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IssueBRIEF

Effectively addressing behavioral health care needs is essential to improving quality and reducing costs.

THE IMPORTANCE OF BEHAVIORAL HEALTH INTEGRATION

- Primary care is the only contact with the health care system for many people with behavioral health conditions.
- Primary care providers are the gateway to other specialists.
- Behavioral health conditions are often addressed during primary care visits.

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Behavioral Health Integration in Primary Care: **A Review and Implications for Payment Reform**

Health care delivery systems have been intentionally reorganizing to become more patient-centered, which means that patients' preferences, needs, and values help guide clinical decisions. Integrating mental health and substance use services into primary care settings, also known as behavioral health integration (BHI), is a core component of such efforts. To identify where BHI has been successful and where there is still room for improvement, we should have a clear idea of what BHI is and understand what policies exist or are needed to implement BHI. This issue brief provides an overview of BHI, including how it is defined and why it is important for improving patient care. Barriers to effective BHI are noted as well as opportunities to overcome those barriers—particularly in light of recent legislation, such as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Although important strides have been made in BHI in recent years, providing incentives for BHI through alternative payment models could significantly improve its implementation by removing financial and logistical barriers that remain.

This brief focuses on individuals with mild to moderate behavioral health conditions that can be treated in primary care settings; individuals with severe mental illness may benefit from different financing models.

Why is BHI important? BHI is important for a variety of reasons, including (1) the high prevalence of behavioral health conditions, (2) the need to address behavioral health conditions as part of comprehensive primary care, (3) the frequent coexistence and interaction of behavioral health conditions with other chronic medical conditions, and (4) the significant overall health care costs and productivity losses associated with behavioral health conditions.

The historical separation of behavioral health care from physical health care promotes the opposite of a whole-person, patient-centered approach to primary care—a challenge that remains but is slowly being addressed. BHI has been supported by a variety of organizations, including the Institute of Medicine and the American College of Physicians (Crowley et al. 2015).

Primary care is well-positioned to address behavioral health problems for several reasons. First, primary care is the only contact with the health care system for many people with behavioral health conditions. Second, primary care providers (PCPs) are the gateway to other specialists. Finally, when behavioral health conditions are addressed, this often occurs

BHI provides a variety of benefits:

(1) Improves interpersonal and informational continuity

(2) Delivers comprehensive services in a single setting

(3) Promotes the treatment of the patient as a whole, rather than addressing individual physical and behavioral health needs in isolation

during primary care encounters (Regier et al. 1978, Unutzer et al. 2006, Hsiao et al. 2010). Recognizing and managing these conditions has long been noted as a core aspect of primary care that is intrinsic to comprehensive care (O'Malley et al. 2015, Rich and O'Malley 2015). Using BHI to enhance these and other core features of primary care (accessibility, continuity, and coordination) for patients with behavioral health concerns provides a variety of benefits. These include enhanced access to doctors' offices and "one-stop shopping" for both behavioral and physical needs (Pourat et al. 2015). PCPs and behavioral health providers working together as a team can (1) improve interpersonal and informational continuity (Klein and Hostetter 2014, Pourat et al. 2015); (2) deliver comprehensive services in a single setting (Institute of Medicine 2006); and (3) promote the treatment of the patient as a whole, rather than addressing individual physical and mental health needs in isolation (Freeman 2015).

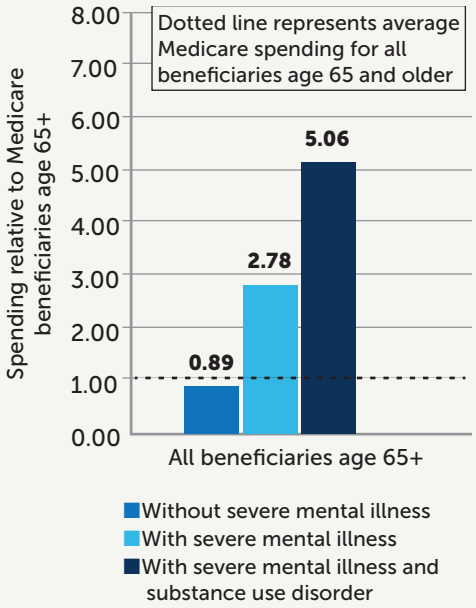
Millions of Americans suffer from behavioral health conditions each year, and many prefer to be treated in primary care settings.

Prevalence and costs of behavioral health conditions. According to the 2013 National Survey on Drug Use and Health, an estimated 43.8 million Americans age 18 or older had a mental illness in the past year, representing 18.5 percent of all adults in the United States (Substance Abuse and Mental Health Services Administration 2014). In addition, an estimated 21.6 million Americans age 12 or older had substance dependence or abuse, representing 8.2 percent of the U.S. population age 12 years or older (Substance Abuse and Mental Health Services Administration 2014). According to Wang et al. (2005), individuals with common behavioral health conditions—such as depression, anxiety, and alcohol and substance use disorders—are more likely to receive care and to prefer receiving care in primary care settings than in specialty mental health settings (Feldman and Feldman 2013, Unützer et al. 2013). Roughly a quarter of primary care patients have a mental disorder at any given time (Kessler and Stafford 2008).

Individuals with behavioral health conditions are among the most costly patients because the conditions can impair self-care and adherence to medical treatments (Unützer et al. 2012). Medicare expenditures for beneficiaries older than 65 who have a serious mental illness are three times higher than expenditures for similar beneficiaries who do not have a mental disorder; expenditures for beneficiaries who have both a serious mental illness and a substance use disorder are more than five times higher (The Scan Foundation 2013). Furthermore, older adults with evidence of a mental disorder are less likely than younger and middle-age adults to receive mental health services (Karel et al. 2012). Due to coexisting physical conditions, older adults are significantly more likely to seek and accept services in primary care settings versus specialty mental health care settings (Institute of Medicine 2012). More coordinated and effective care of behavioral health conditions in primary care settings can improve outcomes and either reduce costs or be more cost-effective than usual care (Gilbody et al. 2006, Glied et al. 2010, Peikes et al. 2012, Unützer et al. 2013).

How is integration defined? One of the most comprehensive attempts to define BHI has been set forth by the Agency for Healthcare Research and Quality (AHRQ). See the box on page 3 for AHRQ's definition (Peek and National Integration Academy Council 2013).

Medicare Beneficiaries With a Severe Mental Illness Cost Nearly Three Times More Than Beneficiaries Without a Behavioral Health Condition



The Scan Foundation. "Medicare Spending for Beneficiaries with Severe Mental Illness and Substance Use Disorder." Data Brief No. 38. Long Beach, CA: The Scan Foundation, 2013.

Dozens of randomized controlled trials have demonstrated the effectiveness of collaborative care, a form of behavioral health integration.

AHRQ's common meaning of integrated care

BHI refers to care that results from a practice team of primary care and behavioral health clinicians working together with patients and families and using a systematic, cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

AHRQ further outlined how to conduct and support BHI. This is important because some of the limitations associated with many current attempts at BHI may be derived from not adhering to the recommended processes and principles. Although a full discussion of each of the defining points of BHI is beyond the scope of this issue brief, they can be summarized as needing to include (1) a practice team that has a wide range of behavioral health and primary care expertise, with shared workflows and practice culture; (2) a shared patient population and mission; (3) a systematic approach—including patient engagement—for identifying who might benefit from care; (4) a unified care plan based on a shared electronic health record (EHR); and (5) systematic follow-up and treatment adjustment as needed.

AHRQ's definition of BHI also considered degrees of integration from separate to fully integrated.

Does integration work? Many well-designed studies have demonstrated the efficacy of BHI. Collaborative care is the most common form of integration in these studies. A meta-analysis of 79 randomized controlled trials that included over 24,000 patients found collaborative care to be more effective at improving depression and anxiety for up to two years compared to usual care (Archer et al. 2012). Although collaborative care is prescriptive, it can be adapted to local contexts. Collaborative care includes the following clinical features:

- A standardized screening tool, such as the two- and nine-question Patient Health Questionnaires (PHQ-2 and PHQ-9) for depression (Arroll et al. 2010)
- A medical diagnosis for patients who screen positive
- Evidence-based, "stepped" depression care
- Care managers
- Patient and family education
- Clinical and administrative staff training
- Ongoing tracking of patient status by using PHQ-9 scores
- A designated psychiatrist who consults with the care manager and the primary care physician
- Continuous performance measurement and improvement (Sederer 2014)

Collaborative care requires regular reporting of specific metrics that demonstrate that primary care practices are delivering these elements, as this evidence links clinical action to health outcomes (Sederer 2014). It is likely that the prescriptive nature of collaborative care is associated with the effectiveness of its results; in other words, model fidelity is important. Despite the benefits of collaborative care, its limitations include a near-exclusive focus on depression and anxiety (with only recent attention to substance use) and the exclusion of more serious mental disorders. In addition, most studies do not address how to pay for BHI or what policy levers could support and sustain BHI.

What does effective BHI include? Based on the studies discussed above as well as national implementation by the U.S. Department of Veterans Affairs (Post and Van Stone 2008), there are several common features of successful integration efforts, including the following:

- Clear screening processes
- Decision support to help PCPs interpret screening results and move patients to the next step of treatment
- Warm handoffs, by which the PCP directly introduces the client to the behavioral health provider at the time of the client's medical visit
- Colocation of PCPs and behavioral health providers
- Processes for tracking progress by using empirically validated tools
- Staff training and feedback
- Ongoing decision support when medications or psychotherapy are no longer working or when they have achieved the treatment goal

- Shared EHRs and other forms of communication between PCPs and behavioral health providers

Although a recent study found that, across the nation, as many as 29 percent of primary care physicians are colocated with psychologists, and 43 percent are colocated with any behavioral health provider, the study also found that there is significant variation along a rural-urban continuum such that in the most rural areas, only 6 percent of primary care physicians are colocated with psychologists, and 22 percent are colocated with a behavioral health provider (Miller et al. 2014). Furthermore, colocating behavioral health providers and primary care physicians does not, in itself, guarantee integration. It could simply lead to "parallel play," in which providers share a space but are not working together closely (Miller et al. 2014). In addition, practices may conduct behavioral health screening, but they may not systematically follow up. Practices may consider colocation without integration and screening without follow-up to be BHI, but neither one goes far enough. This configuration of services can also send the wrong message—that BHI is not effective—when the issue may be poor implementation.

Systemic barriers to effective BHI include regulatory barriers, financial barriers, and the historical separation of primary care and behavioral health professionals.

In terms of effective implementation, collaborative care has started to be disseminated more broadly. For example, the Depression Improvement Across Minnesota program has been implemented in over 80 primary care clinics throughout Minnesota (Lauren Crain et al. 2012), while the Washington State Mental Health Integration Program involved major insurance companies that agreed to pay for collaborative care in over 100 community health clinics and 30 community mental health centers (Unützer et al. 2012). Although the approaches and implementation in Minnesota and Washington were nearly identical to the original collaborative care model, modifications were needed to create a sustainable financing model (Korsen and Pietruszewski 2009).

Care compacts are another approach several practices have begun to adopt. In these compacts, a primary care practice and a behavioral health practice explicitly lay out a process for collaboratively addressing patient needs. The compacts cover topics such as referral processes, patient access to each site, managing care transitions, and patient comanagement. Creating a signed document that outlines areas of mutual agreement and expectations has the potential to effectively address patient needs (Colorado Center for Primary Care Innovation 2012).

What are the systemic barriers to effective BHI? There are a variety of barriers to effective BHI in primary care overall and among Medicare patients specifically. These barriers include regulatory barriers, financial barriers, and the historical separation of primary care and behavioral health professionals. On the regulatory side, providers may mistakenly believe that the Health Insurance Portability and Accountability Act of 1996 prevents them from sharing information with each other, but it does not (Collins et al. 2010).

More challenging are the regulations relevant to reimbursement for behavioral health services. Fee-for-service (FFS) Medicare is not particularly generous with behavioral health benefits. Furthermore, traditional FFS payments (through Medicare and other payers) are ineffective rewards for comprehensive, coordinated, accessible care even for patients with medical conditions (Berenson and Rich 2010)—much less the more challenging and complex patients with combined medical and behavioral health issues (Rich et al. 2012). Thus, it seems quite unlikely that effective BHI can be implemented using FFS reimbursement alone.

In addition to the problems related to FFS care, financing BHI becomes even more challenging in the many communities that have separate funding streams for medical and behavioral health care—through either managed care programs developed under private insurance or distinct programs supported by state agencies. This arrangement can contribute to the challenges involved in serving dually eligible Medicare and Medicaid beneficiaries because behavioral health services are often poorly coordinated, and payment incentives may not align effectively. As a result, in some markets PCPs feel discouraged from attempting to address behavioral health issues, given the uncertainty of financing for this aspect of care. Because of the unique billing or credentialing requirements related to categorical funding for behavioral health services, primary care and behavioral health practices are often physically and administratively separate. Thus, current payment models have limited the widespread adoption of effective BHI strategies such as collaborative care (Zivin and Katon 2015).

What policies can help overcome these barriers? Several health policy reforms could ultimately facilitate more widespread adoption of BHI. These include (1) the Medicare Improvements for Patients and Providers Act of 2008, which eliminated the disparate copayments previously required for psychotherapy (50 percent) compared to other medical services in Medicare (20 percent); (2) the Mental Health Parity and Addiction Equity Act of 2008, which prevents group health plans and insurers from imposing less favorable benefit limitations on mental health or substance use disorder benefits than on medical or surgical benefits (this affects Medicare Advantage plans); and (3) broader health policies included in the Patient Protection and Affordable Care Act (ACA) of 2010. Relevant ACA provisions include increased access to insurance (Medicaid expansion, employer mandate, health insurance exchanges with low-income subsidies); delivery system redesign (patient-centered medical homes [PCMH], Medicaid health homes, accountable care organizations [ACOs]); and the inclusion of mental health in essential benefits packages. Several U.S. Department of Health and Human Services (HHS) agencies have been developing integration models and resources, including the Academy for Integrating Behavioral Health and Primary Care supported by AHRQ. States such as Oregon are using Section 1115 Medicaid demonstration waivers to promote the integration of behavioral health and primary care. In addition, commercial payers have also started to provide support for BHI, such as Aetna's Integrated Primary Care Behavioral Health Program (Patient-Centered Primary Care Collaborative 2015).

In combination with other efforts and resources, chronic care management fees (Centers for Medicare & Medicaid Services [CMS] 2015) could also encourage BHI. In 2015, Medicare began to pay eligible professionals separately under the Medicare Physician Fee Schedule (PFS) for care management activities performed outside of face-to-face office visits for Medicare beneficiaries who have two or more significant chronic conditions. Many patients with chronic medical conditions also have behavioral health conditions. Effective integrated care models typically include care management calls.

The proposed rule on the 2016 PFS may be more relevant to BHI. The rule establishes a separate payment for collaborative care (US DHHS 2015). The proposed rule also requested public comment on how coding under the PFS might facilitate the appropriate valuation of services provided by the collaborative care model. The PFS also requested comments on whether the collaborative care model should be implemented through a Center for Medicare & Medicaid Innovation (CMMI) demonstration; the proposed demonstration would allow Medicare to test its effectiveness with a waiver of beneficiary liability or a variation of payment methodology and funding amounts for both a psychiatric consultant and a PCP. Without these protections, beneficiaries might be responsible for coinsurance payments for physicians, yet they might not understand the role of those physicians in their care (HHS 2015). The goal is to obtain comments to address these issues during 2016 for implementation in 2017.

There has been significant movement in recent years on a variety of policy fronts that could facilitate integrated care. Despite these efforts, there are indications that integrated care models are still limited. Recent research has shown that few ACOs are using BHI (Lewis et al. 2014, D'Aunno et al. 2015), which may partly be due to a limited focus on quality of care and value-based care that includes behavioral health conditions. Findings from the first annual report of the evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration also indicated that a number of participating practices struggled to implement BHI (McCall et al. 2015).

How could MACRA assist in overcoming barriers to BHI? MACRA may provide opportunities to test new payment approaches that could overcome barriers to BHI. MACRA offers two potentially relevant pathways: (1) traditional FFS with the new Merit-Based Incentive Payment System (MIPS) or (2) the Alternative Payment Model (APM). MIPS will replace the Value-Based Payment Modifier, the Physician Quality Report System, and Meaningful Use of EHR technology. Under MIPS, Medicare payments to physicians for individual services will increase or decrease by up to nine percent depending upon a physician's performance on quality measures, resource use, clinical improvement activities, and use of EHRs. MIPS quality measures will build upon existing measures from the programs that MIPS replaces. To date, behavioral health measures have focused primarily on screening, but they have begun to focus on outcomes such as 12-month remission rates. MIPS provides an important opportunity to promote BHI through additional measures that incentivize integrated

care practices. Under MIPS, eligible clinicians will receive composite performance scores based on four categories. One of these categories is called Clinical Practice Improvement Activities (CPIA) (US DHHS 2016). CPIAs will carry a different number of points. To collect points, clinicians select from a list of over 90 options. Among these is a subcategory on the integration of primary care and behavioral health. This subcategory will include measuring such factors as co-location of behavioral health and primary care services, shared/integrated behavioral health and primary care records, or cross-training of MIPS-eligible clinicians or groups participating in integrated care. This subcategory also includes integrating behavioral health with primary care to address substance use disorders or other behavioral health.

The revisions to traditional FFS with MIPS do not create any new PFS payments for high-value services such as BHI that are not currently covered by Medicare. Therefore, services that are not currently reimbursed that may help to support BHI would not be covered under MIPS, even if their use results in better health outcomes, higher quality, or more efficient care. Additional payments to support BHI may be required to make a significant change, not just selectively reporting under MIPS by providers who are already doing a good job. Of note, the recently released Notice of Proposed Rule Making (US DHHS 2015) also makes clear that at least initially, MIPS will not apply to PFS payments to psychologists and other therapists who are key personnel in BHI care teams.

The other payment reform pathway that PFS providers could choose under MACRA is the APM. If providers achieve a minimum threshold of participation in one or more advanced APMs, they would be exempt from MIPS, receive a bonus equal to 5 percent of their Medicare PFS payments, and receive a higher annual increase than providers participating in MIPS in the standard Medicare payment rates for all of their services.

MACRA empowers CMMI to investigate APMs that support care for a defined population for which there are gaps in care. MACRA also provides HHS with the authority to expand APMs that are determined to improve the quality of care without increasing spending (or to reduce spending without reducing the quality of care). Eligible advanced APMs require (1) the use of EHR technology, (2) provider payment based on quality measures comparable to MIPS, and (3) the participation of eligible professionals either in an entity that bears more than nominal financial risk or in a medical home model that meets other criteria. APMs can include a variety of options, such as ACOs, bundled payment models, or PCMHs, all of which could meet criteria as advanced APMs and thus offer the potential to earn the PFS bonus.

Through MACRA, APMs could provide the opportunity to (1) reward physician practices for delivering services that are not currently billable but that support BHI, (2) develop condition payments specific to behavioral health, (3) develop bundled payments that recognize the roles of multiple providers, and (4) develop other payments that support BHI. MACRA also creates an incentive for providers to participate in other (for example, commercial insurance) APMs, which will help practices hit the threshold to qualify for the MACRA APM bonus. Furthermore, under MACRA, the HHS secretary can decide to incorporate into PFS payments to other professionals in future years.

At present, CMMI is conducting and evaluating multiple APMs (with additional models anticipated going forward), which could have an impact on BHI. Current models include the Comprehensive Primary Care Initiative (CPC) (Baron and Davis 2014) and MAPCP (McCall et al. 2015). CPC provides population-based care management fees and shared savings opportunities to participating primary care practices to support primary care redesign. As part of CPC, practices chose one of three advanced primary care strategies starting in the second year of the demonstration; BHI was one of the options. MAPCP includes multiple payer reform initiatives that are currently being conducted by states to make advanced primary care practices more broadly available. Some MAPCP practices elected to use funding to hire care managers to facilitate BHI. CMMI recently announced that it will be implementing a revised and expanded CPC model, CPC Plus (CMS 2016), which will qualify under MACRA as an advanced APM (HHS 2016) and has a track to support practices that provide more comprehensive services for patients with complex medical and behavioral health needs.

Future APM models could have more targeted approaches to support broader and more robust implementation of BHI. Although none of

the current APMs being tested by CMMI (or MACRA itself) is prescriptive regarding testing of specific BHI models, CMMI has been developing APMs with specific programmatic requirements for participation—an approach that could be applied to test implementation of proven BHI models and features. For example, the Independence at Home demonstration tests the effectiveness of delivering comprehensive primary care at home with specific service requirements; the demonstration uses quality measures tied to incentive payments (CMS 2012). Furthermore, for many behavioral health care providers and PCPs, efficient and effective BHI would need to apply not just to the traditional Medicare FFS beneficiaries in the practice, but to all of the patients served by that practice. CMMI has several tests of all-payer APMs (including CPC). Furthermore, under MACRA, providers can be rewarded for serving commercially insured and Medicaid patients, as well as Medicare patients through APMs. Thus, under MACRA, CMMI has the opportunity to test BHI models that might apply to a wide variety of patients in a community. Most important, there are now signs that CMMI will develop a demonstration specifically designed to fund collaborative care, thereby directly testing the use of an APM to support BHI. It would be useful to evaluate not only how different models affect different patient populations with behavioral health needs but also the cost of implementing the models relative to their benefits (Bao et al. 2013).

Conclusion. The goal of improving health care quality and outcomes while decreasing costs will not be achieved without effectively addressing behavioral health care needs (Katon and Unutzer 2013). Important policy changes that are under way may remove some of the barriers to BHI. However, researchers at AHRQ recently found that, although the effectiveness of BHI has been established, the ability to sustain it would depend, in part, upon incentives and support for payment models (Crowley et al. 2015). The outcome of the decision regarding whether to have a collaborative care demonstration could be particularly important to the future of BHI in Medicare. Although significant progress has been made in moving BHI forward, MACRA may also provide additional opportunities to expand it through paying for basic integration activities.

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