November 14, 2024

TO: PTAC/OS/ASPE

FROM: NHMH – No Health without Mental Health  
 American Association on Health & Disability  
 Lakeshore Foundation  
 Mental Health America  
 National Disability Rights Network  
 Policy Center for Maternal Mental Health

RE: RFI on Identifying a Pathway Toward Maximizing Participation in Population-Based  
 Total Cost of Care Models

**I** **MAIN MESSAGE:**

**The integration of behavioral health (mental health and substance use) services in primary care must be an essential foundational component of a high-quality accountable care relationship, including in population-based total cost of care (PB-TCOC) models. (Bipartisan Policy Center, 2021). The quality and reduced cost benefits of integrated care are well documented (AHRQ, 2023). Value-based payment models have structural elements that make them ideal for integrated physical-behavioral health care delivery. Existing payment mechanisms in Medicaid Managed Care Organizations, Medicare Accountable Care Organizations and Medicare Advantage plans have well-defined quality metrics, delivery standards, and payment methodologies through which integrated care ban be applied, enforced and incentivized. What is needed is financial incentives and requiring accountability in order to build integrated care delivery into existing value-based payment models (BPC).**

The October 2024 PTAC/OS/ASPE Request for Information (RFI) re “Identifying A Pathway Toward Maximizing Participation <of all Medicare beneficiaries with Parts A and B> in Population-Based Total Cost of Care Models” did not include any reference to the role of the integration of behavioral health and primary care in those Medicare beneficiary accountable care relationships aimed at quality and total cost reduction.

Yet data and studies show that CMS will not achieve accountable quality care, as evidenced by improved health outcomes and reduced cost, for the most seriously ill, highest-cost, and chronically ill patients without inclusion of integrated medical-behavioral care (BPC; HHS/SAMHSA/CMS; NASEM 2022; Milliman 2018).

Nearly 30% of Americans (55 million) suffer from some behavioral health condition and half of them receive no care at all (HHS/SAMHSA). At the same time, for those patients with chronic medical conditions (e.g. diabetes, cancer, heart disease) who also have a mental health issue, their cost of care, across Medicare, Medicaid and commercial insurers, is *doubled* (Milliman2014, 2018). For patients with a chronic medical and behavioral condition AND a substance use condition, their total cost of care is *quadrupled* (Ibid). This leads to over $400 billion in additional societal social and economic costs. The opioid epidemic and COVIC pandemic haveintensified these stark realities creating the national mental health crisis we now confront.

The federal government has in the past three months stated thatintegrated care ‘is the future of healthcare.’The Department of Health & Human Services stated in August 2024 that ‘integrated care is now the future of health care**’** and specifically that: ‘Theintegration of primary and behavioral health care is considered the future of health care because it uses systematic, evidence-based approaches to improve the delivery of person-centered comprehensive care; increases access to preventive care and screenings; coordinates care to address mental, physical, social, and substance use related needs; and reduces overall costs of care for patients, providers, and health care systems.’<https://www.samhsa.gov/newsroom/press-announcements/20240829/biden-harris-administration-awards-81-point-3-million-funding-further-advance-presidents-unity-agenda>

**II RESPONSES TO RFI’s QUESTIONS TO THE PUBLIC**:

Our feedback responds to the numbered questions listed in the RFI:

1)a)**:** Goals of a Medicare Quality PB-TCOC Accountable CareRelationship: **--** comprehensive, continuous, coordinated whole-person care  
--use of acollaborative, communicating, specially trained integratedcare team **--** patient at center of care team and actively engaged in the co-creation of care goals  
 and treatment plans  
**--** continuous care with stress on early **i**dentification, assessment, treatment and prevention  
**--** longitudinal trusted patient-provider**-**team therapeutic relationship **--** wide reach through population-based patient panels **--** delivery of evidenced-based care, in case of integrated care: primary care behavioral health model (PCBH); collaborative care model (CC); and short brief   
 intervention and referral to care model (SBIRT) and  
**--** high level of patient shared-decision-making andengagement throughout care.

1)b**):** Kinds of Models Best Able to Support Accountable Care Relationships:

Models that allow for financial flexibility and incentives to practices/health systems including alternative payment models (APMs) providing prospective upfront payment for medical and behavioral health care, such asin Medicaid MCOprograms, Medicare ACOs**,** and Medicare Advantage plans,are best able tosupport accountable care relationships (BPC). These programs have well-defined qualitymetrics, delivery standards and payment approaches incentivizing **i**ntegrated care. Models able to support accountable care relationships also need technical assistance programs and specializedintegrated caretraining, and health information technology that allows forinteroperability and real-time information between medical and behavioral health providers.

3)c)**:**  Features Needed to Incentivize Beneficiaries to Align with Providers in APMs:-- delivery of accessibleintegrated medical and behavioral care in same placewith same day services **--** elimination of additional co-pays for mental health encounters in medical settings-- demonstrate to patients thattheir physical and mental health providers work in closecooperation, coordination, and communication with each other   
 and engage in seamless real-time sharing of patients full personal health   
 information data.

4)a)**:** Barriers to Providers Participating in TB-TCOC Models:  
  
**--** inadequate reimbursement to providers  
-- mandatory reporting of unclear, overly complicated, burdensome quality metrics   
-- lack of upfront payment to practices for initial set-up expenditures and ongoing   
 operational expenses required to provide evidence-based integrated care – which is  
 a wholly new way of providing quality, accountable healthcare and which affects   
 every aspect of the practice  
-- need for specialized technical training programs for clinicians to be able to deliver   
 evidence-based integrated care.

4)c): Why Some Providers Cease Participation in TB-TCOC Models:

It is very challenging for practices/health systems to financially sustain integrated care delivery services beyond grant or demonstration program periods, and provide clinicians and staff with needed integration education, training, coaching, plus continuous quality improvement monitoring integrated care processes and activities, in today’s health care workforce shortage, burnout, low employee reimbursement, and staff turnover, environment. The place where most accountable care relationships are now being envisioned, i.e. primary care and family practice, have been underinvested and underfunded for decades. An essential re-visualization and rebranding of what is quality primary care, in the eyes of the healthcare workforce, patient/consumers, and policy makers, must take place to underpin sustained accountable care relationships.

5:) Gaps in Current VBP models and Features Needed to Close Gaps:  
  
-- integration of behavioral health care should be mandatory service requirement   
 in all value-based payment programs  
-- behavioral health providers should be core providers in VBP programs   
-- involvement of patients and caregivers in design of VBP models and monitoring of outcomes  
-- VBP models are not going to work unless patients and caregivers and frontline providers  
 are involved in future  
-- insufficient payment for practices/systems  
-- clearly defined, reliable, valid quality metrics for delivering evidence-based  
 integrated care  
-- allowance for sufficient time for practices to demonstrate the value, in terms   
 of patient health outcomes and total care cost, of integrated care, e.g. 5-7 years  
 in lieu of 2-3 years.

6): Most Effective Payment Approaches for Fostering Accountable Relationships:

-- transitional approaches that balance prospective payment with existing   
 fee for service payment  
-- adequate upfront investment payment to cover first-time setting-up costs  
-- adequate payment to cover hiring of trained integrated care providers  
-- payment that is tiered so as to reward practices that make progress in  
 steadily achieving higher levels of evidence integrated care services across  
 evidence-based implementation framework domains.

6)c): Structures Needed for Organization-Level v Provider-Level Financial incents:

-- primary care *sites* participating in delivery of integrated care services should   
 directly receive financial incentives instead of such payments only going to the  
 healthcare system of which it is a part  
-- payments to primary care site providers should be tiered and tied to  
 attaining progress in advancing in integration implementation levels.

8)b): Implementation Challenges with Implementing Specialty, Condition, or  
 Setting-Specific Measures in PB-TCOC Models:  
  
-- accountability among providers: medical provider, behavioral health provider,  
 prescriber, patient, insurer … where should accountability lie, should   
 accountability be shared among providers, and if so, how?   
-- patient-centered measures: values and patients should be taken into account   
 and patient behavioral activation and active engagement prioritized  
-- patient-centered measures: including patient-reported outcomes (PROs), a core  
 element to quality measurement work and foundational to consumer/patient/family  
 advocacy and accountability efforts  
-- adequacy of health information sharing, analytical and reporting data bases  
-- addressing the question of whether measurement leads to improvement.

9): Best Practices for Establishing Benchmarks for Use in TB-TCOC:

-- use of consensus standards of care and evidence-based strategies  
-- team-based care of collaborating, trained medical and behavioral providers  
-- seamless physical and behavioral data information systems’ HIT   
 interoperability and data-sharing in real time  
-- integrated communications systems among medical and behavioral clinicians  
-- fully engaged patients playing key role in care team

11): What Should Relationship between TB-TCOC and Other Medicare VBP   
 Programs Such As MA Plans, MSSP, Look Like:

--MA and MSSP already have well-defined quality metrics, care delivery  
 standards, and payment strategies through which behavioral health   
 integration can be enforced and incentivized (BPC).

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