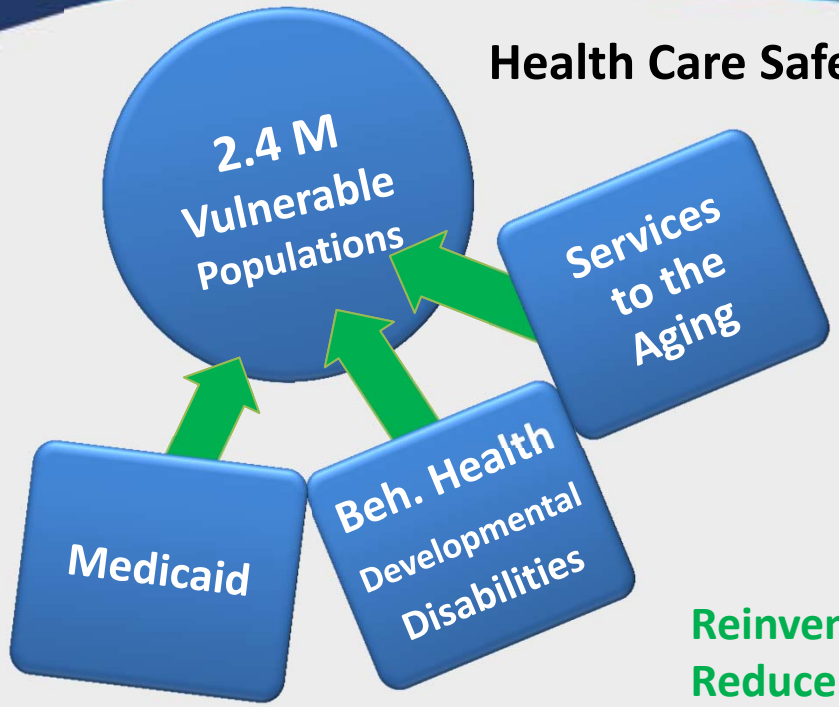
Michigan Department of Community Health

Director Olga Dazzo

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

February 27, 2012

Health Care Safety Net*



Key Issues

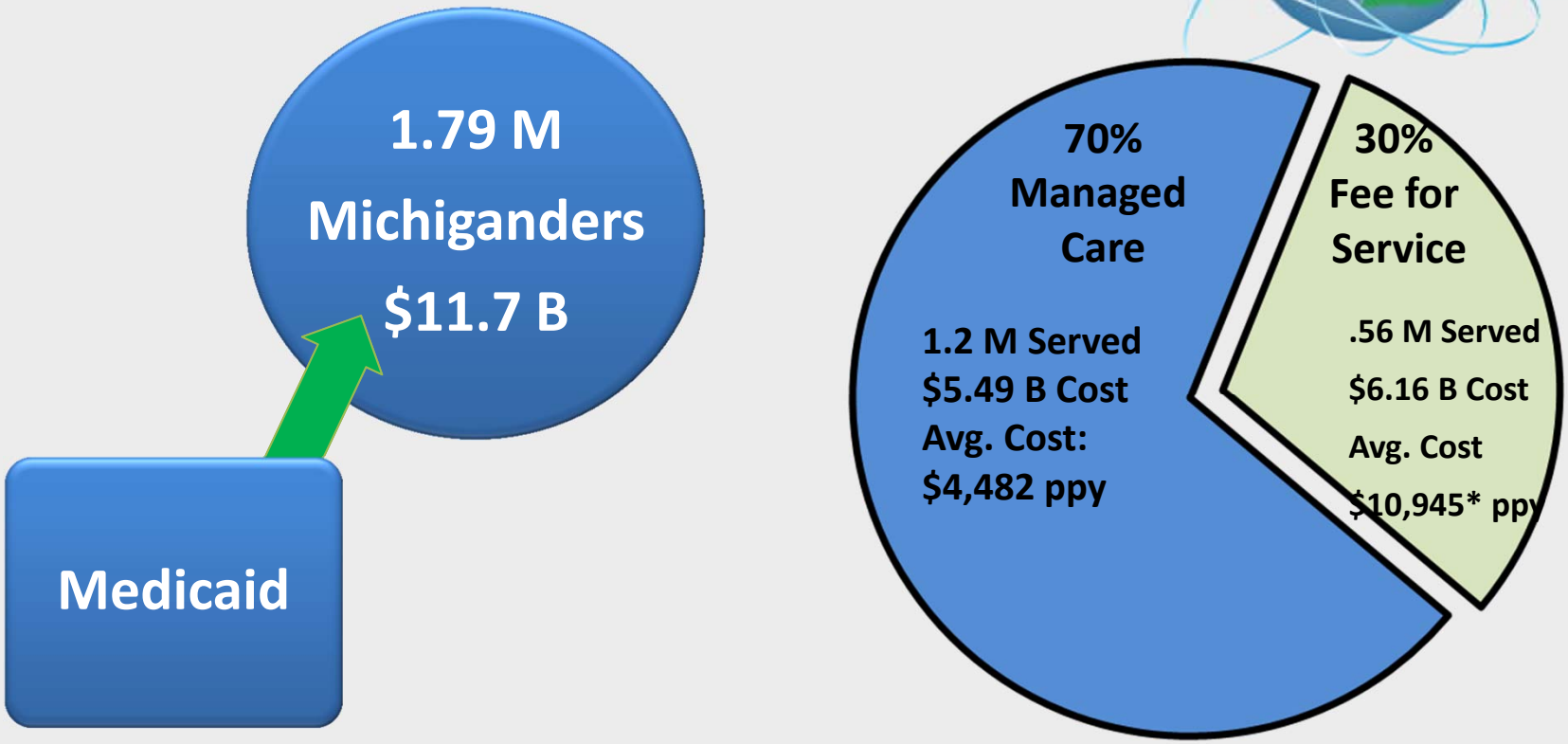
- Fragmented and costly.
- Aging population will require more services.
- Promote community-based system of care.

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

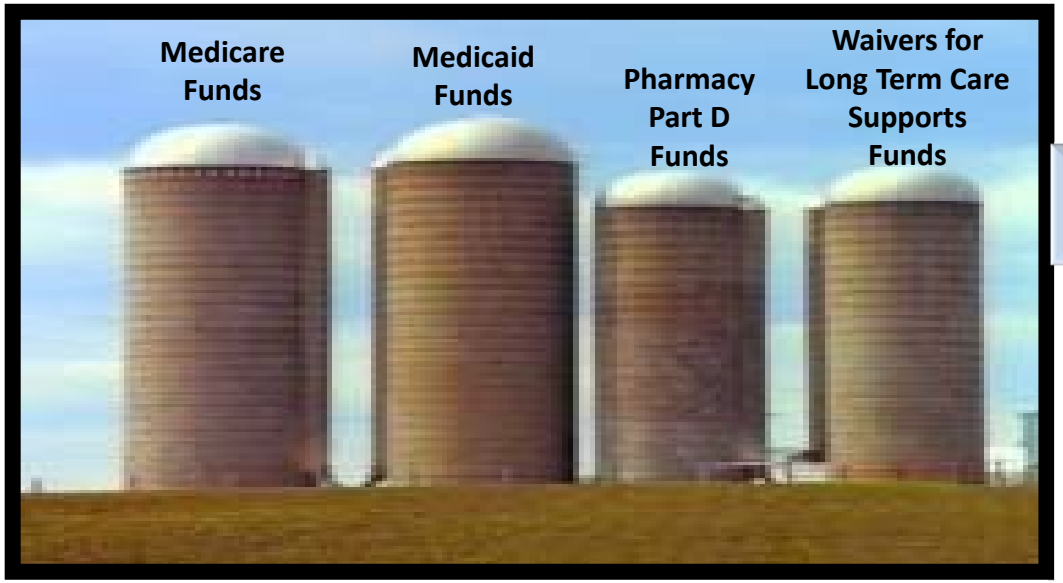


*The current fee for service population requires higher intensity and quantify of medical and long-term care services (nursing home, MiChoice Waiver, Home Help) resulting in higher health care costs per person per year.

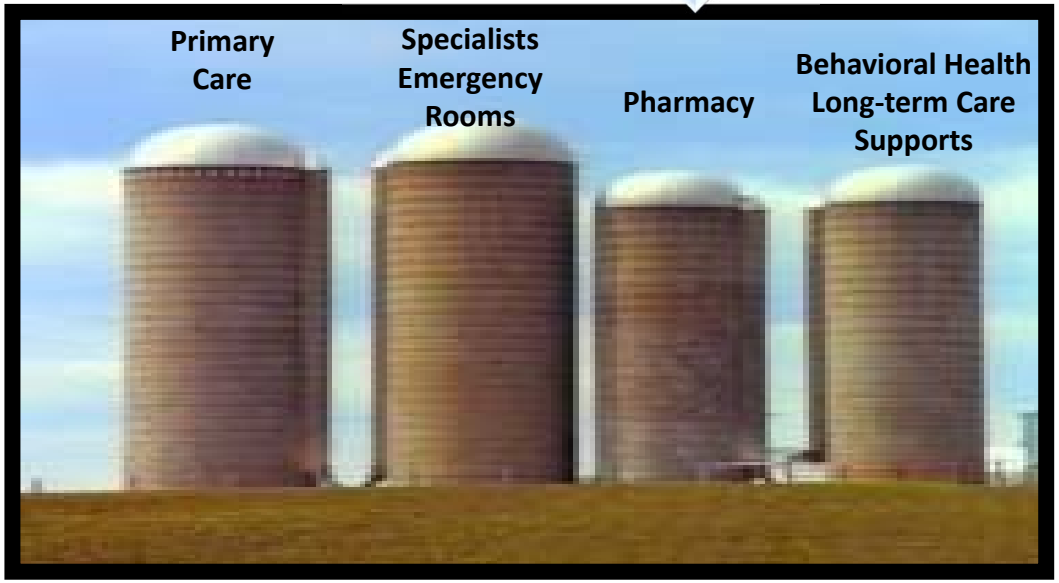
Proposal

- 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

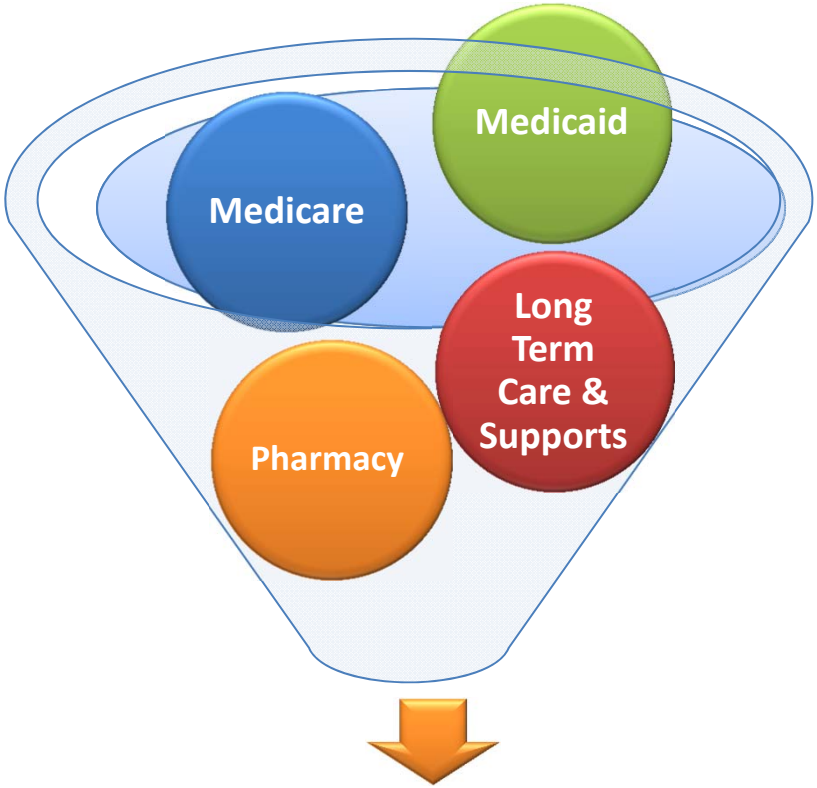
The Problem



- 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

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

*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.

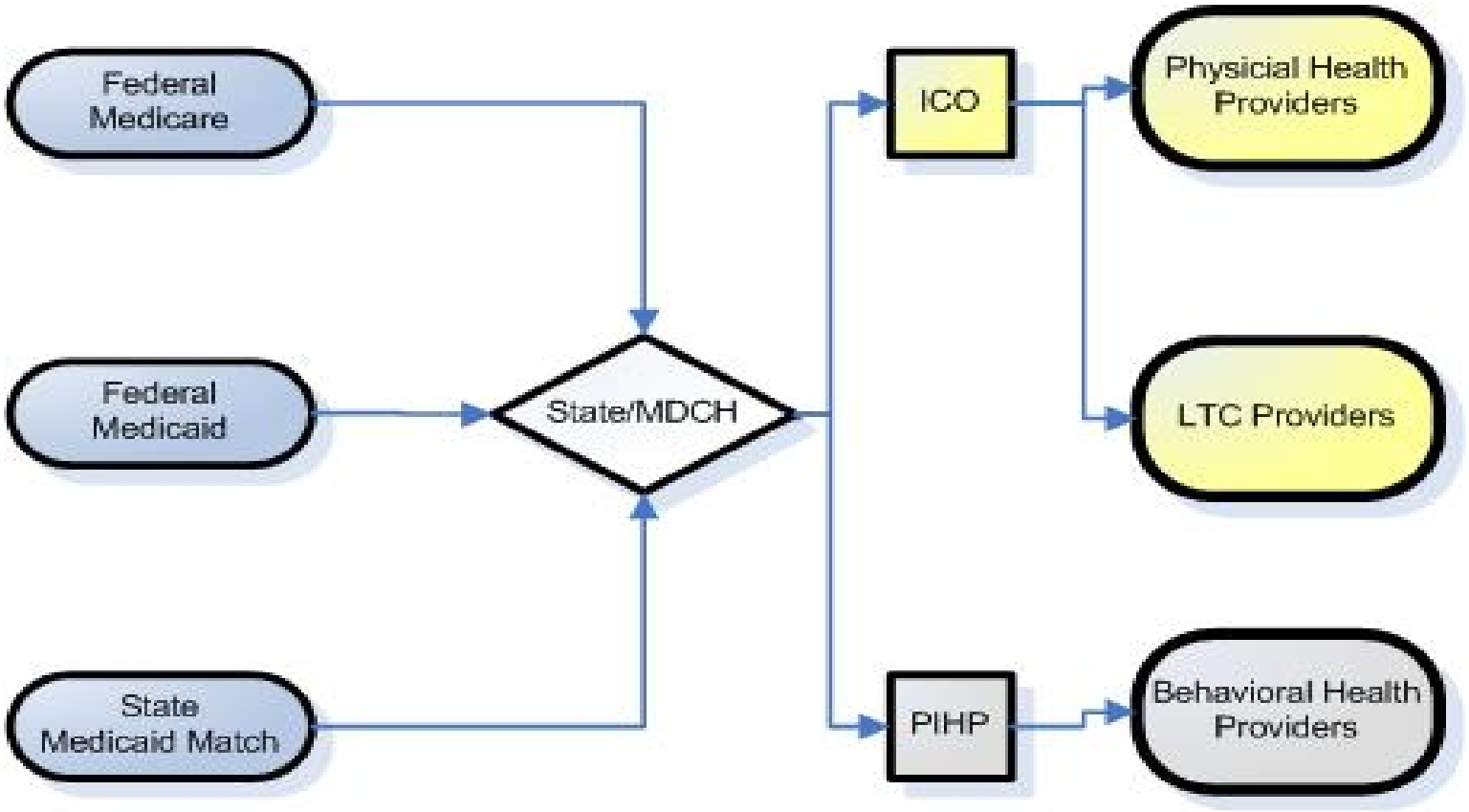
Extensive Stakeholder Input

- 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

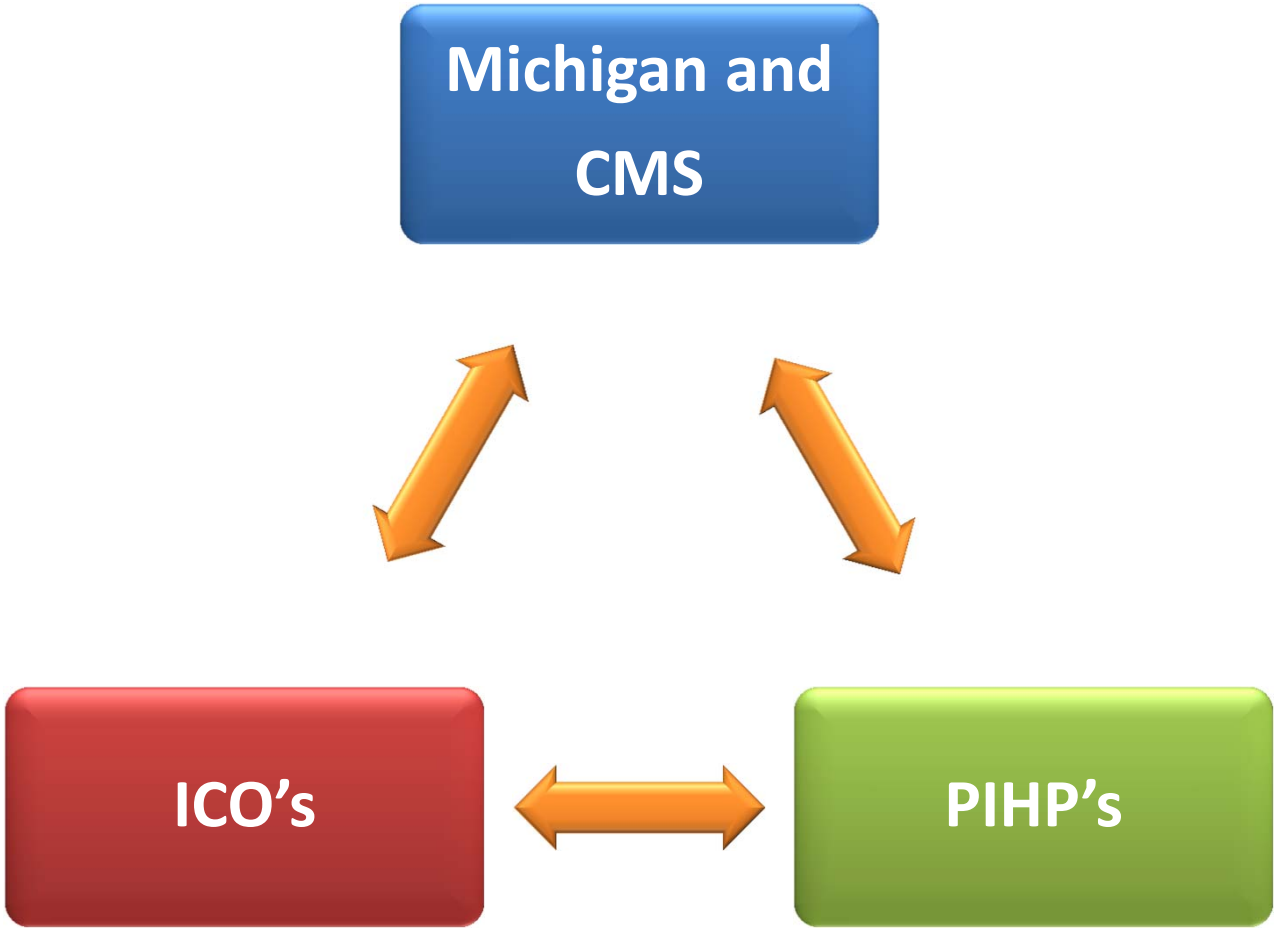
- Importance of self-determination and person-centered planning
- Assurance of access to existing array of services with expansion of service package
- Guarantee services are of high-quality and responsive to participant needs and desires
- Assurance of well-coordinated care
- Access to home and community-based 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



Accountabilities

The ICO is responsible for financing and coordinating benefits:

- **Medicare Part A & B (primary & acute care).**
- **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