Area Agency on Aging 1-B
Advocacy • Action • Answers on Aging

Integrating Care for People Eligible for Both Medicare and Medicaid

Summary of Comments Received at Two Public Forums

March 12, 2012: Warren (Macomb County)
March 19, 2012: Waterford (Oakland County)

The Area Agency on Aging 1-B, as an advocate for older adults and adults with a disability in the six southeast Michigan counties of Livingston, Macomb, Monroe, Oakland, St. Clair, and Washtenaw, conducted two public forums which gave consumers, advocates, and service providers an opportunity to learn more about *Michigan's Proposal* and offer their comments. Participants were told that their feedback would be compiled and given to officials with the Michigan Department of Community Health (MDCH) during the public comment period. This document is the summary report from these public forums.

As expressed during each of the public forums, and elaborated on in a separate document which was given personally to MDCH officials, the AAA 1-B concludes that the draft *Michigan's Proposal* includes most of the principles advocated by the AAA 1-B, yet does not acknowledge the expertise and decades-long experience of the area agencies on aging and MI Choice Medicaid Waiver agents in supports coordination, person-centered planning, self-determination, and service provider management. The proposed integrated care model threatens to disrupt the long standing relationship that has been forged between Area Agencies on Aging, the MI Choice program's participants and its provider network of high quality and compassionate direct service providers. There are no protections that guarantee that consumers can continue to maintain their existing relationship with their existing care manager, direct care worker, and Area Agency on Aging.

To address this point of failure, the AAA 1-B requests that language be added to Michigan's Proposal that Integrated Care Organizations (ICO) be required to develop strategic partnerships with local area agencies on aging to provide supports coordination, and require the use of existing providers and services to current beneficiaries.

The following comments from the public have been organized by subject as they appear in *Michigan's Proposal*.

Model Overview

- It is clear that the department listened to concerns expressed by consumers and providers in the plan development process.
- There is concern that the Centers for Medicare and Medicaid Services will not accept the state's plan to include a Prepaid Inpatient Health Plan (PIHP).
- There are concerns that since many health care providers do not want to serve Community Mental Health consumers, ICO providers may not want to serve this population as well.

Assessment and Care/Supports Coordination

- The plan needs to ensure the continuity of caregivers since they are in an intimate relationship with long term care consumers.
- The ICO managing entity should work with existing coordinators at CMH and AAAs.
- There must be user-friendly data that integrates information about primary care with other non-acute services.
- Support coordinators need to be educated about issues that are important to consumers.
- The care bridge may expose a client's personal medical information to a large number of new people. Protocols should be established to maintain confidentiality.

- It is unclear which entity would be responsible for the care bridge.

Benefit Design

- Forum attendees are pleased to see the global objective to improve the quality of life.
- Family caregiving should be supported in the ICO model, not just the PIHP model.
- MDCH should give preference to ICO applicants who will provide expanded vision, dental, and hearing services.

Services for those Opting Out of Integrated Care

- There is concern about passive enrollment – how low-cognition individuals will know how to opt out or get out if they want.
- There is already a delay in the service delivery system through Department of Human Services. It is uncertain that it will be able to handle the transition of over 200,000 consumers to the integrated care system.

Provider Network/Capacity & Integrated Care Model Fit with Michigan's Existing Systems

- Participants expressed satisfaction with the community- based emphasis.
- Integrated Care Organizations must be introduced to person centered planning (PCP). ICOs must have full understanding of PCP, especially on the primary care side. Behavioral health consumers have trust in PCP.
- There is concern that the medical community will not understand and accept PCP, and hope that the care bridge strategy might help promote this approach.
- The ICO should let consumers choose their providers.
- The plan should include explanation of the current aging network structure.
- AAAs are one of lowest cost long term care coordination providers; they have flexibility –boots on the ground, and are ready to play an important role in the new integrated care model.
    - The aging network has 40 years of transitioning and keeping people in their homes.
    - The aging network deploys and trains a fully competent workforce.
- Services that consumers receive under the current waiver providers (including AAAs) have consistently scored very high in the POSSM survey, a quality-of-life participant satisfaction assessment.
- Existing evidence-based prevention programs should be required of ICOs.
- Reinstate the Michigan Quality Care Coordinating Council, which trained, vetted and kept a comprehensive database of caregivers.
- Funding must adequately support home and community-based MI Choice waiver services. The state hasn't fully realized the savings potential of the home and community-based services (HCBS) model – resulting in an inefficient use of HCBS and institutional long-term care.
- Funding may not be at sufficient level to provide nursing facilities transition (NFT) services for all who qualify in 2013. Funding has not followed the person upon transition. Dedicated NFT resources are needed.
- Verify that with the PIHP managing a behavioral health carve out, the PIHP will take care of all behavioral and Medicaid services for life, and that these patients will not be expected to have services paid for by other service delivery systems.
- Physicians have not been as involved in the plan development as they need to be. Physicians and nurses may not want to participate with health maintenance organizations.
- There is concern about seeing a doctor who is not part of the ICO network. Participants want to know if their doctor will participate in the ICO or if they will have to find a new doctor.

Financing

- Any savings should be utilized to provide extra hours of care for community-based long term care participants.

Implementation Strategy

- Include in the implementation schedule a mechanism to slow the pace should unforeseen problems occur.
- A preference is expressed for a pilot integrated care program rather than the statewide rapid phase-in. Connecticut did this pilot testing successfully.
- There is an inconsistency in the plan, which stated that the number of regions was not determined, but also describes three regions. This conflicts with the fact that there are 18 PIHPs.
- Define geographic regions that match existing CMH and aging services regions.
- MMAP counselors should be used for enrollment. They are unbiased, provide good service, and their technical expertise is high. They are cost-effective...free.
- It is unclear how beneficiaries will be notified about their ability to opt out.
- It is unclear how beneficiaries will get educated during the enrollment period, and ongoing.
- Regarding the assurance of health and safety (p. 32), use as a guideline the standards found in the Federal Nursing Home Reform Act of 1987. Health care and long-term care beneficiaries depend on their workers for their health and safety – it takes 1000 hours of training to become a beautician, yet only 75 hours to become a certified nursing assistant.

Performance Metrics and Evaluation

- Put good metrics in place, including the money saved and how the system performs.