

CALL TO ACTION

~a monthly public policy newsletter from the Mental Health Association in Michigan (MHAM)~

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Principles for Project to Integrate Health Care for Dual Enrollees in Medicaid and Medicare

As many of you know, the Snyder administration is working on steps to integrate all health care of individuals dually enrolled in Medicare and Medicaid. The administration hopes to send a plan to the federal government this spring, and it is possible the new project could begin a year from now.

MHAM has major concerns about the potential new program. In part, they stem from the fact that little substantive information of what will happen (and how it will happen) has been made available yet. We are also concerned because we were represented on one of four related “work groups” convened by the Department of Community Health (DCH) in November-December, and those groups were not organized, structured or run in a way to solicit project recommendations of significant quantity and quality. We are further concerned by a new report from the Congressional Budget Office (CBO) that Medicare cost-containment demonstration projects over the past two decades have been largely ineffective in reducing costs. (CBO Issue Brief, January 2012, “Lessons from Medicare’s Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment”)

Thus, our Association has developed principles we want to see in place for the new integrated care project before it can potentially win our confidence. We invite your inspection of these principles as follow:

1. The administration should engage in comprehensive dialogue with the Legislature and health care stakeholders about respective fee-for-service and capitated managed care funding models for the project before any final decision about what is best for Michigan.
2. DCH has stated that all dual-eligible individuals will be automatically enrolled in the project and then have the opportunity to “opt-out.” It would be more consumer-friendly if individuals had the opportunity of choosing whether to “opt-in.” Under either approach, consumer options must be communicated in plain, clear language that is reading-level-appropriate for beneficiaries. Additionally, consumers should be offered independent assistance, if they desire it, in making “opt-out/opt-in” decisions. The scope and structure of this assistance should be determined via related dialogue between the administration, health care stakeholders, and the Legislature. With final respect to project enrollment, if Michigan ultimately goes with the “opt-out” approach, there should be no minimum waiting period that beneficiaries have to endure before exercising the “opt-out.”
3. DCH has stated this project will be phased-in across the state. A phase-in is not necessarily the same as a pilot. The project should only be piloted initially, and perhaps be limited during piloting to some but not all dual-eligible beneficiaries (e.g., starting with those who have multiple health conditions). A comprehensive pilot evaluation should be undertaken before expansion to other parts of the state or other dual-eligible sub-groups. The initial pilot region should be one where there are ample and diverse services for health care (including mental illness, substance abuse, and developmental disability) so there is a safety net for persons who disenroll from or don’t enroll in the project. Additionally, given the prominence of mental disability among dual-eligible enrollees, the pilot evaluation – and any subsequent project evaluations – should have a specific component directly related to mental illness, substance abuse, and developmental disability. All project evaluations should be conducted by entities independent of service managers and providers.

4. Medicaid and Medicare do not presently have the exact same rules, policies, and procedures. If the federal government leaves decisions on how to resolve these to the state, Michigan's governing principle should be what is most advantageous for consumer well-being in areas such as service access (including medications), treatment-and-support outcomes, and quality-of-life.
5. All grievances, service appeals, rights claims, other beneficiary complaints, and dispute resolution processes under this project should be managed by an independent entity that is separate from service management and provision. This opportunity should be competitively bid on a statewide basis; failing that, such responsibility should be placed in a state government program given Type I (autonomous) status. If permitted by the federal government, service appeals (due process) should primarily utilize Medicaid processes, which are generally simpler than those of Medicare. Service appeals must utilize independent clinical consultation before a final determination is rendered.
6. As the new project would have potentially significant implications for Community Mental Health Services Programs (CMHSPs), which perhaps get up to half their reimbursements from dual-eligible service, Michigan should use this as an opportunity to analyze and make any needed changes to statewide CMHSP structure, accountability, and standardization. At the same time, steps must also be in place to assure that those who don't qualify for this project but still need publicly funded safety net assistance will not lose access to their current scope of services.
7. Health care stakeholders, including consumer, family, and advocacy representation, should be formally involved (beyond "work group" participation) in the actual drafting of a project implementation plan to be submitted to the federal government in 2012. This involvement should also extend to development of the state's RFP for the project and the review of RFP submissions. And, if the project is ultimately implemented, it should have an advisory oversight committee that also includes consumer, family and advocacy representation. Such involvement must include some degree of experience with mental disability, given its prominence among dual-eligible enrollees.
8. The legislative and executive branches, in consultation with health care stakeholders, should determine what state law changes (if any) would be needed for this project, and whether any such changes are practical and worthwhile.
9. Entities bidding to become the project manager(s) should have demonstrated experience with or capacity to meet the needs of those with mental illness, developmental disability, and/or substance use disorders. Evidence of capacity in lieu of experience would include organizational bylaws and policies; staff credentials; letters of support and intended involvement from relevant consumers and providers; and current existence of provider networks and consumer-run programs in other health care areas.
10. The bidding process for project management should be open; i.e., responses to the state's RFP should be subject to public inspection.
11. The state's RFP and subsequent contracting should assure that the manager(s) ultimately selected (and organizations sub-contracted with) will: make available for public inspection all financial statements relating to the dual-eligibility program; be subject to the Freedom of Information and Open Meetings Acts regarding the program; and have in place consumer involvement in their governing operations. (RFP scoring should award extra points to a bidder that can demonstrate consumer involvement in proposal development.)
12. The state should assure that savings generated by this project will be re-invested in actual service delivery under the project and/or other publicly funded health care.

13. The state should annually report and publish for each dual-eligibility project manager performance outcomes on uniform, statewide quality improvement criteria. Such criteria should not only include information on existing program enrollees, but also beneficiaries who were enrolled and for whom treatment-and-support services have lost contact.

14. The state should use this undertaking as an opportunity to also explore amelioration of the problem that Medicaid spend-down poses for medical assistance beneficiaries.

Commemorative Dinner for MHAM's 75th Anniversary May 17 in Troy

Please plan on joining us the evening of May 17 at the Troy Marriott for a dinner commemorating MHAM's 75th anniversary. *Detroit News* columnist Laura Berman will host; Mental Health America President Dr. David Shern will be present; there will be live entertainment and awards; and the National Mental Health Bell, cast from chains and shackles actually used with mental health consumers in the past, will be on display.

Tickets are \$125 per person; a table for ten can purchased for \$1,250; and we will soon be disseminating event sponsorship information.

Please contact Assistant Executive Director Bill Tennant (wtmham@aol.com) in our office for more information

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