AREA AGENCY ON AGING 1-B
THE SENIOR ALLIANCE

INTEGRATING CARE FOR PEOPLE ELIGIBLE FOR BOTH MEDICARE AND MEDICAID

CONSIDERATIONS AND RECOMMENDATIONS FOR DEVELOPMENT OF MICHIGAN'S INTEGRATED CARE MODEL

SOUTHEAST MICHIGAN REGIONAL AREA AGENCY
ON AGING ADVISORY COUNCIL
AD HOC STUDY COMMITTEE ON INTEGRATED
HEALTHCARE FOR DUAL ELIGIBLES

NOVEMBER 2011

"Area Agencies on Aging (AAAs) would support MDCH efforts to develop a plan for integrated care, if that plan is transparent, inclusive, features community based options, is person-centered, takes an incremental and regional approach, and builds upon the expertise and assets that currently exist in Michigan's system of acute, long term care, and behavioral service providers. AAAs stand ready to partner and collaborate with our regional partners and with MDCH when building this improved system of care."

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INTRODUCTION

The Michigan Department of Community Health (MDCH) received a planning grant from the Centers for Medicare and Medicaid Services in early 2011 to "develop a plan to integrate care for beneficiaries of both Medicare and Medicaid (the "dual eligibles"). An integrated care model covers both Medicare and Medicaid services and benefits, including inpatient and outpatient acute care, skilled nursing facility services, long-term nursing home care, behavioral health care, home health services, durable medical equipment, and prescription drugs."[1] The scope of a program of this magnitude across an entire state would be unprecedented, and could have a significant impact on the health and lives of over 200,000 residents. It would also directly impact Area Agency on Aging (AAA) programs like the MI Choice Medicaid Waiver and Medicare Medicaid Assistance Program, as well as hundreds of direct service provider contractors and vendors.

As part of a proactive effort to understand the ramifications of a comprehensive integrated and managed care model on Michigan consumers, AAAs, and other stakeholders, a regional partnership was established between the Advisory Councils for the Area Agency on Aging 1-B (AAA 1-B) and The Senior Alliance (TSA), Area Agency on Aging 1-C. The intent of this partnership is to form a strong alliance, share resources and work together to improve service delivery for the communities and people these organizations support. The AAA 1-B was established in 1974 to serve the needs of over 545,000 older adults who reside in the southeast Michigan counties of Livingston, Macomb, Monroe, Oakland, St. Clair and Washtenaw. TSA was established in 1980 to serve older adults and adults with physical disabilities living in the 34 suburban communities in southern and western Wayne County.

Each AAA is a non-profit organization and takes direction from its Board of Directors and Advisory Council. Advisory Councils are comprised of people supported by the area agency, caregivers, advocates, community representatives, provider agencies and local citizens who live or work within the service area of the AAA. The Advisory Council's role is to advise the AAA Board of Directors of the needs and concerns of the older people living in the service area and advocating for them. Advisory Councils also make recommendations on the development and implementation of multi-year strategic plans.

This regional partnership resulted in the AAA Advisory Councils acting to form the Southeast Michigan Regional AAA Advisory Council Ad Hoc Study Committee on Integrated Healthcare for Dual Eligibles. The purpose of the Committee was to: study the potential impact of integrated care on AAA consumers and providers; strategically plan for the Aging Network's role under an integrated care model; and position the AAAs to effectively advocate and influence the development of Michigan's integrated care model. This report contains: the Committee's findings; a set of principles to guide Michigan's development of a successful integrated care model; identifies important questions that must be resolved before implementation of integrated care is initiated; and presents recommendations to protect the interests of consumers, providers, and the public.

[1] July 1, 2011 letter from Steve Fitton, Director, Medical Services Administration L-11-17

BACKGROUND

The potential to reduce costs while improving quality of and access to healthcare services has long been recognized as potentially achievable through a more integrated system of delivering Medicare and Medicaid services. Several states have had integrated systems of care in place for years, but these systems do not include all Medicare and Medicaid benefits, while others have piloted variations of integrated programs in limited areas of their state. In 2010 this potential was recognized and made a national priority through the creation of the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) pursuant to Section 2062 of the Affordable Care Act, whose goal is to "make sure dual eligible beneficiaries have full access to seamless, high quality health care and to make the system as cost-effective as possible."[2]

Partnered with the Center for Medicare and Medicaid Innovation, the Medicare-Medicaid Coordination Office released a funding opportunity in 2010 for program design contracts that would result in demonstration proposals describing "how states would structure, implement, and evaluate an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of care for dual eligibles."[3] Following the program design phase and review by the Medicare-Medicaid Coordination Office, states could get an opportunity at program implementation, although this was not a guarantee.

> *"The 21st Century customer experience will be simple, seamless, and provide easy access to cost-effective, integrated care coordination"*
>
> - AHIP Medicare & Medicaid Conference, CMS Message September 2011

The State of Michigan, through the Michigan Department of Community Health (MDCH) submitted a response to the solicitation in early 2011, and by June of 2011 it was announced that 15 states had received planning contracts, including Michigan. Michigan's proposal outlined problems related to the fee for service system, redundancies in treatment, confusion in navigating two systems, and limited access to in-home and community based waiver services. With 202,262 dual eligible beneficiaries representing 12% of the total Medicaid population, the proposal also highlighted the apparent high costs that these individuals have on the system since they account for approximately 36% of Medicaid spending. Dual eligible beneficiary spending is estimated to be about $7.7 billion, with $3.6 billion and $4.1 billion being the Medicaid and Medicare expenditures respectively.[4]

In an effort to address these financial and service related problems, Michigan's plan for integrated care includes the following elements:[5]

1. All core Medicaid and Medicare Services with the potential for additional social supports (i.e., acute, inpatient hospital care, skilled nursing care, pharmacy, long-term care, behavioral health, home health, hospice, as well as services like caregiver respite, nutrition, housing, evidence based programming, etc.)

[2] Overview of Medicare-Medicaid Coordination Office website, http://www.cms.gov/medicaid-medicaid-coordination/

[3] December 10, 2010 CMS Solicitation Number RFP-CMS-2011-0009

[4] [5] Michigan's Response to CMS Solicitation State Demonstrations to Integrate Care for Dual Eligible Individuals

2. A comprehensive provider network available across the continuum of services so that participants are assured choice within the network
3. A single standardized assessment tool to identify participant needs
4. Person-centered medical homes to ensure access to care
5. A single care coordinator to assist development of person-centered plans of care based on choice
6. Plan performance metrics to evaluate effectiveness
7. Quality management strategies and measurements unavailable in the current fee for service model
8. Data sharing amongst providers across the continuum of care to enhance care coordination
9. Mandatory enrollment with the ability to opt out
10. Consumer protections, including grievance and appeal processes that meet the standards required by both Medicare and Medicaid

Michigan will target all dually eligible individuals with an estimated enrollment at implementation of 220,050 (assuming an increase of 6%), and the implementation will be phased in statewide. Financing in Michigan is planned to range from full risk for the state to a shared risk/shared savings model. "Medicaid will serve as the designated entity providing oversight, and Medicare funds would be transferred to the state via a risk-adjusted capitation payment derived from Medicare data."[6]

Michigan conducted a stakeholder input process which included six public input forums, with two being hosted in the southeast Michigan region, Southfield and Detroit. A Request for Information (RFI) was issued to solicit input from diverse stakeholders, and a survey was created to identify individuals to participate on workgroups in November and December. Public Sector Consultants (PSC), a research and consulting firm based out of Lansing, Michigan, is assisting MDCH in the coordination of the stakeholder process. The website listed below was created through Public Sector Consultants, where individuals can email comments and questions on the integrated care model. https://janus.pscinc.com/dualeligibles/

Stakeholder input has primarily centered around four general questions as facilitated by PSC. Positives regarding the current system, problems that need to be addressed in the new system, missing program elements that should be considered, and critical issues for the state to keep in mind while developing an integrated system are all central topics that were expanded slightly in the stakeholder interviews and RFI. The stakeholder interviews and RFI began to seek information on provider role, contracting, and service provision. PSC and MDCH have not responded to any questions posed during the stakeholder process by the over 900 people who participated in the public forums.

Each of the four workgroups is charged to consider different elements of the integrated model, review feedback received from stakeholders, and serve in an "advisory capacity" to MDCH.[7]

[6] Michigan's Response to CMS Solicitation State Demonstrations to Integrate Care for Dual Eligible Individuals
[7] October 7, Letter from Steve Fitton, Director of the Medical Services Administration L-11-36

- Individuals serving on the **Care Coordination and Assessment** workgroup were charged with recommending effective ways of promoting information sharing amongst providers, as well as recommend the elements that may or may not need to be included in an assessment of people enrolled in the integrated model.

- The **Education, Outreach, and Enrollee Protections** workgroup was charged with identifying ways to reach the individuals and providers to encourage participation in the integrated model, as well as outlining what should be included in an easy-to-navigate and responsive grievance and appeals process.

- **Performance Measurement and Quality Management** workgroup members were asked to recommend ways to deliver continuous quality and person-centered care that can be measured.

- Recommendations for services and supports and the components of a comprehensive provider network were required of the **Service Array and Provider Network** work group.

Following the workgroup phase, MDCH committed to writing their plan to submit to the Medicare-Medicaid Coordination Office while simultaneously seeking proposals from agencies that will administer the program at local levels. A timeline was outlined and is included in Appendix C of this report, with implementation of the new Integrated Care system potentially beginning by end of 2012. This may be contingent on Medicare-Medicaid Coordination Office approval of an implementation contract, and could be delayed for a number of other potential variables.

LESSONS LEARNED FROM OTHER STATES

Assumptions have been made on the outcomes that can be expected with an integrated model of coordination and providing Medicare and Medicaid services. In general, the goal of any integrated model is to provide quality care with seamless care coordination and fewer administrative burdens. Michigan's expectations include better outcomes due to quality initiatives unavailable under fee for service models, an alignment of provider incentives, and administrative efficiencies and savings.[8] The Southeast Michigan Regional AAA Advisory Council Ad Hoc Study Committee reviewed other state information to try and identify best practices, as well as proven outcomes.

While there were 15 total states that submitted proposals and were awarded funding for phase I of the state demonstrations to Integrated Care for Dual Eligible Individuals, many others have operated or piloted Integrated Care projects previously. Of the 15, Massachusetts, Minnesota, New York, Oregon, Washington, and Wisconsin had Integrated Care models in place prior to the demonstration grant. Other states that have fully-developed or have piloted Integrated Care models include Arizona, Florida, New Mexico, Ohio, Pennsylvania, Vermont and Texas. Information has been made available on these projects and initiatives, but little outcome and best practice information has been published.

> *"Medicare and Medicaid were established as two distinct programs, by two different pieces of legislation. Consequently, they do not always work well together because they have different benefits, billing systems, enrollment, eligibility, appeals, and provider networks…states maintain they have lacked financial incentive to improve coordination between the two programs…"*
>
> – Kaiser Commission on the Medicaid and Uninsured August 2011

One publication with outcome information on Integrated Care was published in October 2008. Titled "Integrated Care Program: Final Evaluation," this document was prepared for the Center for Health Care Strategies, Inc. "The Center for Health Care Strategies (CHCS) is a non-profit agency dedicated to improving health care quality" and in 2005 CHCS created the *Integrated Care Program* to support state efforts to integrated the administration, delivery, and financing of services for dual eligibles."[9] Five states participated in the program, and received technical assistance that focused on performance measurement, rate setting and risk adjustment, and administrative simplification.

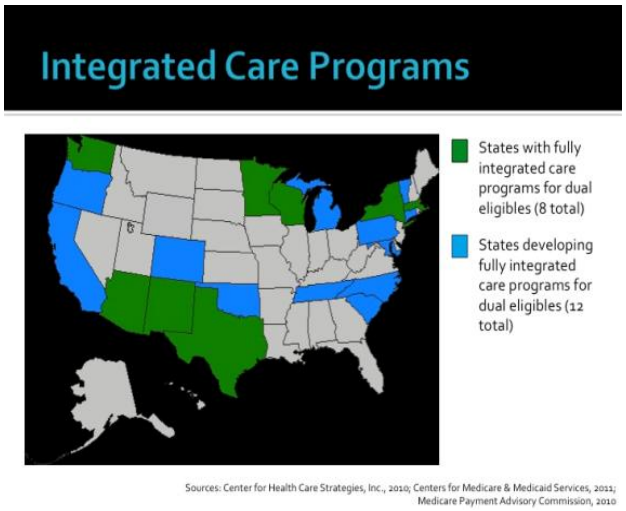
Key findings and lessons learned as published in the final evaluation focused on five key areas: program planning, plan participation, enrollment, financing, and the political environment. In program planning, it was found that program support was best garnered through early involvement of stakeholders, and continued conversation throughout implementation. Program planning also averaged about three years in length, and was a time consuming and resource intensive effort. Under plan participation, it was found that Special Needs Plans (SNPs) most often facilitated the integrated model, as these types of Medicare Advantage Plans focus on individuals with special needs, such as dually eligible beneficiaries, however SNPs have not

[8] Fitton, Steve, Medicaid Director. Presentation to House Appropriations Subcommittee on Community Health. October 25, 2011.

[9] Korb, Jodi, MA and Nelda McCall, MS. *Integrated Care Program: Final Evaluation.* October 2008

been listed as the preferred model in Michigan. Enrollment proved to be cumbersome, and mandatory enrollment was desirable because it provided predictability in expenditures and gave the state more control. One of the biggest challenges noted in the findings was evident from Florida's experience with legislative turnover. Florida's political environment "derailed the mandatory pilot program." Political and legislative involvement, buy-in, and approval are key to integrated care implementation.

Of the states that participated in the CHCS *Integrated Care Program*, New Mexico most closely resembled Michigan in program design due to its statewide implementation for all ages, with a mandatory enrollment. The only difference at the time of the study was that the integrated plan was not limited to dual eligible individuals, and did not include behavioral health services. New Mexico's Association of Home Care and Hospice was interviewed as part of the Committee's research process and reported that New Mexico's model was only partially integrated, and had been implemented in FY 2010. Home Care and Hospice had not been initially considered as part of the model, and were not incorporated until after the program had been tested. It was also shared that reimbursement time frames were initially too lengthy, and it took advocacy and a learning curve to lower the reimbursement time frame to something more manageable and necessary for provider sustainability. A February 14, 2011 program evaluation report to the New Mexico Legislative Finance Committee by the Human Services Department was developed to assess the early implementation of Coordination of Long Term Services (CoLTS), its costs, performance, and oversight. It concluded that "overall, CoLTS holds promise for delivering better care, but costs have far outpaced original projections and continue to increase… For FY 12, HSD has projected spending at over $900 million, or about $110 million higher than CoLTS spending in its first full year of implementation in FY 10."



Another state whose proposed model has gained attention and was researched by the Committee is Oregon. Oregon's model was of interest as the designated Area Agencies on Aging in the state serve as the "point of eligibility" for the Oregon Health Plan. "The Oregon Health Plan (OHP) provides health care coverage to low-income Oregonians through programs administered by the Division of Medical Assistance Program" and was put into practice by a number of bills that were passed by the Oregon Legislature beginning in 1987.[10] Eligibility screens in Oregon include food stamps and the OHP, but the AAA also licenses Adult Foster Care, administers the Adult Protective Services division, and performs case management and authorizes in-home services in the community and in licensed care facilities. While the AAAs handle the long-term care and determine the eligibility for individuals for all of the OHP, managed care entities are responsible for delivering acute and behavioral health services.

[10] Oregon Health Plan: An Historical Overview. Department of Human Services, July 2006. http://www.oregon.gov/OHA/healthplan/data_pubs/ohpoverview0706.pdf?ga=t

Oregon's proposal under the Integrated Care State Demonstration grant moves to integrate behavioral health and acute care services, so that going forward they would not be provided under separate managed care plans. Contracted managed care entities would be required to coordinate with long-term care supports and services, and the proposed method for accomplishing this coordination is through contracts with AAAs. Coordinated Care Organizations (CCO), made up of various providers of services, would be responsible for full-integration and governed through consumer involvement.[11] Legislative involvement is strong in Oregon, beginning with the legislation framing the Oregon Health Plan in the 1980s to the current governor appointed "Health System Transformation Team," and House Bill 3650, which establishes the Oregon Coordinated and Integrated Health Care Delivery System.

While anecdotal outcomes have been demonstrated, e.g., CHCS Integrated Care Program as reviewed above, the Committee failed to identify quantitative evidence of improvements and savings in integrated care models. In fact, interviews with officials in New Mexico and Wisconsin indicated a cost increase as integrated models were implemented. Quality outcomes were not presented in reports, although quality measurements were indicated as important. Compared to other states, the Committee was able to identify that Michigan is planning a robust integrated model by including the full dual eligible population and planning for statewide implementation. States like New Mexico and Oregon have far smaller dual eligible populations, and neither is expediting an integrated model through the demonstration grant that includes all long-term care services, behavioral health services, and acute services. It is unknown that if quantitative data was available, if it could be applied or if it would be statistically relevant to Michigan's population, demographic, and existing and planned health care delivery systems.

The Committee failed to identify quantitative evidence of improvements and savings in integrated care models.

Below is a comparison of Michigan's plan to key areas necessary for integrated care implementation as outlined in the CHCS Integrated Care Program Final Evaluation.

Program Planning: Michigan's plan calls for a stakeholder involvement phase of approximately six months. A successful plan calls for robust and continuous stakeholder involvement, yet Michigan's overall planning phase is less than the average of three years as described in the report.

Enrollment: Michigan will have a mandatory, or auto-enrollment process. This was described as a preferred model for states.

Political Environment: The CHCS report stressed the support of government as necessary for implementation, and should be garnered early on in the planning process. However, Michigan's response to CMS stated that legislative authority would not be required due to administrative rules and statutory authority.

[11] Oregon Health Policy Board Medicare-Medicaid Integration of Care and Services Workgroup Charter, August 2011. http://health.oregon.gov/OHA/OHPB/health-reform/docs/2011-0816-materials-med.pdf

BENCHMARKING MICHIGAN'S HEALTH SERVICES FOR DUAL ELIGIBLES

Even before his 2010 election, Governor Snyder's recommendations for reforming Michigan's healthcare system included creation of a coordinated care program for dual eligibles as a means to "save Michigan over $800 million a year and improve the quality of care".[12] Emulation of Texas' Star+Plus program and the Coordination of Long Term Services (CoLTS) program in New Mexico were identified as examples. Comparing Michigan to other states has been a hallmark of the current administration, and has served as a means to set state priorities and measure progress toward achieving priority outcomes utilizing dashboard indicators. Respecting this approach to governance which emphasizes transparency and accountability, the Committee searched for data which reflects Michigan's performance on key health and long term care measures, and can serve as a benchmark against which the success of future reforms can be evaluated.

> *"Our main priority and focus in this project is providing quality care. It is our goal to do this right so that Michigan residents have better access to care that ultimately will provide the with better, more person-centered care."*
>
> Olga Dazzo, Director, Michigan Department of Community Health

The following represents a collection of performance data from a variety of sources related to the delivery of health and long term care services to Michigan's dual eligible population. The committee believes that integrated care for dual eligibles should be undertaken primarily as a means to improve access to quality healthcare services for this population. Integrated care healthcare reforms should at least maintain the current level of benefits available, maintain or improve the current level of performance for measures that benefit consumers, taxpayers and other stakeholders, and strive to achieve improvements in outcome measures where improvement is warranted.

INTEGRATED CARE FOR DUALLY ELIGIBLE PERSONS

- Section 2602 of the Affordable Care Act created the Federal Coordinated Healthcare Office, whose goals include ensuring that dually eligible individuals have full access to entitled benefits; improve the quality of health care and long term care services for dually eligible individuals; eliminating regulatory conflicts with rules of the Medicare and Medicaid programs; and eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.
- Eleven states reported operating capitated managed long term care programs (MLTC) as of October 2010, with aggregate enrollment of over 400,000. Some of these programs encompass only long term care services and supports, but others include acute medical care as well. Most include only Medicaid services, but programs in three states also include Medicare services. States highlighted numerous challenges associated with MLTC programs, such as contracting with Medicare Advantage SNPs, coordinating with physical health managed care organizations, slow enrollment growth, and plan difficulty contracting with Boarding Homes."[13]

[12] Based on Independent Research, *Reform Michigan's Health Care System*, Rick for Michigan

[13] Kaiser Commission on Medicaid and the Uninsured, A profile of Medicaid Managed Care Programs in 2010: Findings from a 50 State Survey, September 2011

FINANCING/REBALANCING

- FY 2010 Michigan Medicaid long term care expenditures totaled $11.1 billion. Of the total $2.1 billion long term care expenditures, $1.6 billion was spent on skilled nursing facilities and $475 million spent on home and community-based care.[14]

"I have directed the MDCH to develop new practices to reduce the MI Choice waiting period for home-based services. Under current practice, seniors leaving nursing home facilities are given priority for MI Choice home care over those who never left home. Incentivizing seniors to move out of nursing home care when they are physically able is a laudable goal, but it has the unintended consequence of causing seniors to enter nursing home care as a means to accessing MI Choice home care."

- Governor Rick Snyder
Message on Health and Wellness,
September 14, 2011

- The Affordable Care Act assumes a hard cap on Medicare expenditures with actual reductions in Medicare services or reimbursement rates made by the newly created Independent Payment Advisory Board designed to achieve $150 billion in savings over ten years – including, in the case of skilled nursing facilities, a $14.6 billion cut in Medicare rates over ten years.[15]
- Michigan has a low total rate of Medicaid long term care expenditures. In 2008 only 23.6% of Michigan Medicaid dollars were spent on long term care services, which was the lowest percentage of any state and well below the national average of 33.9%.[16]
- From 1993 to 2009, US Medicaid long term care supports and services (LTSS) financing has continuously moved toward parity between institutional settings (which have gone from 83 percent of all Medicaid LTSS expenditures in 2003 to 57 percent in 2009) and community-based LTSS settings (which concomitantly moved from 17 percent in 1993 to 43 percent in 2009).[17]
- Serving dual eligibles in the community is less expensive in total dollars when Medicare and Medicaid costs are added up.[18]

Dashboard Outcome Indicators	Metric	State Rank	Expected Change
Overall Medicaid LTC expenditures should move closer to national average	23.6% of Medicaid dollars spent on LTC	50	⇧
Greater parity between institutional and community-based LTSS will be achieved	24% of Medicaid LTSS dollars spent on community based LTSS		⇧

[14] Senate Fiscal Agency, *Michigan Medicaid Program (Physical Health and mental Health) Expenditure History from FY 2000 to FY 2011,* May 2011

[15] Public Sector Consultants, Michigan Skilled Nursing Facilities, the Minimum Data Set, and the MI Choice Waiver Program: An Analysis and Implications for Policy, May 2011

[16] Kaiser www.statehealthfacts.org

[17] Health Management Associates, *Improving Long Term Services and Supports for Seniors in Michigan: New Opportunities and Options*, December 2010

[18] Health Management Associates, *Improving Long Term Services and Supports for Seniors in Michigan: New Opportunities and Options*, December 2010

LONG TERM SERVICES AND SUPPORTS

A study[19] sponsored by AARP, the Commonwealth Fund and The SCAN Foundation surveyed states and developed a scorecard ranking state performance across four key dimensions of long term supports and services (LTSS). Michigan ranked 31st overall of 50 states. Rankings for the four dimensions are:

37th	Affordability and Access
15th	Choice of Setting and Provider
21st	Quality of Life and Quality of Care
33rd	Support for Family Caregivers

In addition, projections were made of the impact if Michigan improved to equal the top performing state in various categories. The findings estimate:

- 22,905 more low- or moderate-income (below 250% of poverty) adults age 21+ with activity of daily living disabilities would be covered by Medicaid
- 321 more new users of Medicaid LTSS would first receive services in home and community based settings instead of nursing homes
- 3,771 nursing home residents with low care needs would instead be able to receive LTSS in the community
- 3,052 unnecessary hospitalizations of people in nursing homes would be avoided
- Based on an analysis of 2008 Minimum Data Set figures, about 77% of Michigan skilled nursing facility residents would fit the description of what many people historically think of as residents of a nursing home - they have complex or chronic health conditions that require a safe environment and all-inclusive medical and personal care 24 hours a day. The remaining 23% are there to receive short-term intensive rehabilitation services after a major health episode and typically are in a facility for less than 100 days.[20]

Dashboard Outcome Indicators	Metric	State Rank	Expected Change
LTCSS Affordability and Access	AARP State LTCSS Scorecard ranking	37	⇧
LTCSS Consumer Choice of Setting and Provider	AARP State LTCSS Scorecard ranking	15	⇧
LTCSS Quality of Life and Quality of Care	AARP State LTCSS Scorecard ranking	21	⇧
LTCSS Support for Family Caregivers	AARP State LTCSS Scorecard ranking	33	⇧

[19] S. Reindard, E. Kassner, A. Hauser and R. Mollica, Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers, September 2011

[20] Public Sector Consultants, Michigan Skilled Nursing Facilities, the Minimum Data Set, and the MI Choice Waiver Program: An Analysis and Implications for Policy, May 2011

LONG TERM SERVICES AND SUPPORTS - HOME AND COMMUNITY-BASED SERVICES

- In 2007, Michigan ranked 43rd among states in per capita participation in Medicaid home and community-based service (HCBS) programs overall (figure includes both deferral Waiver and non-federal waiver services) and 49th per capita in HCBS waiver participants.[21]
- On any given day, the number of names on Michigan's MI Choice wait lists exceeds or approaches the number of individuals actively being served through the MI Choice program.
- "All three (Florida) Medicaid Waiver programs (Aging and Disabled Adult, Assisted Living for the Elderly, and Nursing Home Diversion) *effectively* delay nursing home care when compared to elders with similar characteristics who did not receive any waiver program service."[22]
- MI Choice funding has risen from $115.8 million in FY 2000 to $185.8 million in FY 2010.[23]
- MI Choice participants report receiving support from family members for their financial (31%), emotional (64%), and care-giving (56%) needs.

> *Health officials did little to ensure that the (Medicare and Medicaid) programs cooperated well. "The best metaphor I can think of here is a dysfunctional joint-custody arrangement," said Lisa Clemans-Cope, who researches the (dual eligible) issue at the Urban Institute, a social-policy think tank.*
>
> – Overlapping Health Plans are Double Trouble for Taxpayers, Wall Street Journal, June 24, 2011

Dashboard Outcome Indicators	Metric	State Rank	Expected Change
Participation in Medicaid community-based LTSS	Per Capita participation	43	
Consumers participating in MI Choice	Per Capita HCBS waiver participation	49	

LONG TERM SUPPORTS AND SERVICES-SKILLED NURSING FACILITIES

- Michigan is a very efficient user of nursing facility services, with fewer beds per 1,000 population age 65 and older than the national average(38 vs. 45), fewer residents per 1,000 population age 65 and older, and a higher occupancy rate (87% vs. 85%).[24]
- In 2008, 81 individuals transitioned from the MI Choice program into a SNF.

Dashboard Outcome Indicators	Metric	State Rank	Expected Change
Nursing facility bed use	38 Beds per thousand		
Nursing facility occupancy rate	87% Occupancy rate		

[21] Ari Houser, Wendy Fox-Grange, Mary Jo Gibson, *Across the states: Profiles of long-term Care and Independent Living, Michigan*, Public Policy Institute, AARP, 2009 (excludes figures for people with developmental disabilities)
[22] Florida Office of Program Policy and Government Accountability, Report No. 10-3
[23] Senate Fiscal Agency, *Michigan Medicaid Program (Physical Health and mental Health) Expenditure History from FY 2000 to FY 2011,* May 2011
[24] Health Management Associates, *Improving Long Term Services and Supports for Seniors in Michigan: New Opportunities and Options*, December 2010

BEHAVIORAL SERVICES

- Michigan's Community Mental Health system has 40 years of experience caring for the Dual Eligible population, and 15 years of experience managing the financial risk associated with this population under a capitated reimbursement model through its Medicaid Specialty Services and Supports contract with the state.
- Michigan CMH consumers include 25% of the state's Dual Eligible population. Of these 54,396 Dual Eligible consumers in FY 2009, 35,339 were adults with severe mental illness, 22 were children with serious emotional disturbances, 18,093 were individuals with a developmental disability and 6,010 were individuals receiving services through the Habilitation Supports Waiver. Medicaid expenditures for this group were $1.1 billion, almost 50% of the total Medicaid expenditures for specialty mental health and developmental disabilities services statewide.

MEDICARE ADVANTAGE SPECIAL NEEDS PLANS (SNPs)

- In 2011 there were over 1.4 million individuals nationwide enrolled in Medicare Advantage Special Needs Plans (SNP), which target dual eligibles that require a nursing facility level of care.
- From 2006 to 2009 about half of the SNPs left the six-state Region V area (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin).
- In 2011 there were 409 SNPs, 256 which target dual eligibles (DSNP), 61 which target institutional (ISNP) residents, and 92 with a Coordinated Care (CSNP) model. No one company dominated the Dual Eligible SNP market.
- In 211 there were 79,000 enrolled in ISNPs, down almost half since 2007; and 160,000 in CSNPs, down 21% from 2010.

Region V State Special Need Plan Enrollment					
State	Total	Total DSNP	Total ISNP	Total CSNP	% of Dual Eligibles in DSNP
Illinois	6,476	4,991	353	1,132	1%
Indiana	1,192	1,898	94	0	1%
Michigan	9,450	8,487	692	271	4%
Minnesota	38,989	38,816	0	133	33%
Ohio	10,705	8,167	2,538	0	3%
Wisconsin	11,541	10,759	782	0	7%

- In 2011 Michigan had 9 operating SNPs administered by seven different companies. Molina Healthcare of Michigan was the largest plan with enrollment of 6,526 followed by United Healthcare of the Great Lakes Health Plan at 2,907. Both plans are duel eligible plans.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

- Twenty-nine states operate PACE (Program of All-inclusive Care for the Elderly) sites, which are paid on a risk basis to provide and coordinate a full range of medical and long term care

services and supports for dual eligibles who qualify for a nursing home level of care. National PACE enrollment is about 20,000.[25]

- Michigan has four operating PACE programs, serving approximately 500 individuals as of January, 2011[26]

ADDITIONAL OUTCOMES THAT SHOULD BE BENCHMARKED

- Medicare Preventive Service Utilization (i.e., flu shots, annual wellness visits, mammograms, pneumococcal shots, colorectal and prostate cancer screenings, bone mass measurements, diabetes self-management training, etc.)
- Evidence-Based Prevention Programs
    - Fall prevention
    - Chronic disease self management
    - Caregiver support
    - Alzheimer's Disease and dementia early detection and education
- Hospital admissions and readmissions
- Hospital length of stay
- Emergency Department visits

ESTIMATED MEDICAID DUAL ELIGIBLES

	Total	Nursing Facility	MI Choice	PACE	Hospice	HAB Supports Waiver
Michigan	219,492	27,533	7,848	623	2,304	5,542
Livingston	1,314	256	58		38	60
Macomb	14,798	2,107	221		218	311
Monroe	2,377	410	66		35	79
Oakland	19,297	2,174	643		239	666
St. Clair	3,195	453	63		32	100
Washtenaw	4,766	539	141		67	274
Wayne	53,716	4,872	1,113	205	340	798

In January, 2006 the Texas STAR+PLUS SNPs (Amerigroup and Evercare) in Harris County passively enrolled 30,000 dual eligibles. However approximately 8,000 other dual eligibles who were passively enrolled, disenrolled from the SNP, and returned to traditional Medicare. "The primary reason for this disenrollment was that the member's primary care provider and/or specialists were not in the HMO network."

Texas Health and Human Services Commission
Medicaid Reform Strategies for Texas, February 2007.

Source: Michigan Department of Community Health Insurance codes, which include both confirmed Medicare eligibles and individuals probably eligible, but not yet confirmed

[25] Kaiser Commission on Medicaid and the Uninsured, A profile of Medicaid Managed Care Programs in 2010: Findings from a 50 State Survey, September 2011
[26] National PACE Association, PACE in the States, January 2011

PRINCIPLES TO GUIDE DEVELOPMENT OF

A MICHIGAN MODEL

The integration of all Medicare and Medicaid benefits for participants of both programs will have a profound impact on the lives of consumers, and the operations of provider organizations. The Michigan Department of Community Health is encouraged to move forward cautiously with design of a Michigan Model, and be guided by a set of principles that achieves the public policy goals of the state while protecting the interests of consumers, preserving the strength of public and nonprofit systems that deliver services to the dual eligible population, and maintaining the Michigan health care market as a viable place to do business for the state's private enterprises. The Committee heard from many industry groups and consumers, and considered the integrated care experiences of other states. Because the state has received a $1 million integrated care planning grant, and the Governor is committed to implementing a managed care model for dual eligibles, it appears likely that development of a Michigan Model for Integrated Care will occur at some time in the near future. As this occurs, the model development should be guided by the following principles:

BUILD ON EXISTING INFRASTRUCTURE

The foundation of Michigan's integrated care service delivery system should be built upon the existing infrastructure of community institutions that have a strong track record of delivering high quality and efficient care to individuals eligible for Medicare and Medicaid.

Michigan-based institutions such as Area Agencies on Aging, Community Mental Health Authorities, Health Plans, MI Choice Medicaid Waiver agents, Public Health, Faith Based Initiatives, Skilled Nursing Facilities, etc. have a long history of delivering efficient and effective services. The advantages of an integrated care model will not accrue from a wholesale change in providers, but from systemic changes that improve coordination, communications, and incentives and lead to desired outcomes. The industry groups who participated in this study all recognized the potential benefits of systemic coordination, and appear ready to take Michigan's health care services to the next level, if it is a movement that is done with the involvement of stakeholders and not at their expense. Michigan should follow the development of Kansas, which is mandating that development of its KanCare integrated care model utilize existing providers and contractors.

SHARED SAVINGS SHOULD BE SHARED WITH ALL STAKEHOLDERS

Any savings achieved through the integration of care for dual eligibles should result in positive improvements for people who rely on these services and be shared equally between government (taxpayers), providers in the form of stable and adequate reimbursement, and consumers in the form of enhanced benefits.

A commitment to share any accrued savings or cost avoidance among all stakeholders will provide a powerful incentive for a collective movement to assure that integrated care for dual eligibles is successful, and create an environment in which a win-win-win situation can be achieved.

PERSON-CENTERED AND SELF-DIRECTED MODEL

The Michigan Model should incorporate existing and new features that foster consumer direction of their supports, treatment, and benefits.

Person-centered and self-directed elements that are most important to consumers include:

- *The right to control and lead the person centered planning process*
- *A robust array of service options from which to choose*
- *Flexibility and portability of funding*
- *The right to choose where they live and whom they live with*
- *The right to choose whom provides services and how those supports are provided*
- *The right to keep their current provider, care manager/supports coordinator, and direct care worker*
- *The option of self-directed home and community-based long term care*
- *The control over reliable and affordable transportation*
- *The ability to advocate as an individual or through consumer advocacy groups*

STAKEHOLDER INVOLVEMENT

The Michigan Model should include provisions for ongoing oversight and involvement of the program's development and ongoing operations by stakeholder groups.

The Michigan Department of Community Health actively sought stakeholder input during the design phase of the model development through input sessions, interviews, written comments, and workgroups. This principle of stakeholder input and involvement should be an ongoing component of the Michigan Model during the final design, implementation, and ongoing operation phases, by creating structured mechanisms to secure input and advice at the state and local levels, such as stakeholder advisory bodies. Participation of physicians has been conspicuously absent in the public input process.

LOCAL CONTROL

The Michigan Model should be based on a system that divides the state into sub-state service areas, and contracts for the management of services on a regional basis.

A key factor in the success of integrated care will be improving communications and coordination of care, and these elements can best be achieved through familiar public and private entities working with each other and based on a shared mission of improving community health. The regionalization of the integrated care model will facilitate relationship building and ownership of the integrated care plan. This system has been successful for the Area Agencies on Aging and the MI Choice program.

INCREMENTAL DEVELOPMENT

The Michigan Department of Community Health should roll out the new model slowly and carefully by selecting geographic areas to pilot test and improve the program before statewide implementation, and start with a plan benefit mix that includes some core benefits, with others being added over time as is deemed appropriate.

Integrating all of the Medicare and Medicaid programs into a single benefit plan is a massive effort that has not been done on a statewide level. The effort will be more manageable, have less chance for error, and assure continuity of care if selected benefits are merged into a plan initially, with others being added once a system is operational and has a structure that is ready and capable of integrating additional benefits. The pilot plans should have clearly articulated outcomes and benefits to consumers, family caregivers, providers and taxpayers, and achieve metrics in a clear and transparent manner before further expansion occurs. These metrics should include measures of consumer quality of life, in addition to quality of care.

MAINTAIN EXISTING BENEFIT LEVELS

No consumer should lose access to benefits which they are currently receiving, or are entitled to receive, prior to implementation of integrated care.

Overall, consumers should be better off, not worse off, under the Michigan Model of care. This means that there should be no reduction of benefits including Medicaid optional services such as MI Choice, health benefits, Home Help, 1915B and Habilitative Waivers, etc.; comparable out of pocket costs for services; continued access to existing options and benefits for those who choose to opt out of integrated care; and access to benefits for those who now depend on a spend down to access Medicaid benefits.

CONSUMER CHOICE

The Michigan Model should offer consumers the option to opt out of integrated care and keep their existing service arrangements without penalty, and for those who choose integrated care, a choice of plans, providers, care managers/supports coordinators, and direct care workers.

Consumer choice and market competition are important factors that contribute to efficiency and quality.

CONSUMER ADVOCACY

The Michigan Model should protect and foster the ability of consumers to advocate on their own, and for others to advocate on their behalf.

The health care system is complex and confusing, and extremely difficult to navigate. Consumers education regarding their benefits, rights, and recourse must be a visible and accessible component of the integrate care system. Advocacy must be an element in operation at the system and individual level, with individual care managers/care coordinators able to advocate with and on behalf of consumers both within and outside of the integrated care system.

PERFORMANCE INCENTIVES

The Michigan Model should utilize financial performance incentives and penalties to achieve and reward high level performance regarding access, quality, efficiency, effectiveness, outcomes, and timeliness.

Existing financial performance incentives that have been proven effective should be preserved, with financial benefits being shared among stakeholder groups, including consumers.

PRIORITY FOR MICHIGAN-BASED ORGANIZATIONS

The selection process for regional contractors and providers should give priority to proposals that include the highest levels of qualified Michigan-based organizations, companies, and affiliates, including area agencies on aging.

Contracting for state-supported services from Michigan-based organizations provides taxpayers with a greater return on their investment of health care dollars through the economic multiplier effect. For example, the 2010 Economic Impact of the MI Choice Waiver Program study[27] found that a $10 million MI Choice increase would bring an additional $27.4 million in federal matching funds to Michigan, create 1,099 new jobs, and return $1.9 million to state and local governments in the form of tax revenue.

EVIDENCE-BASED PREVENTIVE SERVICES

Evidence-based preventive services should be a core required program component of Michigan's integrated care model for dual eligibles.

Evidence-based preventive services such as Matter of Balance (fall prevention), Chronic Disease Self Management, Creative Confident Caregivers, etc. have been proved effective in improving health status and outcomes, and reducing unnecessary health service utilization. The Michigan Model should building on the efforts of the Michigan Office of Services to the Aging and Area Agencies on Aging to make these valuable programs, which have the potential to bend the cost curve for Medicare and Medicaid services, more commonplace and assessable to high risk populations.

SUPPORT FAMILY CAREGIVING

The Michigan Model should include strategies for encouraging and strengthening involvement of and support for family caregivers of participants who require long term care services.

It is estimated that around 80% of all long term care services are provided by family members and other informal caregivers, and a key factor in nursing home admissions is the inability of family caregivers to provide the level of care needed. Area Agencies on Aging have developed a continuum of respite services, which support family caregivers and help preserve and extend their caregiving abilities. These strategies should be a core component of any integrated care model for dual eligibles.

EQUAL AND UNIMPEDED ACCESS TO ENTITLED BENEFITS

All integrated care plan participants should have access to all plan benefits for which they qualify and need, without regard to disability, residential setting or community of residence.

Residents in assisted living settings have historically been denied access to Medicaid home and community-based benefits, and southeast Michigan has been underserved through the MI Choice program, as evidenced by the region's inordinately long wait lists. These inequalities

[27] Economic Impact of the MI Choice Medicaid Waiver, Yong LI, Department of Public Health, Indiana University School of Medicine, July 2010

should be eliminated, and all dual eligibles should have equal assess to needed supports and services, including those who are currently on wait lists for home and community-based services.

COST SAVINGS

The goal of achieving costs savings as a result of integrated care for dually eligible individuals should be achieved through quality improvements and efficiencies, and not as a result of a reduction in reimbursement rates to providers and contractors.

The future of Medicare and Medicaid care reimbursement rates is a sensitive issue in various sectors and will have a direct bearing on access to care for consumers. A cost savings strategy that is based on reducing already low reimbursements would hurt the many organizations and businesses that provide healthcare, and there is no known justification for rate reduction – most evidence suggests the opposite.

KEY QUESTIONS AND RECOMMENDATIONS

While researching the Integrated Care Initiative, the Committee uncovered numerous questions that would need to be addressed prior to implementation in Michigan. Many of the various trade groups that were interviewed had very similar questions and concerns, and these have been compiled below with recommendations on how to address this question.

Person Centered and Self-Directed

Question: "Person-centered" is mentioned numerous times as part of Michigan's proposed program elements. How can a mandatory enrollment process be person-centered for the beneficiary?

Recommendation: *In order for enrollment to be person-centered, individuals should have a choice in their selection of a plan. If enrollees will be "auto-enrolled" into the integrated system, an open enrollment period of at least 60 days prior to plan activation must be held to allow proper consumer education about their plan options, and ample time to select the option that best meets their needs. Notification should outline in writing how an individual would opt-out of the plan prior to plan activation, and provide options to the individual allowing them to remain in their current fee-for-service plan if they have one, or select a plan of their choice. All individuals should receive some sort of follow-up, either by mail or phone. For those individuals who decide to opt-out of the integrated system after their plan has been activated, service delivery should be continuous, seamless, and maintained until their new plan benefit arrangement has come into place.*

Question: What is the timeline for educating individuals on the expected changes? How will people be educated on auto-enrollment and opting-out?

Recommendation: *Education and communication is key. Area Agencies on Aging, when providing enrollment education and assistance for Medicare beneficiaries about the Part D prescription drug benefits, found that a very coordinated and concentrated effort to provide information and outreach to the public was needed and the time and resources needed to do this work were key to successful enrollment numbers. Dually eligible beneficiaries should be receiving notification of this anticipated change a minimum of six months and ideally one year prior to plan activation. It is recommended that this communication come directly from MDCH in a multi media format reaching across mail, public radio, television, news paper and internet. MDCH could partner with its regional networks to assure the communication is distributed. This will insure that accurate information is shared and a consistent and cohesive message is given to the public about the changes that will be implemented. MDCH should also consider establishing a star rating system to rank managed health plan quality, comparable to rankings for Medicare Advantage Plans.*

Question: Will the ability for people to self-direct their services still be an option in the integrated system?

Recommendation: *Integrated care options should include a self-directed option. These options would include a robust array of service provider networks that will allow consumers to choose a*

supports that will allow them to keep their current providers, including family and friends, to the extent possible. The MI Choice program, along with the self-directed options supported through the CMH Habilitative and 1915B Waivers for self-directed community-based long-term care have proven to be a successful and valued option for consumers, and should be retained.

Question: How will a single assessment tool be individualized and address person-centered needs?

Recommendation: *Assessment tools should be separate from the person centered planning process and if used to determine funding levels, should allow for flexibility if the person's needs change. Best practice approaches nationally conduct initial assessment and eligibility determination at one access point. Standardization within this initial tool should be limited to the assessment areas specific to performance expectations and indicators that may determine funding levels. Follow-up assessments in the specialty area of focus (aging, medical, mental health, substance abuse, developmental disability and nursing home care) will be made available for used based on "triggers" found within the initial assessment.*

Question: Will individuals get to "keep" their current care coordinator if that is their preference?

Recommendation: *The established relationships individuals have with their care coordinators should be respected and maintained to assure continuity of care and promote person centeredness. In addition, the requirement for credentialing, skill and experience differs for care coordinators within long-term care, physical health and behavioral health and must be considered when implementing change. Moving to single care coordinator model may result in an immediate workforce issue due to a restructuring within the system. Potential care coordinator candidates may lack the multiple skill sets and required credentialing needed for an integrated system.*

Services

Question: If beneficiaries choose to "opt-out" of the integrated care plan, to where will they "opt-out"? Will current Medicare and Medicaid programs, such as MI Choice, Habilitative and 1915B Waivers still exist in their current form?

Recommendation: *To the extent possible, decisions about Waiver funding should be made and the information communicated prior to the implementation of the integrated system. It is the Committee's recommendation that the existing fee for service model remain in place and that waiver program benefits offered through qualified Area Agencies on Aging exist in both the integrated and fee-for-service systems.*

Question: If a single entity is responsible for managing all Medicare and Medicaid benefits, what will happen to specialty services that are currently offered as a part of the Medicaid Benefits package (e.g., therapy, psychiatric, occupational therapy, physical therapy, speech language pathology, Autism supports, caregiver respite, chore services, personal care, homemaking, etc.)?

Recommendation: *Expanded supports and services should be offered as part of the supports package to all dually eligible individuals, and the scope of these specialty services should be communicated prior to implementation as part of the consumer education and enrollment process.*

Question: How will other health and long-term care initiatives fit within the integrated care delivery system (i.e., nursing facility diversion and transition services, evidence based disease prevention programs, Care Transitions and/or Aging and Disability Resource Centers supported by many Area Agencies on Aging) ?

Recommendation: *Organizations that are participating in these other health and long term care initiatives offer continuity of service and disease prevention. To the extent possible, it is suggested that the providers who have demonstrated improved outcomes for people receiving these supports be partners in the integrated system.The new Medicare Community-Based Care Transitions Program (CCTP) to reduce hospital readmissions is exclusively for Medicare fee for service beneficiaries. Michigan should advocate that the Centers for Medicare and Medicaid retain eligibility for participation in the CCTP by dual eligibles who participate in a managed integrated care plan.*

Question: Patient-centered medical homes are mentioned as a program element – are there initiatives in place to develop these in Michigan?

Recommendation: *Patient-Centered Medical Homes is a national model that is built upon the foundations of care coordination of all long term care services, led by a Primary Care Physician who assures coordination of care. There are a few initiatives in Michigan to establish patient-centered medical homes. However, physician participation in the public input phase of model development has been noticeably absent. If patient-centered medical homes are to play a role in the integrated system, then feedback and input from physicians needs to be sought out and prioritized.*

Question: What range of services will be included to keep people out of institutions?

Recommendation: *Current best practices are nursing facility diversion and transition, care coordination and care transition projects, MI STAAR projects that reduce avoidable admissions to hospitals and waivers that promote community supports for people who would otherwise meet institutional level of care. It is recommended that these best practices be foundationally incorporated into the newly designed system.*

Cost Savings, Quality, and Logistics

Question: If the existing system is the option for those who opt out of the integrated care system, then will the integrated care system be an added layer to the current long term health care options available in Michigan? If no, then how will an added layer be avoided?

Recommendation: *The integrated system should build upon the existing long term care system, including MI Choice waiver programs and community-based care transitions programs administered by Area Agencies on Aging. Contract language and incentives that promote physical, behavioral, aging and nursing home partner coordination of functions should be*

included. Functions may include: co-location of staff, care transition projects, shared electronic health records, patient medical homes, sharing of resources, skill and expertise, etc. This work can be completed through regional workgroups that meet to collectively improve healthcare, meet performance expectations of MDCH and impact change within a region.

Question: Where integrated care for dual eligibles exists nationally, is there evidence that outcomes improve and cost savings result to the state and federal government?

Recommendation: *The Committee was unable to find quantitative data or reliable sources that clearly prove integrated care improve outcomes and saves money. In fact, in some states where integrated care has been implemented, e.g., New Mexico, outcomes were not clearly identified and costs increased. If Michigan implements this project it is recommended that lessons learned from those states that were unsuccessful be considered to avoid making the same mistakes.*

Question: Will the rates be blended or will providers be reimbursed at current Medicare rates? How will rates be balanced and how will they incentivize network expansion?

Recommendation: *Currently, Medicare rates are higher than Medicaid and the fee for service model is a disincentive for cost efficiency and gate keeping. Best practice suggests a managed fee for service model that has strong components for utilization review and gate keeping and allows for incentives for high performers. Workgroups should define what qualifies a high performer.*

Question: What is the anticipated caseload for the single care coordinator responsible for developing person-centered service plans based on individual choice?

Recommendation: *Best practice suggests that caseload composition, frequency of services and level of need be considered when setting caseload criteria for care coordinators. Unmanageable caseloads would be inefficient and these inefficiencies would reflect negatively on costs, savings, and care coordination.*

Question: How will fraud prevention be addressed and by whom?

Recommendation: *Build upon the existing systems that have demonstrated high performance in assuring individual rights, maintaining secure grievance and appeals, and reducing incidents that are in violation. Considerations should be made on the current expectations of organizations within the existing system that respond to and address issues of fraud (e.g., Medicare and Medicaid Assistance Program), and the capabilities of these agencies to respond to suspicions of fraud within their current work expectations.*

Question: Will the current Medicare and Medicaid penalties be preserved in the integrated system?

Recommendation: *If penalties are seen as a successful incentive to maintain quality (e.g., Civil Monetary Penalties) they should remain. Civil Monetary Penalty funds should continue to be used to support long term supports and services.*

Question: What will happen with those individuals who transition back and forth from a dual status to a non-dual status due to a Medicaid spend down?

Recommendation: *The plan for Integrated Care should address the problem of spend down, prior to implementation, so that individuals who need to spend down to reach Medicaid eligibility will be eligible for services continuously.*

Question: How will quality options be identified with the integrated system?

Recommendation: *"Quality" should be defined as the satisfaction of the recipient of services and the achievement of positive outcomes. In order for true quality of the integrated system to be gauged, current perceptions need to be surveyed and captured for comparison. Outcome measures for factors such as health status, hospital readmissions, institutionalization rates, etc. should also be considered indicators of quality. If quality is not considered or addressed until after implementation, it will be too late and costs to adjust services will increase. Quality service provision, at the onset of services, results in lowered costs. Rating systems of contracted providers, such as the star rating systems utilized for existing Medicare Advantage plans, by an unbiased entity who is not a provider of services and can demonstrate no conflict of interest, should be utilized and the results made available to the public as an easy way to guide individual choice and improve service delivery. Certifications by national quality assurance organizations may be another way to identify quality options.*

Question: How will the long wait-lists in programs like the MI Choice Waiver be addressed?

Recommendation: *Not only should the integrated care system remove waiting lists from existing programs and serve all eligible individuals, integrated care should remove disparities in funding and fund regions at a level consistent with the dual eligible population.*

Question: How will executive and legislative oversight be provided in the development, implementation, and review of the integrated system?

Recommendation: *Executive and legislative buy-in and oversight should be included at every step of the process. Given the high number of newly appointed state representatives, it is recommended that Legislators be provided information about this project in time frames that allow them to absorb and understand this information and the impact the project will have on their constituents. Legislative participation should occur at workgroup levels, stakeholders should be invited to testify before legislative committees, and legislative approval should be secured prior to implementation. State plans for integrated care should be made available for public and legislative review at least 30 days prior to submission.*

Question: What is the organizational structure for implementing the integrated model? Will it be phased in or piloted?

Recommendation: *A system of integrated care for dual eligibles should include dividing the state into geographic regions and selecting multiple managed care plans to offer services in the respective regions. The Area Agency on Aging 1-B and The Senior Alliance, Area Agency on Aging 1-C, believe that initial development and testing of the integrated system should be piloted first in select service areas, and expanded incrementally in other areas of the state once the model has been evaluated and proven effective in achieving the objectives of increased access, improved health, and cost savings or avoidance.*

Question: Will the amount spent on direct services have to decrease in order to offset the increased administrative expenses of an integrated care management organization?

Recommendation: *Controls should be placed upon administrative fees and incentives for cost efficiencies should be incorporated into contract language.*

Question: Why did Michigan choose to utilize a fully capitated managed care model for integrated care when CMS has given states the option of either capitated managed care or managed fee for service care?

Recommendation: *The fully capitated model allows administrative allocation of resources to various services and populations through policies that can divert resources from one priority to another. There is some concern that capitation can result in the intentional or unintentional diversion of resources away from one population, such as those with mental illness, to other favored populations or services. Managed fee for service models appear to provide greater protection against this possibility. MDCH should explain why they chose a capitated approach that has been rejected by so many other states, and provide assurance that this is not a strategy to redirect resources.*

APPENDIX A

SOUTHEAST MICHIGAN REGIONAL AGEA AGENCY ON AGING

ADVISORY COUNCIL AD HOC STUDY COMMITTEE ON

INTEGRATED CARE FOR DUAL ELIGIBLES PARTICIPANTS

Elaine Taverna, Community Living Services, Co-Chair
Tiffiny Reo, Premier Physician Services, Co-Chair

Area Agency on Aging 1-B Advisory Council Members
Steve Fein
Dennis Griffin
Robert Hull
Theresa Monsour
Tom Rau
Sue Sweeney

The Senior Alliance Area Agency on Aging 1-C Advisory Council Members
Ray Byers
Mary Lou Carey
Rosemarie Shim
Sandra Abbott
Lisa Boyd
Michael Chappell
Sharon Miller
Dianne Neihengen
Ann Randolph
Patricia Randolph
Joan Siavrakas
Amne Darwish Talab

Committee Staff
Bethany Burge, TSA
Lynn Mabie, AAA 1-B
Jason Maciejewski, TSA
Jim McGuire, AAA 1-B
Maggie Watson, TSA

APPENDIX B

PRESENTERS AT COMMITTEE MEETINGS

Home Care, Hospice, and Durable Medical Equipment
Howard Achtman, Sheldon Medical Supply
Sylvia Brown, Visiting Nurse Association of S.E. Michigan
Lynn Jones, Odyssey Hospice
Brenda Kassees, Compassionate Care Hospice
Susan Mize, Excellacare
Michelle Newton, Odyssey Hospice
Chuck Reese, Health Care Partners
Mary Ann Ryrant, Mercy Home Care & Hospice
Rosemarie Shim, Advanced Home Care

Community Mental Health Authorities
Jeff Brown, Oakland County Community Mental Health Authority
Verda Sharpe, Detroit Wayne County Community Mental Health Authority
Mac Miller, Livingston County Community Mental Health Authority
Jane Terwillinger, Monroe County Community Mental Health Authority
Michael Vicenza, Michigan Association of Community Mental Health Authorities

Health Plans
Jan Getty, Resource Link of Michigan
Rick Murdoch, Michigan Association of Health Plans

Skilled Nursing Facilities
Pat Anderson, Michigan Health Care Association
Tom Rau, Nexcare Health Systems, LLC

Hospitals
Marilyn Litka-Klein, Michigan Hospital Association

Michigan Legislature
Representative Gail Haines, Chair, Health Policy Committee
Representative Lesia Liss, Co-Chair, Health Policy Committee

Michigan Office of Services to the Aging
Peggy Brey, Deputy Director (former)
Lynn McCullom
Kari Sederberg, Director

APPENDIX C

State Demonstrations to Integrated Care for Dual Eligible Individuals – Design Contracts - Summary of Michigan's Initial Design Concepts May 2011

State: Michigan Overview of Proposed Approach	Michigan proposes to integrate Medicare and Medicaid funds to deliver all covered services for dually eligible beneficiaries. Under this proposal, those eligible would be enrolled, but with the ability to opt out of the plan. The State proposes to contract with one or more entities to administer the program under an acuity-based capitation arrangement. Risk would initially be shared between the State and the contracted entities, with full risk eventually transferred to the contractors. The financing arrangement between Medicare and Medicaid could range from full risk for the State to a shared risk / shared savings model. A robust care coordination program would be the hub of the delivery model, with each enrollee having a health home focused on person-centered care.
Target Population (All duals/full duals/subset/etc.)	All dually eligible individuals
Estimated Enrollment (in 2012 and at full implementation)	Current Statewide enrollment for dual eligibless: 207,594 Estimated enrollment April 1, 2012 (with 6% trend): 220,050
Planned Geographic Service Area (Statewide or listing of pilot service areas)	Statewide, but likely a phased implementation.
Planned Stakeholder Process	A thorough Statewide stakeholder process will be conducted to obtain input from all pertinent groups. This process will be carried out in summer of 2011.
Proposed Implementation Date and Related Milestones (Any implementation milestones are pending CMS Approval)	The proposed implementation date is April 1, 2012. Proposed Milestones: **May 2011 and ongoing**: Obtain Medicare data and link to Medicaid data; perform data analysis for overall population. **June through August 2011**: Conduct stakeholder process. **September-October 2011**: Review input from stakeholder process along with results from data analysis and supporting research to determine delivery model(s). **September – December 2011**: Write and submit necessary waivers and address any necessary legislation. Create an enrollment process. **November 2011:** Draft Request for Proposal (RFP). **December 2011-February 2012:** Conduct RFP Process. **February-March 2012**: Contracting process with selected entities. **April 2012**: Implement Integrated Care for Dual Eligibles.
State Contact Person and Email Address	Susan Yontz yontzs@michigan.gov

APPENDIX D

State Demonstrations to Integrated Care for Dual Eligible Individuals – Design Contracts - Summary of All States' Initial Design Concepts May 2011

STATE	# Dual Eligible Adults Estimated to be Served	Approach	Dual Population/ Area covered	Stakeholder Involvement
California	1.1 million	Mixed: MC/ Two-plan county model	All / Pilots first	TA Panel bi-monthly meetings
Colorado	60,000	Hybrid ACO/PCMH	All/Statewide	Ongoing Advisory Committee
Connecticut	120,000	ICO/Affiliations of small & large PCCs	Phase-in starting with 65+	Legislative Oversight Body
Massachusetts	115,000	MC/MassHealth	Ages 21-64	Consumer Advocates Group
Michigan	220,050	MC	All/statewide likely phased-in	Stakeholder process 6-8,2011
Minnesota	107,000	SNP/HCH/FFS	All/Statewide	Dual Demo Stakeholder group
New York	709,430	MC/SNP/PACE	TBD	Stakeholder process & key informants
North Carolina	284,000	Public/Private regional networks	All/Statewide	Stakeholder process
Oklahoma	?	ACO/State HCA /PACE	Three Geographic areas	Working Groups & task groups
Oregon	59,000	Regional plans w/ global budgets	Acute & behavioral care/statewide	Health System Transformation Team
South Carolina	TBD	TBD	Behavioral health & Alzheimers/ Phase-in	Integrated Health Care
Tennessee	137,000	MC: TennCare & CHOICES LTC	Integrate all Medicare Part A&B services	Stakeholder groups to develop program design
Vermont	21,379	State to become MC organization	All/Statewide	Ongoing Advisory Group
Washington	25,000-101,000	MC/Integrated delivery & finance	All/Phase-in State wide 2012 - 2017	Stakeholder process
Wisconsin	20,000 – 53,000	MC: State to function as Medicaid/Medicare	All/Phase-in state wide 2012- 2015	Statewide Long Term Care Council, and involvement of existing MCCOs and PACE

Taken from CMS Medicare Medicaid Coordination Office -http://www.cms.gov/medicare-medicaid-coordination/05_StateDesignContractSummaries.asp#TopOfPage

List of Acronyms:

- MC - Managed Care
- ACO – Accountable Care Organization
- PCMH – Primary Care Medical Home (Colorado)
- ICO- Integrated Care Organization (Connecticut single point of entry)
- PCC – Primary Care Centers – (Connecticut)
- SNP – Medicare Special Needs Plan
- HCH- Health Care Homes (Minnesota)
- FFS – Fee for Service
- PACE – Program of All Inclusive Care for the Elderly
- HCA – Health Care Authority (Oklahoma)