MICHIGAN ASSOCIATION OF HEALTH PLANS | 2012

Michigan Association of Health Plans

Analysis and Recommendations for the Integration of Services in Michigan for Persons with Dual Eligibility

The mission of the Michigan Association of Health Plans is to provide leadership for the promotion and advocacy of high quality, affordable, accessible health care for the citizens of Michigan.

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I. Purpose of MAHP White Paper

The purpose of this MAHP White Paper is to encapsulate the culmination of MAHP advocacy efforts prior to and throughout the stakeholder process, share guidance provided, and provide a summary of key messages resulting from these activities to assist the Michigan Department of Community Health, (MDCH), the Snyder Administration and Michigan Legislature in the development and implementation of an effective integrated care program designed to serve Michigan's most vulnerable older adults and persons with disabilities who are fully eligible for Medicare and Medicaid covered services.

Developing an integrated model is the next key step as a required follow up to the CMS Michigan innovation grant award. Equally important will be insuring that the legislative framework exists to allow for program deployment. MAHP's recommendations are outlined as part of this White Paper and address these concerns.

MAHP welcomes the opportunity to continue the dialogue begun as part of the stakeholder planning and development process and to share expertise and lessons learned from years of experience achieving improved health outcomes serving non-aged, non-disabled Michigan Medicaid recipients.

II. Background Information

The Center for Medicare and Medicaid Services (CMS) estimate there are around nine million dual eligible Medicare and Medicaid recipients. While representing a small percentage of the approximately 100 million people enrolled in the two programs, they account for a disproportionate amount of spending or about $300 billion a year across both programs. For example, dual eligible beneficiaries account for 16 percent of Medicare enrollees but 27 percent of Medicare spending. In the Medicaid program, individuals dually enrolled make up 15 percent of the program but account for 39 percent of costs.

In Michigan, there are over 205,000 dual eligible beneficiaries in Michigan. Michigan Department of Community Health (MDCH) 2010 data indicates this population represented 12% of total Medicaid enrollment at a cost of about $3.6 billion in 2010, representing 38% of total Medicaid spending. At the same time, Medicare spending on duals in Michigan was estimated to be $4.1 billion. Combining both the Medicare and Medicaid costs, 2010 spending on duals in Michigan is estimated to be approximately $8.0 billion in 2010.

Despite the significant spending, the current system in place to serve beneficiaries with both Medicare and Medicaid results in redundancies in treatment because of inadequate care coordination and limited quality assurances in the system. The end result is costly care delivered in a manner that does not support simple, easy access to care or improved health outcomes for beneficiaries.

Distribution by County of Currently eligible persons with Dual Eligibility

Table 1 (following page) summarizes the current distribution of dual eligible beneficiaries across Michigan counties.

Table 1 – Distribution of Michigan Beneficiaries with Dual Eligibility (DE)
Source: MDCH Data – April 2011

County Name	Total	% to Total
Wayne	51,305	24.1%
Oakland	18,704	8.8%
Macomb	14,317	6.7%
Kent	12,320	5.8%
Genesee	10,040	4.7%
All Other Counties	106,523	50.0%
Total	**213,209**	**100.0%**

Distribution by age/sex of Currently Eligible Persons

Tables 2 - 4 (below) provide a summary of Michigan duals gender and age beneficiary demographic information. In summary:

- Women represent 61.5% of all Michigan duals, and 52.6% of DE women are over the age of 65.
- Men represent 38.5% of all Michigan duals, and 64.7% are under 65 years of age.

Table 2 - # of Dual Eligible Beneficiaries by Gender & Age Category

Gender	Under 65	Over 65	Total – All DEs
Female	64,539	71,725	136,264
Male	55,268	30,155	85,423
Total	**119,807**	**101,880**	**221,687**

Table 3 - # of Dual Eligible Beneficiaries by Gender & Age Category

Gender	Under Age 65	Over Age 65	Total – All DEs
Female	53.9%	70.4%	61.5%
Male	46.1%	29.6%	38.5%
Total	**100.0%**	**100.0%**	**100.0%**

Table 4 - % of Dual Eligible Beneficiaries by Gender & Age – By Gender

Gender	Under Age 65	Over Age 65	Total – All DEs
Female	47.4%	52.6%	**100.0%**
Male	64.7%	35.3%	**100.0%**
Total	54.0%	46.0%	**100.0%**

Tables 2 – 4 Source: Medicaid Data Warehouse – 2010 Unduplicated Count of Beneficiaries

III. Michigan Medicaid Managed Care Experience and Outcomes

The Michigan Medicaid managed care program provides access to Medicaid covered services to over 1.2 million Michigan citizens. The demonstrated and audited outcomes of the Medicaid managed care program stand as testimony to policy makers, administrators and beneficiaries of the high quality and comprehensive services Michigan's health plans consistently deliver. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management, built on a framework that delivers cost savings without jeopardizing access to necessary services.

When compared to Medicaid Fee for Services alternatives between FY 00 and FY 12, Medicaid managed care savings were estimated at **$5.0 billion in total savings or about $400 million each year.** These cost savings are accompanied by increasing improvements in health status measures for children and adults that are determined by audited record review, and greater access to needed health care services, documented by provider file contract information retained by the state.

Through development of Medicare Advantage Special Needs Plans (SNPs), many of Michigan Medicaid managed care health plans have also invested significantly in developing and operating federally contracted, comprehensive Medicare managed care specialty plans focused on serving the very specific needs of the dual eligible population. These programs build on the existing strengths of the Michigan Medicaid managed care program, while incorporating the comprehensive Medicare requirements for serving the dual eligible population. By integrating these two (2) programs, SNPs provide a smooth transition for the dual-eligible population to a seamless, continuous, coordinated care solution as they become eligible for Medicare benefits.

By integrating all components of the Michigan Medicaid Program, access to the full continuum of services and programs will be fully available to beneficiaries who rely on both Medicare and Medicaid for their health care needs. In addition, integration will allow dual eligible beneficiaries access to the proven expertise, quality assuring, and cost controlling skills developed within Michigan Medicaid's behavioral health PIHP program, the aging services home and community based MiChoice program, and long-term care providers. As evidenced by the chart below, integration of services is sorely needed.

Michigan DEs
Chronic Conditions

Condition	# of Individuals	% of Duals
Ischemic Heart Disease	70,650	34%
Diabetes	64,570	31%
Depression	53,425	26%
Chronic Heart Failure	49,496	24%
Arthritis	48,491	23%
Behavioral Health	41,863	20%
Alzheimer Related Disease	37,872	18%
Chronic Obstructive Pulmonary Disease	36,754	18%
Chronic Kidney Disease	33,058	16%
Cataract	21,852	11%
Osteoporosis	20,060	10%
Alzheimer's Disease	19,844	10%

•Over 14% have >six (6) multiple conditions.
•8% have five (5) multiple conditions.
•10% have four (4) multiple conditions.
•Over 12% have three (3) multiple conditions.

Source: MDCH Stakeholder Meeting Presentation Slides – July 2011

IV. Integrating Care for Dual Eligibles in Michigan – Developing the Michigan Model

In February 2011, Michigan was one of 15 states awarded a planning contract from the Centers of Medicare and Medicaid Services (CMS) to improve care and services for persons with Medicare and Medicaid eligibility. In its application for this planning contract, the Michigan Department of Community Health (MDCH) described intent to plan for "Implementation of an integrated services and funding model." To apply for the contract award, Michigan was required to outline a concept for integrated care in the state. Michigan's draft plan for integrated care included the following program elements:

- All core Medicare and Medicaid services provided with the potential for additional social supports
- A comprehensive provider network available across the continuum of services so that participants are assured choice within the network
- A standardized assessment tool to identify participant needs
- Person-centered medical homes to ensure access to care
- Family caregiver involvement
- Strong home and community based service options
- A single care coordinator to assist development of person-centered plans of care based on choice and to assist participant navigation of the health care system
- Plan performance metrics to evaluate effectiveness

- Quality management strategies and measurements unavailable in the current fee-for-service model
- Data sharing amongst providers across the continuum of care to enhance care coordination
- Mandatory enrollment with the ability to opt out
- Consumer protections, including grievance and appeal processes that meet the standards required by both Medicare and Medicaid

With the contract funds, Michigan was expected to engage pertinent stakeholders in the planning and development phase, building upon the original concept submitted to CMS. The following provides the planning and development timeline originally proposed, as well as, the actual timeline of activities as deployed:

Task	Anticipated Timeline	Actual Timeline
Conduct Public Forums	July 2011	July 2011
Stakeholder Interviews	August 2011	August 2011
Request for Information	August – September 2011	August – September 2011
Stakeholder Workgroups	September – October 2011	November – December 2011
Development of CMS Report	November 2011 – March 2012	January 2011 (Actual) – March 2012 (Projected)

V. Stakeholder Process

MAHP leadership, staff and members have been actively involved throughout the stakeholder process. This has included participation in the interview process, developing a formalized written response to the "Request for Information" and participation of MAHP members in the Stakeholder Workgroup Process. Refer to **Appendix 2** for the MAHP "Request for Information" response.

MAHP applauds MDCH management and staff for providing all interested parties a participative, inclusive stakeholder process that was well organized and provided a data-driven, educated approach to sharing information and developing a common platform of understanding for all participants. The Stakeholder Workgroup Process was organized in a manner that allowed for cross-industry interaction within the following key disciplines:

1. Service Array and Provider Network Workgroup

2. Care Coordination and Beneficiary Assessment Workgroup
3. Performance Measurement and Quality Management Workgroup
4. Education, Outreach, and Enrollee Protections Workgroup

Each workgroup had a specific set of responsibilities and through the series of three (3) workgroup meetings of each workgroup, common messages emerged. Behavioral health, aging, and disabilities advocates and other participants expressed the importance maintaining "Person-centeredness" as the core foundation of an integrated program. To protect beneficiary choice and maintain continuity of care, workgroup participants recommended that all current providers, plans and services be maintained. At an operational level, all workgroups expressed the need for access to data-sharing technology to insure consistent, real-time access to information. Each workgroup also had specific messages and recommendations that will be summarized in a final report to be released through the workgroup process.

All workgroup materials, participant rosters, and meeting summaries can be reviewed at: https://janus.pscinc.com/dualeligibles/

VI. Consensus through Collaboration

Beginning in July of 2011 and continuing throughout the stakeholder process, a group of Michigan trade associations representing organizations whose members manage and provide healthcare related services to these persons began a series of meetings to develop a consensus recommendation for a set of guiding principles to support and direct the state's planning efforts. The collaboration involved several joint discussions with the leadership of the following endorsing organizations:

- Area Agencies on Aging Association of Michigan
- Aging Services of Michigan
- Health Care Association of Michigan
- Michigan Association of Community Mental Health Services Boards
- Michigan Association of Health Plans

As a result of their discussions, these organizations developed a consensus resolution and guiding principles which was shared with various interested parties, including the MDCH and held a joint meeting with MDCH staff regarding the "Consensus Statement". (Refer to **Appendix 3)**

VII. Executive Summary of MAHP Recommendations

MAHP offers the following recommendations to be considered as the State finalizes the development and implementation of the Michigan's Dual Eligible Integrated Care Program. These recommendations have been developed as a result of MAHP participation in the various stakeholder groups, internal meeting of MAHP members, and consistency with MAHP Strategic Plan.

Implementation Recommendations

1. In order to implement an effective, coordinated, person-centered program within the defined project timeline, MAHP recommends a phase-in by geographic region rather than targeted population. Integrating necessary services locally and across industries for the first time will require close scrutiny and ability to react quickly to unintended barriers or obstacles. Beginning in a defined geographic region will allow issues to be identified and resolved quickly, avoiding unintended beneficiary consequences.

2. To allow sufficient time for potential bidders to prepare for participation in the state's integration project, MAHP recommends the initial targeted geographic region be defined and communicated either before or no later than parallel to the April 2012 CMS program submission.

3. To the extent possible and without jeopardizing Michigan's CMS approval of the integration project, the CMS-submitted timeline must be developed with a detailed project plan to support a successful program launch.

4. To meet the significant operational requirements necessary to effectively integrate Medicare and Medicaid benefits, payments, and care coordination, MAHP recommends contracted entities have the infrastructure in place to administer risk based arrangements, performance based measures, and the technology to administer a comprehensive, integrated Medicare and Medicaid benefit plan and payments.

Care Integration & Performance Measurement Recommendations

5. MAHP supports the development of a person-centered eligibility, enrollment and individualized care assessment and care plan process.

6. To insure access and continuity of care, and as financially funded by MDCH, MAHP recommends the full array of current services be maintained and protected.

7. To protect beneficiary choice, insure access and continuity of care, MAHP recommends maintaining all current health plans and providers, including, all current supports coordination and community-based providers currently serving Michigan's dual eligible beneficiaries. Further, MAHP recommends continued program participation is based on performance measure outcomes. This maintenance of effort can only be accomplished if sufficient funding remains available.

8. To allow for an effective, person-centered assessment and care coordination process, MAHP recommends all contracted entities, including Michigan Department of Community Health, health plans and all providers, utilize a common source of data accessible to electronic medical records (EMR) tools, E-prescribing and pharmacy data, and support integration of other necessary data sharing.

Financial Sustainability Recommendations

9. MAHP embraces the elimination of wait lists and other beneficiary service access barriers. To assure financial stability of the program, however, funding must be sufficient to provide all program defined services and person-centered planning expectations.

10. MAHP recommends expected program savings are utilized to absorb increased volume of services resulting from elimination of wait lists and maintaining current level of necessary services to meet beneficiary person-centered expectations.

11. MAHP understands and embraces the financial uncertainty associated with developing and implementing an integrated care program for dual eligible beneficiaries. With an understanding and agreement of the actuarial rate setting process, MAHP Members are willing to engage in the uncertainty of a shared risk or full financial risk model. MAHP welcomes the opportunity to dialogue with the Michigan Department of Community Health in the development of the rate-setting methodology and data collection process necessary to implement actuarially sound rates.

12. As a minimum requirement to participate, MAHP recommends that contracted entities must be licensed as Michigan risk-bearing insurance entities and accredited by the National Committee for Quality Assurance (NCQA) or URAC with an effective date of January 1, 2012.

Legislative and Regulatory Recommendations

13. MAHP supports a coordinated regulatory oversight process that is consistently applied to all contracted entities chosen to participate as carriers in this initiative.

14. MAHP recommends the development and submission of a comprehensive waiver that will resolve federal regulatory barriers that otherwise would impede successful implementation. MAHP further recommends the resolution of the state regulatory barriers through an executive order, statutory change, or policy, as may be applicable to resolving the barrier.

VIII. Appendix 1: Documents Shared with MDCH Workgroups

In the spirit of open and informative collaboration, the Michigan Association of Health Plans is providing this brief generalized summary of our member plans' services, aims, efficiencies, operations and delivery benefits.

Michigan Health Plans are managed group health insurance plans that provide health care services to plan participants through a broad system of participating health care professionals and facilities. They emphasize preventive health care, including periodic physical exams and encouragement of a healthier lifestyle. As a result, Michigan's Health Plans provide high quality, affordable, accessible health care for the citizens of Michigan. Below are spotlighted essentials.

- State Licensed and Nationally accredited
- 2.7 Million current Michigan health plan members
- 1.3 million current Michigan Medicaid members
- Active Medicaid plan providers since 1997
- Service to all of Michigan's 83 counties
- Accessibility of primary care physicians
- Time and again outstanding national performance and quality rankings
- Proven cost efficiencies

For information on individual MAHP Member Health Plans, links are provided below:

CareSource Michigan: www.caresource.com
Grand Valley Health Plan: www.gvhp.com
Health Alliance Plan: www.hap.org
Meridian Health Plan of Michigan, Inc.: www.mhplan.com/mi/
HealthPlus of Michigan: www.Healthplus.org
McLaren Health Plan: www.mclarenhealthplan.org
Midwest Health Plan: www.midwesthealthplan.com
Molina Healthcare of Michigan: www.molinahealthcare.com
OmniCare Health Plan: www.omnicarehealthplan.com
Paramount Care of Michigan: www.paramounthealthcare.com
Physicians Health Plan: www.phpmm.org
Priority Health: www.priorityhealth.com
ProCare Health Plan: www.procarehp.com
Total Health Care, Inc.: www.totalhealthcareonline.com
United Healthcare Great Lakes Health Plan: www.uhc.com
Upper Peninsula Health Plan: www.uphp.com

Michigan Association of Health Plans (MAHP)
MAHP Advocacy for Developing an Effective Integrated Care Program for Michigan's Dual Eligible Beneficiaries

January 2012

MICHIGAN MANAGED CARE

SUMMARY INFORMATION LINKS

Michigan Health Plans provide high quality, affordable and accessible health care for the citizens of Michigan. Below please find various links to give detail about the efforts of the Michigan health plans. Most of these links are related to quality.

HEDIS--- http://www.michigan.gov/mdch/0,1607,7-132-2943_4860-39268--,00.html

External Quality Review-- http://www.michigan.gov/mdch/0,1607,7-132-2943_4860-28384--,00.html

Quality Check-Up-- http://www.michigan.gov/documents/QualityCheckupJan03_59423_7.pdf

Consumer Assessment Reports-- http://www.michigan.gov/mdch/0,1607,7-132-2943_4860-130530--,00.html

Blood Lead Testing Reports-- http://www.michigan.gov/mdch/0,1607,7-132-2943_4860-102097--,00.html

Reporting Requirements-- http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42544_42644_42680---,00.html

Waivers-- http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42553-181419--,00.html

Medicaid Health Plans Listing by County-- http://www.michigan.gov/documents/mdch/MHP_Service_Area_Listing_326102_7.pdf

Sample Health Plan Contract-- http://www.michigan.gov/documents/contract_7696_7.pdf

Annual NCQA rankings:

- Commercial HMO rankings - http://www.consumerreports.org/health/insurance/private-hmo-1.htm
- Medicare HMO rankings - http://www.consumerreports.org/health/insurance/medicare-hmo-1.htm
- Medicaid HMO rankings - http://www.consumerreports.org/health/insurance/medicaid-1.htm

TABLE OF ADMINISTRATIVE FUNCTIONS PROVIDED BY MEDICAID HMOS

Historically, in the Medicaid fee-for-service program, the state's major administrative functions were to issue monthly ID cards, enroll providers and to pay claims. In that environment, no effective cost controls existed and state budget expenditures increased steeply from year to year and were unpredictable. To gain cost predictability and control without sacrificing medical benefits, the State engaged health plans to perform functions previously not performed for Medicaid beneficiaries. The underlying administrative infrastructure required of each HMO needs to be understood as critical to their ongoing performance.

Costs associated with these "functions" are not included in those costs labeled "medical costs" or "medical loss ratio" as those measures typically are used to identify how much of the premium dollar received by an HMO is spent on direct health care delivery services. Nevertheless, the cost for the "administrative functions" outlined in this Table are inherently necessary in order to establish and sustain the improved delivery of services for Medicaid beneficiaries consistent with the objectives prescribed by the state and to continue to provide the best value for the State of Michigan.

Notwithstanding additional administrative requirements related to the management of care for Medicaid beneficiaries, the overall average administrative costs incurred by Medicaid health plans continue to decline as a percent of the state premium from 10.3% in CY 2003 to under 8% of total premiums estimated for CY 2009.

Administrative Functions of Medicaid Health Plans

Category	Feature of Medicaid Health Plans Under the State's Medicaid Contract and State HMO Requirements
Administration Cost: Beneficiary Services—Member Information	• Member Enrollment Packet (Welcome letter, ID cards, Certificate of Coverage, Provider Directory) • Member Handbook at time of enrollment • Member Newsletter distributed periodically (no less than 3 times per year) • Toll-Free Member Hotline (24/7) to answer questions and resolve problems for members • Member Advisory Committees and/or Membership as Consumer member on Governing Body • Grievance & Appeal Process including Medicaid Fair Hearing • OFIR external reviews • Enrollment services functions including special dis-enrollments
Administrative Cost: Beneficiary Services—Health Education and Health Promotion	• Member Health Education • Targeted Beneficiary Incentive Programs • Health Fairs • Health Assessment Programs • Outreach for EPSDT and for services to pregnant women
Administrative Cost: Beneficiary Services—Care Coordination	• Care Coordination, especially with mental health or substance abuse agencies and for Children with special needs • Case Management • Disease Management to help members with chronic conditions, such as

	diabetes or asthma • Maternal and Infant Support Services (MSS/ISS) • Primary Care Provider—Medical Home • Local Health Department Coordination, including WIC • Coordination with Community Mental Health • Coordination of Transportation • Referral Management • For Cause--Disenrollment • Discharge Planning activities for inpatient services • Pharmacy management
Administrative Cost: Quality of Care Assurance	• Providers who are credentialed every three years • External Health Plan Accreditation (e.g., NCQA, URAC) • Individual Site Visits/medical record reviews of Plan Providers • Focused Clinical Studies and Quality Improvement Plans to improve care identified as less than optimal • Health Care Standards and Policies, including Access Standards • Fraud & Abuse policies and activities • Development and distribution of Clinical Guidelines • Profiling and reviewing physician practices for quality measures
Administrative Cost: HMO Public Accountability	• Data Reporting to the Department of Community Health o Utilization of Services (Encounter Reporting-Monthly) o Paid Claims (Monthly) o Grievance and Complaints (Semi-Annual) o Data Quality Improvement Reviews (Semi-Annual) o Provider Network (Monthly Updates) o Physician Incentive (Annual) o Litigation Reporting (Annual) • Audited HEDIS Reports (Annual) • HMO Financial Reports (Quarterly and Annual—available on OFIR Web Site) • Customer Satisfaction Surveys (CAHPS), including adolescent CAHPS (available as tool only for Medicaid Products) • Provider Satisfaction Surveys • External Quality Reviews (performed by MDCH) • Administration of annual site visit by OFIR and DCH • External Accreditation from a National Organization
Administrative Cost: Provider Services	• Provider Hotline and other provider communications • Provider Manuals, Education, Orientation & Training • Administration of Provider Complaint and Appeals • Electronic Billing Capacity • Serve as Third Party Administrator for Psychotropic Medications prescribed by Community Mental Health Providers • Coordination of Benefit Activities • Physician and Provider Profiling Reports

IX. Appendix 2– Michigan Association of Health Plans (MAHP) MDCH Request for Input – Integrating Care for People Eligible for both Medicare and Medicaid

Questions for All Interested Parties

1. What is working well in the current system of services and supports (i.e., medical care, long-term services and supports, and behavioral health and developmental disabilities services and supports) available to people who are eligible for and enrolled in both Medicare and Medicaid?

   MAHP Response

   The Michigan Medicaid managed care program provides access to Medicaid covered services to over 1.2 million Michigan citizens. The demonstrated and audited outcomes of the Medicaid managed care program stand as testimony to policy makers, administrators and beneficiaries of the high quality and comprehensive services and programs delivered. This is largely due to the nature of the performance-based contract, the inherent flexibility of a managed care system, and the emphasis on prevention, care coordination and disease management, built on a framework that delivers cost savings without jeopardizing access to necessary services.

   When compared to Medicaid Fee for Services alternatives between FY 00 and FY 12, Medicaid managed care savings were estimated at **$5.0 billion in total savings or about $400 million each year.** These cost savings are accompanied by increasing improvements in health status measures for children and adults that are determined by audited record review, and greater access to needed health care services documented by provider file contract information retained by the state.

   Through development of Medicare Advantage Special Needs Plans (SNPs), many of Michigan Medicaid managed care health plans have also invested significantly in developing and operating federally contracted, comprehensive Medicare managed care specialty plans focused on serving the very specific needs of the dual eligible population. These programs build on the existing strengths of the Michigan Medicaid managed care program while building a seamless transition for the dual-eligible population to continue to rely on continuous, seamless, coordinated care as they become eligible for Medicare benefits.

   By integrating all components of the Michigan Medicaid Program, access to the full continuum of services and program will be available to all beneficiaries who rely on the Medicare and Medicaid for their health care. In addition to access to comprehensive programs and services of the MHPs, integration will allow dual eligible beneficiaries seamless access to the proven expertise, quality assuring, and cost controlling skills developed within its behavioral health PIHP program, the aging services home and community based MiChoice program, and long-term care providers.

   The Michigan Medicaid managed care program is working and delivering results throughout the state.

2. What are the problems in the current system of services and supports for people who are eligible for and enrolled in both Medicare and Medicaid? What is not working that might be addressed in an integrated

system that coordinates care across the providers/caregivers you see?

MAHP Response

While 2/3 of the eligible Medicaid population is enrolled in managed care, **¾ of the cost of Medicaid still resides with the remaining fee-for-service Medicaid population not enrolled in managed care.** This has led to **redundancies in treatment because of inadequate care coordination and limited quality assurance.** Currently, duals must navigate the two very different and complicated administrative structures of Medicare and Medicaid. A significant amount of confusion results from **multiple membership cards, varying coverage rules, and numerous uncoordinated specialty providers**.

Currently, Michigan dual eligibles have limited availability of home and community based waiver services. While Medicaid pays for nearly 36,500 dually eligible beneficiaries residing in nursing facilities, only 7,239 individuals are served through MI Choice, Michigan's home and community based (HCBS) waiver for individuals who are elderly or have a disability. With a waiting list of 7,900 individuals, **more people are awaiting waiver assistance than are being served by MI Choice**. A fully integrated care coordination model will allow all dual eligibles access to HCBS when needed and eliminate the wait list.

Furthermore, while nearly 56,000 beneficiaries, including more than 35,000 duals, receive unskilled personal care services through a state plan benefit, these individuals are unable to access additional community supports and services that are available through the waiver.

The current Medicaid eligibility process is not working. The current process often requires weeks and months to determine eligibility, and then results in errors and delays in allowing beneficiaries access to needed services. Implementing eligibility changes consistent with the changes required under ACA for Medicaid expansion for a web-based system, including annual eligibility and simplified re-determination forms and processes will further insure dual eligible beneficiaries experience simple, seamless access to needed services.

Building on Michigan's current Medicaid managed care system and utilization of the proven expertise, quality assuring, and cost controlling skills of its MHP, PIHP, MIChoice and long term care providers will, for the first time, allow for a care dialogue and specialized care management between providers that is currently not done. **The end result will be better access to high quality health care, reduced emergency room visits, hospital admissions, and reduced or eliminated nursing home admissions for Michigan's Medicaid Dual Eligible beneficiaries.**

3. Do you have any comments on the proposed program elements listed on page 1? Is there anything missing from the list?

    a. What program elements or features should be included in an integrated care model that would encourage participation from people who receive services through Medicare and Medicaid? How can we make this program attractive so that people will not opt out?

    MAHP Response: Michigan's Strategic Plan for Integrated Care for the Dual Eligibles should be based on the following core elements many of which are identified in the MDCH Response to the

Centers for Medicare/Medicaid, CMS, "**State Demonstrations to Integrate Care for Dual Eligible Individuals"** grant application:

- All Medicare services currently provided in Michigan and Medicaid services as currently defined in Michigan's State Medicaid Plan and waivers, must be covered by the plan with the potential for investing savings for additional social supports not currently provided to beneficiaries.
- A comprehensive provider network available across the continuum of services so that participants are assured choice within the network
- A comprehensive set of assessment tools to identify participant needs
- Person-centered medical homes to ensure access to care
- Care coordinators to assist development of person-centered plans of care based on choice
- Plan performance metrics to evaluate effectiveness
- Quality management strategies and measurements unavailable in the current fee-for-service model
- Data sharing amongst providers across the continuum of care to enhance care coordination
- Mandatory enrollment with the ability to opt out
- Consumer protections, including grievance and appeal processes that meet the standards required by both Medicare and Medicaid

Further, CMS expects the 21st Century customer experience will be simple, seamless, and provide easy access to cost effective, integrated care coordination. Other program features that, in concert with the previously mentioned elements, would support achievement of CMS expectations AND encourage Medicare/Medicaid beneficiaries to enroll include:

- **Health care technology** that assures rapid, HIPAA-compliant, sharing of appropriate health care data between providers (including pharmacy, lab), has provisions for e-prescribing, and general access for electronic medical records (EMR).
- **An Eligibility system** consistent with the changes required under the Affordable Care Act (ACA) for Medicaid expansion for a web-based system that features annual eligibility and simplified re-determination forms and process.

b. Which specific supports and services do you consider to be most important for people who are eligible for both Medicare and Medicaid? *Please consider the following three categories of care in your response:*

- **Access to a comprehensive set of assessment tools** to identify participant needs.
- **Access to care coordinators** to assist development of person-centered plans of care based on choice.
- **Long-term services and supports** – Personal advocacy, functional assessments, care management, counseling, elder abuse prevention, home safety/environmental assessments/modifications and monitoring, hearing impaired, nutrition support/home delivered meals, transportation, personal care, homemaking (following a hospital admission), medication education/management.

- **Behavioral health and developmental disability services -** housing, work, transportation, consumer-driven support services and peer support and maintenance. The **greater the availability of community supports and care coordination** provided through an integrated care plan, the more likely it is that individuals will remain in the community and out of costly emergency rooms, hospitals and nursing homes.
- **Medical care –** Access to Person-centered medical home and planning, including health risk assessment, care management and coordination services.

4. The purpose of this initiative is to transform the health care system for people who are eligible for both Medicare and Medicaid. What suggestions do you have for care integration/coordination elements that we should require? How can care coordination among medical care, long-term services and supports, and behavioral health and developmental disability services be improved?

   MAHP Response:

   a. Required Care Integration/Coordination Elements – Michigan's Strategic Plan for Integrated Care for the Dual Eligibles should assure that the provision of specialized care management services be structured by needs of the population. These options should be based upon their predominant medical and social need and be PROVIDED BY:
      - Medicaid Health Plans: beneficiaries with acute and chronic physical health care needs OR
      - Prepaid Inpatient Health Plans: beneficiaries with serious mental illness or developmental disabilities OR
      - Long term care manager (potentially the MI-Choice agency): beneficiaries with long term care needs OR
      - A care management entity created by the MHP, PIHP, and long term care managers in each region, which coordinates the care management across all three populations (ACUTE/CHRONIC OR SERIOUS MENTAL ILLNESS OR DEVELOPMENTAL DISABILITIES OR LONG TERM CARE NEEDS).

   b. How can care coordination across continuum be improved?

      MAHP Response

      The current system is one of silos. Each segment of needed services has different entry points. An effective integrated system will provide Medicare/Medicaid beneficiaries a clear path to accessing needed services.

      Michigan's Strategic Plan for Integrated Care for the Dual Eligibles should emphasize that integration of care must be required at the direct service delivery level (where the care meets the consumer/patient), requiring that the care managers in each community share EHR data, coordinate care through active case management, and ensure cross-discipline case consultation.

      Critical to improving care coordination across the continuum is insuring administrative oversight by state government is also an integrated and cohesive unit representing expertise in physical, behavioral, long term care and financial modeling.

The Outcome: Care coordination to Michigan's beneficiaries relying on Medicare and Medicaid services for their care will change from a system of silo-driven care to ***a simple, seamless, easy access process to cost effective, integrated care coordination support and services.***

5. What should contracted entities be required to do to support person-centered care and services?

MAHP Response

Michigan's Strategic plan for Integrated care for persons with Dual Eligibility should build upon the strengths of Michigan's current Medicaid managed care system (using the proven expertise, quality assuring, and cost controlling skills of its MHP, PIHP, MI Choice and long term care SUPPORTS AND SERVICES providers - ensuring that parties knowledgeable of a discrete set of health conditions and understand and embrace the principles of person-centered planning – specifically acute/primary care, behavioral care, and long term care - are retained as the care managers for persons with those conditions.

The person-centered care process must rely on real-time access to health care data. Contracted entities should be required to incorporate health care technology that assures rapid sharing of appropriate health care data between providers consistent with the security and confidentiality provisions of HIPAA. In particular, access to pharmacy and lab data, general access to electronic medical records and incorporating provisions for e-prescribing should be required under each contractor and provider contract.

Michigan's Strategic plan for Integrated care for persons with Dual Eligibility should be data driven and performance based, including measures that demonstrate outcomes of the person-centered care and services process:

- Alignment of incentives to ensure that each contracting entity is responsible for the quality of care and cost control of the entire benefit provided to a consumer.

- Measures of health and system performance beyond basic health measures to include for example psych-social functionality, quality of life years as a core measure.

- Prospectively clear and transparent goals and objectives that are based on measurable and objective data and thus performance requirements for the system and its components.

- Assess consumer satisfaction.

Finally, the person-centered care and service processes is reliant on maintaining a comprehensive, high-quality network of community-based providers. Contracted entities would be required to provide a review of provider credentialing requirements for opportunities to improve care outcomes and/or reduce costs without negatively impacting care outcomes.

6. What are the advantages and/or disadvantages to making single entities responsible for contracting with providers to ensure that all covered services and supports are available to and coordinated for dual eligibles?

MAHP Response

Medicare and Medicaid contracted health plans are required by state and federal regulations to maintain a defined network of provider services based on defined Medicare and Medicaid covered benefits. Plans are required to include regulatory language within provider agreements to downstream compliance to beneficiary protections afforded by state and federal government. Further, Medicare and Medicaid contracted plans have invested significantly in NCQA accreditation which also requires stringent provider credentialing processes. Because of this, plans have the infrastructure and expertise to contract and credential large provider networks.

Because community-based supportive services are services generally outside of the scope of Medicare and Medicaid covered services provided by health plans, contracts with providers of these types of services are sporadic, inconsistent and in various forms. For integrated care, all contracted entities will need to access to these services. Developing collaborative contracting models will help to support an integrated care model will allow for more efficient overall network oversight, management, contraction and expansion as demand for services may require.

7. What financial misalignments do you see in the current system? What incentives would support high-quality, cost-effective care?

MAHP Response

The primary financial misalignment in the current system is the alignment between cost and quality. The Medicaid Programs most significant costs are realized for long-term care institutional care for the dual eligible population. This care is delivered to Michigan's most vulnerable beneficiaries without demonstrable quality outcomes and at the highest cost.

The proposed joint procurement to select contractors to implement Michigan's strategic program for integrated care for persons with dual eligibility should be based on the strengths of Michigan's current Medicaid managed care system, using the proven expertise, quality assurance and cost controlling skills of its MHP, PIHP, Area Agencies on Aging, nursing facilities, and other long-term care providers and:

- Focus on regional implementation based on capacity and readiness of managed care structure.
- Use flexible contracting arrangements and models rather than sole reliance on a single contract model.
- All contracting models should embrace person-centered coordination of care between primary and specialty care providers.
- Administer different financial models by region for the selected contractor(s), depending on capacity, provider contract, **ability to serve specialty populations**, and expertise. Such models may be fully capitated, partially capitated, or operate under a managed fee-for-service structure. **For the Medicare Services,** appropriate risk sharing between the federal/state government and contractor and providers should be incorporated.

The effectiveness of these financial models will be evaluated during the initial phase of the plan relative to:

- member/patient satisfaction with the care experience
- quality of care
- cost control

Accountable results will provide guidance relative to the continued use and/or modification of a range of managed fee-for-service and/or capitated models.

8. What are the most critical issues the state should be mindful of when it formulates a plan to integrate care for people who are eligible for both Medicare and Medicaid? Is there anything you are especially worried about as the state develops this plan? Are there elements of the proposed plan that make you especially supportive of it?

MAHP Response

Critical issues that must be considered in formulating the plan:

a. **Person-centered planning –** Michigan's plan should have person-centered planning THROUGHOUT THE CONTINUUM OF CARE as its fundamental concept for implementation.

b. **Build on Strengths of Existing Systems –** Michigan's plan should build upon the strengths of Michigan's current Medicaid managed care system (using the proven expertise, quality assuring, and cost controlling skills of its MHP, PIHP, MIChoice and long-term care supports and services providers.

c. **Preserve "Safety Net" -** An integral facet of the MDCH participation in the initiative for Michigan's dual eligible beneficiaries is to assure that Michigan must preserve and support the state infrastructure for a "safety net" for **vulnerable segments** of this population.

d. **Choice and Eligibility** – The plan should:

    1. **Embrace consumer choice -** While requiring mandatory enrollment, provide an "OPT-OUT" provision for all beneficiaries. Moreover, the initiative should embrace consumer choice in the enrollment and selection of managed care organizations available in each region and individual providers. In doing so, the program design should avoid adverse selection and ensure that selection/recruitment of enrollees (where low risk and low cost enrollees are drawn/recruited to one plan, leaving other plans with a higher proportion of high risk and high cost enrollees) does not take place.

    2. **Facilitate consumer choice –** Facilitate the choice that needs to be available for the determination of the providers identified in the individual care planning provided for beneficiaries.

    3. **Implement eligibility changes** consistent with the changes required under ACA for Medicaid expansion for a web-based system and which features:

        - **Annual Eligibility**

- **Simplified re-determination forms and process**

e. **Phased-in Implementation Approach –** Michigan's plan should be based on an implementation model that **phases in systems of integrated care,** based upon evidence of preparedness by regions of the state over a reasonable period of time with opportunity to analyze and modify program based upon predetermined performance standards and expectations.

Questions for Potential Contracting Entities

9. Which service components (e.g., medical care, long-term services and supports, behavioral health/developmental disability services, community supports) will be especially challenging for you to provide? What are your suggestions for addressing these concerns?

   MAHP Response: Long-term services and support and behavioral health services beyond the current "20 visit" Medicaid benefit are not services that have been traditionally coordinated by MHPs. However, MHPs have the expertise and infrastructure to effectively integrate these services as part of a broader integrated care strategy. The challenges that would be experienced by MHPs in this transition are the same challenges that are currently faced by MDCH, PIHPs, and Area Agencies on Aging today. Integrating programs without recognizing and/or addressing systemic issues plaguing programs today will create barriers to success in an integrated program. Challenges within service components include:

   a. **Limited funding and capacity** – Michigan funding has limited the availability of home and community-based waiver services. With only 7,239 individuals served through MI Choice, there is a significant lack of capacity in Michigan's home and community based (HCBS) waiver for individuals who are elderly or have a disability. With a waiting list of 7,900 individuals, **more people are awaiting waiver assistance than are being served by MI Choice**. THIS LACK OF INFRASTRUCTURE MAKES IT DIFFICULT TO ALLOW FOR CONSUMER CHOICE FOR INDIVIDUALS NOT IN NEED OF FACILITY-BASED CARE, AND TO MEET CURRENT AND FUTURE DEMAND FOR HOME AND COMMUNITY BASED SERVICES AND SUPPORTS.

      In development of the funding for the integrated model, state rate setting assumptions must consider inclusion of individuals on the MiChoice wait list. Further, reductions in General Assistance funding significantly reduced funding for behavioral health community-based supports and services. State rate setting assumptions must align with expectations of benefits to be delivered. Insufficient funding will have downstream community impacts such as increase in homelessness and crime which will have unintended consequences to Michigan communities.

   b. **Establishing community-based provider credentialing requirements** – Credentialing of behavioral health and home and community-based providers will require developing criteria different than that currently used for medical providers.

10. What information would you need in advance of preparing a response to a future RFP?

MAHP Response

- A defined set of Medicare/Medicaid integrated set of covered benefits.
- At the program and county level, actuarial cost information (i.e. MiChoice, PIHP) for services currently provided.
- Enrollment projections at the county level of all Medicare/Medicaid beneficiaries to be included in initial enrollment and projections of monthly growth. If a regional implementation approach is to be used, than enrollment projections for the phased-in implementation approach.
- Financial contracting methodology model to be used – including any required "downstream" provider contracting requirements (i.e. fee schedules, credentialing, performance requirements)
- Oversight and compliance requirements.
- Quality and performance metrics.

X. Appendix 3 – Trade Associations Consensus Principles

Consensus Joint Policy Position Statement
Michigan's Plan for Integrated Care for Persons with Dual Eligibility

October 2011

Preamble

In February 2011, Michigan was one of 15 states awarded a planning contract from the Centers of Medicare and Medicaid Services to improve care and services for persons with Medicare and Medicaid eligibility. In its application for this planning contract, the Michigan Department of Community Health described intent to plan for "Implementation of an integrated services and funding model."

Beginning in July of 2011, a group of Michigan trade associations representing organizations whose members manage and provide healthcare related services to these persons began a series of meetings to develop a consensus recommendation for a set of guiding principles to support and direct the state's planning efforts.

As a result of their discussions, these organizations have developed the following consensus resolution and guiding principles:

RESOLUTION IN SUPPORT OF THE CONSENSUS PRINCIPLES AND POLICY

Whereas *all Michigan's citizens deserve the highest quality cost-effective healthcare delivery system attainable; and*

Whereas *healthcare services for the whole person (physical, mental, substance abuse) must be seamlessly integrated, planned for and provided through collaboration at every level of the healthcare system, as well as coordinated with the supportive capacities within each community regardless of age or setting; and*

Whereas *each organization supporting these principles are committed to providing leadership in the promotion and provision of high quality, affordable and accessible health care services for all citizens of Michigan; and*

Whereas *persons with Medicare and Medicaid eligibility (Dual Eligibility) represent citizens with some of the most complex and therefore high costs healthcare related needs; and*

Whereas *transformational change in the administration and financing of services for persons with dual eligibility must be made in order to provide and sustain a program of integrated care for these individuals; and*

Whereas *each organization supporting these principles is committed to system transformation in support of quality of life, effective healthcare service delivery and the provision of cost-effective service; and*

Whereas *Michigan should take advantage of the current opportunity with the federal government to advance a strategic plan;*

Therefore *each organization listed below hereby fully commits to positive engagement with each other and the state and federal government in the development and timely submission of a strategic plan of integrative care for Michigan's population with Medicare and Medicaid eligibility (Dual Eligibility) and in the pursuit of achieving the agreed upon principles.*

SUPPORTING ORGANIZATIONS

Area Agencies on Aging Association of Michigan
Aging Services of Michigan
Health Care Association of Michigan
Michigan Association of Community Mental Health Services Boards
Michigan Association of Health Plans

Consensus Principles

Principle # 1: (Core elements)

Michigan's Strategic Plan for Integrated Care for Persons with Dual Eligibility should be based on the following core elements many of which are identified in the MDCH Response to the Centers for Medicare/Medicaid, CMS, and "**State Demonstrations to Integrate Care for Dual Eligible Individuals"** grant application:

- All Medicare services currently provided in Michigan and Medicaid services as currently defined in the Michigan State Medicaid Plan and waivers must be covered by the Strategic Plan.
- A comprehensive provider network available across the continuum of services that assures choice.
- A comprehensive set of assessment tools to identify participant needs
- Person-centered medical homes to ensure access to care
- Care coordinators to assist development of person-centered plans of care based on choice
- Plan performance metrics to evaluate effectiveness
- Quality management strategies and measurements
- Data sharing amongst providers across the continuum of care to enhance care coordination
- Mandatory enrollment with the ability to opt out
- Consumer protections, including grievance and appeal processes that meet the standards required by both Medicare and Medicaid
- Investment of savings with providers and for additional social support services not currently available to beneficiaries.

Principle # 2: (Build on Strengths of Existing Systems)

Michigan's Strategic Plan for Integrated Care for Persons with Dual Eligibility should build upon the strengths of Michigan's current Medicaid managed care system (using the proven expertise of its Medicaid Health Plan (MHP), Prepaid Inpatient Health Plan (PIHP), Area Agencies on Aging, Program for All Inclusive Care for Elderly (PACE), MI Choice, Hospital, Physician and Nursing Facilities - ensuring that parties knowledgeable of a discrete set of health conditions – specifically acute/primary care, behavioral care, and long term care - are retained as the care managers for persons with those conditions.

Principle # 3: (Person Centered Planning)

Michigan's Strategic Plan for Integrated Care for Persons with Dual Eligibility should have person centered planning and self directed care throughout the continuum of care as its fundamental concept for implementation.

Principle # 4: (Non-Traditional Service)

Michigan's Strategic Plan for Integrated Care for Persons with Dual Eligibility must include that the "non-traditional services supports" be part of the essential benefit package.These include non medical or behavioral health clinical services that are vital in terms of maintaining persons with disabilities in the community such as housing, work, transportation, nutrition services, respite, peer support and home maintenance and include all of the non-traditional services currently included in/covered by Michigan's state plan and the State's Medicaid Waivers.

Principle # 5: (Care Coordination and Management)

Michigan's Strategic Plan for Integrated Care for Persons with Dual Eligibility should assure that the provision of specialized care management services is structured by needs of the population. These services should be based upon the individual's predominant medical and social need.

Principle # 6: (Integration of Care and Integration of Administration)

Michigan's Strategic Plan for Integrated Care for Persons with Dual Eligibility should:

(1) Emphasize that integration of care must be required at the direct service delivery level (where the care meets the consumer/patient), requiring that the care managers in each community share EHR data, coordinate care through active case management, and ensure cross-discipline case consultation.
(2) Result in the state structure for administrative and financial oversight itself integrating expertise in physical, behavioral, long term care.

Principle # 7: (Choice and Eligibility)

Michigan's Strategic Plan for Integrated Care for Persons with Dual Eligibility should:

1. Require mandatory enrollment with provisions for an "Opt-Out" option for all beneficiaries. Moreover, the Strategic Plan should embrace consumer choice in the enrollment and selection of managed care organizations and individual providers within the network. The program design should avoid adverse selection and ensure that selection/recruitment of enrollees (where low risk and low cost enrollees are drawn/recruited to one plan, leaving other plans with a higher proportion of high risk and high cost enrollees) does not take place.

2. Implement eligibility changes consistent with the changes required under the Accountable Care Act for Medicaid Expansion for a web-based system that features:
    a. Annual Eligibility
    b. Simplified re-determination forms and process.

Principle # 8: (Performance Measures and Incentives)

The performance measures and incentives developed for Michigan's Strategic Plan Integrated Care for Persons with Dual Eligibility should:

- Develop and use clear and transparent goals and objectives that are based on measurable and objective data including measures for consumer satisfaction.
- Align incentives to ensure that each contracting entity is responsible for the quality of care.
- Use the most cost-effective staffing arrangements that are appropriately credentialed, certified or trained.
- Include measures of health and system performance beyond basic health measures (for example psych-social functionality, quality of life years as a core measures).
- Assure timely and public reporting and accountability.

Principle # 9: (Phase In)

Michigan's Strategic Plan for Integrated Care for Persons with Dual Eligibility should use an implementation model that phases in systems of integrated care, based upon evidence of preparedness by regions of the state over a reasonable period of time with opportunity to analyze and modify program based upon experience of that model.

Principle # 10: (Managed Care Considerations)

The proposed joint procurement to select contractors to implement Michigan's Strategic Plan for Integrated Care for Persons with Dual Eligibility should be based on the strengths of Michigan's current Medicaid managed care system, using the proven expertise, quality assurance and cost controlling skills of its MHPs, PIHPs, Area Agencies on Aging, Hospitals, Nursing Facilities, Physicians and other MI-Choice providers and:

- Focus on regional implementation based on capacity and readiness of the managed care structure (including partnerships among managed care entities) and contracting providers to assure that all covered benefits will be provided.
- Use flexible contracting arrangements and models rather than sole reliance on a single contract model. All selected contracting arrangements and models should embrace coordination of care between primary and specialty care providers.
- Administer different financial models by region for the selected contractor(s), depending on capacity, provider contract, ability to serve specialty populations, and expertise. Such models may be fully capitated, partially capitated, or operate under a managed fee for service structure. For the Medicare services appropriate risk sharing between the federal/state government and contractor and providers should be incorporated. The effectiveness of these financial models, relative to member/patient satisfaction with the care experience, quality of care, and cost control should be evaluated during the

initial phase of the plan – providing guidance relative to the continued use and/or modification of a range of managed fee-for-service and/or capitated models

Principle # 11: (Technology)

Michigan's Strategic Plan for Integrated Care for Persons with Dual Eligibility should incorporate health care technology. Specifications of technology should assure rapid sharing of appropriate health care data between providers consistent with the security and confidentiality provisions of HIPAA. In particular, access of pharmacy and lab data, provisions for e-prescribing and general access for electronic medical records should be required under each contractor and provider contract.

Principle # 12: (Safety Net)

The development of Michigan's Strategic Plan for Integrated Care for Persons with Dual Eligibility should assure that Michigan will preserve and support the state infrastructure for a "safety net" for vulnerable segments of the state's population, including persons with Dual Eligibility.