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The Honorable Mr. Ron Wyden, Chairman
The Honorable Mr. Mike Crapo, Ranking Member
U.S. Senate Committee on Finance

Dear Chairman Wyden, Ranking Member Crapo, and Committee Members,

On behalf of the Mount Sinai Health System, I would like to thank you for this important opportunity to respond to the Committee's request for input on improving access to behavioral health services. The Mount Sinai Health System (MSHS) is an integrated health care system comprised of eight hospitals, over 400 ambulatory practices, and medical, graduate and nursing schools. MSHS is one of the largest not-for-profit healthcare providers in the New York area, with over 43,000 employees. MSHS also has one of the largest and most comprehensive platform of clinical behavioral health services in the New York area. We provide a robust continuum of behavioral health care, with inpatient psychiatric and addictions services; psychiatric emergency services; a diverse array of outpatient behavioral health services for all ages and all types of illness; integrated primary care and mental health care; and community-based services. Prior to the pandemic, MSHS annually had over 1.3 million outpatient behavioral health visits, nearly 10,000 inpatient behavioral health discharges, and over 15,000 psychiatric emergency visits. MSHS has deep expertise and commitment to the care of people with behavioral health conditions, as evidenced by the breadth and depth of our services.

The Mount Sinai Health System therefore respectfully provides input in the following areas specified in the letter from the Committee:

- **Ensuring Parity**
- **Increasing Integration, Coordination, and Access to Care**

We will begin with an overall summary of some of the core issues impacting behavioral health care, and how this translates into continuing disparities. This summary addresses several of the question content areas posed by the Committee. We will then outline some additional key points/recommendations regarding the specific questions raised by the Committee. Finally, we conclude with a potential model of clinical care and funding that may address many of these issues. The reimbursement recommendations made in this letter will be critical to the success of this model.

Summary of Core Parity Issues for Behavioral Health Care

Behavioral health services for mental illness and addiction have historically been siloed from physical health care, and often even between each other. Moreover, the complexity of the system of behavioral health services creates significant challenges in timely and effective access and engagement by the population at large. Behavioral health care delivery must be organized to reflect how such conditions affect the whole person, and serve as a basis of integrating back or achieving better functioning of all aspects of a person's physical, mental and emotional life. The COVID-19 pandemic has exemplified the bi-directional impact of physical and behavioral health *(Czeisler et al, 2020)*. Moreover, the pandemic has further emphasized the need for seamless and timely access to behavioral health services *(Smith, et al, 2021)*.

The issue of access to behavioral health services is not simply one of needing more providers. Access is further complicated by difficulties both patients and other providers face in navigating the different types of behavioral health services. Furthermore, there are critical gaps in types of behavioral health services. The majority of services focus on primarily inpatient and clinic-levels of care. However, in order to effectively treat many behavioral health conditions, as well as to move the field towards a more prevention-oriented model of care, we must increase the number of crisis and intensive outpatient services.

Despite this increasing recognition, many healthcare entities do not choose to offer behavioral health services at all, nor expand services. This is not due to lack of awareness of need; rather it is due to the **under-reimbursement of behavioral health care**. The bottom line is that most behavioral health care providers cannot even meet direct costs of care from payments alone. This is because fee for service payment methodologies are not aligned to the method and content of how behavioral health care is delivered. Over the years, there have been adjustments to the standard fee-for-service methodologies to account for some core differences (i.e., the inpatient psychiatric facility payment system). However, critical crisis services, outpatient services, and outreach and care coordination services remain underfunded and cannot meet direct costs without grants, subsidies or philanthropy. **This chronic under-reimbursement of behavioral health services is in and of itself an example of the lack of parity for behavioral health care**.

Although Federally Qualified Health Centers (FQHCs), Community-Based Organizations (CBOs), and individual provider practices all provide important care, hospitals are uniquely able to provide and lead the kind of robust continuum of care that people with behavioral health conditions need. However, if the basic costs of care cannot be met, hospitals cannot sustain investments in behavioral health care. Moreover, other behavioral health providers rely on public or private grants because payment revenue alone does not meet direct costs of care. This is a vicious cycle of fiscal unsustainability throughout the behavioral health care system that results in **excess emergency visits and hospitalizations. This is not just for behavioral health conditions, but also for physical health conditions, which are exacerbated by untreated or undertreated behavioral health conditions. The ultimate result is increasing health care spend with limited concurrent actual improvement in the state of health.**

Key Points/Recommendations:

A. Ensuring Parity

The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) has been a vitally important step in ensuring parity for behavioral health parity. As noted in the Committee's request for input, there are still key issues that must be addressed to fully achieve a state of parity.

1. **Structural Barriers**: The Committee inquired about additional structural barriers exist that prevent full implementation of behavioral health parity. There is no question that the some of the barriers listed—network inadequacy, medical necessity policies of some health plans which flout basic tenets of MHPAEA—are all significant contributors. However, many of these barriers all root back to the core issue--**the basic reimbursement methodology for most health care services does not adequately take into account the unique service delivery model of behavioral health services**. The following provides some concrete examples for why this is so:

    a. Unlike other medical practices, psychiatric and some addiction services **do not have "physician extenders"** who can provide the kinds of services provided by medical physician assistants, nurse practitioners, or registered nurses. This is because the very **nature of the work of treatment for behavioral health disorders involves a one-to-one work between the provider and the patient,** and the provider cannot "delegate" pieces of individual psychotherapy and treatment. The majority of the work must be done by the single provider—in a limited amount of time.

    b. Counseling or psychotherapy visits cannot be completed in 15 minutes by default of the nature of the treatment. While physical health practices can incorporate as many four patients per hour per provider, therapists can only accommodate realistically at most two per hour. **A payment system that fundamentally is time-based does not permit a financially sustainable outpatient behavioral health practice.**

    c. **The current payment system primarily recognizes physical procedures which require equipment as worthy of higher reimbursement.** The system must concretely recognize that the "equipment" used in behavioral health care is the provider's mind and relationship to the patient, and that the tools to improve health are not just those that are tangible. On the behavioral health provider's end, there must be better use of standardized screening, diagnostic and progress evaluation instruments. Many such instruments exist and need wider adoption, and should be included as part of the "operational integration".

Recommendation #1: This fundamental structural barrier of adequate reimbursement of behavioral health services puts these services at a significant disadvantage, arguably more so than physical health services, even in comparison to primary care services *(Melek SP, 2019)*. Ideally, for behavioral health services to start on the same "level playing field" as physical health services, a payment model that provides a form of upfront funding to address the baseline under-reimbursement of behavioral health services would create significant immediate financial stability for struggling behavioral health services. This could be in the form of testing out an **alternate and more simplified outpatient behavioral health payment methodology**. This would be in principle similar to the rationale for the existence of the Centers for Medicare and Medicaid Services' Inpatient Psychiatric Facility payment system. **It could include, for example, adjusted rates for psychiatry Evaluation and Management codes; or per-patient or per-practice behavioral health case management fee to address the existing unfunded case management that behavioral health providers have always done as a basic part of care.**

Recommendation #2: The predominant way forward for health care however, must be via a value-based payment system. We recommend testing a **global risk model that incorporates an upfront capitated payment** (a percentage of premium). **This model best reflects the concept that the returns on investing in behavioral health services will actually come from decreased physical health spend.** The Mount Sinai Health System conducted a two-year total cost of care, value-based payment pilot for the HARP population, which resulted in $1.3 million dollars in Medicaid savings in the second year. There was a reduction of nearly $42 per member-per month (PMPM) in overall spend, and this was largely driven by a **reduction in inpatient medical spend** (decrease of $27 PMPM). There is also ample evidence from outpatient behavioral health integrated practices that additional funding for behavioral health is offset by significant savings in physical health spend *(Melek SP et al, 2018; Simon GE, 2007)*. In addition, it is important to include in the financial model that there will be an increase in behavioral health spending – but that over time, the overall health improvements from these services will result in a significant reduction in physical health spending.

2. **Health Plan Policies and Practices**

As noted in the Committee's letter, many health plans continue to work around parity rules. Wit v United Behavioral Health is just one of many publicly known examples. In this particular lawsuit, the finding was that United Behavioral Health had a clinical medical necessity policy that at core violated parity rules. However, there are other more subtle ways that some health plans skirt the spirit of the MHPAEA rules. We recommend reviewing the following:

Recommendation #3: The technical billing systems requirements of health plans need to be more thoroughly reviewed. The disparity not only shows up in policy, but also how well these technical

systems are configured to properly pay behavioral health claims. Behavioral health payment codes are quite complex, vary state to state, and many are different from the traditional payment codes largely used by the rest of the health care system. Much of the issues with timely payments and incorrect payments, arise from the technical difficulties and level of proficiency health plans have with behavioral health billing and reimbursement.

Recommendation #4: Health plans that have a national presence vs. those which have more local markets should be reviewed, with an eye towards how well health plans with a national market technically operationalize and follow the local state rules. Similarly, a review of differences between plans which manage behavioral health claims "in-house" versus those with a separate behavioral health claims system/vendor should occur.

Recommendation #5: Finally, health plans must be fully engaged and willing to participate in large-scale value-based payment programs for behavioral health populations. Physical health and behavioral health claims data and operations are often siloed from each other in health plans. Plans should undertake in-depth analysis of their members to better understand how behavioral health conditions impact physical health spend, and engage in rigorous and serious collaborations with behavioral health providers accordingly.

B. Increasing Integration, Coordination, and Access to Care

1. **Lack of Integration Between Mental Health and Addictions Care:** The separation of physical and behavioral health perpetuates disparities, and there are many different efforts to dissolve these silos. Medicaid and Medicare funding of collaborative care models and telebehavioral health services are concrete and important first steps. However, a key aspect of integration that is not often discussed is the **existing separation of care even within behavioral health care.** The most obvious form of this is the separation (by regulations and by funding) of mental health care and addictions care. Federal and state laws often inadvertently perpetuate this silo even within behavioral health services. The **net result is that there are actually three main systems of care: 1) physical health care; 2) mental health care and 3) addictions care.** This tripartite and oft-uncoordinated system creates significant complexities and confusion for the average consumer of health care services, and even for providers themselves. This is due to differing and often complex regulations regarding eligibility criteria for services; varying payment rules and regulations that are different even between mental health and addictions care. The outcome is too often that patients and providers have difficulty not only finding available behavioral health providers, but also finding the right type of behavioral health care for themselves or their patients. **As a result, they may often give up on getting care, or get care only when the illness has progressed significantly and with much greater harm.**

2. **Lack of Integrated and Coordinated Multi-Level Behavioral Health Care:** Another aspect of clinical integration that is often not discussed is the lack of an integrated continuum of levels of behavioral health care, depending on the type and severity of the condition, within behavioral health services. For physical health services, this already exists, but for behavioral health, many providers only have one or two such services. A hospital with an inpatient psychiatric unit but no outpatient services, or a hospital with a clinic but no sub-acute/intensive outpatient behavioral health services (such as partial hospitalization or intensive outpatient programs) result in greater risk of unnecessary emergency room visits and further hospitalizations, with no substantial improvement in behavioral health outcomes. **The needs of a patient who is recovering from an acute mental illness are akin to those who need continued sub-acute care after having a stroke; yet, due to again the under-reimbursement of behavioral health services, providers are not able to create these critical "sub-acute behavioral health' services.** Some hospitals do offer several levels of behavioral health care, but this adds to the financial instability of these hospitals, and therefore no incentive to further expand. Payment models must promote the development of a full continuum of behavioral health services beyond inpatient care *(Pinals et al, 2017).*

3. **Integration needs to Emphasize Prevention:** The behavioral health field is increasingly recognizing the need for preventative behavioral health care. Models such as CAHOOTS, as noted by the Committee, and New York State's own Mobile Crisis Teams and overall mental health crisis services platform demonstrate that when well-coordinated, the system can identify and help patients earlier in their course of illness, and mitigate the severity of the illness (which results in decreased need for emergency visits or hospitalizations). The Mount Sinai Health System engaged in a multi-year pilot with New York State agencies to further improve the work of these Mobile Crisis Teams, as well as test out a new outpatient clinic-based "Mobile Outreach Team". We are happy to provide to more information on these teams and our pilot, which demonstrated significant results in attending outpatient behavioral health visits and engagement in treatment.

In light of the aforementioned issues, we respectfully make the following additional recommendations:

<u>Recommendation #6:</u> A **more robust funding and a payment system that incentivizes a multi-level and integrated outpatient level of behavioral health care is needed**. This payment system provides not only adequate reimbursement for not only clinic-level services, but also **intensive and community based options such as partial hospitalization/intensive outpatient programs, crisis and respite programs, mobile crisis teams, home and community-based services, and recovery-oriented**

services. Although some of these programs are already paid by Medicaid, such programs often still cannot meet direct costs of care, and many are not funded by Medicare.

Recommendation #7: Reimbursement for "Behavioral Health Care Engagement and Coordination": For true system –wide integration to work as outlined above, adequate payment for care coordination specific to people with behavioral health conditions must be included. Behavioral health providers have long provided care coordination services as a part of ongoing individual treatment, most of which is un-reimbursed. Moreover, the kind of care coordination and engagement requires specific expertise and approach. There are hundreds of behavioral health diagnoses, and the **coordination needs and approach for someone with schizophrenia with diabetes and homelessness are different than for someone with episodic moderate depression who can maintain housing and employment**. **Care coordination must be tailored, and must be viewed for some patients as a lifelong need, and not just a one-time assist**. A "Behavioral Health Care Engagement and Coordination" service would provide the critical "glue" that helps patients navigate the entire health care system. These teams of behavioral health care coordinators would have expertise in the behavioral health care system and the diverse needs of patients with different behavioral health diagnoses. They would also have the flexibility to serve certain clients on an ongoing, rather than one-time, basis.

Moreover, financial recognition of the behavioral health provider as the gatekeeper/organizer of care, similar to what primary care practitioners do, is critical. Many patients with behavioral health diagnoses are much more connected to their behavioral health provider than any other provider type. A care coordination system in which the behavioral health provider is formally recognized the organizer of all health care, with these Behavioral Health Care Engagement and Coordination teams working directly to with patients at the direction of the provider, is critical to the successful implementation of behavioral health integration.

A Proposed Model Solution

It is critical to preserve and expand behavioral health services by creating a sustainable path forward for hospitals and all behavioral health providers. We have described above some of the key barriers, as well as key recommendations to help improve access, better ensure parity, and create sustainability. We have also described some of the key clinical and operational elements to achieve these goals. In fact, the Mount Sinai Health System has already created a clinical model of an organized and integrated continuum of behavioral health inpatient, emergency/crisis, outpatient, and community outreach and coordination services. Drawn from the work of refining and integrating our existing services, we are currently building a new Mount Sinai Comprehensive Behavioral Health Center, which is scheduled to open in early 2023.

This Center will be a 'one-stop-shop', and includes an integrated continuum of behavioral health care and physical health care all in one physical location. The Center is based on our model of "**Comprehensive Integrated Behavioral Health Care". This model includes the following key elements** (See Addendum 1 for detail on types of services in each level):

- Services from each of the following 5 main levels of clinical behavioral health care:
  - Inpatient
  - Emergency, Crisis, and Outreach
  - Intensive/Subacute Outpatient
  - "Behavioral Health Primary Care" (i.e., traditional clinic, both for mental health and addictions)
  - Community-Based Care
- Integrated Primary Care with Behavioral Health
- Behavioral Health Care Engagement and Coordination Teams
- Telebehavioral Health

We believe that this model can be replicated; providers adopting this model ideally can have all of these services physically integrated in one site, but it may also include functional organization of multiple levels of behavioral health care at different sites. Although a hospital may be the lead in organizing this model, non-hospital behavioral health and community-based providers should be included to create this continuum. The payment methodology changes made in Recommendation #1 and #2 would concretely allow this model to be sustainable: 1) an alternate outpatient behavioral health payment methodology that helps create more immediate financial stability for providers; and 2) which allows them to build and refine the model of care that would be successful in a value-based global risk model of payment. **Adequate reimbursement of this innovative model, based on principles and recommendations as previously outlined, is critical to its sustainability.**

Thank you for this opportunity to provide input into this critically important issue. Please do not hesitate to contact me at Sabina.lim@mssm.edu, or 212.659.8962 if you have any further questions or would like any further discussion.

Respectfully Submitted,

Sabina Lim, MD, MPH

Addendum 1: List of Major Types of Behavioral Health Services

- **Acute Services:**
  - Inpatient Psychiatric
  - Inpatient Detoxification/Rehabilitation

- **Emergency, Crisis and Outreach:**
  - Comprehensive Psychiatric Emergency Program (CPEP: includes psychiatric emergency room, 72 hour psychiatric observation beds, Mobile Crisis Teams)
  - Crisis Residence Beds
  - Crisis Stabilization Centers
  - Ancillary Detoxification
  - Addictions mobile treatment services (i.e., detox, outreach and engagement)
  - Select Home and Community Based Services (HCBS)

- **Intensive/Subacute Outpatient:**
  - Partial Hospital Program (Psychiatric)
  - Intensive Outpatient Program (Psychiatric and Addictions)
  - Assertive Community Treatment (ACT) Team
  - Ambulatory Detoxification

- **"Behavioral Health Primary Care" (i.e., Outpatient Clinic)**
  - Office-based behavioral health (Psychiatric and Addictions-i.e., clinic-based care)
  - Opioid Treatment Programs

- **Community-Based Care:**
  - Select Home and Community Based Services (HCBS)
  - Psychosocial clubs
  - Peer Support Programs
  - Personalized Recovery-Oriented Services (PROS)
  - Day Treatment Programs

Addendum 2-References:

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