National Association of Psychiatric Health Systems

900 17th Street, NW, Suite 420
Washington, DC 20006-2507
Phone: 202-393-6700
Fax: 202-783-6041
naphs@naphs.org
www.naphs.org

COMMENTS ON DUAL ELIGIBLE DEMONSTRATIONS

The Importance of Adequately Addressing Behavioral Health Issues in Demonstration Design and Evaluation

"DUAL ELIGIBLES" ARE A POPULATION WITH SIGNIFICANT HEALTHCARE NEEDS.
More than nine million Americans are enrolled in both the Medicare and Medicaid programs, and they are often referred to as "dual eligibles." Two-thirds of dual-eligible beneficiaries are low-income and elderly, and one-third are younger than 65 and are disabled.

Mental disorders disproportionately affect the dual-eligible population.
Dual eligibles are more likely to have cognitive impairment and mental disorders than non-dual eligibles. In addition, more than half of dual eligibles who are under the age of 65 and eligible due to a disability have mental or cognitive impairments.

According to the Medicare Payment Advisory Commission (MedPAC), 56% of all Medicare inpatient psychiatric facility patients are dually eligible. Some 79% of these patients are under age 65, and 40% are under age 45. The typical diagnosis is psychosis, and many of these individuals also have medical comorbidities.

People dually eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees) are among the sickest, most vulnerable individuals covered by these programs. They often have complex, chronic illnesses, as evidenced by the fact that half are in fair or poor health, more than twice the rate of others on Medicare.[1] They also have very low incomes (55% have annual incomes below $10,000 vs. 6% for the rest of the Medicare population).[2] The multiple medical and behavioral health needs of this population provide an opportunity to improve the overall integration and coordination of care.

On January 25, 2012, the Medicare-Medicaid Coordination Office (MMCO) issued a document entitled *Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans* (herein referred to as Capitated Demonstration Guidance). The Capitated Demonstration Guidance provides information on the models that will be tested through the Center for Medicare and Medicaid Innovation (CMMI) authority granted in the *Affordable Care Act* (ACA). These models are designed to "test a new payment and service delivery model to reduce program expenditures under Medicare and Medicaid, while enhancing the quality of care furnished to Medicare-Medicaid enrollees."[3]

ALL DEMONSTRATIONS NEED TO ADDRESS FOUR KEY PATIENT-PROTECTION AREAS.
As a national association representing more than 700 behavioral healthcare facilities across the country, the National Association of Psychiatric Health Systems has outlined broad patient-protection themes that we believe all state demonstration proposals should include:

1) **ENROLLMENT.** A key tenet of the Medicare program is that beneficiaries voluntarily enroll in the program and have choice in their providers, in whether or not they enroll in the Medicare

[1] Kaiser Commission on Medicaid Fact: Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries. May 2011.
[2] Ibid.
[3] U.S. Department of Health and Human Services. "Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstrations Plans." January 25, 2012.

Advantage Program, and in enrollment in accountable care organizations (ACOs). There is no sound public policy reason why these key tenets should not be embedded in the dual-eligible demonstrations. Therefore, **we strongly believe that all the dual-eligible demonstrations should have a voluntary opt-in enrollment and not an opt-out enrollment.** The major objectives of states' dual-eligible demonstrations are to provide a broader set of benefits, better integration and coordination of care, and improved outcomes at a reduced costs compared to the current Medicare and Medicaid programs. These features should be the basis by which Medicare and Medicaid enrollees decide to (or decide not to) join these new programs. This is especially important because these demonstrations will combine the Medicare and Medicaid programs for dual eligibles, which would result in a new program for Medicare beneficiaries who happen to be also enrolled in the Medicaid program. Although we understand that national Medicare protections will be part of these demonstrations to some degree, the fact is that **a subset of Medicare beneficiaries (dual eligibles) will no longer have the same national Medicare program that is guaranteed to all other Medicare beneficiaries.** That is why choice and voluntary enrollment are so critical to the success of these demonstration programs.

2) **NETWORK ADEQUACY.** As stated earlier, individuals who are dually eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees) are among the sickest, most vulnerable individuals covered by these programs. It will be critical to maintain a person-centered focus when dealing with a population that often has complex, chronic illnesses that require seeing many physicians, including specialists of all types. These individuals have had longstanding relationships with their doctors, hospitals, and other clinicians.

   These longstanding relationships take on a particularly important role for individuals with behavioral disorders. The personal relationship with psychiatrists and clinical teams is an integral part of the therapeutic recovery process. For those with chronic mental and addictive disorders, the relationship built on trust and personal connections to "my doctor," "my hospital," or "my community mental health center" can be critical in encouraging an individual to stay in treatment and in encouraging overall compliance with treatment recommendations.

   For example, what happens to an individual with schizophrenia as of the first day of implementation when he or she no longer has access to a physician seen for many years who is outside a negotiated network? While the enrollee may be eligible for a comprehensive assessment and treatment plan starting that very day, former providers who choose not to participate in the demonstrations do not have to accept the patient. It will take significant time to identify new providers for potentially thousands of individuals and time for each individual to establish ties with a new provider.

   It is very important that these demonstrations protect these therapeutic relationships by establishing patient-protection safeguards. **We believe these demonstrations should have an out-of-network option for this population.** Under the accountable care organization (ACO) framework within the ACA, enrollees would be able to go outside the ACO. Shouldn't this same option be available to this most vulnerable population?

   There also needs to be special attention placed on reimbursement for essential behavioral health care, including inpatient psychiatric care, because the behavioral health system has shrunk over the last decades. We cannot afford to underpay behavioral healthcare providers when the demand for services continues to exceed the supply. Under current law, Medicare is the primary payer for inpatient psychiatric care for dual eligibles, and Medicare tends to be a better payer than Medicaid. Therefore, maintaining Medicare payment levels will be critical to ensuring continued access to this life-saving service for the dual-eligible population. It has been well-documented that the behavioral health system is very fragile. For example, according to the National Alliance on Mental Illness[4] (NAMI), "in a time of shrinking resources, states face difficult choices about the extent to which resources are targeted for inpatient treatment or community based services. Although NAMI supports the desirability of community based services whenever

[4] National Alliance on Mental Illness (NAMI). *State Mental Health Cuts: The Continuing Crisis: A Report by the National Alliance on Mental Illness.* November 2011. See www.nami.org.

possible, sufficient resources do not currently exist in many communities to address the needs of those individuals who require higher intensity services. Elimination of inpatient treatment capacity is ill advised without appropriate alternatives in place." We must do everything possible to prevent further contraction of the system.

3) **FINANCE AND PAYMENT.** The Capitated Demonstration Guidance states that "the rate [paid to demonstration plans] will provide upfront savings to both CMS and the state. Absent savings for both payers, the demonstration will not go forward." CMS is requiring savings off the top, but determining how much will be saved by these projects before the project even begins will be difficult if not impossible based on the lack of data. The dual-eligible population is a vulnerable group of individuals and, if the spending projections for these projects are lower than the actual cost of care, then access to critical services could be severely restricted. This could have devastating consequences to this very needy population. **CMS should ensure that payments not fall below the cost of care.**

   Savings very well may not be seen in the first year. It will take time for savings to be seen – particularly in states where major infrastructure change is required to implement a demonstration. Will there be federal funding for start-up costs and infrastructure costs (for example, for behavioral health providers – now excluded from health information technology incentives – to purchase, train, and implement electronic health records)?

   Also, developing a rate-setting methodology for this population that ensures that the capitation rate is adequate to meet the multiple medical and behavioral needs of this population is going to be very difficult to construct. Setting a capitation rate accurately requires risk adjusters that will be especially important for the dual-eligible group. Although there has been work done on risk adjusters for medical complexity based on diagnoses, in the behavioral arena research has concluded over the past decades that diagnosis is a poor indicator to predict the cost of care for people with mental illnesses.[5] For this reason, **CMS should require risk-mitigation strategies to be put in place** to ensure that this vulnerable population continues to have access to critical medical and behavioral services.

4) **TIMELINE / ADMINISTRATION**. The Capitation Demonstration Guidance lays out an ambitious timeline for implementing state demonstrations by the end of the year 2012. These demonstrations have the potential to improve coordination and outcomes for dual eligibles, but they are working in areas that have not been tested and remain unproven. Each state will need time once its proposal is approved to contract with managed care entities, develop networks, establish capitation rates, develop education materials, enroll beneficiaries, and build the overall infrastructure to carry out the new combined Medicare and Medicaid program for dual eligibles. Getting this right is more important than getting it done by the end of the year.

   We suggest that these demonstrations move ahead cautiously, and not until all the features are firmly in place.

   To avoid unintended consequences, **CMS should suggest that states being approved for demonstrations conduct pilot demonstrations in limited geographic areas (instead of immediate state-wide initiatives)** because of the complexity of this population and the lack of full knowledge on the best ways to proceed.

   When evaluating demonstration proposals for approval, **CMS should approve sufficient numbers of both types of demonstrations** suggested in the January 2012 Capitated Demonstration Guidance (both the capitated model and the managed fee-for-service model). It will be important to ensure that *both* approaches are fully vetted to truly determine in the long run what works and what doesn't work.

   CMS should also evaluate the capacity of each state to actually implement the major

[5] Schumacher DN, et al. "Prospective Payment for Psychiatry – Feasibility and Impact." *New England Journal of Medicine* [315:1331-1336]. November 20, 1986.

changes that will be required by the demonstrations. Some states will be more advanced in the types of changes required, and it will be important to ensure that access to essential treatment is not compromised for such a vulnerable population during the learning-curve period as demonstrations are developed and implemented.

CURRENT BARRIERS TO ACCESS TO BEHAVIORAL HEALTH SERVICES WILL ULTIMATELY NEED TO BE ADDRESSED.

There is a long history of discrimination against individuals with mental and addictive disorders. The good news is that significant progress is being made to address artificial barriers that have prevented challenges to individuals' recovery and limited access to essential behavioral health services. For example, the historic *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* has laid the foundation for removing arbitrary insurance limits on behavioral health insurance benefits that had not applied to general health care coverage.

The parity law also applies to Medicaid managed care programs.

Each state demonstration – and any future dual-eligible initiatives – should explicitly address how these hard-won parity protections will be maintained and applied for the dual-eligible population.

As part of the process to improve access, coordination, and integration of services for dual eligibles with behavioral disorders, a number of lingering statutory barriers to behavioral health services will ultimately need to be dealt with – including the Medicare 190-day lifetime limit, the Institutions for Mental Disease (IMD) exclusion that excludes adult Medicaid patients (ages 21-64) from psychiatric hospital coverage, and Medicare's limited outpatient coverage.

EXPLICIT EVALUATION OF BEHAVIORAL HEALTH ISSUES IS ESSENTIAL IN ALL DEMONSTRATIONS.

We recognize that routine evaluation of the approved demonstrations will be an integral part of the overall initiative. Because dual eligibles face significant behavioral health issues and lingering barriers to access, **we encourage CMS to explicitly evaluate the successes (or failures) of the demonstrations to meet the needs of this population**. In addition to those with primary behavioral disorders, people with primary physical disorders (e.g., multiple sclerosis) also have behavioral health needs. The success of demonstrations in serving both of these subsets of the dual-eligible population needs to be evaluated.

FOR MORE INFORMATION

The National Association of Psychiatric Health Systems is committed to being a resource to CMS, states, and health plans on the population that our members have devoted their lives to serving – individuals with serious psychiatric and addictive disorders. We would be happy to meet with policymakers, to connect you with behavioral health experts, and to arrange for tours of existing programs to help provide a more in-depth picture of the special needs of this population.

NAPHS Contacts:

Mark Covall, president and CEO, 202/393-6700, ext. 100, mark@naphs.org

Kathleen McCann, R.N., Ph.D., director of quality and regulatory affairs, 202/393-6700, ext. 102, kathleen@naphs.org

Nancy Trenti, J.D., director of congressional affairs, 202/393-6700, ext. 103, nancy@naphs.org