Integrating Care for People Eligible for Both Medicare and Medicaid

Considerations and Recommendations for Development of Michigan's Integrated Care Model – *A Synopsis*

Report Section	Key Message
Introduction	Regional partnership between the Advisory Councils for Area Agency on Aging 1-B (AAA 1-B) and The Senior Alliance (TSA), Area Agency on Aging 1-C, was established to study the potential impact of integrated care on AAA consumers and providers.
Background	The State of Michigan, through the Michigan Department of Community Health (MDCH), received one million dollars in funding for submitting a demonstration proposal to the Medicare-Medicaid Coordination office (part of CMS) in order to plan for the integration and coordination of services for beneficiaries dually eligible for Medicare and Medicaid.
Lessons Learned from Other States	Reviewed other state information to identify best practices and proven outcomes consistent with Michigan's expectations of better quality, provider incentives, and administrative efficiencies and savings. Findings included: • Many other states have piloted integrated care models previously, but little outcome or best practice information has been published. • Outcome information that was identified came from the Center for Health Care Strategies (CHCS) following their Integrated Care Program that began in 2005. o Program support is best garnered through early involvement of stakeholders, with continued conversation throughout implementation o Program planning averaged three years in length o Special Needs Plans most often facilitated these models o Mandatory enrollment was desirable because it provided predictability in expenditures and gave the state more control o Political and legislative involvement and buy-in is key to integrated care implementation • Information from states like New Mexico and Wisconsin indicated costs increased as integrated models were implemented. • Oregon utilizes Area Agencies on Aging as the "point of eligibility" for the Oregon Health Plan. Oregon has also had consistent executive and legislative support for years. • The Committee failed to identify quality outcomes from other states, although quality measures were indicated as important to be developed. • Michigan is planning a very robust integrated care system as compared to other states. Michigan is the only state the Committee identified to be including ALL core Medicare and Medicaid services, as well as service ALL dually eligible beneficiaries. It is unknown whether quantitative or qualitative data from other states could be applied or would be statistically relevant to Michigan's population, demographic, or existing/planned healthcare delivery system(s).

Benchmarking Michigan Services for Dual Eligibles

Financing/Rebalancing

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		↑

Long Term Services and Supports

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	↑

Long Term Services and Supports – Home and Community Based Services

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 Care Services and Supports – Skilled Nursing Facilities

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

Estimated Michigan Dual Eligibles

	Total	Nursing Facility	MI Choice	PACE	Hospice	HAB s 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

Principles to Guide the Development of a Michigan Model	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 Michigan Model should: **BUILD ON EXISTING INFRASTRUCTURE** …build upon community institutions that have a strong track record of delivering high quality and efficient care to individuals eligible for Medicare and Medicaid. **SHARE SAVINGS WITH ALL STAKEHOLDERS** … between government (taxpayers), providers in the form of stable and adequate reimbursement, and consumers in the form of enhanced benefits. **PERSON-CENTERED AND SELF-DIRECTED MODEL** … incorporate existing and new features that foster consumer direction of their supports, treatment, and benefits. **STAKEHOLDER INVOLVEMENT** …include provisions for ongoing oversight and involvement of the program's development and ongoing operations by stakeholder groups. **LOCAL CONTROL** …divide the state into sub-state service areas, and contract for the management of services on a regional basis. **INCREMENTAL DEVELOPMENT** …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. **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. **CONSUMER CHOICE/CONSUMER ADVOCACY** …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… protect and foster the ability of consumers to advocate on their own, and for others to advocate on their behalf. **PERFORMANCE INCENTIVES** … utilize financial performance incentives and penalties to achieve and reward high level performance regarding access, quality, efficiency, effectiveness, outcomes, and timeliness. **PRIORITY FOR MICHIGAN BASED ORGANIZATIONS** …give priority to proposals that include the highest levels of qualified Michigan-based

	organizations, companies, and affiliates, including area agencies on aging. **EVIDENCE BASED PREVENTIVE SERVICES** …be a core required program component. **SUPPORT FAMILY CAREGIVING** … include strategies for encouraging and strengthening involvement of and support for family caregivers of participants who require long term care services. **EQUAL AND UNIMPEDED ACCESS TO ENTILED BENEFITS** …provide access to all plan benefits for which beneficiaries qualify and need, without regard to disability, residential setting or community of residence. **COST SAVINGS** …be achieved through quality improvements and efficiencies, and not as a result of a reduction in reimbursement rates to providers and contractors.
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. The following are only a sample of the questions and recommendations listed within the report: **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 foundation 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:** 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:** 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:** 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 (i.e. Medicare and Medicaid Assistance Program), and the capabilities of these agencies to respond to suspicions of fraud within their current work expectations.* **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 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:** 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.*