Integrated Care for Individuals Eligible for both Medicare and Medicaid
Frequently Asked Questions (FAQ)

April 24, 2012

The following set of questions and answers has been developed to help stakeholders with an interest in Michigan's integrated care proposal to better understand the state's draft plan. This document should be regarded as a "work in progress" that will be continuously updated as additional questions arise and more information becomes available.

Quick Reference Guide For Questions

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GENERAL QUESTIONS

What is really different with this proposed new program?

Currently, individuals with both Medicare and Medicaid coverage have to navigate two completely independent, complicated programs. The services and supports between these programs are not coordinated, which reinforces a lack of communication between health professionals and results in less than optimal outcomes. Additionally, the current system does not give providers the incentive to avoid acute health episodes and provide services that are preventive or treat a condition earlier in its onset, which results in higher costs than necessary. The proposed new program will blend Medicare and Medicaid funding, integrate services and consolidate management structures. The expected result is better health outcomes for those dually eligible and a more cost effective system.

What is the rationale for two separate contracts with Integrated Care Organizations (ICOs) and Pre-Paid Inpatient Health Plans (PIHPs)?

The state is pushing for transformative change while not destabilizing the current service delivery system. For this reason, the state chose to maintain the PIHP system which covers behavioral health and substance use disorders as a separate contract. Behavioral health services covering persons with developmental disabilities, severe mental illness and substance use disorders are effectively managed by a well-established network of community based providers, and the state would avoid disrupting that system. The most significant challenge is the organization and integration of long term care and physical health services and supports. Michigan Medicaid has had great success with managed care and will rely on that experience to improve the quality of care for a very vulnerable population that requires extensive long term supports and services. The additional challenge of integrating care across the ICO and PIHP service delivery systems will be addressed later in this FAQ in the discussion of the Care Bridge.

What will be the roles of the ICOs and the PIHPs?

ICOs and PIHPs are the entities that will engage in a three-way contract between themselves, the state, and the federal government to manage, coordinate, and pay for all services for persons that are eligible for Medicare and Medicaid who participate in the integrated care program. ICOs will be responsible for the provision of physical health services as well as long term care supports and services. PIHP contracts will cover all behavioral health supports and services for people who have intellectual/developmental disabilities as well as all supports and services, including acute inpatient psychiatric care, for persons with serious mental illness. PIHPs will also provide services to people with substance use disorders.

Can the state realistically implement this program across the entire state within a year of when the first phase begins? Why is the state not considering implementing integrated care through a pilot program?

The proposed phase-in represents a reasonable balance between meeting ambitious enrollment goals established by the federal government and offering the state sufficient time to ensure a smooth and effective implementation. The state recognizes the complexities that are inherent in a project of this magnitude which has the potential to profoundly impact the lives of very vulnerable people.

Stakeholders have emphasized concern about moving forward too quickly. They have suggested that the project be initiated as a pilot. If implementing a pilot is not possible, they have stated the need to evaluate each phase to ensure that the program is working appropriately and known problems are addressed before proceeding to subsequent phases. While the Centers for Medicare and Medicaid Services (CMS) has made it clear that they will not support a pilot, the state is committed to carefully evaluating each phase of implementation and to ensuring that integrated care will only move forward if there are no serious problems and the program performs as intended.

How long will the integrated care demonstration run? What will occur after the demonstration time frame is completed?

The integrated care demonstration will last for three years; however, given that the project will be phased in, the state will need to negotiate with CMS to determine what the official start date will be. If the proposed integrated care model proves to be successful, the structure that is established under the demonstration will be continued.

Is it possible that the state could run out of money before those regions or populations that are phased in later are actually incorporated into integrated care?

Funding for integrated care will be consistently available through all phases of implementation. Management entities will be paid on a capitated basis using predetermined rates. These rates will be based on historical experience and in aggregate will not exceed current expenditure levels. These capitation payments will replace expenditures that would otherwise have occurred without integrated care and for which funding would have been appropriated.

Many supports and services that will be part of the integrated care project are currently covered under existing waivers. What will happen to existing waivers and the beneficiaries with dual eligibility who are served under those waivers when integrated care is implemented? Likewise, what will happen to those who opt out of integrated care and those currently served by these waivers who are only eligible for Medicaid?

The state is currently working with the CMS to address the status of existing waivers and the legal authority for establishing the integrated structure. Michigan has several waivers that will be impacted by integrated care including the MI Choice Home and Community Based Services Waiver for people who are elderly or who have a disability, the Habilitation Supports 1915(c) Waiver for people who have developmental disabilities, the 1915(b) Behavioral Health Specialty Services Waiver, and the Comprehensive Health Plan 1915(b) managed care waiver. It is yet to be determined if these waivers will continue to function in their current form. Likewise, it has yet to be determined if the integrated care program will operate under these existing waivers, a completely new waiver, or some other authority. However, the current array of services will be maintained for all persons currently served under Michigan's existing waivers. This applies to persons who will become part of the integrated care program as well as those eligible for integrated care who choose to opt out and persons who are only eligible for Medicaid.

Will the new integrated care plan require a waiver from CMS?

The state is currently working with the CMS to address the legal authority for establishing the integrated structure. It has not yet been determined whether the integrated care program will operate under the existing waivers noted, a completely new waiver, or some other authority.

What role will the legislature play in approving and implementing Michigan's integrated care plan?

The department will work closely with the legislature to ensure that all issues and concerns are adequately addressed. Furthermore, it is assumed that funding for integrated care will be subject to the standard appropriation process.

Will individuals who are not eligible for both Medicaid and Medicare be included under Michigan's integrated care program?

While it is recognized that the implementation of a fully integrated system of services for all Medicaid beneficiaries is an appropriate goal, Michigan's integrated care initiative only covers services and supports for persons dually eligible for Medicare and Medicaid, which is consistent with the state and federal government's shared goal to integrate the two programs. The primary reason for this initiative is to attempt to solve the complexity, fragmentation, and ineffectiveness of having Medicare and Medicaid operate independently without coordination. As experience is gained with the new structures, it is the intent of the state to make the promising elements of this program available to Medicaid-only beneficiaries with similar needs to those of people who are dually eligible.

What happens after the state submits its proposed plan to the federal government?

On or before April 26, Michigan will formally submit its integrated care proposal to the Centers for Medicare and Medicaid Services (CMS) for review. CMS will conduct its own 30 day public review period, after which the process of negotiating details with the state will begin. The first step will involve an evaluation by CMS to determine whether the state proposal meets CMS established standards and conditions. If these standards and conditions are met, the state can begin the process of negotiating a state specific Memorandum of Understanding (MOU) with CMS. Following approval of the MOU, states pursuing the capitated model, including Michigan, would undergo a procurement process with CMS to select qualified health plans. The process will result in a three-way contract among CMS, the state, and health plans or other qualified entities.

How will regions be designed and how many will there be?

Regions will be established based on an acceptable minimum number of likely enrollees and alignments of ICOs and PIHPs. The number of regions has not yet been determined.

FINANCING

Who is paying for integrated care, and how will the program be financed?

The integrated care program will be paid through existing, ongoing funding sources. These sources include Medicare dollars from the federal government as well as state and federal Medicaid funds. No new funds will be needed for integrated care.

Savings of $30 million are built into the FY13 budget. How likely is it that these savings will be achieved?

The amount of savings that can be realized in fiscal year 2013 is dependent upon a number of factors, including when phased implementation of integrated care can be initiated during the year. The amount incorporated into the executive budget reflects an estimate that was based on the best information available at the time. This estimate is subject to change as the state negotiates details of the integrated care plan with the federal government.

In general, how much savings will be realized and how will these savings be achieved?

Integrated care for individuals eligible for both Medicare and Medicaid is a major initiative that features a number of details that still need to be resolved, and the actual amount of savings to be realized over the coming years has yet to be determined. The expectation is that savings will accrue to Medicare through efficiencies in the utilization of physical health services, and these savings will be shared with the Medicaid program and subsequently the state. More efficient utilization of physical health services will be realized through services coordination and effective management of primary care in a manner that will better manage chronic and complex health conditions, reduce emergency room visits and avoidable hospitalizations, improve managed transitions of care, and link to more extensive use of clinically appropriate and generally less expensive community based long term care services and supports in lieu of more expensive institutional services. While some additional costs will be incurred by the Medicaid side of the program to establish services coordination through the care bridge, these costs are estimated to be more than offset by savings.

Will there be a need for information technology (IT) investment? Will that burden fall on the state or on management entities?

The proposed plan states that PIHPs and ICOs will be required to share a secure electronic platform that contains several specific components. Currently, limited capacity exists for the electronic sharing of data for many parts of the integrated delivery system. Development of this capability is vital to the success of integrating care and payment reform over the long term.

The state and its health care partners are already making a significant investment in information technology applicable to the broader health care system. This work will significantly aid the implementation of technology that will be critical for effective care coordination and management of services to persons enrolled in the integrated care demonstration. Still, it is expected that the state, management entities participating in the plan, and their respective providers will need to make continued investment in information technology.

Will Medicaid continue to cover Medicare premiums for dually eligible individuals in the integrated care plan?

Yes. Under the integrated care program, Medicaid will continue to pay Medicare premiums consistent with current policy.

At what level will providers be reimbursed? Will Medicare, Medicaid, or both rate levels apply?

Payment rates to providers will be established by ICOs and PIHPs. Through the procurement process, management entities will be evaluated on their ability to demonstrate innovative financing and reimbursement arrangements with providers that incentivize effective models of supports and services coordination as well as evidence-based practices. In addition, the integrated care proposal indicates that nursing homes will be funded at a minimum of current reimbursement levels.

How can the state establish actuarially sound rates for long term care supports and services with very limited data?

The state will utilize historical Medicaid claims data to establish rates for institutional and community based long term care services and supports. Assistance will be sought from the contracted actuarial firm that currently works with the Michigan Department of Community Health (MDCH) to establish rates for existing Medicaid health plans. Furthermore, Michigan can draw on its experience with work that has been done to establish rates for the four Program of All-Inclusive Care for the Elderly (PACE) programs that are currently operating in the state. CMS has indicated that their actuaries will be utilized to establish rate components related to physical health and any other services currently covered by Medicare.

It should be noted that significant financing issues exist that will need to be negotiated with CMS. The state awaits further guidance from CMS as to exactly how the rate development process will work. The Michigan plan proposes that Medicare funds be sent directly to the state, and a blended payment will be made by the state directly to ICOs and PIHPs. Furthermore, Michigan intends to incorporate risk adjustment into the development of rates for specialty populations, including those populations requiring long term care and/or behavioral health services, and to utilize risk corridors and other mechanisms to establish a partial risk arrangement.

The hospital industry has expressed concern with regard to how integrated care will impact their operations, reimbursement, and levels of reimbursement. What actions has the state taken to address these concerns?

The state recognizes that numerous collateral impacts and technical issues for hospitals and other provider groups will need to be addressed. Examples include Medicare Disproportionate Share Hospital (DSH) payments, bad debt, and 340(b) drug pricing for hospitals. On a broader scale, concerns exist about what role Medicare fiscal intermediaries will play under an integrated system and at what level hospitals will be reimbursed. Many of these issues require further guidance and negotiation with CMS. The state will continue to engage with CMS on these issues and is committed to working with the hospital industry and with any other provider group to identify and resolve any and all problems that are presented.

What entity will be responsible for processing payments to providers?

ICOs and PIHPs will be responsible for processing payments to providers.

SERVICES AND SUPPORTS COORDINATION

What is the "care bridge", and how does it work?

The care bridge is a framework for coordination will include a web-based electronic tool that integrates service level information across ICO and PIHP domains. It is founded on the premise that there should be one person-centered plan that spans all of the service domains needed by the beneficiary. Correspondingly, there should be one lead coordinator that is chosen by the person receiving services who is the main point of contact. That lead coordinator then works with a team that has expertise across the various service domains as needed to coordinate care. The care bridge needs substantial development both at virtual and functional levels to be effectively implemented.

Who will provide all of the care and services coordination functions? Will there be a need to hire additional staff? What about the lead services coordinator? Will that person be drawn from existing resources or will there be a need to hire new staff?

As envisioned, the care and supports coordination function will build on existing capacity in the current delivery system but will be enhanced through investment to establish linkages and functionality that is currently lacking. Lead services and supports coordinators will need to be drawn from experienced personnel in order to be effective. It is anticipated that additional staff will be required to achieve fully functioning multidisciplinary teams.

How will the person serving as the lead services and supports coordinator be selected?

Each individual who enters the integrated care program will undergo an initial screening to determine their most significant needs. The individual, with possible assistance from his or her representative, will make an initial determination regarding who will serve as the lead coordinator. In most cases, it is expected that the lead coordinator will be from the service area where the most intensive needs reside. Subsequent to the initial screening, a more comprehensive assessment will take place to further determine a person's needs and to develop a person-centered plan of service.

How will supports coordination be handled for people currently served under the MI Choice waiver? Will beneficiaries be able to keep the person (or persons) that currently work with them?

ICOs will be responsible for the provision of services and supports coordination to their members requiring long term care, including those currently served by the MI Choice waiver. While the state will not mandate an arrangement whereby the ICO would contract with existing waiver agencies, ICOs will be required, as part of a person-centered model, to allow choice of providers by persons who receive services, including the option to maintain their current providers.

It would likely be very difficult for an ICO to create a whole new system of providers. Therefore, if an existing agency provides effective services and supports coordination to members, the ICO would likely contract with that organization. If existing agencies are determined to be inadequate, it is also possible that the ICO would develop some other arrangement that would utilize local providers but would handle care management through some other venue, such as directly through the ICO.

HEALTH CARE REFORM

Is the integrated care proposal a result of health care reform?

The Affordable Care Act (ACA) is a very large piece of legislation. The Integrated Care for Individuals Eligible for both Medicare and Medicaid proposal does benefit from certain flexibilities provided by the ACA that were previously not possible. However, the integrated care initiative is not connected to the most well publicized parts of the ACA such as the individual mandate or the Medicaid expansion.

The specific relevant provision in the ACA is Section 2602 which created the Federal Coordinated Health Care Office ("Medicare-Medicaid Coordination Office"). The Medicare-Medicaid Coordination Office is charged with making the two programs work together more effectively to improve care and lower costs. Specifically, pursuant to section 2602(c) of the Affordable Care Act, the Office is focused on improving quality and access to care for Medicare-Medicaid enrollees, simplifying processes, and eliminating regulatory conflicts and cost-shifting that occurs between the Medicare and Medicaid programs, states, and the federal government.

Will the new Medicaid groups that become eligible in 2014 be part of the integrated care program?

The integrated care initiative only covers services for persons that are eligible for Medicare and Medicaid.

PERSONAL CARE

Will people currently receiving supports and services still be able to keep the person (people) who provides their personal care services now?

ICOs and PIHPS will be required, as part of a person-centered model, to allow choice of providers by persons who receive services, including the option to maintain their current providers.

Will providers of personal care still be employed by the beneficiary?

The state has not yet determined how personal care services will be structured under its integrated care program. However, management entities will be required, as part of a person-centered model, to allow choice of providers by persons who receive services, including the option to maintain their current providers.

Will the Department of Human Services still have a role in care management for personal care (Home Help) services for persons enrolled in the integrated care program?

The state has not yet determined how personal care services will be structured under its integrated care program.

Will recipients of Home Help services who are not enrolled in the MI Choice waiver be included in the second phase? Will this group be categorized as long term care?

Persons who are dually eligible and are receiving Michigan's State Plan personal care services through the Home Help program will be included in the first phase of integrated care implementation. Only persons who meet the nursing home level of care criteria will be in the second phase of plan enrollment.

PROCUREMENT AND CONTRACTS

When will the state issue a Request For Proposal (RFP) for integrated care?

The state will issue an RFP as soon as possible after negotiating details of its integrated care proposal and completing a Memorandum of Understanding (MOU) with CMS. Barring any serious issues that would delay approval by CMS of Michigan's integrated care plan, management entities with an interest in participating as an ICO should expect to see an RFP in early fall of 2012. Discussions are currently in process to determine whether interested organizations intending to participate in the selection process to become a management entity for the integrated care program will need to adhere to application processes and timeframes established by CMS. Ultimately, the procurement process will be a joint venture with CMS, although the RFP process will follow state specific procurement rules.

Will the PIHPs need to go through a bid process?

The state has yet to determine whether PIHPs will be subject to a full bid process. However, significant contractual changes will be requires as a result of 1) enhanced care coordination, 2) the incorporation of services to people with dual eligibility having mild to moderate mental illness (20 visits) and 3) responsibility for management of psychiatric inpatient services funded with Medicare dollars.

Will the PIHPs be required to engage in a three-way contract similar to the structure that will be used for ICOs?

Pending clarification and approval by CMS, it is assumed that PIHPs will be subject to the three-way contract requirement.

ENROLLMENT AND ELIGIBILITY

What resources will be available to help people decide whether to enroll and which plan to choose if they do decide to enroll?

In order to provide sufficient time prior to enrollment and to maximize the ability of individuals to talk with someone about their options, there will be a two month period of open enrollment prior to the implementation of integrated care in each region during phased implementation and in subsequent benefit years. All eligible beneficiaries will be sent a letter explaining their options, the benefits to be offered under the integrated system, instructions on choosing a plan, information regarding the choice to opt out, and how services will be managed and delivered to persons who decide to opt out. A toll-free number will be provided as an opportunity to speak with someone over the telephone or with an enrollment counselor on a face-to-face basis, if desired, prior to making a decision.

Other resources will include a web site that provides extensive information about the program and assistance provided through the Medicare-Medicaid Assistance Program (MMAP). MMAP counselors will be trained to talk with people interested in learning more about integrated care options. Michigan will also likely contract with an enrollment broker to ensure that eligible individuals are provided unbiased information about integrated care and the plans in which they can choose to enroll.

Will beneficiaries be concurrently enrolled in both an ICO and a PIHP?

Yes.

Will people who are enrolled in the integrated care program who do not require behavioral health services still be enrolled in a PIHP?

All persons who elect to participate in integrated care will be enrolled in both an ICO and a PIHP. Enrollment simply means that services will be provided to beneficiaries who have a need for and are receptive to those services. Enrollment does not imply that each beneficiary needs services from the PIHP.

Are dually eligible individuals who opt out still considered to be part of the integrated care plan?

People who are dually eligible for Medicare and Medicaid and decide to opt out will not be regarded as participants of the integrated care program.

How many people are likely to opt out? What services will be available to these people, and how will that system be structured?

It is not currently known how many people who would be eligible for services under Michigan's integrated care program will choose to opt out. Those individuals who do make this choice will receive all services that are currently available to them under Michigan's State Plan and through various waivers, but will not be eligible to receive enhanced care coordination and other service enhancements.

If a dual beneficiary does not opt out and does not choose a plan, how will the state decide which ICO that person gets enrolled in?

Similar to the current Medicaid managed care system, formulas will need to be developed for the auto assignment of beneficiaries to a plan.

If someone enrolls and decides that they do not like their plan, can they opt out or switch plans at any time, or will there be a "lock-in" period?

The state will propose a period of up to three months after initial enrollment during which a beneficiary would be allowed to opt out or to switch plans. Subject to approval by CMS, the state is also proposing that the opt-out period be followed by a lock-in period that would last until the next open enrollment. The schedule for future periods of open enrollment will likely parallel the schedule that CMS has established for Medicare Advantage plans. It should be noted, however, that policies with regard to enrollment, opt out, switching plans and lock-in requirements are subject to negotiation with CMS.

When the program begins, will dually eligible individuals be able to opt out before being automatically enrolled into a plan?

Michigan's proposal does assume that persons who would be eligible to enroll in the integrated care program will have the opportunity to opt out and to maintain their existing fee for service arrangement prior to being enrolled into an ICO. The state is proposing to initiate the enrollment process three

months in advance of the point at which coverage would begin. Each candidate for enrollment into the integrated care plan (or their designated representative) would have a period of two months to decide whether to participate and to select a plan. The state, its enrollment broker, the selected ICO, and the default PIHP would then have one month to process enrollment.

Since beneficiaries will be enrolled in a PIHP regardless of whether or not they stay in the integrated care plan, what will be different in regard to the coverage and benefits received?

Those individuals who choose to opt out of the integrated care plan will continue to be served for behavioral health needs through their PIHP, separately through fee for service Medicaid, and again separately through Medicare. Persons who are not enrolled in the integrated care plan will have the traditional supports coordinator or case manager that they currently have from the PIHP. The PIHP traditional supports coordinator will continue to manage all behavioral health needs but will not have responsibility or authority for convening the care team in the physical health realm through the care bridge. The person who chooses to opt out will lose the opportunity to have a supports coordinator with responsibility to lead the team that resolves the very complex funding, coordination, and billing issues that cross between behavioral health and physical health and between Medicare and Medicaid.

The state has received significant feedback from persons served in the PIHP system that great difficulty exists in managing the complexities of billing and coordination between Medicaid and Medicare for pharmacy, lab and physical health care. Most of the individuals report that no regular coordination between physical health providers and behavioral health occurs. Persons who choose to remain in the integrated care plan will have a supports coordinator who has additional responsibility to lead the team of professionals that crosses behavioral health and physical health services, bridging the gaps and reducing fragmentation between these funding and service delivery systems.

The state has indicated that enrollees will only have to worry about one card in order to access all of their services. Will that still be the case, even with separate contracts for ICOs and PIHPS, and with Part D remaining essentially unchanged?

It is the intent of the state that enrollees in the integrated care plan would only need one card. However, systems adjustments may be required to accommodate this arrangement. Furthermore, CMS and management entities will also need to be able to agree and handle a single card.

Will people with spend downs be included in the integrated care plan?

Spend downs are currently excluded from the integrated care proposal.