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BILL ANALYSIS

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House Bill 5389 (Substitute H-3 as passed by the House)
Sponsor: Representative Rick Shaffer
House Committee: Health Policy
Senate Committee: Health Policy

Date Completed: 12-6-06

CONTENT

The bill would amend the Social Welfare Act to require the Director of the Department of Community Health (DCH) to designate and maintain locally or regionally based single point of entry agencies for long-term care that would serve as visible and effective access points for individuals seeking long-term care and that would promote consumer choice and quality in long-term care options. The bill would do all of the following:

- **-- Require the DCH to monitor designated agencies.**
- **-- Require the DCH to require designated agencies to perform specified duties.**
- **-- Require the DCH to establish and publicize a toll-free telephone number for areas of the State in which a single point of entry agency was operational as a means of access.**
- **-- Authorize the DCH to take disciplinary action against a designated agency that failed to meet the bill's criteria or that intentionally provided biased information regarding long-term care.**
- **-- Prescribe fiscal and performance standards for a single point of entry agency.**
- **-- Require the DCH initially to designate up to four agencies as single point of entry agencies.**
- **-- Require the DCH to evaluate the performance of single point of entry agencies on an annual basis.**
- **-- Require the DCH to report to the Legislature on the impact of the initially designated agencies, and prohibit the designation of more single point of entry agencies until the DCH had reported.**
- **-- Provide that Medicaid reimbursement for health facilities or agencies could not be reduced below the level of rates and payments in effect on October 1, 2006, as a direct result of the four pilot single point of entry agencies.**

("Single point of entry" would mean a program from which a current or potential long-term care consumer could obtain long-term care information, screening, assessment of need, care planning, supports coordination, and referral to appropriate long-term care supports and services.)

DCH Monitoring

The DCH would have to monitor the agencies to assure, at a minimum, all of the following:

- -- That bias in functional and financial eligibility determination or assistance and the promotion of specific services to the detriment of consumer choice and control did not occur.
- -- That consumer assessments and support plans were completed in a timely, consistent, and quality manner through a person-centered planning process and adhered to other criteria established by the bill and the DCH.

-- That quality assistance and supports were given to applicants and consumers in a manner consistent with their cultural norms, language of preference, and means of communication.
-- That data and outcome measures were being collected and reported as required under the bill and by contract.
-- That consumers were able to choose their support coordinator.

The monitoring also would have to assure the provision of quality assistance and supports, and consumer access to an independent consumer advocate.

("Person-centered planning" would mean a process for planning and supporting the consumer receiving services that built on the individual's capacity to engage in activities that promoted community life and that honored the consumer's preferences, choices, and abilities. The process would involve families, friends, and professionals as the consumer desired or requested.)

Agency Duties & Responsibilities

The DCH would have to require that single point of entry agencies perform the following duties and responsibilities:

-- Provide consumers and any others with unbiased information promoting consumer choice for all long-term care options, services, and supports.
-- Facilitate movement between supports, services, and settings in a timely manner that assured consumers' informed choice, health, and welfare.
-- Assess consumers' eligibility for all Medicaid long-term care programs using a comprehensive level of care assessment approved by the DCH.
-- Assist consumers in obtaining a financial determination of eligibility for publicly funded long-term care programs.
-- Assist consumers in developing their long-term care support plans through a person-centered planning process.
-- Upon the request of a consumer, his or her guardian, or his or her authorized representative, facilitate needed transition services for consumers living in long-term care settings if they were eligible for those services according to a policy bulletin approved by the DCH.
-- Work with designated representatives of acute and primary care settings, facility settings, and community settings to assure that consumers in those settings were presented with information regarding the full array of long-term care options.
-- Reevaluate a consumer's eligibility and need for long-term care services upon the request of the consumer, his or her guardian, or his or her authorized representative or according to his or her support plan.
-- Initiate contact with and be a resource to hospitals within the area serviced by the agencies.
-- Authorize access to Medicaid programs for which the consumer was eligible and that were identified in the consumer's long-term care support plan.

An agency could not refuse to authorize access to Medicare programs for which the consumer was eligible.

("Authorized representative" would mean a person empowered by the consumer by written authorization to act on the consumer's behalf to work with the single point of entry, in accordance with the Act. "Guardian" would mean an individual who was appointed under the Estates and Protected Individuals Code, and would include an individual who was appointed as the guardian of a minor under the Code or who was appointed as a guardian under the Mental Health Code.

"Informed choice" would mean that the consumer was presented with complete and unbiased information on his or her long-term care options, including their benefits, shortcomings, and potential consequences, upon which he or she could base his or her decision.)

Except as otherwise provided, the DCH also would have to require an agency to provide the following services within the prescribed time frames:

-- Perform an initial evaluation for long-term care within two business days after contact by the consumer, his or her guardian, or his or her authorized representative.
-- Develop a preliminary long-term care support plan in partnership with the consumer and, if applicable, his or her guardian or authorized representative, within two business days after the

consumer was found to be eligible for services.
-- Maintain consumer contact information and long-term care support plans in a confidential and secure manner.
-- Provide consumers with a copy of their preliminary and final support plans and any updates to the plans.
-- Complete a final evaluation and assessment within 10 business days from initial contact with the consumer, his or her guardian, or his or her authorized representative.

For a consumer who was in an urgent or emergency situation, within 24 hours after contact was made, the agency would have to perform an initial evaluation and develop a preliminary long-term care support plan. The plan would have to be developed in partnership with the consumer and, if applicable, his or her guardian or authorized representative.

For a consumer who received notice that within 72 hours he or she would be discharged from a hospital, within 24 hours after contact was made by the consumer, his or her guardian, his or her authorized representative, or the hospital discharge planner, the agency would have to perform an initial evaluation and develop a preliminary long-term care support plan. The plan would have to be developed in partnership with the consumer and, if applicable, his or her guardian or authorized representative, or the hospital discharge planner.

Additionally, an agency would have to provide consumers with information on how to contact an independent consumer advocate and a description of the advocate's mission. This information would have to be provided in a publication prepared by the DCH in consultation with these entities. It also would have to be posted in the office of a single point of entry agency.

An agency would have to collect and report data and outcome measures as required by the DCH, including the following data:

-- The number of cases in which admission to a long-term care facility was denied and the reasons for denial.
-- The number of cases in which a memorandum of understanding was required.
-- The rates and causes of hospitalization.
-- The rates of nursing home admissions.
-- The number of consumers transitioned out of nursing homes.
-- The average time frame for case management review.
-- The total number of contacts and consumers served.
-- The data necessary for the completion of the required cost-benefit analysis (described below).
-- The number and types of referrals made.
-- The number and types of referrals that were not able to be made and the reasons why they were not completed, including consumer choice, services not available, consumer functional or financial ineligibility, and financial prohibitions.

A single point of entry agency would serve as the sole agency within the designated area to assess a consumer's eligibility for Medicaid long-term care programs using a comprehensive level of care assessment approved by the DCH.

Although a community mental health services program (CMHSP) could serve as a single point of entry agency to provide services to individuals with mental illness or developmental disability, CMHSPs would not be subject to the provisions of the Social Welfare Act.

Promulgation of Rules

In consultation with the Office of Long-Term Care Supports and Services, the Michigan Long-Term Care Supports and Services Advisory Commission, the Department of Human Services (DHS), and the Office of Services to the Aging, the DCH would have to promulgate rules to establish criteria for designating local or regional single point of entry agencies for long-term care that met all of the following criteria:

-- The designated agency was free from all legal and financial conflicts of interest with providers of Medicaid services.
-- The designated agency was capable of serving as the focal point for all individuals, regardless of age, seeking information about long-term care in their region, including individuals who would pay privately for services.

-- The designated agency was capable of performing required consumer data collection, management, and reporting.
-- The designated agency had in place quality standards, improvement methods, and procedures that measured consumer satisfaction and monitored consumer outcomes.
-- The designated agency had knowledge of the Federal and State statutes and regulations governing long-term care settings.
-- The designated agency maintained an internal and external appeal process that provided for a review of individual decisions.
-- The designated agency was capable of delivering single point of entry services in a timely manner according to standards established by the DCH and prescribed in the bill.
-- The designated agency did not provide direct or contracted Medicaid services.

For the bill's purposes, the services required under it would not be considered Medicaid services.

Disciplinary Action

A single point of entry agency that failed to meet the criteria or other fiscal and performance standards prescribed by contract and the bill (described below) or that intentionally and knowingly presented biased information that was intended to steer consumer choice to particular long-term care supports and services, would be subject to disciplinary action by the DCH. Disciplinary action could include increased monitoring by the DCH, additional reporting, termination as a designated single point of entry agency by the DCH, or any other action as provided in the agency's contract.

Fiscal & Performance Standards

Fiscal and performance standards for a single point of entry agency would include all of the following:

-- Maintaining administrative costs that were reasonable, as determined by the DCH, in relation to spending per client.
-- Identifying savings in the annual State Medicaid budget or limits in the rate of growth of the Medicaid budget attributable to providing the bill's required services to consumers in need of long-term care services and supports, taking into consideration Medicaid caseload and appropriations.
-- Consumer satisfaction with services provided as required by the bill.
-- Timeliness of delivery of the required services.
-- Quality, accessibility, and availability of the required services.
-- Completion and submission of required reporting and paperwork.
-- Number of consumers served.
-- Number and type of long-term care services and support referrals made.
-- Number and type of services and support referrals not completed, taking into consideration the reasons why the referrals were not completed, including consumer choice, services not available, consumer functional or financial ineligibility, and financial prohibitions.

("Administrative costs" would mean the costs that were used to pay for employee salaries not directly related to care planning and supports coordination and administrative expenses necessary to operate each single point of entry agency. "Administrative expenses" would mean the costs associated with the following general administrative functions:

-- Financial management, including accounting, budgeting, and audit preparation and response.
-- Personnel management and payroll administration.
-- Purchase of goods and services required for the agency's administrative activities, including utilities; office supplies and equipment; information technology; data reporting systems; postage; mortgage, rent, lease, and maintenance of building and office space; travel costs not directly related to consumer services; and routine legal costs related to the agency's operation.)

Cost-Reporting Methods

The DCH would have to develop standard cost-reporting methods as a basis for conducting cost analyses and comparisons across all publicly funded long-term care systems, and would have to require agencies to use these and other compatible data collection and reporting mechanisms.

Designation as Single Point of Entry Agency

The DCH would have to solicit proposals from entities seeking designation as a single point of entry agency and, except as otherwise provided, initially would have to designate a maximum of four agencies to serve as a single point of entry agency in at least four separate areas of the State. There could not be more than one single point of entry agency in each designated area. A designated agency would serve for an initial period of up to three years, subject to the provisions regarding failure to meet the bill's criteria or intentionally and knowingly presenting biased information. In accordance with the bill, the DHS would have to require a consumer residing in an area served by a designated agency to use that agency if he or she were seeking eligibility for Medicaid long-term care programs.

Cost-Benefit Analysis

The DCH would have to engage a qualified objective independent agency to conduct a cost-benefit analysis of single point of entry, including the impact on Medicaid long-term care costs.

The DCH would have to make a summary of the annual evaluation, any report or recommendation for improvement regarding the single point of entry, and the cost-benefit analysis available to the Legislature and the public.

DCH Report & Presentation

Between 12 and 24 months after the implementation of the single point of entry agency designated under the bill, the DCH would have to submit to the Senate and House of Representatives standing committees dealing with long-term care issues, the chairpersons of the Senate and House Appropriations Committees, the chairpersons of the Senate and House Appropriations Subcommittees on Community Health, and the Senate and House Fiscal Agencies a written report regarding the array of services provided by the agencies and the cost, efficiencies, and effectiveness of single point of entry. In the report, the DCH would have to provide recommendations regarding the continuation, changes, or cancellation of single point of entry agencies based on data provided, as required by the bill.

The DCH would have to promulgate rules to implement the bill's provisions within 270 days after submitting the report.

Beginning in the year the report was submitted and annually after that, the DCH would have to make a presentation on the status of single point of entry and on the required summary information and recommendations to the Senate and House Appropriations Subcommittees on Community Health, to ensure that legislative review of single point of entry would be part of the annual State budget development process.

Limits on Designation

The DCH could not designate more than the initial four agencies to serve as single point of entry agencies or similar agencies unless all of the following occurred:

-- The written report was submitted as required.
-- Twelve months had passed since the submission of the report.
-- The Legislature appropriated funds to support the designation of additional agencies.

The DCH could not designate more than the initial four agencies to serve as single point of entry agencies or similar agencies unless these conditions were met and the Legislature repealed this provision.

Proposed MCL 400.109i & 400.109j

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

The Department of Community Health began providing funds to four agencies to provide single point of entry for Medicaid long-term care recipients late in FY 2005-06. The FY 2006-07 DCH appropriation provides $9.0 million Gross/$4.5 million GF/GP for the single point of entry pilot projects, with anticipated need in FY 2007-08 of about $18.9 million Gross/$9.45 million GF/GP.

The bill specifies a number of administrative and oversight tasks that the DCH would have to complete in its management of the

single point of entry pilot project. The Department likely would have to devote additional financial and staff resources to meet the requirements of the bill. The fiscal impact of these tasks is not currently known and would be largely determined by what oversight efforts DCH has made to date in relation to the requirements outlined in the legislation.

The final report of the Michigan Medicaid Long-Term Care Task Force estimated that statewide implementation of single point of entry would create a 1.7% gain in cost efficiency for Medicaid long-term care services. While it is difficult to determine the accuracy of this figure, if this gain were realized, it would provide about $35 million Gross/$15.2 million GF/GP in Medicaid savings to the State.

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