



National Alliance on Mental Illness

January 13, 2023

The Honorable Bill Cassidy, M.D.
The Honorable Thomas Carper
The Honorable Tim Scott
The Honorable Mark Warner
The Honorable John Cornyn
The Honorable Robert Menendez
United States Senate
Washington, DC 20510

Submitted electronically to dualeligibles@cassidy.senate.gov

Dear Senators:

NAMI, the National Alliance on Mental Illness, thanks you for your bipartisan collaboration as members of the Finance Committee on opportunities to improve care for individuals jointly enrolled in Medicare and Medicaid (dual eligibles). We appreciate your thoughtful approach in gathering further information and are pleased to offer the following responses to questions raised in your [open letter](#).

NAMI is the nation's largest grassroots mental health organization and is dedicated to building better lives for people affected by mental illness. Throughout our 40-year history, NAMI has fought for dignity, fairness, and equity for people with mental health conditions. We have a unique perspective on the needs of this complex population because so many dual eligibles have mental health conditions and because so many of the people with the most serious mental illnesses are dual eligibles. We hope you find these responses helpful as you consider legislative solutions.

Background on Mental Illness and Dual Eligibles

People who are dually eligible for Medicare and Medicaid are typically individuals with the most significant health and financial concerns. These individuals are three times more likely to live with a mental health diagnosis compared with Medicare-only beneficiaries,ⁱ and carry high rates of comorbidities of chronic health conditions.ⁱⁱ Dual beneficiaries make up more than half of all Medicare inpatient psychiatric facility patients,ⁱⁱⁱ and among those between the ages of 18 and 64 who received behavioral health care services in the past year, dual beneficiaries have significantly greater yearly health care expenditures than adults not dually eligible.^{iv}

Fragmentation and lack of service delivery coordination between Medicare and Medicaid presents additional challenges for dual eligibles. Medicare and Medicaid cover different behavioral health services, and federal mental health parity rules do not apply to dually eligible beneficiaries when their Medicare benefits are provided by Medicaid MCOs.^v In addition, physical and behavioral health care are often provided in different systems, which can reduce care access and worsen health outcomes and

diminish care coordination for other services.^{vi} In the best of circumstances, this situation can be daunting, and for dually eligible individuals and their families who are dealing with mental illness or other chronic conditions, these challenges can be overwhelming.

Response to Questions

Question #2: What are the shortcomings of the current system of care for dual eligibles?

Given that Medicare and Medicaid are separate programs with distinct rules for eligibility, benefits, and payment, this structure can result in unnecessary cost-shifting between the two, duplication of services, and limited incentives to improve quality, curb the total cost of care, and improve the beneficiary experience. Dual eligible individuals must navigate different, often conflicting, processes related to eligibility and enrollment and grievances and appeals, separate provider networks, and conflicting coverage policies (e.g., DME and home health), which can result in both fragmented care experiences and poor health outcomes. The current system requires people with the most significant health needs to navigate one of the most complex systems of coverage.

Question #4: After reviewing these models, would you recommend building upon current systems in place (e.g. improving aligned enrollment and/or coordination of care between two separate Medicare and Medicaid plans) or starting from scratch with a new, unified system that effectively assigns each beneficiary to a primary payor based on their needs?

There are ample opportunities to better integrate care for dual eligible individuals in a manner that improves the quality and experience of care for beneficiaries as well reduces administrative burdens felt by beneficiaries. Some of these opportunities exist under current law and regulation, such as states' use of State Medicaid Agency Contracts (SMACs) and actions through State Plan Amendments or Section 1115 demonstration waivers. Several State Medicaid programs are actively making decisions and developing options to better integrate care for dual eligible individuals in their respective states.^{vii} At the same time, there are actionable proposals for targeted policy changes that would further integrate care for dual eligible individuals which merit your consideration.

As you know, the Medicaid and CHIP Payment and Access Commission (MACPAC) recommended Congress provide states with resources to assist in integrated care strategies,^{viii} and also require states to have an integrated care plan.^{ix} In response to those recommendations, several Senators have worked to translate MACPAC's recommendations into legislative proposals. Specifically, NAMI calls your attention to the following:

- S.4264 *Advancing Integration in Medicare and Medicaid (AIM) Act of 2022*, requires states to develop a concrete strategy for integrating and coordinating Medicare and Medicaid coverage for full-benefit dual eligible individuals.^x
- S.4273 *Supporting States in Integrating Care Act of 2022*, provides states with resources to develop integrated programs and requires states to describe their approach to integration, as well as provides a time-limited, targeted federal resources to support specific administrative activities to advance those integration strategies.^{xi}
- Section 2 of S.3630 *Supporting Care for Dual Eligibles Act*, would provide resources to state Medicaid programs through the creation of a Dual Eligible Quality Care Fund.^{xii}

Each of these policies would be a positive step forward for reducing the fragmentation of care dual eligible individuals experience, as well as supporting state capacity to ensure every dual eligible individual in their state has access to an integrated program specific to that state's needs and priorities.

Question #5: If you believe a new unified system is necessary, what are key improvements we should prioritize? What would such a system look like? Please provide details on financing, administration (e.g. federal government vs. state government), benefit design elements, on whether such a system should be voluntary or mandatory for states, and consumer choice and patient safety protections.

NAMI strongly supports the bipartisan legislation, S.4635 *The Comprehensive Care for Dual Eligible Individuals Act*,^{xiii} introduced by Senators Brown and Portman, which would create a fully integrated option for states for full benefit dual eligible individuals. The legislation would, for the first time, provide beneficiaries with an option that fully combines benefits offered through administering entities, provides robust beneficiary protections, and streamlines financing into one program.

The legislation would create a new title of the Social Security Act, Title XXII, that would provide states an option to implement an All-Inclusive, Integrated Medicare-Medicaid (AIM) Program.^{xiv} States operating an AIM Program would be subject to strong federal oversight to ensure they have sufficient support in providing care and protecting beneficiaries. Below, we have included further information on key design elements of the AIM Program for your consideration.

- **Administration:** The Secretary of HHS, acting through the Federal Coordinated Health Care Office, would oversee the program, and states that opt to participate would be required to undergo a rigorous federal readiness review as a condition of launch, standards they must maintain as a condition of participation. The AIM Program will be operated under a minimum set of federal standards, including access to care, quality of care, beneficiary protections, marketing and enrollment, grievances and appeals, and procurement, among others. States would also have access to funding to assist with the staff, IT, planning and evaluation, program launch, and monitoring. States would in turn contract with administering entities (plans or other entities bearing two-sided risk) in order to administer benefits to dual eligible individuals participating in the state's AIM Program.
- **Financing:** The bill would modernize financing by incentivizing states and administering entities they contract with to effectively manage care for full-benefit dual eligible individuals participating in the AIM Program. The AIM Program combines Medicare expenditures (Parts A, B, and D), the federal share of Medicaid expenditures, and state share of Medicaid expenditures (including for Part D) into a single, integrated funding stream sufficient to cover the cost of care for all individuals enrolled in the program. The funds would no longer be identified as Medicare or Medicaid; they would be AIM Program federal/state contributions. The financing structure provides states an opportunity to receive and reinvest savings gained through quality individual care and outcomes.
- **Benefits:** The AIM Program includes comprehensive care for dual eligible individuals through a structure providing for medical, long-term care, behavioral, and social needs. Each individual participating would receive an assessment to inform their unique plan of care, and the core

package of benefits includes necessary services provided under Medicare Parts A, B, and D, the state's Medicaid program, and other flexible services as approved by HHS. Further, there are not benefit or services carveouts permitted, except for a limited period of time at the Secretary's discretion to ease state transition into the AIM Program.

- **Beneficiary Choice and Protections:** The legislation includes important protections for beneficiaries, maintains beneficiary choice, and ensures strong federal oversight. In a state that takes up the AIM Program, individuals would have the option to participate in AIM, PACE (if available), or Traditional Medicare and the state's Medicaid Program. In addition to continuity of care provisions, other protections include the use of an independent enrollment broker, a dedicated Ombudsman Program, a beneficiary advisory council and consumer advisory board, and the use of grievances and appeals processes currently applicable in Medicare Advantage, Part D, and Medicaid managed care.

Question #6: How can disruption be minimized for current beneficiaries should any changes to the current system of coverage be made?

NAMI believes that any legislative changes need to ensure beneficiary protections to minimize disruptions in changing from the current system of coverage. One easy way for disruptions to be minimized, particularly if large scale changes are contemplated, is to allow beneficiaries to opt-in to any new system rather than a mandate. This is contemplated in the AIM legislation (see answer #5 above). Another option would be establishing a transition time for beneficiaries to adjust to any new system. In addition to minimizing disruption, NAMI encourages you to think about additional supports that could provide beneficiaries support and guidance, such as navigators/ombudsman or dedicated resources for 1-800-MEDICARE to be able to address questions from dual eligibles.

Question #8: What is the best way to ensure that this system takes into account the diversity of the dually eligible population and is sufficiently targeted to ensure improved outcomes across each sub-group of beneficiaries? How should these sub-groups be defined and how should the data be disaggregated? Please provide examples of methodology and the evidence-based rationale for each example.

NAMI appreciates that you recognize the importance of accounting for the diversity of the dually eligible population and ensuring improved outcomes across each sub-group of beneficiaries. NAMI believes it is critical to collect demographic data that is consistent and comprehensive across systems. The HHS Implementation Guidance On Data Collection Standards For Race, Ethnicity, Sex, Primary Language, And Disability Status^{xv} provides uniform data standards for collection, analysis, and reporting of health disparities data. We suggest that these standards provide a basis for looking at health disparities across sub-groups and should be consistently and fully used so that data can be accurate, granular, and disaggregated.

Conclusion

We are grateful for the work of Congress in recent years in efforts to advance the integration of Medicare and Medicaid services for dual-eligible individuals by actively encouraging states to adopt more fully integrated programs. NAMI appreciates the opportunity to comment on this important RFI. We would be happy to serve as a resource on improving quality of care and experience for this

population. If you would like to discuss these comments, please contact Jennifer Snow, National Director of Government Relations & Policy at jsnow@nami.org.

Sincerely,



Chief Advocacy Officer

ⁱ <https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308dualeligibles2.pdf#page=7>

ⁱⁱ https://www.integratedcareresourcecenter.com/sites/default/files/4.15.20%20WWM%20BH%20Slide%20Deck_for%20508%20Review.pdf

ⁱⁱⁱ <http://www.chcs.org/resource/extending-lessons-from-a-medicare-pilot-to-improve-care-for-medicare-and-dual-eligible-beneficiaries/>

^{iv} <https://www.ncbi.nlm.nih.gov/books/NBK384683/>

^v <https://www.kff.org/report-section/behavioral-health-parity-and-medicare-issue-brief/>

^{vi} <https://www.chcs.org/resource/coordinating-physical-and-behavioral-health-services-for-dually-eligible-members-with-serious-mental-illness/>

^{vii} MACPAC, June 2021, Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans, <https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-6-Improving-Integration-for-Dually-Eligible-Beneficiaries-Strategies-for-State-Contracts-with-Dual-Eligible-Special.pdf>.

^{viii} MACPAC, June 2021 Report to Congress, *Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans*, <https://www.macpac.gov/publication/improving-integration-for-dually-eligible-beneficiaries-strategies-for-state-contracts-with-dual-eligible-special-needs-plans/>.

^{ix} MACPAC, October 2021, *Raising the Bar and Supporting State Efforts to Integrate Care for Dually Eligible Beneficiaries*, <https://www.macpac.gov/publication/raising-the-bar-and-supporting-state-efforts-to-integrate-care-for-dually-eligible-beneficiaries/>.

^x S. 4264, Advancing Integration in Medicare and Medicaid (AIM) Act of 2022.

^{xi} S. 4273, The Supporting States in Integrating Care Act of 2022.

^{xii} S. 3630, Supporting Care for Dual Eligibles Act.

^{xiii} S. 4635, The Comprehensive Care for Dual Eligible Individuals Act of 2022.

^{xiv} More information on the AIM Program is available on the Coalition's website: <https://info.leavittpartners.com/dual-eligible-coalition>.