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August 5, 2016

Centers for Medicare & Medicaid Services
7500 Security Boulevard
MD. 21244

RE. Michigan Pathway to Integration

The Michigan Developmental Disabilities Council (MI DDC) appreciates the opportunity to provide comments to Centers for Medicare and Medicaid Services (CMS) regarding Michigan Pathway to Integration Demonstration Project. With thoughtful and careful implementation, we believe that the demonstration project could have the potential to improve the lives of well over 200,000 Michigan citizens by providing coordinated care, robust person centered planning (PCP), better overall health outcomes, as well as improved departmental efficiencies.

Below are our comments. Please feel free to contact me should any clarifications be needed. I can be reached at 517-335-3158 or via email at collinsv1@michigan.gov.

Sincerely,

A handwritten signature in cursive script that reads "Vendella M. Collins".

Vendella M. Collins
Executive Director
Michigan Developmental Disabilities Council

Comments and Concerns

The Michigan Developmental Disabilities Council (MI DDC) submitted comments to the Michigan Department of Health and Human Services during the state's public comment portion of this process. We greatly appreciate the work of the department to address multiple comments and concerns submitted from a variety of stakeholders and advocates. Even though the department had addressed many trepidations, remaining are several noteworthy issues of support and/or concerns we would like to share.

Substance Use Disorder

Substance Use Disorders (SUD) is an extremely debilitating condition that has the potential to destroy the lives of those afflicted as well as people close to them. Page 23 of the submission, under the heading of "Specialty Service and Supports Eligibility, Service Reforms and Service Array for Persons with Substance Use Disorders (SUD)," followed by "Determination Criteria" it states that people with mental illness (MI) or developmental disabilities (DD) would receive substance use disorder treatment "based on person centered planning." It further states that "for beneficiaries with substance use disorders, individualized treatment planning;" The issue stems from the vast inconsistencies in the "Person Centered Plan" (PCP) that is experienced throughout the state. Depending on where one resides in the state, a person's PCP can be extremely robust, where as in other areas of the state a person's needs are not met. The second issue rest within the planning mechanism itself. Even though a PCP can be revisited as often as needed, in some cases, this only done an annual basis. A concern of the MI DDC, centers on access to SUD treatments if it is not specifically outlined in a PCP. The MI DDC would like assurances that people with a PCP and develop a SUD will have access to immediate treatment and their PCP be adjusted accordingly.

The MI DDC fully supports the position of the department that the demonstration project will not have preset limits or fee capitations for SUD treatment (page 28).

We also support the provisions of follow-up with patients who have SUD to ensure a higher rate of success for treatment

Habilitation Support Waiver (HSW) and Children's Waiver Program (CWP)

The MI DDC supports the department's position of "exploring" expanding the number of covered lives under Serious Emotional Disturbances Waiver (SEDW), and CWP and would like to see this expansion occur sooner than later. The children enrolled in these programs are likely to need services for most of their lives. It is imperative that early intervention and supports are provided. Under the current enrollment caps, only 469 children are helped through CWP and only 969 children are served by SEDW. Expanding the enrollment of these services has great potential to long-term savings to the Medicaid program at both state and federal levels.

Promoting Value-Based Payment

On the surface, promoting a value based payment methodology is a sound actuarial plan. However, the emphasis appears to be more cost driven than the providing of services or the improvement of overall health outcomes.

Recognizing that there are substantial cost driven areas that are in need of refinement, we need to be cautious that the integration and collaboration of managed care providers and services are done so in a manner that looks at the total outcome of the beneficiary's' needs as well as health outcomes.

The proposal does address these concerns somewhat *"A consolidated §1115 Waiver design will support the testing and application of value-based payment design across these populations, including the testing, adaptation, and expansion of evidence-based care coordination and integration models across populations that historically have received less focus in integrated care modeling (i.e. SUD and I/DD populations). This approach also recognizes the individualization of supports for beneficiaries by recognizing overall healthcare needs versus the need to specifically slot beneficiaries into discrete populations in order to access necessary supports and services."* The concern arises that within the demonstration project proposal; there is a direct action to identify "high utilizers."

Understanding that, within this proposal, "high utilizer" is a term used for identifying excess emergency room usage and hospital admissions. However, we have strong concerns that this term will eventually target beneficiaries with I/DD who, by no fault of their own, are higher utilizers by cost definition. Our concerns are that Managed Health Plans (MHP) and providers would be reluctant to provide full support services knowing that bonus payments may be linked to overall cost-v-outcome.

Incentives

"A vital component of this demonstration is the alignment of quality and financial incentives between traditional Medicaid Health Plans and Michigan's Specialty Service System." We support increased quality measurements as well as the reduction of cost as long as quality does not suffer due to cost reduction incentives.

Another underlying problem is the inherent differences within each of the ten PIHP's within the state. Even though all PIHP's have the very similar missions and goals, how those goals are measured and how the mission is completed varies greatly. This must be addressed in order to promote and provide consistent services across Michigan

Cost is an easily identifiable outcome whereas quality is a subjective measurement. When Michigan surveyed beneficiaries for the HCBS transition, the results of the survey were distinctly different from participants completed the survey without the help of a secondary source and those who had help from their provider to complete the survey.

The MI DDC strongly encourages that all quality measurements should be completed by a non-vested entity that encompasses a strong conflict of interest firewall. This must be in place prior to final authorization of this demonstration project. We would be reluctant to accept an ambivalent statement from the state “we are exploring” outside evaluations for quality measurements.

Greater clarification is needed on how capitation rates will be established:

1. Will capitation rates be calculated by aggregated data?
2. The Per Member Per Month (PMPM) payment, will this be established by what is needed for the individual (true experienced cost of the member), or, a calculated payment based on population?
3. Will there be data that analyzes true individual cost to determine success of treatments and the improvement of co-occurring conditions?

Skill Building Assistance

“Skill-building assistance consists of activities identified in the individual plan of services and designed by a professional within his/her scope of practice that assist a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the beneficiary’s residence or in community settings. Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for sheltered work services provided by Michigan Rehabilitation Services (MRS).” The MI DDC recognizes that the above is retrieved from the current Medicaid manual. However, we find this to be counterintuitive of the intent of the Workforce Innovation and Opportunity Act (WIOA) and HBCS guidance. This language suggest that “sheltered work services” is the first objective or outcome to be examined, and if the beneficiary is not eligible for sheltered work then skill building assistance is implemented. A person who has competitive, integrated employment listed as a desired outcome in their PCP, is not considering sheltered work services as a desired outcome.

Historically, sheltered work services have not been a leader in skill development that leads to competitive integrated employment. There is little to no incentive for sheltered work services to develop the skillsets of their workers to leave sheltered workshops to gain employment in the community. The MI DDC request language that supports competitive, integrated employment as the desired outcome and if a person is in a sheltered work service location, they will be able to receive skill building assistance that helps prepare them for the transition into fully integrated, competitive employment. Ultimately, a person’s PCP is drafted and implemented through the comprehensive sharing of information that presents all available options to the individual. This is maximized by adequate guidance and counseling based on a person talents, skills and interest. This is essential in order fully implement a PCP that is truly reflective of the wants and desires of the individual and the type of employment he/she chooses.

Permanent Supportive Housing

“PSH, is a set of service and supports provided by a team that combines housing development and the support services for individual with SMI, SUD, or I/DD that require assistance to maintain consistent and permanent housing.”

MI DDC has concerns that this definition promotes an enclave of people with disabilities to be congregated within housing development. In order to receive supportive services. We believe that supportive services should be available to people in a variety of settings such as a private home, an apartment, or in the housing development as well.