



IDEAS
ACTION
RESULTS

Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration

TASK FORCE RECOMMENDATIONS

March 2021

Bipartisan Policy Center

**BPC
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and Governor, Ohio

Vikki Wachino

Principal, Viaduct Consulting, LLC
Former Deputy Administrator and
Director of the Center for Medicaid
and CHIP Services, Centers for
Medicare & Medicaid Services

STAFF

Tyler Barton

Research Analyst, Prevention Initiative

Anita Burgos, Ph.D.

Senior Policy Analyst, Health Project

Joann Donnellan

Senior Advisor, Communications

Lisa Harootunian, J.D.

Senior Policy Analyst, Health Project

Julia Harris

Senior Policy Analyst, Health Project

Tara Hartnett

Project Associate, Health Project

G. William Hoagland

Senior Vice President

Dena McDonough, PA-C

Associate Director, Health Project

Brady Newell

Project Coordinator, Health Project

Mary Nguyen

Intern, Health Project

Brian O’Gara

Project Associate, Health Project

Anand Parekh, M.D.

Chief Medical Advisor

Marilyn Serafini

Director, Health Project

CONSULTANT

Mary Giliberti, J.D.

Executive Vice President of Policy,
Mental Health America

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Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

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DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders or its board of directors.

GLOSSARY OF ACRONYMS

ACA	Affordable Care Act	ISMICC	Interdepartmental Serious Mental Illness Coordinating Committee
ACO	Accountable care organization	IT	Information technology
AHRQ	Agency for Healthcare Research and Quality	LGB	Lesbian, gay, & bisexual
AMA	American Medical Association	LPC	Licensed Professional Counselor
API	Application programming interface	MCO	Managed care organization
BCBSNC	Blue Cross and Blue Shield of North Carolina	MCPAP	Massachusetts Child Psychiatry Access Program
BIPOC	Black, Indigenous and people of color	MH/SUD	Mental health/substance use disorder
CBO	Congressional Budget Office	MIPS	Merit-based Incentive Payment System
CCBHC	Certified Community Behavioral Health Clinics	MMCO	Medicare-Medicaid Coordination Office
CEHRT	Certified electronic health record technology	MSSP	Medicare Shared Savings Program
CHIP	Children's Health Insurance Program	NHSC	National Health Service Corps
CMCS	Center for Medicaid and CHIP Services	OIG	Office of the Inspector General
CMMI	Center for Medicare & Medicaid Innovation	ONC	Office of the National Coordinator for Health Information Technology
CMS	Centers for Medicare & Medicaid Services	P4P	Pay-for-performance
CoCM	Collaborative care model	PAMA	Protecting Access to Medicare Act
CPC+	Comprehensive Primary Care Plus	PCEP	Primary Care Extension Program
DCO	Designated collaborating organization	PCP	Primary care provider
DSRIP	Delivery System Reform Incentive Payment	PI	Promoting Interoperability
EHR	Electronic health record	PMPM	Per member per month
FCC	Federal Communications Commission	PPS	Prospective Payment System
FDA	Food and Drug Administration	REL	Race, ethnicity, language
FQHC	Federally Qualified Health Center	RHC	Rural health clinic
HHS	U.S. Department of Health and Human Services	SAMHSA	Substance Abuse and Mental Health Services Administration
HIE	Health information exchange	SIM	State Innovation Model
HIPAA	Health Insurance Portability and Accountability Act	SMI	Serious Mental Illness
HITECH	Health Information Technology for Economic and Clinical Health Act	SUD	Substance use disorder
HMA	Health Management Associates	TA	Technical assistance
HRSA	Health Resources and Services Administration		
IMD	Institutions for Mental Disease		

DEFINITIONS¹

- **Mental health conditions involve changes in thinking, mood, and/or behavior and can affect how we relate to others and make choices.**
- **Substance use disorders (SUD) occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment.**
- **Behavioral health refers to mental health and/or substance use issues.**
- **Serious mental illness (SMI) is defined as a diagnosable mental, behavioral, or emotional disorder (within the past year) in someone over 18 which causes serious functional impairment that substantially interferes with or limits one or more major life activities.**

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Executive Summary

Even before the COVID-19 pandemic, the unmet need for mental health and substance use services in the United States was significant. Alarming, less than half of adults with mental health conditions received services in 2019, and the percentage was even lower in Black and Latino communities.^{2,3,4} As for substance use, nearly 90% of people with a substance use disorder did not receive treatment.⁵

That is why integrating primary and behavioral health care is necessary and would ensure that individuals with behavioral health conditions and comorbid physical health problems receive high-quality access to care. Comorbid behavioral and physical health diagnoses are common. Addressing them together through integration can provide a patient-centered approach that can be cost-effective for payers and providers, reduce health disparities, and improve patient outcomes.

Yet, the barriers to integration are substantial. As the COVID-19 pandemic has exacerbated behavioral health issues in our nation, so has it highlighted the problems inherent in our health care delivery system that make it difficult to respond.

To be sure, outcomes have worsened during the pandemic. Recent data indicate rising drug overdose deaths,⁶ worsening of existing mental health problems, and increasing incidence of anxiety and depression.⁷ Drug overdose deaths outpaced all previous records for a 12-month period,⁸ and symptoms of anxiety and/or depression in adults have quadrupled.⁹ A September 2020 [study](#) by Yale University School of Medicine found that those with a psychiatric diagnosis were at increased risk of death when they were hospitalized with COVID-19.¹⁰

Critical to meeting America's need for behavioral health services is increasing primary care provider capacity. Additional primary care providers would improve screening for mental health and substance use conditions, treatment delivery for mild to moderate behavioral health issues, and care coordination for patients who need more substantial services. While some primary care providers have already jumped in to do much of this work, many lack the training, financial resources, guidance, and staff to deliver integrated care.

Recognizing the strong connection between physical and behavioral health, the Bipartisan Policy Center convened the Behavioral Health Integration Task Force in 2020, focused on breaking down barriers to integrating primary and behavioral health care. Research shows that integration enhances access to care, improves treatment outcomes, reduces health disparities, and is cost-effective.

BPC contracted with Health Management Associates (HMA) to assess many of the legislative and regulatory recommendations in this report for impact on the provision of care and on the projected cost or savings to the federal government. The results of these analyses are included alongside the recommendations in this report. The overall net cost to the federal government for those recommendations for which estimates were available totals \$2.2 billion over ten years. That includes \$6.9 billion in increased federal spending and \$4.7 billion in savings. An estimated 1 million people would benefit from these recommendations.

The need to use all tools and policy levers to further integrate services is urgent given the national rise in behavioral health conditions and the persistent gaps in treatment. Behavioral comorbidities can lead to medical costs for physical conditions that are two to three times higher than those without behavioral health conditions, supporting the need for integrated care. Several states are already moving toward integration and demonstrating positive results. Illinois, Missouri, Arizona, Colorado, and Washington lowered medical costs by integrating care, primarily through their Medicaid programs. Arizona estimated health care savings of up to \$14.4 million in its Medicaid managed care organization (MCO) contracts over two years,¹¹ and Colorado saved an estimated \$178.6 million¹² from 2016-17 across public and private payers. These savings have often been accompanied by significant improvements in health outcomes for patients, such as increased access to care, reduced hospitalizations, and improved management of diabetes and hypertension.

Still, the nation's current health care system does not adequately support the integration of primary and behavioral health care services. The task force's recommendations create strong incentives for integration, while requiring accountability of providers. Together, these recommendations constitute a comprehensive plan to promote integration. Through developing core integrated care standards and, by ensuring the appropriate financing,

tools, and training, these recommendations support and incentivize providers to deliver integrated care, which ultimately benefits Americans struggling with mental illness and substance use.

BPC's recommendations provide a clear pathway to integration within both existing and new value-based payment structures. They improve the ability of primary care clinicians to handle some behavioral health needs of their patients by providing enhanced payments, training, and technical assistance, and improving access to behavioral health providers for consultation and referral. In order to expand the current workforce and guarantee accessibility, the task force recommends extending federal health care program payments to additional types of providers and reinforcing network adequacy requirements in health plan networks. The recommendations would also address workforce shortages by permanently breaking down barriers to the use of telehealth services.

Specifically, the following legislative and regulatory recommendations are essential to ensuring successful integration of behavioral health and primary care services:

1. Establish core, minimum standards essential for integration.

Currently, there is no standard definition of integrated care across private and public health programs, nor are there core service and quality standards. In addition, current network adequacy standards do not ensure access to behavioral health providers for many health plan enrollees, as providers may not have availability or be taking on new patients.

Recommendations:

- Establish core service and quality standards to improve accountability for integrating care.
- Update network performance standards across payers and health plans to ensure enough behavioral health providers are available to provide services.

2. Drive integration in new and existing value-based payment models.

Value-based payment models have structural elements that make them an ideal home for integration. Existing payment structures in Medicaid MCOs, Medicare accountable care organizations, and Medicare Advantage plans already have well-defined quality metrics, delivery standards, and payment methodologies through which integration can be applied, enforced, and incentivized.

Recommendations:

- Provide financial incentives and require accountability to build integrated care delivery into existing payment models for Medicaid MCOs, Medicare ACOs, and MA plans.

- Create a capitated and risk-adjusted payment model for primary care providers who treat mild to moderate behavioral health services.

3. Expand, train, and diversify the workforce for integrated care teams.

Americans are experiencing a lack of access to behavioral health care providers. Primary care clinicians already handle some behavioral health care needs of their patients, but they report feeling overwhelmed, ill-equipped, and underpaid. To incentivize and enable primary care clinicians to take on a greater role in providing behavioral health care to their patients, they will need training, technical assistance, and access to a larger pool of behavioral health providers for both consultations and referrals.

Recommendations:

- Create a nationwide technical assistance program for primary care practices to receive the training necessary to deliver integrated care and participate in value-based payment models.
- Expand Medicare coverage to additional behavioral health provider types to deliver services within integrated care settings and increase scholarship opportunities and pipeline programs to diversify and broaden the workforce.
- Increase grant funding for state-wide psychiatric consultation services to provide primary care providers with behavioral health expertise for treating mild to moderate conditions.

4. Promote the use of electronic health records, telehealth, and other technology to support integrated care.

There are many barriers to using health technology for improving our nation's health care system, yet it is essential for successful integration. For example, telehealth can increase access to providers and services, and electronic health records (EHR) enable coordination across care teams. While policymakers have eased some telehealth requirements during the pandemic, most changes are temporary. Moreover, behavioral health providers have not fully benefited from a technology-supported practice because of marginal EHR uptake.

Recommendations:

- Test a model offering financial incentives for behavioral health clinicians to adopt EHRs and facilitate information exchange between providers.
- Permanently expand Medicare coverage of telehealth services that advance integration, eliminate access disparities, and address the digital divide.
- Ensure that data collected by behavioral health and other wellness apps are subject to privacy protections under the Health Insurance Portability and Accountability Act.

Below is the full list of recommendations included in this report.

SECTION A: TRANSFORM PAYMENT AND DELIVERY TO ADVANCE VALUE-BASED INTEGRATED CARE (PAGE 25)

Establish core behavioral health integration essentials (Page 26)

Establish a strong foundation for integration

- 1. Define a set of core service elements necessary for behavioral health integration.**
- 2. Work with stakeholders and identify a set of standardized quality and performance metrics for practices integrating behavioral health for use across all programs.**
- 3. Update network performance standards across payers to ensure adequate specialty care for referral and support for primary care providers.**

Build upon existing alternative payment platforms to drive large-volume integration (Page 30)

Incentivize behavioral health and primary care integration in Medicaid managed care contracting

- 4. Provide early guidance and technical assistance to states and MCOs to help them prepare for upcoming FY 2024 congressionally mandated reporting requirements on Medicaid core measurement sets. The mandatory core set of behavioral health measures should include measures of behavioral health integration.**
- 5. Review quality measurement initiatives, and through consultation with experts and stakeholders, identify key measures that highlight outcome disparities and encourage integration for populations with behavioral health conditions.**
- 6. Require states to describe in their managed care quality strategy how the state will advance behavioral health integration.**

7. Reinstating the time and distance-to-provider standards for Medicaid network adequacy and requiring two additional quantitative measures. Quantitative measures that CMS should consider include patient wait times, the percent of providers accepting new patients, and the ratio of patients to providers filing claims over a time period. HMA estimates that this recommendation would save the federal government \$105 million over 10 years. This recommendation is estimated to add 800 to 900 additional behavioral health providers to Medicaid MCO networks, improving access for an estimated 500,000 to 800,000 enrollees.
8. Encourage states to integrate behavioral health in Medicaid by supporting capacity building through a new grant program or 1115 waivers.
9. Include measures of behavioral health integration in the Medicaid managed care quality rating system and recommend that states set a minimum rating for MCOs on performance measures.

Incentivize behavioral health integration in the Medicare Shared Savings Program

10. Update the Affordable Care Act to include behavioral health in the Medicare Shared Savings Program requirements.
11. Include integration in the Medicare Shared Savings Program ACO quality performance standards. HMA estimates that this recommendation would save the federal government nearly \$800 million over 10 years.
12. Provide financial incentives for high-performing ACOs to exceed the Medicare Shared Savings Program performance standards for behavioral health integration. HMA estimates that this recommendation would save the federal government \$3.8 billion over 10 years.

Incentivize behavioral health integration in Medicare Advantage

13. Revise the Medicare Advantage performance rewards system (STAR ratings) to add behavioral health integration measures.
14. Add and align network performance standards across programs. HMA estimates that this recommendation would cost the federal government \$2.3 billion over 10 years, with an increase between 100,000 and 150,000 people receiving behavioral health support.

15. **Include sufficient behavioral health measures in the Medicare Advantage performance rewards system.**
16. **Add additional behavioral health conditions to the Hierarchical Condition Categories for risk adjustment.**

Drive integration at the practice level (Page 48)

Incentivize individual providers to participate in integration

17. **Create a novel payment model that allows primary care providers to cover the full range of primary care and mild to moderate behavioral health services under enhanced risk-adjusted capitated payments in traditional Medicare. HMA estimates that this recommendation would serve between 200,000 and 800,000 Medicare beneficiaries and cost the federal government \$2.9 billion over 10 years.**
18. **Provide funding for a forgivable-loan program to assist individual providers and small primary care practices with the upfront costs of implementing behavioral health services.**
19. **Include additional behavioral health integration measures into Medicare's Merit-based Incentive Payment System (MIPS) to incentivize behavioral health provider participation in integrated care.**

Improve collaboration within traditional Medicare and Medicaid

20. **Remove barriers to the adoption of the collaborative care model (CoCM). HMA estimates that this recommendation would cost the federal government approximately \$224 million over 10 years.**
21. **Provide detailed guidance to states on implementing the CoCM in Medicaid.**

Advance integration through Certified Community Behavioral Health Clinics and Federally Qualified Health Centers (Page 56)

Incentivize coordination and integration among Certified Community Behavioral Health Clinics and Federally Qualified Health Centers

22. Incentivize CCBHCs and FQHCs to strengthen integration of behavioral health and primary care through a voluntary integration bonus payment. HMA estimates that this recommendation would cost the federal government \$153 million over 10 years, while providing an average \$1 million bonus payment to 37 to 48 participating CCBHCs that integrate with FQHCs, to serve about 200,000 individuals.
23. Require CCBHCs to report data by disadvantaged populations to identify disparities such as race, ethnicity, and language (REL); sexual orientation and gender identity; and social determinants of health.
24. Require CCBHCs to report on additional physical health measures.
25. Require FQHCs to align with core integrated care measures and ensure accountability, particularly with respect to health disparities.

Enforce and expand mental health and addiction parity laws (Page 62)

Ensure equal access to mental health, substance use disorder, and medical/surgical benefits

26. Provide the U.S. Department of Labor with authority to assess monetary penalties and increase parity enforcement efforts under existing authority.
27. Ensure mental health and addiction parity in Medicaid and Medicare by expanding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 provisions to all Medicaid fee-for-service and alternate payment and delivery models, Medicare fee-for-service, and Medicare Advantage.

Require agency coordination (Page 65)

Promote strategic coordination among HHS agencies on behavioral health integration

28. Require that CMS, HRSA, and SAMHSA advance the integration of physical and behavioral health services through a strategic plan for greater coordination between the agencies.

SECTION B: EXPAND AND TRAIN THE INTEGRATED WORKFORCE (PAGE 67)

Increase coverage of behavioral health providers in Medicare (Page 68)

Increase the pool of behavioral health providers by reducing barriers to reimbursement

- 1. Pass legislation to increase the behavioral health provider types covered under Medicare and require CMS to adopt measures that would facilitate behavioral health provider placement in integrated care settings.**
- 2. Allow licensed social workers to bill Medicare for chronic care management services. HMA estimates that this recommendation would cost the federal government \$113 million over 10 years.**

Expand access to the currently available workforce (Page 71)

Decrease barriers to integrated, team-based care

- 3. Appropriate more funding to HRSA for statewide primary care-to-psychiatric consultation services.**
- 4. Update practitioner licensing agreements to enable providers licensed in one state to practice in another when state licensure requirements have been waived.**

Improve training, recruitment, and retention (Page 72)

Accelerate integration by increasing access to prerequisite training for the current workforce

- 5. Provide technical assistance to provider practices for integrating behavioral health and primary care services.**
 - Provide appropriate funding for the Primary Care Extension Program. HMA estimates that this recommendation would cost the federal government \$1.1 billion over 10 years.**

- **Establish grant funding for technical assistance for implementation and ongoing delivery of integrated care.**

Improve integrated care education for new primary care and behavioral health providers

6. **Expand financial support for continuing education programs that prepare providers to work in integrated settings, meet the needs of diverse and underserved populations, and improve health disparities.**

Expand and diversify the behavioral health workforce

7. **Increase financial support for programs that recruit diverse students into primary care and behavioral health professions and improve access to and affordability of health care education.**

SECTION C: PROMOTE TECHNOLOGY AND TELEHEALTH TO SUPPORT INTEGRATED CARE (PAGE 76)

Optimize health information technology for behavioral health integration (Page 77)

Enable greater integration by increasing the utilization of EHRs among behavioral health providers

1. **Provide targeted funding to support health information technology adoption and utilization by behavioral health clinicians.**
2. **Require inclusion of common behavioral health terminology in EHRs.**
3. **Require Certified EHR Technology to include clinical decision support tools for behavioral health screening.**

Leverage mobile health for patient engagement within integrated care settings

4. **Include mobile health technology when assessing interoperability in the Medicare Quality Payment Program.**
5. **Direct an independent third-party to evaluate mobile health product effectiveness in real-world settings.**

Expand telehealth access (Page 82)

Address barriers to technology-assisted communication as a component of behavioral health integration

6. Expand patient data privacy protections for behavioral health and wellness applications.
7. Evaluate telehealth utilization to ensure health equity.
8. Remove site of service, geographic, and established patient restrictions for telehealth services. HMA estimates that this recommendation would cost the federal government \$145 million over 10 years.
9. Eliminate the two-way video requirement for telehealth services. HMA estimates that this recommendation would cost the federal government \$66 million over 10 years

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The overall net cost to the federal government for those recommendations for which estimates were available totals \$2.2 billion over ten years. That includes \$6.9 billion in increased federal spending and \$4.7 billion in savings. An estimated 1 million people would benefit from these recommendations.



Introduction

The pandemic is driving more drug overdose deaths,¹³ exacerbation of existing mental health problems, and increased incidence of anxiety and depression¹⁴ in the United States—underscoring the need for more appropriate and timely diagnosis, treatment, and support for people with behavioral health issues. For the purposes of this report, behavioral health refers to mental health and/or substance use issues.

Indeed, recent data indicates rising drug overdose deaths,¹⁵ worsening of existing mental health problems, and increasing incidence of anxiety and depression.¹⁶ Drug overdose deaths outpaced all previous records for a 12-month period,¹⁷ and symptoms of anxiety and/or depression in adults have quadrupled.¹⁸

Yet, even before the pandemic, in 2019, about 1 in 5 adults, or 51.5 million, in the United States had a mental health condition.^{19,20} During the same year, 19.3 million adults experienced a substance use disorder (SUD), and 9.5 million faced a co-occurrence of both substance use and mental health conditions.²¹ A U.S. Census Bureau survey²² also found that COVID-19-associated mental health issues more adversely affected essential workers, young adults, Black and Hispanic individuals, unpaid caregivers to adults, and those with preexisting mental health conditions.²³

With behavioral health disorders on the rise, gaps in who receives treatment have only intensified. While the utilization of behavioral health services has

generally increased over time, many who need services still do not receive treatment. A variety of barriers persist, including an insufficient network of providers to triage and treat mental health and substance use disorders, especially for youth and those living in rural areas. In 2019, 57% of adults with a mental illness went untreated—over 26 million Americans.²⁴ Nearly 90% of people with a substance use disorder did not receive treatment.²⁵

The problem is also considerable for lesbian, gay & bisexual (LGB) individuals and for youth. Indeed, LGB individuals are more than twice as likely than the general population to experience mental health conditions and substance use disorders.^{26,27} Moreover, youth experienced increased rates of persistent feelings of sadness or hopelessness, as well as suicidal thoughts from 2009 through 2019.²⁸ The prevalence of serious thoughts of suicide has also been increasing among youth, especially among LGB-identifying high school students, who experienced a 47% prevalence of suicidal thoughts in 2019—compared to 19% of the general population.²⁹ Suicide rates were highest among American Indians and Alaska Native youth from 2013-2017.³⁰ The Black youth suicide death rate is increasing faster than any other racial/ethnic group.³¹ In 2019, nearly 60% of youth with major depression did not receive any mental health treatment.³²

The recommendations in this report emphasize the need to both incentivize primary care and behavioral health providers to participate in integration models and hold them accountable for meeting key quality and performance metrics. The report also builds upon overall health care trends, including the increased use of such value-based models as Medicare Advantage (MA) plans, accountable care organizations (ACOs), and Medicaid managed care organizations (MCOs), and highlights the enhanced ability to drive policy change through these structures.

Integrated care as a response to increasing behavioral health needs

Given the impact of COVID-19 on mental health and substance use conditions and preexisting unmet need, recovery efforts and ongoing policymaking will need to expand access to behavioral health care. Integrated care has emerged as a cost-effective approach to improving the quality of care for individuals with comorbidities. It also has the potential to reduce racial and ethnic disparities in behavioral health access and treatment, and reduce suicide rates.^{33,34} Primary care providers see 45% of individuals in the 30 days prior to suicide attempts; depression screening and treatment in primary care settings has been shown to prevent suicides.³⁵

According to the Agency for Healthcare Research and Quality (AHRQ), integrated care consists of “a practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.”³⁶

Given the high costs and poor outcomes of patients with both physical and behavioral health conditions, integrating care could be a cost-effective intervention to improve health outcomes.³⁷ Several states focused on integration have already demonstrated positive results. Illinois, Missouri, Arizona, Colorado, and Washington have lowered costs by integrating care, primarily through their Medicaid programs.^{38,39,40,41,42} In Arizona, a Medicaid MCO estimated health care savings of up to \$14.4 million in its MCO contracts over the course of two years from a collaboration that better integrated care, and Colorado saved an estimated \$178.6 million from 2016-17 across public and private payers.^{43,44} These savings have often been accompanied by significant improvements in health outcomes, such as increased access to care, reduced hospitalizations, and improved management of diabetes and hypertension. Savings have also been reported for a range of integrated care models—from fully integrated health systems, such as the systems at Intermountain Healthcare and Cherokee Health,^{45,46} to practices implementing the collaborative care model (CoCM).⁴⁷

Barriers to integrated care

Despite the evidence and real-world examples of successful implementation of integrated care, our current system of health insurance coverage, care delivery, payment, workforce training, and health information exchange does not adequately support the integration of primary and behavioral health care. For instance, integrated care requires health information technology (IT) systems that support enhanced communication and data sharing between behavioral health and primary care providers to facilitate integrated care plan development and track health outcomes and quality metrics. However, as of 2012, approximately 20% of behavioral health providers were using electronic health records (EHR),⁴⁸ compared to 97% of hospitals and 74% of physicians in 2014.^{49,50} Behavioral health providers in solo or small practices tend to be less reliant on standard medical EHR functionality and have not been offered federal financial incentives to update technology. In addition, telehealth has emerged as an important technological tool for expanding access to care during the COVID-19 emergency. Since the beginning of the pandemic, legislative and regulatory flexibilities have enabled expansion of services and may have opened the door for permanent changes.

Beyond technology, payment silos can enable segregated behavioral health and primary care delivery. Insufficient compensation for start-up costs, training, and technical assistance can ultimately hinder practice transformation. Moreover, limited participation of behavioral health providers in insurance networks creates challenges for primary care providers to refer patients to behavioral health clinicians and to receive guidance to treat patients. Patients often delay or do not seek necessary care as a result of the limited number of behavioral health providers overall and specifically, those who participate in insurance networks.

The workforce shortage among behavioral health providers has negatively affected integration efforts. Workforce shortages are even more pronounced in rural areas, where more than 60% of nonmetropolitan counties do not have a psychiatrist, and almost half of nonmetropolitan counties do not have a psychologist, compared to 27% of urban counties without a psychiatrist and 19% without a psychologist.⁵¹ The overall shortage of behavioral health providers has contributed to primary care physicians providing half of all care for common psychiatric disorders and prescribing more medications for depression and anxiety than psychiatrists do.^{52,53,54} According to [one study](#), patients who saw primary care providers for their mental health conditions were more likely to be in rural areas, have low-incomes, be older adults, or have less serious mental health conditions.⁵⁵ However, many primary care clinicians lack the willingness, training, financial resources, guidance, and staff to deliver any behavioral health services, let alone integrated care.⁵⁶ Without an increase in behavioral health providers to work with primary care providers and receive patient referrals, primary care clinicians will continue to be ill-equipped to take on extra responsibility.

Momentum to advance integrated care has been building among provider groups, such as the American Academy of Family Physicians, the American Medical Association, the National Council of Behavioral Health, and the American Psychiatric Association; advocacy groups such as the National Alliance for Mental Illness and Mental Health America; and health plans represented by America's Health Insurance Plans and the Blue Cross and Blue Shield Association.^{57,58,59,60,61,62,63,64} Policies that align across payment, workforce, and health information technology will be crucial to achieving that goal. One caveat is that the policy recommendations discussed below do not address insurance coverage issues, such as individuals who are uninsured or underinsured, which would ultimately affect their ability to access integrated care arrangements or even the most basic of services to address their behavioral and physical health care needs.

Racial and ethnic disparities in behavioral health care

Black, Indigenous, and people of color (BIPOC) face unique barriers to behavioral health care, which include lack of access to adequate and preventive health care services, lack of culturally and linguistically competent providers, and complex social needs. These barriers often stem from, and are exacerbated by, structural inequalities of race, gender, class, sexual orientation, and immigration status. Moreover, COVID-19 is not only disproportionately affecting BIPOC as it relates to physical health outcomes,⁶⁵ but also exposing racial and ethnic disparities in access to mental health care. Although overall rates of mental health conditions in Black and Latino communities are lower than compared to the general population,⁶⁶ disparities in access to behavioral health treatment exist. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 66% of Latino and 67% of

Black Americans with mental health conditions did not receive treatment in 2019.⁶⁷ Similarly, Asian American and Pacific Islander communities experience the lowest rates of mental health conditions of any demographic group, but also experience the lowest rates of treatment.⁶⁸ These disparities are partially due to the lack of racial, ethnic, and language diversity in providers. The current makeup of the behavioral health workforce is predominantly white⁶⁹ and could deter BIPOC populations from seeking care. Research shows that providers who are culturally and linguistically reflective of the communities they serve are more likely to meet the needs of those communities.^{70,71}

Integrating behavioral health into primary care can help BIPOC communities overcome some of the barriers to receiving behavioral health care. BIPOC populations and individuals with limited English proficiency generally prefer to access health care through primary care, making this an important entry point for behavioral health care.⁷² Integrated care teams can address some of the socio-cultural needs of these populations, such as family involvement in treatment, and teams can include non-clinicians who can provide the cultural competency and language capability necessary to identify behavioral health issues and encourage individuals to continue their care.^{73,74} While the task force was not able to estimate the impact of specific recommendations on BIPOC populations, studies indicate that integrated care can improve outcomes in communities of color.⁷⁵ One systematic review across various integration models found that integrated care can improve the number of mental health and SUD visits and diabetes outcomes for Black individuals and improve the indicators for depression among Black and Latino populations.⁷⁶ Another review found that culturally-tailored integrated care in indigenous communities improved access to care and retention, and reduced depression symptoms.^{77,78} Policymakers should consider the racial and ethnic gaps in behavioral health care in addressing integrated care effectively.

Behavioral Health Integration Task Force goals

BPC convened a high-level, bipartisan task force in 2020 to study the promise and challenges of integrating care. This report is the culmination of the task force's work, which includes a set of important legislative and regulatory recommendations. The task force recommendations reflect the need to both incentivize primary care and behavioral health providers to participate in integration and to also hold them accountable for meeting key quality and performance metrics.

The following goals for integrated care will advance health care's triple aim of improving access to care, improving the health care experience, including patient satisfaction and quality, and reducing costs.

Improve access to care.

- *Increase identification of mental health and substance use conditions.* To increase access to care and prevent further worsening of comorbid conditions, primary care providers should screen for those who can benefit from behavioral health services.
- *Improve ability and willingness of primary care providers to treat behavioral health conditions in primary care.* One way to address behavioral health workforce shortages is to leverage primary care to manage mild to moderate behavioral health conditions, such as anxiety and depression, along with an onsite or virtual interdisciplinary team. This would free up the limited number of specialty providers to mostly treat those with complex conditions and would recognize that some patients, regardless of the severity of conditions, prefer to seek help in primary care.
- *Promote health equity through integrated care.* Integrated care would expand access to behavioral health care, especially in rural areas and communities of color, where residents receive much of their care in primary care settings.
- *Achieve greater continuity of care between primary and specialty care.* For patients with complex behavioral health issues, primary care should refer them to behavioral health providers without disrupting continuity of care. Successful referrals would require specialty care networks that include the appropriate level of behavioral health providers.

Improve quality of care.

- *Manage behavioral health symptoms by tracking progress.* A key ingredient to integration is the use of measurement-based care. Both primary care and behavioral health providers should implement measurement-based care by administering symptom rating scales regularly and adjusting treatment accordingly.
- *Improve patient experience, including culturally competent and trauma-informed care.* Providers should implement a patient-centered approach to engage patients and caregivers through culturally competent and trauma-informed strategies to help patients understand and manage health conditions, and provide connections to social and community services when appropriate. Quality metrics should be designed to capture patient experience and satisfaction.

Reduce cost of care.

- *Reducing health care costs through behavioral health integration.* Evidence shows that integrated care can result in cost savings across the health system. However, to achieve savings, it is important to recognize the need for an initial investment in infrastructure, training, and technical assistance.



Recommendations

SECTION A: TRANSFORM PAYMENT AND DELIVERY TO ADVANCE VALUE-BASED INTEGRATED CARE

- Establish core behavioral health integration essentials
- Build upon existing alternative payment platforms to drive large-volume integration
- Drive integration at the practice-level
- Advance integration through Certified Community Behavioral Health Clinics (CCBHCs) and Federally Qualified Health Centers (FQHCs)
- Enforce and expand mental health and addiction parity laws
- Require agency coordination

Despite the well-documented quality and cost benefits of integrated care, most behavioral health and primary care providers continue to operate in silos. Various incentives to provide coordinated care delivery and improve care transition across settings have been largely unsuccessful in spreading integrated care models.

Evidence demonstrates that integration is most likely to succeed when financial flexibility and incentives are present to support services and address patients' holistic needs.⁷⁹ Alternative payment models such as those providing capitated rates for whole care—primary and behavioral health—have structural elements that can be leveraged to integrate care. Payment structures, such as

Medicaid MCOs, Medicare accountable care organizations (ACOs), and Medicare Advantage plans already have well-defined quality metrics, delivery standards, and payment methodologies through which integration can be enforced and incentivized. For integrated care to succeed, payment reform should be paired with technical assistance and training for providers (See Recommendation B-5), as well as health technology that allows for appropriate patient health information exchange between providers (See recommendations under Section C).

ESTABLISH CORE BEHAVIORAL HEALTH INTEGRATION ESSENTIALS

Some capitated payment models have provided powerful incentives to health plans or organizations to save money and improve quality, but these models typically have not focused on behavioral health and as a result, have not maximized their potential for improving access to care and outcomes for individuals with behavioral health conditions.⁸⁰ Capitated funding provides flexibility that has the potential to lead to more integration but must be accompanied by strong quality and performance metrics to ensure accountability and increased access to care. Transparency and linkages to payment can further accountability.

This section sets forth core service elements, quality measures, and health plan network performance standards that apply across payment and health systems to encourage integrated care. These foundational elements would advance integration within any structure for health care delivery and payment and should be applied by HHS across programs.

Establish a strong foundation for integration

1. Define a set of core service elements necessary for behavioral health integration.

Congress should direct the secretary of the Department of Health and Human Services (HHS) or the secretary of HHS should clearly define service components required for integrating behavioral health into primary care settings and comprise a set of core service elements. These elements should include the eight domains for behavioral health integration identified by expert consensus across multiple stakeholders:⁸¹

- Systematic screening for behavioral health conditions, and referral for complex patients
- Ongoing care management between patient and providers
- Multidisciplinary team-based care between behavioral health and primary care providers

- Measurement-based care, using evidence-based tools, to monitor behavioral health symptoms and adjust treatment as needed
- Culturally adapted self-management of health conditions
- Tracking and exchanging patient information among providers
- Assessing social needs and providing links to services
- Systematic quality improvement, using established integration quality metrics

However, integration can differ depending on geographical region, patient demographics, and availability of providers. It will be critical to convene multiple stakeholders to inform development of core elements that can be implemented across primary care settings.

This set of services would align payer, provider, and patient expectations across primary care settings where behavioral health integration is implemented. HHS could then align the core elements of integrated care across SAMHSA, Health Resources and Services Administration (HRSA), the Centers for Medicare & Medicaid Services (CMS), and relevant agencies to identify payment, training, and outreach needed to deliver integrated care.

2. Work with stakeholders and identify a set of standardized quality and performance metrics for practices integrating behavioral health for use across all programs.

Payers and primary care providers are often frustrated by the misaligned quality measures across payment models and payers. CMS has begun an initiative entitled [Meaningful Measures](#) to better align measures and reduce administrative burden. One of the identified areas for measures is “prevention, treatment and management of mental health conditions.” As part of this effort, the secretary of HHS should develop a standardized set of measures to simplify reporting and more precisely capture behavioral health integration.

Currently, few measures exist to capture behavioral health activities or adequately assess outcomes. For example, some value-based payment models limit behavioral health quality reporting to two measures: depression screening and follow up and depression remission at 12 months. Stakeholders have reported that depression remission is too stringent a standard and not clinically appropriate. Existing performance metrics often lack benchmarks and are rarely tied to performance or payment. Notably, quality measures do not capture treatment for anxiety, although generalized anxiety disorder may be prevalent in as many as 20% of primary care patients.⁸² Substance use also is not addressed in many quality measure requirements.

Because behavioral health is not well-represented in existing quality measures, HHS should identify key processes and outcomes for developing a more robust set of behavioral health metrics that increase accountability for effective behavioral health care delivered within primary care. The resulting measure set should prioritize measurement-based care, using validated tools to track the impact of treatment over time and should include patient experience.

In developing this measure set, HHS should seek stakeholder input and build upon the work of previous efforts. For example, America's Health Insurance Plans has convened the Core Quality Measure Collaborative—a broad-based coalition, including the Centers for Medicare & Medicaid Services, health plans, medical associations, patient groups, and purchasers. They developed a set of measures for patient centered medical homes, ACOs and primary care that include several behavioral health measures that could inform the secretary's work in this area.⁸³ [These](#) measures include depression response at 12 months (progress toward remission), depression screening and follow up plan, and unhealthy alcohol use screening and brief counseling.

As the country examines the role of race in health disparities, it is important to collect data to be able to recognize important aspects of the problem and improve the situation. To measure health equity, providers should report quality measures on integration by disadvantaged populations to identify disparities, such as race; ethnicity; language; sexual orientation and gender identity; disability; and social determinants of health. Data should be compared to benchmarks and require corrective action for disparities and poor performance.

Many general health measures can indicate disparities in health outcomes when collected for people with behavioral health conditions. Quality measures such as emergency room utilization and hospital readmission should be broken down by behavioral health admissions. For example, in Oregon, separating out behavioral health in data collection has led to identifying and addressing health disparities based on these conditions.⁸⁴

The integrated care quality initiative that the HHS secretary develops should include, but not be limited to, the following actions:

- Engage stakeholders and consult with CMS, the National Institute of Mental Health, HRSA, SAMHSA, and other appropriate HHS departments.
- Include both process and outcome measures.
- Include patient experience measures and develop with patient input.
- Implement first in CMS programs where quality measurement and data collection are commonly performed, such as Medicaid MCOs, the Medicare Shared Savings Program (MSSP), and the Medicare Advantage plans, and

then incorporate into requirements across risk bearing payment models, Affordable Care Act (ACA) Qualified Health Plans, and Federally Qualified Health Centers (FQHCs).

- Increase accountability through transparency and linkage to payment and/or benchmarking and corrective action.
- Report by disadvantaged populations to address health disparities and social determinants of health.
- Report general health measures specifically for patients with behavioral health conditions.

3. Update network performance standards across payers to ensure adequate specialty care for referral and support for primary care providers.

Achieving meaningful network adequacy standards is challenging, as standards must balance the need for sufficient provider participation with the ability of health plans to meet those standards. One of the most common reasons primary care physicians express concern about identifying behavioral health conditions is the lack of available behavioral health providers for consultation or referral. In addition to the overall shortage of behavioral health providers, their lack of availability in health plan networks is a major barrier to care. Health plan networks often include participating behavioral health providers who are not taking new patients or have long wait times for appointments.

Methods for ensuring network adequacy are not standardized and vary significantly. Qualified Health Plans participating in the ACA Marketplaces, for example, are required to identify whether providers are accepting new patients, but Medicaid and Medicare Advantage do not include such requirements. For Medicaid and Qualified Health Plans, states use various metrics, such as wait times, provider-to-patient ratios, and geographic standards.⁸⁵ With the significant shift to telehealth due to the COVID-19 crisis, the secretary of HHS should consider telehealth and require states to do so as they consider network adequacy requirements, while weighing such factors as broadband availability, patient choice, clinical appropriateness, availability, and accessibility. As collaborative care becomes more available, the secretary may also want to consider how to address these models in network adequacy standards.

Given inadequate behavioral health networks are a key barrier to integrated care, the secretary should hold health plans accountable for time and distance standards and develop core network performance metrics for application across HHS regulated plans. These metrics should include a defined set of quantifiable measures, such as wait times, providers who are taking on new patients, and those who have not submitted a behavioral health claim during the past six months. Having a core set of network

adequacy standards across programs would facilitate compliance for plans subject to parity laws and also align and simplify requirements for insurers that participate in multiple federal programs. Performance bonuses should be considered for addressing the lack of diversity among behavioral health providers and for encouraging a more diverse and culturally competent workforce. SAMHSA and CMS should fund the development of cultural competence network adequacy and performance measures for behavioral health. The secretary should also make reported network adequacy data public.

CMS should develop network adequacy requirements that:

- Include time and distance standards
- Consider telehealth, while considering relevant accessibility issues and patient choice
- Are reported specifically for behavioral health providers
- Include a uniform set of quantitative performance measures
- Are transparent and publicly reported
- Define adequate diversity and cultural competence

BUILD UPON EXISTING ALTERNATIVE PAYMENT PLATFORMS TO DRIVE LARGE-VOLUME INTEGRATION

Medicaid MCOs, Medicare Advantage plans, and ACOs are risk-bearing entities and together they serve a large number of Medicaid and Medicare beneficiaries, making them favorable platforms for widely improving integrated care in those programs. Medicaid MCOs and Medicare Advantage plans generally accept a capitated, risk-adjusted payment to cover the total cost of care for a population. Capitation—fixed per-person payments for the total cost of care for a population—is a payment approach that can incentivize the delivery of high-value services over high-volume of services, if coupled with strong quality requirements and accountability.⁸⁶ The entity receiving the capitated payment accepts financial risk for expenses beyond the risk-adjusted payment and must manage that risk through efficient care delivery. Over the years, providers and payers have gained experience with capitation. ACOs also take on financial risk and benefit from shared savings, even though reimbursement continues to be based on fee-for-service.

During the 1990s, capitation gained popularity among provider practices and physician management companies.⁸⁷ However, many of these large physician management companies soon declared bankruptcy, and provider groups

experienced significant financial losses from their capitation contracts.⁸⁸ Providers had struggled to manage the financial risk associated with capitation due to factors such as insufficient risk adjustment and low payment.⁸⁹ While lessons learned from this experience can now support successful adoption of capitated payment arrangements among providers, Medicaid MCOs and Medicare Advantage plans are experienced in managing financial risk and serve most Medicaid beneficiaries and over one-third of Medicare beneficiaries, respectively.^{90,91} Accordingly, these entities are well positioned to drive behavioral health integration forward on a large scale while managing the financial risk.

Federal laws and regulations specify quality and payment requirements for these entities or states contracting with them.^{92,93,94} While the federal government has taken steps to advance and encourage the integration of physical and behavioral health services in recent years, opportunity exists to improve incentives and financial flexibility in quality and payment requirements for Medicaid MCOs, ACOs, and Medicare Advantage plans.

Incentivize behavioral health and primary care integration in Medicaid managed care contracting

Medicaid provided health insurance coverage to about 74 million low-income individuals in fiscal year 2019⁹⁵ and is a predominant payer for behavioral health services.⁹⁶ According to CMS, more than half of the Medicaid enrollees in the top 5% of expenditures who had asthma or diabetes also had a behavioral health condition.⁹⁷ Medicaid is thus an ideal platform for increasing behavioral health integration in a large population with expensive physical and behavioral health needs.

The vast majority of Medicaid beneficiaries now receive benefits through a managed care structure or a combination of managed care and fee-for-service, making Medicaid managed care organizations an ideal structure for integrated care. States generally deliver Medicaid services through managed care, fee-for-service, or a combination of both.⁹⁸ Under a fee-for-service delivery system, the state reimburses providers directly for each individual service rendered.⁹⁹ Under managed care, the state contracts with MCOs that receive a set per member, per month capitated payment for certain populations and covered services.¹⁰⁰ MCOs may cover a comprehensive set of services—such as acute, primary, and specialty care; behavioral health; and long-term services and supports—or a narrow set of services, such as behavioral health services.¹⁰¹ While states have historically served most beneficiaries through fee-for-service, most Medicaid beneficiaries are now enrolled in managed care. Specifically, almost 70% of all Medicaid beneficiaries were enrolled in comprehensive managed care in recent years and about 82% were enrolled in any type of managed care, including comprehensive managed care, limited benefit plans, or primary care case management programs.¹⁰² This shift toward managed care began in the late

1980s to control rising program costs while improving care quality and access.¹⁰³

The degree to which physical and behavioral health services are integrated for these managed care enrollees is based on several factors, such as the degree to which behavioral health integration is encouraged or required by state laws, state regulations, or MCO contract requirements. For example, many states have traditionally carved behavioral health services out of managed care contracts and delivered those services through a separate managed behavioral health organization or fee-for-service.¹⁰⁴ In recent years, however, some states have begun carving behavioral health services into comprehensive managed care arrangements.¹⁰⁵ In 2019, 40 states contracted with MCOs and more than half of them included behavioral health services in those contracts.¹⁰⁶ States that are carving these services into comprehensive managed care arrangements cite challenges with certain carve-outs, such as siloed delivery systems for physical and behavioral health that lack a single accountable entity and create financial incentives for cost-shifting over improving care.¹⁰⁷

Simply carving behavioral health services into a comprehensive managed care contract, however, is not enough to ensure integration.¹⁰⁸ Both carve-in and carve-out states must be thoughtful in designing their contract standards to advance integration through care coordination and data sharing requirements, quality metrics, contract monitoring, accountability, and other requirements. Also, each state Medicaid program is unique and there is no one-size-fits-all approach to improving integration of behavioral and physical health services. Some states maintain that managed behavioral health organizations have more experience working with community behavioral health providers and are more likely to contract with and credential providers serving beneficiaries with complex behavioral health needs.¹⁰⁹ Some states and advocates also believe delivering behavioral health services separately through managed behavioral health organizations highlights these benefits and supports continued investment in these services.¹¹⁰

States that choose not to carve behavioral health services into a comprehensive managed care contract should effectively strengthen behavioral and physical health integration through carefully developed managed care contract standards.¹¹¹ These states, for example, may require significant coordination and data sharing between MCOs delivering behavioral health benefits and MCOs delivering physical health benefits, providers, and health systems. States must consider their own unique circumstances in selecting a path toward integration, but strong managed care contract requirements are critical to that success, whether a state chooses to deliver behavioral health services through a comprehensive managed care contract or to carve out these services. On a federal level, CMS has promoted integration through waiver approvals, policy guidance, and technical assistance initiatives, but federal policy levers focused on managed care quality and payment should place a greater emphasis on integration.

4. Provide early guidance and technical assistance to states and MCOs to help them prepare for upcoming FY 2024 congressionally mandated reporting requirements on Medicaid core measurement sets. The mandatory core set of behavioral health measures should include measures of behavioral health integration.

Under current federal law, beginning FY 2024, states will be required to report on two core sets of quality measures: (i) the core set for children in Medicaid and the Children's Health Insurance Program (CHIP), which will include behavioral health and primary care measures among others, and (ii) the core set of behavioral health measures for adults in Medicaid.^{112,113} Congress should direct the HHS secretary to provide early guidance and technical assistance to states and MCOs to help them prepare for these upcoming reporting requirements.

Currently, reporting on these measure sets is voluntary and statute requires the HHS secretary to review and update the measures annually.¹¹⁴ CMS has not yet identified the specific measures that will be mandatory in FY 2024. The 2021 [voluntary core set for children](#) in Medicaid and CHIP includes four behavioral health measures and eight primary care measures.¹¹⁵ The 2021 [voluntary core set for adults](#) includes 12 behavioral health measures.¹¹⁶ (See Figure 1 below.) Once CMS establishes the mandatory core set measures, states will report on the standardized measures for beneficiaries in both managed care and fee-for-service.

Figure 1: Select 2021 Voluntary Core Measures for Adults and Children in Medicaid and CHIP^{117,118}

ADULT BEHAVIORAL HEALTH CARE QUALITY MEASURES FOR MEDICAID	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)
	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)
	Antidepressant Medication Management (AMM-AD)
	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)
	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)
	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)
	Concurrent Use of Opioids and Benzodiazepines (COB-AD)
	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)
	Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)
CHILDREN'S BEHAVIORAL HEALTH CARE QUALITY MEASURES FOR MEDICAID AND CHIP	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)
	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)
CHILDREN'S PRIMARY CARE QUALITY MEASURES FOR MEDICAID AND CHIP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)
	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)
	Childhood Immunization Status (CIS-CH)
	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
	Well-Child Visits in the First 30 Months of Life (W30-CH)
	Immunizations for Adolescents (IMA-CH)
	Developmental Screening in the First Three Years of Life (DEV-CH)
Child and Adolescent Well-Care Visits (WCV-CH)	

Sources: Centers for Medicare & Medicaid Services, "[2021 Core Set of Adult Health Care Quality Measures for Medicaid \(Adult Core Set\)](#)."

Centers for Medicare & Medicaid Services, "[2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP \(Child Core Set\)](#)."

Reporting on the mandatory core sets would allow CMS and states to identify trends and compare performance on the measures across states. In developing and updating the core measure sets annually, CMS consults with stakeholders.¹¹⁹ CMS also participates in the Core Quality Measure Collaborative to promote evidence-based quality measures and alignment of measures across payers.¹²⁰

To highlight states' progress and opportunities for improvement in behavioral health integration, the final mandatory core sets should include evidence-based measures that reflect integration of behavioral health and primary care. This should include integration of primary care into behavioral health care settings and integration of behavioral health care into primary care settings. While the current voluntary sets of measures integrate some primary and preventive care into specialty behavioral health care for individuals with SMI, the mandatory core set should include additional measures that encourage integration in behavioral health settings. Similarly, the current voluntary set of primary care measures for children includes screening for depression, but the measures generally do not encourage behavioral health care in primary care. The mandatory core set of measures should reflect integration of behavioral health into primary care.

To address barriers to states meeting the new reporting requirement and accelerate incorporation of these measures into alternative payment models that advance integration, CMS should provide early guidance and technical assistance to states and MCOs. A Medicaid and CHIP Payment and Access Commission [report](#) noted several factors that would bolster state readiness for mandatory reporting on the core measurement sets in FY 2024, including early guidance and ongoing technical assistance from CMS.¹²¹ Specifically, states will need guidance on which measures they will be required to report, since the core sets are currently updated annually. As states will need sufficient time to meet this new reporting requirement, the guidance should include significant advance notice of what the mandatory measures will be. CMS should provide this guidance to states at least two years in advance of the first required reporting period for the core measurement sets. Federal guidance should also address how the requirement will go into effect, including whether it will be gradually phased in or whether states will have to report on the full list of measures beginning in FY 2024. The guidance should also describe if deviations from the technical specifications will be allowed and under what circumstances.

As states may require MCOs to report on measures that align with and support the mandatory core set, CMS should make technical assistance available to both states and MCOs. This technical assistance may address challenges with obtaining data for the measures, calculating measures, incorporating the measures in value-based payment initiatives, or other challenges.

The mandatory core measures have the potential to drive quality improvements in managed care. By incorporating these measures into a value-based payment initiative, states may incentivize improvements on measures of behavioral health integration by linking MCO payment to performance on those measures. For example, [Michigan](#) awarded performance bonuses to MCOs based on national percentile rankings for certain child core set measures.¹²² States could implement similar value-based payment incentives for the behavioral health core set of measures.

5. Review quality measurement initiatives, and through consultation with experts and stakeholders, identify key measures that highlight outcome disparities and encourage integration for populations with behavioral health conditions.

Congress should require the HHS secretary to review quality measurement initiatives and work with experts and stakeholders to identify measures highlighting disparities and encouraging integration for populations with behavioral health conditions. Many physical health measures can indicate disparities in health outcomes when collected for people with mental health and substance use conditions. The Medicaid core set for Health Homes includes emergency room utilization measures and inpatient utilization, but does not separate this information for behavioral health.¹²³ Similarly, the Medicaid core set for adults includes measures for all cause readmissions, but does not include measures of readmission for primarily behavioral health reasons.¹²⁴ A study of 2014 data from the nationwide readmissions database found that the odds of an unplanned 30-day readmission were nearly two times greater for individuals with SMI compared to others.¹²⁵ By reporting data separately for populations with behavioral health conditions, data will better highlight these outcome disparities and promote attention to these conditions by primary care and hospitals.

6. Require states to describe in their managed care quality strategy how the state will advance behavioral health integration.

Under federal rules, states contracting with an MCO must establish a state quality strategy for assessing and improving the quality of care and services provided by the MCO.^{126,127} The state quality strategy must include state-defined network adequacy and availability of services standards for MCOs, the state's goals and objectives for continuous quality improvement, a description of quality metrics and performance targets that will be used to measure MCO performance and improvement, a description of performance improvement projects, and the process for independent reviews of MCO performance, among other requirements.¹²⁸ The quality strategy, however, is not currently required to address behavioral health integration. To support the coordination of clinical and behavioral health services, CMS should require states to describe in their quality strategy how the state will work

with MCOs, any subcontracted entities, and, if applicable, the behavioral health agency in the state to advance behavioral health integration. CMS should work with states to ensure that they have appropriate time to meet this new requirement.

7. Reinstate the time and distance-to-provider standards for Medicaid network adequacy and require two additional quantitative measures. Quantitative measures that CMS should consider include patient wait times, the percent of providers accepting new patients, and the ratio of patients to providers filing claims over a time period.

CMS' 2016 Medicaid managed care rule required states to establish time and distance standards that Medicaid managed care plans must meet to demonstrate network adequacy.¹²⁹ States also had the option of establishing measures in addition to the time and distance standard. In developing the time and distance standards, states were able to consider several factors, including access to services through telehealth. Several states have since updated their telehealth policies or expanded their coverage of services delivered through telehealth in response to COVID-19.¹³⁰ States must decide whether they will retain these telehealth policies after the COVID-19 public health emergency ends.

In November 2020, CMS released a final [Medicaid managed care rule](#) that replaced the time and distance standard with a new, broader quantitative network adequacy standard for providers.¹³¹ Under this rule, states could meet the new requirement by either keeping their time and distance standard or replacing that measure with any quantitative standard. While some stakeholders generally favor the quantitative standard, others that generally favor time and distance standards have expressed concern that a broader quantitative standard could impact access to care for medically underserved regions, such as rural areas. Some stakeholders have also raised concerns that providers who are only available to deliver care virtually are not truly available to meet patients' needs. The new rule also preserves the 2016 requirement that states consider the availability and use of telehealth when developing their network adequacy standards. CMS defers to each state to determine the criteria to be applied to telehealth providers and how such providers will be taken into account when evaluating network adequacy.¹³² In the final rule, CMS also reminds states and health plans to be mindful of their responsibilities for mental health and addiction parity in [subpart K of 42 CFR § 438](#) in selecting measures for network adequacy, network development, and evaluation.¹³³

To more accurately reflect access to behavioral health providers, CMS should revise the rule to reinstate time and distance to provider standards and should require two additional quantitative measures that would apply across states. Given that Medicaid MCOs are subject to parity requirements, a

federal set of network adequacy requirements would promote national compliance. Quantitative measures CMS should consider include patient wait times, the percent of providers accepting new patients, and the ratio of patients to providers filing claims over a time period.

The Bipartisan Policy Center contracted with Health Management Associates (HMA) to estimate the impact of the proposed policy.¹³⁴ HMA estimates this policy change would result in \$105 million in federal savings over 10 years.¹³⁵ HMA assumes states would implement the stricter network standards on participating MCOs and some would raise payments to MCOs in acknowledgement that stricter network rules may require higher payments for certain providers. HMA estimates Medicaid MCOs would add 800 to 900 additional behavioral health providers to their networks, improving access for approximately 500,000 to 800,000 Medicaid managed care enrollees.

To arrive at this estimate, HMA assumes some of the increased costs associated with the broader network would be offset by lower total health care spending due to patients receiving regular behavioral health care. HMA estimates the net impact would be increased premiums in 50-60% of states by 0.1%. HMA also assumes states would assess penalties on a fraction of health plans that did not meet the stricter network standards. In states that do not increase payments to MCOs, HMA assumes MCOs would likely pay penalties rather than increase provider payments. In states that increase payments to MCOs, HMA assumes some MCOs would still not meet the new network requirements and would incur penalties. The higher payments to MCOs would increase spending by \$66 million, but the additional penalties on MCOs would lower overall costs by \$172 million, resulting in federal savings of \$105 million over 10 years.¹³⁶

8. Encourage states to integrate behavioral health in Medicaid by supporting capacity building through a new grant program or section 1115 waivers.

Congress and CMS should encourage behavioral health integration in Medicaid by supporting capacity building through a new grant program or section 1115 waivers. Amid COVID-19, states must now balance increased enrollment and demand for services against limited state resources. As a result, states report that the upfront investment costs for behavioral health integration serve as a barrier for those interested in increasing integration. Without additional resources, many states simply will not be able to invest in delivery system reforms—including advanced value-based payment arrangement initiatives—to increase behavioral health and primary care integration.

In a January 2020 [brief](#), independent evaluators for CMS examined how states have used Section 1115 Medicaid demonstration waivers to test delivery system reforms that include behavioral health integration.¹³⁷ The brief acknowledges that these demonstrations have shown some early signs of progress, but also that challenges related to health information technology, rules around patient data-sharing, and workforce gaps have slowed advancement of integration.¹³⁸ Policy recommendations throughout this report address some of those challenges. While encouraging further integration through 1115 waivers that incorporate lessons learned from previous demonstrations, BPC aims to build upon those early successes and accelerate progress toward value-based payment approaches that increase integration.

Section 1115 Medicaid demonstration waivers currently allow states to test experimental, pilot, or demonstration projects the HHS secretary finds will likely assist in promoting the objectives of the Medicaid program.¹³⁹ Under the authority provided to HHS in section 1115 of the Social Security Act, HHS may waive some requirements of federal Medicaid law. HHS may also authorize states to receive federal Medicaid matching payments for some costs that are not eligible to receive them under federal law. As these 1115 waivers provide states with flexibility to waive certain Medicaid requirements, they offer a flexible vehicle for achieving integration through innovation and payment reforms.

In recent years, CMS has established 1115 waiver opportunities that authorize new expenditures for federal matching payments and encourage states to build infrastructure for delivery system reform. Examples of these opportunities include: (i) Institutions for Mental Disease (IMD) waivers for those with substance use disorder, serious mental illness, or serious emotional disturbance; and (ii) Delivery System Reform Incentive Payment (DSRIP) programs. CMS encouraged infrastructure development under the IMD waivers for mental health treatment by requiring participating states to take actions that improve access to community-based services.¹⁴⁰ Compared to more recent CMS guidance on the SMI/serious emotional disturbance opportunity,¹⁴¹ however, earlier guidance on the SUD opportunity included stronger requirements for continued state investment in community-based services.¹⁴² Similarly, CMS authorized states to receive federal match for designated state health program expenditures under DSRIP waivers to support the initial investment costs of the program and ensure continuation of state health care and provider support programs.¹⁴³

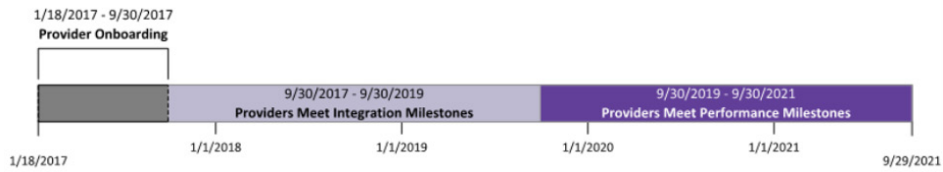
CMS should create a new 1115 waiver opportunity that encourages states to move provider practices toward integrated care through a value-based payment approach with incentives for providers that meet benchmarks for integrated care. Lessons learned from other 1115 waiver programs can help inform the design of this new 1115 waiver opportunity for behavioral health

integration. For example, in accordance with the strategies identified as effective for integration by CMS' independent contractors, the demonstration should encourage states to: foster integration and collaboration at the state level across agencies; address state regulatory barriers to data sharing; allow flexibility to target specific patient populations; include requirements for provider collaborations that support integration; address workforce capacity by supporting overall supply or increasing reliance on community health workers, peer specialists, or others; include integration expectations in MCO contracts; and provide guidance on how to sustain demonstration activities.¹⁴⁴

DSRIP and DSRIP-like programs support state efforts for delivery system transformation and exemplify how states can increase provider partnerships while moving providers toward more advanced value-based payment arrangements with greater financial risk. DSRIP programs generally tie disbursement of DSRIP funding to implementation of provider-led projects and achievement of state-specific performance milestones that increase adoption of more advanced value-based payment over the waiver period.¹⁴⁵ States that have successfully leveraged this approach to support integration of behavioral health and primary care should serve as models for other states interested in pursuing integration through value-based payment.

For example, Arizona established its [Targeted Investments Program](#) through an 1115 waiver to support physical and behavioral health integration for (1) adults and children with both physical and behavioral health needs and (2) individuals transitioning from incarceration into the community.¹⁴⁶ CMS authorized up to \$300 million for the 5-year demonstration program that will operate from 2017 through 2021.¹⁴⁷ Under the program, Arizona provides incentive payments to providers that meet benchmarks for behavioral health integration. Specifically, the state includes directed lump sum payments in its managed care capitation rates for MCOs to provide incentive payments to providers—primary care providers, behavioral health providers, and hospitals—that meet certain core components and performance milestones that advance behavioral health integration.¹⁴⁸ The first year of the program focused on provider recruitment and onboarding, then the state tied incentive payments to integration milestones in years 2 and 3 before tying incentives to performance-based milestones in the final years of the waiver. (See Figures 2 and 3 below.)

Figure 2: Phases of Arizona’s Targeted Investments Program¹⁴⁹



Source: [Arizona's Draft 1115 Waiver Interim Evaluation Report](#), September 2020.

Figure 3: Arizona’s Targeted Investments Program, Incentive Payments by Year¹⁵⁰

<p>TIY 1 (10/16-9/17) Contingent upon acceptance into the program</p>	<p>TIY 2 (10/17-9/18) and 3 (10/18-9/19) Contingent upon successful completion of Core Components and Milestones for Ambulatory and Hospital Projects</p>	<p>TIY 4 (10/19-9/20) and 5 (10/20-9/21) Contingent upon meeting or exceeding performance improvement targets</p>
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Source: Arizona Health Care Cost Containment System, [Targeted Investments Program Overview](#).

Arizona funded part of its nonfederal share of Targeted Investments Program expenses through a federal match for certain designated state health program expenditures up to nearly \$91 million over five years.¹⁵¹ The designated state health program funding is phased down over the demonstration and 10 to 20% of those funds are at risk in demonstration years 3 through 5.¹⁵²

Early DSRIP waivers relied on funding from state revenue, intergovernmental transfers, or provider taxes. Under recent waivers like [Arizona’s](#), CMS also allowed states to claim federal match up to an authorized limit for certain designated state health program expenditures approved by CMS. This allowed those states to redirect additional state resources toward delivery system reform.

The additional designated state health program funding has helped states like Arizona with initial start-up costs that are often a barrier to implementation and has encouraged states to shift toward value-based payments, such as prospective risk-adjusted per member per month (PMPM) payments.¹⁵³ For example, Massachusetts relied on DSRIP funds for startup costs and infrastructure development activities, including “building primary care provider and care coordination capacity, performance management, contracting, enhancing information technology, and developing population health analytics.”¹⁵⁴ Under DSRIP waivers, several states also require their MCOs to meet targets for increased adoption of alternative payment model arrangements.¹⁵⁵

The DSRIP waivers that authorize funding for designated state health programs will expire at the end of 2021.¹⁵⁶ Since 2017, CMS has stated that it will no longer approve these waivers, citing concerns that states were not making comparable increases in state investment¹⁵⁷ and that final evaluation results for four states were mixed.¹⁵⁸

An independent evaluator for CMS conducted the [final evaluation](#) of DSRIP waivers in California, New Jersey, New York, and Texas.¹⁵⁹ The evaluation examined impacts on: emergency department (ED) visits; avoidable ED visits; hospital discharges for ambulatory care sensitive (ACSC) conditions; ambulatory care visits for adults; primary care visits for children and adolescents; behavioral health visits; hemoglobin A1c (hbA1c) testing among beneficiaries with diabetes; and follow-up after an ED visit for ACSC.¹⁶⁰ For behavioral health visits, the evaluation found favorable outcomes in California and Texas, and unfavorable outcomes in New York.¹⁶¹ The final evaluation did not examine the impact on behavioral health integration. Arizona, however, focused its DSRIP program more narrowly on behavioral health integration and early results are promising.¹⁶²

Arizona's draft interim evaluation report found a general increase in integration levels across all participating providers from demonstration years 2 to 3.¹⁶³ Sixty percent of unique provider sites reported an increase in integration by at least one level of SAMHSA's six levels of integrated health care, which range from minimal collaboration to full collaboration in transformed or merged integrated practice.¹⁶⁴ Nearly 25% of participating primary care providers increased their level of integration by four or more levels, meaning that they transitioned from minimal coordination levels to fully integrated care levels.¹⁶⁵ Also, by year 3, there were fewer providers attesting to the lowest level of integration (coordinated care) and more providers attesting to the highest levels of integrated care.¹⁶⁶ Among providers serving the justice-involved population, those who initially reported the lowest levels of integration in year 2 reported reaching the highest levels of integrated care by year 3.¹⁶⁷

Following this general approach for advancing integration through value-based payment arrangements, CMS should develop an 1115 waiver opportunity for a behavioral health integration model with requirements for benchmarks tied to incentive payments for each level of integration. To support state implementation of this waiver opportunity, CMS should offer technical assistance to states. It should also authorize federal matching payments for designated state health program expenditures to address barriers to state participation in a budget neutral way. To address CMS' concerns that states were not making a comparable increase in state investment,¹⁶⁸ and the Government Accountability Office's (GAO) concerns focused more broadly on the need for more consistent and transparent criteria for expenditures under 1115 waivers,¹⁶⁹ CMS could encourage states

to make a comparable investment and require that state savings generated by state health programs be dedicated to behavioral health integration. CMS could also develop consistent and transparent criteria for determining whether federal match for designated state health programs is likely to promote the objectives of the Medicaid program. How the criteria are satisfied could be documented in the waiver approval.

Congress should also consider establishing a grant to states to support capacity building for behavioral health integration, particularly to help small independent practices integrate care. States that participated in the Center for Medicare & Medicaid Innovation's (CMMI's) State Innovation Models (SIM) initiative received awards to advance multi-payer health care payment and delivery system reform models.¹⁷⁰ CMS awarded almost \$300 million for 25 states to either design or test their models in the [first](#) round of SIM from 2013 to 2018.¹⁷¹ CMS awarded \$660 million to 32 states or territories in the [second](#) round of SIM from 2015 to 2020.¹⁷² Several states included a focus on improving behavioral health integration¹⁷³ and invested SIM resources in the infrastructure needed to support provider performance under the model.¹⁷⁴ This included investment in capabilities for health information technology (IT), data analytics, and technical assistance.¹⁷⁵ The fifth annual independent evaluation of SIM in 2018 reported that infrastructure investments including technical assistance, learning collaboratives, and peer-to-peer learning opportunities were important for improving behavioral health integration.¹⁷⁶ Other states interested in pursuing integration would likely need to make similar investments in infrastructure and capacity building. Establishing a grant to states to support capacity building for behavioral health integration, which would require congressional action, would support the adoption and success of integration.

9. Include measures of behavioral health integration in the Medicaid managed care quality rating system and recommend that states set a minimum rating for MCOs on performance measures.

CMS released Medicaid managed care final rules in [2016](#)¹⁷⁷ and November [2020](#),¹⁷⁸ establishing that CMS would consult with states and other stakeholders to develop a framework for a Medicaid managed care Quality Rating System. Under current regulations, CMS will identify performance measures, including a subset of mandatory performance measures, and a methodology that aligns with the qualified health plan quality rating system, the Medicare Advantage 5-Star Rating System, and other related CMS quality rating approaches.¹⁷⁹ States will also have the option to implement an alternative Medicaid managed care Quality Rating System that utilizes different performance measures or applies a different methodology from the CMS-established methodology, but the alternative rating system must still include the mandatory performance measures identified by CMS.¹⁸⁰

States will be required to collect data from each MCO it contracts with and issue an annual quality rating for each based on that data.¹⁸¹ The state must prominently display the quality rating for each MCO on its website as a resource for beneficiaries selecting a health plan.¹⁸² CMS is in the process of developing the framework, methodology, and performance measures for the quality rating system.

In establishing the methodologies and performance measures for the Medicaid managed care Quality Rating System, CMS should require MCOs to report on performance measures for behavioral health integration. CMS should also recommend, but not require, that states set a minimum rating for MCOs on the performance measures.

Incentivize behavioral health integration in the Medicare Shared Savings Program

An ACO is a primary care-based payment model that holds a group of providers financially responsible for the care of their patients. The [Medicare Shared Savings Program \(MSSP\)](#) describes an ACO payment structure that rewards primary care providers for engaging in more coordinated care in hopes of improving outcomes and lowering costs.¹⁸³ It incentivizes providers to prevent hospitalizations and emergency visits by linking reimbursement to overall costs to Medicare, under both Parts A and B.

ACOs in the MSSP should serve as vehicles for normalizing behavioral health services in primary care settings. The core responsibilities of ACOs should include behavioral health and reimbursement should be linked directly to integration. Importantly, ACOs will need technical assistance to support successful implementation of additional services.

10. Update the [Affordable Care Act](#) to include behavioral health in the Medicare Shared Savings Program requirements.

Congress should update the defined components of an ACO to require sufficient behavioral health professionals for the number of assigned beneficiaries. It should also modify the core processes for ACOs to include integration of behavioral health services and utilization of telehealth for care coordination. Finally, Congress should require behavioral health screening and tracking to meet patient-centeredness criteria.

11. Include integration in the Medicare Shared Savings Program ACO quality performance standards.

The MSSP employs safeguards to ensure providers do not attain cost reductions by restricting services to beneficiaries. Medicare currently assesses ACOs on 23 quality measures as part of the criteria for receiving shared savings.¹⁸⁴ Only two of the measures address behavioral health—(1) depression screening and follow up and (2) depression remission at one year.

The majority of ACO quality measures require participants to meet progressively higher performance benchmarks each year. For example, screening 20% of patients for the flu vaccine might satisfy quality reporting requirements in the first year, but not meet a 30% minimum performance benchmark in other years. However, the two behavioral health measures remain reporting measures, without performance benchmarks, and neither is linked to improvement.

The HHS secretary should update the ACO quality performance standard to incorporate a full set of behavioral health measures (See Recommendation A-2) with established performance benchmarks to drive behavioral health integration. In addition, the depression remission measure should be updated to include improvement in symptoms and assessment for shorter time frames. To the extent practicable, changes to the ACO quality measure set should not increase provider reporting burden. New behavioral health measures should replace those which are less reflective of health care quality and outcomes (e.g., “topped out”) and should be aligned with Medicaid quality initiatives and core measurement sets.

Assuming retention of current participants and a 1% reduction in shared savings, due to increased performance standards, HMA has estimated this provision would result in \$767 million in savings over 10 years.¹⁸⁵

12. Provide financial incentives for high-performing ACOs to exceed the Medicare Shared Savings Program performance standards for behavioral health integration.

CMS should provide additional incentives for ACOs to integrate behavioral health and primary care services beyond what is required by the MSSP quality performance standard. The secretary of HHS should define criteria for enhanced integration, such as a more robust panel of behavioral health care services in the primary care setting, improved clinical outcomes, and higher performance benchmarks. ACOs participating in one-sided, or upside-only, risk receive a share of savings, while those taking on downside, or two-sided, risk also share responsibility for costs exceeding a spending benchmark. Incentives could include a two-year extension of upside-only risk for one-sided risk MSSP participants and a permanent 5% increase to the shared savings cap for ACOs already engaging in two-sided risk. The secretary should also consider pre-payment of a portion of shared savings to provide greater incentives for expansive integration efforts, similar to [Community Health Access and Rural Transformation ACO Model](#).¹⁸⁶

HMA estimates the extension of upside-only agreement periods and the potential for greater shared savings would incentivize both MSSP enrollment and retention.¹⁸⁷ Additionally, successful adoption of integrated care is expected to reduce behavioral health costs by 2%. HMA estimates

the additive effect of the two incentives to result in savings of \$3.8 billion over 10 years.¹⁸⁸

Incentivize behavioral health integration in Medicare Advantage

Medicare contracts with commercial insurers to offer Medicare Advantage plans to provide Part A and Part B services. Most plans also offer prescription drug coverage under Part D and have the flexibility to offer additional services, such as dental, vision and hearing. In 2019, one third (34%) of Medicare enrollees were in a Medicare Advantage plan and the Congressional Budget Office (CBO) projects that enrollment will continue to grow and nearly reach one half of participants in 2029.¹⁸⁹ Medicare pays plans more for higher-risk beneficiaries, based in part on their identified health conditions, providing an opportunity for policy change to encourage screening for behavioral health. Plans are also rated on quality using a STAR rating system. This rating system provides a powerful incentive to plans because beneficiaries use the ratings to choose plans, and a bonus payment and rebates are linked to performance on the ratings.

13. Revise the Medicare Advantage performance rewards system (STAR ratings) to add behavioral health integration measures.

Medicare pays plans a capitated rate for enrollees. Competition for enrollees is a significant driver of plan attention and potential beneficiaries often use STAR ratings to assess plan performance. Also, STAR ratings are linked to payment. Accordingly, CMS should carefully assess the STAR ratings and revise them to incentivize integrated care. Currently, there is one behavioral health measure from the Health Outcome Survey asking patients about improving or maintaining mental health within the 32 Part C [measures](#).¹⁹⁰ There are other general measures on care coordination, getting needed care, and getting appointments and care quickly, but they apply to all care.¹⁹¹ CMS should add measures specifically addressing behavioral health integration. CMS should incorporate the set of behavioral health integration measures (See Recommendation A-2) into the STAR rating system. Medicare Quality Improvement Organizations could also focus on this area in their next scope of work.

14. Add and align network performance standards across programs.

Currently, CMS holds plans to quantitative standards for network adequacy. According to CMS guidance on network adequacy, “CMS network adequacy criteria includes provider and facility specialty types that must be available consistent with CMS number, time, and distance standards. Access to each specialty type is assessed using quantitative standards based on the local availability of providers and facilities to ensure that organizations contract with a sufficient number of providers and facilities to furnish health care

services without placing undue burden on enrollees seeking covered services.”¹⁹² CMS should add network performance standards in accordance with Recommendation A-3 to align across programs. Examples could include appointment wait times, number of providers submitting claims over a certain period, and providers taking new patients with an emphasis on behavioral health. HMA estimates that increasing network performance standards in Medicare Advantage is likely to cost \$2.3 billion over 10 years. New standards would likely add 800-1000 total behavioral health providers to MA provider networks. The average behavioral health provider sees 75-150 Medicare patients per year, so an estimated 100-150,000 more MA enrollees would gain access to behavioral health care on an annual basis, which would increase over time as more Medicare beneficiaries are expected to join MA plans.¹⁹³

15. Include sufficient behavioral health measures in the Medicare Advantage performance rewards system.

CMS awards plans bonus payments and the amount of their rebate for the differential between their bid and benchmark is adjusted based on the plan’s STAR rating. CMS should include sufficient behavioral health measures to incentivize plans to work with their providers to ensure they achieve core components and outcomes of integrated health. The Medicare Payment Advisory Commission has recommended a more streamlined bonus payment system linked to population health. If CMS moves in this direction, it should include remission or response to depression as a population health measure, along with other measures.

16. Add additional behavioral health conditions to the Hierarchical Condition Categories for risk adjustment.

In the [21st Century Cures Act](#), Congress required CMS to evaluate additional mental health and substance use conditions to include in the Hierarchical Condition Categories coding risk adjustment process and CMS has added some further conditions. Congress and CMS should revisit and consider adding additional conditions to incentivize screening, for such conditions as anxiety disorders, which are not included for risk adjustment of general costs, but are covered for prescription risk adjustment.¹⁹⁴ The MA program does not currently include risk adjustment for social determinants and social context of health. CMS should collect appropriate data and consider how social determinants of health might be included in calculating risk adjustments.¹⁹⁵

DRIVE INTEGRATION AT THE PRACTICE-LEVEL

This section outlines policy recommendations that could incentivize providers to participate in integrated care within traditional Medicaid and Medicare.

Incentivize individual providers to participate in integration

17. Create a novel payment model that allows primary care providers to cover the full range of primary care and mild to moderate behavioral health services under enhanced risk-adjusted capitated payments in traditional Medicare.

In the 1990s, there were unsuccessful attempts to pay primary care providers through capitated payment arrangements. The factors that contributed to failed efforts included inability to manage risk by practices; lack of quality measures and data infrastructure to track outcomes; payments based on fee-for-service claims that did not accurately capture cost of delivering care, and inadequate risk adjustment methodology.^{196,197,198} Future efforts to implement capitated models in primary care should incorporate lessons learned from previous attempts by providing payments that reflect the true cost of care and are linked to metrics that capture patient-experience and high quality, holistic care.

CMS has increasingly moved towards value-based payment and has begun advancing capitated payment arrangements. Through Comprehensive Primary Care Plus (CPC+), providers received payments through a hybrid payment model, which includes prospective payments and fee-for-service. Under Track 2, practices are paid through prospective Comprehensive Primary Care Payments, along with fee-for-service payments that are expected to decrease as the practice begins providing services that cannot be billed under Medicare.¹⁹⁹ The latest evaluation of CPC+ found that the number of providers choosing the maximum level of risk under Comprehensive Primary Care Payments had doubled.²⁰⁰

Furthermore, COVID-19 has revealed weaknesses in the traditional Medicare model, as it requires a constant stream of reimbursable services. As people drastically curtailed medical appointments and procedures during the pandemic, physician practices experienced a 55% decrease in revenue, according to one [survey](#). The practices that have fared the best during the pandemic rely on prospective fixed payments, which do not rely on payment per service.²⁰¹ There is evidence that this financing approach has been successful in supporting behavioral health integration. A recent [study](#) in Colorado found that using prospective payments for integrated

care in primary care practices led to cost savings of \$1 million over 18 months.²⁰²

To provide additional flexibility and increased financial support for a holistic approach to primary care that includes behavioral health care, Congress should direct CMS to create and offer the Integrated Health Model as voluntary option for primary care providers currently in traditional Medicare. The comprehensive payments would consist of risk-adjusted, per member per month (PMPM) payments for outpatient primary care and integrated behavioral health services, excluding Medicare Part D medications. These types of conditions addressed by the practice would vary depending on patient population, but could include preventive physical care; prevention and management of mild to moderate mental health and substance use disorder conditions; behavioral issues that fall short of a diagnosis, including stress-related physical symptoms, and acute life stressors; behaviors that contribute to chronic illness; and ineffective patterns of health care utilization.

Primary care providers would have access to additional expertise from behavioral health providers with the ability to diagnose and treat mild to moderate behavioral health conditions and provide guidance on pharmacological interventions (See Recommendation B-3).²⁰³ For complex patients, primary care providers could also opt to refer them to a specialist, without disrupting the continuity of care and without receiving a penalty on payment. Taking a whole person approach to primary care would allow for prevention and early intervention of behavioral health conditions before they lead to poor outcomes and high health costs.

Behavioral health integration into primary care practices would incorporate the core services defined by the secretary of HHS (See Recommendation A-1) and could include the following services to manage behavioral health diagnoses, behavioral issues, and address social needs:

- Systematic screening for behavioral health conditions and referral for complex patients
- Ongoing care management between patient and providers
- Team-based care between behavioral health and primary care providers on site or through virtual collaborations
- Measurement-based care, using evidence-based tools to monitor behavioral health symptoms and adjust treatment as needed^{204,205}
- Culturally competent self-management of health conditions
- Tracking and exchanging patient information among providers
- Assessing social needs and providing links to services²⁰⁶

AHRQ has outlined the key competencies that should be expected of each

provider on the integrated care team delivering these core services.²⁰⁷ Primary care providers would have to meet a set of standardized process, outcome, and patient-centered measures as determined by the secretary of HHS to capture the core elements of integration (See Recommendation A-1). Although this model should primarily rely on capitated payments, there are payment designs that could serve to drive specific outcomes or process goals. These could include establishing a complementary pay-for-performance program to reward behavioral health screenings or withholding a percentage of monthly capitated amounts until specific standards or milestones are met.

To adequately compensate for the full range of primary care, including behavioral health integration, Medicare would offer fee-for-service providers the option of receiving prospective PMPM payments, enhanced by 3% of the prior year average cost for enrollees, and risk adjusted to account for health and social risk factors. Current risk adjustment, such as Hierarchical Condition Category coding, which adjusts payments in Medicare Advantage plans and CMMI models (e.g. Comprehensive Primary Care Plus), is not entirely predictive of risk.²⁰⁸ CMS should implement risk adjustments for PMPM payments in an Integrated Health Model (IHM) and future models that include social needs and geographic location to promote equity and ensure accurate payments for patients with complex needs.²⁰⁹ Social risk factors could include low socioeconomic status, race or ethnic background, sexual orientation or gender identity, and living alone.²¹⁰

Payments should also account for start-up costs, including time and resources associated with hiring new staff, planning and establishing protocols for training, and acquiring additional assets. Training staff and ensuring technical assistance for practices are key to successful integration and are addressed separately in the recommendations under Section B.

The IHM would be appropriate for providers with a primary care designation including internal medicine, general medicine, family medicine, geriatric medicine, obstetrics/gynecology, and pediatric medicine. These providers could include physicians, physician assistants, nurse practitioners, and clinical nurse specialists. This payment mechanism should be available on a voluntary basis to all primary care practices that have experience with, or are willing to take on, full financial risk for all of their patients in Medicare fee-for-service.

For primary care providers, fully capitated PMPM payments for primary care with behavioral health integration would provide advantages over Medicare fee-for-service, or partially capitated models. The advantages include simplified billing, increased flexibility, compensation for upfront costs, and steady revenue. This approach would align care delivery and payment transformation, such that practices could hire additional staff and

tailor integrated care to best address the primary and behavioral health needs of their patient population.

Although CMS has taken some steps to incentivize and support behavioral health integration into primary care, scaling current efforts has been largely unsuccessful, as they fall short of adequately compensating providers and measuring behavioral health outcomes. Payment models, such as CPC+, were intended to incorporate care coordination and behavioral health integration as a cost-effective means of improving health outcomes. However, these models remain based in Medicare's fee-for-service structure and lack accountability for behavioral health outcomes and integration. The CMMI Primary Care First model builds on CPC+ and moves practices closer to taking on full risk, while focusing on high need, seriously ill patients. Yet, like CPC+ and Patient Centered Medical Homes, it focuses on physical health rather than on behavioral health outcomes. Without adequate quality metrics, there is limited accountability and assessment of the value of integration.

Congress should direct CMS to establish an IHM, similar to legislation that established the MSSP. HMA estimates that increasing IHM capitated payments by 3% of prior year total health care spending would serve between 200,000 and 800,000 Medicare beneficiaries and cost Medicare \$2.9 billion over ten years.²¹¹ The cost estimate includes changes to evaluation and management codes, which are expected to result in an estimated 12% payment increase in total allowed charges for primary care services.²¹² In addition to increasing the number of individuals receiving integrated care, implementing IHM could encourage other payers to implement similar models.

To promote long-term reform for integrated primary care practices, it will be essential to align payment models across payers. One [study](#) has estimated that capitated payments need to make up at least 63% of practice payments to enable practice transformation.²¹³ CMS should make the IHM option available in Medicare, and work with states and insurers to ensure multi-payer alignment with Medicaid and commercial payers, including Medicare Advantage. Without additional changes in statute to the noninterference clause, which prevents CMS from requiring specific payment structures for Medicare Advantage, Medicare could not require Medicare Advantage plans to pay providers through IHM payments. A 2019 [CMS report](#) to Congress states that Medicare Advantage plans have already started moving toward full risk arrangements with their providers,²¹⁴ and the IHM model in traditional Medicare could provide additional impetus and guidance for primary care arrangements.

To support the IHM or similar models in Medicaid, CMS should provide guidance to states on how to implement the model through existing authorities. For example, states could work with MCOs to include capitated

payment arrangements for providers, and additional funds through 1115 waivers could further advance IHM implementation in Medicaid. States may also take advantage of state directed payments and managed care plan incentive payments and withhold arrangements to financially incentivize Medicaid MCOs to adopt IHM.²¹⁵

18. Provide funding for a forgivable-loan program to assist individual providers and small primary care practices with the upfront costs of implementing behavioral health services.

Many small and independent primary care practices providing a low volume of services struggle to finance the implementation of new interventions, which has limited participation in value-based payment models. Addressing barriers to integration, including upfront costs and administrative burden, may spur increased adoption of high-value care by individual providers, small practices, and those with less experience in value-based settings.

Congress should direct the secretary of HHS to establish a forgivable-loan pilot to support small primary care practices initiating behavioral health integration. The prospective financing should be used to assist with the upfront capital necessary to implement behavioral health services. CMS should provide outreach and guidance targeted to small practices on effective ways to use the loan program to achieve integration. The secretary should define stringent criteria for loan eligibility, including meeting specific quality and performance metrics, such as the integration standards described in Recommendation A-2 of this report. Those failing to implement the required services or meet quality performance benchmarks should be required to repay the loan.

The secretary should assess the cost structure of these practices and consider payment adjustments in Medicare that could support the sustainability of integration. Ongoing funding should also be considered until practice transformation efforts have been fully scaled, as the costs of implementing integrated care are often underestimated. A [2015 study](#) of 10 Colorado practices in the Advancing Care Together program found the cost of new resources averaged \$20,000, while the full cost of integration, including redeployment of existing resources, averaged \$44,000.²¹⁶ There was significant variability among the Advancing Care Together practices, but the larger practices had longer start-up periods and higher implementation costs. Using the \$44,000 estimate, a \$20 million congressional appropriation would allow CMMI to provide loans to nearly 500 practices. Based on early results and provider interest, the pilot could be extended or expanded.

As a condition of participation, loan recipients should be required to submit a plan for meeting ongoing costs of integration, such as concurrent

participation in the Integrated Health Model or another value-based integration model. Practices could also use funding to work with newly emerging vendors offering care management and psychiatric consultation, enabling the adoption of collaborative care models. The secretary should direct CMS to estimate provider interest and potential downstream savings to determine the appropriate investment in a provider loan program.

19. Include additional behavioral health integration measures into Medicare’s Merit-based Incentive Payment System (MIPS) to incentivize behavioral health provider participation in integrated care.

As primary care providers shift to value-based payments that include integration, it will be important to align quality measures and incentivize behavioral health providers to participate in integrated care. A pay-for-performance payment (P4P) model could incentivize behavioral health providers to integrate care by tying bonus payments to integrated care measures. This model would be appropriate for mental health and substance use providers—psychiatrists, psychologists, nurse practitioners with a mental health specialty, and clinical social workers—especially in small practices with limited experience in value-based payments.

Blue Cross and Blue Shield of North Carolina (BCBSNC) has pioneered a P4P model for behavioral health providers. Blue Premier Behavioral Health ties bonus payments of up to 10% of total annual payments to process measures, such as time to first appointment, developing joint care plans, and using symptom rating scales to monitor treatment efficacy (measurement-based care).²¹⁷ BCBSNC has partnered with Quartet, a behavioral health technology company, to provide their platform to participating behavioral health providers as a way of facilitating integrated care delivery and referrals, and tracking quality metrics.

MCOs, ACOs, and MA plans could independently begin implementing P4P approaches for behavioral health providers that incentivize integrated care and align quality measures between primary and behavior health providers. ACOs and MA plans may already offer P4P models,^{218,219} and states can implement P4P models through managed care contracts.²²⁰ [MIPS](#) offers a P4P mechanism for providers receiving payments through traditional Medicare. Through MIPS, providers can receive positive or negative adjustments to Medicare Part B payments based on performance in four categories: quality, cost, promoting interoperability, and improvement activities. CMS should include additional behavioral health integration measures in the MIPS mental/behavioral health measure and improvement activity set. These measures should align with and complement those for behavioral health integration in primary care and should be weighted heavily to incentivize providers to report on these

measures. In 2022, payment adjustments are set to be +/- 9% with an adjustment of up to 10% for exceptional performers. MIPS could provide an opportunity to advance to integrated care within P4P models for behavioral health providers without incurring additional costs because MIPS is budget neutral in aggregate.

The HHS secretary should set forth the MIPS behavioral health integration quality metrics and improvement activities with input from behavioral health providers and patients. Metrics should focus on integrated care processes, patient experience, and measurement-based care. In addition, the measure set should capture cultural competency in order to reduce behavioral health treatment gaps in communities of color.

Improve collaboration within traditional Medicare and Medicaid

20. Remove barriers to the adoption of the collaborative care model (CoCM).

The National Institute of Mental Health and other researchers have extensively studied the CoCM, which is defined by five core principles: patient centered team care, population-based care tracked in a registry, measurement based treatment to target, evidence-based care through psychotherapies and medication, and accountable care for quality, not just quantity.^{221,222} The Improving Mood: Providing Access to Collaborative Treatment study demonstrated that the benefits of collaborative care management were significant when compared to traditional interventions.²²³ At 12 months, 45% of participants receiving collaborative care experienced at least a 50% reduction in depressive symptoms, compared with only 19% of those in usual care.²²⁴ In addition, a later study of cost data showed that mean health care costs for participants of the intervention group were \$29,422 per person—a 10% cost savings when compared to \$32,785 for individuals in the control group.²²⁵ Collaborative care is also an important tool for advancing behavioral health equity. Multiple studies have found that collaborative care reduces health disparities.^{226,227,228,229}

Given this evidence, Medicare developed codes for the CoCM that capture core elements of integrated care. Providers are reimbursed for up to 70 minutes of work for the first month of CoCM services and 60 minutes for subsequent months. For more complicated or time-consuming patients, add-on codes for additional 20 or 30 minutes of service time may be billed in some settings.²³⁰ However, stakeholders have reported an inability to meet upfront and additional staffing costs at the current reimbursement rates.

Start-up costs and insufficient reimbursement have been identified as the principal barriers to the CoCM. A recent study of primary care practices found that the codes reimbursed for some, but not all, of the integrated care activities.²³¹ Reimbursement should more adequately reflect the work required to provide the service. Both an increase to the baseline value of the service and compensation for initial start-up costs could encourage uptake of CoCM. CMS should re-evaluate the codes to ensure adequate payment to incentivize practices to participate. The American Psychiatric Association (APA) has recommended a 75% increase to the current Medicare payment for CoCM billing codes in the first year, a 50% increase in the second year, and 25% in subsequent years. CMS should evaluate evidence from APA and other sources and adjust the payment to increase take up of this evidence-based intervention. This adjustment would help cover the start-up costs associated with staffing, workflow, and infrastructure changes, and encourage practices to adopt this evidence-based practice.

When estimating the costs, HMA used the APA percentages and noted that given the difficulty for CMS to track when a practice is in its first or second year, another option would be to enact a one-time increase in the payment for the codes by 75% in the first year of the new policy for all practices using collaborative care, 50% in the second year, and 25% in subsequent years. This would encourage practices to begin using the codes to receive the higher payment for a limited time. HMA estimates that the cost of this would be \$152 million over 10 years.²³² This cost would vary depending on the CMS analysis and adjustment of rates.

FQHCs are safety-net providers that receive set reimbursement amounts to care for patients, regardless of complexity. FQHCs may bill for CoCM services at 70 or 60 minutes, but they are not permitted to bill for any additional service time. To adequately reimburse FQHCs for caring for a high-need population, Medicare should eliminate this restriction to allow them to bill the add-on codes, which HMA estimates would have a minimal cost of \$2.3 million over 10 years.²³³

Beneficiary cost-sharing responsibility and the need for patient consent has also resulted in limited uptake of CoCM services because it is difficult to relay to patients the value of non-face-to-face services.^{234,235} By exempting beneficiaries from co-insurance responsibility and the need for additional consent for these preventive services, the provision of CoCM services would

increase. CMS currently does not require any cost sharing or co-insurance for bundled opioid treatment provider services and should apply the same policy for collaborative care services to encourage usage. HMA estimates that eliminating the co-payment would increase costs by \$70 million over 10 years.²³⁶ The total cost of this recommendation would be \$224 million over 10 years.²³⁷

21. Provide detailed guidance to states on implementing the CoCM in Medicaid.

In a [2018 letter](#) to state Medicaid directors, CMS identified the CoCM as an evidence-based approach to behavioral health integration.²³⁸ In that guidance, CMS briefly described the CoCM and listed the potential Medicaid authorities and payment strategies that states could use to implement that model. While this was a valuable step in increasing states' awareness and coverage of the CoCM in Medicaid, more detailed guidance and direction is needed from CMS to increase adoption of the model and reimbursement for the collaborative care codes. Currently, only 17 states reimburse for the collaborative care codes and most of those states activated the codes in 2019.²³⁹ CMS guidance should also encourage states to review coverage of collaborative care as part of their parity compliance to ensure they are applying the same evidentiary standard to coverage.

ADVANCE INTEGRATION THROUGH CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

Incentivize coordination and integration among Certified Community Behavioral Health Clinics and Federally Qualified Health Centers

Currently, about 340 Certified Community Behavioral Health Clinics (CCBHCs) exist in 40 states and 1,362 Federally Qualified Health Centers (FQHCs) operated in the United States in 2018 (See Figures 4 and 5).²⁴⁰ Coordination between these entities varies by region, and proposals that foster greater coordination would help to improve behavioral health integration for the nearly 30 million individuals FQHCs serve²⁴¹ and over 326,000 individuals CCBHCs serve.²⁴²

Figure 4: Status of Participation In The CCBHC Model, 2020²⁴³

Source: The National Council for Behavioral Health, [CCBHC Locator](#)

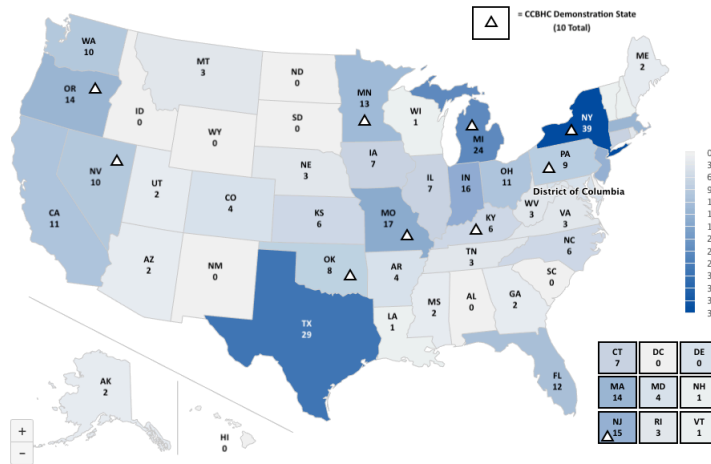
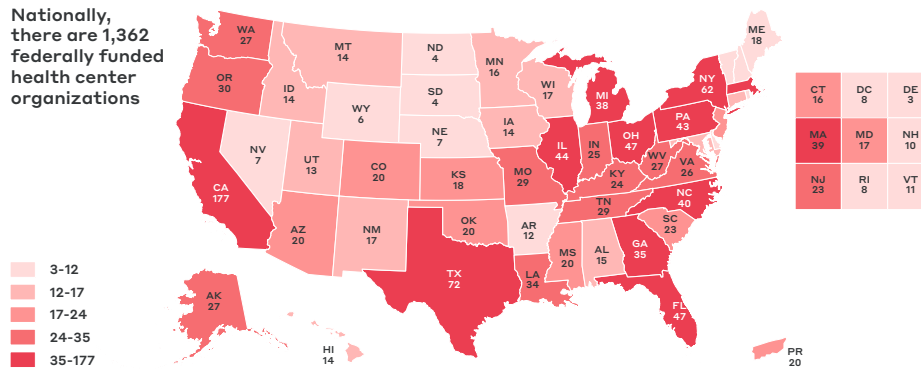


Figure 5: Number of Federally-Funded Health Center Organizations, 2018²⁴⁴

Nationally, there are 1,362 federally funded health center organizations



Notes: Binned by quantile for states and territories shown. National figure includes health centers in every state, territory and D.C. Territories are not shown in the map above. The following territories have 1 grantee: Guam, American Samoa, Northern Mariana Islands, Palau, and Marshall Islands. The Virgin Islands has 2 grantees. The Federal States of Micronesia has 4 grantees.

Source: 2018 Uniform Data System, Bureau of Primary Health Care, HRSA, DHHS

22. Incentivize CCBHCs and FQHCs to strengthen integration of behavioral health and primary care through a voluntary integration bonus payment.

Section 223 of [Protecting Access to Medicare Act of 2014 \(PAMA\)](#) authorized a state-implemented CCBHC demonstration to improve community behavioral health.²⁴⁵ PAMA requires CCBHCs to provide a range of treatment and recovery support services, including: crisis mental health services; screening assessment and diagnosis; patient-centered treatment planning or similar processes; outpatient mental health and substance used services; outpatient clinic primary care screening and monitoring; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family supports; and intensive, community-based mental health care for members of the armed forces and veterans.²⁴⁶

Congress authorized FQHCs under [Section 330 of the Public Health Service Act](#).²⁴⁷ FQHCs provide required primary health services, including: physicians' services and services by physician's extenders, such as physicians' assistants, nurse clinicians, and nurse practitioners; diagnostic laboratory and radiologic services; preventive services, including medical social services, nutritional assessment and referral, preventive health education, children's eye and ear examinations, prenatal and post-partum care, prenatal services, well child care including periodic screening, immunizations, and voluntary family planning services; emergency medical services; transportation services as needed for adequate patient care; preventive dental services; and other services.²⁴⁸

To ensure seamless patient transitions across the full spectrum of health services, PAMA requires CCBHCs to coordinate care across settings and providers by having partnerships or formal contracts with FQHCs to the extent that those services are not provided directly through the CCBHC.²⁴⁹ PAMA also allows CCBHCs to establish formal relationships with other providers, such as FQHCs, to deliver certain required services that are not available directly through the CCBHC.²⁵⁰ When a CCBHC contracts with an FQHC in this way, the FQHC is known as a designated collaborating organization (DCO).²⁵¹ In 2018, about 87% of CCBHCs reported having any relationship with FQHCs, 3% reported a DCO relationship with an FQHC, and 60% reported some other formal relationship with FQHCs.²⁵²

Congress should further encourage and strengthen integration between CCBHCs and FQHCs beyond care coordination and DCO contracts. Formal partnerships for integration between CCBHCs and FQHCs have the potential to provide a more comprehensive range of services and improve care delivery for those with both physical and behavioral health diagnoses.²⁵³ These partnerships would encourage an integrated team-based approach to care and co-locating.

HHS selected eight states, including 66 CCBHCs, to participate in the original 2-year demonstration in 2016.²⁵⁴ Through the [Coronavirus Aid, Relief, and Economic Security \(CARES\) Act](#), Congress extended the demonstration through November 30, 2020 and added two new states that will participate in the demonstration for two years beginning August 2020.²⁵⁵ Congress again extended the CCBHC demonstration through September 30, 2023 and appropriated \$250 million through the Consolidated Appropriations Act, 2021.²⁵⁶ Separate from the demonstration, SAMHSA awarded CCBHC expansion grants to 166 clinics across 32 states in April 2020.²⁵⁷ The expansion grants began August 30, 2020 and included \$200 million in annually appropriated funding and \$250 million in emergency COVID-19 funding.²⁵⁸ Congress also appropriated \$600 million for CCBHC expansion grants through The [Consolidated Appropriations Act, 2021](#).²⁵⁹ These expansion grants will help clinics become certified as

CCBHCs, but the clinics will not be part of the Medicaid demonstration and will not gain access to the prospective payment rates through this program.²⁶⁰

Under the demonstration, CCBHCs receive reimbursement for services provided to Medicaid beneficiaries through a clinic-specific prospective payment system (PPS).²⁶¹ States may choose between a fixed, daily clinic-specific PPS rate or a monthly PPS methodology.²⁶² States selecting the daily rate have the option to provide a quality bonus payment to CCBHCs, while states selecting the monthly PPS rate are required to establish a quality bonus payment.²⁶³ To earn the quality bonus payment, CCBHCs must meet certain state-determined performance goals on six federally required quality measures every six months.²⁶⁴ The quality measures used for determining quality bonus payments do not reflect integration of behavioral health and primary care. The quality bonus payments are also available only to CCBHCs and do not incent FQHCs to partner with CCBHCs to improve outcomes for shared populations.

Future rounds of the CCBHC demonstration should include a separate integration bonus payment available to both CCBHCs and FQHCs that partner to meet escalating clinical outcome measures that reflect integration of behavioral health and primary care. The bonus payment for meeting the integration performance measures should be in addition to, and not a withhold from, the prospective payment rates the clinic and health center each receive. In establishing the integration bonus payment, Congress should consider DCO relationships and should address any barriers to FQHCs receiving that bonus payment when serving as a DCO. The bonus payment would operate similarly to the quality bonus payment, but with a few key differences. While the quality bonus payment was available only to CCBHCs, this integration bonus payment would be available to both CCBHCs and FQHCs that partner to meet integration performance measures. CMS allows states to design the criteria and payment amounts for the quality bonus payments, and states provide the funding for the quality bonus payment through state general revenue or state appropriations.²⁶⁵ In contrast, demonstration states would receive federal funding for the integration bonus payment. The amount of this integration bonus payment should be comparable to the value of the quality bonus payment. For comparison, states made on average, roughly \$2 million available to CCBHCs for the quality bonus payment.²⁶⁶ The lowest amount was \$350,000 and the highest amount was \$4.2 million.²⁶⁷ The amount available to each demonstration state for the integration bonus payment should also reflect the number of participating CCBHCs and the number of partnering FQHCs in the state.

HMA estimates that this policy recommendation would cost the federal government \$153 million over 10 years.²⁶⁸ HMA assumes, under the

demonstration extension through 2025, about 74 to 76 CCBHCs would participate. HMA assumes approximately 50% to 65% of these CCBHCs will have sufficiently integrated with FQHCs to earn the proposed integration bonus payment. HMA also assumes approximately 200,000 individuals would be seen at CCBHCs that have integrated with FQHCs to earn the integration bonus payment. The average integration bonus payment will reach \$1 million per eligible participant, and the amount would be split between payments to CCBHCs and FQHCs.²⁶⁹

To increase system level integration between CCBHCs and FQHCs more widely in the long term, Congress should apply lessons learned from the integration bonus payment opportunity. Best practices that support integration between CCBHCs and FQHCs should also be identified and shared.

While this recommendation strengthens integration between existing CCBHCs and FQHCs, it does not expand the number of CCBHCs in underserved regions, such as rural and tribal areas. According to the Assistant Secretary of Planning and Evaluation [2020 report](#), consumer and family organization representatives reported that CCBHCs improved access to care during the demonstration.²⁷⁰ Specifically, CCBHCs improved access through expanding their scope of services and employing strategies such as same-day scheduling, offering more services in community settings, and outreach to underserved populations.²⁷¹ The original eight states participating in the Medicaid demonstration had some CCBHCs in underserved areas²⁷² that had to meet federal criteria for state certification to participate in the demonstration. Similarly, the CCBHC Expansion Grant program is available to CCBHCs or community-based behavioral health clinics that can meet certification criteria within four months of award.²⁷³ The demonstration and expansion grant programs target clinics that are already providing the standard scope of services. Opportunity exists to explore initiatives designed to increase the number of CCBHCs in underserved regions by helping small providers move toward meeting the CCBHC certification criteria. Approaches to consider may include establishing a glidepath to meeting CCBHC certification criteria with target milestones and resources for small providers in regions with the greatest need. Lessons learned from the CCBHC demonstration and opportunities to encourage coordination between agencies, such as CMS, SAMHSA, and the Indian Health Service may also be explored.

23. Require CCBHCs to report data by disadvantaged populations to identify disparities such as race, ethnicity, and language (REL); sexual orientation and gender identity; and social determinants of health.

Efforts to improve integrated care should promote health equity for disadvantaged populations. Under the CCBHC demonstration, SAMHSA requires states to report on 21 quality measures, including nine clinic-

reported measures and 12 state-reported measures.²⁷⁴ The clinic-reported quality measures are primarily process measures related to service provision targets.²⁷⁵ According to HHS' Office of Assistant Secretary for Planning and Evaluation's [2019 report](#), the state-reported measures primarily include measures for "consumer characteristics (for example, housing status), screening and treatment of specific conditions, follow-up and readmission, and consumer and family experiences of care."²⁷⁶ CCBHCS are not currently required to report on these measures by race, ethnicity, and language; sexual orientation and gender identity, or social determinants of health, but such a requirement by SAMHSA and gradual enforcement would help to identify and address disparities. In demonstration year 1, a majority of CCBHCs used quality measures to inform clinical practice.²⁷⁷ Some CCBHCs used quality measure reports to examine trends, determine areas for improvement, or monitor impacts.²⁷⁸ Reporting on data by race, ethnicity, and language; sexual orientation and gender identity; and social determinants of health would similarly inform clinical practice. CCBHCs could use this information to identify and address inequities and improve integrated care delivery for disadvantaged populations.

Significant technical assistance should be available to CCBHCs to help them meet this new requirement. SAMHSA and CMS could also work with entities that are already convening collaboratives to support CCBHCs with data collection and reporting.

24. Require CCBHCs to report on additional physical health measures.

As discussed above, SAMHSA requires CCBHCs to report on nine quality measures and requires states to report on 12 quality measures.²⁷⁹ Only four of the CCBHC-reported measures and one of the state-reported measures focus on physical health.²⁸⁰ These physical health measures include: adult body mass index screening and follow up; weight assessment and counseling for nutrition and physical activity for children and adolescents; tobacco use—screening and cessation intervention; unhealthy alcohol use—screening and brief counseling; and diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications.²⁸¹ To support integration between physical and behavioral health, SAMHSA should increase the number of physical health measures within the CCBHC demonstration mandatory reporting requirements and enforce that new requirement. Significant technical assistance should be available to CCBHCs to help them meet this new requirement. SAMHSA and CMS could also work with entities that are already convening collaboratives to support CCBHCs with data collection and reporting.

25. Require FQHCs to align with core integrated care measures and ensure accountability, particularly with respect to health disparities.

FQHCs report on a quality measure for depression screening and follow up care and the number of screenings and brief interventions for alcohol use. In 2020, FQHCs were also required to report on depression remission in 12 months.²⁸² In accordance with Recommendation A-2, HHS should develop core quality measures for integration and apply them across HHS programs, including health centers. As previously noted, experts have raised concerns about remission because response or remission is a more appropriate clinical outcome so revisiting and aligning measures after careful consideration will help the health centers in their efforts to integrate. Centers performing poorly in these areas should be accountable for improvement. In addition, HRSA currently analyzes and publishes disparities by race and ethnicity for low birth weight, blood pressure, and diabetes. Given the effect of COVID-19 and longstanding behavioral health disparities for people of color, HRSA should include behavioral health measures in its analysis of health disparities.²⁸³

ENFORCE AND EXPAND MENTAL HEALTH AND ADDICTION PARITY LAWS

Ensure equal access to mental health, substance use disorder, and medical/surgical benefits

26. Provide the U.S. Department of Labor with authority to assess monetary penalties and increase parity enforcement efforts under existing authority.

Congress passed the [Mental Health Parity and Addiction Equity Act of 2008 \(MHPAEA\)](#) and the Affordable Care Act to require most health plans to cover treatment for mental health and substance use disorders no more restrictively than treatment for physical health conditions. The Parity Act's requirements apply to financial requirements (e.g. copays and deductibles), quantitative treatment limitations, and non-quantitative treatment limitations (NQTLs).

NQTLs include prior authorizations, rate setting methodologies, and other aspects of managing benefits. The U.S. Department of Labor is authorized to investigate and take enforcement action under MHPAEA; however, it does not have the direct authority over plans that are sold to multiple employers and it lacks authority to assess civil monetary penalties.²⁸⁴ President Trump's [Commission on Combating Drug Addiction and the Opioid Crisis](#) made expanding authority to levy fines on insurers and funders a key bipartisan recommendation for addressing the opioid crisis.²⁸⁵ Legislation has been introduced that would extend the department's civil

monetary penalty authority to enforce the [Genetic Information Non-Discrimination Act](#) to the federal parity law.²⁸⁶ Congress giving the Labor Department power to issue civil monetary penalties was also a key recommendation of President Obama's [Parity Task Force](#).²⁸⁷

Plans should also be required to provide more transparency in claims data. The goal of the federal parity law is equitable coverage that increases access to care; data is needed to assess progress toward that goal. New York State recently passed a bipartisan bill mandating bi-annual data reporting from plans that compares areas such as utilization review, denial rates, reimbursement, and provider networks.²⁸⁸ Congress should similarly require the secretaries of Labor and HHS to require plans to publicly report comparative mental health and substance use disorder claims data versus medical claims.

New York State also has recently issued regulations requiring insurance plans to implement a comprehensive parity enforcement program, including designating an appropriate responsible person, having written policies and procedures, developing methodologies for identifying and remedying improper practices, training and education of employees, and other provisions.²⁸⁹ Congress recently passed legislation requiring plans to conduct analyses of their NQTLs and to submit those analyses to states when the secretary of the Labor Department requests them.²⁹⁰ Congress should build on the recent legislation requiring plans to conduct analyses with additional components of a comprehensive parity enforcement program.

HMA estimates that the impact of these proposals on costs is likely to be very low for the federal government because this is enforcement of an existing statute.²⁹¹

27. Ensure mental health and addiction parity in Medicaid and Medicare by expanding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 provisions to all Medicaid fee-for-service and alternate payment and delivery models, Medicare fee-for-service, and Medicare Advantage.

The [2008 parity law](#) and subsequent legislation required coverage of treatment for mental health and substance use disorders to be no more restrictive than treatment for physical health conditions in Medicaid for only some beneficiaries. Specifically, financial requirements and treatment limitations must be equal for these benefits. The 2008 parity law applies to Medicaid beneficiaries receiving services through managed care organizations, CHIP, and alternative benefit plans serving the Medicaid expansion population.²⁹² Under current federal parity rules, once an individual is enrolled in an MCO, their entire benefit package is subject to

parity, including any services delivered through another type of managed care plan or fee-for-service.²⁹³ The 2008 parity law, however, does not apply to Medicaid beneficiaries receiving benefits *only* through fee-for-service or alternative payment models. While the majority of Medicaid beneficiaries are enrolled in managed care, several states either exclude certain populations from managed care or primarily deliver services through fee-for-service. Extending parity requirements to Medicaid beneficiaries served in fee-for-service or alternative payment models would address the current inequity between those beneficiaries and others receiving benefits subject to parity requirements.

The 2008 parity law also does not apply to Medicare beneficiaries served through fee-for-service or stand-alone Medicare Advantage plans, except parity rules apply for Medicare-Medicaid beneficiaries served through special needs plans.²⁹⁴ [The Medicare Improvements for Patients and Providers Act of 2008](#) (MIPPA) improved parity in Medicare fee-for-service and Medicare Advantage, but treatment limitations still exist. MIPPA required equal copayments for outpatient behavioral health and medical/surgical benefits in Medicare fee-for-service,²⁹⁵ but Medicare still has a 190-day lifetime limit on inpatient psychiatric care that does not exist for inpatient medical care.²⁹⁶ Cost-sharing in Medicare Advantage plans must be actuarially equivalent to Medicare fee-for-service, but these plans can still apply specialty copayments for mental health treatment.²⁹⁷

Mental health and addiction parity is central to ensuring fair and equal access to critical services for the, on average, approximately 25% of Medicaid and 20% of Medicare beneficiaries treated for at least one behavioral health condition.²⁹⁸ Currently, the limited application of mental health and addiction parity requirements in Medicaid creates inequities for beneficiaries across the managed care and fee-for-service delivery systems. These two delivery systems have different standards for mental health and substance use treatment access. Beneficiaries served in managed care benefit from a higher standard for equal access to these services, while those served in fee-for-service continue to experience treatment limitations that harm access to these services. Similarly, Medicare beneficiaries are not guaranteed equal access to behavioral health and physical health benefits.

To ensure equal access to behavioral health and physical health benefits for beneficiaries in Medicare fee-for-service, Medicaid fee-for-service, and alternative payment models, Congress should require that the 2008 parity law apply for beneficiaries served through these delivery systems. In doing so, Congress should amend Title XVIII and Title XIX of the Social Security Act to alter discriminatory provisions that result in inferior behavioral health benefits compared to physical health—for example, the 190-day lifetime inpatient psychiatric limit within Medicare.

For Medicaid, states would be required to alter their state plans, if necessary, so that the service package in their state plan complies with the principles of the 2008 parity law. Since the entire benefit package of a Medicaid managed care enrollee is currently subject to parity under federal rules,²⁹⁹ states must already change the benefit package for those beneficiaries to make it parity compliant—either by changing their state plan or changing treatment limitations within the benefit package provided by Medicaid MCOs and altering the capitated rate that MCOs receive to provide a parity-compliant package.³⁰⁰

This will limit the ability of states to discriminate against behavioral health coverage when designing their fee-for-service benefit packages. Given the existing federal rule that the entire benefit package of a managed care enrollee is subject to parity,³⁰¹ states that use a combination of managed care and fee-for-service to deliver benefits to managed care enrollees have some experience applying parity to fee-for-service benefits. This may, however, have an indirect impact on MCOs in states that (1) consider fee-for-service rates and utilization in developing managed care payment rates, (2) carve behavioral health services out into fee-for-service, and (3) serve certain populations exclusively in fee-for-service. To the extent that such states remove restrictions on access to behavioral health services or increase provider rates in fee-for-service, MCOs in those states may have to work with the state to recalculate their payment rates. This proposal to extend parity requirements to Medicaid fee-for-service will also be challenging for those states with large populations served only in fee-for-service. CMS should implement this requirement in close partnership with states and MCOs and should provide ample time for compliance.

To apply the 2008 parity law to Medicare Advantage plans, Congress should amend Title XVIII of the Social Security Act to incorporate requirements for parity. CMS should then release new federal regulations implementing the new parity requirements. CMS should implement this requirement in close partnership with health plans and should provide ample time for plans to comply.

REQUIRE AGENCY COORDINATION

Promote strategic coordination among HHS agencies on behavioral health integration

- 28. Require that CMS, HRSA, and SAMHSA advance the integration of physical and behavioral health services through a strategic plan for greater coordination between the agencies.**

Congress should require CMS, HRSA, and SAMHSA to advance the integration of physical and behavioral health services through a strategic plan for greater coordination between the agencies. This strategic plan should include the establishment of a working group on behavioral health integration with representatives from the respective agencies. CMS should ensure representation from all of its core components, such as CMS' Center for Medicaid and CHIP Services (CMCS), Center for Medicare, Medicare-Medicaid Coordination Office (MMCO), Center for Consumer Information and Insurance Oversight (CCIIO), and other components. To provide whole-person, integrated care to Medicaid beneficiaries, a strategic approach is needed at the federal level. Fragmentation of behavioral health policy and Medicaid policy is a barrier for states interested in improving the integration of physical and behavioral health services. While these entities have demonstrated effective collaboration through joint policy guidance and may participate in various workgroups that touch on behavioral health integration, there is opportunity to build on this success through a federal strategic plan for behavioral health integration. This strategic plan should be publicly available and should detail how CMS, HRSA, and SAMHSA will establish an interagency working group, specifically focused on promoting and advancing behavioral health integration.

This working group may also participate in the proposed HHS effort to work with partners and stakeholders in identifying the core elements and quality measures for integration—ensuring those are seeded throughout programs with follow up, coordinated technical assistance, and financing. To support whole-person care and streamline the delivery of behavioral health services, physical health services, and other social services addressing the health-related social needs of an individual, this working group should also develop recommendations to help states develop collaborative funding models, such as braiding or blending funding from various HHS funding streams into a single funding pool. For example, some state officials have suggested aligning funding cycles, application processes, and reporting requirements across federal grants to help states applying for and implementing those grants.³⁰² The working group should explore similar policy changes that would remove barriers to states braiding or blending federal funding sources. Collaborative funding can strengthen coordination and reduce fragmentation between otherwise siloed programs that serve the same individual.³⁰³ The working group's recommendations should aim to improve the beneficiary experience and remove barriers to accessing physical and behavioral health care, housing, transportation, job skills training, nutrition, and other health-related social needs.



SECTION B: EXPAND AND TRAIN THE INTEGRATED WORKFORCE

- Increase coverage of behavioral health providers in Medicare
- Expand access to the currently available workforce
- Improve training, recruitment, and retention

Successful primary care and behavioral health integration depends on the availability of a sustainable workforce. Approximately, 60%-80% of all primary care visits include a behavioral health component, yet many primary care clinicians report feeling overwhelmed and ill-equipped to meet their patients' behavioral health needs.³⁰⁴ Integration would help create a useful partnership for primary care and behavioral health providers to address patient needs in an efficient and effective manner. Yet, severe shortages in the behavioral health workforce make integration difficult. For example, by 2025 the U.S. will have a shortage of 57,490 psychologists, 48,540 social workers, and 26,930 mental health counselors.³⁰⁵ Importantly, due to COVID-19 and the resulting surge in demand for behavioral health services, current shortage projections likely underestimate the needed supply of behavioral health professionals.

These realities contribute to a lack of appropriately trained clinical staff in integrated primary and behavioral health care settings. Bolstering the currently available primary care and behavioral health workforce, as well as strengthening training opportunities, will help make integration possible.

While some of the workforce proposals below may not directly incentivize integration, they can help ensure an adequate behavioral and primary care workforce is available to deliver integrated care.

INCREASE COVERAGE OF BEHAVIORAL HEALTH PROVIDERS IN MEDICARE

Breaking down federal reimbursement barriers to integration would improve nationwide behavioral health workforce shortages. The COVID-19 pandemic has highlighted the need to increase access to behavioral health services as many people struggle with such issues as financial pressures and social isolation, which may worsen or launch behavioral health conditions.

Increase the pool of behavioral health providers by reducing barriers to reimbursement

- 1. Pass legislation to increase the behavioral health provider types covered under Medicare and require CMS to adopt measures that would facilitate behavioral health provider placement in integrated care settings.**

Nationally, more than 50% of counties do not have a licensed behavioral health provider.³⁰⁶ Some communities are disproportionately impacted by the shortage. Indeed, 60% of rural Americans live in mental health shortage areas.³⁰⁷ Compounding this, some areas that have an adequate supply of behavioral health providers often lack providers who accept insurance, which creates an economic barrier for patients. Moreover, behavioral health and primary care integration cannot fully succeed without enough professionals who are trained to practice in integrated care settings. To shore up the behavioral health workforce, Congress should pass legislation that would increase the behavioral health provider types covered under Medicare. This policy change would expand the pool of available providers that can get reimbursed for providing behavioral health services and dissolve some federal reimbursement barriers to integration.

One provider type that should be considered for coverage under Medicare is peer support specialists. Peer support staff are certified and trained at the state level and can be an asset to integrated care teams. These professionals use their lived experience and training to help patients navigate care systems and sustain recovery, especially in patients with severe mental health conditions or substance use disorders. Evidence suggests that peer support services benefit staff as well, helping them to feel a greater sense of connectedness to the behavioral health care system.³⁰⁸ Recognizing these benefits among others, some payers already cover peer support services. As

of 2019, 37 states cover peer support services through Medicaid. CMS has also clarified that the service can be covered under Medicare Advantage as a part of non-opioid pain management.^{309,310}

Peer support staff have proven to be a valuable tool for providers in improving patient-provider relationships and promoting shared decision making with respect to medications and treatment plans.³¹¹ In addition, adding peer support staff offers an opportunity to diversify the workforce to better reflect communities served by the primary care practices. Additional providers who should be considered for Medicare reimbursement include licensed professional counselors and licensed mental health counselors. To further facilitate integration, CMS should adopt measures that would facilitate provider placement in integrated care settings.

2. Allow licensed social workers to bill Medicare for chronic care management services.

Currently, CMS does not include licensed master-level social workers in the list of Medicare-covered providers approved to bill for chronic care management services. These professionals often perform integral duties associated with quality chronic care management, including case management and administrative services. However, their inability to bill for chronic care management services makes insufficient use of their skills in integrated care settings. To mitigate licensed social workers underutilization in integrated care settings, CMS should allow these professionals to bill Medicare for chronic care management services. While these licensed providers do not perform clinical services, they can be an asset to an integrated care team. Licensed nonclinical social workers are appropriately trained to deliver chronic care management services. Including nonclinical social workers as a Medicare-covered provider could help optimize the currently available workforce and create flexibility in the integrated care staffing model. Some experts argue this change could also allow licensed clinical social workers on integrated care teams to dedicate more of their clinical training to psychotherapy services. Allowing licensed social workers to bill Medicare for chronic care management services would require \$113 million in direct federal spending over 10 years, according to HMA's analysis.³¹²

EXPAND ACCESS TO THE CURRENTLY AVAILABLE WORKFORCE

Integrated care settings have not been able to optimize the currently available workforce, which can ultimately impact patient care. For example, some primary care practices are financially unable to hire a full or part-time psychiatrist to manage complex behavioral health needs, or even to attain psychiatric consultation services. As a result, patients may not receive appropriate care. Additionally, state scope of practice and licensure laws can limit the qualified workforce available.

Decrease barriers to providing integrated, team-based care

3. **Appropriate more funding to HRSA for statewide primary care-to-psychiatric consultation services.**

Many primary care clinicians report feeling ill-equipped to handle their patients' behavioral and substance use needs, especially in patients with complex behavioral health conditions. Indeed, a 2019 [study](#) by the University of Michigan's Behavioral Health Workforce Research Center found that 61% of primary care clinicians have little to no confidence in treating patients with serious mental illnesses.³¹³

Psychiatric consultations are essential in providing primary care clinicians with the guidance they need to effectively manage some behavioral health conditions. Consultation services allow integrated care teams to access psychiatric services without necessitating an on-site psychiatric provider. These consultations can help fill knowledge gaps in primary care learning and improve care through real-time training. The CoCM already embeds regular psychiatric consultations in its workflow, and this has been shown to improve patient outcomes and reduce health care costs. Importantly, this policy solution has received widespread support from key stakeholders that represent primary care providers.

[The Massachusetts Child Psychiatry Access Project](#) (MCPAP) for Moms is a model for grantees looking to establish regional psychiatric consultation services. In this model, full-time perinatal psychiatrists are accessible to primary care providers who need assistance in managing their patients' mental health and substance use care. This program relies on state and federal funding and is an extension of a HRSA and state-funded program focused on psychiatric consultation for children's behavioral health issues. For the maternal health program, HRSA currently provides seven states with approximately \$600,000 per year for five years, but this modest amount must support robust program operations and a required evaluation

component. Since MCPAP for Moms is a regional program, larger states face more severe funding issues. Noting this deficiency in current funding, Congress should appropriate more dollars for HRSA grant-funded statewide primary care-to-psychiatric consultation services to make these services more widely available in all primary care settings.

4. Update practitioner licensing agreements to enable providers licensed in one state to practice in another when state licensure requirements have been waived.

To address complex patient needs, primary care providers in integrated care settings should have the ability to readily connect with providers including those who specialize in substance use disorder treatment. Provider-to-provider telehealth services, including eConsult or virtual video consultations, are often used to access such specialty care, particularly in areas with severe workforce shortages. However, the cost and administrative burden associated with obtaining a medical license to practice in each state in which providers wish to practice often deters the currently available workforce from practicing in multiple states.

The current pandemic has raised awareness about the longstanding need for greater access to behavioral health services as health care providers have sought to help address provider shortages in areas of the country that have been hit particularly hard by the virus. Recognizing this burden, the National Governors Association and the Federation of State Medical Boards have provided resources to help outline options available to governors to increase workforce capacity.³¹⁴ In response to COVID-19, almost all states have taken at least some steps to address licensure and reciprocity.³¹⁵ Notably, a majority of states have temporarily suspended the requirement that out-of-state Medicare, Medicaid, and CHIP providers be licensed in the state where they provide services when they are licensed in another state. To address the continued need for provider flexibility and remove federal barriers to meeting workforce demands, CMS should permanently eliminate the out-of-state provider licensure requirement and defer to state licensure requirements.

Congress should also direct the HHS secretary to convene a working group representing state health profession licensure boards—including the Federation of State Medical Boards, National Council of State Boards of Nursing, the National Association of Boards of Pharmacy, patient advocacy groups, and other health professions—to identify federal and state barriers to participation in state medical licensure compacts and develop a framework or model application for reciprocity to facilitate provider approval to practice across state lines. States that participate in compacts and use the framework or model application for reciprocity would receive federal funding to assist in background checks.

Several issues have limited the ability of states and providers to address reciprocity, including the need to conduct criminal background checks. While some states have the resources to conduct background checks, others must rely on the Federal Bureau of Investigation to provide needed information. In some practice areas, providers are not licensed but are granted the right to practice. This has led to confusion and delays in reimbursement, particularly in the Medicaid program. Convening a working group to identify other barriers and to identify solutions could help facilitate reciprocity while preserving the historical role of states in governing health care providers.

IMPROVE TRAINING, RECRUITMENT, AND RETENTION

Despite an increasing focus on holistic patient wellbeing and the dedication of providers to high-quality health care, many providers are unprepared to deliver integrated care, and differences in provider training, culture, and perceptions about the relationship between physical and behavioral health can create additional barriers to integration. Further evaluation of medical education and provider training programs is needed to better prepare providers to work in collaborative, patient-centered care teams and meet the needs of diverse populations. This research must be thorough and well-designed to ascertain the long-term impacts of different training models on providers, patients, and communities with clearly defined goals of improving the delivery of integrated care and services for the most vulnerable.

In addition to the benefits for patients, fully-integrated, team-based care may help prevent burnout for both primary care and behavioral health providers³¹⁶ and improve quality of care and retention. Reevaluation of training programs should also consider the financial and educational barriers to achieving a diverse workforce. This should include funding mechanisms for graduate medical education and the effect of these investments on the supply of various types of providers. These barriers currently perpetuate disparities in access and quality of care. Training initiatives can help bridge the gap and improve the skills of the available workforce but will not meet the national need for more behavioral health and primary care providers alone. In conjunction with parity, reimbursement, and educational reforms, adequate training will enable providers to address the increased demand for mental health and substance use disorder services.

Accelerate integration by increasing access to prerequisite training for the current workforce

5. Provide technical assistance to provider practices for integrating behavioral health and primary care services.

Technical assistance (TA) is critical to aiding primary care practices in successfully implementing integrated models of care, as practice transformation requires significant time, expertise, and upfront investment. These barriers are especially prohibitive for smaller, independent practices and contribute to widening disparities in quality of care in areas where practices are already under-resourced.

TA can include assistance with individual and organizational training, billing and financing, and implementation of EHR technology. Primary care practices vary greatly in structure, workflow, and administration. TA consultation services help practices identify and successfully implement an appropriate evidence-based integrated care model based on their unique needs and capabilities. In addition, TA training programs can assist providers and practices in achieving [core competencies](#) needed to provide integrated care³¹⁷ and help address factors that improve behavioral health equity and reduce disparities, including cultural responsiveness from providers, effective communication with patients, and appropriate diagnosis and level of care.³¹⁸ Under the State Innovation Models Initiative, Massachusetts reported overall compliance with behavioral health integration milestones increased to 93% when participating providers that were struggling to achieve transformation received practice-specific TA in addition to other resources.³¹⁹ Clinical practices could take advantage of TA for integration provided through the following two options:

- **Provide appropriate funding for the Primary Care Extension Program.**

The ACA authorized the Agency for Healthcare Research and Quality (AHRQ) to establish a national [Primary Care Extension Program](#) (PCEP) to support primary care practice transformation through the deployment of community-based Health Extension Agents. While the ACA authorized \$120 million annually for PCEP for fiscal years 2011 and 2012, Congress never appropriated the funding. Instead, AHRQ utilized existing funds to implement a pilot PCEP program from 2011 to 2013—the Infrastructure for Maintaining Primary Care Transformation—to demonstrate the efficacy of a national primary care health extension program. Agents educate primary care providers about behavioral health, health promotion, and chronic disease management; assist with implementing patient centered medical homes and other evidence-based practice improvements; and work with local health authorities and community organizations to improve population health, strengthen local

primary care workforces, and address health disparities.

Through the pilot program, four states received grants for quality improvement and practice transformation and worked with three to four partner states to share successful infrastructure models. This pilot and other initiatives have helped develop an evidence base of PCEP's potential for primary care providers. For example, in Oklahoma, the PCEP pilot helped identify significantly high rates of suicide in Washington County and through the quality improvement process, brought in experts in depression management in primary care, resulting in the implementation of depression screening programs in almost all clinical practices in the county.³²⁰

Funding the PCEP, with an enhanced focus on behavioral health and a variety of integrated care models, would help provide primary care practices with the TA necessary to integrate behavioral health care and establish a network of trusted, culturally competent facilitators to engage practices in transformation. HMA estimates that funding the PCEP would cost the federal government \$1.1 billion over 10 years.³²¹

- **Establish grant funding for technical assistance for implementation and ongoing delivery of integrated care.**

To supplement the financial investment required for practice transformation and encourage uptake of evidence-based integrated care models, Congress should establish new grant funding to cover costs for primary care practices to seek TA from health technology and practice management companies in the private sector. Though the cost and financial implications of integration vary depending on the practice model adopted, covered services would include training for all levels of staff involved in transformation, financing, and use of EHR technology. Following the transition to an integrated care model, practices could seek additional grant funding to cover ongoing assistance with carrying out new services, such as care coordination, case-based billing assistance, and privacy compliance training. Grant funding would offer flexibility to practices seeking assistance from the vendor of their choice and utilize funds based on their practice-specific needs, without some of the costs of administering TA directly.

Improve integrated care education for new primary care and behavioral health providers

- 6. Expand financial support for continuing education programs that prepare providers to work in integrated settings, meet the needs of diverse and underserved populations, and improve health disparities.**

Due to the intensive and specialized nature of many medical and behavioral health care education programs, providers—including physicians, nurses, social workers, and others—often enter the workforce with limited experience working in integrated care teams, insufficient understanding of the [core competencies](#) needed to deliver integrated care, and inadequate training on responding to health disparities.

Post-degree training programs can play a critical role in advancing primary care providers' knowledge of behavioral health, preparing behavioral health providers to work in primary care settings, and strengthening understanding of and responsiveness to the unique needs of diverse populations across the health care system. Continuing education programs can often be completed online, allowing both new graduates and experienced providers to participate in the workforce while expanding their skillset. For example, the Project ECHO (Extension for Community Healthcare Outcomes) model brings providers together virtually for case-based peer learning and expert-led seminars on a wide array of topics.

Other education programs, such as behavioral health training for medical interpreters and other translators can help providers and insurers overcome language barriers in the delivery of integrated care—an important contributor to disparities in access to services and health outcomes. Congress should provide funding to expand post-degree training opportunities by growing existing programs or developing new training opportunities, such as certifications for community health workers and peer support specialists with advanced knowledge of best practices for addressing health disparities or peer learning groups coordinated through technical assistance programs. At the same time, additional research should be conducted to identify programs that most effectively train providers to address these issues, improve current training models and programs that engage providers from underserved backgrounds in these efforts, and develop innovative models that systemically incorporate cultural competency throughout training, such as those supported in the proposed [Black Maternal Health Momnibus Act of 2021](#).

Expand and diversify the behavioral health workforce

7. Increase financial support for programs that recruit diverse students into primary care and behavioral health professions and improve access to and affordability of health care education.

Along with other initiatives, improving the diversity of the health care workforce can increase access to and quality of health care for vulnerable populations and decrease health care disparities.³²² Programs that recruit from diverse communities and support students through their education are integral to these efforts.

Congress should provide additional support for public-private collaborations that can be leveraged to improve diversity in the health care workforce. Options for exploration and possible consideration include grant funding to support partnerships between medical schools and local organizations to create a pipeline for the recruitment of students from underserved or underrepresented populations and internship programs that enhance recruitment of students from institutions with successful records of supporting underrepresented populations, such as Historically Black Colleges and Universities.

In addition, increased funding for programs that improve the affordability of health care education, such as the National Health Service Corps (NHSC) scholarship and Loan Repayment Programs (LRP) can be utilized to reduce financial barriers for aspiring health care providers. The NHSC Federal LRP provides loan repayment assistance to primary care clinicians in exchange for service in underserved areas, including licensed behavioral health clinicians such as child and adolescent psychologists, licensed clinical social workers, and nurse practitioners in behavioral health specialties. However, behavioral health care professions are currently excluded from NHSC scholarships and should be added to the list of eligible provider types. The NHSC is measured by funding, recruitment, and field strength, which includes only providers actively serving their commitment in a given year as scholarship recipients are still completing their training.

As of April 2018, HRSA reported that, though the number of clinicians recruited through these programs had increased in recent years, applications for awards exceeded available funding and there were 4,605 open NHSC positions that could not be filled because the NHSC field strength was insufficient to meet the needs of sites eligible to receive an NHSC provider—a reflection of both the NHSC appropriation and the balance of loan repayment and scholarship awardees.³²³ Mandatory funding for NHSC has remained at \$310 million annually since 2015, with a discretionary addition of \$120 million in 2020 aimed, however, primarily at addressing opioid and substance use disorders. Increasing funding for LRPs and expanding scholarship eligibility would also improve the debt-to-income ratio of behavioral health providers, incentivize service in Health Professional Shortage Areas, and help health plans meet network adequacy standards by increasing the pipeline of available providers.



SECTION C: PROMOTE TECHNOLOGY AND TELEHEALTH TO SUPPORT INTEGRATED CARE

- Optimize health information technology for behavioral health care
- Expand telehealth access

Technology once served to support health care delivery but has increasingly become a driving force in disease diagnosis and treatment. Electronic health records (EHR), smartphone applications, and telehealth can simplify behavioral health integration and offer targeted care for patients in need of enhanced services. Few behavioral health providers have benefited from the full potential of a technology-supported practice because of marginal EHR uptake. Telehealth, however, is well-established in behavioral health settings, particularly outside of Medicare. Indeed, 34% of telehealth services across payers were for mental health conditions in June 2019.³²⁴ During the COVID-19 public health emergency, the most common use of telehealth services was for mental health conditions, accounting for 44% of all telehealth encounters. Musculoskeletal conditions were the second most common at a distant 4%.³²⁵

Still, many barriers exist to the use of health technology. For example, some rural parts of the country lack broadband access and the high-speed internet technology necessary for telehealth and health IT. Approximately one-quarter

of rural Americans and one-third of those living on tribal lands lack broadband access, compared to 1.7% of urban Americans.³²⁶

The Federal Communications Commission has emphasized the need to increase broadband access in rural communities and provide eligible health care providers with funding for telecommunications and broadband services.³²⁷ The cost of doing so, however, is significant. In 2017, the FCC estimated the cost of expanding broadband to 98% of Americans would be \$40 billion; it would cost an additional \$40 billion to reach the final 2%.³²⁸ The FCC's Rural Health Care Program made \$800 million available in FY 2020, representing the highest amount of funding in the program's history.³²⁹ In September 2020, the FCC, HHS, and the U.S. Department of Agriculture announced a joint effort to address broadband access disparities.³³⁰ This interagency Rural Telehealth Initiative is tasked with streamlining information sharing and removing barriers to collaboration across the multiple programs administered by the agencies.

For all the advantages of technology, the potential to exacerbate health disparities is significant. Many patients face barriers to using technology, including a lack of access to technological devices, digital literacy, and reliable internet coverage. These barriers disproportionately affect older individuals, persons of color, and those of lower socioeconomic status.³³¹ More than one in three U.S. households headed by a person age 65 or older does not have a desktop or laptop computer and fewer than half have a smartphone device.³³² Even with access to a computer, 52 million Americans do not know how to use it properly.³³³ Despite some progress, legislative and regulatory barriers preventing the use of all currently available technology should be addressed.

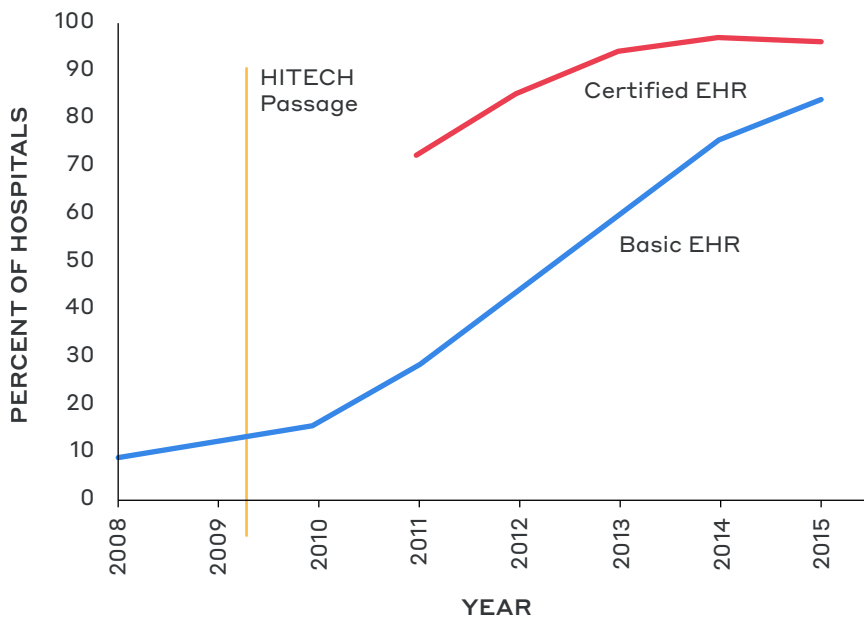
OPTIMIZE HEALTH INFORMATION TECHNOLOGY FOR BEHAVIORAL HEALTH CARE

Behavioral health integration depends on the use of health IT to provide the secure transfer of information to and from primary care settings and support a seamless transition of care across settings.

While patient medical health information is primarily shared using health IT meeting interoperability standards, behavioral health settings often lack the EHR capabilities of more robust systems. The absence of financial incentives may have influenced behavioral health providers, leading them to purchase less expensive platforms lacking the functionality necessary for sufficient integration and interoperability. As a result, EHRs are not optimized for rapid documentation of behavioral health history, nor do they support access to relevant history across settings.

Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act, as part of the [American Recovery and Reinvestment Act of 2009](#), and authorized \$27 billion to increase the utilization of EHRs.³³⁴ The act also introduced meaningful use requirements and spurred the creation of standards for HHS-certified EHRs but excluded behavioral health from HITECH’s health technology incentives.³³⁵ At the time of its signing, only 12% of hospitals and 48% of office-based physicians utilized EHRs.³³⁶ As of 2017, 97% of nonfederal hospitals and 80% of outpatient physicians were utilizing certified EHR technology (CEHRT).³³⁷ Larger hospitals and health systems are now highly reliant on robust EHR platforms and have significantly altered how they deliver care.

Figure 6: Percentage of Nonfederal Acute Care Hospitals with Adoption of EHR, 2008-2015



Notes: EHR is electronic health record. Basic EHR adoption Requires the EHR System to have a set of EHR functions which would include items such as electronically collecting data on patient demographics, discharge summaries, medication lists, and viewing various lab or diagnostic results. Certified EHR is EHR technology that meets the technological capability, functionality, and security requirements adopted by the U.S. Department of Health and Human Services. Only includes non-federally owned acute care hospitals. Source: Henry 2016

Available at: <https://www.macpac.gov/wp-content/uploads/2020/12/Integrating-Clinical-Care-through-Greater-Use-of-Electronic-Health-Records-by-Behavioral-Health-Providers.pdf>.

Meaningful use may have been the impetus for EHR adoption, but medical providers also benefited from new billing functionalities, which ensure adequate documentation and justification of service components. However, many medical EHR systems have been less effective for recording nonmedical information and do not offer sufficient benefit for behavioral health practices to justify the cost. In addition to the inadequate documentation capabilities, the

lack of financial incentives may have also played a role in the limited uptake of EHRs. Ultimately, behavioral health providers have been slow to embrace them, which has created significant barriers to integration and interoperability.

EHRs are the primary means of recording and sharing patient health data. This information is necessary to improve quality and ensure continuity of care. HHS' Office of the National Coordinator for Health Information Technology (ONC) directs the administration's EHR efforts. ONC supports the adoption of health IT throughout the health care system and promotes nationwide health information exchange.³³⁸ As health IT has broadened to include electronic access through online patient portals and mobile applications, ONC has expanded its focus beyond EHRs. The [ONC 21st Century Cures Act Final Rule](#) became final in May 2020 and includes provisions to simplify patient access to medical records and improve the exchange of information between EHR platforms.³³⁹

Interoperability across health IT platforms depends on both system accessibility and also a common language for sharing data. ONC has taken steps to ensure all systems have the capacity to share information by releasing application programming interface (API) certification standards. However, there is continued variability of programming languages across health IT systems, most notably in behavioral health settings.

Integrated care requires the capacity to support a seamless transition of care across settings. While patient information is primarily shared using health IT, behavioral health settings often lack the EHR capabilities of more robust systems. The absence of financial incentives may have influenced behavioral health providers, leading them to purchase less expensive platforms lacking the functionality necessary for sufficient integration and interoperability. As a result, EHRs were not optimized for rapid documentation of behavioral health history, nor do they support access to relevant history across settings. Behavioral health integration will not only depend on behavioral health provider adoption of EHRs, but also on the availability of technology that meets interoperability standards and supports the secure transition of information to and from primary care settings.

Enable greater integration by increasing the utilization of EHRs among behavioral health providers

1. Provide targeted funding to support health information technology adoption and utilization by behavioral health clinicians.

The exclusion of behavioral health providers from HITECH has led many to settle into a workflow absent of technology, with insufficient funding and little incentive to change. Based on the rapid adoption of EHRs initiated by HITECH, targeted funding for behavioral health providers could increase EHR utilization and expand the integrated care workforce.

In 2018, Congress authorized CMMI to offer incentives to behavioral health providers for health IT use under Sec. 6001 of the SUPPORT Act.³⁴⁰ The bipartisan CARRA 2.0 Act further authorized additional funding for Section 6001.³⁴¹ Nevertheless, CMMI has not yet developed a pilot to implement the provision.

According to a [Health Affairs](#) research article, the average cost of EHR implementation is approximately \$46,000 per primary care physician, and ongoing annual expenses are just over \$17,000.³⁴² The cost of this investment can overwhelm behavioral health practices, which tend to have comparatively fewer providers and a lower volume of patients. Moreover, the Behavioral Health IT Coalition estimates the cost of enterprise-level EHR adoption by community mental health centers, CCBHCs, inpatient psychiatric hospitals, and residential substance use disorder treatment facilities to be nearly \$2 billion over five years.³⁴³ A CMMI demonstration targeting grants to the providers most able to integrate care would require a smaller federal investment. For example, the coalition estimates the cost of basic EHR adoption by all psychologists and clinical social workers to be \$827 million over 10 years.³⁴⁴

Congress should direct CMMI to create a targeted funding structure to assist behavioral health providers with startup costs, maintenance, and training for health IT in behavioral health settings. Demonstration participants should be required to integrate behavioral health and primary care services and meet ONC certification and interoperability standards, including the universal Fast Healthcare Interoperability Resource API standards that enable data-sharing between all platforms. Grants should also support the use of lower cost, cloud-based EHRs and direct API sharing tools.

2. Require inclusion of common behavioral health terminology in EHRs.

Current EHRs do not support rapid documentation of behavioral health history or access to relevant social and medical history. Inclusion of universal behavioral health and social determinants of health terminology in coding standards is necessary to simplify documentation. The International Statistical Classification of Diseases and Related Health Problems does not mirror the language used in the Diagnostic and Statistical Manual of Mental Disorders. The secretary of HHS should direct CMS or SAMHSA to provide crosswalks for these sources to improve EHR performance for behavioral health providers.

3. Require Certified EHR Technology to include clinical decision support tools for behavioral health screening.

ONC defines the standards for certification of EHR platforms, ensuring a minimum functionality for recording and sharing patient information. Most CMS and CMMI payment models require the use of CEHRT, but behavioral

health guidelines have not been sufficiently represented. Clinical decision support tools can be utilized for behavioral health screening by providing screening reminders, offering recommendations for next steps based on screening scores, and tracking follow-up.³⁴⁵ The secretary of HHS should add clinical decision support functionality to the EHR certification standards and require its inclusion in basic platforms at no additional charge to the consumer.

Leverage mobile health for patient engagement within integrated care settings

4. Include mobile health technology when assessing interoperability in the Medicare Quality Payment Program.

CMS should recognize apps that enable access to or data sharing with EHRs under the Promoting Interoperability category of the Quality Payment Program. These activities should be progressively valued, through category bonus points, final score bonus points, and, ultimately, be a minimum requirement for reporting under the Promoting Interoperability category. HHS should also require ACOs, MA plans, Medicaid MCOs, and others providing integrated behavioral health care to report on measures that capture mobile health and EHR interoperability.

The use of mobile technology can both improve the patient experience and simplify access to patient data. Providers can utilize third-party behavioral health apps to produce actionable information about patients. For example, providers regularly employ remote patient monitoring to offer additional data and this qualifies as an Improvement Activity for the CMS Quality Payment Program.

According to a 2019 HealthMine survey of 800 Medicare Advantage patients, 18% of respondents are using a smart device to augment health care.³⁴⁶ However, only 9% of those using mobile health reported that their health plan was incorporating the data into their medical record.³⁴⁷ To encourage the incorporation of mobile health data within integrated care models, the use of behavioral health products that support information sharing with EHRs should be similarly leveraged. In addition, applications offering direct patient access to EHRs without the need of a desktop computer should also be encouraged.

5. Direct an independent third-party to evaluate mobile health product effectiveness in real-world settings.

The [American Psychiatric Association](#) has developed a method for assessing patient-specific appropriateness of various applications.³⁴⁸ However, the true value of mobile health products on patient outcomes is unclear. Because the Food and Drug Administration has exercised its discretion to not monitor

claims of effectiveness for third-party behavioral health apps, Congress should require an independent third-party review of applications to ensure claims of effectiveness are legitimate. The evaluation should be performed in real-world patient settings and define a minimum standard for claims of effectiveness. The information can then inform the development of clinical practice guidelines for use.

EXPAND TELEHEALTH ACCESS

Telehealth, or telemedicine, broadly describes technology-supported health care services that augment face-to-face care. It is a tool for increasing patient access to clinicians, providing diagnostic data to distantly located providers, and assisting in the management of one's own health. Innovative technologies, such as remote patient monitoring instruments and mobile health applications, sometimes referred to as mobile health, provide additional resources to support patient-centered care for a variety of health issues.

[The Balanced Budget Act of 1997](#) first introduced telehealth to the Medicare program by authorizing coverage of professional consultations via telecommunications services between a provider located in a rural health professional shortage area and another off-site physician.³⁴⁹ The [Benefits Improvement and Protection Act of 2000](#) further described a Medicare telehealth service as a live, two-way video interaction between a beneficiary located in a certain type of health care facility and a provider at a distant site.³⁵⁰ Despite additions to the list of originating sites, statutorily-defined telehealth services have largely remained unchanged.

The Medicare definition of telehealth services continues to be far more restrictive than the broader range of technology-assisted services available outside the program. In response, CMS has gradually recognized additional communication technology-based services and, in 2019, began covering remote patient monitoring, certain telephone calls, and review of photographs sent by patients by text message and email.³⁵¹

During the COVID-19 emergency, Medicare broadly expanded telehealth services beyond traditional face-to-face video visits.³⁵² The flexibilities created new opportunities for patients and providers to utilize and become accustomed to telehealth as an acceptable modality for care delivery. CMS data show telehealth accounted for 60% of Medicare fee-for-service behavioral health visits during the first months of the pandemic.³⁵³ Indeed, telehealth has now established itself as part of modern health care delivery.

Address barriers to technology-assisted communication as a component of behavioral health integration

6. Expand patient data privacy protections for behavioral health and wellness applications.

Telehealth and mobile health applications can be employed to support patient-centered care delivery and offer regular touch points for behavioral health care. In addition to expanding access to care, digital health applications actively engage and empower individuals to self-manage their health. However, patient data security and privacy concerns continue to rise with the increased use of innovative technologies in health care.

Federal privacy laws and compliance with the [Health Insurance Portability and Accountability Act \(HIPAA\)](#) apply only to medical data and to mobile health applications used in connection with a health care provider.³⁵⁴ HIPAA does not regulate patient-selected wellness apps or the nonmedical information collected, such as activity, sleep, and behavioral health data.³⁵⁵ Moreover, privacy policies and permissions are often difficult for users to locate and understand. As a result, the use of these apps has created uncertainty regarding how nonmedical personal data are used and shared.³⁵⁶

Congress should require all data collected by behavioral health and other wellness apps to be subject to privacy protections under HIPAA. In addition, privacy policies and permissions must be easy to locate and clearly warn users when data leaves the protections of HIPAA. Individuals should also have the ability to select which information may be shared.

7. Evaluate telehealth utilization to ensure health equity.

Congress and the secretary of HHS enabled and encouraged the use of telehealth services to maintain access to care during the COVID-19 emergency.³⁵⁷ However, a recent [study](#) published in *The Journal of the American Medical Association* highlighted access disparities for telehealth during the pandemic. Researchers found that 41.4% of Medicare beneficiaries lacked access to a desktop or laptop computer with a high-speed internet connection at home and 40.9% lacked a smartphone with a wireless data plan.³⁵⁸ When compared to younger and white patients, older and Black patients are much less likely to communicate with a provider through a patient portal.³⁵⁹

A 2019 Pew Research [study](#) also found income, education, race, and ethnic disparities between those using traditional broadband internet and smartphone internet access. Half of those without traditional broadband internet state cost as the reason; one-third cite the cost of a computer.³⁶⁰ Approximately one-quarter of Blacks and Hispanics do not have traditional high-speed internet access and rely solely on their smartphones.³⁶¹ These

findings highlight the ongoing need for telehealth services beyond what is traditionally reimbursed under Medicare.

Audio-only and asynchronous services enable those without computers or sufficient wireless data to use telephones and text messaging for connecting with health providers. These services may engage patients who might otherwise forgo care. CMS should review the telehealth utilization data arising from the COVID-19 flexibilities for variation across beneficiary populations to determine whether audio-only services increased access for those in certain racial, economic, educational, geographic, and other groups.

8. Remove site of service, geographic, and established patient restrictions for telehealth services.

Outside of the public health emergency, telehealth services are restricted to certain geographic and clinical settings. Beneficiaries must live in a rural area and have an initial face-to-face visit with the distant-site provider. Once a relationship has been established, periodic in-person visits are also required. With few exceptions, patients must be located in a clinical setting and may not receive care from their homes. In addition, the distant provider cannot be located in a rural health clinic or FQHC.

Telehealth was initially meant to expand access in rural settings by linking patients to providers in urban hubs. However, the pandemic has demonstrated the appetite for telehealth to expand access to services in urban settings, as well. In fact, telehealth accounted for 9.16% of health care claims in urban settings in May 2020, a dramatic increase from 0.16% one year earlier.³⁶² In comparison, only 4.89% of total rural health claims were for telehealth during that same period.³⁶³

Congress and the Trump administration introduced flexibilities to expand coverage of telehealth services for the duration of the COVID-19 pandemic, allowing beneficiaries to safely receive care. The March 2020 funding bill included provisions lifting telehealth geographic, site of service, and video requirements for all patients.^{364,365} The CMS administrator announced nearly 1.7 million Medicare beneficiaries had received telehealth in the last week of April.³⁶⁶ This is a significant increase from the weekly average of 13,000 beneficiaries receiving these services before the pandemic. However, the temporary flexibilities expanding the eligible sites of service will disappear at the end of the public health emergency unless policymakers extend them.

The [SUPPORT for Patients and Communities Act](#) and the [Consolidated Appropriations Act of 2021](#) removed geographic restrictions and added the patient's home to the list of originating sites for individuals with mental health and substance use disorder diagnoses.^{367,368} However, providers must have billed for a face-to-face encounter with the patient within six months

of the first telehealth service. This remains an obstacle for patients initiating treatment with nonlocal behavioral health providers. The face-to-face requirement should exclude behavioral health services offered as part of an integrated care model, provided the primary care clinician with whom a patient has an established relationship has documented seeing the patient within the previous 90 days. This conforms to the Medicare home health services' face-to-face requirement established through the ACA.³⁶⁹

The 117th Congress has already introduced multiple pieces of legislation to extend telehealth flexibilities. The bipartisan [Protecting Access to Post-COVID-19 Telehealth Act of 2021 \(H.R. 366\)](#) would permanently add FQHCs and rural health clinics to the list of distant provider sites, eliminate geographic restrictions through December 2021, and add the patient's home to the list of originating sites beginning January 2022.³⁷⁰ The bill would also require the secretary to examine the utilization patterns and impact of telehealth during the COVID-19 public health emergency.³⁷¹

The costs associated with widespread telehealth expansion are significant. HMA estimates permanent elimination of geographic, site of service, and established patient restrictions solely for behavioral health services would cost \$145 million over 10 years,³⁷² while the [CBO](#) estimates full extension of all flexibilities introduced during the pandemic through 2022 would cost \$490 million.³⁷³ The CBO estimate does not account for any substitution of in-person visits, reduction of avoidable hospitalizations, or unnecessary emergency services when estimating costs. Congress should consider the potential for downstream savings and pass legislation to make permanent the telehealth flexibilities that Congress and HHS introduced during the pandemic.

9. Eliminate the two-way video requirement for telehealth services.

Congress should remove the telehealth video requirement to address the digital divide and access disparities for those without broadband or video technology.

Medicare telehealth services are defined in statute and, outside of the health emergency, payment is limited to live, two-way video. However, according to a recent [JAMA study](#), a sampling of Medicare beneficiaries found 38% of elderly adults were not ready to participate in telehealth visits because of unfamiliarity with technology and physical or cognitive difficulties.³⁷⁴

Early [Medicare claims data](#) showed one-third of the 9 million Medicare beneficiaries who received telehealth services during the first three months of the pandemic did so using audio-only technology.³⁷⁵ While claims showed even distribution of services across age groups, CMS did not stratify audio-only services by age or level of engagement among those with behavioral health conditions.

Although they do not meet the video criteria for Medicare telehealth services, virtual check-ins have successfully enabled patients and providers to communicate with audio-only communication using the telephone. Virtual check-ins are short, 5-10-minute, patient-initiated, electronic communications with a provider for determining the need for an in-person visit. They are not reimbursed if the patient was seen in-person in the prior seven days or in the 24 hours following the call.

BPC has previously [recommended](#) extending the length of virtual visits to enable full-length audio-only visits. In December 2020, CMS released the [2021 Medicare Physician Fee Schedule Final Rule](#), extending virtual visits on a temporary basis for 2021.³⁷⁶ This created an alternative to telehealth services for providing audio-only visits beyond the pandemic. However, virtual check-ins are reimbursed up to a maximum of 20 minutes and at significantly lower rates than telehealth visits.

Congress has expanded telehealth within certain alternative payment models and for certain conditions, such as end-stage renal disease, cancer, and substance use disorder, but video requirements remain problematic for many Medicare beneficiaries. Senators Angus King (I-ME) and Todd Young (R-IN) introduced the [Mental and Behavioral Health Connectivity Act \(S. 3999\)](#) in the 116th Congress to permanently remove the two-way video requirement for telehealth and allow additional forms of audio-only electronic communication when broadband access or video technology is unavailable.³⁷⁷ However, this broader action to address the digital divide was not signed into law.

Although elimination of the video requirement would have broad applicability, HMA estimates behavioral health services provided through audio-only visits would cost Medicare \$66 million over 10 years.³⁷⁸



Conclusion

The BPC Behavioral Health Integration Task Force urges the Biden administration and the 117th Congress to carefully consider the task force's recommendations.

The barriers to primary and behavioral health care integration are significant. As the COVID-19 pandemic has exacerbated behavioral health issues in our nation, so has it highlighted the problems inherent in our health care delivery system that make it difficult to respond. The time has come to remove barriers to integration to tackle the health care issues that have existed and been exacerbated by COVID-19.

Appendix A: Recommendations for Payment Structures

Payment Structure	Description	Entity Responsible	Applicable Programs
An 1115 waiver opportunity or new grant program to support state capacity building for integrating behavioral health in Medicaid	<p>1115 waiver: CMS should create a new 1115 waiver opportunity that encourages states to move provider practices toward integrated care through a value-based payment approach with incentives for providers that meet benchmarks for integrated care. This would allow federal match for designated state health program expenditures, if certain accountability and transparency requirements are met.</p> <p>Grant program: Congress should also consider establishing a grant to states to support capacity building for behavioral health integration, particularly to help small independent practices integrate care.</p>	<p>1115 waiver: Centers for Medicare & Medicaid Services</p> <p>Grant program: Congress</p>	Medicaid
Financial incentives for high-performing ACOs	CMS should provide additional incentives to ACOs exceeding the minimal MSSP quality performance standards for behavioral health integration. The secretary of HHS should raise the shared savings cap by 5% and extend one-sided risk for ACOs implementing enhanced integration with improved clinical outcomes and higher performance benchmarks.	Centers for Medicare & Medicaid Services	Medicare Shared Savings Program
Integrated Health Model	CMS should offer the Integrated Health Model as a voluntary option for primary care providers currently participating in traditional Medicare. The comprehensive payments would consist of risk-adjusted, per member per month (PMPM) payments for outpatient primary care and integrated behavioral health services, excluding Medicare Part D medications. To support the IHM or similar models in Medicaid, CMS should provide guidance to states on how to implement the model through existing authorities.	Grant program: Congress	Medicare
Forgivable-loan program to assist individual providers and small primary care practices with upfront costs of integration	Congress should fund a forgivable loan pilot to support small primary care practices initiating behavioral health integration. The secretary of HHS should provide prospective financing to assist these practices with the financial capital necessary to fully implement behavioral health services.	Congress	Medicare Shared Savings Program
Pay for performance within Medicare's Merit-Based Incentive Payment System to incentivize behavioral health providers to integrate care	A pay-for-performance payment (P4P) model could incentivize behavioral health providers to integrate care by tying bonus payments to integrated care measures. CMS should include additional behavioral health integration measures in the MIPS mental/behavioral health measure and improvement activity set. These measures should align with and complement those for behavioral health integration in primary care and should be weighted heavily to incentivize providers to report on these measures.	Secretary of the Department of Health and Human Services	Medicare
Voluntary integration bonus payments for FQHCs and CCBHCs	Future rounds of the CCBHC demonstrations should include a separate voluntary integration bonus payment available to both CCBHCs and FQHCs that partner to meet escalating clinical outcome measures that reflect integration of behavioral health and primary care. The bonus payment for meeting the integration performance measures should be in addition to, and not a withhold from, the prospective payment rates the clinic and health center each receives.	Congress	Medicare

<p>Funding for HRSA programs that support behavioral health consultations for primary care providers.</p>	<p>Congress should increase funding for HRSA programs that support behavioral health consultations for primary care providers. Psychiatric consultations are essential in providing primary care clinicians with the guidance they need to effectively manage some behavioral health conditions. Consultation services allow integrated care teams to access psychiatric services without necessitating an on-site psychiatric provider. These consultations can help fill knowledge gaps in primary care learning and improve care through real-time training.</p>	<p>Congress</p>	<p>Health Resources and Services Administration</p>
<p>Funding for the Primary Care Extension Program</p>	<p>Funding the PCEP, with an enhanced focus on behavioral health and a variety of integrated care models, would help integration by providing primary care practices with the technical assistance necessary to integrate behavioral health care and establishing a network of trusted, culturally competent facilitators to engage practices in transformation. The ACA authorized PCEP, but did not fund it. In accordance with the original ACA authorization, funding the PCEP would cost the federal government \$1.2 billion over 10 years.</p>	<p>Congress</p>	<p>Agency for Healthcare Research and Quality</p>
<p>Funding for providers to support technical assistance and ongoing delivery of integrated care</p>	<p>A new grant funding mechanism could cover costs for primary care practices to seek technical assistance from health technology and practice management companies in the private sector. Though the cost and financial implications of integration vary depending on the practice model adopted, covered services would include training for all levels of staff involved in transformation, financing, and use of EHR technology.</p>	<p>Congress</p>	<p>Health Resources and Services Administration, Agency for Healthcare Research and Quality</p>
<p>Funding for continuing education programs to prepare providers to work in integrated settings</p>	<p>Post-degree training could be expanded by increasing funding for existing programs or developing new training opportunities, such as certifications for community health workers and peer support specialists with advanced knowledge of best practices for addressing health disparities or peer learning groups coordinated through technical assistance programs.</p>	<p>Congress</p>	<p>Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration, Agency for Healthcare Research and Quality, and others</p>
<p>Funding for programs that recruit diverse students into primary care and behavioral health professions</p>	<p>Programs that recruit from diverse communities and support students through their education are integral to these efforts. Options for exploration and possible consideration include grant funding to support partnerships between medical schools and local organizations to create a pipeline for the recruitment of students from underserved or underrepresented populations and internship programs that enhance recruitment of students from institutions with successful records of supporting diverse populations.</p>	<p>Congress</p>	<p>Health Resources and Services Administration and others</p>
<p>Funding to support Health IT utilization by behavioral health clinicians</p>	<p>Congress should direct CMMI to create a targeted funding structure to assist behavioral health providers with startup costs, maintenance, and training for health IT in behavioral health settings. Demonstration participants should be required to integrate behavioral health and primary care services and meet ONC certification and interoperability standards, including the universal Fast Healthcare Interoperability Resource application programming interface standards that enable data-sharing between all platforms. Grants should also support the use of lower cost, cloud-based EHRs and direct Application programming interface sharing tools.</p>	<p>Congress</p>	<p>Center for Medicare & Medicaid Innovation</p>

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