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Integrated Care
Medical Services Administration
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Re: Michigan's Proposal: Integrated Care For People Who Are Medicare-Medicaid Eligible.

Ladies and Gentlemen:

Thank you for this opportunity to comment on Michigan's Proposal. There is much to like in terms of the phased-in schedule for implementation, commitment to maintain current levels of service, and respect for Person-Centered Planning and Self-Determination for Persons with Developmental Disabilities. The proposal reflects citizen input and I am grateful for the opportunities provided for that. I concur in the goals of integrated care and the guiding principles for plan development in Michigan.

That said, there are several areas that concern me and, I believe, actually work against the goals of person-centered assessment, service planning, service delivery and results; service integration; and improved cost effectiveness. They are:

- Passive Enrollment
- Safeguards
- Nursing Facilities
- Person-Centered Planning and Self-Determination for Persons with Developmental Disabilities
- Single Care/Supports Coordinator
- Single Plan of Care
- Single Assessment
- Electronic Medical Records
- Enhanced Benefits
- Bidding Process, ICOs and PIHPs

Passive Enrollment: I understand the choice was made to assure adequate numbers of participants, but it does fly in the face of person- directed (person-centered) service and individual choice. These are critical values, held dear by persons who are Medicare-Medicaid Eligible (MME). A two month period to opt out may not be sufficient time to make an informed choice. Will assessment and options be made clear within that time frame?

Safeguards: The statement, "Safeguards will be built into the new delivery model to assure continuity of services and to assure a seamless transition to people receiving services. These will include requirements to continue existing providers and services until an assessment is completed and care transition arrangements are made through the person-centered planning process." [emphasis added]. Transition to what? Will this transition sever relationships with current providers? Changing providers when a person's medical, social, habilitative, and rehabilitative needs are being met is not cost effective. For persons with severe cognitive and other impairments, the relationship between the provider and the MME is essential to effective service. This "safeguard" appears temporary at best.

Nursing Facilities "will be assured payment at current Medicare and Medicaid rates for any participant that is a resident of their facility." This does nothing to facilitate transition out of Nursing Home care to community-based residential services. It perpetuates use of nursing homes and thwarts implementation of the Olmstead court decision. There is an institutional bias in CMS and an apparent revolving door arrangement between hospitals and nursing homes. Poor care in nursing homes results in hospitalization. Hospitals discharge patients to nursing home care. A real cost saver would be to interrupt this cycle. The state might use Independent Living Center staff to work with MMEs with disabilities to develop transition plans. Nursing Homes have a financial interest in maintaining their resident population. I am hopeful that the attention to the goals of this plan will result in expanded MI Choice waiver opportunities.

Person-Centered Planning and Self-Determination for Persons with Developmental Disabilities. These are critical concepts and while they are articulated throughout Michigan's proposal, I am not sure they are fully understood. Person-Centered Planning might better be called Person-Directed Planning. That is, the MME beneficiary is the director of the plan, calling together the various professionals needed (and ONLY those needed) to develop a comprehensive plan of care. Self-Determination for persons with Developmental Disabilities is a national program with very specific principles: Freedom, Authority, Support, Responsibility, and Confirmation. It was developed to provide a more cost-effective system for serving persons with developmental disabilities while simultaneously giving those persons and their families more choice in determining the services they receive. The program has been implemented in many states and studied in depth.

Four elements are central to Self-Determination:

- Person-centered planning, where each individual defined his or her own needs; learned about available services and providers; and received assistance in planning services.

- Independent support brokerage, meaning that independent professionals (brokers) helped individuals and their families identify their needs and find services and providers who could meet those needs.

- Individual budgets, wherein participating states allocated a pool of money that the individual could use to pay for the services and supports he or she chose.

- Fiscal intermediaries to act as business agent, purchasing services and managing wages, taxes, fringe benefits, accounting and compliance with labor and tax regulations.

Evaluative Studies have shown:

- There was a shift in decision-making from professionals to individuals with disabilities, and improvement in some but not all quality-of-life indicators.

- Flexibility, a system-wide approach and the availability of direct support workers were critical factors in the success of self-determination initiatives.

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The **March 29, 2012** Memorandum from Melanie Bella, Director, Medicare-Medicaid Coordination Office, and Jonathan Blum, Director, Center for Medicare, regarding **Additional Guidance on the Medicare Plan Selection Process for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans** causes me to have great concerns about the place of Person-Centered Planning and Self-Determination in a future capitated model.

Throughout the Bella/Blum memorandum descriptions of the Model of Care (MOC) and Plan of Care (POC) and Interdisciplinary Care Team (ICT) reflect the medical model of the 1970s. The Beneficiary will participate in the ICT meeting "as feasible." MOC and POC will be shared with the beneficiary as opposed to being designed in response to the beneficiary's stated needs and desires. "We clarify that it is not our expectation that the MOC will be provided individually to beneficiaries." (page 11). The rubric for evaluating plans makes no mention of Self-Determination and it is clear there is no intention of giving the beneficiary control of the resources to purchase the services he/she needs and desires.

As for the Interdisciplinary Care Team, the Rubric will measure "How **the <u>organization</u> will determine the composition of the Interdisciplinary Care Team."** [emphasis added]. and "How **<u>the beneficiary will participate in the ICT as feasible.</u>**" (page 26 of Bella Blum memo).

If these are to be criteria for evaluating Michigan's plan, I am very concerned. I hope you will speak to these issues in the Conference call April 5th.

The Guidance from HHS/CMS may make the rest of my comments on Michigan's proposal moot. However, I will provide them for the record.

Michigan is proposing two separate contracts to deliver services to people who are eligible for both Medicare and Medicaid: an **Integrated Care Organization** for physical health care needs (acute and primary, long term care supports, etc. and maintenance of the **PIHP service system** for behavioral health, and Developmental Disabilities. The Bridge model to connect the care systems leads me to believe a beneficiary will have **two Care or Supports Coordinators**. **Please have only one Supports Coordinator per beneficiary.** If there must be a supports coordinator (titles are not so important as function) in each system (ICO and PIHP) then give one of them the authority to command all necessary services from all sectors.

When there is more than one "care coordinator" it falls to the beneficiary or his/her representative to coordinate the care across sectors.

Example: When my daughter with profound intellectual disability was in her early 20s, she had an Individual Educational Plan developed by an Individual Educational Planning Team and Team Coordinator, She had a Person-Centered Plan developed by a DMH Supports Coordinator, She received MRS services and had a caseworker, She had a case worker at DSS (now DHS). Each of these coordinators led teams or individually planned services for Ginny. Each prepared a lengthy plan. Each used a separate form (lots of trees died). Sometimes they actually wrote competing goals even though I tried to be sure all of them attended each other's planning meetings. It became my unpaid job to be sure gaps were filled, overlapping and/or competing goals were eliminated, and a coherent, appropriate plan of service emerged ...even if in four parts. The expense of my personal time and that of the professional personnel was huge. The financial costs of those meetings and reports was at least four times greater than it could have been.

I have long advocated a single planning format, a lead coordinator (who could be the beneficiary himself), timely meetings, held as needed and attended by all relevant personnel from all service sectors. That would be cost effective!

For the past 10 years or so, Ginny has had one Supports Coordinator who brings together all services: habilitative, rehabilitative, physical health, nursing services, neurological, dermatological, vision, hearing, speech and language services, employment, housing, recreational supports, etc. as needed. Not all are always needed. There is one Plan of Service. This is, to my mind, Integrated Care including assessment, service planning, implementation and evaluation. I would like to keep things just as crisp and clear as we move forward and not have to return to the days of coordinating the coordinators.

Relating this experience, raises concerns regarding the **single assessment**. If there is to be a single assessment for all 200,000 MMEs, I believe it will have a very high cost and may have a low yield depending upon who administers it and how it is administered. The March 29, 2012 memo from HHS/CMS (Memo, page 32) discusses the Health Risk Assessment tool the organization will use to identify the specialized needs of its beneficiaries. At a minimum it includes: medical, psychosocial, functional and cognitive needs, medical and mental health history. It goes on to discuss how the assessment will be conducted (Memo, page 33) "at a minimum includes: the initial assessment within 90 days of enrollment with annual reassessment within one year of last assessment; conducted by phone interview, face-to-face, written form completed by beneficiary."

Michigan's plan also includes enhanced services e. g. dental and therefore the enhanced services needs will also need to be assessed.

I do not know of a single tool that will be appropriate for assessing all MMEs. A battery of tests may be appropriate. And then there are questions of rater reliability, validity and reliability of the test instruments, whether or not they are normed on the populations assessed (culturally normative), and the role of relationships between rater and MME. What does Michigan envision will be in a brief preliminary assessment /screening process that identifies preferences, needs, and priorities? (Plan, page 14) Will assessors use the person's first language, English, Spanish, ASL, other? Many persons with profound intellectual disabilities and concurrent health, habilitation and rehabilitation needs are non-verbal. Some, like my daughter, need to have established (over a period of time) relationships with the examiner before demonstrating anything. Many individuals need to be observed over a period of time in a variety of settings by a <u>common observer</u> in order to secure a comprehensive assessment. Medical needs, changes in condition, can be detected through regular monthly visits by a single medical professional who has a relationship with the MME. Michigan's proposal states "The lead entity will conduct more extensive person-centered assessments." Who will be interviewed in the instance of persons who are non-verbal?

Example. My daughter will do nothing for someone she does not know well. Psychological exams rarely yield an IQ above 10, although she is capable of so much more: dresses herself, does her own laundry, and things like that. Ginny is now 44 years old. She has profound Intellectual Disability, no verbal speech and limited sign language communication. People who have long standing relationships with her are able to "read" her expressions, gestures, and affect and determine her expressed wishes. She has long standing relationships with her primary care physicians, neurologist, dermatologist, and comprehensive breast care physicians (she is in high risk group). New professionals, who will not have an established relationship, will need to develop the same through frequent visits to familiarize themselves with her. She too will need frequent visits to become comfortable in their presence and their facility. She is comfortable going for her mammogram now, but it took more than 5 years to get to the point where she could cooperate and a reliable assessment could be made. A change in place and practitioner will set her back years in terms of effective assessment. I do *not see where this added activity...that will be essential if health care is to be effective... will save money. Every "getting to know you" visit will result in a charge*

Supports should be Adequate, Accessible, Available, Affordable and Acceptable (the 5 As of Health Care) to the beneficiaries. No one wants more intervention in his or her life than is needed to assure health, safety and a degree of comfort.

Electronic Medical Records (Plan page 16). This is a move in the right direction. However, it is essential to **assure that the protocol requires Interface methodologies that respect and protect the holder of the record against liability for breeches of confidentiality.** This is especially important in a system that blends governmental and non-governmental (non-profit, for-profit) service delivery organizations.

Governmental and quasi-governmental organizations have sovereign immunity. Non-governmental (non-profit, for-profit) organizations do not. To protect non-governmental organizations' ability to get and maintain the full range of liability insurance coverage needed to protect directors and officers of the organization, they must maintain full and complete care, custody, and control of their clinical and administrative records. In designing records systems, this must be a key consideration.

The description of **enhanced benefits** (Plan, page 17) seems more a hope than a promise. The proposal states expanded dental services, vision, vision and hearing aids (for example) "**may be provided** at the option of the ICO and are strongly encouraged."

My experience of 50 years in advocacy for persons with developmental disabilities and mental illness (DD/MI) is that there are very few providers of dental, vision, and hearing services who are willing to serve people with DD/MI at any price and even fewer who will accept MMEs. You have covered yourselves with the words "services the ICO may choose to offer." I believe it would be more honest to admit there is a very limited resource e.g. professionals to provide this services and unless the ICO actually hires qualified dental, vision and hearing professionals to provide this service to the MMEs, it will not become reality. I do understand you are not promising it in the Plan, but people do want it and need it and are led to believe it may become reality.

I think it would be useful to call for professional development programs, and incentives to expand the numbers of professionals available to provide acceptable (5A) care.

Example: From 1982 to 1990 I served in the Michigan Dental Association (MDA) Trustees' Committee on Hospital and Institutional Dentistry. I worked with MDA members to encourage Dental Schools to prepare students to serve persons who are elderly and those with various disability characteristics. I also instituted a Dental Referral Service at my [then] agency Michigan Protection and Advocacy Service (MPAS). We identified dentists who would serve persons with developmental disabilities and linked them to persons needing dental services. The DD Dental Service, as it was known, was highly successful. It ended in 1990 with the *passage of ADA as the new law required all professionals to be accessible to and accommodating of all persons with disability.*

Today the Americans with Disabilities Act requires all professionals to provide accessible, non-discriminatory services to persons with disabilities, those who are regarded as having a disability, and those associated with persons with disabilities. Still, discrimination occurs and ADA complaints are time consuming and not always thoroughly investigated. MMEs who are discriminated against rarely have the time or money to pursue a complaint and so go unserved.

I would like enhanced services to become a reality. It would go a long way toward creating a more healthy population. I also know it will take much more than a reference in this proposal to make them so.

Concerning the discussion of the **bidding process for ICOs and maintenance of 18 PIHPs** (Plan pages 18, 19) and payment arrangements for nursing homes, there are two things I want to say:

1. Look at the <u>nursing home bias in Medicare/Medicaid</u> and refer to my earlier comment about the <u>State missing an opportunity to transition more people to community care.</u>

2. <u>Please do not create any more additional layers of bureaucracy.</u> This is a terrific opportunity to streamline Michigan's service delivery system, which for twenty years has grown layer upon layer of administration with unconscionable overhead costs.

I served on Governor Engler's team that vetted the PIHP applications. As I recall, we reviewed 35,000 pages of plans and budgets. 18 PIHPs were created. in some counties (e.g. Oakland) the Community Mental Health Authority became the PIHP. In other areas (in order to reach 20,000 Medicaid-covered lives) several Community Mental Health Boards were combined and a PIHP developed. Rather than replace the CMHAs in the combo, the PIHP became a super-structure. So in the end, we had everything we had before in terms of bureaucracy and new super structures that used even more resources. Worse, the salaries of the people running these PIHPs, Boards, and Authorities were not controlled by civil service and became obscenely exorbitant, at least to my mind. These PIHPs then contracted with 94 "Core Service Providers" who, in turn, contracted with other service providers and so on. By the time the appropriated dollar reached the beneficiary/MME, it was about 3 cents.

Michigan had, in fact, recreated the Regional Offices of the Department of Mental Health that had been dissolved in the 1980s as redundant and too costly. Only now, the middlemen were in the quasi-governmental, quasi-private sector.

I can attest to both the cost and the duplicative nature of the Regional Offices as I worked in the Metropolitan Regional Office as Director of Community Placement for Wayne County. Each day I received dozens of contracts for residential services, that the community placement *teams at the State facilities had developed. I reviewed them and sent them on to Lansing where the exact same review took place again. It was ridiculous. Each day I processed all the contracts I received; even working through the night, because I knew for every minute of delay a person was having to stay longer in an institution. The job nearly killed me both in the time expended and in the feeling that I was, in fact, a block in the path to freedom for so many* men, women and children.

The new PIHP arrangement and the knowledge I had of the costs weighed heavily on me. When Governor Granholm was elected in 2002, I met with her transition team and proposed she create a 19-person contract development, monitoring, and compliance system in State Government. This team (members could be located around the State to be close to Core Providers) would contract with the 94 Core Providers and the PIHP/CMHA structures (the high cost "middlemen") could be eliminated. Those that were direct service (e.g. core) providers would stay. The net savings at the time of my proposal, after the cost of creating the Unit in State Government, was 100 million dollars.

Later, as a member of Governor Granholm's Mental Health Commission, I again proposed streamlining the DCH administrative overhead, exposing the high costs (salaries) to the public and closing the gap between the source of funds (federal and state) and the delivery of service to the beneficiaries. I was told that I had identified the "elephant in the living room" Big as it was, few on the Commission wanted to see it, let alone remove it.

I tell this story now. Because, not only is the elephant alive and well and growing fatter by the day; this proposal, which keeps the elephant and adds ICOs, expands the herd.

I cannot see how adding to the bureaucracy is cost effective nor how it can enhance services to the beneficiary, the MME, when even more of the funds for care will be used for administrative purposes en route.

We are going to add systems (e.g. enrollment brokers, ICOs), call for more care coordination, require MMEs and their advocates to coordinate coordinators, etc. I know you propose that one will be the lead care coordinator, but there is nothing in the proposal confirming the lead care coordinator's authority to obtain services from the other system. Which means it will remain the responsibility of the MME or his/her personal representative to coordinate the care.

During the meetings of the Service Array and Provider Network Work Group, I mentioned to many that for every layer of bureaucracy designed and implemented, two existing layers be removed. I realize that is not easily done. Legislation is involved and more. The high cost folks who would be negatively affected by the change hold the power. The MMEs by definition have little money or political clout.

This is an opportunity for re-design of the system. It is an opportunity to look at 220,000 citizens of Michigan and ask, What do you need to live a healthy, productive life? How can we

help you access the care you need to prevent disease and promote wellness. The closer we can bring the resources to the people who need them, the better. And, the more likely the goal of this integration proposal will be realized.

If you have questions or need more information, I will be pleased to respond.

Sincerely,

Elizabeth W. Bauer

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