



No Health without Mental Health
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November 1, 2021

The Honorable Ron Wyden
Chairman, Senate Finance Committee
United States Senate
Washington DC 20510

The Honorable Mike Crapo
Ranking Member, Senate Finance Committee
United States Senate
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo,

NHMH – No Health without Mental Health (www.nhnh.org), and the undersigned national advocacy and trade associations, submit the following comments in response to your Committee’s September 21, 2021 letter. We respond specifically to **“Increasing Integration, Coordination and Access to Care” section, and specifically to the 1st bullet - “What are the best practices for integrating behavioral health (BH) with primary care? What federal payment policies would best support care integration?”**

I. NHMH Background on Behavioral Health Integration

We are fully supportive of bi-directional integrated medical-behavioral care. However, our comments focus on best practices and payment approaches for integrating BH services into primary care as that is where the greatest lack of care exists for the most BH patients. 70% of U.S. patients with BH conditions only go to primary care, some even with serious mental illness. If we are to expand access to BH care in any meaningful way, we must address making behavioral health integration (BHI) available in medical settings, particularly primary care.

NHMH has a long history of behavioral health integration (BHI) advocacy:

- * a 14 year advocacy focus on this single issue of medical-behavioral integration;
- * no funding from government, corporations, foundations or guilds, allowing us to consistently represent the voice of the patient;
- * participation in three PCORI national clinical trials on BHI from 2015 to the present;
- * Dr. Wayne Katon of UW/AIMS, the creator of the collaborative care model of integrated care, mentored NHMH;
- * development of a national network of collaborators among researchers, clinicians, educators, stretching from Alaska (WWAMI) to Arkansas, and from Vermont (IBHPC) to Utah (Intermountain Health).

II. Best Practices and Payment Policies:

Based on this background, NHMH offers the Committee six major BHI best practices insights:

- (1) **Flexibility and Choice for Practices:** Given the enormous variety of characteristics which make up primary care practices across the U.S., it is vital to provide those practices and health systems with the ability to select from among a wide array of **proven, evidence-based** BHI approaches to pick an approach one that will work most effectively in their settings(s). We like to think of this as their going to a kind of ‘Cafeteria of Evidence-Based Behavioral Integration Approaches’ in which they consider demonstrated successful approaches that may best suit their own patient population needs, practice financial, operation and administrative situations, geographical area, and other relevant parameters. All the ‘selections’ on offer in the ‘cafeteria’ must have a strong evidence base of efficacy.
- (2) **Longer Timeframe to Demonstrate Results:** studies have shown that practices must be given at least 5-6 years to prove improved health outcomes and reduced costs. All the more so with CC as it involves root-and-branch transformation of the entire clinical care workflow involving the entire clinic staff and is almost always more challenging than practices expect (Source: UW/AIMS).
- (3) **Use of Proven Evidence-Based BHI Building Blocks:** Leaving the specific configuration to practices/system, the essential components for evidenced-based behavioral health care are at this point generally well-known:
 - * inter-disciplinary team-based care;
 - * evidence-based care;
 - * regular systematic monitoring of patient status;
 - * measurement-based care plus ‘treat-to-target’ adjustment when needed;
 - * care management using a care manager to educate patients, liaise with medic and behavioral clinicians, and facilitate links to community resources tackling social impediments to care;
- (4) **Payment eventually need be part of value-based payment models** where reimbursement is tied to health outcomes and lowered costs achieved. We realize that currently a majority of U.S. practices have one foot in FFS and one in value-based worlds. Yet, behavioral integration paid in FFS system is not sustainable as long as practice revenues depend on services volume, since, with integration will come less patient encounters. Rather, we need to set a clear goal of moving in a step-by-step fashion to capitation and value-based approaches. Accountable Care Organizations (ACOs) are a good example. Also, CMS/CMMI voluntary innovative delivery/payment such as CPC, CPC+, Primary Care First. A value-based approach will be able to capture the true VALUE of integrated medical-behavioral care since treated BH issues are shown to lower TOTAL healthcare costs.
- (5) **Behavioral health integration is integral to primary care reform**, not part of a separate ‘behavioral health domain.’ Any discussion of behavioral integration must be in the context of primary care re-prioritization and reform as well as the value-based delivery and payment reform movement. All of the above discussion is a lot to ask of primary care practices. Post-pandemic, a majority of U.S. practices are financially underwater, suffer burn-out and high staffing turnover, and are already challenged on many fronts to make transformative change and quality improvements, including tech innovations and data collection and reporting, with few supports and incentives from our national health system.
- (6) **More Models of Integrated Care Through Increased Federal Research Funding:** This will require increasing federal research funding by NIH/NIMH for the health services delivery. In its FY 2022 Congressional Budget Justification, NIMH indicated less than 10% of its research

funding budget would go to health services research, while 50% is targeted at genomic/neuro-biologic research. While the latter is important, there must be a balance. We need a national healthcare system that is better at DELIVERING the evidence-based BH treatments we already have to meet the needs of the 55 million Americans with BH conditions, half of which go untreated. NIMH should provide Congress with the breakdown on how it arrives at the funding figure for each research funding program area. NIMH's reporting to Congress makes it clear funding for services and intervention research has not moved from the 10% figure over the past few years. NIMH must increase that percentage of the total research grant funding budget devoted to services and intervention research.

III. The Way Forward As Shown in Two 2021 Excellent Reports by BPC and NASEM:

NHMH strongly endorses two very recent reports on BHI: one by the Bipartisan Policy Center (BPC) and the other by the National Academy of Sciences, Engineering & Medicine (NASEM), both published in 2021, which chart a way forward on integration of behavioral health. We urge the Committee to study these recommendations closely particularly the BPC's precise, thorough policy proposals, the highlights of which we report below.

BPC Report: The Bipartisan Policy Center (BPC), in its March 2021 report "Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration" (link to full report attached) has set forth a series of thorough, precise policy recommendations to policy-makers and legislators. We strongly urge the Committee to consider and support its recommendations.

NHMH fully endorses what we believe are the key BPC BHI policy recommendations:

Congressional Legislative Action:

1. Congress direct CMS to encourage BHI in State Medicaid programs as a priority through creation of a new Social Security Act Sec. 1115 waiver opportunity, or new grant program for States. Sec. 1115 waivers for a BHI model should be with benchmarks tied to incentive payments for each level of integration achieved (BPC BHI Report, pp. 8-43).
2. Congress direct CMS to create and offer an Integrated Health Model (IHM) voluntary option for primary care providers in traditional Medicare, offering comprehensive, risk-adjusted, PMPM payments for outpatient primary care with integrated BH services (pp. 49-51).
3. Congress update the Affordable Care Act (ACA) to: a) include BH in the Medicare Shared Savings Program (MSSP) program requirements, and (b) update the Medicare Accountable Care Organizations' defined components to require sufficient number of BH professionals per number of Medicare beneficiaries, and make BHI a core ACO process (pp. 44).
4. Congress require Department of Health and Human Services (HHS) BHI-relevant operating units (e.g. CMS, HRSA, SAMHSA, AHRQ, HIS, NIMH etc) to advance BHI through creation of a Federal Strategic Plan for Behavioral Health Integration,

including developing greater inter-agency coordination and collaboration to advance medical-behavioral care.

HHS Agency Executive Regulatory Action:

1. HHS Secretary review and develop a standardized set of quality measures (QMs) in consultation with leaders in BHI practice and implementation, and develop an integrated care quality initiative inclusive of process and outcomes measures, implementing those measures in Medicaid Managed Care Organizations (MCOs), Medicare MSSPs, Medicare ACOs, and Medicare Advantage programs and plans (pp. 27-29).
2. HHS Secretary review and develop core QMs for BHI in consultation with leaders in BHI clinical practice and implementation, and apply across all HHS unites and programs (p. 62).
3. HHS Secretary require Medicaid MCOs, Medicare ACOs and Medicare Advantage (MA) plans and other entities providing integrated medical-behavioral services to report on measures that capture mobile health and EHR interoperability and add BH professionals to receive HITECH Act federal financial incentives for EHR adoption (p. 81).

Agency Operating Division Regulatory Action:

1. CMS work with States and insurers to ensure multi-payer alignment with Medicaid and commercial payers including in Medicare MA plans for providing BHI.
2. CMS require States to describe in their State Quality Statement for Medicaid MCO contracts how States will work with MCOs to advance BHI (pp. 36-7).
3. CMS revise the Medicare MA performance rewards STAR ratings to add BHI measures (p. 46).

NASEM May 2021 Report on “Implementing High-Quality Primary Care”:

We draw the Committee’s attention to the NASEM report’s Chapter 5 “Integrated Primary Care Delivery” (and also Chapters 6 and 9 on workforce and payment respectively).

We especially urge the Committee to consider the discussion on two highly successful established behavioral integration programs: Alaska’s Southcentral Foundation (Nuka Health system for Alaska Native and American Indian people), and Utah’s Intermountain Health System’s successful 20-year program of integration for Utah, Idaho and Nevada citizens (pp. 144-147).

Additionally, we attach a October 26, 2021 joint letter from NHMH and several other respected national advocacy and professional organizations to NASEM, in which we express full support for its May 2021 Report on Implementation of High-Quality Primary Care, and suggest that going forward they consider

adopting a specific focus on chronic medical conditions, medical-behavioral co-morbidity and behavioral integration.

Respectfully submitted,

NHMH – No Health without Mental Health

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Attachments (5):

BPC March 2021 BHI Report li

NHMH Summary BPC Policy Recommendations re actions to be taken

NHMH Summary BPC Policy Recommendations re payment/workforce/system change/tech

NASEM May 2021 Report on Implementation of High-Quality Primary Care link

Joint Advocates October 26, 2021 Letter

<https://bipartisanpolicy.org/report/behavioral-health-2021/>

<https://mailchi.mp/nas.edu/implementing-high-quality-primary-care-study-release-may-4?e=517e7e8928>