

MAKING PROGRESS ON INTEGRATION OF BEHAVIORAL HEALTH CARE AND OTHER MEDICAL CARE

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I. Brief overview of the problem

Thirty-five years ago, Sam Shapiro and colleagues sounded the alarm that primary care physicians were failing to detect and treat depression in their practices (Shapiro et al., 1987). They provided randomly selected primary care physicians with results of depression screening tests of their patients. The responses to the screening information showed marginal increases in detection and no changes in management of illness. Despite a rigorous program of research on how to best screen for and treat depression and anxiety disorders in primary care practices, only modest progress has been made toward increasing behavioral health expertise in primary care practices. Recent qualitative and quantitative evidence indicates low rates of adoption of evidence-based approaches to managing mental illnesses in primary care practices.

Integrating behavioral health into primary care has long been a goal of health policy makers throughout the health system (AHIP, 2022). Persistently low rates of treatment for people with mild to moderate mental illnesses (around 50%) suggest that there are too few opportunities for treatment (Substance Abuse and Mental Health Services Administration, 2021). Primary care settings are touched by most people and offer a setting that can be less stigmatizing and easier to access than mental health settings. They also offer opportunities to address the range of health and mental health conditions that frequently travel together. More recently, attention to leveraging the supply of primary care practices to address apparent shortages of behavioral health providers in various locations and treatment settings has given still greater import to efforts to integrate behavioral health and primary care services. Specialty behavioral health providers tend to be scarce in low-income neighborhoods and in communities of color (Cummings et al., 2017). By contrast, currently there are approximately 230,000 primary care practices in the U.S. They are located across the country and are more likely, by at least 1.4 times, to be present in small and isolated rural communities than are specialty mental health clinicians (Willis et al., 2021). The result is that in rural areas and small cities, primary care providers are the main potential source of care for people with mental health problems (Cherry et al., 2018). For these reasons, ensuring that primary care practices are well equipped to address common mental health problems is important. Integration of behavioral health into general medical settings may be particularly important as a tool to promote equity in behavioral health care. Federally funded health centers provide primary care to predominately low-income communities and are an important source of access to mental health care as sites of integration. Almost all federally funded health centers report providing some mental health services and conducting depression screening of most patients. Substance use disorder (SUD) services were less widely available in health centers than were mental health services.¹

Beyond using primary care practices as a pathway to care, integration of behavioral and physical health may also be important for a group of people who already have specialty mental health access. Recent evidence shows that people with severe mental illnesses who are primarily treated in specialty mental health settings are dying younger than otherwise similar people not experiencing a severe mental illness (Druss et al., 2011). A substantial share of the excess age-specific mortality is due to under-treated medical conditions such as diabetes and congestive heart failure. These findings have resulted in efforts to integrate general medical care into specialty mental health settings.

¹ Authors analysis of National Health Center Program Uniform Data System (UDS) Awardee Data 2017-2021.

II. Recent policy efforts and the evolving delivery system

Significant new policy initiatives have altered the behavioral health care landscape in recent years. They include the Mental Health Parity and Addiction Equity Act or MHPAEA, the Affordable Care Act (ACA), the addition of Collaborative Care (CoCM) billing codes to reimbursement systems and expanded use of alternative payment arrangements such as capitation and gain sharing, that are increasingly found in the Medicare Advantage, Medicare Shared Savings program, and in Medicaid Managed Care. These were expected to promote more access to behavioral health care and more integration.

Recent research shows that the rates of utilization of all forms of behavioral health care have increased over the past 15 years (Germack et al., 2020; Terlizzi and Schiller, 2022). This includes care delivered in both specialty behavioral health and general medical settings. Notably, however, the growth in use among people of color has been less pronounced than it is in the white population. Recent data on the progress on integration suggests that integration is not yet playing a significantly larger role in behavioral health service provision. While behavioral health care delivered in primary care settings has increased incrementally, its relative share of all behavioral health services has dropped significantly (Germack et al., 2020). Instead, most of the growth in use of behavioral health care is coming from non-MD specialty care providers and Nurse Practitioners and Physician Assistants. One potential inference that stems from these observations is that the recent suite of policy developments that have at once increased demand for behavioral health services have also resulted in the increased demand being met by specialty services and non-physician primary care. Although the data suggests that integration's promise is not yet being realized, there have been promising examples of integration's potential to improve performance on some quality measures and address utilization in systems that align incentives and address resource and infrastructure challenges (Reiss-Brennan et al., 2016). That sort of progress appears more often in integrated delivery arrangements like Intermountain Health.

III. Institutional context: Reasons for limited integration of behavioral health into primary care

Given the interest in promoting integration of behavioral health capabilities into primary care, there have been recent efforts to understand the impediments to the development of those capabilities in primary care practices. Impediments to integration typically fall into several categories (Wakida et al., 2018). These include cultural barriers between general medical practice and behavioral health including stigma, the structure of primary care workflows and time pressures on primary care clinicians, the application of technology, and billing and payment system design and levels. Most qualitative studies conducted in the U.S. and abroad identify cultural and stigma-related factors as central barriers to integration of mental health services into primary care practices. Specifically, these factors include perceptions of the importance of addressing mental health issues, awareness of the availability of community resources, opinions on the degree to which many mental illnesses are subject to treatment in contrast to self-discipline, and the view that people with mental illnesses do not acknowledge their conditions and are not adherent to treatment (Malâtre-Lansac et al., 2020). While some regulatory structures aim to prevent such discrimination, administration and enforcement of those policies are most difficult. As a result, federal policy may not be the most direct or effective means of addressing such cultural influences.

A second impediment is the belief among many primary care physicians that they are not prepared with the skills to successfully treat mental illnesses. Workflows in primary care practices are based on brief patient encounters. Identifying and establishing treatments for people with depression and anxiety disorders typically takes more time than the average 17-minute visit. This challenges the organization of many primary care practices. Too often, physicians respond to such pressures by overlooking mental health problems or rapidly changing the subject when a mental or emotional problem is raised by a patient (Tai-Seale et al., 2007). The Collaborative Care Model seeks to deal with this issue through reliance on trained care managers and specialty behavioral health “back-up” to provide consultation on more complicated cases (Gilbody et al., 2006). Incorporating a care manager either for mental health issues or for chronic conditions broadly along with specialty consultations requires a different sort of team-based approach than is prevalent in most primary care practices and calls for a minimum scale that may not be efficient for smaller practices unless they are linked to other similar clinicians. This challenge has led to the emergence of commercial ventures aimed at providing such connections. Several new firms are using digital and communication technologies to provide care management and specialty back up services to groups of smaller primary care practices and those located in rural areas (e.g., Neuroflow, Cenpatico). Payment and billing practices have stymied greater adoption of the collaborative care model, as discussed later in this paper. In addition, workflows are complicated by the flow of information, especially if a patient is being treated by a specialty provider at the same time as a primary care provider, as is the case in roughly 20% of primary care patients with mental health problems (Germack et al., 2020). Primary care practice records are typically not compatible with clinical records of specialty providers. For example, specialty mental health records rely more extensively on notes and less on so-called drop-down menus.

Policymakers looking for levers to advance integration sometimes turn to payment reforms. The promise of such policies is that models such as capitation can provide greater flexibility, including clinical flexibility, and greater ability to reward outcomes than traditional fee-for-service payments do. These models can theoretically, along with integrated financing, advance recent integrated care delivery innovations such as the Collaborative Care Model. However, the evidence to date does not suggest that this is the case, and such efforts may be held back by established payment rates. That is, capitation payments to MCOs and other forms of non-fee for service payments made to providers, are generally set using historical spending trends. To the extent that these historical trends reflect patterns of care that result in low levels of utilization of mental health services, and fee for service payment rates that have not attracted sufficient mental health providers to meet the population treatment needs, they will fail to promote innovation. There is a risk that historic undertreatment of behavioral health conditions are simply being baked into new payment methods.

Capitation and other existing alternative payment systems can create powerful financial incentives to provide fewer services, and they alone create little accountability for improved behavioral health care. Financial incentives alone are insufficient to drive improvement. Although capitation generally offers financial benefits to providers that do less, providing mental health services through primary care will require doing more, and specifically require increasing the time and effort spent by clinicians and support staff.

Promoting integration, therefore, requires setting payment rates at a level that induces a level of effort consistent with provision of high-quality behavioral health care in primary care practices

and is sufficient to warrant necessary organizational practice changes. Its success will rest on clear accountability measures that promote progress toward integration and guard against any potential to stint or skimp of need care.

i. Strategic considerations

The Department of Health and Human Services (HHS) has identified behavioral health integration as a key strategic priority (Bagalman et al., 2022). HHS has at its disposal a set of important policy instruments that can be deployed in promoting integration of behavioral health and general medical care. Our focus is on the use of existing policy levers. Health care delivery has been evolving rapidly over the past decade. Medicare Advantage (MA) now accounts for roughly half of all Medicare beneficiaries, an additional 17% are enrolled in the Medicare Shared Savings Program (MSSP). Managed care is the dominant form of service delivery in the Medicaid program and plays a particularly large role for Medicaid beneficiaries who are children: 82% were enrolled in comprehensive managed care in fiscal year 2020 and states have increasingly been carving behavioral health services into their Medicaid MCO contracts (Medicaid and CHIP Payment and Access Commission, 2022). However, recent evidence suggests that managed care is not yet realizing its integration potential. The insurer Anthem recently reported on integration progress: 200 of its network primary care practitioners (PCPs) were linked to 80 mental health providers and 50 substance use disorder (SUD) providers (AHIP, 2022). We calculate that the patients served through these providers account for roughly 2% of the 32 million enrollees covered by Anthem. Likewise, Blue Cross-Blue Shield of Michigan announced its effort at behavioral health integration that involved 180 practices, which, we calculate, account for about 10% of the covered lives.²

Leverage include changing regulations and payment arrangements associated with performance measures and the application of critical technologies that can facilitate integration of behavioral health services with general medical care such as pay for performance accountability arrangements, electronic health records, and telehealth. At the same time, federal and state governments have been investing significantly in Certified Community Behavioral Health Centers (CCBHCs) as part of efforts to expand access to community behavioral health services. Our focus is on incorporating measures that promote behavioral health integration with general medical care into these key programs.

ii. Implementation

Payment systems in place for Medicaid MCO and MA plans will only engage in practices that promote development of cost-effective approaches to treatment if they are held accountable for the quality of care delivered by the providers serving their plans. The MA program tries to do this by creating an offsetting incentive through the Quality Bonus Program (QBP) and public reporting of quality. Unfortunately, the quality measures and the consequences for failing to provide good quality behavioral health care in general and integrated behavioral health services specifically are very weak. This means that there are few incentives for health plans in MA to engage in investments, policies, and procedures that promote integrated behavioral health services. Medicaid has established a set of core quality measures, including behavioral health quality measures, for adult and child Medicaid beneficiaries. State reporting on these measures

² It is worth noting that a fragmented commercial insurance market with very different approaches to payment for behavioral health services in primary care also creates friction to organizational changes that would support integration.

has been voluntary but will be required for the child and behavioral health measures beginning in fiscal year 2024 (Tsai, 2022; Center for Medicaid & CHIP Services, 2022). Those that bear a relation to outcomes that might best be realized when services are integrated are modest. For example, there are two measures currently that are likely to be affected by efforts to integrate mental health services and general medical care. They are as follows:

- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

These are significant in that they promote linking people with serious mental illnesses (SMI) to general medical care for medical conditions that people with SMI are at elevated risk for. The core measure set also include indicators regarding the treatment of depression but little that might motivate greater focus on the degree to which primary care practices are positioned to successfully address those conditions. The MSSP includes three measures related to the treatment of depression, however, two are not scored for purposes of pay for performance features of the MSSP (National Association of ACOs, 2021). Thus, a key step towards improved integration of behavioral health services into general medical care is to make accountability for quality of and access to behavioral health care more robust in these programs, especially given their increasing reliance on payment arrangements that use high powered incentives.

IV. Proposed policy actions

Program designs

There are specific actions to promote integrated care that stem from the broad ideas advanced by President Biden and HHS, as well as from bipartisan Congressional efforts to advance mental health services that align with the observations made here. Our policy ideas for MA, Medicaid MCOs, and MSSP all center on performance metrics. Performance measures are increasingly used in combination with payment incentives to drive improvement in the provision of health care services, including, in some cases, behavioral health services. Several efforts have been undertaken to identify relevant characteristics associated with successful integration of behavioral health and general medical care and to propose measurement strategies that can be used to promote integration (Agency for Healthcare Research and Quality, 2014). We recognize the existing threat to accountability systems of “measure overload.” Nevertheless, the minimal inclusion of behavioral health integration performance measures during an era where mental illness and SUDs are problems that need urgent attention, along with broad consensus among policymakers that greater integration is desirable, suggest that some additional integration performance measures must be added to existing accountability systems. The measures proposed would address structural features reflecting efforts to integrate behavioral health services in primary care practices and process measures strongly associated with treatment of mental illnesses likely to result in improved care. Measuring treatment for SUD is also important to efforts to improve care. We focus on process measures for two reasons. First, the limited availability of integrated services suggests a need to prioritize building the process and structures that enable integration. Second, prior efforts to make use of outcome measures for mental illnesses and SUDs have frequently resulted in distortions in the selection of patients into treatment. In the absence of persuasive risk adjusters for outcomes, we recommend

reliance on process measures based on strong clinical evidence. Examples of useful measures include the following:

- Structure: presence in primary care practices of a staff member serving a care manager function that is trained in screening and treatment of depression and anxiety disorders. Some integrated delivery systems, like Intermountain, have established such standards for contracted clinics.
- Process: Screening and evidence-based treatment (appropriate medication management, manualized psychotherapy, or the combination) for depression in people with diabetes, congestive heart failure, and COPD.
- Rates of use of MOUD for treatment of people with opioid use disorder by primary care practices.
- Rates of inappropriate treatment for bipolar disorder (e.g., antidepressant prescribing without a mood stabilizer).

These measures could be included in the measure sets for MA, MSSP, and the core set linked to Medicaid managed care. Applying the same measures across programs will create the most powerful incentives to integrate; HHS can and should play a key role in promoting this alignment. Measurement alone is unlikely to overcome barriers to integration, so HHS, CMS, states, and insurers should create financial consequences for strong or poor performance on the measures (Burke et al., 2021). Legislative proposals being drafted by bipartisan Congressional leaders would establish integration quality measures for Medicare, integration technical assistance, and provider payments that offset some integration startup costs (Senate Finance Committee, 2022).

For MA, the core measures would be publicly reported and included in the program's Quality Bonus Program with a weight sufficient to associate performance on those metrics with meaningful financial consequences. This would imply weights of 5 for those measures. Currently, the QBP weights for behavioral health measures in MA and MA-PD plans is zero. For MSSP, included in the measure set is an indicator of screening for depression and establishment of a follow-up plan. This creates some incentive to attend to mental health in primary care practices, but it does not require any evidence of the presence of an evidence-based approach to integration of behavioral health services into primary care. In fact, since no evidence of actual treatment and follow-up is required, no evidence is provided regarding how patients with depression are treated. Moreover, the National Quality Forum withdrew its endorsement of this measure. Adding measures more closely tied to the structural features associated with integrated behavioral health services and some indication of the receipt of care likely to improve a patient's clinical conditions would represent an important advance.

The Medicaid core measure set would benefit by substituting the measures above, as well as indicators that are more directly linked to successful integration, like screening and appropriate treatment for depression in adults with diabetes, in place of some older and less effective metrics like Screening for Depression and Follow Up Plan for both adults and children or measures where performance is low and appears not to move overtime, such as antidepressant continuation phase treatment or follow up visit within seven days of hospital discharge for a mental illness. In addition, measures where large numbers of states are persistently not reporting might be well considered for replacement (e.g., metabolic monitoring for children and adolescents on antipsychotics). Such reconfiguration of measures must be associated with

financial consequences to drive responses in conduct and management. Financial consequences can be effectuated through MMCO contracts with state Medicaid agencies. CMS can accelerate this through guidance that describes how states can leverage value-based payment models to promote behavioral health integration. In light of growing rates of mental illness among children, and Medicaid's role as the largest insurer of children in the U.S., prioritizing the integration of behavioral health services into pediatric practices could be an effective way of scaling integration through Medicaid and targeting a population in need of greater mental health access. Approaches to doing this are described in a companion paper, *Meeting the moment on children's mental health: Recommendations for Federal policy*.

However important measurement and payment incentives are, they are unlikely to overcome structural imbalances in payment rates that are built on historical spending trends based on low levels of behavioral health service use and limited, if any, integration. Across insurance programs (MA, MSSP, MMCOs), capitated payment rates should reflect modern mental health and SUD treatment policies and practices. Baking in historical spending patterns that reflect strict limits on utilization and payment may constrain integration innovation. This can be accomplished by developing payment rates using utilization and spending programs that have modernized behavioral health payment and delivery. The rates should also build in payments for medical professional to behavioral health professional consultations. The States of Massachusetts and Minnesota have implemented such approaches recently (Mauri et al., 2017). As CMS develops new policies about service access and network adequacy in managed care, it can develop approaches to remedy some of these longstanding imbalances. Payment approaches and efforts to improve access should also recognize that small, standalone primary care practices and providers that work in low income and rural areas will need the most support in integrating behavioral health.

With respect to integrating primary care services for people with ongoing mental health needs, including people with serious mental illness, the key policy lever is CCBHCs. CCBHCs, which are required to provide a set of nine key services, were created to offer favorable, cost-based payment rates made through a prospective payment system (PPS) in exchange for higher provider quality standards. As a result, CCBHCs are assessed against a set of quality indicators 8 of which are reported at the level of the clinic and 13 are reported at the state level. Under the current CCBHC Section 223 federal demonstration payment policy, six of the federally required measures – Suicide Risk Assessment for adults and children, Adherence to Antipsychotics for Individuals with Schizophrenia, Follow Up after Hospitalization for Mental Illness for adults and children, and the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment – are tied to financial incentives. Specifically, a quality bonus payment is paid annually as a lump sum in addition to the PPS rate to any CCBHC that meets the minimum performance targets set forth for all six measures. None of these measures rewards activities that address the medical needs of people with serious mental illnesses that are either the result of treatments with psychotropic medications or because of the deprivation experienced by many people with serious mental illnesses and SUDs. There are two ways that this can be remedied. The first is to expand the number of measures used in determining the quality bonus payment to include measures like the two diabetes-related indicators for people with serious mental illness. The likely consequences of taking this approach would be 1) to promote greater attention to the non-behavioral medical needs of people served by CCBHCs, and 2) to reduce the number of CCBHCs that qualify for a bonus payment. A second approach would be to replace two of the existing measures with measures such as those that are diabetes related. That would have the

effect of substantially increasing the financial consequences of integrating or failing to integrate general medical care into CCBHCs.

Infrastructure and workflows

Four types of factors often pose barriers to integration within insurance arrangements (Medicaid, Medicaid, and Marketplaces). Those include the coverage rules for behavioral health visits in connection with a primary care visit, use of codes by insurers in paying for behavioral health services within primary care practices, credentialing of “non-traditional clinical staff”, and information flow and data sharing. In addition, the ability to provide integrated behavioral health services has been shown to be enhanced by the application of telehealth technology. However, the regulatory framework remains incomplete as does the infrastructure in practices and communities to make access to such contacts widespread.

The collaborative care approach and other integration strategies typically involve a visit with a primary care physician for patients with a mental illness followed by a visit with a care manager to implement the treatment plan set out by the physician. Medicare has clarified its policy toward the propriety of billing for both a primary care visit and a behavioral health visit on the same day. Medicare made it clear that such billing was allowable. In addition, most state Medicaid programs permit same day billing for behavioral health and a primary care visit. However, some Medicaid programs and commercial insurers retain policies that will not pay for two visits from a single practice on the same day. This stands in the way of implementation of evidence-based models such as the collaborative care approach. Since Medicare changed its policy, there has not been evidence of abuse of the policy by primary care practices. That serves to negate the primary argument against altering the prohibition against same-day billing. What remains unclear is how much the change has improved the ability to pay for care managers.

To create a targeted payment that incentivizes integration by recognizing the increased complexity and expanded time requirements associated with a primary care visit involving a mental illness, Medicare developed a set of billing codes for collaborative care that were implemented in 2017. Unfortunately, the codes are infrequently used. The codes are complicated to administer and are largely inconsistent with other billing codes used by primary care practices. For example, codes are billed monthly and call for the cumulative number of minutes of contact to be tracked and reported. Rather than billing at the time of service, team members must keep track of the minutes during which they were engaged with the patient. This requires modifying internal practice data collection and existing billing software.

Moreover, CMS requires that practices obtain consent for the primary care physician to communicate with behavioral health specialists prior to use of the codes (Carlo et al., 2019). These impediments suggest simplification of the code requirements and aligning them with standard coding technology would likely improve the ability to appropriately pay for integrated care. That might be accomplished by expanding existing codes to allow for more time by the primary care physician, expanding behavioral health visit codes to allow for a wider range of physician extenders (currently social workers dominate), including peers. This would in turn require expanded credentialing that would recognize the role of care managers that are nurses, BA-level psychologists, or community health workers. Together, these measures would be likely to better direct appropriate resources to practices engaging in integration of behavioral health services. Finally, the level of payment would need to be adjusted to ensure that reasonable costs are covered.

Information flows have been identified by virtually all qualitative studies of integration of behavioral health services with general medical care. The barriers to information flows among a clinical team (primary care physician, care manager and behavioral health specialist) appear to stem from three sources:

- Misinterpretation of federal statutes and regulations most specifically HIPAA and 42 CFR Part 2.
- Incompatibility between behavioral health records and more general medical care Electronic Health Records.
- Exclusion of non-physician behavioral health providers from Health Information Technology (HIT) subsidies.

Together, these impose critical limitations on the effectiveness and efficiency of efforts to integrate behavioral health services into primary care practices, as well as new costs to adapt existing systems. In larger practices, the incorporation of specialty consultants required that billing arrangements cross internal budget lines complicated intra-organizational responses. The new codes altered the way cost sharing was administered and, in turn, created confusion for patients. Finally, it remains unclear to many that the net impact of the codes improved the financial position of practices choosing to use the codes.

Too often, medical leadership and administrators interpret HIPAA and 42 CFR Part 2 as precluding sharing of behavioral health information between clinicians. This has been clarified, but not effectively communicated, several times. As a result, misinformed views of the law and regulations are allowed to persist limiting the ability to manage the care of people with complex behavioral health conditions. Unfortunately, CMS has often contributed to this confusion with its data release policies and guidance around use of integration codes. Clarification and a deliberate communication strategy backed by altered CMS conduct would improve support for integration. In addition, the incompatibility of behavioral health record with EHRs serves to substantially raise cost barriers to smaller practices. It also reinforces cultural impediments to integration. In the absence of a large change in HIT subsidies, matters could be improved by increasing payments for collaborative care to improve the pay-off to EHR investments. Alternatively, a targeted grant program from SAMHSA and CMS for infrastructure could be established. The target could be based on the size of the practice, the share of Medicare and Medicaid patients served, and community need for behavioral health care.

V. Concluding observations

We are encouraged that the Administration and Congress have, on a bipartisan basis, prioritized greater integration of behavioral health services and general medical care. We also share the view that prior policy efforts aimed at integration have fallen short of the mark. The evolution of the health care system along with important changes in the financing and regulation of mental health care open new opportunities to drive integration of care specifically and improved behavioral health care more generally. Central to our strategy is to leverage existing programs MA, MSSP, EPSDT and MMCOs specifically to drive improvement. The key elements of our proposed strategy focus on enhanced performance metrics, linking performance to financial and market consequences, and greater attention to enforcing existing program requirements to integrate care and make behavioral health care more robust overall. This is especially the case for children, where we see integration in pediatric practice as a particularly promising target for such efforts.

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