

Mental Health Liaison Group

June 6, 2012

Ms. Melanie Bella
Director of the Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Bella:

As organizations concerned about dual eligibles living with mental illness and their providers, we are writing to share our views on the current process of state demonstration proposals to integrate care for beneficiaries that are concurrently eligible for both Medicare and Medicaid.

As you know, two-thirds of dual eligible beneficiaries are low-income and elderly, and one-third are non-elderly people with disabilities. 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. Due to their complicated health conditions, dual eligibles living with serious mental illness incur a high rate of expenditures for both Medicare and Medicaid when compared to their enrollment.

As states move forward in seeking to implement demonstration programs under Section 2602 of the Affordable Care Act (ACA), we would urge your office to scrutinize these proposals to ensure critical protections for dually eligible individuals with mental illness. In our view, a number of the state proposals that have been submitted to your office or posted for public comment raise a number of concerns. Among these are:

- 1) Erosion of Medicare protections – Some states have proposed to substitute their state Medicaid formularies for Part D plan formularies meeting Medicare’s extensive requirements. Among these Part D protections that are critical for beneficiaries with mental illness is the requirement for formularies to include “all or substantially” all of the drugs in the so-called six protected classes (including antipsychotics, antidepressants and anticonvulsants). At least two states have already indicated that they are seeking to have these Part D protections waived, in contrast to the guidance your office issued last year. Demonstrations could lead to loss of access to providers in some states if Medicare beneficiaries who are treated by psychologists are shifted into Medicaid but the state does not include psychological services.
- 2) Passive enrollment, lock-in periods and continuity of care – A majority of the state proposals are planning to passively enroll beneficiaries into a managed care plan, giving beneficiaries no other plan in their area from which to choose. Removing dual eligibles from

their current health and prescription drug plans could cause disruption, particularly if they have established provider relationships or their new drug plan has a different formulary. Moreover, even though an opt-out exists, it would require this group to navigate a complex process to opt out. If they do not affirmatively opt-out, they will be automatically assigned to a managed care plan. This can be particularly problematic for dual eligibles.

3) Access to care – As you know, state budgets are already severely constrained. It is essential that the focus remain on achieving savings through better coordinated care and not be centered upon techniques that historically have been used to restrain spending such as cuts to providers, or limits on the number of prescriptions filled per month. Access to existing public safety net providers, including specialty behavioral health providers such as CMHCs, are critical for dual eligibles with mental illness and it is essential that they be included in provider networks established by integrated care plans.

4) Quality measures – As CMS moves forward to develop a set of core quality measures for these state demonstrations, we urge that measures for behavioral health be included. Earlier this year, the National Committee for Quality Assurance developed a new set of draft measures for Medicaid for serious mental illness that included not only continuity of care for antipsychotic medications and follow-up after inpatient psychiatric care, but also important measures related to access to primary care for persons with mental illness including diabetes and cardiovascular screening. We urge you to include these in your core measures to which all states must adhere.

5) Ongoing Oversight – More than two dozen states have said that they intend to develop managed care programs for the dual eligible population. Given the number of plans and their diversity, CMS will face a complex task in monitoring them for quality. Moreover, many state Medicaid programs do not have extensive experience in working with the needs of dual eligibles as the majority of their service population has been children and families. Also, CMS should work with the states to limit the size of the demonstrations so that they can be fully evaluated before they go statewide. And all issues regarding the sharing of essential information between the states and CMS should be resolved before plan implementation.

We support efforts to better integrate and coordinate care for dual eligibles living with serious mental illness. As you move forward toward helping states achieve this shared goal, we urge you to address the issues raised above in order to avoid disruption in coverage and treatment for vulnerable dual eligibles.

Sincerely,

American Academy of Child and Adolescent Psychiatry
American Art Therapy Association
American Association for Geriatric Psychiatry
American Association for Psychoanalysis in Clinical Social Work

American Association for Psychosocial Rehabilitation
American Association on Health and Disability *
American Foundation for Suicide Prevention
American Group Psychotherapy Association
American Mental Health Counselors Association
American Nurses Association
American Occupational Therapy Association
American Orthopsychiatric Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychoanalytic Association
American Psychological Association
American Psychotherapy Association
Anxiety and Depression Association of America
Association for the Advancement of Psychology
Association for Ambulatory Behavioral Healthcare
Center for Clinical Social Work
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Association
Clinical Social Work Guild 49, OPEIU
Corporation for Supportive Housing *
Depression and Bipolar Support Alliance
Eating Disorders Coalition for Research, Policy & Action
The Jewish Federations for North America
Mental Health America
National Alliance on Mental Illness
National Association for Children's Behavioral Health
National Association for Rural Mental Health
National Association of Anorexia Nervosa and Associated Disorders -- ANAD
National Association of County Behavioral Health & Developmental Disability Directors
National Association of Mental Health Planning & Advisory Councils
National Association of Psychiatric Health Systems
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Community Behavioral Health Care
National Council on Problem Gambling
National Disability Rights Network
Schizophrenia and Related Disorders Alliance of America *
Tourette Syndrome Association
United States Psychiatric Rehabilitation Association