May 30, 2012

Ms. Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Mail Stop: Room 315-H
Washington, DC 20201

Re: Michigan State Demonstration to Integrate Care for Medicare-Medicaid Enrollees

Dear Ms. Bella:

Thank you for the opportunity to submit comments on Michigan's proposal, Integrated Care for People who are Medicare-Medicaid Eligible (the "Proposal"), submitted to CMS by the Michigan Department of Community Health (DCH). As detailed below, we support the Proposal, but we believe that specific modifications are warranted to protect consumers and to ensure that they receive high quality care as the Proposal moves forward.

As a nonprofit, nonpartisan social welfare organization with a membership and offices in all 50 states, AARP's mission is to help people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. We seek to help older Americans live long and healthy lives. AARP Michigan, representing 1.4 million members, is the state's largest organization representing the needs, views, desires, and hopes of Michigan's 50+ population.

We commend the Administration and the State of Michigan for seeking to identify policies and practices designed to break down barriers between Medicare and Medicaid in order to advance better care for beneficiaries ("dual eligibles"), improve health for vulnerable populations, and lower costs through improvement in care and long-term services and supports (LTSS).

AARP Michigan provided a "key informant" interview to the DCH stakeholder input contractor and submitted written comments on the state's draft proposal (attached). It appears that DCH incorporated many comments and suggestions from stakeholder groups even before issuing the draft proposal for public comment at the state level. We applaud the Proposal's stated goals and principles of seamless access to services, increased communication between all domains of the delivery system, elimination of barriers to home and community based services, and person-centered planning and delivery. There are many other aspects of the Proposal that we fully support, or support in principle but require further development and detail from the state,

and other areas that we feel require more significant changes. Our specific concerns include enrollment, integrated care organization (ICO) and provider network requirements, and oversight and consumer protection to help ensure a stronger and more consumer-focused plan. Most of these issues were raised in our written comments on the state's draft proposal but were not fully addressed in the revision process. Accordingly, we urge CMS to work with the state to incorporate the modifications described below into the demonstration as the Proposal moves forward.

Enrollment Process

While we are pleased that the Proposal describes various supports that will be available to individuals during the enrollment process, including "assurance of adequate face-to-face opportunities with an enrollment counselor" (page 30), there are aspects of the enrollment process that have not been addressed. The Proposal provides the thousands of dual eligibles currently receiving LTSS or other important care only two months prior to enrollment to select an ICO or opt-out of the program. The Proposal sets no minimum number of ICOs for each region, so although beneficiaries "may have the option of choosing between two or more ICOs" (page 12), in some areas there maybe only one ICO.

The passive enrollment system contemplated here, as well as the long wait for another open enrollment period once the demonstration has been implemented, raises the issue of whether there is sufficient time in the initial enrollment period for prospective enrollees to select an ICO or to opt-out. This is particularly important for recipients of LTSS where there is a high prevalence of individuals with multiple chronic conditions and dementia that may make the selection process very difficult. Similarly, the pre-enrollment notice provision should be expanded to include information on ICO options, details on provider networks, and objective quality and credential data on the ICOs and their provider networks. This notice should also list the care providers the prospective enrollee has used during the preceding 12 months, based on Medicaid and Medicare data, and indicate whether each provider is part of each ICO's network. If any current and recent health care providers are not part of an ICO network, the notice should state that the enrollee in that ICO will not be able to use that provider after a certain date. If there is more than one ICO available to the prospective enrollee, the notice should also state which ICO the individual will be assigned to if they do not proactively select an ICO or opt-out.

For those who do not decline initial enrollment, auto-assignment should place the individual with the ICO with the provider network that best matches the prospective enrollee's current and recent providers.

Once the demonstration has been implemented and the beneficiaries are enrolled, beneficiaries will be offered additional open enrollment periods only on an annual basis, in sync with the Medicare Advantage enrollment calendar, meaning that the beneficiaries are effectively "locked-in" for nearly an entire year before they have another opportunity to switch ICOs or opt-out of the program entirely. The most highly valued protection in any consumer situation is the ability of the dissatisfied to take their business elsewhere. This will encourage ICOs to provide good quality care and customer service. At a minimum, consumers should have the right to disenroll

for cause, including proposed reduction of the quantity or quality of care or an involuntary change in the provider of LTSS. In addition, it is our belief that consumers should not be automatically enrolled into an ICO if continuity of care and care providers is not ensured for the full duration of any lock-in period.

A significant disenrollment rate will be an indicator of consumer dissatisfaction that warrants robust oversight. DCH and CMS should guard against any effort by an ICO to encourage disenrollment of consumers who are medically challenging and expensive to care for. DCH should be required to conduct exit interviews of those who disenroll and should require corrective action by ICOs when appropriate (e.g., where disenrollment was the result of network inadequacy, poor customer service, or "lemon dropping.") DCH should also develop incentives for ICOs with high retention rates and should consider disincentives or financial sanctions for those with high disenrollment rates. Data on ICO retention rates should be supplied to prospective enrollees and current enrollees at renewal time.

The responsibility of the ICO and the health care professionals within its network should not end with disenrollment. They should be required to develop and implement a transition plan to ensure continuity of care for those who opt-out. AARP strongly recommends that these transitions be driven by the person-centered principles noted in the Proposal.

ICO and Provider Network Requirements

While the Proposal appropriately emphasizes high quality person-centered care, "innovative reimbursement arrangements with providers that encourage best practices and quality care," and the use of evidence-based practices, it fails to incorporate this approach in the ICO's selection standards for health care providers and facilities. The ability of the state and CMS to monitor and assess the performance of participating health plans on an ongoing basis is essential to determine if care is person-centered, high-quality, and efficient—all key goals of the demonstration. Further, in order to use payment as a means of rewarding high-value care, the metrics must be comprised of performance measures that will permit appropriate oversight as well as offer enrollees meaningful and useful information to inform their choices. AARP Michigan discussed these quality measures in our comment letter previously submitted to the state, and we provide further elaboration on this matter below.

AARP encourages the inclusion of measures that give regulators and consumers a comprehensive picture of performance across the full continuum of care. Core measures should focus on areas of performance that have the greatest potential to improve health and LTSS outcomes and increase the effectiveness and efficiency of care (e.g., areas where there is wide variation, high cost/high frequency services, and evidence of inappropriate care). We encourage the use of direct feedback from individuals and their families through consumer experience surveys and consumer-reported outcomes on functional status, complications, pain, etc.

In general, AARP encourages the inclusion of nationally standardized measures, preferably those that have been endorsed by the National Quality Forum. Whenever applicable, we

recommend aligning measurement requirements with other measure initiatives in the public and private sector.

With respect to quality, setting and assessing quality measures are only the first steps. These measures must be shared with the public at-large so that the performance of plans can be understood and the process is transparent. A number of states have identified in their proposals a variety of ways to build quality awareness and improvement. These include:

- Creating public report cards;
- Using quality outcomes to guide assignment into integrated care entities;
- Establishing special enrollment periods to reward high functioning plans; and
- Requiring contractor adherence to person-centered planning that is evaluated, publicly reported, and rewarded from the first year forward.

AARP believes that this demonstration should include at least these specific measures to ensure quality, with contract performance language to protect enrollees and promote quality performance. Plans should also be required to meet quality targets or face the risk of suspension or denial of new enrollment. There should be a protocol for a full range of corrective actions and established quality triggers that signal the need for corrective action to be taken. Additionally, the state should set forth an explicit back-up option in the event a plan is no longer operating in a region, whether voluntarily or involuntarily.

AARP strongly encourages the inclusion of a requirement that ICOs obtain National Committee for Quality Assurance (NCQA) accreditation as a contract requirement. Currently, nine states and the District of Columbia require NCQA accreditation for Medicaid plans. We believe that establishing this baseline for quality will emphasize the value and importance of strong quality measures within the ICO and within the Medicaid program as a whole.

Further, ICOs should be required to provide current and prospective enrollees with information on the objective quality measures considered, minimum standard selection criteria applied in constructing their networks, and data on comparative quality ratings for each network's providers when such ratings are available. If placement with a low-rated provider is necessary, ICOs should be required to notify consumers when placement with a higher rated provider becomes available. Part of the coordination process should include periodic review of consumers already receiving care, especially in the LTSS system, to determine if higher quality placement options are available.

Dually eligible consumers, families, friends and other consumer allies should also be provided contact information for the State Long Term Care Ombudsman Program for additional information on Michigan nursing homes and other types of licensed facilities.

Oversight and Consumer Protection

The Proposal provides a good system of retrospective monitoring for quality indicators, but it does not include a system of targeted, proactive monitoring. The Proposal mentions the need for protections against underutilization and inappropriate denials, and for access to qualified advocates, but provides no additional details on these matters. In addition, the Proposal provides that the state will require ICOs and Prepaid Inpatient Health Plans (PIHP) to include participants on their governance boards, and that the state will also require its contractors to include people who are dually eligible on their governance or advisory bodies. AARP strongly supports such requirements.

For this dual eligible population and their often complex medical needs in the largely uncharted waters of an integrated Medicare and Medicaid managed care system, the interests of consumers, CMS and DCH warrant a prompt, proactive system of oversight. It will be advantageous for all to rapidly identify and address problem areas and to uncover promising, replicable practices that result in improved quality and cost containment.

Given in particular the prevalence of developmental disabilities and behavioral health needs within this population and the inherent incentive of capitated payment systems to limit per enrollee expenditures, the demonstration should include stronger consumer protections to help ensure that Michigan, CMS and taxpayers receive good value for their dollars and that the duals receive the coverage and quality care and support they deserve.

Michigan currently operates an effective prior authorization system to prevent inappropriate utilization of medical services under Medicaid. A similar system should be developed to prevent inappropriate underutilization of care under this Proposal. It would be appropriate to require DCH to prospectively examine ICO-proposed changes in a plan of care that would result in significantly reduced benefits or lower ICO expenditures, and, when appropriate, to reject such changes if they are not in the best interests of the consumer as indicated in his or her person-centered plan. From this review, changes in care that maintain or improve patient care, outcomes and quality of life could be distinguished from those that have adverse impacts.

Dually eligible consumers will also need ready access to assistance with advocacy. The demonstration should include an adequately funded, independent system that provides no-cost advocacy services to ensure that enrollees receive access to the full range of benefits and rights afforded by both Medicare and Medicaid. Advocacy in both programs will be complicated by the significant differences, as well as overlaps, in benefits; by disparate appeals processes with differing coverage standards set by federal and state law, regulation and policy; by different administrative and judicial forums, procedures and timetables; and by different governing state and federal case law. Ensuring that benefits and rights are maintained and protected under both programs will require professional staff with sophisticated knowledge, legal expertise and experience. To provide the necessary oversight and consumer protection as outlined above, AARP strongly recommends that the demonstration include a fully transparent and formal complaint mechanism. Such a mechanism should confidentially accept consumer-identified allegations against parties including providers, payers and administrators, ensure a timely process, and provide opportunities for appeal.

In addition, AARP urges that the demonstration include creation of an independent oversight committee or task force to monitor the demonstration with the ability to ensure that needed modifications and adjustments can be made during the demonstration timeframe. Legislative oversight committees are active in Indiana, and were a valuable vehicle for advancing Tennessee's long-term care transition to managed care plans.

Reinvestment of Savings

Once the demonstration achieves its goal of improved quality and care coordination for dual eligibles, as well as cost savings for the state, AARP strongly believes that the state should commit to using these savings as an opportunity to improve access to and quality of home and community-based care on a larger scale. This commitment should be incorporated into the demonstration as the Proposal moves forward by specific language that directs that any savings achieved through the success of the demonstration be reinvested to improve the network and quality of services and supports available to Michigan's dual eligible population.

Timing

Under the Proposal, the demonstration program would be implemented in quarterly phases beginning July 2013 with statewide implementation by July 2014. In response to stakeholder input, a significant number of other states pursuing demonstration programs have delayed starting their programs to 2014. Given the enormity of the task at hand, and as we review starting dates for other state proposals, we believe that a slower pace for rollout and implementation in Michigan would be a prudent way to increase the chances for the success of this demonstration.

Conclusion

AARP remains committed to working collaboratively with the State of Michigan and CMS on creating and implementing a high quality dual eligible financial alignment demonstration that will improve the delivery of care, health, functional outcomes and quality of life for the dual eligible population. These comments focus on the critical issues we believe should be addressed as the Proposal moves forward. Thank you again for the opportunity to comment on this very important proposal. If you have questions, please feel free to contact Jacqueline Morrison, AARP Michigan State Director, at (517) 267-8918 or JMorrison@aarp.org.

Sincerely,

Jacqueline Morrison
AARP Michigan State Director

Elaine M. Ryan
AARP Vice President
State Advocacy and Strategy Integration

Attachment