No Health without Mental Health
www.nhmh.org • 501(c)(3) organization

January 2021

A CALL TO ALL BEHAVIORAL HEALTH INTEGRATION STAKEHOLDERS:

PUT PATIENTS F-I-R-S-T !!

I.The Issue:

The COVID-SARS-2 virus pandemic has taken a tremendous toll on Americans' mental health status. This comes on top of a pre-pandemic dysfunctional national mental health system. If COVID has taught us anything, it is that as a nation we must ALL adopt a united position NOW to **Put Patients First** to treat their whole health needs, physical and mental. And to work collaboratively to get that done.

We know that until we have mental health and physical health services available together in the same place, it will be hard to ensure coordinated care for **all** our health needs.

II.The human toll:

The human toll of failure to integrate medical-behavioral care is reflected in the following true story: Jack Burke (a pseudonym) was a bright, warm-hearted guy who grew up in an upper/middle class family, had some early typical adolescent rebellion issues, volunteered to serve in Vietnam. Returning to the U.S. in early 70s, despite himself feeling great pride in his hard dedicated war service, he felt the sting of being a Vietnam vet and the anger of the American public towards those veterans. He brought back with him a serious case of PTSD in addition to earlier untreated mental health issues. However, he received little or no Veterans Administration care for his PTSD. Still, he managed to graduate from a four-year university earning a B.A. degree in Business Administration. He found a job he loved as first a fireman then engineer with a national railroad system. But the difficult hours exacerbated his PTSD and because he was getting no mental health treatment, he began self-medicating with alcohol. He became emotionally involved with someone on drugs, leading to one violent incident resulting in involvement in the criminal justice system. He was then diagnosed with schizo-affective disorder.

Returning to civilian life, Jack struggled with his untreated mental disorders and alcohol misuse. While family tried to get him into MH care, he resisted, sensitive to stigma he felt as a result of a sibling diagnosed with schizophrenia though that was not his condition. The lack of needed mental health treatment continued for many years. As his downward spiral continued re jobs and social contacts, he finally did go to a primary care doctor, was given antidepressants which had negative side effects and he stopped taking them. Finally, under the influence of a alcoholic bout, and still having received no mental health treatment, he took his own life in his late forties.

Repeat this scenario millions of times across America for decades: a common mental health need going untreated even though effective treatments exist which can lead to recovery, patients feeling the social stigma of mental disorders refusing to go to specialty psychiatric care, and a general and specialist medical profession untrained and unable to treat the behavioral health needs of their patients.

III.Why Siloed Care Began:

What is holding up advancement of integrated care is key players not putting patients' needs first in order to achieve integrated care. Rather, prioritizing their narrow, vested interests in the *status quo* – whether income, jobs, careers, professional independence and/or autonomy, or policy-makers unwilling to address structural defects in the U.S. health system. The result has been enormous physical and mental health suffering among our population for decades. And a huge needless cost to the nation as untreated behavioral conditions exacerbate and impede medical conditions thereby greatly increasing *medical* expenditures. Per the 2018 Milliman report, the U.S. will continue to pay $406 billion extra in annual health costs for care of patients with BH conditions, largely for unnecessary medical services.

The separation of medical and behavioral care began 40 years ago, and was aimed at reducing the variance in psychiatric care. Since medical administrators were unsure what was necessary for BH care, what should be included, etc., a separate BH system was created to attempt to resolve this issue.

Historically, the model of BH treatment prevalent in the mid/late-20th century was long-term psychoanalytic psychotherapy to "get to the root of a problem." Unlike other insurable conditions, such as broken bones, heart attacks, appendicitis, etc, BH problems were not (then) curable and had no therapeutic endpoint. Once therapy was started, it was hard to see the end of treatment and the bills. In this environment, health insurers tried to reduce their expenses for BH care payment by:

(a) holding down BH professionals' fees (they remain among the lowest-paid),
(b) limiting access to BH services, and
(c) creating a separate BH care delivery system.

Managed care (health plans) then appeared and within 5-10 years the question of fixed accepted psychiatric variances in care came more into line, beginning to look more like medical variances in care … however, the separation of medical and BH continued.

After decades of this separated (carved-out) system, managed BH organizations (MBHOs) did not want to lose their separate, income-producing capability. The MBHO industry is now resisting integrated care delivery in order to protect and maintain the separate payments they receive from payers (health plans) under the current siloed care delivery system.

The situation of MBHOs drives up the cost of healthcare since the majority (70%) of BH patients refuse to go to the BH sector - community mental health centers; private psychiatrist offices; psych hospitals, etc – for care. Hence, untreated mental health needs, worsened medical problems, doubling qne tripling medical care and total care costs (see Milliman report).

Moreover, the place where nearly 95% of BH professionals are forced to practice by MBHOs, i.e., the BH sector, is the place where only about 25% of BH patients go for BH services. That leaves the other 75% of BH patients going only to general medical for their BH care.

MBHOs refuse to allow BH guided treatment to take place in medical settings where most BH patients (the 75%) go for care, like primary care clinics, ERs, general medical hospitals, etc. They do this so they can avoid paying medical facility fees and non-BH practitioners, such as primary care and specialty medical/surgical physicians for treating BH conditions.

Meanwhile life has move on in related areas: Today most BH conditions have effective treatments similar to medical conditions. However, since BH was never re-connected to other "medical" health conditions, BH remains poorly paid in a standalone treatment system, that leads to persistent BH symptoms and high cost. Worse, poorly treated BH conditions adversely affect *medical* illness recovery and improvement, this where the majority of the healthcare dollar is spent. This situation will not change unless and until BH conditions are re-connected and are treated the same as all other medical conditions using "medical" not "BH" dollars and equally covered by health plans in access and treatment.

It is unlikely psychiatrists and psychologists will come together to fight for the delivery of integrated medical-behavioral care due to different perceptions of what constitutes correct care for various BH conditions. While both have roles in BH care delivery for BH patients (setting aside helping patients with healthy behaviors such as losing weight, stopping smoking/drinking, etc.can be done effectively by social workers, counselors, etc), most psychologists are generally against the use of any medications for psychiatric conditions, even in cases where it might be the best approach. This may be due to fact that psychologists are not trained to prescribe psychiatric medications, or handle side effects and drug interactions, without essential medical training. The problem is not one-sided with the psychologists, however, since there are also psychiatrists and non-psychiatrist physicians who do, in fact, over-prescribe psychiatric medications.

In general, the medical field has not yet found a way to have psychiatrists and psychologists to talk together and form more than generally separate BH care offerings. This situation impacts the ability of patients to get BH treatments that they need in order to improve, especially in *medical settings* where 70% of *BH* patients are seen.

Psychiatrists, having broad expertise in BH diagnosis and training in all forms of BH care, should be the go-to professional group advising Congress on how to proceed with relevant policy change. As a part of this process, they should advocate for use of psychologists to deliver the types of BH services that bring value to patients for which they have training and expertise. Many BH conditions do respond to psychological interventions and should be used when indicated.

This split among BH professionals is not unusual. There are many areas of dissension in all branches of healthcare. Yet our country is now in a period of healthcare delivery reform and modernization and facing recovery from a pandemic. Serious, focused efforts must be made to resolve professional competitive issues and allow all patients access to BH services likely to improve their BH conditions.

IV.Systems Solutions Required:

While practitioners may disagree on the best way to deploy psychiatrists, most by now do agree that an essential place of care must be in primary and specialty medical settings allowing simple interventions for patients who do well with them and most importantly with systematic means to identify those patients who need more sophisticated BH services in specialty BH settings.

New Congressional legislation is needed to ensure that medical providers can get paid for treating mental health in their practices. And receive incentives to invest in the training of the clinical care workforce, HIT infrastructure, etc required to provide integration of behavioral health care. The key stumbling blocks for medical practices now trying to integrate BH are sustainable financing, workforce development including recruitment, training, coaching for this team-based care innovation, and support and incentives for HIT tech tools.

NHMH – No Health without Mental Health envisions a future where BH professionals (psychiatrists via telehealth/ psychologists/advance practice nurses/social workers) all assist medical practitioners in primary care and medical specialists with BH care for mild to moderate BH conditions. Patients with serious and persistent mental illness, regardless of where they are seen, can be stabilized by BH professional, in BH settings if needed, and then returned (where possible) to the medical sector for continued care when BH issues have stabilized.

The proven effective collaborative care model of integrated care is efficient, and successful to treat mild, non-complex mental disorders. It can be used effectively by psychologists working with psychiatrists insuring the right care for all patients in the medical outpatient setting. Models for outcome changing BH care in medical inpatient settings and medical emergency rooms are also now available and should be instituted. The challenge is to better train BH and medical health practitioners to decide on the process of integrated care to be used to augment BH care in their individual practices and health systems, and be unbiased in the way that BH providers are used. BH professional trade associations or 'guilds' must also muster the organizational will to abandon a narrow, guild mentality and instead do what is right and Put Patients First.

V. Cost to Fix:

Will integrated care mean runaway healthcare costs? The answer is definitively "No." While it is true that the integration of medical-behavioral services (and contracts) will increase the use of unnecessary BH services to some degree, whatever increase there is would be dwarfed by the savings from reduced medical-surgical use (See Milliman 2018 Report).

The fact is that BH services (mostly medication management and various forms of psychotherapy) are very inexpensive as compared with most other medical services. There should be increased spending for value-based BH services in order to save dollars on the medical-surgical side. (see Milliman report).

That said, the medical and behavioral health field and health policymakers must be careful about approaching reform in a thoughtful, evidence-based way. We should NOT be delivering open-ended, limitless counseling for most BH patients, since that is not what many/most need. Patients largely don't want it, and costs can add up though not excessive *per se.* Yet, there are some patients for whom frequent attention is the best approach. For instance, those with personality disorders, PTSD, schizophrenia, and other less common diagnoses. In these cases, a weekly check-in with the PCP may keep them out of ERs with costly care.

Some patients need brief psychotherapy or counseling. Some need medications that can often be managed by a PCP. Some need both. A small fraction require psychiatry-based specialty care inaccessible through PCPs, such as electroconvulsive treatment.

In 2021, Jack Burke should be able to go to primary care, be assessed and diagnosed for any mental health condition, receive effective care there, or be referred out to specialty BH care if warranted. Have medical and behavioral professionals tracking his progress and adjusting treatment as needed to ensure improvement, not fall through the care cracks. And save his life. We know what needs to be done. It is time for insurers, BH professionals, BH advocates and for health policymakers at federal and state levels to put patients not narrow self-interests. We are literally talking about saving lives.

V. Specific Legislative/Regulatory Asks:

Relevant legislative/regulatory backdrop: The 2010 Affordable Care Act (ACA) began the legislative part of health policy reform to advance integrated care by directing States to lead the design and implementation of integrated care models through their Medicaid Expansion programs. It also created the Centers for Medicare and Medicaid Innovation Center (CMMI) authorizing CMMI to test innovative new integrated care models for possible widescale implementation.

In 2016 Congress passed the 21st Century Cures Act which incorporated the Helping Families in Mental Health Crisis Act provisions but missed an opportunity to include funding that would specifically support and incentivize medical practices to deliver integrated care. On the regulatory side, CMS introduced as part of the 2017 Medicare Physician Reimbursement Final Rule new fee-for-service billing codes for practices supporting their delivery of integrated care. However, these codes have not been widely used by practices who cite complexity in administration, ill-equipped billing systems, and confusion regarding codes and State profession-specific (e.g. social workers, BH counselors etc) restrictions on who could bill for integrated services. Going forward, the following legislative and regulatory health policy changes are needed to support and incentivize American medical practices' widespread uptake of integrated care:

From Congress:

- Legislation directing CMS to reimburse practices for delivery of integrated care key components: team-based care; patient-tracking and monitoring and treatment adjustment care; use of needed HIT tools such as upgraded EHRs, patient registries, CMTS; care management and telehealth links
- Direct CMS to work with States enabling them to design and implement integrated care models
- Direct CMS to accelerate the move towards introducing value-based payment incrementally for practices
- Direct CMS to work with States and payers to eliminate restrictions on same-day and profession-specific FFS billing requirements
- Direct CMS to develop simple and clear integrated care billing codes feasible for most practices
- Legislation providing technical assistance funding for practices to assist their administrative, billing and operational implementation of integrated care
- Legislation for workforce development funding specifically targeted at assisting those medical practices engaged in integrated care workforce development such as recruiting, hiring, training, coaching, ongoing quality improvement training for clinical care staff to deliver evidence-based integrated care.

From States:

- In coordination with the federal government, establish stronger incentives for practices implementing integrated care models, and target financial and technical support to develop HIT capacity
- Develop quality measures for integrated care that reward practices for quality care, ensuring consumers, caregiver, advocate involvement in creation of measure sets
- Encourage MCOs to work collaboratively with each other to ensure consistency of requirements placed on practices.