Brief 7, April 2020

Behavioral Health Integration Policy Brief

Prepared for the Bipartisan Policy Center
Stephanie Gold, MD, Perry Dickinson, MD, Larry Green, MD

The need for behavioral health integration (BHI): The aim of health care is to help people solve or live with their health-related problems. There are constant and unavoidable interactions of mental, emotional, behavioral and physical problems that require integration of primary care and behavioral health.

What is the current landscape of primary care delivery of behavioral health services?

- Integrated care is being implemented in practices of all types
- Payment and workforce shortages remain significant barriers to scaling implementation of integrated care
- More integration in urban, larger practices compared to rural and smaller practices, but rural-urban difference may be mostly explainable by practice size[1]
    - ~ 45% PCPs are co-located with a BH provider (with the rates in urban areas close to twice that of rural areas). No significant change in these numbers 2010 – 2018.[2,3]
- Some states are more advanced than others. The State Innovation Model (SIM) has been a mechanism for advancing BHI in several states:[4]
    - Practice facilitation and multipayer support for BHI into primary care settings (CO)
    - Implementation of behavioral health homes (ME, MN)
    - ACOs requiring or incentivizing BHI (MN, VT, MA)
    - Inclusion of BH metrics in payment and delivery models (OR, MA, VT, MN, ME)
    - Invested in technical assistance for BH (OR, ME, MN, VT, MA)

How do the delivery of care and challenges vary by practice/clinic-size, provider/team make-up, and geographical location?

- Despite challenges, many rural practices and small practices have been successful
- Rural areas face increased BH workforce shortages and may need to rely more on telehealth, sharing BH providers across practices, or other innovative delivery approaches
    - May rely more on BH providers other than psychologists such as licensed clinical social workers (LCSWs)
    - New tele-integration models emerging that include having a BH provider available for virtual warm handoffs and triage
- FQHCs have some advantages in being set up to offer more comprehensive services
- There is also fragmentation/siloing within behavioral health between mental health and substance use disorder care; just because there is a BH provider does not mean the practice has the BH support they need for substance use disorder treatment

Are there specific delivery models that have been more effective in delivering high quality integrated care?

- There is no one-size-fits-all model
- Models will need to vary by practice resources and population needs
- Models include:
    - Primary Care Behavioral Health – onsite BH professional integrated into the primary care team. Warm handoffs during primary care visits, brief interventions, and referral for more complex or treatment-resistant cases.[5]
    - Collaborative Care – treatment monitored by a BH care manager in the practice, reviewing cases periodically with a consulting psychiatrist for medication management.[6]
- BHI is often implemented in a hybrid fashion as opposed to a pure model
- While there is the largest body of evidence for the collaborative care model (and in particular for depression), there is evidence for improved outcomes[7-10] and decreased costs[4,11-15] for BHI irrespective of model used
- Features underlying any effective BHI model:[16]
    - Team-based care (most important): BH providers and PCPs working together, collaborating in patient care. Integration is not just having a BH provider in the same location as a PCP.
    - Shared population and vision: common panel of patients, mission and vision for integrated care shared across the entire practice
    - Systematic clinical approach:
        - Sharing of information: using the same medical record system; BH providers and PCPs are able to access one another's documentation and contribute to shared care plans
        - Screening for behavioral health needs: identification of who may need or benefit from services. This may vary widely based on the patient population and practice resources, from universal screening to targeting a particularly high risk population.
        - Patient engagement: engaging patients in identifying needs and shared decision making regarding treatment plans
        - Systematic follow up: plans in place for adjustment of treatment if not improving
        - Workflows for coordination of care (see below)
    - Continuous quality improvement and measurement of effectiveness
- Regardless of model, coordination between primary care and outside specialty mental health is important for serious mental illness/ more severe MH needs (integration in primary care most relevant for mild-moderate BH needs)
    - Integration of primary care into specialty mental health settings can provide a single site of most care for patients with serious mental illness
- Practice transformation support is often necessary for practices to make this significant shift in care delivery

- Evidence from SIM programs shows this also needs to be on-the-ground (through practice facilitators) and tailored to the practices as opposed to generic technical assistance

Are there payment issues to delivering integrated care and do they vary by size of the practice or other factors?

- Yes. Payment issues:[17,18]
  - Chronic underfunding of both primary care and behavioral health
  - Overreliance on time-limited grant funding for integration
  - Siloing through behavioral health carve-outs
    - Some payers with carve-outs have allowed billing for a limited number of BH visits in primary care – helpful but standardizes a cap on number of visits that may not be appropriate for some patients and may have requirements that don't make sense in integrated care
  - Some payers may have limitations on same day billing which creates large barriers to integrated care
  - Credentialing issues
    - Some plans have limited panels, sometimes with outdated lists of providers.
    - There is often a long process to become credentialed.
    - Numbers used by health plans in computing the number of BH providers needed do not take into account the integrated model.
  - Fee-for-service (FFS) is inherently flawed for BHI (and generally for primary care) – does not allow for flexible care delivery but instead it is tied to delivery of specific services and in some cases limited to billing by only certain types of BH providers. It creates major barriers to team-based care.
    - Adding better codes for integrated services (eg for collaborative care, health behavior assessment and intervention codes) and expanding them for use by a broader set of providers is only an interim solution
  - Global budgets would allow for greater flexibility in delivering integrated care
    - Some experts have expressed concerns that carving in BH under a primary care global budget could lead to "crowding out" of BH – additional requirements/incentives for integration may be necessary
    - Risk-adjustment necessary to have funds commensurate with patient needs and costs
  - Payment tied to regulatory structures specific to specialty mental health does not apply to primary care (eg where there are requirements for formal mental health assessments to receive reimbursement)
  - Practice transformation support is often necessary for practices to integrate and requires funding separately
  - Differences in implementation of support for BHI by payers may lead to increased administrative burden and insufficient funds to make changes; multipayer alignment is necessary

- Variation by practice characteristics:
    - Particular need for adequate billing mechanisms for telehealth services in rural areas (would also be addressed with global budgeting)
    - Practices with BH providers other than licensed psychologists may have more barriers to billing services – smaller practices much more likely to use LCSWs to provide both BH services and support for social needs as a more efficient model
    - Depending on payer sources/region may have barriers to same day billing
    - Pediatric practices may have fewer opportunities to participate in payment model demonstrations. Much longer time frame for return on investment but powerful from a prevention standpoint.
    - Some smaller practices may not have the volume of patients with a particular health plan to qualify for an alternative payment model (APM).

Opportunities for policy change

- Technical assistance
    - Establish a national system for locally delivered and tailored technical assistance. Implementation of new models of care and particularly integrated care requires facilitation. Formation of such a system across the country was written into the Affordable Care Act but was never appropriated. Currently there is a patchwork of systems in place to try to fill this need but funding and availability are insufficient.
- Payment
    - Support multi-payer collaboration and alignment of payment models and metrics, across federal and state governmental payers, commercial insurers, and employer-based plans.
    - Eliminate barriers to same day billing of physical and behavioral health services.
    - Eliminate carve outs of behavioral health services.
    - Promote alternative payment models using risk-adjusted prospective payments as per-member-per-month (PMPM) amounts and ultimately primary care global budgets. Ensure that there are incentives or requirements in place for integrating care within a global budget.
    - Enact changes to FFS codes as interim steps:
        - Create FFS billing codes for telehealth services that do not occur in real time with the patient present and continue expansion of telehealth codes enabled during the coronavirus pandemic. Telehealth codes should be inclusive of care delivered via phone, video, patient portal, and email.
        - Allow for all BH provider types to bill for services using BH codes.
- Workforce
    - Expand funding for scholarships and loan repayment programs for BH providers in underserved areas.
    - Support programs training BH professionals for primary care integration, as it is a different model than standalone practice.

    - Develop a workforce assessment strategy including establishing an entity responsible for setting and meeting goals.
- Information sharing
    - Eliminate requirements under 42 CFR Part 2 to obtain written patient consent for each disclosure of protected health information when for the purposes of treatment, payment, or healthcare operations.

References

1. Petterson S, Henry TL, Miller BF, Green LA. Characteristics of primary care physicians working in the same practice as behavioral health providers. American Association of Medical Colleges Health Workforce Research Conference; 2015; Alexandria, Virginia.
2. Miller BF, Petterson S, Burke BT, Phillips RL, Green LA. Proximity of providers: colocating behavioral health and primary care and the prospects for an integrated workforce. *American Psychologist.* 2014;69(4):443-451.
3. Richman E, Lombardi B, Zerden L. Where is behavioral health integration occurring? Using NPI data to map national trends of co-location. American Public Health Association Annual Meeting and Expo; 2019; Philadelphia, PA.
4. Beil H, Feinberg RK, Patel SV, Romaire MA. Behavioral health integration with primary care: implementation experience and impacts from the State Innovation Model round 1 states. *Milbank Quartlery.* 2019;97(2):543-582.
5. Reiter JT, Dobmeyer AC, Hunter CL. The Primary Care Behavioral Health (PCBH) model: an overview and operational definition. *Journal of Clinical Psychology in Medical Settings.* 2018;25:109-126.
6. Unutzer J, Harbin H, Schoenbaum M, Druss B. *The Collaborative Care Model: an approach for integrating physical and mental health care in Medicaid Health Homes.* Center for Health Care Strategies and Mathematica Policy Research;2013.
7. Gallo JJ, Zubritsky C, Maxwell J, et al. Primary care clinicians evaluate integrated and referral models of behavioral health care for older adults: results from a multisite effectiveness trial (PRISM-E). *Ann Fam Med.* 2004;2:305-309.
8. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews.* 2012(10).
9. Asarnow JR, Rozenman M, Wiblin J, Zeltzer L. Integrated Medical-Behavioral Care Compared With Usual Primary Care for Child and Adolescent Behavioral Health: A Meta-analysis. *JAMA Pediatr.* 2015;169(10):929-937.
10. Balasubramanian BA, Cohen DJ, Jetelina KK, et al. Outcomes of Integrated Behavioral Health with Primary Care. *The Journal of the American Board of Family Medicine.* 2017;1(30):130-139.
11. Grimes KE, Schulz MF, Cohen SA, Mullin BO, Lehar SE, Tien S. Pursuing cost- effectiveness in mental health service delivery for youth with complex needs. *The Journal of Mental Health Policy & Economics.* 2011;14(2):73-83.
12. Lanoye A, Stewart KE, Rybarczyk BD, et al. The impact of integrated psychological services in a safety net primary care clinic on medical utilization. *Journal of Clinical Psychology.* 2017;73:681-692.
13. Melek S, Norris D, Paulus J. *Economic impact of integrated medical-behavioral healthcare: Implications for psychiatry.* Milliman American Psychiatric Association Report;2014.
14. Ross KM, Gilchrist EC, Melek SP, Gordon PD, Ruland SL, Miller BF. Cost savings associated with an alternative payment model for integrating behavioral health in primary care. *Translational Behavioral Medicine.* 2018;9(2):274-281.
15. Ross KM, Klein B, Ferro K, McQueeney DA, Gernon R, Miller BF. The cost effectiveness of embedding a behavioral health clinician into an existing primary care practice to facilitate the integration of care: A prospective, case-control program evaluation. *Journal of Clinical Psychology in Medical Settings.* 2018.
16. Peek CJ, National Integration Academy Council. Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. In. Rockville, MD: Agency for Healthcare Research and Quality; 2013.
17. Shmerling AC, Gold S, Gilchrist E, Miller BF. Integrating behavioral health and primary care: a qualitative analysis of financial barriers and solutions. *Translational Behavioral Medicine.* 2020;In press.
18. Gold SB, Green LA. *Integrated Behavioral Health in Primary Care: Your Patients are Waiting.* Cham, Switzerland: Springer; 2018.