No Health without Mental Health
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and the

American Association on Health & Disability

February 26, 2019

The Honorable Lamar Alexander, Chair
U.S. Senate Committee on Health, Education, Labor & Pensions
428 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Patty Murray, Ranking Member
U.S. Senate Committee on Health, Education, Labor & Pensions
428 Dirksen Senate Office Building
Washington, D.C. 20510

Re: **Recommendations to Address Rising U.S. Healthcare Costs**

Dear Chairman Alexander,

One of the most important, doable health policy reforms that can address quality effective health care delivery to Americans, AND reduce healthcare costs, is to make federal health policy change that accelerates bi-directional medical-behavioral health integrated care.

I. Accelerate *Bi-Directional* Integrated Medical-Behavioral Care Services:

Bi-directional integrated care we define to mean bringing effective behavioral health services into medical and general healthcare settings, such as primary care, and bringing effective medical and health services and supports care in the specialty behavioral health settings, such as community mental health centers and inpatient psychiatric settings.

Creating, testing, implementing and disseminating integrated care in both directions is essential. Many behavioral advocacy groups will advocate for medical services into specialty behavioral health which is needed and important. Yet, that encompasses only 1-3 million Americans with serious mental disorders who receive care, services, and supports in specialty behavioral settings. Also critically important is the 40-50 million Americans with untreated mental disorders seen only in the medical sector of our health system. Their untreated mental conditions impede and prevent improvement and recovery of their *medical* conditions, which in turn cause skyrocketing medical expenditures, 80% of which are for medical services, e.g. ER costs, hospital admissions, re-admissions, and lost productivity at work.

Moreover, research in developing behavioral interventions in medical settings is 20 years ahead of research for medical into behavioral settings, while studies also show that lessons learned in both directions can beneficial to patients in both sectors (Druss). Integrated care in both settings is essential.

Bi-directional integrated care delivery is needed as much for younger Americans as it is for the Medicare beneficiary population, and all health services and supports recipients. An increasing number of youth are suffering from depression and anxiety (see February 2019 Pew Research Center report, attached). Depression is the #1 health benefit cost for employers (National Business Group on Health). For older adults, multiple chronic medical conditions are common and 20-30% of those conditions are accompanied by behavioral issues such as depression and anxiety (CMS). Also, reports over the past decade document that 35-40% of persons receiving services and supports through intellectual disability/developmental disability state agencies have a co-occurring mental illness.

II. Cost Savings of Integrating Medical and Behavioral Health Services:

According to the respected national actuarial firm Milliman, an estimated $38 billion to $68 billion can potentially be saved annually - across all payers, Commercial, Medicare and Medicaid - through effective integration of medical and behavioral services. (see attached Milliman 2014 and 2018 reports).

To put those nationally projected savings into context, the total national expenditures for MH/SU services is projected to be about $240 billion in 2017. These projected healthcare cost savings represent 16% to 28% of all spending for MH/SU services. This is a significant costs *savings opportunity* that will likely continue to increase as medical costs increase, more integrated programs become more effective, and more people in the U.S. develop co-morbid medical and behavioral disorders.

III. Urgent Need to Develop More Integrated Care Delivery Models:

NHMH urges the Senate HELP Committee to act to require NIH/NIMH to direct a larger portion of its federal research funding towards healthcare services delivery innovations, specifically in the area of developing new models of integrated care, and/or supporting existing models with proven effectiveness and cost savings. In past decades, Congress required NIMH to devote at least 10% of its budget to health care delivery services research, particularly testing new models in the organization and financing of services to individuals with mental illness.

Currently, the U.S. has a mere 3 models of integrated care, in various stages of unattainability or ineffectiveness: basic co-location; enhanced /supported co-location; and evidence-based collaborative care. Basic co-location simply places behavioral professionals in the vicinity of the medical practitioners. Although this care delivery is better than merely referring patients with behavioral issues to a BH facility, where 50% of referred patients never show up, and 50% that do, never return ….. it very often fails to engage patients, mainly because the medical/general healthcare and behavioral sides of the practice remain apart, isolated. Many clinicians thus do not consider simple co-location of behavioral and primary care services to be effective integration.

Enhanced co-location has not only BH professionals at the primary care site, but they are supported by a toolkit to aid their efforts to achieve full integration. The toolkit includes extensive self-paced online

curricula for physicians, behavioral health consultants, nurses, office staff, managers, and patient partners. Additionally, there is a highly-structured workbook to guide a local facilitator through group redesign process with the clinic, remote coaching and an online community for support and co-learning. To date, there is no evidence this model changes patient outcomes.

The third model is evidence-based collaborative care developed at the University of Washington and has 80+ randomized control trials (RCTs) comprising a very robust scientific base. It works, it brings down care costs and improves medical and behavioral symptoms. However … it is beyond the reach of the overwhelming majority of U.S. medical practices: collaborative care is a complex, multi-component clinical practice change that affects the *entire* workflow of the clinic and *all* the clinic staff. Studies show that clinics and providers rarely understand the true scale of disruption to usual practice that will be required to effectively implement collaborative care, no matter how much they are told that this is a large-scale systematic change to their entire clinic operations. That said, collaborative care represents the current gold standard in integrated med/psych care models, and we believe the country should aim towards having it eventually deployed throughout the U.S. primary care system.

With the potential cost savings, and improved health outcomes of Americans at stake, the U.S. must recognize that there are potentially additional models of integrated care delivery out there to help primary and specialty medical practices improve behavioral outcomes and lower total healthcare costs. Research funding, testing, demos, spread projects, will all be needed. The CMS Center for Medicare and Medicaid Innovation, CMMI, is beginning this work, but it needs to be fast-tracked, given the very high numbers of untreated mental illness in the country. The fact is that effective treatments and integrated clinical approaches are available. Primary and specialty medical physicians will need to partner with psychiatrists and other behavioral health professionals to support the delivery of effective integrated care models primarily in the medical setting.

IV. **Incentives to Develop a Workforce Able To Deliver Integrated Care:**

Given the above and projected medical and behavioral workforce shortages, the federal government must accelerate a review of graduate medical education and training to begin to develop a workforce able to perform integrated care. Currently there is an inadequate emphasis on the need for care integration in medical/nursing curricula. There are few curricula in medical school or nursing that teach methods associated with medical and behavioral integration. There are even fewer inter-disciplinary training environments. There is also a lack of behavioral health training for advanced practitioners.

Currently more than 50% of Americans patients receive routine care from the primary care workforce, but most primary care physicians and advanced practitioners receive little to no training in behavioral health. Further, while advanced practitioners are becoming critical to the provision of primary care, scope-of-practice conflicts continue among physicians, nurses and other behavioral providers.

It is time for the Congress to carefully consider workforce policy options that will accelerate development of a health workforce able to deliver effective integrated care such as:

-- integrated care training behavioral health providers;

-- promoting integrated medical and BH workforce training programs.
-- promoting integrated care practice models in high-need areas;
-- improving behavioral health graduate medical education (GME) with an emphasis on integrated medical and BH service delivery;
--support for development and dissemination of evidence-based tele-health; and
-- support for adoption of consensus guidelines for evaluating standards of care among state medical boards.

V. **Payment for Integrated Care Services:**

The Congress has taken commendable recent action to advance alternative payment models that reward accountable, transparent, value-based care delivery in primary care. But what many do not appreciate is that as multiple systems of care – PCMHs, ACOs, preventive 30 dy hospital readmissions, etc change towards value, they themselves have begun to realize that many of their highest-cost patients have psychiatric-medical co-morbidity. And, importantly, they (systems) will have to integrate behavioral health care in order to be financially successful.

At the same time, the behavioral health field has to be ready to show their value as part of multi-disciplinary care teams, in improved patient health outcomes and lowered costs. All innovative and alternative payment models must also implement, and publicly report, quality measures, including a focus on patient/beneficiary/recipient experience with the services and supports they receive.

VI. **Insurers Move Towards Unified Plan Contracts:**

The U.S. insurance industry has already begun to realize the potential improvement on their financial bottom line, and some are already moving in an integrated payment direction, i.e. one plan that covers both physical/medical and behavioral benefits. By 2020, it is estimated that 50% of States Medicaid managed care plans will be integrated. The problem is that BH providers will not build and deliver truly integrated services unless they are uniformly paid to do so. Thus, commercial insurers, Medicare and Medicaid will also have to integrated medical and BH *payment procedures*, before uniform integration of services becomes available.

In conclusion, NHMH – No Health without Mental Health, www.nhmh.org, and the American Association on Health & Disability (AAHD) will be pleased to meet with HELP Committee staff if appropriate in order to: (a) provide further detailed information; (b) discuss all of these integrated care issues and recommendations and possible ways forward in more detail; and (c) offer specific legislative approaches that may accomplish these urgently needed objectives. Thank you for your kind consideration of these comments and recommendations.

Respectfully submitted,

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Attachments:

Pew Research Center February 2019 report
Milliman Report January 2018
Milliman Report April 2014