



No Health without Mental Health
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January 20, 2016

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

The Honorable Johnny Isakson
United States Senator
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

The Honorable Mark R. Warner
United States Senator
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Re: **U.S. Senate Committee on Finance - Bipartisan Medicare Chronic Care Working Group - Policy Options Document of December 2015**

Dear Chairman Hatch, Ranking Member Wyden and Senators Isakson and Warner,

In response to your December 18, 2015 invitation to stakeholders to provide feedback on the above-referenced Policy Options Document (POD), NHMH – No Health without Mental Health, www.nhnh.org, a patient advocacy organization, is pleased to submit comments on specific policy proposals that have been shown to improve integrated care for individuals with chronic medical disease and co-morbid behavioral (i.e. mental health and substance use) disorders.

We commend the Senate Finance Committee and Working Group (WG) for focusing needed attention on policies that will improve the integration of care for individuals with chronic medical disease combined with behavioral health disorder (POD, pg. 12).

NHMH is a qualified 501©(3) nonprofit formed in 2007 with offices in San Francisco, CA and Arlington, VA, and a dedicated mission to make evidence-based behavioral health care widely available in primary care, and in all medical settings, a clinical reality. And secondly, by so doing, to create a new broad societal acceptance and *expectation* that healthcare in the medical setting will encompass *both* physical *and* behavioral care services. NHMH believes once that integrated care is indeed available in primary care, we are certain that Americans in large numbers, including older adults, will access that care.

NHMH strongly encourages the Finance Committee's adoption of policy proposals that improve and integrate behavioral health care services in primary care. Primary care is where 80-85% of patients with behavioral health conditions go for care. Depression is among the most common chronic illnesses in the

aged-in Medicare population, affecting approximately 11.5% of Medicare beneficiaries, with estimated costs of approximately \$65 billion annually. Depression often accompanies chronic medical conditions.

Adopting policies that strengthen and support behavioral health services in primary care is urgently needed for three reasons:

- 1) The majority of Medicare patients with chronic medical and behavioral health problems receive their care in primary care;
- 2) The quality of behavioral health care in primary care is now substandard, where that care exists, due mainly to primary care physicians' (PCPs) lack of training in behavioral health; that said, we are very cognizant of *the need to support PCPs' adoption of integrated care* since their medical practices are now undergoing massive change, on many levels, at once;
- 3) Treating co-morbid Medicare patients in both their physical and behavioral illnesses offers major cost savings opportunities.

The WG correctly noted that ACOs and other value-based care delivery models face challenges integrating primary care and behavioral health services, despite the benefits of doing so. This despite extensive research data showing integration of behavioral care in primary care can improve health outcomes, care coordination, and lower care costs. (POD, pg. 13).

NHMH's comments contained herein are focused on policy option proposals that include behavioral health services in Accountable Care Organizations (ACOs); current challenges to including BH services in ACOs; and what can be done.

There is more interest in integrated medical/behavioral care in the last 5 years than we have seen in the previous 20 years. Multiple systems of care are moving toward patient-centered primary care homes, ACOs, and prevention of 30 day readmissions to hospital. As they do so, they are realizing that many of the high-cost patients have medical-behavioral co-morbidity, and that they will *have to* integrate mental health care in order for them (i.e. health systems) to be successful. The 2010 Affordable Care Act is helping push much needed care delivery reforms in the right direction, but it is a bit like turning the Titanic because there are always vested interests that will fight these changes. Nonetheless, the Committee's watchword must be: What is best for the patient while also affordable for the country?

What is happening now is that as health systems develop ACOs, little thought is being given to the inclusion of behavioral health (BH) services *as a part of core provider participation and service delivery*. For many health systems who even think of this possibility, the separate, siloed BH payment and service delivery procedures lead them to exclude active BH participation for logistical reasons. Policy proposals must be developed to overcome this systemic barrier preventing integrated care delivery.

The overarching goal has to be to make it *feasible* for primary care clinics to offer BH services, since BH co-morbidity in primary care is associated with medical treatment resistance, especially in older, complex high-cost patients, resulting in large increases in total health spending. We must find ways to reimburse BH professionals who assist PCPs in delivering mental health services in primary care, such as creating entirely new payment models. The two most promising payment models NHMH would

recommend are: (a) shared savings with BH quality measures, such as depression symptom improvement, and/or depression remission; and (b) a case rate, or capitated per enrolled patient per month, provider payment, where significant pay-for-performance payment bonus is included.

Since the main goal of ACOs is to improve health and lower costs, without the inclusion of BH professionals and services as core members and activities in ACOs, those goals will not be met.

ACOs will increasingly assume full risk for total health outcomes and costs of the patient populations they serve. Only by including BH professionals will they have the opportunity to capture savings by decreasing unnecessary medical service use, as BH conditions such as depression + diabetes, treated in the medical setting, come under control.

We must incentivize policy that allows for coordination and communication between medical and BH practitioners. *By having BH specialists as part of ACO networks*, BH providers will be able to utilize the same clinical documentation, communication and outcome recording approaches, implement the same quality care guidelines, have performance judged by the same outcome metrics as other providers, and have their outcomes analyzed within consolidated medical and BH findings.

NHMH supports policies that permit integration of BH services in a way that maximizes the benefit to the most needy, costly patients, while also establishing value-added programs that produce the best outcomes. Introduction of medical-behavioral “teams” to deliver value-added services for targeted high risk, high cost medical patients is, we believe, the best approach. At-risk patients can be identified, and this should start with chronic and complex patients in medical settings. Once identified, such patients could then be served with the value-added BH services needed.

While each ACO will design a future operational scenario gauged to its own mission, vision and goals, ultimately the desired outcomes is the creation of an ACO that maximizes health, while conserving delivery systems’ resources, in a patient-friendly system. It is therefore necessary to *stage the transition* in a way that financially supports health systems going from fee-for-service contracting, to risk-bearing global contracting for services.

As described in our recommendations above, NHMH strongly encourages the Senate Finance Committee to adopt the above-described policy approaches that improve behavioral health care services in primary care. Such policy reforms will increase access to high quality behavioral health care for thousands of Medicare patients with co-morbid chronic conditions , vastly improving their quality of life and productivity, and will save the U.S. Treasury and taxpayers significant amounts of money, during a time of financial and demographic pressure on government programs such as Medicare.

Sincerely,

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Executive Director

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