primary care collaborative

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January 26, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Dear Secretary Becerra and Administrator Brooks-LaSure,

The Primary Care Collaborative has developed recommendations to advance integration of primary care and behavioral health and I write today to share those recommendations with you. PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 60+ organizational Executive Members (see pps 8-9) ranging from clinicians and patient advocates to employer groups and health plans. PCC's members share a commitment to an equitable, high value health care system with primary care at its base: care that emphasizes comprehensiveness, longitudinal relationships, and "upstream" determinants for better patient experience and better health outcomes. (See the Shared Principles of Primary Care.)

America's specialty behavioral health delivery system is overwhelmed by increasing suicide rates,[1] accelerating rates of substance use disorder deaths[2], and a tripling in the prevalence of depressive symptoms since the beginning of the pandemic.[3] Moreover, noted disparities in mental health by rurality and economic circumstances exist, and for the first time in several years, proportionally more drug-induced deaths among Blacks than whites.[4] The United States will only be able to meet this urgent set of national issues by leveraging team-based primary care that includes behavioral health integration and is available in *all* communities.

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[1] Hedegaard H, Curtin SC, Warner M. Suicide mortality in the United States, 1999–2019. NCHS Data Brief, no 398. Hyattsville, MD: National Center for Health Statistics. 2021. DOI: https://dx.doi.org/10.15620/ cdc:101761.
[2] Hedegaard H, Miniño AM, Warner M. Drug overdose deaths in the United States, 1999–2019. NCHS Data Brief, no 394. Hyattsville, MD: National Center for Health Statistics. 2020.
[3] Ettman CK, Abdalla SM, Cohen GH, Sampson L, Vivier PM, Galea S. Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic. *JAMA Netw Open*. 2020;3(9):e2019686. doi:10.1001/jamanetworkopen.2020.19686
[4] Pain in the Nation: Alcohol, Drug and Suicide Epidemics. Trust for America's Health and Well-Being Trust. May 2021. https://www.tfah.org/wp-content/uploads/2021/05/2021_PainInTheNation_Fnl.pdf

Primary care teams with strong, ongoing patient-relationships are uniquely able to identify behavioral health concerns, triage challenges, and help patients find the right level and setting of care. In fact, more mental health care is rendered in the primary care setting than anywhere else, including the mental healthcare sector; this has been the case for at least the past four decades.[5] An adequate response to the multiple current behavioral health crises demands recognizing that reality. It also requires recognizing that primary care clinicians, particularly those that serve populations who have been historically marginalized, are overextended and desperately in need of enhanced support. Team-based integrated behavioral health can improve outcomes and decrease costs. By leveraging the full healthcare team, the U.S. can most appropriately leverage behavioral health professionals to help those in need of care.

The Foundation for Progress: Payment Reform and Investment in Primary Care

Efforts to scale behavioral health-primary care integration are hampered by chronic underinvestment in the primary care sector overall. Indeed, the draft 2022-2026 Department of Health and Human Services Strategic Plan and the Center for Medicare and Medicaid Services' (CMS') Innovation Strategy both envision equitable access to high-quality, affordable care for all, but that vision may remain out of reach if underinvestment in primary care persists.

To assure a strong foundation for comprehensive, integrated advanced primary care, it will be necessary to change both how the U.S. pays and how much the U.S. invests in primary care overall. The U.S. currently devotes just 5-7% of health spending to primary care, a proportion lower than other nations.[6] Primary care practices need pathways to rapidly transition from a predominantly fee-for-service (FFS) model to predominantly population-based prospective payment models that would include adjustments for health status, risk, social drivers, and other factors. The National Academies of Science Engineering and Medicine has recommended making hybrid models (part FFS, part per member per month payment)[7] the default for Medicare and Medicaid, rather than the fee-based system that consistently and systematically undervalues the cognitive work reflected in primary care and behavioral health services.

Over the medium- and long-term, broader change in how we pay and how much we pay for primary care is vital. PCC is working with our Executive Members and other stakeholders to identify bold steps to strengthen the primary care foundation needed for a health system that achieves equitable outcomes through high-quality, affordable, patient-centered care.

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[5] Regier et al JAMA 1978; Jetty et al Journal of Primary Care & Community Health 2021).
[6] Investing in Primary Care: A State-Level Analysis. Primary Care Collaborative. July 2019. https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf
[7] National Academies of Sciences, Engineering, and Medicine. 2021. Implementing high-quality primary care: Rebuilding the foundation of health care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.

However, in the interim, we recognize the Department confronts the same *immediate* reality that primary care teams and their patients live with daily: a crisis of poor mental well-being and substance use. Exacerbated by COVID-19 and associated economic disruptions, this crisis hits hardest in communities already grappling with health inequities. Because improvements in overall physical health can be more difficult to achieve when individuals face behavioral health comorbidities, this crisis also threatens to derail the fight against other chronic health challenges including heart disease, diabetes, and cancer.[8]

The Department's primary care-behavioral health integration efforts should both respond to the urgency of the immediate behavioral health crisis and lay the groundwork for transformed and integrated whole person primary care.

Paying for Behavioral Health Integration in Medicare and Medicaid

With adequate resources, primary care has the capacity to be flexible. It can effectively provide what patients need and/or connect those patients to other care or resources. At present, evidence supports multiple integrated behavioral health delivery models in primary care, including the collaborative care model and the primary care behavioral health model.[9,10] To maximize the number of patients that can benefit from integrated care across diverse practice settings and communities, primary care payment options must be available to support a variety of evidence-based models of integration. Payment policy that supports multiple care integration models has two additional merits. It can support the development of real-world implementation evidence across diverse populations and spur further innovation in behavioral health integration at the practice level and in practice/payer collaboration.

For these reasons, PCC supports a multi-component policy approach to behavioral health integration. This approach would provide immediate support for scaling integration through the payment methodologies most broadly in use today while testing new ways to integrate behavioral health into comprehensive advanced primary care payment models.

Promote Medicare's existing collaborative care and behavioral health integration codes.

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[8] Murphy SL, Kochanek KD, Xu JQ, Arias E. Mortality in the United States, 2020. NCHS Data Brief, no 427. Hyattsville, MD: National Center for Health Statistics. 2021.
DOI: https://dx.doi.org/10.15620/cdc:112079external icon.
[9] Dissemination of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model. American Psychiatric Association. 2016. https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn
[10] Kearney, L. K., Post, E. P., Pomerantz, A. S., & Zeiss, A. M. (2014). Applying the interprofessional patient aligned care team in the Department of Veterans Affairs: Transforming primary care. American Psychologist, 69, 399–408. http://dx.doi.org/10.1037/a0035909

Existing behavioral health integration codes, currently available in the Medicare Physician Fee Schedule, are underutilized in Medicare, relative to the prevalence of behavioral health conditions among beneficiaries. CMS should re-assess whether the existing payment values are sufficient to expand their utilization and meet the exigencies of the present crisis.

Consider Waiving the Medicare Fee Schedule Budget Neutrality Requirements for Primary Care - Behavioral Health Integration. The Medicare Physician Fee Schedule's budget neutrality requirements are a barrier to increased payment and new payment codes for primary care integration. When new codes are adopted, these neutrality requirements can even result in across the board cuts that affect other primary care services. Insofar as Medicare depends on fee-based payment to expand access to integrated behavioral health care in the current behavioral health crisis, the Department could work with Congress to exempt payments from the current budget neutrality requirements. One approach would be to establish a new code available as an add-on code for all Evaluation and Management claims when a practice can demonstrate the capacity for integrated behavioral care. Such a code would complement and support broader utilization of the existing behavioral health codes, rather than replacing them. Practices could attest to certain core functionalities, such as the ability to screen for behavioral health challenges, offer care management, medication management, participate in measurement-based care through a registry, deliver short-term psychosocial therapy in the practice, and integrate evidence-based treatment for behavioral health conditions, either in person or virtually.

Test Per Behavioral Health Integration Strategies as part of a Per Member Per Month Approach. Policymakers should pursue the development and testing of prospective primary care payment models, such as per-member per-month, that adequately support integrated advanced primary care addressing both physical and behavioral health care needs. However, work may be needed to optimize the balance between external referrals and services delivered in the primary care practice itself. Various integration thresholds, standards and performance measures should be tested using CMS Innovation Center authorities, Medicaid 1115 demonstrations, other CMS demonstration authorities and/or Congressionally authorized demonstrations.

Addressing Other Barriers to Behavioral Health Integration

Investing in and paying for integrated care, as described above, is fundamental. But these changes alone may not be sufficient without addressing specific barriers to broader integration of primary care and behavioral health.

Remove In-person Requirements for Tele-mental Health Services– Once the current COVID-19 Public Health Emergency expires, current Medicare statute and regulation bar reimbursement for tele-mental health services unless a patient has had an in-person encounter with a member of the same provider group in the previous six months and requires an in person visit every twelve months. This limits the ability of primary care practices to leverage tele-mental health services to deliver comprehensive and integrated care. CMS should revisit the in-person visit

requirements for Medicare reimbursement of tele-mental health services, promulgated in the CY 2022 Final Rule, and if necessary, work with Congress to remove them. CMS should also make clear to state Medicaid programs the authorities available to remove similar barriers.

Assure Access to Upfront Resources to Support Transition to Integrated Care

For any primary care practice, the transition to new integrated models of care delivery can involve significant expense, training, technology upgrades and workflow changes. It may involve retraining or expanding the primary care team, including but not limited to nurse case managers, psychiatrists, nurse practitioners, psychologists, social workers, counselors and peer support workers.

To support these changes, practices pursuing integration typically must rely on time-limited grants or partnerships with larger entities, like health plans or health systems. Others have depended on limited duration demonstrations or CMS Innovation Center Models to resource these changes. Yet this limited, ad-hoc approach has failed to enable widespread, sustained implementation of behavioral health integration in primary care.

HHS should work with Congress to develop and enact a broadly available program of forgivable loans to finance costs associated with transformation. Practice support for these transitional costs is particularly crucial for primary care practices which are smaller in size, operate independently and/or serve lower-income communities. To support rapid scaling, transitional support should be available on a nationwide basis, not confined to a limited-scope demonstration.

Ensure Resources for Ongoing Practice Transformation

However, the reality is that practice transformation is not a one-time expense. The best models of behavioral health integration may evolve based on experience and new medical and implementation science. Moreover, the challenge of practice transformation extends beyond behavioral health integration. Some primary care practices are shifting to more comprehensive models of care that integrate across still more domains of care including those that address health-related social needs and oral health.[11,12] Permanent, long-term sources of training and technical assistance for comprehensive, integrated care models are necessary to assure access to the best evidence-based approaches over time.

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[11] The Primary Care Collaborative. (January 2021). Innovations in Oral Health and Primary Care Integration: Alignment with the Shared Principles of Primary Care. https://www.pcpcc.org/resource/innovations-oral-health-and-primary-care-integration-alignment-shared-principles

[12] Kreuter MW, Thompson T, McQueen A, Garg R. Addressing Social Needs in Health Care Settings: Evidence, Challenges, and Opportunities for Public Health. *Annu Rev Public Health*. 2021;42:329-344. doi:10.1146/annurev-publhealth-090419-102204

One potential policy vehicle to encourage practice transformation over the long-term—the Primary Care Extension Program (PCEP) — has already been statutorily authorized.[13] As the U.S. Agricultural Extension service has promoted evidence-based practices in agriculture and community development, the PCEP would have assisted primary care through practice facilitation and community-based collaborations. Yet Congress has so far failed to appropriate resources for this important work. With adequate funding, this program or a similar approach could provide the technical assistance and support that primary care practices need.[14]

Promoting Behavioral Health Integration Across Payers

Convene Stakeholders to Align Integration Efforts
Payers that work together to align documentation, measurement and model design related to integrated care face potential anti-trust action. However, state and/or federal bodies can convene payers and clinician representatives with the goal of aligning documentation, measurement, and payment innovations associated with behavioral health integration. Working with Congress as necessary, the Department should assure all states have the resources necessary to support such efforts.

Incorporate Behavioral Health Coding and Billing as Standard Features in Electronic Health Records: Vendors require practices to pay extra for the module that supports billing for existing integrated care codes. Working with the Office of the National Coordinator for Health Information Technology, CMS should adjust the definition of Certified Electronic Health Record Technology (CEHRT) to address this challenge.

The depth of the mental health and substance use crises facing America's communities is difficult to understate. The inequities in well-being that underlie that crisis are glaring. But the efforts now underway in federal programs have been significant, and Congressional Committees are considering further action on a bipartisan basis.

The time is now for bold action to support behavioral health integration in primary care. PCC urges you to engage across the Department and with the members of the 117th Congress, to make it happen. Please contact PCC's Director of Policy, Larry McNeely (lmcneely@thepcc.org) with any questions.

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[13] 42 USC § 280g–12
[14] Phillips RL Jr, Kaufman A, Mold JW, et al. The primary care extension program: a catalyst for change. *Ann Fam Med*. 2013;11(2):173-178. doi:10.1370/afm.1495

Sincerely,

Ann Greiner
President & CEO
Primary Care Collaborative

PCC Executive Members

Below is a list of the Primary Care Collaborative's executive members that pay dues to the organization and support its mission. Membership does not indicate explicit endorsement of this letter.

AARP
Accreditation Association for Ambulatory Health Care, Inc.
Alzheimer's Association
America's Agenda
American Academy of Child & Adolescent Psychiatry
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Physician Associates (AAPA)
American Association of Nurse Practitioners
American Board of Family Medicine Foundation (ABFM Foundation)
American Board of Internal Medicine Foundation (ABIM Foundation)
American Cancer Society
American College of Clinical Pharmacy
American College of Lifestyle Medicine
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Physicians
American Psychiatric Association Foundation
American Psychological Association
Anthem, Inc.
Array Behavioral Care
Ascension Medical Group
Black Women's Health Imperative (BWHI)
Blue Cross Blue Shield of Michigan
CareFirst, BlueCross BlueShield
Catalyst Health Network
Community Care of North Carolina
CVS Health
Doctor on Demand
Harvard Medical School Center for Primary Care
HealthTeamWorks
Humana
IBM
Innovaccer
Institute for Patient- and Family-Centered Care
Johns Hopkins Community Physicians, Inc.
Johnson & Johnson
Mathematica Policy Research
MedNetOne Health Solutions
Mental Health America
Merck
Morehouse School of Medicine - National Center for Primary Care

National Alliance of Healthcare Purchaser Coalitions
National Association of ACOs
National Coalition on Health Care (NCHC)
National Interprofessional Initiative on Oral Health
National PACE Association
National Partnership for Women & Families
NCQA
Oak Street Health
One Medical
PCC Pediatric EHR Solutions
Pediatric Innovation Center
Primary Care Development Corporation (PCDC)
Purchaser Business Group on Health (formerly Pacific Business Group on Health)
Society of General Internal Medicine
Society of Teachers of Family Medicine
St. Louis Area Business Health Coalition
Takeda Pharmaceuticals
UPMC Health Plan
URAC