No Health without Mental Health
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June 14, 2024

The Honorable Ron Wyden
Chairman
U.S. Senate Committee on Finance
219 Dirksen Building
Washington, D.C. 20510-6200

The Honorable Mike Crapo
Ranking Member
U.S. Senate Committee on Finance
219 Dirksen Building
Washington, D.C. 20510-6200

Re: The Senate Committee on Finance Foundational Document on Bolstering Chronic Care Through Physician Payment: Current Challenges and Policy Options in Medicare Part B

Dear Chairman Wyden and Ranking Member Crapo,

NHMH – No Health without Mental Health, formed in 2007 with a single focused mission to make evidence-based integrated medical-behavioral health services widely available in both general health and behavioral health settings, is joined in these comments by the following organizations:

American Association on Health & Disability
Clinical Social Work Association
International Society for Psychiatric Mental Health Nurses
Policy Center for Maternal Mental Health
Mental Health America
Lakeshore Foundation

We commend the Committee's sustained priority focus on chronic illness care, FFS payment reform, progressing the shift to value based care, and emphasis on the patient experience of care. We also laud the Committee's proactive sharing of this document with the stakeholder community and look forward to inputting on these issues in future legislation aimed at achieving high quality primary care for Medicare beneficiaries.

We have 7 policy recommendations:

1. Adopt Policy Reforms with Behavioral Health Care an Essential Component of Chronic Illness Care.
2. Require that value-based innovation test models for chronic condition care include BH integration.
3. Modify MSSP ACOs to include BH and BHI as core responsibilities and link payment to integration.
4. To FFS Codes add targeted payment for primary care activities currently unreimbursed but essential to practice transformation to high-quality care.
5. Authorize tiered payment for primary care practices engaged in BHI to encourage progress towards greater levels of integration.
6. Provide Medicare beneficiary cost-sharing relief for FFS integrated behavioral health services.
7. Support the COMPLETE Act to enhance Medicare payment rates for BHI services targeting practice start-up costs.

The following discussion provides greater detail on the recommendations:

1. Adopt Policy Reforms with Behavioral Health Care an Essential Component of Chronic Illness Care. We propose that future Medicare chronic care legislation encompass the care of both chronic medical conditions and behavioral health conditions given how inextricably entwined the latter are with the former. And sets the goal of having that care delivered through evidence-based integrated interventions able to achieve improved patient health outcomes, medical and behavioral.

There are several reasons why behavioral health is essential to chronic illness care. The top 5% of Medicare FFS beneficiaries with multiple high-cost chronic conditions account for 40% of Part A/B spending (HHS/ASPE). 20-40% of patients with chronic common medical conditions such as **c**ancer, heart disease, diabetes**,** ALSO suffer from a co-occurring behavioral health issue most commonly depression and/or anxiety (Kathol, 2017). Behavioral health conditions left untreated or undertreated in primary care results in patient's continued poor mental health plus delayed or prevented medical condition improvement or recovery (SAMHSA; Kathol). The majority of potentially preventable heath care spending is among high-cost beneficiaries (HHS/ASPE).

The failure to treat the behavioral conditions of co-morbid chronic illness costs the U.S. health system a staggering amount: 50% of U.S. healthcare costs are attributable to 20% of patients with both chronic medical and mental health or addiction disorders (Milliman, 2018) so-called complexity patients**.** When a patient with a chronic medical illness also has a mental health condition, the cost of care doubles, and when a substance use disorder is also involved, it quadruples, across all payer groups (Ibid). Addressing the quality of care and payment mechanisms for this complex, co-morbid medical-behavioral patient population must be a health policy necessity in today's post-COVID mental health crisis environment.

The care delivery innovation called behavioral health integration (BHI), that integrates evidence-based behavioral health services in primary care, *derives from and utilizes* the foundational Chronic Care Management Model (Rundell JR, The COMPASS Initiative: Implementing a Complex Integrated Care Program, *Gen Hosp Psychiatry*, 2016). The CCM Model, itself a primary care initiative (Bodenheimer, T., Improving Primary Care for Patients with Chronic Illness*, JAMA*, 2002; 288(14): 1775-9; Part 2, *JAMA* 2002; 288 (15), pp 1909-14; Wagner, EH, Meeting the Needs of Chronically Ill People, *BMJ* 2001; 323:945-6) has four core components**:** (1) self-management support; (2) clinical information systems; (3) delivery system redesign, and (4) decision support. They remain highly relevant today as a way to achieve the Triple Aim of improved health, better patient care experience, and lower costs.

One of several evidence-based, effective behavioral health integration strategies, the collaborative care model, added four more core principles to the CCM: (1) team-driven; (2) population focused; (3) measurement-guided; and (4) evidence-based (*Gen Hosp Psych*, 2016).

A further evolution of the Chronic Care Management Model occurred with the landmark 2010 TEAMcare integrated *multi-condition* primary care program for chronic illnesses, medical and behavioral. The TEAMcare intervention targeted both chronic medical conditions such as diabetes**,** heart disease as well as chronic mental health conditions such as depression resulting in significantly improved patient health outcomes in both domains. (Katon, W., et al, Collaborative Care for Patients with Depression and

Chronic Illness, *N Engl J Med* 2010; 363:2611-2620; McGregor, M. et al, *J. Ambulatory Care Management*, TEAMcare - An integrated Multi-Condition Collaborative Care Program for Chronic Illnesses and Depression, *J Ambul Care Manage*. 2011 Apr-Jun; 34(2): 152-162). To this day TEAMcare remains the gold standard for treating chronic medical conditions and co-occurring depression in primary care patients. Policymakers ought to seriously consider how the TEAMcare multi-condition behavioral health integration intervention might be widely disseminated and implemented**.** This policy change would enable improved outcomes for common chronic conditions, medical and behavioral, on a much wider scale in both primary care and specialty medicine.

2. Require That Value Based Innovation Test Models for Chronic Condition Care Include Behavioral Health Integration:

Overview: our overarching point is that the true value of integrating BH care services in chronic illness care is not only the resulting improvement in outcomes of both, but also the reduction of patient *medical* expenditures and thus *total* health care costs. (TEAMcare, 2017). Considering the number of Medicare beneficiaries with multiple co-morbid physical-behavioral chronic illnesses, this cost savings across all payers could be enormous (Milliman, 2018). Thus, our reply to the paper's Question 1 on p. 21 is that behavioral health integration in primary care does in fact provide the most value in reducing downstream total healthcare costs while also improving outcomes for Medicare beneficiaries with chronic illness.

Firstly, we support the paper's focus on value-based care payment strategies while trying to address ongoing problems with the FFS payment system since the reality is most primary care clinicians today have one foot in value-based initiatives and one foot in FFS reimbursement.

And while we are pleased with CMS**'**s recent plethora of primary care-focused innovation test models involving BHI**,** much more needs to be done in this area. Two key changes needed to generate increased practice/system participation are: pay practices more for their participation in these voluntary models, and establish consensus behavioral health quality measures and BHI quality measures for participants' mandatory reporting in order to ensure practice accountability for outcomes.

Current Alternative Payment Models (APMs) such as bundled payments and/or capitated rates for comprehensive primary care including behavioral health, can be leveraged to integrate behavioral health care. Payment approaches such as Medicaid Managed Care Organizations, Medicare ACOs and Medicare Advantage plans have quality measures, delivery standards, and payment mode**l**s through which integrated care can be incentivized.

However, to date, APMs have by and large not focused on behavioral health, and, as a result, have not maximized their potential to expand care access and improve outcomes. While APMs have to some degree the potential to lead to more integrated care, they must be accompanied by strong quality and performance measures to ensure accountability and access to care (BPC). Ensuring accountability through quality measures and providing for sufficient payment levels should be a focus for the Committee's future work.

3. Modify MSSP ACOs to Include BH/BHI as Core Responsibilities and Link Payment to Integration:
ACOs is a primary care-based payment model that holds a group of providers financially responsible for patients' care. Through it Medicare has sought to incentivize clinicians to coordinate care and avoid unnecessary services. While ACOs have had some success in health outcomes and costs, an issue that remains is the lack of requirement to provide behavioral health services as a core service**,** nor requirement to have behavioral health providers in their networks.

The Congress should update the component definitions of an ACO to require a sufficient number of behavioral health professionals for the number of assigned Medicare beneficiaries. It should also modify the core process requirements for ACOs to include evidence-based integration of behavioral health services (Bipartisan Policy Center, 2021).

4. To FFS Codes Add Targeted Payments for Primary Care Activities Currently Unreimbursed but Essential for Practice Transformation to High Quality Care:
We support the proposed additional and targeted Medicare primary care payment provisions in the bill recently introduced by Committee members Whitehouse and Cassidy (S. 4338). It allows for a hybrid prospective, per-member-per-month payment and FFS payments for the following eligible services: (1) case management, (2) communications with patients, families and providers, (3) behavioral health integration, and (4) office visits for evaluation and management. We also recommend payment for another service of efficiency in referrals such as closed-loop referrals. None of these proposed payments are generic higher payments for primary care practices, rather targeted, additional payments. While we appreciate Sens. Whitehouse and Cassidy including behavioral health integration in the services eligible for this new hybrid payment, unless the hybrid payment is adequate and accompanied by other incentives (see section 5 below) not stated in the current bill text, it likely will not result in more primary care physicians be able to provide integrated BH care for their patients.

5. Authorize Tiered Payment for Primary Care Practices Engaged in BHI to Encourage Progress Towards Greater Levels of Integration:
Although we support integrated behavioral health care in the Whitehouse/Cassidy draft bill, to implement these reforms and incentivize greater integration, we recommend authorizing CMS to deploy tiered payment with higher payments for greater behavioral health integration and ability to address health-related social needs.

Providing behavioral health integration in primary care is a wholly new way of providing care and there is a great diversity of size and value-based care delivery experience among practices. In addition, integration implementation is challenging on many levels: clinical, operational, financial, administrative and cultural. To encourage practices to remain engaged in progressing towards greater levels of integration we urge a tiered payment approach of PMPM capitated payment with higher payment for practices delivering greater levels of evidence-based BHI utilizing either the Collaborative Care or General BHI approach.

6. Provide Medicare Beneficiary Cost-Sharing Relief for FFS Integrated Behavioral Health Services:
Currently patient co-pays are required for both the collaborative care and the general behavioral health integration Medicare CPT codes. Clinical care experience has shown that asking beneficiaries to

shoulder the burden of an additional co-pay for the integrated care service acts as a strong disincentive to patient engagement in that care option. We support full waiver of cost-sharing for the integrated care billing codes, and especially when they are for the initial treatment and when billed on the same day as another billing code is submitted; we support doing the same for the Chronic Care Management billing codes under similar circumstances.

7. Support the COMPLETE Act to Enhance Medicare Payment Rates for BHI Services Targeting Practice Start-up Costs:

The bipartisan COMPLETE Care Act (S. 1378 - Connecting Our Medical Providers with Links to Expand Tailored and Effective Care) would augment Medicare payment for BHI services by helping with start-up costs associated with implementation of integrated models. Examples of such costs include practice care delivery re-design; HIT data system installation and upgrading; patient registries; care management tracking systems; development of new professional consultation and communications arrangements between medical and behavioral health providers, being a few of the key start-up costs that can influence successful implementation or not. The COMPLETE Act would address this need and improve uptake of these critical services.

Thank you for developing this foundational document on strengthening chronic illness care and for providing the undersigned organizations with the opportunity to comment. For questions or further information, please contact us at florencefee@nhmh.org.

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