



No Health without Mental Health  
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June 12, 2015

The Honorable Orrin Hatch  
Chairman  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, D.C. 20510

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, D.C. 20510

Dear Chairman Hatch and Senator Wyden,

**Executive Summary:**

This submittal from NHMH – No Health without Mental Health urges the U.S. Senate Committee on Finance to address the critical need of Medicare patients for treatment of both their chronic medical conditions, as well as behavioral conditions, together, in a coordinated fashion, by providing care coverage for proven, evidence based integrated care approaches, such as the collaborative care model (CCM,) shown to both improve health outcomes, medical and psychiatric, and lower costs.

Presently there is a serious concern in the country for the financial sustainability of Medicare, given increasing rates of chronic disease burden, e.g. diabetes, coronary artery disease, chronic obstructive pulmonary disease, depression, dementia, etc in an environment of an aging population.

Often these patients' medical and behavioral conditions are inextricably intertwined, yet the behavioral issues often go untreated, resulting in a doubling or quadrupling of *medical* care claims and costs. Since many Medicare patients suffer *multiple* chronic medical conditions, when you add in the additional cost of untreated behavioral problems, the result is exponential total healthcare costs.

CCM is an evidence based, patient-centered approach in which primary care mid-level providers, e.g. nurses or master's in clinical social work, work closely with primary care physicians (PCPs)/nurse practitioners/psychiatrists to improve patient mental health in primary care.

Given all of the above, we recommend the Committee on Finance incentivize the widespread dissemination and implementation of the evidence based CCM in primary care by allowing for the following Medicare reforms:

- 1) Provide program coverage for the evidenced based collaborative care treatments of behavioral illnesses and physical illnesses for their beneficiaries in the medical setting;
- 2) Designate billing codes and adequate payment for the evidence based care management and psychiatric consultation services that are the key components of CCM; and
- 3) Develop case rate payments for primary care clinics that provide evidence based CCM, including effective care management and psychiatric consultation.

## **General Discussion:**

NHMH – No Health without Mental Health, [www.nhmf.org](http://www.nhmf.org), expresses its appreciation to the Senate Committee on Finance for providing the opportunity to submit recommendations on how to improve outcomes for Medicare patients with chronic conditions in evidence based ways that not only improves their health but also lowers healthcare costs. Thank you.

NHMH is a 501©(3) tax-exempt, bipartisan, nonprofit advocacy organization, established in 2007, with offices on both the West and East Coast (Arlington, VA), dedicated solely to the mission of advancing evidence based integrated medical/behavioral care, as both a clinical reality in medical practices around the country, and gradually leading to a new cultural, social norm that “health” is widely understood to encompass both elements of care. We advocate for behavioral health integration into primary care, as well as medical integration into specialty behavioral health settings. We work with top-tier researchers and clinicians in the field of science and medicine to bring evidence based integrated care innovations to the attention of policy makers, and advocate for development of health policy reforms advancing such integrated care and its their wider adoption in the medical field.

CCM allows the primary care physician (PCP) to treat the Medicare patient’s physical and mental health conditions in primary care, while still retaining overall responsibility for patient care. It is a model that has a 20 year robust research base, demonstrating improved health outcomes and lowered costs.

It is also a model that has been embraced by PCPs who heretofore have been frustrated at being largely unable to access mental health care for their co-morbid patients. CCM will leverage the skill-sets of scarce behavioral health professionals, such as psychiatrists, psychologists and psychiatric nurses, to expand their consultative and treatment reach into primary care, giving many more patients access to mental health care.

CCM is characterized by 5 essential principles:

1. Patient centered: with primary care and mental health providers collaborate effectively using shared care plans;
2. Population based: a defined group of patients is tracked in a patient registry so that no one falls through the cracks;
3. Treatment to Target: progress is measured regularly and treatments are actively changed until clinical goals are reached;
4. Evidence based care: providers use treatments that have research evidence for efficacy;
5. Accountable care: providers are accountable and reimbursed for quality of care and clinical outcomes, not just volumes of care.

The requisite workforce components of the CCM are the PCP, the care manager, and the psychiatric consultant. Recent Medicare reimbursable payments for care coordination now cover some of the services of the care manager, but do not cover the psychiatric consultant’s services.

Re health outcomes, numerous studies have proven that CCM successfully addresses depression, especially in older Medicare beneficiaries, anxiety disorders, symptoms of dementia and chronic pain, in primary care settings. A recent landmark study found that CCM targeting depression, diabetes and coronary artery disease not only improved depression but also improved patients’ control of diabetes, blood pressure and cholesterol.

Re costs, CCM in primary care has also been found to be cost effective, due to cost reductions not just in psychiatric care, but also in medical care costs, including reducing medical hospitalizations. These results are of particular relevance for Medicare patients, including those in Medicare managed care.

A major driver of escalating costs for Medicare is hospitalizations, some of which may be preventable. Ambulatory care-sensitive conditions (ACSCs) comprise a group of chronic and acute illnesses, e.g. diabetes, CAD, COPD, etc) considered not to require inpatient treatment if timely and appropriate care is received. In the U.S., ACSC-related hospitalizations comprise 10% of all admissions and cost approximately \$31 billion annually. Also, readmissions within 30 days of discharge have been found to occur with 20% of Medicare patients and are extremely costly. Studies have shown that psychiatric illnesses play an important role in leading to potentially preventable hospitalizations. Studies have shown that Medicare patients over 50 with depression were 33% more likely to be hospitalized for an ACSC, and those with co-occurring depression and dementia were 66% more likely to be hospitalized for an ACSC. Further, Medicare patients over 50 with depression were 37% more likely to be readmitted within 30 days after a hospitalization for a heart attack, pneumonia or congestive heart failure.

CMS/CMMI is currently funding an important demonstration project called COMPASS (Care of Mental, Physical and Substance Syndromes) which tests the best-of-the-best collaborative care implementation in a variety of clinical settings and across multiple state healthcare groups; results are due in Fall 2015. Its eight healthcare organization participants include some of the finest in the country, e.g. ICSI, Mayo, AIMS Center, KP-SC, KP-CO, MACIPA, among others.

**Conclusion:** Collaborative care, a care delivery model to improve the care of psychiatric illnesses in primary care settings, offers an important opportunity to reduce Medicare healthcare costs while simultaneously improving patients' health outcomes, both behavioral and medical.

Given the enormous database of research supporting both the outcomes and cost effectiveness of primary-care based CCM, and the major role that chronic disease costs, such as those for potentially preventable hospitalizations, play in challenging Medicare sustainability going forward, NHMH – No Health without Mental Health strongly recommends that Medicare programs provide coverage for CCM treatments of psychiatric illnesses and chronic medical conditions for their patients and allow for payment mechanisms for providers offering evidence based collaborative care.

Providing CCM coverage will not only improve the quality of life and functioning of older Americans, but, if implemented widely, is highly likely to contribute to overall reductions in Medicare costs.

Respectfully submitted,

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(Supporting scientific/medical research references available upon request).

