October 26, 2021

Robert L. Phillips, Jr., MD, MSPH
Co-Chair NASEM Implementing High Quality Primary Care Study
National Academy of Science, Medicine & Engineering
Washington, DC 20036

Dear Dr. Phillips,

The undersigned Washington, DC-based national advocacy and trade organizations strongly support the May 2021 National Academy of Sciences, Medicine & Engineering's (NASEM) "Implementing High Quality Primary Care (HQPC)" report and its call for fundamental primary care modernization.

The purpose of this note is to urge your NASEM HQPC Committee to focus your dissemination advocacy of the report on the topics of: (1) chronic medical conditions, (2) co-occurring medical and behavioral health (BH) conditions (including co-occurring BH and disability conditions), and (3) the integration of BH services into primary care.

Both chronic medical conditions and co-existing BH issues must be treated together in a coordinated fashion in order to improve outcomes and reduce costs. Primary care is the gateway to all care and where the majority of BH patients go. This is all the more vital since 80% of our national health system's total expenditures are going towards these complex, co-morbid high-cost, high-need patients. When mental health and substance use disorders are not treated along with physical disorders, the total healthcare cost are much higher. Claims data show an average annual baseline cost for physical-illness-only patients ($4,090) *doubles* when mental illness is added ($9,036), and *quadruples* when physical, mental and substance use present ($19,018). Kathol et al, *Journal of General Internal Medicine* 20; 160-167, 2005.)

Primary care should be playing a vital prevention and early intervention role in these areas of chronic diseases and complex illness, preventing or reducing later very costly multiple chronic conditions.

We believe this focus is entirely consistent with the incisive advice of Sibelius, Burke and Frank discussed during your June 29, 2021 NASEM conference call.
Those leaders stressed that for the HQPC report to have a concrete, meaningful impact resulting in real change in Washington, DC health policy circles, and even more critically, in bipartisan political circles, the focus of the report should:

- Address an urgent, real, present issue which exists today, namely that 80% of total health service spending is on 20% of the population, those with chronic disease and complex illness. 70% of these patients have co-morbid medical and BH conditions. In addition, a coming Boomer enrollment (77 million) over

the next decade will put Medicare, with ¾ of its enrollees having at least 1-2 chronic conditions, in real financial jeopardy. All this amidst the general population's exploding mental health burden, most untreated, as a result of COVID and a still uncontained opioid addiction crisis.

- Where widespread organization building blocks are already in place (National Center for Complex Health & Social Needs; Playbook Better Care for People with Complex Needs; National Health Council members; the NIH-CDC-ASPE studies on cost of chronic medical conditions; and the Milliman 2014 and 2018 studies on total cost of co-morbid med-BH patients across all payers;
- Where the highest-level government champions/supporters exist at the WH, HHS Secretary level and federal health agency heads, and in Congress, who have shown they are motivated, interested and committed to these issues;
- Where the HQPC Committee can build on the above established-issue and committed leaders' 'infrastructure' and leverage its weight for tangible results;
- Where the focus is closely related to improving health disparities among minority populations, and addressing social determinants of health in communities. The Well Being Trust has just reported that in 2020 of U.S. adults with a MH diagnosis, the % of those in minority groups those who received no treatment were: 77% of Asians, 67% black and 66% Hispanic. (50% of whites).

We believe the focus we have suggested meets all those dimensions. Numerous studies by the Robert Wood Johnson Foundation, the Commonwealth Fund and the Milliman actuarial firm have demonstrated the perilous position the country is in due to insufficient early intervention in chronic medical condition and behavioral co-morbidity care. Moreover, new health delivery interventions like the TEAMcare model delivered in primary care, can successfully treat depressed patients with chronic medical conditions, targeting patients with depression, diabetes and heart disease (McGregor, Lin, Katon et al, *J. Ambulatory Care Management*, 2011, Vol. 34, No. 2, pp. 152-162).

Another example of need to focus on chronic conditions and BH integration are the 12.3 million (2019) individuals enrolled in both Medicare and Medicaid (dual eligibles). Of such importance that a CMS agency - MMCO, Medicare and Medicaid Coordination Office - is devoted to this population. Many dually eligible persons have complex care needs, including chronic illness, physical disabilities, behavioral health issues and cognitive impairments. They on average use more services and have higher per capital costs those beneficiaries enrolled in Medicare or Medicaid alone. Many live with major social risk factors. Although Congress created multiple authorities to integrate their care, currently only about 10% are enrolled in integrated care programs (MCS MMCO financial alignment; PACE; D-SNPS; and Medicaid Managed LTSS programs). The division of coverage between Medicare and Medicaid results in fragmented care and cost shifting. A recent RAND study, commissioned by CMS, documented dually eligible persons in Medicare Advantage programs had much greater clinical care quality disparities (using HEDIS measures) than non-dually eligible persons. 2021 studies on the

dually eligible population have been published by MedPAC, Health Management Associates, Alliance for Health Policy, and RAND for CMS. The dually eligible population is also a priority of many advocacy organizations (AAHD, NCOA, Justice in Aging, Community Catalyst, and NQF). Thus, allies abound in this focus area.

Second, we recommend the NASEM HQPC Study Committee coordinate where possible with the Bipartisan Policy Center (BPC) to further build out upon the BPC's March 2021 report on behavioral health integration, "Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration." The report provides specific policy recommendations on payment and delivery reform to advance value-based integrated care; expanding and training the integrated care workforce; and technology support.

Third, we urge the Committee to include in its HQPC report an additional exemplar of behavioral integration that speaks to health disparities and inequality: the outstanding work of Montefiore Medical Group in The Bronx, NYC, where, in a low-income, under-resourced urban area, they have fully integrated medical-behavioral care across their primary care system, adult and pediatric. If your Committee will be linking this issue of primary care transformation to 'human infrastructure' as part of a broader Congressional infrastructure bill, this focus on chronic condition and complex illness among minority populations ought be included along with Intermountain and Southcentral Foundation.

We are hopeful the HQPC Committee can consider these recommendations which highlight the vital, indispensable role primary care must play in treatment of chronic medical conditions, medical-BH co-morbidity and integration of BH services into PC. We are pleased to support NASEM's work in this vital area and future collaboration.

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