STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

OLGA DAZZO
DIRECTOR

June 24, 2011

NAME
TITLE
ADDRESS
CITY STATE ZIP

Dear Tribal Chair and Health Director:

RE: Notification of Intent to Develop the Michigan Plan for Integrated Care for Dual Eligible Individuals

The Michigan Department of Community Health (MDCH) is notifying you of its intent to develop the Michigan Integrated Care for Dual Eligible Individuals model. Michigan is one of 15 states granted approval by the Centers for Medicare and Medicaid Services (CMS) to participate in a demonstration initiative to integrate care for individuals eligible for both Medicare and Medicaid.

The project will integrate services covered by Medicare (Part A, Part B, and Part D services) and current Medicaid services including nursing facility care, home and community based waiver services, other long-term care related services and behavioral health services. An important component of the project will be the coordination of care across all service providers with a person-centered planning focus supporting consumer choice.

CMS requires contracted states to involve stakeholders in the development process of the project. MDCH will be conducting a stakeholder process during the summer of 2011 to gain important insight from consumers and providers. Tribal Chairs and Health Directors will be notified of opportunities to participate in this important endeavor.

Michigan's approved proposal to CMS is attached to this letter. If you would like to discuss the proposal, please contact Mary Anne Tribble, Medicaid Liaison to the Michigan Tribes. Mary Anne can be reached at (517) 241-7185 or via e-mail at tribblema@michigan.gov.

Sincerely,

Stephen Fitton, Director
Medical Services Administration

cc: Leslie Campbell, Region V, CMS
Pamela Carson, Region V, CMS
Jerilyn Church, Director, American Indian Health and Family Services of Southeastern Michigan, Inc.
L. John Lufkins, Executive Director, Inter-Tribal Council of Michigan, Inc.
Kathleen Annette, MD, Area Director, Indian Health Services – Bemidji Area Office
Mary Anne Tribble, MDCH

Enclosure

Distribution List for L 11-14
June 24, 2011

Mr. Jeffrey D. Parker, President, Bay Mills Indian Community
Ms. Laurel Keenan, Health Director, Bay Mills (Ellen Marshall Memorial Center)
Mr. Derek J. Bailey, Tribal Chairman, Grand Traverse Band Ottawa & Chippewa Indians
Ms. Loi Chambers, Health Director, Grand Traverse Band Ottawa/Chippewa
Mr. Kenneth Meshigaud, Tribal Chairman, Hannahville Indian Community
Ms. G. Susie Meshigaud, Health Director, Hannahville Health Center
Mr. W. Chris Swartz, President, Keweenaw Bay Indian Community
Ms. Carole LaPointe, Health Director, Keweenaw Bay Indian Community - Donald Lapointe Health/Educ Facility
Mr. Alan Shively, Tribal Chairman, Lac Vieux Desert Band of Lake Superior Chippewa Indians
Ms. Terry Fox, Health Director, Lac Vieux Desert Band
Mr. Larry Romanelli, Ogema, Little River Band of Ottawa Indians
Mr. Bob Davis, Health Director, Little River Band of Ottawa Indians
Mr. Ken Harrington, Tribal Chairman, Little Traverse Bay Band of Odawa Indians
Ms. Sharon Sierzputowski, Health Director, Little Traverse Bay Band of Odawa
Mr. DK Sprague, Tribal Chairman, Match-E-Be-Nash-She-Wish Potawatomi Indians (Gun Lake Band)
Ms. Phyllis Davis, Health Director, Match-E-Be-Nash-She-Wish Potawatomi
Mr. Homer Mandoka, Vice Tribal Chairman, Nottawaseppi Huron Band of Potawatomi Indians
Mr. Jon Gardner, Health Director, Huron Potawatomi Inc.- Tribal Health Department
Mr. Matt Wesaw, Tribal Chairman, Pokagon Band of Potawatomi Indians
Mr. Arthur Culpepper, Health Director, Pokagon Potawatomi Health Services
Mr. Dennis V. Kequom Sr, Tribal Chief, Saginaw Chippewa Indian Tribe
Ms. Gail George, Health Director, Nimkee Memorial Wellness Center
Mr. Darwin McCoy, Tribal Chairman, Sault Ste. Marie Tribe of Chippewa Indians
Ms. Bonnie Culfa, Health Director, Sault Ste. Marie Tribe of Chippewa Indians - Health Center

CC:

Ms. Leslie Campbell, Region V, Centers for Medicare and Medicaid Services
Ms. Pamela Carson, Region V, Centers for Medicare and Medicaid Services
Ms. Jerilyn Church, Executive Director, American Indian Health and Family Services of Southeastern Michigan
Kathleen Annette, MD, Area Director, Indian Health Service - Bemidji Area Office
Mr. L. John Lufkins, Executive Director, Inter-Tribal Council of Michigan, Inc.

Michigan's Response to CMS Solicitation
State Demonstrations to Integrate Care for Dual Eligible Individuals

Solicitation Number: RFP-CMS-2011-0009
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of Acquisition and Grants Management

Like many other states, Michigan seeks to improve care and services for individuals dually eligible for Medicare and Medicaid. To that end, the state submits this application for a contract to plan for the implementation of an integrated services and funding model.

Michigan's Proposal Description

Statement of Problem
According to a study published by the Lewin Group in 2008, spending on the dual eligible population (individuals covered by both Medicare and Medicaid) accounts for approximately 42% of all Medicaid expenditures and 25% of Medicare spending in the United States.[i] While Medicare is responsible for covering services directed toward the acute physical health care needs of this group, including pharmacy, nearly all behavioral health and long-term care supports and services, including high cost custodial nursing home care, are covered by state Medicaid programs. Combined, expenditures by the federal and state governments for the dual eligible population were over $250 billion in 2008.[ii]

Specifically in Michigan, there are 204,262 dual eligible beneficiaries representing 12% of total Medicaid enrollment. At a cost of about $3.6 billion in 2010, duals accounted for 38% of total Medicaid spending. At the same time, Medicare spending on duals in Michigan was estimated to be $4.1 billion.

Despite the volume of funding focused on this population, the diverse objectives and statutory provisions in federal law for Medicare and Medicaid have led to inefficiencies in both programs. Aside from persons who are covered under traditional Medicaid waivers, states, including Michigan, have been constrained in their abilities to find creative solutions for delivering better coordinated and less costly care for duals. Services continue to be delivered in silos with no financial incentives in the existing systems to change and improve 1) service delivery for beneficiaries, 2) reimbursement for providers, or 3) administrative oversight for the Medicare and Medicaid programs.

In Michigan, health care for dual eligibles is delivered and paid for primarily through a fee for service system. This has led to redundancies in treatment because of inadequate care coordination and limited quality assurance. Experience informs us that these conditions can be dangerous for beneficiaries and costly for the two programs. Furthermore, without an integrated system, duals must navigate the two very different

and complicated administrative structures of Medicare and Medicaid. A significant amount of confusion can derive from multiple membership cards, varying coverage rules, and numerous uncoordinated specialty providers.

Further complicating these issues for dual eligibles in Michigan is the 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. Furthermore, while nearly 56,000 beneficiaries, including 35,527 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 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.

An integrated payment and care delivery system will also improve the provider experience. Effective case management and coordinated care will invariably improve the ability of providers to deliver successful interventions, and with a single payer system, they will likely see a reduction in the administrative burden that accompanies multiple billing and two separate and complex reimbursement mechanisms.

As an antidote to the problems discussed above, the Affordable Care Act offers states the opportunity to remedy the statutory challenges, which prevent their Medicaid programs from working with Medicare to create innovative health care delivery systems for dual eligibles. Michigan is eager to work with the Office of the Duals and the Center for Medicare and Medicaid Innovation to create an integrated care demonstration that will address inefficiencies in the existing system and provide new opportunities in improving lives. Integrated care will bring a significant shift not only to the way in which health care is delivered and reimbursed, but it will also dramatically impact the beneficiary experience in accessing care, the quality of service and participation in the process.

Michigan's Historical Route to Integrated Care

Michigan has given serious consideration to the development of an integrated care model over the last several years. Starting with the work of the Medicaid Long Term Care Task Force in 2004, managed long term care has been viewed by many pertinent stakeholders as a viable solution in assuring that elderly persons and people with disabilities have access to all of the supports and long term care they require, especially to thrive in a community setting. MDCH staff initiated development of a Medicaid--only managed long term care waiver with the assistance of a grant through the Center for Health Care Strategies (CHCS). As work on this waiver progressed, it became evident to those involved that real systemic change and impact on the lives of the dual population could only be achieved through a new model integrating Medicare and Medicaid funds and services.

MDCH was again given opportunity in 2009 to work with CHCS through its *Transforming Care for Dual Eligibles* grant. For the last year and a half, staff from the Medicaid program and the Office of Services to the Aging worked with several other states and the technical experts of CHCS to investigate opportunities for integrated care and to develop plans for creating models in our respective states. Michigan used this grant to evolve its strategy and to begin the development of a plan for integrated care in the state, and in so doing gave consideration to multiple strategies before deciding on the approach that is described in this contract proposal.

Current Environment

Michigan Medicaid has administered a highly evolved and nationally recognized managed care program to deliver acute health care services to its beneficiaries since the late 1990s. As of September 2010, 69 % of the program's 1.85 million beneficiaries were enrolled in and receiving services through one of 14 managed care plans. Since managed care is mandatory, virtually all of those who qualify for health plan enrollment are enrolled. This includes the non-dual disabled population that has been a mandatory HMO population since 1997. Michigan also has experience delivering Medicaid covered behavioral health services through a capitated arrangement called Prepaid Inpatient Health Plans (PIHPs). The Mental Health & Substance Abuse Administration contracts with the regional PIHPs to provide mental health and specialty services to the Medicaid population, including dual eligibles.

Michigan currently has four operational PACE sites in the state with two additional sites under development. Success with PACE has cultivated the state's understanding of the significant impact integrated care can have in providing quality, person-centered care for beneficiaries, while providing significant savings to the Medicaid and Medicare programs.

A recent, but significant, development is that the Michigan Department of Community Health has received a federal grant to implement a multi-payer program to develop patient-centered medical homes. These grants were given to only 8 states, a testament to Michigan's readiness to move this important initiative forward. Every effort will be made to incorporate this delivery system advance into the care system for dual eligibles.

Despite its extensive experience and success with managed care, persons who are dually eligible for Medicare and Medicaid comprise the largest number of Michigan's Medicaid population that continues to be excluded from health plans. This represents immense opportunity for improving access and quality of care for the duals while addressing cost effectiveness for the Medicare and Medicaid programs.

Michigan's Plan

Michigan proposes development of an integrated care demonstration in which Medicaid would serve as the designated entity assuming complete financial and administrative oversight for Medicare and Medicaid funds and services associated with the dual eligible population. The state proposes that funds from Medicare be transferred to the state via a risk-adjusted capitation payment derived from Medicare data demonstrating the acuity of

the dual population and historical utilization trends. The state in turn would contract with managed care organizations on the local level to manage and coordinate care for plan participants. These would include both the traditional managed care model and accountable care organizations. The benefit package will include acute, pharmaceutical, long term and behavioral health care services for the target group. Based on the state's previous experience with managed care, mandatory enrollment will be required because it is important for achieving economies of scale, but participants will be offered the choice of opting out of the plan. With this approach, the state would expect to be held to a high level of accountability by our federal partners. In their totality, these proposed program elements represent innovation on multiple levels.

The critical factor in our thinking is the need for a single contractual relationship between the payers (Medicare and Medicaid) and the entity responsible for service delivery and quality. Having multiple payers with separate contracts and administrative structures diminishes the ability of the payers to establish and enforce expectations and standards since both are responsible for only a partial set of services. Similarly, Michigan sees a certain simplicity and advantage in having full financial responsibility through a risk adjusted payment from Medicare to the State but is receptive to negotiating a more moderate gain-sharing arrangement. The key is the opportunity to share in the savings from more cost effective delivery of the full continuum of services, especially a reduction in unnecessary hospital admissions and readmissions.

Michigan's plan for integrated care includes 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 single standardized assessment tool to identify participant needs
- Person-centered medical homes to ensure access to care
- A single care coordinator 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

While Michigan has given considerable thought to its plan and the goals it hopes to achieve through integrated care, funds from this CMS contract solicitation are critical to fully develop the model and take it to fruition. In addition to supporting contractual services necessary to assist the state in moving the project forward, funds will be used to: conduct and draw conclusions from a thorough stakeholder process; gain access to and

perform analysis on Medicare data; and develop the delivery model based on stakeholder input and data analysis.

Model development would include: creating a rate-setting structure and payment methodology; establishing baseline quality standards for the delivery system and establishing performance metrics; creating a single assessment tool to determine beneficiary needs; writing a request for proposals to engage managed care partners; assessing and developing a plan to integrate Michigan's waiver services (behavioral health and long term care) and state plan personal care option into the new integrated delivery system; creating a marketing plan; develop a methodology for evaluating the model; and developing a plan to assess participant satisfaction.

Because of Michigan's size and significant geographic diversity, the design phase will utilize the stakeholder process and data analysis to inform and examine the feasibility of implementing different models in dissimilar areas of the state. Consideration is being given to an accountable care organization model, as well as a more traditional managed care model. The state will assess, with its contractors, the practicality of moving forward with more than one demonstration model soon after the completion of the stakeholder process. This will be necessary to expedite the next steps.

Regardless of the demonstration model types, Michigan is sure about the following based on the planning work completed to date: Michigan proposes to receive the Medicare funds (on a risk-adjusted basis), and assume all financial risk for Medicare services for dual eligibles. Michigan also is certain that the state then intends to enter downstream contracts with capitated entities that will deliver an integrated array of Medicaid and Medicare services, and assume capitated risk for both.

Michigan currently is contemplating downstream contracts that could include SNPs, ACOs, and/or other capitated entities. Factors that might dictate the downstream contractual entities include penetration in different regions of the state, competency managing Medicaid and Medicare benefits, and other considerations. During the course of Michigan's planning contract with the Center for Medicare and Medicaid Innovation, the state will determine the criteria it will utilize to select downstream capitated entities, and specify these criteria in the demonstration model and the RFP the state will utilize to procure these entities.

Michigan plans to introduce integrated care on a statewide basis as soon as feasible using a carefully planned process. Full project implementation will depend on provider system readiness in the various regions of the state.

Capacity and Infrastructure

Michigan's commitment to integrated care is demonstrated by the quality of internal staff dedicated to design, develop and implement this model. Staff members noted below include some of the most experienced and knowledgeable individuals employed by MDCH, starting with the Medicaid Director. The following individuals and their support are critical to this project:

- Stephen Fitton –Medicaid Director
- Michael Head-Mental Health & Substance Abuse Services Director
- Peggy Brey-Deputy Director, Office of Services to the Aging
- Susan Moran –Director of managed care and quality for Michigan's Medicaid managed care organizations
- Chris Priest –Director of Medicaid Policy
- Richard Miles – Director Medicaid Actuarial Services
- Susan Yontz –Long Term Care Services Policy Manager and State Project Coordinator
- Robert Orme-Long Term Care data procurement and analysis
- Pam Yager – Insurance and Medicare specialist for the Medicaid program
- Cynthia Green-Edwards-Director of Medicaid data warehouse
- Additional management staff and analysts will contribute to program development, including those with the following areas of expertise: policy, actuarial, budget, managed care and quality assurance, data and encounters, MMIS, PACE, aging and disability services, home and community based services and behavioral health

To supplement the extensive resources offered by internal staff, the state has contracted with some of the most highly regarded experts in the country to assist with this project. The following contractors/consultants will contribute their expertise:

- Charles Milligan-University of Maryland Baltimore County, The Hilltop Institute-data analysis
- Milliman & Associates-Actuarial Services
- Health Management Associates, Lansing Michigan –Data analysis, stakeholder process, and project consultation
- University of Michigan Institute of Gerontology-MDS and iHC data analysis

Current Analytic Activity and Capacity

Michigan is well positioned to perform the various analyses needed to research various elements of integrated care, to establish cost effectiveness and to evaluate the success of different models. Of particular significance is the evolution of a robust data warehouse from which significant encounter and fee-for-service data can be drawn for analysis of the Medicaid population. Medicaid's Actuarial staff has extensive experience in using these data to establish rates for 14 Medicaid managed care plans operating in the state, as well as for four PACE organizations. Of particular relevance is the fact that encounter data are used to establish risk adjustment scores by region for each health plan. This experience will facilitate efforts to implement risk adjustment across both payer sources once access to Medicare data is obtained.

Availability of Medicare cost and utilization data for all dual eligibles is essential to the use of a data driven process and will be critical to the success of this initiative.

Therefore, to supplement Medicaid data available through its warehouse, Michigan is actively seeking Medicare data through the Research Data Assistance Center (ResDAC). As noted, Charles Milligan of the Hilltop Institute and principles from Health Management Associates will provide guidance in project development and program analysis, including the linkage and analysis of date from the two programs.

Michigan will also have access to analytical resources from the University of Michigan Institute of Gerontology (UMIG) to assist with incorporating long term care services into participating managed care plans. UMIG is an existing contractor that analyzes Minimum Data Set (MDS) and interRAI Home Care (iHC) assessment information for the Medicaid program. This data will be made available to the state's integrated care management organization(s) to assist them in understanding the health status of individuals residing in nursing homes or using home and community based waiver services.

In combination, all of these quality resources will provide an analytical capability that will enable the state to conduct successful research, to evaluate the degree of success and to effectively represent Michigan's experience to other states.

Summary of Stakeholder Environment

Michigan recognizes the value of early and continuous stakeholder input in creating an integrated care model that is well received by consumers, as well as providers. It is much more likely that a plan developed with stakeholder engagement from the beginning will ultimately be more successful than a model that is developed by state officials alone.

Understanding the importance of stakeholder buy-in, the department initiated talk regarding integrated care as early as Michigan's 2004 Long Term Care Task Force was convened. This group of state officials, consumers and providers from across the long term care industry discussed options for creating a managed care delivery system for the continuum of ltc services. Though not adopted at that time, the discussion continued and helped evolve the state's current thinking regarding integrated care and the importance of stakeholder participation.

While participating in the CHCS *Transforming Care for Dual Eligibles* project, state staff continued to discuss the benefit of an integrated health care delivery system for duals with consumer advocates and provider associations. The Medicaid director and the deputy director for the State Unit on Aging meet on a monthly basis with consumers and advocates from Michigan's Olmstead Coalition, and have solicited thoughts on an integrated care plan. Integrated care has also been discussed with the Long Term Care Supports and Services (LTCSS) Advisory Commission. The message has from these groups has been clear; in order to gain their support, the plan must embrace person-centered care coordination and choice versus a medical model.

In the last two years, the Medicaid director has met with multiple provider groups to discuss the potential for integrated care in the state. There has been broad-stroke

discussion of integrated care with the following provider industry associations: Michigan Association of Health Plans, Michigan State Medical Society, Michigan Hospital Association, Health Care Association of Michigan, Aging Services of Michigan and the Michigan County Medical Care Facilities Council. Plans for developing an integrated care model have also been discuss at a high level with the Medicaid Medical Care Advisory Committee, a consumer and provider group that meets on a quarterly basis to advise the Medicaid agency on health and medical care services. Major health care systems in Michigan have also been contacted to discuss integrated care, but additional conversation and input are necessary with other potential delivery system partners, including home and community based service providers, home health, hospice personal care and PACE providers.

Michigan will use the initial design period of the CMS contract to work through an organized and deliberate stakeholder process assessing key questions relative to the development of an integrated care system ensuring that planning decisions are made in the best interests of Michigan's dual eligible population. During this six month stakeholder process, the State, with the assistance of project consultants, will conduct regional stakeholder meetings throughout the state to solicit input from consumers, advocacy and provider groups regarding integrated care.

The state will perform the following tasks to ensure stakeholder input in designing, and ultimately implementing, integrated care:

- Finalize the list of potential stakeholder participants, ensuring diverse representation
- Conduct an outreach campaign to solicit the participants identified above
- Develop a schedule of meetings
- Draft short and long term meeting objectives and goals and develop workgroups as necessary
- Develop a website to notify stakeholders of meetings, post pertinent documents and information related to integrated care, and respond to questions
- Use consumer groups, community organizations, and provider associations to distribute information and accept comment.
- Once established, the State Health Insurance Program (in Michigan it is called the Medicare and Medicaid Assistance Program-MMAP), will assist the dual eligible population in understanding the integrated care program

The meetings will provide participants with an overview of integrated care and the benefits it can provide, and then comments and concerns will be solicited and considered in the design model. At the end of the initial design period, the State will have the information necessary to determine how best to expand upon or refine its approach to an integrated care system that will have the highest likelihood of achieving the State's goal of implementing a coordinated, effective delivery system that improves the quality, coordination, and cost effectiveness of care for dual eligible individuals.

Timeframe

The target date for implementation of this project is April 1, 2012. Because Medicaid policy in Michigan is established through administrative rules and a process outside of statutory protocol, legislative authority is not required in Michigan. However, given its responsibility for appropriating funds to agencies, it will be important to gain legislative support. Michigan's new administration is currently working with department staff to develop the executive budget recommendation for the next fiscal year starting October 1, 2011.

Budget and Use of Funds

The budget supports the program design for developing an integrated care system for dual eligible individuals in Michigan detailed in our planning activities and timeline. A significant portion of the budget is dedicated to stakeholder involvement similar to the process used in Michigan's State Health Information Exchange (HIE) Cooperative Agreement with the Office of National Coordinator and our Michigan Health Insurance Exchange Planning project through the Department of Health & Humans Services. This plan will allow us to leverage our prior experiences and lessons learned to develop an integrated care system model that meets the needs of dual eligible individuals in the state.

The consultant costs are budget estimates based on previous experiences in Michigan with similar efforts such as the Michigan Health Information Network and Medicaid Managed Care. These past efforts required the acquisition of services of project managers, meeting planners, actuaries, accountants, facilitators, various subject matter experts, and technical writers. The consulting staff will perform such tasks as stakeholder workgroup facilitation, project management, financial analytical services, research and analysis, and model development.

The salary and fringe benefits for two full time equivalent (FTEs) and two part time FTE's were based on the Michigan Department of Civil Services Compensation Plan that was effective October 1, 2009. The Michigan Defined Contribution Retirement Rate for FY 11 is 27.05%. The Group Insurance rate per person for the State of Michigan is $12,500. The travel budget was estimated to support one staff assigned to participate in stakeholder meetings, workgroups that may be established, and any required Centers for Medicare & Medicaid Services meetings at the State of Michigan travel reimbursement rates. The timing and location of stakeholder meeting has yet to be determined. Supplies were calculated at one third of the general office supply purchase expense per State of Michigan employee. The Michigan Department of Technology, Management, and Budget annual desktop support and connectivity fee for FY11 is $2,089 per desktop per year which is included under "Other" charges. The Random Moment Sampling (RMS) costs are also included under "Other" charges.

[i] The Lewin Group, "Increasing use of the capitated model for dual eligibles: cost savings estimates and public policy opportunities, November 2008.

[ii] Center for Health Care Strategies, Testimony of Melanie Bella on Health Reform in an Aging America, U.S. Senate, March 4, 2009.