April 24, 2024

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Ave. SW
Washington DC

Dear Secretary Becerra,

We write as leading mental health and substance use organizations to express our deep concern that the most recent model for enhanced primary care payments released by the CMS Innovation Center, ACO Primary Care Flex, is a missed opportunity to advance the Department's behavioral health integration (BHI) strategy. We applaud the Innovation Center for moving so quickly to improve the financing of critically needed primary care and urge concurrent and urgent attention to addressing the equally important dire need for mental health and substance use services within primary care.

We greatly appreciate your personal commitment and leadership in improving behavioral health outcomes through the Department's Behavioral Health Integration (BHI) Strategy and many other initiatives. We provide several recommendations to better align this model with the Department's BHI strategy so the Innovation Center can advance primary care while also furthering access to integrated behavioral health care services. Without a clear and sustained effort to track, report, and make progress on behavioral health, this model risks joining other value-based payment initiatives that have not helped and even have harmed behavioral health.

A recent article in Health Affairs demonstrates what is at stake, as researchers found that beneficiaries who were assigned to an Accountable Care Organization had worse mental health outcomes than those who remained outside ACOs. The authors concluded, "Among patients not enrolled in ACOs at baseline those who newly enrolled in ACOs in the following year were **24% less likely to have their depression or anxiety treated** during the year than patients who remained unenrolled in ACOs, and they saw **no relative improvement** at twelve months in their depression and anxiety symptoms."[1] (emphasis added)

Previous CMS Innovation Center models also lacked a robust and clear focus on advancing behavioral health. A recent report issued by the Bipartisan Policy Center on integrated primary care concluded:

> Payment models, such as CPC+ were intended to incorporate care coordination and behavioral health integration as cost effective means of improving health outcomes. However, these models remain based in Medicare's fee for service structure and lack accountability for behavioral health outcomes and integration. The CMMI Primary Care First model builds on CPC+ and moves practices closer to taking on full risk, while focusing on high need, seriously ill patients. Yet, like CPC+ and Patient Centered

[1] Hockenberry, J. M., Wen, H., Druss, B. G., Loux, T., & Johnston, K. J. (2023). No Improvement In Mental Health Treatment Or Patient-Reported Outcomes At Medicare ACOs For Depression And Anxiety Disorders: Study examines mental health treatment and patient outcomes at Medicare ACOs. *Health Affairs*, *42*(11), 1478-1487.

> Medical Homes, it focuses on physical health rather than behavioral health outcomes. Without adequate quality metrics, there is limited accountability and assessment of the value of integration."[2] (p. 51).

This lack of accountability and assessment of outcomes for behavioral health integration comes at a time of increased need for mental health and substance use services and decreased capacity to meet those needs. Low reimbursement rates and administrative burdens contribute to low participation rates of behavioral health providers in the Medicare program. A recent study found that nearly 60% of behavioral health providers in one state's Medicaid managed care program were "phantoms," and were not actually seeing patients.[3]

Primary care practices are essential in addressing the nation's mental health crisis, as research shows that nearly 4 out of 10 visits for depression, anxiety, and other mental illness are to primary care physicians.[4] Integrated behavioral healthcare has been demonstrated to reduce disparities and meet the needs of communities who may be hesitant to seek specialty care and face financial and transportation barriers.

We have 4 recommendations to improve the model to be more consistent with the Department's overall behavioral health integration and equity goals and more accountable to meeting these goals:

1. **ACOs should be required to track how much of the initial investment resources and prospective payments have been spent on behavioral health services within primary care.** CMS has previously required entities to report on how they are using initial advancement investment dollars and should require information on how much of the up-front payments in this model will be used to support patient access to behavioral health specialty services. The Innovation Center has stated that it will require states to report on how prospective payments are being spent to ensure that is benefiting primary care, so requiring reporting on integrated behavioral healthcare would not add to the burden of the model, and would provide transparency on whether the model is leading to greater investment in behavioral health integration. The Innovation Center has said it will require reporting by category, and it should require ACOs to report on behavioral health spending as one such category in both the initial investment and prospective payments.
2. **Improving behavioral health outcomes should be an endpoint to the ACO Primary Care Flex model, and the relationship between BHI investment and behavioral outcomes tracked in the short run along with physical health outcomes in the long run.** Currently, Medicare Shared Savings Program (MSSP) participants are required to report two behavioral health measures – screening and follow up for depression and

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[2] Hartnett, T., Loud, G., Harris, J., Curtis, M., Hoagland, G.W., Serafini, M., Glassberg, H., Chung, H. (2023). *Strengthening the Integrated Care Workforce*. Bipartisan Policy Center. https://bipartisanpolicy.org/report/strengthening-the-integrated-care-workforce/

[3] Zhu, J. M., Charlesworth, C. J., Polsky, D., & McConnell, K. J. (2022). Phantom Networks: Discrepancies Between Reported And Realized Mental Health Care Access In Oregon Medicaid: Study examines phantom networks of mental health care providers in Oregon Medicaid. *Health Affairs*, *41*(7), 1013-1022.

[4] Jetty, A., Petterson, S., Westfall, J. M., & Jabbarpour, Y. (2021). Assessing primary care contributions to behavioral health: a cross-sectional study using medical expenditure panel survey. *Journal of primary care & community health*, *12*, 21501327211023871.

remission for depression. Determining whether primary care practices that invested payments in behavioral health performed better on these measures is critical to the success of the model and will allow CMS to more accurately determine if the model should be scaled further. It will also address the behavioral health community's concerns regarding recent research showing ACO models are harmful to mental health outcomes. Again, this does not require any extra work by ACOs as MSSP participants are already required to report this data. HHS should contract for an entity to conduct this analysis because it is critical to advancing HHS's behavioral health integration strategy. In the longer term, the Innovation Center should examine how investing in behavioral health integration impacts physical health outcomes and overall spending. Tracking these outcomes will help scale the models and allow a fuller understanding of their value to beneficiaries.

3. **A second phase of the model should support a tiered approach to integrating behavioral health services, with higher reimbursement for increased scope of services, incentivizing a greater degree of integration and ability to address social needs.** There are many examples of a tiered approach to behavioral health integration. The National Committee for Quality Assurance (NCQA), for example, has a behavioral health distinction for its primary care patient-centered medical home model that could serve as an example for requirements that merit higher reimbursement. Massachusetts and Arizona have developed Medicaid1115 waiver models that also provide greater reimbursement for primary care using a tiered approach that pays more for greater integration. The tiers in the Massachusetts model have been described by a MassHealth policy staff as, "Tier 1 is focused on foundational excellent primary care, which includes good communication, access, prevention, screenings, and referrals. Moving all the way up through Tier 3, we have expectations about integrated behavioral health, health-related social needs, reproductive care, and the ability to keep more moderately complex patients "in-house." We hope that many practices that are currently Tier 1 and Tier 2 will add capacity over time to be able to deliver Tier 3 level of service, but it's not a requirement..." A tiered approach offers the ability to reward practices that are currently integrating care and addressing social needs, but face fee-for-service billing challenges while also encouraging more practices to expand their capacity in these areas over time with the incentive of higher payments.
4. **Beneficiaries, including those with behavioral health needs, must be part of the ACO governance of this model.** HHS has been working to increase the role of beneficiaries in ensuring a program works to meet their needs, such as the recently finalized Medicaid access rules requiring states to establish a Beneficiary Advisory Council.[5] We urge the Innovation Center to ensure the voices of individuals with mental health and substance use needs are well-represented as this model becomes available so they can provide input on communication, awareness of the model, patient experience, and outcomes.

Thank you for considering these recommendations. As national organizations with local affiliates and chapters, we know that communities are struggling to access high quality mental

[5] Medicaid Program; Ensuring Access to Medicaid Services. Retrieved at https://public-inspection.federalregister.gov/2024-08363.pdf .

health and substance use care. Integrated behavioral health care in primary care is such an important solution that it must be a focus and endpoint for this model. We urge HHS to revise the ACO PC Flex Model to better incentivize and scale integrated behavioral healthcare, consistent with the Department's BHI and equity strategies. For further information or questions, please contact Mary Giliberti, Chief Public Policy Officer at Mental Health America, at mgiliberti@mhanational.org or Scott Barstow, Senior Director of Congressional and Federal Relations at American Psychological Association Services, at sbarstow@apa.org.

Sincerely,

American Association of Psychiatric Pharmacists

American Association on Health and Disability

American Psychological Association Services

Anxiety and Depression Association of America

Children and Adults with Attention-Deficit/Hyperactivity Disorder

Clinical Social Work Association

International Society of Psychiatric-Mental Health Nurses

Lakeshore Foundation

Mental Health America

NAADAC, the Association for Addiction Professionals

National Alliance on Mental Illness

National Association of Social Workers

NHMH - No Health without Mental Health

The Kennedy Forum