



STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

October 5, 2018

TO: Interested Party
RE: Consultation Summary
MI Choice Waiver Renewal

Thank you for your comment(s) to the Medical Services Administration relative to the Renewal of the MI Choice Waiver program. Your comment(s) has been considered in the preparation of the final publication, a copy of which is attached for your information.

Responses to specific comments are addressed below.

Comment: Regarding the requirement for reinsurance/stop loss insurance, should this be recommended, vs. required? It appears wording is carried over from last application, but some revisions were agreed to between then and now.

The renewal includes language for stop loss insurance. The new requirement is that "it is recommended" the agent purchase. Stop loss insurance is not available for WA agents as we learned when the original discussion took place. It appears that the risk pool has satisfied the concerns regarding high risk participants so why change it.

Response: Thank you for your comment. The Department of Health and Human Services (MDHHS) is conducting additional research on this issue and will provide notification to waiver agencies once more information is available.

Comment: Question about Home and Community-Based Services (HCBS) Rule language in Appendix C-2, Larger Facilities: Adult Foster Cares (AFCs) and Homes for the Aged (HFAs) indicate visiting times during reasonable hours and shall take into consideration the special circumstances of each visitor.

Response: Thank you for your comment. This language has been removed.

Comment: We are concerned about the number of participants to be served during the five-year period of this Waiver. There is a total of 2,800 added over a six-year period (16,700 in the first year to 19,500 in year five). Currently, there were 4,200 added over a five-year period. With the wait lists that exist for the MI choice program, we recommend that MDHHS actually increase the number of participants over the five-year period.

Response: These numbers were developed based on current utilization and projected for five years. It is always possible to change these numbers later in a Waiver Amendment if necessary.

Comment: Due to the addition of a Community Health Worker service and the addition of Respiratory Therapist under Private Duty Nursing (PDN), we are requesting that MDHHS re-evaluate capitated rates to account for added financial costs for services and administrative duties related to the proposed changes.

Response: Information about the proposed additional services and changes in the PDN service were provided to Milliman, the contracted Actuarial entity. The rate section included in the public comment version of the waiver application with these changes was under development during the review period. Modifications will be made based upon Milliman's analysis, prior to final submission.

Comment: Our comment and suggestion is a topic and issue we have discussed with the MDHHS. Specifically, it involves the handling of the cost of PDN, a MI Choice Waiver covered service. As the participants who qualify for PDN have multiple and complex needs, the costs for care and support are extremely high. While the State Supplemental Payment (SSP) category is designed to encompass these higher costs, they fall significantly short and as a result our agency as well as a few others, continue to lose revenue, resulting in overall financial deficit status. The Risk Pool reimbursement does not cover the costs either. Some agents accept or encounter more participants who require PDN and it does not take many to put an organization in the deficit column. We lose over \$100,000 a month and over \$1.3 million a year. Prior to the Capitation form of reimbursement, these participants were considered Special Memorandum of Understanding (SMOU) status and were calculated as a separate cost from the other service costs. Some states are treating this category as a separate cost under their capitated system. Also, nursing facilities receive special reimbursement for these types of residents. Generally, these participants require continuous nursing services and are dependent daily on technology-based medical equipment such as ventilators and/or

nasogastric tube feedings, both requiring skilled nurses to monitor and provide services such as suctioning and often several times a day. As Michigan moves to expand Medicaid managed long term care and supports, it is essential that there be incentives for health plans and community-based organizations to willingly accept high cost and care participants. They have a right to live in the community as anyone else and the cost in a nursing facility is considerably higher as nursing facilities receive special payments for these types of residents and are treated as a separate cost. We are recommending that MDHHS treat MI Choice participants who fall in this special category the same way - as separate cost.

Response: MDHHS is working with Milliman, Inc. to review several options regarding rates for individuals who receive PDN services.

Comment: A commenter expressed concern about the addition of the new service Community Health Worker (CHW) to the MI Choice Waiver Program. Specific concerns include:

- It is already challenging to support the array of services currently available through MI Choice within the existing rate structure. There are certain services - such as Community Living Supports that are only available through MI Choice and are critical to maintaining and meeting the basic needs of program participants. I think it is more important to focus our dollars on those services by directing attention to provider rates and the support of direct care workers rather than diluting the dollars by adding additional services.
- The term Community Health Worker (CHW) is a position that is still being defined and evaluated in terms of training as well as their role within the medical community. There are also efforts underway to have it be a reimbursable service under Medicaid as well as Medicare. I am concerned that its inclusion in the Waiver Renewal application and the fact that it does not include any specific training or certification requirements makes it a loosely applied service definition that may impact future system efforts to utilize and meaningfully evaluate the impact of CHWs within our health care system.
- The logistics of implementing the CHW as a participant-directed option will be very challenging. By nature of many of the tasks defined in the service definition, it will require a trained individual who can quickly respond following a nursing home or hospital discharge. It is also imperative that this person have an established relationship with the participant's physician. There is a lengthy process involved in setting up participant directed care which includes setting up a fiscal intermediary as well as conducting background checks and completing considerable paperwork. It is not likely this could happen within a time

frame that will make the service be of value following NH and hospital discharges.

- The task defined in the service definition that does not require a quick, short term response is the inclusion of the duties of an independent supports broker. MI Choice already has the option of an independent supports broker so it is unclear why we need to add this option under a service definition.

When CHWs were mentioned at the MI Choice Waiver renewal meetings, the intent was to explore their value within the MI Choice Waiver agency structure. It was part of a discussion on the need to reduce the current burden on Nurse-Social Work Supports Coordinators. Some expressed that a trained CHW working under the direction of a Supports Coordinator would be of benefit to both the WA Agent and the Participant. The current service definition does not support that intent and in reality, adds another layer for both the participant and the Supports Coordinator to navigate through. I am requesting that the Community Health Worker service definition be removed from the current WA Renewal application and that MDHHS take additional time to explore if there is a role for CHWs within the MI Choice Waiver Program.

Response: 1) The MI Choice rate structure will reflect the addition of the CHW service availability should the approved waiver application include this service. 2) There are specific training courses and requirements available for CHWs. As with all MI Choice services, if this service is available through other payers, such as Medicare or Medicaid State Plan service, it would not also be authorized through MI Choice to assure services are not duplicated. The waiver application does require certification as a CHW for providers of this service. 3) CHWs do not have to be utilized through the Self-determination option only. CHWs may be reimbursed through the traditional reimbursement methods. This has been clarified in the waiver application. 4) Independent supports brokers are underutilized currently. The purpose of merging this service with the CHW is to place additional emphasis on the tasks that can be completed via this service so that participants who could benefit from the service have access to it.

During the stakeholder meetings, the intent of the CHW was always to assist the participant in accessing all services to which they are entitled and for which they qualify. An additional benefit would be that the CHW could lessen the burden currently placed on supports coordinators. The current service definition emphasizes collaboration between the participant, the CHW and the supports coordinator. The intent of a CHW was that they assist the participant, the discussions did not focus on this service being conducted under the direction of a supports coordinator.

Comment: Clarification is being requested surrounding the *access to service* and *delivery method* for CHWs. Within the MI Choice Waiver renewal document, it states that CHWs are available to “any participant who needs it”. However, within the service standard, ‘service delivery’ is checked under ‘participant-directed’. To our interpretation, this service would be allowed for participants under the Self-Directed arrangement only. In order for the MI Choice Program to benefit from the CHW service, AAA1B would support that this service be available to any MI Choice participant who meets service criteria. The service has the opportunity to reduce hospital readmissions as well as further connect participants to community resources – both of which have the potential to reduce Medicaid costs related to reduction in re-admissions and cost-efficient utilization of services.

Response: It is the intent of MDHHS to make this service available to individuals using traditional reimbursement as well as the self-determination option. MDHHS will clarify this in the waiver application.

Comment: Is MDHHS requiring a CHW be contracted outside of a waiver agency, therefore a separate entity, or would MDHHS support the CHW to be an employee of the waiver agency? AAA1B would in support of CHWs be an employee of the waiver agency, in order to work closely and collaboratively with the primary Supports Coordinator. Many of the duties outlined for a CHW are supportive roles of the Supports Coordinator, therefore requiring the Supports Coordinator ultimately responsible for monitoring participants’ health and welfare, safety, and access to care. If the CHW is required to be a contracted entity outside of the waiver agency, we believe this would create barriers to accomplishing the intent and mission of the CHW service. In addition to barriers, waiver agencies would continue to be held responsible for meeting contractual requirements for waiver re-enrollments and audited through the CQAR process. If the CHW service is contracted out, this would create undue challenges to meet quality and contractual compliance of the program.

Response: As a Pre-Paid Ambulatory Health Plan, Federal regulations regarding the provision of conflict-free services do not allow for waiver agencies to provide direct services unless there is no other willing and qualified provider in the service area. MDHHS understands that there is a network of community health workers in Michigan and these providers would be willing to assist MI Choice participants with accessing home and community-based services. The CHW service requires strong collaboration between the participant, the CHW and the support coordinators. Collaboration should be less of a burden on the supports coordinator than meeting with the participant to assure their access to home and community-based services and linking the participant to those

services. The SC is already required to document all contacts made with or on behalf of the participant and the availability of a CHW does not negate this requirement.

Comment: Our vote would be that the CHW be a direct service of the waiver agent. We hope this service could be captured in our capitated rates before it is an offered service to our participants.

CHWs are listed as contractual in the renewal versus direct service by the waiver agent. The waiver agent should be allowed to provide CHW services. Doing so will limit the confusion the participant has with multiple agencies in the home. It provides for a seamless transition from one setting to another. Using an in house CHW will increase communication about client care and allow for the CHW to put updates and progress notes in the participant's record. The peer mentoring that the CHW will have with the participant will increase communication between the SC, CHW and the participant. Having to contract CHWs will impede the great benefits that the CHW will bring to the program. The CHW will potentially increase communication with the physician if another agency is used the physician will assume that the CHW is the case management service. The CHW can help bridge that gap and sends a message to the physician that there is a care team to manage the participant for better outcomes.

Response: Federal regulations regarding the provision of conflict-free services do not allow for waiver agencies to provide direct services unless there is no other willing and qualified provider in the service area. MDHHS understands that there is a network of CHWs in Michigan and these providers would be willing to assist MI Choice participants with accessing HCBS. MDHHS must include the cost of this service in the actuarially sound capitation rates developed each fiscal year.

Comment: A commenter requested that CHWs not be an additional service category for the following reasons:

- Duplication of service-Supports Coordination
- Adds a burden for the participant-by making this a service it is another entity from a different agency coming in to the home. This is confusing for the participant.
- A service provider that "may have more contact with the participant than the Supports Coordinator" is ineffective if the CHW and the SC do not work closely together. Having an outside agency provide this service will be a burden to all involved, including the participant. A CHW and a SC would need constant communication to be effective in this role.

- The Senior Alliance has piloted an on-site CHW to work with participants to prevent hospital readmissions. This has required daily interactions with the SC's and the CHW. Even with the CHW on site we find that we are constantly tweaking the communication between the participant, SC and CHW.
- The CHW is an integral part of the Waiver Team and attends all Waiver team meetings.
- Hospitalization trends for the entire agency Waiver population are reviewed by the CHW who works with the Quality and Training Manager to tailor trainings and presentations based on the trends.
- The CHW's assist with tracking all of the WA agents' participants while they are in the hospital or nursing home as well as communicating with the SC's and the discharge planners. This could not be completed by an outside service vendor.
- With this model the CHW is able to provide continuity of care for the participants because the CHW is on site at the Waiver agency working closely with SC's, discharge planners, participants and their allies.
- The CHW also attends nursing home re-enrollment visits with the Supports Coordination Team and the participant so they can all work together to ensure the discharge plan is properly implemented and followed through. Scheduling these visits requires daily coordination with the SC Teams and could not be accomplished using an outside agency.
- The CHW is also an integral part of the Waiver agency's communication with discharge planners at nursing homes and hospitals. She conducts weekly outreach at these facilities to educate discharge planners on the Waiver program and importance of good communication with the Waiver SC's. This could not be accomplished by using an outside service provider as proposed in the Waiver renewal.
- The CHW can be an important part of the overall team and should be considered in administrative costs for the Waiver agent, not as a service provided by an outside vendor. Waiver agencies have many different models for utilizing support staff and should be allowed to utilize based on what works for the agency to be able to provide value added outcomes for the participant. It will be highly underutilized if it is required to be provided as a Waiver service.

Additionally, another comment focuses on a concern regarding the Department's potential classification of the Community Health Worker [CHW] as a service that shouldn't be provided by a waiver agent. CHW functions as described in the renewal are a direct extension of Supports Coordination duties. Forced separation of these functions from Supports Coordination would cause unnecessary fragmentation and set the stage for unprecedented conflict of interest.

To avoid fragmentation and conflict of interest, the CHW functions should be acceptable as a companion service to Supports Coordination, fully allowable and encouraged for use by waiver agents in conjunction with Supports Coordination.

CMS guidelines have repeatedly clarified conflict-free CM as the need to separate care plan development and providing access to care, from provision of ongoing, hands-on service delivery and payment for same. Below is an excerpt from CMS training materials.

Requirements at 42 CFR 431.301(c)(1)(vi)

- *States are required to separate case management (person-centered service plan development) from service delivery functions.*
- *Conflict occurs not just if they are a provider but if the entity has an interest in a provider or if they are employed by a provider.*

When the same entity helps individuals gain access to services and provides services to that individual, there is potential for COI

The CHW description proposed in the draft renewal refers to the CHW performing "...the duties of a supports broker. They may provide assistance throughout the planning and implementation of the service plan and individual budget, assist the participant in making informed decisions...assist in making necessary arrangements to link the participant with those identified supports." **This is an access function that must stay aligned with Supports Coordination in order to remain conflict-free.** Supports brokering has always been a function of Support Coordination. To move it outside not only fragments participant support but sets the stage for conflict of interests that have been here-to-fore protected. To move forward with the proposed perspective would be a serious mistake.

Response: Federal regulations regarding the provision of conflict-free services do not allow for waiver agencies to provide direct services unless there is no other willing and qualified provider in the service area. MDHHS understands that there is a network of CHWs in Michigan and these providers would be willing to assist MI Choice participants with accessing HCBS. MDHHS must include the cost of this service in the actuarially

sound capitation rates developed each fiscal year. Collaboration should be less of a burden on the supports coordinator than meeting with the participant to assure their access to HCBS and linking the participant to those services. The SC is already required to document all contacts made with or on behalf of the participant and the availability of a CHW does not negate this requirement.

Comment: I believe this would be a very bad idea in regard to hospitalization/nursing home placement. For the most part, with a hospital discharge, Skilled Medicare Nursing is ordered along with PT/OT when appropriate. The care manager is usually aware of a discharge and will arrange for more frequent visits, Waiver nursing services and/ or an increase in home services depending on the situation if Skilled care is not utilized. I think that adding an “untrained” individual into the mix would do more harm than good. In my experience, clients are reluctant to have multiple people that they do not know coming into their home. I’m also concerned about “mis information” that could be given by this individual and wonder how they could easily communicate with the client’s medical team (HIPPA) and their inability to make any changes if needed. I would much rather have a Medicare Skilled Nurse in the home, caregivers who they already know and trust or have the ability to schedule Waiver nursing services. Nursing home discharges usually involve the same disciplines on discharge and if someone has been in a nursing home for a while, I would think that a Nursing Home Transition Coordinator would have been assisting with the discharge planning and home services. I don’t think adding another layer of confusion would benefit anyone. If this is just a general proposal for any Waiver client to have, I don’t see the reason. Please re consider this proposal.

Response: 1) The MI Choice rate structure will reflect the addition of the CHW service availability should the approved waiver application include this service. 2) There are specific training courses and requirements available for CHWs. As with all MI Choice services, if this service is available through other payers, such as Medicare or Medicaid State Plan service, it would not also be authorized through MI Choice to assure services are not duplicated. The waiver application does require certification as a CHW for providers of this service. 3) CHWs do not have to be utilized through the Self-determination option only. CHWs may be reimbursed through the traditional reimbursement methods. 4) Independent supports brokers are underutilized currently. The purpose of merging this service with the CHW is to place additional emphasis on the tasks that can be completed via this service so that participants who could benefit from the service have access to it.

During the stakeholder meetings, the intent of the CHW was always to assist the participant in accessing all services to which they are entitled and for which they qualify. An additional benefit would be that the CHW could lessen the burden currently placed on supports coordinators. The current service definition emphasizes collaboration between the participant, the community health worker and the supports coordinator. The intent of a CHW was that the CHW assists the participant, the discussions did not focus on this service being conducted under the direction of a supports coordinator.

Comment: One organization has significant concerns and is not supportive of the proposed addition of the “*Community Health Worker Service*” as it is currently proposed, for the following reasons:

- Current requirements for the MI Choice Waiver program include the evaluation and reassessment of individuals who are discharged from a hospital or nursing facility with a change in condition. Person-centered care planning activities are also required as a result of the change of condition situations.
- We see the addition of this new CHW service category as a duplication of the responsibilities of supports coordinators. Adding another individual into the coordination and service delivery process will certainly increase the level of confusion for the Waiver Participant.
- The CHW requirements, as set forth in the proposed renewal application (face-to-face contact within 3 days of discharge/transition; 30-day follow-up visit; documentation of issues and conditions discussed; etc) are already required of professionally trained and licensed SC.
- The addition of the CHW service may be seen as a possible way to help current MI Choice Agencies who are experiencing difficulties meeting the supports coordination responsibilities for the target population. It would seem, however, that the Department has a responsibility to monitor such agencies and require a corrective Quality Improvement Plan to ensure that the agencies are able to meet the roles and responsibilities associated with the current contract process for the MI Choice program. Such a corrective action plan may, in fact, require the agency to employ a larger Supports Coordinator staff to meet Participant need and contract demands and requirements.
- Having the opportunity to “purchase” a less costly option to the responsibilities of supports/care coordination seems contrary to what has made the program such a success. Replacing a professionally trained/licensed individual with someone “trained in duties of the job”

weakens the program and has the potential to reduce the overall quality of care and quality of life. Adding an additional level of intervention, documentation, and “hopefully” good coordination between the CHW and the SC in all likelihood will only increase the possibility of mistakes, mis-communication, and missed trouble signs. Simply stating that there “...needs to be close collaboration between the CHW and the SC” does not ensure that such collaboration will exist, nor does it provide any guarantee that the problem it is intended to address (the inability of Waiver Agents with high participant to Supports Coordinators to meet current Waiver standards) will be met. It will also require additional clinical quality assurance review components which will need to be monitored by both the Waiver Agency and the CQAR auditors.

- Further, we believe requiring the CHW to be separate from the Waiver Agent will increase the likelihood of poor communication and collaboration since the Waiver Agent will have no real control over the work of the CHW in assuring that the requirements of the position are met.
- It does appear the addition of this position, which has been an on-going request of for-profit health plans, appears to be an attempt to appease the Health Plans participating in the MI Health Link Program. The basis for the Health Plans’ request is to have a less expensive way to perform supports/care coordination activities, and thus paves the road for the health plans to increase their influence in HCBS.
- Finally, by incorporating a CHW as a stand-alone service within the MI Choice Program, we feel the State is taking the next step in its stated desire to require the MI Choice program to be a part of a fully integrated managed care system, and in so doing, eliminating a not-for-profit option for individuals seeking to have their long-term supports and services provided in a home and community setting. Given the complexities of community-based long-term supports and services for a nursing home eligible population, one which has little margin for error much less profit, **there must continue to be a not-for-profit option**, one which the MI Choice program currently provides for the most vulnerable citizens of Michigan.
- UPCAP urges that the proposed CHW Service category be dropped from the MI Choice Waiver Renewal application, or at a minimum, allow existing Waiver Agencies the opportunity to conduct the service internally so that coordination can be maximized and consumer frustrations will be minimized.

Response: During the stakeholder meetings, the intent of the CHW was always to assist the participant in accessing all services to which they are entitled and for which they qualify. An additional benefit would be that the CHW could lessen the burden currently placed on supports coordinators. The current service definition emphasizes collaboration between the participant, the CHW and the supports coordinator. The intent of a CHW was that the CHW assists the participant, the discussions did not focus on this service being conducted under the direction of a supports coordinator.

Federal regulations regarding the provision of conflict-free services do not allow for waiver agencies to provide direct services unless there is no other willing and qualified provider in the service area. MDHHS understands that there is a network of community health workers in Michigan and these providers would be willing to assist MI Choice participants with accessing HCBS. MDHHS must include the cost of this service in the actuarially sound capitation rates developed each fiscal year.

Collaboration should be less of a burden on the supports coordinator than meeting with the participant to assure their access to HCBS and linking the participant to those services. The SC is already required to document all contacts made with or on behalf of the participant and the availability of a CHW does not negate this requirement.

Comment: Although the addition of a Respiratory Therapist is a need for some MI Choice participants meeting the criteria, this creates heightened financial burden to waiver agencies to an already existing high costs and financial hardship to provide PDN. If MDHHS moves forward with the addition of Respiratory Therapist to PDN, it is our hope and request that MDHHS would consider allowing PDN to be a carve out service, therefore move to a Fee-for-Service reimbursement method. Waiver agencies of all sizes are taking on the financial burden of these high cost participants which strains the agencies on achieving and maintaining financial stability. The designated Risk Pool Adjustment and designation of SSP reimbursement is not financially assisting waiver agencies. Some proposed options are below:

1. Placing a cost limit to PDN services. If PDN costs exceed \$_____ dollars per day, MDHHS will pay at 100% of the cost.
2. Moving PDN to a full Fee for Service, carve out, model.

Response: Thank you for your comment.

Comment: The language at the bottom of page 80 states: “24/7 PDN/RC services cannot be authorized for persons who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency back-up plan without assistance. These persons must have informal caregivers actively involved in providing some level of direct services to the participant on a routine basis.” If a beneficiary cannot engage in an emergency back-up plan without assistance due to a *physical* limitation, he or she should not be required to have informal supports. Instead, the supports coordinator should seek creative solutions to ensuring the beneficiary can contact emergency services and/or engage in a frank discussion with the participant about the risks he or she is undertaking. Although due to a multitude of technological advances, we suspect that most beneficiaries will be able to utilize some device to seek emergency help, if there is no way to enhance the beneficiary’s ability to communicate with emergency services, beneficiaries should be entitled to choose to assume the risk inherent in that situation rather than face institutional placement.

Response: In the example referenced, the individual would be able to make informed decisions for themselves, so this exclusion would not apply. Additionally, the exclusion referenced refers only to 24/7 Private Duty Nursing/Respiratory Care services, not 24/7 services in general.

Comment: While this option seems reasonable since participants in the MI Choice Waiver need to qualify for a nursing home level of care and nursing homes likely have capacity to accept participants for respite care, we have some concerns about this possible change and suggestions if it is in fact offered. We note that moving from home to a nursing home can be particularly challenging for individuals with dementia.

Is this change in response to the lack of available settings outside of the individual’s own home? We are concerned that this setting could become a default setting instead of a setting of last resort because it is less onerous than finding in-home respite services. If it is added, we suggest there be language that requires it be utilized only when it is the participant’s choice after other person-centered options are explored and considered with the participant.

Response: Respite services in a nursing facility are temporary services provided outside of the home to relieve and informal caregiver. As with all MI Choice services, the participant or the participant’s guardian would need to approve the service based upon a person-centered plan. If a temporary nursing facility placement for respite is not in the individual’s best interest, other options should be explored. This service option is Federally limited to no more than 30 days per year.

Comment: We suggest removing the restriction that “Respite can only be provided in the home of another when the participant is using the self-determination option for service delivery.” Instead, we suggest that participants utilizing the traditional method of service delivery be permitted to receive respite in the home of other family members or friends and have the agency provide services at the other person’s home. This would likely be a much more person-centered option as most beneficiaries would be more comfortable with those with whom they are familiar, and this is how many families of individuals who do not participate in MI Choice resolve the issue when one informal caregiver is briefly unavailable or in need of a break. Providing the same services in another individual’s home would also be more cost-effective in most cases than short-term nursing home placement.

Response: Thank you for this comment. MDHHS will make this change in the waiver application.

Comment: The State Long Term Care Ombudsman’s should be consulted to determine what would constitute an appropriate nursing home setting for this service – what is the baseline for quality and other factors?

Response: Waiver agencies are free to contact the State Long Term Care Ombudsman’s office as needed to determine an appropriate nursing facility to enter into a contact with for this service. Waiver agencies are familiar with nursing facilities within their service area and nursing facility quality measures are available online.

Comment: One commenter suggested changing CQAR tools some to incorporate more participant satisfaction type measures in this renewal application. This concept would align more with the “person centered planning” meeting that will be replacing some assessment visits. It makes sense to base a good deal of quality scores on if the participant feels they are receiving quality services. We realize there are still CMS guidelines and standards to adhere to in relation to documentation, but it could be equally weighted with participant satisfaction. Also, the “scoring” of CQAR could maybe be more accurate with the number of citations as more of a focus, not so much the levels of citations. This would be a better reflection of the individual Waiver Agent’s quality, as well as, the statewide quality score for MI Choice Waiver.

Response: MDHHS plans to use the CAHPS participant survey to assess participant satisfaction. This survey may also replace the current home visit survey used by the CQAR team.

Comment: Regarding Performance Measure: Number and percent of participants or legal guardians who report having received information and education in the prior year about how to report abuse, neglect, exploitation and other critical incidents. Whether a participant has a legal guardian or not, he or she should receive information and education on how to report abuse and neglect. Indeed, the abuse or neglect may be perpetrated by the guardian. If there is a compelling reason that the participant cannot understand the information being provided, it should be documented.

Response: MDHHS has a MI Choice Participant Handbook that is provided to each applicant upon enrollment and each participant annually. This handbook includes information about abuse, neglect, exploitation and other critical incidents and how to report them. Supports coordinators are required to explain this information to participants and guardians at least annually.

Comment: Can the 180-day PCP meeting be done by one discipline or RN/SW?

Response: MDHHS requires only one supports coordinator to participate in the person-centered planning meeting. However, if the participant wishes to have both supports coordinators present, this choice should be honored.

Comment: This paragraph indicates that participants are informed of the availability of a supports broker in the MI Choice Participant Handbook. We found no mention of this option in the Handbook.

Response: This can be added to the Handbook if it is not there.

Comment: The State's response to the Monitoring Safeguards does not acknowledge some potentially significant conflicts of interest which could impede adequate monitoring. For example, some waiver agents are Meals on Wheels providers.

Response: MDHHS monitors the provider networks of all waiver agencies, including those who provide direct services other than supports coordination to assure there is choice in providers. Additionally, MDHHS assures that participant choices are honored in these situations.

Comment: The move to an annual assessment will allow for the Supports Coordinators to spend increased time with their participants. The change will allow the SCs to work with the participant in a meaningful WA versus repeating assessments. To truly be person centered the SC will need to visit the participant as often as the participant desires to work on the PCP. There should not be a standard time for when the person-centered plan takes place rather it should be said that the SC must conduct a

person-centered plan with the participant as frequently as need with no less than one visit within the fiscal year.

Response: Thank you for your comment. MDHHS set a minimum requirement that the person-centered planning meeting must happen at least once per year. MDHHS also required that communication is addressed on the person-centered service plan. This topic should identify how often the participant wants to communicate with the supports coordinator including phone calls, checks on services, in home visits for assessments, person-centered planning meetings, and for any other reason.

Comment: The outreach section primarily discusses the nursing facility transition program and we agree this is an important part of MI Choice outreach. However, outreach efforts for individuals who would utilize MI Choice without a prior nursing home stay are left to the PAHPs who “may” conduct outreach activities. We encourage the Department to engage in more energetic outreach activities. Although there is concern about encouraging interest in a program that has long waiting lists in some areas, there are three reasons that more outreach would be beneficial.

- First, it would help determine the true level of need and desire for MI Choice services; the lack of outreach about the program means that many people who need, qualify for, and desire MI Choice services never know they can receive services or be added to a waiting list.
- Second, in some areas, there is no or only a minimal waiting list so interested individuals would be able to obtain prompt assistance.
- Third, more outreach and publicity about the program would help in the necessary and continuing education of the public and professionals who are still not sufficiently aware that individuals with nursing home level of care can be served successfully in the community. This is a critical element of long-term rebalancing.

Response: Thank you for your comment. MDHHS will take this under advisement.

Comment: We applaud the efforts of the Department to revise its Level of Care Evaluation process for MI Choice participants and others requiring nursing facility level of care. We believe the MI Choice LOCD process would be significantly enhanced if/when, as in MI Health Link, the process includes a “Door 8” that includes the qualifying factors contained in the current Exception Criteria so that participants are evaluated at the same time for all possible criteria that could result in eligibility instead of relying on a two-step process that beneficiaries do not understand and are often unable to access. We also strongly suggest that the Department include contact with the beneficiary and/or his or her representatives when reviewing

adverse determinations by waiver agents rather than relying solely on information from the agency.

Response: Thank you for your comment. MDHHS is already preparing to allow “Door 8” to be conducted by all providers conducting the LOCD and not having a separate call requirement to MPRO for the Exception Criteria. The changes will be made in CHAMPS and policy as soon as we are able to do so. The other comment relating to contact with the beneficiary for reviewing adverse determinations will be taken into consideration for the MI Choice process as well as the entire LOCD process.

Comment: The application expresses in more than one place requirements for those providing transportation including that they must be physically capable and willing to assist persons requiring help to get in and out of vehicles and be trained to cope with medical emergencies unless expressly prohibited by a labor contract or insurance policy. However, these are important requirements and we wonder how participants’ transportation needs can be safely met if the provider’s insurance or labor policies bar the driver from engaging in those activities?

Response: Waiver agencies have the responsibility to identify participants who require hands-on assistance for transportation and pair them with a provider who is able to offer that assistance. Not all participants require this level of assistance for transportation. This requirement allows more choices for transportation to all participants, not just those who require hands-on assistance.

Comment: Generally, training on reporting and identifying abuse and neglect is highly recommended for providers but not required. This training should be required for most providers. Training should include how to identify abuse, neglect, and exploitation and what resources are available to participants experiencing abuse, neglect, or exploitation.

Response: MDHHS sets minimum standards for providers. Waiver agencies are free to add to those requirements as needed to assure the quality of their provider network.

Comment: Training on Minimum Operating Standards and expectations for Supports Coordinators should be offered by the State instead of relying only on training by the waiver providers.

Response: MDHHS requires licensed professionals to be supports coordinators. Part of the reason for this standard is that licensed professionals must be trained and participate in ongoing training by obtaining continuing education units (CEUs) to keep their licensure. MDHHS is working on

training and certification for MI Choice supports coordinators in conjunction with Grand Valley State University. Several online modules are currently available. Additionally, online training resources for supports coordinators are listed at the end of every MI Choice Bi-Weekly Phone Call agenda, which is widely distributed to waiver agencies and staff.

Comment: Contingency Plan in Case of PAHP Financial Collapse, Significant Administrative Mismanagement, or Other Very Serious Development Affecting Participant's Ability to Receive On-going Safe and Appropriate Services and Supports. We did not see provisions in the proposal for how very serious PAHP malfeasance, financial challenges, or mismanagement would be handled. We wonder if there should be provisions that would allow MDHHS to appoint a temporary manager or some other mechanism to assure appropriate continued services for beneficiaries in times of PAHP crisis.

Response: The Code of Federal Regulations, Chapter 42, §438.706 allows MDHHS to impose temporary management in certain circumstances, including those specified above. Specifics are included in Attachment C of the MI Choice contract.

Comment: In several places in the application, there is language that "Where applicable, the participant must use Medicaid state plan, Medicare, or other available payers first. "While we understand this is necessary, we are concerned about varying PAHP interpretations about what constitutes adequate efforts to obtain services funded by another payer. We are also concerned about delays in obtaining necessary services while other avenues—some of which (e.g. CMH services for individuals not eligible for CMH) seem unlikely to result in adequate services—are pursued. We suggest guidance be provided to define how long the participant has to wait for approval of a service while other insurances or payers are pursued.

Response: Thank you for your comment.

Comment: There is more than one place in the application that states, "These types of services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third-party payer is capable of, or responsible for, their provision." We have repeatedly raised concerns with this requirement and language including during Medicaid Fair Hearings. This language is overly broad, poorly defined, and without guidance regarding the number of contacts and the documentation needed to fulfill this requirement. Moreover, it is simply unrealistic to assume anyone deemed by the PAHP capable of performing or paying for

services in the household will do so. The language should be amended to read “able and willing” not “capable of...their provision” and further guidance should be provided regarding the Department’s reasonable expectations. In addition, on occasion, PAHPs have required participants to pursue volunteer services in situations in which it is absurd to think the volunteer service, even if available, could meet the complex needs of the participant (e.g. contracting Volunteers of America or local churches for coverage of hours of service for an individual on a ventilator who is also almost completely paralyzed).

Response: MDHHS will take this suggestion under advisement.

Comment: Payment of 1st month’s rent. The MI Health Link Waiver recently added the payment of 1st month’s rent (not to exceed \$650) as a billable Community Transition Services. This option could increase the number of transitions in the MI Choice Waiver and should be added.

Response: MDHHS plans to remove community transition services from the MI Choice waiver once they are approved as a state plan service. MDHHS will consider this comment for the transition services 1915(i) State Plan Amendment application.

Comment: Communication and Supports Coordination. We absolutely agree with this reiteration. We suggest changing the segment that states “frequency of the communication” to “frequency of routine communication” to ensure the participant is not locked into an inflexible communication protocol. Also, the participants with a legal representative should decide whether they want to have their own communication schedules and legal representatives may need their own as well. Although we understand that in some cases, communication with the participant is not possible, the legal representative should not be allowed to prohibit contact between the participant and his or her supports coordinator and the “or” in the current language would allow that possibility.

The frequency for client communication should be determined by the participant and his/her allies. Frequency that the participant wishes to be contacted should be honored as that is the person’s choice. Calling every month is not necessary nor wanted by many participants.

Regarding communication, regular communication happens all the time, it’s just another specific line that would have to be added to care plans.

Response: Thank you for your comment. Waiver agencies must adhere to the MDHHS person-centered planning guidelines. Proper use of person-centered planning principles should address these concerns.

Comment: Adult Day Centers are required to have a telephone accessible to all participants. This requirement should include a private area for participants to use the phone.

Response: We can make this clarification since this is required by the HCBS Final Rule.

Comment: The State has stated that there have been no known major system-wide problems. However, there have been long-term discussions about the adequacy of the network, especially the lack of direct care staff. Transportation services are also limited or unavailable in some areas. And Nursing Facility Transitions are slowed because nursing facility transition staff are sometimes unable to respond promptly and because of limited direct care staff in the community.

Response: Availability of direct care staff is not an issue unique to the MI Choice program. This is a nationwide problem with access to home and community-based services in general. MDHHS has addressed the transportation issue by combining non-emergency medical transportation and non-emergency non-medical transportation into one community transportation service.

Comment: What is the penalty or remedy if the PAHP does not comply with the Corrective Action Plan?

Response: The Code of Federal Regulations, Chapter 42, §438.700 to §438.730 allows MDHHS to impose sanctions on waiver agencies in certain circumstances, including those specified above. Specifics are included in Attachment C of the MI Choice contract.

Comment: Could there be a better way to identify a Waiver client in the systems (Champs/Other) that hospitals and nursing homes use to check benefits, so everyone involved could be aware of someone's Waiver status displayed with their other benefits? This may help hospitals or nursing homes provide timely notification to care managers about a client's admission or discharge.

Response: This content is out of the scope of the waiver application.

Comment: First, as participants in the MI Choice Waiver Program we feel that we, the main stakeholders, are being left out of the discussion and there has been no attempt to allow all people at the table. We have concerns about the location being marginally accessible and wonder why you are not taking these meetings on the road to allow for others around the state to participate. Additionally, we want to ask why there are meetings

scheduled at 9:00 a.m. unless your goal is to exclude many of us. At a minimum, these things are thoughtless and inconsiderate.

Response: MDHHS notified stakeholders of the dates and times of the stakeholder meetings and published this notification and the letter on the MDHHS website. MDHHS added five stakeholder meetings to the schedule that were not held in Lansing to accommodate those who were unable to attend the Lansing meetings. Additionally, MDHHS posted the agenda, presentations, and summaries on the MDHHS website and widely advertised the MDHHS-MiChoice@michigan.gov email address for receiving additional comments. Times for the meetings varied to accommodate different schedules.

Comment: Following are the things that this participant group has collectively identified as what is important to us regarding the MI Choice Waiver Program. They are all things we do not want to lose: 1) Relationship with Care Managers, 2) Freedom to say “this is what I want,” 3) flexibility, 4) not having someone tell us what we need, 5) support to remain as independent as possible, 6) connection to the community, 7) we do not want to add to the restrictions we already face, 8) the support to go to church without someone else deciding what is most important for us, 9) support to go shopping and decide what food we want, 10) communication with Care Managers who take the time to listen and understand, 11) personal touches from care managers such as call to wish happy birthday or send holiday card, 12) that the quality of our care remains a higher priority than the cost, 13) that we get to keep our physicians, 14) to never have diminished communication with reasonable assurance we will always be listened to and there will be a response.

Response: MDHHS emphasizes person-centered planning and has kept these things in mind. Nothing in the waiver application nor in other MI Choice policies, procedures, or the MI Choice contract would prohibit any the 14 things identified above. If any participant feels these things are being restricted, it is likely a waiver agency issue. You may use the waiver agency grievance and appeal process to address these concerns. If this does not satisfy you, please contact MDHHS using the beneficiary hotline or via email to MDHHS-MiChoice@michigan.gov.

Comment: The Department is proposing continuing to use the same waiver agencies. We understand that course of action might be influenced by the plan to move to managed long term supports and services which may result in substantial changes to the MI Choice program in any case and a desire to avoid repeated disruptions. However, we do not think there is a current timeline or plan for implementation of MLTSS. In addition, we have observed long-standing significant differences that have a direct impact on

beneficiaries among various waiver agencies and some long-standing frustrations with particular PAHPs. Given that it has been many years since this waiver went through a competitive procurement process, we urge the Department to consider doing so now for the following reasons:

1. The draft waiver renewal has a price tag of just under \$400million by Year 5. The size of that budget should warrant routine competitive bidding.
2. The long-term care landscape is different than it was at the time of the last competitive bid. Going through a competitive bid process now could result in more choice in regions with only one waiver agent.
3. While the waiver renewal and contracts require corrective action plans, being virtually guaranteed a contract year after year removes the teeth from any penalty. A waiver agent could have the same violations and corrective action plans year after year with very little impact on their budgets and the conviction that these deficiencies are unlikely to have any impact on their continued participation in the program.
4. If the State chooses not to rebid the contracts, are there alternatives that would permit additional contractors to provide waiver services?

Response: Thank you for your comment.

Comment: We urge the Department to provide funding for ombudsman services for MI Choice participants as well as other individuals receiving home and community-based services through PACE and Home Help. Like residents of licensed long-term care facilities and MI Health Link participants, these vulnerable individuals often need advocacy and assistance to assure that they receive the full benefit of these programs and that the programs serve them in compliance with all applicable policies, law, and regulations. Since the participant population in MI Choice, PACE, and Home Help is very similar to those in nursing homes and MHLO, and since individuals in nursing homes and MHLO often move through several of these options, it is only sensible that the beneficiaries have the same advocacy services available regardless of the program in which they participate. Moreover, Ombudsman could help provide important feedback to the Department regarding program operations, provider performance, best practices, and challenges.

Response: Thank you for your comment.

I trust your concerns have been addressed. If you wish to comment further, send your comments to Heather Hill at:

Program Policy Division
Bureau of Medicaid Policy and Health System Innovation
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979

Sincerely,

A handwritten signature in black ink, appearing to read "Kathy Stiffler". The signature is written in a cursive, flowing style.

Kathy Stiffler, Acting Director
Medical Services Administration