National Association of Psychiatric Health Systems

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Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS–5507–NC: Request for Information: "Medicare and Medicaid Programs; Opportunities for Alignment Under Medicaid and Medicare" (42 CFR Chapter IV)

Dear Dr. Berwick,

As an association representing behavioral healthcare provider organizations and professionals, the National Association of Psychiatric Health Systems (NAPHS) appreciates the opportunity to respond to your Request for Information titled "Medicare and Medicaid Programs; Opportunities for Alignment Under Medicaid and Medicare" as published in the May 16, 2011, *Federal Register*. We are happy to provide our suggestions on how to improve the alignment between Medicare and Medicaid for individuals enrolled in both programs – particularly those who are experiencing mental and addictive disorders.

ABOUT NAPHS

Founded in 1933, NAPHS advocates for behavioral health and represents provider systems that are committed to the delivery of responsive, accountable, and clinically effective prevention, treatment, and care for children, adolescents, adults, and older adults with mental and substance use disorders. Our members are behavioral healthcare provider organizations, including more than 700 psychiatric hospitals, addiction treatment facilities, general hospital psychiatric and addiction treatment units, residential treatment centers, youth services organizations, outpatient networks, and other providers of care. Our members deliver all levels of care, including inpatient treatment, residential treatment, partial hospitalization, and outpatient services.

As behavioral healthcare providers, we care for millions of individuals with serious and persistent mental illnesses and serious addictive disorders, many of whom are enrolled in both the Medicare and Medicaid programs. For example, according to MedPAC, 56% of all Medicare inpatient psychiatric facility patients are dual eligibles (that is, enrolled in both the Medicare and Medicaid programs). Some 79% of these patients are under 65 years old, and 40% are under 45 years old. The typical diagnosis is psychosis, and many of these patients also have medical comorbidities.

How can the Medicare and Medicaid programs better ensure dual-eligible individuals are provided full access to the program benefits?

What is most critical for dually eligible individuals with serious mental and/or addictive disorders is to have available a coordinated and integrated set of services – from acute inpatient to outpatient services, community-based care, case management, and support services. The Medicare and Medicaid programs include this range of services, but currently there is little coordination between the Medicare and Medicaid benefit structures. The Medicare behavioral health benefits are more focused on short-term, acute, medical-related services, while the Medicaid benefits focus on the longer-term community-based rehabilitative and support type services. Currently, it is very difficult for the beneficiaries and the providers to navigate the two programs and benefit structures. Access to the full range of services needed by this population should be seamless to the beneficiaries.

Other barriers to accessing critical services for dually eligible individuals with mental and addictive disorders are discriminatory provisions that apply to inpatient psychiatric care. Under the Medicare program, coverage for beneficiaries receiving treatment in a psychiatric hospital is limited to 190 days during their lifetime. There is no other lifetime limit for other types of inpatient care. In addition, the Medicaid program prohibits federal matching payments for Medicaid recipients between the ages of 21-64 receiving care in a psychiatric hospital (the so-called Institutions for Mental Disease, or IMD, exclusion). These two provisions substantially reduce access to critical inpatient psychiatric care for many Medicare and Medicaid enrollees. It also affects the continuity of care as well. Under the *Affordable Care Act*, Section 2707, the Medicaid Emergency Psychiatric Demonstration would allow states to cover these patients in a psychiatric hospital when they are in crisis, and the federal government would pay their share of the costs based on the federal matching rate. We would ask CMS to support the elimination of the 190-day lifetime limit as well as move forward with the demonstration.

What steps can CMS take to simplify the processes for dual eligible individuals to access the items and services guaranteed under the Medicare and Medicaid programs?

As mentioned earlier, the Medicare and Medicaid programs operate independently, and it is difficult for the beneficiary to navigate the two systems. Access to the services this population needs would be enhanced by helping these beneficiaries navigate the system with the assistance of a care manager. We believe this is best accomplished by providing a care manager through the national Medicare program. This would help to ensure that the role and scope of the care-manager function is consistent nationally – and seamless to the beneficiary.

Because Medicare and Medicaid are separate and distinct programs, we do not believe it would be wise to fully integrate the two programs for the dual-eligible population. We are concerned that efforts to integrate the two programs could lead to inconsistency across states and confusion for beneficiaries. We are aware that Massachusetts, for example, has asked for comments on a preliminary plan to bring together the Medicare and Medicaid programs, thereby allowing the state to operate a new, combined program for individuals with serious and persistent mental illnesses (SPMI). If this occurs, Medicare would no longer be a national program for this SPMI population. Our concern is that this type of state-by-state action potentially disenfranchises the nine million individuals who are eligible for Medicare and who would no longer be getting the same national program. They would, potentially, have 50 different state plans, while all other Medicare beneficiaries have access to a single, national plan that is clearly understood and nationally communicated.

The Medicare program is the primary payer when individuals are dually eligible. It is a national program that provides a basic set of benefits (and patient protections) for all Medicare beneficiaries. The program has national quality standards for providers as well as clear

guidelines on issues such as medical necessity and payment issues. It would not be fair to treat dually eligible individuals differently than all other Medicare beneficiaries.

On the other hand, the Medicaid program is a federal-state program that provides much flexibility to the states to implement the program. States can have great variability in the way the program operates, in the way the state establishes coverage and eligibility criteria, and in the way the state reimburses providers.

The goals and purposes of Medicaid and Medicare are very different, and we need to build on the strengths of each. What is most important is that the beneficiaries eligible for both programs receive access to the most appropriate services and in the most cost-effective manner.

Improving the coordination and the integration of Medicaid and Medicare benefits will go a long way to saving money and improving access to the critical services needed by Medicare and Medicaid enrollees.

SUMMARY
In summary, we recommend that CMS:

- **Improve coordination of the Medicare and Medicaid programs by providing a Medicare-enhanced program for dually-eligible individuals that offers a care coordinator to this population.** By embedding the care coordinator within the national Medicare program, you will provide a standard, seamless process for dually eligible beneficiaries to receive coordinated care – no matter where they live. Communication and oversight of the care coordination benefit can be done simply through the national Medicare plan.

- **Ensure that Medicare – as the primary payer – remains a national program fully available to *all* Medicare beneficiaries, including those with serious and persistent mental illnesses.** Coordination of Medicare/Medicaid services should not be ceded to state oversight. This would potentially lead to widely divergent state programs that may not have the full patient protections of the national Medicare program. State Medicaid programs can have great variability in the way the program operates, establishes coverage and eligibility criteria, and reimburses providers.

- **Work to end discriminatory practices in Medicare/Medicaid** that create significant barriers to treatment for individuals with serious and persistent mental illnesses by:
    - Moving forward with the Medicaid Emergency Psychiatric Demonstration
    - Eliminating the 190-day lifetime limit in Medicare

CONCLUSION
We look forward to continuing to work with CMS and the Department of Health and Human Services toward improved coordination and care for individuals dually eligible for Medicare and Medicaid.

Sincerely,

Mark Covall
President/CEO