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Financial Alignment Initiative Michigan MI Health Link First Evaluation Report

Final

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FINANCIAL ALIGNMENT INITIATIVE
MICHIGAN MI HEALTH LINK
FIRST EVALUATION REPORT

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Glossary of Terms

AAA	Area Agency on Aging
ALD	Activities of daily living
ADRC	Aging and Disability Resource Center
CAHPS	Consumer Assessment of Healthcare Providers and Systems
Care Bridge	A framework and protocol developed by Michigan stakeholders and state officials for coordinating different domains of care
Care Connect 360	A Michigan Medicaid online portal that allows providers and plans to access beneficiaries' claims history
CHAMPS	Community Health Automated Medicaid Payment System
CIL	Center for Independent Living
CMS	Centers for Medicare and Medicaid Services
CMT	Contract Management Team
CTM	Complaint Tracking Module
DHHS	Michigan Department of Health and Human Services
DinD	Difference in differences
Disenroll	Chose not to participate in the demonstration after the effective date of enrollment
D-SNP	Dual Eligible Special Needs Plan, a Medicare Advantage plan serving only Medicare-Medicaid beneficiaries
EQRO	External Quality Review Organization
HCBS	Home and community-based services
HEDIS	Health Effectiveness Information and Data Set
HMO	Health maintenance organization
HSAG	Health Services Advisory Group, the Michigan Medicaid External Quality Review Organization
ICBR	Individual Care Bridge Record

ICO	Integrated Care Organization, Michigan demonstration term for managed care plans participating in the MI Health Link demo
ICT	Integrated Care Team, Michigan demonstration term for an interdisciplinary care team
I/DD	Intellectual and developmental disabilities
IICSP	Individual Integrated Care & Support Plan, the Michigan demonstration term for a care plan
IRE	Medicare Independent Review Entity
LTSS	Long-term services and supports
MARx	Medicare Advantage Prescription Drug System
MAXIMUS	The company that operates Michigan ENROLLS, the enrollment broker
MDHHS	Michigan Department of Health and Human Services
MDS	Minimum Data Set
MEJI	Michigan Elder Justice Initiative
MFFS	Managed fee-for-service
MI Choice	A 1915(c) HCBS waiver that serves older adults and adults with physical disabilities who are not enrolled in the MI Health Link demonstration
Michigan ENROLLS	The name of the state's enrollment broker
MiHIN	Michigan Health Information exchange
MI Health Link	The name of the Michigan demonstration
MHLO	MI Health Link Ombudsman program, which advocates for people enrolled in the demonstration
MMAP	Medicare Medicaid Assistance Program, the name of Michigan's Senior Health Insurance Program
MMCO	Medicare-Medicaid Coordination Office
MMP	Medicare-Medicaid Plan
MOU	Memorandum of Understanding
NF	Nursing facility

Opt out	Chose not to participate in the demonstration prior to the effective date of enrollment
PACE	Program of All-Inclusive Care for the Elderly
PCP	Primary care physician or primary care provider
PIHP	Prepaid Inpatient Health Plan, a specialty managed care plan delivering Medicaid behavioral health and I/DD services in Michigan
PMPM	Per member per month
SDRS	Stata Dara Reporting System
Waiver agents	Community-based entities such as Area Agencies on Aging and Centers for Independent Living that administer the MI Choice HCBS waiver in each region of Michigan

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Executive Summary

The Medicare-Medicaid Coordination Office and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. CMS contracted with RTI International to monitor the implementation of the demonstrations and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation will include a final aggregate evaluation and individual State-specific Evaluation Reports.

Michigan and CMS launched the MI Health Link demonstration in March 2015 to integrate care for Medicare-Medicaid beneficiaries in four regions. Michigan and CMS contracted with seven health plans to operate Medicare-Medicaid plans, which are called Integrated Care Organizations (ICOs). ICOs receive capitated payments from CMS and the State to finance all Medicare and Medicaid services, including a new home and community-based services (HCBS) waiver specifically for demonstration enrollees. Plans also provide care coordination, supplemental HCBS services, and flexible benefits that vary from plan to plan.

Full-benefit Medicare-Medicaid beneficiaries age 21 and older who reside in one of the four demonstration regions are eligible for the demonstration unless they reside in a State psychiatric hospital, have commercial health maintenance organization coverage, or have elected hospice services. The four service areas are Wayne County (which includes Detroit), Macomb County, an 8-county region in Southwest Michigan, and a 15-county region that covers Michigan's entire Upper Peninsula.

This first evaluation report for the Michigan demonstration describes implementation of the MI Health Link demonstration and early analysis of the demonstration's impacts. The report includes findings from qualitative data for 2015–2017 with key updates through early 2018 and quantitative results for 2015 and 2016. Data sources include key informant interviews, beneficiary focus groups, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, Medicare claims data, the Minimum Data Set nursing facility assessments, MMP encounter data, and other demonstration data. Future analyses also will include Medicaid claims and encounters as those data become available.

Highlights

Integration of Medicare and Medicaid

- Michigan retained the existing carve-out for Medicaid behavioral health services, which relies on Prepaid Inpatient Health Plans (PIHPs) to manage mental health and substance use disorder (SUD) services, and the HCBS waiver for persons with intellectual or developmental disabilities (I/DD).

Eligibility and Enrollment

- More than 106,000 Medicare-Medicaid beneficiaries were eligible for MI Health Link in December 2017, and more than 38,500 (36 percent) were enrolled.

- State officials implemented two changes in mid-2016 that helped stabilize enrollment, which experienced a modest decline after phased enrollment ended. Monthly passive enrollment resumed in June 2016. The State and ICOs also implemented deemed enrollment, which helped the ICOs retain enrollees who might otherwise have been disenrolled due to the temporary loss of Medicaid eligibility.

Care Coordination

- Although the carve-out for Medicaid behavioral health services created challenges for financing and care coordination, State officials and stakeholders said the demonstration had increased access to behavioral health services by identifying enrollees with unmet needs.

- HCBS have been a significant challenge for both the ICOs and the State. The plans had difficulty meeting the State's standards for waiver applications, and the State's waiver unit was understaffed for a period of time, resulting in a large backlog of waiver applications in 2017 and early 2018. The backlog was eliminated by September 2018.

- Timely completion of health risk assessments and care plans was a challenge early in the demonstration. Although the plans improved their assessment completion rates, State officials said that this challenge was an ongoing concern.

Beneficiary Experience

- Focus groups conducted in 2016 and 2017 in the Detroit area found that participants were generally pleased with their plans and access to providers. Participants were most pleased with the lack of co-payments for prescriptions. They generally have been satisfied with care coordination and most had been visited by their care coordinators, although some said their care coordinators had not followed through on service needs.

- Health plan ratings of ICOs by respondents to the Consumer Assessment of Healthcare Providers and Systems in 2016 and 2017 were similar to the national averages for Medicare Advantage (MA) plans and Medicare-Medicaid Plans.

Service Utilization

- As measured across all eligible beneficiaries, the demonstration resulted in a 13.9 percent reduction in the probability of inpatient admission, a 17.8 percent reduction in monthly preventable emergency room visits, a 12.8 percent reduction in the probability of overall ambulatory care sensitive condition admission, and a 13.8 percent reduction in the probability of chronic ambulatory care sensitive condition admission. ***Section 8*** and ***Appendix B*** of this Evaluation Report contain an explanation of the research design and populations analyzed.

- For eligible beneficiaries with long-term services and supports (LTSS) use and for those with serious and persistent mental illness, results on the probability of inpatient admission, preventable emergency room visits, and the probability of ambulatory care sensitive condition admission (overall and chronic) aligned with the results for all eligible beneficiaries, with only one exception (physician evaluation and management visits for eligible beneficiaries with LTSS use).

Table ES-1
Summary of Michigan demonstration impact estimates for demonstration period March 1, 2015–December 31, 2016

($p < 0.10$ significance level)

Measure	All demonstration eligible beneficiaries	Demonstration eligible beneficiaries with LTSS use	Demonstration eligible beneficiaries with SPMI
Probability of inpatient admission	Decreased	Decreased	Decreased
Probability of ambulatory care sensitive condition (ACSC) admission, overall	Decreased	Decreased	Decreased
Probability of ACSC admission, chronic	Decreased	Decreased	Decreased
All-cause 30-day readmissions	NS	NS	NS
Probability of emergency room (ER) visit	Decreased	Decreased	Decreased
Preventable ER visits	Decreased	Decreased	Decreased
Probability of 30-day follow-up after mental health discharge	NS	NS	NS
Probability of any long-stay NF use	Increased	N/A	N/A
Physician evaluation and management visits	Decreased	NS	Decreased

LTSS = long-term services and supports; N/A = not applicable because this measure is only calculated for the total eligible population at risk of any long-stay nursing facility use; NF = nursing facility; NS = not statistically significant; SPMI = serious and persistent mental illness.

SOURCE: RTI analysis of Medicare and Minimum Data Set data.

Quality

- ICO performance on selected Healthcare Effectiveness Data and Information Set measures was mixed relative to Medicare Advantage. For two measures—initiation and engagement of alcohol and other drug dependence treatment, and outpatient visits per 1,000 members—a majority of ICOs performed better than the national MA benchmark value. For most measures, a majority of plans reported values below the benchmarks.

Cost Savings

- The results of preliminary Medicare cost savings analyses using a difference-in-differences regression approach do not indicate savings or losses due to the Michigan

demonstration over the period March 2015–December 2016. The cost savings analyses do not include Medicaid data due to current data availability, but these data will be incorporated into future calculations as they become available.

- Analysis of the ICOs' financial performance in demonstration year 1 was in progress as this report was written. Preliminary results showed that a majority of plans experienced losses. Plans were particularly concerned about the adequacy of Medicaid capitation rates and the high costs for some Medicaid services.

1. Overview

1.1 Evaluation Overview

1.1.1 Purpose

The Medicare-Medicaid Coordination Office (MMCO) and the Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Medicare-Medicaid Financial Alignment Initiative to test, in partnerships with States, integrated care models for Medicare-Medicaid enrollees. The goal of these demonstrations is to develop person-centered care delivery models integrating the full range of medical, behavioral health, and long-term services and supports (LTSS) for Medicare-Medicaid enrollees, with the expectation that integrated delivery models will address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives.

This Evaluation Report on the Michigan capitated model demonstration under the Medicare-Medicaid Financial Alignment Initiative—MI Health Link—is one of several reports that will be prepared over the next several years to evaluate the demonstration. CMS contracted with RTI International to monitor the implementation of the demonstrations under the Financial Alignment Initiative and to evaluate their impact on beneficiary experience, quality of care, utilization, and cost. The evaluation includes a final aggregate evaluation (Walsh et al., 2013) and individual State-specific evaluation reports.

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on the beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for special populations (e.g., people with mental illness and/or substance use disorders [SUDs], LTSS recipients). To achieve these goals, RTI collects qualitative and quantitative data from Michigan each quarter; analyzes Medicare and Medicaid enrollment, claims, and encounter data; conducts site visits, beneficiary focus groups, and key informant interviews; and incorporates relevant findings from any beneficiary surveys conducted by other entities. In addition to this report, monitoring and evaluation activities will also be reported in subsequent evaluation reports, and in a final aggregate evaluation report for the demonstrations under the Financial Alignment Initiative.

1.1.2 What it Covers

This report analyzes implementation of the MI Health Link demonstration from its initiation on March 1, 2015, through December 31, 2017. For this reporting period, qualitative data through 2017 with key updates through early 2018 and quantitative data based on Medicare claims, Medicare Advantage (MA) encounters, and the nursing facility (NF) Minimum Data Set (MDS) 3.0 through 2016 are included. It describes the MI Health Link demonstration's key design features; examines the extent to which the demonstration was implemented as planned; identifies any modifications to the design; and discusses the challenges, successes, and unintended consequences encountered during the period covered by this report. It also includes data on the beneficiaries eligible and enrolled, geographic areas covered, and status of the

participating Medicare-Medicaid Plans (MMPs), known in Michigan as Integrated Care Organizations (hereafter referred to as ICOs). Finally, this Evaluation Report includes data on care coordination, the beneficiary experience, stakeholder engagement activities, and, to the extent that data are available, analyses of utilization and quality, and a summary of preliminary findings related to Medicare savings results in the first demonstration year.

1.1.3 Data Sources

A wide variety of information informed this first Evaluation Report of the MI Health Link demonstration. Data sources used to prepare this report include the following:

Key informant interviews. The RTI evaluation team conducted site visits in Michigan in August 2015 and August 2016, and a telephonic site visit in January 2018. The team interviewed the following types of individuals either on site or during telephone interviews: State policy makers and agency staff, CMS and State Contract Management Team (CMT) members, ombudsman program officials, ICO officials, ICO care coordinators, provider associations, advocates, and other stakeholders.

Focus groups. The RTI evaluation team conducted 16 focus groups in Dearborn (Wayne County), Michigan: eight on June 28–30, 2016, and eight in June 2017. Forty-three enrollees and three proxies participated in the 2016 focus groups. Thirty-two enrollees participated in the 2017 focus groups. Participants were assigned to groups based on their LTSS and behavioral health services use, race, ethnicity, and primary language. Focus groups were not conducted with beneficiaries who opted out of the demonstration or who disenrolled.

Surveys. Medicare requires all Medicare Advantage plans, including MI Health Link plans, to conduct an annual assessment of the experiences of beneficiaries using the Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument. The 2016 and 2017 surveys for MI Health Link were conducted in the first half of 2016 and 2017, respectively, and included the core Medicare CAHPS questions, and 10 supplemental questions added by the RTI evaluation team. Survey results for a subset of 2016 and 2017 survey questions are incorporated into this report. Findings are available at the MI Health Link plan level only. The frequency count for some survey questions may be suppressed because too few enrollees responded to the question. Comparisons with findings from all Medicare Advantage plans are available for core CAHPS survey questions.

Michigan's external quality review organization surveyed MI Health Link enrollees in 2017 using the CAHPS 5.0 Adult Medicaid Health Plan Survey, and results from several measures are also mentioned in this report (Health Services Advisory Group, 2017; hereafter HSAG, 2017).

Demonstration data. The RTI evaluation team reviewed data provided quarterly by Michigan through RTI's State Data Reporting System (SDRS). These data included eligibility, enrollment, and information reported by Michigan on its stakeholder engagement process, accomplishments on the integration of services and systems, any changes made in policies and procedures, and a summary of successes and challenges. This report also uses data for quality measures reported by MI Health Link plans and submitted to CMS' implementation contractor,

NORC at the University of Chicago (hereafter referred to as NORC)[1,2]. Data reported to NORC include core quality measures that all MMPs are required to report, as well as State-specific measures that MI Health Link plans are required to report. Due to some reporting inconsistencies across plans in 2015 and 2016, plans occasionally resubmit data for prior demonstration years; therefore, the data included in this report are considered preliminary.

Demonstration policies, contracts, and other materials. This report uses several data sources, including the following Michigan-CMS agreements: the 2014 Memorandum of Understanding (MOU); the 2014 Michigan three-way contract; the 2016 amended Michigan three-way contracts; the 2018 Michigan three-way contract; State-specific documents (e.g., the Minimum Operating Standards for MI Health Link Program and MI Health Link HCBS [home and community-based services] Waiver), and other materials available on the Michigan Department of Health and Human Services (MDHHS) website; documents available on the demonstration website, *What Is MI Health Link?* (www.michigan.gov/mihealthlink); data reported through the State Data Reporting System [RTI, SDRS]), and documents on the CMS Medicare-Medicaid Coordination website (Centers for Medicare & Medicaid Services, 2016a).

Conversations with CMS and Michigan MDHHS officials. To monitor demonstration progress, the RTI evaluation team engages in periodic phone conversations with the Michigan Department of Health and Human Services (MDHHS) and CMS. These might include discussions about new policy clarifications designed to improve plan performance, quality improvement work group activities, and contract management team actions.

Complaints and appeals data. Complaint (also referred to as grievance) data are compiled from three separate sources: (1) complaints from beneficiaries reported by MI Health Link plans to MDHHS), and separately to CMS' implementation contractor, NORC; (2) complaints received by the MDHHS or 1-800-Medicare and entered into the CMS electronic Complaint Tracking Module (CTM);[3] and (3) qualitative data obtained by RTI on complaints. Appeals data are based on data reported by ICOs to the MDHHS and NORC, for Core Measure 4.2, and the Medicare Independent Review Entity (IRE). Data on critical incidents and abuse reported to the MDHHS and CMS' implementation contractor by the ICOs are also included in this report.[4]

Although a discussion of the ICOs is included, this report presents information primarily at the MI Health Link demonstration level. It is not intended to assess individual plan performance, but individual plan information is provided where plan-level data are the only data available, or where plan-level data provide additional context.

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1 Data are reported for March 2015 through December 2017.

2 The technical specifications for reporting requirements are listed in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

3 Data are presented for the time period March 2015 through December 2017.

4 ICOs report critical incidents for the MI Health Link waiver to the MDHHS Medical Services Administration. The PIHPs report critical incidents for the Habilitation Supports waiver to the MDHHS Behavioral Health and Developmental Disability Administration.

HEDIS measures. We report on a subset of Medicare Healthcare Effectiveness Data and Information Set (HEDIS) measures, a standard measurement set used extensively by managed care plans, that are required of all Medicare Advantage plans.

Service utilization data. The RTI evaluation team analyzed data from many sources for this report. The State provided quarterly finder files containing identifying information on all demonstration eligible beneficiaries in the demonstration period. RTI also obtained administrative data on beneficiary demographic, enrollment, and service use characteristics from CMS data systems for both demonstration and comparison group members. These administrative data were merged with Medicare claims and encounter data, and with the MDS.

Although Medicaid service data on the use of LTSS, behavioral health, and other Medicaid-reimbursed services were not available for the demonstration period and therefore are not included in this report, CMS administrative data identifying eligible beneficiaries who used Medicaid-reimbursed LTSS were available, so that their Medicare service use could be presented in this report. Future reports will include findings on Medicaid service use once data are available.

Cost savings data. Two primary data sources were used to support the savings analyses, capitation payments, and Medicare claims. Capitation payments paid during the demonstration period were obtained for all MA enrollees and demonstration enrollees from CMS MA and Part D Inquiry System (MARx) data. The capitation payments were the final reconciled payments paid by the Medicare program after taking into account risk score reconciliation and any associated retroactive adjustments in the system at the time of the data pull (October 2018). Fee-for-service (FFS) Medicare claims were used to calculate expenditures for all FFS comparison group beneficiaries, demonstration beneficiaries in the predemonstration period, and demonstration eligible beneficiaries who were not enrolled during the demonstration period. FFS claims included all Medicare Parts A and B services.

1.2 Model Description and Demonstration Goals

The Michigan demonstration began on March 1, 2015, and was originally scheduled to end on December 31, 2018 (Michigan three-way contract, 2014). In November 2016, the State, CMS, and the ICOs signed an amended three-way contract that extends the demonstration for 2 additional years, through December 31, 2020 (Michigan three-way contract, 2016).

Michigan and CMS share the goals of the Michigan demonstration: establish a coordinated delivery system that will provide seamless access to services; create a care coordination model that links all domains of the delivery system; streamline administrative processes for both beneficiaries and providers; eliminate barriers to use of HCBS; improve quality and consumer satisfaction; and reduce State and Federal costs through improved coordination, alignment, and payment reform (MOU, 2014, pp. 1–2).

Integration of Medicare and Medicaid functions. The demonstration integrates some Medicare and Medicaid functions, such as managed care enrollment and contract management. Enrollment of beneficiaries into MI Health Link is administered by the State's enrollment broker, Michigan ENROLLS, a contractor that coordinates with Medicare and Medicaid enrollment

systems. A joint CMS-State CMT administers the three-way contract and provides ICO oversight.

Financial model. All Medicare and most Medicaid services are financed through risk-adjusted capitation payments to the ICOs. Michigan maintained the existing system of financing Medicaid behavioral health services through Prepaid Inpatient Health Plans (PIHPs; see ***Section 7.1, Rate Methodology***). The PIHPs are specialty managed care plans that contract with the State and receive capitated payments to deliver Medicaid behavioral health and developmental disability services.

Eligible population. Beneficiaries who are eligible to enroll in the demonstration include full-benefit Medicare-Medicaid beneficiaries who are aged 21 or older and reside in a demonstration region. Beneficiaries who are not eligible to enroll include, among others, those who reside in a State psychiatric hospital, have commercial health maintenance organization (HMO) coverage, or have elected hospice services. Beneficiaries currently enrolled in the MI Choice 1915(c) waiver, the Money Follows the Person (MFP) program, or the Program of All-Inclusive Care for the Elderly (PACE) may choose to enroll in the demonstration but must first disenroll from MI Choice, MFP, or PACE (Michigan three-way contract, 2014, p. 28).

Geographic coverage. The MI Health Link demonstration operates in the following four service areas: Wayne County (Detroit), Macomb County (Detroit metropolitan area), an 8-county region in Southwest Michigan, and a 15-county region that covers the entire Upper Peninsula.

MI Health Link plans. Michigan and CMS contracted with seven health plans, known as Integrated Care Organizations (ICOs), to deliver integrated primary and acute care services, LTSS, and Medicare behavioral health services.

Care coordination. Care management is a core ICO function. The State demonstration's organization of care management processes and ICO implementation experience are discussed in ***Section 4***.

Benefits. MI Health Link enrollees receive Medicare Parts A, B, and D benefits; and Medicaid State Plan and HCBS waiver services through ICO plans, except behavioral health services and HCBS waiver services for persons with intellectual or developmental disabilities (I/DD), which are delivered through the PIHPs.[5] Cost sharing is not allowed under the demonstration; therefore, enrollees do not pay co-payments for their prescription drugs.

The demonstration expanded access to HCBS in two ways. A new HCBS waiver was developed with 5,000 waiver slots for demonstration enrollees; outside the demonstration, older adults and individuals with physical disabilities sometimes faced waiting lists for the MI Choice HCBS waiver. The Michigan three-way contract also requires ICOs to provide four home and community-based services as supplemental benefits to enrollees whose HCBS waiver

[5] PIHPs deliver both Medicare and Medicaid behavioral health services under the demonstration (see ***Section 2.2.2, Integration of Behavioral Health Services***).

applications are pending (Michigan three-way contract, 2016, p.55).[6] ***Table 1*** summarizes the benefits available to MI Health Link enrollees.

Table 1
Summary of benefits covered by MI Health Link plans

Benefits covered by MI Health Link plans	
Medicare and Medicaid health benefits	
Eye care services	Physician services
Hearing services	Prescriptions
Home health care	Preventive care and screening
Hospital services	Therapy
Lab tests and x-rays	Transportation to medical appointments
Medical equipment and supplies	
Medicaid LTSS	
Nursing facility services	HCBS services through the demonstration waiver
Personal care	
Other required services	
Care coordination	Supplemental HCBS benefits
Zero co-payments for prescription drugs	24/7 nurse line

HCBS = home and community-based services; LTSS = long-term services and supports.

SOURCES: MDHHS, List of Required MI Health Link Services. https://www.michigan.gov/documents/mdch/MI_Health_Link_Service_List-FINAL_483381_7.pdf; Michigan three-way contract, 2016, pp. 250–57.

Flexible benefits. In addition to the supplemental benefits noted above, ICOs also offer flexible benefits, which vary by plan and may include over-the-counter products, additional dental benefits, and frozen meals after hospitalizations.

Stakeholder engagement. State officials have engaged stakeholders from each region through the MI Health Link Advisory Committee, as well as meetings with stakeholder organizations (see ***Section 6, Stakeholder Engagement***). ICOs are required to engage enrollees and other stakeholders through their member advisory committees.

1.3 Changes in Demonstration Design

During the first 3 years of the demonstration, Michigan and CMS made several changes to the demonstration's design. The State and ICOs implemented deemed enrollment in July 2016, and a new passive enrollment algorithm in July 2017 (see ***Section 3.3.4, Integration of***

[6] The four supplemental benefits are adaptive medical equipment and supplies, community transition services, personal emergency response system, and respite. One ICO received approval from the State and CMS to provide supplemental benefits to some enrollees who do not meet the nursing facility level of care, in addition to those with pending waiver applications.

Medicare and Medicaid Enrollment Systems). Care coordination requirements in the Michigan three-way contract were revised in 2016 (see ***Section 4.1.2, Care Planning Process)***.

1.4 Overview of State Context

1.4.1 Experience with Managed Care

Michigan has a long history of using managed care to deliver Medicaid services. Michigan first made enrollment into comprehensive managed care organizations (MCOs) mandatory for many Medicaid beneficiaries in 1997. In November 2011, Michigan began enrolling some Medicare-Medicaid beneficiaries into MCOs, a policy that State officials called *duals lite*. By February 2015, the month before the demonstration launched, nearly 56,000 Medicare-Medicaid beneficiaries across the State were enrolled in MCOs to receive Medicaid benefits (Health Management Associates, 2015, pp. 3–4).[7]

Although most of the plans selected for the demonstration had previously operated Michigan Medicaid health plans and/or Dual Eligible Special Needs Plans in Michigan, they lacked experience with Medicaid community behavioral health services for beneficiaries with complex needs, long-term NF services, HCBS waivers, and personal care, because those services had been carved out of the managed care capitation, as the following sections discuss. ***Appendix E*** provides a summary of predemonstration and demonstration design features for Medicare-Medicaid beneficiaries.

1.4.2 Medicaid Behavioral Health Delivery System

Michigan began using PIHPs to deliver behavioral health and substance use services to all Medicaid beneficiaries in 1998 under a 1915(b) waiver. The PIHPs are public entities that serve all areas of the State and provide services for individuals with I/DD, mental illness, and SUDs (Proposal, 2012). Medicaid MCOs were responsible for delivering up to 20 mental health outpatient visits per year, whereas the PIHPs were responsible for all other behavioral health services (Michigan Department of Technology, Management and Budget, 2014a, pp. 23–4). There is one PIHP per geographic area. All Medicaid beneficiaries (including Medicare-Medicaid enrollees) living in a PIHP's geographic service area are considered to be enrolled in the PIHP, and the PIHP receives a capitation payment for each of these enrollees. PIHPs are based in Michigan's community mental health system.

1.4.3 Experience with Managed LTSS

Michigan does not include LTSS in the capitation for Medicaid MCOs, but some Medicaid LTSS used by Medicare-Medicaid beneficiaries is delivered through specialty managed care plans. The MI Choice waiver, which serves Medicaid beneficiaries who meet the nursing facility level of care criteria, is administered by waiver agents, which are community-based organizations such as Area Agencies on Aging and Centers for Independent Living (CILs). The waiver agents assumed an increasing level of risk over the years and evolved into prepaid ambulatory health plans (PAHPs) in recent years. The Habilitation Supports Waiver (HSW)

[7] These enrollment figures include partial-benefit Medicare-Medicaid beneficiaries.

serves those with an I/DD who meet the ICF/IDD level of care and is financed through capitation payments to the PIHPs (Proposal, 2012).

Michigan also has 13 PACE plans that receive Medicare and Medicaid capitated payments to provide integrated health care services and LTSS for enrollees who need a nursing facility level of care. PACE providers operate centers in communities in Wayne County, Macomb County, and several Southwest Michigan counties (MDHHS, PACE website, n.d.; Integrated Care Resource Center, 2019).

1.4.4 Personal Care

Michigan Medicaid has a large personal care program financed through the Medicaid State plan option and State funding and administered by the MDHHS county offices, which were in a separate department from Medicaid until February 2015.[8] The county offices conduct assessments, authorize services, and enroll and pay providers. Many beneficiaries employ family members and neighbors as individual providers. Stakeholders said there had been inadequate oversight in the past due to large caseloads and inadequate staffing, and that as a result, reassessments were not always conducted on a regular basis and providers might be paid based on the authorized hours rather than the actual hours reported on timesheets. Those challenges were addressed when personal care services were transitioned to the ICOs (see ***Section 2.2.4, Provider Arrangements and Services***).

1.4.5 Federal Financial Support

Implementation Funding

Michigan was one of fifteen states that successfully competed to receive a $1 million design award in 2011 to support the development of its original demonstration proposal. Those funds were used to gather stakeholder input through public forums held across the State, and support stakeholder and beneficiary work groups that developed the concepts that would be incorporated into the MI Health Link demonstration.

Michigan also received 2 years of implementation funding from CMS of $12.2 million ($7.4 million in year 1; $4.8 million in year 2). Implementation funds were used to support State demonstration staff; outreach and education activities conducted by the Medicare/Medicaid Assistance Program (MMAP) and the Michigan Disability Rights Coalition; development of the MI Health Link Learning Management System and several training modules for ICO and provider training; development of media including the MI Health Link logo, a brochure, and introductory video; and development of a critical incident reporting system and a waiver management system.

[8] The Michigan Department of Community Health (MDCH) merged with the Michigan Department of Human Services (MDHS) in February 2015 to form the Michigan Department of Health and Human Services (MDHHS). The MDCH formerly housed the Medicaid agency, public health agency, behavioral health agency, and others. It had responsibility for administering the demonstration and is identified as a party to the three-way contract. MDHHS contained the Offices of Services to the Aging, county offices, and other social services agencies. For simplicity, this report uses the acronym MDHHS to refer to MDCH, MDHS, and MDHHS.

Ombudsman Funding

The Michigan Long-Term Care Ombudsman Program, housed within the Michigan Aging and Adult Services Agency, received a 3-year award of $1.1 million from CMS in collaboration with the Federal Administration for Community Living (ACL), in collaboration with CMS, to support the operations of the MI Health Link Ombudsman. The ombudsman program is discussed further in ***Section 3.6.8***.

SHIP/ADRC Funding

Michigan received a 3-year, $630,000 award in May 2015 to support outreach, education, and counseling for Medicare-Medicaid beneficiaries eligible for the demonstration through the State Health Insurance Programs (SHIPs) and the Aging and Disability Resource Centers (ADRCs). These funds were used to conduct specialized outreach to persons who are homeless, persons who have disabilities, and persons who speak English as a second language.

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2. Integration of Medicare and Medicaid

Highlights

- Michigan and CMS contracted with seven health plans to operate Integrated Care Organizations (ICOs)—five plans operating in the Wayne and Macomb County regions, two plans in Southwest Michigan, and one plan in the Upper Peninsula.
- Michigan retained the existing structure for managing Medicaid behavioral health services, which relies on prepaid inpatient health plans (PIHPs) to manage mental health and substance use disorder services, and the HCBS waiver for persons with intellectual and developmental disabilities.
- Integrating behavioral health through two sets of entities created challenges, particularly for the PIHPs, but the ICOs and PIHPs said they were able to meet beneficiaries' needs, and State officials agreed.
- Enrollment of beneficiaries into the MI Health Link HCBS waiver was a significant challenge for both the State and the ICOs.
- There were challenges with paying personal care providers when beneficiaries transitioned to the demonstration, which declined over time as the State, CMS, and ICOs developed processes to improve transitions.

This section provides an overview of the management structure that was created to oversee the demonstration and describes the integrated delivery system, including the role and structure of the Integrated Care Organizations (ICOs), the demonstration's approach to behavioral health integration, and the ICOs' provider arrangements.

2.1 Joint Management of Demonstration

The operations of the ICOs are governed by a three-way contract with the State and CMS, executed in October 2014. The three-way contract was amended effective November 1, 2016, to extend the demonstration by 2 years to December 31, 2020, and add new requirements for care coordination (Michigan amended three-way contract, 2016, p. 186). The three-way contract was amended again effective January 1, 2018, to incorporate requirements of the Federal Medicaid managed care rule and other changes (Michigan amended three-way contract, 2018). In addition to the three-way contract, State requirements specific to the demonstration are compiled in the Minimum Operating Standards for MI Health Link Program and MI Health Link HCBS Waiver (MDHHS, 2018).

The joint CMS-State Contract Management Team (CMT) oversees the ICOs and addresses issues related to the integration of Medicare and Medicaid policies and processes. The CMT is responsible for day-to-day monitoring of the ICOs, including monitoring plans' compliance with the three-way contract; implementing compliance actions when necessary;

reviewing performance and enrollment data; responding to stakeholder concerns; reviewing marketing materials; and monitoring grievance and appeal data.

The Michigan CMT includes representatives from the State Medicaid agency, CMS staff from the Chicago Regional Office (which supports Michigan and other Midwestern states), and the Medicare-Medicaid Coordination Office (MMCO) State Leads, who are authorized to represent their respective agencies in administering the three-way contract. Core CMT members from both the State and CMS bring in additional staff with specific area expertise (e.g., enrollment, marketing) as needed. The CMT meets weekly by telephone. In addition, the State and Federal contract managers meet once a month with each ICO.

CMT calls with the ICOs focused on different topics each month, as well as covering standing agenda items such as the HCBS waiver, and any plan-specific issues. State officials said that the CMT agenda item on complaints had caused plans to pay closer attention to problems with non-emergency medical transportation, leading to changes that helped improve the quality and reliability of services (see ***Section 2.2.4, Provider Arrangements***). Around the end of 2017, the CMT began a practice of letting the ICOs pick the topic for one call each quarter.

The State also holds a monthly operations meeting with all of the ICOs and PIHPs, which CMS typically attends. Those meetings focus on a full range of MI Health Link operations, including issues between the ICOs and PIHPs.

2.2 Overview of Integrated Delivery System

2.2.1 Integrated Care Organizations

Michigan initially selected eight plans in 2014 to participate in the demonstration, but one of the successful bidders withdrew prior to implementation (Crain's Detroit Business, 2014). The seven plans that signed three-way contracts serve four regions (see ***Table 2***). The ICOs receive capitation payments from CMS for Medicare services and from the State for most Medicaid services. The ICOs develop and oversee networks of medical and supportive service providers, coordinate services and supports, and manage enrollees' care. Michigan continues to contract directly with the existing prepaid inpatient health plans (PIHPs) for delivery of Medicaid behavioral health services and HCBS waiver services for individuals with intellectual and development disabilities (I/DD). The PIHPs receive capitation payments from the State for Medicaid behavioral health services, while Medicare behavioral health services are financed through sub-capitation payments from the ICOs to the PIHPs.

Two of the plans contracted as ICOs were new to Michigan Medicaid—AmeriHealth and Michigan Complete Health—and the other five plans were already contracting with Michigan as Medicaid plans.[9] Four of the five companies that operated Medicaid plans also operated Dual Eligible Special Needs Plans (D-SNPs) in Michigan. Michigan Complete Health operated a D-SNP, but did not have a Medicaid plan. Although most of the plans operated in multiple States,

[9] Centene acquired Fidelis SecureCare of Michigan, which had been awarded an ICO contract for the Michigan demonstration. The ICO's name was changed to Michigan Complete Health in 2017. To prevent confusion, we refer to the ICO as Michigan Complete Health.

two of the plans operated only in Michigan: the Upper Peninsula Health Plan serves members only in that region, and HAP Midwest Health Plan operated in Southeast Michigan.

Table 2 presents each ICO's enrollment by region in February 2018. Molina had the largest enrollment, with over 27 percent of total demonstration enrollment. Michigan Complete Health and AmeriHealth had the lowest enrollment, with 6.8 and 8.4 percent, respectively.

Table 2
Enrollment in MI Health Link by ICO and region, February 2018

Health plan	Region 1 Upper Peninsula	Region 4 Southwest Michigan	Region 7 Wayne County	Region 9 Macomb County	Total enrollment	Percentage of demonstration enrollment
Aetna	N/A	3,557	3,303	722	7,582	19.3
AmeriHealth	N/A	N/A	2,708	602	3,310	8.4
HAP Midwest	N/A	N/A	4,062	858	4,920	12.5
Meridian	N/A	5,674	N/A	N/A	5,674	14.4
Michigan Complete Health (Centene)	N/A	N/A	2,220	450	2,670	6.8
Molina	N/A	N/A	9,198	1,511	10,709	27.3
Upper Peninsula	4,412	N/A	N/A	N/A	4,412	11.2
Total	4,412	9,231	21,491	4,143	39,277	100.0

ICO = Integrated Care Organization; N/A = not applicable.

SOURCE: Michigan DHHS, MI Health Link Enrollment Dashboard, February 2018. https://www.michigan.gov/documents/mdhhs/MI_Health_Link_Public_Dashboard_502731_7.pdf.

2.2.2 Integration of Behavioral Health Services

The Michigan demonstration maintains the existing PIHP system for Medicaid behavioral health services, which was strongly supported by stakeholders. The demonstration regions are aligned with the PIHP regions, with one PIHP in each of the four demonstration regions. The PIHPs continue to receive Medicaid capitation payments from Michigan Department of Health and Human Services (MDHHS) and deliver the Medicaid behavioral health services they delivered prior to the demonstration—mental health and substance use services, HCBS waiver services for persons with I/DD, and care coordination for their enrollees.

Medicare behavioral health services are financed through capitation payments from CMS to the ICOs (see ***Section 7.1, Rate Methodology***). Although the PIHPs are not parties to the three-way contract, ICOs were required to offer the PIHPs a contract to deliver Medicare behavioral health services. As a result, the PIHPs serve a new population under the demonstration, which stakeholders referred to as the *mild-to-moderate* population. Prior to the demonstration that population's behavioral health needs were met through their Medicare benefit, or by the Medicaid plans, which covered up to 20 outpatient visits per year. Meeting the needs of the mild-to-moderate population required the PIHPs to expand their provider networks beyond their community mental health center base.

Coordination of Medicare and Medicaid benefits was another new responsibility for PIHPs, and PIHPs said it was a challenge to accurately process the Medicare portion of claims. Because PIHPs are neither contracted Medicare plans nor providers, they do not have direct access to information needed to process individual claims and correctly assign coverage of the service to Medicaid or Medicare.[10] PIHPs said the ICOs did not initially provide sufficient help in addressing these concerns, though over time the ICOs have been better able to provide the PIHPs the support needed to correctly assign coverage.

Submitting Medicare encounters to the ICOs was another challenge for PIHPs, due to differences between ICOs in their encounter and response file formats, as well as differences between Medicare and Medicaid encounter formats. One PIHP noted that if encounters are not accepted by the ICOs, the missing data would impact how ICOs set Medicaid behavioral health capitation rates for the next year. Other challenges cited by both PIHPs and ICOs include electronic sharing of health information and quality reporting (see ***Section 4.2, Information Sharing***).

Although neither the ICOs nor the PIHPs were pleased about the demonstration's approach to behavioral health integration, which forces them to share responsibility for coordination of behavioral health, both groups indicated that they had resolved many of the early challenges and were collaborating effectively to meet beneficiaries' needs. Feedback from PIHPs and ICOs suggested better relationships in Southwest Michigan and the Upper Peninsula, where there are fewer ICOs; PIHPs in Wayne and Macomb Counties expressed some frustration about working with five different ICOs that each have their own systems and procedures.

Other stakeholders confirmed the difficulties in integrating ICOs and PIHPs, and some said that the specialized focus on behavioral health was both a strength and a weakness for the demonstration. Though the PIHPs brought special behavioral health knowledge and skills that the ICOs lacked, the structural separation of the ICOs and PIHPs seemed counter to the goal of integration.

2.2.3 HCBS Waiver Administration

One of the demonstration's key objectives is to eliminate barriers to the use of HCBS. To achieve this goal, Michigan developed a new 1915(c) waiver for the demonstration with 5,000 slots to serve older adults and persons with physical disabilities, who often encountered waiting lists for the existing MI Choice waiver outside the demonstration. Beneficiaries enrolled in MI Choice were not passively enrolled into the demonstration, so the demonstration waiver began with no enrollees and enrollment grew gradually during the first 2 years.

Developing and implementing the new MI Health Link waiver created challenges for both the State and the ICOs (see ***Section 4.1.3, HCBS Waiver Coordination***). One challenge was identifying an entity with the LTSS expertise to determine eligibility for the MI Health Link waiver that did not have a conflict of interest. The State did not have that capacity internally

[10] One example provided by the PIHPs was not having information on the benefits period of the member for hospital services. Therefore, the PIHP did not know when to report an inpatient hospital service as being paid for with Medicare funding (benefit days 0 to 60) or Medicaid (benefit days 61 to 90).

because outside the demonstration, the State relies on the waiver agents—area agencies on aging and home care agencies —to administer the MI Choice waiver, including assessing applicants, determining nursing facility level of care, and developing service plans; the State retrospectively reviews a sample of waiver applications.[11]

The State solicited bids for a single entity that did not have a conflict of interest and could determine waiver eligibility in all four demonstration regions. The State received one bid that did not meet the selection criteria, so the ICOs were assigned responsibility for conducting functional assessments, completing the nursing facility level of care tool, and preparing waiver services plans, in addition to coordinating service delivery. The Integrated Care Division of MDHHS took on the responsibility of determining nursing facility level of care and reviewing and approving MI Health Link waiver applications submitted by the ICOs. Both the State and the ICOs experienced challenges with these new roles (see ***Sections 4.1.3 HCBS Waiver Coordination***).

2.2.4 Provider Arrangements and Services

Most of the plans had existing networks of Medicare and Medicaid providers and did not report challenges contracting with medical providers. The biggest challenges with provider arrangements involved payments to providers for Medicaid services that were new to the plans, including nursing facilities, and personal care providers.

Payment Methods

The ICOs generally contract with providers based on the fee-for-service (FFS) arrangements that were in place prior to the demonstration. According to the three-way contract, ICOs are responsible for developing alternative payment methods for contracting with their providers. For services that are traditionally covered under the Medicaid benefit, including LTSS services, the ICO must offer a reimbursement model that is at least the current FFS Medicaid payment level, unless an alternative arrangement is made between the ICO and provider (Michigan three-way contract, 2014, p. 87). Several ICOs said in 2018 that they were using value-based payment methods with some providers, including some arrangements with downside risk.

Payment Challenges

ICOs said they experienced challenges with payments to NFs due to delays in receiving files from the State with the patient pay amounts (resident share of cost) for Medicaid long-term services, as well as frequent retroactive adjustments. ICOs and hospitals reported challenges in determining Medicare bad debt payments early in the demonstration.

Home medical equipment providers said in early 2018 that they were experiencing challenges with billing the ICOs and that payment delays were routine. Providers said that unlike Medicare Advantage (MA) plans, the ICOs did not follow standard Medicare billing practices,

[11] The MI Choice waiver agents are Area Agencies on Aging and other community-based organizations (see ***Section 1.4.3***).

and each ICO took a different approach to use of modifiers, such as those indicating rental equipment and the month during which the rental is billed.

Home and Community-based Services

The plans contracted with the Area Agencies on Aging (AAAs) to use their existing HCBS provider networks, which included many small provider organizations and specialized services that were not familiar to the ICOs. HCBS stakeholders said in 2018 that some plans had begun to develop their own HCBS networks by contracting with larger providers, raising concerns about whether smaller "mom-and-pop" providers will be left out in the future.

Personal Care

Michigan experienced significant challenges transitioning State Plan personal care services from FFS to managed care, despite the State's efforts to prepare for the transition. Many individual personal care providers experienced long waits for their paychecks after the transition, according to advocates, who said the providers are often relatives of the consumers and low-income individuals themselves who cannot afford to wait weeks for their paychecks. Advocates and some ICOs said that as a result, many beneficiaries disenrolled. Provider stakeholders and advocates said that many adult foster care and homes for the aged providers had similar difficulties getting payments for residents' personal care supplements and encouraged their residents to disenroll.

An ICO said that during the early waves of passive enrollment, the State did not provide timely data to support continuity of care, so plans often had to start from scratch by assessing enrollees, obtaining provider enrollment forms, and completing background checks for providers. State officials addressed that problem by adding personal care data to Care Connect 360, an online portal for providers, so that the plans could identify personal care users and obtain service plan information such as hours, tasks, and providers. The CMT also allowed plans to conduct outreach calls to beneficiaries up to 60 days prior to their enrollment effective dates, providing another means of identifying existing services and providers in order to plan continuity of care. ICOs said they made special efforts to enroll personal care providers; several plans used the AAAs to assist providers with enrollment, and one plan held open houses at network clinics for personal care consumers and providers. Despite these efforts, advocates said during the 2016 site visit that two of the ICOs were still having problems getting payments started for individual providers.

Transportation

Some of the ICOs improved Medicaid non-emergency medical transportation services by contracting with new providers rather than relying on the large vendor used by MDHHS, which is known for poor service and unreliability, according to multiple stakeholders. Stakeholders mentioned ICOs contracting with AAAs and other social service providers to provide transportation, as well as using volunteer drivers in rural areas. An ICO that continued to use the same vendor as MDHHS was singled out for poor transportation services by advocates and beneficiary focus group participants.

2.2.5 Training and Support for Plans and Providers

The demonstration required plans to provide new services, and brought new provider types into managed care. To help plans and providers adapt to this transition, Michigan provided support on a range of topics, particularly for the ICOs. In-person training sessions for ICOs were provided on person-centered planning, self-determination, HCBS waiver applications and care plans, and the nursing facility level of care tool. In addition, online training modules on several topics were made available through an online learning management system, and through webinars. Written guidance was provided to ICOs and providers on topics such as personal care services and behavioral health benefits.

2.3 Major Areas of Integration

2.3.1 Integrated Benefits and Enrollment

MI Health Link enrollees receive Medicare and Medicaid medical, LTSS, and Medicare behavioral health services through their ICOs, as well as care coordination, zero co-payments for prescription drugs, and supplemental HCBS, as described in ***Section 1.2, Model Description and Demonstration Goals***. The demonstration integrates Medicare and Medicaid managed care enrollment through the State's Medicaid managed care enrollment broker, as described in the ***Section 3, Enrollment.***

2.3.2 Integrated Care Coordination and Care Planning

Care coordination by the ICOs integrates medical care, behavioral health, and LTSS. Integrated care teams led by the care coordinators are responsible for developing and implementing care plans to address each enrollee's needs (see ***Section 4, Care Coordination***).

2.3.3 Integrated Quality Management

The MI Health Link quality management framework includes four primary components: joint oversight by the State and CMS, quality measurement and reporting, quality and performance improvement activities by the plans, and external quality reviews by the Medicare Quality Improvement Organization and Michigan Medicaid's External Quality Review Organization (see ***Section 9, Quality of Care***).

2.3.4 Integrated Financing

All Medicare and some Medicaid services are financed through risk-adjusted capitated payments to the ICOs from Medicare and Medicaid. The demonstration savings percentage and quality withholds are applied to the payments for Medicare Parts A and B and Medicaid, but not to Part D capitation payments. Medicaid behavioral health services —including mental health and substance use services, and HCBS waivers for persons with I/DD—are financed through capitated payments to the PIHPs (see ***Section 7, Financing and Payment***).

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3. Eligibility and Enrollment

Highlights

- More than 106,000 Medicare-Medicaid beneficiaries were eligible for MI Health Link in December 2017, and more than 38,500 (36 percent) were enrolled.
- The demonstration experienced a modest decline in enrollment after phased enrollment ended. Contributing factors included voluntary disenrollment, involuntary disenrollment due to loss of Medicaid eligibility, and a 7-month period without passive enrollment.
- State officials implemented several changes in mid-2016 that helped stabilize enrollment levels. Monthly passive enrollment was resumed in June 2016, and deemed enrollment was implemented the following month.
- In 2017, Michigan implemented a new method of auto-assignment for passive enrollment that uses performance indicators to determine the percentage of passively enrolled beneficiaries assigned to each plan.

3.1 Introduction

This section provides an overview of the enrollment process for MI Health Link. Eligibility for the demonstration, enrollment phases, and the passive enrollment process are included in this section. Enrollment and opt-out data are presented, and factors influencing enrollment decisions and recently implemented enrollment strategies are also discussed.

3.2 Enrollment Process

3.2.1 Eligibility

Full-benefit Medicare-Medicaid beneficiaries, age 21 years or older, who reside in a demonstration region, are eligible to enroll in the demonstration. Beneficiaries who reside in a State psychiatric hospital, have elected hospice services,[12] or have commercial health maintenance organization (HMO) coverage are not eligible to enroll. Beneficiaries currently enrolled in the MI Choice 1915(c) waiver or the Program of All-Inclusive Care for the Elderly (PACE) are not eligible for passive enrollment but may opt into the demonstration if they disenroll from MI Choice or PACE (Michigan three-way contract, 2018, pp. 36–7).

[12] Although beneficiaries already enrolled in hospice are not eligible for the demonstration, MI Health Link enrollees who elect hospice services may remain in the demonstration and receive hospice services through their Medicare FFS benefit, as in Medicare Advantage (Michigan three-way contract, 2018, pp. 34, 35, 207).

3.2.2 Phases of Enrollment

Michigan conducted two phases of enrollment into MI Health Link, described in ***Table 3***. During Phase 1, eligible beneficiaries in two demonstration regions—Upper Peninsula and Southwest Michigan—were enrolled. During March and April 2015, only opt-in enrollments were effective; passive enrollment in those two regions occurred in May and June 2015. Phase 2 began in May 2015 with 2 months of opt-in enrollment in the two remaining demonstration regions—Wayne and Macomb Counties. Passive enrollments for those regions were effective in July, August, and September 2015. Opt-in enrollment continued beyond Phases 1 and 2 for all eligible individuals.

Table 3
MI Health Link phased enrollment plan

Characteristic	Phase 1	Phase 2
Start date	March 1, 2015	May 1, 2015
Eligible population	All eligible beneficiaries in two regions	All eligible beneficiaries in two regions
Geographic area	Upper Peninsula: Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft Southwest Michigan: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren	Wayne and Macomb Counties
Demonstration enrollment method	Opt-in enrollment began March 1, 2015; passive enrollment began May 1, 2015 (Note: opt-in enrollment continues for all eligible individuals)	Opt-in enrollment began May 1, 2015; passive enrollment began July 1, 2015 (Note: opt-in enrollment continues for all eligible individuals)
Gradual roll-out	Passive enrollments in these two regions were effective in May and June 2015	Passive enrollments in these two regions were effective in July, August, and September 2015

SOURCE: RTI International, State Data Reporting System (SDRS). 2015.

3.2.3 Passive Enrollment Experience

Enrollment peaked at 41,694 in September 2015, the final month of phased enrollment. After the completion of phased enrollment, Michigan was unable to begin monthly passive enrollment because the State's enrollment system did not have the capacity to identify beneficiaries who had already been passively enrolled into a Part D plan during the calendar year. There was no passive enrollment from October 2015 through May 2016, except in January 2016. During this period, enrollment declined to 30,813 in May 2016 (RTI, SDRS, 2016).

Michigan began monthly passive enrollment in June 2016 after developing a process to identify beneficiaries who could be passively enrolled. State officials and ICOs cited the resumption of monthly passive enrollment as an important factor in stabilizing enrollment levels

and gradually increasing enrollment. One of the plans also noted that small monthly waves of enrollment were easier to manage than the large waves they received during phased enrollment.

Opt-outs and disenrollment were an ongoing challenge. During the first 3 years of the demonstration, 65 percent of the demonstration eligible beneficiaries opted out or disenrolled. State officials indicated that the rate of opt-outs and disenrollments was in line with their expectations, and some stakeholders echoed this sentiment. Some ICOs, however, said that opt-outs and disenrollments posed a challenge because they had planned for higher enrollment. Stakeholders said that many beneficiaries who were passively enrolled did not understand the demonstration and chose to opt out or disenroll (see ***Section 3.2.6, Factors Influencing Enrollment Decisions***).

3.2.4 Integration of Medicare and Medicaid Enrollment Systems

Enrollment Broker

Michigan modified the contract of its existing Medicaid managed care enrollment broker to administer enrollment for MI Health Link. For the demonstration, the enrollment broker is responsible for assigning beneficiaries to ICOs, mailing enrollment notices, counseling beneficiaries who contact the Michigan ENROLLS call center, and sharing enrollment data with CMS and the plans. State staff reported working closely with the enrollment broker to develop and update scripts, flow charts, and grids to help enrollment counselors provide appropriate information to beneficiaries.

Assignment Method

During the first 2 years of the demonstration, beneficiaries eligible for passive enrollment were assigned to ICOs using an assignment algorithm that first considered whether beneficiaries were enrolled in a Medicare Advantage (MA) or Medicaid managed care plan that operated an ICO, as well as the enrollments of other family members with a common Medicaid case number. The remaining beneficiaries were assigned randomly to one of the ICOs in their region.

In July 2017, Michigan began using ICO performance to assign ICOs to one of three tiers that determine the percentage of auto-assigned enrollees they receive. State officials said that plans had responded by improving their performance on the metrics used for the algorithm, which included the percentage of enrollees with an in-person assessment, HCBS waiver enrollment, the ratio of care coordinators to enrollees, and several other measures. Several ICOs said that using HCBS waiver enrollment as one of the metrics was unfair because State staffing challenges had contributed to the large backlog in waiver applications. State officials noted that some ICOs had much better performance on waiver enrollment, and said they were addressing staffing challenges (see ***Section 4.1.2, Care Planning Process***).

Enrollment Systems and Discrepancies

Enrollment processes required interactions among multiple systems, including the MAXIMUS enrollment broker system; CMS' Medicare Advantage Prescription Drug System (MARx); Bridges (the Michigan computer system that conducts and tracks enrollment in Medicaid and other public benefits, primarily used by the former Michigan Department of Human Services); and the Community Health Automated Medicaid Payment System

(CHAMPS), the Medicaid provider enrollment and payment system—which tracks information related to nursing facilities.

One of the challenges for the demonstration has been enrollment discrepancies, which occur when data in the Medicare, Medicaid, and enrollment broker systems are not in sync. Discrepancies cause confusion about whether beneficiaries are enrolled in the demonstration and if so, in which ICO. State officials said that enrollees' right to opt in and opt out at any time caused "havoc" in the enrollment systems. They also noted that some discrepancies were caused by internal errors by State staff, such as replacing the health plan code with an enrollee's nursing facility code, which disenrolled the beneficiary from the demonstration. State officials instructed the ICOs to treat all beneficiaries who appeared in either system as members and to cover all services they utilize until the discrepancies were resolved.

In 2016, State officials said they had been able to develop processes to resolve most discrepancies in the same month they are identified, and that the volume of discrepancies was much more manageable than earlier in the demonstration. However, in 2018 State officials reported a large volume of new discrepancies had resulted from MAXIMUS and CHAMPS systems updates that went into effect January 1, 2018, which required considerable staff resources to address. Michigan also found that the systems changes resulted in ineligible beneficiaries being included in the passive enrollment file. As a result, they stopped passive enrollment in April 2018 until the systems challenges could be resolved.

ICOs expressed frustration about receiving separate enrollment files from Medicare and Medicaid and incurring significant costs due to the continued need to identify discrepancies, report them to the State, and provide services to beneficiaries who might not end up enrolled in their plan. ICOs said there should be a single source of truth about whether a beneficiary is enrolled and in which plan; State officials said they explored the single source of truth process used by the South Carolina demonstration but determined that it was not feasible for Michigan due to programmatic differences. Although the State was not able to provide unified files prior to enrollment, it is required under the demonstration to reconcile beneficiaries' enrollment history so that the State and the CMS enrollment systems match. State officials said they address discrepancies as they are identified.

Medicaid Eligibility Re-Determinations

One of the early challenges was disenrollment due to enrollees losing their Medicaid coverage because their eligibility was not re-determined in a timely manner. If individuals regained their Medicaid eligibility, the State was not able to passively re-enroll them into their ICOs, due to the limit of one passive enrollment per calendar year. To address this issue, the State provides redetermination dates to the ICOs, and some ICOs assist enrollees with the process. However, an ICO expressed frustration that even enrollees who return their re-certification forms on time may be disenrolled because county offices are not always able to update records promptly due to large caseloads.

Deemed Enrollment

To increase retention of beneficiaries who lose Medicaid temporarily, the State and all of the ICOs agreed to implement deemed enrollment in July 2016. Under this procedure, which is a

CMS option for Financial Alignment Initiative (FAI) demonstrations, enrollees who lose Medicaid may remain enrolled in their ICOs for up to 3 months. ICOs are required to provide covered Medicare and Medicaid services to deemed enrollees, but they receive only Medicare capitation payments until the enrollee regains Medicaid coverage.[13] If an enrollee regains coverage within 3 months, the Medicaid capitation is paid retroactively; if not, the beneficiary is disenrolled and the plan absorbs the cost of his or her Medicaid services during the deeming period.

State officials did not have data on the impact of deemed enrollment on retention, but ICOs said that it had helped stabilize their enrollment levels. One ICO said it enabled them to retain approximately half of their members who lost Medicaid, who would otherwise have been disenrolled.

Enrollment Materials

Prior to enrollment, beneficiaries receive an introductory letter describing MI Health Link and 60- and 30-day passive enrollment letters. Some stakeholders said beneficiaries had difficulty understanding the notices and therefore had limited understanding of the enrollment process and the advantages of the demonstration. One ICO said that many enrollees did not receive enrollment notices or packets due to out-of-date addresses. The high number of passively enrolled beneficiaries who were unaware of the demonstration posed several challenges: some enrollees were unaware of their ICO enrollment until they accessed services, and others were reluctant to engage with ICO care coordinators because they did not realize they were enrolled in a plan.

Outreach and Education

In 2015, some advocates said that the State had not done enough community outreach and advertising to publicize the demonstration's launch. A State official said there were several barriers, including the launch of the State's Medicaid expansion program during the same time period, lack of support from the department's communications staff, and dispersed demonstration regions, which required separate outreach efforts. In response to stakeholder concerns, the State developed educational materials with input from the demonstration's Outreach, Education, and Communications Work Group. These materials are posted on the MI Health Link website (MDHHS, MI Health Link website, n.d.).

Options Counseling

Independent enrollment assistance and options counseling was provided by MMAP, the State's Senior Health Insurance Program, and the MMAP network, which includes AAAs, senior centers, and Centers for Independent Living (MOU, 2014, pp. 10, 61).

3.2.5 Reaching Enrollees

State officials and ICOs said that reaching prospective and new enrollees was a challenge. In addition to the problems with out-of-date addresses, ICOs said they encountered

[13] Deemed enrollment only applies to Medicare and Medicaid services financed through the ICO capitation. PIHP services financed through the Medicaid behavioral health capitation are not available to beneficiaries in deemed status.

some difficulties completing welcome calls, as some beneficiaries did not have telephones, may have changed their telephone numbers, were not willing to accept calls due to limited minutes on a prepaid phone plan, or did not recognize the callers' phone numbers. As a result, some new enrollees first learned their coverage had changed when they attempted to fill a prescription or see their doctor. Challenges reaching enrollees also hindered completion of health risk screenings and assessments (see ***Section 4.1.1, Assessments***).

Initially, ICOs were allowed to make calls up to 20 days prior to enrollment; the timeframe was extended to 60 days in the 2016 amended three-way contract. Several plans said these pre-enrollment calls helped to reduce opt-outs and disenrollments. One plan said they spent 45 to 60 minutes per member on welcome calls. Another ICO said they did not call beneficiaries until their enrollments in the plan began.

3.2.6 Factors Influencing Enrollment Decisions

Many Medicare-Medicaid beneficiaries in Michigan had previous experience with Medicaid managed care and with Medicare-Medicaid integration through the State's duals lite initiative (see ***Section 1.4.1, Experience with Managed Care***). State officials said that although some beneficiaries may have been more willing to participate in the demonstration due to their familiarity with managed care, others did not understand why they could not remain in their duals lite MCOs and therefore opted out or disenrolled. Stakeholders said that some beneficiaries disenrolled from the demonstration without understanding that they could not return to their duals lite MCO.[14]

Although Medicare-Medicaid beneficiaries in the demonstration regions lost one managed care option, beneficiaries in three of the four regions (Southwest Michigan, Macomb County, and Wayne County) could choose between ICOs and D-SNPs. In some locales, beneficiaries who met the criteria for a nursing facility level of care could also choose a PACE plan (CMS, 2018b; HMA, 2017; MDHHS, n.d.). Beneficiaries who met the nursing facility level of care could also choose the MI Choice waiver.

Factors Contributing to Enrollment in the Demonstration

Advocates involved in outreach and education said demonstration features that are attractive to beneficiaries include care coordination, zero co-pays for prescription drugs, and flexible benefits such as over-the-counter products and vision.

Demonstration enrollment rates have been highest in the rural regions. In the Upper Peninsula, 51.8 percent of eligible beneficiaries were enrolled in December 2017, compared to 47.0 percent in Southwest, 33.7 percent in Wayne County, and 20.4 percent in Macomb County (MDHHS, 2018). Advocates noted that beneficiaries in the Upper Peninsula may have been more willing to participate in the demonstration due to their familiarity with the Upper Peninsula Health Plan—the only ICO and only Medicaid MCO in the region.

[14] When MI Health Link was launched, Michigan ended the duals lite arrangement in the demonstration regions, and beneficiaries who disenrolled from the demonstration were not able to re-enroll in an MCO. Although they retained a full range of Medicare options, their Medicaid options were limited to FFS and MI Health Link.

Factors Contributing to Opt-Out and Disenrollment

Several factors contributed to enrollee decisions to opt out and disenroll. State officials and stakeholders commented on the difficulty of educating beneficiaries about the demonstration. Advocates said some beneficiaries were apprehensive about managed care, and others objected to passive enrollment, including one 2016 focus group participant, who nevertheless remained enrolled: "They decided to change [my health coverage]... They just assigned me [to a new health plan] without asking, without sending me anything."

Some types of providers played a role in enrollee decisions. During the early implementation period, some NFs and guardianship agencies[15] attempted to disenroll large groups of beneficiaries from the demonstration. The enrollment broker instead established a process to schedule blocks of time with NFs, guardianship agencies, and individual beneficiaries to work through their cases on a one-by-one basis, rather than accepting batches of disenrollments.

Delayed payments to individual providers of personal care services was another early challenge. In some cases, individual providers were not paid for months, causing beneficiaries to disenroll, according to advocates. Adult family care home providers were also affected by payment delays and may have encouraged their residents to disenroll, according to provider organizations and advocates.

Marketing by Medicare Advantage plans during the annual open enrollment period was also identified as a factor in disenrollment. Medicare Advantage plans have fewer marketing restrictions than the ICOs, and beneficiaries have trouble differentiating between different types of plans, according to the ICOs. To address this issue, State officials said they had sent letters to inform demonstration enrollees that no enrollment action was needed during open enrollment if they wanted to remain with their ICOs.

3.3 Summary Data

As of December 2017, approximately 38,259 beneficiaries were enrolled in the MI Health Link demonstration, representing about 35 percent of the eligible population. More than half of MI Health Link enrollees in December 2017 resided in Wayne County (54.6 percent), followed by the Southwest Michigan region (23.6 percent), the Upper Peninsula (11.3 percent), and Macomb County (10.5 percent). The percentage of eligible beneficiaries enrolled in the demonstration increased from 33.3 percent in December 2015 to 35.0 percent in December 2017 (see ***Table 4***).

[15] Guardianship agencies may be assigned by courts to act as guardians for adults who have been determined incapacitated.

Table 4
Demonstration enrollment at the end of each calendar year

Enrollment indicator	Number of beneficiaries		
	December 2015	December 2016	December 2017
Eligibility			
Beneficiaries eligible to participate in the demonstration as of the end of the month	104,690	107,423	109, 417
Enrollment			
Beneficiaries currently enrolled in the demonstration at the end of the month	34,858	36,761	38,259
Percentage enrolled			
Percentage of eligible beneficiaries enrolled in the demonstration at the end of the month	33.3%	34.2%	35.0%

SOURCE: RTI International, SDRS, 2016, 2017, and 2018, as revised March 2019.

4. Care Coordination

Highlights

- Integrated Care Organizations' (ICOs') care coordinators are responsible for coordinating enrollees' medical health, behavioral health, long-term services and supports (LTSS), and social services. In addition, they conduct functional assessments to determine nursing facility level of care and prepare HCBS waiver applications.
- Early in the demonstration, ICOs faced challenges completing health risk assessments and care plans within 90 days. Assessment completion rates improved after phased enrollment ended, whereas care plan completion rates remained a challenge through the end of 2017. Michigan's care plan completion rates reached the national average during 2018.
- Coordination of medical and behavioral health services required collaboration between the ICOs and PIHPs. Stakeholders said the demonstration was increasing access to behavioral health services for enrollees with previously unmet needs.
- The HCBS waiver application process created challenges. ICOs' lack of LTSS experience and delays in processing waiver applications by the State resulted in a significant backlog of waiver applications during 2017. The backlog was eliminated by September 2018.

4.1 Care Coordination Model

Care coordination is a core function of MI Health Link, and ICOs are required to provide care coordination services to all enrollees through multidisciplinary integrated care teams (ICTs). After enrollment, each beneficiary's goals, needs, and strengths are assessed, and the assessments inform the development of care plans. Although the three-way contract provides a framework for care coordination activities to be performed by the ICOs, State officials said they sought to give the ICOs flexibility to develop their own care coordination processes.

This section provides an overview of the demonstration requirements related to the care coordination function, including assessment processes, use of ICTs and the development of care plans, delivery of care coordination services, and the role of care coordinators. The experience of ICOs is included in this section as is the care coordination of LTSS and behavioral health services and data exchange.

4.1.1 Assessment

All enrollees must receive an initial screening within 15 days of enrollment to identify any immediate needs. Plans are required to complete Level I assessments using a comprehensive health risk assessment tool within 45 days, and make at least five attempts to reach enrollees for the assessment. If the initial screen, which involves reviewing an enrollee's utilization history, or the Level I assessment indicates the need for a specialized assessment, a Level II assessment

must be conducted in person within the next 15 days. Level II assessments focus on LTSS, behavioral health, substance use disorders, intellectual and developmental disabilities (I/DD), and complex medical needs, and must be completed by LTSS Supports Coordinators, Prepaid Inpatient Health Plan (PIHP) Supports Coordinators, or behavioral health case managers (Michigan three-way contract, 2018, pp. 81-2).[16]

Although the contract prescribed a 45-day timeframe for assessments, a different timeframe was used as a core measure for the demonstration, assessments completed within 90 days of enrollment.[17] During the second half of 2015, over 38,000 enrollees reached their 90th day of enrollment, and the plans completed assessments for less than half of them within 90 days (***Table 5***). Further, by quarter 3 of 2016, a majority of enrollees who could be reached and were willing to participate had completed assessments within 90 days. This trend continued throughout calendar year 2017. In addition to the challenge of large waves of passive enrollees, as described in ***Section 3.2.5***, the plans reported challenges reaching enrollees due to out-of-date addresses, disconnected telephones, and limits on enrollees' cell phone minutes that made them reluctant to speak by phone with care coordinators, as well as enrollees' general reluctance to engage. During most quarters, ICOs were unable to reach more than 20 percent of enrollees within 90 days of enrollment (see ***Table 7***).

In an effort to provide more time for the ICOs to conduct the assessments, the CMT offered ICOs the option to conduct Level I assessments up to 20 days before the enrollment effective date. Some ICOs used that opportunity, and others chose not to begin the process until after the enrollment effective date, due to the high opt-out rate and the cost of conducting assessments. One plan reported that its care management and tracking system was not set up to support enrollee records prior to enrollment.

ICOs said they contracted with other organizations, such as home care agencies, to assist with completion of assessments. The plans used various methods to reach and engage enrollees, including contacting primary care providers and pharmacies for up-to-date contact information, knocking on doors, and visiting enrollees while they were in the hospital. In some cases, ICOs used community health workers or vendors to conduct outreach at senior centers, local churches, food banks, and shelters.

The percentage of all enrollees with assessments completed within 90 days of enrollment improved after phased enrollment ended, remaining consistently in the 60 percent range throughout 2016 and 2017 (see ***Table 6***). For enrollees the ICOs were able to reach and engage, the completion rate has exceeded 90 percent in some quarters.

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[16] The contract identifies four specific tools that must be used as a Level II assessment: interRAI home care assessment system (interRAI) for enrollees needing MI Health Link waiver services; supports intensity scale (SIS) for enrollees with intellectual or developmental disability needs; the level of care utilization system (LOCUS) for enrollees with behavioral health needs; and the American Society of Addiction Medicine (ASAM) tool for enrollees with substance use disorder needs (Michigan three-way contract, 2014, pp. 56–67).

[17] Assessments completed within 90 days (Core 2.1) was a quality withhold measure for demonstration year 1 (calendar years 2015 and 2016), so plans were financially accountable for their performance (see ***7.1.3 Performance Incentives***).

Table 5
Assessments completed within 90 days of enrollment

Quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Assessment completed within 90 days of enrollment (%)	
		All enrollees	All enrollees willing to participate and who could be reached
2015			
Q1	*	*	*
Q2	134	91.0	98.4
Q3	22,743	42.3	63.6
Q4	15,662	36.9	48.2
2016			
Q1	1,688	58.2	73.0
Q2	1,103	61.1	74.1
Q3	8,334	65.4	91.7
Q4	2,466	67.4	91.3
2017			
Q1	2,467	62.9	85.1
Q2	3,428	64.0	90.8
Q3	2,919	61.0	84.7
Q4	2,522	61.4	85.7

NOTE: * = because the Michigan demonstration began in March 2015, there are no data for quarter 1, 2015.

SOURCE: RTI analysis of MMP reported data for Core Measure 2.1 provided to RTI as of October 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

Table 6
Percentage of members that MI Health Link plans were unable to reach following three attempts, within 90 days of enrollment, by quarter

Quarter	Calendar year 2015	Calendar year 2016	Calendar year 2017
Q1	*	16.5%	21.4%
Q2	6.0%	15.4%	23.8%
Q3	27.5%	25.3%	22.0%
Q4	19.2%	23.4%	23.0%

NOTE: * = because the Michigan demonstration began in March 2015, there are no data for quarter 1, 2015.

SOURCE: RTI analysis of MMP reported data for Core Measure 2.1 provided to RTI as of October 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

4.1.2 Care Planning Process

The Integrated Care Team

ICOs are responsible for establishing an ICT for each enrollee. The ICT works together to develop, implement, and maintain an Individual Integrated Care and Supports Plan (IICSP), as well as coordinate the delivery of benefits and services to the individual. The ICT always includes the enrollee, his or her chosen allies or legal representative, the ICO care coordinator, and the primary care physician. The ICT may also include other providers, such as an LTSS and/or PIHP Supports Coordinator. The ICO care coordinator leads the ICT, but the enrollee may request that his or her LTSS or PIHP Supports Coordinator act as the main point of contact for the ICT (Michigan three-way contract, 2014, pp. 9, 44–6).

State officials said in early 2018 that over the first 3 years they had learned that it was very difficult for the ICOs to include PCPs in the ICT meetings because physicians are busy seeing patients and do not have time to participate. Later in 2018, State officials said the three-way contract update for 2019 would include a provision allowing other licensed professionals who work in the PCP's office and who are familiar with the member, such as social workers, nurses, or medical assistants, to represent PCPs in ICT meetings. This change will be addressed in the next evaluation report.

The Individual Integrated Care and Supports Plan

The care coordinator, enrollee, and other ICT members develop a comprehensive, person-centered IICSP. ICOs must complete the initial care plan within 90 days of enrollment, and all enrollees must have IICSPs unless they refuse. Care plans must be reviewed monthly for high-risk enrollees, quarterly for moderate-risk enrollees, and at least every 180 days for low-risk enrollees. The IICSP must be updated annually, or more often if needed (Michigan three-way contract, 2014, pp. 66–7).

The CMT strengthened care coordination requirements in 2016 to address concerns that ICOs were not engaging enrollees in person-centered care planning. State officials said that, in some cases, plans had used vendors to conduct assessments and ICO care coordinators developed care plans based on these assessments and mailed them to enrollees without any direct contact. The new guidance required in-person meetings to develop IICSPs at a time and location convenient to the enrollee, and required that some of the required care plan reviews be conducted in-person, rather than by telephone, with in-person reviews at least every quarter for high-risk enrollees and every other quarter for moderate-risk enrollees. This guidance was incorporated into the amended three-way contract in 2016 (Michigan three-way contract, 2016, p.83). The State also required evidence of enrollee acceptance of their care plans by signatures or documentation that in-person care planning meetings took place (Michigan, Minimum Operating Standards, 2018).

Several ICOs said in 2016 that the new requirements were excessive and costly to implement, that in-person contacts were not necessary for all enrollees, and that the documentation requirements involved time-consuming system changes. ICOs were particularly concerned about the signature requirement, and said that sending staff in the field to collect signatures reduced their availability to assist members.

The CMT reviewed five care plans from each ICO during 2016 and found them to be too generic and lacking in measurable goals. State officials also expressed concern that ICOs were using care management systems designed for a medical model, and had not modified them to support documentation of personal goals, preferences, and enrollee approval within the care plan document. Several ICOs said that they were already documenting enrollee goals, preferences, and care plan approval in the case notes; however, State officials said the information was often fragmented and took too much time to find within care management systems. Two plans interviewed in 2018 said they had changed to different systems that were more suitable for a person-centered approach.

State officials said in 2018 that they were not satisfied with the percentage of enrollees who had care plans completed within 90 days of enrollment, although the rates did show improvement in the third and fourth quarters of 2017. By the end of quarter 4 2017, 44 percent of all enrollees had completed care plans within 90 days of enrollment, and more than one-half of those who could be reached and were willing had completed a care plan within 90 days of enrollment (see ***Table 7).*** State officials said that although the care planning requirements may make completion of care plans challenging for ICOs, enrollee engagement in the process remains a priority. Care plan completion rates improved to the national average during 2018, according to CMS officials; more details will be provided in the next evaluation report.

Table 7
Members with care plans within 90 days of enrollment

Quarter	Total number of enrollees whose 90th day of enrollment occurred within the reporting period	Care plan completed within 90 days of enrollment (%)	
		All enrollees	All enrollees not documented as unwilling to complete a care plan or un-reachable
2015			
Q1	*	*	*
Q2	141	85.8	93.8
Q3	24,024	35.6	43.5
Q4	16,691	26.5	32.8
2016			
Q1	1,723	24.6	27.8
Q2	1,145	31.0	36.2
Q3	8,792	29.1	37.0
Q4	2,542	35.9	43.8
2017			
Q1	2,546	35.2	44.0
Q2	3,508	29.1	37.7
Q3	3,065	35.8	46.6
Q4	2,629	44.2	57.4

NOTE: * = because the Michigan demonstration began in March 2015, there are no data for quarter 1, 2015.

SOURCE: RTI analysis of MMP reported data for State-specific measure MI2.1, provided to RTI as of October 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html.

Enrollee engagement in care planning is also reflected in the percentage of enrollees with an initial care plan completed who had at least one documented discussion of care goals (see ***Table 8***). Demonstration performance on this measure was greater than 90 percent during 2016 and 2017, and increased to 98 percent in the fourth quarter of 2017.

Table 8
Members with care goals

Quarter	Total number of members with an initial care plan completed	Members with at least one documented discussion of care goals in the initial care plan (%)
2015		
Q1	*	*
Q2	2,426	83.3
Q3	9,781	57.5
Q4	8,493	75.5
2016		
Q1	3,280	98.0
Q2	4,214	95.7
Q3	4,168	92.2
Q4	2,737	91.1
2017		
Q1	2,251	92.6
Q2	1,940	96.2
Q3	2,498	94.3
Q4	2,454	97.7

NOTE: * = because the Michigan demonstration began in March 2015, there are no data for quarter 1, 2015.
SOURCE: RTI analysis of MMP reported data for state-specific measure MI2.3 provided to RTI as of October 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Michigan-Specific Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

Care Coordination at the Plan Level

ICO care coordinators must be Michigan licensed registered nurses, nurse practitioners, physician's assistants, or social workers with bachelor's or master's degrees (limited or full license) who receive required training, including training conducted by the Michigan Department of Health and Human Services (MDHHS) on person-centered planning. ICOs can use employed staff as care coordinators and/or delegate the function via subcontract. However, to avoid conflict of interest, the ICO cannot delegate the function to an LTSS provider that also delivers services to the enrollee (e.g., a nursing facility) (Michigan three-way contract, 2014, pp. 47–52). Michigan did not establish any caseload requirements in the contract.

ICO representatives and State officials said it was common for the plans to use vendors to conduct assessments and some other tasks, and two ICOs said that they used vendors to perform all care coordination. Although there were differences among plans, all of the ICOs interviewed said they had specialization within their care coordination teams, with some staff or vendors that specialize in HCBS and others that focus on nursing facility residents.

Several plans said they increased staffing in 2016 in response to the new requirements for more in-person contacts and signatures. One plan reported it had increased the number of care coordinators from 17 to 42, in addition to 60 other staff in their care coordination program for conducting assessments, making welcome calls, and helping to reach enrollees. Another plan noted the challenge of hiring care coordinators with experience in HCBS waiver and nursing facility services.

Retaining care coordination staff has also been a challenge for the ICOs, according to plans and State officials, with plans experiencing an average turnover rate of 30 percent in 2016, when average caseloads peaked at 205 members per care coordinator (see ***Table 9***). One factor that contributed to the turnover rate was competition among plans, which resulted in care coordinators changing jobs. State officials said in 2018 that the plans' caseloads ranged from 139 to 256.

Table 9
Care coordination staffing

Calendar year	Total number of care coordinators (FTE)	Percentage of care coordinators assigned to care management and conducting assessments	Member load per care coordinator assigned to care management and conducting assessments	Turnover rate (%)
2015	192	95.8	193.93	13.3
2016	186	98.4	205.26	29.8
2017	233	99.1	169.62	20.2

FTE = full-time equivalent.

SOURCE: RTI analysis of MMP reported data for Core Measure 5.1 as of October 2018. The technical specifications for this measure are in the Medicare-Medicaid Capitated Financial Alignment Model Core Reporting Requirements document, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html

4.1.3 HCBS Waiver Coordination

During the second and third years of the demonstration, delays in processing HCBS waiver applications resulted in a significant backlog. Many applications were submitted by the ICOs with incomplete documentation of activities of daily living needs and service plans that did not match assessed needs, according to State officials, and some waiver service plans were submitted that did not include any waiver services. State agency staff took time to write comments on incomplete applications and send them back to the plans to be corrected, which took time away from reviewing other applications. State officials said that since they were relying on the ICOs to assess applicants, the applications needed to be well documented and thoroughly reviewed by the State officials.

As the demonstration progressed and the plans assessed more enrollees and submitted more applications, the backlog grew to approximately 800 applications in early 2018; waiver enrollment at that time was nearly 1,000. State officials said more than half of the applications processed each day were sent back to the plans for more information. State officials attributed

the problems to the ICOs' lack of familiarity with LTSS and high turnover among care coordination staff. ICOs said that processing of waiver applications by the state was slow and there were not enough state staff to review applications.

State officials said in 2018 that they were taking several steps to address delays, including conducting additional training for ICO staff, developing a checklist for waiver application packets, adding State staff to review applications, and requesting CMS approval to streamline the waiver application review process. In September 2018, State officials said the backlog had been eliminated. The RTI evaluation team will report on this in more detail in the next evaluation report.

Although most of the plans struggled with the waiver application process, two plans achieved higher approval rates and thus were able to serve a majority of their enrollees who required LTSS with waiver services rather than NF services. Both ICOs said they had prioritized waiver enrollment and that some of their care coordinators specialized in conducting Level II HCBS assessments and preparing waiver applications.

4.1.4 Behavioral Health Integration

Behavioral health integration has been a major challenge due to the behavioral health carve-out (see ***Section 2.2.2, Integration of Behavioral Health Services***), which creates the need for collaboration and timely communication between ICOs and PIHPs. Enrollee referrals from ICOs to PIHPs for Level II assessments were an early challenge, due to the tight timeframes for assessments, differences in the entities' perspectives about which enrollees should be assessed, and difficulties with information exchange (see ***Section 4.2, Information Exchange***). Early in the demonstration, some PIHPs reported that ICOs were making inappropriate referrals, including many enrollees who were already receiving PIHP services. State officials and advocates, however, said the process seemed to be working and that enrollees with unmet behavioral health needs were being identified and referred for appropriate services. Several PIHPs confirmed that they are serving more Medicare-Medicaid enrollees under the demonstration.

PIHPs said in 2018 that they receive much more information about enrollees' physical health than before the demonstration. According to the PIHPs, referrals from ICOs include the Level I health risk assessment, demographic information, care coordinators' names and contact information, and a clinical snapshot written by the care coordinator, but referrals do not list enrollees' medications. PIHPs send Level II assessments to ICOs, and ICO staff can log in to the PIHP's care management system to check enrollees' status and determine which enrollees are in the hospital.

In addition to electronic communications, PIHPs and ICOs have regular case conferences, and in some cases, PIHP staff attend ICT meetings. One PIHP said that only one ICO in its region routinely includes it in ICT meetings for enrollees they share, but that collaboration was much better for high-acuity cases: "[W]hen individuals are coming from a hospital setting and needing services wrapped around them, care coordinators from both PIHP and ICOs definitely work collaboratively to ensure that services are wrapped around clients."

PIHPs expressed mixed views about the extent to which integration of Medicare and Medicaid coordination between the two sets of behavioral health services and providers. One PIHP said in 2016 that as the payer for Medicare behavioral health, they are better able to connect enrollees with recovery-oriented Medicaid community services. However, during the same site visit another PIHP said it was still challenging to make timely connections because hospitals do not send admit, discharge, and transfer (ADT) notices for psychiatric hospitalizations, Medicare behavioral health claims are often delayed because providers do not know which payer to bill, and Medicare providers still do not refer beneficiaries to Medicaid community behavioral health services.

4.2 Information Exchange

A key component of the Michigan integrated delivery system is the Care Bridge. State officials and stakeholders envisioned it as a framework and protocol for coordinating different domains of care. As part of the Care Bridge, each ICO must implement a secure, web-based care coordination platform to maintain the enrollee's electronic health record. The platforms facilitate information sharing and communication between the ICO, primary care provider, PIHP and LTSS Supports Coordinators, and other providers (Michigan three-way contract, 2014, pp. 3, 43–4).

In addition to the ICO portals, the demonstration leveraged the Michigan Health Information Network (MiHIN), the State's health information exchange, which ICOs and PIHPs use to exchange protected health information. Initially the demonstration planned to use MiHIN temporarily until each ICO established its portal. However, the PIHPs in Wayne and Macomb Counties expressed concern about having to use five different ICO portals. The State responded by requiring ICOs to transmit referrals and Level 1 assessments to the PIHPs through MiHIN, and that method is now considered part of the Care Bridge. PIHPs also use MiHIN to send completed Level II assessments to the ICOs. Although the PIHPs found this process helpful, some ICOs said the process was a step backward because they had already implemented provider portals.

Patient privacy laws have posed a barrier to the exchange of behavioral health information. Because PIHPs contract directly with the State to deliver Medicaid behavioral health services, there is no provider-payer relationship between PIHPs and ICOs for Medicaid services. Early in the demonstration, ICOs complained that one of the PIHPs required a patient release each time it requested protected information. A PIHP said in 2018 that sharing of behavioral health data had improved due to a change in the Michigan Mental Health Code to permit sharing of information for care coordination, but that sharing of protected information for quality reporting was not included in the change, which had "dismayed" the ICOs.

5. Beneficiary Experience

Highlights

- Stakeholders said the demonstration has improved access to behavioral health, personal care, and dental services, and improved the reliability of transportation services.
- Focus group participants, State officials, and advocates agreed that the lack of cost sharing is a very positive feature of the demonstration. Participants were generally positive about care coordination and improvements in transportation services.
- Enrollees with pending HCBS waiver applications were reportedly receiving at least some HCBS while waiting for their applications to be approved.
- Health plan and drug plan ratings of ICOs by CAHPS survey respondents in 2016 and 2017 were similar to the national averages for Medicare Advantage plans and Medicare-Medicaid Plans. Two ICOs received member satisfaction ratings that ranked in the top five among all Medicare-Medicaid Plans nationally in 2017.

5.1 Introduction

Improving the experience of beneficiaries who access Medicare- and Medicaid-covered services is one of the main goals of the demonstration under the Financial Alignment Initiative (FAI). Many aspects of MI Health Link are designed expressly with this goal in mind, including emphases on working closely with beneficiaries to develop person-centered care plans, delivering all Medicare and Medicaid services through a single plan, providing access to new and flexible services, and aligning Medicare and Medicaid processes.

This section highlights findings from various sources that indicate the levels of beneficiary satisfaction with MI Health Link overall. It also describes beneficiary experience with new or expanded MI Health Link benefits, medical and specialty services, and care coordination services; access to care and quality of care, person-centered care, and patient engagement; and personal health outcomes and quality of life. For beneficiary experience, we draw on findings from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, and RTI focus groups and stakeholder interviews. Please see ***Section 1.1.3, Data Sources and Methods***, for details about each data source. This section also provides information on beneficiary protections, and data related to complaints and appeals and critical incident and abuse reports. The section includes anecdotal information on the experience of special populations.

5.2 Impact of the Demonstration on Beneficiaries

This section summarizes the findings of focus groups, beneficiary surveys, and stakeholder interviews reflecting beneficiary experiences with service delivery and quality of life

under MI Health Link. Beneficiary experiences related to the early enrollment process, including experiences of beneficiaries who chose to opt in, opt out, or who were passively enrolled, are discussed as part of ***Section 3, Eligibility and Enrollment***.

5.2.1 Overall Satisfaction with MI Health Link

Most participants in beneficiary focus groups conducted in 2016 and 2017 indicated a low awareness of the demonstration, but they had opinions about their plans and services, which improved over time. In 2016, experiences were mixed, with some participants pleased with their new and improved benefits and care coordination, and others who expressed dissatisfaction with managed care limitations such as using network providers and referral requirements.

In 2017, beneficiaries indicated that overall they were satisfied or very satisfied. One enrollee said, "[My plan] is wonderful. I don't pay for prescriptions. I get rides wherever I need to go. …If I go take my testing, regular checkups that I normally do, I still get a little gift card…It's better [than my previous coverage]."

Nearly all participants in 2017 said that having Medicare and Medicaid combined was a good thing. Although participants said they liked integration, some participants were confused about whether they still needed their Medicare and Medicaid cards and which card to present at their doctor's office. Advocates said they had heard similar comments at community outreach events and used those events to educate consumers about their cards and other features of MI Health Link.

As shown in ***Table 10***, the percentages of MI Health Link CAHPS survey respondents rating their health plans as 9 or 10 in 2016 and 2017 were similar to the national averages for Medicare Advantage (MA) and Medicare-Medicaid Plans (MMPs). The percentage of Michigan respondents who rated their drug plans as a 9 or 10 and reported that their health plans gave them needed information was similar to the national averages in both years.

We provide national benchmarks from MA plans, where available, understanding that there are differences in the populations served by the MI Health Link demonstration and the MA population, including health and socioeconomic characteristics that must be considered in the comparison of the demonstration to the national MA contracts.

State officials highlighted the member ratings of two ICOs. The Upper Peninsula ICO tied with a Massachusetts plan for the highest member rating among all MMPs operating in FAI demonstrations, and the Meridian ICO was also in the top five.

Table 10
Beneficiary overall satisfaction, 2016–2017

CAHPS survey item	Year	National distribution: all MA Plan contracts (%)	National distribution: all MMP contracts (%)	Michigan distribution: MMP contracts (%)	AmeriHealth Michigan, Inc (%)	Aetna Better Health of Michigan, Inc. (%)	Michigan Complete Health (%)	HAP Midwest Health Plan, Inc. (%)	Meridian Health Plan of Michigan, Inc. (%)	Molina Healthcare of Michigan, Inc. (%)	Upper Peninsula Health Plan, LLC (%)
Percent rating health plan 9 or 10 on scale of 0 (worst) to 10 (best)	2016	61 (n = 142,984)	59 (n = 9,765)	—	62 (n = 183)	56 (n = 177)	52 (n = 111)	57 (n = 160)	65 (n = 222)	62 (n = 446)	70 (n = 276)
	2017	64 (n = 188,484)	63 (n = 14,662)	66 (n = 2,386)	64 (n = 227)	65 (203)	61 (n = 286)	60 (n = 196)	72 (n = 280)	64 (n = 887)	75 (n = 315)
Percent rating drug plan 9 or 10 on scale of 0 (worst) to 10 (best)	2016	61 (n = 132,613)	61 (n = 9,617)	—	67 (n = 176)	60 (n = 177)	60 (n = 111)	63 (n = 159)	72 (n = 221)	64 (n = 431)	70 (n = 273)
	2017	63 (n = 172,033)	64 (n = 14,087)	69 (n = 2,246)	68 (n = 205)	71 (n = 195)	68 (n = 260)	66 (n = 175)	77 (n = 236)	67 (n = 863)	71 (n = 320)
Percent reporting that health plan "usually" or "always" gave them information they needed	2016	81 (n = 42,677)	79 (n = 3,669)	—	81 (n = 73)	88 (n = 69)	N/A	83 (n = 79)	89 (n = 86)	83 (n = 204)	89 (n = 57)
	2017	87 (n = 84,304)	86 (n = 8,234)	87 (n = 1,317)	85 (n = 149)	87 (n = 106)	87 (n = 171)	N/A	91 (n = 158)	87 (n = 526)	93 (n = 167)

— = data not available; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; N/A indicates that few beneficiaries responded to the question to allow reporting or the score had low reliability.

SOURCE: CAHPS data for 2016–2017.

5.2.2 New or Expanded Benefits

ICOs are not allowed to use cost sharing for any services other than the resident share of Medicaid long-term nursing facility services. According to focus group participants, beneficiary advocates, and State officials, zero co-payments is a very positive feature. One advocate noted that residents of group homes spend nearly all of their income on room and board, so zero co-pays allows them to fill their prescriptions and have a little money for personal items.

State officials said they had taken several steps to ensure that beneficiaries were not charged co-payments or deductibles. ICOs were asked to include language on the member cards indicating zero co-pays, and all plans made this change. Plans also added language about zero cost sharing on explanations of payments sent to providers, and provided members with an information sheet to show their providers. Advocates said the plans respond quickly to address member complaints from inappropriate billing.

Focus group participants did not cite the new HCBS waiver or supplemental HCBS benefits as positive features, although State officials considered the waiver to be an attractive feature due to the availability of 5,000 new slots for demonstration enrollees. Advocates did not cite HCBS as a positive feature either, due to concerns about the backlog in waiver applications at the time of the 2018 site visits. State officials said they hoped that as waiver enrollment grows it will be more widely appreciated and encourage enrollment in the demonstration.

Most of the ICOs offer some flexible benefits, and the over-the-counter product benefit offered by some plans was popular among focus group participants. Examples of other benefits offered by plans included home-delivered meals after hospitalization, additional dental benefits, and fitness club memberships. There was generally low awareness of these benefits among focus group participants and stakeholders.

5.2.3 Medical and Specialty Services

Most focus group participants said they were able to keep the same doctor when they enrolled in their plans, and most were pleased with their doctors; this feedback was consistent with results of the State's 2017 CAHPS survey. When asked whether they had the same personal doctor before joining their current health plan, 65 percent of respondents answered "yes" (HSAG, 2017, pp. 6.1).

5.2.4 Care Coordination Services

MI Health Link enrollees' experiences with care coordination have been mixed but have improved over time, according to State officials, advocates, and focus group participants.

Face-to-face contacts by care coordinators have increased over time, according to some stakeholders—a view that was consistent with feedback from focus group participants. In 2016, some participants said they were visited by their care coordinators on a regular basis, and others said they did not have care coordinators or know that service was available. In 2017, most participants said they had care coordinators, and approximately half reported receiving visits every 3 months (or more often). Others said they had been visited in the past year. One

participant said, “They’ll come out to your house, check on you, see if you need anything…I like it.”

Focus group participants and advocates provided mixed reviews about the effectiveness of care coordinators. Some 2016 participants were pleased with the assistance they received from care coordinators. For example, one participant said the following:

> Someone calls at least twice a month to make sure I have all my medications that I need, to make sure that I have my doctors’ appointments made. If [there are] other things that I need and can’t get it, they’ll help get it.

Other 2016 participants described situations in which their care coordinators were not helpful or knowledgeable. Feedback remained mixed in 2017 when participants said their care coordinators had helped them resolve issues with inappropriate billing, and some described a high level of support for accessing physical health services. Care coordinators were less effective assisting with HCBS, according to State officials and advocates.

Another component of care coordination is communication among providers. Most focus group participants in 2017 said they felt their personal doctors were informed about care they received from other providers. In the one ICO with sufficient data to report on this question, 88 percent of respondents in 2016 and 85 percent in 2017 said their personal doctors were “usually” or “always” informed about care they received from specialists. These results were similar to national averages for MA plans and MMPs (see ***Table 11***).

5.2.5 Beneficiary Access to Care and Quality of Services

Overall, focus group participants in 2016 and 2017 reported satisfaction with their access to medical care and behavioral health services.

Some focus group participants in 2016 reported challenges with locating specialists who would accept their insurance. State officials said that some of the plans had limited networks at the beginning of the demonstration, but had worked to add more providers. In 2017, participants did not report any challenges with access to medical providers in the Detroit area. However, an advocate who works with enrollees in all four service areas said some enrollees still faced challenges finding the specialists they needed.

State officials and advocates credited the ICOs with improving transportation services and access to dental care, compared to the situation prior to the demonstration. Focus group participants gave these services mixed reviews.

Table 11
Care coordination, 2016–2017

CAHPS survey item	Year	National distribution: all MA Plan contracts (%)	National distribution: all MMP contracts (%)	Michigan distribution: MMP contracts (%)	AmeriHealth Michigan, Inc (%)	Aetna Better Health of Michigan, Inc. (%)	Michigan Complete Health (%)	HAP Midwest Health Plan, Inc. (H0480) (%)	Meridian Health Plan of Michigan, Inc. (%)	Molina Healthcare of Michigan, Inc. (%)	Upper Peninsula Health Plan, LLC (%)
Percent reporting that in the past 6 months personal doctor "usually" or "always" was informed and up to date about care received from specialists	2016	84 (n = 69,952)	83 (n = 4,130)	—	N/A	N/A	N/A	N/A	N/A	88 (n = 186)	N/A
	2017	87 (n = 103,052)	86 (n = 6,942)	84 (n = 1,088)	N/A	N/A	N/A	N/A	N/A	85 (n = 433)	N/A

— = data not available; MA = Medicare Advantage; MMP = Medicare-Medicaid Plan; N/A indicates that few beneficiaries responded to the question to allow reporting or the score had low reliability.

SOURCE: CAHPS data for 2016–2017.

Transportation Services

Many participants in 2016 expressed dissatisfaction with transportation services, including timeliness, reliability, and service area restrictions:

> They drop you off and say, "I'll be back to pick you up in an hour," and don't come back for another four or five hours.

> I've tried [to use the transportation service] but they stood me up every time… One time...they…dropped me off at the wrong place and left me.

However, most participants in 2017 agreed that transportation services were better than before the demonstration, though some said services were still not satisfactory. Participants said there were sometimes long waits for rides to appointments and for rides home.

Dental Care

State officials and advocates said that at least some ICOs had improved access to Medicaid dental services by contracting with more providers, and in some cases offering additional dental benefits. Despite these improvements, advocates said that dental care remains a major concern for enrollees because the Medicaid benefit is limited and does not cover root canals. Even some enrollees whose plans offered additional dental benefits said they had difficulty accessing needed dental care. For example, one focus group participant said, "They don't give up enough money for you to get your dentures…[You] wind up having to pay out [of] your pocket…They give me $1,000 for the whole plan for five years."

5.2.6 Person-centered Care and Patient Engagement

A majority of focus group participants in 2017 said they felt like part of a team and that their doctors were listening to their needs. Most respondents to the State's survey (88 percent) indicated they were "always" (68 percent) or "usually" (20 percent) involved as much as they wanted to be in decisions about their health care during the past 6 months (HSAG, 2017, pp. 6.1).

The demonstration has also sought to ensure that enrollees are engaged in development of their care plans (see ***Section 4.1.2, Care Planning Process***). In addition to discussing their physical, behavioral, functional, and social needs with care coordinators, enrollees may set personal goals. Some focus group participants discussed their goals:

> I…have goals with my team leader from [my plan]...They don't tell me the goals they want me to [pursue], but they ask me, "What [are] 10 goals that you want to accomplish?"

> [Getting physically stronger is] my goal…I want to be doing pushups by myself…. [The care coordinator]…had me in [physical] therapy, but I got fed up...I told her that [but] she said, "Stick it out."

5.2.7 Personal Health Outcomes and Quality of Life

Many focus group participants in 2016 and 2017 indicated that their health and well-being had improved as a result of care coordination, improved access to services, or good care provided by their doctors:

> …My knees are better. They don't hurt as much…I couldn't dance [before]. I love to dance. So I'm back doing those activities again, because [the health plan] sent me to physical therapy.

> … My health is getting better. Because [I have someone] calling and checking up on me and helping me with little things that I can't do—takes a big pressure off of [me].

5.2.8 Experience of Special Populations

This section summarizes the beneficiary experience for MI Health Link special populations, including individuals with LTSS, behavioral health needs, and racial and ethnic minorities.

Behavioral Health Services

State officials said in 2018 that coordination between physical health and behavioral health systems under the demonstration had helped enrollees with unmet needs obtain services. Officials said that the PIHPs' knowledge of behavioral health specialty services is an advantage in assessing enrollees' needs and making referrals to the appropriate mental health and substance use disorder services. Other State officials said that enrollees who have behavioral health hospitalizations are more likely to be connected with community behavioral health services under the demonstration, because Medicare and Medicaid behavioral health services are now integrated through the PIHPs. Improvements in dental services and transportation services are also helpful for persons with behavioral health needs, according to State officials.

State officials and PIHPs said persons with I/DD have been much less likely to participate in the demonstration than those with serious mental illness and substance use disorder. One PIHP explained that enrollees with I/DD already had PIHP service coordinators and did not see the need for ICO care coordination, and nearly all of them already had PCPs and saw them regularly. State officials said that I/DD caregivers, advocates, and providers were suspicious of managed care, which had contributed to opt-outs and disenrollment. However, State officials said in 2018 that some individuals had changed their minds and enrolled in the demonstration after previously opting out or disenrolling.

Long-term Services and Supports

The demonstration has experienced challenges with LTSS, particularly with delays in payments to State Plan personal care providers (see ***Section 2.2.4, Provider Arrangements and Services***) and delays in processing applications for HCBS waiver services (see ***Section 4.1.3, HCBS Waiver Coordination***). In 2016, some focus group participants said they were satisfied with their personal care services, or were receiving services for the first time, whereas others

were displeased because they had to change providers after enrolling. One participant said the following:

> When I got into the program [demonstration], a lot of things did change…My caregiver wasn't able to be my caregiver anymore. I had my…housekeeper for the last 12 years…I wanted that person [to continue as my caregiver].

Focus group participants in 2017 did not voice concerns about access to HCBS or needing to change providers. Many participants said they had been asked by care coordinators whether they needed home-delivered meals; and most said they had declined. Advocates said there had been significant improvement in continuity of care for personal care services, although there were still some problems.

Advocates expressed concern in 2018 about whether enrollees with pending HCBS waiver applications were receiving all of the HCBS they needed. ICOs said they are enabling waiver applicants to remain in the community by providing personal care and services such as home-delivered meals, personal emergency response systems, and respite care to enrollees whose HCBS waiver applications are pending. Two ICOs said they also provide supplemental HCBS to some enrollees who need supports to remain independent but do not yet meet the nursing facility level of care.

Racial and Ethnic Minorities

In 2016, some focus group participants said that some doctors had discriminated against them based on their race or ethnicity, particularly providers in the Detroit suburbs:

> …A Caucasian can walk in [to a doctor's office] and…[the staff's] body language is different. The whole feel is different…Everything is upbeat and smiling…I just came in here…and they barely wanted to acknowledge me…

> Sometimes when you're a black…woman and you stand before the foreign doctors, even white doctors, they don't listen to you. They treat you like they're refusing you medical care…Because you're a black woman…

Some participants in 2017 said they had experienced discrimination by providers, but they attributed it to their status as Medicaid beneficiaries, rather than to racial or ethnic discrimination.

5.2.9 Beneficiary Protections

This section describes the beneficiary protections available to demonstration enrollees and enrollees' awareness and use of those protections. It also includes a summary of grievance (complaint) and appeals data received from (1) data reported by MMPs on complaints made directly to them; (2) data reported on the CTM for complaints received by the Michigan Department of Health and Human Services and 1-800-Medicare; (3) information collected during site visit interviews; (4) data reported by the Independent Review Entity, which is a second-level review of appeals; and (5) qualitative information collected by the evaluation team. Reporting periods vary across these sources.

Enrollee Awareness of Beneficiary Rights

MI Health Link enrollees have a right to make complaints and appeal adverse decisions by their plans, and ombudsman services are available to assist enrollees with filing complaints and appeals. Michigan contracted with two legal services programs, the Michigan Elder Justice Initiative (MEJI) and Counsel and Advocacy Law Line (CALL), to operate the MI Health Link Ombudsman (MHLO) program (MI Health Link Ombudsman, n.d.). MHLO staff said they are often able to resolve complaints quickly through three-way calls between the enrollee, the ICO, and the MHLO program, as most of the plans were very responsive. A State official said it was helpful to have an independent ombudsman program: "The fact that they're external to the department gives them a great deal of credibility with enrollees."

Some focus group participants in 2017 said they had submitted complaints to their plans, typically about providers and services. Very few participants were familiar with the ombudsman program; those who had heard the term ombudsman were not able to explain its purpose. However, participants said they contacted various people and entities for assistance accessing services, including their ICOs' member services departments, care coordinators, providers, social workers, and other advocates. It was not clear how many of their complaints were handled as grievances, but participants seemed to feel their complaints had been resolved.

Grievances

Grievances (complaints) are handled at the ICO level. ICOs are required to provide timely acknowledgment, review, and responses to enrollee grievances, and ensure that individuals who make decisions on grievances were not involved in previous levels of review and decision making (Michigan three-way contract, 2018, pp. 133–34). ICOs are required to report to CMS and the State any grievances filed by an enrollee and how the plan addressed them.

There was no consistent trend in the number of ICO-reported grievances over the course of the demonstration. The rate of grievances fluctuated but remained relatively low, ranging from 4.3 to 32.6 grievances per 1,000 enrollees. The greatest number of complaints reported through December 2017 were related to enrollment and disenrollment, followed by benefits, access, and quality of care. Complaints in other categories were minimal.

The MHLO program said in early 2018 that the most common complaints at that time involved difficulties contacting care coordinators and limited dental benefits. Complaints were also received about personal care provider payments and hours, transportation services, inappropriate billing, passive enrollment, and prior authorization.

Early in the demonstration, transportation was a major topic of complaint. State officials said that each month the CMT discussed complaints with each of the plans, and felt that this attention had spurred ICOs to make changes that resulted in improved services (see ***Section 2.1, Joint Management of the Demonstration***). These changes included increased monitoring, corrective action plans, and in some cases, contracts with new vendors. Although complaints continued, there was broad agreement among stakeholders that most ICOs had improved their services.

Although most of the ICOs were very responsive and quick to resolve complaints, according to MHLO staff, one plan did not respond to messages for "days or weeks," and took even longer to resolve complaints. To address this particular issue, the State asked MHLO to enter complaints about this ICO in the CTM, which allows the contract manager to monitor the plan's handling of grievances submitted through the ombudsman. Except for some complaints related to this particular ICO, MHLO reported beneficiary complaint data to Michigan Department of Health and Human Services (MDHHS) and the Administration for Community Living (ACL), but were not entered into the CTM.

Appeals

Michigan and CMS took several steps to align Medicare and Medicaid appeals processes. An integrated denial notice was developed that allows ICOs to indicate whether a denial of service is based on Medicaid policy, Medicare policy, or whether there is overlapping coverage that would allow the enrollee to appeal through either Medicare or Medicaid. The demonstration also adjusted appeal timelines to have consistency between Medicare and Medicaid.

Appeals for Medicare Part A and B and Medicaid services must be submitted first to enrollees' ICOs.[18] If a Medicaid appeal to the plan is not resolved in an enrollee's favor, the Michigan Patient's Right to Independent Review Act (PRIRA) allows enrollees to appeal adverse decisions to an external review process through the Michigan Department of Insurance and Financial Services. Enrollees can also file a request for fair hearing with the Michigan Administrative Hearings Service (MAHS), either concurrently or after the external review process. Appeals related to Medicare must first be processed by the ICO, and then can be externally appealed to the CMS Medicare Independent Review Entity (IRE).

The rate of Medicare appeals was relatively low through 2017, ranging from 0.1 to 10.9 appeals per 1,000 enrollees. The total number of appeals reported to the IRE for the demonstration for 2015, 2016, and 2017 was 732, of which 520 (71.0 percent) were upheld, 149 (20.4 percent) were dismissed, and 54 (7.4 percent) were overturned in favor of beneficiaries. The most common category of appeals referred to the IRE was ground transportation.

State officials said that during the first year of the demonstration, many requests for Medicaid fair hearings were withdrawn or dismissed because they involved delays in payments to personal care providers rather than service denials. The MHLO program said some enrollees did not receive denials when their ICOs approved fewer hours of personal care services than they requested. After an enrollee won a Medicaid appeal on that issue, the State provided guidance to the plans instructing them to issue denial notices when they approved fewer hours of services than requested.

[18] Prior to 2018, enrollees were able to request a Medicaid fair hearing "in lieu of, prior to, concurrently, or after" their appeal to the plan, but that provision was changed to comply with the Medicaid managed care rule when the three-way contract was amended, effective January 1, 2018 (Michigan three-way contract, 2018, p. 146; CMS, n.d.).

Critical Incidents and Abuse

Michigan plans are required to submit to NORC the number of critical incidents and abuse reports received each quarter.[19] Over the course of demonstration, the number of critical incidents and abuse reports has varied but has remained relatively low, ranging from 0.48 to 6.82 incidents per 1,000 members receiving LTSS.

[19] Definitions of critical incidents and ICO reporting requirements are stated in the Minimum Operating Standards for MI Health Link Program and MI Health Link Waiver (MDHHS, 2018, pp. 33–8).

6. Stakeholder Engagement

Highlights

- Michigan launched the design phase of the demonstration in 2011 with extensive stakeholder engagement. Stakeholders credited the State with incorporating their feedback into the design of MI Health Link, including a person-centered approach and a strong role for the PIHPs.
- Michigan continued to actively engage stakeholders during the implementation and operational phases. The State engaged ICOs and PIHPs through monthly operational meetings, and advocates through the Outreach, Education and Communications Work Group.
- The State met with provider groups and held webinars to inform providers about MI Health Link. Also, the State worked with 10 provider associations to plan and convene a provider summit in 2016 attended by more than 300 people.
- Ongoing engagement of enrollees was slower to develop, but a robust level of engagement was achieved when the State launched the MI Health Link Advisory Committee in 2017. Regional meetings are used to facilitate enrollee participation, and enrollees dominate the meetings.
- The State and advocates held local Lunch and Learn events in each region to educate enrollees and demonstration eligible beneficiaries about the demonstration.

6.1 Overview

This section describes the approach taken by Michigan for engaging stakeholders, the mechanisms for soliciting stakeholder feedback, and the impact of those efforts on the demonstration.

6.2 Organization and Support

6.2.1 State Role and Approach

Michigan actively engaged a wide range of stakeholders throughout the design, implementation, and operational phases of the demonstration. The State has emphasized engagement of enrollees and advocates, and developed a structure that provides enrollees with opportunities to express their concerns without being overshadowed by providers and advocates.

Michigan launched the design phase in 2011 with extensive stakeholder engagement that included a series of 30 stakeholder interviews with individuals knowledgeable about the current delivery system, and entities likely to be affected by the MI Health Link demonstration. Concurrent with the interviews, the State held six regional public forums to introduce the basic concept for the demonstration and conduct facilitated discussions about ways to improve the

existing system. More than 1,000 people participated in the forums, including many Medicare-Medicaid enrollees and advocates. As a result of the strong participation in the regional forums, the State added a Request for Input (RFI) to its stakeholder engagement plan. An online survey tool was used to solicit feedback on the demonstration design concept, and the State received responses from over 600 people and organizations. Later in 2011, the State convened four large stakeholder work groups to provide feedback on key areas of the demonstration design (Proposal, 2012, pp. 19–20).

Many stakeholders, including advocates and PIHPs, noted in 2015 that the State adapted plans for the demonstration to take stakeholder feedback into account, notably that MI Health Link have person-centeredness as a central tenet. State officials said they had fully adopted this outlook and appreciated strong engagement from stakeholders. Stakeholders also emphasized the need for a strong role for the State's regional PIHPs, which had a long history of providing behavioral health services to persons with serious mental illness.

During the implementation phase, the State used several structures for ongoing engagement of stakeholders. The State holds monthly operational meetings with the ICOs and PIHPs, and convened work groups of ICO and PIHP representatives to resolve several issues related to behavioral health integration. These collaborations resulted in the process for using the MiHIN health information exchange for behavioral health referrals, and development of a coordination of benefits matrix for Medicare behavioral health services.

The State worked closely with advocates as well. During the early implementation phase, State officials met weekly with the Outreach, Education and Communications work group, comprised of advocates. The work group provided feedback on a range of implementation-related topics. State officials also interacted with the Olmstead Work Group. CMS members of the CMT said they also meet with advocates each month.

The State engaged providers through webinars and meetings with provider associations during the design and implementation phases. Despite those efforts, issues with delayed provider payments and confusion about which payer to bill led to provider relations challenges. State officials said that even after payment issues were resolved and processes improved it was difficult to regain the trust of some providers, and other providers did not have a good understanding or lacked awareness of MI Health Link.

In an effort to improve provider participation and awareness in MI Health Link, the State convened a provider summit in November 2016. State officials worked with 10 different provider associations to plan and promote the summit, including associations representing for-profit and nonprofit long-term care facilities, hospitals, federally qualified health centers, and behavioral health providers. More than 300 people attended the event.

6.2.2 MI Health Link Advisory Committee

Michigan organized the MI Health Link Advisory Committee along regional lines, to facilitate participation by enrollees in all four regions and reduce costs for the State. There are actually three committees—one in the Upper Peninsula, one in Southwest Michigan, and one in Southeast Michigan (Macomb and Wayne Counties). The membership is divided between enrollees and provider representatives, but State officials said that most providers do not attend

so meetings are dominated by enrollees. Advocates organize and facilitate the meetings but do not serve as committee members. Topics discussed at committee meetings have included problems with service providers, dental benefits, and HCBS caregiver hours. Members have also provided feedback to the state on beneficiary notices and survey questions (RTI International, SDRS, 2017).

State officials said their initial efforts to recruit beneficiaries for the committee met with a poor response, but after the application form was shortened to one page, several hundred enrollees applied. State officials said they modeled their recruitment mailing on similar materials used by the South Carolina demonstration under the Financial Alignment Initiative. The committee held its first regional meetings in 2017, with two meetings in one region, and one meeting in the other two regions.

6.2.3 Lunch and Learn events

In addition to the advisory committee meetings, Michigan held a series of well-attended local Lunch and Learn events for MI Health Link enrollees and demonstration eligible beneficiaries in communities throughout the four regions. Although these events were designed to provide information to enrollees and beneficiaries, they also provided an opportunity for State officials, ICOs, and advocates to obtain feedback from enrollees and interested beneficiaries about their experiences with and perceptions of the demonstration. Eleven Lunch and Learn events were held during 2016 and 2017, and these events continued into 2018. The events were organized and facilitated by advocacy organizations that had outreach and education contracts for the demonstration (RTI International, SDRS, 2017).

State officials said the Lunch and Learn events were an effective outreach method because they mailed invitations only to MI Health Link enrollees and demonstration eligible beneficiaries in select ZIP codes near the event site. Transportation was provided, a simple lunch was served, and interpreters were arranged if requested. The agenda for the events included an overview of demonstration features, and short presentations on various topics such as care coordination, the ombudsman program, and enrollment processes. The events also included table discussions among beneficiaries and staff from the various agencies.

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7. Financing and Payment

Highlights

- Risk corridor payments for demonstration year 1 were still being assessed during 2018, and no other data on the plans' financial performance was available; therefore, the RTI evaluation team is unable to report on how well Integrated Care Organizations are performing financially.
- ICOs expressed concern that the Medicaid capitated rates do not reflect the cost of serving the population, particularly the costs of personal care services and new requirements for care coordination.
- Plans received 61 percent of their quality withholds for calendar year 2015 and 86 percent for calendar year 2016.
- The financial arrangements between the ICOs and PIHPs have been challenging, particularly for the PIHPs. PIHPs reported concerns regarding late payments by ICOs and challenges reconciling payments.

7.1 Rate Methodology

All Medicare services and most Medicaid services are financed by capitated payments to the ICOs; Medicaid behavioral health services are financed separately as discussed below. The Medicare and Medicaid contributions represent baseline spending, or the estimated costs if the demonstration had not been implemented. Capitation payments are risk adjusted, using separate methodologies for Medicare Parts A and B, Medicare Part D, and the Medicaid components of the rate. The demonstration savings rate is applied to baseline spending. This section describes the rate methodology of the demonstration and findings relevant to early implementation.

The State and CMS contribute to a capitated monthly payment to the ICOs. The Medicare and Medicaid contributions represent a function of spending during the 2-year predemonstration period to approximate enrollee costs had the demonstration not been implemented. Three payments are made monthly for each enrollee to the ICO and include one amount from CMS for Medicare Parts A and B services, one amount from CMS for Part D services, and a third amount from MDHHS reflecting Medicaid services. The Medicaid portion of the capitated payment is separated into tiers in which the rate varies by level of LTSS need, age, and region. A savings percentage is applied to the Medicare Parts A and B and Medicaid rate components. For behavioral health services, MDHHS pays the Medicaid component of the rate on a capitated basis directly to the PIHPs. The Medicare portion of the rate for members enrolled in PIHPs is paid by the ICOs to the PIHPs on a capitated basis. The savings percentage is not applied to the Medicaid portion of the PIHP payment.

This section describes the rate methodology of the demonstration and findings relevant to early implementation.

7.1.1 Rating Categories and Risk Adjustments

Each component of the rates is adjusted to reflect risk. The Medicare Parts A/B component of the payment to the ICOs is risk-adjusted using the CMS Hierarchical Condition Category (HCC) and the CMS-HCC end-stage renal disease (ESRD) risk adjustment models. The Medicare Part D rates is the national average monthly bid amount (NAMBA) risk-adjusted using the Part D RxHCC methodology. CMS also estimates the average monthly prospective amounts for the low-income cost sharing subsidy and Federal re-insurance; these payments are not risk-adjusted (Michigan three-way contract, 2018, p. 208-9).

The Medicaid component is risk-adjusted through the use of four enrollment categories that reflect the enrollees' expected level of care: community, two subtiers of nursing facility care, and nursing facility level of care provided as a waiver service. The nursing facility population is split into privately owned (Subtier A) and publicly owned (Subtier B) nursing facilities. ***Table 12*** presents the risk-adjusted Medicaid rate cell structure. These rates are also adjusted by age and region.

Table 12
Rate cell Medicaid payments per member per month, demonstration year 1 and demonstration year 2

Rate cell	Medicaid rate calendar year 2015	Medicaid rate calendar year 2016	Medicaid rate calendar year 2017
Tier 1 NF: subtier A			
Age 65 and older	$5,907.39	$6,006.08	$6,139.18
Under age 65	$4,845.02	$5,207.17	$5,442.71
Tier 1 NF: subtier B			
Age 65 and older	$8,504.70	$9,158.64	$9,841.41
Under age 65	$8,710.76	$9,254.62	$9,579.56
Tier 2 NF LOC: waiver			
Age 65 and older	$2,059.64	$2,229.41	$2,147.89
Under age 65	$3,139.47	$2,771.22	$2,752.78
Tier 3 community residents			
Age 65 and older	$160.66	$141.93	$146.29
Under age 65	$120.71	$121.08	$120.23
Transition case rate	$1,475.00	—	—

— = data not available; LOC = level of care; NF = nursing facility.

NOTE: Milliman developed the Medicaid rates for the Michigan demonstration.

SOURCES: Milliman, 2015; Milliman, 2016; Milliman 2017.

7.1.2 Savings Percentage

The aggregate savings percentage is applied to the Medicare Parts A/B and to the Medicaid components of the monthly rate, but not to the Medicaid portion of the PIHP payment or the Medicare Part D component of the rate (Michigan three-way contract, 2014, p. 170). These payments are based on what CMS and MDHHS expect to be a reasonable amount of savings achieved by the plans over the course of the demonstration year, relative to the cost of Medicare and Medicaid service delivery in the absence of the demonstration. The aggregate savings percentage was 1 percent for demonstration year 1, 2 percent for year 2. A 4 percent rate was planned for years 3, 4, and 5 (see ***Table 13***). However, the aggregate savings percentage will be adjusted to 3 percent for the final 3 years if more than one-third of the plans experienced a revenue loss greater than 3 percent for demonstration year 1 (Michigan three-way contract, 2013, p. 170). State officials said in mid-2018 that the 2018 savings percentage, and thus the 2018 capitation, rates had not been finalized pending analysis of ICO financial performance in demonstration year, which could affect the savings percentage.

Table 13
Savings percentages by demonstration year

Demonstration year	Coverage period	Savings percentage (%)
Year 1	March 1, 2015–December 31, 2016	1
Year 2	January 1, 2017–December 31, 2017	2
Year 3	January 1, 2018–December 31, 2018	4
Year 4	January 1, 2019–December 31, 2019	4
Year 5	January 1, 2020–December 31, 2020	4

SOURCE: Michigan three-way contract, 2014.

7.1.3 Performance Incentives

Quality Withholds

CMS and the State withhold a percentage of payment that ICOs are able to earn back based on performance on specific quality measures. In demonstration year 1 (March 2015–December 2016), CMS and the State withheld 1 percent of the Medicare A/B and Medicaid components of the payment, but not the Medicare Part D component. The quality withhold was 1 percent for demonstration year 1, 2 percent for demonstration year 2, and 4 percent in demonstration years 3, 4, and 5. (Michigan three-way contract, 2018, pp. 207-8).

ICO performance on the quality withhold measures in calendar year 2015 and calendar year 2016 was mixed (see ***Section 9.1, Quality Measures***). ICOs received, on average, 61 percent of the withheld amount in calendar year 2015. For calendar year 2016, four out of seven ICOs received 100 percent of the withhold amount; overall, the plans received an average of 86 percent (CMS, 2018).

Rebalancing Incentives

Michigan introduced two incentives to encourage a rebalancing away from facility-based LTSS toward community-based LTSS. First, when members enter nursing facilities, the ICOs receive the lower Tier 3 Medicaid community rate for the first 3 months before they begin receiving the higher Tier 1 nursing facility rate, which provides a disincentive for nursing facility placement. The second incentive supports transitions from nursing facilities to the community by paying the ICOs a transition case rate for members who are transitioned after they have spent at least 3 months in a nursing facility.[20]

7.1.4 Risk Mitigation

Risk Corridors

MDHHS established risk corridors for ICOs during the first demonstration year, but they will not be applied to demonstration years 2 and 3. The risk corridors are applicable to Medicare Parts A/B and Medicaid costs, but not Medicare Part D costs. ***Table 14*** illustrates the bands at which the ICOs are subject to the gain/losses in the first demonstration year.

Table 14
Risk corridor tiers

Percentage of loss or gain	ICO share	Medicare share	MDHHS share
≤ 3	100%	0%	0%
> 3 and ≤ 9	50%	Percent based on Medicare share of combined capitation payments, excluding Part D, with a 2% maximum Medicare payment/recoupment of the risk-adjusted Medicare capitated payment	Percentage based on Medicaid share of combined capitation payments, excluding Part D, subject to the Federal Medical Assistance Percentage
> 9	100%	0%	0%

ICO = Integrated Care Organization; MDHHS = Michigan Department of Health and Human Services.

SOURCE: Michigan three-way contract, 2014.

Results from the risk corridor program for demonstration year 1 were not available when this report was written. State officials indicated that the analysis took longer than expected in part due to reconciling the level of care for some enrollees, resulting in adjustments to the tier-based Medicaid capitation payments.

Medical Loss Ratio

ICOs are required to meet a target Medical Loss Ratio (MLR) of 85 percent beginning in demonstration year 2. This percentage is the minimum revenue that must be used on expenses directly from medical claims or care coordination. The numerator of the MLR includes all

[20] The transition case rate is a one-time "kicker payment" of $1,475, rather than a change in the capitation payment. The ICO must provide transition services to the enrollee to receive the transition case rate (Michigan three-way contract, 2014, p. 183).

covered services required by the demonstration, any services consistent with the objectives of the demonstration, and coordination personnel costs. The denominator includes the capitated payment amount for services delivered during the coverage year. If the MLR is calculated as falling below the 85 percent threshold, then the ICO is required to reimburse the State and CMS an amount equal to the difference between the calculated MLR and 85 percent, multiplied by the coverage year revenue (MOU, 2014, p. 55). The payment amount to CMS and the State will be proportional between each component (Michigan three-way contract, 2014, p. 173).

7.2 Financial Impact

7.2.1 Early Implementation Experience

Since early in the demonstration, ICOs have expressed concern about costs that are higher than anticipated, particularly for care coordination and personal care services. ICOs considered the requirements for in-person care planning meetings and signatures on care plans to be burdensome and costly. They said the Medicaid capitation rates for community residents were inadequate because personal care services were being utilized at a higher rate than anticipated, and they were held to a higher standard than the State's own county offices. One plan said the average cost of personal care services was $1,200 per month, compared to the community capitation rate of only $160 per month (see ***Table 14***).[21]

There is no definitive evidence at the time of this report as to how the ICOs were performing financially. The risk corridor analysis and more general analysis of plan financial experience was in progress in December 2018, and as a result the 2018 capitation rates had not been set. The ICOs' financial performance could impact the demonstration year 3 savings percentage, which will be reduced if at least three ICOs experienced a loss exceeding 3 percent of revenue in demonstration year 1.

Financing of behavioral health services remained a challenge, with PIHPs reporting concerns in 2018 about delayed payments from the ICOs. A PIHP said it had not been paid by one ICO for a year; other ICOs were also behind or paying sporadically. PIHPs also noted challenges in reconciling payments for previous years, due to discrepancies in enrollment data and challenges in getting encounters for Medicare services accepted by the ICOs (see ***Section 2.1.2, Integration of Behavioral Health Services***). ICOs said they were making timely payments to the PIHPs, and one ICO noted that it had not had any problems with PIHP payments.

7.2.2 Cost Experience

ICO officials reported anecdotally that they had seen some declines in hospitalizations, length of stay, and readmissions, but whether this will result in net savings over time is unclear. An ICO official said that achieving savings from care coordination will take time. PIHP officials noted that some cost savings could result from coordination of behavioral health services. State officials noted that at least one reason for ICOs to remain in the demonstration is the expectation that over time, savings will be achieved through reduced acute services and institutional long-term care.

[21] Enrollees in the waiver also use State Plan personal care services, and the waiver capitation is much higher.

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8. Service Utilization

Highlights

- As measured across all eligible beneficiaries, the demonstration resulted in a 13.9 percent reduction in the probability of inpatient admission, a 17.8 percent reduction in monthly preventable emergency room visits, a 12.8 percent reduction in the probability of overall ambulatory care sensitive condition admission, and a 13.8 percent reduction in the probability of chronic ambulatory care sensitive condition admission.
- Although these relative percentage changes may seem large, they are based on small changes (less than 1 percentage point) in the monthly counts or probabilities of service use. Because utilization of these services is typically infrequent, absolute changes in monthly service use are smaller than the relative differences imply.
- For eligible beneficiaries with long-term services and supports use and for those with serious and persistent mental illness, difference-in-differences results on the probability of inpatient admission, preventable emergency room visits, and the probability of ambulatory care sensitive condition admission (overall and chronic) aligned with the results for all eligible beneficiaries, with only one exception.

The purpose of the analyses in this section is to understand the effects of the MI Health Link demonstration through demonstration year 1 (through calendar year 2016) using difference-in-difference (DinD) regression analyses that control for differences in health and other factors between the demonstration and comparison groups. The results of this analysis represent impact estimates of the demonstration on all demonstration eligible beneficiaries—not just those enrolled in a Medicare-Medicaid Plan (MMP). In addition, descriptive statistics on service utilization are provided for selected Medicare services in ***Appendix C***. Utilization data were analyzed for only five of the seven Medicare-Medicaid Plans (MMPs) in MI Health Link; HAP Midwest and Molina encounters were not included or analyzed because the RTI evaluation team deemed them incomplete.

Table 15 presents an overview of the results from impact analyses using Medicare and Minimum Data Set (MDS) data through demonstration year 1. The relative direction of all statistically significant results at the $p < 0.10$ significance level (derived from 90 percent confidence intervals) is shown.

The Michigan demonstration had a statistically significant effect on seven utilization and quality of care outcomes through demonstration year 1. The probability of an inpatient admission, overall and chronic ambulatory care sensitive condition (ACSC) admission, an emergency room (ER) visit, monthly preventable ER visits, and monthly physician evaluation and management (E&M) visits decreased for the demonstration group compared to the comparison group. The probability of any long-stay (101 days or more in a year) nursing facility

(NF) use, however, increased. There was no statistically significant difference between the demonstration and comparison groups in all-cause 30-day readmissions or the probability of a 30-day follow-up visit after mental health discharge.

Most impact estimates for the population receiving long-term services and supports (LTSS) and for persons with serious and persistent mental illness (SPMI) were in the same direction and of a similar magnitude as those for all demonstration eligible beneficiaries. One exception was the estimated impact on physician E&M visits, as it was not statistically significant for the LTSS population. The demonstration's impact on the probability of skilled nursing facility (SNF) admission was not estimated because the RTI evaluation team deemed the encounter data for this service to be incomplete.

Table 15
Summary of Michigan demonstration impact estimates for demonstration period March 1, 2015–December 31, 2016
($p < 0.10$ significance level)

Measure	All demonstration eligible beneficiaries	Demonstration eligible beneficiaries with LTSS use	Demonstration eligible beneficiaries with SPMI
Probability of inpatient admission	Decreased	Decreased	Decreased
Probability of ambulatory care sensitive condition (ACSC) admission, overall	Decreased	Decreased	Decreased
Probability of ACSC admission, chronic	Decreased	Decreased	Decreased
All-cause 30-day readmissions	NS	NS	NS
Probability of emergency room (ER) visit	Decreased	Decreased	Decreased
Preventable ER visits	Decreased	Decreased	Decreased
Probability of 30-day follow-up after mental health discharge	NS	NS	NS
Probability of any long-stay NF use	Increased	N/A	N/A
Physician evaluation and management visits	Decreased	NS	Decreased

LTSS = long-term services and supports; N/A = not applicable because this measure is only calculated for the total eligible population at risk of any long-stay nursing facility use; NF = nursing facility; NS = not statistically significant; SPMI = serious and persistent mental illness.

SOURCE: RTI analysis of Medicare and Minimum Data Set data.

8.1 Overview of Plan Benefits and Services

Under MI Health Link, eligible beneficiaries enroll in Integrated Care Organizations (ICOs) that cover Medicare and Medicaid services with no deductibles or co-payments. The ICOs cover HCBS through a new 1915(c) waiver and supplemental HCBS services, which plans may authorize for enrollees whose waiver applications are pending. The ICOs also provide care coordination and flexible benefits, which vary by plan. Michigan retained the existing carve-out structure for delivering Medicaid behavioral health services, which relies on Prepaid Inpatient Health Plans (PIHPs), rather than the ICOs, to manage mental health and substance use disorder

(SUD) services and the HCBS waiver for persons with intellectual and developmental disabilities (I/DD).

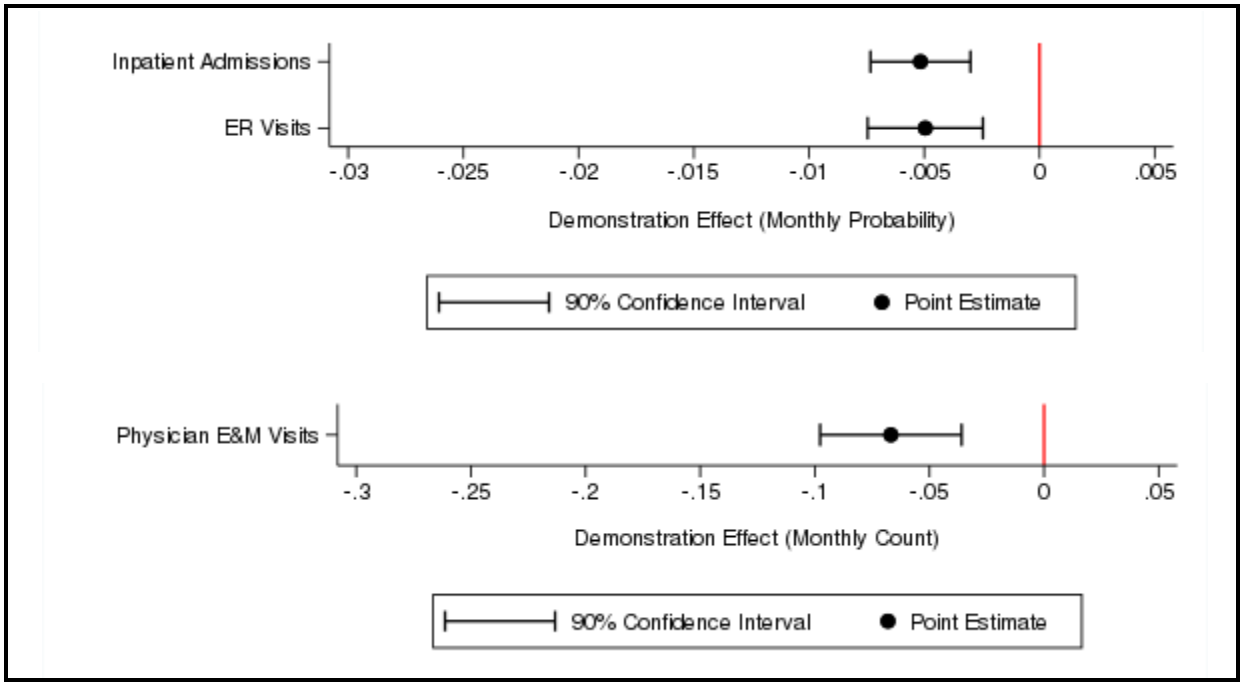
8.2 Impact Analyses on the Demonstration Eligible Population

The population analyzed in this section includes all beneficiaries who met demonstration eligibility criteria in Michigan or in the comparison areas for Michigan. For context, in Michigan, approximately 37 percent of eligible beneficiaries in demonstration year 1 whose utilization was analyzed were enrolled in the MI Health Link demonstration. ***Appendix A*** provides a description of the comparison group for Michigan and discusses how propensity scores were estimated and used to weight the comparison group. Please see ***Section 3.2*** for details on demonstration eligibility. Subsections following this section present the results for demonstration eligible beneficiaries with any use of LTSS (defined as receipt of any institutional-based services or home and community-based services [HCBS]) and for demonstration eligible beneficiaries with SPMI.

Appendix B contains a description of the evaluation design, the comparison group identification methodology, data used, measure definitions, and regression methodology used in estimating demonstration impacts using a DinD approach. The regression methodology accounts for differences between the demonstration and comparison groups over the predemonstration period (March 1, 2013–February 28, 2015) and the demonstration period (March 1, 2015–December 31, 2016) to provide estimates of demonstration impact.

Figures 1 and ***2*** display the Michigan demonstration's effect on key service utilization measures for the demonstration group relative to the comparison group through demonstration year 1. The demonstration decreased the probability of any inpatient admission by 0.52 percentage points (90 percent CI: –0.73, –0.30), decreased the probability of any ER visits by 0.50 percentage points (90 percent CI: –0.75, –0.25), and decreased the number of monthly physician E&M visits by 0.0668 visits (90 percent CI: –0.0977, –0.0360). However, the demonstration resulted in a 0.94 percentage point increase (90 percent CI: 0.62, 1.27) in the probability of any long-stay NF use during the first demonstration year.

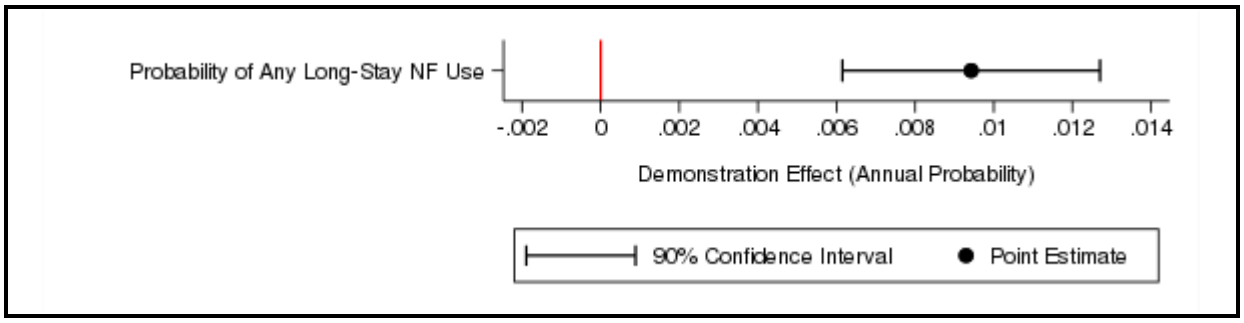
Figure 1
Demonstration effects on service utilization for eligible beneficiaries in Michigan—Difference-in-differences regression results for the demonstration period March 1, 2015–December 31, 2016
(90 percent confidence intervals)



E&M = evaluation and management; ER = emergency room.

SOURCE: RTI International analysis of Medicare data.

Figure 2
Demonstration effects on long-stay nursing facility use for eligible beneficiaries in Michigan—Difference-in-differences regression results for the demonstration period March 1, 2015–December 31, 2016
(90 percent confidence intervals)



NF = nursing facility.

SOURCE: RTI International analysis of Minimum Data Set data.

Table 16 provides estimates of the regression-adjusted mean values of the utilization measures for the demonstration and comparison groups for the predemonstration and demonstration periods for each service. The purpose of this table is to understand the magnitude of the DinD estimate relative to the adjusted mean outcome value in each period. The values in the third and fourth columns represent the postregression, mean-predicted value of the outcomes for each group in each period, based on the composition of a reference population (the comparison group in the demonstration period). These values show how different the two groups were in each period as well as the relative direction of any potential effect in each group over time. In addition to the graphic representation above, the DinD estimate is also provided, along with the *p*-value and the relative percent change of the DinD estimate compared to an average mean use rate for the comparison group during the first demonstration period.

Table 16
Adjusted means and impact estimate for eligible beneficiaries in the demonstration and comparison groups in Michigan through December 31, 2016

Measure	Group	Adjusted mean for predemonstration period	Adjusted mean for demonstration period	Relative difference (%)	Regression-adjusted difference-in-differences (90% confidence interval)	*p*-value
Probability of inpatient admission	Demonstration group	0.0373	0.0313	−13.9	−0.0052	< 0.0001
	Comparison group	0.0390	0.0373		(−0.0073, −0.0030)	
Probability of ER visit	Demonstration group	0.0677	0.0683	−7.0	−0.0050	0.0011
	Comparison group	0.0657	0.0710		(−0.0075, −0.0025)	
Number of physician E&M visits	Demonstration group	1.0173	0.9674	−6.9	−0.0668	0.0004
	Comparison group	0.9680	0.9746		(−0.0977, −0.0360)	
Probability of any new long-stay NF use	Demonstration group	0.1356	0.1125	9.5	0.0094	< 0.0001
	Comparison group	0.1305	0.0994		(0.0062, 0.0127)	

E&M = evaluation and management; ER = emergency room; NF = nursing facility.

NOTE: Even though the comparison group was carefully developed to have similar characteristics to the demonstration group, there are always slight differences in demographic, health, and area characteristics between the demonstration and comparison groups. The two types of results reported in this table take these differences into account, but use different statistical methods to do so. Before calculating the mean values reported in the third and fourth columns in this table, RTI adjusted the composition of the demonstration's baseline and demonstration period groups and the comparison baseline period group to match the characteristics of the comparison group in the demonstration period so that the means do not reflect any differences in the groups' characteristics. The regression DinD approach, results reported in the sixth column of this table, controls for these differences automatically, without changing the underlying characteristics of the demonstration and comparison groups. Because of these differing methods, the difference-in-differences results obtained from the regression may differ slightly from a similar calculation using the results in the adjusted mean columns. The relative percentage difference in the fifth column is calculated by dividing the difference-in-differences value in column 6 by the value for the comparison group in the demonstration period in column 4.

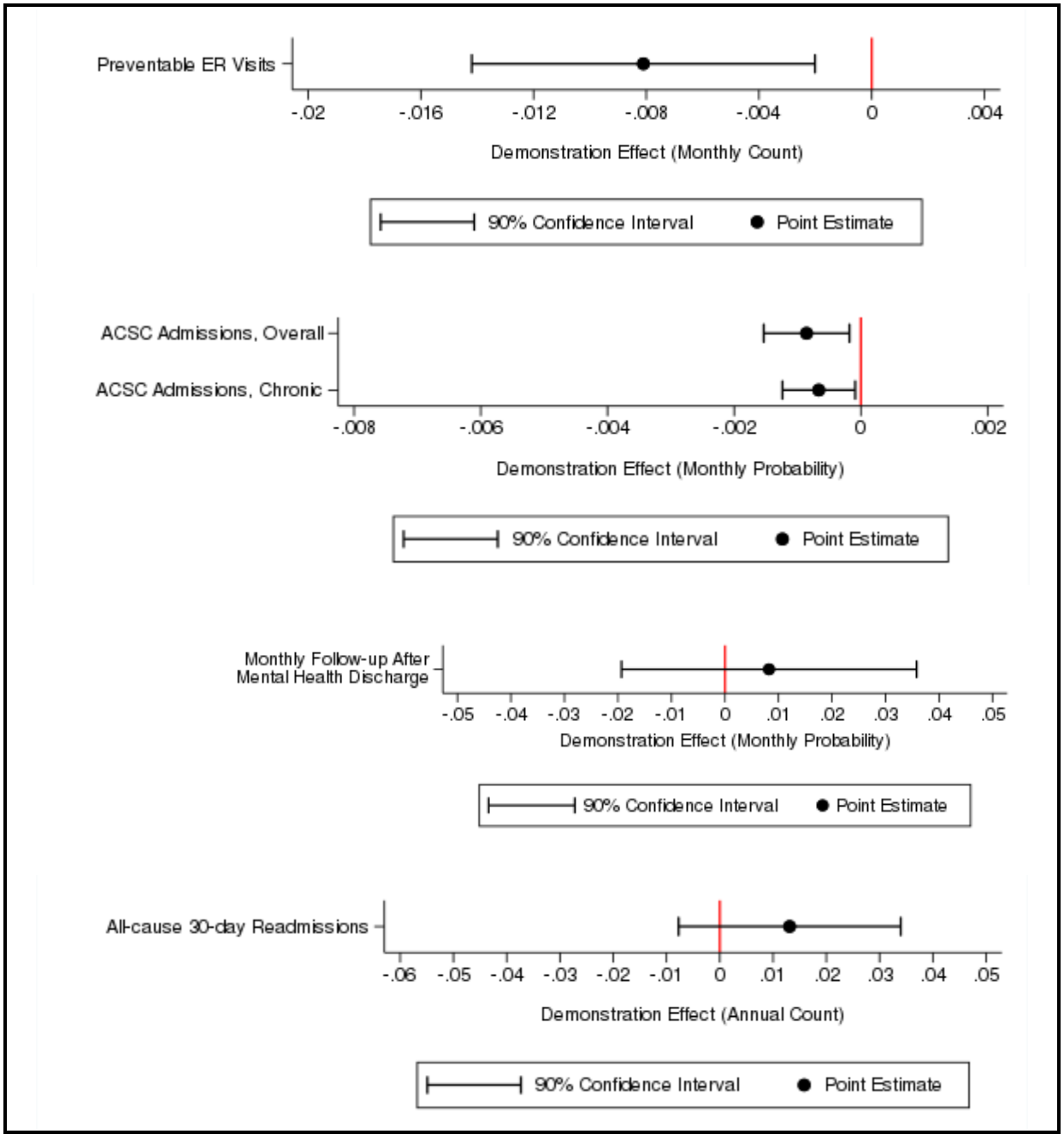
SOURCE: RTI International analysis of Medicare and Minimum Data Set data.

To interpret the adjusted mean values in the third and fourth columns, for example, the adjusted mean of monthly inpatient admissions was lower for the demonstration group than for the comparison group in both the predemonstration period and demonstration period. Alternatively, the adjusted mean of the probability of monthly ER visits was higher for the demonstration group than for the comparison group in the predemonstration period but was lower relative to the comparison group in the demonstration period.

The size of the demonstration's effect on medical service utilization as well as statistics on the level of utilization before and after the demonstration, taken together, are presented to demonstrate the size of the demonstration's effects in both absolute and relative terms. For example, in ***Table 16***, during the demonstration period, 3.73 percent of the comparison group had an inpatient admission in a given month (column 4). The demonstration decreased the probability of an inpatient admission by 0.52 percentage points (column 6), which in relative terms represents a 13.9 percent decrease (0.52/3.73, column 5) in the probability of any inpatient admission. Because utilization of these services is typically infrequent, absolute changes in monthly service use are smaller than the relative differences imply.

Figure 3 displays the Michigan demonstration's effects on RTI quality of care and care coordination measures for the demonstration group relative to the comparison group through demonstration year 1. The demonstration decreased monthly preventable ER visits by 0.0081 visits (90 percent CI: −0.0142, −0.0020). The demonstration also resulted in a 0.09 percentage point decrease (90 percent CI: −0.15, −0.02) in the probability of an overall ACSC admission and a 0.07 percentage point decrease (90 percent CI: −0.12, −0.01) in the probability of a chronic ACSC admission. There was no statistically significant demonstration effect on the probability of a 30-day follow-up visit after mental health discharge or all-cause 30-day readmissions through demonstration year 1.

Figure 3
Demonstration effects on RTI quality of care measures for eligible beneficiaries in Michigan—Difference-in-differences regression results for the demonstration period, March 1, 2015–December 31, 2016
(90 percent confidence intervals)



ACSC = ambulatory care sensitive condition; ER = emergency room.

SOURCE: RTI International analysis of Medicare data.

Table 16 provides estimates for the regression-adjusted mean value for each of the demonstration and comparison groups for the predemonstration and demonstration periods for the RTI quality of care and care coordination measures. The purpose of this table is to understand the magnitude of the DinD estimates for quality of care outcomes relative to the adjusted mean values in each period. The values in the third and fourth column represent the postregression, mean-predicted value of the outcomes for each group in each period, based on the composition of a reference population (the comparison group in the demonstration period). These values show how different the two groups were in each period and the relative direction of any potential effect in each group over time. In addition to the graphic representation in ***Figure 3***, the DinD estimate is also provided for reference, along with the *p*-value and the relative percent change of the DinD estimate compared to an average mean use rate for the comparison group during the first demonstration year.

To interpret the adjusted mean values in the third and fourth columns, as an example, the adjusted mean of preventable ER visits was higher for the demonstration group than for the comparison group in the predemonstration period but was lower relative to the comparison group in the demonstration period. The size of the demonstration's effect on measures as well as statistics on the level of quality of care before and after the demonstration, taken together, are presented to demonstrate the size of the demonstration's effects in both absolute and relative terms. For example, in ***Table 17***, during the demonstration period, the comparison group had an adjusted average of 0.0454 preventable ER visits in a given month (column 4). The demonstration decreased the number of preventable ER visits by 0.0081 visits per month (column 6), which in relative terms represents 17.8 percent decrease (0.0081/0.0454, column 5) in the number of preventable ER visits in a given month. Because utilization of these services is typically infrequent, absolute changes in monthly service use are smaller than the relative differences imply.

Table 17
Adjusted means and impact estimate for eligible beneficiaries in the demonstration and comparison groups for Michigan through December 31, 2016

Measure	Group	Adjusted mean for predemonstration period	Adjusted mean for demonstration period	Relative difference (%)	Regression-adjusted difference-in-differences estimate (90% confidence interval)	*p*-value
Number of preventable ER visits	Demonstration group	0.0468	0.0428	−17.8	−0.0081	0.0287
	Comparison group	0.0422	0.0454		(−0.0142, −0.0020)	
Probability of ACSC admission, overall	Demonstration group	0.0063	0.0055	−12.8	−0.0009	0.0370
	Comparison group	0.0068	0.0067		(−0.0015, −0.0002)	
Probability of ACSC admission, chronic	Demonstration group	0.0047	0.0040	−13.8	−0.0007	0.0569
	Comparison group	0.0049	0.0048		(−0.0012, −0.0001)	
Probability of 30-day follow-up visit after mental health discharge	Demonstration group	0.3821	0.4099	NS	0.0082	0.6233
	Comparison group	0.3672	0.3867		(−0.0193, 0.0358)	
Number of all-cause 30-day readmissions	Demonstration group	0.3602	0.4918	NS	0.0131	0.3009
	Comparison group	0.3784	0.5044		(−0.0077, 0.0340)	

ACSC = ambulatory care sensitive conditions; ER = emergency room; NS = not statistically significant.

NOTE: Even though the comparison group was carefully developed to have similar characteristics to the demonstration group, there are always slight differences in demographic, health, and area characteristics between the demonstration and comparison groups. The two types of results reported in this table take these differences into account, but use different statistical methods to do so. Before calculating the mean values reported in the third and fourth columns in this table, RTI adjusted the composition of the demonstration's baseline and demonstration period groups and the comparison baseline period group to match the characteristics of the comparison group in the demonstration period so that the means do not reflect any differences in the groups' characteristics. The regression DinD approach, results reported in the sixth column of this table, controls for these differences automatically, without changing the underlying characteristics of the demonstration and comparison groups. Because of these differing methods, the difference-in-differences results obtained from the regression may differ slightly from a similar calculation using the results in the adjusted mean columns. The relative percentage difference in the fifth column is calculated by dividing the difference-in-differences value in column 6 by the value for the comparison group in the demonstration period in column 4.

SOURCE: RTI International analysis of Medicare data.

8.2.1 Descriptive Statistics on the Demonstration Eligible Population

In addition to the findings presented for the demonstration eligible population in this section, ***Appendix C, Tables C-1*** through ***C-3*** present weighted descriptive statistics for the demonstration eligible population for each service for the predemonstration and demonstration years to help understand the utilization experience over time. We examined 11 Medicare service utilization measures, 6 RTI quality of care utilization measures, and 5 nursing facility (NF)–related measures derived from the MDS. No testing was performed between groups or years. The results reflect the underlying experience of the two groups, and not the DinD estimates presented earlier.

The demonstration and comparison groups were similar across many of the service utilization measures in each of the predemonstration (baseline) years and the first demonstration year (see ***Table C-1***). There was no notable difference in institutional or non-institutional service utilization between the comparison and demonstration groups across the predemonstration and demonstration period, except that inpatient admissions, observation stays, and primary care E&M visits were more frequent among demonstration service users.

The demonstration group was similar to the comparison group on some of the RTI quality of care and care coordination measures (see ***Table C-2***). Key differences included lower rates of all-cause 30-day readmission and higher rates of 30-day follow-up visit after mental health discharge, overall ACSC admissions, and clinical depression screening for the demonstration group relative to the comparison group.

Finally, there were more differences between the demonstration group and comparison group in long-stay NF utilization (see ***Table C-3***), including a higher percentage of long-stay NF users in the demonstration group. Demonstration eligible beneficiaries with a long-stay NF admission also had better functional status and a higher percentage with low level of care need relative to the comparison group.

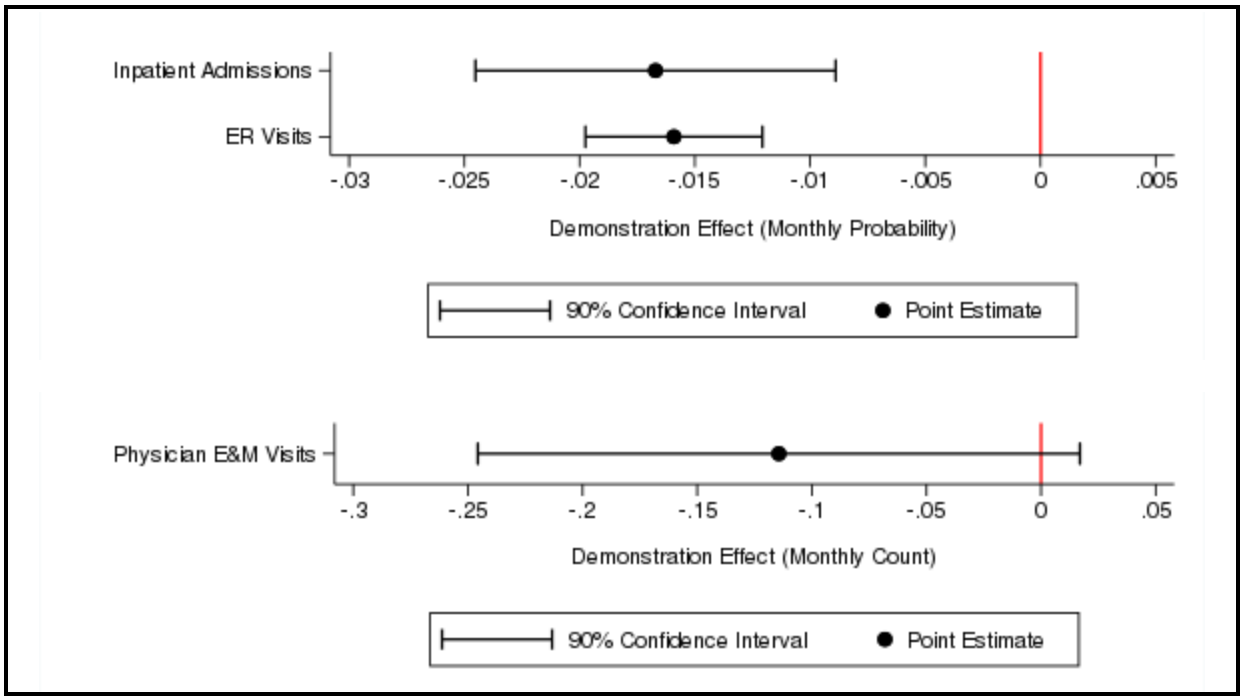
8.2.2 Impact Analysis on Demonstration Eligible Beneficiaries with LTSS Use

Demonstration eligible beneficiaries were defined as using LTSS in a demonstration year if they received any institutional or HCBS services. Approximately 17 percent of all eligible beneficiaries in demonstration year 1 were LTSS users. As was true for the overall demonstration eligible population, those with LTSS use had a decreased probability of inpatient admission, a decreased probability of ACSC admission (overall and chronic), a decreased probability of ER visits, and fewer preventable ER visits, with no statistically significant effect on all-cause 30-day readmissions, or the probability of a 30-day follow-up visit after mental health discharge. In contrast to the overall demonstration eligible population, the demonstration did not have a statistically significant effect on physician E&M visits among eligible beneficiaries with LTSS use.

Figure 4 displays the Michigan demonstration's effects on key service utilization measures among the demonstration eligible population who were LTSS users through demonstration year 1. The demonstration resulted in a 1.67 percentage-point decrease (90 percent CI: −2.45, −0.89) in the probability of an inpatient admission and a 1.59 percentage-point decrease (90 percent CI: −1.98, −1.21) in the probability of an ER visit. There were no

statistically significant effects on physician E&M visits among demonstration eligible beneficiaries with LTSS use.

Figure 4
Demonstration effects on service utilization for eligible beneficiaries with LTSS use in Michigan—Difference-in-differences regression results for the demonstration period, March 1, 2015–December 31, 2016
(90 percent confidence intervals)



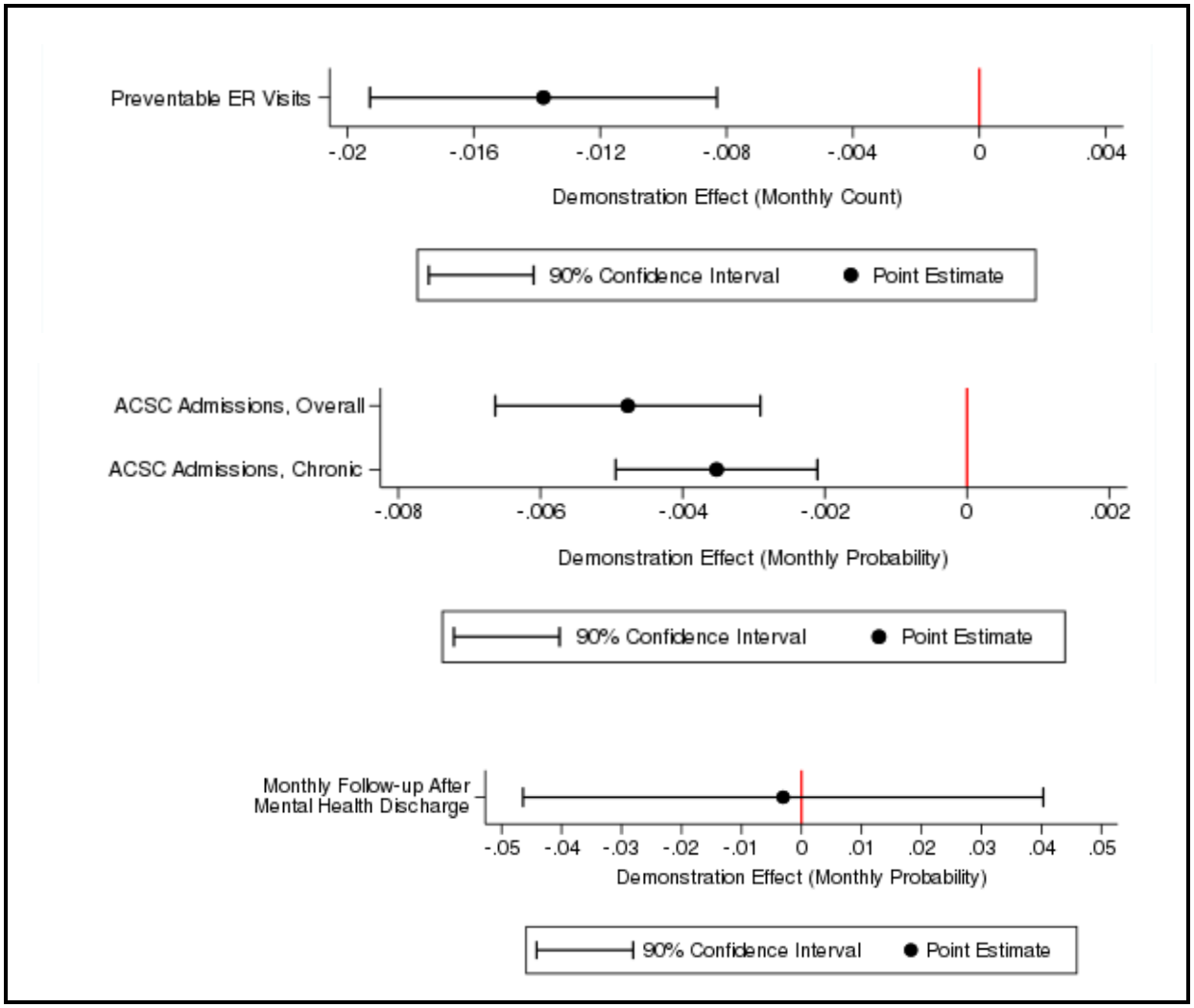
E&M = evaluation and management; ER = emergency room; LTSS = long-term services and supports.

NOTES: Beneficiaries who first met LTSS criteria during the demonstration period were removed from the regression model to address analytic issues in estimating results. Results should be interpreted with caution as there may be important observable and unobservable factors specific to the LTSS population that are not included in the propensity score model and weights.

SOURCE: RTI International analysis of Medicare data.

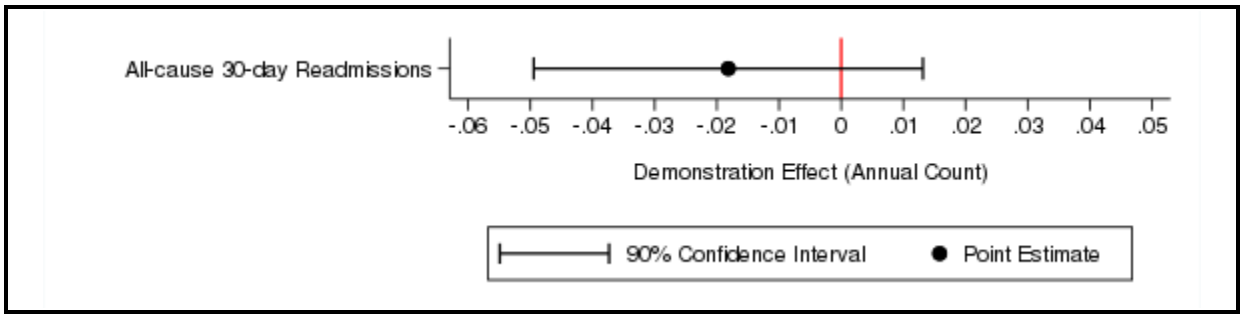
Figure 5 displays demonstration effects on RTI quality of care and care coordination measures among the demonstration eligible population who were LTSS users through demonstration year 1. The demonstration resulted in 0.0138 fewer (90 percent CI: −0.0193, −0.0083) monthly preventable ER visits, a 0.48 percentage point decrease (90 percent CI: −0.66, −0.29) in the probability of an overall ACSC admission, and a 0.35 percentage point decrease (90 percent CI: −0.49, −0.21) in the probability of a chronic ACSC admission. There were no statistically significant demonstration effects on the probability of a 30-day follow-up visit after mental health discharge or all-cause 30-day readmissions among the demonstration eligible population with LTSS use.

Figure 5
Demonstration effects on RTI quality of care and care coordination measures for eligible beneficiaries with LTSS use in Michigan—Difference-in-differences regression results for the demonstration period, March 1, 2015–December 31, 2016
(90 percent confidence intervals)



(continued)

Figure 5 (continued)
Demonstration effects on RTI quality of care and care coordination measures for eligible beneficiaries with LTSS use in Michigan—Difference-in-differences regression results for the demonstration period, March 1, 2015–December 31, 2016
(90 percent confidence intervals)



ACSC = ambulatory care sensitive conditions; ER = emergency room; LTSS = long-term services and supports.

NOTES: Beneficiaries who first met LTSS criteria during the demonstration period were removed from the regression model to address analytic issues in estimating results. Results should be interpreted with caution as there may be important observable and unobservable factors specific to the LTSS population that are not included in the propensity score model and weights.

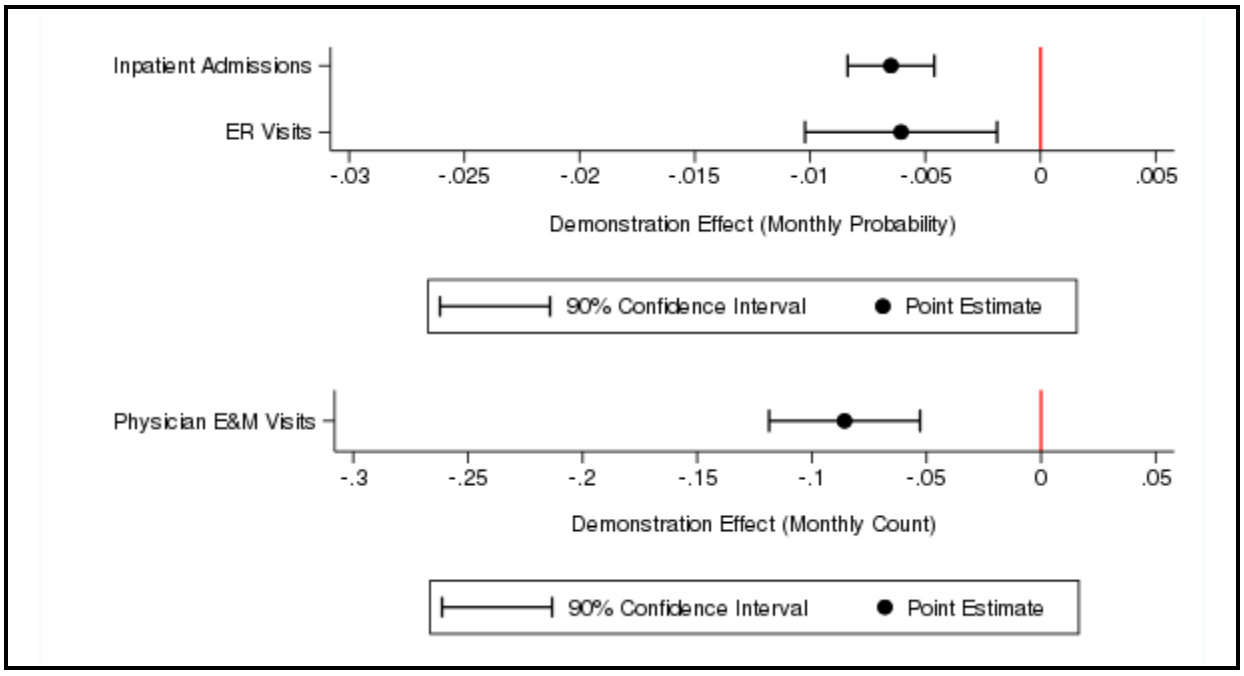
SOURCE: RTI International analysis of Medicare data.

8.2.3 Impact Analyses on the Demonstration Eligible Population with SPMI

Demonstration eligible beneficiaries were defined for the Financial Alignment Initiative (FAI) evaluation as having SPMI if there were any inpatient or outpatient mental health visits for schizophrenia or bipolar disorders in the last 2 years (see ***Appendix B***, page 6 for additional information). Approximately 43 percent of all eligible beneficiaries had SPMI in demonstration year 1. As was true for the overall demonstration eligible population, demonstration eligible beneficiaries with SPMI had a decreased probability of inpatient admission, a decreased probability of ACSC admission (overall and chronic), a decreased probability of ER visits, fewer preventable ER visits, and fewer physician E&M visits relative to the comparison group. There was no statistically significant effect on all-cause 30-day readmissions or the probability of a 30-day follow-up visit after mental health discharge among demonstration eligible beneficiaries with SPMI.

Figure 6 displays the Michigan demonstration's effects on key service utilization measures for the demonstration eligible population with SPMI through demonstration year 1. The demonstration resulted in a 0.65 percentage point decrease (90 percent CI: −0.84, −0.46) in the probability of an inpatient admission, a 0.61 percentage point decrease (90 percent CI: −1.02, −0.19) in the probability of an ER visit, and 0.0857 fewer (90 percent CI: −0.1186, −0.0528) monthly physician E&M visits among demonstration eligible beneficiaries with SPMI.

Figure 6
Demonstration effects on service utilization for eligible beneficiaries with SPMI in Michigan—Difference-in-differences regression results for the demonstration period, March 1, 2015–December 31, 2016
(90 percent confidence intervals)



E&M = evaluation and management; ER = emergency room.

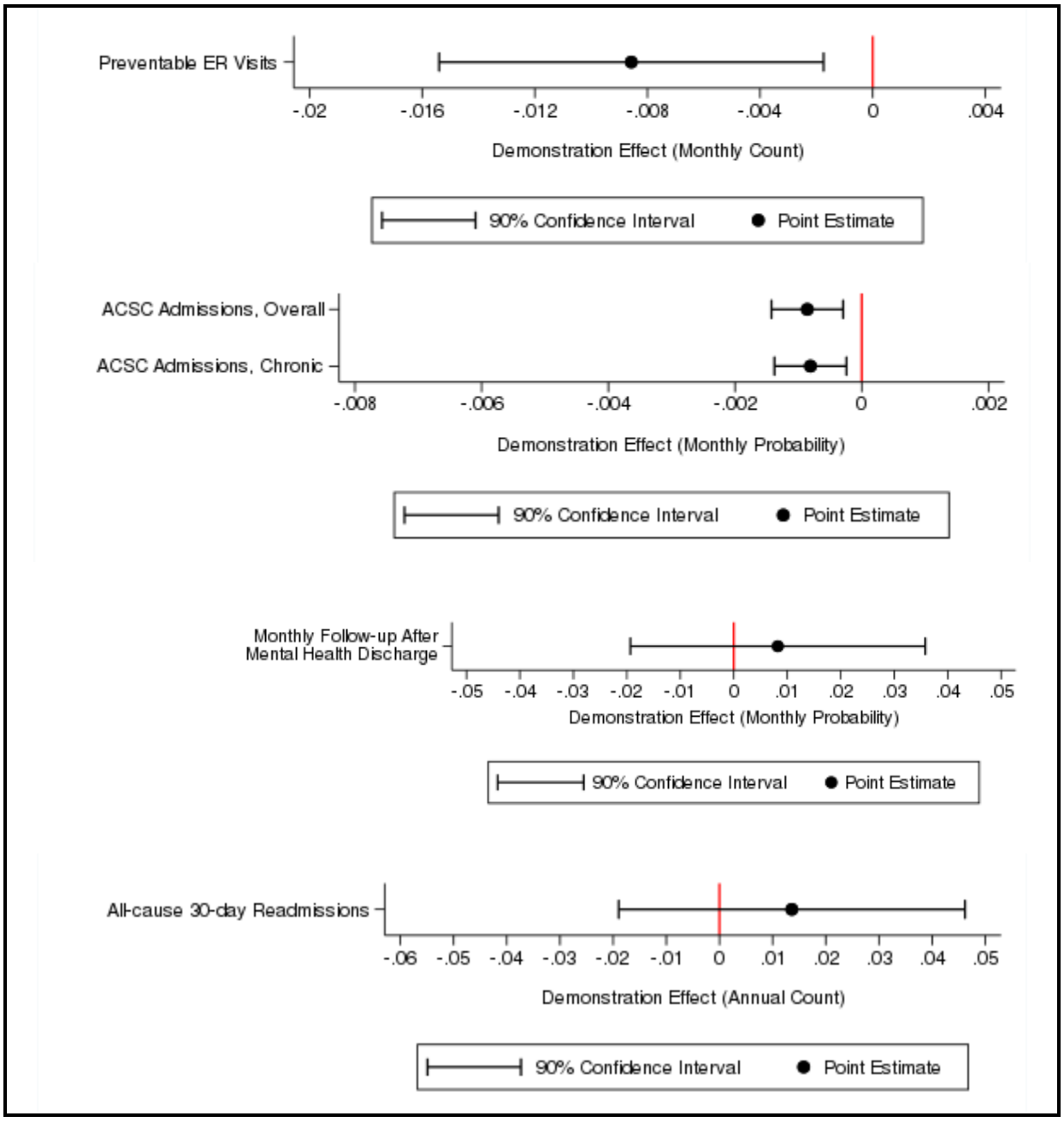
SOURCE: RTI International analysis of Medicare data.

Figure 7 displays demonstration effects on RTI quality of care and care coordination measures for the demonstration eligible population with SPMI through demonstration year 1. The demonstration resulted in 0.0086 fewer (90 percent CI: −0.0154, −0.0018) monthly preventable ER visits, a 0.09 percentage point decrease (90 percent CI: −0.14, −0.03) in the probability of an overall ACSC admission, and a 0.08 percentage point decrease (90 percent CI: −0.14, −0.02) in the probability of a chronic ACSC admission. There were no statistically significant demonstration effects on the probability of a 30-day follow-up visit after mental health discharge or all-cause 30-day readmissions among the demonstration eligible population with SPMI.

Figure 7

Demonstration effects on quality of care and care coordination measures for eligible beneficiaries with SPMI in Michigan—Difference-in-differences regression results for the demonstration period, March 1, 2015–December 31, 2016

(90 percent confidence intervals)



ACSC = ambulatory care sensitive conditions; ER = emergency room.

SOURCE: RTI International analysis of Medicare data.

8.2.4 Service Use for Enrollee and Non-Enrollee Populations in Michigan

To provide insights into the utilization experience over time within the Michigan demonstration***, Tables C-4*** and ***C-5*** in ***Appendix C*** present weighted descriptive statistics for the enrolled population, compared to those demonstration eligible beneficiaries who were not enrolled, for each service in the first demonstration year.

There were some observable patterns in terms of service utilization for demonstration eligible enrollees versus non-enrollees during the first demonstration year. For example, enrollees were less likely to use various services types, including inpatient admissions, observation stays, primary care E&M visits, and outpatient and independent therapy care (***Table C-4***). Enrollees have lower utilization for all quality of care and care coordination measures compared to non-enrollees in the first demonstration year. (***Table C-5***).

8.2.5 Service Use by Demographic Characteristics of Eligible Beneficiaries

To examine any differences in racial and ethnic groups, ***Figures 8, 9,*** and ***10*** provide month-level unadjusted results for five settings of interest for Michigan's eligible beneficiaries: inpatient admissions, emergency department visits (non-admit), hospice admissions, primary care E&M visits, and outpatient therapy (physical therapy [PT], occupational therapy [OT], and speech therapy [ST]) visits. Results across these five settings are displayed using three measures: percentage with any use of the respective service, counts per 1,000 eligible beneficiaries with any use of the respective service, and counts per 1,000 demonstration eligible beneficiaries.

Figure 8 presents the percentage of use of selected Medicare services. Black beneficiaries appeared to be more likely to use inpatient, emergency department, and primary care E&M services, whereas White beneficiaries appeared more likely to use outpatient therapy services.

Regarding counts of services used among users of each respective service, as presented in ***Figure 9***, there were limited differences across racial groups for inpatient admissions, hospice use, and physician E&M visits. However, Hispanic beneficiaries had almost double the number of ER visits as the other groups. In addition, White and Black beneficiaries received more outpatient therapy visits in months where there was any use, relative to other racial groups, with Hispanic beneficiaries having the lowest use if any use.

Figure 10 presents counts of services across all Michigan demonstration eligible beneficiaries regardless of having any use of the respective services. Trends for utilization across most service settings were broadly similar to those displayed in ***Figure 8,*** with White and Black beneficiaries appearing generally to have higher use than Asian and Hispanic beneficiaries; the count of emergency department visits, however, was highest among Hispanic beneficiaries.

Figure 8
Percent with use of selected Medicare services

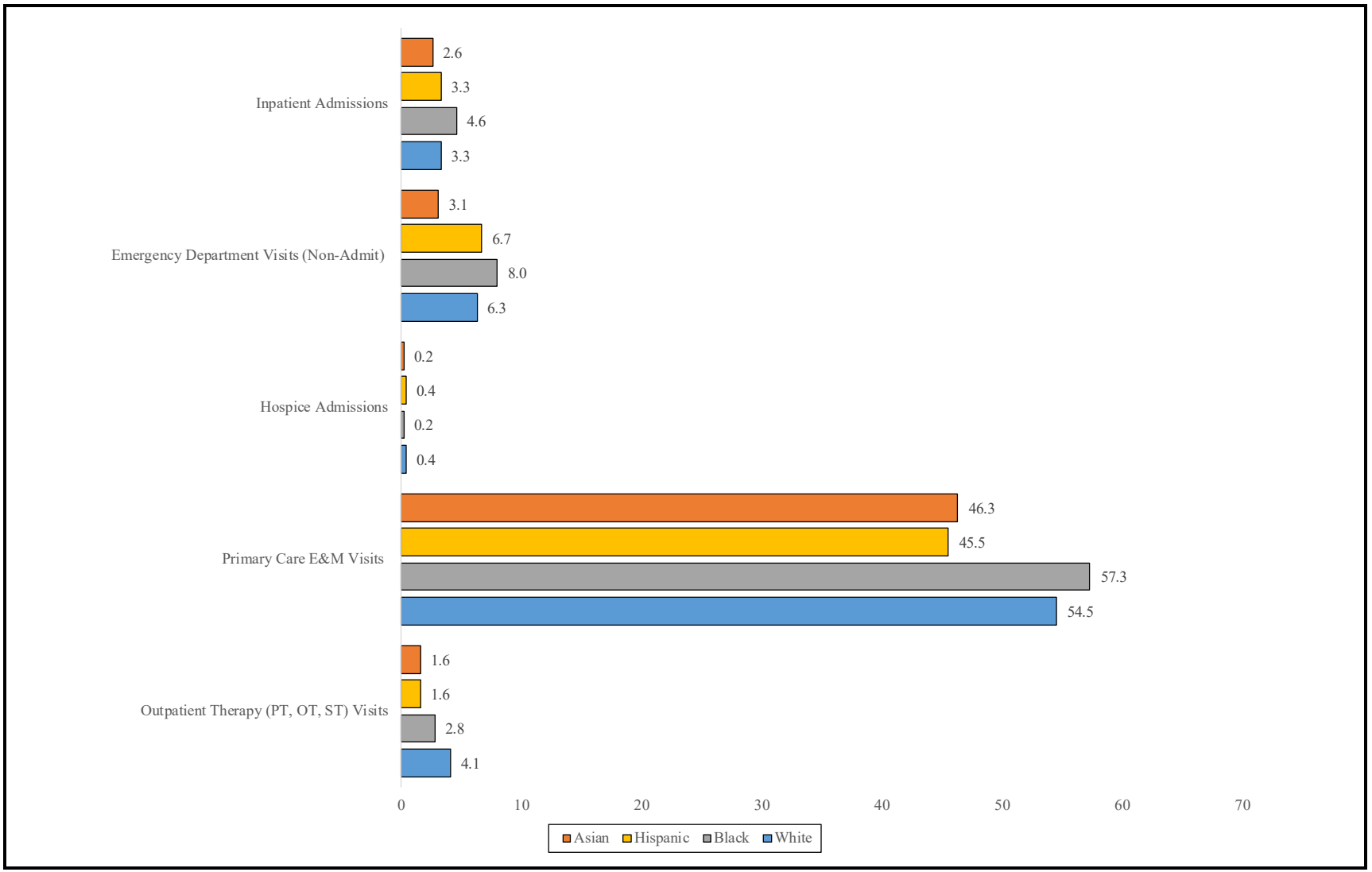


Figure 9
Service use among all demonstration eligible beneficiaries with use of service per 1,000 user months

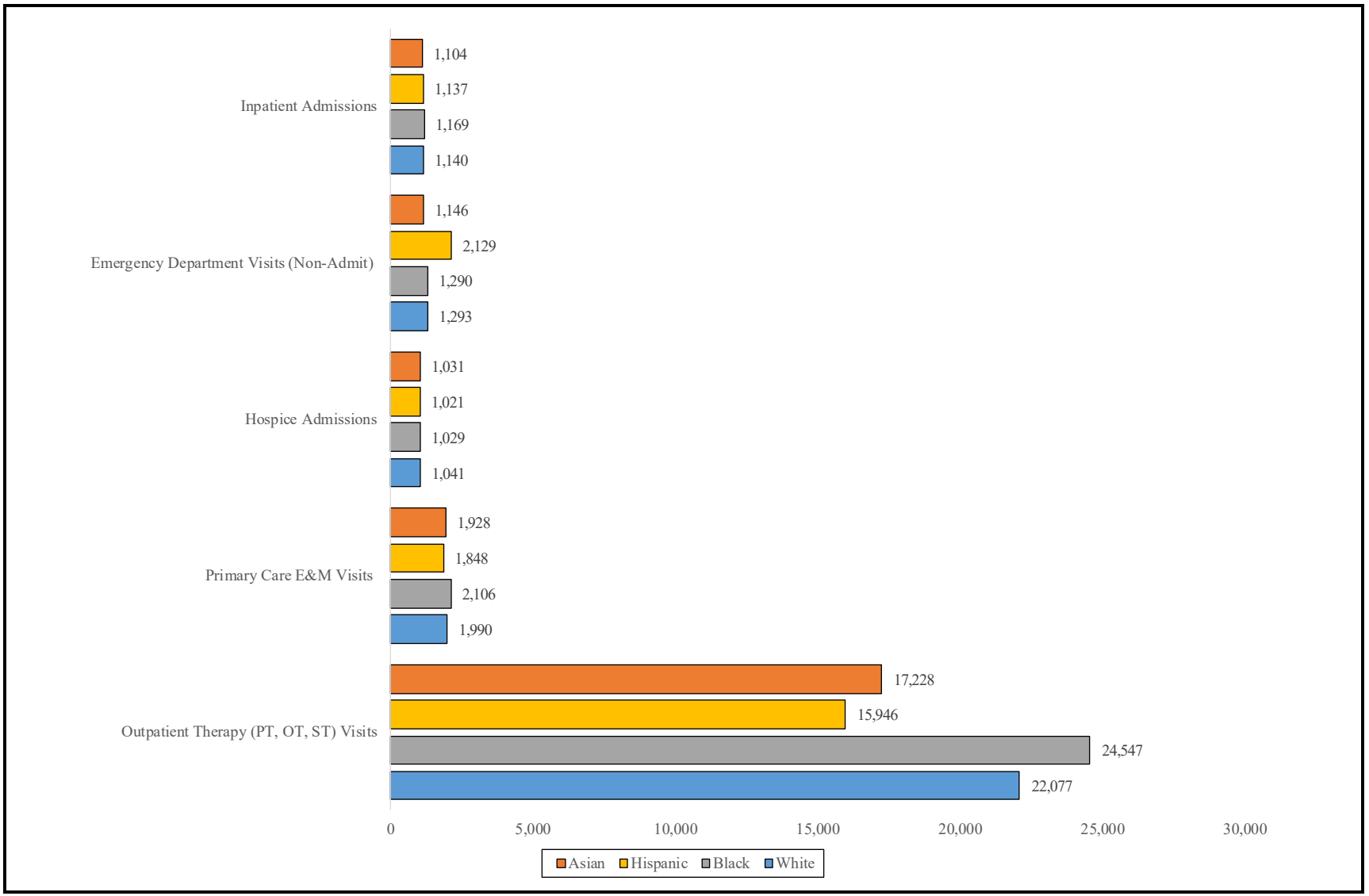
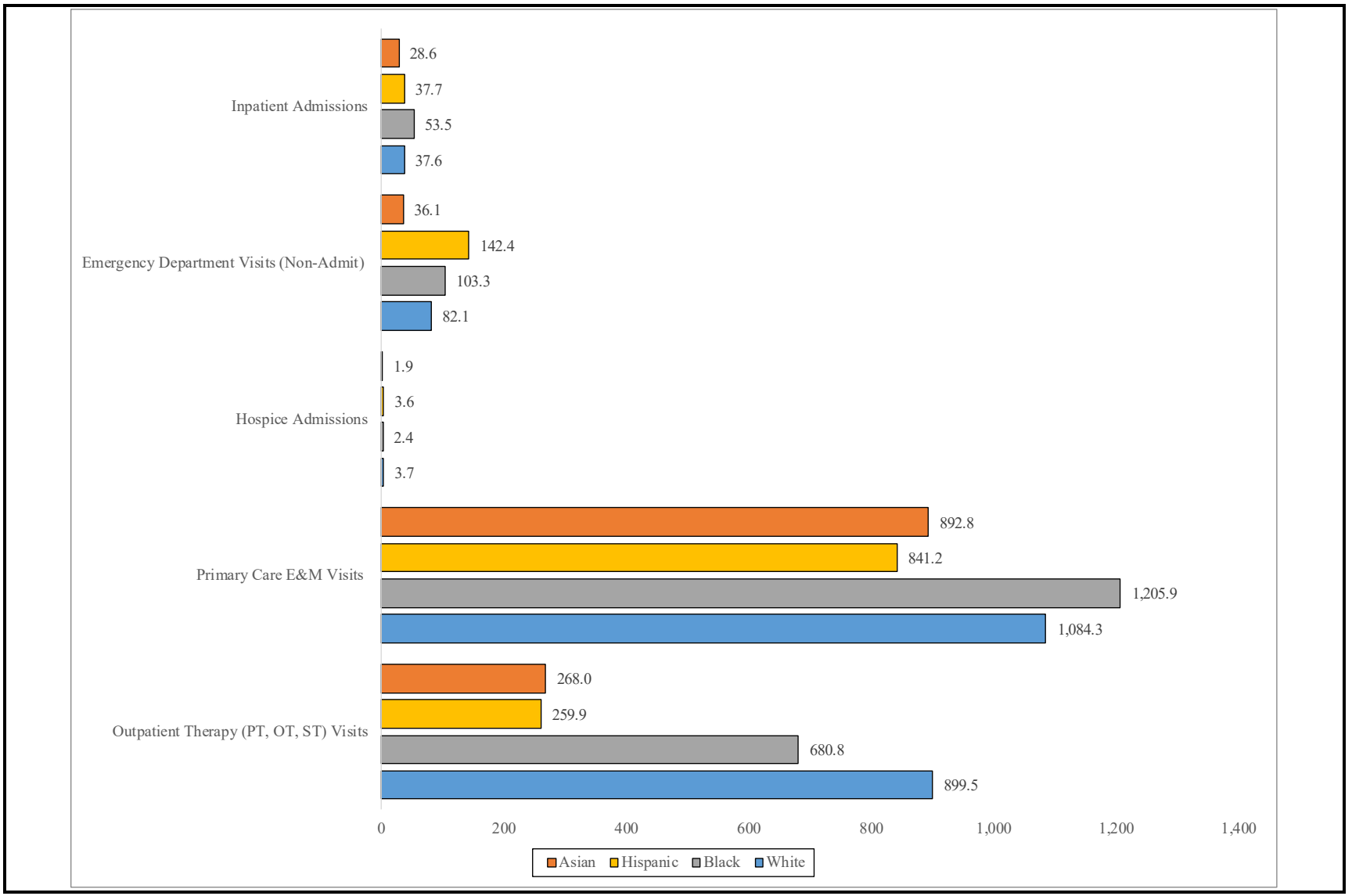


Figure 10
Service use among all demonstration eligible beneficiaries per 1,000 eligible months



9. Quality of Care

Highlights

- ICOs' performance on HEDIS measures in 2016 varied across plans. For one measure (initiation and engagement of alcohol and other drug dependence treatment), most ICOs reporting data performed better than the national Medicare Advantage benchmark value.
- One ICO performed better than the Medicare Advantage benchmark values for the majority of HEDIS measures.
- In 2017, MI Health Link began using a performance-based algorithm to assign passive enrollment to the ICOs. Plans are assigned to tiers based on six measures that reflect their capacity to serve new enrollees.

9.1 Quality Measures

The Michigan demonstration requires that ICOs report standardized quality measures. These measures include the following:

- A set of core measures specific to all capitated model demonstrations under the Financial Alignment Initiative (FAI) that address domains of access, assessment, care coordination, enrollee protection, organization structure and staffing, performance and quality improvement, provider network, and systems and service utilization (https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPReportingRequirements.html)

- A set of 21 State-specific measures were selected by the Michigan Department of Health and Human Services (MDHHS) staff in consultation with CMS after considering feedback from stakeholders; four measures were retired in 2018 and two others were temporarily suspended. These include additional assessment and care coordination measures, as well as measures in other domains including quality of care, enrollee protections, and utilization.

CMS and the State use reporting and performance on several of the core and State-specific measures to determine what portion of the capitation rates retained by CMS and the State as a "quality withhold" will be repaid to the plan.

The demonstration also utilizes quality measures required of Medicare Advantage (MA) plans, including applicable measures from the Part C and Part D reporting requirements such as

appeals and grievances, pharmacy access, payment structures, and medication therapy management.

ICOs are required to submit the following three additional measure sets as part of the Medicare Advantage requirement:

- A modified version of the Medicare Advantage and Prescription Drug Plan (MA-PD) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey that, in addition to the core survey used by Medicare Advantage plans, includes 10 supplemental questions proposed by the RTI Evaluation Team to capture beneficiary experience specific to integration, behavioral health and LTSS (see ***Section 5*** for CAHPS findings);

- The subset of Medicare Healthcare Effectiveness Data and Information Set (HEDIS) measures, a standard measurement set used extensively by managed care plans, that are required of all Medicare Advantage plans; and

- Selected Health Outcomes Survey (HOS) measures based on a recurring survey of a random sample of Medicare beneficiaries to assess physical and mental health outcomes (Michigan three-way contract, 2014).

Data related to these measures are reported in relevant sections of this report.

In addition, the RTI Aggregate Evaluation Plan identified a set of quality measures that will be calculated by the RTI evaluation team using encounter and fee-for-service (FFS) data. Many of these measures are part of the HEDIS measurement set and are largely clinical in nature (e.g., preventive screens, follow-up care) or related to service use (e.g., avoidable hospitalizations, emergency department use) (Walsh et.al., 2013, pp. 77–85).

State officials and ICOs noted a number of challenges with reporting quality measures. State officials said in 2018 that some plans were still making systems changes needed to report valid information, and that one plan had experienced systems challenges with almost every measure. ICOs said the State had made changes in measure specifications that took time and systems changes to implement. For example, when the care coordination requirements were changed to ensure person-centered care planning (see ***Section 4.1.2, Care Planning Process***), a provision was added to the specifications for four State-specified measures clarifying that care plans should only be counted if they comply with the signature requirements (CMS, March 15, 2016, Cover memo for Revised Michigan-Specific Reporting Requirements).

Quality Withhold Measures

Because demonstration year 1 crossed 2 calendar years, the results from the quality withhold measures for calendar year 2015 and calendar year 2016 were analyzed separately. For 2015, three core measures and two State-specific measures were used. Five core measures and three State-specific measures were used for 2016.

Quality withhold measures were of particular concern to the ICOs because the plans are financially accountable. One withhold measure, discussions of care goals, was affected by the

higher standard of reporting under the signature requirements. Another withhold measure of concern to the plans was care transition records transmitted to a health care professional; Michigan retained this measure even when the core measure was retired by CMS. State officials acknowledged that this measure is challenging because it requires transition of patient records from hospitals to doctors or post-acute care providers within 24 hours of discharge (note that as of calendar year 2017 reporting, the measure specifications were modified to capture the number of members for whom a transition record was transmitted on the day of discharge or the following day, rather than within 24 hours of discharge).

In recognition of this challenge, the State modified the care transition measure benchmark for the second half of demonstration year 1 (calendar year 2016) to utilize the same benchmark as the first half of demonstration year 1 (calendar year 2015), which required timely and accurate reporting and submission of a narrative describing the ICO's plans to achieve compliance and continual improvement. The State set a similar benchmark for demonstration years 2 and 3. Percentage benchmarks will be used for demonstration years 4 and 5. Additionally, the State modified the specifications for a third State-specified withhold measure—annual medication review—to address ICOs' concerns. The revised measure allows review by either the patient's physician or clinical pharmacist working for the plan.

For calendar year 2015, all seven ICOs met the State's benchmark for the care transition record transmitted to health professional measure, whereas three of seven met the benchmark for the other State-specified measure, members with documented discussions of care goals. For CMS core measures, four ICOs met the benchmark for the consumer governance board measure, three met the assessment measure benchmark, and one met the benchmark for the submission of encounter data measure (CMS, 2018).

In calendar year 2016, all seven ICOs met the State's benchmark for the care transition record transmitted to health professional measure, six met the benchmark for the members with documented discussions of care goals measure, and four met the medication review measure benchmark. For the five CMS core measures, seven plans met the consumer governance board measure benchmark, five met the benchmarks for the assessments measure and the getting appointments and care quickly measure, and four met the encounter data measure benchmark. Six plans met the customer service measure benchmark; one plan's score had very low reliability and was removed from the analysis (CMS, 2018).

Passive Enrollment Assignment Algorithm

In 2017, MI Health Link began using a performance-based passive enrollment system (see ***Section 3.2.4, Integration of Medicare and Medicaid Enrollment Systems***). The demonstration distributes enrollment among ICOs based on six measures that reflect each ICO's current performance and capacity to serve new enrollees, such as the percentage of enrollees with an in-person assessment and the care coordination ratio.

9.2 Quality Management Structures and Activities

This section examines the components of the MI Health Link quality management system, including its interface with CMS, ICOs, and other independent entities, and describes how well the quality management system is working from various perspectives.

9.2.1 State and CMS Quality Management Structures and Activities

The joint CMS-State Contract Management Team (CMT) is responsible for the day-to-day monitoring and oversight of demonstration ICOs' operation and performance. The CMT monitors ICO compliance with the terms of the contract, issues notices of noncompliance, coordinates periodic audits and surveys, conducts meetings with ICOs, provides technical assistance as needed, reviews marketing materials, and reviews grievance and appeals (Michigan three-way contract, 2014, p. 162). A State member of the CMT said that they use every opportunity to review available data and compare ICOs to the State or national averages. The CMT's quality management responsibilities also include quality assurance for the MI Health Link waiver and oversight of the external quality review activities related to the demonstration.

9.2.2 ICO Quality Management Structure and Activities

ICOs are required to maintain a quality improvement organizational and program structure to provide consistent and ongoing quality improvement monitoring and activities (Michigan three-way contract, 2014, p. 128). ICO officials reported that teams are allocated for quality management activities, such as reporting Healthcare Effectiveness Data and Information Set (HEDIS) measures and disease management. ICOs are also required to develop advisory councils to obtain enrollee and community input on issues related to quality improvement (Michigan three-way contract, 2014, p. 8).

ICOs are required to implement quality improvement projects (QIPs) and chronic care improvement projects (CCIPs). The topic for QIPs was reducing hospital readmissions, whereas the CCIP topic was reducing cardiovascular disease. State officials said detailed reporting specifications were developed to ensure the plans' data on QIPs will be comparable. ICOs made their second QIP submissions through CMS' Health Plan Management System (HPMS) in January 2018. A State official said at the time that the ICOs were still making adjustments and improving transition programs to reduce readmissions. CMS no longer requires plans to submit reports on their CCIPs, although they are still required to conduct the projects.

9.2.3 Independent Quality Management Structures and Activities

Michigan contracts with an external quality review organization (EQRO) to conduct ICO compliance reviews, validate QIPs, and conduct a CAHPS survey of MI Health Link enrollees (HSAG, 2017).

The MI Health Link Ombudsman (MHLO) program (see ***Section 5.2.9, Beneficiary Protections***), receives enrollee complaints about the ICOs. MHLO staff meet each month with the CMT to discuss enrollee complaints and questions.

9.3 HEDIS Quality Measures Reported for ICOs

Fourteen Medicare HEDIS measures for MMP enrollees are reported in ***Table 18***. RTI identified these measures for reporting in this Evaluation Report after reviewing the list of measures we previously identified in RTI's Aggregate Evaluation Plan as well as the available HEDIS data on these measures for completeness, reasonability, and sample size; 2016 calendar year data were available for all seven MI Health Link demonstration plans. Detailed descriptions

of the measures can be found in the RTI Aggregate Evaluation Plan.[22] Results were reported for measures that had a sample size greater than 30 beneficiaries. In addition to reporting the results for each MMP, the mean value for Medicare Advantage plans for each measure is provided for comparison.

We provide national benchmarks from Medicare Advantage plans, if available, understanding that Medicare Advantage enrollees and demonstration enrollees may have different health and sociographic characteristics that may affect the results. Previous studies on health plan performance revealed poorer quality ratings for plans serving a higher proportion of dual eligible beneficiaries and beneficiaries with disabilities. HEDIS measure performance, in particular, is slightly worse among plans active in areas with lower income populations and those with a higher proportion of minorities (Office of the Assistant Secretary for Planning and Evaluation, 2016). Benchmarks should be considered with this limitation in mind.

These findings on Michigan MMP HEDIS measure performance represent the early experience in the demonstration, and are likely to change over time as MMPs gain more experience in working with enrollees. Monitoring trends over time in MMP performance may be more important than the comparison to the national Medicare Advantage plans given the population differences. Several years of HEDIS results are likely needed to determine how well MMPs perform relative to each other and whether they perform above or below any potential benchmark.

Results reported in ***Table 18*** compare the seven ICOs, with the exception of some measures for which the sample size was fewer than 30 beneficiaries. Results vary across plans; one plan, Upper Peninsula, performed better than the Medicare Advantage benchmark values for the majority of measures. For one measure reported (initiation and engagement of alcohol and other drug dependence treatment), a majority of the plans reporting data performed better than the national Medicare Advantage benchmark value. For another behavioral health measure (antidepressant medication management), three plans performed better than the Medicare Advantage benchmark value.

For the outpatient visits per 1,000 members benchmark, the majority of plans performed below the Medicare Advantage benchmark value, which is not desirable. Molina, however, exceeded the Medicare Advantage benchmark value for this measure by approximately 4,000 visits per 1,000 members. The majority of plans performed below the Medicare Advantage benchmark value for the remaining measures. These measures are related to adult body mass index (BMI) assessment, annual monitoring for patients on persistent medications, adult BMI assessment, blood pressure control, breast cancer screening, colorectal cancer screening, comprehensive diabetes care, disease-modifying anti-rheumatic drug therapy in rheumatoid arthritis, and emergency department visits.

[22] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf

Table 18
Selected HEDIS measures for MI Health Link demonstration plans, 2016

Measure	National Medicare Advantage Plan, mean	Aetna	AmeriHealth	HAP Midwest	Meridian	Michigan Complete	Molina	Upper Peninsula
Adult access to preventive/ambulatory health services	94.7%	87.9%	82.7%	85.6%	92.5%	80.2%	92.2%	93.7%
Adult BMI assessment	93.9%	—	—	87.4%	91.2%	76.4%	97.6%	97.1%
Ambulatory care (per 1,000 members)								
Outpatient visits	9,181.9	7,323.0	8,120.9	8,463.3	8,703.3	8,081.2	13,078.4	8,215.3
Emergency department visits (higher is worse)	637.8	843.1	960.7	1,063.4	1,251.6	931.0	1,027.0	956.4
Annual monitoring for patients on persistent medications								
Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs)	92.4%	82.0%	85.6%	83.5%	89.2%	84.4%	90.6%	93.6%
Annual monitoring for members on digoxin	57.3%	55.6%	42.9%	56.5%	43.6%	16.7%	73.8%	84.8%
Annual monitoring for members on diuretics	92.9%	82.8%	84.9%	85.0%	89.6%	86.6%	90.3%	95.8%
Total rate of members on persistent medications receiving annual monitoring	92.1%	81.2%	84.8%	83.9%	88.6%	84.5%	90.3%	94.3%
Antidepressant medication management								
Effective acute phase treatment [1]	69.3%	80.3%	52.6%	47.4%	78.7%	67.2%	57.5%	72.3%
Effective continuation phase treatment [2]	54.3%	74.8%	39.5%	32.0%	70.7%	50.8%	44.5%	59.0%
Blood pressure control [3]	69.0%	63.5%	46.9%	57.9%	76.5%	44.1%	54.5%	79.1%
Breast cancer screening	71.6%	—	—	58.6%	61.8%	40.9%	68.1%	61.7%

(continued)

Table 18 (continued)
Selected HEDIS measures for MI Health Link demonstration plans, 2016

Measure	National Medicare Advantage Plan, mean (2016)	Aetna (2016)	AmeriHealth (2016)	HAP Midwest (2016)	Meridian (2016)	Michigan Complete (2016)	Molina (2016)	Upper Peninsula (2016)
Care for older adults [4]								
Advance care planning	—	27.9%	22.5%	9.0%	20.5%	36.54%	54.9%	53.8%
Medication review	—	70.7%	43.4%	52.6%	74.6%	36.92%	78.1%	87.1%
Functional status assessment	—	25.4%	29.7%	12.7%	40.2%	67.07%	65.7%	67.1%
Pain assessment	—	62.8%	50.8%	29.9%	57.7%	68.51%	80.3%	68.5%
Colorectal cancer screening	66.2%	—	—	56.9%	55.6%	—	67.6%	54.3%
Comprehensive diabetes care								
Received Hemoglobin A1c (HbA1c) testing	93.4%	88.1%	83.1%	87.4%	88.4%	85.0%	92.9%	93.3%
Poor control of HbA1c level (> 9.0%; higher is worse)	27.2%	39.1%	48.4%	39.2%	35.3%	40.4%	29.2%	16.4%
Good control of HbA1c level (< 8.0%)	62.2%	51.0%	45.1%	51.3%	56.3%	49.7%	58.9%	69.7%
Received eye exam (retinal)	70.0%	49.5%	43.7%	56.5%	72.9%	46.1%	62.0%	76.8%
Received medical attention for nephropathy	95.6%	92.1%	92.4%	94.2%	94.8%	94.6%	94.5%	93.1%
Blood pressure control (< 140/90 mm Hg)	69.0%	58.5%	42.1%	57.9%	70.8%	43.2%	63.3%	79.6%
Disease-modifying anti-rheumatic drug therapy in rheumatoid arthritis	76.6%	71.4%	—	65.9%	74.3%	—	52.3%	64.3%
Follow-up after hospitalization for mental illness	53.2%	—	—	40.8%	65.5%	31.8%	55.4%	45.3%
Initiation and engagement of alcohol and other drug (AOD) dependence treatment								
Initiation of AOD treatment [5]	32.3%	30.4%	20.7%	33.7%	30.3%	45.4%	42.2%	36.8%
Engagement of AOD treatment [6]	3.5%	4.1%	2.4%	3.0%	4%	5.4%	3.0%	4.0%

(continued)

Table 18 (continued)
Selected HEDIS measures for MI Health Link demonstration plans, 2016

Measure	National Medicare Advantage Plan, mean (2016)	Aetna (2016)	AmeriHealth (2016)	HAP Midwest (2016)	Meridian (2016)	Michigan Complete (2016)	Molina (2016)	Upper Peninsula (2016)
Plan all-cause readmissions (average adjusted probability total; higher is worse)	—	25.0%	26.0%	22.0%	22.0%	—	23.0%	20.0%

— = data not available, or the number of enrollees in the plan's provided HEDIS data available for inclusion in the measure was less than 30, and therefore not reported per RTI's decision rule for low addressing sample size.

[1]Represents the percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks)

[2]Represents the percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

[3]The following criteria were used to determine adequate blood pressure control: less than 140/90 mm Hg for members age 18–59 years; diagnosis of diabetes and < 140/90 mm Hg for members age 60–85 years; no diagnosis of diabetes and < 150/90 mm Hg for members age 60–85 years.

[4]There is no Medicare Advantage benchmark for these measures as they are not required.

[5]Represents the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.

[6]Represents the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

SOURCE: RTI analysis of 2016 HEDIS measures.

NOTES: Detailed descriptions of HEDIS measures presented can be found in the RTI Aggregate Evaluation Plan, which is available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf

10. Cost Savings Calculation

Highlights

- RTI conducted a preliminary estimate of Medicare savings using a difference-in-differences analysis examining beneficiaries eligible for the demonstration in the Michigan demonstration area and comparison areas.
- The results of the preliminary cost analyses of beneficiaries eligible for the demonstration do not show statistically significant savings or losses as a result of the demonstration. This aligns with CMS expectations, given rate structure and modifications during the demonstration period covered.

As part of the capitated financial alignment model, Michigan, CMS, and plans have entered into a three-way contract to provide services to Medicare-Medicaid enrollees (Michigan three-way contract, 2014). Participating plans receive prospective blended capitation payment to provide both Medicare and Medicaid services for enrollees. CMS and Michigan developed risk adjusted capitation rates for Medicare Parts A, B, and D, and Medicaid services to reflect the characteristics of enrollees. The Medicare component of the payment is risk-adjusted using CMS' hierarchical risk-adjustment model. The rate development process is described in greater detail in the Memorandum of Understanding and the three-way contract, and a description of the risk adjusted Medicare components of the rate are described in the Rate Reports (CMS and State of Michigan, 2017).

The capitation payment incorporates savings assumptions over the course of the demonstration. The same savings percentage is prospectively applied to both the Medicare and Medicaid components of the capitation payment, so that both payers can recognize proportional savings from this integrated payment approach, regardless of whether the savings is driven disproportionately by changes in utilization of services typically covered by Medicare or Medicaid. The goal of this methodology is to minimize cost shifting, to align incentives between Medicare and Medicaid, and to support the best possible outcomes for enrollees.

This chapter presents preliminary Medicare Parts A and B savings calculations for the first 22 months of the demonstration period using an intent-to-treat (ITT) analytic framework that includes beneficiaries eligible for the demonstration rather than only those who enrolled. More than 106,000 Medicare-Medicaid beneficiaries in Michigan were eligible for and approximately 38,569 (36 percent) were enrolled in the demonstration as of December 2017.

The Medicare calculation presented here uses the capitation rate for beneficiaries enrolled in the demonstration, and not the actual payments that plans made to providers for services, so the savings are calculated from the perspective of the Medicare program. A similar approach will be applied to the Medicaid savings calculation when data is available. Part D costs are not included in the savings analysis but will be included in the final evaluation report.

The results shown here reflect quality withhold repayments for the period March 2015 to December 2016 but do not include risk corridor repayments or recoupments. Note that Medicare and Medicaid savings calculations will be conducted by RTI for each year of the demonstration as data are available.

The following sections discuss the analytic approach and results of these analyses.

10.1 Evaluation Design

To assess the impact of the demonstration on Medicare costs for Medicare-Medicaid enrollees, RTI used an ITT approach comparing the population eligible for the Michigan demonstration with a comparison group not affected by the demonstration. An ITT approach diminishes the potential for selection bias and highlights the effect of the demonstration on all beneficiaries in the demonstration eligible population. All Medicare-Medicaid enrollees eligible for the demonstration constitute the evaluation sample, regardless of whether they enrolled in the demonstration or actively participated in the demonstration care model. Therefore, the analyses presented here cover demonstration eligible beneficiaries including those who opted out, or who participated but subsequently disenrolled; who were eligible but were not contacted by the State or participating plans; and those who enrolled but did not seek services.

Beneficiaries eligible for the demonstration were identified using quarterly files submitted by the State of Michigan. These files include information on all beneficiaries eligible for the demonstration, as well as indicators for whether each beneficiary was enrolled. Results are presented for all demonstration eligible beneficiaries, even for beneficiaries whose MMPs may not have had encounter data deemed ready for analysis by RTI International for this report.

A comparison group was identified in two steps. First, RTI identified comparison areas that are most similar to Michigan with regard to area-level measures of health care market characteristics such as Medicare and Medicaid spending and State policy affecting Medicaid-Medicare enrollees. Second, beneficiaries were selected using a propensity score model (described in further detail below). Further discussion of the comparison group selection process is detailed in ***Appendix A***.

RTI used a difference-in-differences (DinD) approach to evaluate the impact of the demonstration on Medicare costs. DinD refers to an analytic strategy whereby two groups—one affected by the policy intervention and one not affected by it—are compared on an outcome of interest before and after the policy intervention. The predemonstration period included 2 years prior to the start of the Michigan demonstration (March 1, 2013–February 28, 2015), the first demonstration period (demonstration year 1) included the first 22 months of the demonstration (March 1, 2015–December 31, 2016).

To estimate the average treatment effect on the demonstration eligible population for monthly Medicare expenditures, RTI ran generalized linear models (GLMs) with a gamma distribution and a log link. This is a commonly used approach in analysis of skewed data or in cases where a high proportion of observations may have values equal to zero. The model also employed propensity score weighting and adjusted for clustering of observations at the county level.

The GLM model included indicators for demonstration period, an indicator for assignment to the demonstration group versus the comparison group, and an interaction term for demonstration period and demonstration assignment. The model also included demographic variables and area level variables. The interaction term represents the combined effect of being part of the demonstration eligible group during the demonstration periods and is the key policy variable of interest. The interaction term is a way to measure the impact of both time and demonstration group status. Because the difference-in-difference variable was estimated using a non-linear model, RTI employed a post-estimation procedure to obtain the marginal effects of demonstration impact. The aggregation of the individual marginal effects represents the net demonstration impact and are reported below.

- Demographic variables included in the model were:
  - Gender,
  - Race, and
  - ESRD status.
- Area level variables included in the savings model were:
  - Medicare spending per Medicare-Medicaid enrollee age 19 or older
  - Medicare Advantage penetration rate
  - Medicaid-to-Medicare fee for service (FFS) fee index for all services
  - Medicaid spending per Medicare-Medicaid enrollee age 19 or older
  - Proportion of Medicare-Medicaid enrollees using
    - Nursing facilities age 65 or older
    - Home and community-based services (HCBS) age 65 or older
    - Personal care age 65 or older
    - Medicaid managed care age 19 or older
  - Population per square mile, and physicians per 1,000 population

Additional area-based variables—such as the percent of adults with a college degree and proximity to hospitals or nursing facilities—were used as proxies for sociodemographic indicators and local area characteristics. Note that these variables were also used in the comparison group selection process. Though the demonstration targets beneficiaries age 21 and over, these variables are meant to control for health care market characteristics generally and will not bias the savings calculation for Michigan. Individual beneficiary demographic characteristics

are controlled for in the models and are also accounted for in the propensity score weights used in the analysis.

In addition to the variables noted here, the propensity score weights used in the cost savings analyses also include Hierarchical Condition Category (HCC) risk score. HCC risk score is not included as an independent variable in the regression models predicting costs because HCC risk score is directly related to capitated payments. Due to the potential for differences in diagnoses coding for enrollees compared to beneficiaries in FFS after the start of the demonstration, the HCC risk score used to calculate the weights was "frozen" to the value at the start of the demonstration period. Diagnoses codes are the basis for risk score calculations, and by freezing the score prior to any potential impact of the demonstration, we are able to control for baseline health status using diagnosis codes available prior to the demonstration.

10.2 Medicare Expenditures: Constructing the Dependent Variable

RTI gathered predemonstration and demonstration monthly Medicare expenditure data for both the demonstration and comparison groups from two data sources. Capitation payments paid to Medicare Advantage plans in the predemonstration and demonstration periods and paid to ICOs during the demonstration period were obtained from CMS Medicare Advantage and Prescription Drug system (MARx) data. The capitation payments were the final reconciled payments paid by the Medicare program after taking into account risk score reconciliation and any associated retroactive adjustments in the system at the time of the data pull (October 2018). Medicare claims were used to calculate Medicare Parts A and B expenditures for fee-for-service beneficiaries. ***Table 19*** summarizes the data sources for Medicare expenditure data.

Table 19
Data sources for monthly Medicare expenditures

Group	Predemonstration March 1, 2013–February 28, 2015	Demonstration period March 1, 2015–December 31, 2016
Demonstration group	Medicare FFS	Medicare FFS for non-enrollees
	Medicare Advantage Capitation	Medicare Advantage Capitation for non-enrollees
		MI Health Link Capitation for enrollees
Comparison group	Medicare FFS	Medicare FFS
	Medicare Advantage Capitation	Medicare Advantage Capitation

FFS = fee for service.

A number of adjustments were made to the monthly Medicare expenditures to ensure that observed expenditures variations are not due to differences in Medicare payment policies in different areas of the country or the construction of the capitation rates. ***Table 20*** summarizes each adjustment applied by the evaluation team and specifies the application to FFS expenditures or to the capitation rate.

The capitation payments in MARx reflect the savings assumptions applied to the ICOs and Medicare components of the rate (1 percent for March 1, 2015–December 31, 2016), but do

not reflect the quality withhold amounts (withhold of 1 percent in the first demonstration period). The results shown here reflect quality withhold repayments for the first demonstration period.

Table 20
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
FFS	Indirect Medical Education (IME)	Capitation rates do not include IME	Do not include IME amount from FFS payments
FFS	Disproportionate Share Hospital (DSH) Payments and Uncompensated Care Payments (UCP)	The capitation rates reflect DSH and UCP adjustments	Include DSH and UCP payments in total FFS payment amounts.
FFS	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013 (reflected in the claims data). Because the predemonstration period includes months prior to April 1, 2013 it is necessary to apply the adjustment to these months of data so that any observed changes are not due to sequestration.	Reduced FFS claim payments incurred before April 2013 by 2% so all claims reflect this adjustment.
Capitation rate (MA and MMP)	Medicare Sequestration Payment Reductions	Under sequestration Medicare payments were reduced by 2% starting April 1, 2013. Sequestration is not reflected in the capitation rates.	Reduced capitation rate by 2%
Capitation rate (MA)	Bad debt	The capitation rate includes an upward adjustment to account for bad debt. Bad debt is not part of FFS claim payment amount and therefore needs to be removed from the capitation rate for the savings analysis. (Note, "bad debt" is reflected in the hospital "pass through" payment separate from the total claim payment amount)	Reduced capitation rate to account for bad debt load (historical bad debt baseline percentage). This is 0.91 for CY13, 0.89 for CY14, 0.89, for CY15, and 0.97 for CY16.

(continued)

Table 20 (continued)
Adjustments to Medicare expenditures variable

Data source	Adjustment description	Reason for adjustment	Adjustment detail
Capitation rate (MMP)	Bad debt	The capitation rate includes an upward adjustment to account for bad debt. Bad debt is not part of FFS claim payment amount and therefore needs to be removed from the capitation rate for the savings analysis. (Note, "bad debt" is reflected in the hospital "pass through" payment separate from the total claim payment amount)	Reduced blended capitation rate to account for bad debt load (historical bad debt baseline percentage). This is 0.91 for CY13, 0.89 for CY14, 0.89 for CY15, and 0.97 for CY16. Reduced the FFS portion of the capitation rate by an additional 1.71% for CY 2015 and by an additional 1.84% for CY 2016to account for the disproportional share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS.
FFS and capitation rate (MA and MMP)	Average Geographic Adjustments (AGA)	The Medicare portion of the capitation rate reflects the most current hospital wage index and physician geographic practice cost index by county. FFS claims also reflect geographic payment adjustments. In order to ensure that change over time is not related to differential change in geographic payment adjustments, both the FFS and the capitation rates were "unadjusted" using the appropriate county-specific AGA factor.	Medicare expenditures were divided by the appropriate county-specific AGA factor for each year. Note that for a single year-specific AGA factor based on claims paid in the year, rather than the AGA factor used in Medicare Advantage (based on 5 years of data and lagged 3 years) was used to account for year specific policies. Note also that the AGA factor applied to the capitated rates for 2014 reflected the 50/50 blend that was applicable to the payment year.
Capitation rate (MA and MMP)	Education user fee	No adjustment needed.	Capitation rates in the MARx database do not reflect the education user fee adjustment (this adjustment is applied at the contract level). Note, education user fees are not applicable in the FFS context and do not cover specific Part A and Part B services. While they result in a small reduction to the capitation payment received by MMPs, we did not account for this reduction in the capitated rate.
Capitation rate (MMP)	Quality withhold	A 1% quality withhold was applied in the first demonstration year but was not reflected in the capitation rate used in the analysis.	Final quality withhold repayments for 2015 and 2016 were incorporated into the dependent variable construction.

(continued)

Table 20 (continued)
Adjustments to Medicare expenditures variable

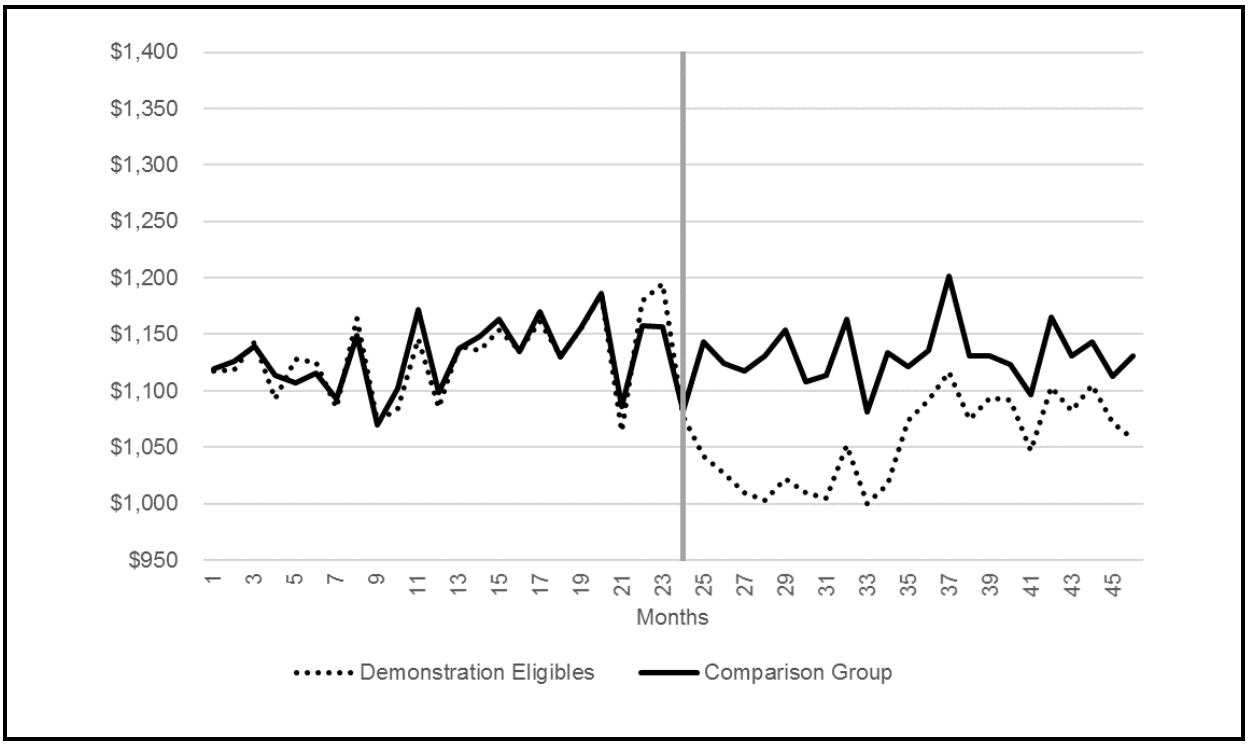
Data source	Adjustment description	Reason for adjustment	Adjustment detail
Capitation rate (MMP)	Risk corridor	Risk corridor payments or recoupments are based on reconciliation after application of risk adjustment methodologies.	Final risk corridor payments and recoupments will be incorporated into future calculations as they become available.

CY = calendar year; FFS = fee for service; MMP = Medicare-Medicaid Plan.

10.3 Results

The first step in the analysis was to plot the unweighted mean monthly Medicare expenditures for both the demonstration group and the comparison group. ***Figure 11*** indicates that the demonstration group and the comparison group had parallel trends in mean monthly expenditures during the 24-month predemonstration period, which is an important assumption to the DinD analysis.

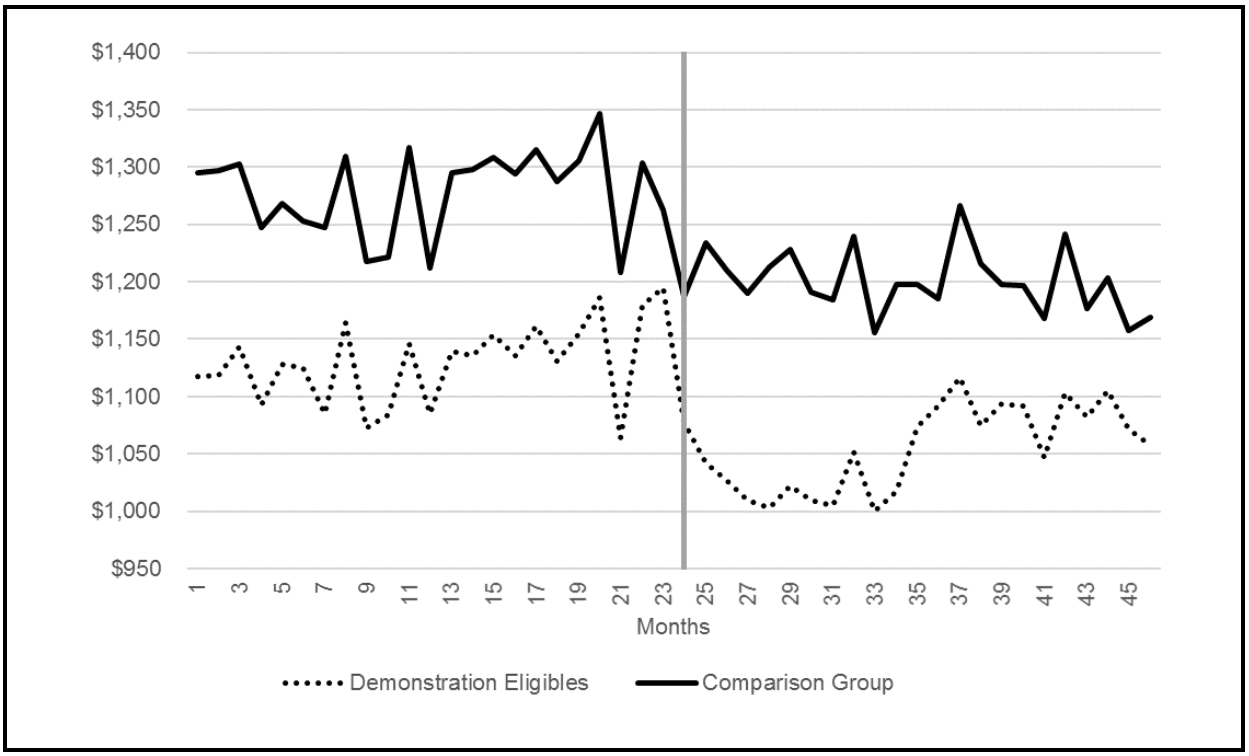
Figure 11
Mean monthly Medicare expenditures, predemonstration and demonstration period, MI Health Link eligible and comparison group, March 2013–December 2016



SOURCE: RTI Analysis of Michigan demonstration eligible and comparison group Medicare data (program: MI480_qc_20181227_0435PM).

Figure 12 demonstrates the same plot of mean monthly Medicare expenditures for both the demonstration group and the comparison group, after applying the propensity weights and establishes the parallel trends for both groups.

Figure 12
Mean monthly Medicare expenditures (weighted), predemonstration and demonstration period, MI Health Link eligible beneficiaries and comparison group, March 2013–December 2016



SOURCE: RTI Analysis of Michigan demonstration eligible and comparison group Medicare data (program: MI480_qc_20181227_0435PM).

Table 21 shows the mean monthly Medicare expenditures for the demonstration group and comparison group in the predemonstration and each demonstration period, unweighted. The unweighted tables show a decrease in mean monthly Medicare expenditures for the demonstration group and an increase in mean monthly Medicare expenditures for the comparison group during demonstration period 1. The unweighted mean decrease in demonstration period 1 for demonstration eligible beneficiaries was $72.04 and the unweighted mean increase was $1.60 for the comparison group. Decreases were shown for demonstration period 1 for both the demonstration group and the comparison group in the weighted table (***Table 22***).

The DinD values in each table represent the overall impact on savings using descriptive statistics. These effects are descriptive in that they are arithmetic combinations of simple means, without controlling for covariates. The change in the demonstration group minus the change in the comparison group is the DinD value. This value would be equal to zero if the differences between predemonstration and the demonstration period were the same for both the demonstration group and the comparison group. A negative value would indicate savings for the

demonstration group, and a positive value would indicate losses for the demonstration group. The DinD value in demonstration period 1 is positive but not statistically significant in the weighted table (illustrated by the 95 percent confidence intervals that include 0).

Table 21
Mean monthly Medicare expenditures for MI Health Link eligible beneficiaries and comparison group, pre-demonstration period and demonstration period 1, unweighted

Group	Pre-demonstration period Mar 2013–Feb 2015	Demonstration period 1 Mar 2015–Dec 2016	Difference
Demonstration group	$1,128.34 ($1,093.16, $1,163.51)	$1,056.29 ($1,027.55, $1,085.04)	−$72.04 (−$85.40, −$58.68)
Comparison group	$1,129.85 ($1,084.31, $1,175.39)	$1,131.46 ($1,080.51, $1,182.40)	$1.60 (−$17.66, $20.87)
Difference-in-difference	—	—	−$73.65 (−$97.05, −$50.24)

— = data not available.

NOTE: 95 percent confidence intervals are shown in parentheses below estimates.

SOURCE: RTI Analysis of Michigan demonstration eligible and comparison group Medicare data (program: cap savings\Michigan\lgs_mics500_log).

Table 22
Mean monthly Medicare expenditures for MI Health Link eligible beneficiaries and comparison group, pre-demonstration period and demonstration period 1, weighted

Group	Pre-demonstration period Mar 2013–Feb 2015	Demonstration period 1 Mar 2015–Dec 2016	Difference
Demonstration group	$1,128.34 ($1,093.16, $1,163.51)	$1,056.29 ($1,027.55, $1,085.04)	−$72.04 (−$85.40, −$58.68)
Comparison group	$1,275.04 ($1,233.99, $1,316.10)	$1,200.83 ($1,151.16, $1,250.50)	−$74.22 (−$100.09, −$48.35)
Difference-in-difference	—	—	$2.17 (−$26.96, $31.31)

— = data not available.

NOTE: 95 percent confidence intervals are shown in parentheses below estimates.

SOURCE: RTI Analysis of Michigan demonstration eligible and comparison group Medicare data (program: cap savings\Michigan\lgs_mics500_log).

10.3.1 Regression Analysis

While the descriptive statistics are informative, to get a more accurate estimate of savings, RTI conducted a multivariate regression analysis to estimate savings controlling for beneficiary and area level characteristics. Given the structure of the data, RTI used the GLM

procedure in Stata with a gamma distribution and a log link, and adjusted for clustering at the county level.

In addition to controlling for beneficiary and market area characteristics, the model included a time trend variable (coded as months 1–46), a dichotomous variable for whether the observation was from the pre-demonstration or demonstration period ("Post"), a variable to indicate whether the observation was from a beneficiary in the comparison group or the demonstration group ("Intervention"), and an interaction term ("Intervention*Post") which is the difference-in-differences estimate in the multivariate model for the net effect of demonstration eligibility.

Table 23 shows the main results from the DinD analysis for demonstration year 1controlling for beneficiary demographics and market characteristics. To obtain the effect of the demonstration from the non-linear model we calculated the marginal effect of coefficient of the interaction term. The marginal effect of the demonstration for the intervention group over demonstration year 1 was positive (16.13) but not statistically significant, indicating that there were no net losses to Medicare as a result of the demonstration using the ITT analysis framework.

Table 23
Demonstration effects on Medicare savings for eligible beneficiaries—Difference-in-difference regression results, MI Health Link eligible beneficiaries and comparison group

Covariate	Adjusted coefficient DinD	*p*-value	95% confidence interval	90% confidence interval
Intervention*DemoYear1 (March 2015–December 2016)	$16.13	0.2709	(−$12.58, $44.84)	(−$7.96, $40.22)

SOURCE: RTI Analysis of Michigan demonstration eligible and comparison group Medicare data (program: cap savings\Michigan\lgs_mics480_log).

Table 24 shows the magnitude of the DinD estimate relative to the adjusted mean outcome value in the predemonstration and demonstration periods. The second and third columns represent the post-regression, mean predicted savings or loss for each group and period, based on the composition of a reference population (the comparison group in the demonstration period). These values show how different the two groups were in each period, and the relative direction of any potential effect in each group over time. The remaining columns show the difference-in-differences estimate (the coefficient on Intervention*Post), the *p*-value demonstrating significance, and the relative percent change of the difference-in-differences estimate compared to the mean monthly Medicare expenditures for the comparison group in the entire demonstration period.

The adjusted mean for monthly expenditures increased between the predemonstration and demonstration period for the demonstration and comparison groups. The DinD estimate of $16.13 (the coefficient on Intervention*Post) is positive, but the losses are not statistically significant (p = 0.2709), indicating that there were no statistically significant losses in Medicare Parts A and B from the demonstration, using the ITT analysis framework. The DinD estimate for

demonstration year 1 reflected an annual relative cost increase of 1.33 percent, but this was not statistically significant.

Table 24
Adjusted means and overall impact estimate for eligible beneficiaries in the demonstration and comparison groups, MI Health Link eligible beneficiaries and comparison group

Group	Adjusted mean for pre-demonstration period	Adjusted mean for demonstration period	Relative difference (%)	Adjusted coefficient DinD	*p*-value
Demonstration group	$1,155.05	$1,098.68	1.33	$16.13	0.2709
Comparison group	$1,292.66	$1,211.18			

CI = confidence interval; DinD = difference-in-differences

NOTE: Adjusted coefficient DinD 95 percent CI: (−12.58, 44.84); and 90 percent CI: (−7.96, 40.22). Even though the comparison group was carefully developed to have similar characteristics to the demonstration group, there are always slight differences in demographic, health, and area characteristics between the demonstration and comparison groups. The two types of results reported in this table take these differences into account, but use different statistical methods to do so. Before calculating the mean values reported in the second and third columns in this table, RTI adjusted the composition of the demonstration's baseline and demonstration period groups and the comparison baseline period group to match the characteristics of the comparison group in the demonstration period so that the means do not reflect any differences in the groups' characteristics. The regression DinD approach, results reported in the fifth column of this table, controls for these differences automatically, without changing the underlying characteristics of the demonstration and comparison groups. Because of these differing methods, the difference-in-differences results obtained from the regression may differ slightly from a similar calculation using the results in the adjusted mean columns. The relative percentage difference in the fourth column is calculated by dividing the difference-in-differences value in column 5 by the value for the comparison group in the demonstration period in column 3.

SOURCE: RTI Analysis of Michigan demonstration eligible and comparison group Medicare data (program: cap savings\Michigan\lgs_mics490_log).

In addition to the cost savings analysis on all eligible beneficiaries (ITT approach), RTI conducted several sensitivity analyses to provide additional information on potential savings or losses associated with the demonstration overall and for the subset of beneficiaries enrolled in the demonstration. These sensitivity analyses included (1) simulating capitated rates for eligible enrollees not enrolled in the demonstration and comparing these rates to actual FFS expenditures; (2) predicting FFS expenditures for beneficiaries enrolled in the demonstration and comparing to the actual capitated rates; and (3) calculating a DinD estimate based on a subgroup of beneficiaries enrolled in the demonstration with at least 3 months of eligibility in the baseline period. The results of these analyses are presented in ***Appendix D***.

The findings of the sensitivity analyses indicate that the predicted capitated rates are statistically significantly higher than actual FFS expenditures for beneficiaries eligible but not enrolled and that predicted FFS expenditures are higher than actual capitated rates for enrollees. The enrollee subgroup DinD analysis indicates additional costs compared to a comparison group, and this finding is statistically significant. Note that these analyses do not control for unobservable characteristics that may be related to the decision to enroll in the demonstration.

The enrollee subgroup DinD analysis was conducted to learn more about the potential impact of the demonstration on the subset of beneficiaries touched by the demonstration for at least 3 months. Note that similar 3-month eligibility criteria were applied to the comparison group for the baseline and demonstration periods for this analysis and weights were recalculated. The enrollee subgroup analysis is limited by the absence of person-level data on characteristics that potentially would lead an individual in a comparison area to enroll in a similar demonstration, and thus the results should be considered in the context of this limitation.

10.4 Discussion

The results of the preliminary multivariate analyses presented here do not indicate statistically significant savings or losses during the first 22 months of the Michigan demonstration. The savings calculated here are based on capitation rates paid for enrollees and the FFS expenditures for eligible beneficiaries that did not enroll in the demonstration. The estimates do not take into account actual payments for services incurred by enrollees and paid by the ICOs. The estimates do not include risk corridor payments or recoupments.

One potential reason that savings were not identified in these analyses is that that there was not sufficient time for the program to demonstrate impact. It is also important to note that given the ITT framework used to calculate savings, all eligible beneficiaries, regardless of their enrollment status were included in the calculation.

RTI will continue to examine these results and will rerun the analyses when complete information on risk corridor payments or recoupments become available. Once Medicaid data become available to the evaluation team, and a similar calculation can be conducted on the Medicaid costs, it will be possible to have a more complete understanding of potential savings from the first year of the MI Health Link demonstration. Preliminary estimates provided by the State of Michigan indicate Medicaid savings as a result of the demonstration. The State of Michigan projects savings to the State of $2.75 million for the first demonstration year.[23] Additional Medicare and Medicaid savings calculations will be conducted by the evaluation contractor for each year of the demonstration as data are available and future reports will show updated results for the first year of the demonstration based on data reflecting additional claims runout, risk score reconciliation, and any retroactive adjustments.

[23] Estimates are assessed and provided by the State of Michigan and are independent from the analyses presented in this evaluation report. CMS has not validated this estimate.

11. Conclusions

11.1 Implementation-related Successes, Challenges, and Lessons Learned

During its first 3 years, the MI Health Link demonstration experienced challenges with enrollment, behavioral health services integration, care coordination, and long-term services and supports (LTSS). The State, CMS, ICOs, and other stakeholders were able to address these challenges to varying degrees, and most of the challenges had limited impact on enrollees. Positive features cited by beneficiary focus group participants and advocates included no cost sharing, care coordination, good access to medical and behavioral health services, and more reliable medical transportation services.

The ICOs, the State, and CMS addressed enrollment discrepancies by developing manual processes to identify and resolve them. Resumption of monthly passive enrollment and implementation of deemed enrollment helped stabilize enrollment, and the State developed an algorithm that assigned new enrollees to plans based on their capacity to serve them.

In response to CMT's concerns about the timeliness of health risk assessment completion rates, ICOs developed effective strategies to reach enrollees and rates improved. Care plan completion rates improved at a slower rate, as ICOs engaged enrollees in the care planning process through in-person meetings and discussions of care goals.

Although neither the ICOs nor the PIHPs were pleased with Michigan's approach to behavioral health integration, which forces them to collaborate, it appeared to be working relatively well for the enrollees; more enrollees are accessing behavioral health services, and the PIHPs have more information about enrollees' physical health. ICOs and PIHPs have worked together to coordinate care and the health information exchange has been an effective means of transmitting referrals and assessments. Capitation payments from the ICOs are an ongoing concern for PIHPs.

The home and community-based services (HCBS) waiver was a major operational challenge in early 2018, which State officials expected to resolve during the year by adding additional reviewers and providing feedback and training for the ICOs. The backlog appeared to have a limited impact on enrollees because ICOs authorized personal care and some HCBS while their applications were pending. State officials hope that once the backlog is eliminated, access to HCBS will be seen as a positive feature of MI Health Link and a reason for beneficiaries to enroll.

Stakeholder engagement was a strength of the demonstration, particularly engagement of beneficiaries and advocates. Frequent meetings with advocates, as well as the advisory committee and Lunch and Learn outreach events, helped keep State officials and ICOs focused on the beneficiary experience and provided actionable information about MI Health Link to enrollees and demonstration eligible beneficiaries.

The RTI evaluation team's observations of the Michigan demonstration suggest several lessons. Integration of previously carved-out benefits can create significant operational challenges in States with Medicaid managed care experience. Additionally, launching a major

new programmatic initiative—such as the HCBS waiver—concurrently with the demonstration led to major capacity challenges for the State and ICOs. The launch of the HCBS waiver might have been more successful if the State had been able to contract with an independent entity to conduct functional assessments and prepare waiver applications as originally planned, rather than adding that to the ICOs' responsibilities.

11.2 Demonstration Impact on Service Utilization and Costs

Impact analyses from the first year of the Michigan demonstration reveal changes in service utilization patterns attributable to the demonstration and mostly consistent with overall improvements in beneficiaries' reported experience, such as care coordination provided by the ICOs. Results show decreases in inpatient admissions, ambulatory care sensitive condition admissions (both overall and those specific to chronic care), emergency room (ER) visits, preventable ER visits, and physician evaluation and management (E&M) visits. There was no change in the 30-day all-cause readmission rate or the probability of 30-day follow-up visits after mental health inpatient discharge. One measure—the rate of long-stay nursing facility (NF) admissions—increased. Challenges with implementing either LTSS integration or the HCBS waiver, or both, may have contributed to the increase in NF admissions.

In addition to providing care coordination, the demonstration reduced barriers to accessing prescription drugs by eliminating co-payments, which may have impacted enrollee health. The RTI evaluation team also notes that most demonstration enrollees were enrolled in ICOs operated by parent organizations that had experience operating Medicaid and Medicare managed care plans in Michigan, as well as experience with the Illinois and Ohio FAI demonstrations, which launched before the Michigan demonstration.

Results from subgroup analyses for the population with a serious and persistent mental illness (SPMI) followed the same direction and to a similar degree on all measures as for the overall demonstration eligible population. In addition, results for the long-term services and supports (LTSS) population—defined as those who used either long-stay nursing facility or HCBS—were qualitatively the same as the broader demonstration eligible population, except that there was no statistically significant finding regarding any change in physician E&M visits.

Results for these two subgroups may vary due to differences in enrollment and implementation for these populations. State officials said that persons with SPMI enrolled at a relatively high rate. State officials and stakeholders reported effective coordination between the ICOs—which provided overall care coordination—and the PIHPs, which continued to coordinate behavioral health services. For LTSS, relatively few beneficiaries who used waiver services enrolled in the demonstration; most LTSS users who enrolled were NF residents. State officials said the ICOs lacked experience coordinating LTSS, which resulted in delays in enrollment in the HCBS waiver. It is not clear whether this impacted the use of medical services.

The results of the preliminary multivariate cost savings analyses presented here do not indicate statistically significant Medicare savings or losses during the first 22 months of the Michigan demonstration. The savings calculated here are based on capitation rates paid by CMS to the ICOs for enrollees, and the FFS expenditures and Medicare Advantage capitation rates for eligible beneficiaries that did not enroll in the demonstration. The estimates do not take into

account actual payments for services incurred by enrollees and paid by the ICOs. RTI will continue to examine these results and will rerun the analyses when more data become available. Once Medicaid data become available and a similar calculation can be conducted on the Medicaid costs, it will be possible to have a more complete understanding of potential savings from the Michigan demonstration. Additional Medicare and Medicaid savings calculations will be conducted by the evaluation contractor for each year of the demonstration as data are available.

11.3 Next Steps

The RTI evaluation team will continue to collect information on a quarterly basis from Michigan officials through the online State Data Reporting System, covering enrollment statistics and updates on key aspects of implementation. The RTI evaluation team will continue conducting quarterly calls with the MI Health Link State and CMS staff and will request the results of any evaluation activities conducted by the State or other entities, such as results from the Consumer Assessment of Healthcare Providers and Systems survey and State-specific demonstration measures the plans are required to report to CMS. RTI will conduct additional qualitative and quantitative analyses over the course of the demonstration.

The next report will include a qualitative update on the implementation of the MI Health Link demonstration and descriptive analyses of quality and utilization measures for those eligible for the demonstration and the comparison group. As noted previously, Michigan requested an extension from CMS to continue the demonstration, which will provide further opportunities to evaluate the demonstration's performance.

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Appendix A:
Comparison Group Methodology for Michigan Demonstration Year 1

The Centers for Medicare & Medicaid Services (CMS) contracted with RTI International to monitor the implementation of demonstrations under the Financial Alignment Initiative (FAI) and to evaluate their impact on beneficiary experience, quality of care, utilization, and cost. This appendix presents the comparison group selection and assessment results for the FAI demonstration in the State of Michigan (MI Health Link) and focuses primarily on all beneficiaries eligible for the demonstration, with a brief discussion of demonstration enrollees.

This appendix lists the geographic comparison areas for Michigan, provides propensity model estimates, and shows the similarities between the comparison and demonstration groups in terms of their propensity score distributions. Separate analyses were conducted for three time periods for the Michigan demonstration: predemonstration year 1 (March 1, 2013–February 28, 2014), predemonstration year 2 (March 1, 2014–February 28, 2015), and demonstration year 1 (22 months, March 1, 2015–December 31, 2016). Analyses were conducted for each period because eligible beneficiaries are identified separately for each time period.

The Michigan demonstration group included dual eligible beneficiaries age 21 and older. The RTI evaluation team included beneficiaries who had been attributed to another Federal Medicare shared savings initiative, as ascertained using the beneficiary-level version of CMS' Master Data Management (MDM) file. Beneficiaries in the demonstration group during demonstration year 1 were identified from quarterly finder files of beneficiaries enrolled in the MI Health Link demonstration. Beneficiaries qualified for the demonstration group if they participated for at least 1 month during the demonstration period. During the 2 predemonstration years, all beneficiaries who met dual eligible beneficiary criteria and metropolitan statistical area (MSA) residency requirements were selected for the demonstration and comparison groups. Beneficiaries were omitted from further analyses if they had missing geography data, passed away before the beginning of the analysis period, had zero months of eligibility as a dual eligible beneficiary, lived in both a demonstration area and a comparison area during the analysis period or had missing Hierarchical Condition Category (HCC) risk scores during a year.

A.1 Comparison Areas

The Michigan demonstration area consists of 25 counties that are part of six MSAs (i.e., Battle Creek, Detroit-Warren-Dearborn, Grand Rapids-Wyoming, Kalamazoo-Portage, Niles-Benton Harbor, and South Bend-Mishawaka) and 17 nonmetropolitan counties in Michigan. The comparison area comprises 18 counties in nine MSAs from four States, including 40 nonmetropolitan counties in Michigan. The pool of States was limited to those with timely submission of Medicaid data to CMS as of 2013. All comparison MSAs are listed in ***Table A-1***.

Table A-1
Comparison areas in four comparison States

Michigan MSAs
- Bay City
- Lansing-East Lansing
- Midland
- Monroe
- Muskegon
- Saginaw

California MSAs
- San Francisco-Oakland-Hayward

Pennsylvania MSAs
- Philadelphia-Camden-Wilmington

Missouri MSAs
- Fayetteville-Springdale-Rogers

MSAs = metropolitan statistical areas.

Table A-2 shows the distribution of beneficiaries by comparison State in the first predemonstration year. California contributed the largest share of comparison beneficiaries, followed by Pennsylvania, and comparison areas within the State of Michigan. State shares were very similar in predemonstration year 2 and demonstration year 1. The total number of comparison beneficiaries was comparatively stable throughout the three time periods (317,791 in predemonstration year 1; 325,032 in predemonstration year 2; and 375,723 in demonstration year 1).

Table A-2
Distribution of comparison group beneficiaries for the Michigan demonstration by comparison State, predemonstration year 1

Comparison State	Comparison beneficiaries
California	38.27%
Pennsylvania	37.70%
Michigan	23.81%
Missouri	0.22%
Total percent	100%
Total beneficiaries	317,791

A.2 Propensity Score Estimates

RTI's methodology uses propensity scores to examine initial differences between the demonstration and comparison groups and then to weight the data to improve the match between them. The comparability of the two groups is examined with respect to both individual beneficiary characteristics as well as the overall distributions of propensity scores. This section describes the results of the model that generates propensity scores and future sections show how weighting eliminates initial differences between the groups.

A propensity score is the predicted probability that a beneficiary is a member of the demonstration group conditional on a set of observed variables. Our propensity score models include a combination of beneficiary-level and region-level characteristics measured at the ZIP

code (ZIP Code Tabulation Area) level. Region-level covariates were drawn from a factor analysis of ZIP code–based variables for the adult population. These covariates capture features of the age, employment, marital, and family status categories of households in each region. Total distances to hospitals and nursing facilities (NFs) were also included.

The logistic regression coefficients, standard errors, and z-values for the covariates included in the propensity model for Michigan are shown in ***Table A-3***. These coefficients and the underlying data are used to generate propensity scores for each beneficiary. In general, individual covariates had similar effects in each period. The coefficients for several variables reflected some important differences between the demonstration and comparison groups. The magnitude of these differences may also be seen in the unweighted standardized differences in ***Tables A-4*** to ***A-6***. Relative to the comparison group, demonstration eligible beneficiaries were younger, had a higher percentage of Black beneficiaries and a lower percentage of Asian beneficiaries, were more likely to participate in another Federal Medicare shared savings initiative, were less likely to live in married households, and were more likely to live in areas with a higher percentage of adults with self-care limitations and a lower percentage of adults with a college degree. We elected to exclude the share of months eligible from the logistic regression model because of the staggered rollout of the demonstration in Michigan. This is consistent with our treatment of the variable in other States with staggered roll-out, such as California.

Table A-3
Logistic regression estimates for Michigan propensity score models

	Predemonstration Year 1			Predemonstration Year 2			Demonstration Year 1		
	Coefficient	**Std. Err.**	**z-score**	**Coeff.**	**Std. Err.**	**z-score**	**Coeff.**	**Std. Err.**	**z-score**
Age (years)	−0.006	0.000	−18.10	−0.006	0.000	−18.41	−0.008	0.000	−22.78
Died during year (0/1)	0.186	0.018	10.25	0.183	0.018	10.24	0.152	0.030	5.06
Female (0/1)	−0.158	0.008	−19.07	−0.115	0.008	−14.33	−0.093	0.008	−11.74
Black (0/1)	0.430	0.010	41.95	0.432	0.010	42.97	0.506	0.010	51.94
Asian (0/1)	−1.255	0.021	−60.46	−1.258	0.020	−62.14	−1.086	0.020	−53.95
Disability as original reason for Medicare entitlement (0/1)	−0.007	0.011	−0.59	−0.012	0.011	−1.05	−0.040	0.011	−3.71
ESRD (0/1)	−0.034	0.023	−1.46	−0.035	0.024	−1.49	−0.105	0.023	−4.61
HCC risk score	0.086	0.004	24.54	0.066	0.003	19.37	0.020	0.003	6
Other MDM (0/1)	0.591	0.010	58.96	0.453	0.009	48.41	0.472	0.009	53.34
MSA (0/1)	1.940	0.018	106.62	1.957	0.018	107.06	2.117	0.018	117.07
% of population living in married households	0.032	0.000	86.8	0.033	0.000	89.02	0.037	0.000	100.85
% of households with member age ≥ 60 years	0.005	0.001	6.58	0.012	0.001	17.9	0.004	0.001	5.94
% of adults with college degree	−0.064	0.000	−128.82	−0.064	0.000	−129.47	−0.071	0.000	−142.86
% of adults with self-care limitation	0.296	0.003	115.54	0.286	0.002	116.58	0.284	0.002	116.88
% of households with member age < 18 years	−0.009	0.001	−14.13	−0.010	0.001	−16.09	−0.023	0.001	−37.84
Distance to nearest hospital (miles)	0.046	0.001	41.97	0.046	0.001	41.67	0.045	0.001	41.72
Distance to nearest nursing facility (miles)	0.013	0.002	8.11	0.007	0.002	4.2	0.011	0.002	7.04
Intercept	−4.583	0.051	−89.06	−4.753	0.050	−94.23	−4.326	0.051	−85.53

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; MDM = ; MSA = metropolitan statistical area.

A.3 Propensity Score Overlap

Propensity score weighting is used to mitigate the potential for selection bias by increasing the equivalence of the demonstration and comparison groups. Any beneficiaries who have estimated propensity scores less than the smallest estimated value in the demonstration group were removed from the comparison group. This resulted in the removal of 791; 3,026; and 1,294 comparison beneficiaries in each of the 3 years, respectively (i.e., predemonstration years 1 and 2, and demonstration year 1).

The distributions of propensity scores by group are shown for each time period in ***Figures A-1 to A-3*** before and after propensity score weighting. Estimated scores covered nearly the entire probability range in both groups. In each period, demonstration group scores were less skewed to the right than the unweighted comparison beneficiary scores, which skewed sharply to the right.

The figures show that inverse probability of treatment weighting pulls the distribution of weighted comparison group propensity scores (dotted line) much closer to that of the demonstration group (solid line). Weighting shifted the comparison group distribution to the right, greatly increasing the comparability of the demonstration and comparison groups.

Figure A-1
Distribution of beneficiary-level propensity scores in the Michigan demonstration and comparison groups, weighted and unweighted, March 2013–February 2014

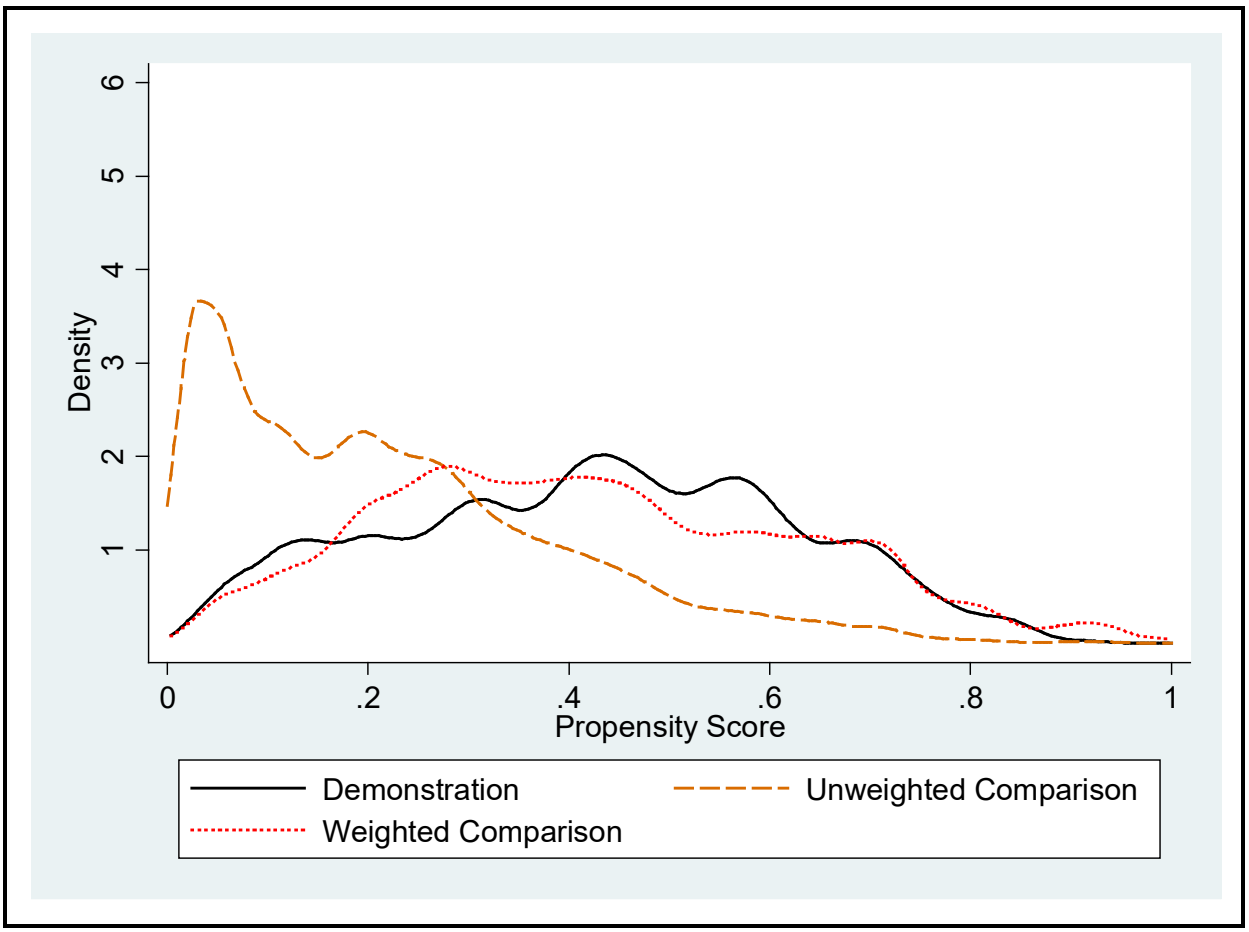


Figure A-2
Distribution of beneficiary-level propensity scores in the Michigan demonstration and comparison groups, weighted and unweighted, March 2014–February 2015

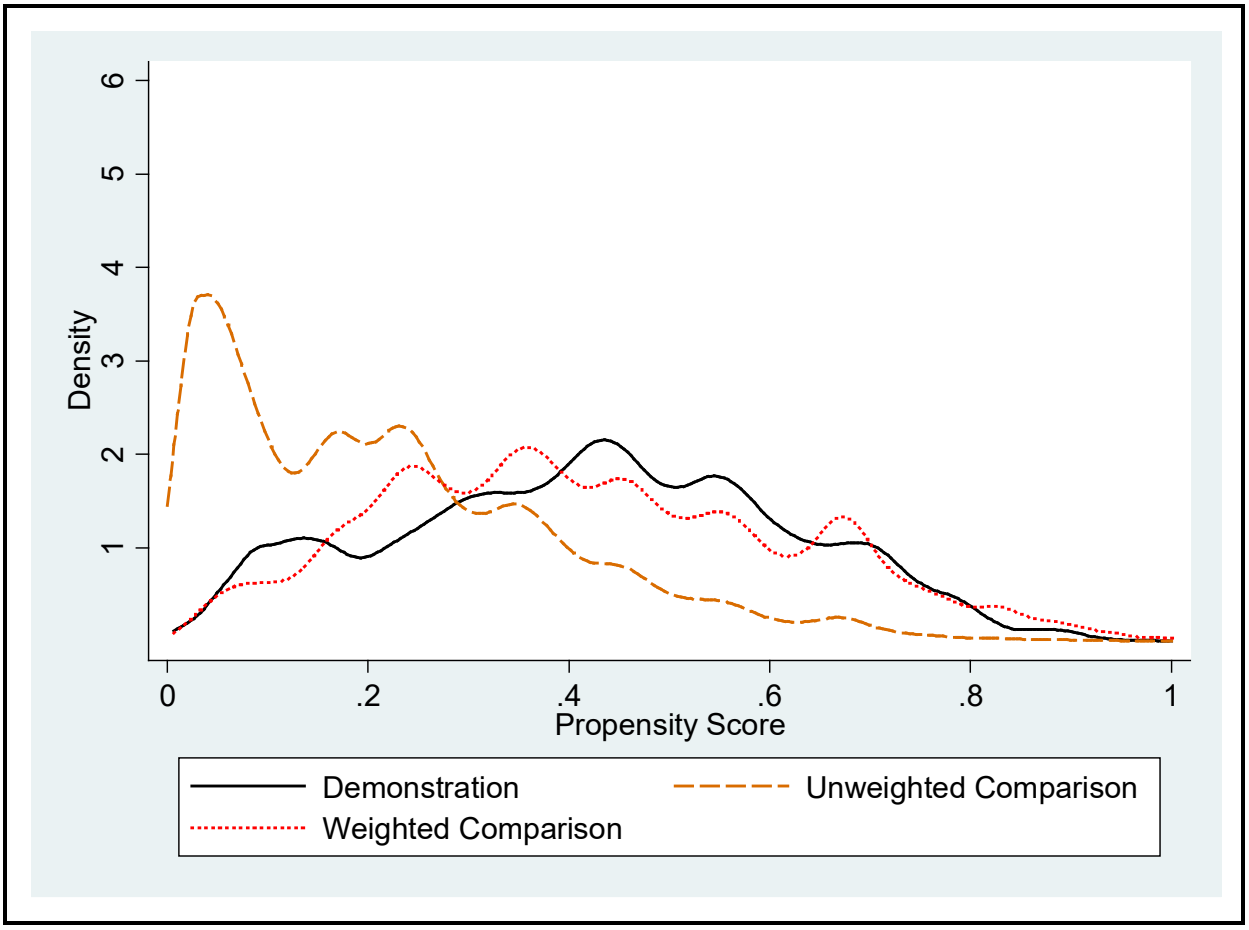
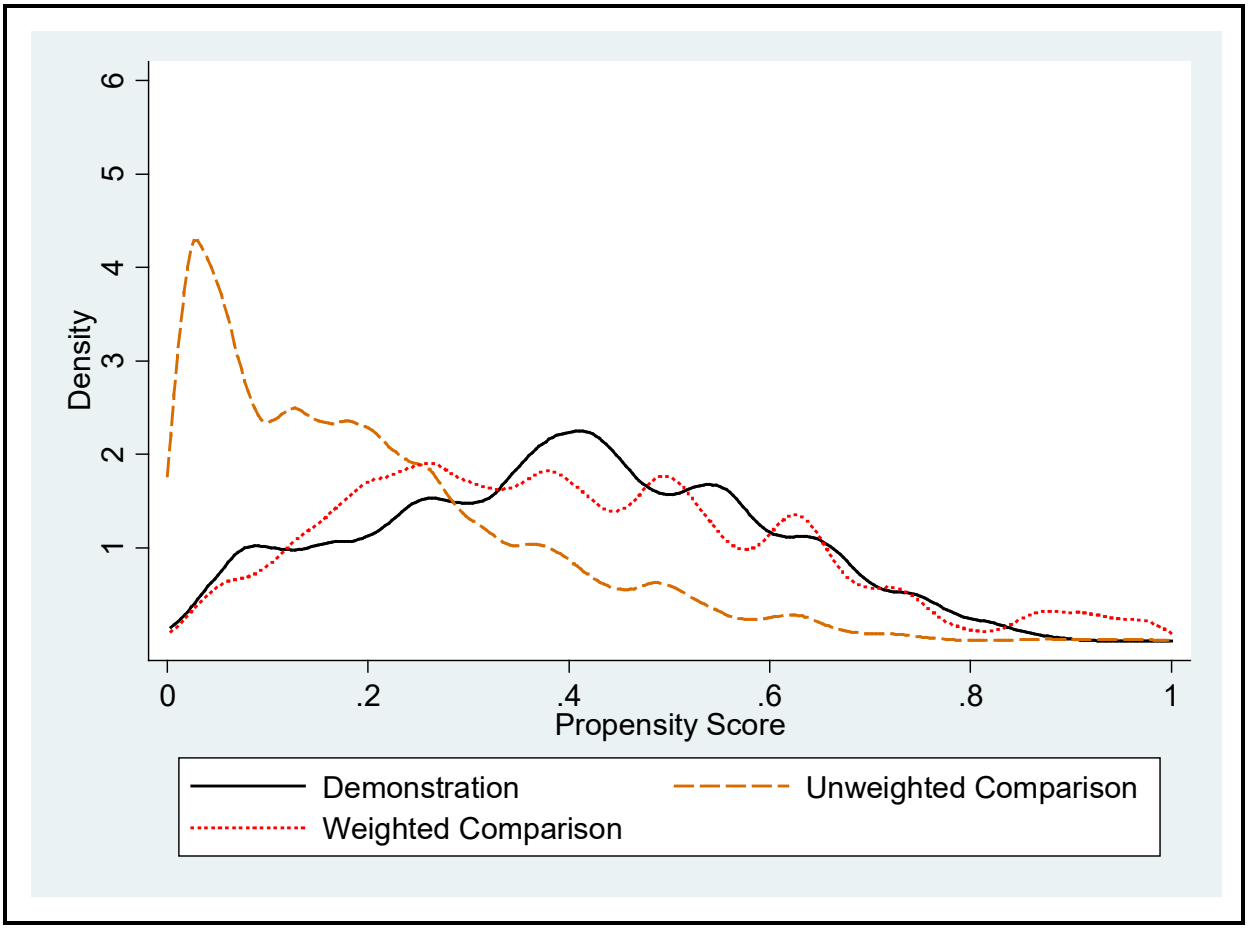


Figure A-3
Distribution of beneficiary-level propensity scores in the Michigan demonstration and comparison groups, weighted and unweighted, March 2015–December 2016



A.4 Group Comparability

Covariate balance refers to the extent to which the characteristics used in the propensity score are similar (or "balanced") for the demonstration and comparison groups. Group differences are measured by a standardized difference (the difference in group means divided by the pooled standard deviation of the covariate). We follow an informal standard that has developed within the literature: groups are considered comparable if the standardized covariate difference is less than 0.10.

The group means and standardized differences for all beneficiary characteristics are shown for each time period in ***Tables A-4 to A-6***. The column of unweighted standardized differences indicates that several of these variables were not balanced before running the propensity model. The area-level variables consistently exhibited larger standardized differences than individual-level variables across the three time periods. Demonstration beneficiaries were less likely to have college degrees and live in married households. More demonstration beneficiaries have a self-care limitation and they live in areas with higher percentages of

beneficiaries have a self-care limitation and they live in areas with higher percentages of households containing members age 60 years or older as well as members younger than 18 years old. Average distances to both nearest hospitals and nursing facilities were farther for demonstration beneficiaries. These differences were relatively stable across time periods.

The results of propensity score weighting for Michigan are illustrated in the last column (weighted standardized differences) in ***Tables A-4 to A-6***. Propensity score weighting pulled comparison group means closer to the demonstration group means, thereby reducing the standardized differences and improving the balance between the two groups. In each year, weighting reduced the magnitude of the group differences below the desired threshold of 0.10 for most of the covariates except for Black, MSA, percent of population living in married households, and distance to the nearest hospital. Black beneficiaries in the demonstration group represented 40 percent, compared to approximately 25 percent in the comparison group, before weighting. After weighting, the percentage of Black beneficiaries increased to 35 percent for the comparison group, although its standardized difference is slightly greater than 0.10. The adjusted difference for the distance to the nearest hospital was quite small, amounting to only 1.1 miles or closer. The MSA difference fell below the 0.10 criterion in the first demonstration year.

Table A-4
Michigan dual eligible beneficiary covariate means by group before and after weighting by propensity score—Baseline year 1: March 2013–February 2014

Year 1	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age (years)	61.652	65.171	61.511	−0.205	0.008
Died during year	0.051	0.044	0.053	0.033	−0.007
Female	0.608	0.592	0.602	0.031	0.011
Black	0.400	0.248	0.340	0.329	0.123
Asian	0.024	0.153	0.023	−0.466	0.009
Disability as original reason for Medicare entitlement	0.538	0.439	0.545	0.199	−0.014
ESRD	0.030	0.023	0.028	0.042	0.013
HCC score	1.431	1.297	1.416	0.120	0.013
Other MDM	0.212	0.123	0.204	0.238	0.019
MSA	0.889	0.864	0.846	0.075	0.124
% of population living in married households	58.826	65.040	61.981	−0.335	−0.164
% of households with member age ≥ 60 years	36.549	35.449	37.017	0.160	−0.068
% of adults with college degree	16.588	27.152	16.855	−0.772	−0.027
% of adults with self-care limitation	5.029	3.723	4.971	0.619	0.023
% of households with member age < 18 years	31.446	29.866	30.828	0.188	0.081

(continued)

Table A-4 (continued)
Michigan dual eligible beneficiary covariate means by group before and after weighting by propensity score—Baseline year 1: March 2013–February 2014

Year 1	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Distance to nearest hospital (miles)	5.944	4.880	6.994	0.164	−0.127
Distance to nearest nursing facility (miles)	4.456	3.792	4.961	0.136	−0.094

Table A-5
Michigan dual eligible beneficiary covariate means by group before and after weighting by propensity score—Baseline year 2: March 2014–February 2015

Year 2	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age	61.755	65.272	61.638	−0.207	0.007
Died	0.051	0.045	0.053	0.029	−0.009
Female	0.605	0.590	0.603	0.031	0.003
Black	0.401	0.249	0.344	0.330	0.119
Asian	0.025	0.154	0.023	−0.465	0.009
Disability as original reason for Medicare entitlement	0.544	0.444	0.551	0.201	−0.014
ESRD	0.028	0.022	0.026	0.040	0.013
HCC score	1.387	1.269	1.382	0.105	0.004
Other MDM	0.229	0.151	0.225	0.200	0.010
MSA	0.891	0.867	0.856	0.075	0.105
% of pop living in married households	58.373	64.456	61.630	−0.327	−0.170
% of household w/ member greater than age 60	37.422	36.116	37.815	0.190	−0.057
% of adults with college degree	17.059	27.529	17.433	−0.760	−0.038
% of adults with self-care limitation	5.141	3.765	5.011	0.633	0.053
% of household w/ member less than age 18	30.977	29.655	30.370	0.158	0.080
distance to nearest hospital	5.896	4.843	6.881	0.164	−0.122
distance to nearest nursing facility	4.424	3.772	4.933	0.134	−0.095

Table A-6
Michigan dual eligible beneficiary covariate means by group, before and after weighting by propensity score—Demonstration Year 1: March 2015–December 2016

Year 3	Demonstration group mean	Comparison group mean	PS-weighted comparison group mean	Unweighted standardized difference	Weighted standardized difference
Age	62.144	65.998	62.097	−0.232	0.003
Died	0.015	0.015	0.017	0.003	−0.012
Female	0.602	0.584	0.596	0.036	0.012
Black	0.406	0.247	0.350	0.346	0.116
Asian	0.025	0.142	0.023	−0.435	0.010
Disability as Original reason for Medicare entitlement	0.546	0.442	0.552	0.211	-0.012
ESRD	0.028	0.023	0.026	0.033	0.011
HCC score	1.385	1.334	1.386	0.047	-0.001
Other MDM	0.256	0.161	0.253	0.236	0.006
MSA	0.894	0.866	0.867	0.086	0.084
% of population living in married households	57.919	64.527	61.039	−0.354	−0.159
% of household with member age ≥ 60 years	37.939	36.795	38.551	0.160	−0.084
% of adults with college degree	17.275	28.091	17.546	−0.779	−0.027
% of adults with self-care limitation	5.244	3.847	5.199	0.639	0.017
% of household with member age < 18 years	30.634	29.598	29.834	0.125	0.105
Distance to nearest hospital	5.826	4.866	6.671	0.150	−0.108
Distance to nearest nursing facility	4.369	3.795	4.830	0.119	−0.088

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; MDM = Minimum Data Set; MSA = metropolitan statistical area; PS = propensity score.

A.5 Enrollee Results

In addition, we performed propensity score weighting on a subgroup of demonstration enrollees (approximately 33 percent of the eligible demonstration population). We define the enrollee group, as well as its comparison group, as follows: (1) The demonstration enrollees are those with at least three months of enrollment during the 1-year demonstration period as well as three months of eligibility during the 2-year predemonstration period, and (2) The corresponding comparison group beneficiaries are those with at least three months of eligibility in both the 1-year demonstration period and the 2-year predemonstration period. The propensity score weighting analysis on enrollees and their associated comparison group yielded better results than

our analysis of all eligible beneficiaries. Propensity score weighting lowered the weighted standardized differences to below the 0.10 threshold for all covariates, except for the percent of population living in married households and percent of households with members less than 18 years old, both of which have standardized differences at around 0.11.

A.6 Summary

Our analyses revealed differences between the Michigan demonstration and comparison groups before covariate balancing with regard to several area-level characteristics as well as demographics. The propensity score-based weighting process reduced most of these disparities to standardized differences of less than 0.10 over the three time periods. The only exceptions were for Black, MSA status, percent of population living in married households, and distance to the nearest hospital, although the differences were small in absolute terms.

The weighted score distributions were similar for the demonstration and comparison groups, with propensities covering a wide range of probabilities in both groups. The weighted data reduce the risk that selection bias will contaminate outcome analyses of the Michigan demonstration. The propensity score covariates may also be incorporated in the multiple regression models used to estimate demonstration effects for key outcomes to further reduce the potential for biased estimates.

Further analysis of the enrollee group similarly showed that propensity score weighting reduced standardized differences between the demonstration and comparison groups. Indeed, the enrollee results had even fewer standardized differences exceeding the 0.10 threshold than the all-eligible beneficiary results.

Appendix B:
Analysis Methodology

Methodology

We briefly describe the overall evaluation design, the data used, and the populations and measures analyzed.

Evaluation Design

RTI International is using an intent-to-treat (ITT) approach for the impact analyses conducted for the evaluation, comparing the eligible population under each State demonstration with a similar population that is not affected by the demonstration (i.e., a comparison group). ITT refers to an evaluation design in which all Medicare-Medicaid enrollees eligible for the demonstration constitute the evaluation sample, regardless of whether they actively participated in demonstration models. Thus, under the ITT framework, analyses include all beneficiaries eligible for the demonstration, including those who are eligible but are not contacted by the State or participating providers to enroll in the demonstration or care model; those who enroll but do not engage with the care model; and a group of similar eligible individuals in the comparison group. The ITT approach diminishes the potential for selection bias.

Results for special populations within each of the demonstration and comparison groups are also presented in this section (e.g., those with any long-term services and supports [LTSS] use in the demonstration and comparison groups; those with any behavioral health claims in the demonstration and comparison groups). In addition, one group for which descriptive results are also reported are *not* compared to the comparison group because this group does not exist within the comparison group: Michigan demonstration enrollees. For this group, we compare them to in-State non-enrollees.

Comparison Group Identification

The comparison group will serve to provide an estimate of what would have happened to the demonstration group in the absence of the demonstration. Thus, the comparison group members should be similar to the demonstration group members in terms of their characteristics and health care and LTSS needs, and they should reside in areas that are similar to the demonstration State in terms of the health care system and the larger environment. For this evaluation, identifying the comparison group members entailed two steps: (1) selecting the geographic area from which the comparison group would be drawn and (2) identifying the individuals who would be included in the comparison group.

To construct Michigan's comparison group, we used both in-State and out-of-State areas. We compared demonstration and potential comparison areas on a range of predemonstration period measures, including spending per Medicare-Medicaid enrollee by each program, the shares of LTSS delivered in facility-based and community settings, and the extent of Medicare and Medicaid managed care penetration. Using statistical analysis, we selected the individual comparison metropolitan statistical areas (MSAs) that most closely match the values found in the demonstration area on the selected measures. We also considered other factors when selecting

comparison States, such as timeliness of Medicaid data submission to CMS. We identified a comparison group from MSAs in Michigan, California, Pennsylvania, and Missouri. For details of the comparison group identification strategy, see ***Appendix A***.

Data

Evaluation Report analyses used data from a number of sources. First, the State provided quarterly finder files containing identifying information on all demonstration eligible beneficiaries in the demonstration period. Second, RTI obtained administrative data on beneficiary demographic, enrollment, and service use characteristics from CMS data systems for both demonstration and comparison group members. Third, these administrative data were merged with Medicare claims and encounter data on utilization of Medicare services, as well as the Minimum Data Set (MDS).

Although Medicaid service data on use of LTSS, behavioral health, and other Medicaid-reimbursed services were not available for the demonstration period and therefore are not included in this report, CMS administrative data identifying eligible beneficiaries who used *any* Medicaid-reimbursed LTSS or *any* Medicare behavioral health services were available, so that their Medicare service use could be presented in this report. Future reports will include findings on Medicaid service use once data are available.

Populations and Services Analyzed

The populations analyzed in the report include all demonstration eligible beneficiaries, as well as the following special populations: those receiving any LTSS; those with any behavioral health service use in the last 2 years for a serious and persistent mental illness (SPMI); demonstration enrollees; and demographic groups (race/ethnicity).

For all demonstration eligible beneficiaries and service types analyzed, we provide estimates of as many as three access to care and utilization measures: the percent of demonstration eligible beneficiaries with any use of a service, and counts of service use for both all eligible beneficiaries and users of the respective service.

The 13 service settings analyzed include both institutional (inpatient, inpatient psychiatric, inpatient non-psychiatric, emergency department [ED] visits not leading to admission, ED psychiatric visits, observation stays, and hospice) and community settings (primary care; outpatient as well as independent physical, speech, and occupational therapy; and other hospital outpatient services).

In addition, six quality measures representing specific utilization types of interest are presented: 30-day all-cause risk-standardized readmission rate; preventable emergency room visits; rate of 30-day follow-up after hospitalization for mental illness; ambulatory care sensitive condition overall composite rate (Agency for Healthcare Research and Quality [AHRQ] Prevention Quality Indicator [PQI] #90); ambulatory care sensitive condition (ACSC) chronic composite rate (AHRQ PQI#92); and depression screening rate.

Five nursing facility (NF)–related measures are presented from the MDS: two measures of annual NF utilization (admission rate and percentage of long-stay NF users) and three

characteristics of long-stay NF residents at admission (functional status, percent with severe cognitive impairment, percent with low level of care need).

The analyses were conducted for each of the years in the 2-year predemonstration period (March 1, 2013, to February 28, 2015) and for the first demonstration period (March 1, 2015, to December 31, 2016) for both the demonstration and comparison groups.

Table B-1 presents descriptive statistics on the independent variables used in multivariate difference-in-differences (DinD) regressions for impact analyses. Independent variables include demographic and health characteristics and market- and area-level characteristics. Results are presented for six groups: all demonstration eligible beneficiaries in Michigan, its comparison group, demonstration enrollees, non-enrollees, demonstration eligible beneficiaries with any LTSS use, and demonstration eligible beneficiaries with an SPMI.

The most prevalent age group overall as well as among those with SPMI was younger than age 65 years, although most people among the LTSS user group were older than age 75 years. In the comparison group, 51.7 percent were younger than age 65 years; 50.9 percent were younger than age 65 years in the demonstration group. Across all groups, the majority of eligible beneficiaries were female (LTSS was 65.9 percent; SPMI was 64.5 percent), and a majority were White (58.5 and 54.1 percent in the enrollee and demonstration group, respectively). Nearly two-thirds (61.5 percent) of the SPMI population had a disability as the reason for their Medicaid enrollment. Hierarchical Condition Category (HCC) scores ranged from 1.2 in the enrollee group to 2.2 in the LTSS user group. The HCC score is a measure of the predicted relative annual cost of a Medicare beneficiary based on the diagnosis codes present in recent Medicare claims. Beneficiaries with a score of 1 are predicted to have average cost in terms of annual Medicare expenditures. Beneficiaries with HCC scores less than 1 are predicted to have below average costs, whereas beneficiaries with scores of 2 are predicted to have twice the average annual cost. The vast majority of eligible beneficiaries resided in the metropolitan areas, compared to nonmetropolitan areas. The percent of months of dual eligibility was lowest among those who did not enroll in the demonstration or LTSS users.

There were limited differences in area- and market-level characteristics. Those who were in the comparison group resided in counties with a lower population density, relative to those in the demonstration group (1,213.9 vs. 1,641.6 residents per square mile). Enrollees also resided in counties with a lower population density, relative to non-enrollees (1,274.4 vs. 1,861.8). Additionally, those in the comparison group resided in counties with higher Medicaid spending per dual eligible, relative to counties in the demonstration group ($15,111 vs. $10,967). LTSS users resided in counties with a higher percentage of adults with a college degree, relative to other groups (19.4 vs. 17.5 percent).

Table B-1
Characteristics of demonstration eligible beneficiaries in current demonstration year by group

Characteristics	Demonstration group	Comparison group	Demonstration group enrollees	Demonstration group eligible, non-enrollees	Demonstration group, LTSS users	Demonstration group, SPMI diagnosis
Number of eligible beneficiaries	100,144	375,717	37,539	62,605	16,696	42,749
Demographic characteristics						
Age						
0 to 64	50.9	51.7	54.9	48.5	18.5	61.5
65 to 74	26.3	25.8	24.8	27.1	20.1	19.3
75 and older	22.9	22.5	20.4	24.4	61.4	19.2
Female						
No	39.1	40.4	42.8	37.0	34.1	35.5
Yes	60.9	59.6	57.2	63.0	65.9	64.5
Race/Ethnicity						
White	54.1	54.6	58.5	51.5	70.4	60.8
Black	38.3	35.0	34.0	40.9	27.1	34.6
Hispanic	0.9	3.9	1.2	0.7	0.4	0.7
Asian	2.1	2.3	2.4	1.9	0.5	0.9
Disability as reason for Original Medicare entitlement						
No (0)	46.0	45.2	42.3	48.2	72.3	34.9
Yes (1)	54.0	54.8	57.7	51.8	27.7	65.1
ESRD status						
No (0)	97.2	97.4	97.6	97.0	96.0	97.5
Yes (1)	2.8	2.6	2.4	3.0	4.0	2.5
MSA						
Non-metro (0)	13.3	13.3	19.3	9.6	21.3	14.3
Metro (1)	86.7	86.7	80.7	90.4	78.7	85.7
Months with full-dual eligibility during year (%)	0.7	0.8	0.8	0.6	0.6	0.7
HCC score	1.4	1.4	1.2	1.5	2.2	1.6

(continued)

Table B-1 (continued)
Characteristics of demonstration eligible beneficiaries in current demonstration year by group

Characteristics	Demonstration group	Comparison group	Demonstration group enrollees	Demonstration group eligible, non-enrollees	Demonstration group, LTSS users	Demonstration group, SPMI diagnosis
Market characteristics						
Medicare spending per dual, ages 19+ ($)	18,650.9	17,258.2	17,744.5	19,194.3	18,098.0	18,437.2
MA penetration rate	0.3	0.3	0.3	0.3	0.3	0.3
Medicaid-to-Medicare fee index (FFS)	0.5	0.6	0.5	0.5	0.5	0.5
Medicaid spending per dual, ages 19+ ($)	10,966.5	15,110.6	11,536.5	10,624.7	11,474.6	11,089.2
Fraction of duals using NF, ages 65+	0.2	0.2	0.2	0.2	0.2	0.2
Fraction of duals using HCBS, ages 65+	0.1	0.1	0.1	0.0	0.1	0.1
Fraction of duals using personal care, ages 65+	0.3	0.2	0.3	0.3	0.3	0.3
Fraction of duals with Medicaid managed care, ages 19+	0.0	0.0	0.0	0.0	0.0	0.0
Population per square mile, all ages	1,641.6	1,213.9	1,274.4	1,861.8	1,438.4	1,552.0
Patient care physicians per 1,000 population	0.7	0.9	0.7	0.6	0.7	0.7
Area characteristics						
% of pop. living in married households	59.2	61.0	61.6	57.8	64.4	60.3
% of adults with college education	17.6	17.5	17.6	17.6	19.4	17.9
% of adults with self-care limitations	5.1	5.2	4.8	5.3	4.7	5.0
% of household with individuals younger than 18	30.3	29.8	29.9	30.5	28.7	29.9
% of household with individuals older than 60	38.2	38.6	38.7	37.9	39.5	38.2
Distance to nearest hospital	6.4	6.7	7.8	5.6	7.8	6.8
Distance to nearest nursing facility	4.9	4.8	6.0	4.2	5.8	5.1

ESRD = end-stage renal disease; FFS = fee-for-service; HCBS = home and community-based services; HCC = Hierarchical Condition Category; LTSS = long-term services and supports; MA = Medicare Advantage; MSA = metropolitan statistical area; NF = nursing facility; pop. = population; SPMI = serious and persistent mental illness.

Detailed Population Definitions

Demonstration eligible beneficiaries. Beneficiaries are identified in a given month if they were a Medicare-Medicaid enrollee and met any other specific demonstration eligibility criteria. Beneficiaries in the demonstration period are identified from quarterly State finder files, whereas beneficiaries in the 2-year period preceding the demonstration implementation date are identified by applying the eligibility criteria in each separate predemonstration quarter.

Additional special populations were identified for the analyses as follows:

- *Enrollees*. A beneficiary was defined as an enrollee if they were enrolled in the demonstration during the demonstration period.

- *Age*. Age was defined as a categorical variable where beneficiaries were identified as *0 to 64*, *65 to 74, and 75 years and older* during the observation year (e.g., predemonstration period 1, predemonstration period 2, and demonstration period 1).

- *Gende*r. Gender was defined as binary variable where beneficiaries were either male or female.

- *Race/Ethnicity*. Race/ethnicity was defined as a categorical variable where beneficiaries were categorized as *White*, *Black*, *Hispanic*, or *Asian*.

- *LTSS*. A beneficiary was defined as using LTSS if there was any use of institutional-based services or home and community-based services during the observation year.

- *Serious and persistent mental illness (SPMI).* A beneficiary was defined as having a SPMI if a beneficiary, for each year of data analyzed, had incurred a claim for serious and persistent mental illness within the past 2 years.

Detailed Utilization and Expenditure Measure Definitions

For any health care service type, the methodology for estimating average monthly utilization and the percentage of users takes into account differences in the number of eligibility months across beneficiaries. Because full-benefit dual eligibility status for the demonstration can vary by month over time for any individual, the methodology used determines dual eligibility status for the demonstration for each person on a monthly basis during a predemonstration or demonstration period. That is, an individual can meet the demonstration's eligibility criteria for up to 12 months during the observation year. The methodology adds the total months of full-benefit dual eligibility for the demonstration across the population of interest and uses it in the denominator in the measures in ***Section 5***, creating average monthly utilization during a given year for each service type. The methodology effectively produces average monthly use statistics for each year that account for variation in the number of dual eligible beneficiaries in each month of the observation year.

The utilization measures below were calculated as the aggregate sum of the unit of measurement (e.g., counts) divided by the aggregated number of eligible member months [and

user months] within each group (g) where group is defined as (1) Michigan base year 1, (2) Comparison base year 1, (3) Michigan base year 2, (4) Comparison base year 2, (5) Michigan demonstration year 1, (6) Comparison demonstration year 1.

We calculated the average number of services per 1,000 eligible months and per 1,000 user months by beneficiary group (g). We defined *user month* as an eligible month where the number of units of utilization used [for a given service] was greater than zero during the month. We weight each observation using yearly propensity weights. The average yearly utilization outcomes are measured as:

$$Y_g = \frac{\Sigma_{ig} Z_{ig}}{\left(\frac{1}{1{,}000}\right) * \Sigma_{ig} n_{ig}}$$

Where

Y_g = average count of the number services used [for a given service] per eligible or user month within group g.
Z_{ig} = the total units of utilization [for a given service] for individual i in group g.
n_{ig} = the total number of eligible/user months for individual i in group g.

The denominator above is scaled by $\frac{1}{1{,}000}$ such that the result is interpreted in terms of average monthly utilization per 1,000 eligible beneficiaries. This presentation is preferable, compared with per eligible, because some of the services are used less frequently and would result in small estimates.

The average percentage of users [of a given service] per eligible month during the predemonstration or demonstration year is measured as follows:

$$U = \frac{\Sigma_{ig} X_{ig}}{\Sigma_{ig} n_{ig}} \quad \text{x } 100$$

Where

U_{ig} = average percentage of users [for a particular service] in a given month among beneficiaries in group g.
X_{ig} = the total number of eligible months of service use for an individual i in group g.
n_{ig} = the total number of eligible or user months for an individual i in group g.

Quality of Care and Care Coordination Measures

Similar to the utilization measures, for the appendix tables of descriptive statistics, the quality of care and care coordination measures were calculated as the aggregated sum of the numerator divided by the aggregated sum of the denominator for each respective outcome within each beneficiary group, except for the average 30-day all-cause risk-standardized readmission rate and the 30-day follow-up after hospitalization for mental illness, which are reported as percentages.

Average 30-day all-cause risk-standardized readmission rate (percent) was calculated as follows:

$$30 - Risk\ Standardized\ Readmission = \frac{\left(\frac{\sum_{ig} x_{ig}}{\sum_{ig} n_{ig}} X\ C\right)}{Prob_g} * 100$$

Where

C = the national average of 30-day readmission rate, .238.
X_{ig} = the total number of readmissions for individual *i* in group *g*.
n_{ig} = the total number of hospital admissions for individual *i* in group *g*.
$Prob_g$ = the annual average adjusted probability of readmission for individuals in group *g*. The average adjusted probability equals:

Average adjusted probability of readmission by demonstration group

Demonstration group	Average adjusted probability of readmission
Predemonstration year 1	
Michigan	0.224
Comparison	0.203
Predemonstration year 2	
Michigan	0.226
Comparison	0.208
Demonstration year 1	
Michigan	0.224
Comparison	0.206

Rate of 30-day follow-up in a physician or outpatient setting after hospitalization for mental illness (percent) was calculated as follows:

$$MHFU = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} n_{ig}} * 100$$

Where

MHFU = the average rate of 30-day follow-up care after hospitalization for a mental illness (percent) for individuals *in* group *g*.
X_{ig} = the total number of discharges from a hospital stay for mental health that had a follow-up visit for mental health within 30 days of discharge for individual *i* in group *g*.
n_{ig} = the total number of discharges from a hospital stay for mental health for individual *i* in group *g*.

Average ambulatory care sensitive condition admissions per eligible month, overall and chronic composite (PQI #90 and PQI #92) was calculated as follows:

$$ACSC_{ig} = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

$ACSC_g$ = the average number of ambulatory care sensitive condition admissions per eligible month for overall/chronic composites for individuals in group *g*.
X_{ig} = the total number of discharges that meet the criteria for AHRQ PQI #90 [or PQI #92] for individual *i* in group *g*.
n_{ig} = the total number of eligible months for individual *i* in group *g*.

Preventable ER visits per eligible month was calculated as follows:

$$ER_{ig} = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

ER_g = the average number of preventable ER visits per eligible month for individuals in group *g*.
X_{ig} = the total number ER visits that are considered preventable based in the diagnosis for individual *i* in group *g*.
n_{ig} = the total number of eligible months for individual *i* in group *g*.

Average number of beneficiaries per eligible month who received depression screening during the observation year was calculated as follows:

$$D_g = \frac{\Sigma_{ig} x_{ig}}{\Sigma_{ig} \mathrm{n}_{ig}}$$

Where

D_g = the average number of beneficiaries per eligible month who received depression screening in group *g*.
X_{ig} = the total number eligible beneficiaries age 65+ who ever received depression screening in group *g*.
n_{ig} = the total number of eligible months among beneficiaries in group *g*.

Minimum Data Set Measures

Two measures of annual nursing facility-related utilization are derived from the MDS. The rate of long-stay NF admissions per 1,000 eligible beneficiaries is calculated as the number of NF admissions for whom there is no record of NF use in the 100 days prior to the current

admission and who subsequently stay in the NF for 101 days or more. Individuals are included in this measure only if their NF admission occurred after their first month of demonstration eligibility. The percentage of long-stay NF users is calculated as the number of individuals who have stayed in a NF for 101 days or more, who were long-stay after the first month of demonstration eligibility. The probability of any long-stay NF use includes both new admissions from the community and continuation of a stay in a NF.

Characteristics of long-stay NF residents at admission are also included in order to monitor nursing facility case mix and acuity levels. Functional status and low level of care need are determined by the Resource Utilization Groups Version IV (RUG-IV). Residents with low care need are defined as those who did not require physical assistance in any of the four late-loss activities of daily living (ADLs) and who were in the three lowest RUG-IV categories. Severe cognitive impairment is assessed by the Brief Interview for Mental Status (BIMS), poor short-term memory, or severely impaired decision-making skills.

Regression Outcome Measures

Five utilization measures are used as dependent variables in regression analysis to estimate the difference-in-differences effect for the entire demonstration period as well as the effect in each demonstration year. These measures are derived from Medicare inpatient, outpatient, carrier, encounter data and MDS long-term nursing facility use. All dependent variables are based on a monthly basis except for the MDS long-stay nursing facility measure and 30-day inpatient readmission measure, which are annual.

The outcome measures include:

- *Monthly Inpatient Admissions* is the monthly probability of having any inpatient admission in which a beneficiary has an admission date within the observed month.

- *Monthly Emergency Department Use* is the monthly probability of having any emergency department visit that occurred during the month that did not result in an inpatient admission.

- *Monthly Physician Visits* is the count of any evaluation and management visit within the month where the visit occurred in the outpatient or office setting, nursing facility, domiciliary, rest home, or custodial care setting, a federally qualified health center or a rural health center.

- *Long-stay Nursing Facility Use* is the annual probability of residing in a nursing facility for 101 days or more during the year.

In addition to the five measures above, this evaluation will estimate the demonstration effects on quality of care. The following quality of care and care coordination measures use claims/encounter-level information and are adopted from standardized HEDIS and NQF measures. The outcomes are reported monthly, with the exception of the 30-day all-cause risk-standardized readmission rate, which is annual.

- *30-day all-cause risk-standardized readmissions (NQF #1768)* is calculated both as the rate of risk-standardized readmission, defined above, as well as the count of the number risk-standardized readmissions that occurs during the year.

- *Preventable ER visits* is a continuous variable of weighted ER visits among adults. The lists of diagnoses that are considered as either preventable/avoidable, or treatable in a primary care setting were developed by researchers at the New York University Center for Health and Public Service Research.[24]

- *30-day follow-up after hospitalization for mental illness (NQF #576)* is estimated as the monthly probability of any follow-up visit within 30-days posthospitalization for a mental illness.

- *ACSC admissions—overall composite (AHRQ PQI # 90)* is the monthly probability of any acute admission that meets the AHRQ PQI #90 (Prevention Quality Overall Composite) criteria within the month.

- *ACSC admissions—chronic composite (AHRQ PQI # 92)* is the monthly probability of any admission that meets the AHRQ PQI #92 criteria within the month.

Regression Methodology for Determining Demonstration Impact

The regressions across the entire demonstration period compare all demonstration eligible beneficiaries in the FAI State to its comparison group. The regression methodology accounts for both those with and without use of the specific service (e.g., for inpatient services, both those with and without any inpatient use). A restricted difference-in-differences equation will be estimated as follows:

$$\text{Dependent variable}_i = F(\beta_0 + \beta_1 \text{PostYear} + \beta_2 \text{Demonstration} + \beta_3 \text{PostYear} * \text{Demonstration} + \beta_4 \text{Demographics} + \beta_{5\text{-}j} \text{Market} + \varepsilon)$$

where separate models will be estimated for each dependent variable. *PostYear* is an indicator of whether the observation is from the pre- or postdemonstration period, *Demonstration* is an indicator of whether the beneficiary was in the demonstration group, and *PostYear* * *Demonstration* is an interaction term. *Demographics* and *Market* represent vectors of beneficiary and market characteristics, respectively.

Under this specification, the coefficient β_0 reflects the comparison group predemonstration period mean adjusted for demographic and market effects, β_1 reflects the average difference between post period and predemonstration period in the comparison group, β_2 reflects the difference in the demonstration group and comparison group at predemonstration, and β_3 is the overall average demonstration effect during the demonstration period. This last term is the difference-in-differences estimator and the primary policy variable of interest, but in all regression models, because of nonlinearities in the underlying distributions, postregression

[24] https://wagner.nyu.edu/faculty/billings/nyued-background

predictions of demonstration impact are performed to obtain the marginal effects of demonstration impact.

In addition to estimating the model described in Equation 1, a less restrictive model was estimated to produce year-by-year effects of the demonstration. The specification of the unrestricted model is as follows:

$$\text{Dependent variable} = F(\beta_0 + \beta_{1\text{-}k}\text{PostYear}_{1\text{-}n} + \beta_2\text{Demonstration} + \beta_{3\text{-}k}\text{PostYear}_{1\text{-}n} * \text{Demonstration} + \beta_4\,\text{Demographics} + \beta_{5\text{-}j}\,\text{Market} + \varepsilon)$$

This equation differs from the previous one in that separate difference-in-differences coefficients are estimated for each year. Under this specification, the coefficients $\beta_{3\text{-}k}$ would reflect the impact of the demonstration in each respective year, whereas the previous equation reflects the impact of the entire demonstration period. This specification measures whether changes in dependent variables occur in the first year of the demonstration only, continuously over time, or in some other pattern. Depending on the outcome of interest, we will estimate the equations using logistic regression, Generalized Linear Models with a log link, or count models such as negative binomial or Poisson regressions (e.g., for the number of readmissions). We used regression results to calculate the marginal effects of demonstration impact.

Impact estimates across the entire demonstration period are determined using the difference-in-differences methodology and presented in figures for all demonstration eligible beneficiaries, and then for two special populations of interest—demonstration eligible beneficiaries with any LTSS use, and demonstration eligible beneficiaries with SPMI. A table follows each figure displaying the annual demonstration difference-in-differences effect for each separate demonstration period for each of these populations. In each figure, the point estimate is displayed for each measure, as well as the 90 percent confidence interval. If the confidence interval includes the value of zero, it is not statistically significant at that confidence level.

The three adjusted means tables presented for the full demonstration eligible population in the report provide both DinD results as well as accompanying adjusted mean values that allow direct comparisons regarding service utilization and costs across the baseline and demonstration periods, separately for the demonstration and comparison groups. The purpose of these tables is to understand the magnitude of the difference-in-differences estimate relative to the adjusted mean outcome value in each period. The adjusted mean values show how different the two groups were in each period, and the relative direction of any potential effect in each group over time. To make meaningful comparisons for the adjusted mean value results, we needed to take into account any differences in population characteristics across the four groups. To do this, we replaced the data values for all demographic, health, and area- related characteristics in each group to be those of the comparison group in the demonstration period, which we selected as the reference group.

The steps involved in this process for each type of outcome measure are:

1. Run the regression estimating the probability or level of service use or costs
2. Predict DinD (last two columns in each adjusted means table)

3. Replace the data values for three of the four groups to be those of the comparison group in the demonstration period so all four groups have the same population characteristics
4. Predict the weighted mean for each of the four groups using the regression results stored in computer memory.

The difference-in-differences estimate is also provided for reference, along with the *p*-value, and the relative percent change of the difference-in-differences estimate compared to an average mean value for the comparison group in the entire demonstration period. The relative percent annual change for the difference-in-differences estimate for each outcome measure is calculated as [Overall difference-in-differences effect] / [Adjusted mean outcome value of comparison group in the demonstration period].

Table B-2 provides an illustrative example of the regression output for each independent variable in the logistic regression on monthly inpatient admissions across the entire demonstration period.

Table B-2
Logistic regression results on the probability of any inpatient admissions during a month
(n = 16,770,072 person-months)

Independent variables	Coefficient	Standard error	z-value	p-value
Post period	−0.0484	0.0213	−2.270	0.023
Demonstration group	−0.0480	0.0328	−1.460	0.143
Interaction of post period x demonstration group	−0.1397	0.0345	−4.040	0.000
Trend	0.0015	0.0009	1.540	0.124
Age	0.0029	0.0006	5.250	0.000
Female	−0.0047	0.0128	−0.370	0.712
Black	0.0219	0.0129	1.700	0.089
Asian	−0.4872	0.0329	−14.810	0.000
Hispanic	−0.1764	0.0279	−6.320	0.000
Other race	−0.2608	0.0315	−8.270	0.000
Disability as reason for original Medicare entitlement	0.0340	0.0186	1.830	0.067
End-stage renal disease	1.5345	0.0268	57.230	0.000
HCC score	0.3741	0.0048	78.460	0.000
Metropolitan statistical area residence	0.1287	0.0473	2.720	0.007
Percent of population living in a married household	−0.0015	0.0012	−1.270	0.203
Percent of households with family member greater than or equal to 60 years old	−0.0051	0.0008	−6.060	0.000
Percent of households with family member less than 18 years old	−0.0035	0.0013	−2.730	0.006
Percent of adults with college education	−0.0015	0.0013	−1.180	0.236
Percent of adults with self-care limitation	−0.0056	0.0048	−1.170	0.242
Distance to nearest hospital	−0.0027	0.0020	−1.320	0.185
Distance to nearest nursing facility	0.0061	0.0037	1.670	0.094
Medicare spending per full-benefit dual eligible	0.0000	0.0000	4.280	0.000
Medicare Advantage penetration rate	−1.1984	0.6451	−1.860	0.063
Medicaid-to-Medicare fee index	−1.0087	0.3343	−3.020	0.003
Nursing facility users per full-benefit dual eligible over 65	−0.0939	0.2138	−0.440	0.373
Patient care physicians per 1,000 (total) population	−0.0562	0.0847	−0.660	0.507
Participating in shared savings program	0.2687	0.0524	5.130	0.000
Intercept	−3.5617	0.3592	−9.910	0.000

Appendix C:
Descriptive Tables

Tables in ***Appendix C*** present weighted results on the average percentage of demonstration eligible beneficiaries using selected Medicare service types during the months in which they met demonstration eligibility criteria in the predemonstration and demonstration periods. In addition, average counts of service use are presented across all such eligible months, and for the subset of these months in which eligible beneficiaries were users of each respective service type. Data is shown for the predemonstration and demonstration periods for both Michigan eligible beneficiaries (i.e., the demonstration group) and the comparison group. Similar tables are also presented for the RTI quality of care and care coordination measures.

Tables are presented for the overall demonstration eligible population (***Tables C-1*** through ***C-3***), followed by tables on Michigan demonstration eligible beneficiaries who were enrollees and non-enrollees (***Tables C-4*** and ***C-5***).

Table C-1
Proportion and utilization for institutional and non-institutional services for the Michigan demonstration eligible beneficiaries and comparison groups

Measures by setting	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
Number of demonstration eligible beneficiaries		102,899	103,573	100,144
Number of comparison eligible beneficiaries		317,784	325,024	375,717
Institutional setting				
Inpatient admissions[1]	Demonstration group			
% with use		4.5	4.6	3.8
Utilization per 1,000 user months		1,156.9	1,163.6	1,152.1
Utilization per 1,000 eligible months		51.9	53.1	43.2
Inpatient admissions[1]	Comparison group			
% with use		3.8	3.8	3.7
Utilization per 1,000 user months		1,144.5	1,148.2	1,156.4
Utilization per 1,000 eligible months		43.2	43.3	43.1
Inpatient psychiatric	Demonstration group			
% with use		0.3	0.4	0.3
Utilization per 1,000 user months		1,082.4	1,082.8	1,082.6
Utilization per 1,000 eligible months		3.8	3.8	2.9
Inpatient psychiatric	Comparison group			
% with use		0.3	0.3	0.3
Utilization per 1,000 user months		1,072.1	1,078.9	1,077.6
Utilization per 1,000 eligible months		3.4	3.3	3.4

(continued)

Table C-1 (continued)
Proportion and utilization for institutional and non-institutional services for the Michigan demonstration eligible beneficiaries and comparison groups

Measures by setting	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
Inpatient non-psychiatric	Demonstration group			
% with use		4.2	4.3	3.5
Utilization per 1,000 user months		1,149.9	1,157.7	1,145.7
Utilization per 1,000 eligible months		48.1	49.2	40.3
Inpatient non-psychiatric	Comparison group			
% with use		3.5	3.5	3.5
Utilization per 1,000 user months		1,137.3	1,141.5	1,149.1
Utilization per 1,000 eligible months		39.8	40.0	39.7
Emergency department use (non-admit)	Demonstration group			
% with use		6.9	7.1	6.9
Utilization per 1,000 user months		1,290.3	1,296.5	1,296.1
Utilization per 1,000 eligible months		89.6	91.6	88.8
Emergency department use (non-admit)	Comparison group			
% with use		6.7	6.9	7.1
Utilization per 1,000 user months		1,290.8	1,298.2	1,298.4
Utilization per 1,000 eligible months		86.7	89.0	92.2
Emergency department use (psychiatric)	Demonstration group			
% with use		0.4	0.4	0.4
Utilization per 1,000 user months		1,272.4	1,258.4	1,202.6
Utilization per 1,000 eligible months		4.7	4.8	4.5
Emergency department use (psychiatric)	Comparison group			
% with use		0.4	0.4	0.4
Utilization per 1,000 user months		1,227.2	1,215.0	1,222.5
Utilization per 1,000 eligible months		4.4	4.4	4.8

(continued)

Table C-1 (continued)
Proportion and utilization for institutional and non-institutional services for the Michigan demonstration eligible beneficiaries and comparison groups

Measures by setting	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
Observation stays	Demonstration group			
% with use		1.1	1.1	1.0
Utilization per 1,000 user months		1,077.3	1,088.8	1,098.6
Utilization per 1,000 eligible months		12.1	12.1	11.3
Observation stays	Comparison group			
% with use		0.6	0.7	0.8
Utilization per 1,000 user months		1,068.7	1,074.2	1,087.4
Utilization per 1,000 eligible months		6.9	7.5	8.5
Hospice	Demonstration group			
% with use		0.6	0.5	0.3
Utilization per 1,000 user months		1,027.3	1,011.8	1,036.7
Utilization per 1,000 eligible months		5.7	5.1	3.1
Hospice	Comparison group			
% with use		0.5	0.5	0.7
Utilization per 1,000 user months		1,018.2	1,013.8	1,017.2
Utilization per 1,000 eligible months		5.5	5.1	6.8
Non-institutional setting				
Primary care E&M visits	Demonstration group			
% with use		57.7	57.3	55.0
Utilization per 1,000 user months		2,116.5	2,098.9	2,030.5
Utilization per 1,000 eligible months		1,220.8	1,201.7	1,115.9
Primary care E&M visits	Comparison group			
% with use		50.9	51.6	51.8
Utilization per 1,000 user months		1,838.7	1,865.0	1,858.9
Utilization per 1,000 eligible months		936.0	963.0	963.5

(continued)

Table C-1 (continued)
Proportion and utilization for institutional and non-institutional services for the Michigan demonstration eligible beneficiaries and comparison groups

Measures by setting	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
Outpatient therapy (PT, OT, ST)	Demonstration group			
% with use		3.7	3.6	3.4
Utilization per 1,000 user months		20,759.9	22,674.2	22,643.5
Utilization per 1,000 eligible months		765.0	819.0	770.0
Outpatient therapy (PT, OT, ST)	Comparison group			
% with use		3.7	3.8	4.0
Utilization per 1,000 user months		19,911.3	20,814.5	20,430.2
Utilization per 1,000 eligible months		732.0	795.4	820.6
Independent therapy (PT, OT, ST)	Demonstration group			
% with use		1.0	1.1	1.2
Utilization per 1,000 user months		14,364.2	15,548.2	14,524.3
Utilization per 1,000 eligible months		148.9	167.3	179.1
Independent therapy (PT, OT, ST)	Comparison group			
% with use		1.2	1.2	1.2
Utilization per 1,000 user months		14,935.3	15,395.0	15,793.2
Utilization per 1,000 eligible months		175.4	177.6	190.1
Other hospital outpatient services	Demonstration group			
% with use		28.5	29.3	28.9
Utilization per 1,000 user months		—	—	—
Utilization per 1,000 eligible months		—	—	—
Other hospital outpatient services	Comparison group			
% with use		27.7	27.4	27.7
Utilization per 1,000 user months		—	—	—
Utilization per 1,000 eligible months		—	—	—

— = data not available. E&M = evaluation and management; OT = occupational therapy, PT = physical therapy, ST = speech therapy.

[1] Includes acute admissions, inpatient rehabilitation, and long-term care hospital admissions.

SOURCE: RTI International analysis of Medicare data.

Table C-2
Quality of care and care coordination outcomes for demonstration eligible and comparison beneficiaries for the Michigan demonstration

Quality and care coordination measures	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
30-day all-cause risk-standardized readmission rate (%)	Demonstration group	19.2	19.8	20.0
	Comparison group	20.5	19.9	20.1
Preventable ER visits per eligible month	Demonstration group	0.0429	0.0443	0.0426
	Comparison group	0.0383	0.0426	0.0445
Rate of 30-day follow-up after hospitalization for mental illness (%)	Demonstration group	47.4	48.5	43.1
	Comparison group	44.0	44.1	38.7
Ambulatory care sensitive condition admissions per eligible month—overall composite (AHRQ PQI # 90)	Demonstration group	0.0079	0.0082	0.0073
	Comparison group	0.0065	0.0065	0.0072
Ambulatory care sensitive condition admissions per eligible month—chronic composite (AHRQ PQI # 92)	Demonstration group	0.0054	0.0056	0.0052
	Comparison group	0.0044	0.0046	0.0052
Screening for clinical depression per eligible month	Demonstration group	0.0006	0.0014	0.0030
	Comparison group	0.0003	0.0009	0.0019

AHRQ PQI =Agency for Healthcare Research and Quality Prevention Quality Indicator; ER = emergency room.

SOURCE: RTI International analysis of Medicare data.

Table C-3
Minimum Data Set long-stay nursing facility utilization and characteristics at admission for the Michigan demonstration and comparison groups

Measures by setting	Group	Predemonstration year 1	Predemonstration year 2	Demonstration year 1
Annual nursing facility utilization				
Number of demonstration eligible beneficiaries	Demonstration group	*76,096*	*76,853*	*71,080*
Long-stay nursing facility admissions per 1,000 eligible beneficiaries		12.7	11.2	19.4
Number of comparison beneficiaries	Comparison group	*245,491*	*252,928*	*271,572*
Long-stay nursing facility admissions per 1,000 eligible beneficiaries		11.5	11.5	17.4
Number of demonstration eligible beneficiaries	Demonstration group	*84,165*	*84,684*	*77,135*
Long-stay nursing facility users as % of eligible beneficiaries		11.0	10.5	10.5
Number of comparison beneficiaries	Comparison group	*267,975*	*275,389*	*291,047*
Long-stay nursing facility users as % of eligible beneficiaries		9.7	9.5	8.8
Characteristics of long-stay nursing facility residents at admission				
Number of admitted demonstration beneficiaries	Demonstration group	*967*	*861*	*1,377*
Number of admitted comparison beneficiaries	Comparison group	*2,830*	*2,903*	*4,723*
Functional status (RUG-IV ADL scale)	Demonstration group	7.8	8.1	8.1
Functional status (RUG-IV ADL scale)	Comparison group	8.5	8.9	8.6
Percent with severe cognitive impairment	Demonstration group	38.0	39.1	34.5
Percent with severe cognitive impairment	Comparison group	37.3	35.9	34.7
Percent with low level of care need	Demonstration group	1.8	2.0	1.5
Percent with low level of care need	Comparison group	0.7	1.2	0.8

RUG-IV ADL = Resource Utilization Group IV Activities of Daily Living.

SOURCE: RTI International analysis of Minimum Data Set data.

Table C-4
Proportion and utilization for institutional and non-institutional services for the Michigan demonstration enrollees and non-enrollees

Measures by setting	Group	Demonstration year 1
Number of enrollees		37,539
Number of non-enrollees		62,605
Institutional setting		
Inpatient admissions[1]	Enrollees	
% with use		2.4
Utilization per 1,000 user months		1,124.1
Utilization per 1,000 eligible months		27.2
Inpatient admissions[1]	Non-enrollees	
% with use		4.3
Utilization per 1,000 user months		1,157.3
Utilization per 1,000 eligible months		50.1
Inpatient psychiatric	Enrollees	
% with use		0.1
Utilization per 1,000 user months		1,046.5
Utilization per 1,000 eligible months		0.8
Inpatient psychiatric	Non-enrollees	
% with use		0.3
Utilization per 1,000 user months		1,085.0
Utilization per 1,000 eligible months		3.5
Inpatient non-psychiatric	Enrollees	
% with use		2.3
Utilization per 1,000 user months		1,122.3
Utilization per 1,000 eligible months		26.4
Inpatient non-psychiatric	Non-enrollees	
% with use		4.1
Utilization per 1,000 user months		1,150.0
Utilization per 1,000 eligible months		46.6
Emergency department use (non-admit)	Enrollees	
% with use		6.4
Utilization per 1,000 user months		1,327.9
Utilization per 1,000 eligible months		84.9
Emergency department use (non-admit)	Non-enrollees	
% with use		6.9
Utilization per 1,000 user months		1,282.8
Utilization per 1,000 eligible months		88.8

(continued)

Table C-4 (continued)
Proportion and utilization for institutional and non-institutional services for the Michigan demonstration enrollees and non-enrollees

Measures by setting	Group	Demonstration year 1
Emergency department use (psychiatric)	Enrollees	
% with use		0.4
Utilization per 1,000 user months		1,180.3
Utilization per 1,000 eligible months		4.6
Emergency department use (psychiatric)	Non-enrollees	
% with use		0.4
Utilization per 1,000 user months		1,179.1
Utilization per 1,000 eligible months		4.2
Observation stays	Enrollees	
% with use		0.8
Utilization per 1,000 user months		1,180.5
Utilization per 1,000 eligible months		9.3
Observation stays	Non-enrollees	
% with use		1.1
Utilization per 1,000 user months		1,080.9
Utilization per 1,000 eligible months		12.3
Hospice	Enrollees	
% with use		0.3
Utilization per 1,000 user months		1,117.2
Utilization per 1,000 eligible months		2.8
Hospice	Non-enrollees	
% with use		0.4
Utilization per 1,000 user months		1,015.3
Utilization per 1,000 eligible months		3.6
Non-institutional setting		
Primary care E&M visits	Enrollees	
% with use		42.0
Utilization per 1,000 user months		1,850.7
Utilization per 1,000 eligible months		777.6
Primary care E&M visits	Non-enrollees	
% with use		61.1
Utilization per 1,000 user months		2,114.5
Utilization per 1,000 eligible months		1,292.0

(continued)

Table C-4 (continued)
Proportion and utilization for institutional and non-institutional services for the Michigan demonstration enrollees and non-enrollees

Measures by setting	Group	Demonstration year 1
Outpatient Therapy (PT, OT, ST)	Enrollees	
% with use		2.0
Utilization per 1,000 user months		12,863.1
Utilization per 1,000 eligible months		258.3
Outpatient therapy (PT, OT, ST)	Non-enrollees	
% with use		4.2
Utilization per 1,000 user months		24,940.2
Utilization per 1,000 eligible months		1,041.9
Independent therapy (PT, OT, ST)	Enrollees	
% with use		0.5
Utilization per 1,000 user months		11,884.0
Utilization per 1,000 eligible months		59.9
Independent therapy (PT, OT, ST)	Non-enrollees	
% with use		1.5
Utilization per 1,000 user months		14,963.2
Utilization per 1,000 eligible months		229.4
Other hospital outpatient services	Enrollees	
% with use		25.8
Utilization per 1,000 user months		—
Utilization per 1,000 eligible months		—
Other hospital outpatient services	Non-enrollees	
% with use		30.2
Utilization per 1,000 user months		—
Utilization per 1,000 eligible months		—

— = data not available. E&M = evaluation and management; OT = occupational therapy; PT = physical therapy; ST = speech therapy.

[1] Includes acute admissions, inpatient rehabilitation, and long-term care hospital admissions.

SOURCE: RTI International analysis of Medicare data.

Table C-5
Quality of care and care coordination outcomes for enrollees and non-enrollees for the Michigan demonstration

Quality and care coordination measures	Group	Demonstration year 1
30-day all-cause risk-standardized readmission rate (%)	Enrollees	18.9
	Non-enrollees	20.5
Preventable emergency room visits per eligible month	Enrollees	0.0409
	Non-enrollees	0.0422
Rate of 30-day follow-up after hospitalization for mental illness (%)	Enrollees	36.9
	Non-enrollees	44.4
Ambulatory care sensitive condition admissions per eligible month—overall composite (AHRQ PQI # 90)	Enrollees	0.0051
	Non-enrollees	0.0085
Ambulatory care sensitive condition admissions per eligible month—chronic composite (AHRQ PQI # 92)	Enrollees	0.0036
	Non-enrollees	0.0060
Screening for clinical depression per eligible month	Enrollees	0.0017
	Non-enrollees	0.0037

AHRQ PQI =Agency for Healthcare Research and Quality Prevention Quality Indicator; ER = emergency room.

SOURCE: RTI International analysis of Medicare data.

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Appendix D:
Sensitivity Analysis Tables

Tables in ***Appendix D*** present results from sensitivity analyses focusing on the Michigan demonstration cost saving models.

D.1 Predicting Capitated Rates for Non-Enrollees

The goal of this analysis was to identify beneficiaries eligible for the Michigan demonstration in the first demonstration period (March 2015–December 2016) and to look at what the capitation rate would have been (had they enrolled) compared to their actual fee-for-service (FFS) expenditures in the demonstration period.

D.1.1 Sample Identification

- We identified eligible but nonenrolled Michigan beneficiaries in demonstration period 1 (March 1, 2015–December 31, 2016). Predicted capitated rates were calculated using the beneficiary risk score and the county of residence.

D.1.2 Calculating the Capitated Rate for Eligible by Non-Enrolled Beneficiaries

- Predicted capitated rates were calculated using the monthly beneficiary risk score (final resolved) and the base rate associated with the beneficiary's county of residence.

- Mean predicted capitated rates were compared to mean FFS expenditures (non-Winsorized). Note that bad debt was removed from the capitated rate as this is not reflected in FFS payments. Sequestration was reflected in both the FFS payments and the capitated payment. Disproportionate share hospital payments and uncompensated care payment amounts were included in the FFS expenditures, as these amounts are reflected in the capitated rates.

- The predicted capitated rate was $1,350 compared to actual FFS expenditures of $1,304 suggesting potential Medicare losses for the non-enrolled beneficiary population had this population been enrolled during demonstration period 1 (***Table D-1***).

Table D-1
Observed FFS and predicted capitated rates for eligible but not enrolled beneficiaries

Variable	Obs	Mean	Std. err.	Std. dev.	[95% conf. interval]	
Predicted cap	917,374	$1,349.6	$1.6	$1,493.5	$1,346.6	$1,352.7
Observed FFS	917,374	$1,303.8	$5.3	$5,045.4	$1,293.4	$1,314.1
Difference		$45.9	$5.1	$4,848.3	$35.9	$55.8

FFS = fee for service.

NOTES: RTI also tested the accuracy of the predicted capitated rate by generating a predicted capitated rate for enrollees and comparing it to the actual capitated rate from the plan payment files. RTI's mean predicted capitated rate for enrollees was $1,047.3 compared to an actual capitated rate of $1,054.9 (difference of −$7.6). Observed FFS and predicted capitated values reflect parallel adjustments.

D.2 Predicting FFS Expenditures for Enrollees

The goal of this analysis is the converse of what is presented in Analysis D.1. Here, we look at predicted FFS expenditures for enrollees based on a model predicting FFS expenditures for non-enrollees.

D.2.1 Methods

A data set with observations from base year 2 and from demonstration year 1 was created from the full data set to allow us to look at expenditures between the two periods. Beneficiary expenditures were summed across all months of each period and then "annualized" to represent the full 12 months of base year 2 (or 22 months of demonstration year 1).

The estimation process involved two steps. First, using non-enrollees, we regressed demonstration year 1 expenditures on base year 2 expenditures, base year 2 Hierarchical Condition Category (HCC) score, and a set of base year 2 demographic and area-level variables. We used an unlogged dependent variable and ran ordinary least squares (OLS) models with and without propensity score weights (using the frozen HCC scores in the composition of the weights). The data were clustered by Federal Information Processing Standards (FIPS) code. This model explained 17.4 percent of the variation in expenditures for non-enrollees.

In the second step, we used the covariate values for demonstration enrollees estimated in the OLS non-enrollee model (from step 1) to calculate predicted expenditures for enrollees. We compared the predicted expenditure values for enrollees to the actual capitated payments made under the demonstration.

D.2.2 Results

Table D-2 shows that enrollees had lower predicted expenditures in base year 2 ($809 for enrollees vs. $1,215 for non-enrollees) and a lower mean HCC score (1.155 for enrollees vs. 1.442 for non-enrollees).

Table D-3 shows that actual capitated payments for enrollees were, on average, $218 per month lower than the predicted mean expenditures for enrollees in demonstration year 1 suggesting Medicare savings under the capitated Medicare rates for the enrolled population

compared to the predicted FFS expenditures for this same population had they not been enrolled during demonstration period 1. Mean predicted expenditures for enrollees were $534 per month lower than actual expenditures for non-enrollees (not shown).

Table D-2
Mean values of model covariates by group

Covariate	Eligible but not enrolled (N= 40,119)	Enrolled (N = 46,158)
Average monthly FFS expenditures in demo year 1	$1,560	.
Average monthly capitated payment demo year 1	.	$1,025
Average monthly FFS expenditures in base year 2	$1,215	$809
HCC Health Risk Score	1.442	1.155
Age	61.473	58.574
Also in another CMS demonstration	0.307	0.199
Female	64%	56%
Black	42%	38%
Asian	2%	3%
Other	1%	2%
Hispanic	1%	1%
ESRD	3%	2%
Disabled	54%	57%
Patient care physicians per 1,000 population	0.650	0.658
% of households w/ member >= 60 yrs.	37.303	37.471
% of households w/ member < 18 yrs.	30.954	31.236
% college education	17.224	16.790
% with self-care limitation	5.254	5.046
Number of full-year duals, age 19+	44,705	39,644
Medicare Advantage penetration rate, all enrolled	0.264	0.260
Fraction of full-year duals with Medicaid Managed Care, ages 19+	0.011	0.015
% of pop. living in married household	57.540	59.374
Population per square mile, all ages	1,871.371	1,650.694
Medicaid spending per dual, ages 19+	10,602.120	10,927.480
Medicare spending per dual, ages 19+	19,217.400	18,677.340
Fraction of duals using nursing facilities, ages 65+	0.196	0.210
Fraction of duals using personal care, ages 65+	0.275	0.269
Distance to nearest hospital (miles)	5.575	6.294
Distance to nearest nursing home (miles)	4.181	4.760

ESRD = end-stage renal disease; HCC = Hierarchical Condition Category; FFS = fee for service.

SOURCE: RTI Program: predictingFFS_MI: Summary statistics: mean by categories of: enrollee

Table D-3
Expenditure prediction results from an unweighted OLS model

Enrollee observations = 46,158	Mean expenditures over the first year of the demonstration (22 months)	95% confidence interval
Predicted FFS for enrollees	$27,353	($27,104, $27,601)
Actual PMPM for enrollees	$22,559	($22,323, $22,794)
Difference	$4,794 ($218 per month)	($4,622, $4,965) P = 0.0000

FFS = fee for service; OLS = ordinary least squares; PMPM = per member per month.

SOURCE: RTI program: predictingFFS_MI unweighted FFS3a

D.3 Enrollee Subgroup Analyses

The enrollee subgroup analyses focused on a subgroup of beneficiaries identified as enrolled for at least 3 months in the demonstration period and with at least 3 months of baseline eligibility. Note that a subset of the comparison group developed for the ITT analysis was used in the enrollee subgroup analyses. Comparison group beneficiaries used in the enrollee subgroup analyses were required to have at least 3 months of eligibility in the demonstration period (March 1, 2015–December 31, 2016) and at least 3 months of eligibility in the predemonstration period (March 1, 2013–February 28, 2015), analogous to the criteria for identifying enrollees. The descriptive and regression results in ***Tables D-4*** and ***D-5*** indicate additional costs associated with enrollees. This enrollee subgroup analysis is limited by the absence of person-level data on characteristics that potentially would lead an individual in a comparison area to enroll in a similar demonstration, and thus the results should be considered in the context of this limitation.

Table D-4
Michigan demonstration, mean monthly Medicare expenditures, revised enrollee subgroup analysis, predemonstration period and demonstration period 1, weighted

Group	Predemonstration period March 2013–February 2015	Demonstration period 1 March 2015–December 2016	Difference
Demonstration group	$711.95 ($685.67, $738.24)	$922.93 ($889.38, $956.49)	$210.98 ($190.23, $231.73)
Comparison group	$896.95 ($875.78, $918.13)	$1,002.91 ($961.89, $1,043.92)	$105.95 ($70.39, $141.51)
Difference-in-difference			$105.03 ($64.33, $145.73)

SOURCE: RTI Analysis of Michigan demonstration eligible and comparison group Medicare data (program: lgs_mics510_log).

Table D-5
Demonstration effects on Medicare savings, revised enrollee subgroup analysis, DinD regression results, Michigan demonstration (weighted)

Covariate	Adjusted coefficient DinD	*p*-value	95% confidence interval	90% confidence interval
Intervention*Demo Period (March 2015–December 2016)	142.28	<0.0001	(109.24, 175.31)	(114.55, 170.00)

NOTE: Adjusted coefficient greater than zero are not indicative of Medicare savings.

SOURCE: RTI Analysis of Michigan demonstration eligible and comparison group Medicare data (program: lgs_mics510_log).

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Appendix E:
Summary of Predemonstration and Demonstration Design Features for Medicare-Medicaid Beneficiaries in Michigan

Table E-1
Demonstration design features

Key features	Predemonstration	Demonstration [1]
Summary of covered benefits		
Medicare	Medicare Parts A, B, and D	Medicare Parts A, B, and D
Medicaid	Medicaid State Plan and HCBS waiver services	Medicaid State Plan and HCBS waiver services, plus supplemental benefits not previously available under the State Plan
Payment method (capitated/FFS/MFFS)		
Medicare	FFS and capitated [2]	Capitated
Medicaid (capitated or FFS)		
Primary/medical	FFS and capitated	Capitated
Behavioral health	Capitated through PIHPs; except up to 20 outpatient mental health visits covered by MCOs	Capitated through PIHPs[25]
LTSS (excluding HCBS waiver services)	FFS	Capitated
HCBS waiver services	FFS	Capitated
Other (specify)	N/A	ICOs have discretion to provide flexible benefits under the capitation rate.
Care coordination/case management		
Care coordination for medical, behavioral health, or LTSS and by whom	N/A	ICOs have primary responsibility for care coordination. Care coordinators will coordinate with LTSS Supports Coordinators, PIHP Supports Coordinators and case managers, and PCPs.
Care coordination/case management for HCBS waivers and by whom	PIHPs provide supports coordination for persons with I/DD receiving waiver services; waiver agencies provide coordination for those with the MI Choice waiver.	ICOs will provide LTSS Supports Coordination for enrollees who qualify for waiver services based on the nursing facility LOC, including those who disenroll from MI Choice to opt into the demonstration. PIHPs will continue to provide supports coordination for persons with I/DD receiving waiver services.

(continued)

[25] Under the demonstration, PIHPs serve a new population: those whose behavioral health needs can be met with 20 or fewer outpatient visits per year. Additional information on PIHPs can be found in ***Section 2.2.2***.

Table E-1 (continued)
Demonstration design features

Key features	Predemonstration	Demonstration [1]
Case management for State plan personal care and by whom	County MDHHS offices provide case management.	ICOs will provide supports coordination for enrollees who are assessed to need personal care services.
Targeted case management	Case management is provided through the PIHPs for persons with behavioral health needs.	No change.
Rehabilitation option services	Case management is provided through PIHPs for persons receiving Assertive Community Treatment provided through PIHPs.	No change.
Clinical, integrated, or intensive care management	N/A	ICOs have overall responsibility for care coordination; PCPs coordinate primary care, initiate referrals for specialty care, and maintain enrollees' medical records.
Enrollment/assignment		
Enrollment method	All beneficiaries are enrolled in a PIHP regardless of whether they actually use PIHP services. People eligible for Medicare and Medicaid may opt into a Medicaid-contracted MCO or receive services on a FFS basis	Medicaid and Medicare beneficiaries who qualify for the demonstration have an opportunity to select an ICO. Those who did not select an ICO or opt out will be passively enrolled. All beneficiaries are enrolled in a PIHP regardless of whether they actually use PIHP services.
Attribution/assignment method	N/A	Same as for enrollment method, above.
Implementation		
Geographic area	N/A	Four geographical areas: Wayne County (Detroit), Macomb County, an 8-county region in Southwest Michigan, and a 15-county region covering the Upper Peninsula.

(continued)

Table E-1 (continued)
Demonstration design features

Key features	Predemonstration	Demonstration [1]
Phase-in plan	N/A	The State plans two phases of enrollment. For the Upper Peninsula and Southwest Michigan, opt-in enrollments began March 1, 2015 and passive enrollment on May 1, 2015. For Wayne and Macomb Counties, opt-in enrollment began on May 1, 2015, and passive enrollment on July 1, 2015.
Implementation date	N/A	March 1, 2015

DHHS = Department of Health and Human Services; FFS = fee-for-service; HCBS = home and community-based services; ICOs = Integrated Care Organizations; I/DD = intellectual and developmental disabilities; LOC = level of care; LTSS = long-term services and supports; MCO = managed care organization; MDHHS = Michigan Department of Health and Human Services; MFFS = managed fee-for-service; N/A = not applicable; PCP = primary care provider; PIHP = Prepaid Inpatient Health Plan.

[1] Information related to the demonstration in this table is taken from the Michigan three-way contract, 2014; the Michigan MOU, 2014; and the Michigan Department of Health and Human Services, Medicaid Provider Manual, 2015.

[2] As of February 2015 (the month before the demonstration launched), there were approximately 1.6 million Medicaid beneficiaries in MCOs, including 55,777 Medicare-Medicaid enrollees. (Health Management Associates, 2015a)