INTEGRATION OF PRIMARY CARE AND BEHAVIORAL HEALTH

Addendum to the RAND Report to the Pennsylvania Health Funders' Collaborative:

Policy Barriers and Potential Strategies for Overcoming Them

September 2009

Introduction

This Addendum was developed by the RAND project team in response to a request by the Pennsylvania Health Funders' Collaborative to provide additional information about the policy barriers to primary care and behavioral health integration, both in Pennsylvania and beyond, and potential strategies for overcoming them. The content is derived from surveys and interviews of Pennsylvania stakeholders conducted by the RAND team (as described in the original report to the Collaborative) as well as several related published documents previously identified by the project team. As such, the findings are selective, rather than comprehensive, and in some cases may represent opinions and view points, rather than established facts.

Policy Barriers Identified by Pennsylvania Stakeholders and/or Noted in the Literature

Barriers	Primary Care Providers	Behavioral Health Providers	Insurers/ Payers	County-level Officials	State-level Officials	Literature
1. Financing/regulatory Requirements	X	X	X	X	X	X
2. Information sharing	X	X	X	X	X	X
3. Workforce development	X	X	X	X	X	X
4. Managed behavioral health carve outs	X	X	X	X		X
5. Information technology	X					X
6. Quality improvement						X

These barriers, and potential solutions for addressing them, are described in further detail below. The order reflects the number of Pennsylvania stakeholder groups that identified the barrier in our interviews and surveys, and not a predetermined judgment of the importance of any one type of policy issue in the context of primary care-behavioral health integration.

1. Financing/Regulatory Requirements

Barriers Identified in the Literature:

- Financial barriers are a major impediment to integrated care primarily because many activities associated with integrated care, such as many care management functions, consultations, and other communication activities between providers, and telephone consultation with patients, are not traditionally reimbursed under typical fee-for-service (FFS) care.[1]

- In 2006, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the Centers for Medicare & Medicaid Services (CMS) convened an expert forum to discuss barriers to the reimbursement of behavioral health services in primary care settings. The Expert Forum identified the following seven priority barriers:[2]
    - State Medicaid limitations on payments for same-day billing for a physical health and a behavioral health service/visit
    - Lack of reimbursement for collaborative care and case management related to behavioral health services
    - Absence of reimbursement for services provided by non-physicians, alternative practitioners, and contract practitioners and providers
    - Medicaid disallowance of reimbursement when primary care providers (PCPs) submit bills listing only a behavioral health diagnosis and corresponding treatment
    - Level of reimbursement rates in urban and rural settings
    - Difficulties in getting reimbursement for behavioral health services in school-based health center settings
    - Lack of reimbursement incentives for screening and providing preventive behavioral health services in primary care settings

- Research clearly demonstrates that existing financial arrangements impede incorporation of evidence-based depression care into routine practice. Common problems include the inability of PCPs to bill for depression treatment (in the context of behavioral health carve-out programs) and the absence of payment mechanisms for key elements of the collaborative care model, such as care management and psychiatric consultation services. Also, since appropriate care of people with depression typically involves more time than the average case, PCPs reimbursed on a capitated basis, or rewarded for the number of patients seen, may opt to refer patients to specialty care who could be treated successfully in primary care.[3-5]

- Ongoing confusion about billing practices is another major impediment to implementing and sustaining evidence-based models of care for common behavioral health disorders in primary care and for common medical conditions in specialty behavioral health settings.[6]

- Medicare has led the way in adopting CPT codes (the 96150 series) to support collaborative care, and intermediaries around the country are now paying on these codes and/or using them in their commercial plans. As a result, there has been some initial success in obtaining payment for services that are focused on behavioral health issues provided under a medical, not psychiatric, diagnosis. However, for Medicare-covered individuals seen principally for behavioral health diagnoses in primary care (e.g., depression), the differential co-pay requirement for a

mental health visit (50%) as contrasted with a primary care visit (20%) remains a significant barrier.[6]

- State-level regulatory and paperwork requirements make it difficult to integrate behavioral health services in primary care as well as medical services within specialty behavioral health settings. Behavioral health specialists wanting to work with primary care practices are disadvantaged if they must complete lengthy assessments and paperwork in order to access behavioral health funding for persons seen in a primary care setting. Even when they plan to use other funding sources, behavioral health agency licensing may be tied to regulations requiring more intensive assessment and documentation processes.[6]

- Another major barrier, especially in safety net systems, is whether the consumer has insurance coverage (e.g., Medicare, Medicaid or private) or is indigent and/or uninsured. Unlike community health centers, community mental health centers have no national requirement to serve the uninsured population, lacking the equivalent of 330 funding and special reimbursement relationships with Medicaid.[6]

Solutions Identified in the Literature:

- The 2006 Expert Forum convened by SAMHSA, HRSA, and CMS suggested a number of actions for dealing with the reimbursement barriers identified above. These actions include:[2]
    - Clarify policies, definitions, and services, and broadly disseminate the clarifications
    - Promote targeted collaboration among Department of Health and Human Services agencies and national stakeholder organizations
    - Provide education and technical assistance that crosses settings, payers, and practitioner and provider types; consistent information must be shared among all players
    - Provide additional services and support, such as linking payment incentives to prevention, screening, and follow up.

- Stakeholders need to have a better understanding of how to obtain reimbursement on the primary care/behavioral health interface in the public sector. [6]
    - At the federal level, there needs to be support for billing key service components, such as screening, care management, and psychiatric consultation under Medicare and clarification for the states regarding what they may do under Medicaid.
    - At the state level, it is critical to better understand how to implement existing Medicaid billing codes (and how to incorporate new ones) and to identify key individuals at CMS, Medicaid Authorities, legislatures, and Mental Health Authorities who need to be involved in the process.
    - At the local level, it is important for administrators and communities to begin to build bridges between behavioral health and medical safety-net providers to ensure a seamless continuum of care.

- Purchasers should modify policies and practices that preclude paying for evidence-based screening, treatment, and coordination of behavioral health care, paying particular attention to practices that prevent primary care providers from receiving payment for the delivery of the behavioral health services they provide.[7]

- Documentation methods to be used in collaborative care will vary depending on the business model that is adopted. If the clinician is an employee of the primary care practice, the documentation becomes a part of the medical chart. If the clinician is the employee of a behavioral health provider, providing services through a contractual agreement, the clinician may work under the direction of the PCP, and document the visit in the medical chart, using medical rather than behavioral health codes, or bill using behavioral health codes. The decision about business model and staff ownership should be made after considering all possible revenue streams, both medical and behavioral health, in order to determine the most stable and advantageous revenue mix.[8]

- Whether the documentation becomes part of the medical chart or the behavioral health chart, there is consistent agreement regarding brief, immediate documentation of behavioral health services delivered in a primary care setting. This will require behavioral health specialists, who often have extensive documentation requirements, to develop alternate methods of documentation of primary care based services.[6]

- Community mental health centers and community health centers in each state must engage in a discussion with the State Medicaid Agency and the State Mental Health Authority to develop policy direction that addresses the need for greater access to behavioral health services for the Medicaid population.[9]

Related Comments from Pennsylvania Stakeholders:

- Coordination of care, or case management, is not a billable service. One representative from a Medicaid physical health managed care organization (MCO) explained that compensation for care coordination is included in the capitation payment, but PCPs believe that they are not compensated adequately for the time they spend communicating with behavioral health providers and vice versa.
  Potential solutions:
  - [Insurer X] is now providing PCPs with a "bill above" number (using a CPT code) so they can bill for case management work, time that is usually not considered to be included in the capitation rate.
  - Adopt a standard definition of care coordination before considering an add-on payment.

- Non-FQHC PCPs cannot currently bill for behavioral health services, so they have to code it as something else (e.g., somatic illness).
  Potential solution:
  - In some states, non-FQHC PCPs can bill Medicaid for behavioral health services.

- The current billing structure for behavioral health visits (e.g. 30- or 60-minute appointments) does not conform to the practice structure of primary care, where there are typically shorter appointments. Similarly, billing and documentation requirements that were developed for specialty behavioral health care do not translate well to primary care settings (e.g. billing codes and procedures associated with opening a case, treatment planning, discharge planning).

2. Information Sharing

Barriers Identified in the Literature:

- Clinicians providing treatment to individuals with behavioral health illnesses must comply with multiple different sets of rules governing release of information.[7]
    - Health Insurance Portability and Accountability Act (HIPAA) regulations generally permit health care organizations to release—without requiring patient consent—individually identifiable information (except psychotherapy notes) about the patient to another provider or organization for purposes of treatment. However, the HIPAA regulations are superseded by more stringent state statutory and regulatory provisions that may make it difficult for different providers or treatment organizations to share information. Each of the fifty states and the District of Columbia has a number of statutes governing medical record confidentiality and specifically governing aspects of behavioral health records, many of which are more stringent than the HIPAA requirements, and the variation among them is great.
    - HIPAA also permits health care organizations to implement their own patient consent policies for the release of patient information to other treating providers sometimes resulting in even more stringent privacy protections that impose additional procedures on participating providers.
    - Separate federal laws govern the release of information pertaining to an individual's treatment for drug or alcohol use. These do not permit sharing of records relating to substance-use treatment or rehabilitation by organizations conducted, regulated, or funded by the federal government without the patient's consent, except within a program or with an entity with administrative control over it, communications between a program and organizations that provide support services such as billing and data processing, or in the case of a "bona fide medical emergency." These federal laws are also superseded by any state laws that are more stringent.

Solutions Identified in the Literature:

- Federal and state governments should revise laws, regulations, and administrative practices that create inappropriate barriers to the communication of information between providers of health care for behavioral health conditions and between those providers and providers of general care.[7]

- Purchasers should modify policies and practices to require (with patients' knowledge and consent) all health care organizations with which they contract to ensure appropriate sharing of clinical information essential for coordination of care with other providers treating their patients.[7]

- There are several principles related to assuring accessibility of information wherever a person presents for care, including:[6]
    - Seek consumers' consent to share information, acknowledging that some will decline, but most will want care coordinated
    - Comply with federal and state regulations
    - Maximize the intent of HIPAA regarding information sharing for the purposes of coordinating care.

Related Comments from Pennsylvania Stakeholders:

- There are perceived barriers related to including information about behavioral health conditions in medical records, and for sharing this information between providers. This may be an over-sensitivity to HIPAA regulations and/or to state regulations (Bureau of Drug and Alcohol Programs) which preclude inclusion of substance abuse information in medical records.
  Potential solutions:
  - Implement an information campaign about state/federal laws and regulations about sharing privileged information between providers, including what is allowable in a medical record.
  - Advocate for changing the BDAP regulation (though Estelle Richman has attempted this vigorously and has not been successful).

3. Workforce Development

Barriers Identified in the Literature:

- Clinicians licensed to diagnose and treat behavioral health issues are much more varied than those licensed to diagnose and treat general illnesses, and each has differing education and training. Moreover, not all types of clinicians who treat behavioral health issues and subscribe medications have been certified as mental health or substance abuse treatment specialists, or have some minimum level of competency, or some known level of special added competencies. This variation has been shown to impact the quality of behavioral health care delivered.[7]

- Professional licensure and ongoing assurance of competencies in specific behavioral health therapies involves many different bodies. Experts in the education of the behavioral health workforce report that pre-licensure education is uneven, as are licensure standards and use of post licensure competency evaluation mechanisms.[7]

- Concerted efforts are needed to advance multiple levels of workforce development, including training and competencies for PCPs in provision of care for common behavioral health disorders, behavioral health specialists in screening and treatment of common medical conditions, and each type of provider in developing skills for working as consultants in the other setting. Leaders of successful programs report that it is difficult to find clinical staff with the skills and knowledge to be effective bridges between the two systems.[6]

Solutions Identified in the Literature:

- Congress should authorize, create, and maintain a Council on the Mental and Substance-Use Health Care Workforce as a public-private partnership for (1) identifying the specific clinical competencies that all behavioral health specialists must possess to be licensed or certified and the competencies that must be maintained over time; (2) developing national standards for the credentialing and licensure of behavioral health specialists to eliminate differences in standards now used by the states; such standards should be based on core competencies and should be included in curricula and education programs across all behavioral health disciplines.[7]

- The University of Massachusetts Medical School has recently initiated a Certificate Program in Primary Care Behavioral Health, targeted to licensed mental health professionals. The 56 hours of didactic and experiential training is focused on training individuals to function successfully as behavioral health providers in primary care.[6]

Related Comments from Pennsylvania Stakeholders:

- MBHOs require credentialing for behavioral health specialists that join their network to ensure that they meet professional competence standards. Credentialing is a barrier to PCPs providing and getting reimbursed for behavioral health care and to behavioral health specialists working in a primary care setting. The process is very lengthy and time consuming, and the requirements are not seen as conducive to a collaborative care approach.

- There is a need for cross training of PCPs and behavioral health specialists to increase knowledge as well as foster better working relationships.

- PA Medicaid data indicates that PCPs are not doing a good job of prescribing psychiatric drugs. *Potential solution*:
    - Require PCPs to undergo training or to work in consultation with a psychiatrist if they plan to prescribe psychiatric medications.

- Time spent training or educating staff and providers about primary care/behavioral health integration and care is neither reimbursed nor incentivized.

4. Managed Behavioral Health Carve Outs

Barriers Identified in the Literature:

- Over the past two decades, employers and other group purchasers of health care (e.g., state Medicaid agencies) have increasingly provided behavioral health care benefits through managed behavioral health organizations (MBHOs) that are administratively and financially separate from the health insurance plans through which individuals receive their general health care, informally referred to as "carved-out" behavioral health services.

  Evidence is clear that MBHOs have been successful in reducing employers' behavioral health costs, and also in achieving greater use of community-based care, as opposed to institutionalization. They have also been credited with keeping down costs in the face of broadened benefits, moving clinicians from solo practice into group practices, nurturing support for specialized knowledge of behavioral health problems and treatment expertise, and attenuating problems in the adverse selection of individuals with behavioral health illnesses in insurance plans.

  Evidence of the effects of carve-out arrangements on quality of care is limited and mixed. Problems in coordinating care in the presence of behavioral health carve-outs could arise from several situations: (1) PCPs generally are not expected to treat (and may not always be able to be reimbursed for treating) behavioral health problems; (2) information about the patient's health problems, medications, or treatments must now be shared across, and meet the often different privacy, confidentiality, and additional administrative requirements imposed by the

different health plans; (3) difficulties for quality measurement and improvement arise because the true prevalence of behavioral health illnesses in primary care is masked (PCPs may code visits for the patient's somatic complaint in order to get reimbursed) and confusion is created about accountability for quality and coordination.[7]

Solutions Identified in the Literature:

- Carve-out models can be customized to support clinical integration efforts, and carve-in models can be designed to reduce overall levels of behavioral health spending and services, especially for populations with serious mental illness.[8]

Related Comments from Pennsylvania Stakeholders:

- Managed behavioral health care separates the financing (and risk assumption) of behavioral health and physical health care. Health plans subcontract with a MBHO to assume the financial risk for covering and managing the behavioral health care needs of its subscriber population, including reimbursing behavioral health care providers. In PA, the Health Choices behavioral health carve-out for Medicaid managed care was implemented in 1997.

- One payer observed, "When PA implemented the behavioral health carve-out, it was a business person's solution to managing costs because there was insufficient infrastructure in most offices to do a carve-in**.** The state has created artificial barriers to service delivery, patient care, and information sharing."

- Some PCPs believe that the carve-out limits continuity of care and their ability to refer (or to know who to refer to). Some have also observed that payments are not consistent across health plans and MBHOs.

- Carve-outs may create a "passing the buck" situation, where neither the health plan nor the MBHO is willing to pay for coordination of care, since both feel it is the responsibility of the other.
  Potential solution:
  - Systematically evaluate the effects of managed behavioral health care on access, quality, and ability to integrate behavioral and physical health care. Results from this evaluation could be used to advocate for changes to public sector carve-out mechanisms.

5. Information Technology

Barriers Identified in the Literature:

- Behavioral health information technology systems lag behind those of general health care.[7]

- Reporting on the use of information technology in integrated care is scant. Programs have used information technology for systematic screening and case identification, communication between primary care and specialty behavioral health providers, decision support, and monitoring of medication adherence and patient clinical status; telemedicine can bring services to traditionally underserved areas. However there is not enough evidence to comment on the

effectiveness or impact of specific types of health information technology for improving integrated processes of care.[1]

- A key issue to be managed with respect to information technology in the context of primary care/behavioral health integration is the balance between privacy and the need for shared communication.[6]

Solutions Identified in the Literature:

- The IOM has identified several actions for ensuring that the developing National Health Information Infrastructure (NHII) serves consumers of health care for behavioral health conditions as well as it does those with general health care needs. These include: coordinating the activities of the NHII and public sector behavioral health initiatives; bringing behavioral health expertise to the development of the NHII; and supporting individual behavioral health specialists in their use of information technology.[7]

- In the future, Electronic Health Records (EHRs) and Personal Health Records (PHRs) will provide a data set that can be mined for aggregate data. We must assure that EHR and PHR templates include data elements needed to manage and coordinate general health care and behavioral health care. In addition, Regional Health Information Organizations (RHIOs) are now being formed to develop electronic networks containing data elements essential to care coordination and accessible by diverse participating health care organizations in a defined geographic region.[6]

Related Comments from Pennsylvania Stakeholders:

- One primary care provider commented that some staff members are concerned about sensitive [behavioral health] issues being documented in shared electronic medical records.

6. Quality Improvement

Barriers Identified in the Literature:

- Many purchasers delegate their attention to quality of care issues by accepting the quality of care determinations made by expert quality oversight organizations, such as accrediting organizations. Accreditation requirements are not consistent across general medical care and behavioral health care. For example, the National Committee for Quality Assurance's behavioral health quality measures (i.e., those contained in its HEDIS measurement set) are required to be reported by comprehensive managed care plans seeking accreditation, but not by MBHOs seeking accreditation. Also, accreditation standards do not always make clear the responsibilities for care coordination when an individual is served by two health plans, such as a managed care plan providing general health care and an MBHO.[7]

- The infrastructure for supporting the identification and dissemination of best practices, providing decision support for clinicians at the point of care delivery, measuring the extent to which effective practices are applied, and incorporating measurement results into ongoing improvement activities is less well developed for behavioral health care than for general health care.[7]

- Clinical assessment and treatment practices (especially psychosocial interventions) have not been standardized and classified for inclusion in the administrative datasets widely used to analyze variations in care and other quality-related issues in general health care.
- Initiatives to disseminate advances in evidence-based care often fail to use effective strategies and available resources.
- The development of performance measures for behavioral health care has not received sufficient attention in the private sector, and efforts in the public sector have not yet achieved widespread consensus.
- The understanding and use of modern quality improvement methods has not yet permeated the day-to-day operations of organizations and individual clinicians delivering behavioral health services, both those in the general health care sector and those in the specialty behavioral health care sector.

- When organizations or providers are reimbursed separately for the separate services they provide, each organization/provider may perceive no responsibility for the services delivered by others, making point (or points) of accountability for patient outcomes unclear.[7]

- Incentives must be provided to improve care on the primary care/behavioral health interface. However, despite the proliferation of pay-for-performance programs focusing on general medical care, few pay for performance efforts specifically address behavioral health care.[11]

Solutions Identified in the Literature:

- Organizations that accredit behavioral health or primary health care organizations should use accrediting practices that assess, for all providers, the use of evidence-based approaches to coordinating care.[7]

- The IOM recommends a five-part strategy to build the quality improvement infrastructure and improve the quality of behavioral health care:[7]
  - A more coordinated strategy for filling the gaps in the evidence base
  - A stronger, more coordinated, and evidence-based approach to disseminating evidence to clinicians
  - Improved diagnostic and assessment strategies
  - A stronger infrastructure for measuring and reporting the quality of behavioral health care
  - Support for quality improvement practices at the locus of health care

- The IOM further recommends that points of providers' accountability for patient outcomes be explicitly identified in the providers' agreements with their purchasers.[7]

- The Center for Quality Assessment & Improvement in Mental Health has presented three sets of quality measures for use, including structure, process, and outcome measures. These include measures for patients with co-occurring medical and behavioral health conditions receiving treatment in primary care settings; measures for patients with co-occurring medical and behavioral health conditions receiving treatment in behavioral health specialty settings; and measures for patients with co-occurring substance use and psychiatric conditions receiving treatment in behavioral health specialty settings. [12]

- A number of actions can be taken in order to increase the effectiveness and use of behavioral health pay-for-performance programs in the future. These include: [11]
    - Adopting a longitudinal perspective on quality measurement, beginning with offering incentives to providers for developing structures of care that support quality improvement, followed by incentives for using these structures to enhance the quality improvement process, and, ultimately, for measuring the outcomes of these processes
    - Developing outcome measures that are valid, practical to implement, and have buy-in from multiple stakeholders
    - Ensuring that all providers who are responsible for a particular patient's care are held accountable for the quality of care they provide
    - Enhancing the focus on behavioral health and the incentives that are offered to improve performance so that they are large enough to matter to providers
    - Experimenting with new models for improving performance and rewarding quality (e.g., DIAMOND project)

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