NEHI Network for Excellence in Health Innovation

Behavioral Health and Primary Care Integration:

Accelerating Adoption in Massachusetts Through Stakeholder Alignment

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Overview

This document summarizes an initiative that convened major Massachusetts stakeholders to identify collaborative efforts that would advance adoption of behavioral health integration in primary care in the Commonwealth. The initiative surfaced experience-based insights about the challenges of advancing behavioral health and primary care integration (BH integration) across industry sectors. It also produced two potential solutions to these challenges. While the project participants supported the advancement behavioral health integration, they did not achieve consensus to pursue a collective pilot and test the solutions identified. Nevertheless, based on participants' exchanges in this project, informed by existing research, the authors believe that there are opportunities for collaborative work to advance access to effective behavioral health care and, as an initial step, urge participants to share and discuss this report within their respective organizations.

Background

NEHI launched this initiative with the goal of expanding behavioral health integration by primary care practices in Massachusetts.[1] Less than 40% of primary care groups have incorporated any type of behavioral health integration in their practices,[2] with far fewer adopting recognized models of integration, despite the evidence demonstrating its effectiveness and importance in redressing access issues to needed behavioral health care. The project also grew out of a previous study, which provided the motivation for connecting payer and provider representatives. In that study, we concluded that payers and providers need to collaborate more intentionally in devising incentives and supports to promote the effective integration of behavioral health in primary care.

We engaged leaders in adult & pediatric primary care, commercial and government payers, and vendors offering BH integration solutions. Participants were motivated to join the initiative for various reasons: 1) to advance a specific model of integration; 2) to stimulate discussion regarding alternative approaches; 3) to advance integration tools; and/or 4) to identify integration strategies that work to enable smart investments that can move the market. We held three two-hour sessions with participants after interviewing most participants individually to gather their goals and understand their perspectives. The first session involved only provider representatives. The second session included only payers. The final session included both payers and providers. In between the meetings, we distributed notes containing learnings and obtained participants' comments.

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[1] We use behavioral health to encompass both behavioral and mental health conditions.

[2] We have been unable to find a clear assessment of the percentages of practices that have integrated behavioral health. The adoption rate in community health centers has been studied to a greater extent, with estimates of adoption between 18 and 40 percent. https://bphc-ta.jbsinternational.com/sites/default/files/2024-02/Research%20Brief_Behavioral%20Health%20Integration%20and%20State%20Medicaid%20Approaches.pdf; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9743793/. Perhaps more importantly, estimates of the number of patients reached in practices that have adopted behavioral health integration are low. One study less than half of the patients deemed eligible for integrated care received integrated services. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7315784/#:~:text=among%20elderly%20patients.-,Screening%20REACH,CI%2C%200.6%E2%80%9315.1).

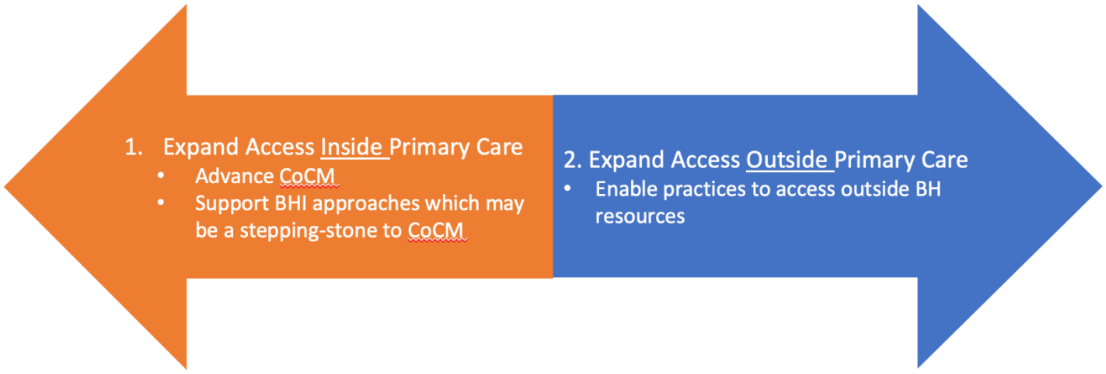
Takeaways

All participants were motivated to address the growing need for behavioral health services and committed to expanding behavioral health integration in primary care. Reflecting the overall market, our participants' approach to BH integration is fragmented, with each deploying unique strategies. As such, a key part of our discussion was whether practices and payers should continue to go their own way or coalesce around an approach.

Participants agreed that more must be done to expand access to behavioral health services inside primary care, but also concluded that improving access to available services "outside" of primary care was important (see Figure 1); we can no longer think of BH integration in primary care without deeper consideration of today's market, where all patients and providers leverage multiple tools to expand access.

Figure 1:

A Dual Approach to Improve BH Access for Primary Care Patients



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1. Participants were not fully aligned on the specific "inside" approach, disagreeing on whether incentives to implement behavioral health integration should be focused solely on the Collaborative Care Model (CoCM) or include a wider spectrum of activities providing behavioral health in primary care. All participants acknowledged that CoCM was a structured, evidence-based pathway that represented the most oft-cited standard for behavioral health integration ("the gold standard"), but raised four concerns:

    - It is not feasible for all practices to implement CoCM as its benefit is limited for certain populations of patients. Moreover, differences in practices' size and location

affect their ability to incorporate on-site behavioral health managers and other elements of CoCM.

- Reimbursement for behavioral health system integration (through the general integration codes, as well as specific collaborative care codes) is necessary but not sufficient to enable CoCM's implementation. The codes do not cover the costs of the practice transformation required to build and maintain the model.

- Although there are guides and technical assistance resources available to assist practices in implementing CoCM, several providers noted that they are not sufficient in supporting all that is required for practices to build and sustain CoCM. Relatively well-resourced health systems have required several years to implement CoCM.

- Practices continue to express concern about the model's rigidity and associated complexity of billing for the collaborative care codes.

Acknowledging these points, participants agreed to concentrate on recommending strategies that enabled incremental advances toward CoCM, thus continuing to treat CoCM as a guidepost but designing ways to mark (and reward) progress in its implementation.

2. Participants were aligned on the right side of the arrow – ensuring primary care practices can access BH resources for their patients. Examples included (but were not limited to): expanding prescriber training and facilitated navigation to digital and/or network resources. Participants shared three key observations:

    - Efforts on the right side of the arrow are plentiful but must be aligned with integration efforts.

    - Payer participants view BH access strategies as market differentiators and have a clear interest in partnership with providers and their utilization of tools.

    - The variety of access points and resources available makes it difficult for primary care providers to navigate and assess their effectiveness.

<u>The Challenges/ Problems to Solve</u>

Pursuing even an incremental approach to BH Integration requires a deep understanding of participants' most significant challenges. Many of these are described in the literature on behavioral health integration. Participants gave emphasis and context to the issues as follows:

- **Behavioral health integration does not seem urgent or rise to the level of a standard of care.** Despite the substantial evidence from randomized clinical trials on the benefits of CoCM, and the growing need for behavioral health care, payers and providers acknowledge that practices have not adopted BH integration as the standard of care in the same way we have seen for diabetes, hypertension, etc. Urgency around the value of BH

integration is not widely shared because participants are not able to measure—or specify clearly-- the value of behavioral healthcare on reducing the total cost of care (despite studies demonstrating return on investment under various circumstances).

- **The effort and resources required to implement CoCM is a significant barrier and represents only one of a myriad of challenges that primary care practices face.** There was substantial consensus that increased supports for primary care were requisite to behavioral health integration. But behavioral health integration is only part of the focus of multiple national reports advocating for policy changes to improve primary care delivery and payment.[3] Indeed, the Massachusetts Medicaid Waiver primary care sub-capitation model, as well as several CMMI pilots, are focused on this broader goal.[4]

- **There is not an approach to adoption of behavioral health integration that accommodates varying practices and their capabilities.** Practices differ not only in their infrastructure capabilities, but in their leadership, workflow and cultural features. One participant noted the disparity in practice readiness for change; this makes it difficult to design a standardized playbook. Although there are multiple guidebooks and consultative services available, practices have not utilized these effectively for reasons of cost, complexity, and/or lack of awareness. All acknowledged that these approaches best serve large practices.

- **Although the Collaborative Care Codes are intended to provide an incentive for adoption of CoCM, for many practices, reimbursement through the Codes comes too late in the adoption process and is inadequate to support CoCM fully**. The Collaborative Care Codes serve as the primary reimbursement for services encompassed by behavioral health integration. While Massachusetts payers universally pay these, only a small minority (<10%) of practices bill the codes. The Codes do not cover the activities required to initiate the Collaborative Care Model (start-up costs) and many providers insist that the reimbursement rates are inadequate to cover the actual cost of the work required.

- **Vendor solutions to advance behavioral health integration are available but not fully leveraged.** In recent years, various companies have developed technologies and workforce solutions that provide functions to facilitate behavioral health integration, including ways to monitor treatment plan outcomes and identify individuals at risk. The use of generative AI will likely add to the utility of vendor solutions by advancing detection, diagnosis and appropriate evidence-based treatments. Nevertheless, it is difficult for practices to identify, locate, and adopt appropriate solutions. To date, many

[3] Among the most oft-cited of these is report of the ad hoc committee under the auspices of the National academy of Sciences, Engineering and Medicine: Implementing High Quality Primary Care: Rebuilding the Foundation of Health Care (2021)

[4] [insert footnote on both the sub-cap and CMMI's models]

vendor solutions have focused on large health systems and/or health plans, although there are local solutions developing to assist small to medium size practices.

- **There is an insufficient behavioral health workforce to respond to access demands via primary care. It is also challenging to find staff to implement a new model of care.** There is a significant shortage of behavioral health providers, including psychiatrists, psychologists, and licensed social workers willing to participate in behavioral health integration models for two reasons: (1) their training and orientation is not aligned with the requirements of participating in a collaborative practice and (2) in many markets, cash pay reimbursement is far more lucrative than compensation provided by integrated practices. This also limits the referral options when the integrated model is not appropriate for certain patients

- **There is no standard approach to measuring and reporting the utilization of behavioral health integration or its impact.** Producing real world evidence of the benefits of behavioral health integration requires practices and payers to align on the data they collect and publish. Agreement on practical outcome measures has remained elusive. Payers and providers also acknowledge that they are not working to examine overall benefits in quality or cost of care. Finally, the "squishy" metrics particularly for practices are key including clinician burnout.

- **Efforts to stimulate integration co-exist with broader alternative payments; providers lacking scale or who do not wish to take on risk can be left behind.** CMMI models focused on the implementation of more robust primary care functions are also linked to improving "value-based" care. While the more recent models incorporate both fee for service and risk-based approaches, there remains concern about having feet in two different canoes.

The Strategies to Improve Adoption of Behavioral Health Integration

To achieve our initiative's goal and address the challenges outlined above, we committed at the outset to outline a pilot project and assess whether initiative participants would support it. "Support" would entail an agreement to be part of the pilot if we secured additional funding to pursue it. The pilots needed to increase the number of practices in Massachusetts that were advancing CoCM or integration activities that were steppingstones to CoCM. We envisioned that integration would be advanced through a progression of measurement-based activities.

We developed two potential pilots.

The first targeted the promotion of integration activities within the primary care setting via a payer/provider effort to establish a tiered per member per month (PMPM) payment. Our goal was to tie enhanced payments to a common set of defined milestones (adopted by all payers), which could be evaluated with existing technology and infrastructure across practice types.

The second pilot was focused on improving primary care practices' access to external resources. We proposed building a prototype "clearinghouse" for primary care providers that identifies available external resources appropriate for a given patient's diagnosis and circumstances. Our second pilot recognized and would be an adjunct to the substantial effort payers were making to provide their members with immediate access to behavioral health services—outside of the primary care setting.

a. Pilot 1: PM/PM Payment Model

The payment model pilot proposal sought to provide an alternative to CoCM code reimbursement given their underutilization and provide a pathway for practices to access funding for integration. In constructing the pilot, we assumed that practices could choose to bill either the CoCM codes *or* pursue a per member/per month (PM/PM) payment. We aimed to address some of the major problems noted above by proposing the following approach; while not detailed, we hoped to gain specificity after participants embraced the concept:

- PM/PM payments would be linked to milestones and allow practices to recoup some costs as they implement integration strategies which may be full CoCM or a stepping toward CoCM. PMPM design would define how practices demonstrate achievement of a given milestone for payment.

- The milestones would serve as a roadmap (or glidepath) for building an integrated model, clarifying expected outcomes. PM/PM payments would provide needed flexibility balanced by a focus on both activities and outcomes.

- Practices would have to meet a single set of standards via an aligned payer approach. Administration of the CoCM codes has been subject to some variation by Medicare region and by payer and we would seek to remedy this via strong alignment with and clarity of payment standards.

- The pilot would complement and be as consistent as possible with the Massachusetts' Medicaid program, MassHealth's, primary care sub-capitation program in the Accountable Care Organizations (ACOs) program. A PM/PM methodology also builds on efforts by CMS to strengthen primary care. The most recent ACO Primary Care Flex model embraces population-based payments alongside FFS payments.

Participants had varied reaction to the PMPM pilot proposal and raised some fundamental areas of concern including the following:

1. It may be confusing to Introduce another form of reimbursement (in addition to the CoCM codes) and possibly undermine growth in and support for the use of the codes, which still have the potential to expand.

2. It is unclear whether a PM/PM initiative would align with participants current activities in Figure 1 to advance integration and overall BH access.

3. The difficult logistics of developing the PM/PM payment, including the basis on which a PM/PM payment should be made. One issue participants raised was whether a PM/PM should be paid for a practice's full panel of patients, only those with a behavioral health diagnosis, or solely for patients engaged in identified integration activities.

4. The difficulty of accounting for/ covering start-up costs of integration within the PM/PM.

5. Payers' concern about working with practices that were unprepared to manage and administer PM/PM payments, limiting their willingness to pursue these with only those practices in ACO arrangements.

b. Pilot 2: Clearinghouse for identifying external resources

With respect to a pilot that coordinates external resources and facilitates primary care practices' ability to connect patients to these, the following points served as our foundation:

- Payers are more and more actively engaged in identifying resources for their members and connecting their members to these directly, producing a proliferation of pathways for patients. Primary care practices have significant difficulty connecting with these resources and may be unaware of their use by patients in their care. Both points may make the external treatment options less effective, potentially delaying access and/or failing to incorporate them in a care plan with measured outcomes.

- A central clearinghouse would potentially reduce the complexity and challenges noted above and well as provide an opportunity to track key metrics regarding their use and impact, including access issues, patient satisfaction, and length of engagement.

Participants provided less feedback on this 2nd pilot than 1st pilot. In subsequent discussions with a few payers, they expressed a willingness to explore the pilot further. At least one provider offered that a resource guide that assisted patients and providers in locating behavioral health care in Massachusetts would be useful. This could build on the Behavioral Health Help Line. This is also an area where the use of AI tools and advances in automation may provide an "easy button" for primary care practitioners to locate appropriate external resources for patients they cannot serve or for whom other resources are available, allowing practitioners to conserve their own capacity. It would be optimal to identify how patients and primary care providers could leverage a resource together to emphasize the importance of maintaining involvement, as needed, by primary care.

Conclusions / Recommendations

This initiative reinforced the importance of providing access to behavioral health care within primary care – whether integrated directly in the practice or enabling primary care practices to connect more seamlessly to resources outside of the practice. The participants were candid in their exchanges and willing to have difficult conversations about internal and market pressures. Our discussions of the pilot proposals, however, reinforced the status quo; we could not

collectively devise a compelling path forward. Participants have many ideas for how to advance behavioral health access for primary care patients; we could not achieve consensus on what we needed to do together either to promote behavioral health integration or the coordination of access outside of primary care. Nevertheless, participants led us to the following key "lessons learned:

- Payers and providers remain largely focused on finding ways to advance adoption of CoCM, despite the recognition that there has been limited progress in implementing CoCM over more than a decade and that it cannot solve many challenging behavioral health access issues. More needs to be done to identify how other strategies can complement this work or how they might accelerate the capacity of primary care practices to address their population's priorities. Exclusive focus on implementation of the model will delay that work.

- Those who have been successful, both as payers and providers, in effecting meaningful changes in behavioral health access through primary care, recognize that institutional imperatives are critical in sustaining the efforts required to overcome the challenges so well-articulated by our participants and elsewhere. Often, "leadership" is identified as the key.

- Pilots can be useful but incite skepticism that the solutions pursued will be sustained. Nevertheless, some participants offered initiatives (if not pilots) that might be worth exploring:
    - One participant returned to the issue of measuring the impact of providing behavioral health care on common medical conditions (such as hypertension and diabetes) by allowing behavioral health providers to bill for their role in treating these.
    - Another participant noted that concentrating on redressing workforce issues was critical, whether through loan forgiveness programs or other approaches.
    - Several participants raised the importance of examining differences in engagement and outcomes for behavioral health integration based on patients' socio-economic status.
    - As mentioned, participants also voiced support for continuing to develop greater technical assistance to practices, as well as external resource guides, although we did not identify funding for these efforts.
    - Finally, establishing a baseline standard, expectation, of BH care in primary care was noted.

As a post-script, there still needs to be a way to tip the scale toward better access to behavioral health through primary care. Although there is more controversy on this point, at the least, public payers should embrace their market power and roles more intentionally. Greater cohesion among public payers could overcome obstacles among commercial payers, which remain reluctant to invest in BH integration efforts where they have limited market share and/or the need for differentiation. Efforts to improve alignment between Medicare and Medicaid in their policies

should continue, whether through 1115 waivers or Medicare's value-based approaches.[5] Likewise, incorporating BH integration explicitly and consistently in CMMI pilots testing new payment models and models of primary care could provide incentives and valuable feedback.

And, as a last thought, providing access to behavioral health through primary care requires persistence. Even though we were unable to move forward with a concerted effort in Massachusetts, conversations like these, and, more importantly, a willingness to share individual experiences of what works and what doesn't –and why—must continue, despite competitive pressures in the market. The routine examination of data and results to determine whether the care provided is having its desired impact both in terms of its quality and its cost is foundational. A commitment to ongoing innovation and flexibility must remain core as well.

[5] The most comprehensive and thoughtful recommendations on the contributions Medicare and Medicaid could make to behavioral health integration are laid out by a Task Force of the Bipartisan Policy Center in "Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration," March 2021.

APPENDIX

Behavioral Health and Primary Care Integration Program Participants		
Organization	**Individual Participant**	**Title**
Aetna | CVS Health	Taft Parson, MD	VP & Chief Psychiatric Officer
Beth Israel Lahey Health	Patrick Aquino, MD	Chair, Division of Psychiatry and Behavioral Medicine
Blue Cross Blue Shield MA	Gregory Harris, MD	Associate Medical Director for Behavioral Health
Boston Children's Hospital	Mike Lee, MD	ED & Medical Director, Dept. of Accountable Care & Clinical Integration
Boston Community Pediatrics	Robyn Riseberg, MD	Founder and ED
Bowman Family Foundation	Matt Bowman, MBA	President
Brookline Center	Ian Lang, MBA	Chief of Strategic Partnerships and Innovation
Concert Health	Virna Little, PsyD, LCSW	Co-Founder and Special Advisory for Advocacy and Research
Concert Health	Spencer Hutchins	Co-Founder and CEO
Foley Hoag	Brian Carey	Anti-Trust Attorney
Lifestance	David Aziz, MS	VP of Integrated Behavioral Health and Enterprise Strategy
Lynn Community Health Center	Dr. Carlos Cappas, PhysD, MBA	Chief Behavioral Health Officer
MA Association for Mental Health	Melanie Wasserman, PhD	MAMH CoCM Project Consultant
MA Association for Mental Health	Danna Mauch, PhD	President and CEO
MA Association for Mental Health	Louise Povall, MHSM (MPA)	Senior Consultant to MAMH
Mass General Brigham	Trina Chang, MD	Medical Director for Behavioral Health
Mass General Brigham	Lucille Jordan, LICSW	Senior Program Manager, BH Integration & SUD Programs
MassHealth	Lee Robinson, MD	Medical Director for Behavioral Health
MassHealth	Ryan Schwarz, MD	Chief, Office of Accountable Care and Behavioral Health,
NeuroFlow	Tom Zaubler, MD	Chief Medical Officer
Oak Street Health	Katherine Suberlak,MSW	SVP, Population Health, CVS Healthspire
Optum	Tristan Gorrindo, MD	Chief Mental Health Officer, Optum Behavioral Health
Point32Health	Bill Harlan, MEd	VP Behavioral Health and Health Engagement
UMass Memorial	Amy Harrrington, MD	Vice Chair, Quality and Ambulatory Psychiatry
United Healthcare	Don Tavakoli, MD	National CMO for Behavioral Health