Michigan Department of Health and Human Services
Medical Services Administration

MI Choice Waiver Renewal Stakeholder Meeting

MINUTES

Date: Thursday, September 28, 2017

Time: 1:00PM – 4:00PM

Where: **Michigan Department of Health and Human Services (MDHHS)**
Capitol Commons Center (CCC) Conference Rooms E and F
400 S. Pine Street
Lansing, MI 48913

Welcome and Introductions

The MI Choice Renewal Panel is made up of the MI Choice Design Team. This Lean Process Improvement team is comprised of the following individuals: Elizabeth Gallagher of MDHHS, Weylin Douglas of MDHHS, Cheryl Decker of MDHHS, L. Alisyn Daniel-Crawford of MDHHS, Stacy Strauss of Senior Resources, and Ben Keaster of Area Agency on Aging Region II. The application renewal of the MI Choice Waiver Program provided an opportunity for the MI Choice Design Team to approach the application with a focus on continuous quality improvement.

Meeting Overview

Elizabeth Gallagher, manager of the Home and Community Based Services Section at MDHHS, began the meeting off with an overview and roadmap of the initial meeting. A brief overview was provided about the history of the MI Choice Waiver Program, which is a Michigan 1915(b)(c) home and community-based service waiver for the elderly and disabled individuals who would otherwise require nursing facility services.

Application Renewal Process

The MI Choice Waiver program started twenty-five years ago in 1992. A waiver is approved by CMS (Center for Medicare and Medicaid Services) for five years, at which point, a new application must be submitted to CMS for approval. The current MI Choice Waiver is approved through September 30, 2018. This will mark the 25th year of providing home and community-based supports and services through this program. This renewal represents an opportunity to update the program to better address the needs and preferences of the population it serves.

The intent the stakeholder meetings is to solicit input and opinions regarding the elements of the waiver program that work well, those that might need improvement, and proposals for new program elements. This is the best opportunity for anyone interested in the MI Choice waiver program to help establish the direction for the next five years.

Attendees were informed of the typical renewal process, which consists of (1) stakeholder meetings, (2) application preparation, (3) internal review, (4) public and tribal review, (5) submission to CMS, (6) request for additional information from CMS, and (7) CMS approval. The goal is to submit the waiver application by July 2018.

Assurances

While stakeholder feedback and input are paramount in the success of the waiver program, it is also imperative that the program operates within federally mandated requirements. As such, the Federal Government requires the State to meet the following assurances within the waiver application before approval:

- The program must include safeguards to protect the health and welfare of participants.
- The State maintains appropriate records for home and community-based services expenditures.
- An initial evaluation of Level of Care (LOC) is done prior to providing services and at least annually thereafter.
- The State informs applicants of alternatives to the waiver (Freedom of Choice) and allows them to choose between those alternatives.
- The average per person cost of waiver services does not exceed the average cost of institutional services (i.e., nursing facilities).
- Total waiver expenditures do not exceed total expenditures for the same population receiving institutional care.
- Participants would receive institutional care if this alternative (MI Choice Waiver Program) was not available.
- The State agrees to provide CMS with information on the type, amount, and cost of waiver services.

Application Elements

The waiver application is comprised of Appendices, lettered A through J, which focuses on the following:

Appendix A – Waiver Administration and Operation

- Line of authority and oversight
- Assessment of contracted and other agencies
- Distribution of operational and administrative functions

Appendix B – Participant Access and Eligibility

- Target groups
- Cost limitations
- Number of participants
- Allocation of waiver capacity
- Eligibility criteria
- Post-eligibility treatment of income
- Freedom of Choice
- Access for Limited English Proficiency persons

Appendix C – Participant Services

- Participant services
- Service definitions
- Provider qualifications and verification
- Criminal history and background checks
- Services in licensed facilities
- Provision of services by legally responsible individuals
- Open enrollment of providers
- Limits on services

Appendix D – Participant-Centered Service Planning and Delivery

- Person-Centered Service Plan (PCSP) development process and responsibility
- PCSP safeguards
- Participant support in PCSP development
- Risk assessment and mitigation
- PCSP update schedule
- PCSP implementation and monitoring

Appendix E – Participant Direction of Services

- Description of participant direction (i.e. Self-Determination or SD)
- Information furnished to SD participants
- SD by participant representative
- SD services
- Financial management services
- Independent advocacy
- Voluntary/involuntary termination of SD
- Budget authority/flexibility

Appendix F – Participant Rights

- Procedure to request grievances, appeals, and a Medicaid Fair Hearing
- Additional dispute resolution processes

Appendix G – Participant Safeguards

- Critical incident (CI) reporting requirements
- Participant training and education
- Responsibility of CI response
- Responsibility of CI oversight
- Use of restraints or seclusion
- Use of restrictive interventions
- Medication Management
- Medication administration by providers
- Medication error reporting and oversight

Appendix H – Quality Improvement Strategy

- System improvements
- System design changes

Appendix I – Financial Accountability

- Financial integrity
- Rate determination
- Flow of billings
- Billing validation process
- Payment methods
- Supplemental payments
- Provider retention of payments
- Other cost sharing arrangements

Appendix J – Cost Neutrality

- Number of participants served
- Average length of stay
- Waiver service cost projections
- Non-waiver service cost projections
- Institutional cost projections

Services and Provider Qualifications

Next, L. Alisyn Daniel, waiver policy analyst, gave a brief overview on services and provider qualifications in the MI Choice Waiver Program. Currently there are 17 MI Choice Waiver services with the recent addition of Non-Emergency Medical Transportation (NEMT). We went on to discuss the services a participant can utilize when they are self-determined. Provider qualifications for both traditional MI Choice Services and Self-Determined Services were also discussed.

Current MI Choice Services

- Adult Day Health
- Chore Services
- Community Living Supports (CLS)
- Counseling
- Environmental Accessibility Adaptations
- Fiscal Intermediary
- Home Delivered Meals
- Non-Medical Transportation
- Nursing Facility Transition
- Personal Emergency Response System
- Private Duty Nursing
- Respite Services
- Specialized Medical Equipment and Supplies
- Training
- MI Choice Nursing
- Non-Emergency Medical Transportation

Self-Determined Services

- Chore Services
- Community Living Supports
- Environmental Accessibility Adaptations
- Fiscal Intermediary

- Goods & Services
- Transportation
- Private Duty Nursing
- MI Choice Nursing
- Respite (in home & in home of another)

Provider Qualifications – Traditional

- ✓ Background/reference checks
- ✓ Knowledge of standard precautions
- ✓ Record-keeping/insurance coverage
- ✓ Training/Supervision of workers
- ✓ Procedures for participant signature in timesheets
- ✓ No smoking in participant homes
- ✓ Workers must be able to communicate with participant
- ✓ Workers cannot threaten or coerce participants
- ✓ Waiver agents inform of new/revised standards
- ✓ Additional qualifications may be required for specific services (i.e. licensure)
- ✓ Must be able to perform required tasks as specified in PCSP
- ✓ At least 18 years old
- ✓ Cannot be legally responsible relative

Qualifications Self-Determined Providers

- ✓ Background/reference checks
- ✓ At least 18 years old
- ✓ Ability to communicate effectively
- ✓ Trained in
  - o Universal precautions
  - o Blood-borne pathogens
- ✓ Cannot be legally responsible for participant
- ✓ Additional qualifications for specific services
  - o Licensure
  - o CPR (unless DNR order)
  - o Driver's license (if transporting)

Quality Management System

MDHHS Quality Specialist, Cheryl Decker went on to discuss the Quality Management System within the MI Choice Waiver Program.

CMS Quality Requirements

For a state to be approved for a Home and Community Based Services waiver, the state must show that there are systems in place to measure and improve performance in assuring the following: (1) participant health and welfare; (2) financial accountability; (3) qualified providers; (4) Level of Care determination; (5) service plans; and (6) administrative authority. The state must also describe evidence-based discovery activities and remediation activities to correct individual problems.

Quality Management Collaborative Committee

The MI Choice Waiver Program supports the efforts of the Quality Management Collaborative Committee (QMC). The QMC has membership of at least seven program participants, family members, caregivers, and advocates, as well as waiver agencies and providers. The QMC is currently chaired by a program participant. The committee provides an excellent venue and opportunity to include participants and caregivers in the development, discussion and review of quality issues and problems, performance outcomes, and plan improvements. Narrowly, waiver agencies are required to form their own QMCs to address local quality issues.

Quality Management Plan

A Quality Management Plan addresses quality assurance and improvement using measurable goals, quality performance indicators, and outlines MDHHS' plan for Quality Improvement activities. It also functions to provide guidance to waiver agencies for their own Quality Management Plans, which includes quality reviews, quality improvement goals using quality indicators, and Critical Incident Management. This initiative was developed by MDHHS with feedback provided by the MI Choice QMC.

Clinical Quality Assurance Reviews (CQAR)

Qualified reviewers conduct reviews of (1) participant enrollment, (2) assessment data, (3) NFLOC eligibility, (4) PCSPs and PCP planning processes, and (5) reassessment data. For each waiver agency, the CQAR team reviews a percentage of randomly selected participants.

Administrative Quality Assurance Reviews (AQAR)

The Home and Community Based Services Section staff conducts on-site visits to verify administrative and program policy and procedural requirements on a biennial basis. The AQAR examines policy and procedure manuals, peer review reports, results from participant satisfaction surveys, provider monitoring reports, provider contract templates, financial systems, claims accuracy, quality management plan, and required provider licenses/certifications. Home visits may also be conducted as part of AQAR.

Critical Incident Management

Critical Incidents are incidents, events, and occurrences that jeopardize the health and welfare of a participant. Waiver agencies must report critical incidents to MDHHS using the online reporting system. Agencies must also (1) follow-up with the incident until its resolution, and (2) help the participant determine how to avoid future occurrences of the critical incident. Critical Incidents are categorized in levels. A Level One Critical Incident is noted as a "Cause for Concern" and may include things similar in nature to verbal abuse and illegal activity in the home. A Level Two Critical Incident is noted as "Serious" including but not limited to theft and worker drug/alcohol use while on duty. Lastly, a Level Three Critical Incident is noted as "Urgent" and may include incidents similar to exploitation, physical abuse, neglect, critical provider no show, sexual abuse, and suspicious death.

Participant Satisfaction Surveys

Beginning in 2017, Michigan State University will be sending satisfaction surveys to MI Choice participants and MSU will analyze the results. The surveys were developed by the QMC.

MI Choice Application Renewal

Required Additions

Next, Elizabeth reviewed additional requirements that will need to be incorporated into the waiver renewal application. Those required additions include the following:

- Beneficiary Support System
- Conflict Free Case Management
- Managed Care Quality Strategy
    - Network adequacy

    - Continuous quality improvement
    - Performance improvements projects
    - External Quality Reviews
- Telemedicine, e-visits, other technological advances in service delivery
- Managed Care Internal Appeal and Grievance Processes

Vision and Values

Lastly, the MI Choice Design Team provided an overview of the vision and values of the MI Choice Waiver program to aid in guiding discussion and ideas for improvement.

- Respect, support, encourage, and promote individual self-determination and family/community empowerment and involvement.
- Create an efficient and dynamic continuum of LTSS
- Provide accessible, regionally and locally decided single points of information, assessment, care planning, and entry into the system for those seeking LTSS.
- Use of person-centered processes and tools.
- Assure all those who need high levels of services and supports have a range of options that allow them to live in the community, of that is their choice.
- Build and sustain an adequate, well-trained, highly motivated, and appropriately compensated workforce.
- Include the planning and oversight of efforts to realize this vision, including a central, meaningful role for participants and families, as well as other stakeholders.
- Build the capacity to educate the general population by increasing awareness about the continuum of LTSS.

Stakeholder Open Discussion

The remainder of the meeting focused on open discussion with seventy plus attendees.

- A provider inquired about the State's current focus on Medicaid rebalancing.
- A MI Choice participant asked about the availability of pet-friendly housing.
- A consumer group expressed dissatisfaction with the accessibility of the meeting location and the meeting times. They expressed that given those factors, they felt left. The consumer group provided a letter addressing what they want from the waiver program (please see attached), such freedom to say what they want, flexibility, the ability to remain as independent as possible, and connection to the community.
- Some attendees had questions and concerns regarding long-term restricting and integrated care models. The attendees were informed that nothing has changed at this point but change may occur at some point. There were additional comments expressed about managed long term

care versus the current system and a provider indicated that their agency would not be able to survive in a managed long term support and services model.

- A provider stated that connections to resources within the current model are better with community-based organizations than it would be with a large managed care organization.
- Providers indicated that did not want their concerns to be brushed aside.
- An attendee asked about possibly adding a service to MI Choice for overnight standby care.
- Tri-County AAA expressed concerns with understaffing.
- Attendees expressed concerns with being below the standard of spending as a state on Home and Community-Based Services versus institutional care. Someone reported that the state is at about 50% the cost of a nursing home.
- Attendees expressed a push and desire to reduce problems associated with program waitlists.
- There was much discussion regarding compensation and reduced workforce of direct care workers.
- Attendees speculated that Conflict Free Case Management would be a big change to the current model.
- A participant provided a personal story of how the MI Choice program helped them and expressed that there is great need for the program.
- An attendee noted that nursing homes have spousal allows that allows them to live in the community while their spouse is in a nursing home but this is not so in an assisted living facility.
- An attendee questioned whether it would be possible to increase compensation for community living supports services at the rate setting stage.
- There were a few questions concerning electronic verification visits (EVV) and the attendees were informed that implementation of such would not occur until 2019; however, stakeholder feedback will be garnered during the implementation process.