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Dear Senators Crapo and Wyden,

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work within the health care sector is driven by a recognition that the system both costs too much and fails to adequately care for the people it seeks to serve. Our work spans a wide array of issues including prescription drug prices, health care prices, provider payment incentives, and complex care.

Arnold Ventures is committed to improving access and care for vulnerable populations. Our work on the Complex Care initiative centers on the needs of the population eligible for Medicare and Medicaid services. Behavioral health needs make up a critical piece of this work. We thank the Finance Committee for its focus on individuals with mental health and substance use disorders and for initiating this request for input. We hope to learn alongside the Committee and that our work to improve health care through philanthropic support of research and policy can complement your efforts on this important topic.

Our contribution focuses on your questions related to increasing integration, coordination, and access to care.

The prevalence of behavioral health conditions among people who are dually eligible for Medicare and Medicaid makes a focus on this population important for achieving care improvements. Individuals with serious mental illness diagnoses including major depression, bipolar, and schizophrenia—arguably, a group of individuals for whom care coordination is especially important—may qualify as disabled, which may entitle them to health insurance coverage through both Medicaid and Medicare, a status referred to as “dual-eligible”.¹ Anxiety disorders, bipolar disorders, depression, Schizophrenia, and other psychotic disorders are particularly common among the dual-eligible population, and this group is three times as likely as the Medicare-only population to have a mental health diagnosis.² Furthermore, dual-eligible individuals are more likely than the average Medicare beneficiary to be low-income, have multiple chronic conditions, face food and housing insecurity, and identify as racial or ethnic

¹ Substance Abuse and Mental Health Services Administration. [Medicaid Handbook: Interface with Behavioral Health Services](#). 2013.

² Congressional Budget Office. [Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies](#). June 2013.



minorities—realities that only exacerbate their care complexity.^{3,4} Despite accounting for a disproportionate share of Medicare and Medicaid spending—\$300 billion annually—dual-eligible individuals experience poor health outcomes.

For this group, Medicare acts as the primary insurer, covering acute care services (e.g., inpatient stays, emergency room visits, primary care visits, etc.), while Medicaid may cover some combination of Medicare co-pays and cost-sharing and additional benefits not covered by Medicare (e.g., long-term services and supports and certain therapies).⁵

These two programs were not designed to work seamlessly together and often do not. Navigating both programs at once means facing complicated and disparate enrollment systems, experiencing difficulty finding providers who accept both forms of insurance, and most dangerously, being at risk of gaps in care or care errors due to lack of coordination between providers who should be working as a team. A dual-eligible beneficiary named Owen Taeger in Pittsburgh, PA wrote of this coordination challenge, “While some people have trouble finding a therapist who accepts Medicaid, I've found it even more difficult to find a therapist who accepts Medicare. Because I'm dual-eligible, it's crucial that any therapist I see accepts Medicare...If not, they're off the table for me.”^{6, 7}

There is a solution that can make the system simpler to navigate and lead to better health outcomes: integration between Medicare and Medicaid. Several models exist that pool Medicare and Medicaid dollars and give at-risk entities responsibility for the full range of dual-eligible individuals' health outcomes. These models provide a valuable platform for addressing the behavioral health needs of the dual-eligible population. Aligning Medicare and Medicaid benefits in a single entity improves care management and allows for more individualized care plans, both of which are critical for addressing behavioral health needs. Coordination between the two programs allows for a clearer picture of the patient's entire clinical profile as well as their social risk factors. Integrated models are also designed for populations with complex needs, including a range of behavioral health needs, making them better equipped to more rapidly and effectively support dual-eligible individuals with mental health and substance use disorder diagnoses.

These claims have been tested in Massachusetts as part of the Financial Alignment Initiative, a demonstration for integrating Medicare and Medicaid under the authority of the Center for

³ Association for Community Affiliated Plans. [Addressing Social Determinants of Health Through Dual-Eligible Special Needs Plans](#). October 2020.

⁴ The Medicare Payment Advisory Commission. [July 2020 Data Book, Section 4: Dual-Eligible Beneficiaries](#). July 17, 2020.

⁵ Substance Abuse and Mental Health Services Administration. [Medicaid Handbook: Interface with Behavioral Health Services](#). 2013.

⁶ Owen Taeger. [Finding a therapist who takes Medicare feels like a full-time job. I've been looking for a year](#). 2021.

⁷ Juliette Rihl. [Medicaid Ensures low-income residents have mental health care. But are enough Pittsburgh therapists approved to take it?](#) June 3, 2021.



Medicare and Medicaid Integration. Massachusetts' demonstration enrolls only the non-elderly dual-eligible population, an estimated 70 percent of whom have behavioral health service needs. The program offers one membership card, one point of care coordination, one provider network and expanded Medicaid state plan benefits, as well as diversionary behavioral health and community support services. People enrolled in this demonstration generally appreciated the model—the plans operating this model had higher overall satisfaction rates than Medicare Advantage plans.⁸ To learn more about the potential benefits of integrated models for populations with behavioral health needs, we are funding Urban Institute to conduct an evaluation of the impact of this demonstration on utilization and spending, using both Medicare and Medicaid claims data.

While Congress has historically supported integrated models, many dual-eligible individuals lack access to fully integrated options—only one in ten dual-eligible individuals is enrolled in an integrated coverage model today.⁹ Further, models vary in the degree of integration offered and in the range of services they include. In line with the Committee's objective to improve access to behavioral health services, Congress should make meaningfully integrated models more widely available, support enrollment in these models, and ensure that the mix of services offered addresses dual-eligible individuals' wide array of needs, including their behavioral health needs.

There are myriad policy approaches that could accomplish these goals, but we recommend that Congress do so by prioritizing a permanent model that is intended to integrate Medicare and Medicaid and can be broadly scaled—the Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP). Some specific approaches for achieving change are outlined below:

Increase Access to Integrated Models and Degree of Integration: States currently act as the gatekeeper for the availability of integrated models, including by playing an important role in defining the degree to which the Medicare and Medicaid programs are aligned. Congress could use various carrots and sticks to encourage or require states to make these models available.¹⁰ For example, Congress could allow states to share in any Medicare savings generated through an integrated model. Congress could also provide additional flexibility to the Centers for Medicare and Medicaid Services (CMS) to ensure that the agency has adequate authority to amend certain administrative Medicare Advantage requirements so that the agency can coordinate with state Medicaid agencies when making an integrated model available. This can ensure that the two programs

⁸ RTI International. [Financial Alignment Initiative: Massachusetts One Care Preliminary Fourth Evaluation Report](#). Summer 2021.

⁹ Centers for Medicare and Medicaid Services. [Fact Sheet: People Dually Eligible for Medicare and Medicaid March 2020](#). Accessed June 1, 2021.

¹⁰ Policy Center. [A Pathway to Full Integration of Care for Medicare-Medicaid Beneficiaries](#). July 2020.



appear as one to enrollees—for example, offering one membership card, one provider directory, and one set of marketing materials.

Increase Enrollment in Integrated Models: Congress could automatically enroll dual-eligible individuals into integrated models with an option to opt out. In order to be most effective, this policy must be coupled with adequate education and an approach to enrollment that connects the individual with the coverage option that reflects their medical history and provider preferences. Evidence also suggests that funding states to offer neutral enrollment supports or even establishing a national navigation program for integrated options alone would also increase enrollment in these models. Additionally, Congress could make individuals' coverage options clearer by ensuring that Dual-Eligible Special Needs Plans (D-SNPs) are aligned. To do this, Congress could limit the available D-SNP options to only those where the D-SNP either has a Medicaid contract to serve the dual-eligible population or no such Medicaid coverage option exists (i.e., Medicaid FFS). Simultaneously, Congress could crack down on the myriad of Medicare Advantage plans that target dual-eligible individuals without offering any degree of alignment with Medicaid, or so-called D-SNP-look alikes.

Improve the Mix of Services: Congress could improve the mix of services offered through integrated models by empowering CMS to extend plan flexibilities, including clarifying their ability to address social risk and other factors related to behavioral health. Congress could also require that all integrated models be held accountable for outcomes that span both the Medicare and Medicaid program that are most important to the individuals that these models seek to serve.

These options represent just some of the many mechanisms to promote integration and improve the provision of behavioral health care. We welcome a more detailed conversation about the potential paths forward. Please contact Arielle Mir at amir@arnoldventures.org with any questions. Thank you again for your important work and your consideration of the above.

Arielle Mir