COMMENTARY AND CRITIQUE
MICHIGAN'S PROPOSAL TO INTEGRATE CARE FOR DUAL ELIGIBLES

Introduction

This briefing paper stems from a larger, more ambitious and still unfinished project examining how Michigan's community mental health system might be reconfigured and best deployed in state health care reform strategies, health care delivery system changes and alternative payment arrangement models. These larger - and more compelling - considerations have been temporarily deferred to address a more pressing concern: the precipitous and ill-considered proposal put forth by the Medical Services Administration (MSA) to move all "full" dual eligibles (Medicaid/Medicare) into existing Health Plans.

Michigan's Challenges and Reform Considerations

This is unquestionably a grueling time for communities, counties, the state, and indeed, the entire nation. The continuing economic downturn is putting tremendous pressure on governmental entities, municipalities, not-for-profit agencies, health facilities and practitioners, large firms, small businesses and individual citizens.

Much of recent state government activity has been focused upon changing the calculus for business and capital investment decisions, to make the state more attractive for firms and investors. Attention has also been directed to measures that might encourage and incentivize innovation and entrepreneurial efforts.

State government has also adopted measures to reduce expenditures in various governmental agencies and publicly financed service systems. Whatever the merits of such actions, the premise behind these measures seem to be that governmental, municipal, and other publicly operated services are - in some manner or degree - too costly, indirectly inhibiting economic growth. There is, however, a contradiction in this diagnosis, since many publicly funded services are performed by non-governmental or private sector contractors (health plan, hospitals, nursing homes, IT development projects, etc.), whose compensation arrangements, margins and profit profile are not yet subject to the same intense scrutiny.

Calling attention to this contradiction is not intended as a gratuitous insult or an effort to reignite controversies regarding sectorial preferences for service delivery. In Michigan and across the nation, a thick and interconnected web of public, non-profit, and for-profit entities and network arrangements are used to perform various public duties and to provide a broad array of publicly funded services. Such arrangements are so common that this mixed sector service regime is often unnoticed by end-user citizens.

The larger question being posed - in this brief review of the dual eligible proposal - is whether the state is truly interested in innovative and pragmatic solutions to address certain civic obligations, service provision and collective interest situations, or if it instead is reverting to on older, narrowly focused, "reform" prescriptions promising hypothetical savings and putative service delivery improvements.

Background Summary and Implications of the MDCH Proposal for Dual Eligibles

The Michigan Department of Community Health (MDCH), in response to a RFP issued by the Centers for Medicare and Medicaid Services (CMS), submitted a *design proposal* for integrating the care, benefits, and financing for "dual eligibles" - beneficiaries enrolled in both Medicare and Medicaid. Proposal submissions were limited to 10 pages, with the expectation that successful applicants would - over an 12

month period - flesh out the design proposal and develop a detailed, working model for deployment. In the solicitation, CMS expressly reserved the right to determine (over an additional 6 month period) whether a state could move forward - after completion of the design phase - with implementation of its plan. MDCH was subsequently awarded (along with 14 other states) up to $1,000,000 - under CMS's *State Demonstration to Integrate Care for Dual Eligibles* initiative - to pursue its design proposal for coordinating care for persons with Medicare and Medicaid coverage.

The state's submission outlines MDCH basic design concept and direction:

> *"Michigan proposes development of an integrated care demonstration in which Medicaid would serve as the designated entity assuming complete financial and administrative oversight for Medicare and Medicaid funds and services associated with the dual eligible population. The state proposes that funds from Medicare be transferred to the state via a risk-adjusted capitation payment derived from Medicare data demonstrating the acuity of the dual population and historical utilization trends. The state in turn would contract with managed care organizations on the local level to manage and coordinate care for plan participants. These would include both the traditional managed care model and accountable care organizations.*
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> *The benefit package will include acute, pharmaceutical, long term and behavioral health care services for the target group. Based on the state's previous experience with managed care, mandatory enrollment will be required because it is important for achieving economies of scale, but participants will be offered the choice of opting out of the plan."*[1] (Emphasis added)

In discussing some of the issues that need to be addressed during the design and model development process, the MDCH proposal notes the need for:

> *"…assessing and developing a plan to integrate Michigan's waiver services (behavioral health and long term care) and state plan personal care option into the new integrated delivery system.* (Emphasis added)

In essence, the state's proposal envisions the enrollment of all "full" dual eligibles (roughly 204,000 beneficiaries) into "traditional" managed care models (e.g., Health Plans) and (purportedly) accountable care organizations (ACOs). The reference to possible use of ACOs seems odd, given the proposal's insistence on the need for *mandatory enrollment*, which is not a necessary or defining feature of the ACO model (ACO arrangements typically don't entail mandatory enrollment; instead beneficiaries are "attributed" to the ACO based upon past primary care practitioner utilization patterns). Despite mention of other possible integrated arrangements (ACOs, Special Need Plans), the prominence given to Medicaid Health Plans in the proposal strongly suggests that the prime objective is to move dual eligiblies into existing "traditional" models (Medicaid Health Plans):

> *"Despite its extensive experience and success with managed care, persons who are dually eligible for Medicare and Medicaid make up the largest number of Michigan's Medicaid population that continues to be excluded from health plans. This represents immense opportunity for improving access and quality of care for the duals while addressing cost effectiveness for the Medicare and Medicaid programs."*

[1] Quotations regarding the proposal are excerpts from *Michigan's Response to CMS Solicitation: State Demonstrations to Integrate Care for Dual Eligible Individuals.*

Other elements of the design proposal further reinforce this interpretation:

> *"Regardless of the demonstration model types, Michigan is sure about the following based on the planning work completed to date: Michigan proposes to receive the Medicare funds (on a risk-adjusted basis), and assume all financial risk for Medicare services for dual eligibles. Michigan also is certain that the state then intends to enter downstream contracts with capitated entities that will deliver an integrated array of Medicaid and Medicare services, and assume capitated risk for both."*

Hence - from the material referenced above - it is a reasonable to conclude that under the proposal, the "capitated entities" designated to manage *all* Medicare and Medicaid benefits (including "optional" Medicaid benefits such as mental health clinic services, mental health community rehabilitation services, psychosocial rehabilitation services, crisis residential services, targeted care management, 1915(c) HAB waiver services, etc.) for the dual eligible population will be the incumbent Medicaid Health Plans (or some variant of these types of plans).[2]

The conclusion that Health Plans will be the primary vehicle for managing all benefits for Medicare-Medicaid dual eligibles is further reinforced by language in the MDCH appropriation bill (P.A. 63):

> *"Sec. 1775. If the state's application for a waiver to implement managed care for dual Medicare/Medicaid eligible is approved by the federal government, by April 1, 2012 the department shall provide a report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies. This report shall include information on the amount of Medicare funding that would be provided to the state, the number of individuals who would be enrolled in the program, which health plans would be among those providing the services, and the estimated savings from the new program."*

A fiscal agency analysis of the bill (as agreed to by the conference committee) notes that savings from the proposed arrangement have already been factored into the appropriation bill:

> *"The Conference concurred with the Governor in assuming savings from implementation of managed care for CSHCS Medicaid clients and dual eligibles. Two sections of boilerplate from the Senate bill, requiring reports to the Legislature on the development of these new managed care programs, were included. (Sec. 1204 and 1775)."*

The pressure to achieve savings - explicitly mentioned in analysis of the MHCH appropriation bill - is also reflected in the state's timeline for implementation, which is months ahead of the CMS timeline for implementation approval:

> *"The target date for implementation of this project is April 1, 2012. <u>Because Medicaid policy in Michigan is established through administrative rules and a process outside of statutory protocol, legislative authority is not required in Michigan."</u>* (Emphasis added)

[2] CMS issued a State Medicaid Director letter on July 8, 2011 (*Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees*), indicating that in states employing a "capitated approach" to integrated care for dual eligibles, CMS, the State, and health plans would enter into a "three-way contract" and "…eligible health plans include entities currently offering Medicare Advantage or Medicaid managed care."

While the MDCH proposal does mention that gaining legislative support for this plan is "important," the significance of the Legislature is referenced solely in its "…responsibility for appropriating funds to agencies," (hence the emphasis on meeting spending targets), without any parallel or balancing allusion to the Legislature's responsibilities for state health policy oversight. In this respect, the proposal suggests overreaching and misuse of "ministerial" or agency discretion.

Basic Questions

What are we to make of these strong signals that the capitated model (Health Plans) for duals is a *fait accompli*, a done deal? And how practical is the notion of moving Medicaid specialty service and support benefits for duals with serious mental/developmental conditions from current managing structures (i.e., Community Mental Health/Prepaid Inpatient Health Plans) into Health Plan configurations? One appraisal might be that such a plan, while arguable audacious, is seriously flawed, ill conceived (perhaps to the point of recklessness), and intended - not to better coordinate care - but to achieve conjectured savings,[3] to the detriment of special need dual eligible beneficiaries.

Prior to passage of the Affordable Care Act (ACA), states could voluntarily enroll dual eligibles in Medicaid managed care, or (with Federal approval) mandate that dual eligibles receive their *Medicaid benefits* through Medicaid managed care arrangements. But (with a single state exception) states could not *compel* dual beneficiaries to enroll in a managed care plan (Medicare Advantage – Part C) to obtain *Medicare benefits*. States seeking to enroll duals in parallel managed care arrangements had to utilize somewhat complicated mechanisms, such as contracting with a plan that was certified both as a Medicaid Health Plan and as a Medicare Advantage Plan. Given these complexities, it was not surprising that the uptake of such arrangements was low.

With the passage of the Affordable Care Act (ACA) – and the creation of two new agencies within CMS (i.e., Federal Coordinated Health Care Office and the Center for Medicare and Medicaid Innovations) – new possibilities for integrating/coordinating care for dual eligibles have emerged. As noted above, MDCH proposal represents *one variant* of the "capitated" model to Medicare-Medicaid alignment, although it appears (in light of the July 8th State Medicaid Director Letter) that the MDCH approach (in terms of Health Plan requirements and assurances) would have to be significantly modified for implementation approval.

In reviewing the plans of other states - both the 14 other award states as well as states that were not successful applicants for the design funds - Michigan's proposal appears to be somewhat of an anomaly in its shape and scope. Other states are contemplating or pursuing a broader (and more thoughtful) range of models, organizational configurations, target populations, phased approaches and pilots to better coordinate care for duals, while Michigan's proposal seems dated and static, a cookie-cutter, one-size-fits-all approach.

Concerns and Critique

The Kaiser Family Foundation recently issued a policy brief[4] examining the design proposals of all 15 states awarded funds by CMS under the "State Demonstration to Integrate Care for Dual Eligibles" initiative. The policy brief revealed that many of the awardee states proposed varied, flexible, nuanced, and less hurried design plans. States that proposed expanding managed care service delivery

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[3] As H.L. Mencken is reputed to have famously observed, "when someone says its not about the money, its about the money."

[4] *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS*; August 2011

arrangements for dual eligibles indicated that they would explore offering different service delivery models in different geographic regions or for different subpopulations of dual eligibles in the state. Several maintained existing carve-out benefit systems even as they proposed expanding managed care. Some states opted for what CMS has termed a "managed fee-for-service" shared savings model, or other innovative service delivery arrangements and payment structures such as accountable care collaboratives, integrated care networks, enhanced primary care case management (PCCM) programs, the health home option, and other "hybrid" arrangements.

What is puzzling about the MDCH proposal is that it transfers management of crucial Medicaid state plan and 1915(b)/(c) waiver services and supports – designed for persons with serious mental illnesses, substance use disorders and/or a developmental disabilities - to entities that have limited experience with the general dual eligible population, and literally no experience with duals that have serious mental illnesses, substance use disorders and/or developmental impairments. These dual-eligible beneficiary groups have not typically been enrolled in Medicaid Health Plans for *Medicaid* physical health benefits, (remaining instead in the Medicaid fee-for-service system for covered physical health services). Nor have most dual eligibles been enrolled in Medicare Advantage Plans for their *Medicare* benefits, (retaining their Medicare fee-for-service status).

While Medicare is the primary payer for physical health care services utilized by duals with serious mental illness, substance use disorders and/or developmental disabilities, Medicaid - through the concurrent 1915(b)/(c) specialty services waiver – underwrites the delivery of community-based treatments, rehabilitative, habilitative, and support services required by these beneficiaries. The services are provided through highly evolved and networked community systems of care. These collaborative community-based networks (i.e., CMHSPs/PIHPs and their extended value chain of non-profit partners) are also tightly linked to agencies that provide/arrange critical non-medical supports (e.g., housing vouchers, transportation, income support, employment training, etc.) that contribute significantly to the health status and well being of the under-65, seriously mentally ill and/or developmentally disabled dual eligible population. By treating the issue of integrated care for duals as simply a blending diverse medical benefits and funding streams, MDCH has ignored the limits of medicalization and the importance of community support services.

The state's assertion that simply moving the under-65 duals with mental/developmental impairments into Health Plans will improve care coordination, beneficiary health status and reduce costs is a highly speculative claim. Other models of care coordination (enhanced primary care case management programs, community health teams, health home initiatives, regional partnerships, safety net ACOs, etc.) and innovative community network arrangements in other states (e.g., Colorado, New Jersey, North Carolina, etc.) hold as much (or more) promise for improving the health status and reducing the cost profile of duals with special needs.

In fact, a persuasive argument can be made for a care coordination model in which the specialty mental health sector assumes a prominent position in integrating care for duals with serious mental/developmental conditions. The prevalence of mental/developmental impairments in the under-65, disabled, dual-eligible populations is striking[5], and these impairments frequently drive medical

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[5] A report (July 2010) by the Kaiser Foundation estimates roughly 38% (depending upon inclusion criteria) of duals under age 65 have both a mental/cognitive disorder AND one or more chronic physical condition(s). The presence of a mental/cognitive disorder and a chronic physical condition drives higher service use and dictates more intricate and complex coordination requirements. See *Chronic Disease and Multimorbidity Among Dual Eligibles* (July 2010)

morbidity patterns and physical health care costs. A recent study[6] of Medicaid beneficiaries (not specific to duals), found that an index condition such as serious mental illness, mental illness and substance use, or a developmental disability, constituted the major cost and severity driver for physical chronic illness and multimorbidities, compared to other Medicaid beneficiaries with similar chronic physical illnesses/multimorbidities but lacking an index mental/developmental condition.

Moreover, the preliminary results of a two year MDCH funded disease management pilot in Washtenaw County (that involved a significant number of duals with serious mental/developmental conditions) indicate that a collaborative care management program – with a dedicated health coordination team, strong connections to primary care clinics, motivational and patient activation strategies, health information exchange technology, peer support workers and the participation of community social support agencies can produce measureable and significant improvements in health status and chronic illnesses management in this beneficiary cohort.

What's the Matter Here?

Governmental interest in the well being of citizens with serious mental illnesses and/or developmental disabilities reflects constitutional and statutory public values and commitments. Public expenditures for these populations are a particular category of government-funded goods; they are "directed goods," paid for publicly (out of the "common-wealth") but delivered *specifically* to certain individuals with particular conditions or impairments.

When the state initiated the movement of the serious mentally ill and developmentally disabled from massive institutions to community placements and supports, it determined that county-sponsored public entities (community mental health services programs) were more reliable "agents" to effect this change and less likely to misuse any discretion allocated to them in this joint venture. Over the last twenty years Michigan has steadily built a statewide community-based specialized service delivery system to address the multiple needs of individuals – including dual eligibles - with serious mental illness and/or developmental disabilities, and has closed 16 state hospitals and developmental centers in this transition.

***What is striking about the current MDCH proposal is <u>its radical redistributive agenda</u>, essentially transferring Medicaid funds slowly acquired to support community-based care for the under-65 seriously mentally ill and/or developmentally disabled duals (and other recipients) to expand historically underfunded home and community based services for aged (over-65) dual eligibles*.**

Robbing Peter to pay Paul is not a health policy; rather, it reflects someone's opinion or conjecture that some duals have "too much" and hence their benefits should be diluted in scope/scale to accommodate other constituencies. Surely we can do better than this.

The state's proposal emerged after discussions with various experts, professional associations and groups purporting to represent beneficiaries. The framework of the proposal was developed before extensive stakeholder involvement, and state staff often had difficulty answering specific operational questions during stakeholder public forums. However, as Aristotle noted, it is the person who wears the shoe, and not the shoemaker, who knows if it fits. As beneficiaries and families - who often have

[6] *Clarifying Multimorbidity to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*; Center for Health Care Strategies, December 2010.

experiences that make them valuable judges of experts and proposed plan - learn more about the proposal's particulars, opposition is likely to become more widespread and vocal.

Seeking Collaboration, Alternative Models and the Common Good

Rather than blindly pursuing one (capitated) model, the state should indicate its intention (to CMS) to also explore the "managed fee-for-service," shared savings, collaborative care approach to integrating Medicare and Medicaid for dual eligibles. Such an approach would not require dismantling the concurrent 1915(b)/(c) specialty service waiver, since Medicaid covered benefits within the alternative model "…shall be in accordance with the requirements in the approved Medicaid State plan and any applicable waivers."[7]

Configuring and operationalizing a managed fee-for-service approach will require some heavy lifting. However, it will also provide a scaffold for the larger task of health care redesign in Michigan, opening up consideration of new public-private collaborative arrangements. It will propel, rather than impede, the discussion and decision of how best to reshape, reconfigure and join public mental health with health and human service systems. Descriptions and conceptual models of broader and bolder changes will be the topic of an upcoming paper. The urgent task of the moment is, however, to persuade the state from executing the duals proposal in its current form, since the implementation of such an arrangement will effectively preclude consideration and future development of other, more vibrant and innovative, models.

[7] CMS State Medicaid Director letter, July 8, 2011 (Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees)