Final Report of Stakeholder Work Group Input and Recommendations

Integrating Care for People Eligible for Both Medicare and Medicaid

February 2012

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Work Group Process Overview

INTRODUCTION

In early 2011, the MDCH received a contract from the Centers for Medicare and Medicaid Services (CMS) to develop a plan to integrate the financing and delivery of services and supports for people who are eligible for both Medicare and Medicaid (that is, they are "dually eligible"). A critical piece of the planning process has been the engagement of diverse stakeholders to provide input on various aspects of the model. From July through October, more than 30 stakeholder interviews were conducted to provide the MDCH with initial input regarding critical issues for consideration from key constituencies; six public forums were held throughout the state to provide an opportunity to learn about and offer input into the state's plans; and a Request for Input (RFI) was issued to gather additional ideas and information.

The final phase of the formal stakeholder engagement process involved the convening of four stakeholder work groups to provide more in-depth input into the state's plan. The four work groups were:

- Care Coordination and Assessment
- Education, Outreach, and Enrollee Protections
- Performance Measurement and Quality Management
- Service Array and Provider Network

A broad array of stakeholders was invited to consider specific questions and issues regarding the design of a model for integrating care in Michigan. The work groups were advisory in nature; the process was designed to give the state a sense of where consensus exists and opinions diverge on key issues, not to arrive at final decisions regarding the implementation of an integrated care model.

WORK GROUP MEMBER RECRUITMENT AND SELECTION

In early October, an e-mail was sent to a list of more than 1,000 stakeholders, organizations, and associations, inviting them to indicate their interest in participating in the work group process. Potential work group members used an online form to provide their contact information, identify which sector they represent, indicate their top three work group choices, and provide a brief statement of their experience and knowledge. Nearly 500 people in all used the online form to indicate interest in work group participation.

In late October, a diverse set of people and organizations whose experience and knowledge aligned with that needed for the work groups was identified. To ensure that discussions were meaningful and manageable, work groups were limited to 35 members each. Broad stakeholder membership in each work group was ensured. The individuals selected for the work groups represented the following stakeholders:

- Behavioral health and developmental disabilities
- Consumer advocates
- People who are dually eligible
- Health care professionals
- Health plans
- Hospital/health systems
- Long-term care
- Non-hospital safety net providers
- Public health

Rosters for each work group can be found in Appendix A.

The work groups came together for a plenary session in early November before meeting separately three times each over the course of the next five weeks. At the plenary meeting, work group members (1) had an opportunity to hear about the federal perspective on integration from a CMS representative, (2) were provided a more detailed description of the MDCH's proposed approach to integrating care, and (3) learned more about the work group process.

WORK GROUP CHARTERS AND TASKS

Prior to work group member recruitment and selection, charters were developed for each work group to lay out meeting schedules, expected outcomes, tasks and deadlines, work group member responsibilities, and the role of the facilitator. The charters were included with the initial invitation to indicate interest in work group participation so that potential members could identify where their interests and experience matched the topics for each of the work groups. The primary tasks for each work group are described below. Charters for each work group can be found in Appendix B.

Care Coordination and Assessment

The Care Coordination and Assessment Work Group was asked to discuss and recommend a process for assessing needs and preferences of enrollees, and to assist the MDCH in defining guidelines for care coordination and information sharing among providers. In the course of its work, the group developed general recommendations for an assessment process, the role and qualifications of care coordinators, and the sharing of information among contracted entities and providers.

Education, Outreach, and Enrollee Protections

Over its three meetings, the Education, Outreach, and Enrollee Protections Work Group was tasked with providing suggestions for reaching and providing education to enrollees and providers regarding the integrated care model. The group was also asked to develop recommendations for an easy-to-navigate, responsive, and appropriate grievance and appeals process. The work group made several recommendations regarding what information should be shared with enrollees and how the information should be shared, how an integrated appeals process might work, and additional enrollee protections the state should consider as it develops the integrated care model.

Performance Measurement and Quality Management

The Performance Measurement and Quality Management Work Group was asked to develop recommendations for measuring the success of the integrated care delivery model and to recommend strategies to encourage the delivery of high-quality, person-centered care. The group reviewed examples of measures and reporting requirements and recommended measures for use in the integrated care model. The work group also identified potential strategies for promoting high-quality care.

Service Array and Provider Network

The Service Array and Provider Network Work Group was tasked with recommending services and supports that should be available to enrollees in an integrated plan. The group was also asked to develop recommendations to assist the MDCH in defining standards for the composition of a comprehensive provider network that would meet the needs of these individuals in an integrated care plan. During the course of this group's meetings, the members developed and voted on recommendations regarding the services that should be available to enrollees, the inclusion of current providers in the networks of contracted entities, and way in which the state should implement its plan.

Common Themes across Work Groups

While each work group was intended to focus on a specific topic related to the design of a model for integrating care for people who are dually eligible in Michigan, a few common themes were threaded throughout the discussions. Within each group's deliberations, the need for ongoing stakeholder input and/or oversight was identified. Members of each group also suggested that the state pilot or phase in its model (the Service Array and Provider Network Work Group made a direct recommendation to this effect). And each group placed a strong emphasis on ensuring that the person receiving services is at the center of planning and implementation.

ONGOING STAKEHOLDER INPUT AND OVERSIGHT

While the state has made a solid effort to obtain stakeholder input into the development of a model to integrate the delivery and financing of care and services for people who are eligible for both Medicare and Medicaid, members in every work group suggested that the process for obtaining input should not end with the state's development of a plan. Work group members recommended that the state seek additional input before its plan is submitted to the CMS; members also suggested that the state contemplate and implement ongoing input and oversight roles for stakeholders.

A suggestion made by a member of the Education, Outreach, and Enrollee Protection Work Group which was well-received by other members is for the state to reconvene members of all of the work groups for a plenary session once the plan is drafted. The purpose of the meeting would be for the state to lay out its plan, highlighting those work group recommendations that are incorporated into the plan and explaining which recommendations were not incorporated and why they were not. This Work Group also emphasized the importance of including enrollees in the governance bodies of the contracted entities.

The Performance Measurement and Quality Management Work Group put forth an explicit recommendation that the state convene an ongoing advisory group to consider measures, assess effectiveness of measures, add or modify measures to address emerging problems, and eliminate measures that do not provide useful information. It suggested that the advisory group should include people with expertise in behavioral health, substance use disorders, services for the frail elderly, and developmental disabilities.

During its second meeting, the Service Array and Provider Network Work Group stated its desire for the state to convene an ongoing, broadly representative advisory group of stakeholders to assist the MDCH in implementing the plan and modifying its operations when appropriate. During its final meeting, this desire was made explicit as part of a vote taken on a recommendation that the state phase in its plan and evaluate early efforts. The recommendation included the need for ongoing stakeholder advisory capacity.

The Care Coordination and Assessment Work Group did not spend much time discussing ongoing input. When offered an opportunity during its last meeting to share any additional thoughts or recommendations, however, a few members suggested that consumer involvement will continue to be important in the design and implementation of the model.

PILOT OR PHASE-IN AND EVALUATE

Throughout the stakeholder input process, many of those providing comments suggested that the state pilot or phase-in the new model. Two out of the four work groups also discussed the need to implement gradually and ensure that the model is evaluated. This recommendation was made directly by the Service Array and Provider Network Work Group. The work group did not ultimately say whether the state should pilot the model versus phasing it in, but it emphasized the need for an opportunity to pause to evaluate the results of the model before it is implemented statewide. The recommendation, which was supported nearly unanimously, is as follows:

Establish a process that allows for implementing the model in limited geographic areas (e.g., pilot or phase-in) and reviewing the results with an independent evaluation. Consider testing different versions of a capitated model. Allow for ongoing stakeholder advisory capacity.

During its final meeting, members of the Care Coordination and Assessment Work Group made similar suggestions, saying the new system should be piloted regionally to work out any problems. They suggested identifying and starting with willing partners in a few regions of the state to determine what works and eventually spread the concept statewide.

PERSON-CENTEREDNESS

A recurring theme throughout the entire stakeholder engagement process has been the express desire for enrollee needs to be at the center of planning and implementation of the integrated model. This idea came through implicitly in all work group discussions and, in many cases, explicitly.

When discussing enrollee protections and the grievance and appeals process, the Education, Outreach, and Enrollee Protections Work Group was passionately focused on ensuring that the ultimate model was implemented in such a way that enrollees would have a full understanding of their options; have access to a completely non-threatening, user-friendly process for registering and resolving complaints; and be protected to every extent possible from potential unintended negative consequences of integrating Medicare and Medicaid.

The need for a person-centered model of care is exemplified in the Education, Outreach, and Enrollee Protections Work Group's identification of four components necessary for shifting providers toward a person-centered approach to providing services to enrollees:

1. Provider training and education on person-centered care, self-determination, and recovery
2. Enforceable enrollee rights
3. Fidelity to the person-centered approach
4. Provider incentives and sanctions to ensure compliance

Further discussion of these four components can be found on page 11 *and* in Appendix C2.

As the Care Coordination and Assessment Work Group discussed the assessment process, the role of care coordinators, and information sharing, members repeatedly reminded each other of the need to ensure that the person receiving services is at the center of any process. When reviewing definitions of care coordination and related terms, the work group embraced those that emphasized meeting the needs and preferences of the individual and supporting people in making decisions. A key component of the work group's discussion around assessments was the conclusion that every enrollee should have a person-centered plan, however brief, that is developed in partnership with the enrollee and that is based on the enrollee's preferences. The work group agreed that the care coordinator should have as a core responsibility helping and supporting a person in making decisions, and knowledge of and experience with person-centeredness was identified as a necessary skill for care coordinators. Finally, when discussing information sharing to support care coordination, the work group included the person-centered plan as an essential element to include in a person's record. It also emphasized that enrollees should have access to and be able to amend any record that describes the care and services they have received, and should have control over who has access to those records.

As the Performance Measurement and Quality Management Work Group deliberated on quality domains and measures, members were sure to include measures of enrollee satisfaction, emphasizing the importance of ensuring that the model is working for those it is intended to serve. When discussing the domain of "Functional Status," work group members emphasized the importance of considering a recipient's view of quality of care and quality of life and suggested that performance measures should allow for enrollees to define their view of an optimal outcome. Within the review of measures, a great deal of discussion was focused upon measures related to person-centered planning and identifying member satisfaction with the planning process and outcome of the plan. The vast majority of work group members voted in favor of including a measure of plan adherence to a person-centered plan in the first year of implementation of the integrated care model.

The Service Array and Provider Network Work Group emphasized the need to ensure that services offered are those needed and wanted by enrollees. The group suggested that the state clearly define the list of services to be covered to ensure that the benefits are clear to the people who will access the services. When identifying criteria on which to prioritize the addition of benefits to the array of services, the group suggested that one criterion be that the service promotes self-directed care. Several members of the work group identified the need for a health advocate or supports coordinator to be assigned to every enrollee to advocate for that person and help ensure person-centered care.

When discussing the composition of a comprehensive provider network, the Service Array and Provider Network Work Group identified experience with person-centered planning and self-determination as core competencies needed by providers. The group also recommended that the MDCH require or arrange for enrollee satisfaction surveys on provider and contracted entity performance. One of the firm recommendations made by the work group is that current qualified providers be included in the networks developed by contracted entities to ensure continuity of care and existing care plans.

Work Group Input and Recommendations

The following summary of key themes, ideas, and recommendations made in each of the four work groups is presented for consideration by the MDCH as it develops a plan for an integrated system of care for people who are dually eligible for Medicaid and Medicare. Some, but not all, of the work groups took votes when they wanted to directly endorse a recommendation or gauge the level of support for an idea or proposal under discussion. These specific recommendations and voting results are described along with the rationale and prominent minority perspectives. In some groups, and for some discussions in each group, however, votes were not taken, but there appeared to be general consensus around certain concepts. These ideas are also described in this section.

This summary is not an exhaustive account of the deliberations or all of the opinions and ideas conveyed during the discussions. Readers are strongly encouraged to review the detailed meeting summaries for a more comprehensive illustration of the deliberations and to gain a fuller appreciation of the variety of views expressed. Summaries of all work group meetings can be found in Appendices C1 through C4.

CARE COORDINATION AND ASSESSMENT

The Care Coordination and Assessment Work Group did not take any votes and did not make *explicit* recommendations, but there was general agreement among members on a few key ideas, including what an assessment process should entail, the role and qualifications of care coordinators, and what types of information should be shared among contracted entities and providers.

Screening and Assessment

During its first meeting, the work group made the following general recommendation regarding assessment and the development of person-centered plans:

The work group recommends that every enrollee have a person-centered plan, however brief. They agree that not every enrollee will need to undergo a comprehensive assessment or be involved in a lengthy person-centered planning process to arrive at that plan. The plan should be person-centered in that it is developed in partnership with the member and that it is based on the member's preferences.

The work group recommends that a brief screen or assessment be used with all enrollees to identify their needs and preferences, and that a more comprehensive assessment be used as necessary. Work group members suggest that the MDCH explore the National Institutes of Health (NIH) PROMIS project questions for use as a brief assessment, and the Wisconsin Family Care Partnership Program as a model for a more comprehensive assessment. The home base for a comprehensive assessment will likely be a person's primary care provider or health home, but some components or elements may be performed by other providers with whom the individual interacts.

Key points made in support of this recommendation are as follows:

- It is important to ask all beneficiaries what they want out of life.
- Thirty-six percent of dual eligible individuals have 0 or 1 chronic conditions and don't need person-centered planning to the same degree as those who may have multiple chronic conditions. There is a continuum of person-centered planning, and individuals with more than one condition may need a higher degree of supports and services.
- There is a need to distinguish between an initial assessment, or screening, and a more comprehensive assessment.

- For screening we should consider a quadrant system: high-low utilization and medical-behavioral needs. The degree of specificity for assessments could vary depending on the quadrant. We shouldn't be thinking about one assessment.
- The NIH just spent $100M on the PROMIS project to develop items for every domain. They have developed 30 questions for a broad and brief assessment to sort out who needs a more comprehensive assessment.
- Wisconsin's comprehensive assessment covers the waterfront. It seems like this would be a good process to use after an initial screen.

Additional considerations were also offered by work group members during this discussion:

- The assessment alone should not drive the development of a person-centered plan.
- Information from an assessment can be useful, but the *person* is the most useful in planning.
- The assessment needs to be face-to-face versus telephonic, and should not be used to reduce choices for people if they hit a certain threshold of diagnosis. Assessments should be bare-bones while *conversations* and *relationships* inform the details of care plans.
- Because the dually eligible population is extremely diverse and their circumstances vary widely, people conducting the assessments need latitude. The MDCH should be reasonably definitive about what an assessment is, but offer flexibility as to who does it and when.

Care Coordinators

During its second meeting the Care Coordination and Assessment Work Group focused primarily on the role and qualifications for care coordinators; the state identified care coordinators as a core element in its initial description of the model.

Work group members arrived at the following general description of the function and role of a care coordinator:

The care coordinator should facilitate assessment, identify a team of care providers as prescribed by the care plan, follow up to ensure that services are delivered, and hold team members accountable for their responsibilities. The care coordinator should be responsible for convening a team that is most appropriate on an as-needed basis.

Work group members recommend that the coordinator have the ability to make some decisions about medications, services, and evaluations without further authorization to ensure the right care at the right time and place.

While the care coordinator will unavoidably have some allegiance to a contracted entity and a provider, his or her primary goal should be to ensure that the needs of the enrollee are being met. The care coordinator should act as an advocate. While a conclusive approach was not agreed upon, work group members identified the need to allow for varying levels of care coordinator involvement in a person's care and services.

Key points made in support of the above recommendations are as follows:

- There ultimately needs to be one quarterback to execute the game plan.
- A care coordinator facilitates the process where the team performs assessment, planning, implementation, and evaluation. The team decides who does what and when, while the care coordinator holds them accountable.

- If the team of providers has authority to authorize care or treatment, then the care coordinator can carry out those directives. There may even be potential for delegating authority to the care coordinator.
- Brokering and advocacy should be part of the care coordinator definition. At the very least, care coordinators should see themselves as an advocate for the person they are serving.
- If a person's circumstances change, the system of care coordination needs to offer flexibility. A person may need one set of people involved in their care at one point and another set at another point, or sometimes they may not really need anyone involved.

The work group identified the following characteristics and skills as necessary for successful care coordinators:

- Awareness and understanding of available community services and resources
- Knowledge of and experience with person-centeredness
- Motivational interviewing and enhancement skills
- Comfort with advocacy and brokering
- Understanding of family dynamics
- Sympathy and empathy
- Cultural competence
- Creativity and innovativeness
- Competent in administrative skills
- Ability to assess risk and prioritize needs

Additional considerations related to care coordinators identified by work group members include the following:

- Care coordination should be as close to a provider as possible.
- Care coordination has to be about supporting a person in making decisions and supporting the decision-making process.
- If you can link care management, which happens at the level of the managing entity, with care coordination, which should be more hands-on, you can get a frictionless system.
- Alignment of incentives is important for shared savings, and positive outcomes. Coordinators need to be responsible for the outcomes of the person, not the outcomes for the organization.

Data Sharing

At its final meeting, the Care Coordination and Assessment Work Group discussed its ideas regarding what information should be shared, and identified critical elements of information sharing that should be considered as the integrated care system evolves.

Although consensus was not reached on the items that might be included in a centralized enrollee record, work group members agreed that several items should be shared among providers, including, but not limited to, a person-centered plan, the results of any assessments, a medication profile, test and lab results, claims and encounter data, and diagnoses. Some work group members emphasized that such a record can be useful in identifying and eliminating gaps in care. Information about missed appointments, adherence to prescribed medications, and hospital or emergency care admissions will be critical, they noted.

Work group members agreed that it will be essential to address the issue of privacy when developing any sort of centralized record. Ideally, they said, enrollees will have the ability to decide who can have access to what information. Enrollees themselves should also have access to their record and the ability to update or correct information as needed.

As for electronic data sharing, work group members grappled with the fact that although it is ideal, it is unrealistic to believe that all care providers will be capable of using electronic data systems as this new model is implemented. They suggested that initially, the state should require only the sharing of critical elements such as the person-centered plan, hospital/ER visits, test results, and a medication profile. These should be shared electronically, if possible, but not necessarily.

EDUCATION, OUTREACH, AND ENROLLEE PROTECTIONS

The Education, Outreach, and Enrollee Protections Work Group was charged with developing recommendations for reaching and providing education to enrollees and providers to encourage participation in the integrated care delivery model, and developing recommendations for the development of an easy-to-navigate, responsive, and appropriate grievance and appeals process. The work group also discussed enrollee protections more broadly, including the planned passive enrollment with the option to opt-out, maintenance of existing rights for enrollees, and assurance of a person-centered planning process and self-determination.

Education and Outreach

The work group discussed the education needs of both enrollees and providers. For enrollees, members emphasized the need for clear communication about the details of the model and available options. For providers, work group members said that it is important to ensure they have proper understanding of the complex needs of people with disabilities and incentives to meet those needs.

Beneficiary Education and Outreach

Work group members said that the state needs to provide clear, concise, and consistent information. The state's message needs to be very clear on why it is changing to an integrated system of care, how the new system will meet the needs of the enrollee (e.g., services and providers available to the enrollee), and any cost implications for the individual.

Work group members stressed the importance of having ample time to educate current beneficiaries before the system is implemented so that individuals can decide if they are going to stay in the system or opt-out.

The majority of work group members supported the idea of providing one-on-one consultation to people who are dually eligible to help them understand the impact of any changes and how the integrated system will meet their individual needs. The work group made the following recommendation:

The Education, Outreach, and Enrollee Protections work group recommends that enrollees be provided with consultation to inform them about the new integrated system of care and any impact the changes will have on them. This consultation should be one-on-one, face-to-face, and available for all enrollees; take place prior to implementation; and be provided by an independent entity.

Twenty-four work group members fully supported the recommendation and eight supported the recommendation with some reservations. The reservations voiced by work group members were focused on whether people who are eligible for both Medicare and Medicaid should have a choice about participation in a consultation, and whether it must be provided face-to-face. A few members suggested that providers and health plans should be allowed to provide the consultations, and another suggested that consultations could be provided in a group setting in some cases.

Work group members suggested the following strategies for conducting the outreach campaign:

- Engage communication experts to develop messages and materials that are culturally appropriate and address different literacy levels for each population within the dually eligible population. Make sure the message speaks to each of these populations.
- Examine how federal agencies, other states, and different organizations have effectively communicated with each of these populations and build on this work.
- Develop messages to be delivered through various methods including, but not limited to, listening and communication devices, large print, and Braille.
- Utilize existing entities and peer-to-peer support organizations to conduct outreach and education activities with beneficiaries who are dually eligible.
- Fund an independent entity to provide consultation to people who are dually eligible and their caregivers and/or families.
- Provide adequate training for education and outreach providers so they are well-versed in the details of the integrated system of care.

In order to discern the features of the model that should be promoted, work group members were asked to think about the questions they would ask as an enrollee, an advocate, or a guardian to help them decide whether to participate in integrated system of care or opt-out. They said they would want to know:

> *When can the beneficiary make the decision to opt-out? Immediately? Is there a waiting period? Can a beneficiary reverse his or her decision to opt-out?*
>
> *How do benefits and services compare? If I stayed in my current plan, tell me what my current benefits and services are and what I would have in the integrated system.*
>
> *Can I continue the relationships that I already have with the different doctors that I see now?*
>
> *What does it means to me in terms of personal autonomy? How do I get services in the community, and what does it mean in terms of choice and dignity?*
>
> *How timely will services be? For example, will it take longer or less time to see a specialist?*
>
> *How far will I have to go geographically to access services?*
>
> *We already know that the integrated system will include person-centered planning, but what does it mean to have a person-centered plan and how it is done?*
>
> *What additional requirements does the plan have in place that I need to be aware of as a beneficiary? For example, what does the person-centered health home mean? What is it? What impact does it have on me?*
>
> *What is the new payment system going to look like? What is incentivized and dis-incentivized?*
>
> *Will the appeals process remain the same as in Medicaid currently or will it be different?*

Work group members said the state needs to consider the various communication needs for each population within the population of people who are dually eligible (e.g., the elderly have different needs than people with developmental disabilities). The following ideas were suggested:

- Create an actual, comprehensive communication plan.

- Messages and materials need to be released using multiple forms of media including television, radio, website, hard-copy packets, etc.
- Messages and materials need to be culturally appropriate.
- There needs to be ample time for education saturation prior to implementation.
- Everyone needs to be educated about the integrated system, including beneficiaries, families, guardians, caretakers, local government and support agencies, state legislators, local officials, and all Medicaid and Medicare beneficiaries. The message needs to be clear that the new system does not apply to people who have only Medicaid or only Medicare.
- Beneficiaries need a source to call to ask questions and get answers immediately from a knowledgeable person.

Work group members suggested the state partner with community health centers, community mental health centers, disability area networks, peer support specialists, pharmacists, professional medical associations (e.g., Michigan State Medical Society, Michigan Osteopathic Association), support coordinators, and non-traditional partners (e.g., pastors, ministers, beauty shops, and barber shops) to get the word out to beneficiaries and their families about the integrated system of care.

Provider Education and Outreach

Work group members emphasized the need for expanding the medical community's knowledge and implementation of person-centered care and emphasized that this will require a shift in providers' attitudes from a medical approach to an approach that recognizes an individual's unique, complex needs and capacity for self-determination and recovery. Work group members identified the following four components as critical in order to create a change in provider attitudes:

1. **Provider training and education on person-centered care, self-determination, and recovery**

   All health professionals (e.g., physicians, nurses, frontline staff in nursing homes) who provide care to enrollees should be trained in the person-centered approach to care, which recognizes the individual's right to self-determination and emphasizes recovery. This training should also cover the role of consumer advocates and peer support specialists in person-centered care.

   In the short term, according to work group members, providers should be trained through a variety of mechanisms such as e-learning modules, training sessions through a professional association, or educational sessions in providers' offices with health plan provider relations staff. It was also suggested that training be mandatory and that professional licensing boards consider developing continuing education requirements (e.g., CMEs, CEUs) for training in the person-centered approach to care. In the long term, work group members stressed the need to change how health care providers are formally educated so that new graduates are thoroughly trained in person-centered care.

2. **Enforceable enrollee rights**

   A provider manual should be developed that establishes standards of care that are person-centered and recognize the individual's right to self-determination and recovery. Work group members would also like to see a manual for enrollees which details their consumer rights and the services that are available to them so that those rights can be enforced.

3. **Documentation of fidelity to the person-centered approach**

   Providers should become certified in person-centered care to demonstrate their commitment to the approach and to the enrollees. It was also suggested that providers be monitored to assure that person-centered care is being implemented appropriately.

4. **Provider incentives and sanctions to ensure compliance**

   There is a need to develop provider incentives and financial sanctions to ensure compliance. The mechanisms to ensure provider compliance should include allowing individual enrollees to make decisions about how their care dollars are spent.

The work group made the following recommendation in support of the concepts outlined above:

The Education, Outreach, and Enrollee Protections Work Group recommends that the person-centered care model for the integrated system be supported by four distinct, but related components: provider training and education; enforceable enrollee rights; documentation of fidelity to the person-centered approach; and provider incentives and sanctions to ensure compliance.

Twenty-nine work group members supported the four components described above. Five work group members expressed some reservations, including the concern that if regulations are too restrictive they could conflict with individual choice or create demands on providers that interfere with their ability to spend time with patients. One member said that the person-centered approach would not be effectively implemented unless enrollees are allowed to bring their own allies or a consumer advocate into the process. Another member suggested that provider training should be expanded to include administrators.

Grievance and Appeals

Work group members were asked to describe the features that work well in the current grievance and appeals process that should be maintained, and the features that don't work and need to be changed. Group members suggested simplifying the process, including mediation or dispute resolution as a first step, making sure information about whether a service is covered is provided up-front, providing immediate opportunity for appeal if recipients are told services are not covered, and allowing an option to use an internal appeal or go directly to an external appeal. Two elements that are essential to the process, according to work group members, are that (1) recipients continue to receive benefits while they are pursuing an appeal, and (2) there must be a way to enforce decisions made as a result of a grievance or appeal.

Two work group members collaborated between meetings to develop a written proposal for the work group to consider for an improved grievance and appeals process within the integrated system. This proposal, which was discussed during the work group's final meeting, can be found in Appendix C2 on page 82. The proposal recommends that the state develop an independent, single entity to handle all types of complaints and levels of appeal. The entity would provide access to collaborative dispute resolution as well as traditional appeals processes. The intent of the proposal is to simplify the process to make it easier for the enrollee to navigate, while preserving enrollee rights and offering an array of methods for resolving disputes.

Some of the key features of the proposal as discussed by the work group are as follows:

- One entity would be established for beneficiaries to contact in order to resolve issues, whether the issue is about a decision or action regarding covered service, a grievance about how services are delivered, and/or an alleged violation of rights. This entity would be a "one-stop shop" to deal with complaints across all systems, but not necessarily a new "super agency."
- Service appeals would follow Medicaid guidelines, except when Medicare timelines and decision deadlines are deemed more favorable to the enrollee. The National Senior Citizens Law Center states that Medicare timelines for filing are usually more generous and are therefore preferred, and Medicare decision deadlines for expedited processing of appeals and expedited review for prescription drugs are faster and therefore preferred to Medicaid deadlines.

- If dictated by federal or state requirements, the fair hearing process under this proposal could continue to use state administrative law judges as hearing officers.
- Hearing officers would be required to use independent, clinical consultation in determination of service appropriateness appeals.
- There would be no separate local appeal process since the independent entity would handle all complaints. However, the proposal includes mediation between the provider and enrollee as one option for resolving disputes.
- While not expressly mentioned in the proposal, a quality of care complaint process would be included to address the type of issues that are currently handled by the Medicare Quality Improvement Organization for Michigan (MPRO).
- Education and training for beneficiaries and the people who serve them regarding dispute resolution, as well as evaluation of the system, are important features of the proposal.

Eighteen work group members fully supported the proposal as discussed by the work group. Four work group members supported the proposal and the concept of a comprehensive, one-stop shop with some reservations, saying they were not clear how the new entity would function. They also expressed concerns about how large the new entity would be, the costs of implementing the proposal, and how it would be funded. Ten work group members did not support the proposal, expressing concerns about duplication of current processes, inefficiency, and cost. Some of these members also voiced concern about elimination of the initial, local level of appeal. One member noted that person-centered care implies dignity and respect for those receiving services and should entail a posture of communication between providers and enrollees. A few members said they are satisfied with the current grievance and appeal processes, and others suggested enhancing current systems rather than creating a new, independent system.

Enrollee Protections

The state's proposed plan for passive enrollment into the integrated system of care with the option to opt out received a great deal of discussion during meetings of the Education, Outreach, and Enrollee Protections Work Group. Some work group members said passive enrollment limited the beneficiary's' choice, and many had questions about available options for people who are dually eligible who choose to opt out.

At the first meeting of the work group, members requested a vote regarding the planned passive enrollment with the ability to opt out. Fourteen work group members voted that they have a high level of concern with the opt-out approach; 13 work group members voted that they have some concerns but are withholding judgment until they see how the integrated system and opt-out enrollment are implemented; and 6 are comfortable with the approach and believe the state and stakeholders can make it work. Work group recommendations for beneficiary education and outreach were shaped in part by members' concerns that enrollees have clear, complete information about the new system and its impact on them as an individual so that they can effectively exercise the opt-out provision.

During the final meeting of the work group, members discussed enrollee protections more broadly, including not only the planned passive enrollment, but also maintenance of existing rights for enrollees and assurance of a person-centered planning process and self-determination. One work group member drafted and distributed a list of enrollee protections for consideration by work group members, noting that although the list is written specific to individuals with developmental disabilities, all of the protections could be relevant to other dually eligible populations. The list is modeled after recommendations from the National Senior Citizens Law Center and can be found in Appendix C2 on page 84.

Work group members requested that a vote be held on the first item on the list: "Joining a plan should be an opt-in decision on the part of eligible individuals." Twenty-one members supported the statement; 5

supported the statement with some reservations; and 6 members opposed the statement. Following this vote, work group discussion focused on the remainder of the draft list. Specific questions and clarifications discussed by work group members are detailed in the meeting summary found in Appendix C2. A summary of the suggestions made during the discussion follows:

- Governing boards should be required to include 50 percent rather than one-third consumers as proposed in the draft list, and governing boards should comply with the Open Meetings Act and Freedom of Information Act.
- Maintenance of current rights of recipients should include all rights enumerated in any legislative rules and regulations, including the mental health code and administrative rules for substance abuse, long term care, and hospice.
- The recommendation to maintain the mental health code definition of medical necessity as the basis for authorizing services should be expanded to include the level of care determination for long-term care and substance abuse.
- The recommendation that self-determination arrangements result in meaningful control over the individual's budget will need to be clarified or revised for applicability to the various populations within the dually eligible population.
- Assuring enrollee choice of the person(s) to provide supports coordination should be revised to refer to "supports/care coordination or similar function," and beneficiaries should also be able to choose not to have a support/care coordinator.

Work group members noted that the time remaining to discuss each of the listed enrollee protections was inadequate. A vote was taken to determine the level of support for the list of enrollee protections as a whole. Thirteen work group members said they support the whole list of protections, while 16 said they support the list with some reservations, and 4 did not support the list of enrollee protections. Some members expressed concerns following the vote saying that while they support the whole list in principle, the general or universal principles contained in the list might be lost in the specifics. One member suggested that there are a number of medical health principles that should be articulated, too. Another member suggested the list is too restrictive for individuals who live independently in the community, and enrollee protections must take into account everyone in the dually eligible population.

PERFORMANCE MEASUREMENT AND QUALITY MANAGEMENT

The Performance Measurement and Quality Management Work Group explored and assessed a number of emerging models for measuring the performance of integrated care for people who are dually eligible and identified a set of guiding principles and recommended domains and measures for assessing quality. The work group also identified current practices for incentivizing high-quality care and recommended several performance incentives.

Performance Measurement

Large-scale efforts to integrate Medicare and Medicaid services for people who are dully eligible are in fairly early stages of development. While some programs, such as the Program of All-Inclusive Care for the Elderly (PACE), have been in operation for many years, enrollment numbers have been low and they have been limited to specific populations, such as the frail elderly.

Concepts, structures, and methods to measure the effectiveness and quality of integration of Medicare and Medicaid services have been limited as well. Over the past five years, however, the interest in integrating Medicare and Medicaid services for people who are eligible for both has grown rapidly, and several major initiatives have been or are developing to identify and test performance and quality measures that assess the effectiveness of integrated care. To date, no single initiative has addressed performance of integrated funding.

Members of the work group assessed a number of emerging models, and found that while certain elements appear in each approach, they are separate and distinct, and no one model is clearly preferred over another. The models that were assessed make use of existing measures and simply apply them more broadly in the integrated approach. For example, a measure of timely access to behavioral health services is drawn from the community mental health system and applied by the contracted entity to the entire dually eligible population. It was noted that few new measures in the models are entirely new, although some, like those used by the National Committee for Quality Assurance (NCQA) to evaluate Special Needs Plans (SNPs), are not widely known beyond the SNP community.

In addition, it was recognized that there are no uniform definitions of domains across the current initiatives, and that the work group itself did not have time to develop concurrence on these important definitions.

Michigan's challenge will be to identify a panel of measures, current and new, to be used by contracted entities to measure the quality of care they deliver. The work group determined that Michigan would be best served by continuing to actively monitor emerging models and their use, and to select measures and features from any or all of them, in order to build a quality measurement system that best serves Michigan's unique approach to integrating care.

Implicit in this approach is continuous analysis of the quality performance measurement system.

Guiding Principles

There is no definitive set of measurements of the effectiveness of integrating Medicare and Medicaid. Michigan must select and implement a set of measures designed for its unique integration project. The work group identified a set of guiding principles that should guide the state as it develops and refines its performance measurement program. Some were drawn from the initiatives noted above, and others were explicitly identified by the work group.

Recommended Guiding Principles

1. New measures should be small in number, in recognition of the vast amount of reporting and quality measurement that is required by Medicare and Medicaid and in recognition of the significant administrative burden associated with performance measurement.
2. To the extent possible, new measures should be evidence-based.
3. New measures should be broadly applicable to the full population served.
4. New measures should provide new and useful information.
5. The dually eligible population is a combination of several distinct populations with unique needs. As such, any sub-group's experience could be "lost" in the aggregate. Important trends or problems could remain unidentified if measures are reported only in the aggregate and annually. To protect the vulnerable people served in the integrated model, the performance measurement system must also report data by geographic designation, by select population, and at intervals that serve as an "early warning system."
6. Measures should take full advantage of the new opportunity to capture all of a person's health care services and experiences, and therefore should focus on outcomes (rather than process) wherever possible.
7. Measures should honor person-centered planning as fundamental to this demonstration, and therefore recognize that a person's choices may deviate from an expected clinical practice.

Quality Domains

None of the models reviewed by the work group addressed the same domains of measurement, and the language used to describe domains was not consistent across the models. Members of the work group were frustrated by not having enough time to discuss and agree on definitions of the most common domains, especially “quality of life.” The work group strongly recommended that the MDCH’s first step in identifying quality and performance measures be to develop standardized definitions of domains across all populations.

The work group arranged the domains from several models across a matrix (see page 107), and identified those most important to Michigan’s project.

The work group identified 17 domains it recommends the state consider in its quality measurement program, as can be seen on the matrix on page 107. Of them, the following nine domains were deemed of high priority:

- Quality of Life
- Supports and Services/Care Coordination
- Behavioral/Mental Health
- Service Integration/Care Transitions
- Effectiveness of Care
- Access to Care
- Person-Centered/Self-Direction
- Individualized, Shared Care Plan
- Complaints, Appeals, and Disenrollment

Performance Measures

Although the work group recommended that the state draw measures of integration from emerging models, it strongly recommended the measures listed below for consideration. These would be applied across the entire population served by a contracted entity.

Recommended Measure	Domain	Source
Functional status as measured by Outcome and Assessment Information Set (OASIS)	Functional Status	Recommended by Center for Health Care Strategies (CHCS)
Percentage of members annually screened to identify impairments in physical and cognitive functioning	Functional Status	Recommended by CHCS
Ability to access behavioral health services quickly	Behavioral Health	MI PIHP measure
Follow up within 7 days of psychiatric hospital discharge	Behavioral Health and Care Transitions	MI PIHP measure
Member complaints and grievances	Complaints, Appeals, and Disenrollments	Dual SNP measure
Quality of preparation for post-hospital care from the patient’s perspective	Care Transitions	Recommended by CHCS
Acute care hospital readmissions, all causes	Care Transitions, Effectiveness of Care	Dual SNP Measure
Depression remission at 12 months	Effectiveness of Care	NEW
Percentage of members screened for substance use disorders in primary care at least annually	Effectiveness of Care	NEW
Managing care transitions	Care transitions	NCQA Dual SNP measures

Recommended Measure	**Domain**	**Source**
Supporting members through care transitions	Care transitions	NCQA Dual SNP measures
Reducing care transitions	Care transitions	NCQA Dual SNP measures
Percentage of members screened for pain in primary care at least annually	Quality of Life, Effectiveness of Care	Dual SNP measure
Percentage of members opting out of demonstration	Consumer Satisfaction and Experience	NEW
Percentage of members changing plans within 90 days	Consumer Satisfaction and Experience	NEW
Proportion of people reporting service coordinators help them get what they need	Care Coordination	Recommended by CHCS
Member satisfaction with care coordination	Care Coordination	NEW
Member served in least restrictive setting	Care Coordination	Composite

Population-Specific Dashboards

The Performance Measurement and Quality Management Work Group recommended that the state use dashboards that combine the measures above with others that are currently collected on sub-populations within the dually eligible population. These dashboards will illustrate emerging or ongoing situations by group, serving as the "early warning system" recommended above. A large majority of work group members support this concept. Several members expressed moderate reservations which would most likely be alleviated if dashboards were clearly developed, easily compiled, and meaningful.

Contracted entities would produce the dashboards, but would likely draw some of the indicators from contractors serving specific populations, which are required to frequently collect and report population-specific measures. Data elements selected for dashboards should be reliable, consistently reported across providers, and reported at least quarterly (and preferably monthly). Sample dashboard measures follow, which would be reported in combination with population-wide measures.

Sample dashboard measures for MIChoice Waiver participants:

- Level of care determinations where the level of care criteria was accurately applied
- Service plans reviewed and revised upon participant request or when needs change, but at least every 90 days.
- Participant received services identified in the service plan
- Participant record contains complete, signed freedom of choice form that specifies choice was offered between institutional care and waiver services

Sample dashboard measures for persons with developmental disabilities:

- Percentage of enrollees needing emergency medical treatment or hospitalization
- Percentage whose Individual Plan of Service (IPOS) includes services and supports that align with the individual's assessed needs
- Percentage whose IPOS changed when the needs of the individual changed
- Percentage who had face-to-face meeting within 14 days on non-emergent request for service
- Percentage whose services started within 14 days of assessment

Sample dashboard measures for persons with serious mental illness:

- Pre-admission screening for psychiatric inpatient care completed within 3 hours

- Face-to-face meeting within 14 days on non-emergent request for service
- Service started within 14 days of assessment

Quality Management

The integrated care initiative will combine services and supports from several existing programs that have various practices to incentivize high-quality care. These include:

- *Publicly available report cards*: These are used by Michigan Medicaid for the Medicaid Health Plans (MHPs) and by Medicare for Medicare Advantage Plans, including Medicare Special Needs Plans (SNPs) for dual eligibles.
- *Auto-assignment algorithms and special enrollment periods that reward plans with higher quality*: Michigan currently awards a higher proportion of auto-assignments to plans with high quality scores and Medicare allows special enrollment periods for people who wish to move to a five-star plan.
- Incentive payments (usually from a withhold pool): This strategy is used by Medicaid on a small-scale basis for the MHPs and under the Affordable Care Act (ACA) will apply to Medicare plans with four stars or more.

Recommended Performance Incentives

Work group members noted concerns with the accuracy of data for new measures, especially as new data systems are implemented. The following recommendations had unanimous or nearly unanimous support:

1. From the outset, there should be a report card on the performance of contracted entities based on existing measures of medical care.
2. Plan adherence to person-centered planning should be included in the first-year report card.
   - It should be noted that there was significant discussion about the need to adequately define meaningful person-centered planning, but that without it a high number of people who are dually eligible will opt out of the program.
3. There should be public reporting of the number (and proportion) of individuals who “opt out” of integrated plans for each contracted entity and also the number of individuals who choose to change plans.
4. Incentive measures used in the ICDE program in years two and three (and beyond) should be determined by an advisory board that includes broad stakeholder representation.
   - There was strong sentiment for an ongoing stakeholder role in determining not only the appropriate quality and performance measures as they evolve, but also the incentive strategies.

SERVICE ARRAY AND PROVIDER NETWORK

The Service Array and Provider Network Work Group voted on three recommendations that received unanimous or near-unanimous support from work group members. These votes were made in support of the current service array and provider network and to ensure that the plan ultimately implemented by the state is rolled out in such a way that it can be evaluated and adjustments can be made. The work group also used a voting process to identify the most important services and supports to add to those already covered for people who are eligible for both Medicare and Medicaid.

Service Array

During its first meeting, the Service Array and Provider Network Work Group reviewed a list of the services and supports that are currently available to people who receive services from both Medicare and Medicaid, including state plan and waiver services that are available to people who meet certain eligibility criteria. During the discussion, several members expressed concern that services and supports available through Medicare might duplicate those available through Medicaid, or that supports offered through one waiver might also be offered in another. They emphasized the need for the state to create a single benefit package that is not duplicative or confusing for enrollees. Group members also noted particular challenges that exist in the current service delivery system, including limits on home and community-based services, limited availability of transportation services, and lack of access to mental health services for people with less severe needs.

Maintain Existing Services

Early in the meeting, work group members voted unanimously to affirm that *all* of the currently covered services should continue to be covered in the integrated care model.

While problems exist with the current service array, the work group's vote reflects the concern expressed most often during the public forums and through the Request for Input (RFI)—that people who are eligible for both Medicare and Medicaid will lose services through the implementation of an integrated model.

Potential Additional Services

Following its vote to maintain the existing service array, the work group began to identify a set of additional services that should be made available to enrollees. The group was asked to consider both new types of services and an expansion of current services, such as those available to a limited population through the waivers. The group identified a lengthy list of services to add or expand, which can be found on page 118 in the meeting summary in Appendix C4. Group members also suggested a set of criteria for prioritizing these services. These criteria are:

- The services and supports should control or reduce costs, perhaps even be able to demonstrate a return on investment.
- The services should be evidence-based and improve outcomes.
- The service prevents the need for higher-acuity care such as inpatient or residential.
- The service promotes self-directed care.
- There is precedence for the need of the service among high-risk beneficiaries and populations.
- The service should be "scalable." That is, it should be able to be offered in any region of the state where enrollees could benefit from the service.
- The service supports access to other necessary services (e.g., transportation, room and board).

The work group did not vote on these criteria. This is a list that was compiled as individual members identified them. It is important to note, though, that no strong opposition to any of these was voiced. Work group members did discuss whether the criteria should be given equal weight, and agreed that they should not.

At its second meeting, members of the Service Array and Provider Network Work Group were allotted three sticky dots apiece (each dot representing one ballot) and were asked to vote for the three additional services or supports they considered most important for the dually eligible population. These are services that are either not available now that members indicated should be available, or services that are available to a narrowly defined population or as a limited benefit (e.g., dental benefits) and should be a more broadly defined benefit. Bearing in mind the prioritizing criteria, the 27 members present cast their votes. The six services that received the most votes are:

- Expanded dental coverage (16 votes)
- Health advocate (10)
- Transportation (10)

- Medication management (9)
- Personal consultation/counseling on nutrition, home injury control, chronic disease management, fitness, money management, etc. (7)
- Caregiver supports/respite (7)

Throughout the discussion leading up to the vote, work group members emphasized the importance of oral health care beyond extractions. They also discussed at length the need for an advocate who can help people navigate the system and follow through on their person-centered plan, similar to the care coordinator role discussed in the Care Coordination and Assessment Work Group. Transportation was recognized by work group members as critical to allowing access to all of the services people need, and they noted that transportation services are not available in many areas of the state. Medication management was also identified as a service that can help ensure that people are taking medications that are safe and efficacious. Work group members thought it would be important for enrollees to have access to consultation or counseling on issues that will support them in self-care and managing their own health. Finally, they recognized that caregivers face many challenges in their day-to-day care for people with severe disabilities, and they want to ensure that these caregivers are able to receive the support they need, including respite care.

Provider Network

After discussing and voting on the service array, the work group turned its attention to the composition of a comprehensive provider network for enrollees in an integrated care plan. This led to the identification by members of several core competencies that providers and contracted entities should be required to demonstrate, as well as suggestions for the MDCH as it develops an RFP and implements its plan. The work group also developed a recommendation to encourage the inclusion of current providers in newly developed networks.

Competencies and Requirements

The core competencies and requirements as suggested by members are as follows:

Provider competencies:

- Experience with person-centered planning, self-determination
- Use of evidence-based practices, and specific levels of quality outcomes
- Experience with common disabilities
- Cultural competence

Contracted entity competencies and responsibilities:

- Articulate a plan for coordinating care across all types of providers
- Demonstrated ability to exchange information electronically
- Provider payments should not be less than Medicare rates
- Articulate plans to incentivize care coordination and the achievement of desired plan outcomes; specify plans for the use of any financial savings
- Minimize administrative/paperwork hassles
- Minimize administrative layers that add cost and time to the care delivery process
- Entities should not have a vested interest in a particular provider
- Prohibit providers with a history of fraud
- Ensure enrollee choice of providers

- Ensure services are provided in a timely manner
- Require availability of providers within geographic areas, or managed care organization agreement to pay for out-of-network providers
- Credential only properly trained providers
- Educate consumers on covered benefits and how to access them
- Articulate and specify roles for enrollees in the design, evaluation, and implementation of the model
- A quality management plan

MDCH responsibilities:

- Centralize provider credentialing and claim filing
- Use the existing Michigan Quality Community Care Council (MQC3) registry for home-based providers; ensure enhanced roles for home-care workers, integrating them into the care team
- Standardize contracting between managed care organizations and providers
- Require or arrange for enrollee feedback, such as through independent satisfaction surveys or provider and contracted entity performance
- Develop a strategy for workforce development, particularly for direct-care workers and consumer advocates and care coordinators
- Include baseline data on outcomes in the RFP for contracted entities, and ensure strong oversight of plans
- Assess the impact of the new integrated plan upon the existing system to which beneficiaries may opt out

Maintain Existing Network

A key concern that has arisen throughout the stakeholder engagement process also came through in a discussion and vote in the Service Array and Provider Network Work Group—that of maintaining current beneficiary-provider relationships. Several work group members signaled their concern that the implementation of an integrated model, including new contracted entities, will disrupt long-standing positive relationships between enrollees and their current providers.

To guard against this, work group members felt it would be important to include current providers to every extent possible in the networks that are formed in the integrated care model. The group unanimously supported the following recommendation:

> *To respect continuity of care and existing care plans, the MDCH should start with a network that includes, but is not limited to, all qualified providers in existing programs who meet current care standards.*

Key points made in support of the recommendation include:

- Ensure that enrollees can continue existing relationships with providers.
- Restrictions on providers could cause great disruption for beneficiaries, particularly the developmentally disabled, in terms of the relationships they've developed.
- I'm concerned that some current providers will end up being "locked out" of networks by health plans.
- In mental health, provider choice is the law.

Pilot or Phase-in and Evaluate the Model(s)

At its final meeting, the Service Array and Provider Network Work Group discussed and made a recommendation not directly related to service array or provider networks. When offered the opportunity to provide any general suggestions for the state regarding the implementation of an integrated care model, the work group developed and came to agreement on the following recommendation:

> *Establish a process that allows for implementing the model in limited geographic areas (e.g., pilot or phase in) and reviewing the results with an independent evaluation. Consider testing different versions of a capitated model. Allow for ongoing stakeholder advisory capacity.*

Key points made in the discussion leading up to the recommendation include:

- The state should do a pilot program, figure out the bugs—what does and doesn’t work—before we upset the whole apple cart.
- There should be an independent evaluation of cost savings and the outcomes in terms of beneficiary health.
- A “pilot” tests something to see if it works and stops if it doesn’t. Phasing something in implies that you start small and expand, but with the full intention of moving forward.
- The critical aspect is stopping along the way to evaluate. Even if it is phased in, the state needs to stop and look at how it is working.
- It should be phased in by geography as opposed to segments of the population because you want to see if it works as an integrated model for all segments of the population at once. What we want to evaluate is whether an integrated dual eligible plan works for the entire population of dual eligibles.

Appendix A:

Work Group Rosters

Integrating Care for People Eligible for both Medicare and Medicaid

Care Coordination and Assessment Work Group Roster

Donald Beam MD
Blue Cross Blue Shield of Michigan

Mark Bomberg
Upper Peninsula Commission for Area Progress

Michael Brashears
Community Mental Health of Ottawa County

Bradley Casemore
Summit Pointe-Venture Behavioral Health

Michael F. Dabbs
Brain Injury Association of Michigan

Norman DeLisle
MI Disability Rights Coalition

Linda Dickinson RN, BSN, CCM
CareSource

Donna Elston
Spectrum Health Continuing Care

Susan Erspamer
Alzheimer's Association

Suzanne Filby-Clark
Area Agency on Aging of Western Michigan

Jill Greenhoe
Ciena Healthcare Management

Theo Omo
Thurston Woods Village

Laura Hall
Consumer Advocate

Marianne Harrington
Consumer Advocate

Carrie Harris-Muller
Detroit Medical Center

Julia Herzog MSW
National Kidney Foundation

Alison Hirschel
Michigan Elder Justice Initiative

Paul Ippel
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David Johnson
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Anne M. Lawrence
Washtenaw County Community Support and Treatment Services

Kathy McGeathy
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Carolyn Merucci-Anderson
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Thomas Muszynski
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Program of All-inclusive Care for the Elderly

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Tri-County Office on Aging

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Michael Roaleen
Recovery Academy

Peggy Rose
Consumer Advocate

Robert C. Schlueter
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Kristie Schmiege
Michigan Association of Substance Abuse Coordinating Agencies

Mary Anne Sesti
PHP Family Care

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Leslie E Sladek
Northern Lakes Community Mental Health

Pam Sorenson
Upper Peninsula Health Plan

Sandra L. Spoelstra
Michigan State University College of Nursing

Rich VandenHeuvel
West Michigan Community Mental Health System

Heather Visingardi
Common Ground

Michelle Wiseman
Sparrow Hospice Services

Integrating Care for People Eligible for both Medicare and Medicaid

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Darma J. Canter
Community Mental Health Muskegon

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Connie Connolly
Consumer Advocate

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Jackie Doig
Center for Civil Justice

Andrew Farmer
AARP Michigan

Cheryl Gallon
HealthPlus Partners, Inc.

Guy Gauthier
Priority Health Government Programs

David Gruber
Dispute Resolution Education Resources, Inc.

Melissa Holmquist
Upper Peninsula Health Plan

Dohn Hoyle
The ARC Michigan

Marianne Huff
Allegan County Community Mental Health Services

Kathleen Johnston-Calati
Michigan Disability Rights Coalition

Marlene Lawrence
SHARE Center (Drop-In-Center)

Michele Lundberg
Molina Healthcare of Michigan

Ron McGough
Consumer Advocate

Jo Murphy
Medicare and Medicaid Assistance Program (MMAP)

Chris Pinter
Bay-Arenac Behavioral Health

Diane Rapaport
Hospice at Home

Mark Reinstein
Mental Health Association in Michigan

Kelsey Schwartz
Advantage Management Group

Stephanie Shooks Winslow
Aging Services of Michigan

Kim E. Sibilsky
Michigan Primary Care Association

Karen Spring
Blue Cross Blue Shield of Michigan

Pamela Stants
Clinton-Eaton-Ingham Mental Health Authority

Mark Stevens
Ingham County Medical Care Facility

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Evelyn Thomas
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Janie Vermeulen
Consumer Advocate

Betty Vreeman
Consumer Advocate

Tom Watkins
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Edward Wollmann
Ann Arbor Center for Independent Living

Integrating Care for People Eligible for both Medicare and Medicaid

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Margaret Watson
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Sandra Withers
Area Agency on Aging Region 3B

Tim Wittstock
OmniCare Health Plan

Integrating Care for People Eligible for Both Medicare and Medicaid

Service Array and Provider Network Work Group Roster

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Mary Ablan
Area Agencies on Aging Association

Bob Allison
SEIU Healthcare Michigan

Pat Anderson
Health Care Association of Michigan

Roselyn Argyle
A&D Home Health Care Waiver Division Region 7

Craig Bass
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Elizabeth W. Bauer
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Rick Bossard
University of Michigan

Sherri Boyd
The Arc Michigan/Michigan Alliance for Families

Linda Burghardt
NAMI Michigan

Barry Cargill
Michigan Home Health Association

Rita Chambers Bird
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Rebecca Cienki
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Marilyn Litka-Klein
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David Livingston
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Bob Piccirelli
Consumer Advocate

Alison Pollard
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Michele Reid MD
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John Sczomak, PhD, LP
Neighborhood Service Organization

Robert Stein
Michigan Assisted Living Association

Mark Swan
Michigan Optometric Association

Keith Tarter MD
CareSource

John Thorhauer
United Methodist Retirement Communities, Inc.

Nancy Vannest
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Steve Velzen-Haner
HHS, Health Options® for Life

Phillip W. Weaver
Hope Network

Tammy Yeomans
Consumer Advocate

Karen Youngs Hartley
Lakeshore Coordinating Council

Appendix B:

Work Group Charters

Integrating Care for People Eligible for both Medicare and Medicaid

Care Coordination and Assessment Work Group Charter

Meeting Dates and Location

This charter lays out the tasks and expected outcomes for the Care Coordination and Assessment Work Group. Meeting dates and times for the work group are below. All meetings will be held at the Causeway Bay Lansing (6820 South Cedar Street, Lansing, MI 48911).

- Wednesday, November 9 from 1:00 to 3:30 PM
- Tuesday, November 15 from 8:30 AM to 12:00 PM
- Tuesday, November 29 from 8:30 AM to 12:00 PM
- Tuesday, December 13 from 8:30 AM to 12:00 PM

All work group members are expected to make every effort to attend each of the meetings.

Expected Work Group Outcomes

- Recommendations for promoting effective care coordination and information sharing among providers and plans.
- Recommendations for elements to include in an enrollee assessment.

Work Group Tasks and Deadlines

Task	Deadline
Review models of care coordination and stakeholder input regarding care coordination	Meeting 2
Develop recommendations to assist the MDCH in defining guidelines for care coordination and sharing of information among plans and providers	Meetings 2 and 3
Review MDCH proposed approach regarding beneficiary assessment	Meeting 3
Develop recommendations to assist the MDCH in developing an assessment that identifies the needs and desires of enrollees	Meetings 3 and 4

Work Group Member Roles and Responsibilities

Work group members should make every effort to attend all meetings and come prepared to discuss the issues at hand, having reviewed all materials sent in advance of the meetings by the facilitator. Work group members should also act in good faith to promote ideas that they believe will lead to the success of an integrated care delivery model.

Work Group Facilitator Roles and Responsibilities

- Provide background information to work group members ahead of meetings
- Ensure that all work group members are aware of and understand the group’s objectives and tasks
- Provide the work group members with a set of guiding questions for discussion
- Guide the flow of discussion to accomplish objectives in a timely manner
- Ensure balanced participation in discussions
- Monitor and control meeting pace
- Test for consensus
- Prepare a summary of each meeting and write up the work group’s proposed recommendations

Integrating Care for People Eligible for both Medicare and Medicaid

Education, Outreach, and Enrollee Protections Work Group Charter

Meeting Dates and Location

This charter lays out the tasks and expected outcomes for the Education, Outreach, and Enrollee Protections Work Group. Meeting dates and times for the work group are below. All meetings will be held at Causeway Bay Lansing (6820 South Cedar Street, Lansing, MI 48911).

- Wednesday, November 9 from 1:00 to 3:30 PM
- Tuesday, November 15 from 1:30 to 5:00 PM
- Tuesday, November 29 from 1:30 to 5:00 PM
- Tuesday, December 13 from 1:30 to 5:00 PM

All work group members are expected to attend each of the meetings.

Expected Work Group Outcomes

- Recommendations for reaching and providing education to people who are dually eligible and providers to encourage participation in the integrated care delivery model.
- Recommendations for the development of an easy-to-navigate, responsive, and appropriate grievance and appeals process.

Work Group Tasks and Deadlines

Task	Deadline
Review stakeholder input regarding education and outreach.	Meeting 2
Develop recommendations to assist the MDCH in developing education and outreach strategies to reach people who are dually eligible and providers.	Meetings 2 and 3
Review descriptions of current Medicaid and Medicare grievance and appeals processes and models for an integrated process.	Meeting 3
Develop recommendations to assist the MDCH in defining an appropriate grievance and appeals process for the integrated care delivery model.	Meetings 3 and 4

Work Group Member Roles and Responsibilities

Work group members should make every effort to attend all meetings and come prepared to discuss the issues at hand, having reviewed all materials sent in advance of the meetings by the facilitator. Work group members should also act in good faith to promote ideas that they believe will lead to the success of an integrated care delivery model.

Work Group Facilitator Roles and Responsibilities

- Provide background information to work group members ahead of meetings
- Ensure that all work group members are aware of and understand the group’s objectives and tasks
- Provide the work group members with a set of guiding questions for discussion
- Guide the flow of discussion to accomplish objectives in a timely manner
- Ensure balanced participation in discussions
- Monitor and control meeting pace
- Test for consensus
- Prepare a summary of each meeting and write up the work group’s proposed recommendations

Integrating Care for People Eligible for both Medicare and Medicaid

Performance Measurement and Quality Management Work Group Charter

Meeting Dates and Location

This charter lays out the tasks and expected outcomes for the Performance Measurement and Quality Management Work Group. Meeting dates and times for the work group are below. All meetings will be held at the Causeway Bay Lansing (6820 South Cedar Street, Lansing, MI 48911).

- Wednesday, November 9 from 1:00 to 3:30 PM
- Wednesday, November 16 from 8:30 AM to 12:00 PM
- Thursday, December 1 from 8:30 AM to 12:00 PM
- Thursday, December 15 from 8:30 AM to 12:00 PM

All work group members are expected to make every effort to attend each of the meetings.

Expected Work Group Outcomes

- Recommendations for measuring the success of the integrated care delivery model.
- Recommendations for strategies to encourage the delivery of high-quality, person-centered care.

Work Group Tasks and Deadlines

Task	Deadline
Review examples of measures and reporting requirements and stakeholder input regarding performance measurement.	Meeting 2
Develop recommendations to assist the MDCH in defining quality metrics for evaluating the success of the integrated care delivery model.	Meetings 2 and 3
Review quality management models and stakeholder input regarding quality management.	Meeting 3
Develop recommendations to assist the MDCH in developing and defining strategies that will promote the delivery of high-quality, person-centered care.	Meetings 3 and 4

Work Group Member Roles and Responsibilities

Work group members should make every effort to attend all meetings and come prepared to discuss the issues at hand, having reviewed all materials sent in advance of the meetings by the facilitator. Work group members should also act in good faith to promote ideas that they believe will lead to the success of an integrated care delivery model.

Work Group Facilitator Roles and Responsibilities

- Provide background information to work group members ahead of meetings
- Ensure that all work group members are aware of and understand the group’s objectives and tasks
- Provide the work group members with a set of guiding questions for discussion
- Guide the flow of discussion to accomplish objectives in a timely manner
- Ensure balanced participation in discussions
- Monitor and control meeting pace
- Test for consensus
- Prepare a summary of each meeting and write up the work group’s proposed recommendations

Integrating Care for People Eligible for both Medicare and Medicaid

Service Array and Provider Network Work Group Charter

Meeting Dates and Location

This charter lays out the tasks and expected outcomes for the Service Array and Provider Network Work Group. Meeting dates and times for the work group are below. All meetings will be held at the Causeway Bay Lansing (6820 South Cedar Street, Lansing, MI 48911).

- Wednesday, November 9 from 1:00 to 3:30 PM
- Wednesday, November 16 from 1:30 to 5:00 PM
- Thursday, December 1 from 1:30 to 5:00 PM
- Thursday, December 15 from 1:30 to 5:00 PM

All work group members are expected to make every effort to attend each of the meetings.

Expected Work Group Outcomes

- Recommendations for services and supports that should be available to enrollees in an integrated care plan.
- Recommendations for the composition of a provider network that is comprehensive enough to meet the needs of enrollees in an integrated care plan.

Work Group Tasks and Deadlines

Task	Deadline
Review materials describing services currently covered by Medicare and Medicaid and relevant waiver services; relevant stakeholder input; and data on service use and needs among current beneficiaries.	Meeting 2
Develop recommendations to assist the MDCH in defining the services and supports that should be covered in an integrated plan.	Meetings 2 and 3
Review materials regarding provider network	Meeting 3
Develop recommendations to assist the MDCH in defining standards for the composition of a comprehensive provider network for enrollees in an integrated care plan.	Meetings 3 and 4

Work Group Member Roles and Responsibilities

Work group members should make every effort to attend all meetings and come prepared to discuss the issues at hand, having reviewed all materials sent in advance of the meetings by the facilitator. Work group members should also act in good faith to promote ideas that they believe will lead to the success of an integrated care delivery model.

Work Group Facilitator Roles and Responsibilities

- Provide background information to work group members ahead of meetings
- Ensure that all work group members are aware of and understand the group's objectives and tasks
- Provide the work group members with a set of guiding questions for discussion
- Guide the flow of discussion to accomplish objectives in a timely manner
- Ensure balanced participation in discussions
- Monitor and control meeting pace
- Test for consensus
- Prepare a summary of each meeting and write up the work group's proposed recommendations

Appendix C1:

Care Coordination and Assessment Work Group Meeting Summaries

Integrating Care for People Eligible for Both Medicare and Medicaid

Care Coordination & Assessment Meeting Summary for November 15, 2011

Questions/Topics Discussed

At its first meeting, the following two questions were posed to the Care Coordination and Assessment Work Group:

1. What should an initial assessment of enrollees include?
2. How does this assessment process fit into a person-centered planning process?

Key Points of Discussion

The work group began its discussion by talking broadly about how an initial assessment process would work in the integrated care model. Members emphasized the need for a person-centered process. They discussed what would be the purpose of an initial assessment and whether the assessment should be a "tiered" process. They considered who, or what entity, would conduct the screening; and they talked about potential models for the development of an assessment process in Michigan.

Work Group Recommendation for Assessment

The discussion topics below support the following general recommendation made by the Care Coordination and Assessment Work Group:

The work group recommends that every enrollee have a person-centered plan of care, however brief. They agree that not every enrollee will need to undergo a comprehensive assessment or be involved in a lengthy person-centered planning process to arrive at that plan. The plan should be person-centered in that it is developed in partnership with the member and that it is based on the member's preferences.

The work group recommends that a brief screen or assessment be used with all enrollees to identify their needs and preferences, and that a more comprehensive assessment be used as necessary. Work group members suggest that the MDCH explore the National Institutes of Health (NIH) PROMIS project questions for use as a brief assessment, and the Wisconsin Family Care Partnership Program as a model for a more comprehensive assessment. The home base for a comprehensive assessment will likely be a person's primary provider of care or health home, but some components or elements may be performed by other providers with whom the individual interacts.

Person-centeredness as a Foundation

Throughout the discussion, many work group members emphasized the importance of person-centeredness in the assessment process. They said that every enrollee should have a person-centered plan of care. They agreed, though, that this does not mean that everyone will require an exhaustive person-centered planning process as is carried out currently for people who receive MI Choice waiver services or community mental health services. Members made the following points and observations during their discussion of person-centeredness and person-centered planning.

- The assessment itself should not drive the development of a person-centered plan.
- It is important to ask all enrollees what they want out of life.
- Inquiry about preferences up front is important.

- Thirty-six percent of dual eligible individuals have 0 or 1 chronic conditions and don't need person-centered planning to the same degree as those who may have multiple chronic conditions. There is a continuum of person-centered planning, and individuals with more than one condition may need a higher degree of supports and services.
- Information from an assessment can be useful, but the *person* is most useful in planning.
- The person-centered plan is basically a document, but it is important to remember that person-centered planning is primarily listening to what a person wants.

Screening vs. Assessment/Tiered Process

As the work group grappled with the question of what should be included in an assessment, it noted that the population of people who are dually eligible varies greatly—both in type and level of need—and that the assessment process will necessarily have to account for these differences. The discussion among work group members generally concluded that a brief assessment or screen may be appropriate before conducting a more comprehensive assessment, and that not every enrollee will require a comprehensive assessment. When the members considered what is done in other states as described in materials prepared for the meeting, many expressed a preference for what is done in Wisconsin because it is comprehensive and person-centered. They agreed, however, that such a comprehensive assessment may be unnecessary for many enrollees. The bullets below capture the comments of work group members.

- There is a need to distinguish between an initial assessment, or screening, before a more comprehensive assessment.
- A blanket assessment upon enrollment is not necessary.
- If I screen and you need a service I can help you with today, I'm going to provide that service. Then, I can refer you to who you need to see next based on screening. I agree that the health home is where the integration happens.
- A thin screening could be attached to a more in-depth assessment in a certain domain. A first provider can do the assessment in conjunction with the other expert providers. For example, behavioral health could link to LTC.
- Assessments could be tiered: the first could cover demographics (age, gender, where they live, if they have a power of attorney for health care); and the second tier could be related to whichever provider they first access care from.
- For screening we should consider a quadrant system: high-low utilization and medical-behavioral needs. The degree of specificity for assessments varies depending on the quadrant. We shouldn't be thinking about one assessment.
- The Wisconsin model is a good starting place since it blends different types of care for a psychosocial approach and promotes different disciplines acting as a team.
- The Wisconsin model highlights integrated assessments. There are many potential sites of assessment but multiple assessments with common coordination may be the best approach.
- The Wisconsin model has person-centered aspects in initial assessments, unlike the other two models.
- A managing entity will take responsibility to ensure that each dually eligible person has a health home and access. For those without that, a brief screening process will need to occur.

Designing the Screening and Assessment

When considering the screening and assessment process, work group members offered suggestions for developing the types of questions and elements that should be included in a brief screen/assessment and a more comprehensive assessment. Work group members discussed what an assessment would be used for, suggesting that it should identify, at least broadly, what types of services and supports an individual will need as well as the person's preferences related to services and supports. The latter, they said, is critical to ensuring that the assessment and, ultimately, the provision of services is person-centered.

One work group member noted that a set of questions developed by the National Institutes of Health (NIH) PROMIS project (www.nihpromis.org) might serve as a possible brief assessment. Others who were familiar with the NIH-developed questions supported recommending that the MDCH review them as a source of questions for a brief assessment that leads to a more comprehensive assessment as necessary. For the comprehensive assessment, work group members agreed that the MDCH should look closely at what is done in Wisconsin’s Family Care Partnership Program. There was limited discussion about the actual elements that ought to be included in an assessment, but a few suggestions were made for specific items that should be included, as well as what should *not* be included.

- It needs to be face-to-face versus telephonic, and should not be used to reduce choices for people if they hit a certain threshold of diagnosis. Assessments should be bare-bones while *conversations* and *relationships* inform the details of care plans.
- Because the dually eligible population is extremely diverse and their circumstances vary widely, people conducting the assessments need latitude. The MDCH should be reasonably definitive about what is assessment, but offer flexibility as to who does it and when.
- The NIH just spent $100M on the PROMIS project to develop items for every domain. They have developed 30 questions for a broad and brief assessment to sort out who needs a more comprehensive assessment. There has yet to be very good uptake.
- I support using something that is already started and is a government project.
- Screening should explore preferences from the very beginning. Wisconsin’s model includes things under “preferences” that should be done regardless.
- Wisconsin’s comprehensive assessment covers the waterfront. It seems like this would be a good process to use after an initial screen. Not everyone will need or want to have all of this included in their assessment.
- An assessment should include a medical/physical assessment to know where their risks are (such as family history, current and past medications).
- Telling someone about my personal finances is too personal and seems intrusive. How is it necessary—how will it help me determine my vocational direction? It’s uncomfortable to be on the other side of these assessments.
- It may make more sense to screen for mental health and substance abuse versus perform a full blown comprehensive assessment if you know that these are not the primary issues for which a person is obtaining services.
- Physicians should perform SAMSHA’s screening, brief intervention, and referral to treatment (S-BIRT) as a small percentage of dual eligibles are in substance abuse treatment.
- We need to more effectively screen for people with a brain injury and provide coverage for effective treatments since it can cause or accelerate disease.

Who Should Perform an Assessment?

There were varying opinions about who should perform screenings and assessments and in what setting. Many work group members suggested that an assessment should be performed by a team of providers with knowledge of physical, mental, and social needs. Some suggested that a case manager or care coordinator should be responsible for conducting the assessment. Overall, work group members agreed that assessments should also be performed in close proximity to where enrollees live and by people located in a similar geography. The general idea is that a brief assessment or screen could be conducted by almost any provider an individual comes into contact with, but a more comprehensive assessment would be more closely linked to the types of services and supports available through the individual’s health home.

- Care managers should be assigned to do the full assessment since they know the person best and have a relationship with beneficiaries.

- It's really best if the assessment is done by the person closest to the enrollee in a clinical setting.
- The assessment should be done by the provider where an enrollee is looking to first receive services.
- Not all providers will be skilled in thinking about person-centeredness.
- There are not enough people trained in both physical and mental health. Providers should only be conducting assessments related to the services that they provide.
- Assessment should *not* be done by an individual provider. An assessment should arise out of a system of supports that a person may need.
- People should have a choice of where they want their "home" to be. It is likely where they have the most needs that need to be met.
- Each health home might cater to different needs, so if a consumer comes to one provider they can have a brief assessment of all domains, but we need to ask them if they want to pursue further assessment or additional services.

Care Coordination

Toward the end of the meeting work group participants began to discuss how care coordination should work in an integrated model. There was consensus that the coordinating entity should be geographically close to the enrollee and aware of local medical and social services and resources. Related to assessments, work group members indicated that it would be very useful to be able to share the information obtained through what may be multiple assessments conducted by an assortment of providers. They recognize that there is significant overlap in the assessments currently carried out by providers and that people who are dually eligible who come into contact with more than one provider are likely answering similar (or the same) questions over and over. Work group members do not think people should have to undergo multiple similar assessments. Perhaps a unified process developed for the model will solve the issue, but some members assume that many of the currently required assessments will continue to exist. They suggested that information sharing, perhaps through a health information exchange, could bring together the common elements of the assessments.

- Care coordination is the single most valued aspect of system integration.
- Care coordination is about the relationship between the person and the system of services available.
- Care coordinators should be in the community and know what services and resources exist (e.g., transportation, vocational advice).
- Everyone does not need to know everything about the system but it would be nice if we knew how to get people over to other aspects of the system they might need.
- Care coordination is required for medical home designation because it is an ongoing, continuous process. We have about 700 primary care designees as PCMH and many of our doctors' offices are beginning to work with CMH organizations. The care coordinator will bridge the gap between the medical model and the social model and improve upon what we've been doing.
- It is unwise to have someone really far from services delivery doing the care coordination. The contracting entity or entities should be very close to the consumer and not so far away that there is paperwork or telephonic approvals.
- I think the sub-specialty medical home model is the way to integrate medical and social models.
- Electronic medical records and health information exchanges are critical tools in care coordination and could facilitate communication among various providers involved in a person's care.
- Assessments should not be repeated or required when moving from one provider to another.
- Technology should allow us to utilize the assessments we already perform.
- We don't know what other providers are doing, nor do we share information. We just meet our own regulatory requirements.

Public Comment

One observer offered comments and questions:

- Existing assessment tools should be able to be shared among all of those providing care for dually eligible individuals. CMS has no defined tool for Special Needs Plans.
- Will assessors need to be credentialed?

Next Steps

Work group members agreed that definitions of the various terms used in discussing care coordination should be clarified for future discussions. Otherwise, work group members may not be talking about the same thing even when they are using the same words. They also noted that without specific definitions, there is a risk of varied interpretation of work group recommendations. There was general agreement that the language and terminology used in the state's plan ought to be in alignment with what practitioners know and use (including nurses, social workers, and care coordinators) in order to avoid a backlash.

Prior to the next meeting, a list of commonly used terms and definitions will be shared with work group members for use and discussion at the next meeting, during which members will discuss how care should be coordinated, including the use of care coordinators and health homes.

The next meeting of the Care Coordination and Assessment Work Group will be Tuesday, November 29, 8:30AM – 12:00 PM at the Causeway Bay Hotel in Lansing.

Integrating Care for People Eligible for Both Medicare and Medicaid

Care Coordination & Assessment Meeting Summary for November 29, 2011

Questions/Topics Discussed

At its second meeting, the following questions were posed to the Care Coordination and Assessment Work Group:

1. How should primary responsibility for care coordination be determined? How should a person's health home be identified?
2. What should be the role of a care coordinator?

Key Concepts in Care Coordination

During the discussion, work group members identified several concepts of care coordination that they believe are critical for the state to consider as it develops an integrated care model. When reviewing the definitions of care coordination and related terms that were sent to them in advance of the meeting, several members identified phrases that resonated with their own ideas of what care coordination should exemplify. But the definitions also contained wording and phrases that concerned members who fear that the integrated model will favor the "medical model" of care. Beyond the definitions presented, work group members also described key underpinnings to person-centered care coordination.

- I like that the definitions emphasize meeting the needs and preferences of the individual.
- They also refer to using care coordination to achieve the optimum wellness of the individual and describe the deliberate inclusion of the patient.
- I agree with the emphasis the definitions have on communication and information sharing. That is critical to solid care coordination.
- It is only through legitimate exchange of information that we will be able to achieve even close to what we need.
- I see very little [in these definitions] about the things that we are most concerned about: self-actualization, inclusion in the community, and nurturing. I could see these definitions as written moving us toward a medical model.
- Care coordination has to be about supporting a person in making decisions and supporting the decision making process.
- Improving care coordination includes "behavior activation" of the individual—giving them more responsibility for their own health through motivational interviewing and the teach-back method.
- If you can link care management, which happens at the level of the managing entity, with care coordination, which should be more hands-on, you can get a frictionless system.

Many work group members also emphasized the fact that many challenges to effectively coordinate care exist in the current system, largely due to silos among different types of services. There is a need to build a system that comprises all of the currently separate systems of care (e.g., physical, mental, behavioral). Work group members also discussed the need to consider the realistic context in which care will be coordinated.

- We should build around what exists and base this model in reality.
- We should be aware of the silos that exist and know the context we're working in.

- We need to aim for a care management model that builds a team across all different systems.
- The Department of Human Services should not be ignored as it provides many critical services to the dually eligible population.
- The Program of All-Inclusive Care for the Elderly is a model that could be applied to a broader population.
- Aging and Disability Resource Centers are a growing trend and offer Options Counselors that fulfill a role similar to that of the concept of care coordinators.
- Prepaid Inpatient Health Plans already have many care coordinator attributes.
- Community Mental Health Service Programs offer people both case managers and supports coordinators.

Identifying Primary Responsibility for Care Coordination

Work group members were asked to consider how the provider or group of providers that will be involved in providing care and/or supports to an individual should be identified and how primary responsibility for coordinating care and supports should be determined. They suggested, generally, that the "team" of people who would provide care and supports would be largely determined, at least initially, by an up-front assessment and the development of a plan of care. They said that the entity that has primary responsibility for care coordination should be where a person's most immediate and predominant needs would be met. While the group did not go into great detail on the concept, this entity was often referred to as a person's "health home."

- Care plans will determine who will be on a person's team.
- The care plan itself will determine who will be on that person's team.
- Patient-centered care should require someone—whatever the title—to build a strong relationship with the person.
- Care coordination should be as close to a provider as possible.

One work group member noted that data shared at the first meeting of all work group members could be instructive in thinking about where care should be coordinated and how much coordination is needed. He suggested thinking of a quadrant system in which one quadrant represents low physical health and low behavioral health needs, another represents high physical health and behavioral health needs, and the other two represent a combination of low and high physical and behavioral health needs. He and others cautioned, though, that the data that currently exists may be misleading. For example, people who appear on paper to have high physical health needs and low behavioral health needs may not have had their behavioral health needs properly assessed.

- There is a behavioral health population that is spending a lot on the physical health side, but some folks with behavioral health needs can be addressed almost exclusively on the behavioral health side. Conversely, there are people who have no chronic conditions at all and are just healthy, old, and poor.
- We need to be careful because those statistics are reflective of the silos we operate in now. The trick is to create a care management type of system that builds a team comprising all of these different systems.
- There is little money being spent on behavioral health for people in nursing homes or in the MI Choice waiver, but is that because they don't need the care or because the assessment isn't there?

A model for care coordination that appeared to gain support from many in the group was described by one member who drew a diagram that showed a health home having several providers connected to it, while a care coordinator, who may be "housed" at the health home would work to coordinate care across the multiple providers connected to the health home. Some members suggested that a 2013 health home could be something other than a primary care practice. In this model, health homes integrate care at the “10,000-foot level,” while care coordination would occur “on the ground.”

The Care Coordinator

Work group members talked at length about the potential function or role of a care coordinator and the qualifications and set of skills such a person should have. The following is a detailed summary of the major themes that were discussed among the group.

Function and Role

Work group members described a care coordinator as being the person that facilitates assessment, identifies a team of care providers as prescribed by the care plan, follows up to ensure that services are delivered, and holds team members accountable for their responsibilities. They emphasized that care coordinators should be accessible to members – not just a voicemail-box or automated operator – and be the go-to facilitators of care and services. Many work group members suggested that care coordinators are in some ways analogous to quarterbacks, responsible for executing a plan and bringing a team together. Work group members also indicated that it may not make sense to automatically assign a team or pre-defined set of providers to work with an enrollee. They suggested that the care coordinator, who would be familiar with the person’s care plan and their immediate needs, should be responsible for convening the team that is most appropriate on an as-needed basis.

- A multi-dimensional assessment should lead to one person being held accountable for the delivery of those services.
- There ultimately needs to be one quarterback to execute the game-plan.
- There needs to be accountability after a care plan is established.
- A care coordinator facilitates the process where the team performs assessment, planning, implementation, and evaluation. The team decides who does what and when, while the care coordinator holds them accountable.
- The “go-to facilitator of care” is a critical concept.
- A care coordinator could determine if someone needs to be seen by seven people or if six of them are irrelevant.

To carry out this comprehensive function, work group members agreed that it would be useful for care coordinators to have the ability to make decisions about medications, services, and evaluations without further authorization to ensure the right care at the right time and place. While many members suggested that the care coordinator should have this authority, others suggested that authority could easily rest with the team of providers in which the coordinator operates. This, they say, would avoid the addition of a new layer of decision making and would still enable the coordinator to ensure that these decisions are carried out. Some work group members expressed concern about adding a layer of decision making beyond the single coordinator. They fear that a care coordination committee or team of providers may negatively affect cost, timeliness of services, and quality.

- The care coordinator should be involved in helping and supporting the person in making decisions. The care coordinator should have personal contact with the individual receiving services.
- The person closest to the individual needs authority and shouldn’t be a third-person separated from the patient, provider, and state.
- I think the care coordinator needs to have the ability to make decisions. If a person needs something at 7:00 PM on a Tuesday, it may be difficult to reach someone else for authorization.
- The team should have authority to get authorizations for medications, etc.

- If the team of providers has authority to authorize care or treatment, then the care coordinator can carry out those directives. There may even be potential for delegating authority to the care coordinator.
- I fear that a care coordination committee will interfere with people doing the hands-on work. Not every person should have a huge committee and the care coordinator should be hands-off. More layers make services more expensive but lower quality.

Many work group members signaled their belief that advocacy on behalf of enrollees should be at the center of the care coordinator role. Several suggested that care coordinators should be unaffiliated with payers or providers to enable them to be "pure" in their advocacy. Many conceded, however, that it is unlikely that coordinators would be unaffiliated and concluded that coordinators are likely to have some allegiance to payers, providers, and enrollees. If coordinators are likely to have any authority as described above, they will necessarily have some allegiance to payers and providers. Work group members agreed, though, that primary allegiance to enrollee needs would be ideal. For this to occur, many noted that it will be critical that incentives for good enrollee outcomes are aligned among payers and providers. Alignment of goals will also be important for supporting the care coordinator in convening care teams and advocating for follow-through. Care coordinators may be housed within one service area (e.g. community mental health, or primary care) but are likely to work across many providers, and therefore need aligned incentives to encourage cooperation and effective communication for frictionless coordination.

- Brokering and advocacy should be part of the care coordinator definition.
- At the very least, the care coordinator should see themselves as an advocate for the person they are serving.
- Services should not be vested in an organization's interests. The care coordinator should be objective and not affiliated with a certain care organization.
- The coordinators need authority, which may mean they are attached in some way with the payer, the provider, and the patient. They shouldn't be a completely "third person."
- Alignment of incentives is important for shared-savings and positive outcomes, etc. Coordinators are responsible for the outcomes for the person, not the outcomes for the organization.
- Being the quarterback of a team that doesn't necessarily want to play together is hard, so incentives must exist to support care coordination.

In discussing the role of care coordinator, work group members had several ideas about how to account for varying levels of care type and intensity among enrollees and over time. One idea is that a care coordinator may exist with overarching responsibility for *x* number of enrollees. They would assign case managers/supports coordinators as necessary for people with more in-depth needs. In this scenario, supports coordinators would have smaller caseloads than care coordinators. Another approach suggested by work group members is to have a single care coordinator role that is more heavily involved with some enrollees (those with more complex needs), and less with others (those with less complex needs). These approaches offer "thick" and "thin" versions of care coordination.

- The care coordinator could assign case managers to handle beneficiary care on-the-ground if needed and based on the different tiers of care intensity. The case manager would be part of the team convened by the care coordinator.
- I would separate a care coordinator from a supports coordinator: care coordination for people with severe needs would be subsumed in the supports coordinator role that is linked to a team.
- The care coordinator would have a larger caseload and, perhaps, supports coordinators would have smaller lists of people to work with. If someone doesn't have intense or complex needs, then the care coordinator may just call them every once in a while to check in to see if their needs are being met.

- Maybe a care coordinator is not the boss of a supports coordinator or case manager, but instead there is a thin and thick version of the care coordinator role.
- If a person's circumstances change, the system of care coordination needs to offer flexibility. A person may need one set of people involved in their care at one point and another set at another point, or sometimes they may not really need anyone involved.
- We should have natural times of interdisciplinary re-evaluation built into the model. Make an opportunity to restructure.

A brief discussion ensued about appropriate caseload size for care coordinators but was not conclusive. It was noted that the MI Choice waiver case managers are largely considered effective and have between 40–100 enrollees, though some think that quality of care begins to decline when caseloads reach 40.

It was also suggested that the "care coordinator" title might sound demeaning or condescending toward enrollees. The state may need to consider other terms for the person in this role such as supports coordinator, broker, case manager, or social worker.

Skills and Qualifications

Work group members listed numerous characteristics and skills that they believed would be necessary for a successful care coordinator:

- Awareness and understanding of available community services and resources
- Knowledge of and experience with person-centeredness
- Motivational interviewing and enhancement skills
- Comfort with advocacy and brokering
- Understanding of family dynamics
- Sympathetic
- Culturally competent
- Creative and innovative
- Administratively competent
- Risk assessment skills/able to prioritize greatest needs

Work group members acknowledged the tension that exists between valuing specialization and knowing about everything. They recognized that a care coordinator should not necessarily be an expert in all issue areas, but should be capable of working across the entire spectrum of care (physical to behavioral). There was some discussion as to whether or not a degree was even necessary for care or supports coordinators. One consideration work group members noted was the fact that workforce shortages may limit the number of qualified people, especially if the cost or time commitment for a degree is prohibitive. Some members felt that it was more effective to interview and hire people with the above skills and characteristics. One member noted that The Standards Group is currently identifying a set of competencies for supports coordinators. Finally, clinical supervision/mentorship may provide support for people in the care coordination or supports coordination roles since it is a position with many responsibilities, accountability, and high rates of employee burn-out.

- I feel the care coordinator should be a medical social worker. They would best be able to bridge the gap between medical and behavioral health issues.
- There will be workforce development issues. A degree does not qualify a person; it's a skill set.
- It's really a value set and an ability to assist with what the person wants.
- They need the ability to partner and engage people swiftly and strongly, facilitate planning and prioritization in partnership, and be creative to overcome other access barriers.

Public Comment

Two observers offered several comments at the end of the session:

- The group should keep in mind that this is a model that potentially everyone here will one day use. It will be important to evaluate the model created compared to baseline.
- There are four roles: an interdisciplinary team for assessment; a coordinator or executive assistant to the beneficiary that coordinates needs and brings the team together; an advocate; and a specialized case manager close to service providers.
- Incentives should help doctors in hospitals to talk to doctors in the community to reduce silos.
- There is a case manager certification that requires licensure or certification, as well as a code of professional conduct.

Next Steps

Throughout the discussion, work group members emphasized how important information sharing is to coordinating care and supports. Many work group members felt that that there needs to be more, perhaps incentivized, meetings among all providers involved in a person's care. Others noted that such meetings are time-consuming and unrealistic. Though real-time information sharing appears to be a simple solution, many work group members felt that it would be complex to implement.

- It is only through legitimate exchange of information that we will be able to achieve even close to what we need.
- Information sharing is critical. We all possess information but it is not shared.
- Real-time information sharing is so simple yet so complex, and would really change the way care is delivered so we know where care is happening.

At the next and final meeting, work group members will discuss information sharing in further detail. The next meeting of the Care Coordination and Assessment Work Group will be Tuesday, December 13, 8:30 AM–12:00 PM at the Causeway Bay Hotel in Lansing.

Integrating Care for People Eligible for Both Medicare and Medicaid

Care Coordination & Assessment Meeting Summary for December 13, 2011

Questions/Topics Discussed

At its third and final meeting, the following questions were posed to the Care Coordination and Assessment Work Group:

1. What information about a person's care and supports should be shared?
2. How should electronic data sharing among contracted entities and providers support care coordination?

Work group members began the discussion by reviewing the Senior Care Options Program Centralized Enrollee Record used in Massachusetts to discuss their ideas regarding what information should be shared in such a record. They also identified critical elements of information sharing that should be considered as the integrated care system evolves. From this discussion, some work group members raised ideas previously discussed related to screening, assessment, and care coordination.

Information to Share

In discussing what information should be shared in a centralized record, the following items were mentioned by work group members:

- The person-centered plan should be in the record.
- Results of the initial and any subsequent assessments.
- The record should include the person's needs and preferences. Somehow it needs to reflect what the beneficiary is asking for and why they are visiting a certain provider. It shouldn't just be an impersonal listing of data about the person.
- It needs to include contact and other information for providers the person sees, guardians, power of attorney, etc.
- You need a medication profile that includes both prescribed and over-the-counter medication.
- Test results are important to have access to.
- Access to claims data is important. They you know how often certain providers are seen, how often certain medications are prescribed, etc. You also know what tests have been performed. I see a lot of duplication in terms of repeated exams, MRIs, etc.
- Encounter data would be even more useful than claims data, because it is available sooner.
- Knowing when beneficiaries are admitted to the emergency department or hospital is important.
- Accommodations and regular needs, like interpreters or Braille, should be described or listed in the record.
- Any diagnoses should be recorded.
- Any history of substance use/abuse should be included.
- Caregivers need to know what supports are available to them, like respite care. The record should include whether or not these supports have been described to caregivers, and which ones.

- To maintain person-centeredness and beneficiary control over their personal information, there needs to be some indication in the record of who may or may not access beneficiary information.

Privacy

Work group members agreed that privacy is a critical yet difficult issue to address in developing a centralized record for people who are dually eligible. Although information sharing among providers can help ensure better quality care, it was mentioned that it must also fall within the guidelines of the Mental Health Code and HIPAA regulations, and respect enrollee rights. Ideally, information will be available to providers of all types of care, services, and supports, and enrollees will have the ability to decide who can have access to what information. Some work group members also wanted to ensure enrollees have access to their record and the ability to update or correct information as needed.

- The record should have who to share information with and who not to.
- Permission for access to any information should come from the individual.
- It should be documented when information is accessed.
- It should be HIPAA-compliant across the board.
- We've discussed the fact that substance abuse is under-assessed among this population. The state will need to decide if substance abuse records will be disclosed or if you opt-in.
- Health plans do not have substance abuse information. We really do need to ensure that the state grapples with HIPAA. It is a release of information issue.
- For direct service providers, there need to be protocols about what is shared. Irrelevant information should not be shared.
- We need to recognize the Mental Health Code, enrollee rights, and confidentiality.
- People need access to their own records (perhaps using a PIN number) and an easy way to update inaccurate information and their history.

Gaps and Duplications in Care

Within the conversation about what elements should be included in a centralized record, some work group members emphasized that the record can be useful in identifying and eliminating gaps in care. Information about missed appointments, adherence to prescribed medications, and hospital or emergency care admissions will be key. It was also discussed that it might be useful for certain events to trigger a notice to be sent to specific and relevant providers for an individual. For example, if a person is admitted to the emergency department or has an unanticipated hospitalization, the care coordinator or care team for that individual could be electronically or telephonically notified. Contracted entities, to the extent possible, should be aware of such activity in real time.

Electronic Data Sharing

Work group members were asked to think about how electronic data sharing can and should support care coordination in the integrated model. Several participants noted that some systems have developed their own internal electronic data networks, but lack the ability to speak to external networks. Thus, they noted that interoperability will be critical to ensure that information can be shared among providers. To help with this, it was suggested that electronic health records developed by contracted entities or providers be consistent with the Michigan Health Information Network (MiHIN), which aims to allow healthcare providers to access and exchange electronic information regardless of which electronic health record they use. Work group members also suggested that electronic health records used by contracted entities and providers meet meaningful use standards established by the federal government and be certified by the Certification Commission for Health Information Technology.

- This should fit within the MiHIN. Avoid duplication and duplicated data entry, and allow for opting-out. Typically, releases are opt-in but electronic information is the opposite.

- The more information providers have, the better care can be.
- CCHIT is fairly well-defined.
- It should be consistent with *meaningful use* criteria.
- Hospitals are all creating their own databases, but those networks need to speak to each other.
- Data sharing has to be a public utility and not just restricted to the dually eligible individuals. It's important to use the old system and update that to the point we can revamp things for everyone.
- Every provider network is creating electronic health records of their own. Electronic data sharing requirements among systems are needed.
- Widespread use of HL7 is 5–6 years out. Initially, be open and capable of sharing information and sending to other systems.
- Keep in mind the state is going to write the insurance exchange piece. We are not going to have a HIE or EHR that is dual-specific.
- Dual eligibles swing in and out of eligibility so the sharing system needs to be comprehensive.

Work group members grappled with the fact that although electronic information sharing is ideal, it is unrealistic to believe that all care providers across the state are capable of using electronic data systems nor will they have that capability within the year. Initial steps will be necessary to foster information sharing across providers, and over the course of several years, a more final product will evolve. They suggested that initially, the state should only require the sharing of critical elements such as the person-centered plan, hospital/ER visits, test results, and a medication profile. This should be shared electronically, if possible, but not necessarily.

- I'm concerned about asking for premier systems. Initially, we can't expect that.
- We need to be realistic about what we can do in year 1, 2, and 3.
- This is only going to work is if we continue to communicate freely across organizations/silos.
- Prioritize the information people need: the person-centered plan and crisis/ER information.
- Diagnoses and pharmaceutical information also need to be shared
- It's important to know test results as well.

Screening, Assessment, and Care Coordination

Some work group members acknowledged the fact that deciding how information sharing will work largely depends on how the assessment and care coordination will be modeled.

Screening and Assessment

At this meeting, work group members revisited the topic of screening and assessment, emphasizing the importance of this process for ensuring that all needs are identified and no one falls through the cracks.

- Multidisciplinary assessments ought to include alcohol and other drug use. These issues often go unindentified.
- How do you assess who are the 40,000 that don't need anything?
- Sometimes those who appear not to need anything really have needs that have not been identified in the past because they have had limited contact with providers of services and supports. We have a lot of people that are not in contact with anyone—no phones, no primary care visits.
- Consider those people that don't have the capacity to participate in the screening process and don't have advocates.
- If possible, assessments should be done in person and in the beneficiary's home. We know from experience that some people's living conditions are far from optimal, but that can be kept from providers unless a home visit is part of an assessment.
- There needs to be a way to identify those with very high or very low needs.

- I think there should be a few weighted questions with maybe numerical values.

One new concept that was discussed among the group was the idea of a pre-analysis of available data on the dually eligible population. Group members suggested that the state use Medicaid and Medicare data to stratify current dually-enrolled individuals based on the intensity and types of needs they experience to help contracted entities and providers identify those who should be reached out to for an assessment first.

- The list of dual eligibles should be pre-analyzed by the state in terms of history and intensity of service. If someone has multiple conditions, they go to the top of the list. If they are elderly, poor, and healthy, then maybe they go to the bottom of the list.
- I can't stress enough the wealth of information that is currently available and the need for analytics to help us understand what we have.
- The Medicaid health plans currently receive a lot of the data for those individuals that are assigned to them or choose their health plan. It's been very helpful to have that historical Medicaid data and we need the Medicare data moving forward.
- The more chronic and more complicated the care, the more uncoordinated the care gets. This will be expensive with large start-up costs, so the analytics will be important.

Care Coordination

At the last meeting work group members suggested that a care coordinator may operate somewhat like a "quarterback", pulling care team members together and holding them accountable to the care plan for individuals. They might, however, be more hands-on with some enrollees and work closely with those with complex needs and less intensely for those with fewer needs. Work group members reiterated key ideas regarding the care coordinator at today's meeting. They especially focused on the need to align incentives to ensure that the coordinator could maintain primary allegiance with the enrollee rather than with a particular provider or payer.

- The difficulty in using existing systems is the inherent bias that case managers have for their organization. There has to be a way to separate the case manager from their preferences and biases.
- A care coordinator *should* have to balance the beneficiary's needs and preferences with the availability of resources. The tensions are a good thing and should be woven into the model in a way that's good for consumers.
- The individual needs to know what's out there and know what financial strings are attached to certain services.
- A person should not be punished for asking, "Where might we find this service?" when they are trying to work outside the box in terms of helping a beneficiary.
- In the last several years, the concept of person-centered planning has encouraged a sense of advocacy. This needs to carry through into the integrated model.

Other Considerations

Toward the end of the session, work group members had the opportunity to share any final thoughts they had to offer as the state moves forward in its planning:

Assessment

- It's imperative that the start of coordination—the initial assessment—is flawless. We can't afford any mistakes and there should be more eyes on the first assessment if financially feasible.
- Caregiver needs assessments are needed too, especially for those whose loved ones have Alzheimer's or dementia.

- A registered nurse and social worker should perform the assessment.

Pilot or Phase-in the Model

- This new system should be piloted regionally to work out any problems. By using willing partners in smaller regions, the state can find out what works and eventually spread the concept statewide.
- It will be less risky to require integration after we know more about how to do it.
- The state should encourage collaborative documentation to help systems integrate more easily.
- Maybe phase in the implementation by population. First, target the frail elderly, but not everyone.
- I agree with stratifying most critical and complex beneficiaries, but it may be harder to differentiate than we think. Sometimes people look critical, and look complex, but looks can be deceiving.

Care Coordination

- The more complex the needs, the more care coordination needs to happen close to the person.
- The care coordinator *must* be close to the participant since community resources vary.

Keep What Is Working

- We don't want to see a reduction in services, only enhancement.
- Consumers are afraid of losing services, and losing relationships with those providing them care.
- The state ought to consider what's working well in Michigan. Services should be examined carefully before they are thrown out for something less expensive.
- Utilize complex case management practices that are already in place.
- Consumer involvement is still important moving forward.

Public Comment

Two individuals offered comments and suggestions at the end of the session:

- I've learned a lot through this process and this is a major undertaking. As a nursing home representative, eligibility issues are huge. Getting eligibility in the beginning and redetermination over time is critical, especially for those people whose families are not involved.
- We are very supportive of EHR. They are expensive and many providers are not that far along in this process. The state should look at what is already used, such as the MDS 3.0.
- A care coordinator needs a lot of information and public services are so complex. I suggest an on-line data warehouse be available to care managers. Creating such a tool could help the state realize what services already do or don't exist.

Next Steps

Public Sector Consultants will compile a report of all of the work group meeting summaries to give the state a comprehensive idea about what the work groups recommend for their integrated care system moving forward. This report will be sent to all work group members. The state will prepare a draft plan to submit to the Centers for Medicare and Medicaid Services by April 1st and allow at least 30 days for stakeholders to review the plan and offer input.

Appendix C2:

Education, Outreach, and Enrollee Protections Work Group Meeting Summaries

Integrating Care for People Eligible for Both Medicare and Medicaid

Education, Outreach, and Enrollee Protections Work Group Meeting Summary for November 15, 2011

Questions/Topics Discussed

At its first meeting, the Education, Outreach, and Enrollee Protections work group addressed the following questions:

1. What education and outreach will be necessary prior to implementation for providers, people who are dually eligible, and other stakeholders?
2. How can the MDCH, contracted entities, and providers encourage participation among people who are dually eligible?
   - What features and advantages of the model should be promoted to encourage ongoing participation of people who are dually eligible?
   - What outreach techniques, approaches, and messages would be most effective to communicate the advantages of enrollment to people who are dually eligible and their families?
   - What is the best way to reach this population? Who should the state partner with to get the word out about the model to people who are dually eligible and their families?

Thirty-three work group members participated in the meeting either in person or by telephone. This summary reflects the discussion that took place in the meeting, but it is not a transcription of the dialogue. Many, but not all, comments by work group members appear below.

Key Points of Discussion

In their opening comments, some work group members raised concerns about passive enrollment (opt out) proposed for the integrated system of care and the options that would be available to people who are dually eligible who choose to opt-out. Other members questioned how the work group could decide what and how to communicate information, such as information on enrollee protections, when the enrollee protections have not yet been determined.

The work group facilitator acknowledged that, while the decision to implement passive enrollment has been made, decisions regarding many other aspects of the integrated system of care have not been made. Other work groups are being asked for recommendations regarding the services and provider network, care coordination and assessment, and quality management and performance measurement. The Education, Outreach, and Enrollee Protections Work Group is being asked to develop recommendations without knowing the outcome of the other work groups, which makes the task more difficult. The facilitator suggested that the questions that work group members have about the integrated system of care may help identify information that is needed and should be communicated to people who are dually eligible and others, such as opt-out provisions and enrollee protections. With this in mind, work group members were asked to share their responses to the following discussion question:

Question 1: What education and outreach will be necessary prior to implementation for providers, people who are dually eligible, and other stakeholders?

Work group members said that the state needs to provide clear, concise, and consistent information. They said the message needs to be very clear on why the state is changing to an integrated system of care, how the new system will meet the needs of the enrollee (e.g., services and providers available to the enrollee), and any cost implications to the individual.

- People are hearing "how do we get the cost down" and they don't hear "we want to coordinate your services." The message needs to be clearer as to why the system is changing.
- I'm concentrating on the "why" question. Anytime there is a change you think about why? If individuals are disabled and getting good outcomes now, then telling them why you are making this change is going to be important.
- Why wouldn't you expect people to be fearful? The slides at last week's meeting were about saving money. Beneficiaries hear that carve out is being eliminated and that they are being put back into acute care. If beneficiaries don't know what the model is then it is pretty hard to convince people, especially if they are satisfied with what they have now.
- In the initial plan, the phrase "developmental disabilities" doesn't appear. My kids are severely disabled and it's expensive to take care of them. They have targets on their backs because they do cost more comparatively. Persons with disabilities have a full range of needs and we need to know that [this system] isn't going to make it worse.
- This framework looks like a medical model to me. This looks like "somebody is trying to fix me." Where is the recovery or wellness model? This does not sound like the beneficiary is in charge. Beneficiaries are not their medical file.
- Maybe start with laymen's language describing "how these changes affect me."
- How much of a cost increase is there going to be for me?
- People need to know that they will be able to continue receiving the services they already receive, and they need to know how they can enforce their rights.

Work group members stressed the importance of having ample time to educate people who are dually eligible before the system is implemented so that individuals can decide if they are going to stay in the system or opt-out.

- Communication is going to be the cornerstone to either make or break [the integrated system]. The education piece needs to be baked into the state's timeline for implementation. This is also very connected with the provider population. Everyone needs to understand the programs and be able to communicate what the programs are with their patients and constituents. The timeline is very important so that the education doesn't happen at the same time that everyone is enrolling.
- There must be adequate time for beneficiaries to understand what the integrated system is going to be and how it will cover their needs.

Several work group members supported the idea of providing one-on-one consultation to potential enrollees to help them understand how the integrated system will meet their individual needs.

Work group members suggested the following strategies for conducting the outreach campaign:

- Engage communication experts to develop messages and materials that are culturally appropriate and address different literacy levels for each population within the dually eligible population. Make sure the message speaks to each of the populations within the dually eligible population.
- Examine how federal agencies, other states, and different organizations have effectively communicated with each of these populations and build on this work.
- Develop messages to be delivered through various methods including, but not limited to, listening and communication devices, large print, and Braille.
- Utilize existing entities and peer-to-peer support organizations to conduct outreach and education activities with beneficiaries who are dually eligible.

- Fund an independent entity to provide consultation to dually eligible beneficiaries and their caregivers and/or families.
- Provide adequate training for education and outreach providers so that they are well-versed in the details of the integrated system of care.

Many work group members raised concerns and questions about the planned passive enrollment with the option to opt-out. Some thought this limited the beneficiary's choice and many had questions about what the options would be for people who are dually eligible who choose to opt out.

- I think it is critical that no one be automatically enrolled without a one-on-one meeting to assess the wisdom of this system for the individual and whether [the individual] should drop out.
- Choice is the hallmark of this system, up and down the service array. If choice is offered at the beginning it could create an alliance that we haven't had in the past.
- It seems like the state has made the decision that [enrollment] is opt-out. If we do our job to inform everybody then every single person will have an informed choice. We need to focus on that. The last I heard implementation begins January 2013, so that gives us eleven months.
- There should be some period of time for beneficiaries to learn what the options are before they have to make a choice.
- The state needs to alleviate fear. Opt-out to what? You can't make a good choice unless you know the options. We believe that we are striving to build a system to serve people. That is the assumption that is there, but there is a lot of cynicism that it is going to happen.
- The reality is that we need [enough] enrollment numbers to make this work. If we were going with [an opt-in approach], we would make sure the product was valuable enough for beneficiaries to understand. Since the decision has been made [to use an opt-out approach], then we need to figure out what works best. It is going to be problematic if the program is not good.

Work group members requested a chance to vote regarding the planned passive enrollment with the ability to opt-out. Work group members were asked to indicate their level of concern by holding up a red card if they have a high level of concern with the opt-out approach, a yellow card if they have some concerns but are waiting to see how the integrated system and opt-out enrollment are implemented, or green care if they are comfortable with the approach and believe we (the state and stakeholders) are going to make it work. Fourteen work group members voted that they have a high level of concern with the opt-out approach; 13 work group members have some concerns but are withholding judgment, and 6 believe it can be made to work.

Question 2: How can the MDCH, contracted entities, and providers encourage participation among people who are dually eligible?

Following a break, work group members were asked to expand upon their earlier discussion and think specifically about the following questions:

> *What features and advantages of the model should be promoted to encourage ongoing participation of people who are dually eligible?*
>
> *What outreach techniques, approaches, and messages would be most effective to communicate the advantages of enrollment to people who are dually eligible and their families?*
>
> *What is the best way to reach this population? Who should the state partner with to get the word out about the model to people who are dually eligible and their families?*

To get at the features of the model that should be promoted, work group members were asked to think about the questions they would ask as an enrollee, an advocate, or a guardian to help them decide whether to participate in an integrated system of care or opt-out. They said they would want to know:

- When can the beneficiary make the decision to opt-out? Immediately? Is there a waiting period? Can a beneficiary reverse their decision to opt-out?
- How do benefits and services compare? If I stayed in my current plan, tell me what my current benefits and services are and what I would have in the integrated system.
- Can I continue the relationships that I already have with the different doctors that I see now?
- What does it mean to me in terms of personal autonomy? How do I get services in the community, and what does it mean in terms of choice and dignity?
- We already know that the integrated system will include person-centered planning, but what does it mean to have a person-centered plan and how is it done?
- What is the new payment system going to look like? What is incentivized and dis-incentivized?
- How timely will services be? For example, will it take longer or less time to see a specialist?
- How far will I have to go geographically to access services?
- What additional requirements does the plan have in place that I need to be aware of as a beneficiary? For example, what does the person-centered health home mean? What is it? What impact does it have on me?
- Will the appeals process remain the same as in Medicaid currently or will it be different?

Work group members said the state needs to consider the various communication needs for each population within the dually eligible population (e.g., the elderly have different needs than people with developmental disabilities). The following ideas were suggested:

- Create an actual, comprehensive communication plan.
- Messages and materials need to be released using multiple forms of media including television, radio, website, hard-copy packets, etc.
- Messages and materials need to be culturally appropriate.
- There needs to be ample time for education saturation prior to implementation.
- Everyone needs to be educated about the integrated system, including beneficiaries, families, guardians, caretakers, local government and support agencies, state legislators, local officials, and all Medicaid and Medicare beneficiaries. Part of the message needs to be that the system does not apply to people who have only Medicaid or Medicare.
- Beneficiaries need a source to call to ask questions and get answers immediately from a knowledgeable person.

Work group members recommended the state partner with community health centers, community mental health centers, disability area networks, peer support specialists, pharmacists, professional medical associations (e.g., Michigan State Medical Society, Michigan Osteopathic Association), support coordinators, and non-traditional partners (e.g., pastors, ministers, beauty shops, and barber shops) to get the word out to people who are dually eligible and their families about the integrated system of care.

A couple of work group members suggested lessons could be learned from successful models for outreach and education.

- When we began Medicaid managed care enrollment and outreach, there were people out in the field at local community organizations, people familiar with the community and trained on what the program was, and they were able to enroll people while being face-to-face. It was an effective enrollment process.

- When the state contracted with my program to conduct outreach for Medicare Part D, they provided us with people's names, addresses, and phone numbers. We were able to send letters, hold neighborhood meetings, and call individuals. Knowing who the people were that we were trying to reach made a world of difference. Compare that to the low income subsidy program where we were given lists of ZIP Codes of where people with low income may live. That is not effective.

Public Comment

No comments were offered during the period set aside for public comment.

Next Steps

Documents for Next Meeting

Work group members were handed the following two issue briefs as background information for future work group meetings:

- *Ensuring Consumer Protection for Dual Eligibles in Integrated Models* by Kevin Prindiville and Georgia Burke, National Senior Citizens Law Center, July 2011.
- *Building an Integrated Appeals System for Dual Eligibles* by Georgia Burke and Kevin Prindiville, National Senior Citizens Law Center, October 2011.

Questions/Topics that Will Be Addressed During the Next Work Group Meeting

- What education and outreach will be necessary prior to implementation for providers, legislators, local officials, and other stakeholders?
- How can we assure that the grievance and appeals process is appropriate, easy-to-navigate, and responsive?

Next Meeting

The next meeting of the Education, Outreach, and Enrollee Protections Work Group will be Tuesday, November 29, 1:30PM – 5:00 PM at the Causeway Bay Hotel in Lansing.

Integrating Care for People Eligible for Both Medicare and Medicaid

Education, Outreach, and Enrollee Protections Work Group

Meeting Summary for November 29, 2011

Questions/Topics Discussed

At its second meeting, the Education, Outreach, and Enrollee Protections Work Group addressed the following questions:

1. What will be the best approach for providing education and outreach to providers and other stakeholders?
2. How can we ensure that the grievance and appeals process is appropriate, easy-to-navigate, and responsive?

Thirty-two work group members participated in the meeting either in person or by telephone. (Two members joined the meeting during the discussion, which brought the number of participants to 34 for the second vote.) This summary reflects the discussion that took place in the meeting, but is not a transcription of the dialogue. Many, but not all, comments by work group members appear below.

Key Points of Discussion

Consultation with Enrollees Prior to Implementation of the Integrated System

In their opening comments, some work group members suggested that the work group discussion on November 15 regarding one-on-one consultation with enrollees prior to implementation of the integrated system be formulated as a work group recommendation.

<u>Recommendation</u>

The Education, Outreach, and Enrollee Protections Work Group recommends that enrollees be provided with consultation to inform them about the new integrated system of care and any impact the changes will have on them. This consultation should be one-on-one, face-to-face, and available for all enrollees, take place prior to implementation, and be provided by an independent entity.

Twenty-four work group members fully supported the recommendation; eight supported the recommendation with some reservations. The comments shared by work group members who had reservations were as follows:

- My major concern is that the one-on-one consultation is mandatory. I would prefer that a beneficiary have the consultation as a benefit that he or she chooses to have, but not have the consultation be mandatory.
- I am not sure that the face-to-face consultation needs to be a one-on-one consultation. I am concerned with the vastness of that recommendation. Another option for a face-to-face consultation could be in a group setting instead of one-on-one.
- I agree. I think that beneficiaries should have a choice as to how they want the information presented to them. I think there should be a choice for the one-on-one consultation and a choice for the face-to-face consultation.
- I also think that the health plans should be allowed to conduct consultations. Currently, our health plan enrolls individuals who are dually eligible into Special Needs Plans (SNPs). The consultations are effective in helping beneficiaries make decisions. I also think providers have

staff people who could provide the consultation even though they may not be completely independent. (Two other work group members agreed with this comment.)

- I agree. I guess I assumed the consultation was a choice, that a person would not be forced to have a one-on-one consultation.

Question 1: What will be the best approach for providing education and outreach to providers and other stakeholders?

When asked to talk about the best approach for providing education and outreach to providers and other stakeholders, work group members emphasized the need for expanding the medical community's knowledge and implementation of person-centered care. Work group members stressed that this will require a shift in providers' attitudes from a medical approach to an approach that recognizes an individual's unique, complex needs and capacities for self-determination and recovery.

- There is not enough knowledge about person-centered care. Person-centered care has a whole lot to it, and there are a lot of providers who need training in the approach.
- There is a stigma towards people with mental illness that exists within the medical community. A physician may not take an individual's physical health issues seriously because he or she has a mental illness like schizophrenia or bi-polar disorder. Instead, the person is seen as his mental illness. Everybody in our mental health system is recovery focused. How do you train medical providers about this approach? I think it is more of an attitudinal change; it is a way of looking at people. How do we view people as people instead of looking at them like people who need to be fixed or repaired? I think that when you talk about education, we should talk about how we bring understanding between two systems with extremely opposite perspectives together.

Work group members also said that providers will need a better understanding of the role of consumer advocates and peer support specialists in an integrated system of care.

- Consumer advocates need to be available in every provider office when an expensive service is being denied or when a service that a consumer doesn't want is being promoted. A peer support specialist would help with communication between the provider and enrollee.
- The use of peer support specialists needs to be encouraged to educate providers and the enrollees.
- But we have to be careful about inserting consumer advocates into decision making. The decisions that people make are very individualized. Some people will not want to involve a consumer advocate. It needs to be a choice.

Work group members identified the following four components critical for a change in provider attitudes: provider training and education, establishment of enrollee rights, documentation of provider fidelity to the person-centered approach, and provider incentives and sanctions to ensure compliance.

1. Provider training and education on person-centered care, self-determination, and recovery

Work group members said all health professionals (e.g., physicians, nurses, frontline staff in nursing homes) who provide care to enrollees need to be trained in the person-centered approach to care, which recognizes the individual's right to self-determination and emphasizes recovery. This training should also cover the role of a consumer advocate or peer support specialist.

In the short term, work group members said providers should be trained through a variety of mechanisms such as e-learning modules, training sessions through a professional association, or educational sessions in providers' offices with health plan provider relations staff. Work group members also suggested that training be mandatory and that professional licensing boards consider develop continuing education requirements (e.g., CMEs, CEUs) for training in the person-centered approach to care. Work group members said:

- Providers need to demonstrate that they have a basic understanding of these approaches to care for individuals who are dually eligible. There needs to be some manner of mandatory training, possibly even continuing education units (CEUs).
- Frontline staff needs to be trained. Staff turnover, especially in long-term care, creates a challenge that needs to be addressed.
- Providers need to understand the role of the consumer advocate as a facilitator of communication between the provider and consumer, so that the consumer's decision is informed.
- One of the best approaches [to provider training] could be through electronic media.
- Community mental health uses e-learning modules that are required for every CMH employee.
- Electronic training can be used by all types of providers; it is there for them to do at their leisure.
- Licensure boards have some control of turning essential learning into annual CEUs.
- I would suggest short-term education, for example, mandatory continuing medical education (CMEs) credits or online learning. There are also other effective channels to train providers. For example, Medicaid has relationships with all provider groups, community health centers have provider liaisons, and professional associations host training events for providers.
- The health plans have a presence in provider offices. Health plans have staff that conduct face-to-face education sessions with providers on the medical side.

In addition to training providers now, work group members also stressed the need to change how health care providers are formally educated so that our new graduates are thoroughly trained in person-centered care.

- In the long term, we need to start educating our new doctors and nurses. Shame on us if we don't start insisting that education of medical providers should reflect what is best for the consumer.

2. Enforceable enrollee rights

Work group members suggested that there be a provider manual establishing standards of care that are person-centered and recognize the individual's right to self-determination and recovery. In addition, work group members said a manual for enrollees should be available so they know their consumer rights and the services that are available to them so that those rights can be enforced

- We need written standards for enrollees to know what services they are entitled to so they can enforce the provision of services and rights.
- There are also ways of incorporating informed decision-making into health plan agreements with providers, which allows the consumer to really know their options. If people are informed, they make much better choices.

3. Fidelity to the person-centered approach

Work group members also suggested that providers become certified in person-centered care to demonstrate their commitment to the approach and to the enrollees. It was also suggested that providers be monitored to assure that person-centered care is being implemented appropriately.

- There is a big emphasis on "best practices" in health care delivery. Models are put together with training and followed up with measures of fidelity. When a provider is actually practicing the concepts, then over time they could become certified after they have demonstrated their skills. If I was going to choose, I would want to choose providers who are certified in approaches to self-determination or person-centered care.

4. Provider incentives and sanctions to ensure compliance

Finally, work group members discussed the need to develop provider incentives and sanctions through financial mechanisms to ensure compliance. These mechanisms should include allowing individual enrollees to make decisions about how dollars are spent.

- The current system is driven by procedures, the more [providers] do, the more they make. In the disability community, there is going to be a drive to push toward more expensive procedures. Give the individual choices on how to use dollars. When consumers have the authority to manage how the dollars are spent, that is a really important way to educate the providers.
- A person-centered plan entitles consumers to an itemized record of their cost of services for a month and over a year. A consumer can decide to spend so many dollars on this or over here, or over there. This allows the consumer to take more control of his or her own life, instead of the doctor making decisions for them. The individual is making decisions for themselves.
- Reimbursement speaks loudly. Part of the model needs to be incentivized through reimbursement. Incentivize the person-centered care approach and look at PACE as a model.
- I agree that PACE is a good program. We need to think positively. I think we can bring together the best of community health, mental health, and the medical community.

Recommendation

The Education, Outreach, and Enrollee Protections Work Group recommends that the person-centered care model for the integrated system be supported by four distinct, but related components: provider training and education; enforceable enrollee rights; documentation of fidelity to the person-centered approach; and provider incentives and sanctions to ensure compliance.

Twenty-nine work group members supported the four components described above; while five work group members had some reservations. The work group members who shared their reservations said the following:

- I agree with all of [the components], but whenever I see “enforcement” it raises concerns for me. In long-term care we have regulations that are in conflict with person-centered care. For example, a resident would like to eat a hot dog but we have a regulatory environment that says it is not safe. This resident cannot eat a hot dog unless his/her physician says it is okay. Also, I would like the provider training part to be expanded to everyone, including administrators. I would love to understand mental health and developmental disabilities better.
- Our experience implementing person-centered planning within community mental health shows that until someone independent of the system is secured, it is difficult to control dollars. Person-centered is empty unless the consumer brings their own allies or supports to the table as opposed to a paid staff person. This is the only way we can protect consumers. Person-centered planning can be whatever someone imagines it to be and unfortunately it favors the provider and not the consumer.
- I agree with the comments about the importance of person-centered planning and the consumer advocate.
- My only comment is that we take caution when discussing specific requirements for providers. I know right now, working for a Medicaid health plan, providers do not want more rules to adhere to when they really want to be treating their patients.

Question 2: How can we ensure that the grievance and appeals process is appropriate, easy-to-navigate, and responsive?

Work group members were asked to describe what features work well in the current grievance and appeals processes that should be maintained, and what doesn’t work that needs to be changed. Work group members suggested simplifying the process; including mediation or dispute resolution as a first step; making sure information about whether a service is covered is provided up front; providing immediate opportunity for appeal if recipients are told services are not covered; and allowing an option to use an internal appeal or go directly to an external appeal. Work group members said it is essential that recipients continue to receive benefits while they are pursuing an appeal. Work group members also said there must be a way to enforce decisions made as a result of a grievance or appeal.

- We've never had one single grievance process. Some people can't even get their complaint heard. We're taught to follow the money, but it's a lot to figure out.
- There are also the federal mandated external rights. Unless the internal system has some authorization to force correction, [the appeal] goes back to the people against which the complaint is going to be filed. There may be other ways than a costly, elaborate system that circles around and has no enforcement power anyway.
- What would it be like if we were to make it any way we want? The best indicator for consumer outcomes is their relationship with their providers. If [that relationship] is based on respect for the consumer's knowledge and the consumer's rights, that's a great relationship and people could solve their own problems. But many times people follow all the processes, they are not satisfied, there is an uproar, and the problem is not solved. Start by getting all the people involved together to see if there is a reasonable solution that satisfies everybody. Consumers don't care about the process, they care about the problem. Are we designing a system that is for the providers, payers, and attorneys, or one that provides customer satisfaction and good personal outcomes?
- There is room for mediation. That has never been put in place like it should have been to allow for a solution. But I have to have immediate access to appeal when I'm told I can't have a service. I have to have something that I can go back to and say I am entitled to that service.
- I agree that there needs to be some internal system. But when it gets to the point of determining whether a service is necessary or available, that is triggered by affordability and that is where it falls apart.
- In the Medicaid system right now, beneficiaries have to be told up front by a provider whether a service is covered by Medicaid or not. This feature should stay because recipients do not know what is covered. However, in the managed care setting providers don't typically explain that a service is not provided because it is not covered by the plan. And if the consumer is not getting the service they want, they are not advised of their rights to an administrative appeal or a right to a second opinion. Responsibility for providers, plans, and the appeal process [administrators] to advise recipients of their rights could be better established and enforced.

  The levels of appeal in the current system work well, for example, using an internal grievance process or going directly to an administrative hearing. This works well in the current system, although I do think there needs to be a clearer timeline for a decision to be made. It is absolutely essential that recipients continue to receive benefits while they are pursuing an appeal.
- I think the rights are really important. The system for enforcing them is uneven. We could do a better job of coming up with a way to investigate and enforce them. The rights that are in Chapter 7 [of the mental health code] are key, but the mechanism for enforcing the rights in Chapter 7 is not adequate.
- It is important to acknowledge policies and procedures that are governed and monitored by the Department of Community Health and leverage those that are already in place.

Two work group members offered specific proposals for the work group to consider for an improved grievance and appeals process within the integrated system. One suggestion was to develop an independent, single entity to handle all types of complaints. The second suggestion was to create a dispute resolution process using mediation (similar to the Michigan Department of Education's Special Education dispute resolution process). These ideas are described briefly below.

Single entity for all grievances and appeals

- To simplify the process, I suggest one independent entity for those cases that a consumer is not able to work out with their provider. Every layer of our current grievance and appeal process is another step toward beating the consumer down. I am suggesting a one-stop shop for all grievances and appeals.

Dispute resolution with mediation

- I think it might be helpful to envision the single entity mentioned as providing a continuum of services to handle grievances and appeals. For example, my organization helps to mediate disputes with the Department of Education. We developed a continuum of training to allow people to resolve their own disputes using mediation techniques. I work outside of the medical and mental health systems, but I am familiar with collaborative work. It is important to strengthen relationships within these systems, and dispute resolution using mediation can do that. It has been shown when individuals, like providers, consumers, and health plans, get together at the same table to identify their real interests, an agreement can be reached most of the time. There is considerable advocacy for person-centered planning, but when you get to the appeals process "person-centered" seems to disappear because decisions are made by somebody else. You have to go through several tiers to persuade someone and to get a final answer. More often than not, in a mediated setting the parties can spell out their needs and everyone can say what they need to say.

Work group members Mark Reinstein and David Gruber offered to put their suggestions in writing for consideration by the work group at the next meeting. Work group members also requested help understanding the various grievance and appeal processes within the current systems. Individual work group members volunteered to work with the facilitator to develop a matrix summarizing features of current grievance and appeals processes as background for work group discussion at the next meeting.

Public Comment

Two observers provided the following comments:

- When talking about the dually eligible population, you are talking about some other person, but by the end of life most of us will likely be on Medicare and Medicaid. So think personally, as if you are a person being served. Regarding your discussion about provider education, we need to change incentives and people need to think differently about their jobs. Work on quality of care, not cutting services, which may cost more to start with because we have done it wrong for so long. We need to think about the patient as a person. We need to collaborate, bring together different perspectives and insights. Professionals need to feel peer pressure to do it right. One suggestion, I can see every provider office with "these are the principles we live by" posted on the wall. If a patient sees that the provider isn't living by that principle then it should be reported. Regarding the discussion on the grievance and appeals process, beyond just process there has to be objectivity. There has to be corrective action, not just "you are wrong" and then the providers go back to what they were doing. There needs to be systemic change. People being served need to know what their choices are so that they know if their choices are being violated. People need information and internal processes to resolve issues. Every provider ought to be solving problems without going through an appeals process. There should be best practices to adopt. We should not let these things be resolved and then put under the covers. Even if you resolve these things yourselves we need to know that these problems have existed because even if they are small they need to be addressed systemically. Finally, we are talking about a population that is dually eligible, which is a fraction of a larger population. We are creating more fragmentation and creating another piece.

- Please be aware of the primary care side. We need to think not only of training, but also how can we create an integrated system that allows the primary care provider to function while managing the complex care for these patients?

Next Steps

Documents for Next Meeting

Work group members were handed the following as background information for the next work group meeting:

- *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C.,* provided by Dohn Hoyle
- *Mediation and the Medicare, Medicaid Appeals Processes,* provided by David Gruber
- *Michigan Health Plans, Summary of member plans' services, aims, efficiencies, operations and delivery benefits,* provided by Michele Lundberg

Questions/topics that Will Be Addressed during the Next Work Group Meeting

- What are the desired features for the grievance and appeal process?
- What should be the structure for the grievance and appeals process?
- What other enrollee protections should be addressed in the new integrated system of care? How should they be addressed?
- How can the work group recommendation for one-on-one, face-to-face consultation be accomplished in a cost-efficient manner?

Next Meeting

The next meeting of the Education, Outreach, and Enrollee Protections Work Group will be Tuesday, December 13, 1:30PM – 5:00 PM at the Causeway Bay Hotel in Lansing.

Integrating Care for People Eligible for Both Medicare and Medicaid

Education, Outreach, and Enrollee Protections Work Group

Meeting Summary for December 13, 2011

Questions/Topics Discussed

At its final meeting, the Education, Outreach, and Enrollee Protections Work Group continued its discussion of an integrated grievance and appeal process and also discussed other enrollee protections.

1. How can we ensure that the grievance and appeals process is appropriate, easy-to-navigate, and responsive?
    - What are the desired features for the grievance and appeal process?
    - What should be the structure for the grievance and appeals process?
2. What other enrollee protections should be addressed in the new integrated system of care? How should they be addressed?

To address these questions, the group considered two documents developed by members of the work group: a proposal for a one-stop approach for grievances and appeals, and a draft list of enrollee protections.

Thirty-two work group members participated in the meeting either in person or by telephone. (One member joined the meeting during the discussion, which brought the number of participants to 33 for the last vote.) This summary reflects the discussion that took place in the meeting, but it is not a transcription of the dialogue. Many, but not all, comments by work group members appear below.

November 29 Meeting Summary

One work group member asked for clarification of a comment recorded in the meeting summary regarding a "push toward more expensive procedures." The work group member who had made the comment clarified that the "push" is driven by providers responding to the incentive they have to do more procedures, and perhaps more expensive procedures, because reimbursement in the current health care delivery system is based on the number and type of procedures performed. He suggested that giving consumers the authority to manage how their health care dollars are spent can have a moderating influence on this behavior.

Key Points of Discussion

As background for the discussion, the facilitator directed work group members to meeting handouts: draft flowcharts illustrating the Medicaid and Medicare grievance and appeals processes, and draft matrices summarizing features of various grievance and appeal processes for Medicare Advantage Plans, Medicaid, Medicaid MIChoice, and health plans, as well as substance abuse and long-term care grievance procedures. (A flow chart depicting the recipient rights complaint process under the mental health code was distributed at the November 29 meeting.)

Some work group members began by voicing their concerns about how consumers who are dually eligible will be protected in the integrated system:

- Not all people who are dually eligible are under the protections of [the mental health code]. There are multiple systems with multiple layers of appeals, depending on funding streams. Are we going to make recommendations or have input on how to streamline those multiple systems? I think it was suggested at the last meeting the need for one entity, a need to restructure the design so that we do not have multiple agencies doing the same work.

- One of the issues is that $7 billion is serving this population. Often dollars will leave the state and transfer to a nonprofit organization. They will say "we are private and we don't have to comply" with things like recipient rights and open meeting requirements. The question is, if dollars leave CMH [Community Mental Health], is there a string tied to the dollars so that we can determine if applicable state laws are being followed? A lot of these issues were fought over decades to get them written into law. If all of a sudden the system changes and the managing entity is private, I think the fear is that [the private entities] don't have to deal with it.
- Let's just say, under a new system, if dollars are not going to a CMH entity and instead go to a private insurer, would that private insurer have to be held accountable?

Content experts from the Michigan Department of Community Health offered the following clarifications regarding current recipient rights protections:

- The Office of Recipient Rights protections apply to any state department or agency, or any hospital or provider under contract with the Michigan Department of Community Health. So however the new integrated system is designed, [the contracting entity] will be required to have a recipient rights system.
- The managing entity will be the entity that holds the checkbook of Medicaid and Medicare dollars. If that entity and its network of providers include a private psychologist, for example, that provider is now receiving public funds. Therefore, that provider becomes a public mental health service provider, so all rights under the mental health code would accrue to beneficiaries receiving care from that provider.

Proposal for a One-Stop Approach for Dual-Eligible Grievances and Appeals

A proposal for a one-stop approach for enrollees to resolve grievances and appeals (see Attachment A), drafted by work group members Mark Reinstein and David Gruber, was disseminated to work group members for review prior to the December 13 meeting. The proposal recommends that there be a single, independent entity to manage all grievances and appeals for people who are dually eligible for Medicaid and Medicare. Mark and David introduced the proposal for work group members and described how they envision the grievance and appeals process operating under this new entity:

- I think a single entity simplifies things. [Our proposal] would simplify the process, keeping everything that exists except for most of the Medicare due process procedures. The Medicare timelines and decision deadlines that were judged more consumer friendly by the NSCLC [National Senior Citizens Law Center[1]] would be retained. Otherwise, all due process service appeals would follow what is currently in Medicaid. Improvements to the current system include requiring a hearing officer to use clinical consultations and using mediation at any one person's request. Currently in the mental health code [recipient rights process], unless both parties agree, you can't have mediation. Right now mediation cannot be initiated by the consumer. The single entity will have to be independent of consumer organizations, service providers, and service managers. A consumer would get straight to the entity that handles grievances and appeals without having to go through somebody first. We listed several features that are much easier to navigate. If a consumer is disappointed with an outcome, just like today, they can prepare a court case.
- I would like to make the distinction between rights and methods for resolving disputes. [The proposed process] is intended to preserve rights, but incorporates an array of existing methods for

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[1] Burke, G. and Prindiville, K. *Building an Integrated Appeals System for Dual Eligibles*. National Senior Citizens Law Center. October 2011. Washington, DC.

> resolving disputes. Part of the design [in this proposal] is to make the dispute resolution system easier for the beneficiary to navigate and to give them choice. An additional reason for having a number of methods available is so disputes may be resolved through accurate information, more information, mediation, or reconfiguring services. Different disputes can be resolved in different ways in different rounds. This [proposal] is intended to match the method with the dispute so [the dispute] can be resolved as quickly and efficiently as possible, while giving the beneficiary an opportunity to pursue their interests. The flow chart lists the different types of resolution processes that may be available within a single independent entity. If you have a complaint of any type, you contact the entity and somebody is available to take questions or concerns. This is the intake step on the flow chart. That person would either respond, direct you to get further information, or otherwise inform you of a resolution method. Once a person is in the system, however they get there, a good test of the system is how it responds when there is disagreement. If the system of resolving disputes offers choice, that is one incentive to appreciate the system, but if disputes can be resolved in an efficient manner and provide alternatives to resolve disputes so that beneficiaries needs are met – that's the definition of a system that they will want to be a part of. Resolving the question of opt-in and opt-out.
>
> "Options counseling" in the flow chart refers to the options or the methods available outlined [in the proposal for resolving a dispute]. The intake person can say "this is how you can process this dispute." If the consumer needs more information, the intake person can send them to an expert in that area. If the question is about the appropriate way to handle a grievance, for example mediation or due process, that can be discussed with the intake person. If you are certain that you want to go to mediation or another option you want to pursue, the intake person can help you schedule that. Intake is to learn about the nature of the dispute, how the consumer would like to see it resolved, and which options can be pursued.

Mark and David provided additional clarification in response to questions from work group members, and work group members contributed their own ideas about how the grievance and appeal process might operate under a single, independent entity. Many of the comments made during the discussion are listed below, organized by topic:

Appeal of a service decision/action

Quite often when we get calls, it is about services that are not covered. What if someone is calling and the service is not covered? If something is not a covered service, then it is simply not a Medicaid covered service. Say they want a pink puppy; can they go through the grievance process just to prove that a pink puppy is not covered?

What about a person with special needs? I require an IV medication every 14 days that costs $4,800 per treatment. I just researched my health plan options that are in my area for duals. None, except one that my other providers will not accept, covers this IV medication. I am out of options.

- Right now, you could file an appeal under a Medicaid fair hearing that the denial of that is an inappropriate denial of a service that you need. Or you could go through Medicare's six step, cumbersome process. If right now, you felt there was a right under state or other law that you were being denied, you could pursue a recipient rights complaint. You could also possibly file a grievance, if you don't think it fits a fair hearing. But none of that would go away [with this proposal]. You could do any of those things, but just go to one entity for any of these processes, or if you want to file a grievance. This is one entity to go to for pursuing all of them. Now if you want to arrange for mediation dispute, if the other party doesn't want it there is no mediation.
- I just want to clarify. If you have a dispute you would come to this system if there is something that you need that you are not getting. This [proposal] offers multiple ways to see if you can get

what you want or need. You would file a claim of any sort to find out what might be the best way to get what you need.

- The problem you are describing is what is happening now. Who do you go to approve? There are so many layers you have to go through that you may not ever get what you want. How was your person-centered plan written? Are there alternatives that are covered? [This proposal] just streamlines the system. Can we figure out a way to streamline the system with one entity? How do you solve the problem at the most immediate level?
- The current system is like walking into the equivalent of the Secretary of State office that has 15 lines, with multiple hours of waiting in one line, only to be told you are in the wrong line. From what is described [for this proposal], you would go into one place and get into one line to get your issue resolved, whether the issue is about a covered service or you have had a right violated. It is more than a clearinghouse; I wouldn't want to wait in one line and then have to go to a building 5 miles away. The issue will get resolved through a system that is set up to resolve it even though they will have to interact with others.
- This entity will be sure that [the beneficiary's] issue will get resolved.

Fair hearing process

What happens to the state fair hearing process?

- We put in our proposal "unless the federal government dictates otherwise." We are assuming that the federal government will say, "Michigan, you figure out what you want to do given that Medicaid and Medicare have many different processes." Of course there has to be a fair hearing process, but it doesn't say that you have to have an ALJ [administrative law judge] who works for the State of Michigan. If the federal government or the state says the ALJ would be the hearing officer, then that's who it is. Either way, we would use all existing Medicaid due process guidelines except for weaving in the ones from Medicare [that the NSCLC recommended as better for the beneficiary].
- Looking at them side by side, it appears that both Medicaid and Medicare utilize the ALJ. By definition, if you have a one-stop shop, the access to the ALJ should help to meet both of those processes. You have got this place and that person, under Medicare. Then there is an independent review entity that is a specifically defined entity or could it be provided through this structure? Could you have a sufficient number of folks that no matter what channel you decided to follow you could configure that group and put the process into play?
- We're proposing that Medicaid processes be followed for due process except in a couple of small instances [as recommended by the NSCLC]. Other than that [the proposal] does away with the Medicare due process which is more difficult to deal with than a Medicaid fair hearing. The IRE [independent review entity] and IRE appeal [required under Medicare] would technically go out the window. [In this proposal] you are dealing with an independent entity right off the bat.
- At what point in the process does it go to OFIR [Office of Financial and Insurance Regulation] for review? Will that piece always be outside this process?
- As it applies to Medicaid HMOs, the OFIR process would not be under our proposal.
- [In this proposal] lawsuits could be external to the process in the last steps.

Quality of care complaints/grievances

How will quality of care issues be handled?

- I think this is a good model. I appreciate the work to create a new way of managing overlapping processes and think of new ways to do things differently. I'm not as concerned about the external process, it will be done by an independent entity without limiting potential avenues for the consumer. It's a good model in looking forward. One thing I'm not seeing is the quality of care kinds of complaint issues, which are what the Michigan Peer Review Organization [MPRO] addresses. Those issues end up being a lot more than a grievance. We do need to build in some kind of sense of urgency for immediate issues to be responded to. I endorse this approach but make sure we talk about what you do if it is urgent. Timeframes are always given, but we need to be sure we have something that can be responded to. For example, Medicare discharge has a 24 hour number and MPRO will review the discharge before you are discharged if you don't want to be discharged. I would like to have a friendly amendment to include a quality of care complaint review process in the proposal. [Mark and David accepted this suggestion that Medicare quality of care complaints be included under the proposed approach.]
- An independent person, like an ombudsman, to go to first in a nursing home administration or the health plan, that could be part of the one-stop approach.
- I always worry about the money. The one thing I am not clear about is if Medicare is paying for the ALJ, MPRO, and the independent entity. If Michigan wants to do it, are we asking Medicare to pay for what is already there through the current system?
- Health plans have independent member satisfaction teams to look at grievances objectively. There is communication between the member, his/her authorized representative, and the team. There are requirements in the member satisfaction team contracts that if they were a part of the decision, then they cannot be a part of the appeal. We have those protections already in place.
- I think the question of independence is in part to a degree in the eye of the beholder. We may never get agreement. In 2003, CMS [Centers for Medicare and Medicaid Services] developed a mediation program for quality of care issues for organizations like MPRO. Developing that program, even with internal processes, you will have some cases that need to go outside due to conflict of interests. I would say that the beneficiaries and providers are the immediate starting point. This proposal for a single-entity includes training to help all of the players in the system work more effectively with each other. In addition, some of the benefits of a single agency are to get the same information out to everybody, gather dispute resolution information about what works and doesn't work, provide services in a more cost effective manner, explore benefits of internal staff or outsourcing, and collect data on the disputes and resolution to analyze itself utilizing an annual outside evaluation to improve over time.
- Education that takes place for people served and those that serve them is an important feature of this proposal.

Internal/local grievance process

In the current Medicaid appeals process, the first step after notice of action is the local [appeal], could that be seen as the equivalent of mediation in this proposal?

- It would have to be independent so there would be no local grievance process.
- I would love to hear the plans position regarding that step.
- Often, health plans help to resolve those [grievance] issues with discussion. [The plans'] perspective is that we have rigorous internal processes in place. We take issues, complaints, and grievances very seriously with an effective turn around while looking at the situation and the patient's situation. We need to look at what is there right now and look across the landscape; we

do not want to administer [Medicaid programs] differently. I vote for consistency and streamlining.

- That is what typically happens; it starts as a complaint and grievance. Then more information is provided or it is discovered that it is not a covered benefit. With this integrated system having one contracted entity responsible for care, we would be doing away with [the beneficiary] having to go from one agency to another to pursue an appeal or grievance. Remember that under the current process [the beneficiary] can go directly to the state or process it legally, too.
- Consumer advocates would like to work [the issue] out with their provider, with the first step being mediation.
- That is still there [in this proposal] as one of the strategies.

Desired features of an integrated grievance and appeal system

- The key is to make it easy for everyone. We do not want to establish a process that untangles great processes that are happening now. We need to blend the good with good. My concern is that we are going to establish something that is going to create a great deal of cost and administration with one entity performing all of these roles. We need to step back to look at what is in place and build upon what is there.
- I don't think we are suggesting we create a new super agency. What I understand is with one-stop shopping you go to a place that will deal with your rights that cut across the systems. When I turn on my computer I don't know what happens, it just gets me to the internet. In this [proposed] process, all I know is that I have a problem, I got into one line, and it got resolved. How it got resolved in the backroom is between the state agencies. I don't think we will resolve how it happens. With this process you can't pass the buck. It is the entity's responsibility and they resolve it in the back room.
- I love that example. It gives me clarity. We need to wrap into this that there is no wrong door. Right now if I go to CMH to talk with a person, then they send me over there, and then no one knows where I go. The system is huge.
- If I talk with support staff, I want them to help me get there quick. It is the system itself that needs to say "here's the door."
- I like the [proposed] flow chart, but I also want to know when I go talk to someone at an ACO [Accountable Care Organization] or CMH that everyone is going to point me to one place and help me through. That is still a mystery.
- I understood the one-stop plan to be an objective, outside entity that will get the consumer to the right agency and through the process. That doesn't do away with all of these agencies.
- Whether we integrate care or not, this [proposal] is a good idea. I would certainly like to replace the current system, not just for the dual eligible population.

The facilitator asked for a vote by work group members to determine the level of support for the proposal as discussed. Eighteen work group members fully supported the proposal. Four work group members supported the proposal with some reservations, and ten did not support the proposal.

The comments shared by work group members who supported the proposal with reservations were as follows:

- I understand that this proposal describes one place to get things done. However I cannot imagine how big that must be. I am having a hard time visualizing this entity. What would it take to implement protections and a one-stop shop without isolating people from service delivery? I haven't got a picture of that in my head.
- I agree with the concept of a comprehensive, one-stop shop. My reservation comes from not understanding the entity we are talking about. Is it a clearinghouse or an independent organization that duplicates what Medicaid and Medicare already do? How does this affect the cost [of the

integrated system] in Michigan? What is the cost for implementation? I think CMS would have those concerns. [CMS has] a myriad of rules and regulations, which are out of my scope of knowledge, that set out what we must do and what we are allowed to change. Can we assume that we can create what we want?

- I support a one-stop concept. I am totally behind that concept; that is what my organization does. However, my concern is about the cost and how this entity would be funded. I am not quite clear; is this entity a new place or a place that points beneficiaries in the direction to where they need to go? There are too many unknowns for me.
- Are we just going to redo what we are using or will it be truly independent? Timeliness is important and continuing services during the process is important. Consumers need access to a care manager or advocate going with them to the one-stop shop. It is really important for consumers to have a person with them to help them all the way through the process.

The comments shared by work group members who did not support the proposal were as follows:

- This would be adding another layer to the current process. If we followed a participant through this process, they are going to [contact the] contracted entity if they have any problems or issues, similar to what is done now through the grievance process. They would still have all their current rights and responsibilities.
- I agree. I am not sure if CMS would go along with the [proposed] process because it appears to cut out initial levels of appeal as an option.
- I am comfortable with the grievance process that we have in place. I know that if I have a Medicare issue, I call them. If my issue is with Medicaid, I call them. That is one-stop to me.
- We are trying to create an integrated system that emphasizes person-centered care, which implies dignity and respect for those receiving services. Those providing services have to adopt a posture that is communication, talking to people to solve their problems.
- Ditto all the comments made in the room about duplication, efficiency, and cost. In our current system, we have components that are centralized, the real issue is navigation.
- Many of my reservations have been voiced. One concern that has not been mentioned is that we have MPAS [Michigan Protection and Advocacy Services] already. Instead of going through a grievance process with a Medicaid issue, we can go through MPAS for mediation. [The consumer] reviews the issue with the individual who is responsible for the decision. The appeals process is in place for the consumers. It could be better. Right now it is the best thing they have going.
- Many of my concerns have been raised. My biggest concern is whether CMS will allow us to adjust the current requirements. We do not know the additional cost if we were to utilize this type of process or additional FTEs to administer the process. Beneficiaries would most likely still come to the health plan if they do not get the service they want. By default, beneficiaries would begin two grievance processes instead of just one.
- My concerns are similar to those already stated. To add to them, rather than creating a new independent system, why not enhance systems that are currently in place. If beneficiaries are not aware of the process, we need to focus on education to make sure beneficiaries know how to access those opportunities.
- I agree with all of the concerns that have been said.
- I would like a personal advocate for consumers. I feel like this proposal is being pushed through when the group isn't exactly sure what [this independent entity] is.

Proposed List of Enrollee Protections

The work group was also sent a list of enrollee protections (see Attachment B), drafted by work group member Dohn Hoyle and modeled after recommendations from the National Senior Citizens Law Center.[2] Dohn explained that although the list is written specific to individuals with developmental disabilities (for example, Item 10), all of the protections could be relevant to other dually eligible populations.

Work group members requested that a vote be held on the first item on the list, "Joining a plan should be an opt-in decision on the part of eligible individuals." Twenty-one members supported the statement; 5 supported the statement with some reservations, and 6 members opposed the statement. (Refer to the November 15 work group meeting summary for previous discussion on this issue.)

The following questions and clarifications were discussed by work group members with regard to specific items on the draft list of enrollee protections:

Item 2: Governing Board is composed of one-third primary and secondary consumers.

- I would like to see the Governing Board [in item 2] be composed of 50 percent primary and secondary consumers; 25 percent each of primary and secondary consumers. I believe that Federally Qualified Health Centers have a good model for composition of this type of board.
- We are talking about integrating the Medicaid and Medicare systems. [Enrollee protections] will probably be overseen by Medicaid. Medicaid and Medicare have not had "managing entities" or "boards" before.
- Board meetings need to comply with the Open Meetings Act and FOIA [Freedom of Information Act].
- Any information regarding public money and the integrated system should be subject to FOIA. Any business of the managing entity and all providers should be subject to FOIA.

Item 3: Members are appointed by a governmental body composed of elected officials.

- I need clarification about "members are appointed by a government body." What does that mean, a legislator is going to be picking board members?
- I don't know [who would make the appointments because I don't know yet] what the managing entity is going to cover. The point is the leverage we will have if someone appoints the board members. Then you have someone to go back to if you are dissatisfied.

Item 6: The current rights of recipients, enumerated in the Mental Health Code, must be maintained.

- This item should include all populations within the dually eligible population. It needs to say "as enumerated in any legislative rules and regulations, including the mental health code, and administrative rules for substance abuse, long term care and hospice."

Item 9: The definition of medical necessity that is contained in the current Mental Health specialty services plan is maintained as the basis for authorizing services.

- This item needs to include the level of care determination of MDCH for long term care and substance abuse. There needs to be training on what constitutes medical necessity, as determined by the MDCH level of care determination process.

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[2] Prindiville, K. and Burke, G. *Ensuring Consumer Protection for Dual Eligibles in Integrated Models*. National Senior Citizens Law Center. July 2011. Washington, DC.

Item 16: Self-determination arrangements that purport to provide individuals with self-directed services result in meaningful control over the funds allotted for the individual budget must be available.

- I need a better understanding of Item 16. Medicare beneficiaries are not given a budget. I do not know what this means.
- In long-term care services, either the MI Choice Waiver or the mental health system, people have the option for self-direction and control of their budget. [The budget] is an important part of self-determination and the consumers' ability to make their own choices. Self-direction is choosing what service is going to be provided and who is going to provide it.
- In Medicare, you can stay within the traditional Medicare or choose one of the different waivers. They do not get a budget. It is important to think about the different types of people we are thinking about in the dually eligible population.
- I think they should have a choice. The budget might not look the same, but you know what the cost is to support your living situation. There needs to be an opportunity to self-direct and even control money. There is nothing that helps to act quicker than a person who controls the dollars. It may not be applicable in every situation.

Item 21: Enrollee choice of the person(s) to provide supports coordination or (fill in the blank) must be assured.

- Do I get to be the one to fill in the blank?
- In developmental disabilities there are "supports coordinators;" in community mental health I believe it is a "care manager." Fill in the blank to what that support person it is for you.
- Instead of having a blank, maybe it should read "supports/care coordinator or similar function."
- Whether we are putting together a medical model or a person-centered model, we're talking about people and functioning. I don't know how to reconstruct that. I think we've heard a commitment to a recovery model, and we have some opportunity to make sure this says that.
- Currently Medicaid offers you a choice, while in Medicare you have a limited choice. This item allows people to choose a supports coordinator from the community. There are some great options and choice is really important to people when it comes to this.
- The description the state put forward is that everyone has a care coordinator. I want to have protections in place so that people have their choice or can choose not to have [a care coordinator]. A beneficiary should have that choice.
- There are several different ways that a person can have facilitation. Through a support coordinator, a facilitator, or an advocate. Make sure these things are in place. If a person wants to have someone, you want to make sure [facilitation] is given to them.

Items 11, 13, 17, and 20:

- Wherever it states "department," for example in items 11, 13, 17, and 20, it should be plural– "departments." Or take it a step further to say "departments and/or agencies."

The facilitator asked for a vote by work group members to determine the level of support for the list of enrollee protections as a whole. Thirteen work group members said they support the whole list of protections, while 16 said they support the list with some reservations, and 4 did not support the list of enrollee protections. Comments from work group members following the vote were as follows:

- I support some of the items and I am against some. In principle, I support the list as a whole. If we were talking about consumer representation and transparency, I would say I support it. However, there are a number of medical health principles that are not articulated, for example, informed decision making. I could sit down and make this a set of generalized principles in 15 minutes.

- I think that the fundamental values are critical. There is a need to have things written down not just as values, but as enforceable rights. That needs to be reflected for the decision makers.
- I am especially concerned that the universal pieces get lost as we talk about specific things like the definition of developmental disabilities in Item 10, and other specific things. I would support taking a vote on the principles without some of the specifics.
- [In this proposal] I tried to write down what is important for enrollee protections for those with developmental disabilities. We are talking about what matters to individuals, some of which are in place for many populations. I did not want to lose any of them. I understand that some of these items may not apply to some populations.
- If you read the standards described in the Affordable Care Act or descriptions of Accountable Care Organizations, they both talk about a lot of the principles in this list. The federal government wants to use best practices from community mental health. One of the determinants of quality care is consumer satisfaction. Basically, we have very different systems that have different value systems. We keep bumping up to those very things whenever we try to put [the two systems] together.
- There is part of the dually eligible population who live independently in the community. They come and go within skilled nursing facilities or see family practitioners. I support the principles, as has been said generally. However, for the people that I work with, this is very restrictive. We need to be aware of everyone in this pool [of people who are dually eligible].
- I'm not ready for this document to speak for me. I think that some of this is out of [the work group's] scope and that we have already talked about some of it.

Ongoing Stakeholder Engagement

Throughout the work group process, many work group members said they had concerns about the discussion topics and the short timeframe to discuss such complex issues. In their last meeting, some work group members said the following:

- In none of the stakeholder input or sessions was there an opportunity to discuss the assumption that the integrated system is to be handed over to a private managed care company that will provide services to all of the dually eligible. What that will probably do is destroy the community mental health system. What are the advantages and disadvantages to that? It is disappointing that the most controversial aspects of this plan [for an integrated system] are not on the table.
- I think all of the protestations about stakeholder involvement are because of the decisions made about opt-in/opt-out, assuming risk for the managing entity, and all of the other decisions that have been made without public input. Nobody has had a chance to respond to a plan. Decisions were made when money was received from the federal government without public input.
- I think there is something fundamentally wrong with a process that leaves one hour for discussion for such a broad array of enrollee protections. Enrollee protections deserve more time to discuss each protection individually.
- Three meetings are very, very inadequate. I have felt very frustrated with this process. The state has a very tight time frame. I am worried about how this [discussion] is going to be interpreted and boiled down to go to the state. [Work group members] should have been educated about what we are doing. We are talking about taking an entire health system and putting it under one roof. I want to go on record as saying that I have grave concerns of how this process has occurred.
- I would like to offer thanks to Director Dazzo, the staff, and the facilitators and recorders. This has not been an easy process because it involves our friends and families. It is as good as it could be. I would like to suggest that Director Dazzo pull together all of the work group members when the plan has been drafted, and present a matrix to show each of the work groups'

recommendations compared to what is accepted, rejected, and the reasons why. That would help to bring closure rather than looking at a cold piece of paper.

Public Comment

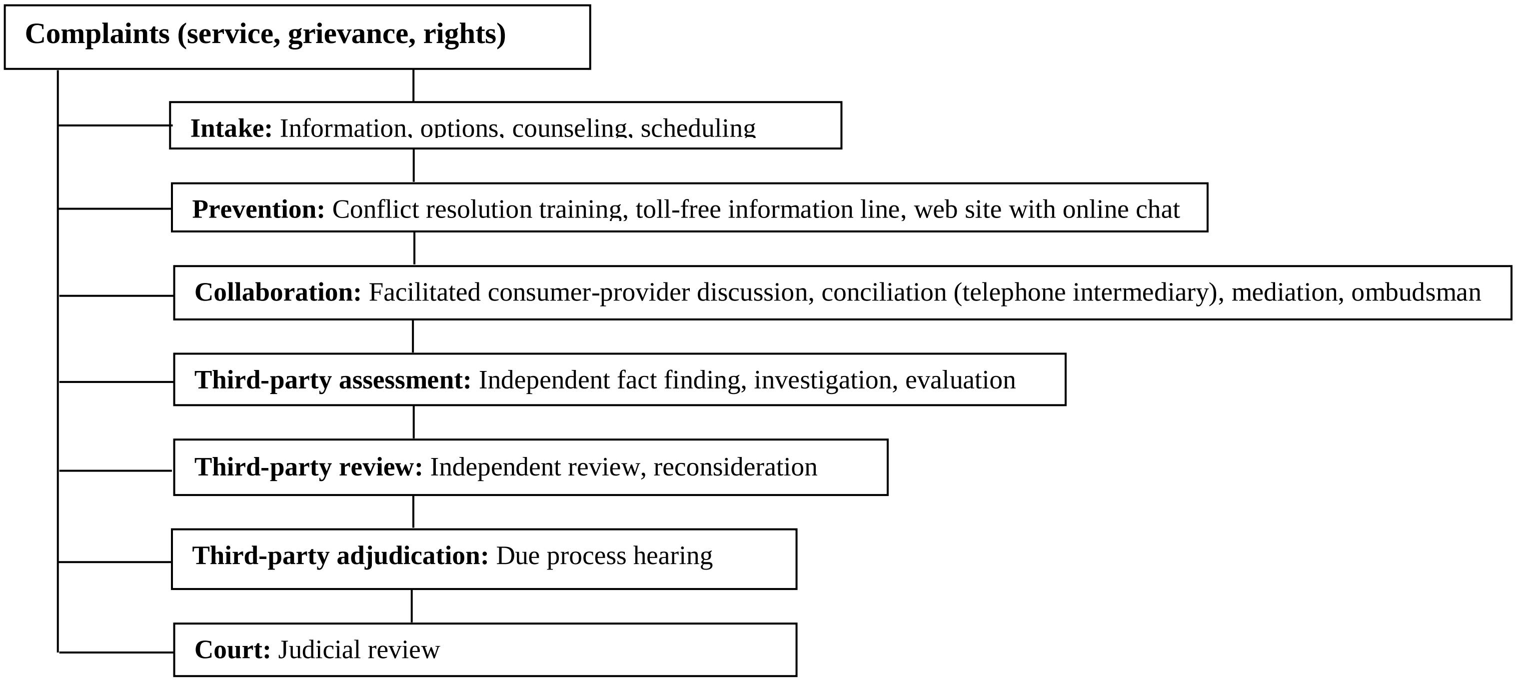
No comments were offered during the period set aside for public comment.

Next Steps

Public Sector Consultants will compile a report of all of the work group meeting summaries to give the state a comprehensive idea about what the work groups recommend for the integrated care system moving forward. This report will be sent to all work group members. The state will prepare a draft plan to submit to the Centers for Medicare and Medicaid Services by April 1st and allow at least 30 days for stakeholders to review the plan and offer input.

Attachment A: Proposed One-Stop Approach for Dual-Eligible Appeals, Grievances, Rights

Draft 12-9-11, prepared by David Gruber and Mark Reinstein



There should be a single independent statewide entity that handles all complaints and levels of appeal, not counting cases that are pursued through the courts. A complaint may be a grievance regarding dissatisfaction with service, appeal of a decision/action regarding services, and/or an alleged rights violation. This entity would provide early collaborative and traditional processes to resolve complaints at the choice of the parties. Access to the entity should be immediate and external to service providers, service managers, and consumer organizations.

This entity would be led and staffed by persons supportive of and well versed in health care rights and collaborative dispute resolution methods, including mediation. The entity would produce its own educational material and report annually on budget, training activities, service requests, dispositions and aggregate results. An annual outside evaluation would focus not on number of cases “won” or “lost” but on matters such as timeliness, consumer satisfaction ratings and random case file review to assure fidelity to existing laws, rules, policies. Finally, the entity could potentially be the vehicle for providing beneficiaries with independent enrollment counseling, as called for by our work group.

Service appropriateness (due process) appeals must employ clinical consultation relating to the beneficiary’s health condition(s). For example, if we still have something akin to administrative law judges conducting Fair Hearings, one or more independent clinicians, familiar with the health condition(s) experienced by the beneficiary must review and comment upon the case before a final determination is rendered. Service appropriateness appeals should otherwise follow all current external Medicaid appeal procedures, excepting deadlines for prescription drug review and beneficiary filing, which would follow current Medicare procedures (as the National Senior Citizens Law Center article we were provided says Medicare is more consumer-friendly in these two aspects).

Unless the federal government dictates otherwise, complainants could pursue any or all options from the first paragraph (grievance regarding dissatisfaction with service, appeal of a decision/action regarding services, and/or an alleged rights violation) with the independent "protection" entity. Grievances, service appeals and rights complaints could be filed concurrently or at respectively separate times.

A request for and use of dispute resolution/mediation would put a temporary hold on assessment, review, and adjudication through other levels of the process. Mediation would be confidential, and all mediation agreements would be in writing and enforceable in court. Unresolved issues post-mediation could still be pursued through the other levels of assessment, review, and/or adjudication. Mediation could not be used to deny due process.

A complainant dissatisfied with the outcome(s) from the independent "protection" entity could – as is the situation today – explore taking his/her case to court if it qualifies for such consideration.

We have been asked to recommend an "easy-to-navigate, responsive" set of protections. The above approach is far easier to navigate than the myriad of processes and responsible parties that Medicaid and Medicare beneficiaries must presently deal with. This approach would also be more responsive to and better serve beneficiaries, and perhaps could be a selling point to them as an extra inducement to participate in the dual-eligibility project. Among the enhancements are:

~Providing collaborative as well as traditional dispute resolution options through a single, independent entity would promote choice, fairness and cost effectiveness for all parties.

~The "protection" process would be uniform and equal for all dual-eligible individuals enrolled in the project.

~There would be less confusion among consumers, families and advocates about where to go and what to do regarding complaint filings.

~Coordination of information between and across various complaints and cases would be improved.

~Complainants wouldn't have to endure time-consuming, emotionally draining and potentially awkward and intimidating first-step internal hearings to be decided upon by the entity financially responsible for managing their services.

~Complainants upon request would be able to initiate mediation of a dispute. (In at least some cases – e.g., Chapter 7A of the Mental Health Code – both parties must agree to mediation for it to take place.)

Attachment B: ENROLLEE PROTECTIONs
DRAFT LISTING
Draft 12-12-11, prepared by Dohn Hoyle

1. Joining a plan should be an "opt-in" decision on the part of eligible individuals

2. Governing Board is composed of one-third primary and secondary consumers

3. Members are appointed by a governmental body composed of elected officials

4. Consumers and family members involved in review and oversight of the plan's service providers

5. Departmental monitoring and approval of a plan's methods for monitoring provider quality in the provision of services & supports

6. The current rights of recipients, enumerated in the Mental Health Code, must be maintained.

7. Training and oversight of services to support individuals with behavior issues, in order to assure that a gentle approach rather than a forceful approach is used successfully by their providers.

8. The array of services approved by CMS under the current specialty services plan is fully maintained in the dual-eligibles model such that Services are specified and available as a matter of entitlement based on need, as determined using a person-centered planning process. Thus there is opportunity to be able to appeal a denial of access to or restriction from use of specialty services under the Fair Hearings provisions.

9. The definition of medical necessity that is contained in the current MH specialty services plan is maintained as the basis for authorizing services.

10. The current definition of "developmental disabilities" as contained in the MH Code is maintained as the basis for determining initial eligibility for services.

11. The Department makes an investment in training in PCP such that it becomes incumbent upon a plan's providers to assure competency in the use of the Person-Centered Planning process.

12. There are provisions for access to and use of trained independent PCP facilitators who can assist a person during the PCP process.

13. There are policy guidelines for the conduct of the person-centered planning process which then form the basis for how the plan and the Department will gauge the quality and sufficiency of PCP.

14. Plan participants and those who were involved with their planning are solicited for their feedback about their experience with using the PCP planning process, to assure that this experience conforms with Departmental policy and guidelines.

15. Options for consumer-directed services arrangements are made available using the policy and guidelines for self-determination now in place in the Specialty Services plan.

16. Self-determination arrangements that purport to provide individuals with self-directed services result in meaningful control over the funds allotted for the individual budget must be available.

17. The Department will make investments in training and guidance readily available in order to assist a plan's providers to successfully implement self-determination options for enrollees who prefer to manage their use of services using an individual budget.

18. All enrollees are provided with information that informs them of the costs of their services and supports as soon as their planning process is concluded.

19. There is transparency of the results of quality monitoring and plan evaluation such that enrollees and their allies can make informed decisions about choosing and maintaining a particular plan or a provider within the plan.

20. There must be sufficient investment in staff and expertise at the Department to provide the monitoring and evaluation necessary to test for and assure improvement in the quality of life and enrollee experience in any plan.

21. Enrollee Choice of the person (s) to provide supports coordination or ___________ must be assured.

Appendix C3:

Performance Measurement and Quality Management Work Group Meeting Summaries

Integrating Care for People Eligible for Both Medicare and Medicaid

Quality Management and Performance Measurement Work Group

Meeting Summary for November 16, 2011

At its first meeting the Quality Management and Performance Measurement Work Group discussed the following:

1. Guiding principles for quality management and performance measurement.
2. Domains for quality management and performance measurement.
3. Existing quality and performance measures.

DISCUSSION

Topic 1: Guiding Principles for Quality Management and Performance Measurement

Facilitation staff referenced a June, 2006 paper published by the Center for Health Care Strategies.[3] The paper identifies recommended measures for performance measurement within an integrated care program.

Facilitators provided work group members with additional issues that should be addressed in a discussion about principles guiding a performance measurement strategy.

Potential Principle 1: A performance measure should accommodate specific measures for special populations within an integrated care system.

The work group provided the following thoughts on this issue:

- The work group should be careful in defining special populations for purpose of measurement. Use of this strategy could become overly granular and not helpful within smaller communities.
- Use of measures specific to special populations may not be necessary if the program appropriately measures whether an individual's needs (whatever they may be) are being met. Use of this measure would eliminate the need to pre-define special populations for measurement.
- There are a number of current performance measures that are focused upon specific populations, many of them are used in HEDIS. As long as the population can be identified in the data, tracking of specific measures for special populations would not be difficult.

Potential Principle 2: A performance measure should be reported in the aggregate, by unique populations and geographically.

Major themes from this discussion were:

- Measures should also look at quality by setting. This may be difficult as recipients transition between settings.

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[3] Center for Healthcare Strategies, *Integrated Care Program: Performance Measures and Recommendations*, June, 2006, http://www.chcs.org/usr_doc/ICP_Resource_Paper.pdf

- Principles may need to be more outcome driven to communicate to the public that the program is effective. Measures should be designed to account for their likely audience.
- Measures should be structured to assist administrators in identifying problems at their genesis.
- Measures should be sensitive to concept of consumer self determination. It is important to account for consumer wishes about the life they would like to have. Program could measure the degree to which person-centered planning is honored. Examples include a measurement of the effectiveness of contracted entities in understanding and adding value to enrollees' wishes and did funding follow the needs of the enrollee.
- Effective integration of services starts at the local level; assessments of effectiveness must capture this data at this point.
- Funding flexibility will be important within a capitated system. It is likely that there will be times within an enrollee's experience when their funding need will be larger (for example during care transitions). Contracted entities need to be willing and able to provide the necessary resources to support these spikes in funding need.

Potential Principle 3: Performance monitoring needs to provide early identification of trends and problems by special population or geography.

The work group discussion focused upon the following themes:

- Monitoring must also focus upon type of care provided and changes in the availability of care. Any sudden change in the availability of care should be quickly identified within the integrated care program.
- Increased financial capacity for home and community-based services will likely create workforce problems. Measures should identify availability of quality providers.
- It is not clear which entity would be doing the monitoring. Would this be done locally or centralized? This needs to be addressed.
- Monitoring needs to occur locally and needs to be linked to services proactively.

Other principles of performance measurement worthy of consideration.

- Monitoring should be risk adjusted, populations with more risk will need more robust monitoring.
- The integrated care system will need research and evaluation built into its structure.
- Design of a monitoring system should account for electronic tools (i.e., health records) that may be available. This should be connected into Michigan's Health Information Exchange process.
- Availability of providers within this system goes beyond health providers. Availability of quality public transportation and similar supports are necessary to support the needs of likely enrollees.
- Measures should focus upon the underutilization of some service. Contracted entities should conduct outreach to ensure adequate utilization of needed services.
- Performance measurement should apply to the process of building a provider network. It is preferable to identify quality providers prior to inclusion into an integrated care provider network.

Topic 2: Domains for Quality Management and Performance Measurement

Facilitation staff reviewed quality management and performance measurement domains identified in the 2006 Center for Healthcare Services paper.[4] Work group members were asked to provide input related to the major domains identified within the paper.

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[4] Ibid

Domain 1: Functional Status

- Performance measures should not be exclusively focused upon provider perceptions of quality but also a recipient's view of quality and quality of life.
- A performance measurement system should be sensitive to the fact that some recipients are willing to risk longer-term deterioration in order to enjoy a higher quality of life in the short. This will create a tension between maximizing enrollee health outcomes and patient preferences related to his/her quality of life.
- System should be sensitive to recipient rights.
- Measures should provide the enrollee an opportunity to define their view of an optimal outcome.
- Community inclusion should be included as part of the recovery concept. Recipient satisfaction with the terms of their life should be measured and valued within the integrated care program.
- There is a danger that existing program eligibility requirements could bias quality management away from measures of enrollee quality of life.
- Adherence to person-centered planning would address many of the concerns outlined above.

Domain 2: Care Coordination

- Care coordination should not be the ultimate goal of the program, improved recipient outcomes should be the goal. Outcome measures should not be completely linked to process.
- Care coordination will be a significant element of the new Michigan Primary Care Transformation Project; it may be helpful to explore care coordination measures linked to this new effort.
- Care coordination should not be exclusively linked to supports and services but to medical care as well.
- Use of consumer surveys to measure effectiveness of care coordination can be problematic. It is necessary to use external, independent parties to administer survey instruments.

Domain 3: Care Transitions

- The model should focus upon transition preferences of the client. Discharge planners' concerns about recipient safety can stand in the way of recipient preferences.
- Transitions should be thought about in a broader context, more consistent with the definition used in mental health settings.
- Coordination between providers is necessary for successful transitions. Those engaged in serving recipients must be aware when transitions are implemented.

Domain 4: Behavioral Health

- Existing measures focus upon whether treatment was available when needed right away and whether treatment was available when recipient wanted it when it was not an emergency.

Domain 5: Safety Nursing Home Eligible

Additional Comments

- Discussion has not touched upon substance use disorders. This should be included in future discussions.
- Work force should be tracked as well. Trends in the availability and quality of staff to meet recipient needs should be tracked.
- Core definitions used to describe these domains will be different across time and care setting. It will be necessary to get a common understanding of what each domain means.

Topic 3: Existing Performance Measures

Medicare SNPs

- Results could impact whether a plan is able to participate in the program.
- Data is valuable for internal improvements within health plans.
- Staff problems at the state level could reduce effective use of these measures.

HEDIS

- HEDIS reporting is the most onerous upon plans of any reporting system. A high volume of information must be generated and reported.
- Measures are helpful to managed care plans.
- No current measures related to serving those with mental illness or developmental disabilities.
- Medicare SNPs are currently inputting their care plans into the person-centered plans for those with developmental disabilities. This process should be built upon in the integrated care program.
- Program should measure access and availability of needed accommodations.

CAHPS Survey

- This instrument does not get responses from those without verbal ability to participate.
- Plans can add supplemental questions to this instrument. Allows plans to target populations and collect information to support internal initiatives.
- The instrument is lengthy and provided to recipients through a method that leads to many respondents accidently throwing it out.
- Recipients can be confused about which services are provided by which provider. This can bias scores.
- Changes in State Medicaid policy (elimination of covered benefits for example) will bias health plan scores downward.

Health Outcomes Survey

- Medicare Advantage plans can use it. A plan must have more than 500 enrollees to be required to administer the survey.
- Survey is provided through the mail and excludes the responses from those who are incapable of filling out the form.

PIHP Performance Measures

- Uses different measures of recipient satisfaction than other instruments.
- Measures increase focus upon community inclusion and function.

Other Comments

- The work group may need greater outside expertise related to the Medicare program.
- Many performance measurements have lag between collection and reporting of data (3-12 months), dynamics that have created problems have already passed unaddressed.

Public Comment

Sara Slocum, Long-Term Care Ombudsman for the State of Michigan provided the following comments.

- ■ Provider performance review process should begin before inclusion in the provider network.

- Tension between choice and access vs. quality. The ultimate goal of high number of quality providers.
- The state should monitor how the system works once providers/consumers are enrolled and participating. Program design/funding/quality measures will drive behavior within the program.
- Safety/quality of life tension. Consumers want clinical competence, access to providers who help them to get best outcome but not at expense of their independence. People maintain the right to refuse services, and refusal that leads to poor health outcome should not be viewed as poor program outcome.

Integrating Care for People Eligible for Both Medicare and Medicaid

Performance Measurement and Quality Management Work Group

Meeting Summary for December 1, 2011

At its second meeting the Quality Management and Performance Measurement Work Group discussed the following:

1. Current performance measures for persons receiving long-term care services.
2. Proposed measures of quality associated with integrated care.
3. The creation of a performance dashboard and the most appropriate measures to include in a performance dashboard.
4. A summary of potential recommendations to provide the State of Michigan. Guiding principles, domains measures of integration and dashboards.
5. Likely practices and policies meant to induce contracted entities to delivery high quality care.

DISCUSSION

Topic 1: Current performance measures applied to persons receiving long-term care services

Department of Community Health staff provided a brief presentation on performance measures currently utilized within Michigan's Home and Community-Based Services waiver and Michigan's Habilitation Supports waiver.

Facilitation staff provided a review of the Special Needs Plans (SNPs) 5 Star rating system.

Group members provided a proposed domain structure for performance measurement within the Integrated Care for Dual Eligibles project.

The discussion focused upon the following:

- The state should review licensure requirements. Currently, the state does not license home care providers. As a result there are few providers with access to training prior to beginning to work in the field.
- While the state does not license providers, clients are able to work with their workers to demonstrate necessary tasks to do their job. There is fairly immediate feedback to workers that do not meet a client's needs: the client lets them go.
- Staff employed at nursing facilities can lose certification. The state currently doesn't integrate lists of staff found to have engaged in abuse or neglect in congregate care settings with home care programs.
- Waiver agents are required to ensure that workers pass a criminal background check; however, the state does not provide guidance about what waiver agents should do with information about criminal history. The current background check process does not allow prospective workers with criminal history to demonstrate they have changed.

- Given the number of existing reporting requirements, how should the state approach creating new performance/reporting requirements? The state should work to meet ongoing data needs while implementing new data collection measures that are more streamlined and simple.
- From the perspective of health plans a number of contracted providers are licensed or certified. In instances where this is not the case the health plan contracts with agencies. The agencies are required to establish standards for their work force.
- There are few standards imposed upon home care agencies. For example, one could establish a home care business and not have a nurse on staff.
- The state should explore focusing some resources on measurement of the program's effectiveness in identifying those eligible for enrollment in the program. Currently there are a number of individuals eligible for Medicaid or Medicare who are not enrolled, especially those who are homeless or who have been incarcerated.
- Measures of access to care should include availability of providers. In particular, access to care for Long Term Supports and Services should also be measured through job vacancies and provider census.
- Measures should also focus upon access to care with respect to accessibility. Examples of possible measures include the number of missed appointments, the cause of missed appointments and access to needed transportation.
- The needs of those with communication disabilities are often overlooked. Performance measurement related to access to care should account for the access needs of those with communication disabilities.

Vote #1: Should the state have an ongoing performance measurement input process?

The proposal was unanimously supported.

Topic 2: Proposed measures of quality associated with integrated care

The work group reviewed existing measures of quality and was asked to propose new measures of quality for the Integrated Care for Dual Eligibles program.

The work group reviewed a number of measures of integration currently used or developed by the National Committee on Quality Assurance, the National Quality Forum and the State of Massachusetts.

Discussion related to existing measures focused upon the following:

- The NCQA measures used for SNPs are very onerous for health plans. The required detail necessary for reporting is the same for very small or large populations. A health plan must allocate a lot of staff resources to meet these data requirements.
- The NCQA measures place the patient at the center of the process.
- The NCQA focus upon care transitions has allowed more information to get back to impacted primary care physicians. SNPs have improved coordination with their behavioral health teams on issues related to care transitions.
- The state, through the Michigan Nursing Facility Transition Initiative, already demonstrates an interest in measurements related to care transitions.
- The NCQA care transitions model is applicable to the MIChoice program and Michigan's Habilitation Supports waiver.
- The NCQA tool would be more helpful if it were designed to be a bit more specific to Michigan and the range of care transitions available in Michigan. The state will need to define the optimum care transition.

- Discussions with states further along in integrating care for dual eligibles suggests that best practices have not yet been identified.
- Staff should review measures currently used in Michigan Programs for All Inclusive Care for the Elderly (PACE) programs.

Discussion specific to measures of quality identified the following:

- Inpatient recidivism should be included in any quality measurement program. A good start would be to look at measures of readmissions as a measure of transition effectiveness. It will be important to recognize that at the start performance on this measure will likely be poor.
- The process needs to start with a person-centered plan. Does a recipient have a case manager one phone call away, or is access to a case manager more limited? Recipients view a case manager as a tool, or "a parachute who slows the process of falling between the cracks in the system."
- The state should explore efforts to streamline the reporting requirements in this program. Health plans can more easily report data collected through billable codes instead of a process of chart review. Efforts to code measures would be effective. Implementation of electronic health records could make access to charts for reporting easier.
- A concern about reporting care transition measures through a billing code is that they may not measure individuals who transition to circumstances outside the system (homelessness, criminal justice settings, institutions). The system may become self-referential if interest is just transition between care settings.
- The state must take care not to create labor intensive measurement tools at a time when provider capacity is becoming a problem. It is important that providers devote most of their time to serving people and not participating in measurement efforts.
- Measuring outcomes related to care transitions instead of process may be a more effective strategy.

Work group members were shown a grid identifying possible domains or measures of integrated care. Members were asked to identify elements worthy of highlighting, adding or deleting from this grid. The work group identified the following:

- The grid should include palliative care.
- Emphasis should be placed upon individualized shared care planning.
- The grid should include adoption of health information technology within the system and between providers.
- Emphasis should be placed upon care coordination.
- Emphasis should be placed upon behavioral and mental health.
- Measures related to safety should be paired with recipient choice. This measure would be more appropriately identified as "Person driven safety measures."
- Emphasis should be placed upon effectiveness of care.
- Measures of support coordination should be rolled into care coordination.
- Consumer satisfaction and experience should be included.
- Provider quality and accommodation should be emphasized.
- Constant theme and mission of the measure should be "is this what quality of life means?"
- Outcomes should be driven by the individual receiving the care. Data collection should account for circumstances when an action viewed as sub-optimal is taken at a patient's request.
- Cross system activity should be measured.
- Self management area of patient registry, little different than health record. Stanford model of self-management.

Topic 3: Appropriate measures for inclusion in a performance dashboard

Vote #2: Would it be wise that the state's measurement system include a dashboard to identify "early warning issues"

The majority of work group members in attendance supported this option. There were several work group members who provided conditional support for this proposal. Their statements are provided below:

- Would the State of Michigan have sufficient staff to generate the dashboard? How would data used in the dashboard be collected?
- Performance measurement cannot just be early warnings and longer-term program management.
- Complete support for a dashboard cannot be provided without a clear understanding about what would be measured through the dashboard.
- State would need to define standard for what is necessary for early warning.

Discussion about appropriate measures that could be included on a dashboard touched upon the following:

- It will be difficult to generate good data related to serious reportable adverse events. Accessing this data is typically reliant upon voluntary reporting by a health care provider.
- Measures of recipient access should include review of pharmacy hold times. Excessive hold times are correlated with lower medical compliance and readmissions.
- Additional measures of access should focus upon recipients with physical disabilities in need of mental health services. Access to inpatient mental health services can be difficult for those with disabilities.
- Many of the measures discussed would not be appropriate for a dashboard. Data collection that requires chart reviews will not be timely enough to populate a dashboard.
- It is necessary that dashboard information be reported by population and geography.
- It is not clear who would administer the dashboard. Data would likely be provided by contracted entities. Data would be reported by subgroups.
- A dashboard should include fixed measures reported statewide and flexible measures that could be generated at the user level.
- Many data elements discussed for a dashboard measure the delivery of care and its functioning. It is necessary to examine system capacity as well. Examples of capacity measures are the number of unfilled positions within the work force, how many positions are currently being advertised. This information could support efforts by local Michigan Works! agencies to match unemployed individuals with training and placement opportunities.
- A dashboard could also include measures of financial stress within the program. What proportion of a provider's defined capacity is currently filled? A low census for some providers could be an indication of stability problems within the program.
- Another measure of capacity could be enrollment and disenrollment measures by contracted entity.
- Dashboard measures could include out of plan placements. Recipient complaints related to abuses within the system.
- Many of the measures discussed would be difficult for contracted entities to collect and report.
- The reporting model could be similar to that of contracted pre-paid inpatient health plans which are responsible for monitoring and assuring that they have an adequate provider panel.
- Work force size issues are critical for operation of state's MIChoice program. These would not be easily monitored by the state without the assistance of their contracted entities.

- Measures of accommodations should not be included in the dashboard. This issue should be addressed through strengthened provider participation requirements.

Topic 4: Summary of work group deliberations, guiding principles, domains, measures of integration and dashboards.

Facilitation staff provided a verbal summary of work group progress to date. This summary will be organized and presented to the work group at the December 15 meeting of the work group.

Topic 5: Practices and policies to induce high quality care

Staff provided a review of existing efforts to incent desired behaviors within medical programs. Specific incentives related to Medicaid managed care organizations, contracted Prepaid Inpatient Health Plans, MIChoice providers, long-term care facilities and Medicare Special Needs Plans were reviewed.

Work group members were asked to identify possible incentives to apply to contracted entities to induce improvements in the quality of services provided to enrolled recipients. A summary of responses is provided below.

- There are separate measures collected through the Medicare and Medicaid programs. Disallowances through Medicare drive Medicaid claims within Medicare SNPs, this means that a plan in many instances must initially deny a service through Medicare to drive recipients' Medicaid eligibility. It is not clear whether contracted entities will be able to provide a service up front and determine how a service fits within the continuum of programs after the fact.
- PACE programs in the state have this freedom to pay up front.
- Would contracted entities have to follow a single prior authorization process or have to structure it between the two programs?
- It is important that the contracted entity have ability to measure the direct experience of their members. The further they get from the people they cover, the more difficult it will be to identify and meet their needs. Advisory boards are not sufficient; there needs to be beneficiary involvement in governance. Ideally everyone who works for a contracted entity would spend a day with a beneficiary.
- True recipient self-determination means recipients having authority over their care plan. It has been demonstrated that when people have control where their resources go you get a more efficient allocation of dollars.
- The contracted entities will need to be clear where financial resources are available to support the needs of their clients. The program will need to transfer successful self-determination models from the non-medical world into the medical world.

Public Comment

Fred Cummins from the Oakland Alliance for the Mentally Ill provided the following comments.

- ■ Success of this effort should be measured about whether the delivery of health services was improved, not whether cost savings were achieved. Dashboard measures should account for the following:
  - Population statistics.
  - Technical performance, compliance with process.
  - Issues related to professional judgment, provider decisions impacted by program incentives.
  - Patient experience.

- Planners should consider how this program would fit into Michigan’s health care system as a whole. An effort should be made to identify those eligible for services but not currently enrolled.

Integrating Care for People Eligible for Both Medicare and Medicaid

Performance Measurement and Quality Management Work Group

Meeting Summary for December 15, 2011

At its third meeting the Quality Management and Performance Measurement Work Group discussed the following:

1. Elements contained in a draft report summarizing decisions made to date.
2. Possible incentives to induce quality and performance improvement.
3. Identification of points of consensus related to performance measurement and quality management within Michigan's Integrated Care for Dual Eligibles (ICDE) program.

DISCUSSION

Topic 1: Review of draft report of stakeholder work group on performance measurement and quality management

The facilitation staff for the Performance Measurement and Quality Management Work Group prepared a summary report of the work group's discussion and recommendations related to performance measures and quality incentives. The final report is attached to this summary. When given the opportunity to provide general comments about the draft report presented for member approval during the December 15 meeting, work group members offered the following observations:

- The state should participate in current efforts by the National Quality Forum (NQF) to endorse quality measures for services provided to dual eligibles. The state and Michigan-based interests should influence the evaluation of national measures for services and supports provided to dual eligibles.
- Measures should not be limited to just those endorsed by NQF. ICDE project is an opportunity to test new concepts.
- The NQF has not taken steps to ensure beneficiary participation in the process of developing quality measures and it shows.
- The NQF illustrative measures are not impressive. Discussion related to advance care planning is of specific concern.
- The NQF is important but limited input from beneficiaries requires additional measures related to client experience.
- It is important that the state identify a basic, common, definition of domains before establishing performance measures. Once these definitions are established, a validated statewide tool can be developed for use within the program.
- Measures based upon chart review would be onerous for contracted entities. Measures related to subjective criteria will be difficult to quantify.
- Those creating measures should account for mental health concept of recovery. Measures are specific to individual's view of whether they have improved due to services and supports.
- Current draft report does not address quality of life measures.
- How do existing measures of quality of life align with populations that are likely to not attend school or work? For those who are disabled, there is no single definition that fits all

circumstances. Definitions must have the flexibility to meet the circumstances of all dual eligibles.

- Measures do not address implementation of the project. Measures of quality and performance are meaningless unless services and supports being measured have actually been implemented.
- Performance measurement must account for circumstances that are infrequent but indicative of available capacity within the program.
- It is difficult to implement anything until conflicts between regulations governing Medicare and Medicaid are resolved.

Comments Related to Domains in Draft Report

Discussion of domains included in the draft report included the following comments:

- Due to time constraints, the work group has not established a common definition of the domains under discussion. The validity of the selected domains is contingent upon uniform definitions, and therefore the state *must* begin with that step.
- Access to care is critical.
- Care transitions and integration of physical health and mental health are important.
- Feedback from consumers is necessary. Health plan responsiveness and care input from the beneficiary's perspective about how well care is provided should be incorporated.
- Phrasing for planning should focus upon person-centered plan. Shared care plan could just focus upon medical supports.
- Measurements of person-centered plan cannot just focus upon whether the plan exists, but whether the plan is implemented to the satisfaction of the beneficiary.

Comments Related to Measures in Draft Report

Discussion of measures reviewed in the draft report focused upon the following:

- Some items identified in the draft report are best described as measures and some are not. For example, member complaints and grievances are a concept or a domain but not a measure. There needs to be consistency with vocabulary used in the report.
- Most HEDIS measures were not developed for special needs populations, though glaucoma screening, care of older adults-pain screening, and other exceptions exist.
- There needs to be some thought about how these measures will be reported. Many of these data elements are currently collected through HEDIS. Application of existing measures such as HEDIS to the dually eligible population will necessitate modifications to age, benchmarks, definitions etc.
- Nothing discussed in the draft report makes current measures go away. Providers and health plans will be required to continue to report and follow existing measures while implementing new measures for the ICDE project.
- Measures created for the ICDE project may be used in other settings. This may create consequences that beneficiaries, advocates, providers may not like.

Within the review of measures, a great deal of discussion was focused upon measures related to an individual shared care plan and person-centered planning. Discussion centered around the following:

- Will measures focus upon the process or the outcome of care planning? Measures should focus upon whether the consumer is happy with his plan and the outcome of the plan.
- It is possible to utilize an external review process to measure satisfaction with the person-centered planning process. Service provided by My InnerView could assist in this process.

- There is no existing measure of the effectiveness of a care plan. There is no common definition of a person-centered plan.
- SNPs are required to develop a Model of Care that effectively ensures person-centered planning. CMS scores the model of care, but does not measure its effectiveness.
- An appropriate way to think about the effectiveness of a person-centered plan is quality is measured as choice, satisfaction, and beneficiary independence.
- The most important aspect of a person-centered plan is adherence to the plan. The state will need to figure out how to get information about compliance with a person-centered plan.
- There is a distinction between medical services and long-term care supports and services. Beneficiaries receiving long-term care supports and services want all options discussed and their preferences honored. There is fear among those that receive long-term care supports and services that their preferences will not be honored in this new system. The definition of effective person-centered plan should not be same in the medical and long-term care supports spheres.
- Measurement should account for competing interests within the system. For example, if an individual wants to be ambulatory and independent then a provider should not be held accountable for the increased risks from falls.
- The quality of services, care, and supports should be defined by the individual and not by health providers. Quality is defined by the individual.
- The beneficiary comes first. The current medical model recognizes the implication of a "do not resuscitate" order, measures impacted by a beneficiary directed plan that leads to an increased risk of falls or other adverse health outcomes should be no different.
- There needs to be integration between processes of person-centered care and patient centered care. Self-determination should include collaboration between beneficiary and health providers. Health providers are obligated to communicate their concerns to a beneficiary so that he/she can make a truly informed decision.
- It is dangerous to separate the person-centered plan process from the "medical model." Those who make choices that increase health risk should not be completely excluded from quality measures.

Comments Related to Discussion of Dashboards[5] in Draft Report

The work group provided the following comments about how dashboards were treated in the draft report:

- Dashboards must provide actors information by sub-group to identify specific problems that may not be apparent in complete data set.
- The value of dashboards comes from providing decision makers timely, actionable data.
- Dashboards must provide administrators the ability to address concerns at a local level. There is not as much value in providing real time data at the state level.
- Indicators that may be useful at the state level include the number of transitions into and out of contracted plans.
- When contracted entities are required to report data on a quarterly basis, it influences their behavior in administering the program.
- A dashboard must be commonly structured for all populations with the ability to create unique measures for specific populations.
- A dashboard should be focused upon low-income beneficiaries with poor access to care. If this is not addressed then this work group has not addressed its charge.
- There are dashboards at multiple levels within the system. Providers and health plans already utilize this tool. Data should be meaningful over smaller intervals of time and actionable.

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[5] Defined in prior meeting as a compilation of indicators reported more often than annually and intended to illustrate experience of a sub-population using measures that apply to the full population and measures specific to the sub-population.

- Dashboards should address system capacity. Specifically a review of job vacancies and the amount of time it takes to fill a vacancy should be tracked on a monthly basis to ensure sufficient capacity is available to meet the needs of beneficiaries.

Topic 2: Proposed measures of quality associated with integrated care

Facilitation staff discussed four types of practices used to induce the delivery of high quality supports and services. A summary of work group member comments is provided below.

Report Cards

- Pre-paid inpatient health plans (PIHP) system currently utilizes a similar tool to report cards known as the "fingertip report." This report is created by MDCH from encounter data, QI data, performance indicators, and other raw information submitted by PIHPs to the state. Reports are posted on the state website. This information is not used to allocate individuals to plans but can be viewed by beneficiaries.

Preferential Assignment of Members

- No work group comments were made about this topic.

Incentive Payments

- PIHPs have performance measures tied to incentive payments. These incentives are related to self-determination, employment placement and follow up after substance abuse detoxification. The pool for this incentive program is $200,000.

Other Financial Incentives

- No work group comments were made about this topic.

Other Incentives

- The MDCH does an intensive audit of each Community Mental Health agency (CMH)/PIHP. Audit is completed on a bi-annual basis. Agencies are only audited on issues not passed during the first year review. This provides an incentive for the agency to pass their initial audit.
- Centers for Medicare and Medicaid Services (CMS) $1.0 billion pool for innovation projects.
- Audit should include perspective of consumers of services when determining the effectiveness of programs.
- Some state Medicaid programs incent individual providers. Ohio provides financial incentives to nursing homes for meeting targets related to person-centeredness and process change.
- Contracted entity may be required to create incentives for its subcontractors. The state will need to determine whether financial incentives should be targeted to contracted entities administering the plan, individual health and service providers or both.
- Vocational providers should be offered incentives to help providers adapt to change. The hourly rate should be adjusted to assist in the transition of people from a licensed facility to home-based care. Agencies should be provided a bonus if they find a beneficiary a job.
- The State of Colorado created incentives for effective use of person-centered care.
- State will need to figure out how to create incentives for alignment of Medicaid Adult Home Help program into the ICDE program. Will incentives need to be provided to Michigan Department of Human Services workers to ensure appropriate integration of the Home Help program into the ICDE effort?

Topic 3: Identification of points of consensus related to performance measurement and quality management within Michigan's Integrated Care for Dual Eligibles (ICDE) program

Incentives Michigan Should Choose for Year 1 of the ICDE Program

Work group members were asked to comment on possible incentive measures that should be created for the ICDE program in the first year of its operation. The work group also voted on several proposals. The results of this discussion are provided below.

- There are concerns linked to Medicare rebates. This could negatively impact access to needed services and supports. These rebates incent low program cost and limited provider reimbursement.
- There are concerns about the accuracy of the data. The state should hesitate to put real money behind first year incentives until data bugs are worked out.
- Report cards should not be created until the program has good data systems in place.
- Incentives in the first year could be tied to existing tested measures used for medical and mental health services.
- Disenrollments could be another measure linked to incentive efforts.

Vote #1: Should there be a report card for year one results based upon existing measures of medical care?

This proposal received unanimous support.

Vote #2: Should there be a public reporting of disenrollments by contracted entity?

This proposal received majority support. Work group members who expressed reservations about this proposal noted that individuals may choose to opt-out of a plan or the integrated care program for reasons that have little to do with the quality of the plan.

Vote #3: Should there be a public reporting of number of enrollees who choose to change plans?

This proposal received majority support. One work group member noted that it is not clear what actions by enrollees to change plans really means at this point.

What would be an appropriate measure of a single, integrated person-centered planning during year 1 of the ICDE effort?

- The program should measure that there is a person-centered planning process in place from day one of operation. This could be a requirement for credentialing the plan.
- Plans should demonstrate that they have a person-centered planning process in place. This means that they have contracts with providers that require the establishment of and adherence to a person-centered plan.
- To what extent is the state ready to define person-centered plan? Changes in this definition would increase costs to plans. This becomes a contracting issue instead of a yes/no measure of plan performance.

- There is enough information available to guide contracted entities in building a credible person-centered plan process. If plans are not willing to start the process with the person, they already have a problem.
- Medicare Special Needs Plans (SNPs) already provide a model of care to CMS. Most of the measures relate to patient centered care. CMS assesses plans on a pass/fail basis for this measure.
- The MDCH has already articulated a coherent definition of person-centered plan for use in the CMH/PIHP system.
- If a person-centered planning process is not mandated when the program is implemented the state will experience a high number of beneficiaries opting out of the program.

Vote #4: Should a plan's adherence to a person-centered plan be included in the first year report card?

This proposal received majority support with one yellow vote.

- Effective measure of adherence to a Person-Centered Plan will require data reporting stratified by diagnosis, race, gender, sex etc. If this data is not stratified it is possible to see a plan with 95% adherence to the person-centered plan requirement while missing one cohort of beneficiaries altogether.

Incentive Measures Michigan Should Choose for Years 2 and 3 of the ICDE Program

Vote #5: Should incentive measure used in the ICDE program in year 2 and 3 be determined by an ongoing stakeholder advisory board?

This proposal received unanimous support.

Public Comment

No public comment was offered.

Information submitted by members subsequent to the meeting

- MDCH working definition, core value/principles, and elements of person-centered planning.
- Training has been created and delivered on these issues, and the definition has been incorporated into the CON comparative review process.
- A CMP-funded provider group, *One Vision: Moving Forward*, in collaboration with My InnerView (www.myinnerview.com) has developed resident, family and staff surveys to measure satisfaction and person-centeredness in MI nursing homes.
- Colorado and Ohio have developed Pay for Performance incentives related to person centeredness.

REPORT OF STAKEHOLDER WORKGROUP ON PERFORMANCE MEASUREMENT AND QUALITY MANAGEMENT

EMERGING EVIDENCE-BASED QUALITY MEASURES AND METHODS

Large-scale efforts to integrate Medicare and Medicaid services for people who are dully eligible are in fairly early stages of development. While some programs, like PACE, have been in operation for many years, they have limited enrollment and are designed for specific populations such as the frail elderly.

Concepts, structures, and methods to measure the effectiveness and quality of integration of Medicare and Medicaid services have been limited as well. However, over the past five years, the interest in integrating care for people who are eligible for both Medicare and Medicaid has grown rapidly, and several major initiatives have been or are developing to identify and test performance and quality measures that assess the effectiveness of integrated care. To date, no one has addressed performance of integrated funding.

The stakeholder workgroup assessed a number of emerging models, and found that while certain elements appear in each approach, they are separate and distinct, and no one model is clearly preferred over another. The workgroup also noted that the models make use of existing measures, but apply them more broadly in the integrated approach. For example, a measure of timely access to behavioral health services is drawn from the community mental health system but applied by the contracted entity to the entire dually eligible population. The workgroup also noted that few purportedly new measures in the models are entirely new, though some, like those used by the National Committee on Quality Assurance (NCQA) to evaluate special needs plans (SNPs), are not widely known beyond the SNP community.

The workgroup also noted that there are no uniform definitions of domains across the current initiatives, and that the workgroup itself did not have time to develop concurrence on these important definitions.

Michigan's challenge will be to identify a panel of measures, current and new, to be used by contracted entities to measure the quality of care they deliver. The workgroup determined that Michigan would be best served by continuing to actively monitor emerging models and their use, and to select measures and features from any or all of them, to build a quality measurement system that best serves Michigan's unique approach to integrating care.

Implicit in this approach is continuous analysis of the quality performance measurement system.

Recommendations

1. The state should actively monitor the following initiatives and models, and select features and measures from any or all of them, to build a quality measurement system that best serves Michigan's approach to integrating care.
    - Center for Health Care Strategies (CHCS)
    - National Qualify Forum (NQF)[6]
    - NCQA research on measures funded by the SCAN Foundation
    - Massachusetts' Integrated Care Initiative

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[6] NQF endorses measures, it does not create them. Also, several work group members note that the NQF does not include sufficient representation from enrollees at this time.

- Wisconsin's Integrated Care Initiative
- Care Coordination Measures Atlas, produced by Agency for healthcare Research and Quality in December 2010.[7]

2. The state should consider active participation in the National Quality Forum.
3. The state should consider approaches that address comorbidities within the population of people eligible for both Medicare and Medicaid, as this is common and adds complexity to providing care and quality measurement[8].
4. The state should appoint an ongoing advisory group to consider measures, assess effectiveness of measures, add or modify measures to address emerging problems, and eliminate measures that do not produce useful information. The advisory group should include persons expert in the sub-groups of the population, including behavioral health, substance use disorders, frail elderly, and persons with disabilities. *Note this was a unanimous assertion.*
5. The workgroup strongly recommends that MDCH's first step in identifying quality and performance measures be to develop standardized definitions of domains across all populations.

GUIDING PRINCIPLES

There is no definitive set of measurements of the effectiveness of integrating Medicare and Medicaid. Michigan must select and implement a set of measures designed for its unique integration project. The work group identified a set of guiding principles that should guide the state as it develops and refines its performance measurement program. Some were drawn from the initiatives noted above, and others were explicitly identified by the work group.

Recommended Guiding Principles

1. New measures should be small in number, in recognition of the vast amount of reporting and quality measurement that is required by Medicare and Medicaid, and of the significant administrative burden associated with performance measurement.
2. To the extent possible, new measures should be evidence-based.
3. New measures should be broadly applicable to the full population served.
4. New measures provide new and useful information.
5. The dually eligible population is a combination of several distinct populations with unique needs. As such, any sub-group's experience could be "lost" in the aggregate. Important trends or problems could remain unidentified if measures are only reported in the aggregate and annually. To protect the vulnerable people served in this demonstration, the performance measurement system must also report data by geographic designation, by select population, and at intervals that serve as an "early warning system."
6. Measures should take full advantage of the new opportunity to capture all of a person's health care services and experiences, and therefore should focus on outcomes (rather than process) wherever possible.

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[7] http://www.ahrq.gov/qual/careatlas/

[8] CHCS's publication *"Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Service to Medicaid Populations" December 2010* was explicitly recommended

7. Measures should honor person-centered planning as fundamental to this demonstration, and therefore recognize that a person's choices may deviate from an expected clinical practice.

OTHER RECOMMENDED CONSIDERATIONS

Through its deliberations, the workgroup identified several issues that are neither measures nor principles, but rather are factors that the state should actively consider as it develops its quality measurement program. They include:

1. Access to some of the services and supports may be hampered by lack of trained workers, especially in certain locations. Access measures must capture this situation, and may include reporting on waiting lists, delays in care, etc.
2. Certain factors to assure the quality of provider networks should be built into credentialing of networks, rather than measured later. Provider credentialing should include practice-specific accommodations and staff training to address physical, visual, and communication disabilities. Networks should include at least some providers who offer these accommodations.
3. Research and evaluation should be built into the state's demonstration.
4. Measures of satisfaction cannot rely solely on written surveys, as many in the population cannot respond to them.
5. Measures should address screening and intervention for substance use disorders, which are highly prevalent in this population.
6. There will be inherent tension between the traditional medical model of measuring care to practice guidelines and the person-centered approach in which an individual may opt not to receive care according to medical practice or safety guidelines. Performance measurement must be sensitive to this tension, and not penalize providers who honor a person's choices.

DOMAINS OF QUALITY MEASUREMENT

None of the models the workgroup reviewed addressed the same domains of measurement, and the language used to describe domains was not consistent across the models. The workgroup was frustrated by not having enough time to discuss and agree on definitions of the most common domains, especially "quality of life." The workgroup strongly recommends that MDCH's first step in identifying quality and performance measures be to develop standardized definitions of domains across all populations.

The work group arrayed the domains from several models across a matrix, and identified those most important to Michigan's project.

The workgroup identified 17 domains it recommends the state consider in its quality measurement program, as can be seen in the following matrix. Of them, the following nine domains were deemed of high priority:

- Access to Care
- Quality of Life
- Supports and Services/Care Coordination
- Care Transitions
- Behavioral Health
- Appeals, and Disenrollments
- Effectiveness of Care
- Individualized Shared Care Plan
- Person-Centered/Self-Direction
- Complaints

DOMAINS AND/OR MEASURES OF INTEGRATED CARE

	NQF	CHCS	NCQA Model			MASS.	Dual SNPS	Work Group
			Structure	Process	Outcomes/ Experience			
Quality of Life	X							**X**
Supports and Services/Care Coordination	X					X		**X**
Screening and Assessment	X							X
Behavioral/ Mental Health	X	X						**X**
Substance Use	X							X
Structural Measures	X							
Functional Status		X	X					X
Safety (Prefer "Patient-Driven Safety Measures")		X	X					
Service Integration/Care Transitions		X		X		X		**X**
Prevention		X					X	
Utilization		X						X
Community Integration		X						X
Effectiveness of care		X						**X**
Palliative Care		X						X
Medication Management		X						
Consumer Satisfaction and Experience		X						X
Family/Caregiver Support		X	X					
Access to Care		X	X					**X**
Health Plan Stability		X						
Population/Condition Specific		X						
Person Centered/Self-Direction		X	X			X		**X**
Quality Management						X		
Administrative Simplicity						X		
Provider Quality and Accommodations								X
Comprehensive Needs Assessment								
Individualized, Shared Care Plan			X	X	X			**X**
Adoption of Health Information Technology								
Staying Healthy							X	
Managing Chronic Conditions							X	
Health Plan Responsiveness and Care							X	
Complaints, Appeals, and Disenrollments							X	**X**
Customer Service							X	
Provider Quality and Accommodation								X
Organizational Supports IT and QI			X	X				
Self-Management Support (Use of Registry)			X		X			X
Cultural Sensitivity			X					

RECOMMENDED MEASURES

Population-Wide Measures

The workgroup noted several key factors about using existing measures for the dually eligible population.

- Most HEDIS measures, though widely used, are not tailored to the issues of special populations.
- Using HEDIS measures will require that they be modified, which could add significant effort to their use.

- Quality of life (QOL) measures typically consider a person's ability to be gainfully employed or attend school. These situations do not apply to a large portion of people with disabilities. There are no evidence-based QOL measures for the disabled.
- MDCH uses standardized working definitions, core values, principles, and elements of Person Centered Planning in its long-term care and CHP/PIHP programs. These should be merged and adopted for use by all contracted entities and service providers. In addition, Colorado and Ohio have "pay for performance" systems that link reimbursement to person centered practices in nursing homes. The state should explore these.
- Any new measures should be developed using the NQF Quality Data Model (QDM)[9] and its Measure Authoring Tool (MAT)[10]. The QDM is a model of information and a way to describe clinical concepts in a standardized format so individuals (i.e., providers, researchers, measure developers) monitoring clinical performance and outcomes can clearly and concisely communicate necessary information. It allows Electronic Health Records and other clinical electronic system vendors to unambiguously interpret the data and clearly locate the data required.

The workgroup has recommended that the state draw measures of integration from emerging models, discussed above. However, the workgroup strongly recommends the following measures for consideration. They would be applied across the entire population served by a contracted entity.

Recommended Measure	Domain	Source
Functional status as measured by Outcome Assessment and Information Set (OASIS)	Functional Status	Recommended by CHCS
Percentage of members annually screened to identify impairments in physical and cognitive functioning	Functional Status	Recommended by CHCS
Ability to access behavioral health services quickly	Behavioral Health	MI PIHP measure
Follow up within 7 days of psychiatric hospital discharge	Behavioral Health and Care Transitions	MI PIHP measure
Member complaints and grievances	Complaints, Appeals, and Disenrollments	Dual SNP measure
Quality of preparation for post-hospital care from the patient's perspective	Care Transitions	Recommended by CHCS
Acute care hospital readmissions, all causes	Care Transitions, Effectiveness of Care	Dual SNP Measure
Depression remission at 12 months	Effectiveness of Care	NEW
Percentage of members screened for substance use disorders in primary care at least annually	Effectiveness of Care	NEW
Managing care transitions	Care transitions	NCQA Dual SNP measures
Supporting members through care transitions		

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[9] http://www.qualityforum.org/Projects/h/QDS_Model/Quality_Data_Model_(QDM)__Technical_Questions_and_Answers.aspx

[10] http://www.qualityforum.org/MAT/

Reducing care transitions		
Percentage of member screened for pain in primary care at least annually	Quality of Life, Effectiveness of Care	Dual SNP measure
Percentage of members opting out of demonstration	Consumer Satisfaction and Experience	NEW
Percentage of members changing plans within 90 days		NEW
Proportion of people reporting service coordinators help them get what they need	Care Coordination	Recommended by CHCS
Member Satisfaction with Care Coordination	Care Coordination	NEW
Member served in least restrictive setting	Care Coordination	Composite

Population-Specific Dashboards

In addition, the workgroup advises the state to consider using dashboards that combine the measures above with others that are currently collected on sub-populations within the dually eligible population. These dashboards will illustrate emerging or ongoing situations by group, serving as the "early warning system" recommended above. A large majority of work group members support this concept. Several members expressed moderate reservations which would be alleviated if dashboards were clearly developed, easily compiled, and meaningful.

Contracted entities would produce the dashboards, but would like draw some of the indicators from contractors serving specific populations, which are required to frequently collect and report population-specific measures.

Data elements selected for dashboards should be reliable, consistently reported across providers, and reported at least quarterly though preferably monthly. Sample dashboard measures follow, which would be reported in combination with the population-wide measures.

Sample dashboard measures for MIChoice Waiver participants:

- Level of care determinations where the level of care criteria was accurately applied
- Service plans reviewed and revised upon participant request or when needs change, but at least every 90 days.
- Participants received services identified in the service plan.
- Participants records contain complete, signed freedom of choice form that specifies choice was offered between institutional care and waiver services

Sample dashboard for persons with developmental disabilities:

- % needing emergency medical treatment or hospitalization
- % whose Individualized Plan of Service includes services and supports that align with assessed needs
- % whose IPOS changed when the individual's needs changed
- % face-to-face meeting within 14 days on non-emergent request for service
- % services started within 14 days of assessment
- % enrollees needing emergency medical treatment or hospitalization
- % enrollees who is Individualized Plan of Service includes services and supports that align with the individual's assessed needs.

Sample dashboard measures for persons with serious mental illness

1. Pre-admission screening for psychiatric inpatient care completed within 3 hours
2. Face-to-face meeting within 14 days on non-emergent request for service
3. Service started within 14 days of assessment

Practices and Policies to Induce High Quality Care

The Integrated Care initiative will combine services and supports from several existing programs that have various practices to incentivize high quality care including:

- Publicly available report cards. These are used by Michigan Medicaid for the Medicaid Comprehensive Health Plans (MHPs) and by Medicare for Medicare Advantage Plans, including Medicare Special Needs Plans (SNPs) for dual eligibles.
- Auto-assignment algorithms and special enrollment periods that reward plans with higher quality. Michigan currently awards a higher proportion of auto-assignments to plans with high quality scores and Medicare allows special enrollment periods for people that wish to move to a 5-star plan.
- Incentive payments (usually from a withhold pool). This strategy is used by Medicaid on a small scale basis for the MHPs and under ACA will apply to Medicare plans with 4 stars or more.

Recommended Performance Incentives

The workgroup noted concerns with the accuracy of data for new measures, especially as new data systems are implemented. The following recommendations had unanimous or nearly unanimous support from the workgroup.

1. From the outset, there should be a report card on the performance of contracted entities based on existing measures of medical care.
2. Plan adherence to Person-Centered Planning (PCP) should be included in the first year report card.
    a. It should be noted that there was significant discussion about the need to adequately define meaningful PCP but that without PCP a high number of people who are dually eligible will opt out of the program.
3. There should be public reporting of the number (and proportion) of individuals that “opt out” of the ICDE initiative for each contracted entity and also the number of individuals that choose to change plans.
4. Incentive measures used in the ICDE program in years two and three (and beyond) should be determined by an advisory board that includes broad stakeholder representation.
    a. There was strong sentiment for the need for an ongoing stakeholder role in determining not only the appropriate quality and performance measures as they evolve, but also the incentive strategies.

Appendix C4:

Service Array and Provider Network Work Group Meeting Summaries

Integrating Care for People Eligible for Both Medicare and Medicaid

Service Array and Provider Network Work Group

Meeting Summary for November 16, 2011

Questions/Topics Discussed

1. How can the services and supports that are going to be covered in the integrated model be enhanced?
    - What additional services could or should be made available to enrollees?
    - Which services and supports that are currently available only to people eligible for the MI Choice of Habilitation Supports Waivers might be beneficial to all enrollees?
2. How would you prioritize these services?

Key Points of Discussion

Question 1: How can the services and supports that are going to be covered in the integrated model be enhanced?

Workgroup members began by reviewing a list of services and supports that are currently available to beneficiaries of Medicare and Medicaid, including state plan and waiver services that are available to the people who meet certain eligibility criteria. The list of services and supports also included those that will be available through a Traumatic Brain Injury Waiver if the state's application is approved by the Centers for Medicare and Medicaid Services (CMS). While care management services available through the Office of Services to the Aging are not covered by Medicare or Medicaid, these services were included in the document to ensure work group members were aware of these other services that are available to older adults in Michigan. These services are available to individuals age 60 and over who have complex medical issues and are at risk or in need of long-term care.

As members began to identify ways to enhance the initial list of benefits, many asked questions and/or offered clarifying statements based on their knowledge of the current system. Staff from the MDCH in attendance at the meeting also offered clarification when necessary. Several work group members indicated concern that services and supports available through Medicare might duplicate those available through Medicaid, or that supports offered through one waiver may also be offered in another. It was clarified that the state will be responsible for creating a single benefit package based on the services and supports that are currently available and the recommendations made by this work group for potential additional services and supports.

- Can cost-effective preventive programs that are not currently included in Medicare or Medicaid be included in the integrated plan for dually eligible beneficiaries?
- Many health plans currently develop and provide services that they have found to help reduce the cost of care for people with chronic conditions. We should expect that these types of services would be offered by plans in the integrated model.
- Like a restaurant menu, having more choices can produce better results for the individual.
- If we add services, we have to reduce costs; services should provide some kind of return on investment

- It is difficult to identify the services that should be added without knowing what the reimbursement model will be.
- Credentialing for non-traditional providers (e.g. refrigerator repairs) may be needed
- There are a variety of eligibility criteria for existing programs and waivers. The MDCH expects current criteria to remain in place.
- The legislature may have some influence on how this program ultimately works given its role in appropriating funds. We'll have to be sure they understand the importance of the services and supports made available through the integrated care model so they do not cut funding for services funded by Medicaid.
- Perhaps the legislature could require that any savings generated by the program be spent on the dual eligible population and the services available through the integrated care model.
- What billing codes will be covered under the integrated plan, and how are differences in service definitions and codes between Medicare and Medicaid going to be resolved?
- The state will be responsible for blending and meshing the services; the work group's focus is on determining the array of services.
- How do we help integrate care if all services in both programs are included, no matter how duplicative?
- Through coordination of care by the contracted entities and their provider networks, the integrated program will offer unified beneficiary cards, unified billing, and coordinated, person-centered care.
- If we decide to expand mental health, we may have to recommend that the legislature pass mental health parity
- Limits on home and community-based services should be relaxed.
- Transportation is problematic for many dually eligible beneficiaries.
- Mental health services are preventative; they help people hold jobs and learn better language skills. If they are not provided, overall health can just deteriorate.
- Substance abuse is not considered a disability, so those patients don't have access to the array of services that could really help them and lower costs.
- Self-directed programs offer more flexibility, allowing people to tap into good services that can be cheaper, like ordering medication online. Self-direction is proven to reduce costs.
- We need to affirm as a group that we want the state to continue to cover every service and support that is currently covered. We don't want there to be any question about that.

VOTE

The work group voted to affirm that all of the currently covered services for people who are dually eligible, whether through Medicare, Medicaid, or a state plan or waiver should continue to be covered in the integrated care model.

- The 32 members participating in the meeting voted unanimously in favor.

Potential Additional Supports and Services

Work group members offered a wide variety of suggestions for enhancing and adding services. Those getting the most emphasis were:

- Memory care for adults with conditions such as Alzheimer's disease, dementia, or traumatic brain injuries, which is limited or non-existent under the current waiver programs; possibly including a reminder service to help people stay on track with their care
- Explicit coverage for the coordination of each beneficiary's personal plan of care, regardless of whether that is primarily medical, behavioral, nursing, HCBS, etc.

- Coverage for personal consultations/coaching and group visits/classes on nutrition, home injury control (fall prevention), chronic diseases, fitness, money management
- Explicit coverage of medication management, including consultation regarding prescriptions, for each beneficiary by nurses and pharmacists to help prevent adverse drug interactions
- Expansion of substance-abuse services, which are now limited under Medicaid, including federally funded services provided by coordinating agencies
- Expanded coverage for dental and vision care
- Expanded access to preventive services, mental health, and personal assistance
- Transportation, including relaxed eligibility requirements regarding home and car ownership

Work group members also suggested the following additions to services covered by the integrated plan for enrollees:

- Cognitive evaluations
- Assistive technology
- Training and educational services for unpaid caregivers
- Room and board for substance-abuse detox
- Chiropractic services
- Medications not covered under formularies
- Communication supports for staying in touch with patients, e.g. offer cell phone minutes, provide laptop computers

Question 2: How would you prioritize these services?

While work group members were identifying and suggesting additional services for inclusion in the integrated care plan, many also identified criteria that might help the MDCH prioritize which services should be added. They expanded on the list after continued discussion to arrive at the following initial set of prioritization criteria:

- The services and supports should control or reduce costs, perhaps even be able to demonstrate a return on investment
- The services should be evidence-based and improve outcomes
- Prevent the need for higher-acuity care such as inpatient or residential
- Promotes self-directed care

Work group members also indicated that as the MDCH designs the service array, it should keep things simple, allow for innovation, and ensure that provider networks exist to make the services available and accessible.

Public Comment

- An observer who works in the MDCH mental health and Alzheimer's programs commented that, along with emphasis on person-centered care and self-direction, she would like to see support for caregivers, since 70 percent of the care is provided by families. She said coverage is needed for such things as counseling, training and education on diseases, and for respite care, whether the caregivers work in homes or institutions, since they tend to have high levels of morbidity.

Next Steps

Work group members requested that a single comparison grid showing all covered services by program be developed for its next session. Having a single list will help highlight gaps in programs, they indicated.

Where possible, the number of people who are dually eligible covered by a specific program should be included.

Another person asked that a list of all types of providers who would serve enrollees in an integrated plan also be created.

With the re-organized list of services in hand, the work group will revisit the questions posed at this meeting and perhaps identify additional criteria for prioritizing the list of additional recommended services at its next meeting. If time allows, the work group may begin discussing ways to ensure that provider networks are comprehensive.

The next meeting of the Service Array and Provider Network Work Group is scheduled for 1:30 to 5:00 PM on Thursday, December 1 at the Causeway Bay Hotel in Lansing.

Integrating Care for People Eligible for Both Medicare and Medicaid

Service Array and Provider Network Work Group

Meeting Summary for December 1, 2011

Questions/Topics Discussed

1. How can the services and supports that are going to be covered in the integrated model be enhanced?
   - What additional services could or should be made available to enrollees?
   - Which services and supports that are currently available only to people eligible for the MI Choice or Habilitation Supports Waivers might be beneficial to all enrollees?
2. How should additional supports and services be prioritized? What criteria should be used?

Key Points of Discussion

Question 1: How can the services and supports that are going to be covered in the integrated model be enhanced?

During the previous work group meeting, members voted unanimously to affirm that all of the currently covered services for beneficiaries of Medicare and Medicaid, whether through Medicare, Medicaid, or a state plan or waiver, should continue to be covered in the integrated care model. Also, members offered a variety of suggestions for enhancing and adding services.

In reviewing the November meeting summary, participants proposed several clarifications concerning the group's suggestions for enhanced or additional services:

- When we're talking about expanding dental benefits, we mean the addition of hygiene and restoration services; it shouldn't just cover tooth extractions.
- It is important to add supports for caregivers, such as respite.
- Medication management should include more than screening for possible drug interactions; it is important to look at all drugs being taken by each beneficiary from the standpoint of necessity, appropriateness, and efficacy.
- Expanded vision care services should include well vision care, eyeglasses, eye health evaluations, coverage for medical problems like glaucoma, treatment and rehabilitation of impairments caused by injury or illness.
- The services of registered dietitians should be included to ensure that beneficiaries receive adequate and proper nutrition.
- Room and board should be covered for all residential substance-abuse services (e.g, rehabilitation), not just detoxification.

The work group returned to the discussion of what additional services and supports should be provided, beyond the previous list. Again, members offered a variety of recommendations for inclusion:

- Advance care planning and palliative care.
- Mental health services more extensive than those currently provided through Medicare.
- PACE services, even though they were intentionally left off the list of services contemplated for the integrated plan.

- Similarly, because TBI services (Michigan Traumatic Brain Injury Waiver - Section 1915c) have not been included, three services that are only covered by the proposed TBI waiver should be explicitly included for anyone who needs them: nursing services, transitional residential rehabilitation, and community transitions.
- Community living supports that would be helpful across the populations, such as assistive technology, emergency response systems, and other goods and services that prevent the need for more intense services.
- Transportation services should be universally available.
- Medicaid has rules preventing purchase of cars for individuals; these limitations should be relaxed for certain beneficiaries, e.g., people with disabilities who are capable of driving or arranging for their own drivers.

During the course of the conversation, work group members also expressed questions and recommendations concerning the *operation* of the integrated plan for enrollees.

- Health records should be accessible by most providers for each beneficiary—medical, behavioral, and rehabilitative professionals, and well as [certain] providers of support services.
- There are different terms for similar services in the service-array matrix; uniform terms should be developed.
- Services available for each beneficiary should be dictated by the person's needs, abilities, and care plan.
- There should be clinical criteria for utilizing these services, and ensuring that the services are necessary for each person who receives them.
- Needed services should be covered by the integrated model regardless of the person's setting.
- Work group members further expressed a desire for feedback from MDCH: "We want to avoid duplication of services and supports, and we also want to make sure things don't fall through the cracks."
- A team of providers should be assigned to an individual on a long-term basis, perhaps accessed by the case manager; that's missing now, so caregivers have to create the team on their own.

More of the ensuing discussion focused on the care coordinator or manager who would help prioritize services delivered to individual enrollees. The facilitator shared with the work group some of the discussion that has taken place in the Care Coordination and Assessment Work Group, which spent much of its last meeting focused on defining a role for a care coordinator. The ideas discussed in the Service Array and Provider Network meeting were captured in the list of potential additional services as a "health advocate."

- If the care is going to be person-centered, you need a person to center on the individual.
- This is not someone who is overburdened in their work and time.
- We're talking about having a health advocate, not necessarily someone with a master's degree, who is a certified care manager.
- A *supports* coordinator should be assigned to every beneficiary.
- We have a project that funds an advocate to make sure people get the care they need; for about $200,000 a year we have five people keeping 45 beneficiaries on track with their health care. But how do you pay for that for 200,000 beneficiaries?
- Beneficiaries primarily need help in connecting with services. What is the spectrum of services that are absolutely needed? Which ones are most helpful in keeping people in their homes and in the community?
- The care coordinator or manager should ensure that services needed are actually provided.

Question 2: How would you prioritize these services?

Previously, this work group recommended that MDCH use the following initial set of criteria to prioritize additions to the existing Medicare and Medicaid services that will be provided through the integrated program:

- The services and supports should control or reduce costs, perhaps even be able to demonstrate a return on investment
- The services should be evidence-based and improve outcomes
- Prevent the need for higher-acuity care such as inpatient or residential
- Promotes self-directed care

During the current session, members offered a few more criteria:

- Precedence for the need of the service among high-risk beneficiaries and populations should be considered.
- The service should be "scalable." That is, it should be able to be offered in any region of the state where beneficiaries could benefit from the service.
- Support services essential to beneficiaries receiving needed health care (e.g., transportation, room & board)

Recognizing that the initial plan for integrated care is bound to be modified over time, work group members recommended that the state should engage stakeholders in an ongoing advisory capacity to assist with the design, operation, and revision of the integrated plan.

Vote on Priority Service and Supports for an Integrated Care Plan

At this point, bearing the prioritizing criteria in mind, the 27 work group members present were allotted three sticky dots apiece (each dot representing one ballot) and were asked to vote for the three *additional* services or supports they considered most important for the dually eligible population. These are services that are either not available now that members indicated should be available, or services that are available to a narrowly defined population or as a limited benefit (e.g., dental or vision) and should be a more broadly defined benefit. These items (identified at the first meeting and in further discussion at the second meeting) are listed below in the order of the number of votes received (if any):

- Expanded dental coverage (16)
- Health advocate (10)
- Transportation (10)
- Medication management (9)
- Personal consultation/counseling on nutrition, home injury control, chronic disease management, fitness, money management (7)
- Caregiver supports/respite (7)
- Memory care (4)
- Expanded mental health services outside of CMH (3)
- Expanded vision coverage (3)
- Room and board for substance abuse treatment (2)
- Assistive technology (2)
- Coverage for medications not included in the formulary (2)
- Advance care planning (1)
- Cognitive evaluations (1)
- Communication supports for staying in touch with patients—cell phone minutes, laptops (1)
- Include/cover PACE services (1)
- Nutrition services from dietitians (1)
- Palliative care (1)
- Chiropractic services
- Community living services for anyone who needs them
- Community transition services
- Emergency response systems

- Medical records accessible by all providers
- Nursing services
- Team assigned to individual, accessed by care manager
- Training and educational services for unpaid caregivers

The six services or benefits that received the most votes are expanded dental coverage, access to a health advocate, transportation services, medication management, personal consultation on a variety of self-care items, and caregiver supports and respite. Throughout the discussion leading up to the vote, work group members emphasized the importance of oral health care beyond extractions. They also discussed at length the need for an advocate who can help people navigate the system and follow through on their person-centered plan, similar to the care coordinator role discussed in the Care Coordination Work Group. Transportation was recognized by work group members as critical to enabling enrollees to access all of the services they need, and they noted that transportation services are not available in many areas of the state. Medication management was also identified as a service that can help ensure that enrollees are taking medications that are safe and efficacious. Work group members thought it would be important for enrollees to have access to consultation or counseling on issues that will support them in self-care and managing their own health. Finally, they recognized that caregivers face many challenges in the day-to-day care for people with severe disabilities, and they want to ensure that these caregivers are able to receive the support they need, including respite care.

Question 3: How would you recommend that MDCH define standards for the composition of a comprehensive provider network for enrollees in an integrated care plan?

The facilitator then opened the meeting up for discussion regarding provider networks in the integrated model, asking the group to describe the issues that are most important to them in thinking about how to ensure a comprehensive and accessible provider network.

At first, the discussion focused on the concept of building a provider network based on regional population needs, similar to the Certificate of Need process for construction of health care capital projects. One member suggested that network providers could be selected on the basis of their ability to meet the needs of a specific population.

Next, the discussion shifted to the "core competencies" that the providers and provider network should exhibit. This was complicated by the fact that the network for the integrated plan could include a broad range of providers—from hospitals and health systems and nursing homes, medical, dental, and behavioral health specialists, and allied professionals such as nurses, physician assistants, therapists, technicians, social workers and care managers, to direct-care workers, transportation services, home helpers and repair services—all potentially under the supervision of a contracted entity.

Core competencies for individual/group providers:

- Experience with person-centered planning, beneficiary self-determination
- Use of evidence-based practices, and specific levels of quality outcomes
- Experience with common disabilities
- Cultural competency

Core competencies and responsibilities for contracted entities:

- Articulate a plan for coordinating care across all types of providers
- Demonstrated ability to exchange information electronically
- Provider payments should not be less than Medicare rates

- Articulate plans to incentivize care coordination and the achievement of desired plan outcomes; identify plan for the use of any financial savings
- Minimize administrative/paperwork hassles or many providers won't participate
- Minimize administrative layers that add cost and time to the care delivery process
- Entities should not have a vested interest in a particular provider
- Prohibit providers with a history of fraud
- Ensure beneficiary choice of providers
- Ensure services are provided in a timely manner
- Require availability of providers within geographic areas, or MCO agreement to pay for out-of-network providers
- Credential properly trained providers
- Educate consumers on covered benefits and how to access them
- Articulate and specify roles for beneficiaries in the design, evaluation, and implementation of the model
- A quality management plan

Responsibilities for MDCH:

- Centralize provider credentialing and claim filing; MDCH has already set stringent requirements for mental health providers
- Use the existing MI Quality Community Care Council registry for home-based providers; ensure enhanced roles for home-care workers, integrating them into the care team
- Standardize contracting between MCOs and providers
- Require or arrange for beneficiary feedback—independent satisfaction surveys on provider and contracted entity performance
- Develop a strategy for workforce development, particularly for direct-care workers and consumer advocates/care coordinators
- Include baseline data on outcomes in the RFP for contracted entities, and ensure strong oversight of plans
- Assess the impact of the new integrated plan upon the existing system to which beneficiaries may opt out

Next came a discussion concerning the inclusiveness of the provider network for the integrated plan.

- We need to ensure that beneficiaries can continue existing relationships with providers.
- Restrictions on providers could cause great disruption for beneficiaries, particularly the developmentally disabled, in terms of the relationships they have developed.
- I'm concerned that some current providers will end up being "locked out" of networks by health plans.
- In mental health, provider choice is the law.
- The state should be careful not to set this up so we shut out non-traditional providers with credentialing or technology requirements; e.g., some are refrigerator repair people.
- We've already got provider vetting and monitoring processes in place—systems that work—and would be wise to keep and modify them as necessary.
- Medicare and Medicaid fee for service are any-willing-provider programs; it would make sense for the integrated program to take any willing provider, too.
- I would suggest it should also take any willing payer.

- Start with any willing provider network; otherwise, dually eligible beneficiaries won't have sufficient access to providers.
- Is there a way to offer a unified plan without creating a whole new administrative model? Hard to conceive how this will work fairly for recipients and still be efficient for the state.
- The system we help design is important; the number of dual eligibles in Michigan is going to grow rapidly from today's 200,000.

VOTE

In agreement that the integrated plan must offer a robust provider network at the outset, the work group voted on the recommendation that **to respect continuity of care and existing care plans, the MDCH should start with a network that includes, but is not limited to, all qualified providers in existing programs who meet current care standards.**

- The 27 members present, and the three members joining by phone, voted unanimously in favor.

Public Comment

- Fred Cummins, president of the Alliance for the Mentally Ill-Oakland County, noted that each of us faces the prospect of becoming dual eligible: It is necessary to include not only the services that must be available, but the criteria by which recipients qualify for those services. There must be a formal process for determining these criteria. People should get services when they need them, not when they reach crisis. Services must be continued for chronic illnesses to maintain recovery. To achieve integration and efficiencies, there needs to be a melding and clustering of services that work together.

- Tom Bird, parent of developmentally disabled consumer and a DD advocate, said he had received input from a number people in the DD community concerning the integrated plan design process: I was relieved to see final point endorsing the existing network of providers. The question we are repeatedly asked is 'What are we opting into? And if we're preserving the existing network, will be something left to opt out to?' The illusion is that the system will be able to provide better services and save money. Try to develop a fallback plan so that the system as we know it will be there for people who rely on it.

Next Steps

Work group members again asked that a list of all types of providers who would serve enrollees in the integrated plan be provided so as to inform the discussion at the next session. They expressed a wish to talk about "criteria for what we need from medical professions vs. support providers," and the need to "define the scope of work/practice of everyone in the provider network." Meeting organizers assured the group that the list of provider types would be available for them at the next session.

A subject matter expert from MDCH pointed out that committees in the Michigan House and Senate were scheduled to take public comment on dual eligible plan implementation on Dec. 6 and 8, respectively.

The next and final meeting of the Service Array and Provider Network Work Group is scheduled for 1:30 to 5:00 PM on Thursday, December 15 at the Causeway Bay Hotel in Lansing.

Integrating Care for People Eligible for Both Medicare and Medicaid

Service Array and Provider Network Work Group

Meeting Summary for December 15, 2011

Questions/Topics Discussed

1. How might requirements and credentialing be different for different types of providers? How can we ensure a good balance between the quantity and quality of providers?
2. What additional thoughts would you like to offer the state as it develops an integrated care model for people who are eligible for both Medicare and Medicaid?

Key Points of Discussion

Question 1: How might requirements and credentialing be different for different types of providers? How can we ensure a good balance between the quantity and quality of providers?

As requested at the previous meeting, the facilitator furnished group members with MDCH lists of provider types working in Medicaid and the MI Choice Waiver and Habilitation Supports Waiver programs. Participants pointed out that the list was incomplete and inaccurate in some respects (e.g., did not include Speech Therapist, included CAT Scan under the Physicians heading.) Since the group had previously voted to include all current services and, to the extent possible, current providers, they agreed that the Michigan Department of Community Health should make a concerted effort to create an official, inclusive list of provider types that will be recognized and included in the integrated care model.

Given the variety of provider types expected to be included in the integrated care model, the work group discussed what types of provider requirements might be necessary to ensure that they are able to meet the needs of the population.

- There needs to be competency across the board, in whatever service they're providing.
- Many providers, including physicians, may need to be trained in helping people with behavioral health problems and/or developmental disabilities.
- It's important to keep in mind the range of dual eligibles. Many professionals don't have the skills needed for geriatric patients. The same argument can be made for mental health patients. But there are many people who are qualified to address the issues of the developmentally disabled who aren't going to disappear, and there are a ton of people who are effectively and competently trained to deal with the needs of a frail elderly person. We shouldn't spend too much time trying to figure out how to make sure every provider can work with every type of dually eligible patient.
- We might have to split it up into different groups, or by the type of providers who work with a particular type of beneficiary. Someone who shovels snow doesn't need high competency in working with people with developmental disabilities or the frail elderly, but someone who delivers nursing care does.
- The principle might be that competency be determined by type of work and how the provider interacts with the patient.
- MDCH already has pages of provider qualifications, sometimes they are program-based and sometimes it's by type of provider—core competencies by discipline, defined by the profession and their trade associations. We don't need to create anything new here.

The work group members talked specifically about the need to ensure adequate capacity and competency among direct care workers, whom, they say comprise a large proportion of providers of services for people who are dually eligible.

- Currently, the majority of providers of services for dually eligible beneficiaries are direct-care workers, and their competency needs to be addressed on a statewide basis.
- I think the system should look at home care provider credentialing, but not maintenance workers.
- We need to look at payment for home care workers or we won't get the number and quality needed.
- Adequate reimbursement is important for *all* providers. A comprehensive network will depend on people being adequately paid.

Work group members also specified the need to ensure that each network has adequate *capacity* to meet the needs of the dually eligible population.

- Sometimes a network will be developed that has very little capacity for serving patients. We need to have entities ensure capacities.
- Specialty care in only three parts of the state is not going to help this statewide population. That would not be an adequate network. This point needs to be made.
- We credential all (HMO) providers and re-credential every two years based on NCQA requirements, but that doesn't apply to snow removal. Capacity requirements are reviewed monthly for primary care providers, and a plan is cut off from enrolling more Medicaid beneficiaries if it gets too close to that number.
- Monthly capacity assessments could be considered for specialized care too.
- It goes back to the beneficiary of the services and their choice. We should design the network around the needs of beneficiaries.
- A big piece of assessing competence is getting feedback from the people who receive the services in order to evaluate the quality of services delivered.

When considering the contracted entities that will be responsible for pulling together and reimbursing the providers in their networks, work group members indicated that they believe it will be important to ensure that as much money as possible is put into the provision of services and not into administering the plan.

- Ensure that as much of the program dollars as possible reach the recipients. Use a medical loss ratio that shows the people of the state that it's ensuring the entities' performance, and they're not spending $100 million a year to advertise and recruit members.
- Yes, one of the reports should be a budget that shows how much money the plan actually spent toward the care of enrollees.

Question 2: What additional thoughts would you like to offer the state as it develops an integrated care model for people who are eligible for both Medicare and Medicaid?

The work group members recommended that the state move slowly in implementing the model, completing an evaluation after an initial pilot or demonstration of the model so that adjustments can be made as necessary.

- The state should do a pilot program, figure out the bugs—what does and doesn't work—before we upset the whole apple cart.
- There should be an independent evaluation of cost savings and the outcomes in terms of beneficiary health.

- The state should consider different models, not just capitated, but managed fee for service. By the way, there are almost 40 states working on this. A lot of them are open to both. Why not try different models to see how they work?
- I think of a pilot as testing something to see if it works and stopping if it doesn't. Phasing something in implies that you start small and expand, but with the full intention moving forward.
- The critical aspect is stopping along the way to evaluate. Even if it is phased in, the state needs to stop and look at how it is working.
- Should it be phased in by segment of the dually eligible population or in certain areas of the state?
- It should be phased in by geography because you want to see if it works as an integrated model for all segments of the population at once. What we want to evaluate is whether an integrated dual eligible plan works for the entire population of dual eligibles.
- It would be ideal if the state could conduct more than one pilot with independent evaluations that test both the capitation and managed fee-for-service models.
- The state should pilot different models—not just in terms of the financial model—and define success in advance in terms of cost and outcomes with an independent evaluation report to the public. We're talking about different versions of a capitated model in, say, three geographic regions.
- The state is committed to move forward with full implementation eventually. A pilot has not been discussed. And, while no financing model is "off the table," the state has submitted a letter of intent to CMS stating that it will use the capitation model rather than managed fee-for-service.
- We also can't expect contracted entities and providers to invest resources in something that is considered a pilot. They're more likely to commit if they know that this is going forward for sure. Regardless, the state needs to be able to adjust the plan if parts of it aren't working. An evaluation should be appropriately funded and done with some ongoing key stakeholder advisory involvement.

VOTE

The group then voted on the following recommendation, which represents the key ideas presented above.

- Establish a process that allows for implementing the model in limited geographic areas (e.g. pilot or phase-in) and reviewing the results with an independent evaluation. Consider testing different versions of a capitated model. Allow for ongoing stakeholder advisory capacity.
    - Everyone present and on the phone, save two people, supported the recommendation with the show of a green card. Two work group members indicated having minor reservations with the recommendation (yellow cards).

In addition to the recommendation above, work group members offered the following comments on the implementation of the integrated care model:

- If this is done well by contactors and providers, it will benefit many people.
- I think the department has made a commitment to consumerism and person-centeredness. The full participation of beneficiaries is absolutely necessary at every step of this process.
- Remember as we go into this that we want to be careful not to hurt people as we do it.
- When considering the service array, the state needs to ensure that the right care is available and provided to beneficiaries. Where appropriate, new or enhanced services should be developed to improve the care provided and eliminate gaps.
- Ensure that there is a seamless transition to another plan if a beneficiary decides to opt out. Make sure there is no delay.
- Person-centered planning should be listed as a specific service. Also, you can't be working with a person unless you first have an assessment of the person, then a plan, then a review of the

services provided, and you must have access to the services needed. … I don’t think this can be done by just showing a list of services to an individual and saying, “Pick what you want.” It has to be done by teams of providers working to help the individual.

- We still have a problem of access for those who access Medicaid through a very high deductible, which makes them choose between spending on basic needs or health care.
- The providers and potential providers need a much greater framework than what’s been put out so far. Having a sense of payment rates will be very important in the development of a provider network. More detail must be provided by the state before it implements the program late next year.

Public Comment

An internist from the Veterans Administration hospital in Ann Arbor said:

- It warms my heart to hear the talk of evaluation and metrics in advancing your work. I care for folks who have tremendous physical and mental needs. There are good models out there. As a baseball fan, I favor walks and singles. It’s important to choose evaluative criteria carefully. Community-based participatory research is a good model for evaluation.

Next Steps

Summaries will be available for all four work groups by year-end. A final report of the work group deliberations will be available by mid-January. MDCH will prepare its plan for submission to CMS in January and make it available for review and public comment in February. A plan will then be submitted to CMS by April 1, 2012, with the objective of having the model in place by Jan. 1, 2013.