No Health without Mental Health
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January 23, 2026

The Honorable Gregory F. Murphy, M.D.
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Kimberly Schrier, M.D.
U.S. House of Representatives
Washington, D.C. 20515

The Honorable John Joyce, M.D.
U.S. House of Representatives
Washington, D.C.

Re: Legislative Reforms to Primary Care/ CMMI Models / Physician-Led Quality Programs

Dear Representatives Murphy, Joyce and Schrier,

NHMH – No Health without Mental Health is pleased, and appreciative of, the opportunity to respond to your bipartisan request for information regarding the above-referenced subjects. We greatly appreciate the leadership of the GOP Doctors Caucus to prioritize meaningful reforms to improve Americans' medical and behavioral health. We are also joined in this comment by the undersigned allied organizations at the end of this letter.

NHMH is a 19 yr old patient advocacy nonprofit with a focused mission to make evidence-based behavioral health (mental health + addiction) care widely available to Americans in medical settings. Since our inception NHMH has worked very closely with the internal medicine and family medicine fields, in addition to the behavioral health fields, including the National Academy of Science, Engineering & Medicine (NASEM), the American College of Physicians (ACP) and the American Academy of Family Physicians, among others. Our belief is that primary care clinicians should play a major role in the integration of behavioral health with physical health, and in primary care reform writ large, and should receive the support needed to do that. Ensuring primary care professionals are encouraged to participle in new care delivery and payment models, including behavioral health integration models, is foundational and should be central to your legislative work.

We are in full support of the recommendations made by the Primary Care Collaborative (PCC) in their January 16, 2026 submittal to you. In addition, we offer the following recommendations:

Question #1: What legislative reforms are most needed to ensure future CMMI models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?

In terms of priorities, we believe CMMI should be more aggressively pursuing more advanced payment and care delivery innovative approaches, particularly where there is already an existing scientific basis of proven effectiveness. We are in full agreement with the PCC that if Congress were to act on the 6 recommendations it submitted, that would allow CMMI to pursue bolder, more innovative, and much needed model testing to meet the moment the country is in.

Specifically, we would like to see CMMI better support prevention and management of patients' chronic conditions, both medical and behavioral, by targeting naturally-occurring clusters of chronic conditions for treatment in one integrated, multi-condition intervention, an approach robustly supported by the scientific literature evidence base, yet not implemented over the past 15 year.

We urge CMS/CMMI to prioritize the widespread implementation and dissemination of the proven TEAMcare model of behavioral health integration in primary care (McGregor et al, 2011, *Journal of Ambulatory Care Management,* 34: 152-162; Katon et al, 2010, *NEJM*, 363:27).

In the TEAMcare proven integrated, multi-condition primary care intervention, patients with diabetes, coronary heart disease and depression, all at risk for continuing, worsening and costly disease, received a care management intervention that integrated collaborative depression care with systematic chronic illness care designed to improve multi-conditions (diabetes, depression and coronary heart disease. Key components of the intervention are: patient-centered focus; collaborative patient-clinician goal-setting; practical care planning; and consistent, targeted patient support and assistance. Care managers worked collaboratively with the primary care physician and care team interventions for each condition until goals were reached.

The TEAMcare intervention has the potential to be widely adopted as a practical approach to managing multiple chronic medical conditions among patients with comorbid depression. These multi-condition approaches with a concentration on chronic conditions, should be CMMI's top priority for model testing. Testing and successful scaling of the TEAMcare multi-chronic-condition model has the strong potential to deliver much greater health, medical and behavioral, outcomes and cost savings than we are currently experiencing.

Question #2: If MIPS were to be reformed or replaced, what would a new physician-led quality program look like? How can we ensure a new program reduces administrative burdens and is applicable to all types of clinicians in all settings while focusing meaningfully on real outcomes?

We offer full support for the PCC enumerated recommendations on quality measures:
--government should act quickly to streamline and simplify quality measures stressing clarity;
--regulations should avoid measurement duplication and unnecessary measurement burden;
--incorporate new quality measures that better reflect the value of primary care with behavioral health integration
--health system benefits accrue when quality measures are evidence-based, standardized, collected, reported;
--common measure sets with transparency and accountability raise the level of quality measurement system-wide.

Accountability especially must be clearly and explicitly built in to new, advanced primary care services with clear, lean and less administratively burdensome quality measures. Measures that can evaluate the quality of new habits and skills needed by both patients and the integrated care team clinicians, are needed, as well as measures on the quality of external cooperative partnerships (e.g. with health professionals, or community social service entities) as recommended by NASEM.

Further, we urge Congress and CMS to consider adopting a new "advanced patient-centeredness" quality measure for use in integrated interventions as part of advanced primary care management (APCM) services. The data and studies demonstrate that effectiveness of new innovative care models often owe much to their pragmatic, patient-centered, patient-care team as partners in care approach.

Patient-centered processes that have been shown to facilitate improvements in outcomes are:

co-created care plan: care plans co-created by the PCP+care team and stress patient control and choice;
co-developed goal setting: treatment goals that are clear, shared by the care team and patient, and regularly reviewed by both;
behavioral health strategies: behavioral strategies as part of treatment that are consistently reviewed and updated by both patient and care team;

patient self-monitoring: patient self-monitoring goals that are co-created with the care team, clearly defined, an work in conjunction with the clinicians' measurement-informed care; and
medication measurement: regular, joint patient-care team review of the patient's medication regiment, and revision of the medication list to reflect what the patient is actually taking.

We recommend the CMMI focus on the following patient-reported outcomes measures for integrated, multi-condition treatment of co-morbid medical and behavioral chronic conditions all of which have been shown to improve outcomes and patient engagement:

patient quality of life	patient cost of care
patient continuity of care	patient comprehensive care
patient physical functioning	patient pain interference
patient social participation	patient-centeredness index score

We further recommend zero patient cost-sharing for advanced primary care services, behavioral health integration inclusive, as preventive services. Moreover, we encourage consistency with the American Board of Family Medicine (ABFM) sponsored quality measures: continuous patient-care team relationships; person-centered are; an comprehensiveness of care.

Finally, we urge CMS to test and where successful incentivize patient self-care strategies and activities as part of providing APCM services. CMS should research and develop innovative and cost-effective new 21st c means of patient self-care. Particularly for complex patients with comorbid chronic medical and behavioral health conditions. Successful integrated, multi-condition interventions have shown that self-care by patients is paramount to effect meaningful patient behavioral health change that translates into improved health outcomes and lowered total cost of care. Among the most effective self-care and related activities identified to date for this complex, comorbid patient population are:

*Patients' ability to be co-creators of their own care plans
*Use of home monitoring techniques
*Stress on simple and practical encouraging patient readiness to: health, behavior change, maintenance
*Patients seen in-person until relationships with care team established
*Attention to transition to maintenance care

Final Comment: The undersigned organizations take no position on the MIPS program itself.

NHMH and our allied partners appreciate the opportunity to work with you to further develop the above recommendations and create concrete legislative steps to reform MACRA and strengthen primary care. If our team can answer any questions or provide further information, please contact Florence Fee, NHMH Executive Director at florencefee@nhmh.org.

Sincerely,

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