Guidance for responding to Request for Input (RFI) for dual eligibles

RFI Question	Main Points/Description of Issues	Local CMH/provider considerations and examples	Suggestions for Soliciting Consumer & Family Input
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 transitioned Michigan from state-based institutional care to a network of community-based alternatives during the past 30 years. The PIHPs/CMHSPs have successfully expanded access to services by 16% since 2002 have demonstrated consistently good cost controls illustrated by low administrative expenses and rates increases significantly lower than our counterparts in traditional healthcare. The impact of behavioral health care management on overall healthcare costs is well-documented. Numerous studies have shown that there are significant cost savings when care is provided that focuses on both medical and behavioral health interventions. Blount (2007) cites studies that have demonstrated a 17% reduction in medical costs when integrated collaborative care is implemented. A study conducted by Parks, Swinfard, 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%	Use outcome/cost data collected in your local programs or other national/state studies that make the business case. Use short examples that tell the stories. Consumer programs, collaborative efforts, how lives are helped/changed. Use local examples of controlling cost-drivers, effective programs, utilization management, coordination efforts Utilize successful evaluations by external sources (audits, HSAG site reviews, accreditation surveys, etc.) as evidence of local capabilities. Look at the number of hab support consumers served at the CMH that have dual eligibility as evidence of experience coordinating care for this population. Per MDCH , of the habilitation supports waiver consumers served statewide, 75% are dual eligible.	What is working well for you in terms of the services you currently receive that are paid for by Medicaid or Medicare? What services (through CMH or through your primary care office) are you currently receiving and how are those services helpful to you? Are your health care/medical needs services currently coordinated with your behavioral health services? Do your various treatment providers talk to one another about your care? What are some of the Medicaid services you receive now that you don't want to lose? What are some of the services you receive now that are paid for by Medicare that you don't want to lose? How is it working to have local care and management of your mental health and medical/physical health care services? Would you prefer that this be centralized across the state?

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	drop in unmet medical need with one year of mental health case management. To build upon CMH successes of 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 means that a group who knows the consumer and has done this kind of work for decades does not have to go through another group to make decisions about the care that the consumer receives. As Governor Snyder pointed out in his address on healthcare, administrative structures should only exist to facilitate improved care and services. In addition to providing care coordination and essential mental health services, the current public behavioral health system also provides for and/or arranges a wide range of additional supports and services to Medicaid consumers. These services, such as transportation, employment assistance, ancillary public entitlements, and community-based supports assist individuals in living productive, meaningful lives in their communities and reduce costs to other systems. The current array of supports and services provided under Michigan's 1915 b,c waivers and (b3) plan meets the service needs of this high cost population via psychiatry, care coordination, case management, wrap-around services, etc. The public behavioral health system includes an		

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	extensive provider network that has experience in the following: • Person-centered planning • self-determination, vouchers, community-based treatment • Integrated treatment for individuals with substance use and mental health conditions. • Administration of both managed care waivers and fee for service programs • chronic care management with high acuity and high risk populations • Capability for sustained Individualized care across multiple provider boundaries • Mitigating the social determinants of health		
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?	There is poor alignment of incentives to support meaningful integration across all healthcare partners. Volume-based payment mechanisms incentivize the parties to provide more services, but not more coordination/integration of health treatment. See New Yorker article on lowering 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. There is a lack of coordination of treatment planning across healthcare providers. Redundant, non-value-added requirements	Point to local examples of poor alignment and offer a suggestion for how it could improve in an integrated model. Offer local examples of difficulties accessing health care for our population Example: Medicaid MH consumers are unable to get mental health counseling or psychiatry paid for by the Medicaid Health Plan in which they are enrolled	What's not working in terms of your medical care and/or your mental health care currently? What services are difficult to access as a person who is eligible for both Medicaid and Medicare? What "extra hoops" do you go through now in terms of access, coordination of benefits, choice of provider because of your dual coverage? How important is it to you to maintain your current provider(s) of medical/physical health and CMH services?

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	Lack of access to quality providers in rural areas – both in behavioral and traditional healthcare.		
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**	What is missing from the proposed elements: -A requirement that the integration of care be done first at the direct service delivery level (where the care meets the consumer), requiring that the care managers and providers in each community share clinical records and coordinate care to consumers -that the care management be done by organizations who are experts in their areas (mental health, DD, substance abuse by one expert group, nursing home and long term care by another expert group; and physical healthcare by another group. -SUD is not mentioned in the population or proposal Specialty populations are best served by specialized supports and systems that understand the long-term needs of this population. Individual level integration leads to improved health outcomes and controlled costs over the long-term. 3 (a) We propose that the management of dual eligibles incorporate the inclusion of "Health Homes" (as described in Sec 2703 of the ACA) as the hallmark of integration and improved care coordination. As demonstrated in feedback from consumers at the public input sessions on dual eligibles, Health Homes via CMHSP's are likely to materially reduce "opt-outs" from duals integrated care	Local voice in leadership and decision-making about healthcare systems—all healthcare is local. Emphasis on the essential consumer voice in all provider and management entities Consider providing examples of local integrated healthcare.	Solicit specific consumer input on the proposed program elements listed on pg 1 of the RFI– "The state's intent is to create a service delivery model based on these principles/program elements." Do you agree with these? Which ones are most important to you? What questions do you have about the state's proposed plan that would inform you about whether you wanted to choose this new option for managing care? What is confusing to you about this plan? What specific services are you currently receiving or would you like to receive under a new model for dual eligibles? What are the most important behavioral health and/or developmental disabilities services you currently receive – (ie: case management, supports coordination, community living supports, personal care, respite, psychiatric, peer supports, nursing, OT, PT, ACT,) What kinds of additional social supports do you currently receive

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	delivery regardless of final design due to the widespread comfort and favor individuals with SPMI and DD show for their CMHSP/PIHP system. Health homes would allow consumers to have their care provided and coordinated by their CMH. The State should maintain its well-developed system of managed care for Medicaid using specialized care managers while enhancing it through the addition of a fee for service approach to integrating Medicare services. This approach that would allow consumers to keep their providers and not require the development of a large and costly capitated managed care system. This program should be phased in, with several different models for integrated care developed regionally. Results should be analyzed and key findings identified and used in the design of the final, statewide system. We are looking for an expansion of services to Medicare eligibles, NOT a reduction in service to Medicaid consumers. State should look at an expansion of Health Home model to include Medicare Answer 3b. The full range of services and supports included in the current Medicaid waivers (including 1915b, b(3)) must be in the service array for both Medicaid and Medicare recipients. These include non-medical services that are vital in terms of 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		help with through the CMH system? (ie: transportation, housing, benefits assistance, employment assistance) How important are these services to you? How important is it to you that you keep your current provider(s)?

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	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?	Since dual eligibles are among the most chronically ill and costly individuals enrolled in both the Medicare and Medicaid programs, and are more likely to have a mental illness and limitations in activities of daily living, the public behavioral health system must play a vital role in managing care for this population. Care coordination happens at the ground level with support/communication among the various partners. The public behavioral health system in Michigan recommends the expansion of the 2703 health home concept to all dual eligibles in the State of Michigan. The State should maintain its well-developed system of managed care for Medicaid using specialized care managers while enhancing it through the addition of a fee for service approach to integrating Medicare services. A managed FFS arrangement for Medicare would build upon the strengths of the public behavioral health system, in co-managing integrated services and ensure that specialty populations don't bear the cost burden of services for lower need groups. Single-payer systems do not ensure integration: It happens at the ground-level of service provision. By the state supporting the development of health homes for persons with chronic health care needs – allowing consumers to have their	Give examples of local integrated arrangements that are working (co-locating, providing staffing support, joint ventures with FQHCs, local health delivery systems) Emphasize the critical elements of quality care: 1) Local Access, 2) Effective Engagement and partnership 3) Accurate and timely assessment of need, 4) Effective, inclusive, comprehensive and person centered planning, 5) Care Management, 6) Service Delivery. This is how the local public behavioral health system has managed risk, attained outcomes and controlled costs	What would "coordinated care" look like for you? Who would you want to be responsible for "coordinating your care"? What works/doesn't work currently in terms of your medical/physical health care services and your mental health/DD/SUD services working together? Do your various doctors or support staff talk to one another about your care?

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	care provided and coordinated by their CMH. This would not be a significant change for this population, as many individuals consider the community behavioral health system as their health home. The public behavioral health system has historically provided 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. 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?	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. The following must be required in order to provide service to specialty populations: • Competencies in person-centered approaches to care • Align incentives with outcomes. Good person-	Discuss how you, at your PIHP and CMHSP, provide person-centered care and services. Demonstrate importance of having the person providing the service and care that is knowledgeable in the specific needs of the consumer and their population. Emphasize the protections in place for individuals we serve.	How much voice, control and choice do you have in your current plan of service for mental health and/or developmental disabilities services and for your physical health/medical services? How important is it for you to be involved in developing your plan of service for all of your supports and/or treatment needs? Is it important to you for consumers

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	centered planning is linked to positive outcomes for the people we serve. • Guarantee rights and protections under for grievance and appeal as exists under current Medicaid guidance with a single grievance/appeal process • Retain expertise in serving people who have the following, predominant health conditions: • mental health, developmental disabilities, and substance abuse • nursing home and long term care • physical health care •Be required to provide the full range of services included in the current Medicaid state plan and behavioral healthcare waivers.		and family members to be involved in policy and planning at the local level?
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?	Overall, the disadvantages of making a single entity responsible for contracting outweigh the advantages. The disadvantages are to a single entity include: • there is no one group can be an expert in the needs of consumers with a wide variety of health care needs • this one single entity would need to take an administrative cost off of the top before it provides funding to the other groups who will actually manage the care – this greatly reduces the dollars available to serve consumers. Integrating financing at the "Plan" level does nothing to incentivize care coordination at the service level and is really building off of Medicare Advantage Plan models, which has been under	Describe the local impact of a potential reduction in service dollars. How would adding a more centralized/single administrator help or harm the current method of local service delivery? Mechanisms or incentives would have to be deeply ingrained in whatever single entity is responsible for "managing" care throughout the State in order to ensure and encourage effective locally driven collaborations. Further, whatever single entity is designed or under consideration must have some kind of tie back to the legislature or State	What are consumers and family members most concerned about when considering an "integrated care model" or a "single entity" to manage this plan? How important is it to you to be involved or have someone representing your interests be involved in healthcare policy and planning? What should that involvement look like?

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	federal scrutiny and slowly being replaced by ACO's. States around the country are also beginning to explore variations of Specialty Service (or conditioned based) ACO's for Medicaid populations. Michigan should explore these options for portions of its dual eligible populations. These Specialty Service ACO's build off of the Managed Fee for Service model but also allow variations state wide that could accommodate rural and urban service areas that require much more collaboration and coordination across multiple hospital and physician organizations. CMS has been clear in its expectation that they wish to see something greater than integrated funding. In fact, they have directly requested an improved, integrated care experience for the persons served.	government so that it is held accountable to the needs of the citizens of the State in the event that the single entity loses its sense of mission.	
7. What financial misalignments do you see in the current system? What incentives would support high-quality, cost-effective care?	Current models reinforce quantity of services delivered and de-emphasize quality. The goal in any good integrated care model should be ensuring that the individual receives the right services in the right quantity at the right time toward the desired outcomes. A managed fee for service model for Medicare services that begins with the individual and his/her needs supports this model of care delivery, and is key to proper financial alignment in the current system of care integrating existing dual eligible populations. Incentives must be aligned to ensure that each party is responsible for the quality of care and cost control of the entire benefit provided to a consumer.	Add your local recommendations re: incentives for quality care and cost-effectiveness. Add your local perspectives about the impact of misalignments that exist currently. How do you manage the current array of funding sources? What is your administrative capacity to manage an integrated model?	Are there medical or behavioral health services you are NOT getting currently because of financial issues? What are the most important outcomes in terms of health & well-being for individuals eligible for Medicaid & Medicare? (ie: Living in the community? Reduction in obesity? Stable housing? Employment? Fewer days of hospital care?)

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	True beneficiary choice must exist while preventing opportunistic selection/recruitment of enrollees. 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 (LOS). Any incentive system developed must go beyond rewarding service utilization and remunerating excellent care coordination and integration.		
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 business case for integrated care that fails to retain focus on the lives affected by integrated care is a loss for the most vulnerable citizens of Michigan. The primary focus must remain the improvement of overall care and outcomes for the lives affected by the plan to integrate care. Competency development will be a critical factor for any managed care entity or provider. The group(s) chosen to manage the care will not be an expert in the needs of all consumers with a wide variety of health care needs. Concern that the group chosen to manage care will need to account for its administrative costs	Describe what would happen locally to specific "sub-populations" – DD, MI/SUD, those with criminal justice history if we lose the capacity and competency we have built into our existing specialty system.	What are the values of consumers and family members that might be lost in a cost-driven managed care system? What are the most important services that you do not want to lose with any change to the state's plan?

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	off of the top before it provides funding to the other groups who will actually manage the care – this greatly reduces the dollars available to serve consumers. How would a single entity/manager not have a monopoly and effectively hold the state hostage with no real accountability? How will public oversight role be maintained for public funds? Must ensure statutory rules align with care and funding models. Must incentivize performance of all partners in healthcare redesign, or true integration cannot occur. It is essential that the entities responsible for managing this care be required to integrate care at the direct service delivery level (where the care meets the consumer/patient), requiring that: • these entities in each community share clinical records and actively coordinate the care to consumers or • they form health homes for persons with chronic health care needs be supported by the state – allowing consumers to have their care provided and coordinated by their CMH system. 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	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	Give examples of the partnerships being considered or already formed at the local level.	N/A

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services, community supports) will be especially challenging for you to provide? What are your suggestions for addressing these concerns?	be flexible, particularly based on different regional needs and availability of services, this can be accomplished. No one entity can provide all for 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?	Assurance that the state will 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. Service RFPs to the chronically ill Medicaid population would require inclusion of the following: • Eligible categories with detailed demographics • Aggregate healthcare Medicaid and Medicare spends ideally as much detail as possible • Detailed benefits with cpt and HCPC codes • Draft or model contracts • CMS agreed guidance (musts, don'ts, mays) • Financing schemes including payment types, risk management/corridors, shared savings, etc. • Capitation (if applicable) rate cells and amounts • Applicable enrollee rights and protections •Provider payment schemes and options		N/A