix, MCO presence, existing program capacity, and potential program impact by sub-population and by geographic region
- Recommend an approach by sub-population and geographic region
- Determine how prepared MCOs are to meet State MLTSS requirements by sub-population through a gap analysis
- Process options with stakeholders
- Identify best practices in consumer protections in a mandatory or voluntary program
- Determine the impact of a mandatory or voluntary approach on quality and financial operations

Finalize Program Design

- Review and confirm program design, including consistency and cohesiveness of all MDHHS decisions
- Propose an overall implementation strategy to the state

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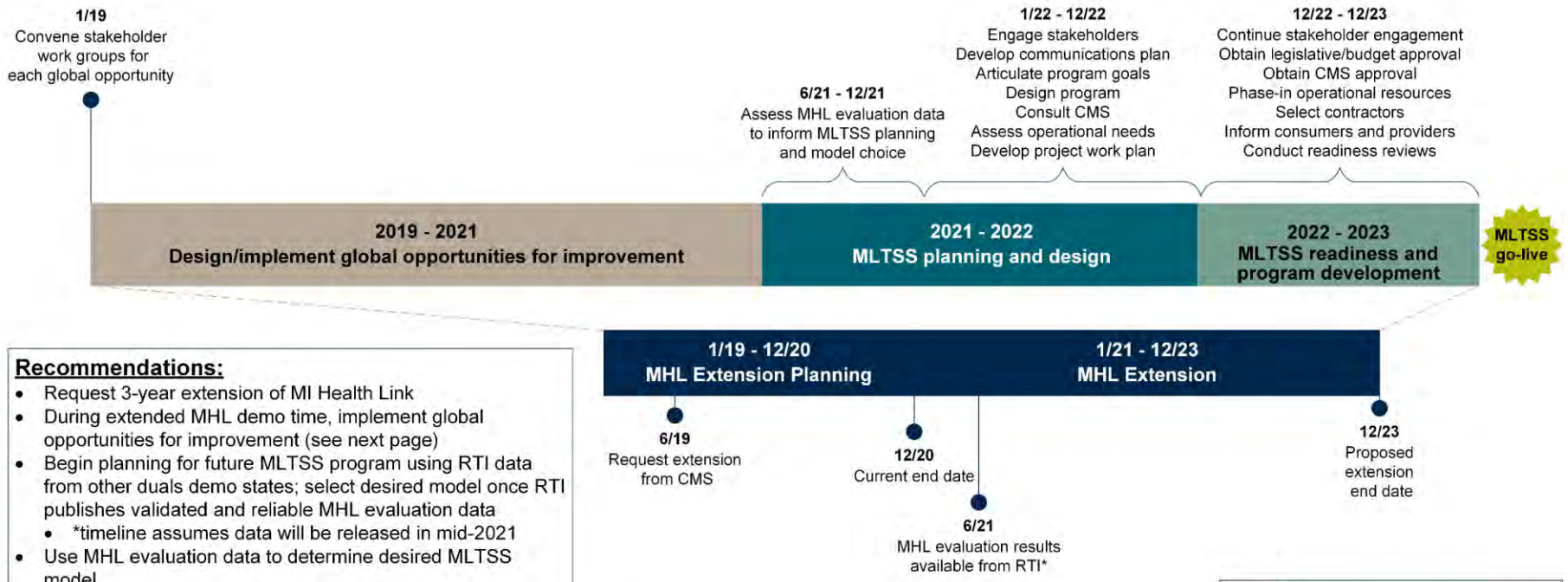
In the program development/implementation phase, CMS recommends states conduct the following activities:

- Continue stakeholder dialogue
- Obtain legislative and budgetary approval, as needed
- Obtain CMS approval
- Phase-in operational resources for contract management, quality measurement, rate setting, and data systems
- Select contractors and vendors, including developing contract requirements/program specifications, developing and issuing an RFP, providing historical data on LTSS populations for prospective contractors, and procuring additional third-party vendors (i.e., an enrollment broker, fiscal intermediaries, and an external quality review organization)
- Inform beneficiaries and providers
- Conduct comprehensive readiness reviews

In addition to these activities, MDHHS should focus on opportunities to incorporate best practices on quality measurement, person-centered planning, and integrated care management into an eventual MLTSS program design.

While CMS recommends an overall two-year process, decisions within MDHHS and the State of Michigan may impact timing. MDHHS' timing should, to the extent possible, remain flexible and responsive to operational needs and stakeholder input. For example, Pennsylvania, began its planning process for MLTSS in April 2015. While the state had originally targeted January 2017 as the go-live date for its first MLTSS region, it opted to delay rollout by one year, until January 2018, due to the volume of stakeholder comments it received in the planning process and the substantial resources needed to stand up the program.

Proposed Timeline for LTSS Opportunities for Improvement and MLTSS Design/Implementation



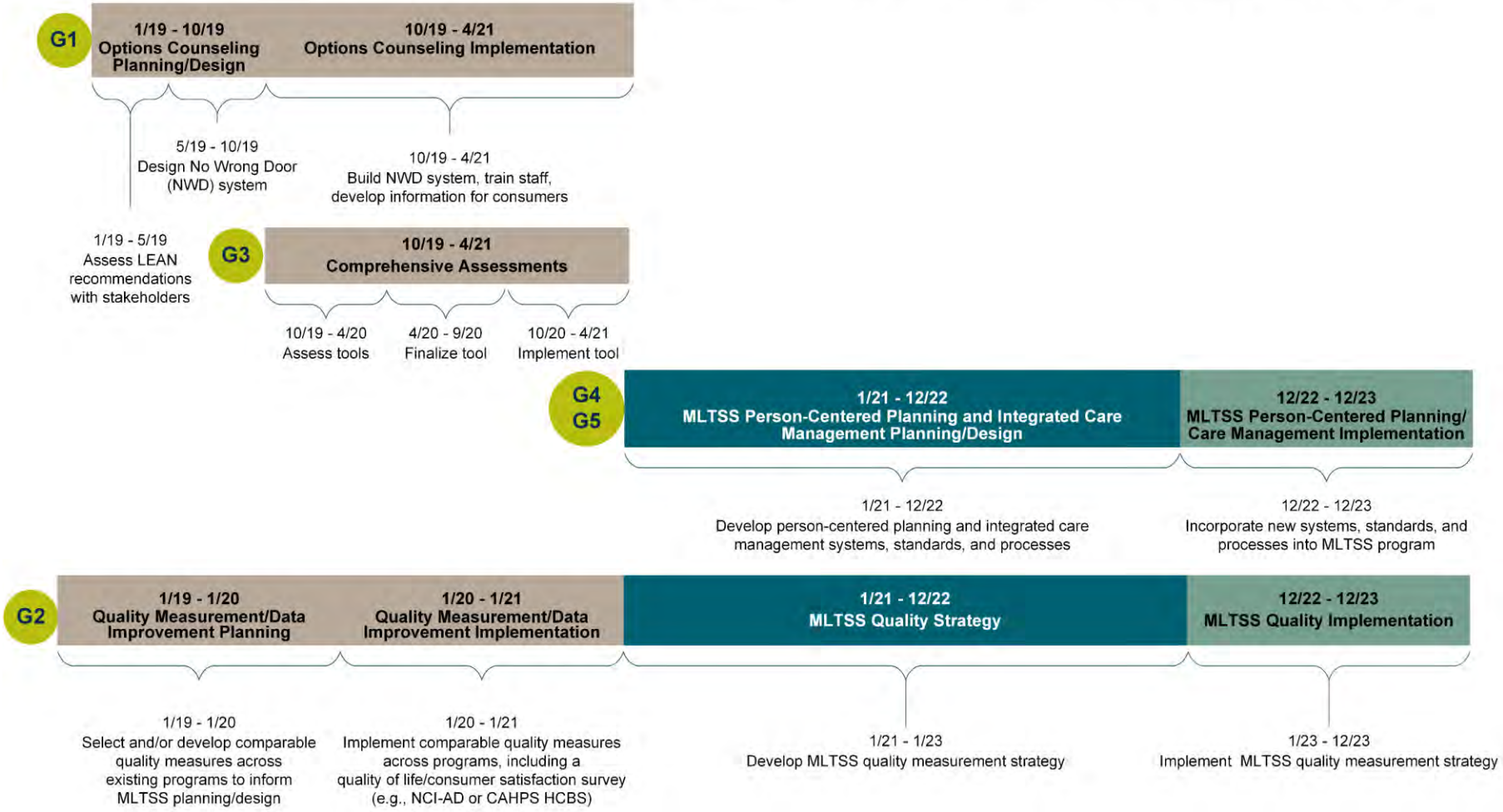
Recommendations:

- Request 3-year extension of MI Health Link
- During extended MHL demo time, implement global opportunities for improvement (see next page)
- Begin planning for future MLTSS program using RTI data from other duals demo states; select desired model once RTI publishes validated and reliable MHL evaluation data
  - *timeline assumes data will be released in mid-2021
- Use MHL evaluation data to determine desired MLTSS model
- CMS recommends a two-year timeline for MLTSS design and implementation:
  - 12 months for planning and design
  - 12 months for readiness activities and implementation
- Plan for phased-in MLTSS enrollment following implementation period

Legend:

- Current system improvement activities
- MLTSS planning and design activities
- MLTSS implementation activities
- MI Health Link activities

Proposed Timelines to Implement LTSS Opportunities for Improvement and Incorporate Improvements into MLTSS Design/Implementation



III. Gap Analysis: LTSS Opportunities for Improvement

This section includes a gap analysis of the LTSS system in Michigan to identify both what works well and opportunities for improvement and increased efficiency. CHRT/HPM reviewed current LTSS program benefits, services, policies, and procedures, and created work flows to map the process across the global LTSS system as well as within each program. We then interviewed program staff to ensure accuracy of the work flows and to receive input on opportunities for improvement within specific programs and across the system.

Global Opportunities for Improvement to the Existing LTSS System

CHRT/HPM developed flow charts depicting current processes in key consumer-facing areas within the Medicaid LTSS system and the five major Medicaid LTSS programs: Home Help, MI Choice, MI Health Link, Nursing Facilities, and PACE. CHRT/HPM identified a number of opportunities for improvement across the broader Medicaid LTSS system and within each Medicaid LTSS program. (Program-specific opportunities are included on pages 33 to 42 of this report.)

The most salient opportunities for system-wide LTSS improvement are described below, and correspond to an accompanying flow chart. The opportunities are listed here in order of their appearance within the overall LTSS enrollment/assessment process, as depicted on the accompanying flow chart. Global opportunities are labeled with a "G" to distinguish them from program-specific opportunities. Please refer to accompanying flow charts for visual depictions of these opportunities.

G1. Create an independent, conflict-free options counseling center to provide information to individuals seeking LTSS and to direct consumers to appropriate services more quickly than in the current state.

G2. Identify appropriate goals and structure for LTSS quality measurement moving forward, including the adoption of a core set of common quality measures across programs to inform consumer choice and to facilitate evaluation and improvement of program performance. (Further discussion of quality measurement is located in Section III of this report.)

G3. Create common processes for initial and comprehensive assessments with standardized, interoperable electronic documentation. Design decision tree-based assessments where consumers' answers will direct them to different subsequent questions and drill-downs depending on their needs and preferences, as well as program-specific requirements. Data elements from the comprehensive assessments could be automatically populated in the consumer's record or plan of care, potentially saving time and avoiding duplicative assessment.

G4. Create a more consistent person-centered planning process that includes standardized training and expectations for all case managers and providers of LTSS with centralized, electronic documentation for assessments, care plans, care plan revisions, admission/discharge/transfer (ADT) notifications).

G5. Adopt a common stratified care management model for all LTSS programs that coordinates physical health, behavioral health, LTSS, and psychosocial supports, depending on an individual's needs and preferences. This could include enhanced

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training among care coordinators and care managers to address social determinants of health (SDOH).

G6. Create processes to help ease consumer transitions from one program to another (e.g., the Department's proposed policy to allow LOCDs to follow a person across programs).

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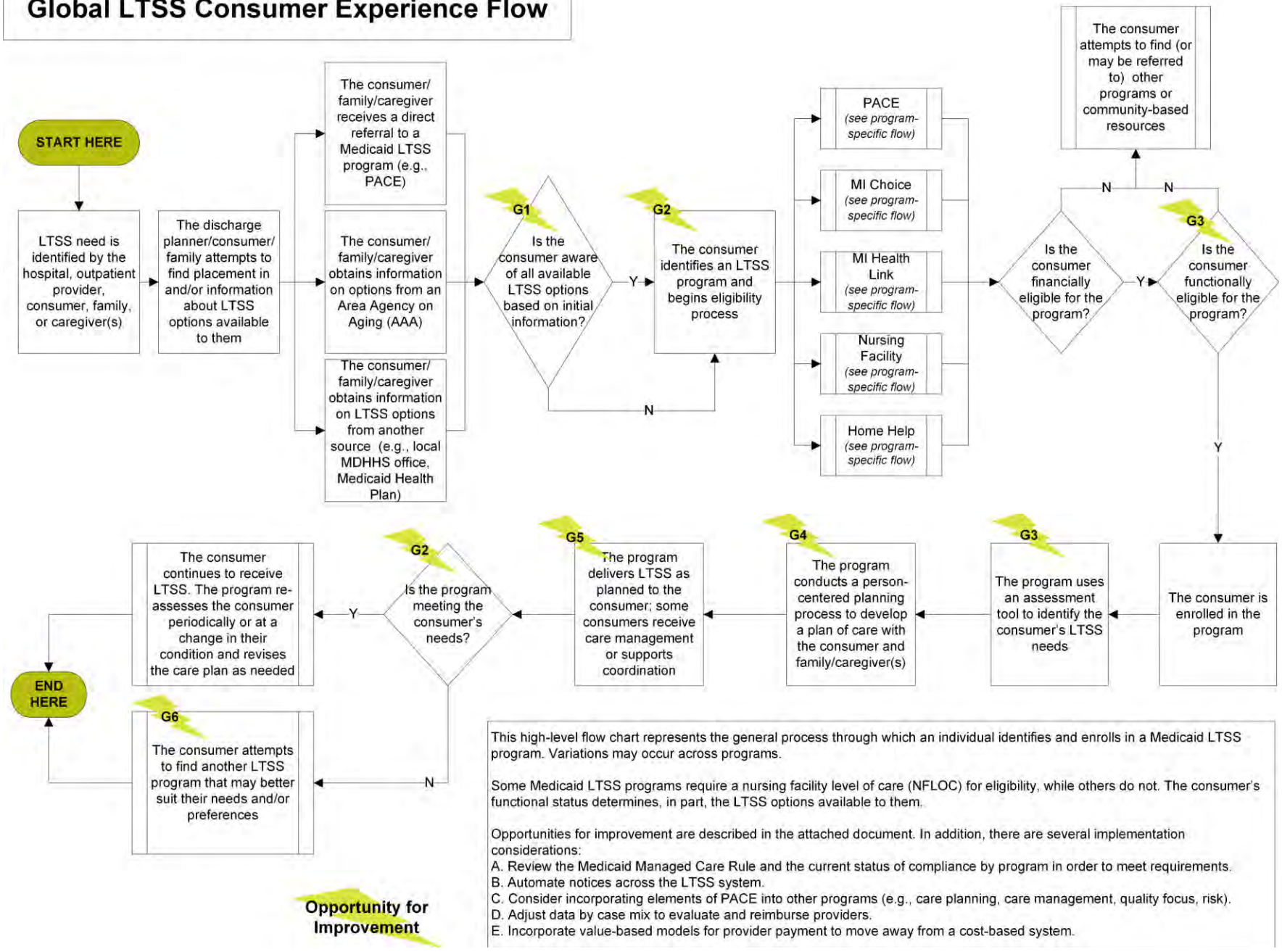
Global LTSS Consumer Experience Flow



This high-level flow chart represents the general process through which an individual identifies and enrolls in a Medicaid LTSS program. Variations may occur across programs.

Some Medicaid LTSS programs require a nursing facility level of care (NFLOC) for eligibility, while others do not. The consumer's functional status determines, in part, the LTSS options available to them.

Opportunities for improvement are described in the attached document. In addition, there are several implementation considerations:

A. Review the Medicaid Managed Care Rule and the current status of compliance by program in order to meet requirements.
B. Automate notices across the LTSS system.
C. Consider incorporating elements of PACE into other programs (e.g., care planning, care management, quality focus, risk).
D. Adjust data by case mix to evaluate and reimburse providers.
E. Incorporate value-based models for provider payment to move away from a cost-based system.

Best Practices to Implement Global Opportunities for Improvement

CHRT, HPM, and MDHHS reviewed the six identified global opportunities for improvement and decided to prioritize further analysis into G1 through G5. As the MLTSS quality group was in the process of conducting activities related to G2 (see section III of this report), CHRT/HPM conducted research into best practices on the four remaining opportunities: G1 (options counseling); G3 (comprehensive assessments); G4 (person-centered planning); and G5 (integrated care management processes). The group felt that G6 (transitions between programs) could potentially be addressed through the other opportunities for improvement. Best practices were gleaned from a review of national and state LTSS programs that were relevant to the identified opportunities. This section contains descriptions of best practices for each of the opportunities listed above, as well as recommendations for MDHHS to address the opportunities for improvement.

G1: Options Counseling

Opportunity: Create an independent, conflict-free options counseling center to provide information to individuals seeking LTSS and direct consumers to appropriate services more quickly than in the current state.

Current State of Options Counseling Processes in Michigan

- Currently, options counseling primarily occurs through the Freedom of Choice form, which is a required form for individuals with a nursing facility level of care (NFLOC) who wish to enroll in MI Choice, MI Health Link, PACE, or nursing facilities. Individuals are sometimes counseled on the LTSS options presented in this form. However, this counseling generally takes place after an individual is deemed functionally and financially eligible for a specific program. At this late point in the eligibility and assessment process, it is unlikely that a consumer would choose to switch to a different LTSS program, even if it may fit their needs better.
- There is no formal options counseling process for the Home Help program. For programs using the Freedom of Choice form, individual entities (i.e., MI Choice waiver agencies, MI Health Link ICOs, nursing facilities, PACE organizations) have varying processes to inform consumers of their options.
- Having individual program entities responsible for providing information on LTSS options means that consumers are not always guaranteed an unbiased source of comprehensive information on all options available to them.
- A LEAN design team is currently developing recommendations on options counseling for MDHHS.

Best Practices in Options Counseling Nationally

The Balancing Incentive Program (BIP), created under the Affordable Care Act (ACA), provided federal funding to states to increase access to home and community based services (HCBS). States were eligible for BIP funding (through enhanced federal matching rates) if they spent less than 50 percent of their Medicaid LTSS expenditures on HCBS. Among other requirements, participating states established a No Wrong Door (NWD) system for consumers seeking LTSS by:

- Establishing a toll-free telephone number and website, as well as physical locations for consumers to receive assistance
- Developing standardized informational materials
- Training staff on eligibility determination and enrollment processes
- Implementing a process to guide individuals from assessment to eligibility determination

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Under the BIP model, consumers/families who are seeking information on LTSS options can enter a state's NWD/options counseling system in three ways: through a toll-free phone number, website, or physical location (such as an Area Agency on Aging). Consumers then complete an initial screen that gathers basic data on financial and functional status to identify potential needs and program eligibility. Consumers who are deemed potentially eligible through this initial screen then advance to a comprehensive, in-person functional assessment. After completion of the comprehensive assessment, eligible consumers are enrolled in a Medicaid LTSS program. A dedicated eligibility coordinator or case manager guides the individual consumer throughout this entire process, from initial inquiry to program enrollment. The benefits of implementing a centralized system for options counseling and eligibility/assessment include:

- Consumers are assessed just once for the full range of Medicaid LTSS options, avoiding duplicative processes and the need for a consumer to be assessed multiple times.
- Processes for options counseling, eligibility determinations, and enrollment are streamlined and consistent across all Medicaid LTSS programs.
- Consumers are more easily able to learn about the status of their eligibility determination and next steps in the enrollment process.

Selected State Examples

Massachusetts

- MA used BIP funds to develop MassOptions, a toll-free phone number and website where consumers can learn about HCBS options, complete an initial screen, and receive a referral to an Aging and Disability Resource Center (ADRC) or other partner entity for further options counseling, assessment, and eligibility and enrollment assistance.
- MassOptions' customer service center operates seven days a week, from 8am-8pm. For consumers seeking assistance outside of those hours, the platform includes online chat, email, and voicemail.
- The MassOptions platform is able to track consumers' referrals to partner agencies. Referrals include the results of the initial screen and other basic information about the consumer to avoid the need for duplicative questions.
- Massachusetts developed a public awareness campaign that included paid media and social media, engagement with community partners, and public events. Incoming calls and website activity increased while this campaign was underway.
- ADRCs had a strong community presence and brand identity prior to the development of MassOptions, which helped increase visibility of MassOptions as a go-to source for LTSS information.[8]

Wisconsin

- Local ADRCs provide choice counseling for individuals seeking services from the FamilyCare MLTSS program, with an emphasis on connecting consumers to HCBS.
- Individuals seeking information on LTSS options contact a local ADRC, who will conduct an in-person functional screen to determine the individual's LTSS needs and available options. If a consumer appears to be eligible for FamilyCare or another Medicaid LTSS program, the ADRC will provide a warm hand-off to a financial eligibility specialist. After final functional and financial eligibility determinations have been made, the ADRC will contact the individual again to make sure they understand their options and finish the enrollment process.
- MCOs are required to maintain separation from eligibility determination and options counseling processes, ensuring independent and conflict-free counseling.

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Recommendations for Options Counseling in Michigan

Michigan has attempted to develop a Single Point of Entry (SPE) and ADRC system in the past. Lessons from MI's prior experience should inform any efforts to develop an independent options counseling system, including:

- Ensure all relevant state agencies and external partners are heard and included in program development from the outset to generate buy-in and trust
- Detach options counseling from service provision to ensure information is conflict-free
- Evaluate distribution of consumers, acuity, and funding to ensure it is objectively performed by an options counseling entity
- Clearly define roles and responsibilities of participating entities, including state agencies and external partners
- Create and enforce expectations for options counseling processes to ensure standardization
- Identify a consistent funding model that is not reliant on federal grant funding
- Implement a standardized approach to individuals determined NF LOC ineligible:
    - Mandate all ineligible individuals to receive NF Level of Care Exception Review
    - Establish program-wide protocol to assist/inform/guide ineligible individuals with appeal process

G3: Comprehensive Assessments

Opportunity: Create common processes for initial and comprehensive assessments with standardized, interoperable electronic documentation. Design decision tree-based assessments where consumers' answers will direct them to different subsequent questions and drill-downs depending on their needs and preferences, as well as program-specific requirements. Data elements from the comprehensive assessments could be automatically populated in the consumer's record or plan of care, potentially saving time and avoiding duplicative assessment.

Current State of Comprehensive Assessment Administration in Michigan

- Multiple comprehensive assessment tools are used across different programs. While some programs may require unique information, tools could be more consistent and streamlined.
- Specifically, assessment tools can be improved through interoperability within programs; increased logical flow of information gathering within programs (e.g., where multiple assessments are done), and the development of person-centered assessment data that could be further leveraged to create more robust person-centered care plans.
- For some programs, multiple assessments are conducted in one visit. In many instances, this is too much for frail consumers to handle adequately.

Best Practices in Comprehensive Assessment Administration Nationally

- Incorporating population risk scoring and stratification to determine priorities among the population based on scoring. Comprehensive assessment data is often combined with (or part of) risk scoring to stratify consumers into a low, moderate or high-risk level, thereby offering information to set priorities. Such requirements should be included in vendor contracts.
- Using a person-centered assessment as a foundational component of the person-

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centered treatment plan. This means the assessment content must incorporate any information required to create a truly person-centered plan such as consumer goals and preferences for service delivery, information regarding caregiver and family relationships and priorities.

- Conducting the comprehensive assessment in a manner that allows sufficient time to collect and document all the necessary information over an appropriate period of time
- Requiring a comprehensive assessment at least annually and more often if significant changes in the consumer's circumstances or condition warrant. Best-practice tools are electronic and pre-populate data fields within person-centered service plans. If telephonic administration would compromise the assessment, the assessment should be performed in-person, within the community, at a location of the consumers' choosing.
- Fully integrated domains including physical and behavioral health as well as a functional assessment component to identify LTSS needs as well as data on psychosocial support and social determinants of health needs (e.g., transportation, housing, and literacy).
- A universal set of assessment questions that are required for all consumers *in addition to* modular assessment components that apply to consumers with specific needs (e.g. diagnoses such as CHF, COPD, diabetes or SMI). In this manner, consumers only have to respond to applicable questions creating a more efficient and effective process.
- Using a valid, uniform, and reliable assessment tool.
- Leveraging information collected by other agencies or providers who support the consumer, such as the Area Agency on Aging.
- Ability to be administered by a non-licensed individual, when appropriate, with oversight by a healthcare professional (based on CMS rules). Or, a non-licensed individual can assist a licensed individual with the assessment.
- Enabling electronic data collection and centralized data storage with the potential for data sharing across the full care continuum and with other stakeholders in the care management process in a HIPAA-compliant manner.
- Enabling care managers to discern the intensity of the consumer's needs.
- A training component with a focus on consistent administration and interrater reliability for all assessors.
- A process for overseeing effective assessment administration.

Recommendations to Identify or Create and Implement a Comprehensive Assessment Tool and Process in Michigan

MDHHS might consider all options with regard to comprehensive assessment. MDHHS can potentially:

- Purchase and implement a commercially available comprehensive assessment tool
- Purchase a commercially available comprehensive assessment tool and customize it to meet MDHHS' and stakeholder needs
- Create a customized comprehensive assessment tool that reflects MDHHs' specific needs and preferences while accommodating stakeholder needs, as well.

Creating a customized tool supports state-specific needs, allows for greater advocate input, and can reflect a specific custom-designed process, as elected by MDHHS staff. A commercial tool likely will incur higher costs and also allows for less customization or

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input, by staff or by stakeholders, though there are some potential advantages, including launch and ongoing product support.

To select the most appropriate option for Michigan, CHRT/HPM recommend that MDHHS:

- Review existing LTSS assessments and review the pros and cons of each, as well as program-specific needs and preferences among staff including, but not limited to:
    - The purpose of the tool
    - If the tool is mandatory or optional
    - The timing of the tool in the process
    - A detailed inventory of the overlap across data elements in the full set of tools used within and across programs
- Identify specific best-practice tools used in other LTSS programs as well as literature reviews conducted by other states
- Gather information from contracted MCOs regarding existing tools, system constraints and their ability to change assessment tools over time (e.g. what are other considerations)
- Review available tools in the marketplace and determine whether and how those tools would meet MDHHS' goals and objectives for each program and across programs.
- Discuss the systems and cost implications of developing a customized tool, and the pros and cons of doing so
- Convene a group that includes LTSS advocates and consumers from a variety of subpopulations, State agency staff, LTSS providers, and provider association representatives to review detailed options, including an analysis of costs, level of effort to implement each tool, level of effort to administer the tool and systems considerations regarding data storage and transfer
- Determine a process to refine the content of the chosen tool
- Develop a person-centered process, as detailed below, to implement the comprehensive assessment tool as intended
- *If the committee elects to utilize a commercially available tool,* we recommend that MDHHS:
    - Decide if any domains should be added to the existing tool (and related costs) or need to be developed in addition to the existing domains.
    - Embark on a process to assess whether the tool is appropriate for all programs (e.g. nursing home eligible or non-nursing home eligible) and how to implement the new tool in one or more programs, with the aim of implementing it across all appropriate programs.

MDHHS should plan for approximately: six months to determine whether the staff wish to develop a tool internally or purchase a commercial tool; six months to finalize the tool; and six months to fully implement the new assessment tool, including staff training.

G4: Person-Centered Planning

Opportunity: Create a more consistent person-centered planning process that includes standardized training and expectations for all case managers and providers of LTSS with centralized, electronic documentation for assessments, care plans, care plan revisions, admission/discharge/transfer (ADT) notifications.

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Current State of Person-Centered Planning in Michigan

- Today, information gathering efforts are not consistent; information is not always documented during the assessment visit; and the assessment process may or may not form the foundation of a person-centered planning process.
- Processes for person-centered planning could benefit from greater consistency and rigorous assessment. Specifically, more organized, streamlined assessment processes could result in more person-centered care plans for consumers.
- Person-centered processes could include significant input from consumers, as well as input from family members, informal caregivers, and other stakeholders in the consumer's care.
- Measurable goals are central to person-centered planning processes, but they are not consistently identified or documented today.
- In-person planning efforts could significantly enhance person-centered planning, especially for high-risk, high-need individuals.
- A LEAN design team has articulated core values and principles for person-centered planning that should be incorporated into any changes to these processes.

Person-centered planning is a key element of self-determination for consumers who receive LTSS, and is designed to respond to a person's preferences and desires. MDHHS is committed to person-centered processes to meet the needs of LTSS consumers with a greater emphasis on improving person-centeredness going forward. Person-centered planning has many elements, including the ability to promote the consumer's participation in their service delivery. When individuals are engaged in their supports, and are respected by their care team and encouraged in their pursuit of independence and other identified goals, they will be more satisfied and have better health outcomes.

Best Practices in Person-Centered Planning Nationally

- Leveraging foundational information from a person-centered comprehensive assessment including consumer goals and information about formal and informal supports
- A robust process to conduct person-centered planning, in line with core person-centered planning values
- Consumer, family and caregiver input, with the consumer's approval
- A central, meaningful role for consumers—one that allows them to express their preferences, focuses on their strengths and abilities, and supports their objectives
- A process to assist consumers in identifying person-centered goals and facilitate access to services and supports to meet such goals.
- Creating a comprehensive person-centered service plan that integrates and includes all services (i.e., medical, behavioral, LTSS, psychosocial) with a focus on local service delivery to the extent possible
- Inclusion of a backup care plan for absent caregivers or emergencies, and crisis plans if appropriate
- An appropriate level of contact with the consumer (individuals at high risk may require weekly contact at first, moving to a lower level of contact; low-risk consumers may require a monthly check-in)
- Appropriate provision of resources based on the consumer's preferences and needs, especially for consumers at high risk for poor outcomes

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- A focus on continuity of care with existing providers and community-based organizations and LTSS providers when possible with an emphasis on local care delivery
- Consistent staff training and expectations on person-centered planning protocols
- A consumer survey to determine if consumers are experiencing person-centered care delivery and if their needs and preferences are being met appropriately

Recommendations for Person-Centered Planning in Michigan

- Consider all best practices in other states as appropriate in addition to recommendations developed by the MDHHS LEAN design team.
- Develop a person-centered approach that meets the needs of low, moderate, and high-risk consumers based on needs and goals.
- Leverage best practices to create a truly person-centered planning process:
    - Ensure that the comprehensive assessment is central to planning
    - Include caregivers and/or family members, when appropriate
    - Gather clear, objective information including goals, needs, and preferences
    - Conduct the assessment in-person where possible
    - Conduct mandatory training on person-centeredness and assessment
- Develop contract requirements to allocate resources for person-centered planning appropriately.
- Develop standardized processes that maximize the State's ability to develop person-centered care plans for consumers including family and caregiver input.
- Assess the needs of the caregiver to minimize the risk of social isolation, physical demands and emotional strain, all detrimental to the quality of care provided to the consumer
- Develop systems to leverage all assessment data in the person-centered planning process.
- Assess MCO and provider capacity to collect data as well as capacity for storage and data sharing, including where/how the electronic comprehensive assessment and subsequent care coordination data can/will be stored and what might be required to enable any requisite data sharing among affiliated organizations.
- Address privacy concerns related to data sharing, especially for individuals with serious mental illness (SMI) where sensitivity to data sharing is significant.
- Develop IT systems to collect, share, and leverage all data appropriately under HIPAA to promote sharing of information about the consumers' needs and preferences.

G5: Integrated Care Management

Opportunity: Adopt a common stratified care management model for all LTSS programs that coordinates physical health, behavioral health, LTSS, and psychosocial supports, depending on an individual's needs and preferences. This could include enhanced training among care coordinators and care managers to address social determinants of health (SDOH).

Current State of Integrated Care Management in Michigan

- Michigan is currently operating under a fragmented system, resulting in poor coordination of care across physical, behavioral, LTSS, and other supports.

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Consistent care management planning and implementation, with a particular focus on care integration, could significantly improve outcomes.

- Michigan could increase its focus on the social determinants of health (SDOH), which are estimated to account for a substantial portion of health outcomes. This is consistent with practice expansion that has taken place in the country.

Across the country, states and managed health care delivery systems have recognized the importance of providing a flexible, person-centered, whole health-focused system of care for persons receiving LTSS. The 2016 revisions to the federal managed care rule have also made it easier to include nonmedical interventions that address social and structural determinants of health to help states attain the whole health vision for their citizens.

Best Practices in Integrated Care Management Nationally

Key best practices in Medicaid-only MLTSS or Medicaid/Medicare demonstrations include:

- A simple method to determine the types and amounts of services and supports required to respond to the needs, preferences, and desires of the person.
- Appointment of a single qualified accountable care manager to manage the delivery of person-centered care based on the consumers' needs.
- Hiring of qualified care managers with appropriate credentials in physical health, behavioral health, SDOH, LTSS, and care integration.
- Use of care teams, including a lead care manager, for high risk individuals
- An approach to transitions of care including, but not limited to, proactive discharge planning activities following an acute care stay or transition of any kind (e.g., ED to home, change from an acute hospital to a rehab hospital, or for post-hospitalization medication reconciliation services) to avoid inpatient re-admissions and ED visits.
- Performance metrics that emphasize quality of care, person-centeredness, attention to social determinants, and consumer experience with care coordination and the care planning process.
- Potential formation of naturally occurring geographic service areas within the state to organize the physical, psychosocial, and LTSS delivery system.
- The provision of non-traditional benefits as well as access to non-traditional providers (e.g., peers, paraprofessionals, and community health workers).
- Collaborative Memoranda of Understanding (MOUs) between MCOs, hospital systems, community-based organizations, behavioral health providers, LTSS providers and the state regarding care integration methods.

Recommendations for Integrated Care Management in Michigan

- Consider all best practices in other states as appropriate.
- Evaluate MI Health Link internally and identify strategies to advance care management efforts for individuals at high-risk based on best practices while awaiting evaluation data.
- Convene a group that includes state agencies that oversee LTSS, BH, physical health, and social services to develop a model of care.
- Develop a model of care with common elements across LTSS programs that ensures measurable, person-centered, quality care delivery across a full continuum of integrated services.
- Develop standards of care across the full continuum with input from stakeholders.
- Explore strategies to offer alternative providers and services to individuals with LTSS needs to maximize consumers' ability to live in the community, based on needs and preferences.

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- Develop quality measurement goals, an approach, and a plan to assess and continuously improve the quality of person-centered care and to assess and improve the level of coordination provided to consumers.

Program-Specific Opportunities for Improvement

In addition to creating a global workflow and identifying global opportunities for improvement, CHRT/HPM also gathered data on specific program processes to develop program-specific work flows and opportunities for improvement.

Home Help

The most salient opportunities for improvement within the **Home Help (HH)** program are described below, in order of their appearance within the Home Help enrollment/assessment process, as depicted on the accompanying flow chart.

HH1. Ensure consumers are made aware of all their LTSS options at the outset of the eligibility and enrollment process. This includes a discussion of spenddown considerations at the outset of the process, based on a person's financial status.

HH2. Consider what information is needed to assist a consumer in choosing a provider, based on whether a person has a provider in mind when initial contact is made with the ASW. This could include tailoring the amount of education provided to Home Help consumers regarding choosing and managing a personal care services provider.

HH3. Increase consistency in electronic documentation of the Comprehensive Home Help Assessment in order to capture more information in real time.

HH4. Increase consistency in the administration of the Comprehensive Assessment. This could include strengthening training for Adult Services Workers on assessment processes (asking the right questions, observing, being more aware of people's needs, being comfortable with complex care needs), which is already underway within the program.

HH5. ASWs should ask if there is another adult in the home prior to developing the Time and Task schedule, rather than after. If so, with the consumer's permission, include the caregiver in all aspects of the care plan.

HH6. ASWs should assess a consumer's social needs (e.g. food security, transportation) earlier in the process, potentially as part of the Comprehensive Home Help Assessment.

HH7. Ensure revisions to the plan of care are always completed following a change in condition.

HH8. Improve consistency in the process used to assess a consumer's fit with other programs if Home Help does not fit the consumer's needs.

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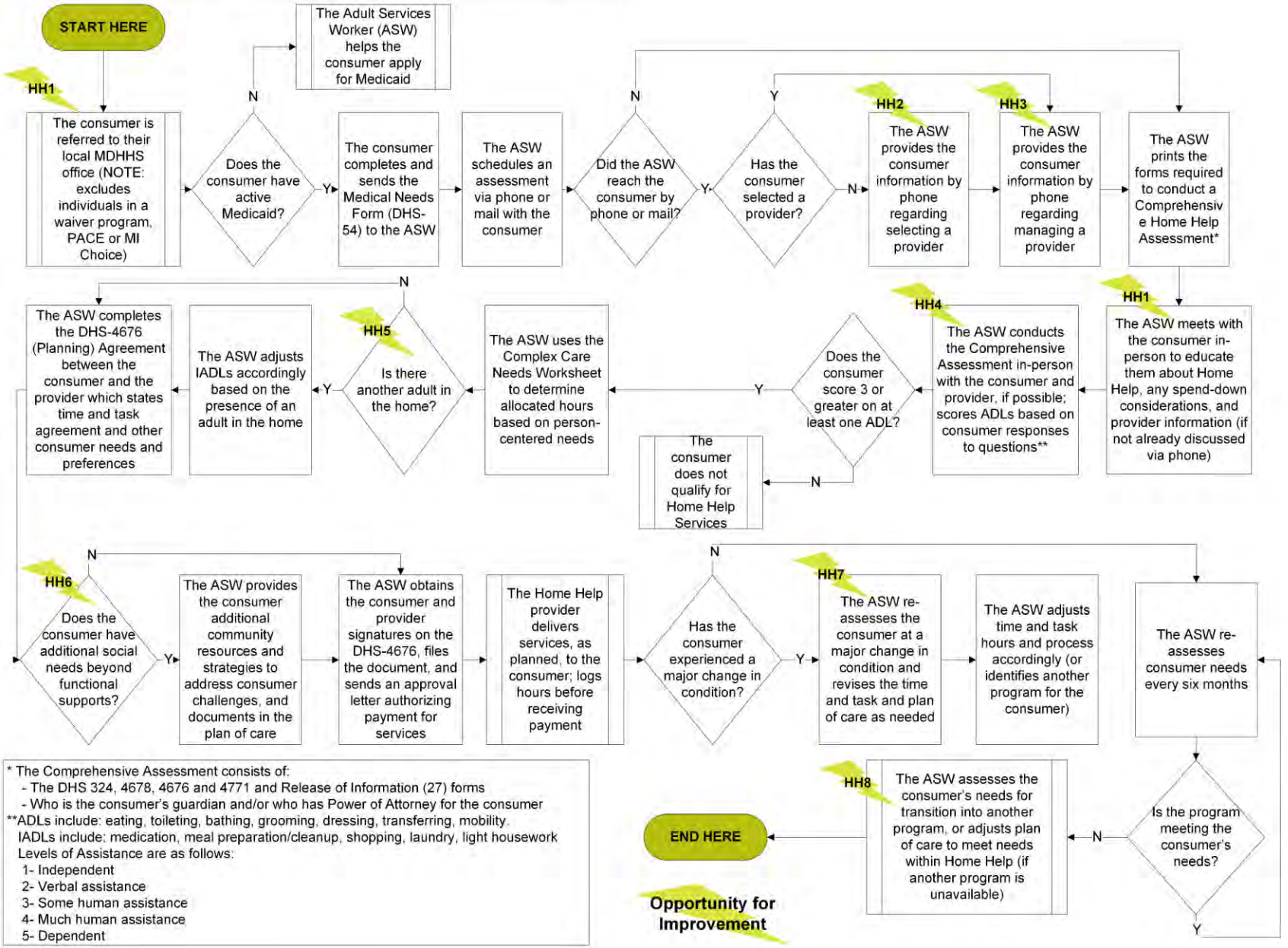
Home Help Eligibility and Assessment Flow



MI Choice

The most salient opportunities for improvement within the **MI Choice (MC)** program are described below in order of their appearance within the MI Choice enrollment/assessment process, as depicted on the accompanying flow chart.

MC1. Improve efficiency in financial eligibility determinations to reduce duplicative processes for the consumer. Currently, financial eligibility is assessed at multiple points in the enrollment process – upon initial contact and at the same time as the LOCD is conducted.

MC2. Ensure consumers are made aware of all their LTSS options at the outset of the eligibility and enrollment process.

MC3. Add waiver slots to expand program capacity and facilitate a commensurate reduction in nursing facility use.

MC4. Improve consistency in electronic documentation across agencies.

MC5. A centralized intake, assessment and referral process might offer the opportunity to better utilize access across all LTSS programs, including MI Choice.

MC6. Ensure consumers have received sufficient information regarding all of their LTSS options before signing the FOC form.

MC7. Improve consistency in person-centered planning processes across waiver agencies.

MC8. Improve consistency in clinical staff's adherence to MI Choice operating standards.

MC9. Improve consistency of sharing the care plan and practices to integrate care.

MC10. Develop a more standardized approach to supports coordination across waiver agencies.

MC11. Cover some services (e.g., PDN) under the State Plan, and not under waiver agents' capitation rates.

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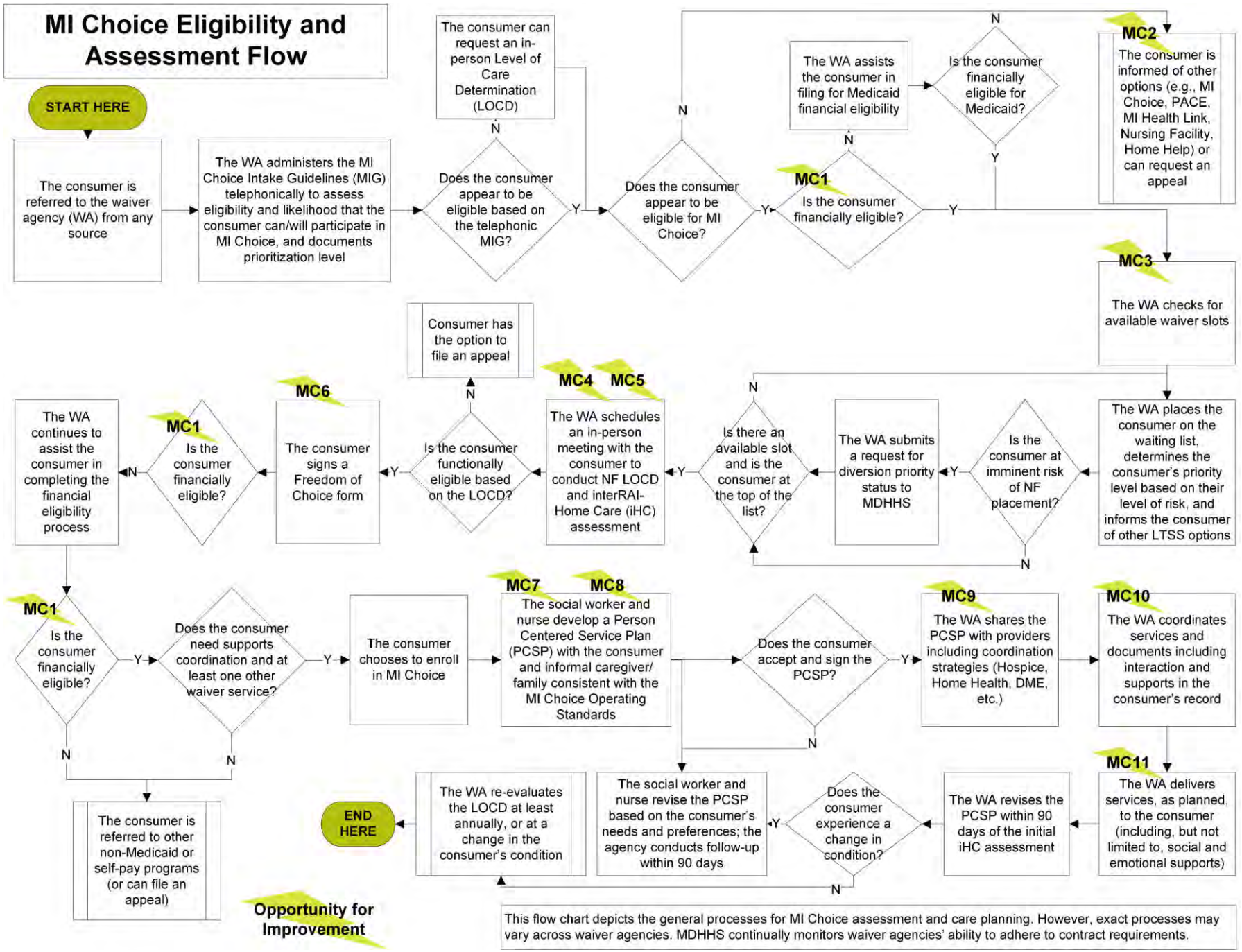
MI Choice Eligibility and Assessment Flow



This flow chart depicts the general processes for MI Choice assessment and care planning. However, exact processes may vary across waiver agencies. MDHHS continually monitors waiver agencies' ability to adhere to contract requirements.

MI Health Link

The most salient opportunities for improvement within the **MI Health Link (MHL)** program are described below in order of their appearance within the MI Health Link enrollment/assessment process, as depicted on the accompanying flow chart.

MHL1. Enhance the process by which ICOs administer assessments to avoid duplicative questions and overwhelming both the consumer and ICO clinical staff (i.e., order, combining data elements, and electronic documentation).

MHL2. Improve consistency in ICO Level I Assessments. ICOs are required to cover common domains, but there is no standardized Level I Assessment used by all ICOs.

MHL3. Ensure consumers have received sufficient information regarding all of their LTSS options before signing the FOC form.

MHL4. Integrate assessments for BH needs into the broader assessment process.

MHL5. Improve coordination of BH assessments.

MHL6. Improve coordination and information sharing between ICOs and PIHPs.

MHL7. Develop consistent standards across ICOs to stratify person-centered planning processes based on risk. For example, it is encouraged, but not required, to do person-centered planning in person. However, different processes may be appropriate for different levels of need.

MHL8. Strengthen ICOs' coordination across physical health, behavioral health, LTSS, and psychosocial supports for consumers.

MHL9. Strengthen training for ICO care coordinators/care managers.

MHL10. Increase consistency across ICOs in documentation and sharing practices. ICOs have different care management software capabilities, including the ability to share information on an enrollee-specific basis for the purpose of coordination.

MHL11. Develop a value-based contract management strategy to ensure maximum consistency and adherence to contract requirements.

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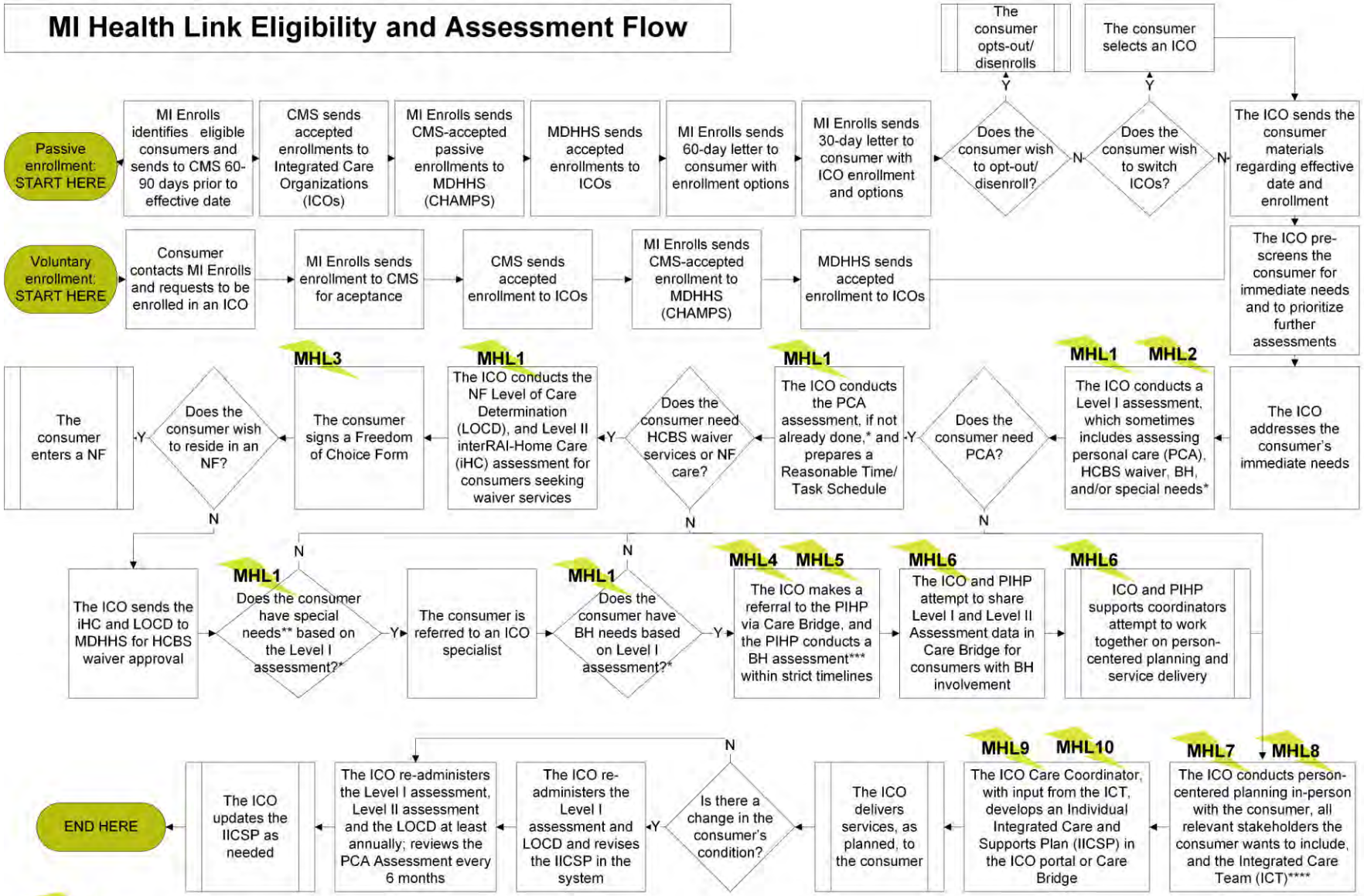
MI Health Link Eligibility and Assessment Flow



MHL11 This flow chart depicts the general processes for MI Health Link assessment and care planning. However, the sequence of these processes may vary across ICOs. MDHHS continually monitors the ICO's ability to adhere to contract requirements.

*ICOs sometimes assess a consumer's need for PCA services, HCBS waiver services, BH services, and complex care at the time of the Level I assessment. These additional assessments are sometimes conducted later in the assessment process, depending on ICO processes and/or the consumer's ability to complete all assessments in the same visit.

** Special Needs include, e.g., Complex Medical Needs, Multiple Needs, Expanded Community Living Supports, Adaptive Equipment (DME)

*** BH Assessments include ASAM, LOCUS and SIS

**** For high-risk individuals, the ICT is required to meet in-person. While not encouraged, the consumer has the right to refuse care management.

Opportunity for Improvement

Nursing Facilities

The most salient opportunities for improvement within the **Nursing Facilities (NF)** program are described below in order of their appearance within the nursing facility enrollment/assessment process, as depicted on the accompanying flow chart.

NF1. Ensure consumers are made aware of all their LTSS options at the outset of the eligibility and enrollment process.

NF2. Develop a consistent process to provide information and assistance about Medicaid eligibility to consumers already in a nursing facility under the Medicare SNF benefit before the end of their 90-day stay. This should include information and resources for individuals seeking to transition out of the nursing facility.

NF3. Establish a requirement that nursing facilities assist consumers or refer them to outside help (e.g., Michigan Medicare/Medicaid Assistance Program, or MMAP) in applying for Medicaid.

NF4. Ensure consumers have received sufficient information regarding all of their LTSS options before signing the FOC form.

NF5. Ensure consumers have received sufficient counseling regarding LTSS options in the community (MDS Section Q) as part of the RAI assessment process.

NF6. Seek opportunities to improve quality in the NF setting (e.g., bringing medical resources into NFs to avoid inpatient admissions/re-admissions; tying payments to quality and outcomes that consider value based on the state's definition, rather than CMS's 5 Star rating process).

NF7. Address housing barriers to NF transitions back to the community for individuals who are in the NF for 90 days or less.

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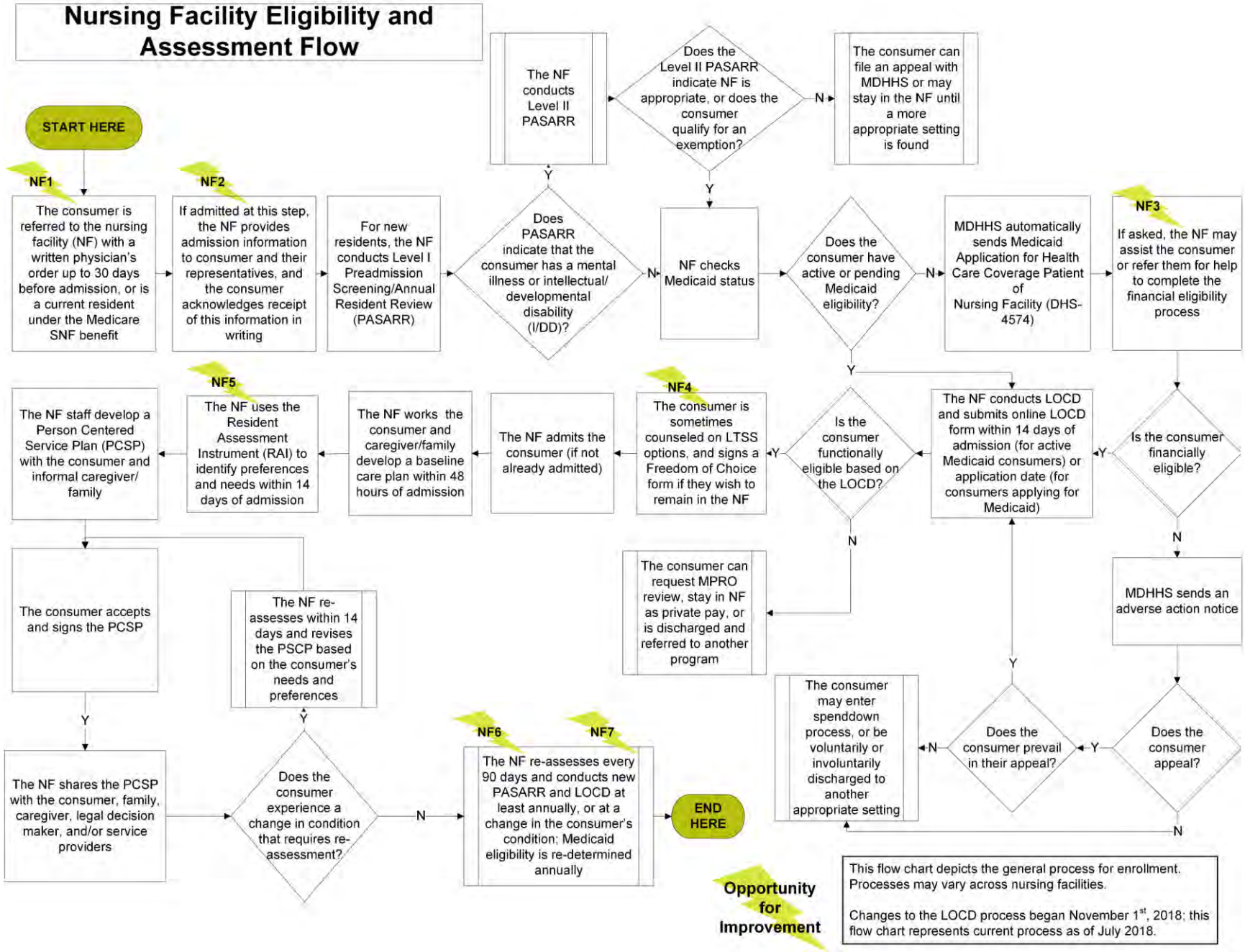
Nursing Facility Eligibility and Assessment Flow



PACE

The most salient opportunities for improvement within the **PACE (P)** program are described below in order of their appearance within the PACE enrollment/assessment process, as depicted on the accompanying flow chart.

P1. Ensure consumers are made aware of all their LTSS options at the outset of the eligibility and enrollment process.

P2. Ensure consumers have received sufficient information regarding all of their LTSS options before signing the FOC form.

P3. Improve consistency in the level of documentation and choice of EMR platform across PACE organizations.

P4. Improve consistency in eligibility determinations across PACE.

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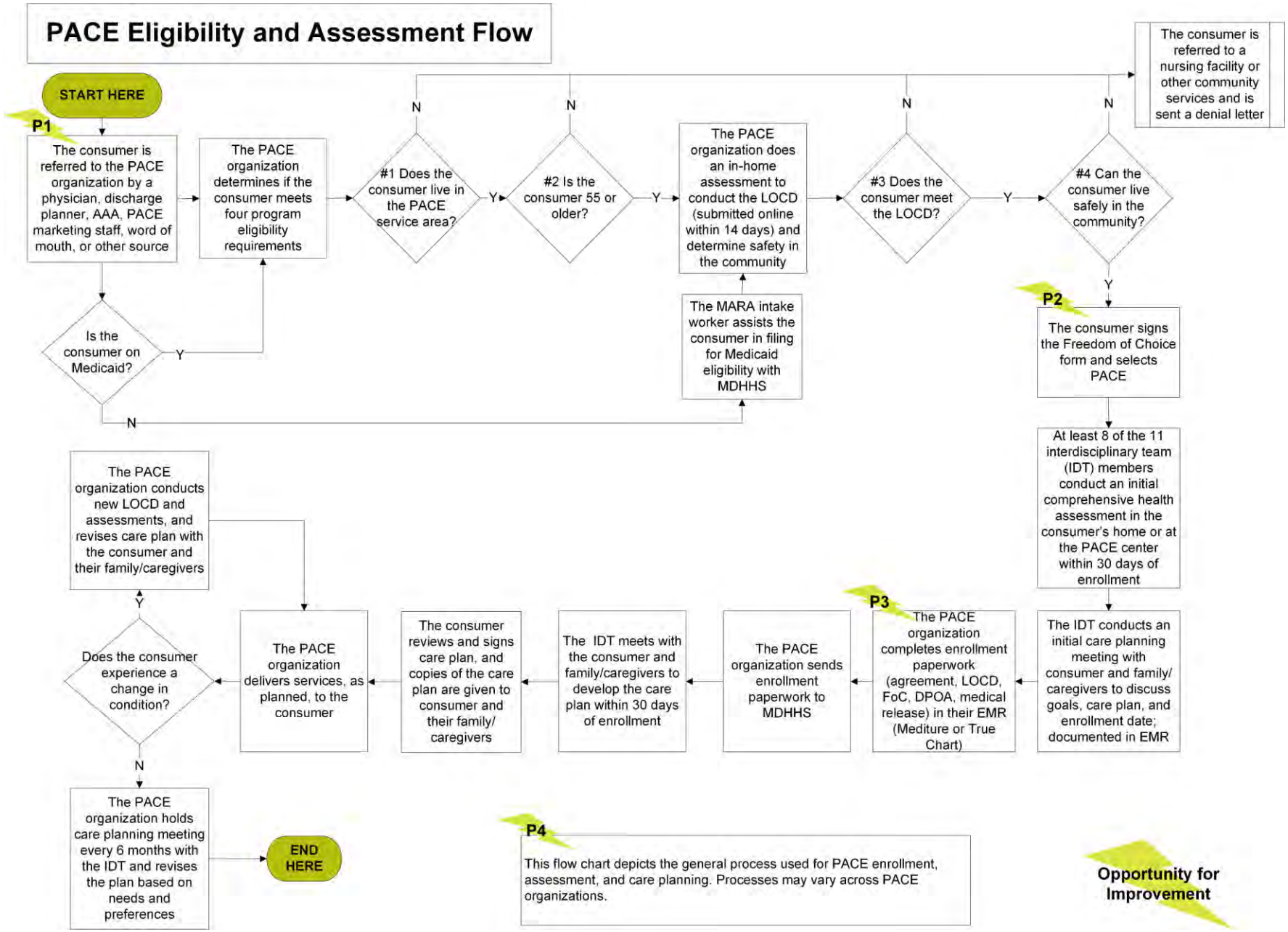
PACE Eligibility and Assessment Flow



IV. Quality Analysis

This section includes an overview of current quality measures across LTSS programs. MDHHS is focused on delivering high-quality services to Michigan consumers in need of LTSS. To that end, an internal workgroup was established to examine quality-related issues within the LTSS system. The initial goal of the work group was to identify and compare common MLTSS measurement activities across current Medicaid LTSS programs. In addition, the group also reviewed validated national MLTSS measures from the Centers for Medicare and Medicaid Services (CMS), and developed a matrix comparing current LTSS measures to eight validated MLTSS measures. This matrix includes relevant quality measures, data sources, and measurement methodologies across existing programs.

Currently there are few comparable quality measures across LTSS programs, though each program reports on a variety of quality and performance measures. As MDHHS continues to move toward the development of an MLTSS program, there is an opportunity to standardize key measures across LTSS programs. CHRT/HPM recommends that the MLTSS Quality Subgroup continue to meet on a regular basis during the development of MLTSS programs in order to determine and implement comparable quality measures across existing programs. The group's continued work would identify and assess needed changes to current quality measurement practices, and develop an MLTSS quality and measurement strategy, including areas for measure alignment across programs with validated national measures, such as the CMS MLTSS metrics.

In addition, the group could consider selecting and implementing a nationally validated quality-of-life/consumer satisfaction survey across all current programs, such as the National Core Indicators-Aging and Disability survey or the Consumer Assessment of Healthcare Providers and Systems-Home and Community Based Services survey. [9,10] Fielding such a survey would help facilitate an objective comparison across programs and develop a baseline set of consumer satisfaction measures upon which MLTSS performance could be measured.

Matrix of Quality Measurement Across LTSS Programs Relative to CMS MLTSS Measures

The MLTSS Quality Work Group developed a matrix to identify common quality measurement elements across Michigan Medicaid LTSS programs related to eight CMS-validated quality metrics. For each chart that follows, programs have reported on the following elements within each program that could be used to fulfill the CMS measure: 1) Quality measure; 2) Data source; 3) Data extraction, calculation, and validation; 4) Historical experience with measure; and 5) Future plans for measure. If no relevant measure exists, this is indicated in the appropriate box.

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CMS Quality Measure 1: Percentage of MLTSS members who have documentation of a comprehensive assessment in a specified timeframe that includes documentation of core and supplemental elements

PROGRAM	MEASUREMENT
Home Help	Comprehensive Home Help Assessment is performed on 100% of cases. Currently, the HH case management system is unable to track date of assessment. This enhancement should be in place during FY19.
MI Choice	iHC is a standardized comprehensive assessment. MPHI case record review would capture this measure. FY 2019 CQAR Protocol has been revised to specifically include this measure.
MI Health Link	iHC is used by all ICOs for the Level 2 Assessment (for HCBS). ICOs do not have a standardized Level 1 Assessment (L1A), but are required to include core elements in the L1A and each ICO's L1A is approved by MDHHS. The L1A must be completed within 45 days of enrollment in MHL (moving to 60 days starting in 2019), as measured through Contract Management Team (CMT) tables. In addition, there is a core measure (2.1) reported on by all the FAI MMPs that captures members with an L1A completed within 90 days of enrollment. This measure/data is reported to CMS and calculated by NORC and has been validated annually throughout the demo (PMV) through HSAG. This measure would be further audited in MHL's on-site audit process for enrollees in the HCBS Waiver.
PACE	Reviewed on audit, but not submitted to CMS. Eight assessments are required annually, plus LOCD, but they are not standardized. However, it is rare to find missing assessments.
Nursing Facilities	Report MDS data to CMS, and CMS shares the MDS data with the State of Michigan.

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CMS Quality Measure 2: Percentage of newly enrolled MLTSS plan members who have documentation of a care plan in the specified timeframe that includes documentation of core and supplemental elements

PROGRAM	MEASUREMENT
Home Help	HH does have a care plan, but it is not very detailed. HH would like to have a more meaningful care plan. Currently, the Reasonable Time/Task Schedule contains information on what care is needed.
MI Choice	Not measured currently. FY 2019 CQAR Protocol has been revised to specifically include this measure.
MI Health Link	Not standardized – e.g., NF residents have two separate care plans – one developed by the NF, one by the ICO. Elements required in the MHL care plan referred to as the Individual Integrated Care and Supports Plan (IICSP) are defined in the three-way contract. Historically, this information has been captured through MI 2.1, but as of Q1 2018 it was moved to a Core Measure in the demo (Core 3.2). This measure was added to the PMV completed by HSAG starting with 2016 data. These two measures were selected for ongoing PMV because they are included in the MMP performance data file posted publicly by CMS each year. This information is further evaluated through MDHHS on-site audit process for enrollees in the HCBS waiver. Of note, Michigan's performance on this measure has fallen below average when compared to other states in the demo. A large contributing factor is that not all states require an enrollee signature in order for the care plan to be considered complete. Waiver members must have a wet signature. Enrollees outside of the waiver must have a signature but there are multiple methods (defined in the MHL signature requirements) the ICOs may use to obtain the signature, which appears to be similar to the new CMS measure for care plan completion.
PACE	PACE staff keep track of enrollments per center each month. CMS and the state audit yearly a sample of medical records to verify care plans are completed timely and appropriately.
Nursing Facilities	Care plan completion is reported in the MDS, but the care plan and supporting documentation is not reported by the NF. Supporting documentation could be captured in the MPRO LOCD review or in LARA health surveys – but both of those are a small sample of residents.

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CMS Quality Measure 3: Percentage of MLTSS plan members with a care plan for whom all or part of the care plan was transmitted to the primary care practitioner (PCP) within 30 days of the care plan's development or update

PROGRAM	MEASUREMENT
Home Help	Not measured. HH staff ask at six-month reviews if there have been any recent hospitalizations. A reassessment is only done if needs increase after discharge and clients call to notify the worker of a change in their condition.
MI Choice	Not measured currently. FY 2019 CQAR Protocol has been revised to specifically include this measure.
MI Health Link	Not measured. CMT tables do capture number of enrollees who have had an Integrated Care Team (ICT) meeting. The IICSP would be reviewed in this meeting. PCP participation in ICT meetings has been low despite attempts to include them. The 2019 contract will allow additional licensed designees from the PCP's office to participate in lieu of the PCP. There is a MI-specific measure (2.6) that ascertains whether the transition of care record was transmitted to the PCP (or doctor responsible for f/u) within a specified timeframe following hospital discharge.
PACE	PCPs are members of the mandated IDT.
Nursing Facilities	Not measured currently.

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CMS Quality Measure 4: Percentage of discharges from inpatient facilities in the measurement year for MLTSS plan members resulting in a re-assessment and/or care plan update within 30 days of discharge

PROGRAM	MEASUREMENT
Home Help	Not measured. HH staff ask at six-month reviews if there have been any recent hospitalizations. A reassessment is only done if needs increase after discharge and clients call to notify the worker of a change in their condition.
MI Choice	Not measured currently. FY 2019 CQAR Protocol has been revised to specifically include this measure.
MI Health Link	No exact measure related to this, but other contractual requirements and reporting mechanisms are related to and/or drive IICSP reviews/updates. The three-way contract requires that a reassessment and IICSP update is performed as warranted by the enrollee's condition and at least every 12 months after the initial L1A. The same is required when there is a change in the enrollee's health status or need or as requested by the enrollee, their caregiver, or their authorized representative or provider. The three-way contract listed six specific trigger events that include a hospital admission and transition between care settings, but these events will be removed in the 2019 contract. This is audited through the on-site audit process for HCBS waiver members. The QIP project the ICOs worked on for the first three years of the demo was related to decreasing avoidable hospitalizations and many plans focused on avoidance of re-hospitalizations and transition of care services following hospitalizations. In addition, there is a MI-specific measure (2.5) that evaluates members with a first follow up visit within 30 days of hospital discharge. This measure is utilized in the auto assignment algorithm used to distribute passive enrollees among plans. Additionally, plans report on the HEDIS measures Follow Up after Hospitalization (FUH) for mental illness at 7 days and 30 days. Though not yet finalized, MDHHS is likely going to focus on these two HEDIS measures in the new QIP project plans will work on in 2019 and 2020.
PACE	PACE collects ED visits and admissions quarterly. CMS and the state audit yearly a sample of medical records to verify care plans and reassessments.
Nursing Facilities	All discharged NF residents must have an MDS discharge assessment completed (unless the discharge was due to their death), however this type of MDS assessment does not require care plan reporting. If a resident is readmitted to that NF or admitted to another NF, a new assessment must be completed (except in certain circumstances). It is possible to measure the percentage of discharges with a reassessment. If the resident is admitted/readmitted to a NF within 30 days of a discharge, it is possible to see the date a new care plan was developed.

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CMS Quality Measure 5: a) Percentage of MLTSS members who have documentation of screening for history of falls and/or problems with balance or gait; and b) Percentage of MLTSS members with a documented history of falls who have documentation of a falls risk assessment and plan of care to prevent future falls

PROGRAM	MEASUREMENT
Home Help	This data is not being collected at this time.
MI Choice	This information is included on the iHC. MI Choice can run quality indicator reports. One of the indicators is "prevalence of falls". The numerator is participants who recorded a fall on follow-up assessment. The denominator is all participants excluding those completely dependent in bed mobility. This does not directly correspond to this quality measure, but MI Choice could add it to the CQAR Protocol if needed.
MI Health Link	MI Health Link does not extract this data in a standard way currently. MI Health Link's Level 1 Assessments (L1A), though not standard across all ICOs, do require a domain that captures "medical health risk, status and history, including but not limited to frequent falls." In addition, both the Inter RAI/iHC used for HCBS and MDS for enrollees in NF gather information about the environment and falls. Likewise, the IICSP should address any health and safety risks identified through assessment. This is audited through our on-site audit. There is a measure that looks at enrollees in NF with one or more falls with serious injury.
PACE	MDHHS does not collect this information. CMS does collect falls with no injuries: location, time of fall, contributing factors and action taken. Data is collected quarterly and entered in HPMS (their federal system). Falls with injuries are treated differently and require a Level II Assessment, which often results in a root cause analysis.
Nursing Facilities	Falls and fall history are reported in section J of the MDS assessment, which the department has access to in the DataWarehouse. MDHHS does not have access to any data relating fall risk assessments and the plan of care to prevent future falls, but LARA may review this for a small sample of residents on health surveys. MDS data is largely unaudited. These measures have historically not been looked at and there are no current plans relating to the measures.

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CMS Quality Measure 6: Number of MLTSS member admissions to an institutional facility (i.e., nursing facility) from the community that result in a short-term (1-20 days), medium-term (21-100 days), or long-term (101+ days) stay, stratified by age (18-64, 65-74, 75-84, 85+)

PROGRAM	MEASUREMENT
Home Help	Home Help monitors nursing home stays to make sure HH payments were not made during the stay. Staff do not currently have access to the data to look at number of MLTSS admissions per client.
MI Choice	MI Choice does not directly measure this currently, but does track institutionalizations and could obtain this data.
MI Health Link	MI Health Link does not currently track this, but does have two somewhat related measures: 1. *Unduplicated members receiving HCBS and unduplicated members receiving nursing facility services.* 2. *NF Diversion* The first measure captures those that received both HCBS and NF services during the calendar year reporting period. Members must have been continuously enrolled for six months during the year to be included. The second measure captures the percentage of members classified as Nursing Home Certifiable for more than 100 continuous days during the prior year who did not reside in a NF for more than 100 continuous days during the prior year and who did not reside in a NF for more than 100 continuous days during the current reporting period. Waiver members are included in this measure, and ICOs can also use LOCD, PCA data, claims and enrollment data to determine Nursing Home Certifiable. MI Health Link also informally capture NF transitions to community on the CMT tables and with access to encounters could track Transition Case rate payments made to ICOs for transitioning enrollees out of NF to community. This requires at least a 90 day stay in the NF (previously 180 days).
PACE	MDHHS does not collect as written. The department does collect the # of individuals admitted to a nursing home and whether the admission was for a rehab, residential, or respite stay. Data is collected quarterly in an Excel spreadsheet. It is not broken down by ages. PACE is only available to those age 55 and up. CMS does not collect this information.
Nursing Facilities	NF admission information is reported in CHAMPS, and MDHHS can extract this data by querying the Data Warehouse. The information can be queried by beneficiary and can look at the length of stay. The data is largely unaudited. MDHHS has not consistently measured NF lengths of stay at a program wide level and does not have any set plans to look at this measure in the future.

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CMS Quality Measure 7: Proportion of admissions to an institutional facility (i.e., nursing facility) for MLTSS members that result in a successful discharge (community residence for 60+ days) within 100 days of admission

PROGRAM	MEASUREMENT
Home Help	This is not being tracked.
MI Choice	MI Choice tracks this data and could measure it.
MI Health Link	See response for Quality Measure 6.
PACE	MDHHS does not collect as written, but does collect rehab stays (see response for Quality Measure 6), which could apply. CMS does not collect this information.
Nursing Facilities	NF admission information is reported in CHAMPS, and MDHHS can extract this data by querying the Data Warehouse. Discharge information can be queried from this data, along with where residents went after discharge. The data is largely unaudited. MDHHS has not consistently measured NF discharges to the community within 100 days of admission and does not have any set plans to look at this measure in the future.

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CMS Quality Measure 8: Proportion of MLTSS members who are long-term (101+ days) residents of institutional facilities who are successfully transitioned to the community (community residence for 60+ days)

PROGRAM	MEASUREMENT
Home Help	This is not being tracked.
MI Choice	MI Choice would have this data.
MI Health Link	See response for Quality Measure 6.
PACE	MDHHS does not collect. One must live in the community to join PACE. One can be in PACE and then go to nursing home for one of three stays (see Quality Measure 6). CMS does not collect this information.
Nursing Facilities	NF admission information is reported in CHAMPS, and MDHHS can extract this data by querying the DataWarehouse. Discharge information can be queried from this data, along with where residents went after discharge. The data is largely unaudited. MDHHS has not consistently measured NF discharges to the community after 101 days of admission and does not have any set plans to look at this measure in the future.

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V. Stakeholder Feedback on Proposed MLTSS Models

Following CHRT/HPM's development of potential model options for MLTSS expansion, Public Sector Consultants engaged key stakeholders to identify the potential implications of the proposed strategies for improving the existing LTSS system and models for expansion and how the state can best address those implications as it works to ensure that people are able to live in the setting of their choice. PSC conducted a survey and interviews with key managed long-term services and supports (MLTSS) stakeholders, including representatives of managed care organizations (MCOs), LTSS providers, nursing homes, Area Agencies on Aging, community mental health, organizations representing recipients of services and supports, and the state long-term care ombudsman's office. CHRT/HPM adapted the continuum of MLTSS options to help inform this process (see figure on following page). This section presents key findings from the survey and interviews.

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Options for Possible MLTSS Models

	Strengthen Existing LTSS System	Moderate Expansion of MLTSS	Significant Expansion of MLTSS	Full Transition to MLTSS
Description of Potential Model	Implement opportunities for improvement within current LTSS system, such as: • Independent, conflict-free options counseling • Common quality measures across all programs • Common, integrated assessment processes across all programs • Consistent person-centered planning processes across all programs • Risk-stratified, integrated care management model Existing LTSS programs (Home Help, MI Choice, MI Health Link, Nursing Facilities, and PACE) could retain current structure, with improvements to the overall system and within specific programs.	Expanded MLTSS options for **dually eligible individuals**, which might entail: • ICOs at full risk for coordination of physical and LTSS benefits • Could adapt and expand MI Health Link ICO model statewide, or use another statewide approach, such as a Dual-Eligible Special Needs Plan (D-SNP) • Could expand PACE to new regions, if feasible • Could retain MI Choice, Nursing Facilities, and Home Help in current form In addition, this model would include all elements described in "Strengthen Existing System" option.	Expanded MLTSS options for **dually eligible individuals and Medicaid-only individuals with a nursing facility level of care**, which might entail: • MCOs at full risk for coordination of physical and LTSS benefits • Could adapt and expand MI Health Link ICO model statewide and develop a statewide MLTSS product for individuals with a nursing facility level of care statewide • Could expand PACE to new regions, where feasible • Potential changes to MI Choice and Nursing Facilities program structures • Could retain Home Help in current form In addition, this model would include all elements described in "Strengthen Existing System" option.	Expansion of MLTSS to **all consumers receiving Medicaid LTSS**, which might entail: • MCOs at full risk for coordinating physical health and LTSS benefits • MLTSS for all consumers who receive LTSS, including duals, individuals with a nursing facility level of care, and individuals receiving personal care services • Could adapt MI Health Link as the underlying foundation with necessary program changes, expand statewide, and develop new MCO contracts for Medicaid-only consumers • Could retain PACE as an LTSS option and expand to new regions/ populations, where feasible • Potential changes to MI Choice, Nursing Facilities, and Home Help program structures In addition, this model would include all elements described in "Strengthen Existing System" option.
Potential Outcomes for Consumers and the State of Michigan	• Consumers could be more empowered to choose among LTSS options • LTSS system could be more effective and efficient • LTSS system could promote consumers' abilities to receive services in the setting of their choice	• Greater integration/alignment of Medicare and Medicaid benefits for duals • Could incorporate lessons learned from MI Health Link implementation and adapt the MI Health Link model to enhance consumer experience	• Potential to promote consumers' abilities to receive services in the settings of their choice, by providing MCOs incentives for nursing facility transition and diversion	• Would move state closest to MLTSS for all consumers • More administrative simplicity for the state and consumers • Could provide most seamless consumer experience, as MCOs would serve as primary point of contact for coordination of all services

Implementing Improvements to the Existing System

Stakeholders were generally supportive of the proposed strategies for strengthening the existing system and said they should also be addressed to improve MI Health Link, if it is to be expanded to additional areas of the state.

Conflict-Free Options Counseling

LTSS providers believe strongly that any expansion of managed LTSS should be accompanied by conflict-free options counseling to ensure consumers are able to make a fully informed choice when it comes to where they receive services. Most stressed that conflict free options counseling is crucial to increasing home and community-based services (HCBS) and noted how other state MLTSS expansions are skewed toward enrollment in institutional care (e.g., Pennsylvania) when this was not in place. Some stakeholders said that monitoring is the only realistic way to ensure options counseling is, indeed, conflict-free, and others said that developing a basic set of regulatory expectations would help. Another recommended moving responsibility for the Level of Care Determination (LOCD) Tool to an independent third party.

Common Quality Measures Across All LTSS Programs

Several stakeholders called for the standardization of all reporting measures for comparability, while one stakeholder said measures should vary based on the profile of the LTSS recipient. Stakeholders who are supportive of a transition toward MLTSS also felt that this would be perceived as a gesture of good faith by MLTSS opponents, many of whom suggest that the state is prioritizing streamlined administration over quality of care or patient satisfaction. Many stakeholders also said this would facilitate better data-driven decision making.

Standardized Assessments Across All LTSS Programs

Numerous stakeholders recommended implementing a universal assessment of consumers' physical and behavioral health care needs and social determinants of health. Stakeholders cited PACE's multidisciplinary assessments and level of care determinations as a model to be emulated. These assessments are performed with every participant at least annually and are followed by smaller semiannual visits and regular status update meetings between care team members to assess progress toward participant goals.

Consistent Person-Centered Planning Process Across All LTSS Programs

Stakeholders said that implementing a consistent person-centered planning process across all LTSS programs would require training of both providers and service recipients. Some said that participants are often limited to options identified or suggested by providers rather than being invited to proactively define their own needs, including basic needs not normally associated with health outcomes, such as food and shelter (social determinants of health). Another respondent said that the state should respond to complaints about the lack of person-centered processes with sanctions and remedies.

Common, Stratified Care Management Model

Numerous stakeholders emphasized that different populations have different needs and that consumers of varying acuity levels should be seen more or less frequently based on prioritization of known needs and risk of hospitalization or other increase in acuity. To support care coordinators in their efforts to work effectively with beneficiaries, stakeholders recommended that MDHHS include a firm maximum caseload per coordinator (e.g., 150 people) in its ICO contracts, stratified according to beneficiary population or acuity levels, with smaller caseload limits for higher acuity consumers and

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vice versa. Lastly, they recommended making these stratified caps consistent across ICOs to ensure comparability.

Expanding Managed Long-Term Services

Stakeholders noted that this is the most complex health care transition that Michigan has ever attempted, and any expansion should be well thought out with proper due diligence. When considering the state's proposed options for expanding MLTSS, stakeholders offered several items they believe the state should consider as it continues its research and planning efforts. Many stakeholders focused their comments on the MI Health Link demonstration because of its potential to be a foundation for a model moving forward.

ICO Selection and Support

Stakeholders recommended limiting a competitive bid process to no more than 5 or 6 providers and excluding Medicaid health plans from eligibility that didn't participate in MI Health Link or that participated but performed poorly. Many stakeholders advocated for the state to require more than attestation, allowing only MCOs with demonstrated evidence of LTSS experience, high performance, and quality LTSS provision with current staff to participate in the bidding process. Stakeholders did not recommend adding ICOs, unless replacements for poor-performing ICOs were necessary to ensure access to services.

Given the limited number of MCOs with experience as ICOs, one consumer advocate recommended having successful ICOs share what they have learned with new applicants. A disability advocate said the MDHHS should plan carefully to address MCO training needs and provide reasonable and thoughtful oversight.

Mandatory Versus Passive Enrollment with Opt-Out

ICOs were emphatic that mandatory enrollment is necessary for ensuring a large enough pool of resources to serve the dual eligible population. In the absence of mandatory enrollment, ICOs recommended a three-month lock in period and eliminating the requirement for signatures on plans of care for low-risk consumers. Other stakeholders believe that allowing consumers to opt out of the demonstration is the best way to honor consumer choice. They also lauded how the state placed ICOs in tiers based on a set of criteria during passive enrollment and assigned more beneficiaries to ICOs in higher tiers.

Monitoring and Oversight of Service Delivery

Multiple stakeholders noted how difficult it is to ensure that services are provided, once authorized. Some recommended implementing electronic visit verification (EVV) for personal care services. Multiple stakeholders stressed that the state must give true and final oversight authority to ICOs, requiring them to ensure quality for beneficiaries of their program, including patients in nursing facilities, and not allowing them to delegate this responsibility to other vendors. ICOs want LTSS providers, including home health providers and family caregivers, trained to ensure quality, efficiency, and effectiveness of services for which they pay.

Stakeholders noted that, because personal care services are carved out of the waiver benefit, those services are not closely examined in annual audits of the HCBS waiver in MI Health Link. They recommended including a process to audit personal care service delivery and dramatically reducing the turnaround time for producing audit findings to increase their utility.

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Provider Enrollment and Payment

Some stakeholders recommended creating a standardized provider enrollment process. One stakeholder recommended that LTSS providers organize themselves to negotiate rates with the state, which ICOs would agree to pay. A similar model in Illinois made contracting with providers very easy because MCOs obtained entire networks without any negotiating, and which afforded the MCOs much closer oversight of vendors. Stakeholders also encouraged the state to publicize rates and payment processes before providers enter into contracts with the ICOs (some providers have a very small margin and would be burdened by extended payment periods). Stakeholders noted that it has been challenging to ensure that LTSS providers get paid since services are provided through the standard claims process.

Care Coordination

Numerous stakeholders noted challenges with care coordination in the MI Health Link demonstration. They said beneficiaries often do not know who their care coordinator is or how to contact them. LTSS providers indicated having difficulty reaching ICO supports coordinators. One stakeholder asserted that the care coordination system in MI Health Link is good but said most care coordinators have far too many cases to be able to provide all of the mandated services. Several stakeholders noted there are high turnover rates among care coordinators, which they asserted are due, primarily, to high caseloads and lack of flexibility in determining supports for beneficiaries.

Direct Care Workforce Shortages

Stakeholders acknowledged that the caregiver shortage is acute, extensive, and getting worse. They stressed that adjusted, more appropriate, capitation rates based on level of care determination are needed to address the direct care worker shortage and transition people to HCBS. Stakeholders added that supports for informal caregivers are also needed to transition people to HCBS.

Network Adequacy Requirements

Some stakeholders cited MCOs' ability to meet provider network adequacy requirements as evidence that ICOs could contract with a sufficient provider network under MLTSS. However, others felt that finding the right mix of providers to meet consumer needs within existing MI Health Link requirements for distance and travel would be difficult, particularly in rural areas. They recommended that the state review these requirements to see if any flexibility should be offered depending on the types of services to be delivered.

Incentivizing Access to Home- And Community-Based Services

Many stakeholders noted that capitation rates must improve in order to improve availability of HCBS providers statewide and that many consumers opted out of MI Health Link because their provider did not want to participate. Some feel that fee-for-service nursing facilities are able—but have no incentive—to transition people to HCBS. They advocated stronger oversight, consumer protections, and penalties for poor-quality nursing homes. Multiple stakeholders recommended rolling up the long-term care line item in the state budget into a single budget and letting the money follow the person rather than allocating a portion to nursing facilities and to MI Choice, noting concurrent increases in state funding and MI Choice enrollment (along with decreased waitlists) and high levels of consumer satisfaction.

Data-Driven Decision-Making

Many stakeholders stressed the need for data-driven decision making, and some expressed concerned about the state's willingness to change the LTSS system without

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outcome and customer satisfaction data from the MI Health Link demonstration. Several stakeholders, including those supportive of a move toward MLTSS, expressed disappointment in how little encounter data is available from a demonstration of this size. In the absence of these data, opponents of MLTSS cite disenrollment from MI Health Link as anecdotal evidence that the pilot is not effective, while proponents of MLTSS cited positive anecdotal outcomes reported by those who remain enrolled.

Beneficiary Protections

Stakeholders recommended that all caregivers be given mandatory training on elder abuse and abuse of other vulnerable consumers (e.g., younger people with disabilities). They felt it was both a universal necessity across stakeholder groups and an unfulfilled promise of MI Health Link. Stakeholders noted that many consumers lack recourse and recommended that the Ombudsman be equipped and authorized for expanded oversight, stressing that numerous Ombudsman programs in other demonstrations have such a system.

Beneficiary Communication

Stakeholders stressed that MI Health Link's enrollment process was frenetic and that future rollout efforts must be more deliberate and systematic, educating beneficiaries, providers, and state employees about the MLTSS program prior to any launch. They said MDHHS should engage the department's communications office early to ensure that clear, timely, and appropriately targeted messaging goes to those impacted by the new program. They also suggested calling upon consumer advocates to assist in the delivery of information and proactively engaging providers such as nursing facilities, who were especially resistant to MI Health Link. Stakeholders feel that a better understanding of MLTSS among consumers will foster greater program engagement, satisfaction, growth, and retention.

Expansion to Additional Populations

When asked what changes should be made to MI Health Link for it to effectively serve Medicaid-only consumers, ICOs acknowledge that services would differ for this population but that not many changes would be necessary on the financial side because the Medicaid benefit is the same in MI Health Link. All stakeholders stressed the need for a staged implementation approach (by geographic area, population, or both), adding that any protections the state afforded to dual eligibles should also be extended to Medicaid-only consumers. Some stakeholders disagreed, arguing that MI Health Link should not be expanded to Medicaid only consumers given current participants' disenrollment from the program.

Integrating Physical and Behavioral Healthcare

Consider Whether to Eliminate the Behavioral Health Carve Out

Medicaid health plans and ICOs are interested in moving LTSS into managed care and in expanding their services throughout the state. However, they are not comfortable moving statewide without elimination of the behavioral health carveout. Numerous stakeholders agreed, advocating that the state eliminate the behavioral health carveout and prepaid inpatient health plan (PIHP) involvement for consumers with behavioral health, substance use, and/or intellectual and developmental disabilities and allow selected ICOs with demonstrated ability to integrate care to contract directly for Medicaid specialty services and supports.

Some LTSS providers disagreed, stating that the behavioral health benefits for Medicare and Medicaid programs should be managed by the state's PIHP and community mental

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health system, given their expertise in this area, and that coordination of care management and services can best be accomplished among the ICOs and the PIHPs, with the expertise of each applied to this effort. Current LTSS providers also noted with concern that the actuarial incentive for MCOs is to deny services and their lack of experience with this population may lead them to deny services that are truly necessary. Some stakeholders also emphasized that MCOs' definition of care coordination is not equivalent to person-centered planning, and many current LTSS providers felt that the move toward expanding MLTSS presupposes applying the medical definition.

Implement an Alternative to MLTSS

Several stakeholders stressed that, according to the 2017 Long-Term Services and Supports State Scorecard, published by the AARP Public Policy Institute, four of the top five states do not use MLTSS at all and that better approaches to doing so exist. One AAA representative advocated an alternative model in which existing structural links between primary care providers and HCBS are strengthened, using electronic health records, for example. This stakeholder recommended that the model mimic the MI Choice waiver's person-centered flexibility by offering a flexible capitation rate to address the incentive for ICOs to not provide services. This could be accomplished by having MCOs contract with MI Choice waiver agents to perform care coordination. Finally, they stressed identifying metrics other than improved access to medical care, noting that, for many people who need LTSS, the goal is caregiver stabilization and quality of life in the home.

Several stakeholders cautioned against "dismantling and rebuilding Michigan's effective long-term care system" and "building upon what already works within the current system" to include such features as a programmatic review of customer needs, conflict-free case management and navigation, access to the full range of integrated services and supports, use of high-quality providers, choice for all consumers regardless of payment source, and full accountability to the consumer as well as the taxpayer

VI. Landscape Analysis: Michigan Medicaid LTSS

In Fiscal Year 2016 (the most recent year for which national data are available), Medicaid programs across all 50 states and the District of Columbia spent approximately $167 billion on long-term services and supports. From FY2015 to FY2016, Medicaid LTSS spending increased by 4.5 percent while total Medicaid spending increased by 5.9 percent.[12] On average, 57 percent of national Medicaid LTSS expenditures was dedicated to the provision of home- and community-based services (HCBS), while 43 percent was for LTSS provided in institutional settings. While individual states vary, HCBS spending represents the majority of LTSS spending in 30 states and the District of Columbia.[13]

Michigan lags behind the national average, ranking 45th among states in its proportion of LTSS expenditures in HCBS in FY2016.[14] According to data provided by MDHHS, in FY2017, 43 percent of Michigan's Medicaid LTSS expenditures supported HCBS, while 57 percent supported care in institutional settings. Relative to the national benchmark, Michigan has an opportunity to increase the proportion of LTSS spending for community-based services. If Michigan implemented or expanded programs to increase HCBS to the level of national benchmarks and concurrently reduced its reliance on institutional care, the state would be able to serve a substantially larger share of individuals in community settings. For every nursing facility level of care (NFLOC) individual who remains in a community setting and does not transition to a nursing facility, the state would save approximately $2,176 per-member, per-month (PMPM) in 2017 dollars,[15] creating an opportunity to provide HCBS to more individuals within the same LTSS expenditures.

If designed and implemented with appropriate oversight and accountability, creating a system of managed LTSS (MLTSS) has the potential to better integrate LTSS with physical and behavioral health care and increase access to community-based LTSS options. Below is a descriptive analysis of Michigan's major Medicaid LTSS programs for MDHHS to consider in weighing the implications associated with a move toward greater MLTSS. This analysis focuses on the five major Medicaid programs that provide LTSS: Home Help, MI Health Link, MI Choice, PACE, and nursing facilities.

Important Note: In the analyses included in this report, expenditure data includes only Medicaid expenditures and does not include Medicare expenditures for all dually eligible individuals. All per-member-per-month expenditures represent total Medicaid costs only for individuals enrolled in a given program. For dually eligible individuals, therefore, this analysis understates the total cost of care for many enrollees, including nearly all enrollees in PACE and MI Health Link.

Key Findings

- In FY2017, individuals receiving Medicaid LTSS comprised just 5 percent of total Medicaid enrollment, yet they accounted for 23 percent of total Medicaid expenditures.
- In FY2017, 82 percent of individuals enrolled in Medicaid LTSS programs were dually eligible for Medicare and Medicaid. All Medicaid LTSS programs have between 90 and 100 percent dually eligible enrollees, except Home Help with 60 percent.
- In 33 of Michigan's 83 counties, 25 percent or less of individuals with a nursing facility level of care received LTSS in a home- or community-based setting in FY2017.

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- For programs serving individuals with a nursing facility level of care, nursing facility and MI Choice enrollees had similarly high hospital admission rates in FY2017. However, MI Choice enrollees had approximately a 50 percent lower readmission rate than those in nursing facilities.

Figure 1: Enrollment, PMPM Medicaid Costs, and Utilization in MI Medicaid LTSS Programs, FY2015-2017

	AVG ANN'L ENROLL FY17	AVG ANN'L % CHANGE FY17	PMPM FY17	AVG ANN'L % CHANGE 2015-17	HOSPL ADMIT RATE PER 1,000 FY17	HOSPL READMIT RATE PER 1,000 FY17	ED VISIT RATE PER 1,000 FY17
Home Help	51,682	-4%	$1,550	5%	264	9	919
MI Health Link[16]	37,478	118%	$732	-5%	--	--	--
HCBS Waiver	683	1,735%	$2,450	10%	--	--	--
Nursing Facilities	2,075	122%	$5,298	0%	--	--	--
Comm. Well	34,720	117%	$425	-7%	--	--	--
Nursing Facilities	27,567	-1%	$4,910	3%	544	66	376
MI Choice	11,841	4%	$2,688	-2%	535	35	541
PACE	1,961	27%	$3,297	2%	--	--	--
Total LTSS	130,529	11%	$2,153	-4%	270	21	849
Total Medicaid	2,452,528	3%	$509	1%	--	--	--

Source: MDHHS Actuarial Division, 2018
*PMPM expenses account for Medicaid expenses only.

Enrollment in MI Medicaid LTSS Programs

Overview

Enrollment in Medicaid LTSS in MI is distributed across five major programs. Three are delivered through a capitated financing approach (MI Choice, PACE and MI Health Link), while two are delivered through a fee-for-service (FFS) model (Home Help and Nursing Facilities). The majority of those enrolled in Medicaid LTSS programs in MI are

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enrolled in FFS LTSS programs (71 percent in FY2017). (See Appendix A for a detailed table of Medicaid LTSS program components and Appendix B for detailed average annual enrollment figures.)

Enrollees in LTSS programs have a mix of acuity and receive services in different settings. For the purposes of comparing key measures across programs, wherever possible, CHRT/HPM's analyses group similar enrollees into categories based on level of care:

- **Nursing facility level of care (NFLOC)**: Individuals deemed to require a nursing facility level of care includes enrollees in fee-for-service nursing facilities, MI Choice, PACE, MI Health Link nursing facilities, and the MI Health Link HCBS Waiver.
- **Non-NFLOC**: Individuals who have not been deemed to require NFLOC includes enrollees in Home Help and the MI Health Link Community Well pool.

To analyze the type of setting where consumers receive LTSS, CHRT/HPM also conducted several analyses of enrollment and expenditures in institutional settings and home- and community-based settings. These analyses are restricted to those individuals deemed to be at an NFLOC, so enrollees in Home Help and MI Health Link Community Well are excluded.

- **Institutional**: Individuals at NFLOC who receive LTSS in an institutional setting includes enrollees in fee-for-service nursing facilities and MI Health Link nursing facilities.
- **HCBS**: Individuals at NFLOC who receive LTSS in home- and community-based settings includes enrollees in MI Choice, PACE, and the MI Health Link HCBS Waiver.

Finally, CHRT/HPM analyzed enrollment and expenditures by type of program financing, i.e., fee-for-service versus managed care. These analyses include all enrollees in LTSS programs in addition to a focus on those at NFLOC.

- **Fee-for-service (FFS)**: Individuals receiving LTSS in programs that are financed through a fee-for-service approach includes individuals in fee-for-service nursing facilities and Home Help.
- **Managed care**: Individuals receiving LTSS in programs that are financed through a capitated approach includes individuals in MI Choice, PACE, and MI Health Link (all enrollee types).

MI Medicaid LTSS Programs

There are five LTSS programs included in this analysis.

Home Help, the personal care state plan benefit program that is available to individuals who need assistance performing activities of daily living (ADLs)

- FY2017 average annual enrollment: 51,682
- 2015-2017 average annual percent change in enrollment: -4 percent
- FY2017 enrollment as a percent of total enrollment in LTSS programs: 40 percent
- Statewide service area

MI Health Link, for individuals over age 21 with dual eligibility for Medicare and Medicaid

- FY2017 average annual enrollment: 37,478[17]

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- 2015-2017 average annual percent change in enrollment: 118 percent (the program has grown significantly since its launch in 2015)
- FY2017 enrollment as a percent of total enrollment in LTSS programs: 29 percent
- Limited service area – four regions spanning 25 counties
- Within the MI Health Link program, there are three general enrollee types: Nursing Facility (MHL NF), HCBS Waiver (MHL HCBS), and Community Well. MHL NF and MHL HCBS enrollees are deemed to be at a nursing facility level of care (NFLOC). Where possible, this analysis breaks out MHL data by enrollee type to ensure more accurate comparisons across populations and programs.
- **MI Health Link – HCBS Waiver**
    - FY2017 average annual enrollment: 683
    - 2015-2017 average annual percent change in enrollment: 1,735 percent
    - FY2017 enrollment as percent of total MHL enrollment: 1.8 percent
- **MI Health Link – NF**
    - FY2017 average annual enrollment: 2,075
    - 2015-2017 average annual percent change in enrollment: 122 percent
    - FY2017 enrollment as percent of total MHL enrollment: 5.5 percent
- **MI Health Link – Community Well**
    - FY2017 average annual enrollment: 34,720
    - 2015-2017 average annual percent change in enrollment: 117 percent
    - FY2017 enrollment as percent of total MHL enrollment: 92.6 percent

Nursing facility care

- FY2017 average annual residents: 27,597
- 2015-2017 average annual percent change in enrollment: -1 percent
- FY2017 enrollment as a percent of total LTSS: 21 percent
- Statewide service area – Medicaid certified nursing facilities are located in all counties except Keweenaw

MI Choice, for individuals who require a nursing facility level of care

- FY2017 average annual enrollment: 11,841
- 2015-2017 average annual percent change in enrollment: 4 percent
- FY2017 enrollment as a percent of total LTSS: 9 percent
- Statewide service area, but limited access (average waitlist was approximately 3,400 individuals in FY2017).

PACE, for mainly dually eligible individuals over age 55 with a nursing facility level of care

- FY2017 average annual enrollment: 1,961
- 2015-2017 average annual percent change in enrollment: 27 percent
- FY2017 enrollment as a percent of total LTSS: 2 percent
- Limited but expanding service area – 13 counties plus 234 zip code areas

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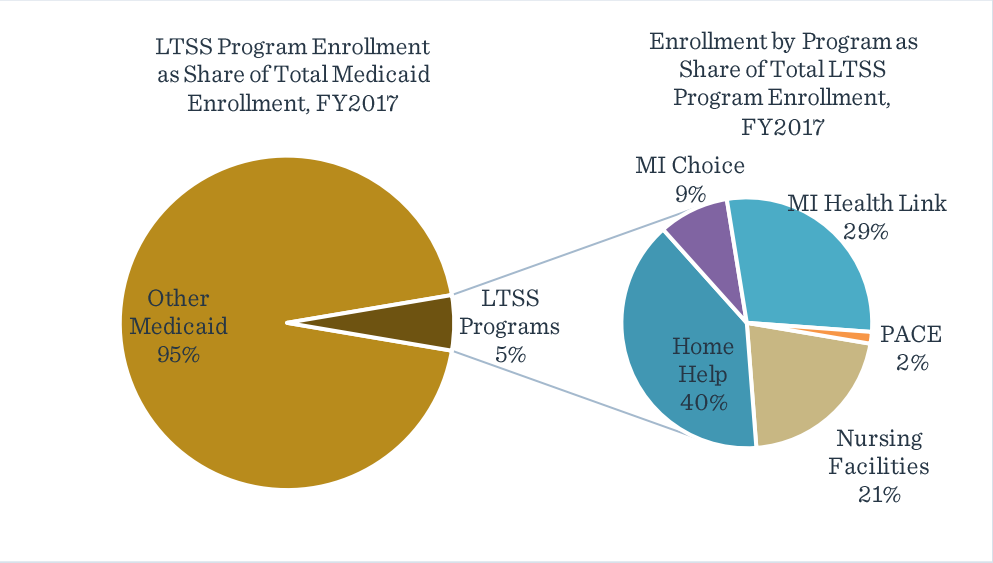
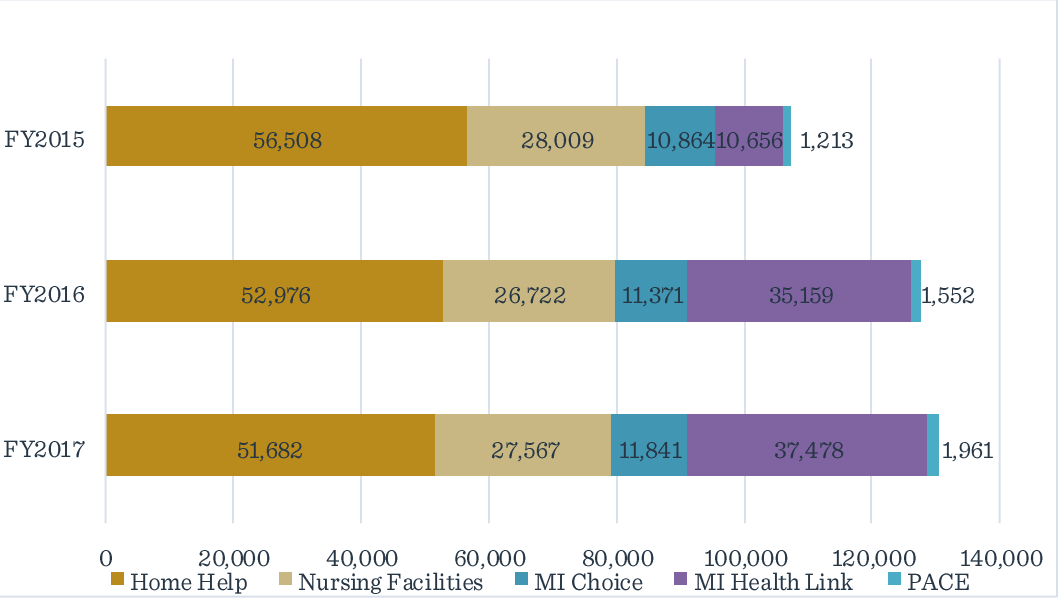
Figure 2: Enrollment in Michigan Medicaid LTSS Programs, 2017



Source: MDHHS Actuarial Division, 2018

In FY2017, enrollment in LTSS programs remained a relatively small proportion of the Medicaid program overall, with just 5 percent of Medicaid enrollees receiving LTSS. However, the growth of LTSS enrollment outpaced the growth of overall Medicaid enrollment during this time. Enrollment in the five major programs that provide LTSS increased by an average of 11 percent annually from FY15 to FY17, 3 percent annually for Medicaid overall. Enrollment in the Home Help and nursing facilities programs decreased during this time.

Figure 3: Average Annual Enrollment in MI Medicaid LTSS Programs, FY2015-2017



Source: MDHHS Actuarial Division, 2018

Enrollment by Level of Care

The five Medicaid LTSS programs serve consumers with varying levels of acuity. Individuals enrolled in the Home Help program and in the Community Well pool of MI Health Link generally have a functional status that is less than a nursing facility level of

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care and live in community settings.[18] These individuals are considered "Non-NFLOC" in this and all subsequent analyses. MI Choice, PACE, MI Health Link HCBS Waiver, and nursing facilities (encompassing both FFS beneficiaries and MI Health Link NF residents) are limited to individuals determined to be in need of a nursing facility level of care (NFLOC). These individuals are considered "NFLOC" in this and all subsequent sections of this analysis. In FY2017, 66 percent of enrollees (86,402 individuals) in the five Medicaid LTSS programs were deemed to be at less than NFLOC, while 34 percent (44,127 individuals) had a NFLOC. The number of non-NFLOC individuals enrolled in programs providing LTSS has increased by 30 percent since FY2015, primarily due to enrollment of lower-acuity duals in the MI Health Link community well pool.

Figure 4: Average Annual LTSS Enrollment, by Level of Care, FY2015-FY2017

	FY2015 TOTAL	SHARE OF LTSS PROG. ENR.	FY2016 TOTAL	SHARE OF LTSS PROG. ENR	FY2017 TOTAL	SHARE OF LTSS PROG. ENR.	AVG ANN'L % CHANGE FY15-17
Nursing Facility LOC	40,719	38%	42,005	33%	44,127	34%	4%
Non-Nursing Facility LOC	66,531	62%	85,774	67%	86,402	66%	15%

Source: MDHHS Actuarial Division, 2018

Enrollment by Care Setting

In recent years, MDHHS has implemented efforts to increase access to, and use of, home- and community-based LTSS to allow individuals to receive services and supports in the setting of their choice. Among enrollees with a nursing facility level of care,[19] the majority of individuals continue to reside in institutional settings, though the share of individuals in an institutional setting has declined slightly since FY15. In FY17, approximately one-third of all individuals with a nursing facility level of care received LTSS in a home or community-based setting. The share of NFLOC individuals receiving HCBS has increased from 30 percent in FY2015 to 33 percent in FY2017. This suggests that the state is shifting some spending toward home and community-based services, though the pace of that shift has been slow. (See Appendix B for detailed enrollment tables by program, level of care, and care setting.)

Figure 5: Average Annual LTSS Enrollment for Individuals with Nursing Facility Level of Care, FY2015-FY2017

	FY2015 TOTAL	SHARE OF NF LOC ENR.	FY2016 TOTAL	SHARE OF NF LOC ENR.	FY2017 TOTAL	SHARE OF NF LOC ENR.	AVG ANN'L % CHANGE FY15-17
Institutional	28,636	70%	28,914	69%	29,642	67%	2%
Community	12,083	30%	13,091	31%	14,485	33%	9%

Source: MDHHS Actuarial Division, 2018

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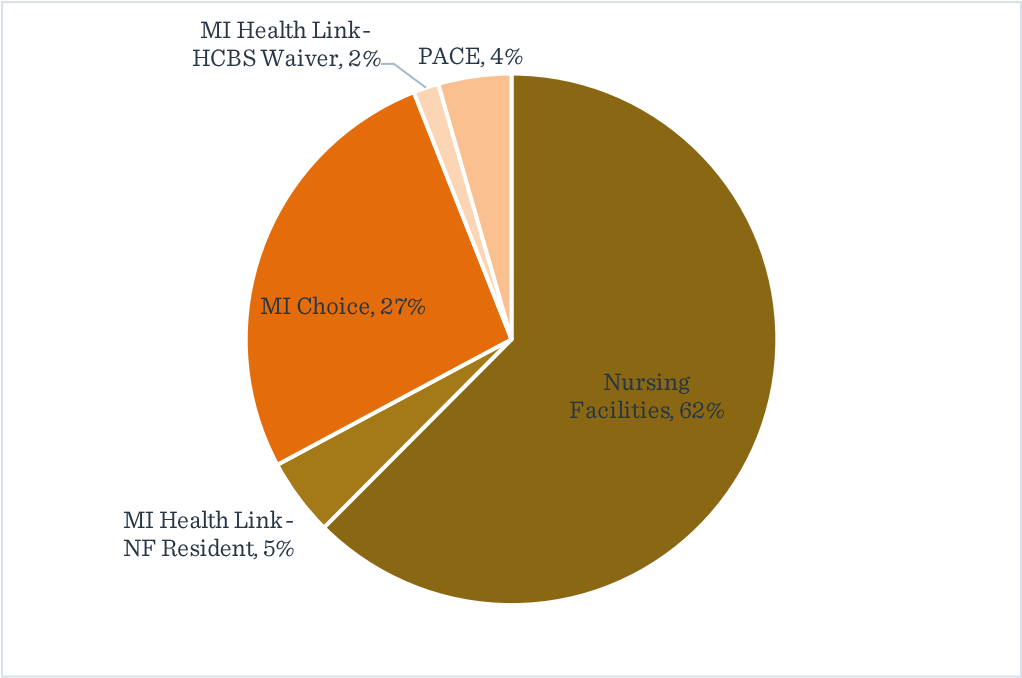
Among individuals with a NFLOC, FFS nursing facility residents account for the largest share of institutional LTSS enrollment. MI Choice enrollees account for the largest share of HCBS enrollment.

Figure 6: LTSS Setting for Enrollees with Nursing Facility Level of Care, FY2017



Source: MDHHS Actuarial Division, 2018

Enrollment by Age

With the exception of PACE, which is limited to eligible adults age 55 and older, most Medicaid LTSS programs are open to all eligible adults regardless of age.[20] Medicaid LTSS generally serves an older population than the overall Medicaid program, though age distribution of LTSS enrollees varies by program.

Approximately half of all enrollees in Medicaid LTSS programs are under age 65. Home Help has the largest share of younger enrollees, with 71 percent under age 65. MI Health Link also has a majority of enrollees, 56 percent, under age 65. Nursing facilities, PACE, and MI Choice serve older individuals: 80 percent of NF enrollees, 82 percent of PACE enrollees, and 67 percent of MI Choice enrollees are over age 65. Nursing facilities also have the largest share of adults over age 85, who accounted for 36 percent of total NF enrollment in FY17.

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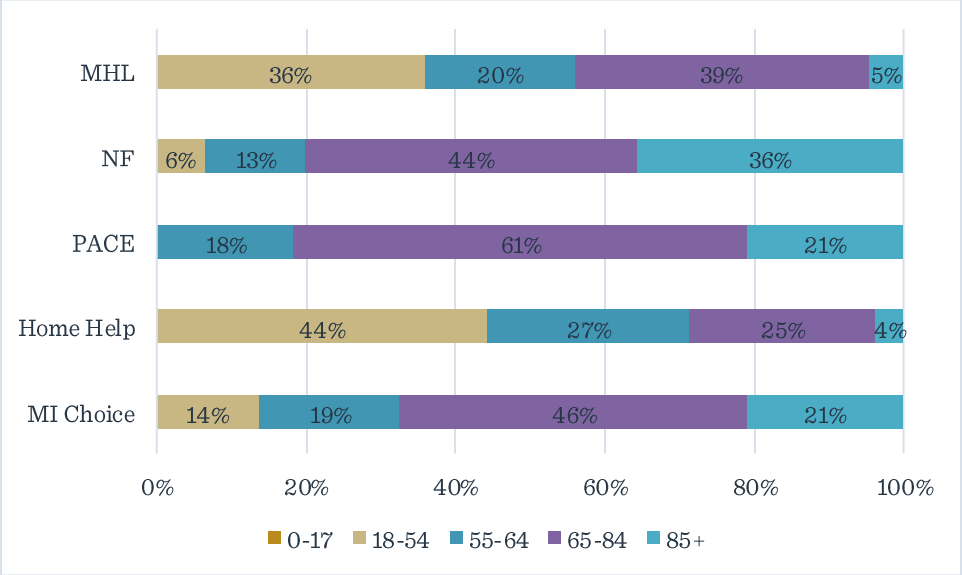
Figure 7: Medicaid LTSS Program Enrollment by Age Group, FY2017



Source: MDHHS Actuarial Division, 2018

Enrollment of Dually Eligible Individuals

Many of those enrolled in Medicaid LTSS programs are also eligible for Medicare benefits due to their age or disability. In fact, dually eligible individuals comprise the majority of enrollment in Medicaid LTSS programs. In addition to MI Health Link, which serves only duals, duals represent over 90 percent of enrollment in nursing facilities, MI Choice, and PACE and 60 percent of enrollment in Home Help. Enrollment of dually eligible individuals in Medicaid LTSS programs has grown in recent years, driven by the creation of the MI Health Link program and the expansion of the PACE program, while dually eligible enrollment in Home Help and nursing facilities decreased slightly. According to interviews with MDHHS program staff, these enrollment declines are, in part, due to individuals switching from these programs to the MI Health Link program.

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Figure 8: Average Annual LTSS Enrollment, Dually Eligible Individuals Only, FY2015-2017

	FY 2015	FY 2016	FY 2017	DUALS AS SHARE OF PROGRAM ENROLLMENT	AVG ANNUAL % CHANGE FY 15-17
Home Help	35,016	31,813	31,039	60%	-6%
Nursing Facilities	25,867	24,445	25,133	91%	-1%
MI Choice	10,099	10,595	11,071	93%	5%
MI Health Link*	10,651	35,149	37,478	100%	118%
PACE	1,165	1,477	1,865	95%	27%
Total Dual Eligible	82,798	103,479	106,586	82%	14%
Total LTSS Programs	107,250	127,779	130,529		11%
Duals as % of LTSS Enrollment	77%	81%	82%		3%

Source: MDHHS Actuarial Division, 2018
*Note: MI Health Link enrollment data for dually eligible individuals are not broken out by enrollment type (e.g., Community Well, NF resident, HCBS Waiver).

Fee-For-Service vs. Managed Care

While the trend in Michigan from 2015-2017 shows increases in the proportion of individuals enrolled in capitated LTSS programs, fee-for-service is still the dominant payment model for LTSS. The Home Help program and nursing facilities are paid on a fee-for-service basis. Michigan's current managed care LTSS programs include MI Choice, MI Health Link, and PACE. In FY17, 61 percent of individuals were enrolled in a fee-for-service program compared to 39 percent in managed care. However, that represents a 126 percent increase in managed care enrollment (due to the launch of MI Health Link in 2015) and a 6 percent decrease in fee-for-service enrollment since FY15.

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Figure 9: Average Annual LTSS Program Enrollment, FY2015-FY2017

	FY 2015 TOTAL	SHARE OF LTSS PROGRAM ENROLLMENT	FY 2016 TOTAL	SHARE OF LTSS PROGRAM ENROLLMENT	FY 2017 TOTAL	SHARE OF LTSS PROG. ENROLLMENT	AVG ANN'L % CHANGE FY 15-17
Fee-for-service	84,517	79%	79,698	62%	79,249	61%	-3%
Managed Care	22,733	21%	48,082	38%	51,280	39%	59%

Source: MDHHS Actuarial Division, 2018

Among enrollees with a NFLOC, the majority receive LTSS through fee-for-service programs (62 percent compared to 38 percent for managed care in FY17). Similar to the total population of those in Medicaid LTSS programs, fee-for-service enrollment for those with a nursing facility level of care decreased while managed care enrollment increased over the FY15-17 period, though at a slower rate.

Figure 10: Average Annual LTSS Program Enrollment, NFLOC, FY2015-FY2017

	FY 2015 TOTAL	SHARE OF NF LOC	FY 2016 TOTAL	SHARE OF NF LOC	FY 2017 TOTAL	SHARE OF NF LOC	AVG ANN'L % CHANGE FY 15-17
Fee-for-service	28,009	69%	26,722	64%	27,567	62%	-1%
Managed Care	12,710	31%	15,284	36%	16,561	38%	14%

Source: MDHHS Actuarial Division, 2018

Expenditures in MI Medicaid LTSS Programs

On a per-member-per-month (PMPM) basis, total Medicaid expenditures for LTSS programs have actually decreased by an average of 4 percent annually from FY2015 to FY2017 because of an influx in non-NFLOC dually eligible individuals in the MI Health Link program. PMPM Medicaid costs are, in general, higher for those deemed NFLOC ($4,223) than for those who are not at NFLOC ($800), and the vast majority of MI Health Link enrollees are not at NFLOC. MI Health Link has the lowest PMPM Medicaid costs of any the five Medicaid LTSS programs because of its large, lower-acuity Community Well population. In general, total Medicaid PMPM costs for individuals in LTSS programs ($2,155) still remain far higher than PMPM costs for those enrolled in the Medicaid program overall ($509). LTSS-only PMPM expenditures decreased by 8 percent since FY2015 for the four programs with available data, including Home Help, MI Health Link, Nursing Facilities, and MI Choice.

In this section, we report on two types of expenditures within Medicaid LTSS programs. Total Medicaid Cost of Care (TCOC) expenditures represent total Medicaid costs for individuals enrolled in a given program. LTSS-only expenditures represent the Medicaid cost of LTSS for individuals enrolled in a given program. Expenditures are reported in terms of PMPM costs to facilitate comparison across programs. Expenditures in PACE

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include all services, not just LTSS services. Expenditures for all programs include only Medicaid expenditures and do not include Medicare expenditures. This analysis reports on total Medicaid expenditures for all programs and therefore understates the true total cost of care for dually eligible enrollees.

Home Help

- FY2017 PMPM total Medicaid expenditures: $1,550
- FY2017 PMPM LTSS-only expenditures: $497
- 2015-2017 average annual percent change in PMPM Medicaid expenditures: 5 percent
- 2015-2017 average annual percent change in LTSS-only PMPM: 7 percent
- FY2017 total program Medicaid expenditures as a percent of total Medicaid spending for LTSS enrollees: 28 percent

MI Health Link

- FY2017 PMPM total Medicaid expenditures: $732
- FY2017 PMPM LTSS-only expenditures: $467
- 2015-2017 average annual percent change in PMPM Medicaid expenditures: -5 percent
- 2015-2017 average annual percent change in LTSS-only PMPM: 3 percent
- FY2017 total program Medicaid expenditures as a percent of total Medicaid spending for LTSS enrollees: 10 percent
- **MI Health Link – HCBS Waiver**
  - FY2017 PMPM total Medicaid expenditures: $2,450
  - FY2017 PMPM LTSS-only expenditures: $2,254
  - 2015-2017 average annual percent change in PMPM Medicaid expenditures: 10 percent
  - 2015-2017 average annual percent change in LTSS-only PMPM: 15 percent
- **MI Health Link – NF**
  - FY2017 PMPM total Medicaid expenditures: $5,298
  - FY2017 PMPM LTSS-only expenditures: $5,328
  - 2015-2017 average annual percent change in PMPM Medicaid expenditures: 0 percent
  - 2015-2017 average annual percent change in LTSS-only PMPM: 0.5 percent
- **MI Health Link – Community Well**
  - FY2017 PMPM total Medicaid expenditures: $425
  - FY2017 PMPM LTSS-only expenditures: $142
  - 2015-2017 average annual percent change in PMPM total Medicaid expenditures: -7 percent
  - 2015-2017 average annual percent change in LTSS-only PMPM: 0.13 percent

Nursing facilities

- FY2017 PMPM total Medicaid expenditures: $4,910
- FY2017 PMPM LTSS-only expenditures: $4,408
- 2015-2017 average annual percent change in PMPM Medicaid expenditures: 3 percent
- 2015-2017 average annual percent change in LTSS-only PMPM: 3 percent

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- FY2017 total program Medicaid expenditures as a percent of total Medicaid spending for LTSS enrollees: 48 percent

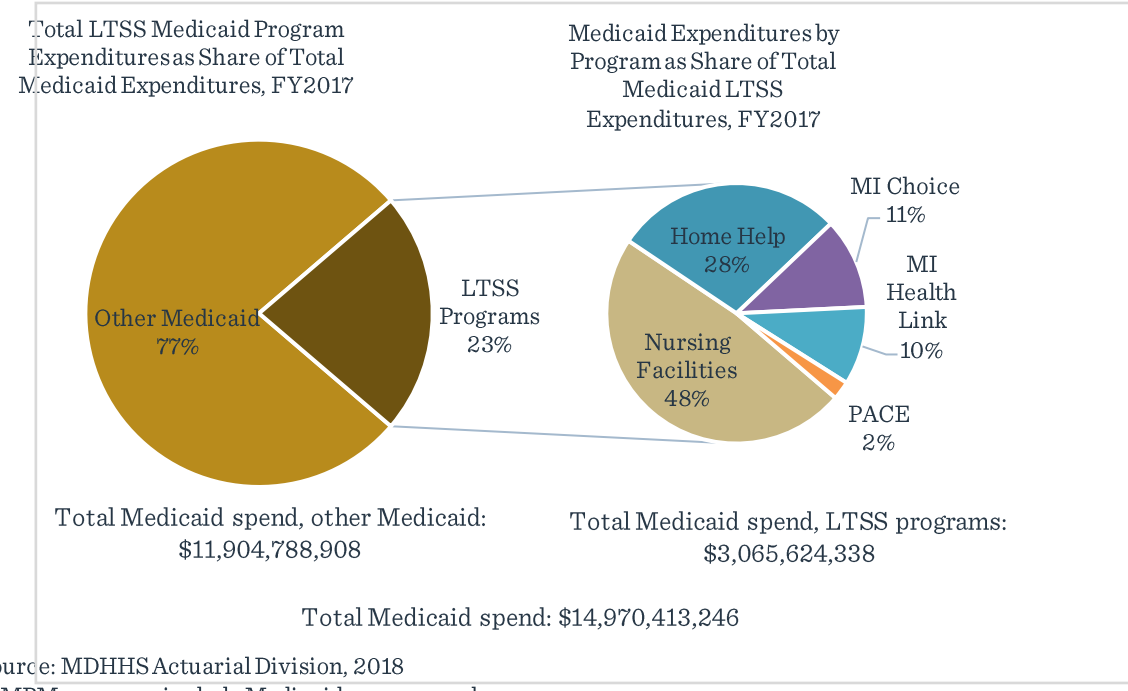
MI Choice

- FY2017 PMPM total Medicaid expenditures: $2,688
- FY2017 PMPM LTSS-only expenditures: $2,254
- 2015-2017 average annual percent change in PMPM Medicaid expenditures: -2 percent
- 2015-2017 average annual percent change in LTSS-only PMPM: -2%
- FY2017 total program Medicaid expenditures as a percent of total Medicaid spending for LTSS enrollees: 11 percent

PACE

- FY2017 PMPM total Medicaid expenditures: $3,297
- 2015-2017 average annual percent change in PMPM Medicaid expenditures: 2 percent
- FY2017 total program Medicaid expenditures as a percent of total Medicaid spending for LTSS enrollees: 2 percent
- LTSS-only expenditures not available for PACE

Figure 11: Total Medicaid Expenditures for Medicaid LTSS Programs, FY2017



Source: MDHHS Actuarial Division, 2018
*PMPM expenses include Medicaid expenses only.

In FY2017, individuals receiving Medicaid LTSS comprised just 5 percent of total Medicaid enrollment, yet they accounted for 23 percent of total Medicaid expenditures. In FY17, nursing facilities accounted for nearly half of all Medicaid LTSS expenditures. Nursing facilities also have the highest PMPM total costs of care. In recent years, PMPM expenditure trends have been mixed across Medicaid LTSS programs. Three programs—Nursing Facilities, PACE, and Home Help—have seen growth in their PMPM total Medicaid expenditures from FY15 to FY17, while MI Choice and MI Health Link have

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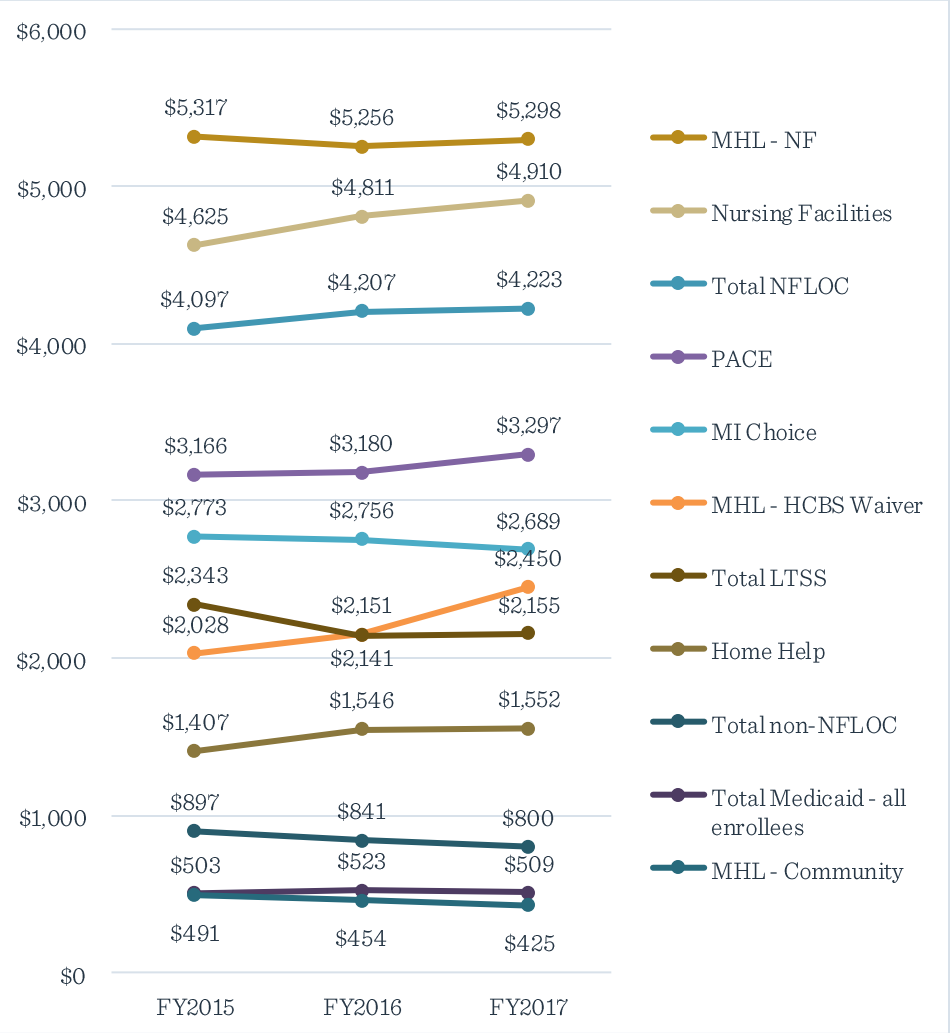
seen decreases in their PMPM total Medicaid expenditures during this time. Medicaid overall has experienced a 1 percent increase in PMPM total Medicaid expenditures during this time.[21] (See Appendices C and D for detailed information on aggregate Medicaid and LTSS-only expenditures by program.)

Figure 12: PMPM Total Medicaid Expenditures by Program, FY2015-2017



Source: MDHHS Actuarial Division, 2018
*PMPM expenses include Medicaid expenses only.

Expenditures by Level of Care

In FY2017, PMPM total Medicaid expenditures for non-NFLOC enrollees was $800, compared to $4,223 for NFLOC enrollees. LTSS-only PMPM expenditures for non-NFLOC enrollees was $355 compared to $3,813 for NFLOC enrollees in FY2017.

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Figure 13: Total and LTSS-Only Medicaid PMPM Expenditures for LTSS Enrollees, by Level of Care, FY2015-FY2017

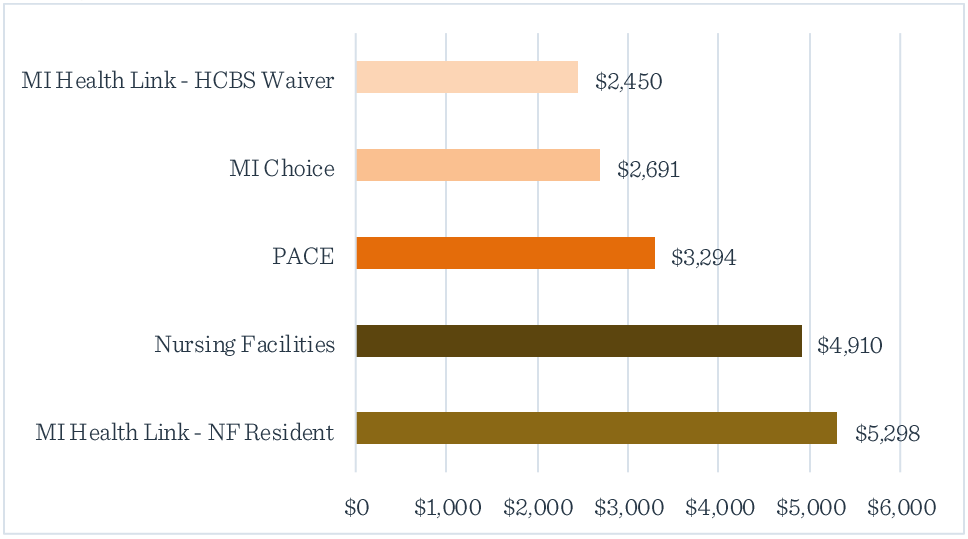
	FY 2015	FY 2016	FY 2017	AVG ANN'L % CHANGE FY 15-17
Nursing Facility LOC	$4,098	$4,207	$4,223	2%
LTSS-Only	$3,698	$3,787	$3,813	2%
Non-LTSS	$405	$420	$410	-1%
Non-Nursing Facility LOC	$897	$841	$800	-6%
LTSS-Only	$393	$342	$355	-5%
Non-LTSS	$504	$499	$445	6%

Source: MDHHS Actuarial Division, 2018
*PMPM expenses include Medicaid expenses only.

Expenditures by Setting

For individuals with a nursing facility level of care, PMPM Medicaid expenses are 79 percent greater for nursing facility residents than for individuals receiving HCBS. In FY2017, PMPM total Medicaid expenditures for a FFS nursing facility resident was $4,909, and for a MI Health Link nursing facility resident was $5,297. MI Choice, MI Health Link HCBS Waiver services, and PACE all have lower Medicaid PMPM costs:

Figure 14: Total PMPM Medicaid Expenditures by Program and Setting for Nursing Facility Level of Care, FY2017



Source: MDHHS Actuarial Division, 2018
*PMPM expenses include Medicaid expenses only.

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From FY15 to FY17, among individuals with a NFLOC, PMPM total Medicaid expenditures for enrollees in institutional settings increased, while PMPM total Medicaid expenditures for HCBS decreased. (See Appendices E and F for detailed PMPM Medicaid and LTSS-only expenditure information by program, level of care, and setting.)

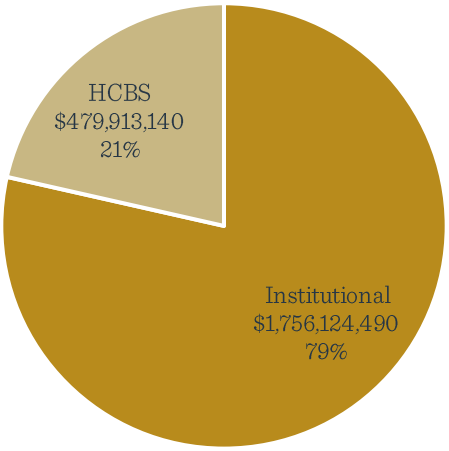
Figure 15: Medicaid PMPM Expenditures for LTSS Enrollees with NFLOC, FY2015-FY2017

	FY 2015	FY 2016	FY 2017	AVG ANN'L % CHANGE FY 15-17
Institutional	$4,640	$4,844	$4,937	1%
Community	$2,812	$2,798	$2,761	0%

Source: MDHHS Actuarial Division, 2018
*PMPM expenses include Medicaid expenses only.

The state has made some progress in shifting expenditures toward HCBS from institutions from FY15-FY17. However, despite evidence that HCBS services are provided at a lower cost to the state, the majority of expenses for individuals with a nursing facility level of care are directed toward institutional facilities, with institutional enrollees accounting for 79 percent of total expenses compared to HCBS enrollees accounting for just 21 percent of total Medicaid expenses.

Figure 16: Share of Total Medicaid Expenditures for LTSS Enrollees with a Nursing Facility Level of Care, FY2017



Source: MDHHS Actuarial Division, 2018
*PMPM expenses include Medicaid expenses only.

Expenditures by Age

Per-member-per-month (PMPM) total Medicaid expenditures vary by program and by age group. Across all LTSS programs, adults over age 85 have the highest PMPM total Medicaid expenditures, with a PMPM of $3,655 in FY2017. Adults age 18-54 have the lowest PMPM total Medicaid expenditures, with a PMPM of $1,787 in FY2017.

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Within programs, there is substantial variation in total PMPM Medicaid costs across age groups. For example, within the fee-for-service nursing facility program, younger enrollees tend to have higher Medicaid expenditures than older adults: in FY2017, adults age 18-54 had PMPM total Medicaid expenditures of $6,277, adults age 55-64 had a PMPM of $5,678, adults 65-84 had a PMPM of $4,553, and adults 85+ had a PMPM of $4,809. Within the MI Choice program, PMPM total Medicaid expenditures in FY17 were highest in the 18-54 age category ($4,217) and lowest in the 85+ age category ($2,235). (See Appendix G for detailed PMPM tables by age.)

Managed Care Expenditures vs. Fee-For-Service Expenditures

The PMPM total Medicaid expense for individuals in fee-for-service LTSS programs was greater than for those in managed care programs from FY2015-2017 due to the high cost and relatively high enrollment of the FFS nursing facility program. PMPM total Medicaid expenditures increased for fee-for-service LTSS programs while managed care PMPM total Medicaid expenditures decreased from FY15-17.[22] Mirroring enrollment, total Medicaid PMPM expenditures for individuals with a NFLOC in fee-for-service programs is higher than for those in managed care programs. For individuals with a NFLOC, the PMPM increased from FY15-17 for both fee-for-service (3 percent annually) and managed care (2 percent annually) programs.

Figure 17: Medicaid PMPM Expenditures for LTSS Enrollees, FY2015-FY2017, FFS and Managed Care

	FY 2015	FY 2016	FY 2017	AVG ANN'L % CHANGE FY 15-17
Fee-for-Service	$2,473	$2,641	$2,719	5%
Nursing Facility LOC	$4,625	$4,811	$4,910	3%
Non-Nursing Facility LOC	$1,407	$1,546	$1,550	5%
Managed Care	$1,858	$1,311	$1,281	-16%
Nursing Facility LOC	$2,936	$3,151	$3,077	2%
Non-Nursing Facility LOC	$491	$454	$425	-7%

Source: MDHHS Actuarial Division, 2018
*PMPM expenses include Medicaid expenses only.

Utilization in MI Medicaid LTSS Programs

Currently there are no consistent quality or utilization measures across all LTSS programs. However, proxy measures for quality comparisons include rates of hospital admissions, readmissions, and emergency department visits for some LTSS programs. As a benchmark for these rates we included 2016 utilization data for the general population from the Kaiser Family Foundation. For admissions and emergency department visits, we compare FY16 utilization data for MI Choice, nursing facilities, and Home Help to national benchmarks.

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Complete encounter data for the PACE and MI Health Link programs are not available and are not included in this analysis. For dually eligible enrollees both Medicare and Medicaid encounters are required to calculate utilization rates. The analysis in this section includes data for Home Help, MI Choice, and nursing facilities only.

Those using LTSS have much higher rates of hospital admission than the general population. The average rate of hospital admission per 1,000 LTSS enrollees in Michigan was 387 admissions in 2016, a much higher rate than the general US population at 103 per 1,000 and the general population in Michigan at 117 per 1,000.[23] Among Michigan LTSS programs for which we have complete encounter data, enrollees in MI Choice had the highest admission rates at 533 per 1,000 enrollees. Enrollees in nursing facilities had 518 admissions per 1,000 enrollees and Home Help had 290 per 1,000.

Figure 18: Hospital Admission Rates, by Program, MI Medicaid LTSS Enrollees, FY2015-FY2017

	FY 2015 TOTAL ADM	RATE (PER 1,000)	FY 2016 TOTAL ADM	RATE (PER 1,000)	FY 2017 TOTAL ADM	RATE (PER 1,000)
Home Help	16,761	296	15,369	290	13,656	264
Nursing Facilities	14,150	505	13,851	518	15,009	544
MI Choice	5,869	540	6,061	533	6,339	535
Total	36,780	386	35,281	387	35,004	384

Source: MDHHS Actuarial Division, 2018

The average rate of hospital readmissions in Michigan was 29 readmissions per 1,000 LTSS enrollees in 2016. Nursing facilities had the highest rate of readmissions at 62 per 1,000 enrollees.[24] All enrollees in the MI Choice program have NFLOC, and while admission rates for MI Choice and nursing facilities are comparable, MI Choice had a considerably lower rate of readmissions than enrollees in nursing facilities - just 33 readmissions per 1,000 enrollees.

Figure 19: Hospital Readmissions, by Program, MI Medicaid LTSS Enrollees, FY2015-FY2017 by Program

	FY 2015 TOTAL READMIT	RATE (PER 1,000)	FY 2016 TOTAL READMIT	RATE (PER 1,000)	FY 2017 TOTAL READMIT	RATE (PER 1,000)
Home Help	522	9	557	10	482	9
Nursing Facilities	1,641	58	1,683	62	1,821	66
MI Choice	427	39	385	33	415	35
Total	2,590	27	2,625	29	2,718	30

Source: MDHHS Actuarial Division, 2018

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The average rate of emergency department visits for LTSS enrollees in Michigan was 746 visits per 1,000 in 2016. The rate in the general population in the US was much lower at 440 visits per 1,000, and in the general population in Michigan the rate was 519 visits per 1,000. Home Help had the highest rate at 969 visits per 1,000 enrollees, and nursing facilities had the lowest at 376 visits per 1,000 enrollees.

Figure 20: Emergency Department Visits, by Program, MI Medicaid LTSS Enrollees, FY2015-FY2017

	FY 2015 TOTAL	RATE (PER 1,000)	FY 2016 TOTAL	RATE (PER 1,000)	FY 2017 TOTAL	RATE (PER 1,000)
Home Help	57,808	1,023	51,367	969	47,498	919
Nursing Facilities	9,107	325	9,838	368	10,386	376
MI Choice	5,773	531	6,704	589	6,407	541
Total	72,688	762	67,909	746	64,291	706

Source: MDHHS Actuarial Division, 2018

Geographic Variation in MI Medicaid LTSS Programs

There is substantial regional variation in Michigan in the availability of LTSS programs to consumers seeking services. Three programs offer services on a statewide (or nearly statewide) basis: nursing facilities, Home Help, and MI Choice. Other LTSS programs, PACE and MI Health Link, are only available in limited regions of the state.

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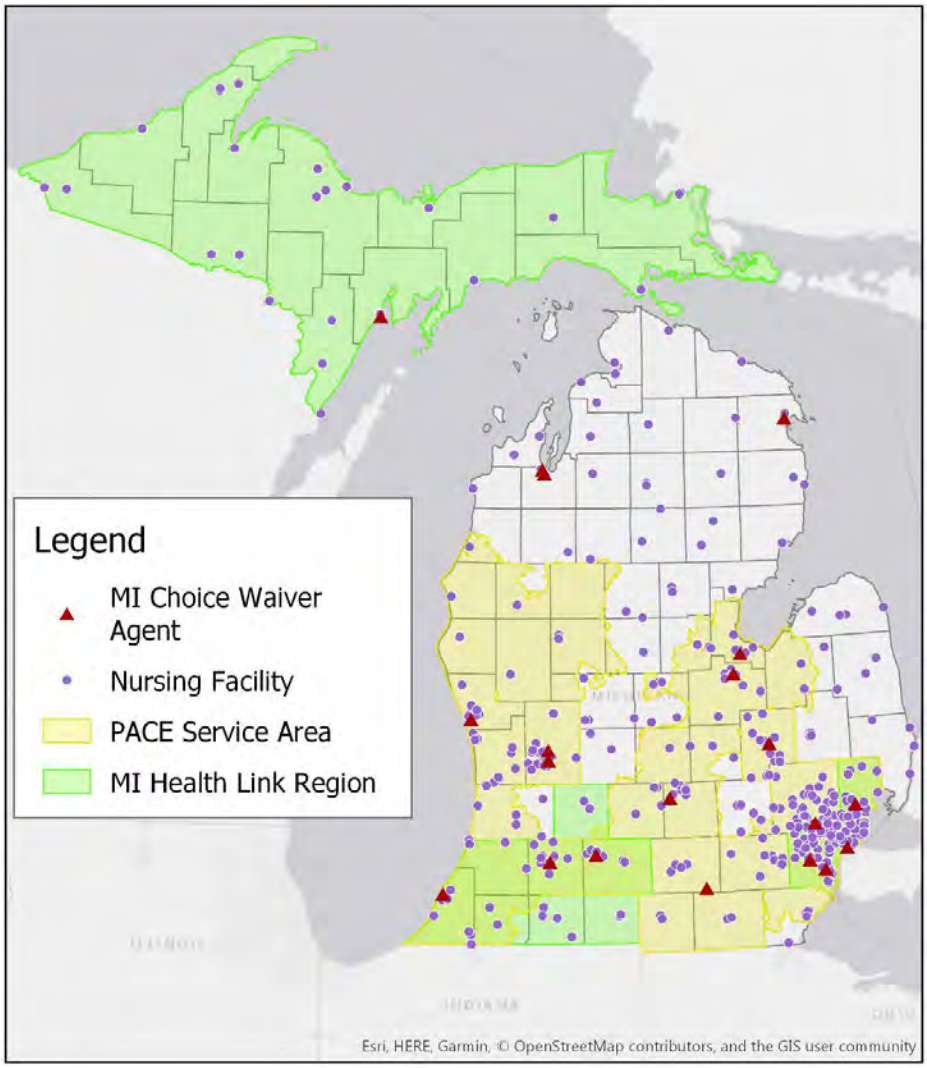
Figure 21: Overview of LTSS Program Service Areas in MI



Source: MDHHS Actuarial Division, 2018

Enrollment by Level of Care and Care Setting

Enrollment in Medicaid LTSS programs varies across counties and regions of Michigan, in part due to the limited geography of the PACE and MI Health Link programs. Other factors that may contribute to varying enrollment include wait lists for MI Choice, provider availability, nursing facility bed availability, consumer information, or consumer preferences.

For individuals with NFLOC, there is substantial regional variation in the share of NFLOC enrollees receiving HCBS. This may be driven, in part, by regional differences in HCBS availability (including whether a county lies in a MI Health Link region or PACE service area) and varying waitlists for MI Choice services. In FY2017, only eight counties had greater than 50 percent of NFLOC enrollees receiving HCBS. Thirty-three counties had 25 percent or less of NFLOC enrollees receiving HCBS.

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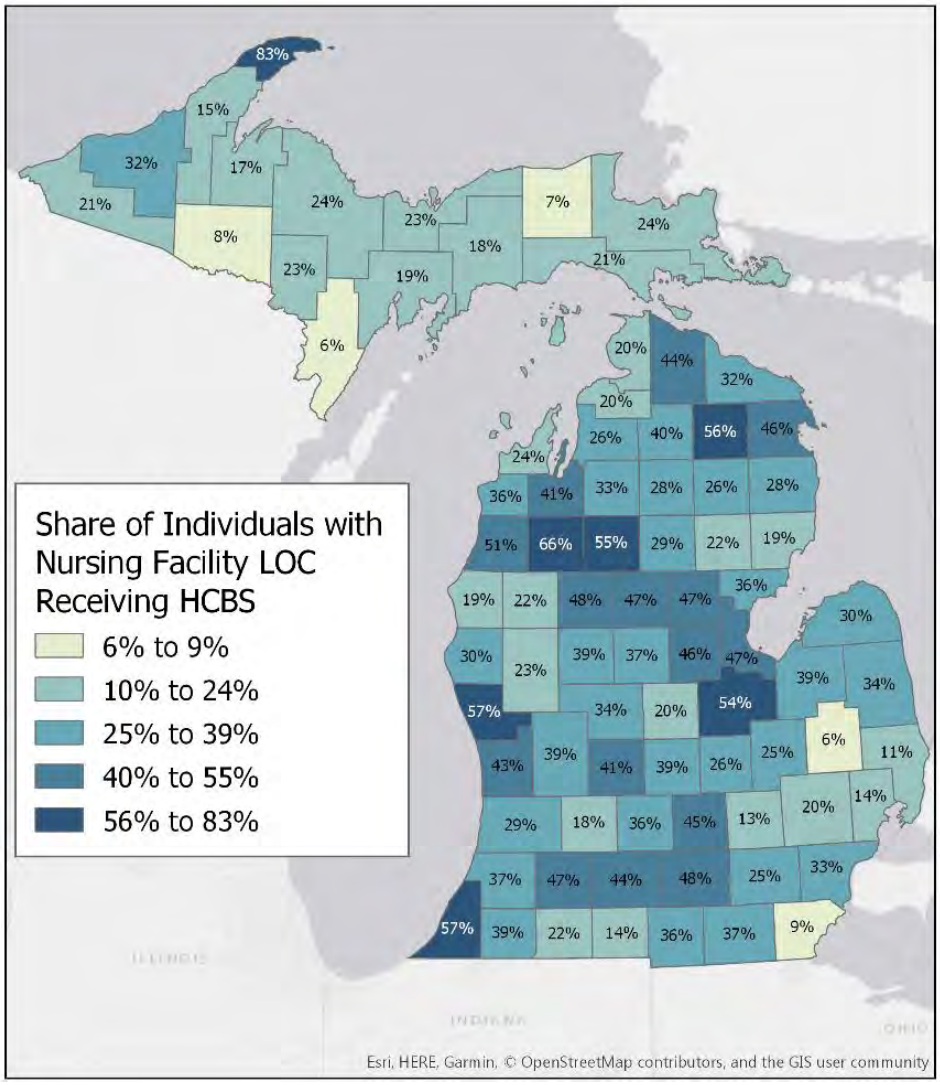
Figure 22: Share of Individuals with Nursing Facility Level of Care Receiving Home and Community-Based Services by County, FY2017



Source: MDHHS Actuarial Division, 2018

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The ten counties with the lowest and highest HCBS enrollment among NFLOC individuals are as follows:

Figure 23: Counties with the Highest and Lowest Shares of NFLOC Enrollees in HCBS, FY2017

LOWEST COUNTIES	% OF NFLOC RECEIVING HCBS	HIGHEST COUNTIES	% OF NFLOC RECEIVING HCBS
Lapeer	6%	Keweenaw	83%
Menominee	6%	Wexford	66%
Luce	7%	Muskegon	57%
Iron	8%	Berrien	57%
Monroe	9%	Montgomorency	56%
Saint Clair	11%	Missaukee	55%
Livingston	13%	Saginaw	54%
Branch	14%	Manistee	51%
Macomb	14%	Osceola	48%
Houghton	15%	Jackson	48%

Source: MDHHS Actuarial Division, 2018

Expenditures by Level of Care

Per-member-per-month (PMPM) Medicaid expenditures vary across populations and regions of the state. Because Medicare expenditure data was not available for this analysis, we are excluding county-level analyses of overall PMPM expenditures. For NFLOC individuals, PMPM Medicaid costs are lower in all 83 counties for individuals receiving LTSS than for those living in an institutional setting. There is substantial variation in PMPM Medicaid costs across counties within HCBS and institutional settings.

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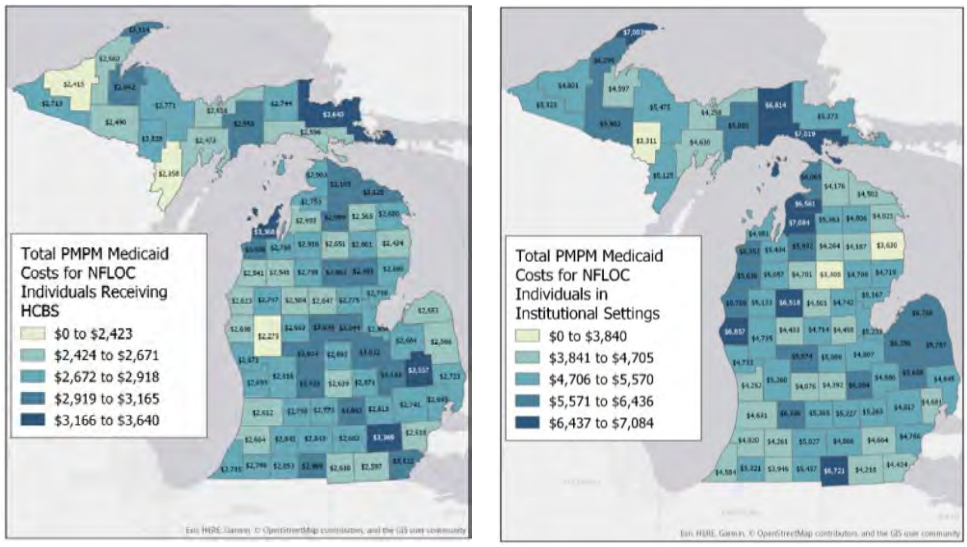
Figure 24: Total PMPM Medicaid Costs, NFLOC Individuals, HCBS and Institutional Settings, FY2017



Source: MDHHS Actuarial Division, 2018

Utilization by Region

CHRT/HPM analyzed the three utilization measures - hospital admissions, hospital readmissions, and emergency department (ED) visits – geographically to look at patterns across LTSS programs in the ten Prosperity Regions in FY2017. The ten Prosperity Regions include: Upper Peninsula, Northwest, Northeast, West, East Central, East, South Central, Southwest, Southeast, and Detroit Metro.

Regional Patterns:

- The Northwest had the lowest rate of admissions for MI Choice, nursing facilities, and Home Help; it also had the lowest rate of ED visits for MI Choice and Home Help
- Detroit Metro had the highest rate of admissions for MI Choice, and nursing facilities; it also had the highest rate of readmissions for nursing facilities and for Home Help and the lowest rate of ED visits for MI Choice
- The Southwest had the lowest rate of readmissions for MI Choice and for Home Help

Program Patterns:

- **Home Help**
  - East Central had the highest rates of hospital admissions and ED visits
- **Nursing facilities**
  - Detroit Metro had the highest rates of hospital admissions, readmissions, and ED visits
  - The Upper Peninsula had the lowest rate of hospital admissions; the Northwest had the lowest rates of readmissions and ED visits
- **MI Choice**
  - Detroit Metro had the highest rate of hospital admissions but the lowest rate of ED visits

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Appendices

Glossary of Terms

Term	Definition
AAA	Area Agency on Aging
ADLs	Activities of Daily Living (eating, toileting, bathing, grooming, dressing, transferring, mobility)
ASW	Adult Services Worker
BH	Behavioral Health
COMPASS	Web-based information system (for tracking MI Choice participant data)
DHS	Department of Human Services (now MDHHS, but some forms still use DHS)
DME	Durable Medical Equipment
DPOA	Durable Power of Attorney
EMR	Electronic Medical Record
FFS	Fee-for-service programs: includes Home Help, Nursing Facilities.
FOC	Freedom of Choice
IADLs	Instrumental Activities of Daily Living (taking medication, meal prep and cleanup, shopping, laundry, light housework)
ICO	Integrated Care Organization (for MI Health Link)
ICT	Integrated Care Team (for MI Health Link)
IDT	Inter-Disciplinary Team (for PACE)
iHC	interRAI – Home Care assessment (for MI Choice)
IICSP	Individual Integrated Care and Supports Plan (for MI Health Link)
LOCD	Level of Care Determination
Managed Care	Managed Care/capitated programs: includes PACE, MI Choice, MI Health Link.
MARA	MDHHS eligibility intake worker, embedded in PACE sites
MAXIMUS	Enrollment broker for MI Health Link (also known as MI Enrolls)
MDHHS	Michigan Department of Health and Human Services
MHL	MI Health Link
MIG	MI Choice Intake Guidelines
NF	Nursing Facility
NFLOC	Nursing Facility Level of Care: individuals in nursing facilities, MI Choice, PACE, MHL NF, and MHL HCBS Waiver
Non-NFLOC	Non-Nursing Facility Level of Care: individuals in Home Help, MHP Community Well
PACE	Program of All-Inclusive Care for the Elderly
PASARR	Preadmission Screening/Annual Resident Review
PCSP	Person-Centered Service Plan
PMPM	Per-member-per-month
RAI	Resident Assessment Instrument
RTS	Reasonable Time Schedule (for the Home Help program)

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Appendix A: Detailed Description of MI Medicaid LTSS Programs, Waiver Authorities, and Eligibility Requirements

	HOME HELP	MI CHOICE	PACE	MI HEALTH LINK	MI HEALTH LINK + HCBS WAIVER	NURSING FACILITY
Average annual enrollment, FY17	51,862	11,841	1,961	37,478 5% reside in NFs 1.8% receive waiver services	683	27,597
Authority	State Plan – Personal Care Benefit	1915(b1), 1914(b4) and 1915(c)	State Plan	1915(b1), 1915(b2), and 1915(b4)	1915(c)	State Plan
Requires NFLOC?	No	Yes	Yes (must be able to live safely in community)	No	Yes	Yes
Other functional requirements?	Require physical assistance to perform at least one ADL	Require supports coordination and at least one other MI Choice service	None	None	Require verbal assistance to perform ADLs	Require physician-written order for nursing facility services
Dual-eligible only?	No	No	No	Yes	Yes	No
Integrates Medicare and Medicaid benefits?	No	No	Yes	Yes	Yes	No
Expanded financial eligibility?	None	Income up to 300% of monthly SSI rate	Income up to 300% of monthly SSI rate	None	Income up to 300% of monthly SSI rate	Can spend-down to meet Medicaid eligibility
Geographic Requirements	None	None	Must reside in a PACE region	Must reside in a MI Health Link region	Must reside in a MI Health Link region	None

Appendix B: Average Annual Enrollment in Medicaid LTSS, by Program, Level of Care, and Care Setting, FY2015-FY2017

	SETTING	FY2015 TOTAL	FY2016 TOTAL	FY2017 TOTAL	AVG ANN'L % CHANGE FY15-17
		NFLOC			
Nursing Facilities	Institutional	28,009	26,722	27,567	-1%
MI Health Link – NF Resident	Institutional	628	2,193	2,075	122%
MI Choice	Community	10,864	11,371	11,841	4%
PACE	Community	1,213	1,552	1,961	27%
MI Health Link – HCBS Waiver	Community	5	169	683	1792%
Total NFLOC		40,719	42,005	44,127	4%
		Non-NFLOC			
Home Help	Community	56,508	52,976	51,682	-4%
MI Health Link – Community Well	Community	10,023	32,798	34,720	117%
Total Non-NFLOC		66,531	85,774	86,402	15%
Total LTSS		107,250	127,779	130,529	11%

Appendix C: Medicaid Aggregate Expenditures by Program, Level of Care, and Care Setting, FY2015-FY2017

	SETTING	FY2015 TOTAL	FY2016 TOTAL	FY2017 TOTAL	AVG ANN'L % CHANGE FY15-17
NFLOC					
Nursing Facilities	Institutional	$1,554,370,300	$1,542,580,085	$1,624,199,401	2%
MI Health Link – NF Resident	Institutional	$40,043,174	$138,284,422	$131,925,089	120%
MI Choice	Community	$361,551,079	$376,069,882	$382,299,231	3%
PACE	Community	$46,054,695	$59,176,070	$77,526,829	30%
MI Health Link – HCBS Waiver	Community	$125,717	$4,354,373	$20,087,080	1862%
Total NFLOC		$2,002,144,965	$2,120,464,832	$2,236,037,630	6%
Non-NFLOC					
Home Help	Community	$657,033,090	$686,985,604	$652,597,661	0%
MI Health Link – Community Well	Community	$59,091,951	$178,800,046	$176,989,047	101%
Total Non-NFLOC		$716,125,041	$865,785,650	$829,586,708	8%
Total LTSS		$2,718,270,006	$2,986,250,482	$3,065,624,338	6%
Total Medicaid		$13,977,616,977	$14,959,237,913	$14,970,413,246	4%

*Note: Expenses include Medicaid expenses only.

Appendix D: LTSS-Only Medicaid Aggregate Expenditures by Program, FY2015-2017

	SETTING	FY2015 TOTAL	FY2016 TOTAL	FY2017 TOTAL	AVG ANN'L % CHANGE FY15-17
NFLOC					
Nursing Facilities	Institutional	$1,404,681,572	$1,377,321,805	$1,458,079,637	2%
MI Health Link – NF Resident	Institutional	$39,756,431	$141,187,460	$132,665,625	125%
MI Choice	Community	$306,023,448	$316,129,873	$320,245,873	2%
MI Health Link – HCBS Waiver	Community	$105,392	$3,941,345	$18,486,265	2,004%
Total NFLOC		$1,750,566,843	$1,838,580,483	$1,929,477,400	5%
Non-NFLOC					
Home Help	Community	$297,129,843	$296,030,926	$308,512,938	2%
MI Health Link – Community Well	Community	$17,016,484	$56,193,005	$59,095,182	118%
Total Non-NFLOC		$314,146,327	$352,223,931	$367,608,120	8%
Total LTSS-Only		$2,064,713,170	$2,190,804,414	$2,297,085,520	5%

*Note: Expenses include Medicaid expenses only. LTSS-only costs are not available for the PACE program.

Appendix E: Medicaid PMPM Costs by Program, Level of Care, and Care Setting, FY2015-FY2017

	SETTING	FY2015 TOTAL	FY2016 TOTAL	FY2017 TOTAL	AVG ANN'L % CHANGE FY15-17
NFLOC					
Nursing Facilities	Institutional	$4,624.66	$4,810.60	$4,909.94	3%
MI Health Link – NF Resident	Institutional	$5,317.11	$5,255.96	$5,297.77	0%
MI Choice	Community	$2,773.25	$2,756.14	$2,690.50	-1%
PACE	Community	$3,163.75	$3,178.09	$3,294.39	2%
MI Health Link – HCBS Waiver	Community	$2,027.69	$2,151.37	$2,449.64	10%
Total NFLOC		$4,097.50	$4,206.73	$4,222.72	2%
Non-NFLOC					
Home Help	Community	$968.93	$1,080.66	$1,052.27	4%
MI Health Link – Community Well	Community	$491.31	$454.30	$424.80	-7%
Total Non-NFLOC		$896.98	$841.15	$800.13	-6%
Total LTSS		$2,112.09	$1,947.53	$1,957.18	-4%

*Note: Expenses include Medicaid expenses only.

Appendix F: LTSS-Only Medicaid PMPM Expenditures by Program, Level of Care, and Care Setting, FY2015-2017

	SETTING	FY2015 TOTAL	FY2016 TOTAL	FY2017 TOTAL	AVG ANN'L % CHANGE FY15-17
NFLOC					
Nursing Facilities	Institutional	$4,179	$4,295	$4,408	3%
MI Health Link – NF Resident	Institutional	$5,279	$5,366	$5,328	0%
MI Choice	Community	$2,347	$2,317	$2,254	-2%
MI Health Link – HCBS Waiver	Community	$1,700	$1,947	$2,254	15%
Total NFLOC		$3,693	$3,787	$3,813	2%
Non-NFLOC					
Home Help	Community	$4,179	$4,295	$4,408	3%
MI Health Link – Community Well	Community	$5,279	$5,366	$5,328	0%
Total Non-NFLOC		$2,347	$2,317	$2,254	-2%

*Note: Expenses include Medicaid expenses only. LTSS-only costs are not available for the PACE program.

Appendix G: Medicaid PMPM Expenditures by LTSS Program, By Age, FY2015-2017

	0-17	18-54	55-64	65-84	85+
FY2015					
Home Help	$3,370	$1,791	$1,484	$710	$714
Nursing Facilities	$1,017	$5,999	$5,386	$4,321	$4,520
MI Choice	$0	$5,075	$3,146	$2,179	$2,114
MI Health Link	$291	$632	$684	$698	$2,645
PACE	$0	$0	$3,439	$3,145	$3,058
Total LTSS	**$3,196**	**$2,020**	**$2,158**	**$2,198**	**$3,560**
Total Medicaid	**$265**	**$545**	**$964**	**$920**	**$2,743**
FY2016					
Home Help	$2,949	$1,957	$1,678	$762	$747
Nursing Facilities	$756	$6,163	$5,646	$4,448	$4,718
MI Choice	$0	$4,191	$3,107	$2,377	$2,290
MI Health Link	$0	$614	$649	$705	$2,623
PACE	$0	$0	$3,562	$3,130	$3,037
Total LTSS	**$2,804**	**$1,789**	**$2,057**	**$1,962**	**$3,599**
Total Medicaid	**$252**	**$573**	**$1,043**	**$970**	**$2,858**
FY2017					
Home Help	$2,979	$1,966	$1,666	$798	$792
Nursing Facilities	$205	$6,277	$5,678	$4,553	$4,809
MI Choice	$0	$4,217	$3,005	$2,312	$2,235
MI Health Link	$0	$591	$617	$688	$2,652
PACE	$0	$0	$3,651	$3,242	$3,151
Total LTSS	**$2,850**	**$1,787**	**$2,049**	**$1,992**	**$3,655**
Total Medicaid	**$243**	**$549**	**$1,010**	**$978**	**$2,890**
Average Annual % Change FY2015-FY2017					
Home Help	-6%	5%	$1,666	$798	$792
Nursing Facilities	-49%	2%	$5,678	$4,553	$4,809
MI Choice	0%	-8%	$3,005	$2,312	$2,235
MI Health Link	-50%	-3%	$617	$688	$2,652
PACE	0%	0%	$3,651	$3,242	$3,151
Total LTSS	**-5%**	**-6%**	**$2,049**	**$1,992**	**$3,655**
Total Medicaid	**-4%**	**0%**	**$1,010**	**$978**	**$2,890**

*Note: MI Health Link enrollment data are not broken out by enrollment type (e.g., Community Well, NF resident, HCBS Waiver).

Endnotes

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[3] My Care Ohio Evaluation 2018. Ohio Department of Medicaid, June 2018: http://www.jmoc.state.oh.us/Assets/documents/reports/MyCare_Ohio_Evaluation_2018.pdf
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5 The Balancing Incentive Program: Implementation Manual, Mission Analytics Group, Feb 2013: http://www.balancingincentiveprogram.org/sites/default/files/Balancing_Incentive_Program_Manual_2.0.pdf
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9 National Core Indicators for Aging and Disabilities Project Overview, National Association of States United for Aging and Disabilities and Human Services Research Institute: http://nci-ad.org/upload/presentation/NCI-AD_Project_Overview_2017-2019.pdf
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11 Measures for Medicaid Managed Long Term Services and Supports Plans, Technical Specifications and Resource manual, Centers for Medicare and Medicaid Services, August 2018: http://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf
[12] R. Rudowitz, A. Valentine, V. Smith. Medicaid Enrollment & Spending Growth: FY2017 and 2017, Kaiser Family Foundation, Oct 2016: http://www.kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2016-2017/
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14 Ibid.
15 This dollar amount represents the difference between PMPM total Medicaid costs for NFLOC individuals in institutional settings ($4,910) and PMPM total Medicaid costs for NFLOC individuals receiving HCBS ($2,761) in FY2017.
16 FY 2015 data for MI Health Link represents less than a full year of enrollment, as the program launched during this fiscal year and ramped up enrollment slowly. We have excluded MI Health Link utilization data from this analysis due to a lack of complete Medicare data.
17 Does not include individuals in the deeming process for Medicaid eligibility redetermination. In January 2017, there were 719 individuals in the deeming process.
18 Some individuals in the MI Health Link – Community Well pool receive personal care services through their ICO. Some individuals receiving Home Help services may qualify for a nursing facility level of care, but prefer to remain in Home Help rather than transition to another program.
19 Analyses in this section are restricted to the population determined to be at a nursing facility level of care (NFLOC). Individuals with lower acuity are largely enrolled in community-based programs, with no comparable institutional option. For a more accurate analysis, we have excluded individuals with lower acuity from these specific analyses.
20 While children under 18 are eligible to receive services through Home Help and nursing facilities, a very small number of children age 0-17 are enrolled in these programs. In FY17, there were an average of 48 children in the Home Help program and just two children in nursing facilities.
21 Note: PMPM Medicaid expenditures do not include Medicare expenditures.
22 Note: Managed Care PMPM total Medicaid expenditures includes PMPM Medicaid expenditures for MI Choice, PACE, and MI Health Link. PMPM amounts do not include Medicare expenditures.
23 Kaiser Family Foundation, State Health Facts, Hospital Admissions per 1,000 Population by Ownership Type 2016. http://www.kff.org/other/state-indicator/admissions-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

24 Kaiser Family Foundation, State Health Facts, Hospital Emergency Room Visits per 1,000 Population by Ownership Type, 2016. http://www.kff.org/other/state-indicator/emergency-room-visits-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D