CONSUMER ADVOCACY COUNCIL

Northern Lakes Community Mental Health
105 Hall Street
Training Room 124B (first floor)
Traverse City, Michigan

AGENDA

September 14, 2011

1:30 p.m. Welcome and Introductions

1:35 p.m. Public Comment/Advocacy Stories

1:40 p.m. Accept Meeting Minutes of August 10, 2011

1:45 p.m. Presentation by Pam Webster, Dietician

2:15 p.m. Network Providers

2:25 p.m. Mini-Grant Application

2:35 p.m. Dual Eligibles

2:45 p.m. Old Business
- Update on Budget
- Freedom to Work Amendment
- RCF Meeting
- CAC Assessment

2:55 p.m. Current Literature, Articles and Movies

3:00 p.m. New Business
- Membership

3:05 p.m. Agenda Planning
- NLCMH Strategic Plan
- Disability Network

3:10 p.m. Public Comment

3:15 p.m. Meeting Evaluation/Adjourn

Enclosures: Consumer Advocacy Council Minutes 07/13/2011
CAC Assessment
Membership List
DHS Memo

Please call Greg Paffhouse (231-876-3200 or 231-935-3083) if you need transportation assistance; and contact Deb Lavender (231-935-3677) if you are unable to attend the meeting.

STATE OF MICHIGAN
Department of Human Services

www.michigan.gov

Tel:
Fax:

Memo

To: County Directors

Date: 08/09/11

From:

Subject: 60 Month Limitation

Clients who may be affected by a policy change enforcing federal lifetime limits will receive a notification letter as soon as Wednesday, Aug. 10.

Clients who reach the federal five-year limit for cash assistance will no longer receive Family Independence Program benefits starting Oct. 1, 2011. The policy on lifetime limits does not apply to clients who receive cash benefits because of disability.

The letter directs clients to call a toll-free line – 855-763-3677 (Monday through Friday, 8 a.m. – 5 p.m.). The line will be staffed by Family Independence Specialists, Eligibility Specialists and Assistance Payment Supervisors.

Callers will be given information about programs available to help them in their step toward independence. That will include programs that focus specifically on the welfare of children – their health, care and development. The letter also directs clients to work with their local Michigan Works! office if they're not doing so already, at www.michiganworks.org.

In addition to the state programs, clients may also contact the United Way's 2-1-1 system for local support.

Should you receive media inquiries about the changes, please direct them to the DHS Office of Communications at 517-373-7394.

Please exercise patience and your best judgment in dealing with affected clients and contact your local office manager or Richard Thelen, DHS security coordinator (517-373-7621), with any concerns.

Thank you for your continued support to ensuring the safety net for those who are truly needy.

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF HUMAN SERVICES
LANSING

MAURA D. CORRIGAN
DIRECTOR

Tuesday, August 9, 2011

Dear (client name),

I am writing to inform you that your federal lifetime limit for cash assistance will likely be reached on Oct. 1, 2011. If you reach this limit, you will no longer receive cash benefits. The policy on lifetime limits does **not** apply to recipients receiving cash benefits because of disability.

The State of Michigan has a number of programs available to help you in this step toward independence. We offer programs that focus specifically on the welfare of your children – their health, care and development. Please see the next page for a listing of available programs and resources, from food and rent assistance to health care and child daycare. If you have any questions on these programs or this notice, please call toll-free **1-855-763-3677** (Monday through Friday, 8 a.m. – 5 p.m.) where expert caseworkers are available to assist you.

In addition to the numerous programs offered by the State of Michigan, the United Way operates a free and confidential referral service in most counties. The United Way referral service can be reached by dialing 2-1-1 or visiting www.uwmich.org/2-1-1/2-1-1-call-centers. Hearing-impaired callers may use the Michigan Relay Center to access 2-1-1. That number is 1-800-649-3777 or 7-1-1.

You will continue to be eligible for some of the work placement programs that have been available since you began receiving benefits. If you are not already working with your local Michigan Works! office, we recommend that you visit www.michiganworks.org to schedule an appointment and find the center nearest you. Michigan Works! offers many resources to assist with education and employment needs.

Later this month, you will receive a letter to confirm whether your cash benefits will end on Oct. 1. If you have any additional questions or need help contacting the resources listed on the next page and/or employment services, please call our toll-free number: **1-855-763-3677** (Monday through Friday, 8 a.m. - 5 p.m.), where our team is ready to help.

Maura D. Corrigan

Maura D. Corrigan
Director, Department of Human Services

235 SOUTH GRAND AVENUE • P.O. BOX 30037 • LANSING, MICHIGAN 48909
www.michigan.gov • (517) 373-2035

The Program	How It Can Help
Medicaid	Medical insurance for your family.
Food Assistance	A debit card is provided for use at grocery stores and farmers markets.
Child Development and Care	Help with daycare costs.
WIC	The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serves low and moderate income pregnant, breastfeeding, and postpartum women, infants, and children up to age 5 who have a nutrition-related health problem.
MIChild	A health care program for the low income uninsured children.
Step Forward Michigan	A comprehensive, statewide strategy focused on unemployed and underemployed residents to help homeowners who are at high risk of default or foreclosure with federal funds secured by the State of Michigan.
Children's Special Health Care Services:	A program that provides certain approved medical service coverage to some children and adults with special health care needs.
Michigan Works!	Areas of this program will still be available to you, including resume writing, workshops and access to the Michigan Talent Bank with job postings.
Vaccines for Children	Childhood vaccines provided by participating doctors and clinics for eligible children.
Child & Adolescent Health Center Program	Offers preventive and primary care to uninsured, underinsured and children receiving Medicaid.
Maternity Outpatient Medical Services (MOMS)	Provides immediate health coverage for pregnant women who may not qualify for Medicaid.
State Emergency Relief	Emergency help for heating fuel, electricity and home repairs.

Call 1-855-763-3677 (Monday through Friday, 8 a.m. - 5 p.m.) for more information on any of these programs.

Consumer Advocacy Council **Sept. 14, 2011**

Nutrition Ideas For Healthy Eating **Pam Webster R.D.**

- Eat a variety of foods each day.
- Don't skip meals.
- Drink adequate amounts of fluids each day.
- Eat foods of appropriate portion sizes.

Tips for Making Better Food Choices

- Check food labels for portion sizes, and nutrient content.
- Avoid foods with, more than 500 mg of sodium per serving.
- Avoid foods with more than 30% of the calories from fat.
- Avoid cravings for sweets by eating fruits, and drinking enough fluid each day.
- Eat routinely, don't wait to eat until you are starving.
- Don't eat large amounts of food late at night.
- Try to exercise routinely to build up a appetite and increase your metabolism.

Medicaid, Medicare, & Dual Eligibles.

Medicaid

Medicaid is a means tested safety net program, meaning an individual must meet certain income criteria to qualify and those individuals may not qualify indefinitely; that is, circumstances may change where the individual no longer meets the criteria.

Medicaid is funded jointly between the state and federal government. It covers many services, including long-term care.

Medicare

Medicare is an entitlement program, meaning the criteria to qualify are specified such that once a person meets the criteria, they will be permanently eligible (age, disability).

Medicare is a wholly federal program and consists of Part A (Acute hospitalization), Part B (physician services - requires a premium payment), Part C (Medicare Advantage - Part A & B managed care plans), and Part D (prescription coverage - also requires premiums & copays).

Dual Eligibles

Almost 222,000 Medicaid beneficiaries are "dual eligible," meaning they qualify for both programs.

Dual eligibles are either very low-income seniors or younger persons with disabilities. This population is extremely poor and generally extremely unhealthy.

Dual eligibles are more likely to have mental health needs and live in nursing homes.

Generally, those who are dual eligible receive Medicaid services (long term care) and Medicaid assists with premiums and co-pays required by Medicare.

Cost Savings

Cost savings for dual eligibles will be most effective when care is coordinated for persons in this category. Avoiding duplicative services, safe long term care options and mental health treatment are important factors when discussing cost savings.

Coordinating care has traditionally been discussed using managed care models.

Lynda Zeller
Deputy Director
Michigan Department of Community Health
Lansing, Michigan

August 16, 2011
DDAdvocates of Michigan
40698 Breckenridge Lane
Plymouth, Michigan 48170

Electronic Copies to:
Olga Dazzo
Michael Vizena
Select Committee Chairs

Subject: Dual Eligible Integration for Persons with Developmental Disabilities

DDAdvocates of Michigan is a state-wide network of advocates for persons with developmental disabilities. We are writing to express our concerns with the process and pace of the current project to integrate primary healthcare and behavioral health services for persons with developmental disabilities that are recipients of both Medicare and Medicaid. Please note that we wish these comments be included with other material that has been obtained from stakeholders across the state of Michigan.

We have carefully considered available information that applies to the proposed integration including: the process, the legal implications, safety concerns, the advantage of maintaining existing relationships with current providers and community stakeholders, the pros and cons of local control, budget considerations and cost management objectives such as "value-based purchasing".

It is our recommendation that integrated care in Michigan for persons with developmental disabilities be deferred for the reasons spelled out in the Attachment. No integration should take place until the selected "Accountable Care Organization" (ACO) or "look-alike" is operational and has exhibited through both the implementation of an effective process and a successful pilot that the proposed integration will support the safety and well being of Michigan's most vulnerable citizens.

Sincerely,

Jill Barker, Washtenaw
President: Friends of the Developmentally Disabled
Editor: The DD News Blog

Rita Bird, Ottawa
County Mental Health Board

Tom Bird, Ottawa
Editor; Town Hall Coalition

Ed Diegel, Wayne
Community Opportunity Center Bd.
Editor: ddAdvocates Newsletter

Maryanne Huff, Allegan
Director: Allegan CMH Agency

Jan Plas, Livingston
Livingston County CMH Board

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

- 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?

- 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?

Dual Eligible Integration for Persons with Developmental Disabilities: Attachment

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.

Michigan's Plan to Integrate Care for Dual Eligible's and the Link to National Healthcare Reform

Dr. Michael Brashears
Executive Director
Community Mental Health of Ottawa County
9/8/11

In July 2011, the State of Michigan held a series of public forums educating stakeholders to the State of Michigan's participation in a Federal demonstration project related to integrating care for Michigan's Medicare-Medicaid (dual eligible) population. *(Please see the attached materials related to the public forums and the goals and objectives of the demonstration project).* What might not be known to many is that the State of Michigan's plan to integrate services for the dual eligible populations is in fact the early implementation of National Healthcare Reform. The following is a brief summary of the link between Michigan's plan to integrate dual eligibles and National Healthcare Reform.

Centers for Medicare and Medicaid Services (CMS) Dual Eligible Demonstration Project

In partnership with the CMS Medicare-Medicaid Coordination Office, The State of Michigan and with 14 other States were granted a contract to develop models to address the following goals:

1. Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.
2. Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.
3. Improving the quality of health care and long-term services for dual eligible individuals.
4. Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.
5. Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.
6. Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.
7. Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.
8. Improving the performance quality of services providers and suppliers under the Medicare and Medicaid programs.

What should be known is that the CMS Medicare-Medicaid Coordination Office was established pursuant to Section 2602 of the Affordable Care Act.

Section 2602 of the Affordable Care ACT

CMS provides the following brief summary of Section 2602[1]

"Section 2602 of the Patient Protection and Affordable Care Act (Pub. L. 111-148), enacted on March 23, 2010, as revised by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), together known as the Affordable Care Act, created the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office"). The Medicare-Medicaid Coordination Office is charged with making the two programs work together more effectively to improve care and lower costs. Specifically, pursuant to section 2602(c) of the Affordable Care Act, the Office is focused on improving quality and access to care for Medicare-Medicaid enrollees; simplifying processes; and eliminating regulatory conflicts and cost-shifting that occurs between the Medicare and Medicaid programs, States, and the Federal government."

In essence, the Medicare-Medicaid Coordination Office was established via National Healthcare Reform. The State of Michigan voluntarily applied and was granted a contract by the Medicare-Medicaid Coordination Office to enact the goals and objectives of National Healthcare reform as related to the dual eligible population. What is not clear is whether the State of Michigan has evaluated the variables associated with early adoption of National Healthcare reform.

Conclusion

While there is no doubt that there is a need to better coordinate care for the Medicare-Medicaid population, early adoption of National Healthcare Reform for one specific population (the duals), raises the following general questions:

1. What is the impact to individuals who only have Medicare or Medicaid?
2. What happens if the Affordable Care Act is repealed by the federal government?
3. How does the integration of care for dual eligibles impact the rest of healthcare now and in the future?
4. What is the impact of the dual eligible demonstration project to implementing the rest of National Healthcare reform?

By electing to voluntarily enact one aspect of National Healthcare Reform with one specific population, the State of Michigan has in essence signed on to fully implement National Healthcare Reform.

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[1] CMS letter to State Medicaid Directors, Re: Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees, July 8th, 2011.

Northern Lakes
COMMUNITY MENTAL HEALTH

Free Movie Night at the Library!

Because of licensing restrictions we are not allowed to tell you the name of the movie being shown, but here are some hints:

- It is a major movie recently released on DVD starring Jodie Foster and Mel Gibson.
- The movie concerns a man who is hit with major depression and begins communicating using a toy hand puppet.
- The name of the movie is a furry animal with big buck teeth that chews down trees and builds dams.

The movie will begin at 6:00 PM, run until about 7:30, and then there will be a discussion panel following until about 8:00 PM.

No charge, we hope to see you there!

Place: Cadillac Wexford Public Library, 411 South Lake Street

Date/Time: Thursday, September 29, 6:00-8:00 PM