No Health without Mental Health
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July 15, 2024

The Honorable Sheldon Whitehouse
U.S. Senate
530 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Bill Cassidy, M.D.
U.S. Senate
455 Dirksen Senate Office Building
Washington, D.C. 20510

Re: **RFI on the Pay PCPs Act of 2024 (S.4338)**

Dear Senators Whitehouse and Cassidy,

This comment letter is submitted on behalf of NHMH – No Health without Mental Health (NHMH) and the undersigned organizations. Thank you for the opportunity to provide feedback including recommendations on the proposed bill. NHMH is a patient advocacy nonprofit formed in 2007 with a dedicated mission to make evidence-based behavioral health care (mental health + substance use) widely available in medical settings such as primary care. Over the past 17 years our advocacy on behalf of behavioral health integration in primary care has been directly informed by the lived experiences of our families' loved ones'partially treated, undertreated, or untreated mental illness. During this time, NHMH has been a stakeholder-participant in several PCORI national, multi-year RCT trials on integrated care, held leadership roles in the two main Washington, D.C.-based BH coalitions (Mental Health Liaison Group, Coalition on Whole Health), and played a key role in organizing the June 22-23, 2017 HHS Federal Partners in Integrated Care Conference, which convened all HHS operating divisions involved in integrated medical-behavioral care for cross-agency information exchange and strategizing.

We are hopeful the Pay PCPs Act of 2024 will help to enable the transformation and modernization of Medicare primary care practices towards effective, high-quality care; encourage acceleration of CMS value-based care initiatives; and improve access to mental health care for Medicare beneficiaries by the bill's inclusion of behavioral health integration. It is an important initial step in advancing those goals, and has our full general support.

In your RFI, you stated the bill would serve as a marker for future primary care legislation and was intended to secure feedback on important policy questions. Responding to the RFI guidance, we provide recommendations on future primary care legislation, and secondly on the proposed bill's provisions.

PART ONE: Future Primary Care Legislation: The Importance of Integrated Primary Care

We thank the bill's sponsors for recognizing the importance of integrating behavioral health as a vital component of primary care transformation in their proposed legislation and we offer the following recommendations for future primary care legislation:

- **Behavioral health (BH) integration is core to high-quality primary care delivery**
- **Studies show adding BH services particularly adds value to older adult care**
- **BH care must be included in the MSSP requirements as ACOs will not achieve financial success without it since highest-cost patients have med/psych co-morbidity**
- **Provider payment reforms must consider tiered payment to foster continuous integration**

Details:

Priority should be given to policy supports and incentives to primary care practices to enable them to deliver, on a population basis, evidence-based behavioral health services as a standard *core component of effective, high-quality primary care*. This is especially the case for those practices with co-morbid, complex patients having multiple chronic conditions, common among Medicare beneficiaries. The National Academy of Sciences, Engineering & Medicine (NASEM) has called integrated medical-behavioral primary care delivery "a foundational strategy for healthcare organizations to support a culture of high-quality, person- and family-centered primary care built on trust, accessible, and continuous relationships" (NASEM, "Implementing High-Quality Primary Care," June 2021, p. 141). This ground-breaking NASEM report, published one year into the COVID pandemic, established a data-driven strategic path forward for primary care transformation and integrated care. The ensuring years and national mental health crisis have made this strategic approach to primary care, in which behavioral health integration features strongly, all the more vital.

As the NASEM report states primary care is the venue that delivers most mental health care (Gard et al, 2013; Pinto and Bloch, 2017). The evidence for primary care integration is strongest for a behavioral health-primary care model (Asarnow et al, 2015; Coventry et al, 2015; McGinty and Daumit, 2020; Miller at al, 2014. Integrating mental and physical health through screening, diagnosis and team management deploying measurement-informed care in primary care increases the likelihood whole person care can be addressed equitably, efficiently and effectively (Anderson et al, 2015; Foy et al, 2019; Hodgkinson et al, 2017; Miller and Druss, 2013; Reisss-Brennan, 2014, 2016).

We note that the important subject of education and training of the integrated inter-professional care team was not addressed in the bill but we assume it will be the focus of future legislation.

Integrating BH services in primary care is shown to add value to older adult care: Integrating BH services in primary care has been shown to add value specifically to the care of older adults (Katon, 2006; Unutzer et al,2002, 2008). Studies have found that older patients may be more willing to accept screenings and treatment within a primary care setting than referral to external specialty BH (Bartels et al, 2004). Research has also shown that primary care clinicians believe that 'older adults were more likely to experience greater convenience with less stigma if the mental health services were integrated within the primary care setting' (Gallo et al, 2004, p. 307).

Incentivize BH integration in the Medicare Shared Savings Program (MSSP) by requiring that the core services activities of Accountable Care Organizations (ACOs) include BH services, have reimbursement linked directly to integration, and require that integration be included in the MSSP ACO quality performance standards (BPC, 2021). Multiple systems of care are moving toward patient-centered

medical homes and accountable care organizations, and as they do this, they are realizing many high-cost patients have psychological-medical co-morbidity, and they will have to integrate mental health care in order to be financially successful. (Katon, 2015).

This will require updating the ACA to include BH in the MSSP requirements. Congress should update the defined components of ACOs to require sufficient BH professionals for the number of assigned beneficiaries, include BH services, and include utilization of telehealth for care coordination, plus require BH screening and tracking to meet patient-centeredness criteria.

Congress should also include BH integration in the MSSP ACO quality performance standards. Medicare currently assesses ACOs on 23 quality measures as part of the criteria for receiving shared savings. Only 2 address BH: depression screening and follow-up and depression remission at 1 year. These 2 BH measures remain reporting measures, without performance benchmarks and are not linked to improvement. ACO quality performance standards should be updated to incorporate a full set of BH measures with established performance benchmarks. And the depression remission measure should be updated to include symptom improvement and assessment for shorter timeframes. And finally, CMS should provide additional incentives for ACOs to integrate BH and primary care services beyond what is required by the MSSP quality performance standard.

Authorize tiered payment for primary care practices engaged in BHI to be able to progress towards greater levels of integration: Since behavioral health integration is an *evolving* care delivery innovation and many practices are at *various stages* of clinical implementation, provider payment reforms for integrated care should be tied to tiered payments. This would allow providers/practices to receive increasing payment as they successfully progress along the implementation adoption curve (Chung, BHI and GHI Integration Implementation Framework for practices). And, as mentioned, such payment must be directly linked to practices' ability to demonstrate improved patient health outcomes using consensus quality and performance measures.

PART TWO: Specific Comments on the Bill Provisions:

Our comments and recommendations are organized to fit with the general sections of the bill.

Section 2: Findings

- **Include measurement-based care, patient information tracking as core services**

Details:

In referring to elements of practice transformation producing effective primary care, the bill mentions multidisciplinary team-based care and care coordination. We recommend adding several additional core service elements found crucial for effective behavioral health integration in primary care: measurement-informed care; tracking patient symptom status and exchange of patient information amongst the medical and behavioral health providers; culturally adapted patient self-management of health conditions; and ongoing, systematic quality improvement using established integration quality metrics. The primary care transformation and integrated care fields have long recognized these

additional core service elements as essential to high-quality integrated primary care (Bipartisan Policy Center, Tackling America's Mental Health Crisis, March 2012, p. 26).

Section 3: Establishing Hybrid Primary Care Payment in Medicare

- **Reforms should not underestimate the difficulty for practices in integrating BH care**
- **Patient-centered quality measures must be expanded to include measures that reflect what matters most to patients.**
- **Policy change must include new ways to engage patients in their integrated care**

Details:

Many primary care clinicians and integration researchers have expressed the view that behavioral health is "a new world for primary care." (PCORI SPIRIT IBHPC trials). We support the legislation's intent to encourage the Centers for Medicare & Medicaid (CMS) to accelerate its current ongoing efforts to shift primary care practices from full fee-for-service (FFS) to value-based care (VBC) delivery and payment. Holding practices accountable through mandatory reported quality metrics for positive patient health outcomes, including patient-reported outcomes, is crucially important for the success of this healthcare reform and for health plans continuing backing. While we agree a new prospective PMPM payment, as part of a new Medicare PCP hybrid payment, would provide practices with a predictable, flexible revenue source to support delivery of effective, quality primary care, including integrated care, simply providing additional reimbursement does not by itself mean practices will actually succeed in integrating BH services. In our involvement over many years in large-scale pragmatic real-world clinical care research (PCORI SPIRIT and IBHPC trials), we (and researchers) have learned how difficult it is for practices to depart from usual care delivery habits and procedures and successfully adopt new innovations in delivering care.

Accountability must be clearly and explicitly built into the PCP hybrid payment scheme with well-defined consensus quality measures meant to cover the new habits and skills needed to be deployed by both medical and behavioral health providers and the entire clinical staff, plus development of new cooperative relationships with other external providers and community social services entities.

In addition to clinical quality measures such as for example depression screening and follow-up plan; depression response at 12 months; initiation and engagement of SUDs treatment; anti-depressant medication management, we recommend that the following patient-reported quality measures be added in addition to 'patient experience':

Patient quality of life	Patient restricted activity days
Patient continuity of care	Patient comprehensive care
Patient physical functioning	Patient social participation
Patient pain interference	Patient sleep disturbance
Patient's cost of care	Patient Centeredness Index score

In addition to the above patient-centered quality measures, large pragmatic clinical trial studies have shown other ways patient engagement in integrated primary care can be encouraged and incentivized

include (team (Katon, *J Amb Care Manag*, 2011):

Care plan design:	Care plans co-created by the care team and the patient and which emphasize patient control and choices;
Goal-setting:	Treatment goals that are clear, congruent (same goals shared by care team and patient) and regularly reviewed by both;
Behavioral strategies:	Including life-style changes which are consistently reviewed, and updated by both patient and care team
Patient self-monitoring:	Patient self-monitoring goals should be co-created with the care team, clearly defined, and work in conjunction with the clinicians' measurement-based care;
Medication measurement:	Regular, joint patient-team review of the patient's regimen, and revision of the medication list to reflect what the patient is actually taking.

Section 4: Reducing Beneficiary Cost Sharing for Primary Care Services

- **Recommend zero patient cost-sharing for integrated medical-behavioral care as way to engage patients in this intervention.**

Detail:

Given the indispensable nature of patient engagement in the care team which is integral to the behavior change that is the basis of effective integrated primary care, we recommend there should be zero cost sharing for patients for behavioral health integration services as part of the hybrid payment approach to fostering primary care transformation. This approach should be seen as another key element for engaging patients in their integrated medical-behavioral care by making the option attractive to them.

Section 5: Establishing a New Technical Advisory Committee on Relative Value Updates and Revisions

- **Include a representative from the behavioral health provider field on the technical advisory committee.**

Detail:

We support the establishment of a new technical advisory committee within CMS to provide technical input relating to relative value units under the fee-for-service Physician Fee Schedule and recommend that of the 13 appointed members there be a representative from the behavioral health provider field.

For more information or questions, please contact Florence Fee at florencefee@nhmh.org.

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