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CMS NEW DIRECTIONS for the INNOVATION CENTER

COMMENTS on FOCUS AREA #7: MENTAL & BEHAVIORAL HEALTH MODELS

The undersigned behavioral health advocacy organizations, NHMH – No Health without Mental Health, the National Association of County Behavioral Health and Development Disability Directors, the National Association for Rural Mental Health, and the American Association on Health and Disability, support advancement of ACOs to achieve the Triple Aim.

That said, multiple systems of care which are moving toward PCMHs, ACOs and prevention of 30 day readmissions to hospital, are realizing that, as they do so, many of the high-cost patients in their health systems have psychiatric-medical co-morbidity, and that their health systems will have to integrate behavioral health in order to be successful.

Our comments and recommendations follow on focus area #7 Mental & Behavioral Health Models:

(A)Medical-Behavioral Integration Part of Triple Aim:

As regards healthcare delivery, the ACA is helping to push the U.S. health care system in the right direction towards achieving the Triple Aim, but it will be a long, slow, arduous process as vested interests remain which will oppose these changes toward efficiency, higher quality care and improved access.

An important first step is to educate health systems, and medical and behavioral health (BH) clinicians, and administrators, on value-added medical-behavioral integration of care delivery.

A further step would be to create in-sourced medical payment procedures for patients. In other words, BH care becomes a part of medical benefits, and paid from medical dollars. There would no longer be separate payers for medical and behavioral health services.

A future goal will be to consolidate medical and BH provider networks and payment procedures (i.e. sunset managed behavioral health organizations).

That will allow for the process of step-by-step integration of value-added medical-BH services to unfold, in inpatient, outpatient, and post acute care settings. Included in this care delivery innovation should be integrated case management for complex, co-morbid, multiple chronic care patients.

(B)Current Models of Medical-BH Integration Show Value, Yet Limited in Number:

Evidence-based value-added *models* of integrated care *are limited in number*. However, the ones that are out there, clearly show value. More effective models need to be developed, tested and disseminated with incentives and supports to allow for wide-scale implementation.

Current models with evidence of value in the outpatient setting are: TEAMcare, collaborative care, targeted BH interventions for focused conditions, and medical-BH prevention.

TEAMcare and collaborative care models for depression, anxiety and substance use disorder, as compared to usual care or enhanced referral, have demonstrated better clinical improvement for up to 4 yrs in adults. There is however a high variability in the deployment of this multi-faceted, challenging innovation. *But when implemented with close fidelity to the multiple essential components, there is improved medical and BH outcomes and high patient and provider satisfaction*. The collaborative care model has been shown to reduce annual cost $450 in first 12 months, $900 at 24 months, and $3,350 at 48 months.

The counseling or BH consultant model shows improved satisfaction among patients and providers, but no long-term clinical improvement or cost reduction.

(C) Integrated Care Shows Value in Variety of Settings:

Current models in the inpatient setting are: proactive psychiatric consultation; delirium prevention and treatment; routine "sitter" review; and complexity intervention units (CIUs). All demonstrate health improving and cost saving capabilities.

Current models in the emergency room setting include: medical and BH services routine in medical ER, and sunsetting of psychiatric ERs, leading to a 75% reduction in BH admissions, shortening of medical ER stays, and 25% reduction in costs.

Current models in the post-acute care setting: nursing home settings with support for medical and BH coverage.

An important conclusion from the accumulating data on value from adult integrated medical-BH care management, is that the *necessary components of integrated care* are: targeting of high-need, high-cost patients; longitudinal care management assistance; and a treat-to-target, measurement-based, multi-disciplinary medical-BH approach.

The outcomes on the above are fewer hospital and SNF home days; fewer ER visits/admissions; higher home health and hospice costs; and equal mortality (Edes et al: *JAGS,* 62: 1954-61, 2014), but lower total health costs, and annual savings of $1,300-$8,500 per patient (12%-17%) and that implementation cost can be economically feasible, especially when enough patients are managed this way.

(D) Three Options Exist for Behavioral Health Care Delivery:

In delivering behavioral health services, we are faced with three options:

(1)**Status Quo**: With resulting health outcomes of poor BH access, and non-existent or delayed medical illness improvement due to untreated BH co-morbidity, with doubling to quadrupling of total health care costs* in co-morbid patients, e.g. 1 to 1.5 day long ALOS, >$6M for sitters, 30% to 70% higher 30-day readmissions, and $22M+ in extra service delivery costs for hospital and delivery systems admitting >100,000 patients/year.

(2)**Buy Traditional BH**: With resulting BH outcomes equivalent to Status Quo; small impact on medical sector health outcomes; and doubling to quadrupling total health, especially medical, costs.

(3**)Build BH into Medical**: With improved health outcomes due to BH access in medical setting, medical-BH provider communication/coordination/consultation, patient satisfaction, and increased inpatient and outpatient care coordination with better medical and BH outcomes, and lower total health care costs now coming from medical benefits, e.g. gap closure on ALOS, sitter use, 30-day readmissions, and cost/net margin for general medical patients with BH co-morbidity.

(E)Recommendations :

Firstly, that, given the above present situation and accumulating data, CMS direct the Innovation Center to set a firm new prioritized direction towards accelerating the development of additional effective integrated care models in the medical setting (and v.v. – see para 3 below).

Secondly, that CMMI seek to support and incentivize integrated care models that will work in the real world of clinical practice. This includes finding innovative, step-by-step approaches for behavioral health integration into small and medium-size practices, e.g. 5 clinicians or less, which constitute well over 50% of U.S. primary care sites.

Need are phased-in approaches that will allow for the staged adoption of the key components of outpatient integration for example found in TEAMcare and collaborative care. Without support and incentives, small and medium size medical practices will be unable to achieve behavioral health integration in their resource-

constrained clinics. Supports and incentives must also allow for sustaining those integrated care services.

Thirdly, while under the above recommended care delivery, many BH services will likely be possible to be delivered in the medical setting, at the same time, there has to be recognition that patients with serious and persistent mental illness will still have specialty BH services available to them, and their medical care augmented in an expanded medical-BH setting when needed.

Fourthly, we encourage HHS and CMS to convene the state and local intellectual/developmental disability administrators, and state mental health administrators, to address integrated services and supports for persons with co-occurring intellectual and development disability and mental illness. State ID/D systems have co-occurrence data and examples of integrated delivery.

CMS can continue to make a major difference in assisting practices across the U.S. to achieve behavioral health integration if it makes that goal one of its highest strategic priorities.

Respectfully submitted,

NHMH – No Health without Mental Health

NACBHDD – The National Assn of County Behavioral Health & Developmental Disability Directors

NARMH - The National Association for Rural Mental Health

AAHD - American Association on Health and Disability

* (See Milliman Behavioral Integration Report, April 2014).