Michigan’s Proposal to Integrate Care for People who are Medicare-Medicaid Enrollees

February 27, 2012
Key Issues

- Fragmented and costly.
- Aging population will require more services.
- Promote community-based system of care.

Reinvent our health care system. Reduce health costs per person served.

- Achieve Person-centered care by integrating clinical, long-term and support services.
- Ensure access to excellent and compassionate behavioral and DD services.
- Continue to build community-based system of care for our aging population.

*Children With Special Needs Program and WIC are also part of the Michigan Health Care Safety Net.*
Medicaid – Financing Models

1.79 M Michiganders
$11.7 B

Medicaid

70% Managed Care
1.2 M Served
$5.49 B Cost
Avg. Cost: $4,482 ppy

30% Fee for Service
.56 M Served
$6.16 B Cost
Avg. Cost $10,945* ppy

*The current fee for service population requires higher intensity and quantify of medical and long-term care services (nursing home, MiChoice Waiver, Home Help) resulting in higher health care costs per person per year.
Proposal

• Change financing model for ~200,000 persons who are dually covered by Medicare and Medicaid.
  – Move from the current Fee for Service model to an organized system of care.

• Dually eligible persons include:
  – Frail elderly
  – Mentally ill
  – Developmentally disabled
The Problem

- **Health care silos** major contributors to
  - Poor quality care
  - More illness
  - High cost
  - Premature death
The Solution

Person-Centered Organized System of Care
## Medicaid & Medicare Expenditures
### Michigan Dual Eligibles - 2008

<table>
<thead>
<tr>
<th>2008 Annual Spending on Dual Eligibles (198,644 Enrollees)</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Both</th>
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</thead>
<tbody>
<tr>
<td>Long Term Care</td>
<td>$764,883,909</td>
<td>$2,317,330,874</td>
<td>$3,082,214,783</td>
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<tr>
<td>Inpatient Hospital*</td>
<td>$1,709,795,363</td>
<td>$38,573,636</td>
<td>$1,748,368,999</td>
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<tr>
<td>Outpatient Physical Health Care*</td>
<td>$1,516,682,325</td>
<td>$147,058,863</td>
<td>$1,663,741,188</td>
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<td>Pharmacy</td>
<td>$534,878,292</td>
<td>$15,769,962</td>
<td>$550,648,254</td>
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<tr>
<td>Behavioral Health</td>
<td></td>
<td>$843,551,051</td>
<td>$843,551,051</td>
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<tr>
<td>Grand Total</td>
<td>$4,526,239,890</td>
<td>$3,362,284,386</td>
<td>$7,888,524,276</td>
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</tbody>
</table>

*Includes inpatient and outpatient mental health services paid by Medicare.
The Goal of Integration

Organized and coordinated service delivery system across all service domains.

• Seamless delivery of services
• Reduce fragmentation
• Reduce barriers to home and community-based services
• Improve quality of services
• Simplify administration for beneficiaries & providers
• Cost effectiveness aligning financial incentives
The Process

• Obtained planning contract, April 2011
• Held multiple stakeholder input events, July – December 2011.
• Draft proposed integration model, February 2012.
• Present to Administration, February 2012.
• Present to key legislators, February 2012.
• Release for 30-day public comment, March 5, 2012.
• Public meeting scheduled for March 20, 2012.
• Submit plan to CMS, April 26, 2012.
Extensive Stakeholder Input

- Informant Interviews
- Regional Forums
- Request for Input
- Topic-Driven Work Groups
- Email box
- 30-day Public Comment Period on Proposal
- Public Meeting on Draft Proposal
Stakeholder Themes

- Importance of self-determination and person-centered planning
- Assurance of access to existing array of services with expansion of service package
- Guarantee services are of high-quality and responsive to participant needs and desires
- Assurance of well-coordinated care
- Access to home and community-based supports and services versus facility-based care
- Maintenance of existing relationships between people receiving services and their providers, including specialists
- Choice must be afforded in all areas of the plan
- Importance of maximum enrollee protections throughout the process, especially in the enrollment process and in the due process rights afforded enrollees
- Quality standards must be established and monitored
Integrated Care Flow of Funds for Medicare/Medicaid Duals

Flow of funds – subject to CMS approval
Three Way Contracting

Michigan and CMS

ICO’s

PIHP’s
The ICO is responsible for financing and coordinating benefits:
- Pharmacy Part D
- Long term care services & supports including community based and nursing facility, both skilled and custodial
- Management of person-centered medical home.
- Care and supports coordination team at the bridge.

The PIHP is responsible for financing and coordinating benefits for all behavioral health services for persons with:
- Intellectual/developmental disabilities
- Serious mental illness
- Substance use disorders
- Care and supports coordination team at the bridge.
Where Integration Happens

The Care Bridge:

- A services or supports coordinator leads a multidisciplinary team to coordinate services & supports for the participant according to self-determined person centered plan of care.
- The services or supports coordinator has 24/7 contact responsibility for the beneficiary.
- Leading coordinating entity (ICO or PIHP) is defined by beneficiary and highest care need.
Quarterly Phase-In

**First Quarter:** Non-nursing facility or MI Choice older people, non-elderly with disabilities, persons with serious mental illness.

**Second Quarter:** People using long term care services (nursing facility & MI Choice waiver)

**Third Quarter:** Persons with intellectual/developmental disabilities
Thank You