State Demonstrations to Integrate Care for Dual Eligibles

Demonstration Proposal

Michigan

Summary: In 2011, Michigan was competitively selected to receive funding through CMS' *State Demonstrations to Integrate Care for Dual Eligible Individuals.* As part of this Demonstration, CMS provided support to the State to design a demonstration proposal that describes how it would structure, implement, and monitor an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of services for dual eligible individuals. Through the demonstration proposal, the State must demonstrate its ability to meet or exceed certain CMS established standards and conditions including beneficiary protections. These standards and conditions include factors such as beneficiary protections, stakeholder engagement, and network adequacy among others. In order for CMS to determine whether the standards and conditions have been met, States are asked to submit a demonstration proposal that outlines their proposed approach for integrating care for dual eligible individuals. The Michigan Department of Community Health has submitted this proposal for CMS review.

As part of the review process, CMS will seek public comment through a 30-day notice period. During this time interested individuals or groups may submit comments to help inform CMS' review of the proposal.

CMS will make all decisions related to the implementation of proposed demonstrations following a thorough review of the proposal and supporting documentation. Further discussion and/or development of certain aspects of the demonstration (e.g., quality measures, rate methodology, etc.) may be required before any formal agreement is finalized.

Publication of this proposal does not imply CMS approval of the demonstration.

Invitation for public comment: We welcome public input on this proposal. To be assured consideration, please submit comments by 5 p.m., May 30, 2012. You may submit comments on this proposal to MI-MedicareMedicaidCoordination@cms.hhs.gov.

Michigan's Proposal

Integrated Care for People who are Medicare-Medicaid Eligible

April 26, 2012

Michigan's Proposal

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Contents

A. Executive Summary

The Michigan Department of Community Health (MDCH) is pleased to present its plan to integrate care for people who live within the state and are dually eligible for both Medicare and Medicaid (MMEs). The proposed plan has been developed through a contract with the Centers for Medicare and Medicaid Services (CMS) following an extensive stakeholder process. Michigan's integrated care model covers all Medicare and Medicaid services and benefits, including inpatient and outpatient acute care, skilled and custodial nursing facility care, behavioral health services, hospice, home health care, other community-based long term supports and services, durable medical equipment, and prescription drugs.

The goal of this integration proposal is to offer high quality, seamless and cost effective care through coordinated, person-centered services that meet the unique needs of all MMEs. When fully implemented, Michigan's program will integrate services and funding for more than 200,000 people who are eligible for and enrolled in both Medicare and Medicaid which, on an annual basis, currently costs the state and the federal government in excess of $8 billion.

The proposed care model is based upon:

- Goals of improved health outcomes and improved cost-effectiveness,
- Input from an extensive and on-going stakeholder process,
- A strategy of incorporating into the model those elements of current systems that have proven to be effective,
- A bias to provide care in the setting desired by the person receiving services , which is usually the community rather than an institution,
- Assurance of choice, autonomy and the principles of self-determination, and
- A structure that emphasizes service and program integration for the benefit of the persons served.

CMS requires three-way contracts between the federal government, the state and management entities selected to participate in the demonstration. Within this structure, the state will propose separate contracts for integrated care organizations (ICOs) and for Prepaid Inpatient Health Plans (PIHPs).

The application of separate contracts will maintain the behavioral health specialty services managed care system that is currently provided through PIHPs. Throughout the stakeholder process people who receive services through the PIHPs and their advocates asserted that the existing PIHP system provides quality community-based services and supports to people who have intellectual or developmental disabilities, those who have serious mental illness, those who have a substance use disorder and those who have a combination of these disabilities. Many stakeholders articulated their belief that the existing system works well, that they are being effectively served and that the services and supports currently received should be maintained. Michigan was one of the earliest adopters of managed care for these special populations and has built and refined systems that serve the populations well.

The state will propose that participating ICOs should include any management entity that meets all applicable conditions of participation established by the state Medicaid program and by Medicare. ICOs will cover physical health and long term care services, including both institutional and community-based services and supports. PIHPs will cover all behavioral health services including those for people who have an intellectual/developmental disability, who have a serious mental illness and/or who have a substance use problem.

A person-centered delivery system and supports coordination model will serve as the foundation of Michigan's integrated care plan. At the core of the care and supports coordination function is the care bridge (described in Section C) that ensures integration and coordination of services for participants across the delivery system.

Eligible individuals will be passively enrolled into the integrated system unless they explicitly indicate a choice to opt out. Initial enrollment will offer a two-month period to decide whether to opt out or to select an ICO. The state and its enrollment broker will provide extensive outreach and education services to all potential enrollees. People subject to passive enrollment can choose to opt out prior to the enrollment effective date.

Upon enrollment, all beneficiaries will be initially screened to determine basic needs, followed by a more in-depth standardized assessment to determine the possible array of services. The need for specialty services through the separately contracted PIHPs will also be determined at this time. People entering the integrated care program through the implementation phases will continue to receive all current services through the screening and assessment period.

The state will propose risk-based capitation rates with partial risk applied to management entities. A reliable risk adjustment methodology will be developed to address special populations, including people with intellectual/developmental disabilities and people who need long term supports and services. Management entities will be converted to full risk as the program matures and reliable risk adjustment methodologies are implemented.

ICOs and PIHPs will negotiate innovative reimbursement arrangements with providers that encourage best practices and quality care, as well as focusing on coordination across the service domains. Financial incentives will be built into the contracts of the ICOs and PIHPs that will promote the coordination that is lacking in the current delivery system.

Safeguards will be built into the new delivery model to assure continuity of services and to assure a seamless transition for people receiving services. These will include requirements to continue existing providers and services until an assessment is completed and care transition arrangements are made through the person-centered planning process. Further, nursing facilities will be assured payment at current Medicare and Medicaid rates for any participant that is a resident of their facility.

In addition to continuity of care and services, the principles of personal preference through choice and self-determination will be continued through the integrated care demonstration as these are key elements of Michigan's existing home and community-based waiver programs and important to the people receiving services through these programs.

The program will be phased in by quarter starting in 2013. The quarterly phase-in will be done by region and within each region by population.

- The state will establish several regions, each with a critical mass of potential enrollees
- The initial group to be enrolled within each region will include all beneficiaries except people needing long term care and those who have an intellectual/developmental disability
- The second group will include people needing long term care services
- The third group will include people with intellectual/developmental disabilities

The Michigan proposal includes significant beneficiary protections including an appeals process that incorporates the most comprehensive policies of each program (Medicare and Michigan Medicaid).

The intent is for the program to be built on evidenced based best practices with clearly defined metrics to effectively measure outcome and quality.

Overview of Michigan's Integrated Care Proposal	
Target Population	All full-benefit Medicare-Medicaid enrollees
Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide	198,644
Total Number of Beneficiaries Eligible for Demonstration	198,644
Geographic Service Area	The demonstration will be statewide with a rolling phase-in of implementation across geographic areas based on population.
Summary of Covered Benefits	Medicaid State Plan; Medicare Parts A,B, & D; Behavioral health and Developmental Disabilities services; 1915 (c) waiver services and 1915 (b)(3) services
Financing Model	Capitated Model
Summary of Stakeholder Engagement/Input *(Provide high level listing of events/dates—Section D asks for more detailed information)*	Informant Interviews; Six Public Forums in various regions of the state; Request for Input; Topic-Driven Workgroups (Four groups, three meetings each); Integrated Care e-mail box and website; 30-day Public Comment period; Two public meetings in March 2012.
Proposed Implementation Date(s)	2013

Highlights of Michigan's proposal are included in the table above. Details of Michigan's proposal are presented in the following pages.

B. Background

i. Status of Current System

In 2010, Michigan spent over $3.7 billion for Medicaid services on people who hold full dual eligibility for Medicare and Medicaid. For the same period, Medicare spending was more than $4 billion for this group of people. These numbers are trending upward and illustrate that integration and coordination of care is desperately needed so that resources are more effectively utilized and MMEs are ensured access to quality care. Despite increased spending by the two programs, the current service delivery model has not proven to be particularly effective in improving access to necessary services and in many instances the lack of coordination has led to an increase in costs. The following is a description of the current health care delivery system for MMEs in Michigan. Although there are many positives found in the existing system, there are also many opportunities for improving the mechanism through which MMEs receiver their health care services.

The health care delivery system for people who are eligible for both Medicare and Medicaid in Michigan has been largely disjointed and uncoordinated for those over the age of 21. Until November 2011, this population of roughly 200,000 people was unable to elect to receive physical health care through Michigan's Medicaid Health Plans (MHPs) despite the fact that roughly two-thirds of the state's Medicaid beneficiaries are enrolled in managed care. Likewise, Michigan has relatively low penetration of Medicare enrollees choosing to receive health care through Medicare Advantage plans, thus resulting in one of the most vulnerable groups of people being left to navigate the fee-for-service system without assistance in gaining access to basic health care.

Similarly, access to long term care services in Michigan has been uncoordinated for people who are eligible for both Medicare and Medicaid. The state covers nursing home care and personal care services under its Medicaid State Plan, but home and community based waiver services for people who are elderly or physically disabled are limited to the number of individuals that can be covered under the annual appropriation for the program. Limited access to waiver services has resulted in a significant waiting list,

sometimes resulting in admission to a nursing home for people who could be more appropriately served in the community. The use of institutional care for someone who could remain in a community setting can result in the loss of autonomy and self-determination for the individual as well as higher costs both to the state and to the federal government.

Medicaid-covered behavioral health, developmental disability and substance use services in Michigan for people who are dually eligible are delivered through a prepaid inpatient health plan (PIHP) system under a 1915(b)(c) waiver. Managed specialty services are provided under the (b) portion of the waiver and home and community based services are provided under the (c) portion to people who have an intellectual/developmental disability and meet the ICF/MR level of care (called the Habilitation Supports Waiver or HSW). Having closed most of its ICF/MR institutions, Michigan provides the majority of its behavioral health and developmental disabilities services in outpatient, home, and community settings. Today, Michigan only has four psychiatric hospitals and one forensic center. Medicare, on the other hand is covering most acute inpatient psychiatric admissions for people who are dually eligible. There is no connection to the Medicaid delivery system to coordinate care and provide less costly treatment before people decompensate and require an admission.

Notably lacking in the existing service delivery system described above is an effective person-centered care and supports coordination model that connects individuals and their various health care providers and community support systems across service domains. There is little, if any, sharing of information and coordination across the Medicaid delivery systems for Medicaid beneficiaries, and there is even less between the Medicare and Medicaid systems at the macro level for people who are MMEs. Without this connection, access to quality services cannot be assured, and additional cost is incurred to both the Medicare and Medicaid programs because of the inherent inefficiencies.

Despite the limitations noted above, it is important to note that the current systems deliver vitally important services effectively and that they are often well coordinated within their domains. Person-centered principles are utilized within some of these domains. The various services currently in place have evolved over time and all are essential in individual situations.

ii. Barriers to Address

Throughout the stakeholder process described later in this proposal, people who use Medicare and Medicaid services in Michigan described various scenarios in which they could sometimes access select pieces of the health care delivery system, but frequently would have difficulty gaining access to other services that were just as necessary for maintaining or improving their health status. Persons enrolled in Michigan's two 1915 (c) waiver programs (MI Choice and HSW) were pleased that they could access supports allowing them to live in the community instead of a facility, but they also expressed concern at the inconsistent ability to find physicians or specialists to address medical needs. For other stakeholders, the substantial waiting list for access to MI Choice is a major frustration and significant barrier to accessing services and supports in a community setting. This has frequently caused people to rely on emergency services, unnecessary hospitalizations or nursing home admissions because assistance was unavailable to them in gaining entry to a more preferred setting for care.

Barriers to health care in the current delivery system also extend to people with behavioral health diagnoses such as mental illness and substance use disorder, as well as to people with intellectual/developmental disabilities. While Michigan has a very well-established and successful behavioral health and developmental disability delivery system, there are no formal ties to medical care through which beneficiaries can access primary and acute services when needed. Even if they are fortunate enough to find medical care on their own, there is inconsistent linkage back to the behavioral health system through which health information is shared or a coordinated plan of care and supports is developed. An integrated and coordinated health care delivery system with financial incentives described later in this document would rectify situations such as those described above.

In addition to barriers posed by the service delivery systems, there are also challenges that people who are dually eligible must overcome in navigating the administrative complexities inherent to the existing Medicare and Medicaid structures. Most people have at least two or three membership cards for the two programs, which can lead to confusion in understanding enrollment processes and benefit coverage. It can be even more difficult for some when trying to understand the multiple appeals processes and other administrative differences between the two systems. Administrative simplification through integration will significantly improve the beneficiary experience.

iii. Goals and Principles

From the beginning of its work to establish an integrated health care delivery system, the state of Michigan created an overarching set of core principles to meet its goals of providing more accessible, affordable and better quality services and supports to people who are dually eligible. These principles were articulated at the outset of the stakeholder process, and they further evolved over the course of the stakeholder events to more accurately reflect the thoughts of those who receive, provide and advocate in the services and supports delivery system for MMEs.

The primary goal of integrating care and supports in Michigan is to design and implement an organized and coordinated delivery system that:

- Provides seamless access to all services for beneficiaries
- Creates a care and supports coordination model that communicates within its structure by linking back to all domains of the delivery system
- Streamlines administrative processes for beneficiaries and providers
- Eliminates barriers to home and community based supports and services
- Improves quality of services and customer satisfaction
- Reduces the cost of providing care to the state and federal government through improved care and supports coordination, financial realignment and payment reforms.

To achieve these goals, MDCH and its stakeholders believe certain principles must be followed. These principles were debated and emphasized throughout the stakeholder process (described in Section IV). They are:

- Above all else, the person receiving services must be at the core of the delivery model and the principles of person-centered planning developed in Michigan by advocates and people who receive services must be preserved and carried forward in any plan for a new care/supports coordination model
- The components of the existing service delivery model that work well must be maintained and not thrust aside for the sake of creating something new
- Innovation in a new system must rely on evidenced based practices
- Self Determination must be incorporated into a new delivery model
- Access to all services must be maintained and improved upon in a new model
- Quality standards and measurements that are not available in the existing delivery system must be developed to demonstrate successes and opportunities for improvement
- A standardized risk and health assessment is essential to eliminating redundancies and improving efficiencies in a new system
- Care and supports coordination is vital, with a care/supports coordinator made available to every participant

These goals and principles serve the dual purposes of preserving what is important and necessary in the current system while reaching for vastly improved integration across service domains and systems functions. This initiative will include protections and safeguards to maintain essential services and keep from disrupting or destabilizing current systems. Certain features have been proposed specifically for this reason. This does not diminish the need for change that will transform what is dysfunctional into a

coherent integrated system that greatly improves the lives of our vulnerable citizens who are dually eligible for both Medicaid and Medicare.

Finally, these goals and principles have enduring qualities that are built for the long term. This initiative recognizes that change is a process and that it will take time to achieve meaningful results. To that end, this proposal will default to what is solid in the long run and reject short term but transitory victories such as near term cost savings.

iv. Description of the population

This description of the population is based on data from calendar year 2008. During that year 198,644 "full benefit" dual eligibles were served in Michigan.[1] As of March 2011 this population had increased to 211,309 individuals.

a. Demographics

As is true across the country, Michigan's dual eligible population is predominantly female (63%). The gender disparity is especially true for most elderly MMEs.

Table 1: Gender by Age

Gender	Under 21	22-49	50-64	65-74	75-84	85+	Total
Male	38	22,685	20,235	12,880	10,161	6,653	72,652
Female	24	22,961	26,656	24,474	23,776	28,101	125,992
Total	62	45,646	46,891	37,354	33,937	34,754	198,644

A description of the MMEs by gender and age is included in the table above.

Since the 2008 data from Medicare did not allow us to easily see the transitions of people among care settings during the year, Michigan decided on a hierarchical analysis of clients by category of health care services and supports. Individuals were only counted in one category, based on their status at the end of 2008. They were assigned to the first applicable category that occurred on the list displayed in the chart below, even though they might have received services in other categories.

Table 2: Age by Sub-Population Category

Age	Under 21	22-49	50-64	65-74	75-84	85+	Total
Habilitation Supports Waiver	1	1,858	2,604	698	263	75	5,499
DD not HSW	1	5,217	3,573	1,128	487	148	10,554
Adult with Mental Illness	1	10,596	8,564	2,615	1,430	914	24,120
MI Choice HCBS Waiver	0	359	1,109	1,347	1,866	2,134	6,815
Nursing Home	0	234	1,264	2,830	7,291	19,531	31,150
Adult Home Help	0	4,180	6,475	6,572	6,532	4,150	27,909

[1] Individuals enrolled in Medicare Advantage plans were included in the analysis, so per capita Medicare costs may be understated. Also there were 333 PACE enrollees in Michigan in 2008. These individuals are included in the total population but their Medicare and Medicaid costs during the time they were enrolled in PACE are not included. Michigan only recently received the Medicare claims data for 2008 through 2010 and still does not have the Medicare Part D data. As a result, our descriptions of the dual Medicare/Medicaid enrollees and their health care utilization and costs are based on 2008, a period for which we have composite annual data from Medicare. The initial data file included just over 208,000 individuals. For this analysis several groups that receive support from both Medicaid and Medicare have been excluded. The first are those than only receive assistance from Medicaid with their Medicare premiums – the Specified Low-Income Beneficiaries (SLMBs) and the Qualified Individuals (QIs), of whom there were 2,942 individuals. In addition we have excluded individuals eligible for Medicaid only when they meet a "spend-down" or deductible threshold since they are not eligible for an entire month and therefore would not be candidates for a capitated plan. There were 6,579 of these individuals. Our analysis thus includes 198,644 full benefit dual eligibles.

Table 2: Age by Sub-Population Category

Age	Under 21	22-49	50-64	65-74	75-84	85+	Total
ESRD	58	865	832	320	165	53	2,293
Other Disabled	1	22,337	22,470	2,849	-	-	47,657
Other Aged	0	-	-	18,995	15,903	7,749	42,647
Total	62	45,646	46,891	37,354	33,937	34,754	198,644

A description of MMEs by age and sub-population category is included in the table above.

b. Utilization and Cost Data[2]

Table 3: Service Costs by Sub-Population Category

Measure	Mental Health Payments including HCBS Waiver	MIChoice HCBS Waiver Services	Nursing Facility Services	Hospice	Adult Home Help	Pharmacy	Other Acute Care Services	All Services
DD - Habiliation Supports Waiver								
Medicaid #	5,499	1	266	13	1,603	4,265	5,499	5,499
- pmpm	$5,412.83	$1.37	$1,683.80	$1,715.74	$607.30	$18.97	$83.68	$5,773.76
Medicare #	-	-	112	105	-	5,343	5,499	5,499
-pmpm			$1,521.83	$1,467.27		$348.91	$802.78	$1,200.80
DD not enrolled in Waiver								
Medicaid#	10,541	13	1,043	54	3,288	5,344	10,554	10,554
-pmpm	$2,067.64	$705.33	$2,502.05	$2,205.25	$428.87	$16.80	$54.39	$2,521.03
Medicare#			368	121		9,709	10,554	10,554
-pmpm			$1,896.97	$1,293.98		$233.77	$726.60	$1,022.63
Adults with Mental Illness								
Medicaid#	24,085	47	2,935	218	3,066	15,055	24,120	24,120
-pmpm	$801.03	$391.56	$2,883.45	$1,785.64	$286.45	$23.75	$60.58	$1,278.56
Medicare#			1,250	382		23,329	24,120	24,120
-pmpm			$1,809.14	$1,246.69		$384.32	$1,222.30	$1,707.53
MI Choice HCBS Waiver Enrollees								
Medicaid#	482	6,797	6,797	103	217	3,057	6,815	6,815
-pmpm	$182.72	$1,331.32	$1,396.92	$920.02	$315.71	$9.99	$104.79	$2,867.19
Medicare#			949	573		6,312	6,815	6,815
-pmpm			$1,728.03	$1,491.77		$312.61	$2,441.29	$3,096.89
Nursing Facility Residents								
Medicaid#	716	-	30,161	3,508	790	16,691	31,150	31,150
-pmpm	$37.18		$4,166.46	$2,469.26	$304.14	$6.49	$53.03	$4,377.33
Medicare#			9,316	5,342		28,917	31,150	31,150
-pmpm			$2,007.66	$1,507.22		$216.94	$1,781.39	$2,839.59
Adult Home Help Recipients								
Medicaid#	23,842	-	1,325	160	27,877	16,530	27,909	27,909
-pmpm	$31.71		$686.08	$1,072.80	$368.31	$9.79	$93.41	$532.92
Medicare#			1,667	881		26,872	27,909	27,909
-pmpm			$1,445.47	$1,216.88		$258.56	$2,187.24	$2,560.94
End Stage Renal Disease								
Medicaid#	42	-	180	42	-	1,596	2,293	2,293
-pmpm	$83.00		$1,804.83	$845.76		$26.49	$432.66	$609.78
Medicare#			205	80		2,163	2,293	2,293
-pmpm			$1,744.07	$763.02		$386.93	$7,651.84	$8,212.47
Other Disabled								
Medicaid#	1,275	-	1,706	153	-	21,555	47,657	47,657
-pmpm	$92.10		$626.96	$2,040.88		$16.83	$65.50	$918.09
Medicare#			550	370		43,848	47,657	47,657
-pmpm			$1,410.80	$1,388.36		$214.25	$104.57	$1,142.28
Other Aged								
Medicaid#	1,301	-	3,458	724	-	16,369	42,647	42,647
-pmpm	$82.69		$2,615.60	$3,177.12		$4.89	$58.72	$329.14
Medicare#			2,396	7,260		40,306	42,647	42,647

[2] The number of individuals receiving other acute care services may be overstated, but the total costs are accurate. Errata Notice: The indicated utilization and spending for nursing facility services for MI Choice HCBS waiver enrollees is overstated. As the capitated financial alignment demonstration moves forward, the data will be corrected.

Table 3: Service Costs by Sub-Population Category

Measure	Mental Health Payments including HCBS Waiver	MIChoice HCBS Waiver Services	Nursing Facility Services	Hospice	Adult Home Help	Pharmacy	Other Acute Care Services	All Services
-pmpm			$1,708.26	$500.06		$151.66	$1,214.93	$1,507.83
Michigan's Totals All Dual Eligibles								
Medicaid#	67,756	6,858	47,871	4,975	36,841	100,462	198,644	198,644
-pmpm	$1,061.61	$1,323.50	$3,301.13	$2,433.62	$375.62	$13.08	$70.91	$1,411.47
Medicare#			16,813	9,534		186,499	198,644	198,644
-pmpm			$1,850.31	$1,429.18		$239.00	$1,449.22	$1,898.81

The same hierarchical categories were used for our utilization analysis as shown in the table above.

While Michigan looks forward to the opportunity to perform more detailed analyses based on the recently obtained Medicare claims files, the data from 2008 provides some interesting insights into historical patterns of service for Medicare-Medicaid enrollees.

Table 4: Medicare and Medicaid PMPM Costs by Sub-Population Category

Population	Number	Medicaid pmpm	Medicare pmpm	Total pmpm
DD – Habilitation Supports Waiver	5,499	$5,773.76	$1,200.80	$6,974.56
DD not enrolled in Waiver	10,554	$2,521.03	$1,022.63	$3,543.66
Adults with Mental Illness	24,120	$1,278.56	$1,707.53	$2,986.09
MiChoice HCBS Waiver Enrollees	6,815	$2,867.19	$3,096.89	$5,964.08
Nursing Facility Residents	31,150	$4,377.33	$2,839.59	$7,216.92
Adult Home Help Recipients	27,909	$532.92	$2,560.94	$3,093.86
End Stage Renal Disease	2,293	$609.78	$8,212.47	$8,822.25
Other Disabled	47,657	$918.09	$1,142.28	$2,060.37
Other Aged	42,647	$329.14	$1,507.83	$1,836.97
Total	198,644	$1,411.47	$1,898.81	$3,310.28

The table above shows the roles of Medicare and Medicaid in financing services and supports for different sub-populations of people who are dually eligible. The data is based on paid claims.

Information from the preceding two tables leads to the following observations.

- Most of the cohorts in the hierarchy include a sizeable number of individuals. The patterns of service utilization vary greatly among the cohorts. The implication is that the integrated care plan and the competencies of the ICOs may require development of multiple models of care planning and service coordination and delivery.
- Individuals with intellectual/developmental disabilities receive most of their services from Medicaid. In addition to receiving extensive support services from Medicaid, their Medicare costs are lower than average. In particular, their use of Medicare-financed acute physical health care services is only about half the per capita level for the entire dual eligible group.
- Individuals needing nursing facility level of care who are enrolled in the MI Choice HCBS waiver receive more Medicare services than Medicaid. By contrast nursing facility residents receive significantly more Medicaid than Medicare services. They are also the oldest cohorts of dual eligible enrollees, accounting for more than half of those over the age of 85.
- For individuals with ESRD and for "other" aged individuals, Medicare is the predominant provider of services.

- For adults with mental illness, Medicare spending exceeds Medicaid spending. This is in part due to the fact that Medicare pays for acute psychiatric care for this cohort of people and Part D covers most of their psychiatric medications.
- "Other" disabled individuals receive slightly more than half of their services from Medicaid.

c. Physical Health

As shown in the table below both Medicaid and Medicare provided significant services to Michigan's 198,644 full benefit dual eligibles in 2008. While Medicaid is the predominant source of long term care and mental health services, Medicare provides most of the acute physical health care services for the full benefit MMEs, including practitioner services, inpatient and outpatient hospital care and pharmacy.

Table 5: Medicare and Medicaid Monthly Costs by Provider Category

Provider Category	Monthly Medicaid $	Monthly Medicare $
Practitioners/Carriers	$1,896,256	$70,298,796
Inpatient Hospital	$2,831,527	$142,482,947
Outpatient Hospital	$1,616,624	$43,566,757
Pharmacy (Medicaid cBN4 and Part D)	$1,314,163	$44,573,191
Durable Medical Equipment	$2,576,856	$12,524,641
Home Health	$60,840	$19,005,225
Hospice	$12,107,258	$13,625,835
Skilled Nursing Facility	$158,028,196	$31,109,265
MI Choice	$9,076,546	$0
Home Help (State Plan Personal Care)	$13,838,066	$0
Medicaid HMO	$3,616,716	$0
Payments to PIHPs	$71,930,614	$0
Other (vision, dental, hearing, transportation, auxiliary medical)	$1,487,230	$0
TOTAL	$280,380,894	$377,186,658

The Medicare and Medicaid monthly costs by provider category are described in the table above.

d. Long Term Care

Excluding home and community-based services specific to the HSW, Medicaid spending in 2008 for long term care was $187.5 million per month while Medicare spending was $43.6 million per month. These expenditures include nursing facilities, hospice, MI Choice waiver services and Michigan's adult home help program (State Plan personal care services). Every category of MMEs identified in the hierarchy included individuals who used long term care supports and services, in particular those provided in nursing facilities and through hospice. These facts speak to the need for integration and care coordination between long term care and acute care services, which are primarily provided by Medicare. In addition, Michigan currently has a waiting list for its MI Choice waiver that provides community-based long term supports and services. The integrated care initiative offers the opportunity to expand these services to additional individuals.

e. Behavioral Health and Intellectual/Developmental Disabilities

Michigan Medicaid spent over $843.6 million on behavioral health and developmental disability services for full-benefit duals in 2008. Most of these funds are delivered through capitation payments to PIHPs. Of that amount, $225.7 million covered services for people with serious mental illness, $617.4 million for people with an intellectual/developmental disability and $2.3 million for those with substance use disorders. For the I/DD population, $356.8 million was spent for those enrolled in the HSW, which served 5,500 individuals who are dually eligible. An additional $260.6 million was spent on services and supports for persons who have an intellectual/developmental disability and are not enrolled in the (c) waiver.

While most of the payments to Michigan's behavioral health system were made on behalf of individuals with mental illness or intellectual/developmental disabilities, some individuals from every cohort in our client hierarchy received some form of behavioral health services. This speaks to the importance and need for coordination and communication amongst **all** providers of services and supports for these individuals. For persons with mental illness, the coordination of Medicare and Medicaid is particularly important. Medicare currently covers the hospital-based inpatient and outpatient psychiatric care. Coordination of these services with community-based behavioral health services through PIHPs could result in improved health care, improved health status and decreased costs if interventions provided in the behavioral health system serve to reduce avoidable inpatient psychiatric admissions.

While substance use is an issue for all categories of dual eligible individuals, in 2008 treatment for substance use was primarily provided for individuals with mental illness or other disabled individuals (as shown in the following table).

Table 6: Dual Eligibles Receiving Substance Use Services from Medicaid in 2008

DD - Waiver	0
DD not Waiver	33
Adult with Mental Illness	578
MI Choice	2
Nursing Home	6
Adult Home Help	123
End Stage Renal Disease	8
Other Disabled	560
Other Aged	42
Total	1352

The number of MME individuals receiving substance use services from Medicaid in 2008 is listed in the table above.

There may be other individuals with substance use disorders who are not in active treatment today. A key benefit of the integrated care initiative would be the opportunity to assess all full benefit dual eligibles for substance use disorder and to provide services as necessary. Most full benefit MMEs receiving their acute care services from Medicare on a fee-for-service basis have not been screened for substance use issues if they have no other contact with Michigan's behavioral health system.

C. Care Model Overview

i. Model Overview

Michigan's proposed care model is based upon:

- Goals of improved health outcomes and improved cost-effectiveness,
- Input from an extensive and on-going stakeholder involvement process,
- Incorporation into the model those elements of current systems that have proven to be effective,
- A bias to provide care in the setting desired by the person receiving services , which is usually the community rather than an institution,
- A fully integrated network of providers and linked through a Michigan-specific care and supports coordination model
- Assurance of choice, autonomy and the principles of self-determination, and
- A structure that emphasizes service and program integration for the benefit of the people served.

Michigan's integrated care plan proposes use of two separate contracts to deliver services to people who are eligible for both Medicare and Medicaid. One contract will cover all physical health services (acute and primary care) and long term supports and services. The second will address all behavioral health and developmental disability inpatient and outpatient supports and services including those necessary for people with intellectual/developmental disabilities, serious mental illness and/or substance use disorders. Contractors will be required to work together to coordinate care and the contracts will specify expectations and include incentives to assure the relationships are built for maximum coordination and integration. Services provided through these two contracts will be phased in by region and by population as described in Section H of this proposal. The specific geographic areas remain under consideration by the state, and factors such as the eligible population and service provider distribution will influence final decisions.

A major consideration of the two contract approach is to avoid destabilizing the current system and to recognize the value of existing service delivery structures. Michigan has a unique behavioral health and developmental disabilities system, one that has had a strong managed care framework for 15 years. This has resulted in an effective management and service delivery capacity for behavioral health services. The program has solid data analytics, quality standards and metrics to support its effectiveness. While integration with physical health and long term care services is the challenge, it is important not to disrupt this system. Instead, the emphasis will be on establishing the linkages needed between the two contractors to achieve integration with the other service domains (acute, primary, long term and pharmacy services).

All persons who are dually eligible for both Medicare and Medicaid coverage will be served under the framework described below. The experience of the applicant or program participant will not be defined by which of the two contractors has primary responsibility for care and supports coordination. Instead, the participant's experience will be one of seamless access to a fully integrated system. Integration and coordination between the two systems will be achieved through the following system elements:

- no wrong door access to the delivery system,
- a single person-centered screening and assessment tool and process,
- integrated information technology (developed over the course of the demonstration),
- care and supports coordination teams that draw membership from both contractors,
- access to common services and provider networks,
- common participant protections, and
- common monitoring and evaluation standards.

Eligible individuals will be passively enrolled into the integrated system unless they explicitly indicate a choice to not participate. See Section H of this proposal for additional discussion of the enrollment process for those who choose to opt out, as well as a discussion of the subsequent process and timeline for future enrollment periods.

People who opt out of integrated care will continue to receive all state plan services, and it is the intent of MDCH that they will continue to receive other optional 1915(b)(3) services, as applicable. However, those who choose not to participate will not receive the enhanced care management and supports coordination package that will be offered through integrated care. Furthermore, they will not be eligible for the enhanced services package that will include dental and vision, as well as other optional services that a plan may decide to offer.

The venue for delivery of services and supports for people who are not enrolled in integrated care will depend on the configuration of Michigan's current set of waivers once integrated care is implemented. The status of waivers is currently under joint review by CMS and the state. People who currently receive supports and services through the existing waiver structure but who will not qualify for Medicare, and therefore, the integrated care program, will continue to receive their current array of services through existing Medicaid programs.

Note that all Medicaid beneficiaries are currently enrolled in a PIHP. Therefore, even if they opt out of integrated care, they will continue to have PIHP enrollment; however, the array of services will be different as noted above.

Integrated Care Organizations (ICOs) will provide coverage for all physical health (acute and primary care), pharmacy and long term supports and services. The term physical health references all services currently covered by Medicare Parts A and B including hospital inpatient and outpatient services, physician and other professional services and ancillary services. Long term care services, which are currently covered mostly by Medicaid, will include home and community based services currently provided through the MI Choice waiver and nursing facility care. The Part D pharmacy benefit will also be managed by the ICO.

Organizations bidding to be ICOs may include any management entity that can meet all applicable conditions of participation, including requirements mutually established by the state with its CMS partners (such as licensing), with the intent of attracting as wide a group of entities as feasible. Specific requirements will be outlined in a procurement document to be released in conjunction with CMS at a later date.

Behavioral health and developmental disabilities services will be managed by Prepaid Inpatient Health Plans (PIHPs), the entities that currently deliver the Michigan Medicaid behavioral health and developmental disabilities benefit. PIHP contracts will cover all supports and services for people who have intellectual/developmentally disabilities as well as all supports and services, including acute inpatient psychiatric care, for persons with serious mental illness. PIHPs will also provide services to people with substance use disorders. MMEs enrolled in PIHPs for behavioral health will be concurrently enrolled in an ICO for physical health services. Through a collaborative process between the ICOs and PIHPs, primary care health homes provided through the PIHPs may be developed and are encouraged by the state.

Within any given region, beneficiaries may have the option of choosing between two or more ICOs; however, only one PIHP will be available. The state will configure ICO and PIHP boundaries so they will be aligned. Therefore, geographic regions are unlikely to conform to current Medicaid HMO or PIHP regions.

For MMEs with serious mental illness (SMI), substance use disorder, and intellectual/developmental disabilities (I/DD), ICOs will be offered incentives to contract with primary care providers who partner with PIHPS for the physical co-location of primary care services at community mental health centers (CMHCs)or in Federally Qualified Health Centers (FQHCs).

PIHPs and ICOs will be required to share a secure electronic platform that contains at a minimum 1) a current integrated problem list; 2) a single integrated person-centered plan of care; 3) contact information for lead coordinator(s); 4) a current medication list; and 5) dates of service and servicing providers for most recent provider and service contacts within PIHP and ICO systems.A person-centered delivery system and supports coordination model will serve as the foundation of Michigan's integrated care plan. A person-centered model requires the person receiving supports and services to be the focus of the planning process and it involve families, friends, and professionals as the individual desires. Every person receiving supports and services will have a person-centered plan, to the extent desired by each person, which honors the individual's preferences, choices and abilities.

To ensure a person-centered delivery system, all health professionals who provide medical care, supports and services to persons who are eligible for both Medicare and Medicaid must be trained in the person-centered approach, which recognizes the individual's right to self-determination and emphasizes recovery. Providers will be required to have person-centered planning as a core competency. In addition, quality measures will focus on ensuring that supports and services offered are those needed and desired by the individual receiving the supports and services.

Within the procurement process, it will be the responsibility of the state to determine whether ICOs that submit bids have the capability of implementing person centered planning and supports and services coordination. The state, with stakeholders having expertise in person centered planning, will provide training on the person-centered approach to entities that are selected to become ICOs. Success with effectively implementing a person centered model will be a primary quality measure.

ii. Assessment and Care/Supports Coordination

One of Michigan's stakeholder workgroups focused specifically on discussion of care coordination and assessment, making general recommendations with regard to how these activities should be carried out in an integrated delivery system. Taking the stakeholder recommendations into account, every participant will have a person-centered plan (to the degree that they want to participate in the process) that is based on an initial brief assessment to identify health care needs and preferences and later a comprehensive assessment process if necessary. Every participant will have a care or supports coordinator that leads a multidisciplinary group of providers (or the assigned care managers from that discipline) in a care bridge (described below) to assure integration and communication in delivering services and supports. While these concepts will be more fully developed, a description of the assessment and care/supports coordination model in its current form follows.

a. Assessment

Applicants for services will participate in a brief preliminary health assessment/screening process that identifies personal preferences, needs, and priorities. The screen will also identify the medical and financial factors that determine eligibility for the integrated care demonstration if necessary, as well as identifying existing informal supports and other non-financial factors that may impact the assessment and planning process. The screen results will assist in determining the entity (ICO or PIHP) that will have primary responsibility for working with the participant in the care and supports coordination model described later in this section.

Once determined, the lead entity (the ICO or PIHP) will conduct a more extensive person-centered assessment. The assessment process will include a more extensive discussion of preferences, strengths, needs and priorities and an assessment instrument will be administered that includes a core set of information gathered for each participant. The core instrument can trigger the use of multiple sub-sections that, together, span the full ranges of needs and, individually, allow for gathering in-depth information in specific areas. For example, an individual may identify as a priority the threat of complications from unmanaged diabetes. That person may also have cerebral palsy that limits mobility and may have future implications for assistance with activities of daily living (ADL) or instrumental activities of daily living (IADL). The core assessment would trigger the use of a sub-section with the capacity to identify the diabetes and associated risk factors that lead to medical testing and treatment. It may also trigger another sub-section related to IADL or ADL needs. As the assessment is repeated over time, other sub-sections may be triggered, leading to identification and linkage to new services.

For many participants, the core assessment will identify very limited needs (e.g., monitoring blood pressure and cholesterol) and lead to the lowest level of care management and monitoring. Other participants may have needs that warrant more extensive assessment and planning, using a person-centered model. The planning process will also determine the level of care or supports coordination, monitoring and assessment necessary for each person.

b. Care and Supports Coordination

Care and supports coordination will operate on a continuum from basic to extensive, depending on the needs and preferences of the participant. A person may move back and forth along this continuum as needs increase or decrease, in response to acute events or gradual changes in health. Basic care coordination will include assessment, person-centered planning, monitoring, information and referrals, and facilitating transitions between care settings. Basic care coordination may be as minimal as annual

visits, semi-annual phone calls, and regular monitoring of medical records to identify events, such as a hospitalization, that could trigger more extensive care coordination. Care coordination will expand in response to changing needs and preferences. This may include creating or expanding a care team, accessing additional services, more frequent contacts including team meetings, more extensive planning to include all team members and services, and crisis interventions.

Each enrolled participant will choose or work with the preferred entity to select a care or supports coordinator, depending on their primary service needs. For example, a person requiring mostly supports through the PIHP would work with that entity to choose his or her supports coordinator. A person requiring primarily medical care services would work with the ICO to select a care coordinator. Metrics will be established and the contractors will be monitored to ensure that MMEs have access to the services they need and desire.

The PIHP will provide supports and service coordination for all MMEs with intellectual/developmental disabilities including those who are currently enrolled in Michigan's 1915 (c) waiver as well as those who are not enrolled in the (c) waiver but receive comparable services through the Specialty Services 1915 (b)(3) waiver services. Lead responsibility for supports and services coordination for persons who have intellectual/developmental disabilities will reside with the supports coordinator chosen by the participant. The supports coordination function will require collaboration with the ICO's primary care medical home. The care coordination model is described later in this section.

The PIHP will serve as the provider of supports and service coordination for MMEs with serious mental illness or substance use disorders. The state of Michigan is working to develop the health home concept with PIHP partners and anticipates that this will be part of the services delivery model. For persons who have an intellectual/developmental disability and those with serious mental illness or substance use disorder, the supports coordinator within the PIHP will be responsible for leading other members of the participant's care team across the delivery system to ensure integration of physical and behavioral health care. PIHPs will be required to deliver all supports and services in the least restrictive setting, to use person-centered planning and to make self-determination arrangements readily available.

ICOs will provide a person-centered primary care medical home (PCMH) for all participants where acute and primary care services will be managed. Each enrollee will have a care coordinator from the ICO to coordinate physical health services. The care coordinator will collaborate with the other members of the multi-disciplinary care coordination team, including the supports or services coordinator from the PIHP should the participant also be receiving behavioral health or developmental disabilities services. Michigan will encourage structures that integrate services across delivery domains. The creation of health homes is an example that holds potential as the demonstration matures and experience is gained.

The ICO will be responsible for the management of services and supports coordination for people who are elderly or physically disabled and require long term supports and services. ICOs will be required to serve these participants in the least restrictive setting, and the care coordination model will require inclusion of self- determination and person-centered planning. Persons who require long term care supports and services will choose a supports or care coordinator through the ICO. The supports coordinator will have primary responsibility for the management and coordination of all services, including the integration of all physical health services and will work in tandem with other members of the multi-disciplinary team.

c. The Care Bridge:

At the core of the Michigan's care and supports coordination model is the care bridge. The care bridge serves as the fundamental element in Michigan's proposal to ensure and support the integration and coordination of services for participants across the delivery domains. It is the conduit for coordinating and facilitating access to services and supports. The coordinator with lead responsibility for working with any given enrollee will coordinate with a multidisciplinary team that draws members from all sectors of an

enrollee's service and supports array. The supports coordinator for someone who has an intellectual or developmental disability, for example, will be directly tied to the PIHP, but will coordinate with the care manager from the primary medical home that is responsible for coordinating physical health services. If a person is receiving home and community based long term services, and is also accessing medical care for a chronic illness as well as mental health treatment through the PIHP for depression, members of the multi-disciplinary care bridge will work with the participant to assure that the necessary supports and services are in place with no duplication.

d. Person Centered Medical Home

Referenced earlier, each enrollee will have a Person Centered Medical Home (PCMH) responsible for providing access to and coordination of acute and primary care services. The PCMH, to be facilitated by the ICO, will be responsible to ensure provision of comprehensive medical care and will be accountable for meeting the large majority of each person's care needs including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, psychologists, and care coordinators. Although some medical home practices may bring together large and diverse teams of care providers to meet the needs of their patients, many others, including smaller practices, will build virtual teams linking themselves and their patients to providers and services in their communities. Members of the team may play a role in the care coordination bridge.

e. Integrated Information Technology

Currently there is limited capacity for electronic sharing of medical records for many parts of the integrated delivery system. Development of this capability is vital to the success of integrating care and payment reform in the long term. Michigan will require that the integrated care contractors create over the course of the demonstration an electronic health records system that allows for secure sharing of information across providers and between contractors. Until such capacity is developed, contractors and their care managers will be required to share information through their respective members of the care bridge as outlined above. This sharing of information is critical to successful care management and to achieve the goals of an integrated delivery system.

iii. Benefit Design (Covered Services)

Michigan's integrated care demonstration will offer a robust benefit package, incorporating all services currently covered under the Medicare fee-for-service program, the Michigan Medicaid State Plan, and the services and supports in Michigan's 1915 (c) waiver programs. The plan will include all physical health care services (acute and primary care); all behavioral health, substance use and developmental disabilities services covered by Medicare and Medicaid (State Plan and 1915 (b)(3)); all long term care services covered by the two programs; and all supports and services covered by Michigan Medicaid in its 1915 (b) and (c) waiver programs. Contractors will have flexibility to include optional services currently not available or that are limited under the existing Medicare and Medicaid benefit packages. Michigan will work with CMS in the procurement process to encourage provision of benefits that will enhance the quality of life for those enrolled. A chart identifying the covered services and supports is included in the appendices of this proposal.

The current array of long term care services for persons eligible for both Medicare and Medicaid include nursing facility care, as well as all community-based services currently offered under the MI Choice Home and Community Based Waiver, and personal care services currently provided through Michigan's State Plan personal care option and the Home Help program. Eligibility for these long term care services will require the same qualifying criteria that are currently applied. Individuals who demonstrate a "nursing facility level of care" under a prescribed state assessment tool will have access to nursing facility and 1915 (c) waiver services.

Under Michigan's model, ICOs will be required to offer non-emergency transportation to covered medical services. Other physical health services (expanded dental services, vision, vision and hearing aids, for example) may be provided at the option of the ICO and are strongly encouraged. ICOs will also have the option of providing enhanced community based supports and services.

iv. Services for those Opting Out of Integrated Care

People who opt out of integrated care will continue to receive all Medicaid state plan physical health services through the Medicaid Health Plans or fee-for-service. For individuals with serious mental illness, substance use disorder, or intellectual/developmental disabilities, their Medicaid specialty supports and services (state plan and 1915(b)(3)s) will be managed by the PIHPs. However, those who choose not to participate will not receive the enhanced care management and supports coordination package that will be offered through integrated care. Furthermore, they will not be eligible for any enriched services packages that an ICO may choose to offer, such as enhanced dental and visions benefits.

The venue for delivery of services and supports for people who are not enrolled in integrated care will depend on the configuration of Michigan's current set of waivers once integrated care is implemented. The status of waivers is currently under joint review by CMS and the state. People currently receiving supports and services through the existing structure, but who will not qualify for Medicare, will continue to receive their current array of services through existing Medicaid programs.

Note that all Medicaid beneficiaries are currently enrolled in a PIHP. Therefore, even if these people opt out of integrated care, they will continue to have PIHP enrollment for the current Medicaid behavioral health benefit. However, the array of services will be different as noted above.

v. Provider Network/Capacity

In order to be selected to participate in Michigan's integrated care program, management entities will be required to demonstrate the availability of adequate provider networks as defined by the state. Both the management entities and their providers must possess core competencies as described below. These capabilities will be addressed through the procurement process.

Michigan's stakeholder group for provider networks and service array agreed that the contractors for integrated care and their providers should have the following competencies:

- Experience with person-centered planning and self determination
- Use of evidenced-based practices and specific levels of quality outcomes
- Experience in working with people who have disabilities
- Cultural competence

With these competencies in mind, Michigan will work with CMS in the procurement process to require bidders to demonstrate they have the capacity to provide all services and supports covered under this demonstration, including those currently covered under the Medicare and Medicaid programs. Adequate access and quality standards will be developed in the contracts as well as requirements that providers are trained in person-centered planning and service delivery.

The provider network must include specialists in the conditions common to demonstration participants and they must have the capability of communicating in the languages or adaptations used by the participants. ICOs and PIHPs must assure that provider practices are respectful of the multiple cultures represented in their memberships. Dignity of each person is vital. For example, stakeholders identified the need for providers, as applicable, to have facilities that accommodate people who have physical disabilities. A specific example identified by stakeholders was the need for examination tables that can be accessed by people who have disabilities. The state will seek these capabilities in the contracting process.

The stakeholder work group that discussed requirements for the provider network noted the importance of continuity of both services *and* providers for people who are dually eligible for Medicare and Medicaid. To that end, ICOs and PIHPs must reach out to current providers as they develop their provider panels. Linkage with the existing community-based service delivery systems is important. ICOs and PIHPs must also have a mechanism for participants to continue existing out-of-network relationships in those cases for which a person is undergoing active treatment for a specific condition. This process will be based on an existing Michigan Medicaid process for continuity of medical care in specific circumstances.

With the focus on providing more community-based supports and services, there will be a need for more providers of attendant care or personal care services. Hiring this type of non-professional provider will be new to ICOs as they incorporate long term supports and services into their portfolios. ICOs may find the new experience of hiring and contracting with this provider group to be challenging because of the unique nature of the provider type. Emphasis will be on the concepts of self-direction and person-centered planning in developing this component of the delivery system.

vi. Integrated Care Model Fit with Michigan's Existing Systems

The existing service delivery system in Michigan places the state in a strong position to implement managed integrated care for people who are dually eligible for Medicare and Medicaid. Since the 1990s, the state has been working to develop a system of managed care plans for the provision of health coverage to Medicaid beneficiaries. Currently with 1.2 million members, fourteen Medicaid Health Plans (MHPs) cover about two thirds of all Medicaid beneficiaries, including both the TANF and disabled populations. Michigan's Medicaid health plans are ranked among the best in the nation for quality and performance, and have significantly enhanced access and quality of care for Medicaid beneficiaries in the state.

The behavioral health population is likewise served in a managed care system operated by eighteen prepaid inpatient health plans (PIHPs) covering all areas of the state. PIHPs are public entities that receive capitation payments for all Medicaid beneficiaries in the state. They are responsible for providing services to people with developmental disabilities, to persons with mental illness, and to those who have substance use disorders. While the PIHPs are responsible for serving people experiencing serious mental illness, the Medicaid Health Plans currently provide services to those with mild to moderate mental illness in the form of up to 20 outpatient visits annually.

For persons requiring long term care services, nursing home care is provided on a fee-for-service basis while community-based services are delivered through the state's MI Choice home and community based services waiver. In addition, the Home Help program through which Michigan's personal care state plan service is provided is the largest and fastest growing component of the state's long term care system. Home Help provides assistance with activities of daily living for people who do not necessarily exhibit a nursing home level of care need and thus do not require or do not want nursing home or waiver services. While the Home Help program is one source through which personal care services are provided in Michigan, there are also many people who receive personal care services through the MI Choice and Habilitation Supports waiver programs, as well as other programs provided through the PIHPs.

There are also four PACE programs operating in different geographic areas of the state with two more under development. The state's experience with PACE provides a fundamental understanding of integrated health care delivery, albeit a different model than the one outlined in this proposal. It should be noted that the state is proposing that MMEs who choose to enroll in PACE be excluded from the integrated care demonstration.

The state anticipates that different types of licensed entities will consider bidding to participate in this demonstration as ICOs. The existing network of Medicaid Health Plans are experienced in providing primary and acute care for Medicaid beneficiaries There are also 11 health maintenance organizations in Michigan that offer Medicare Advantage plans, as well as one Institutional Special Needs Plan (I-SNP). Contracts will be awarded based on a competitive procurement process in conjunction with CMS that will require bidders to demonstrating an integrated person-centered approach across many domains. For behavioral health, the PIHPs described above have provided an effective management and service delivery mechanism for behavioral health services. Michigan proposes a strategy to incorporate into the model those elements of current systems that have proven to be effective. It is for this reason that the state is proposing separate contracts for ICOs and for PIHPs.

Likewise, the state intends to preserve those components of the existing long term care services system that are efficient and that serve their participants well. However, the integrated care proposal provides opportunity for the state to evaluate how similar supports and services currently offered through different delivery models, such as personal care, can be better coordinated and delivered more efficaciously through a single management entity. The state will continue to work with CMS and its stakeholders to determine the best means for delivering these community-based supports and services that are currently the responsibility of the MI Choice Waiver and the Home Help program.

vii. Impact on including existing waivers, and other health care reform initiatives with Integrated Care

a. Waivers

Michigan has two 1915(b) and two 1915(c) waivers that must be aligned with the integrated care demonstration in some form. It is unclear at this point whether the state will need to amend its existing waivers or develop new ones. The state will continue to work with CMS through the Coordinated Care Office and Region V office to determine how this will best be accomplished.

b. Health Care Reform Initiatives

CMS selected three hospital systems in Michigan to participate as Pioneer Accountable Care Organizations under the Affordable Care Act. It has yet to be determined how these entities will interact with Michigan's integrated care demonstration, but the state will continue to work with CMS and these organizations in the manner that will best benefit the people who currently receive services through them. At a minimum, beneficiary choice will be honored.

D. Stakeholder Engagement

With the assistance of Health Management Associates (HMA) and its subcontractor, Public Sector Consultants (PSC), the state of Michigan conducted a multi-faceted stakeholder engagement process to initiate planning for its integrated care proposal. Aware of the substantial impact the integrated care demonstration will have on those with a significant stake in the existing delivery systems (especially people who receive services, MHPs, PIHPs and providers such as hospitals and physicians), Michigan sought to create a process in which stakeholders would have multiple opportunities to not only provide input, but also gain meaningful insight and learn from the perspectives of all who hold interest in the project.

Michigan believes that it was successful in gathering noteworthy information, suggestions and ideas through numerous stakeholder events held to incorporate findings into the proposal. The stakeholder activities conducted to advise the project design included baseline interviews with key stakeholders, regional public forums, a request for input (RFI), topic-focused workgroups, a web page specific to integrated care and an e-mail box for continuous written input. Summarized comments from each of the stakeholder events were placed on the integrated care website. In March 2012, two public meetings were scheduled during which the state discussed the content of this proposal, provided a summary of the previous input and how it was included in the proposal and accepted comments on the proposal. A 30-day public comment period for the demonstration proposal ran from March 5 to April 4 of 2012.

In addition to the formal stakeholder opportunities, MDCH staff and leadership met with multiple advocates and industry organizations to assure ample opportunity to understand the state's intent for the demonstration and to listen to suggestions from these stakeholders.

i. Stakeholder Engagement - Planning Stage

a. Informant interviews

To gain a baseline perspective of Michigan's existing health care delivery system for people enrolled in Medicare and Medicaid and how the system could be improved through integrated care, Michigan kicked off its stakeholder process in July 2011 by initiating interviews with more than 30 people and organizations identified as being knowledgeable of the existing delivery system. The constituencies represented in the interviews included a cross section of interested parties likely to be affected by a plan to integrate care. People receiving services through Medicare and Medicaid, advocates, health care provider industry organizations, health plans, PIHPs, insurers, long -term care providers, universities and others participated in the interviews conducted by PSC. A summary of the informant interviews can be found at https://janus.pscinc.com/dualeligibles.

b. Regional public forums

Concurrent with the informant interviews, Michigan convened public meetings in geographically diverse areas of the state to provide opportunities for state staff and the public to interact relative to integrated care in Michigan. The forums were conducted in July and August of 2011. State staff provided an overview of the basic components included in the project proposal to CMS and PSC facilitated discussion with stakeholders, including MMEs and advocates, to gain insight about the existing delivery system and how it could be improved by integrating care. Nearly 1,000 people attended the forums to participate in the discussion, offer comments, and ask questions. The forums were held in Gaylord (northern Lower Peninsula), Marquette (Upper Peninsula), Grand Rapids (West Michigan), Southfield (suburban Detroit), Lansing (central Michigan) and Detroit (southeast Michigan). A summary of the input provided at the forums is available at https://janus.pscinc.com/dualeligibles.

c. Request for Input

Because of the intense interest stakeholders demonstrated in the integrated care forums, a request for input (RFI) was added to the stakeholder process. MDCH solicited comment on the development of an integrated care plan through the RFI issued from September 14 through October 14, 2011. Ten questions were posed to interested stakeholders who submitted comments through an on-line survey tool. Eight general questions were posed to all interested parties, and two questions were designed specifically for response by potential contractors. In all, 623 people and organizations responded to the RFI. A summary of the RFI can be found at https://janus.pscinc.com/dualeligibles/resources/RFI%20Final%20Report_11-11-11.pdf

d. Topic-based work group discussions

In November and December 2011, four stakeholder work groups consisting of approximately 35 members each were developed and convened to provide additional and more in-depth input into Michigan's integrated care planning process. To select the workgroup participants, an e-mail invitation was issued in October to more than 1,000 stakeholders including MMEs, advocates, organizations, and associations inviting them to indicate interest in workgroup participation. Stakeholders were asked to express their interest in the following four workgroups, prioritizing their preferences and indicating their particular experience and knowledge.

- Care Coordination and Assessment
- Education, Outreach, and Enrollee Protections
- Performance Measurement and Quality Management
- Service Array and Provider Network

To ensure that the work groups were meaningful and manageable, participation was limited to 35 members. Participants were selected in a manner to assure broad representation across all stakeholder groups to ensure that no single cohort would have an advantage in the discussions. Other interested parties were able to attend the meetings and time was allotted at each session for public comment.

A plenary session for all work group members was held on Wednesday, November 9, 2011. During this meeting, group members reviewed findings from the stakeholder interviews, forums, and RFI to develop a common understanding of the issues to be addressed. Each of the four work groups then met on three different occasions to engage in prolonged discussion on topics pertinent to each group. A summary of the discussion is posted at https://janus.pscinc.com/dualeligibles.

The workgroup sessions were significant to Michigan's project in multiple ways. A key outcome of these sessions was dialogue among providers, health plans, persons served and their advocates. The work groups provided a venue for providers to gain perspective from each other and understanding as to what is valued by people receiving supports and service through Medicare and Medicaid. Knowledge shared and gained in the workgroup sessions had considerable influence on the final design of Michigan's proposal.

e. E-mail Box and Web Site

Throughout the course of the design phase for Michigan's proposal, an email box (IntegratedCare@michigan.gov) has been available for individuals or organizations to offer comment or ask questions related to the integrated care design. Making this opportunity available for comment has allowed many people and organizations to provide input or comment without having to participate through more formal channels. Information related to the integrated care project has been posted on https://janus.pscinc.com/dualeligibles throughout the stakeholder process. In addition to navigating to this web site directly, there is a link to it from the MDCH home page.

f. Individuals meetings with organizations

MDCH leadership and staff have met with numerous organizations throughout the stakeholder process to discuss plans for integrated care. Staff attended many external meetings with provider and advocacy organizations to talk about the integrated care proposal design and listen to ideas and comments. Likewise, many other organizations and constituencies brought their concerns to meetings requested with MDCH.

g. Tribal Consultation

Michigan's 12 federally recognized Indian tribes were invited to participate in all facets of the stakeholder process with notification being sent to all chairpersons and health directors. The MDCH tribal liaison and

another representative of MDCH attended a health directors meeting in October 2011 to discuss the integrated care proposal. The final proposal was shared with all 12 tribes during the 30 day public comment period in March 2012.

ii. Enrollee Protections

Enrollee protections are of utmost importance to Michigan's stakeholders as evidenced by the passionate discussions that transpired in a stakeholder work group dedicated entirely to this topic. The state is committed to working with CMS according to the guidance provided to develop the maximum protections that can be afforded to Michigan's integrated care participants. This is necessary to ensure that participants' rights as Medicare and Medicaid beneficiaries are safeguarded when they enroll in the program, receive services, and exercise their rights to due process.

a. Education and Outreach

Michigan's stakeholder workgroup focused on protecting both participants and providers when it discussed education and outreach. Participant rights begin with the opportunity to be informed and educated about enrollment in the integrated care program and all that it entails. This is particularly important because the state will passively enroll people who are dually eligible and offer the choice to opt out of the program. To ensure that potential enrollees have informed choice, the state will develop clear, concise, and consistent materials about the program and what it has to offer. These materials will be developed and distributed well in advance of the enrollment period to minimize confusion and maximize understanding about the program. These materials will also be available in languages other than English and in alternative formats for individuals with disabilities.

For initial enrollment the state anticipates that it will work with an enrollment broker to assist with education and outreach similar to the process used for outreach and enrollment into Michigan's Medicaid and MI Child programs. The state also anticipates using local resources available through Michigan's Medicare-Medicaid Assistance Program (MMAP) described previously in Section VII. B. to help educate and inform potential enrollees about the program. This program is operated locally using many senior citizen volunteers, so it provides opportunity for peer-to-peer counseling.

b. Choice of Providers

As noted previously in discussion related to the provider network, Michigan will require ICOs and PIHPs to provide choice of providers for primary care and behavioral health and developmental disabilities services and supports. It is expected that ICOs will also contract with a diverse group of specialists, hospitals, nursing facilities and home and community based service providers to ensure rights of choice.

Especially important will be the ability of the ICOs and PIHPs to ensure the ability of participants to select the care and supports coordinators of their choice since this function is critical to the success of integrated care. The relationships developed between the participants and qualified care and supports coordinators should be founded on trust in order to succeed, therefore making choice essential.

c. Appeals System Protections

Michigan expects to provide maximum protections to MMEs to ensure that the rights they currently enjoy through the Medicare and Medicaid programs are not lost and instead are enhanced to the greatest degree possible. The state will work with CMS through the contracting process to develop uniform requirements to which both the ICOs and PIHPs must adhere with a goal of offering a system that is user-friendly for participants while assuring that the state and federal requirements are incorporated.

For appeals related to benefits, Michigan currently provides a more generous time frame for appeals through its Medicaid fair hearings process, 90 days, than is required by Medicare, so it is anticipated the

90 day standard will apply. If appeals are filed within the established time frames, benefits will be continued until the point at which a decision is rendered.

The state will work with CMS to develop standards for ICO and PIHP internal complaint and grievance processes to ensure that Medicare requirements are incorporated. Michigan law permits internal complaint and grievance processes to occur simultaneously with external processes. For PIHPs, Michigan has an established recipient rights process that will be maintained under the integrated care system.

Standard documents and language will be developed clearly explaining participant membership and appeal rights.

d. Other protections

Additional protections will be built into Michigan's integrated care proposal. A requirement will be developed for contracting purposes that requires the ICOs and PIHPs include participants on their governance boards. It will also be required that quality committees include people who receive services on their boards. In collaboration with CMS, the state will determine the feasibility of establishing an external entity such as an ombudsman to assist participants in navigating the appeals processes or other concerns.

Protections regarding freedom from abuse and neglect and assurance of health and safety will be established in the integrated care proposal for individuals who are the most vulnerable.

iii. Ongoing Stakeholder Process

In addition to the process conducted for the integrated care design phase, Michigan is committed to seeking and accepting input from stakeholders going forward. Stakeholders had an opportunity to comment on the proposal for a 30 day period in March 2012. Michigan will also assure that stakeholders have opportunity to provide comment and feedback throughout the implementation and operational phases of the demonstration. Stakeholders participating in the Education, Outreach and Enrollee Protections work group recommended that the state require its contractors to include people who are dually eligible on their governance or advisory bodies and the state intends to incorporate this suggestion. It was also suggested by the Performance Measurement and Quality Management work group that the state convenes an ongoing quality-focused advisory council to assess the effectiveness of quality standards and measures included in the demonstration and in the operations of the contractors. This suggestion will also be included in the implementation plans for the demonstration.

E. Proposed Financing and Payment Reform Model

i. Financing and Risk

In the Care Model Description section of this proposal (Section C), Michigan proposed using separate contracts with ICOs and PIHPs to deliver and integrate services and financing for this demonstration. Because this demonstration will address a distinct population of people with an entirely new model for delivering services, Michigan proposes that risk adjusted capitation rates be paid to each management entity for each enrolled dual eligible beneficiary as described below.

a. ICOs

ICO capitation rates will utilize a base rate to cover all medical services for their entire enrolled population. Medical services will include Medicare and Medicaid acute and primary care services, along with management of the person-centered medical home. The medical home will be responsible for care and supports coordination including the approval of nontraditional services. Codes will be developed by the state to enable PIHPs and ICOs to bill for care coordination/management services to allow the reporting of these services in encounter data. The ICO will also receive a capitation payment to cover

prescription drug services for the entire enrolled population to be developed with CMS in accordance with Medicare Part D requirements.

ICO rates will include an amount for long term care supports and services, including both community-based and nursing facility care, both skilled and custodial. ICO rates will also cover services and supports coordination and work required as a member of the multi-disciplinary care bridge for participants who require and wish to receive this level of care coordination and management.

b. PIHPs

Capitation payments to PIHPs will be based on three separate rate structures. One structure will cover enrollees who are not categorized as having an intellectual/developmental disability, serious mental illness, or substance use disorder. Rates for this group will reflect the cost for beneficiaries who have little or no need for mental health services, and those requiring services to address mild and moderate mental illness. The capitation payment for this group will accommodate 1) inpatient psychiatric service; 2) outpatient mental health visits including psychiatric visits currently provided by Medicaid Health Plans; 3) psychiatric consultation to primary care physicians (PCPs) regarding prescription and management of psychotropic medication; 4) support to PCPs for screening, intervention and referral for substance use problems; and 5) substance use disorder treatment services. An additional amount will be included for participation in care coordination and care management as a member of the multi-disciplinary care bridge to cover people within this group who require care management and coordination.

A second PIHIP rate structure will cover enrollees who have an intellectual/developmental disability. Within this category, separate rates will be developed for persons who currently receive services under the Habilitation Supports HCBS waiver and those who are not enrolled in the waiver. Rates will cover all current behavioral and habilitative supports and services as well as supports coordination and multidisciplinary team functions.

The third PIHP rate structure will cover enrollees who have a serious mental illness. Rates will cover all supports and services as well as care coordination and multidisciplinary team functions.

c. Rates & Reimbursement- General

ICOs and PIHPs will have the ability to negotiate innovative reimbursement arrangements with providers that will provide incentives for best practices and quality care. ICOs will be required to pay not less than the calculated state rate to nursing facilities.

Rates paid to ICOs and PIHPs will be actuarially sound. It is the intent of the state that the rate development process will be a joint initiative involving actuaries from both the state Medicaid program and the federal Medicare program. Michigan proposes that Medicare and Medicaid funds will be blended at the state level and paid by the state to participating ICOs and PIHPs. Standard rate adjustments will be applied for age, gender and regional utilization factors. The state will work with its actuaries and CMS to develop a more encompassing risk adjustment methodology over the course of the demonstration period.

It is also the intent of the state that partial risk will apply to participating ICOs and PIHPs using risk corridors. Fully-developed and dependable risk methodologies applicable to special populations including those needing long term care, those who have intellectual/developmental disabilities and those with serious mental illness, those who have a substance use disorder are not yet available, and hence risk is not adequately predictable. Without predictability, risk sharing is imperative in order to attract qualified management entities. As predictive methodologies become sufficiently reliable, management entities would be expected to take a progressively greater proportion of risk, eventually resulting in full risk contracts.

Michigan would strongly support a joint initiative involving states, the federal government, academic institutions and any other interested non-governmental organizations to develop reliable risk methodologies for use with special populations.

ii. Financial Incentives

The state proposes the establishment of an incentive pool to supplement regular capitation payments. Supplemental payments will be paid to management entities, both ICOs and PIHPs, which achieve or make measureable progress on specific desired outcomes. These outcomes will be defined in detail in the procurement process as will the metrics to be applied and the methodology for distribution of these funds.

Examples of desired outcomes include:

- Diminished use of acute care and other institutional services
- Implementation of a person-centered services and supports model
- Integration of services, particularly between ICOs and PIHPs
- Development of integrated information technology with a specific focus on electronic medical records and the sharing of data between ICOs and PIHPS
- Progress towards the improvement of scores on specified quality, wellness, and customer satisfaction metrics
- Consistently high performance on enrollee satisfaction surveys
- Effective disease management programs
- Implementation of programs that encourage members to engage in healthy lifestyles

Management entities will likewise be expected to offer incentive payments to providers and provider groups in their networks to develop and implement innovative approaches to the management and delivery of care and the coordination of supports.

F. Program Evaluation and Expected Outcomes

i. Performance Metrics and Evaluation

Michigan's demonstration will include a robust program of performance monitoring and quality measurement with uniform measures reported by all ICOs and PIHPs. The program will identify and define domains of quality measurement, which will include but not be limited to:

- Access to care
- Effectiveness of care
- Quality of life, including assurances of health and welfare of participants
- Coordination of care and services/supports
- Care transitions
- Person-centeredness
- Consumer satisfaction

In selecting specific measures within selected domains, the demonstration will rely on information emerging from numerous national efforts underway and favor measures that provide useful information, are evidence-based, and do not add undue administrative burden. The state will also make use of measures already reported by Special Needs Plans (SNPs), Medicaid Health Plans, the PIHPs, and providers of long term supports and services. New measures of the effectiveness of the ICOs and PIHPs will include rates of beneficiary opt-out, proportion of individuals changing plans within 90 days, consumer satisfaction with care coordination, and screening for substance use disorders across the continuum of care.

Michigan's demonstration will mitigate the experience of enrollee sub-populations being "lost" in the aggregate. ICOs will be required to disaggregate performance and quality metrics and report them for unique populations (i.e., persons with serious mental illness) and selected geographic regions prone to network or workforce challenges. The demonstration may also require ICOs and PIHPS to draw special metrics on certain populations that, in combination with the demonstration-wide measures, create population-specific "dashboards" of the integrated care experience. For example, a dashboard for frail elderly residents of nursing facilities may display data on flu shots, hospital admissions, and falls, in addition to the ICO/PIHP-wide measures, thereby providing a more comprehensive description of the impact of integrated care for this vulnerable population.

The demonstration will apply performance incentives that will evolve over the demonstration period. Incentives may include public report cards, auto-assignment into ICOs and special enrollment periods to reward high functioning ICOs/PIHPs, and incentive payments funded by withholds and supplemental pools. Contractor adherence to person centered planning will be evaluated, publicly reported, and rewarded from the first year forward, while other measures may apply later in the demonstration.

Critical to the demonstration's success is the collaboration between ICOS and PIHPs to ensure that essential health care and support services are provided to demonstration participants. This will require that the ICOs and the PIHPs work together with enrollees through the care coordination bridge. Performance measurements will be established that provide a holistic picture of the services and supports provided through the integrated system of care. The enrollee's perception of care and services will be taken into account in the performance evaluation process. Also, taken into account will be those factors that demonstrate the ICOs and PIHPs have an infrastructure and system in place to facilitate information sharing for care coordination, care planning, and reporting of encounters and enrollee interactions.

Performance measurement and evaluation of Michigan's demonstration will evolve over the project's lifecycle as the demonstration participants, ICOs, PIHPs, the state and other stakeholders gain experience with the model and find certain measures more or less useful and informative. To support this iterative approach, the state will appoint an advisory body of key stakeholders to review performance data and emerging measures from other sources, and recommend modifications to performance measurement, evaluation, and incentives throughout the demonstration.

ii. Payment Reforms

Michigan views the integrated care demonstration as an opportunity to address much needed reform in the Medicare and Medicaid reimbursement systems, not only as stand-alone payers but also in how they should function together. In many ways, Medicare and Medicaid are dysfunctional members of the same family working in opposition to each other. Many providers in Michigan struggle with coding and billing correctly when Medicare and Medicaid are both involved, resulting in wasted time and effort on the part of the providers, the state, and health plans in correcting claims. In other situations, providers have learned to "game" the two systems, which results in overpayments and sometimes fraud. The integrated care demonstration represents an opportunity to finally address some of the issues associated with payments made by the two programs. The integrated care demonstration can be the conduit to improving the efficiency and cost effectiveness of providing care for the dual eligible population, while also improving health care for people who receive services through the two systems.

a. Stop Cost Shifting

Within the context of the integrated care demonstration, the term "cost shifting "does not have the same meaning it might have in other discussions of Medicaid and Medicare. The issue is not that Medicaid and/or Medicare payment rates result in costs being shifted to other payers. Rather the issue is in shifting of costs between Medicaid and Medicare. The issue is not a question of which payer is billed by a provider. Given lower Medicaid payment rates, providers are incentivized to bill as many services to

Medicare as possible, which is generally appropriate since Medicare is primary to Medicaid. The issues observed in Michigan include the following:

- Medicare may bear costs for acute care hospitalization if nursing facilities paid by Medicaid do not maintain optimum health status for their residents.
- Medicaid may bear extra costs for nursing facility days if individuals do not receive adequate community-based supports and services to prevent deterioration of their health status , ultimately leading to a nursing facility admission
- Overly strict utilization review decisions regarding Medicare home health often results in Medicaid payment for home health that should have been covered by Medicare.
- Securing authorization and therefore payment for items such as durable medical equipment can be frustrating to providers assisting MMEs. The coverage and authorization processes between the two payers are not always clear and are frequently inconsistent. As a result, providers may submit multiple applications before they successfully receive authorization.
- MMEs may have more Medicare-financed inpatient psychiatric stays and outpatient psychiatric visits than necessary if their acute psychiatric care is not coordinated with supportive services, such as Assertive Community Treatment, available through the Medicaid program.

b. Opportunity for savings

Michigan's hypothesis is that while there is some duplication in an uncoordinated health care system, the greatest opportunities for savings derive from improved health. To the extent that nursing facilities maintain optimum health status for their residents, there will be fewer acute care events. If Medicare/Medicaid eligibles with mental illness receive supportive services through the community mental health system there will be less acute inpatient and outpatient psychiatric cost. Initiatives to reduce the number of falls by the frail elderly can improve their health status and save significant costs both for acute Medicare services and long term Medicaid services. All dual eligibles may experience better health as a single person-centered care plan and coordination of their health care results in treatment of the whole person and improvement of their health status.

c. Anticipated impact on Medicare and Medicaid costs

Michigan just recently received the Medicare claims file from 2008 through 2010. As a result, no analyses of the specific cost savings opportunities have been completed. As we have reviewed the aggregate Medicare data from 2008 and considered the services that will be integrated we offer the following hypotheses:

- Medicaid costs are expected to increase for community-based services for the frail elderly as the cap on the current Home and Community Based Services waiver is lifted and as ICOs otherwise increase the level of care planning, supportive services and interventions for this population. However these increased costs should be more than offset by year two through reductions in preventable acute care events and costs.
- Medicare costs for inpatient and outpatient psychiatric care are expected to decrease as individuals released from inpatient psychiatric care are promptly transferred for follow-up care through the community mental health system.

G. Infrastructure

i. State capacity to implement and manage the demonstration

The integrated care demonstration will be implemented and operated by the Michigan Department of Community Health, Medical Services Administration(MSA), Michigan's single state agency administering the Medicaid program. Olga Dazzo, MDCH Director, has broad oversight of the program and Stephen Fitton, Medicaid Director, will have primary responsibility for administering the program through the three

Medicaid bureaus that report to him: Medicaid Policy and Health System Innovation, Bureau of Medicaid Operations and Quality Assurance, and Bureau of Medicaid Financial Management. The MSA will work collaboratively with the Behavioral Health & Developmental Disabilities Administration (BH&DDA) led by Lynda Zeller, and the Office of Services to the Aging (OSA) directed by Kari Sederburg, throughout the continued development, implementation and on-going operation of Michigan's integrated care demonstration.

Because of the all-encompassing nature of the demonstration, staff members from the BH&DDA and OSA were key contributors in work with Medicaid staff to design Michigan's proposal. This experience has confirmed the need for continued partnerships between the agencies because of the unique expertise within these areas of the department. In particular, the institutional knowledge of the BH&DDA is paramount to fostering the success of the new system. This administration within the department has administered the Medicaid behavioral health benefit in Michigan for over ten years and it will continue to do so for the integrated care program. It has yet to be determined if the department will reorganize its resources to administer the integrated care program, but existing resources do possess the portfolio of skills necessary for its management. In the interim, the following narrative describes how Michigan's integrated care program will be operated.

The Medicaid Operations and Quality Assurance Bureau has been recognized as a national leader in developing and implementing managed health care since the 1990s. This bureau will maintain its role managing the contracts and overseeing the quality and performance of the ICOs, having responsibility for physical health and long term supports and services.

As noted above, the BH&DDA will retain oversight of the behavioral health component of the demonstration, using the Bureau of Community Mental Health Services, the Quality Management & Planning office, and the Bureau of Substance Abuse Services to perform administrative functions as they are currently doing. Michigan's PIHP system and the MDCH staff administering it are nationally recognized for the state's specialty managed care program for behavioral health. Contract Management and Quality oversight will be coordinated between Medicaid Operations and Quality Assurance Bureau and the BH & DDA.

Michigan currently operates a robust data warehouse that supports both the Medicaid Health Plan and PIHP encounter data. This capacity is significant in that all new data from the integrated care demonstration will be readily stored and available for analytical purposes as necessary. Although some modifications may be required prior to implementation, the data warehouse is a significant asset that Michigan brings to the table.

An internal MDCH collaborative body similar to the one used to develop the integrated care proposal will be established between the three administrations (MSA, BH&DD and OSA) and this entity will report to Medicaid Director Fitton through the Medicaid Bureau of Medicaid Policy and Health System Innovation. A steering committee established during the design phase will be retained in an advisory capacity for Director Fitton. This committee is comprised of the Medicaid Director, the BH&DD Director, the OSA Director, the three Medicaid bureau directors reporting to Mr. Fitton, the Chief Physician from the Medicaid Office of Medical Affairs, and the Office of Medicaid Health Information Technology Director. An implementation and ongoing operations group composed of pertinent MDCH staff will meet on bi-weekly basis until program operations have been completely subsumed by the identified responsible organizational areas. The operations work group will continue to work with CMS throughout the demonstration period.

a. Use of Existing State Staff and Resources

Final decisions have yet to be made as to how the program will be operated on a day-to-day basis. From experience with its existing managed care operations within the Medicaid program (Medicaid Health Plans and PIHPs), it is anticipated that the following dedicated staff will be required:

- An ICO/PIHP program manager for day-to-day program oversight
- Contract Managers to act as liaisons with the ICOs and PIHPs to address day-to-day issues
- Quality Analysts to establish quality standards and metrics, assess, analyze and report on the performance of the ICOs and PIHPs against the standards
- Data Analysts to query, aggregate and analyze data in the Medicaid data warehouse and report on results
- Financial Analyst to maintain financial oversight of the demonstration
- Enrollment services staff to provide oversight of an anticipated enrollment broker, to ensure that eligibility determinations are conducted in a timely manner and to facilitate disenrollment activity when necessary
- Medicaid Provider Support and Beneficiary Help staff to provide customer service and assistance to providers and enrollees
- Other State Resources and Infrastructure
  - The Medicaid Actuarial Division will work with the state's contracted actuary in the rate setting process with CMS
  - The Medicaid Payments Division will enroll providers in the Community Health Automated Medicaid Payments System (CHAMPS-Michigan's MMIS) and make the capitation payments to the ICOs/PIHPs
  - Michigan has a robust data warehouse that will be used to maintain all encounter and performance data associated with the demonstration
  - The MDCH Grants and Purchasing Division will work in conjunction with the Integrated Care team through the procurement and contracting processes with CMS
  - MDCH Accounting will have primary financial oversight of the demonstration

b. Contractors

Michigan will likely use contractual relationships, existing or new, with multiple entities for portions of the Integrated Care demonstration for which state resources are unavailable. It is anticipated that contracted resources will be used for outreach and enrollment, actuarial analysis for rate setting, development of an assessment tool specific to integrated care and some analytic capacity to support state staff where necessary. The state has already engaged with its contractors in the analysis of the Medicare claims data it has received and will likely continue to use contractual relationships for this purpose. The state intends to utilize existing contractual arrangements to assist with data analytics and rate development. The state will also likely use existing contract resources for quality oversight and monitoring (e.g. EQRO, HEDIS, and customer satisfaction).

ii. Additional Demonstration Advisory Bodies

The Medicaid Director will convene the aforementioned steering committee, initially on a monthly basis, to provide oversight to the demonstration. In addition to this internal group, the following organizational bodies meet regularly with the Medicaid Director and will act in an advisory capacity on an on-going basis:

- The Medical Care Advisory Committee
- The Michigan Olmstead Coalition
- The Michigan Long Term Care Commission
- An on-going stakeholder advisory group yet to be determined and convened
- An integrated care quality advisory group yet to be determined and convened

iii. Impact on Service Delivery Providers

Providers who serve persons dually eligible for Medicare and Medicaid currently receive Medicaid reimbursement from the state on a fee-for-service basis, while Medicare is a mix of fee-for-service and managed care. Under an integrated capitated arrangement, these reimbursement relationships will

transition to an arrangement whereby providers will receive payments from ICOs or PIHPs as part of a provider network.

While managed care may not be new for physical health, some modifications will apply to the reimbursement structure for providers of long-term care services, both institutional and community based. It has been noted previously that nursing facilities will be assured of payment at current Medicare and Medicaid rates. However, under integrated care, the reimbursement relationship will be with the management entity rather than with the state. Likewise, providers of personal care services under the current Home Help Program, as well as those who provide supports and services to the elderly and physically disabled under the MI Choice waiver, will experience some change. The state will need to adjust existing infrastructures to accommodate this shift, and will ensure continuity of services through the period of transition to integrated care. Detailed requirements that will govern these relationships will be presented in conjunction with the procurement process.

As with any major change in how health care systems are structured and financed, there are a number of collateral impacts that will need to be identified and addressed, many of which are quite technical. Examples include how Medicare DSH, bad debt and 340(b) drug pricing will be handled for hospitals. On a broader scale, there are concerns about what role Medicare fiscal intermediaries will play under an integrated system.

H. Implementation Strategy

i. Phased Implementation

Beginning July 2013, Michigan will employ an enrollment strategy that phases entry into the integrated care plan by geographic region and by population groups. A timeline that identifies key tasks to be completed by the state and other responsible parties is included in the appendices of this proposal. Stakeholder comments, particularly those received from the developmental disability advocacy community, overwhelmingly supported this approach to allow early experience to inform and perhaps improve the overall process as it progresses.

Implementation will be initiated at quarterly intervals using several regional areas of the state. Regions will be developed based on the potential for enrollment volume and other readiness factors. Specifically, Michigan will assign the state's counties into multiple designated areas, and enrollment will be phased in a sequential order through the regions. The first group of counties will be selected to assure a sufficient number of enrollees to demonstrate the plan, but it will include less than half of the state's people eligible for Medicare and Medicaid. In addition to the size of the eligible population, the state will also consider the strength of local behavioral health organizations, long term care provider capacity (home and community based, as well as facility based), and managed care providers in the region. The state will group the remaining counties along logical geographic and health care market lines.

Within each of the regions, implementation will be phased in by quarter based on specific groups in the covered population. In the first quarter of operation in a county, non-elderly people with disabilities, elderly people not using long term care services (nursing facility or MI Choice waiver services), persons with serious mental illness, and persons with substance use disorder will be enrolled. In the second quarter, eligible people residing in nursing facilities and those using MI Choice waiver services will be enrolled. In the third quarter, persons with intellectual/developmental disabilities will be enrolled[3]. The same enrollment process for the three groups of people will occur in the three regions. This phase-in process will allow the ICOs and PIHPs to develop relationships and assure that the care and supports coordination bridge is operating as it should prior to expanding enrollment to groups for which this

[3] For the third phase of counties, enrollment of persons using long term care services and people who have intellectual/developmental disabilities will be combined into a single quarter, as this group is small and there will be sufficient experience to provide a smooth transition.

function is essential to living successfully in the community. The plan is to have all of Michigan's people who are eligible for both Medicare and Medicaid enrolled by June 30, 2014. The following table is illustrative of the implementation strategy.

Table 7 Implementation Strategy

Geographic Phase	2013		2014		
	Jul-Aug-Sep	Oct-Nov-Dec	Jan-Feb-Mar	Apr-May-Jun	
1	Non-Elderly People with Disabilities; People with Serious Mental Illness; People with Substance Use Disorder; Non-Nursing Facility Older People	Nursing facility residents; MI Choice Waiver enrollees	People who have intellectual/develop-mental disabilities		
2		Non-Elderly People with Disabilities; People with Serious Mental Illness; People with Substance Use Disorder; Non-Nursing Facility Older People	Nursing facility residents; MI Choice Waiver enrollees	People who have intellectual/ developmental disabilities	
3			Non-Elderly People with Disabilities; People with Serious Mental Illness; People with Substance Use Disorder; Non-Nursing Facility Older People	Nursing facility residents; MI Choice Waiver enrollees	People who have intellectual/ developmental disabilities

The integrated care proposal implementation strategy is explained in the table above.

ii. Enrollment Process

The Michigan model proposes passive enrollment with an option for voluntary opt out of the integrated care plan. Under passive enrollment, people who are eligible will automatically be enrolled into the integrated care demonstration unless they explicitly indicate a choice not to opt out during the enrollment process.

Because of passive enrollment, Michigan stakeholders were vocal in expressing the need for a transparent enrollment process that affords people maximum protections in understanding their rights associated with enrollment and disenrollment in integrated care. Central to the discussion was providing assurance of adequate face-to-face opportunities with an enrollment counselor to discuss the meaning of enrollment in integrated care and the impact it would have, if any, on their existing services and provider relationships.

In order to maximize the ability of individuals to talk with someone about their options, on a face-to-face basis if they choose, it is important to provide sufficient time prior to enrollment for this visit to occur. Therefore, there will be a two month period of open enrollment prior to the implementation of integrated care in each region during phased implementation and in subsequent benefit years. At the beginning of the enrollment period, all eligible beneficiaries will be sent a letter explaining their options, the benefits to be offered under the integrated system, instructions on choosing a plan, information regarding the choice to opt out and how services will be managed and delivered to persons who do decide to opt out. Finally, the person will be provided a toll-free number if they choose to speak with someone over the telephone or wish to speak with an enrollment counselor on a face-to-face basis prior to making a decision.

MDCH will provide extensive outreach and education opportunities through a variety of venues in order to make the enrollment process as transparent as possible to people who are eligible for Medicare and Medicaid. These will include, in addition to the letter noted above, a web site that provides extensive information about the program, and steps that the beneficiary must take to maintain enrollment, choose an ICO and to opt out if that is what the individual determines to be in his or her best interest. The letter that is sent to beneficiaries will also provide a toll-free telephone number that eligible people, their family members and representatives can call for advice on options and to obtain information about the integrated care program in advance of making a decision. Assistance will also be provided through Michigan's State Health Insurance Program (SHIP), the Medicare -Medicaid Assistance Program (MMAP). MMAP counselors will be trained to talk with people interested in learning more about integrated care options. In Michigan, MMAP counselors are located within senior centers and other sites throughout the state. In many instances, MMAP counselors are older adult volunteers trained to work with their peers in understanding the nuances of Medicare and Medicaid.

Although the services of MMAP will be used to provide information and some enrollment counseling, Michigan will likely contract with an enrollment broker to administer and carry out many of the functions noted above. By using the services of an enrollment broker, the state can ensure that eligible people are provided unbiased information about integrated care and about the plans in which they can choose to enroll.

Once the demonstration has been implemented, beneficiaries will be offered an open enrollment period on an annual basis, in sync with the Medicare Advantage enrollment calendar. Similar opportunities for guidance on whether and how to participate in integrated care will be offered to people during open enrollment, as well as to persons eligible for Medicaid who are determined to qualify for Medicare as the result of a disability, or who age into Medicare eligibility.

During initial enrollment, management entities will be required to continue providing all services currently in place for a beneficiary throughout the screening and assessment process.

iii. Impact on Medicaid and/or Medicare Rules

The state will continue to partner with CMS to identify Medicaid and/or Medicare rules that would need to be waived to implement the demonstration. The state anticipates negotiating with CMS over the proposed mid-year implementation date and dual contracts.

iv. Systems Readiness

Michigan must work with state information technology staff and external stakeholders to assure that data systems are prepared for the integrated care system. The state's Medicaid eligibility system, Bridges, is operated under an inter-agency agreement between MDCH and the Department of Human Services (DHS). Some system changes and staff training will be necessary.

The Community Health Automated Medicaid Payment System (CHAMPS) will need to be programmed to accommodate the capitation payments associated with the demonstration. It is anticipated that this will be accomplished in a timely manner with CHAMPS ready to make capitation payment by the first day the program is implemented.

Michigan will need to adapt its data warehouse to accept encounters from the integrated care demonstration. This data is vital to developing quality standards, measures, and incentives. The state anticipates the need to work with its data warehouse contractor, Optum, in order to accommodate this necessary component of the program, but there are no issues foreseen in doing so. Funding will be necessary for all of these information technology systems.

I. Feasibility and Scalability

The proposal outlined in this document is one that is feasible in Michigan given the existing delivery systems and input offered by stakeholders over the last eight months. The following narrative identifies the state's current thinking with regard to its ability to take the demonstration to scale and its challenges in doing so.

i. Statutory Changes and Scalability

Michigan has proposed a model that can be taken to scale relatively quickly across the state with the approach outlined previously. There are no statutory changes needed to implement the recommended and proposed model. The care coordination model proposed for the ICOs could readily be replicated in other states.

ii. Potential barriers and challenges

A contingent of stakeholders from the behavioral health and developmental disability advocacy community remain skeptical that an integrated care model could improve upon the current delivery system. There is also concern from the same group that the long-fought battles to move people out of institutions will be reversed despite assurances that the intent is to build upon the gains that have been made in the past. Thus it will be critical to have contractual requirements and performance metrics for providing services and supports in the least restrictive environments.

A significant challenge for the demonstration will be to integrate long term supports and services into the ICOs. Unfamiliarity with the population as well as the supports and services that sustain many people in the community will make it more difficult for some ICOs to prepare, develop and implement plans that can meet all the needs and desires of the population within a short period of time. Additional challenges for the demonstration are also related to long term supports and services. The state has a significant waiting list for its MI Choice home and community based services waiver. The integrated care demonstration holds potential for addressing the significant wait, depending on how the waiver and the demonstration interrelate. The state will continue to address this challenge through its waiver discussions with CMS.

Another anticipated challenge is determining how functions performed by the Michigan Department of Human Services will interface with the integrated care demonstration. This department currently performs two functions that are critically associated with the project. First, this agency determines Medicaid eligibility for all Medicaid applicants. A new eligibility system was implemented by DHS in the last two years and introducing a new level of care could pose challenges and impose system costs. Secondly, DHS administers Michigan's State Plan personal care service option through its local offices. It is anticipated that this service will be subsumed into the integrated care demonstration and it is yet to be determined how this will be accomplished. The state will continue to address this issue in the coming months.

Appendix A: Glossary of Terms and Acronyms as Used in this Proposal

ACO - Accountable Care Organization

Behavioral Health Supports and Services - An array of mental health and substance use outpatient and inpatient clinical interventions and monitoring, and community-based supports, aimed at helping individuals reduce symptoms of serious mental illness or substance use disorder, improve their ability to function in life and move toward recovery.

Beneficiary - A person who receives Medicare and/or Medicaid benefits.

Care Bridge - A mechanism developed for the integrated care demonstration through which members of an enrollee's care management and supports coordination team come together to coordinate formal and informal supports and services in an enrollee's person-centered care plan.

Care Coordination - A process used by a person or team to assist beneficiaries in gaining access to necessary Medicare, Medicaid, and waiver services, as well as social, educational, and other support services, regardless of the funding source for the services.

CMS - Centers for Medicare and Medicaid Services

Community Support Services - Services that promote disease management, wellness, and independent living, and that help avert unnecessary medical interventions (e.g., avoidable or preventable emergency department visits and facility admissions).

Covered Services - For the purpose of this demonstration, the set of services and supports offered by the contracted ICOs and PIHPs and paid for with integrated Medicare and Medicaid funds.

Enrollee - A person enrolled in the integrated care demonstration.

Fee-for-Service (FFS) - A method of paying an established fee for a unit of health care service.

Habilitation Supports Waiver - A 1915 (c) waiver program through which beneficiaries with developmental disabilities may be enrolled to receive supports and services as defined in the approved waiver and Medicaid policy. Beneficiaries may also receive other Medicaid state plan or additional B3 services.

Home and Community Based Services (HCBS) - Services and supports provided to individuals in their own home or other community residential settings that promote their independence, inclusion, and productivity.

Home Help - Michigan Medicaid's state plan personal care option to provide assistance with activities of daily living and instrumental activities of daily living to people who meet qualifying criteria.

Integrated Care - Comprehensive supports and services that include all Medicare and Medicaid covered benefits, and additional services identified for the demonstration. Integrated care is delivered using a person-centered approach that ensures that all of the health and support needs of individuals in the target population are met. Services and supports are coordinated across the health care, behavioral health and developmental disabilities, and long term services and supports delivery realms such that all care is regarded as a single comprehensive system of care, and such that beneficiaries receiving

integrated care experience the provision of their Medicare, Medicaid, and other included services, and care management as a single program.

Integrated Care Organization (ICO) - An insurance-based or provider-based health organization contracted to and accountable for providing integrated care to people eligible for both Medicare and Medicaid.

Integrated Financing - Federal and state Medicare and Medicaid funds combined at the state level for people who are eligible for both Medicare and Medicaid and who are enrolled in an integrated care plan.

Long Term Services and Supports (LTSS) - A wide variety of services and supports that help people meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing, and other basic activities of daily living and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Managing Entity - An entity with which the Michigan Department of Community Health and CMS contracts to receive a capitation payment to provide a specified array of supports and services for a group of individuals eligible for both Medicare and Medicaid.

MDCH - Michigan Department of Community Health

Medicaid - The program established under authority of Title XIX of the Social Security Act that covers medical assistance for low-income people who meet specific eligibility criteria.

Medical Services Administration - The state agency responsible for administration of the Michigan Medicaid program.

Medicare - The federal health insurance program established under Title XVIII of the Social Security Act to provide health care for people aged 65 and older, people under the age of 65 with certain disabilities, and people with end stage renal disease (ESRD; permanent kidney failure requiring dialysis or a kidney transplant). Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides coverage for most pharmaceuticals.

MHP - Medicaid Health Plan, or health management organization (HMO) under contract with the state that is paid an amount per member per month to provide managed health care services to enrolled Medicaid beneficiaries.

Michigan Medicaid State Plan - An agreement between the state and federal government that identifies the general health care services, reimbursement, and eligibility policies in effect under Michigan Medicaid. It is the basis for the federal government to pay federal financial participation (FFP) for the program's operation.

MI Choice Waiver - A 1915 (c) waiver program operated by the Michigan Department of Community Health to deliver home and community-based services to elderly persons and adults with physical disabilities who meet the Michigan nursing facility level of care criteria that supports required long term care (as opposed to rehabilitative or limited term stay) provided in a nursing facility.

MMAP - Michigan Medicare-Medicaid Assistance Program

MME - Medicare-Medicaid Eligible

Person-centered Planning - A process for planning and supporting a person receiving services that builds on the individual's desire to engage in activities that promote community life and that honors the person's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.

Person-centered Health Home - Health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health services, and long term community-based services and supports.

Pre-paid Inpatient Health Plan (PIHP) - This benefit plan covers mental health and substance abuse services for Medicaid beneficiaries who have a specialty level of need for behavioral health and intellectual/developmental disabilities supports and services.

Program of All-Inclusive Care for the Elderly (PACE) - A comprehensive service delivery and financing model that integrates medical and long term supports and services under dual capitation agreements with Medicare and Medicaid. The PACE program is limited to individuals age 55 and over who meet the skilled nursing facility level of care criteria and reside in a PACE service area.

Recovery - A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Self-determination - Self-determination incorporates a set of concepts and values which underscore a core belief that people who require support from the Medicaid program should be able to define what they need in terms of the life they seek, should have access to meaningful choices, and control over their lives. This may include direct control over the delivery of services, the selection, supervision and dismissing of workers, and the development and approval of an individual service budget.

Supports Coordinator - The supports coordinator works with individuals to assure all necessary supports and services are provided to enable them to achieve desired outcomes in their homes and communities. The supports coordinator uses person-centered planning principles to help individuals identify their desires and needs, identify and implement the supports and services desired and needed, address housing and employment issues, develop social networks, schedule appointments and meetings, use natural and community supports, link and coordinate supports and services, and maximize income and benefits. The supports coordinator also monitors the quality of supports and services, documents activities performed, and reviews plans of supports and services at intervals indicated through the person-centered planning process.

Appendix B: Medicare-Medicaid Eligibles by County

County	Number of Dual Eligibles	Percent
Alcona	311	0.2
Alger	293	0.1
Allegan	1,847	0.9
Alpena	1,032	0.5
Antrim	493	0.2
Arenac	524	0.3
Baraga	291	0.1
Barry	844	0.4
Bay	2,762	1.4
Benzie	388	0.2
Berrien	4,151	2.1
Branch	964	0.5
Calhoun	3,484	1.8
Cass	996	0.5
Charlevoix	465	0.2
Cheboygan	726	0.4
Chippewa	828	0.4
Clare	1,016	0.5
Clinton	643	0.3
Crawford	395	0.2
Delta	1,108	0.6
Dickinson	757	0.4
Eaton	1,373	0.7
Emmet	719	0.4
Genesee	8,972	4.5
Gladwin	784	0.4
Gogebic	621	0.3
Grand Traverse	1,687	0.8
Gratiot	1,076	0.5
Hillsdale	1,063	0.5
Houghton	1,052	0.5
Huron	984	0.5
Ingham	4,887	2.5
Ionia	1,091	0.5
Iosco	827	0.4
Iron	532	0.3
Isabella	1,149	0.6
Jackson	3,116	1.6
Kalamazoo	4,567	2.3
Kalkaska	499	0.3
Kent	11,347	5.7
Keweenaw	68	0

County	Number of Dual Eligibles	Percent
Lake	531	0.3
Lapeer	1,162	0.6
Leelanau	157	0.1
Lenawee	1,775	0.9
Livingston	1,158	0.6
Luce	228	0.1
Mackinac	245	0.1
Macomb	12,270	6.2
Manistee	727	0.4
Marquette	1,491	0.8
Mason	700	0.4
Mecosta	970	0.5
Menominee	647	0.3
Midland	1,495	0.8
Missaukee	323	0.2
Monroe	2,137	1.1
Montcalm	1,293	0.7
Montmorency	377	0.2
Muskegon	4,924	2.5
Newaygo	1,256	0.6
Oakland	16,533	8.3
Oceana	739	0.4
Ogemaw	763	0.4
Ontonagon	285	0.1
Osceola	554	0.3
Oscoda	346	0.2
Otsego	548	0.3
Ottawa	2,603	1.3
Presque Isle	391	0.2
Roscommon	868	0.4
Saginaw	4,978	2.5
St. Clair	2,875	1.4
St. Joseph	1,336	0.7
Sanilac	1,115	0.6
Schoolcraft	340	0.2
Shiawassee	1,332	0.7
Tuscola	1,188	0.6
VanBuren	1,871	0.9
Washtenaw	4,183	2.1
Wayne	50,235	25.3
Wexford	954	0.5
County Unknown	9	0

Total	**198,644**	**100**

The number of MME individuals by county are listed in the table above.

Appendix C: Medicare-Medicaid Eligibles by County MAP

The number of MME individuals for each county is depicted in the map above.

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Appendix D: Table of Existing and Proposed Services and Supports for Dually Eligible Individuals

Benefits	FFS	MHP	MI Choice HCBW	PIHP MSSP (MH) B Covered Svcs	PIHP HAB Waiver	PIHP MSSP (MH) B3 Add'l Svcs	PIHP MSSP (SA) B3	ICO	ICDE PIHP
Adult Day Health			X					X	
Ambulance	X	X						X	
Assertive Community Treatment Program				X					X
Assessments				X					X
Assistive Technology						X			X
Behavior Treatment Review				X					X
Behavioral Health Services (Basic)	X	X						X	
Case Management	X	X						X	
Certified Mid-Wife Services	X	X						X	
Childbirth and Parenting Classes		X						X	
Child Therapy				X					X
Chiropractor	X	X						X	
Chore Services			X					X	
Clubhouse Psychosocial Rehabilitation Programs				X					X
Community Living Supports			X		X	X		X	X
Counseling		X	X					X	
Crisis Interventions				X					X
Crisis Observation Care						X			X
Crisis Residential Services				X					X
Dental	X							X	
Emergency Services	X	X						X	
End Stage Renal Disease Services		X						X	
Enhanced Medical Equipment and Supplies			X		X			X	X
Enhanced Pharmacy					X	X			X
Environmental Modifications			X		X	X		X	X
Family Planning	X	X						X	
Family Therapy				X					X
Family Training/ Family Support and Training					X	X			X
Fiscal Intermediary Services			X			X		X	X
Good and Services			X		X			X	X
Health Services				X					X

Benefits	FFS	MHP	MI Choice HCBW	PIHP MSSP (MH) B Covered Svcs	PIHP HAB Waiver	PIHP MSSP (MH) B3 Add'l Svcs	PIHP MSSP (SA) B3	ICO	ICDE PIHP
Hearing Aids*	*	*						X	
Home Delivered Meals			X					X	
Home Health	X	X						X	
Homemaker Services			X					X	
Hospice	X	X						X	
Housing Assistance						X			X
ICFMR (16 Beds or Less)				X					X
Immunizations		X						X	
Individual/Group Therapy				X					X
Inpatient Hospital	X	X						X	
Inpatient Hospital Psychiatric Services				X					X
Inpatient Psychiatric Hospital Admissions				X					X
Intensive Crisis Stabilization Services				X					X
Laboratory, Diagnostic & X-Ray	X	X						X	
Medical Supplies/DME	X	X						X	
Medication Administration				X					X
Medication Review				X					X
Non-Emergency Transportation								X	
Nursing Facility	X	X						X	
Nursing Facility Mental Health Monitoring				X					X
Nursing Facility Transition Services			X					X	
Occupational Therapy	X	X		X				X	X
Organ & Bone Marrow Transplant	X	X						X	
Out-of-Home Non-Vocational Habilitation					X				X
Out-of-State Services	X	X						X	
Outpatient Hospital	X	X						X	
Outpatient Mental Health Services		X						X	
Outpatient Partial Hospitalization Services				X					X
Outpatient Therapy	X	X						X	
Peer-Delivered or -Operated Support Services						X			X

Integrated Care for People who are Medicare-Medicaid Eligible

Benefits	FFS	MHP	MI Choice HCBW	PIHP MSSP (MH) B Covered Svcs	PIHP HAB Waiver	PIHP MSSP (MH) B3 Add'l Svcs	PIHP MSSP (SA) B3	ICO	ICDE PIHP
Personal Care in Licensed Spec. Res. Setting				X					X
Personal Care Services/ Home Help	X		X					X	
Personal Emergency Response System			X		X			X	X
Pharmacy	X	X						X	
Physical Therapy	X	X		X				X	X
Physician/Practitioner Services	X	X						X	
Podiatry Services	X	X						X	
Preventive Care and Screening		X						X	
Prevention Direct Service Models (Children Only)						X			X
Prevocational Services					X				X
Private Duty Nursing	X		X		X			X	X
Prosthetics/Orthotics	X	X						X	
Residential Services			X					X	
Respite Care			X		X	X		X	X
Respiratory Care	X	X						X	
Restorative or Rehabilitative Nursing		X						X	
Skill Building Assistance						X			X
Speech, Hearing and Language	X	X		X				X	X
Substance Abuse	X			X				X	X
Substance Abuse - Residental Treatment							X		X
Substance Abuse - Sub-acute Detoxification							X		X
Supported Employment					X	X			X
Supports Coordination			X		X	X		X	X
Targeted Case Management				X					X
Telemedicine	X	X		X				X	X
Therapy Evaluation	X	X						X	
Tobacco Cessation	X	X						X	
Training			X					X	
Transplants and Immunosupressive Drugs	X	X						X	

Integrated Care for People who are Medicare-Medicaid Eligible

Benefits	FFS	MHP	MI Choice HCBW	PIHP MSSP (MH) B Covered Svcs	PIHP HAB Waiver	PIHP MSSP (MH) B3 Add'l Svcs	PIHP MSSP (SA) B3	ICO	ICDE PIHP
Transportation (Non-emergency and Non-medical)		X	X	X				X	X
Transportation Medically Necessary (Non-ambulance)	X	X						X	
Treatment for STD	X	X						X	
Treatment Planning				X					X
Urgent Care Clinic		X						X	
Vision**	X	X						X**	
Wellness Visits		X						X	
Wraparound						X			X

*Hearing aid replacement parts only

**Eye glasses to be covered by ICO

The table above depicts the services and supports currently provided and the proposed services and supports to be provided through the ICOs and PIHPs.

Appendix E: Michigan's Timeline for Implementation

Timeframe	Key Activities/Milestones	Responsible Parties
April 26, 2012	Plan submitted to CMS	MDCH/MSA
May 2012	CMS public review process	CMS
June – July 2012	State negotiates MOU with CMS	MDCH & CMS
August – Sept 2012	Development of RFP	MDCH & CMS
October 2012 – January 2013	Conduct MDCH & CMS joint procurement process	MDCH & CMS
September 2012	Interested organizations submit Notice of Intent to Apply	Management Entities
September – October 2012	Medicare application process for interested organizations • Submit formularies • Submit Medication Therapy Management program • Submit application	Management Entities & CMS
February 2013	Select management entities	MDCH & CMS
February – March 2013	Three way contract developed, finalized and signed	MDCH & CMS
May 2012 - January 2013	Actuarial analysis and rate setting	MDCH & CMS
May 2012 – June 2013	Develop quality measures and metrics	MDCH & Stakeholders
May 2012 – June 2013	Develop integrated appeals process	MDCH & Stakeholders
May 2012 – June 2013	Systems updates and adaptations	MDCH & DHS
March 2013	Readiness reviews	MDCH and Management Entities
January 2013 forward	Education and outreach qualified dual eligibles	MDCH & Contractors
April – December 2013	Beneficiary notification and enrollment	MDCH & Contractors
July 2013 October 2013 January 2014 July 2014	Phased implementation • Phase 1 • Phase 2 • Phase 3 • Program implemented statewide	MDCH & Management Entities
July 2013 – July 2014	Assessment • Initial screening • Comprehensive assessment	Management Entities & MDCH
May 2012 – June 2013	Legislative Issues • Budget development and implementation • Alignment with state laws (as needed)	MDCH

The timeline above lists the key activities and milestones to be completed by various parties during the implementation of the integrated care plan.

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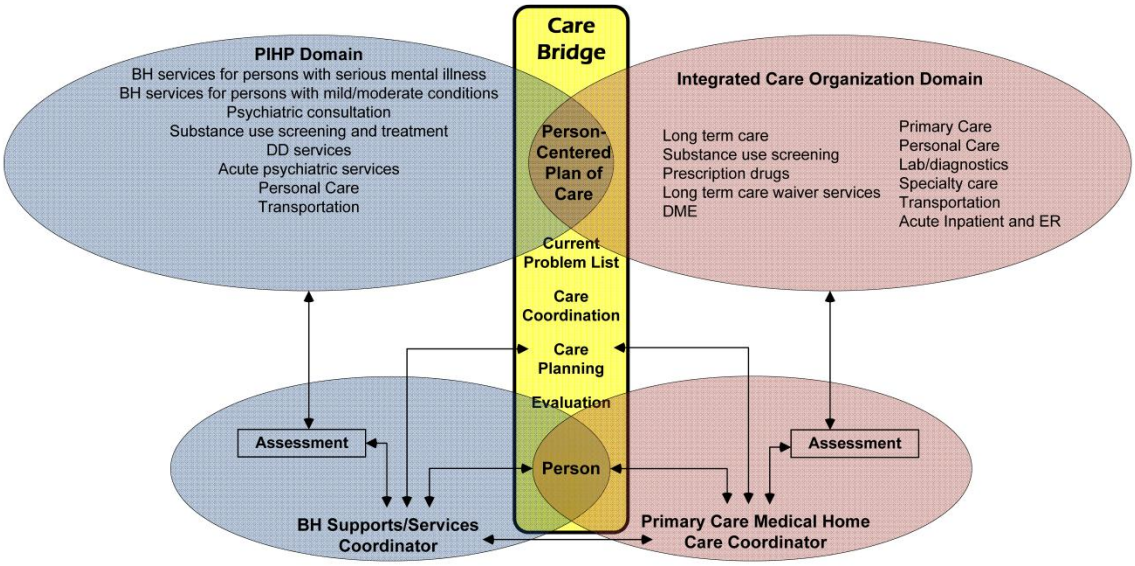
Appendix F: Proposed Care Bridge Design



The graphic above portrays the proposed relationships between the different elements of the care bridge. Further description of the care bridge can be found in Section III.B. Assessment and Care/Supports Coordination, Section V.A.Financing and Risk, and Appendix A: Glossary of Terms and Acronyms as Used in this Proposal.

Appendix G: Integrated Care for Individuals Eligible for both Medicare And Medicaid - Frequently Asked Questions (FAQ

Integrated Care for Individuals Eligible for both Medicare and Medicaid

Frequently Asked Questions (FAQ)

April 24, 2012

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

GENERAL QUESTIONS

What is really different with this proposed new program?

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

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

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

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

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

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

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

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

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

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

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

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

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

The state is currently working with the CMS to address the status of existing waivers and the legal authority for establishing the integrated structure. Michigan has several waivers that will be impacted by integrated care including the MI Choice Home and Community Based Services Waiver for people who are elderly or who have a disability, the Habilitation Supports 1915(c) Waiver for people who have

developmental disabilities, the 1915(b) Behavioral Health Specialty Services Waiver, and the Comprehensive Health Plan 1915(b) managed care waiver. It is yet to be determined if these waivers will continue to function in their current form. Likewise, it has yet to be determined if the integrated care program will operate under these existing waivers, a completely new waiver, or some other authority. However, the current array of services will be maintained for all persons currently served under Michigan's existing waivers. This applies to persons who will become part of the integrated care program as well as those eligible for integrated care who choose to opt out and persons who are only eligible for Medicaid.

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

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

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

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

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

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

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

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

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

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

FINANCING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What entity will be responsible for processing payments to providers?

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

SERVICES AND SUPPORTS COORDINATION

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

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

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

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

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

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

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

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

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

HEALTH CARE REFORM

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

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

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

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

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

PERSONAL CARE

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

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

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

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

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

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

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

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

PROCUREMENT AND CONTRACTS

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

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

Will the PIHPs need to go through a bid process?

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

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

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

ENROLLMENT AND ELIGIBILITY

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

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

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

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

Yes.

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

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

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

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

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

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

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

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

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

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

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

Michigan's proposal does assume that persons who would be eligible to enroll in the integrated care program will have the opportunity to opt out and to maintain their existing fee for service arrangement prior to being enrolled into an ICO. The state is proposing to initiate the enrollment process three months in advance of the point at which coverage would begin. Each candidate for enrollment into the integrated care plan (or their designated representative) would have a period of two months to decide whether to participate and to select a plan. The state, its enrollment broker, the selected ICO, and the default PIHP would then have one month to process enrollment.

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

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

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

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

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

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

Spend downs are currently excluded from the integrated care proposal.