No Health without Mental Health
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August 29, 2023

The Honorable Chiquita W. Brooks-LaSure, MPP
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore, MD 21244

Submitted online at https://www.regulations.gov/

RE: Medicare Program; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies (CMS-1784-P)

Dear Administrator Brooks-LaSure,

NHMH – No Health w/o Mental Health and the undersigned organizations are pleased to be able to comment on the CY 2024 proposed Medicare Physician Fee Schedule payment rule. **These comments relate specifically to how CMS might further expand access to behavioral health integration (BHI) services for Medicare beneficiaries.**

I. INTRODUCTION: No Health w/o Mental Health (NHMH) is a patient advocacy nonprofit with a focused mission since 2007 to make bidirectional integrated care widely available in medical and behavioral health settings. Over the past 16 years we have achieved a leadership position in integrated care advocacy including participation in two national large pragmatic PCORI RCT BHI clinical trials; stakeholder participation in a State (NY) DSRIP BHI demonstration project; participation in the Bipartisan Policy Center BH Workforce Taskforce, 2023; Board membership in the Mental Health Liaison Group; and partnership in a national network of clinicians, researchers and advocacy partners united in a shared goal to make high-quality, evidenced-based BHI services accessible to Medicare beneficiaries. These comments are submitted by:

- NHMH – No Health w/o Mental Health
- American Association on Health & Disability
- International Society for Psychiatric Mental Health Nurses
- Clinical Social Work Association
- Lakeshore Foundation
- Policy Center for Maternal Mental Health

II. PRELIMINARY GENERAL COMMENTS: *Integration of behavioral health services within primary care will never be financially sustainable in a fee-for-service (FFS) payment system since over time improved care results in less patient encounters and thus reduced income for practices*. A shift to a value-based payment model rewarding accountable, quality care and away from a FFS billing system is the real long-term solution to BHI financial sustainability. We acknowledge and encourage CMS's actions to drive BH integration utilizing existing CMS value-based programs such as MA, MSSP/ACOs, EPSDT, and MMCOs alongside adequate behavioral health quality measures, performance tied to financial reward, and making behavioral health more integral and robust overall in our health system.

We strongly recommend that CMS support and incentivize only those BHI approaches which meet these essential requisites: (1) be evidence-based, (2) focus on a patient-centered and patient engaged approach, and (3) achieve positive patient health outcomes.

III. SPECIFIC REQUESTS FOR ACTION: We have the following recommendations:

Concern #1: While pleased to see a payment increase for CPT code 99484, Care Management Services for Behavioral Health, we request that CMS provide adequate Medicare FFS reimbursement rates for all of the current behavioral health integration codes (99484, 99492, 99493, and 99494). CMS should support and incentivize all evidence-based models of behavioral health integration so that primary care practices continue to have a menu of proven effective models from which to select one or several (sequential) that they consider might meet the needs of their setting and their patients.

Our organizations believe that all evidence-based, patient-centered and population health focused models demonstrating health outcomes, should receive CMS support and incentives in its regulation and rulemaking; that those approaches be equally promoted and fostered, and that their complementary and potentially sequential nature be highlighted with clinicians and administrators. The goal being to give primary care practices as many options as possible from which to choose, customize to their circumstances, and over time gain proficiency in offering integrated care.

Currently there are three proven effective BHI approaches: Primary Care Behavioral Health (PCBH), Collaborative Care (CC), and Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT is a condition-specific model providing screening, diagnosing and treatment of substance use disorders in primary care, with referral to external specialist BH providers as needed. Each of the three evidence-based models of integrated care have a substantial body of evidence in the scientific literature to support them.

We urge CMS to avoid a single-model-messaging approach when it comes to BHI implementation. The massive burden of mental health in the nation now, plus the great diversity, in terms of resources, patient needs, staffing, and clinic culture, of primary care sites across the U.S., suggests the need for CMS to ensure clinicians have a complete array of proven integrated care approaches from which to select and customize their implementation approach since no one model fits all. (Rundell, J, The COMPASS Initiative, *Gen Hos Psychiatry* (2016); Unutzer J, AIMS Center, All Hands on Deck, *Psychiatric News*, 2016).

The existing three evidence-based models should not be viewed as necessarily separate or compartmentalized, rather, should be seen as complementary integration services in both goals and practices, whose interventions may in some cases be sequenced in a "Stepped Model of Integrated Behavioral Health Care" approach depending on patient need (Unutzer J, *Psychiatric News*, 2016; Reiter, J The Primary Care Model: An Overview, (2018), *Journal of Clinical Psychology*, 25:109-126, p. 120).

Concern #2: We request that CMS closely capture and track the BH integration uptake and other relevant data to understand what is driving a persistent divergence in utilization of BHI approaches by primary care practices. In the real world of clinical care, primary care practices are electing to adopt the PCBH model over the CC model in significant numbers. This trend began 10-15 years ago and has continued over the past 5 years of Medicare CPT integration codes. CMS needs to understand what is driving this result so that it can appropriately shape future integration policy to ensure it is offering

practices options for what they indicate they need and want in implementation that works for their patients**.** Billing under the Medicare integration payment codes since 2017 has shown a utilization split with practices adopting the PCBH code (General BHI 99484) over the CC codes (99492, 99493, 99494). This divergence in model uptake has been consistent from 2018 through 2021.

Integration Code	2019	2020	2021
99484 (PCBH)	53,912	128,255	171,060
99492 (CC)	16,034	6,958	10,686
99493 (CC)	16,201	23,187	33,887
99494 (CC)	26,507	13,820	20,505

(Source: CY 2021 PFS Final Rule Utilization Data Crosswalked to 2023).

Explanations for collaborative care's low utilization have included inadequate financing and Medicare and Medicaid reimbursement, as well as complicated billing processing procedures. However, a growing body of evidence suggests additional reasons.

After over 20 years, the PCBH model has been associated with improved access to care, improved health outcomes, higher patient satisfaction, and decreased healthcare costs (Hunter et al, PCBH model research, *Journal of Clinical Psychology in Medical Settings*, (2018):25(2): 127-156. There is an established literature on the patient health outcomes benefits of PCBH (Landoll R, Training the Doctors, *Journal of Clinical Psychology in Medical Settings* (2019) 26:243-258). PCBH was developed organically in the clinic by clinicians. It was designed for, and sprang out of, primary care clinics. From its inception, it was specifically designed to meet the needs of the PCP and care team and patients (Funderburk J, et al 2021, What is the recipe for PCBH? *Families, Systems & Health*, 39(4), 551. The collaborative care model by contrast developed out of the more common research route of: conceptualization -> small pilot -> larger randomized control trials -> implementation studies. The PCBH approach's grassroots origins have allowed for widespread dissemination of ideas which have spawned more interest and advanced the model's focus and refined its approach (Strosahl et al, 1994; Strosahl, 1998; Strosahl & Robinson, 2008; Robinson & Reiter, 2007; Dobmeyer et al, 2016; and Doller et al, 2018). PCBH's implementation success have been consistent for over 15 years now (Freeman, 2011; Hill, 2015; Hunter et al 2014, 2018).

Healthcare systems where PCBH has been well established and continues to be the norm for care include the Department of Defense (Dobmeyer et al, 2016), the Veterans Health Administration (Funderburk et al, 2013), the Southcentral Foundation Health System of Alaska, Kaiser Permanente, the Cherokee Health System of Tennessee, and many Federally Qualified Health Centers (Funderburk, 2021).

An expert consensus definition of the PCBH includes: "services offered by an embedded behavioral health provider. This approach involves providing patient-centered behavioral health services to primary care patients in a collaborative framework within primary care teams that utilize a shared medical record. Behavioral health appointments are usually brief (30 minutes or less), typically limited

in number, 1-6 visits with an average of between 2 and 3 per care episode, and are provided in the primary care practice area. These appointments are structured so that the patient views meetings with the behavioral health provider as a routine primary care service. Primary care providers maintain responsibility for patient care decisions, but are supported by the behavioral health providers who emphasize patient self-management across a broad scope of concerns, including common mental health diagnoses, physical health issues, and prevention." (Boehler G. et al (2013) Psychometric assessment of the PCBH Provider Assessment Questionnaire, Translational Behavioral Medicine, 3(4), 379-391; Funderburk, 2021).

The role of the BH consultant in PCBH is not just to enhance the PCP's skills, but rather enhance the entire primary care team's ability to manage and treat a wide variety of mental health/addiction and biopsychosocial problems with resulting improvements in total health for the entire clinic patient population. This differs from the CC approach in which the BH provider, the consulting psychiatrist, is offsite and treats predominantly one condition: mood disorders primarily depression and anxiety (Archer, J, Collaborative Care for People with Depression and Anxiety, *Cochrane Database of Systematic Reviews*, 2012). The PCBH behavioral health provider may be a psychologist, social worker, psychiatrist, psychiatric nurse practitioner, or other licensed behavioral health provider (Possemato et al, 2018). In collaborative care the behavioral health provider (BHP) role can only be filled by a psychiatrist, hence name 'psychiatric consultant.'

The population health aspect of PCBH is an important feature, that clinicians in particular value as studies show. The BH provider in PCBH works as a diagnostic, assessment and treatment consultant and educator on BH conditions and therapies to the PCP and the entire clinic staff (Reiter, *Journal of Clinical Psychology in Medical Settings* (2018) 25: 109-126.). The population aspect of the PCBH distinguishes it from other BHI approaches. The focus is not just on improving the health of an individual patient but of the entire clinic patient population, and in the process, educating the entire care team to mental health treatments and psychotherapies and behavioral therapies so that the entire clinic population benefits. Patients are followed by both BHP and PCP with the BHP working to improve the PCP's biopsychosocial management of health conditions in general. Interestingly, the PCBH model also affords the BH provider the opportunity to learn how to work in primary care, a setting normally not familiar to behavioral health professionals trained and acclimated to work in specialty mental health settings.

The patient-centered and patient engagement aspects of PCBH touch on priorities patients value: improved functional health outcomes; convenience accessing care; and strengthening the trusted doctor-patient relationship. (Commonwealth Fund, 2023). Integration in the PCBH model improves access to BH care offering patients faster receipt of BH treatment, and an increased likelihood of patients initiating and continuing in care (Possemato, 2018; Funderburk J, et al Prevalence and predictors of team-based care, (2023) *Journal of Interprofessional Care,* Vol. 37, No. 1, 58-65).

Primary care providers and patients report satisfaction with the inclusion of an integrated BHP on their treatment team (Hunter et al, 2018). Patients appreciate timely same-day medical-behavioral visits; team care centered around the patient; the handoff from PCP to BHP; in-person, fact-to-face care from BH provider; receiving coordinated integrated care; and a focus on functional quality of life issues and

goals. The BH provider is physically present in the clinic able to be called into the exam room spontaneously by the PCP and be introduced to the patient by the PCP, with the option for follow-on longer visits with the BH provider (Reter 2018).

Concern #3**: **We support CMS initiating new FFS billing codes to allow for inter-professional (IP) consultation to be billed by practitioners authorized for the diagnosis and treatment of mental illness. Such reimbursement may facilitate greater team-based care activities resulting in improved health outcomes (Funderburk J, 2023). We urge CMS to view consultation activities as being one of *several* inter-professional *team-based care activities and communications* essential to delivery of evidence-based integrated care. While more research is needed as to what constitutes team-based care activities associated with improved patient outcomes, team-based care including consultation offers the ability to provide coordinated care to patients (Coletti, 1999). Studies also show IP learning environments work best when BH professionals are able to learn how to practice integrated care alongside their medical colleagues (Porcerelli et al, 2013) and where both sides embrace inter-professionalism, seek to learn from each other, respect diverse skillsets and build a common language (Landoll, 2019).

***Concern #4: CMS should work with NIH/NIMH to ensure there is a pipeline of novel, innovative BHI models in the future*.** PCBH, CC and SBIRT are all service delivery models of integrated care. NIH/NIMH allocates *a mere 10%* of its annual budget to funding services delivery research. Inadequate funding of health services research constitutes a major barrier to fostering a future where there will be sufficient evidence-based BHI models in the pipeline for clinicians to consider beyond the current approaches. (NIMH Congressional Justification FY 2022, Dept of HHS, National Institutes of Health, pp. 21-22).

IV CONCLUSION: The undersigned organizations support promotion of **all** evidence-based models of behavioral health integration as well as adequate FFS payment. We support CMS's efforts to advance value-based care as well as CMS' Services Addressing Health-Related Social Needs, Community Health Integration Services, SDOH Risk Assessment, and Principal Illness Navigation Services with certified peer support specialists and community health workers. We concur with the CMS quality measurement observation, (p. 962) that: 'Whole person care requires depth and scope of services including both primary and specialty care and aims to provide ACOs with tools better engage specialists, test way to better link primary and specialty care upstream in the patient journey and further movement into value-based care.' All of these efforts can enhance CMS' expansion of access to quality behavioral health services for Medicare beneficiaries. With best regards,

NHMH – No Health w/o Mental Health
Florence C. Fee, J.D., M.A. Executive Director

Clinical Social Work Association
Laura W. Groshong, LCSW, Director Policy & Practice

American Association on Health & Disability
E. Clarke Ross, D.P.A., Public Policy Director

Lakeshore Foundation
E. Clarke Ross, Washington Representative

International Society for Psychiatric Mental Health Nurses
Sally Raphel, Policy Committee Chair

Policy Center for Maternal Mental Health
Sarah Johanek, Policy Project Manager