ACAP
Association for Community Affiliated Plans

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Howard A. Kahn, Chairman | Margaret A. Murray, Chief Executive Officer

September 30, 2013

The Honorable Max Baucus
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Baucus and Senator Hatch,

The Association for Community Affiliated Plans (ACAP) appreciates this opportunity to comment on your August 1, 2013 solicitation for input regarding methods to improve the mental health system in the United States.

ACAP is an association of 58 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 24 states. ACAP member plans provide coverage to over 10 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Advantage Special Needs Plans for dual eligibles. Nationwide, ACAP members serve approximately one in three individuals enrolled in Medicaid managed care plans. ACAP's mission is to represent and strengthen its member plans as they work with providers and caregivers in their communities to improve the health and well-being of vulnerable populations in a cost-effective manner. Our plans are full partners with the federal government and the states in meeting the coverage needs of our nation's low-income health care consumers.

This letter draws on the experiences of our Safety Net Health Plans, highlighting their successes and challenges in delivering integrated mental and behavioral health care to vulnerable populations served by Medicaid, CHIP, and Medicare Advantage Special Needs Plans. While the diversity of measures our plans are taking to address this issue is too extensive to include in this letter, we touch on a number of promising areas: improving access through telehealth and telemedicine; ensuring affordable, stable housing; integrating care for dual eligibles; and appropriately addressing substance use disorders.

Similarly, there are significant challenges to providing integrated care for beneficiaries with mental and behavioral health needs, but this letter will focus on one in particular – providing comprehensive and continuous care for beneficiaries who are subject to "churning", that is, being dis-enrolled and re-enrolled in Medicaid or CHIP due to bureaucratic or administrative problems, or small, and often short-term, changes in income which often result in long periods of no health care coverage.

Senate Finance Committee Questions

I. What administrative and legislative barriers prevent Medicare and Medicaid recipients from obtaining the mental and behavioral health care they need?

Medicaid and CHIP provide coverage to almost 75 million individuals annually. Unfortunately, they suffer from a significant problem known as "churning", where people who are eligible and enrolled are dis-enrolled and re-enrolled in the program, often owing to bureaucratic and paperwork problems, as well as small income changes. Churning leaves many uninsured and often in poorer health status than had their health coverage continued. Additionally, churn creates costly, unnecessary administrative burdens for providers and health plans participating in Medicaid and CHIP, as well as states that must spend time and money to re-enroll individuals who, while they lost coverage, never lost eligibility for Medicaid or CHIP.

Recent research shows churn and its impacts to be widespread. The George Washington University's 2013 analysis of continuity in the Medicaid program shows the average adult to be enrolled for just 8½ months of the year; children are enrolled, on average, for 10 months.[1] A November 2012 report from the Government Accountability Office found that beneficiaries with partial year health insurance were more likely to report difficulties obtaining needed care, whether covered by Medicaid or private health insurance. In calendar years 2008 and 2009, the percentage of Medicaid beneficiaries enrolled for a partial year who reported difficulties obtaining needed medical care was almost double that of full-year Medicaid beneficiaries.[2]

While discontinuous coverage, which results in discontinuous care, affects all beneficiaries, it has a particularly significant impact on those with mental or behavioral health needs. A study of individuals with schizophrenia found that those with continuous Medicaid coverage were significantly less likely to be hospitalized in an inpatient psychiatric facility, and have shorter stays when they were hospitalized, than individuals with discontinuous coverage.[3] Likewise, individuals with depression who were dis-enrolled from Medicaid had much higher psychiatric care costs upon re-enrolling in Medicaid than did those who had been continuously enrolled for the duration of the study period.[4] Because comprehensive and integrated mental and

[1] Leighton Ku and Erika Steinmetz, George Washington University. "Bridging the Gap: Continuity and Quality of Coverage in Medicaid." September 2013 http://communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%20%209-10-13.pdf

[2] Government Accountability Office. "States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance." 2012 http://www.gao.gov/assets/650/649788.pdf

[3] Harman, J.S., Manning, W.G., Lurie, N., Christianson, J.B. "Association between interruptions in Medicaid coverage and use of inpatient psychiatric services." Psychiatr Serv. 2003 Jul;54 (7):999-1005. http://ps.psychiatryonline.org/data/Journals/PSS/4357/999.pdf

[4] Harman, J,S,, Hall, A.G., Zhang, J. Changes in health care use and costs after a break in Medicaid coverage among persons with depression. *Psychiatr Serv*. 2007 Jan;58(1):49-54. http://ps.psychiatryonline.org/data/Journals/PSS/3790/07ps49.pdf

behavioral health care is so dependent upon established relationships with providers and medication management, patients need continuous Medicaid or CHIP coverage.

Establishing 12-month continuous enrollment in Medicaid and CHIP would protect vulnerable beneficiaries and ensure continuity of care. Further discussion of establishing 12-month continuous enrollment in Medicaid and CHIP follows as the response to Question III.

II. What are the key policies that have led to improved outcomes for beneficiaries in programs that have tried integrated care models?

Many ACAP-member Safety Net Health Plans have implemented programs to provide integrated, comprehensive care for those with mental and behavioral health needs. These innovative programs take different forms, but all go beyond traditional health interventions and have great potential to help achieve the triple aim of reducing costs, improving quality of care, and improving outcomes for all populations, especially those with mental illnesses and behavioral health needs.

Telemedicine and Telehealth Technologies

A number of payers and providers are turning to telehealth and telemedicine to expand access not only to rural patients but increasingly to urban ones. While telemedicine is used in numerous specialties, it shows great potential for mental health. At a recent Alliance for Health Reform briefing on telehealth and medicine, the presenters pointed to mental and behavioral health providers as those who are embracing the opportunities provided by telehealth most readily.[5] Tele-mental health has the potential to more easily transcend the social barriers and stigma that discourage patients from seeking treatment, and extend its reach to environments including schools and jails. Several ACAP-member plans use telemedicine in a number of areas to counteract provider shortages and improve access to care for their members and are providing or exploring tele-mental health. Driscoll Children's Health Plan, a Safety Net Health Plan in Texas, has partnered with the University of Texas Medical Branch and the Behavioral Health Services of Nueces County to provide and evaluate pediatric tele-psychiatry for its members who live in areas with severe shortages of pediatric psychiatrists. Other plans are looking to add tele-mental health to their existing telehealth programs. Telemedicine and telehealth are promising tools to increase access to mental health providers for Medicaid and Medicare beneficiaries, both rural and urban.

[5] Alliance for Health Reform Briefing. *Telehealth and Telemedicine: Adopting New Tools of the Trade.* September 13, 2013. Replay and materials available at: http://www.allhealth.org/briefing_detail.asp?bi=306

Affordable, Stable Housing Support

Lack of access to affordable, stable housing can be a barrier to improving health outcomes among vulnerable patients. Access to stable housing is a particularly salient issue when discussing mental health, as those with mental or behavioral care needs make up a disproportionate share of the homeless population. Securing stable housing can be used as a "clinical intervention" to improve care and reduce costs. For institutionalized patients with severe and persistent mental illness, lack of stable housing can be the primary barrier to reentry to the community. Additionally, a significant proportion of the highest-cost patients suffer from severe mental illness, and many meet the HUD definition of homelessness. Addressing their need for stable housing has large effects – reducing inpatient hospitalizations and emergency department use, and lowering costs overall, even accounting for the cost of housing. The University of Pittsburgh Medical Center (UPMC *for You*) works with local supportive housing authorities to secure affordable housing for its members; results have been positive, and several other ACAP-member plans are exploring the option.

Duals Integration

Another promising area for further integrating care is the CMS Financial Alignment Duals Demonstration Projects authorized under the ACA. Persons with severe mental illnesses are vastly over-presented among dually-eligible beneficiaries – and the duals demonstrations provide a unique opportunity to address their complex medical needs in the context of coordinated and integrated service delivery systems.[6] We recognize that, if integrated programs for duals populations were easy, more states would have done so. As such, the efforts being undertaken to ensure a robust stakeholder process, clear and consistent beneficiary protections, appropriate payment levels and carefully implemented operational details are very important. Over one third of ACAP-member plans serve dual eligibles in Special Needs Plans or Medicare Advantage plans, and others are ready to serve duals in these demonstrations in newly-configured Medicare-Medicaid Plans. We appreciate the continued support of Congress for the efforts to promote a successful demonstration program and your support on reauthorizing D-SNPs for a substantial period to allow stability for duals whose states choose the D-SNP model for integration.

One area that disadvantages duals with mental health needs is the current HCC (hierarchical condition category) model for risk adjustment which is used in both the Duals Demonstrations and in the D-SNPs. It undervalues mental health diagnoses (partly because original Medicare does not pay for many mental health services) and does not recognize the intensity of serving people with multiple chronic conditions and co-occurring mental health and substance abuse needs. In addition, D-SNPs with a focus on persons with mental health have been challenged by the Stars measurement system, which does not recognize that stabilization of the primary mental health diagnosis should be a primary quality metric. As you know, a lower score in the Stars

[6] Families USA. *The Managed Fee-for-Service Option To Integrate Care for Dual Eligibles: A Guide for State Advocates*. Rep. May 2013.

system allows less money to go to the plan, which in turn provides fewer resources to support supplemental benefits to the dual member.

Appropriately Addressing Substance Use Disorders (SUD)

Prescription medication substance use disorders and mental or behavioral health needs frequently co-occur, and prescription drug abuse increases the risk of other illicit drug abuse. SUD is a complex issue that must be addressed from multiple angles. ACAP-member Safety Net Health Plans, including CareOregon and UPMC *for You*, have taken a variety of approaches, including developing enhanced opioid management programs, to address the issue. Currently, seventeen other ACAP-member plans are participating in a collaborative on SUD, which will provide education and support to plans through structured networking opportunities in order to identify and implement evidenced-based best practices for substance abuse identification and treatment. Plans are focusing on particularly vulnerable populations, including pregnant women and dual eligibles, when designing their programs, as well as those who will gain coverage through the Medicaid expansion. Strengthening tools to address substance use disorders is a related, and necessary, action to fulfill the mental and behavioral health needs of patients.

III. How can Medicare and Medicaid be cost-effectively reformed to improve access to and quality of care for people with mental and behavioral health needs?

As discussed previously, interruptions in Medicaid and CHIP coverage have significant adverse effects on access to care for beneficiaries. Establishing 12-month continuous enrollment for all Medicaid and CHIP beneficiaries will prevent these interruptions and improve the quality of care that can be delivered. Additionally, 12-month continuous enrollment will reduce administrative burdens and costs associated with re-enrolling individuals who lost coverage despite never losing eligibility. Bipartisan legislation has already been introduced to do this in the House (H.R. 1698) and similar legislation is expected to be introduced shortly in the Senate. Establishing 12-month continuous enrollment in Medicaid and CHIP would protect beneficiaries, especially those with mental illness, by providing them coverage they can count on.

Additionally, working to integrate care and improve access in novel ways beyond standard medical interventions, including telehealth, stable housing, integrating care for dual eligibles, and addressing substance use disorders improves the integration and coordination of care for individuals with mental illnesses while reducing costs.

ACAP thanks you for the opportunity to provide input on the Committee's bipartisan efforts to improve access to and quality of care for people with mental and behavioral health care needs and would be happy to further discuss any of the above with you. Please do not hesitate to contact me at mmurray@communityplans.net or 202-204-7509 if we can be of any further assistance.

Sincerely,

Margaret A. Murray
CEO