STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

RICK SNYDER
GOVERNOR

OLGA DAZZO
DIRECTOR

July 1, 2011

Dear Stakeholder:

The Michigan Department of Community Health has contracted with the Centers for Medicare and Medicaid Services (CMS) 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. The goal of an integrated care model is to offer beneficiaries person-centered, coordinated services that meet the unique needs of dual eligibles. As the MDCH seeks to establish more integrated and accountable systems of care for its dually eligible beneficiaries, it is seeking input from stakeholders about the goals and key elements of care integration to help shape its final plan.

We invite you and your members or constituents to participate in one of four public forums to be held around the state to learn about and offer input into the state's plans for integrating care for dual eligibles in Michigan. In addition to hearing a presentation from Michigan's Medicaid agency, forum participants will be asked to describe features of the current system that should be preserved and issues that exist within the current system that can be improved. They will also offer feedback regarding the state's proposed approach for integrating care. A draft forum agenda, including discussion questions, and a description of the state's general approach are attached.

Forums will be held in Gaylord, Grand Rapids, Marquette, and Southfield. Dates and times are listed below. You can learn more about our plans for obtaining stakeholder input and register to attend a forum at https://janus.pscinc.com/dualeligibles/.

Gaylord
Wednesday, July 20, 2011
9:00 AM to 12:00 PM

Grand Rapids
Monday, July 25, 2011
1:00 to 4:00 PM

Marquette
Thursday, July 21, 2011
9:00 AM to 12:00 PM

Southfield
Wednesday, July 27, 2011
1:00 to 4:00 PM

We understand that the timeframe is tight, and we apologize for the short notice regarding the forum dates. The state is working under a very tight deadline to prepare a plan for CMS. We hope that you or your colleagues can attend a forum nonetheless. We value your input.

Please forward this message to others you believe may be interested in attending a forum. If you have questions regarding the forums, please contact Dawn Wade at Public Sector Consultants at (517) 484-4954.

Sincerely,

Stephen Fitton

Stephen Fitton, Director
Medical Services Administration

attachments

Integrated Care for Dual Eligible Beneficiaries in Michigan

Overview

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]

There are over 205,000 dual eligible beneficiaries in Michigan. This population represents 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.

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

CMS recently granted Michigan and 14 other states a contract to develop integrated care delivery models that will address the inefficiencies of the current parallel Medicare and Medicaid systems. In order to apply for the contract award, Michigan was required to outline a concept for integrated care in the state. With the contract funds, each state is expected to engage pertinent stakeholders in the planning and development phase, building upon the original concept submitted to CMS. Michigan has planned its stakeholder process for the summer and early fall of 2011. The Michigan Department of Community Health has engaged Public Sector Consultants, Inc. to conduct a phased stakeholder process that will engage all interested parties from consumers of the system to providers of services.

Michigan's Concept for Integrated Care

The state will integrate Medicare and Medicaid funds to contract for the delivery of all covered services for dually eligible beneficiaries. Covered services will include: all acute care benefits currently covered by Medicare; pharmacy benefits; behavioral health services; and all long-term care benefits provided through Medicare and Medicaid including short term re-habilitation and long-term nursing facility care, all home and community based services currently provided under a 1915 (c) waiver, home health services, hospice, personal care services and care for ventilator dependent beneficiaries.

Those eligible for the plan will be enrolled but consistent with Medicare rules, individuals will retain the ability to opt out if they choose to do so. The current vision is that the state will contract with one or more entities to administer the program under an acuity-based capitation arrangement. Risk will initially be shared between the state and the contracted entities, with full

Integrated Care for Dual Eligible Beneficiaries in Michigan

risk eventually transferred to the contractors. A robust care coordination program is the hub of the delivery model, with each enrollee having a health home focused on person-centered care.

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 standardized assessment tool to identify participant needs
- Person-centered medical homes to ensure access to care
- Family care-giver involvement
- Strong home and community based service options
- A single care coordinator to assist development of person-centered plans of care based on choice and to assist participant navigation of the health care system
- Plan performance metrics to evaluate effectiveness
- Quality management strategies and measurements unavailable in the current fee-for-service model
- Data sharing amongst providers across the continuum of care to enhance care coordination
- Mandatory enrollment with the ability to opt out
- Consumer protections, including grievance and appeal processes that meet the standards required by both Medicare and Medicaid

With the development of an integrated care system for dual eligibles, Michigan seeks to create a delivery model that will improve the health care experience for beneficiaries while reducing inefficiencies and aligning incentives for providers. It is anticipated that integrated care will provide plan enrollees with a seamless delivery system offering a full spectrum of services. It will eliminate the fragmentation currently experienced by beneficiaries in the existing fee-for-service model. Each dual eligible will have the benefit of working with a single care coordinator to assist in accessing the supports and services identified in a person-centered plan of care. The existing barriers to home and community based services will be eliminated as incentives will align for beneficiaries to receive the services they need in the setting of choice.

Providers will experience administrative efficiencies by working with a single administrative system and payer source thereby eliminating the need for dealing with multiple entities for authorization and payment of services. In an integrated model, providers will have more opportunity to work with enrollees to eliminate redundancies in service and improve quality through better care coordination. The incentives for providers to provide the right care at the right time will be enhanced through an integrated system.

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[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.

Integrated Care for Dual Eligibles in Michigan

REGIONAL PUBLIC FORUM AGENDA

1. Welcome — 10 minutes
2. Presentation by MSA staff — 30 minutes
   - Overview of dual eligibles
   - Description of current system and problems to be addressed by care integration
   - Brief description of state's proposed approach and program elements*
3. Facilitated discussion — 2 hours
   - What do you like about the way the current system works?
   - What problems have you experienced that should be addressed with an integrated care model?
   - In looking at the state's list of program elements, are there any missing that you think are critical for a successful program for dually eligible beneficiaries?
   - What are the most critical issues the state should keep in mind when developing an integrated care delivery system?
4. Next steps and adjourn — 10 minutes

*** Proposed program elements**:

- All core Medicare and Medicaid services, with the potential for additional social supports
- A comprehensive provider network across the continuum of services
- A single standardized assessment tool to identify participant needs
- A single care coordinator to assist in the development of person-centered plans
- Person-centered medical homes
- Family caregiver involvement
- Strong home- and community-based options
- Plan performance metrics to evaluate effectiveness
- Quality management strategies and measurements not available in the current fee-for-service system
- Data sharing among providers across the continuum of care
- Mandatory enrollment with the ability to opt out
- Consumer protections, including grievance and appeal processes that meet the standards required by Medicare and Medicaid