

North Country Community Mental Health
Response to MDCH Request for Information
Medicare and Medicaid Dual Eligible Project
September 2011

1. What is working well in the current system of services and supports (i.e., medical care, long-term services and supports, and behavioral health and developmental disabilities services and supports) available to people who are eligible for and enrolled in both Medicare and Medicaid?

Specialty needs populations (which are heavily represented in those dually eligible for Medicaid & Medicare) need special supports and expertise in their service delivery. It is essential to retain what works well at the individual level and not sacrifice this service quality for a streamlined financial model. The public behavioral health system – as the only system currently managing dual eligible – has effectively managed care for this group since 1998. The PIHPs/CMHSPs have successfully demonstrated consistently good cost controls illustrated by low administrative expenses and rate increases significantly lower than seen in traditional healthcare. Locally, low administrative costs have been achieved through the consolidation of functions such as centralized access and centralized data collection and reporting.

The impact of behavioral health care management on overall healthcare costs is well-documented. [A study conducted by Parks, Swinfard, and Stuve \(2010\)](#) demonstrated a reversal in the trends of rising health care costs through effective CMH case management interventions. [New York State Office of Mental Health Bureau of Evaluation and Services Research \(1991\)](#) demonstrated a 32% drop in unmet medical need with one year of mental health case management.

To build upon CMH successes in innovation and integration, the state should maintain its well-developed system of Medicaid managed care, while enhancing it through the addition of a managed fee for service approach to integrating Medicare services through direct contracting with Michigan's Public Behavioral Healthcare System. This will build on demonstrated experience and competency. The state should maintain the current range of supports and services that include coordination with transportation, housing, employment and supports that assist individuals in living productive, meaningful lives in their communities.

2. What are the problems in the current system of services and supports for people who are eligible for and enrolled in both Medicare and Medicaid? What is not working that might be addressed in an integrated system that coordinates care across the providers/caregivers you see?

Volume-based payment mechanisms (non-managed fee for service) incentivize providers to schedule more services, but not more coordination/integration of health

treatment. (See The Hot Spotters an article in [The New Yorker](#) discussing how to lower medical costs by improving treatment to patients with highest need.) Benefit management is a barrier to healthcare management. Consumers and their family members focus on benefits rather than on the importance of wellness and supportive services.

Most significantly, there is a lack of primary care physicians in Northern lower Michigan that are willing to accept Medicaid enrollees as patients. This compounds the lack of coordination of treatment planning across healthcare providers.

3. Do you have any comments on the proposed program elements listed on page 1? Is there anything missing from the list?
 - a. What program elements or features should be included in an integrated care model that would encourage participation from people who receive services through Medicare and Medicaid? How can we make this program attractive so that people will not opt out?
 - b. Which specific supports and services do you consider to be most important for people who are eligible for both Medicare and Medicaid? *Please consider the following three categories of care in your response: Long-term services and supports; behavioral health and developmental disability services; and medical care.*

There are two notable items not included:

- **A requirement that integration of care occurs at the direct service level. This requires that care managers in each community coordinate not only traditional health care services but also appropriate social and community services, such as community integration, employment and housing assistance. Further, care management must be done by entities with demonstrated competence serving the population in question and understand their long term needs.**
- **There is no mention of substance use disorder services, unless this is assumed to be included in behavioral health services.**

3.a.

The most important element in an integrated care program is the use of patient centered health homes. For those with behavioral health needs, this should be within the behavioral health structure. (See [Specialty Care Medical Homes for People With Severe, Persistent Mental Disorders](#), Alakeson, Frank and Katz; Health Affairs) The State should seek the expansion of the 2703 health home concept to all dual eligibles in the State of Michigan. The State should adopt a phased implementation plan that allows for adequate preparation and transition and affords the opportunity to learn from each phase.

This approach maintains a proven system of managed care for Medicaid while incorporating a managed fee for service Medicare component. Building on the strengths of the current system, those served will experience less turmoil and change. This will reduce the number of individuals choosing to “opt out.”

3.b.

The full range of services and supports in the current Medicaid waivers (1915b, b(3)) must be maintained for all dual eligibles. These include non-medical services vital to maintaining persons with disabilities in the community – housing, work, transportation, entitlements, and social supports. Connectedness to an environment of solid social supports is a key determinant in mortality rates independent of other factors, and remains necessary to holistic healthcare integration. (Haan, Kaplan, & Camacho, 1987)

4. The purpose of this initiative is to transform the health care system for people who are eligible for both Medicare and Medicaid. What suggestions do you have for care integration/coordination elements that we should require? How can care coordination among medical care, long-term services and supports, and behavioral health and developmental disability services be improved?

Dual eligibles include the most chronically ill and costly individuals enrolled in both the Medicare and Medicaid programs and include a high percentage of individuals with a mental illness and resultant complex needs. Coordination of care, particular complex care happens at the ground level with support/communication among the various partners. This is best accomplished by a patient centered health home. For those with behavioral health needs, the most effective approach is to locate the health home within the behavioral health structure. (See [Specialty Care Medical Homes for People With Severe, Persistent Mental Disorders](#), Alakeson, Frank and Katz; Health Affairs) As a part of this demonstration project, the State should seek the expansion of the 2703 health home concept to all dual eligibles in the State of Michigan.

The State should maintain the well-developed system of managed care for Medicaid and enhance it with a managed fee for service Medicare structure. Supporting the development of health homes for persons with chronic health care needs, within the existing public behavioral health system, will prevent a significant change for this population. This will likely reduce the number of “opt outs” within this population.

The public behavioral health system has provides the six health home services (comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support services and referral to community and social support services). Only the PIHP/CMHSP system has the proven record of success in de-institutionalization and Home & Community Based Services including personal care, community living services, transportation, social connectedness, etc., and remains the only system that is currently managing the needs and risks for any segment of the dual eligible population. It would be inefficient and imprudent to not utilize the service and management expertise that exists in the current behavioral health system.

5. What should contracted entities be required to do to support person-centered care and services?

The individuals that are enrolled in both Medicaid and Medicare typically experience either complex acute and primary care needs; behavioral health needs; or long term care needs; or some combination. The State must ensure that parties knowledgeable of a discrete set of health conditions – specifically acute/primary care, behavioral care and long-term care – are retained as care managers for persons with those conditions.

Any entity chosen to manage care for the dual eligible population should be required to demonstrate competency in the delivery of person centered care. This includes a planning process that incorporates other community based, health and non-health services necessary to the individual’s needs.

Any care management contract must include individual protections such as those currently afforded to Medicaid enrollees. Additionally, the recipient rights protections for those currently served by the public behavioral health system should be maintained.

6. What are the advantages and/or disadvantages to making single entities responsible for contracting with providers to ensure that all covered services and supports are available to and coordinated for dual eligibles?

The advantages of combining Medicare and Medicaid funding to a single stream for those with dual enrollment are substantial, if done properly. Presently, the complexity of two payer rules, differing covered benefits, and differing provider panels create significant burdens and expense for enrollees and providers. Most importantly, the lack of coordination prevents achieving optimal outcomes. A single management structure for both resources offers the opportunity to properly coordinate care, reduce administrative burden and improve access through an expanded provider panel.

If, however, the question is “what are the advantages/disadvantages of a single entity managing the combined Medicare/Medicaid benefit statewide,” the disadvantages are numerous. As noted in previous questions, it is essential that the managing entity have demonstrated experience with the primary health conditions of the population served. There is no single entity that has the broad based experience needed to do this for the entire dual enrolled population. Consequently, any one entity given a contract for the entire state would, by necessity, then contract with multiple entities to gain the specific experience needed. This would simply result in additional administrative expense.

Further, to achieve the desired and attainable improvement in health outcomes, care must be integrated at the delivery level. Integrated financing does not ensure

coordinated care. This requires local control and community awareness. As previously noted, individuals with chronic and complex health needs also have chronic and complex social and support needs. Meeting these needs is a local task.

Overall, the disadvantages of making a single entity responsible for contracting statewide outweigh the advantages.

7. What financial misalignments do you see in the current system? What incentives would support high-quality, cost-effective care?

Most current fee for service financing models reward quantity of service rather than quality or outcomes. The benefit of a well-integrated care delivery model is that the individual receives the right services, in the right amount, and at the right time for the desired outcomes. As noted in the article from The New Yorker, cited in a previous answer, misalignment of payment incentives will negatively impact the care manager's ability to effectively control costs while coordinating needed care. Effective payment structures must, at a minimum, include a managed fee for service arrangement with appropriate shared savings to incentivize those providers least motivated to cooperate.

Health home arrangements are intended to reduce inpatient and emergency room care, thereby reducing costs. If hospitals do not share in these savings, they are not as apt to cooperate with the health home. The same applies to specialists. Sound prevention and early intervention will effectively reduce dependence on high cost specialty care. As with hospitals, specialty care must be incentivized to cooperate. Additionally, incentives must be aligned to ensure that the management entity is responsible for the quality of care and cost control of the entire benefit provided to a consumer.

The public behavioral health system is developing potential financial models for Medicaid and Medicare that provide savings over the current systems. Such a model would improve upon Medicare FFS while leveraging the advantages of Medicaid managed care. A managed FFS system applied to Medicare services with integrated utilization management methodologies reduces or eliminates unneeded care, care above standard levels, and excessive lengths of stay.

8. What are the most critical issues the state should be mindful of when it formulates a plan to integrate care for people who are eligible for both Medicare and Medicaid? Is there anything you are especially worried about as the state develops this plan? Are there elements of the proposed plan that make you especially supportive of it?

The single most critical issue for the State to consider when consolidating the financing and care management for persons with dual enrollment is the impact on and outcome for those individuals. The dual enrolled population includes many of Michigan's most vulnerable citizens.

The State should be mindful of the competencies necessary to coordinate care for a population with significant and chronic health conditions. While a coordinated funding stream with a single care manager promises vastly improved outcomes for individuals served, if poorly designed, this promise will not be realized. Local or regional control of funding by entities with experience appropriate to the individuals' primary condition (acute/primary care, behavioral health, long term care) offers the most realistic opportunity to achieve improved outcomes for those served and financial savings for the State.

Publicly funded safety net services are a primary responsibility of state and local government. Any plans that move this responsibility to a private, for profit entity must be carefully considered. The first concern is accountability for administrative costs and profit taking. Secondly, if a single entity obtains a contract; appropriate safeguards must be in place to prevent a monopoly. And most importantly, any approach that dismantles the existing public structure for a three year demonstration project would expose the State and its residents to significant cost and challenges if the demonstration project is not successful.

The public behavioral health system provides an outstanding model to use as a launching pad for further development and ideas. Administrative structures need to support integrated care from the consumer up to the funding level.

9. Which service components (e.g., medical care, long-term services and supports, behavioral health/developmental disability services, community supports) will be especially challenging for you to provide? What are your suggestions for addressing these concerns?

This depends on the design chosen. The public mental health system is interested in actively partnering with other entities to ensure a full array of services. If arrangements are allowed to be flexible, particularly based on different regional needs and availability of services, this can be accomplished.

No one entity can provide all of the specialty services needed by specialty populations without partnerships. Design and incentives must align to support, not preclude these types of partnerships. The biggest local barrier is not the lack of service availability but the lack of ability to coordinate care, as incentives do not currently support it.

10. What information would you need in advance of preparing a response to a future RFP?

First, it is essential that the state provide opportunities for feedback on any draft model or proposal before anything is finalized in a RFP. This includes ample time for real and constructive consumer /family and stakeholder input into the system design prior to releasing an RFP. Additionally, the State should share any plans for submission of a State Plan Amendment for specialty medical homes, consistent with Section 2703 of the Patient Protection and Affordable Care Act.

Additional information needed relative to any RFP would include:

- **Aggregate Medicaid and Medicare expenditures for the past three years with as much detail as possible,**
- **Eligible categories with necessary demographic detail,**
- **Detailed benefits with related CPT and HCPC codes,**
- **Proposed contract language,**
- **CMS approved compliance guidance,**
- **Financing schemes including funding models, risk arrangements and shared savings,**
- **Capitation (if applicable) rate cells and amounts, and**
- **Applicable enrollee rights and protections.**