

## Dual Eligible Integration for Persons with Developmental Disabilities: Attachment

### Process Issues

The integration of individuals who are "dual eligibles" is being pursued by bureaucrats who have failed to consider many of the most basic elements of an effective process improvement initiative. In fact, as is typical with many projects that are focused on "managing from the top down" – those who will be impacted most directly by the integration have not been included in the process design. The plan to "integrate" the primary healthcare of persons who are recipients of both Medicare and Medicaid contains many examples of "top down management" and lack of control that Michigan 3.0 opposes:

- In the formulation of an integration plan, there has been little or no input gathered in a meaningful manner that seeks to obtain and integrate the experience and input of persons in the entire delivery chain from clients and their families through providers, CMH organizations and payers. Failure to gain input and technical assistance from those who are impacted by proposed systemic changes will result in the formulation and implementation of a system that fails to meet basic requirements and does not address consumer input and satisfaction which is one of the key aspects of Value-Based Purchasing:
- The scope of the integration at this late date (six months to launch) is not clear –
  - Which services are in, which are out – medical only or medical, residential and vocational supports? Has any consideration been given to the specialty supports and services that the community mental health system provides, such as specialized residential services, community living supports, nursing services, environmental modifications and housing assistance, to name a few?
  - What is the role of the Community Mental Health Board in both the process and in the transition? How can a system that has existed for over forty years survive the dismantling of its infrastructure and programs without impacting the quality of care that it provides to the persons it serves?
- There has been no identification of the metrics that are being used to quantify success and therefore no strategy is being shared on how it will be accomplished. In other words: What are the concrete expectations of the MDCH and CMS in regards to the following:
  - How much savings is expected to come from rate reductions?
  - How much savings is expected to come from eliminating procedures –which procedures and when?
  - How much is planned to come from quality improvement; how will you measure it?
  - How do the metrics apply to the various populations: Mentally and emotionally disabled, developmentally disabled, autistic, children, adults all now combined with seniors and all of their issues from home care through long term care and Alzheimer's. What about substance abuse? Who can assemble the body of knowledge and expertise to set and administer the necessary guidelines?
- Any process improvement exercise of this magnitude must have a robust change management and quality control system which captures feedback from the same communities that participated in the initial design and is charged with responsibility for correction and improvement—no plan described for this

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- Finally, no business change of this magnitude should be implemented in the Governor's Business Process Environment without an effective pilot and, if the pilot validates program assumptions, a controlled roll out to other areas.

Failure to take these steps puts the lives of the most physically involved persons in the state at risk.

### **Value Based Purchasing and Evidence Based Care**

The most effective Value Based Purchasing Agents in the state are the moms and dads of the developmentally disabled children and adults they seek quality medical care for.

- When good parents are empowered to seek out good doctors who respect both the child and the parent's understanding of their child, you eliminate the waste and human tragedy inherent in so many of our so called 'managed care' systems.
- It is common for persons with Developmental Disabilities to be associated with care givers in several medical centers. It is unusual to find a full range of competent and willing physicians in one center. How does the state propose to assemble the care giver and administrative expertise to take on this project in 6 months?
- By definition, persons with developmental disabilities are likely to be unable to understand and effectively respond to physician inquiries. This puts them at greater risk for misdiagnosis and mistreatment. This is one reason that Guardianship is so critical. Effective physicians know how to use the family to interpret and help guide the diagnostic process. Over utilization of so called objective evidence by either the physician or the administrator will be counter productive in the Value based environment.

### **Opt Out**

When there is effective family navigation in place, families are, in effect, performing value based purchasing on behalf of persons with Medicare and Medicaid at no cost to the individual or the state. Hiring an administrator to look over that shoulder is a waste of money. If a patient / family elect to opt out, there is no information concerning what the terms of the opt out will be—are Medicare and Medicaid still in effect on a fee for service basis for Medical needs, and what will become of the current Medicaid carve-out that supports the CMH system and the many waiver services that it provides, i.e. residential and vocational and community supports? If individuals are automatically "enrolled" in October, how are they to know what they are being enrolled in when the plan has yet to be solidified and completely defined, and is at least 6 mos. from being introduced as pilot programs? If they don't initially "opt out", will they retain the right to opt out at a later date if the system fails to deliver adequate and meaningful services? Will there be any remaining CMH delivery system to serve them? If not, then the choice to "opt out" is not a choice at all.

### **Mental Health Code**

There is no mention of the protections of the Mental Health Code for persons with Developmental Disabilities and others.

- What happens to person centered plans, least restrictive environment, community inclusion, face to face in-home and work place visitations and so on?

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- How will an organization known (unhappily) for its impersonal centralized call centers provide the on-site oversight and quality control for the developmental disability citizen? Even today's recipient rights system is not mentioned.
- What has happened to local control and administration of programs to fit local needs?
- In today's world serious rights and performance issues can be taken directly to the CMH Board members or County Commissioners. What happens in the future?

### **Existing Relationships**

The literature distributed to date makes no mention of preserving current medical, social work, residential and vocational providers for persons with developmental disabilities; only to a 'comprehensive provider network.' Most families work years to select and develop relationships with providers that they count on to provide ongoing supports for their children when they are no longer able. Continued access to these providers is crucial; else, medical and community services for persons with developmental disabilities will be unnecessarily and catastrophically disrupted.

### **Budget**

We understand the launch of the integrated care process to be April 2012. We know State budget controls require firm plans within a matter of days. We are not aware of any communication with local CMH agencies concerning the implications of this program on their 2011-2012 budgets. With 25 to 40% of populations served being dual eligible this presents a huge impact on budget assumptions, programming and staffing plans. Given the needs of the folks being served, and their dependence on a well run and administered system, this timing puts thousands of persons at risk

### **Risk vs. Dollars**

Whoever the ultimate managers of the plan turn out to be they have been promised a significant share in the assumed "cost savings". So public dollars get removed from the service delivery process and are shared by the state and the integration agency. An historic look at Commercial insurance carriers (including those who are supposed to be non profit) indicates higher premiums and less coverage. They have exorbitant reserves and extravagant executive salaries and benefits resulting in administrative cost ratios significantly higher than that of the CMHSP system. Accordingly, any new administrator must be limited to **existing CMH administrative rates, not industry standard!**

The obvious concern is that if the goal is sharing in "Cost Savings Revenue" what is the potential for inappropriate gutting of services, controlling medications, and limiting diagnostic testing? Where are the independent safeguards in the current process and who pays for them? They need to be independent and their cost counted against any calculated cost savings.

There is no mention that there will be hundreds of thousands of new dual eligibles beginning in April of 2012 coming with a Federal match which is at best questionable. How will the new administrator take on this burgeoning workload and at the same time take on responsibility for the developmental disability population with all of its special needs? There is already a scarcity of medical practitioners who accept Medicaid patients; will the system be overloaded by the newly created demands and effectively curtail access to prompt medical care as has been experienced in Massachusetts?

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Who will ultimately control final decisions as to who is served, what services will be deemed appropriate, whether current Person Centered Plans will be honored, and whether the most severely disabled receive any priority? What is the potential that the most severely impaired will be considered "too costly" to support in any meaningful manner?

### **Recommendation**

There has been nothing to indicate that any serious consideration has been given to the safe guard of citizens with developmental disabilities. In fact these considerations are accentuated by their absence. In order to avoid serious disruption to the existing fragile service delivery process, maintain the safety of clients and avoid great embarrassment and cost to the state, we recommend that launch of integrated care in Michigan for persons with developmental disabilities be deferred until such a time as the new administrator(s) are operational and until they have exhibited through process structure and a successful pilot that the proposed integration will support the safety and well being of Michigan's most vulnerable citizens.