

Enhancing Patient Outcomes and Health System Value through Integration of Behavioral Health into Primary Care

Providers in the US health care system often assess and treat patients with physical health conditions and behavioral health (mental health and substance use) conditions in siloes, yet physical and behavioral health are inextricably linked. Up to 70% of physician visits involve a behavioral health issue, and a similar percentage of adults with behavioral health conditions have one or more physical health issues.^{1,2}

In addition to the individual consequences of undiagnosed or undertreated behavioral health conditions, the economic impacts of such conditions are substantial. Health care costs for patients with behavioral health conditions are typically 2-3 times higher than for patients without these conditions.³

The Agency for Healthcare Research and Quality (AHRQ) defines **behavioral health** broadly to include mental health and substance abuse conditions, health behaviors, life stressors and crises, and stress-related physical symptoms.⁴ This brief, however, focuses on programs to address mental health disorders that are frequently diagnosed and managed in primary care settings. It does not address treatment of serious mental illness or substance use disorders.

Behavioral health integration (BHI) into primary care refers to screening and treatment to address both physical health and behavioral health needs in primary care settings through systematic coordination and collaboration among health care providers.

The overall goals of integrated behavioral health and primary care are those of the Triple Aim – better outcomes, better care experience, and reduced costs. While many organizations have attempted to address patient needs more comprehensively over the past 20 years by integrating care, there is considerable variation in their approaches and in the terms used across the field to describe the elements of integrated care.

This brief summarizes the latest evidence on the effectiveness and value of behavioral health integration (BHI) into primary care, and it offers policy recommendations to stakeholders on how best to address key implementation issues. Resources for payers, clinicians, and policymakers to assist with implementation are available in companion Action Guides, and the policy recommendations listed below are described in more detail in the full report on which this brief is based. Visit the [CEPAC](#) and [CTAF](#) websites for additional materials.

What Works: Improved Health Outcomes

Several programs have emerged across the nation as models for implementing integrated behavioral health and primary care services. The Collaborative Care Model (CCM) is the most studied model and is based on the well-established Wagner Chronic Care model.⁵

Key components of the CCM include:

- Care coordination and care management,
- Screening and regular, proactive monitoring using validated clinical rating tools, with treatment adjustments as needed, and
- Team-based care involving a primary care physician, care manager, and psychiatrist consultant.

This model has been evaluated through the type of research studies that are of highest quality: randomized controlled trials (RCTs). These studies have consistently found that collaborative care improves patients' depression, anxiety, quality of life, and satisfaction with care. Currently there are no RCTs of other approaches to BHI, including the Behavioral Health Consultant (BHC) model that shares many elements of the CCM. Distinctive features of the BHC model are that generalist behavioral health clinicians a) are fully embedded members of the primary care team who provide patients with rapid access to behavioral health treatment through warm "handoffs" between behavioral health clinicians and primary care physicians, and b) address a broader range of health, mental health, and substance use disorder conditions.

Cost-effectiveness and Value

Nearly all RCT-based economic studies published in the last 15 years have focused on the CCM model of BHI. These studies have shown the CCM to be more effective clinically than usual care but also more costly over 6 months to 2 years. Costs to deliver CCM-based interventions vary widely by setting and disease burden of the population served, ranging from \$20 to \$3,900 per diagnosed patient in published studies; however, many studies did not include all start-up or screening costs in these estimates. In some cases, reductions in health care spending have helped to offset the increased costs, primarily in specialty mental health services and in inpatient or emergency department care for specific patient groups (e.g., patients with diabetes). Longer-term studies have shown the potential for cost-neutrality or even overall cost savings, but such studies are limited in number and of poorer methodological quality.

Does the additional cost of BHI in the first 2 years after implementation represent a “good” value? Findings from multiple studies across a variety of settings and populations suggest that the clinical improvements and costs ascribed to the CCM model of BHI translate into cost-effectiveness ratios of \$15,000-\$80,000 per quality-adjusted life year (QALY), a range that falls within generally-acceptable thresholds for cost-effectiveness. Comparative data on approaches to BHI other than the CCM are extremely limited, making it impossible to calculate reliable estimates of cost-effectiveness.

Policy Recommendations

The following recommendations in several categories identify changes in practice and policy that are needed to support BHI. They were developed to guide the application of evidence to BHI implementation and are derived from two sources: 1) insights from interviews with national and regional policy experts in New England and California who provided real-world perspectives on the challenges to and opportunities for integrating behavioral health into primary care; and 2) themes from policy roundtable discussions at recent public meetings of the California Technology Assessment Forum (CTAF) and the New England Comparative Effectiveness Public Advisory Council (CEPAC).⁶

Care Delivery Models

1. Effective BHI can be accomplished through different care delivery models, and in practice, implementation will be tailored to distinct patient populations and other local considerations. Since the approach to integration with the strongest evidence base is the Collaborative Care Model, practices implementing BHI should use available resources (click here for the [California](#) or [New England](#) action guide and resource compendium) and seek guidance from organizations that have experience with the CCM while accounting for differences in patient population, resources, treatment priorities, and options for funding. A second promising approach to integration is the Behavioral Health Consultant model.
2. Researchers, research funders, and clinicians should work together to generate more evidence on the effectiveness of BHI approaches in addition to the CCM and on the effectiveness of BHI in treating health conditions other than depression and anxiety.

“While RCTs answer the question of whether something works, context is essential when trying to integrate behavioral health into primary care, so the right question here is ‘What works, where, and for what populations and individuals?’ Those are the lessons that will help us build effective programs.”

*--Neil Korsen, MD, MSc, Medical Director
Behavioral Health Integration, MaineHealth*

Reimbursement and Payment Policies

3. To align incentives among providers and encourage integration, payment for behavioral health services should be shifted away from fee-for-service (FFS) to value-based reimbursement contracts, including risk-adjusted capitation and opportunities for shared savings and/or shared risk. When developing reimbursement arrangements, decision-makers should consider the following:

- Where possible, supplemental capitated payments or performance bonuses should be based on implementing and sustaining BHI.
- To support the transition towards value-based reimbursement, payers and state agencies should activate currently available billing code sets for care and case management so the incremental services being provided in integrated settings can be documented.
- Behavioral health carve-outs, though not ideal for achieving the goals of BHI, are likely to remain an important aspect of health care financing. To the extent possible, carve-out arrangements should be improved through enhanced communication, information sharing, and care planning across entities to encourage collaborative care planning and follow-up.

FFS reimbursement makes it difficult for providers to receive payment for activities core to BHI, including care management and collaboration across providers working in teams. Much of the daily interaction among care team members that supports integrated care (e.g., formal or informal "huddles", reading medical records in complex cases, informal consults in the hallways) is not allowable for FFS billing, and yet is critical to collaborative care planning. Capitation and bundled payments are alternatives to FFS that better support BHI. Capitation payments should be risk-adjusted with an increase in per-member-per-month (PMPM) payments to help fund care coordination, case management, and other practice enhancements.

Though global payments may provide additional flexibility for practices to better provide coordinated, comprehensive services, new challenges may make implementation difficult. It is, for example, difficult to monitor whether the services paid for by the global payment rate are being delivered and improving health (see recommendation # 14 below).

Though the ultimate goal should be to shift towards value-based contracts, in the short-term, activating existing FFS billing codes for care management and case management services will help decision makers understand what services individuals are accessing in primary care and help determine the true costs of implementing and managing BHI.

See the textbox below for an example of how Massachusetts is facilitating BHI through its payment policies.

Massachusetts Primary Care Payment Reform Initiative (PCPRI)

As a response to 2012 legislation requiring the development of alternative payment methodologies, MassHealth (the combined Medicaid and State Children's Health Insurance Program in Massachusetts) launched a payment reform initiative designed to improve the integration of behavioral health and primary care. The PCPRI develops the patient-centered medical home (PCMH) model and grants primary care physicians more flexibility to deliver comprehensive services. The program involves a three-pronged payment structure that includes risk-adjusted capitated payment for primary care services (based on previous year's billings), annual quality incentive payment for performance on specific measures, and shared savings from reductions in non-primary care spending (e.g., hospital and specialist services) for primary care providers.

Participating practices receive a Comprehensive Primary Care Payment based on the level of BHI provided:

Tier 1: No requirement for behavioral health services to be provided, but care coordination is expected

Tier 2: Practice meets minimum BHI services, including diagnostic evaluations, depression screening, individual and group therapy, etc. A full-time behavioral health provider is on-site with ability to schedule appointments within 14 days of request.

Tier 3: Practice meets higher level of BHI services, including medication management and psychiatric testing. On-site psychiatrist is part of care team that has access to behavioral health record for each patient.

Payments for higher tiers are coordinated with behavioral health carve-outs. 70% of participating programs chose Tier 1 in the first year.

Source: Harris J. Transition to alternative payment methods: From patient medical homes to the Primary Care Payment Reform Initiative. MassHealth, 2012. <http://www.mass.gov/anf/docs/hpc/pcmhi-andpcpr-presentation-to-the-hpc.pdf>. Accessed March 2015.

Reimbursement and Payment Policies (cont.)

4. Even with a shift toward capitation, FFS will continue to be a reality of the reimbursement landscape, at least in the short-term. Therefore, several changes to billing requirements are needed. In states with the billing restrictions listed below, the following changes would enhance BHI:
 - Activate Health and Behavior Assessment and Intervention (HBAI) codes to allow billing for services related to behavioral, social, psychological, and cognitive issues that affect the management of physical health conditions
 - Ease restrictions on licensing requirements for the use of different billing codes to be more inclusive of behavioral health clinicians (e.g., physicians typically bill using evaluation and management (E&M) or psychiatric codes, whereas behavioral health clinicians typically use HBAI codes)
 - Establish billing codes for care management and case management, including for services provided when a patient is not present such as provider-to-provider consultation and referral coordination
 - Allow behavioral health and physical health visits to be billed on the same day
 - Ease the requirement that patients must receive a full intake evaluation and assessment before providers can bill and be reimbursed for behavioral health services
5. Health plans should design benefits and provider networks to support a role for behavioral health providers as members of primary care teams and not require that patients pay specialist-level copayments for these providers. An alternative approach is to have a single copayment for a visit that covers any care provided by the primary care team.
6. Providers should be reimbursed for behavioral health services delivered via telehealth. While some payers allow some telehealth services to be reimbursed, there is an opportunity to expand access to care for patients, particularly in underserved areas. Since the availability of psychiatrists and other behavioral health clinicians is often limited, expanding telehealth reimbursement would allow for a broader geographic distribution of behavioral health consultations.

Licensing and Certification

7. States should take steps to alter licensing and certification requirements that serve as a direct barrier to BHI and pursue policies that streamline licensing processes for integrated or multi-site care settings. Some states have recently changed or are actively pursuing changes to licensure requirements to better support integration, and it is important for states to ensure that licensing and certification standards keep pace with desired transformations in primary care practice. The current requirement for separate licensing and associated fees for each clinic housing an integrated team and each clinician practicing as part of the team serves as a barrier to BHI. Experts have recommended allowing discounted fees for professionals who certify as a care team and creating an option for integrated practice groups to apply for a single license rather than acquiring separate licenses for each facility, as is often required.

Innovation and Collaboration

8. Public and private payers, clinicians, patients, and others should collaborate to reduce fragmentation of care and develop innovative system-wide solutions that include BHI, building on efforts already underway and utilizing state and federal programs. The significant efforts across the US to integrate behavioral health and primary care could be further advanced and sustained with the involvement and support of additional partners. Examples of initiatives that encourage stakeholder engagement on collaborative solutions include Medicaid waivers and State Innovation Model (SIM) grants from the federal Center for Medicare & Medicaid Innovation (CMMI) that allow states to test multi-payer health care delivery and payment reform models for improving care quality while reducing costs (see the textbox on page 5 for an example of how California is applying to use a Medicaid waiver to enhance BHI).

Technology/Information Sharing

9. BHI depends on the ability of clinicians to collaborate and share patient information. Systems that better support communication between primary care providers and specialty behavioral health providers are therefore needed, particularly where electronic health record (EHR) systems are not used or lack interoperability. Clearer guidance is also needed from federal and state officials to help clinicians understand laws that affect the sharing of patient information related to mental health and substance use disorders.⁷ Enhanced information sharing would allow for more coordinated treatment, particularly around vulnerable times of transition, and would help to avoid duplication of services.

Medi-Cal Integration Efforts: 1115 Waiver Application

The California Department of Health Care Services (DHCS) administers the Medi-Cal program and has recently submitted a new 1115 waiver application with a goal of facilitating system transformation. Specific to BHI, the waiver seeks to 1) better coordinate and promote BHI so patients experience more seamless care, and 2) reduce overall costs of care through aligned financial incentives and value-based payments.

Key elements of the application related to BHI include:

Provider training and capacity

- Expanding cross-training of providers in primary care, mental health, and substance use disorder services to support integration of multi-disciplinary teams across care settings

Service capacity and delivery

- Improving care coordination by expanding the use of peer providers as part of a care team treating behavioral health conditions
- Expanding Screening, Brief Intervention, and Referral to Treatment (SBIRT) to more care settings and making training and certification available to a broader set of providers

Payment

- Implementing value-based purchasing strategies (e.g., joint incentive pools with managed care plans, behavioral health systems, and providers) to align incentives at each layer of the delivery system
- Restructuring the current capitation rate-setting methodology to enable shared savings

Technology/information sharing

- Supporting adoption of EHRs for behavioral health with a focus on interoperability to support timely data transfer across all primary care, mental health, substance use disorder treatment entities, and managed care plans

For more information, visit: <http://www.dhcs.ca.gov/provgovpart/Pages/WaiverRenewal.aspx>

Clinic Operations, Workflow, and Space

10. Flexible workflows facilitate BHI. To the extent possible, clinic operations should allow for “warm hand-offs” and real-time (in-person or virtual) collaboration and consultation across providers. The specific staffing model that a practice adopts should reflect the disease burden and broader psychosocial characteristics of the population served and should include designated leadership positions to facilitate team collaboration and oversee the transition to integrated care.
11. If a population-based approach to BHI is not feasible, practices should consider rolling out BHI interventions to a subset of the patient population with the greatest clinical need and potential benefit. Resource availability and other realities may lead practices to limit screening and treatment efforts to depression and anxiety before taking on all behavioral health conditions, for example, or to limit interventions to patients with multiple conditions and more complex management needs (e.g., patients with diabetes and depression). Practices should exercise caution in screening for conditions if they cannot reasonably provide services to patients needing treatment or cannot refer them elsewhere for timely and high-quality treatment.

Provider Training and Capacity

12. The capacity for practices to implement BHI is strained by an overall shortage of primary care and behavioral health providers and by a lack of providers with expertise in integrated care. Additional specialized training or re-training of staff is necessary to build the integrated care workforce and help each team member understand their scope of work and the goals of integrated care.
13. To address network capacity concerns, provider organizations should develop systems that link providers electronically and help triage patients to the level of care most appropriate for their individual needs.

Measurement, Outcomes, and Standards

14. Payers, practices, patients, and policymakers should work collaboratively to build consensus around a set of validated structure and outcome measures for BHI. Standardized measures would help payers and practices understand the degree of integration being achieved, the benefit, and the true cost of implementing and maintaining BHI.

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About ICER

The Institute for Clinical and Economic Review ([ICER](http://www.icer-review.org)) is an independent non-profit health care research organization dedicated to improving the interpretation and application of evidence in the health care system. ICER directs two core programs: the New England Comparative Effectiveness Public Advisory Council ([CEPAC](http://www.icer-review.org)) and the California Technology Assessment Forum ([CTAF](http://www.ctaf.org)). For more information, visit ICER's website, www.icer-review.org

About CEPAC

The New England Comparative Effectiveness Public Advisory Council (CEPAC) is an independent, regional body of practicing physicians, methodological experts, and leaders in patient advocacy and engagement that provides objective, independent guidance on the application of medical evidence to clinical practice and payer policy decisions across New England. CEPAC is supported by a broad coalition of state Medicaid leaders, integrated provider groups, public and private payers, and patient representatives. For more information, visit cepac.icer-review.org

About CTAF

The California Technology Assessment Forum ([CTAF](http://www.ctaf.org)) reviews objective evidence reports and holds public meetings to develop recommendations for how patients, clinicians, insurers, and policymakers can improve the quality and value of health care. CTAF is supported by grants from the Blue Shield of California Foundation and the California HealthCare Foundation. For more information, visit www.ctaf.org