NEHI Network for Excellence in Health Innovation

Scaling Behavioral Health Integration in Primary Care: *Wading through the Complexity to Tackle a Decades-Old Challenge*

A NEHI Report

March 2023

Acknowledgments

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Acknowledgments

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Additional Acknowledgment

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About NEHI

NEHI is a national nonprofit, nonpartisan organization composed of stakeholders from across all key sectors of health and health care. Its mission is to advance innovations that improve health, enhance the quality of health care, and achieve greater value for the money spent.

NEHI brings together expert stakeholder perspectives with relevant research to devise policies that speed the adoption of innovations.

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Overview

This report results from a project that NEHI pursued to determine whether it could offer insights on expanding the integration of behavioral health[i] in primary care settings[ii] to improve access to much-needed care. To pursue its goal, NEHI relied heavily on a group of individuals whom it identified as experts because of their research and practice experiences. The observations here reflect their wisdom as well as NEHI's review of peer-reviewed research and trade publications on the topic. Backed by a fair approximation of consensus from its advisors,[iii] this report offers NEHI's conclusions.

- Given the urgency of improving evidence-based access to behavioral health treatments, we support continued efforts to expand the adoption of the Collaborative Care Model, but not to the exclusion of other approaches that are being developed and evaluated. Clear goals for behavioral health integration, which we articulate, can act as guardrails that avoid ineffective, duplicative, and unproductive efforts.
- There is abundant, well-researched guidance available on what primary care practices must do to adopt behavioral health integration. The guidance is overwhelming and complex. We connect the core goals of behavioral health integration to an operational set of essential launch activities.
- Nevertheless, it is insufficient to focus on what primary care must do. Likewise, addressing payment terms is key, but will not go far enough. Demonstrations of structured collaborations among payers and primary care providers that include policies that incentivize integration efforts, especially the use of outcome measures, provide promise. Different provider

[i] We use behavioral and mental health here interchangeably; behavioral health is generally used more expansively to include mental health and substance abuse conditions, life stressors and crises, stress-related physical symptoms, and health behaviors.[3]

[ii] We use "primary care" in its most general sense to include health services that cover a range of prevention, wellness, and treatment offered by doctors, nurses, nurse practitioners, and physician assistants generally licensed in pediatrics, family medicine, or internal medicine.

[iii] Our conclusions build substantially on existing work and observations. We acknowledge that support and feedback from Advisory Group members were especially influential but also that our conclusions were not unanimous; we review their caveats in this report.

circumstances will require different payer arrangements. A more robust understanding of payer/provider relationships that promote evidence-based integrated care is needed.

- There are now a host of companies focused on providing technological and technical assistance, as well as access to behavioral health clinicians through outsourcing arrangements. Studies that enable practices to make appropriate "buy" decisions (to avoid expenses and accelerate implementation) are needed. Technologies that ease measurement challenges and promote quality improvement will be highly valued.

Context

According to a poll this summer conducted by CNN in partnership with the Kaiser Family Foundation, 9 out of 10 adults in the United States believe that the country is facing a mental health crisis. Last year, a coalition of professional organizations declared a National State of Emergency in Children's Mental Health. This crisis is not new. But if it creates a sense of urgency, there may be a silver lining to the emphatic and public recognition of the problem.

There is robust evidence that the integration of behavioral health in primary care, especially through the Collaborative Care Model, improves access to needed care and health outcomes for several mental health conditions when compared to usual care. Indeed, there is no shortage of publications calling for the integration of behavioral and physical health, especially in primary care, which remains the place where most individuals are treated for mild to moderately severe anxiety and depression.[1,2] And there is a wealth of advice on how to bring behavioral health integration to scale. Despite all of this, experts, advocates, and policymakers concede that integration has not scaled. According to our best estimates, less than 50% of primary care practices have any form of behavioral health integration.

Methodology

The Network for Excellence in Health Innovation (NEHI) is a member-driven organization with the mission of moving critical healthcare innovations from idea to implementation. We bring together stakeholders from multiple sectors of the healthcare industry to find solutions to problems that require collaboration and dialogue. This project was sponsored by three of our member organizations. CVS Caremark and the Aetna Foundation provided the major portion of our project funds, joined by Blue Cross Blue Shield of North Carolina and NeuroFlow. We are also grateful to the Sunflower Foundation and Concert Health for its funding contributions. Mark Wenneker of The Chartis Group provided hours of pro-bono assistance throughout the project, and as noted below, participated as a member of the project's Advisory Group.

We began the project by conducting a preliminary literature review (peer-reviewed journals, trade publications and reports) on the adoption of behavioral health integration, focusing especially on commentary that identified evidence-based integration practices and efforts to scale these. Concurrently, we identified a group of individuals who had written about or were involved in efforts to implement behavioral health integration and invited them to join the project's Advisory Group. Approximately 20 individuals agreed to volunteer their time over the course of 9 months. They are listed in Exhibit A and include academics, entrepreneurs, physicians, insurance plan executives, and mental health advocates.[iv] We met virtually as a group on three occasions. We also conducted a smaller focus group with approximately half of the Group's participants and supplemented our interactions with Group members through interviews with our project sponsors and several individuals whom they referred to us. We provided Advisory Group members with a draft of this report. We considered the comments we received but this report reflects NEHI's conclusions. Individual Advisory Group member views are specified only with permission.

As a last note, we need to highlight a major caveat regarding this project. Behavioral health integration in primary care is one side of addressing physical and behavioral health needs together. Integration of primary care in mental health settings recognizes

[iv] Some individuals joined us for our final meetings when we identified their interest in doing so through other members.

the need to improve access to physical health for individuals with serious mental illness.[3,4] We do not discuss approaches focused on improving physical care for persons with serious mental illness. In addition, we do not delve into the increasing discussions of "whole person" care, which has various definitions but emphasizes attention to social and financial determinants of health and the incorporation of community resources and environmental factors in promoting health.[5]

In addition, while we discuss the importance of technologies and digital health in promoting the integration of behavioral health in primary care, we do not explore the intersection of behavioral health integration in primary care and direct-to-consumer applications that connect individuals to mental and behavioral health providers. This is a topic that will likely attract further research on outcomes and comparative effectiveness.[6,7]

Key Findings

Access to Effective (Evidence-Based) Mental Health Treatment is Urgently Needed

The COVID-19 pandemic has served to emphasize the country's unmet behavioral and mental health needs, though the problem is longstanding. According to the Kaiser Family Foundation, which compiled data from several government sources, 7.4% of adults report an unmet need for mental health treatment in the period 2019-2020. This means that more than 18 million individuals have recognized a need for help they cannot obtain.[8] Moreover, more than 90% of individuals with substance use disorder are not receiving any form of treatment; 15% of adults had a substance use disorder in the past year.[9] The situation for children and adolescents is discouraging as well. Last year the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association joined together to declare a National State of Emergency in Children's Mental Health.[10] Roughly half of US children with a mental health disorder did not receive mental health treatment in 2019.[11] According to the National Alliance on Mental Illness, nearly 20% of high school students report serious thoughts of suicide and 9% have made an attempt to take their lives. The human toll is echoed by the economic impact of mental illness. The National Alliance on Mental Illness estimates that untreated mental illness costs up to $300 billion annually due to lost productivity and associated costs (absenteeism, employee turnover, and increases in medical and disability expenses).[12] This adds to estimates of treatment spending for mental health and substance use disorders, which the Substance Abuse and Mental Health Services Administration estimates amounted to more than $280 billion in 2020.[13]

Calls to expand access to mental health and addiction services, especially services that are available in communities, rather than hospitals and residential facilities, are numerous and loud.[12] Surveys and reports of actual practices indicate that primary care clinicians appreciate the importance of treating mental health conditions. Primary care physicians already serve as managers of psychiatric disorders in one-third of their patient panels and two-thirds of patients with depression receive treatment for their depression in the primary care setting.[14] "Integrated care" is seen as a cost-effective

and systematic approach to improving health outcomes for patients with both physical and behavioral health conditions. Studies focused on the Collaborative Care Model have shown that behavioral health integration in primary care is effective in treating depression and anxiety, the most common mental health conditions, and mental health conditions that co-occur with physical conditions such as cancer, diabetes, and HIV.[15] During his first State of the Union address, President Biden outlined a four-part unity agenda with targeted investments to take on what he described as the country's mental health crisis. It calls explicitly for the integration of behavioral health in primary care settings.

The Definition of Behavioral Health Integration Is Straightforward and Elusive

The Lexicon for Behavioral Health and Primary Care, funded by the Agency for Healthcare Research and Quality (AHRQ) recognized the need to find a common language and concepts related to integration that would allow providers, practices, health plans, purchasers, governments, and researchers, among others, to communicate effectively to advance implementation. The essence of the definition is "care that results from 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."[16] This overview definition is deceptively straightforward. Discussions in academic and trade publications have enumerated nuances that have not consistently contributed to clarity.

The search for clarity is about what constitutes effective, evidence-based behavioral health integration. There is almost no debate among practitioners or scholars that the Collaborative Care Model fills this bill.[17,18,19] It is often referenced as the gold standard and a substantial number of practitioners and scholars argue that fealty to the model (and policy/practice supports that enable its implementation) are necessary given the lack of conclusive research on other models. The Path Forward for Mental Health and Substance Use, a prominent coalition of employers, professional associations, and advocates is unequivocal in this assertion:

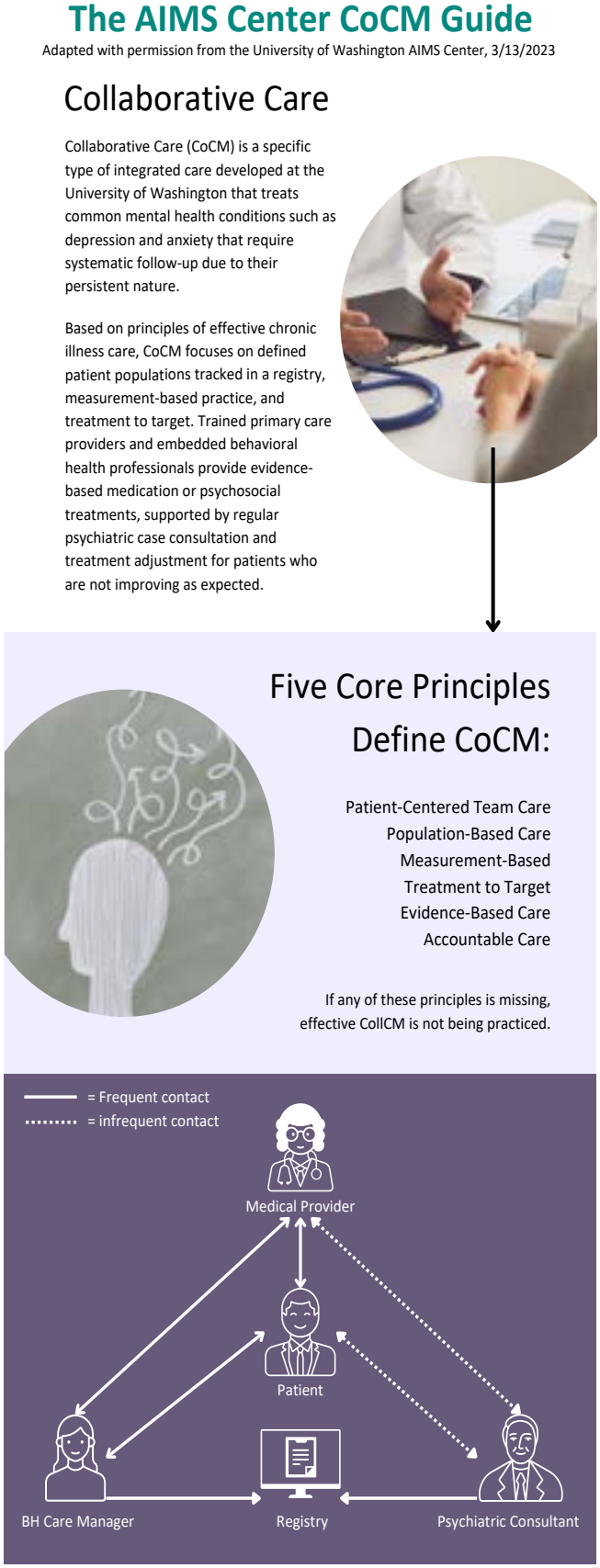
> *[W]e are calling upon all mental health advocates to move beyond simply advocating for undefined 'best practices in mental health integration with primary care' and instead focus on the Collaborative Care Model in their proposals and recommendations. …there is no other evidence-based practice in primary care which is immediately available to be scaled and implemented to increase our country's ability to systematically screen and treat mental health conditions while reducing health inequities and improving outcomes.*[20]

The Path Forward pointedly remarks that gains in reimbursement for Collaborative Care, as the model defines it, took decades to achieve.[v] It implies that testing and

[v] There are 5 CPT codes for Psychiatric Collaborative Care Management services: 99492, 99493, 99494, G2214, and G0512.

validating other models will distract from continued concerted support for a proven approach.[21]

The appeal of this position is that it provides a clear path forward, as advertised. It is straightforward and scientifically sound. Moreover, there is a tremendous amount of detailed and accessible guidance to enable implementation from academic, government, and professional sources. By far the most comprehensive can be found at the AIMS Center, University of Washington, Psychiatry and Behavioral Sciences Division of Population Health. CMS has also posted guidance through the Medicare Learning Network, Behavioral Health Integration Services.[vi] Moreover, there is a growing amount of technical assistance available. Two participants in this project's Advisory Group (NeuroFlow and Concert Health) developed significant analytical, information systems, and workforce supports for the implementation of the Collaborative Care Model and these companies are far from alone in their fields.[vii]



As of the publication of this report, over 23 commercial plans and 26 Medicaid plans cover CoCM.[22,23]

[vi] A good example of a peer-reviewed study of CoCM implementation that attempted to tackle some of the model's challenges is Addressing Common Challenges in the Implementation of Collaborative Care for Mental Health: The Penn Integrated Care Program.

[vii] There were strong supporters of the Collaborative Care

In our research, however, we were forced to note emerging guidance to primary care practices that side-stepped the specific requirements of the CoCM. Two major professional associations, the American Medical Association (AMA) and America's Health Insurance Plans (AHIP),[viii] publicized strong positions on the benefits of behavioral health integration in primary care but treated CoCM as one model among several that could be pursued.[ix]

In its Behavioral Health Integration Compendium, the AMA explains that the goal of the document is to provide detailed information on the steps required to integrate behavioral health care by different types of practices based on "a wide range of carefully vetted existing resources."

> *Different pathways may be taken to integrate behavioral health into primary care, pedatrics, obstetrics and gynecology, or other specialty care…[recognizing] the importance of meeting practices wherever you are on your journey to integration and providing relevant tools for success as you go forward. Integration is a continuous process and not a time-limited project. There are many ways to pursue BHI [behavioral health integration] and numerous opportunities to modify such efforts as patient needs and practice resources evolve.*[24]

AHIP's recent issue brief on Integrating Behavioral and Primary Care likewise highlights the importance of addressing behavioral health needs and provides examples of behavioral health strategies that its members have adopted. Supporting a range of approaches (including the CoCM), AHIP also cites work by the Center For Health Care Strategies that describes a continuum of models that states have adopted in contracting with Medicaid MCOs.

Model on the Advisory Group, but they were reluctant to declare that it provided the sole solution even as their work was focused on its implementation.

[viii] Advice from federal agencies also became more expansive. See the Substance Abuse and Mental Health Services Administration (SAMSHA) and the Agency for Healthcare Research and Quality (AHRQ).

[ix] Several articles reference prominent models of integrating behavioral health services in primary care including the Screening, Brief Intervention and Referral to Treatment (SBIRT) model and the Primary Care Behavioral Health (PCBH) model. See Integrating Behavioral Health Services into Primary Care: Spotlight on the Primary Care Behavioral Health (PCBH) Model of Service Delivery. See also Successful Examples of Integrated Models from Across the Country, describing "models" implemented in different states and An Evidence Roadmap for Implementation of Integrated Behavioral Health Under the Affordable Care Act, Table 2.

From a Fixed End Point to Quality Improvement Frameworks

The academic literature also showed a marked shift. Focused as well on providing flexibility to primary care practices in integrating behavioral health, within a two-year period researchers published five separate "frameworks"[x] intended to guide practices in implementing behavioral health integration.[xi] Each framework defined slightly different stages of integration and milestone measures. Nevertheless, they explicitly shared the desire to identify "core elements" of integrated behavioral health that would help practices improve behavioral health and provide measures of accountability that multiple stakeholders—especially payers—could use in real world settings. All were explicit in the need to continue the development of an evidence base for identified elements but were likewise unwilling to endorse a singular implementation end point or absolute requirements.

> *Several factors impede the adoption of the many available approaches to integrated care. These factors include a lack of clarity on what constitutes core components of these models and how models and their core components can be successfully adapted to local contexts… and research is lacking to identify the structures and processes of care that have the strongest evidence to improve outcomes.*[25]

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[x] In chronological order: Evaluation of a Continuum-Based Behavioral Health Integration Framework Among Small Primary Care Practices in New York State, Defining and measuring core processes and structures in integrated behavioral health in primary care: a cross-model framework, The Comprehensive Healthcare Integration Framework (which shared and built on the General Health Integration Framework for behavioral health organizations), The Building Blocks of Behavioral Health Integration, The Colorado Multi-Payer Collaborative: A Framework for Integration of Whole-Person Care. In addition, AHRQ published a Framework for Measuring Integration of Behavioral Health and Primary Care ("Building Blocks").

[xi] It is important to note that we refer to integrated frameworks. As one author of such a framework noted (and described) there are existing frameworks that are model-specific (e.g., the Integrated Practice Assessment Tool, NCQA's Patient-Centered Medical Home Behavioral health distinction).[26] It is also possible, if not likely, that we missed additional comprehensive frameworks, but those we identify featured prominently in internet searches to identify guidance on behavioral health integration.

The National Council on Mental Wellbeing was the most explicit in arguing that a comprehensive framework was necessary to address barriers to "broad uptake" of integrated services for individuals with co-occurring physical, social and mental health needs. The barriers included the following:

- Lack of flexible pathways for improving integrated services that are both specific enough to operationalize and flexible enough to adapt to each organization's resources and populations served.
- Lack of appropriate evidence-based bidirectional measures of progress in integration.
- Lack of relevant metrics that demonstrate the connection between integration and value.
- Lack of methods for payers to finance both implementation efforts and sustainable integrated services.[xii]

The frameworks are united in relying on both peer-reviewed studies and expert clinical consensus[xiii] to set forth "domains" of integrated care, together with structures and progressive process steps toward greater integration. They unambiguously reflect the determination that there is more than one way to deliver integrated services that represent "measurable improvement compared to historical practice."[xiv, 27] Perhaps more significantly, the frameworks permit practices to succeed through continuous quality improvement in defined activities, a shift away from adoption and fidelity to an integration model as a single evidence-based paradigm.[xv]

[xii] The National Council referenced the extensive report by the Bipartisan Policy Center Behavioral Health Integration Task Force as a major source of the barriers it sought to address. The Report contains more than 50 legislative and regulatory recommendations, including an assessment of the net costs of their implementation. It is the most thorough discussion of policy, financial and operational issues to date and NEHI relied on its analysis to guide several discussions during this project. Notably, the Task Force recommended establishing core minimum standards essential for integration.

[xiii] The framework authors used a combination of interviews, surveys, and expert panel guidance.

[xiv] Although not strictly a "framework" approach, we note the work of Goldman et al to describe structural components of integration based on four models (national initiatives) other than CoCM. These include the Primary and Behavioral Health Care Integration Program, the Certified Community Behavioral Health clinic demonstration, the Medicaid Medical Home, and the Patient-Centered Medical Home. We later reference the article's conclusions about "essential components."[25]

[xv] Gold et al. attempts to distinguish the framework proposed in Building Blocks from other published frameworks and thus, if unintentionally, illustrates the difficulty of sorting through the approaches (pp.9-12).[26]

In discussions with the Advisory Group, four points stood out:

- Most obvious: Frameworks abandon efforts to find the best model of complete integration in favor of articulating features of integration that improve access to effective behavioral health care.[xvi]
- Frameworks propose ways to engage payers in supporting integration. (We discuss this further below.) Three of the frameworks[xvii] address their application to payment models for both initial and sustaining activities.[26, 27, 28] The CHI framework provides "a progression of complexity in the application of various payment methodologies (e.g., CPT code payments, pay for process achievement, and pay for performance) to incentivize progress along the Integration Constructs."[xviii, 28]
- The Frameworks contain many common elements–both in terms of structures and processes, but they are not identical and thus they likely contribute confusion.[xix]
- Implicitly or explicitly, the Frameworks continue to require technical assistance and support in their application, a feature sometimes underplayed.

In our Advisory Group meetings, we discussed whether there was sufficient consensus to endorse one of the frameworks. In this way, we shared the Path Forward's desire to unite the field and focus on a single direction. We could not achieve this outcome

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[xvi] Some Advisory Group members remain concerned that the Frameworks will produce "effective" care because they are not subject to the same evidentiary standards as the CoCM. As a practical matter, it would be very difficult to subject Framework activities to randomized controlled trials; the Framework concept allows different phases of activities that have an evidentiary base, as noted above, but rely on ongoing measurement to determine whether an activity contributes to improved outcomes.

[xvii] The Comprehensive Health Integration Framework, The Building Blocks of Behavioral Health Integration, and The Colorado Multi-Payer Collaborative.

[xviii] The CHI framework also emphasizes that its applicable to both primary care and behavioral health settings, as well as to adult, adolescent, and child populations. The authors maintain that "[t]he CHIC Framework can function as a measurement tool for integratedness that permits practices, programs and provider organizations to delineate to themselves, payers, and population managers their progress in delivering integrated services to people served."[28]

[xix] The National Committee for Quality Assurance (NCQA) may have a role to play in uniting the frameworks. Translating framework elements into quality measures that payers and providers could use collectively to measure improvement and incentivize collaborative activity could be powerful. Current certification of PCMH and Behavioral Health Distinction do not appear aligned with the Frameworks.

through the endorsement of a specific framework.[xx] Nevertheless, even strong proponents of the CoCM in the Group supported further work with the frameworks, with the caution that they were overly complex and contained elements that required further evaluation to determine which elements were necessary to produce desired outcomes. The framework authors themselves emphasize this limitation. It contributed significantly to the Group's hesitancy in endorsing any one of the frameworks. Thus, the Group left open the question of whether the frameworks need to be aligned and formally endorsed. As explained in our conclusions, we answer both questions in the affirmative.

In addition, several members of the Advisory Group commented that, with a few exceptions,[xxi] there was inadequate data to evaluate the impact that published guidance had on adoption of any form of behavioral health integration. Consultants and vendors provide some testimony on what they can achieve as part of their marketing efforts, but these focus on the products they introduce, and not on the impact of the published guidance.[xxii] Practitioners and payers would benefit from additional assessments of the advice and technical assistance that has enabled (which types of) practices to integrate and sustain the provision of behavioral health.

[xx] This was likely due to the format of the project and the time allotted to group meetings. NEHI staff inferred that the Advisory Group members wanted to support the framework authors, some of whom participated in the Group, and did not have sufficient time to review, evaluate and compare the distinctions among the frameworks.

[xxi] See Chung's Evaluation of a Continuum-Based Behavioral Health Integration Framework Among Small Primary Care Practices in NYS.

[xxii] See The Behavioral Health Integration Implementation Guide, The Behavioral Health Integration Compendium, and Implementing the Collaborative Care Model.

An Increasing Number of Technological Supports Can Fill Critical Capacity Gaps

Access to technological capabilities is as important as workforce challenges in discussing barriers to implementation of integrated behavioral healthcare. At the very least, behavioral health and primary care providers must be able to exchange accurate information effectively and engage in systematic reviews of treatment outcomes. The Collaborative Care Model is explicit in requiring a patient registry for tracking. The extent to which certified EHRs currently contain clinical decision support tools for behavioral health or enable rapid documentation of behavioral health history is not clear. Most EHRs do not support the functionality a registry requires. Moreover, while medical practices have adopted electronic health records because of financial incentives provided through federal legislation, behavioral health practices are said to have less adequate documentation capabilities. Finally, electronic billing and revenue cycle management are both keys to reimbursement. Even for practices that have adopted behavioral health integration, incomplete information flow between behavioral health organizations and non-behavioral health clinicians, as well as billing difficulties (compliance with specific documentation requirements) continue to pose challenges.[29] CMS has called out some of these difficulties in its recent proposed Rule, Advancing Interoperability and Improving Prior Authorization Process (CMS-0057-P), reissuing a request for information to inform potential future rulemaking on how to advance electronic data exchange among behavioral health providers who have lagged behind other provider types in EHR adoption.

The dramatic acceleration of digitally enabled care and technological capabilities should enable practices to overcome these barriers. As the AMA pointed out in its recent report, Accelerating and Enhancing Behavioral Health Integration Through Digitally Enabled Care: Opportunities and Challenges, there are digital tools that can perform essential functions required to improve the integration of behavioral health in primary care. These include digital intake and screening tools, digital referral tools, platforms to facilitate care planning, and proactive outcome monitoring, as well as systematic caseload reviews. Our Advisory Group members further highlighted the growth in technologies that address workflow challenges such as automated workflows and remote patient assessments. Moreover, telehealth can expand the access that both patients and care team members have to psychiatrists and other behavioral

health providers in areas where these specialists are limited. A few companies provide "turn-key" solutions, offering technological as well as workforce support. Two of these (Concert Health and NeuroFlow) participated in our Advisory Group. Despite the great promise of many of these digital tools, there are very few of these enhancements that are routinely included in EMR's. It is critical that the data generated by these tools are available to both primary care and BH providers through inclusion of this information in health records—in a way that is comparable to other health data.

The frameworks and specific "readiness" assessments are designed to assist practices in evaluating where they stand on the path to behavioral health integration. Vendors have also begun to develop survey tools that identify gaps in practices' capabilities, with questions geared to highlighting the solutions they provide. These should assist practices in determining whether they should look to develop needed resources internally and/or evaluate what they can purchase from outside companies. The possibility of coordinating with other practices and payers to contract for skills required in common may make this alternative both efficient and effective. Our conclusions emphasize that scaling behavioral health integration may require scaling these technological and digital health solutions as well.

Technologies are not, of course, technical assistance, although the overlap is increasing. Companies that aid primary care practices using technological platforms also address associated needs, including connections to behavioral health clinicians. These companies appear to be growing in both number and reach. From discussions NEHI has had with several, both in and outside of the Advisory Group, they are focused on ways to bring their tools to scale. Some payers have indeed promoted these solutions. In our conclusions below, we note that joint assessments (by payers and practices) of the technological and technical assistance required by practices may ensure speed as well as efficiency in the adoption of behavioral health integration.[xxiii]

[xxiii] We need to emphasize that our paper is far from an exhaustive review of the role that technologies play in behavioral health, especially, as noted earlier, in examining AI-curated content for patient self-management.

Sorting Through Payment Models and Payer Roles, However, is Challenging

The frameworks acknowledge the important role that payers must play in the adoption of behavioral health integration. Indeed, there has been long-standing discussion of "payment models" as either enablers or barriers to innovation generally. In the fee-for-service environment, the five Collaborative Care CPT (current procedural terminology) codes have clearly assisted uptake of the Collaborative Care Model.[xxiv] Provided the practice has implemented foundational elements of the Collaborative Care Model, these codes (with the exceptions noted) enable primary care physicians to bill for time spent coordinating care that is complementary to direct service delivery and provided by care managers.

Two codes (99484 and the newly minted G0323, the latter as of 1/1/23) do not require CoCM elements like a registry or a psychiatric consultant and can be used by practices in conjunction with other models (e.g., primary care behavioral health homes); G0323 allows psychologists and clinical social workers to serve as the billing provider, rather than billing under the primary care provider. The payment levels for these non-CoCM codes are, however, less generous than those requiring implementation of CoCM elements, which have also been criticized. Providers and consultants have noted both variability and deficiencies in the rates in relation to the initiation (startup) as well as the ongoing costs of CoCM.[30] For this reason, grants and demonstration project funding have been required as supplements.

Although some argue[xxv] that the codes have the power to incentivize the adoption of the CoCM if the rates are increased to cover the real costs of start-up and maintenance, and/or practices receive assistance in complying with the codes' billing requirements,[xxvi]

[xxiv] Medicare was the first payer to allow billing with these codes, but Medicaid programs and commercial payers have increased their use in recent years.[23, 31, 32, 33, 34, 35]

[xxv] One of our Advisory Group members noted that interest in pursuing behavioral health integration increased substantially –as evidenced by outreach for assistance in implementing the CoCM—when the collaborative care code rates were raised It is worth continuing to examine this.

[xxvi] On December 12, 2022, the national Council for Mental Well Being tackled this very issue, publishing a decision support toll and billing modules to help provider organization "sustainably finance integrated care." Because our project was substantially complete by this date, we did not have the opportunity to discuss it, but thank Virna Little for highlighting its

Medicare implemented the codes in 2018 and few would declare "mission accomplished". It seems fair to conclude that the availability of reimbursement for integration activities through the collaborative care codes will not (alone) accelerate integration for many types of practices.[xxvii]

Perhaps consequently, there is strong advocacy for adoption of value-based payment models[xxviii] or payment arrangements classified as alternatives to FFS. In Integrating Behavioral Health and Primary Care, AHIP (America's Health Insurance Plans) has identified and described many of its members' efforts to support behavioral health integration through value-based arrangements. We were not, however, able to assess whether there is greater uptake of behavioral health integration with these alternatives. We concede that the lack of studies on this point may indicate that it is too difficult to do them. It may also be telling that as of 2019, less than 40% of healthcare dollars flowed through a value-based payment model and few incorporated incentives around managing behavioral health conditions. In addition, even value-based arrangements can burden primary care practices. Inadequate access to data and the assumption of risk in value-based arrangements can result in the same financial deficits that practices experience with fee-for-service payments that fail to cover costs.[36]

Payment models can certainly influence adoption of behavioral health integration. But the Bipartisan Policy Center has implicitly clarified, through the sheer number and scope of its recommendations, that neither alternative payment platforms nor traditional fee-for-service arenas are likely to incentivize behavioral health and primary care integration without significant policy changes. Their recommendations are both logical and impressive in their detail but will require political will and coordination.

Ways to accelerate at least some of the Task Force recommendations are, however, emerging.[2] Payers and providers have begun to customize and buy in jointly to payment models that produce mutual benefit and outcomes. We found several applications of payer-provider relationships that signal the importance of incorporating features of

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importance.

[xxvii] Over 23 commercial plans and 26 Medicaid plans cover CoCM.[23]

[xxviii] Value-based payment arrangements are described as those tying payments for care delivery to the quality of care provided, with providers assuming financial risk under some of the value-based care models (bundled payments; accountable care organizations). For providers to succeed financially, they must have good access to accurate data regarding their patients' care and outcomes.

"partnership" and mutual accountability. These include primary care transformation efforts based on the Comprehensive Primary Care Plus Model (CPC+), efforts to expand the Collaborative Care Model by Blue Cross Blue Shield of Michigan and Blue Cross Blue Shield of North Carolina, and a four year initiative known as the Colorado Multi-Payer Collaborative.[xxix]

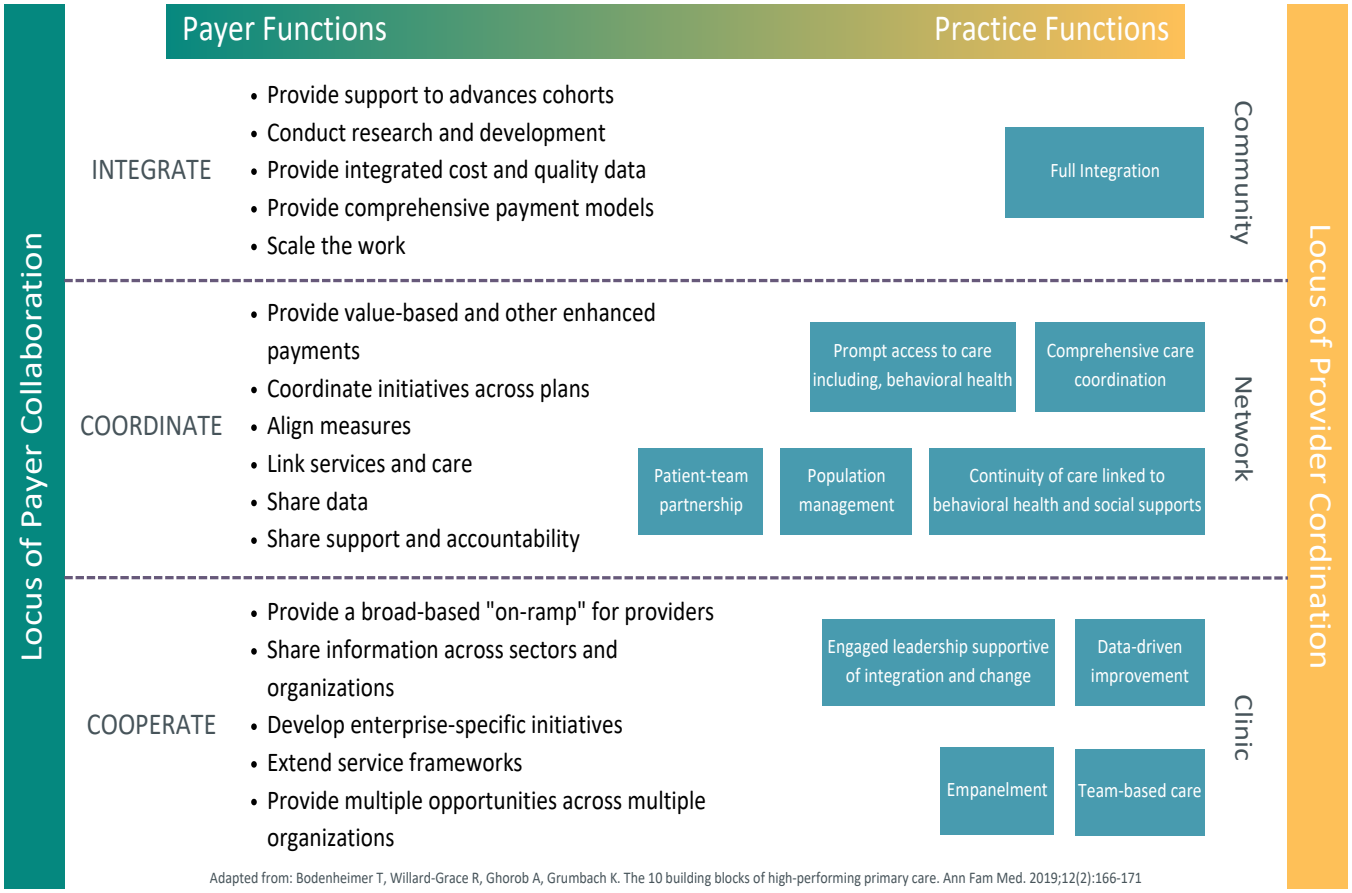
The most intriguing report—in part because it is the most detailed—is from the Colorado Collaborative.[xxx] It is also the only report we found that joined payers and providers in the development and implementation of a specific framework. The results of the collaboration among multiple providers and payers, which lasted four years, are admittedly mixed and frustratingly unclear. On the plus side, the Collaborative reported supporting more than 250 practices and approximately 2100 individual providers "through various initiatives.". It also produced a "shared" framework (built on "The 10 Building Blocks of High-Performing Primary Care,")—from shared work—that emphasized coordination and collaboration among and between providers and payers. This distinction from other frameworks appears to be greater than nuance. The framework was, from the start, locally organized and intentionally actionable by those who created it. The Collaborative is one of the only reports we found that recognizes not only the role that payers must play in promoting elements of behavioral health integration, but the role that they must play in coordinating with one another and in formulating common payer goals, measures, and metrics.[xxxi]

[xxix] We cannot represent that our list is comprehensive. We note especially that we have not identified state Medicaid efforts to collaborate with providers. Efforts involving state agencies that are worth noting include Rhode Island's Care Transformation Collaborative (Advancing Integrated Care) and Minnesota's multi-stakeholder recommendations sponsored by the Institute for Clinical Systems Improvement. The Rhode Island effort focused on pursuing pilots to implement behavioral health integration, with payer support, in both adult and pediatric primary care settings. The latter gathered health leaders, medical leaders, and employers to identify and overcome barriers to the adoption of the Collaborative Care Model. The recommendations urge what we conclude is a form of ongoing partnership—the creation of a regional center for excellence to support the advance of the CoCM that enables sharing of workforce, training, implementation support, measurement and monitoring of progress, and alignment of care delivery/payor/state efforts.

[xxx] The Oregon Health & Science University, which facilitated the original collaborative, issued a second evaluation of the effort. We spoke with the author briefly.

[xxxi] In 2012, the MPC brought prominent payers together, including Aetna, Anthem Blue Cross Blue Shield of Colorado, Humana Inc., Rocky Mountain Health Plans, UnitedHealthcare, WellPoint, Medicaid, Teamsters Union Health Plan and CMS. By the end of 2021, five primarily national players remained in the group. At least in 2015, there were a total of six participating insurers: Anthem, Cigna, Rocky Mountain Health Plans, United, Colorado Access, Colorado Choice Health Plans, as

The Colorado Multi-Payer Collaborative: A Framework for Integration of Whole Person Care.[37]



The Multi-Payer Collaborative (MPC) added four "dimensions" to The Ten Building Blocks, two of which we emphasize in the graphic: (1) the addition of the "locus of provider coordination"; and (2) the organization of payer functions into "levels of collaboration". The common payer goals, as the MPC describes them, extend beyond adequate financial support, and must be further defined by the providers with which payers interact to address other critical payer functions. These include providing and sharing cost and quality data and working with providers to develop specific initiatives that may be coordinated across plans. It seems critical to determine whether "shar[ing] support and accountability" extends to developing and retaining a network

well as Colorado's Medicaid program. In 2019, Rocky Mountain Health Plans published a guide for practices to support the financial sustainability of behavioral health integration. In 2022, Rocky Mountain Health Plans announced a partnership with UnitedHealthcare. Whether these events were connected to the Collaborative is a matter left to interviews, which we were not able to pursue.

of behavioral health providers, a key issue in enabling integration and a point that advocates have emphasized in reference to expansion and enhanced enforcement of the 2008 Parity Act.[38, 39] But—and this is a significant reservation—the Collaborative itself no longer exists and further progress is pending.[xxxii] Certainly that report will yield useful insights. We surmise that the Collaborative structure was difficult to maintain given the significant market changes among payers and providers during that time. We take this into account in our conclusions but remain firm about the importance of payers' full collaboration in support of effective behavioral health integration in primary care. A Commonwealth Fund report in December 2022 helps bolster our confidence. It described the comprehensive approach by Rocky Mountain Health Plan, one of the Collaborative's former participants and a Medicaid managed care plan in an area of Colorado that experienced suicide rates three times what could be expected in a county of its size. As described in the report, the program increased the number of RMHP members receiving behavioral health services outside of community mental health centers by 66 percent, a reflection of the number of primary care sites that were able to offer meaningful behavioral health services.

RMHP use payments to support more robust primary care capabilities and it provided technical assistance to providers with respect to critical aspects of evidence-based integration practices. It developed a separate contract (the Community Integration Agreement) to support behavioral health integration flexibly, in accordance with a practice's needs. Especially noteworthy are the "Lessons" derived from its approach, two prominent among them since they mirror our own:

- To integrate behavioral health services, practices need more than funding.
- Scaling behavioral integration will require investments from all health care payers — as well as solutions for the uninsured.

[xxxii] Conversations with Oregon Health & Sciences Univ.

Conclusions

Many dedicated and smart researchers, practitioners, and health care executives have been trying for years to find the secret sauce that will scale behavioral health integration. We observed a progression in the literature. For at least 20 years, clarifying the benefits of behavioral health integration in primary care and demonstrating its value (especially through the Collaborative Care Model) consumed academic research attention and, to a lesser extent, advocacy. In the last decade or so, the growing attention to gaps between need and treatment for mental health conditions has highlighted the discordance between a "proven" approach (CoCM) to improving access and outcomes and the disappointing adoption of integrated care outside of grant and demonstration programs. This has accelerated analysis of the barriers to adoption and advocacy for changes, many of which have been effective.[xxxiii] The incredibly thorough Bipartisan Policy Center Task Force recommendations, "Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration" appears to be the most comprehensive example of this shift.

What are we contributing here? Given the approach and scope of this project, we offer what we have learned from a review of relevant reports and peer-reviewed research, supplemented by the perspectives and opinions of individuals who have been working on issues related to behavioral health integration for years. We also offer a view of where we might go from this point, to accelerate turns of the proverbial flywheel. Our conclusions are directional and stated with deep humility. We would venture that a few pilots could put them to the test. Indeed, we hope our conclusions spur further activities between payers and providers and among payers. These activities should incorporate market-based innovations—in telehealth, in information technologies, in workforce development and patient engagement. As noted, our conclusions reflect comments made by the Advisory Group members, but our biases undoubtedly gave credence to some comments at the expense of others. Therefore, the conclusions are our own. Where possible, we note any strong disagreements with them.

[xxxiii] The Behavioral Health Integration Workgroup organized by the Primary Care Collaborative set two priorities in 2020: including behavioral health in state-based primary care investment legislation and advancing virtual support for the integration of behavioral health and primary care. They credit their work with the adoption of related legislation in 13 states.[23, 32, 33, 34, 35]

Flexible Approaches to Behavioral Health Integration Are Necessary

There is an undercurrent of controversy in the field among academics, advocates, and practitioners that positions supporters of the Collaborative Care Model against those who are willing to endorse "other" approaches. This is distracting and ultimately unproductive given the goals that both sides of the debate share. There is little question that practices should adopt the Collaborative Care Model where they can—and policies and payers should continue to support adoption of the model through payment for collaborative care codes, among other things. Likewise, entrepreneurs should continue to develop technologies and related solutions to support implementation of the CoCM. In this regard, we very much appreciate and applaud the efforts of the National Alliance of Healthcare Purchaser Coalitions, the Path Forward. In the "RESET" regions in which the practice structures, workforce, and payer policies coalesce sufficiently to facilitate implementation, a further push to scale the model seems like the best approach.

But practices have been urged to implement the Collaborative Care Model for more than 15 years, following at least 10 years of studies. Given the crisis we face today in access to behavioral health treatments, encouraging flexibility and continuing development of ways to provide behavioral health in the context of primary care seems wise, if not essential. Moreover, published Frameworks are grounded in literature and consensus among experts, providing guidance that synthesizes evidence from the implementation of different models of behavioral health integration. Because they do not require a specific set of activities and explicitly allow practices to implement activities in different sequence, implementation efforts that rely on them may, however, avoid accountability or evaluation. We attempted to address this issue below.

Focusing on Basic Goals and Activities of Behavioral Health Integration In Primary Care Align Stakeholders; Setting Goals and Measures Are Necessary to Ensure Quality Improvement and Frameworks Provide Guidance on Key Points of Accountability

By defining goals and set of activities geared to meeting these, our discussion with the Advisory Group suggested a way to address accountability while maintaining flexibility. We also concluded that doing so would mitigate the complexity of multiple frameworks while clarifying ways in which they serve as important references.

1. An Accessible Set of Core Goals

Members of the Advisory Group noted that practices are often strongly motivated by their own needs and goals in deciding to pursue behavioral health integration, calculating that the model, or some facsimile thereof, will serve those goals.[xxxiv] With the discussion of the role that goals played in motivating the adoption of behavioral health integration, we observed that there were few statements of the goals that behavioral health integration should achieve—despite the statement of benefits produced by different models and applications. Members of the Advisory Group voiced concern that we had lost the motivating vision or true north, and thus the advantage of inspiration and aspiration. From experts in the field, this was a notable comment. It resulted in a substantial discussion of what the goals of behavioral health integration should be. There was substantial consensus on the following goals:

I. Improvement in patient symptoms and measurement-based care
II. Improved patient perception of quality of life and willingness to seek help
III. Reduction in primary care clinicians' reports of burn out and burden
IV. Reduced morbidity and mortality; lower use of emergency care
V. Improved access to behavioral health for underserved populations

The goals reflect a commitment to more system-based objectives and, we surmise, lead to further recommendations about the transformation of primary care within the

[xxxiv] For example, reducing suicide rates in the adolescent population or addressing high rates of anxiety among elderly panel members.

healthcare system. Moreover, and more importantly, The Advisory Group members underlined this point. Validated measures must be developed for these goals. Indeed, many have pointed out the dearth of measures to assess the quality of integrated care.[xxxv] After reading a draft of this paper, Henry Chung, a member of the Advisory Group, felt we did not sufficiently emphasize a related point: There is not just a lack of measures; there are insufficient incentives to utilize those measures in a way that accords with quality improvement, including, for example, the administration of measures at least once every 2-3 months while an individual is under treatment and regular reports of "realistic" response and remission measures—i.e., using agreed upon scores rather than difficult to calculate percentage reductions. While this topic presents a core issue, it is beyond the scope of our work—except to note its importance in the context of our recommendations. We add that a recent publication provides validated measures to track symptoms and functional outcomes in the context of mental health and substance use treatment,[xxxvi] and argues that these have been used in real-world settings without undue burden to primary care practitioners. As a first step, it is essential to incorporate these as part of the goal setting process and to continue the effort to link goals with metrics that can be used to evaluate success in achieving them.

2. Identifying Activities Essential to Achieving Specific Goals

Guidance for implementation of the Collaborative Care Model and the Frameworks for progressive implementation of behavioral health integration identifies "domains," "building blocks," and "key elements," among other descriptors. The Advisory Group concluded that there was utility in describing essential activities above this level of detail, in plain, operational terms that included processes associated with the launch and maintenance of integrated care. We reached consensus on the following activities:

I. (As per above) Identification of clear goals and quality improvement measures for integration activities.

[xxxv] One of the participants in our Advisory Group, has made the point (in our project, in multiple webinars, and in peer-reviewed publications) that there are few validated measures for the quality of integrated care. There is consensus on this point. Examining the measures in use could further advance measure development work.

[xxxvi] Alter et al describe thirty-six rating scales that meet standards of reliability and validity necessary for use – all of which can be used in primary care or specialty care settings for the MH/SU conditions they address. They included measures that have evidence of use in real-world settings with the notation that these were not considered burdensome for clinicians or patients to complete.

II. Identification of a single, operational leader in the primary care setting for integrating behavioral health.
III. Calculation of resources required to build or buy core capabilities of behavioral health integration.
IV. Execution of one or more arrangements with payers that provides financial and technical support for initiating and sustaining those core capabilities
V. Incorporation of evidence-based treatment activities in a management and care plan that is led by a primary care practitioner and explicitly includes clinical and administrative staff.
VI. Adoption of health record tools that support screening patients for behavioral and medical health conditions, assessment of safety/suicidality, and—critically—ongoing evaluation of the treatment plan's impact on health outcomes and enable improvement against treatment goals.
VII. Implementation of electronic health record tools that are accessible to "team" members to manage patients outside of specified appointments and maintain a coherent treatment approach.[xxxvii]
VIII. Execution of a training program to orient patients to the practice and facilitate provider-provider and provider to patient communications

In devising this list, we discussed at length the need to identify leadership (an element of most frameworks). We focused as well on essential technology. Clinical members of the Advisory Group highlighted the importance of establishing a management and care plan incorporating evidenced based treatment activities. Companies involved in providing technical assistance to practices insisted that plans must align clinical and administrative staff.

We added activities that explicitly required practices to calculate their resource needs and secure arrangements that provided sustaining support.[xxxviii] Some Advisory Group members expressed discomfort or hesitancy on this point, with the view that practices can assume some risk to develop proof of concept. Our conclusion remains that an advance calculation is essential and, indeed, a deficit in current efforts, although we have no reliable data on how many practices suspend efforts to integrate behavioral health or abandon integration after implementation of key activities.

[xxxvii] This includes the use of self-directed behavioral health tools and resources for patients, who are critical members of their treatment team.

[xxxviii] Technological supports are available for this function, including patient risk-stratification.

As we have noted elsewhere, "readiness" assessments are available. We hope our list might also function in this capacity, especially to identify for practices where they might seek resources to supplement their own capabilities, aiding completion of the list's second bullet.

3. Integrating Framework Guidance

We have enormous respect for the work that went into creating the BHI Frameworks and the integrity of their recommendations. It would be foolhardy to set them aside. Instead, we argue that the description of core goals and activities here might make the Frameworks more useful. They are detailed reference guides or maps for various activities. They provide milestones or measures for these, thus building into the implementation process ways to assess whether activities have been achieved. They also, in some cases, clarify activities' components. Combining an assessment of activities with an evaluation of the extent to which the practice has achieved its goals should produce –at least at the individual practice level—a path to determine whether it is the implementation process or the activities themselves that require modification. As discussed in a subsequent section below, payers are particularly well suited to disseminate learning from these from these individual efforts.[xxxix]

[xxxix] Framework sponsors have indeed remarked on the need for this type of evaluation. They have also noted its challenges. An evaluation by one of the Advisory Group's participants of behavioral health integration adoption among small primary care practices in New York using a specific framework included both qualitative and quantitative analyses, with significant involvement from the project team, a baseline and subsequent surveys, as well as interviews and focus groups. Although this provided significant information on the framework's strengths and weaknesses, which led to modifications by the authors, they noted that submission of quality metrics by the practices themselves was challenging. Requested reports from 10 practices of data on PHQ screening and yield rates, follow up rates for depression, billing and revenue received screening, yielded mixed response rates (e.g., only three sites reported on depression score monitoring and prompt follow-up; only one site was able to report any data on external referrals and shared communication). Noting these results, the authors recommended "building collection and tracking of quality metrics in future BHI advancement work from the beginning."

Scaling Behavioral Health Integration Requires the Expansion of Payer-Provider Partnerships

Guidance has been focused disproportionately on the activities that primary care must pursue, with far less well-stated views on payers' participation and accountability for improving behavioral health integration, despite the many commentaries that highlight the need for greater financial support from payers to address the costs of integration and the benefits that accrue to payers from addressing their members' behavioral health needs. Given the different positions from which primary care practices start on the journey to integrate behavioral health as well as differences in their patient populations that will affect their goals and their activities, we conclude that payers and providers must be open to devising tailored arrangements that address regional, if not local, circumstances.

1. Policy options are well-stated, but many will take time; payers and providers have room to move forward proactively

Given the number of articles, webinars, and presentations about the importance and benefits of integrating behavioral health in primary care (and, increasingly, integrating physical health in behavioral health settings) the case for doing so has been made. We agree with the policy recommendations made by the Bipartisan Policy Center Task Force that leverage federal and state contracting authority to "incentivize" adoption of behavioral health integration. These include various ways of structuring states' contracts with Medicaid managed care organizations, requiring states to make behavioral health integration part of its quality strategy with MCOs, and making behavioral health integration part of the Medicaid managed care quality rating system. Noting, however, that only 26 states require reimbursement of the collaborative care codes, we would also urge CMS to create incentives for states to do so, with guidance for appropriate and adequate payment, even (as the BPC urges) supporting capacity building through section 1115 waivers. Activation of CPT Code 99484 for case management and non-CoCM integration by Medicaid is also necessary. States' activation of inter professional codes for Medicaid beneficiaries could likewise help with non-CoCM behavioral integration. It may also be time for states to consider providing legislative and regulatory incentives through coverage mandates. We acknowledge that these inevitably generate opposition, often based on principled objections to

legislative interference in insurers' coverage decisions, which can produce unintended consequences. Even as we acknowledge the need for some legislative and regulatory supports, we must note that policy is subject to politics and, accordingly, we offer a concurrent path to move adoption of behavioral health integration forward more immediately, if incrementally.

As of December 29th, moreover, the enactment of the Consolidated Appropriations Act, 2023 (H.R. 2617) provides a boost to efforts to adopt the Collaborative Care Model. It provides grants and technical assistance to primary care practices to implement the Model for early intervention and prevention of mental health and substance use disorders.

2. Innovative arrangements between payers and providers, and collaboration among payers, can accelerate learning and create standards that reduce unproductive variation and burden

We are encouraged by the efforts of many national commercial payers. Momentum for payer support for the integration of behavioral health seems to be growing, both in terms of contractual arrangements with providers and with vendors who offer platforms that enable primary care practices to integrate behavioral health in their practices. That said, we had difficulty finding payer driven adoption of behavioral health integration, other than the examples we cited and Medicare's implementation of the collaborative care codes. Aside from the Colorado Multi-Payer Collaborative example, moreover, examples of payer initiatives were individual contractual arrangements with few shared learnings. We could not determine whether this relative lack of data (especially in comparison to published reports of primary care implementation efforts) stems from payers' reticence to share their behavioral health strategies or from a deficit in coordinated and intentional strategies. We appreciate that competition among payers on both quality and premium cost is an important foundation of our health care system. We believe, however, given the mental health crisis in this country, payers might consider something akin to the approach that children's hospitals across the country have employed to improve patient safety. Launched in 2012, the Children's Hospitals' Solutions for Patient Safety Network includes more than 137 hospitals that work together to eliminate patient and employee/staff harm across all children's hospitals with significant improvements in eight harm conditions.

Recommendations

We venture three recommendations along these lines, acknowledging that they are outlines and hoping they inspire further thought and development.

1. Payers and providers should set mutual goals and identify their roles in plans to achieve them. This incorporates at least two of the essential activities we derived from our discussions:

I. Calculation of resources required to build or buy core capabilities of behavioral health integration
II. Execution of one or more arrangements with payers that provides financial and technical support for initiating and sustaining those core capabilities

Payers have long designed financial and other incentives (e.g., audits) for provider activities and outcomes. The challenge with our recommendation is payers' accountability in executing a joint plan given the few cards that providers hold once within the payer's network. To the extent that state oversight agencies can require public reporting of joint initiatives and payers' progress in expanding behavioral health integration among its network providers, this may function as sufficient motivation in upholding negotiated commitments. Moreover, payers may seize the opportunity to tout cooperation and mutual benefit to expand their network of both primary care and behavioral health providers, which provides immediate benefit to their members and prospective members. To scale implementation of behavioral health integration, however, it is necessary to collate and share what works and what doesn't. Payer partnerships provide an efficient way to standardize and share evaluation efforts—as well as provide critical supports.[xl]

[xl] Although anti-trust issues may come into play, we believe there is significant room for collaboration without running afoul of statutory prohibitions. A pilot among payers and providers would be the appropriate setting in which to clarify the guideposts.

2. Payers and providers must structure ways to share data, learning, and uptake of third-party solutions. They can build on existing structures to do so.

Insurance plan variations in payment model, definitional terms, and measures pose further hurdles for practices in advancing integration.[xli] Although we do not join the National Alliance of Healthcare Purchaser Coalitions in advocating solely for adoption of the Collaborative Care Model, we find their RESET strategy provides a strong foundation for payer collaboration and, thereby, for accelerating approaches to scale behavioral health integration. RESET regions also echo the Multi-Payer Collaborative model that contributed to the uptake of behavioral health integration in Colorado. Structured collaboration is a necessary counterpart to flexibility in individual arrangements between primary care providers and payers, which fosters initiation of the journey and learning. But individual contractual requirements—in terms of quality measures and payment streams—will burden primary care practices and will miss the opportunity to advance practices that have proven successful at scale. In addition, the call to standardize measurements that guide implementation efforts would seem answered by the elaboration of measurements in use among payers and providers. Utilizing structures akin to RESET regions will allow payers and providers to identify a centralizing resource and learning collaborative that addresses variations in culture, governance, and payer coverage. It may also allow the more rapid deployment of technological and telehealth solutions at scale. This seems like the time to pursue collaboration aggressively to accelerate the integration of behavioral health in primary care settings and improved in parallel to patient safety in children's hospitals.

3. Digital Tools Are Key Accelerants in Scaling BHI for Practices and Payers Alike

This is the shortest section of our report because it requires little explanation. We have no doubt that both turn-key solutions for behavioral health integration in primary care and solutions that perform specific functions have the potential to accelerate BHI adoption by individual practices. Thus far, however, practices and payers must rely on finding the right vendor tools and must—to varying extents—invest in them without a

[xli] Adjusting behavioral health activities based on different insurance plan requirements runs squarely against practicing medicine in a consistent way and treating patients without regard to their insurance coverage.[40]

secure financial return. At the least, it would be useful to classify the technological solutions available in connection with the set of basic activities we have outlined and make this part of a shared investment by payers and providers. As a related point, independent studies are needed to clarify the circumstances and impact of vendor solutions in real world settings. Finally, as others have suggested, it would also be worthwhile for HHS' Office of the National Coordinator for Health Information Technology (ONC) to consider EHR certification requirements and interoperability standards that enable and promote these activities while addressing concerns about privacy.[xlii]

Parting Thought

The scope of this project was relatively small and overwhelming at the same time. Thank you to the experts who provided patient guidance and feedback. We look forward to a burst in activities that continue to make the integration of behavioral health in primary care a standard of care with the knowledge that this will not provide access to treatments for all those with mental health conditions and needs. Calling the mental health situation in this country a crisis is a start, but that must translate to a sense of urgency that boosts coordinated activities.

[xlii] See also Bipartisan Task Force report, p. 79-83.

Endnotes

1. Physician groups issue call to accelerate behavioral health integration [Internet]. American Medical Association; 2022 Jul 8 [cited 2022 Nov 30]. Available from: https://www.ama-assn.org/press-center/press-releases/physician-groups-issue-call-accelerate-behavioral-health-integration

2. Barton T, Donnellan J, Harootunian L, Harris J, Hartnett T, Hoagland GW, Newell B, Nguyen M, O'Gara B, Parekh A, Serafini MW, Burgos A, McDonough D. Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration [Internet]. Washington, D.C.: Bipartisan Policy Center; 2021 Mar 30 [cited 2022 Nov 20]. 122. Available from: https://bipartisanpolicy.org/report/behavioral-health-2021/

3. What is Integrated Behavioral Health? [Internet]. The Academy. [cited 2022 Nov 11]. Available from: https://integrationacademy.ahrq.gov/about/integrated-behavioral-health

4. Cheung S, Spaeth-Rublee B, Shalev D, Li M, Docherty M, Levenson J, Pincus HA. A model to improve behavioral health integration into serious illness care. Journal of Pain and Symptom Management; 2019 Sep 1;58(3):503-14.

5. Ramanuj PP, Talley R, Breslau J, Wang SS, Pincus HA. Integrating behavioral health and primary care services for people with serious mental illness: a qualitative systems analysis of integration in New York. Community mental health journal. 2018 Nov;54(8):1116-26.

6. Whole person health: What you need to know [Internet]. National Center for Complementary and Integrative Health. U.S. Department of Health and Human Services; 2021 [cited 2022 Nov 8]. Available from: https://www.nccih.nih.gov/health/whole-person-health-what-you-need-to-know

7. Fortney JC, Bauer AM, Cerimele JM, Pyne JM, Pfeiffer P, Heagerty PJ, Hawrilenko M, Zielinski MJ, Kaysen D, Bowen DJ, Moore DL. Comparison of teleintegrated care and telereferral care for treating complex psychiatric disorders in primary care: a pragmatic randomized comparative effectiveness trial. JAMA psychiatry. 2021 Nov 1;78(11):1189-99.

8. Hohman JA, Martinez KA, Anand A, Rood M, Martyn T, Rose S, Rothberg MB. Use of Direct-to-Consumer Telemedicine to Access Mental Health Services. Journal of general internal medicine. 2022 Jan 29:1-9.

9. Adults reporting unmet need for mental health treatment in the past year [Internet]. KFF. 2022 [cited 2022Oct24]. Available from: https://www.kff.org/other/state-indicator/adults-reporting-unmet-need-for-mental-health-treatment-in-the-past-year/?currentTimeframe=true

10. The state of Mental Health in America [Internet]. Mental Health America. [cited 2022Oct24]. Available from: https://mhanational.org/issues/state-mental-health-america

11. AAP-AACAP-CHA Declaration of a national emergency in child and Adolescent Mental Health [Internet]. American Academy of Pediatrics . 2021 [cited 2022Oct24]. Available from: https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/

12. Wachino V, Frank RG, Humphreys K, O'Brien J. The kids are not all right: The urgent need to expand effective behavioral health services for children and Youth [Internet]. Brookings. Brookings; 2021 [cited 2022Oct24]. Available from: https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/12/22/the-kids-are-not-all-right-the-urgent-

need-to-expand-effective-behavioral-health-services-for-children-and-youth/

13. Gillison DH, Kelley A. 2020 devastated US mental health — healing must be a priority. The Hill [Internet]. 2021Feb23 [cited 2022Oct24]; Available from: https://thehill.com/opinion/healthcare/539925-2020-devastated-us-mental-health-healing-must-be-a-priority/?rl=1

14. Substance Abuse and Mental Health Services Administration. Projections of national expenditures for treatment of mental and substance use disorders, 2010–2020. HHS Publication No. SMA-14-4883. 2014 Mar 4.

15. Mental Health Care Services by family physicians (position paper) [Internet]. AAFP. 2019 [cited 2022Oct24]. Available from: https://www.aafp.org/about/policies/all/mental-health-services.html

16. Evidence base for COCM [Internet]. Evidence Base for CoCM . University of Washington AIMS Center; 2021 [cited 2022Nov8]. Available from: https://aims.uw.edu/collaborative-care/evidence-base-cocm

17. Unützer J, Harbin H, Schoenbaum M, Druss B. The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes [Internet]. Health Home Information Resource Center; 2013 May [cited 2022 Dec 5]. Available from: https://www.chcs.org/media/HH_IRC_Collaborative_Care_Model__052113_2.pdf

18. Dissemination of Integrated Care Within Adult Primary Care Settings [Internet]. American Psychiatric Association Academy of Psychosomatic Medicine; 2016 [cited 2022 Dec 5]. Available from: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/APA-APM-Dissemination-Integrated-Care-Report.pdf

19. Building the Business Case for Team-Based Integrated Care [Internet]. Washington: University of Washington AIMS Center; [cited 2022 Nov 30]. Available from: https://aims.uw.edu/collaborative-care/building-business-case-cost-effectiveness-studies-collaborative-care

20. Peek CJ. Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus.

21. Accelerating the Path Forward During Turbulent Times: The Case for Collaborative Care During Covid-19 [Internet]. Center for Workplace Mental Health. American Psychiatric Association Foundation; [cited 2022Oct24]. Available from: https://workplacementalhealth.org/getmedia/6c3af0d4-fe9e-4697-aafb-d0cb62f75a36/The-Path-Forward-Case-for-Collaborative-Care-During-COVID-19

22. Henry TA. Learn about 4 new CPT codes to bill for collaborative care [Internet]. The American Medical Association; 2021 Aug 17 [cited 2022 Dec 8]. Available from: https://www.ama-assn.org/practice-management/cpt/learn-about-4-new-cpt-codes-bill-collaborative-care

23. Coverage for Psychiatric Collaborative Care Management (CoCM) Codes [Internet]. The American Psychiatric Association; 2021 April [cited 2022 Dec 5]. Available from: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Coverage-Psychiatric-CoCM-Codes-Payers.pdf

24. Behavioral Health Integration Compendium [Internet]. BHI Collaborative . American Medical Association; [cited 2022Nov11]. Available from: https://www.ama-assn.org/system/files/bhi-compendium.pdf

25. Goldman ML, Scharf DM, Brown JD, Scholle SH, Pincus HA. Structural Components of Integrated Behavioral Health Care: A Comparison of National Programs. Psychiatric Services. 2022 May 1;73(5):584-7.

26. Gold SB, Gilchrist E, Kirchner S, Razeen B, Green LA, Dickinson WP. The Building Blocks of Behavioral Health Integration [Internet]. The Eugene S. Farley, Jr Health Policy Center & the Practice Innovation Program at the University of Colorado Anschutz Medical Campus; 2022 June [cited 2022 Dec 5]. Available from: https://medschool.cuanschutz.edu/docs/librariesprovider231/default-document-library/wbt-bhiframeworkfinaljune7.pdf?sfvrsn=48e794ba_0
27. The Comprehensive Healthcare Integration Framework [Internet]. National Council for Mental Wellbeing. National Council for Mental Wellbeing's Center of Excellence for Integrated Health Solutions; 2022 [cited 2022Nov11]. Available from: https://www.thenationalcouncil.org/resources/the-comprehensive-healthcare-integration-framework/
28. Curtis P, Vizzini D, Church B. The Colorado Multi-Payer Collaborative: A Framework for Integration of Whole Person Care [Internet]. Milbank Memorial Fund; 2022 June 16 [cited 2022 Dec 5]. Available from: https://www.milbank.org/publications/the-colorado-multi-payer-collaborative-a-framework-for-integration-of-whole-person-care/
29. Malâtre-Lansac A, Engel CC, Xenakis L, Carlasare L, Blake K, Vargo C, Botts C, Chen PG, Friedberg MW. Factors influencing physician practices' adoption of behavioral health integration in the United States: a qualitative study. Annals of Internal Medicine. 2020 Jul 21;173(2):92-9.
30. Richmond LM. Three Health Systems find success with collaborative care [Internet]. Psychiatric News. American Pyschiatric Association; 2021 [cited 2022Nov8]. Available from: https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2022.12.26
31. Collaborate in an Orderly and Cohesive Manner Act 2021 (US). Available from: https://www.congress.gov/bill/117th-congress/house-bill/5218/text
32. Act No. 457 2022 (LA). Available from: http://www.legis.la.gov/legis/ViewDocument.aspx?d=1289517
33. An Act Relative to Collaborative Care 2021 (MA). Available from: https://malegislature.gov/Bills/192/S769
34. Public Act 101-0575 (IL). Available from: https://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=101-0574
35. An Act Relating to Medicaid Coverage of Certain Collaborative Care Management Services 2021 (TX). Available from: https://capitol.texas.gov/tlodocs/87R/billtext/html/SB00672S.htm
36. Integrating Behavioral Health and Primary Care [Internet]. America's Health Insurance Plans; 2022 [cited 2022Nov11]. Available from: https://ahiporg-production.s3.amazonaws.com/documents/202202-AHIP_IB_Behavioral_Health_Integration-004.pdf
37. The Colorado multi-payer collaborative: A framework for integration of whole-person care [Internet]. Milbank Memorial Fund. 2022 [cited 2022Nov11]. Available from: https://www.milbank.org/publications/the-colorado-multi-payer-collaborative-a-framework-for-integration-of-whole-person-care/
38. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (US). Available from: https://www.congress.gov/bill/110th-congress/house-bill/6983
39. The Mental Health Reform Act of 2016 (US). Available from: https://www.congress.gov/bill/114th-congress/senate-bill/2680
40. Torrence R. Concert Health snags $42M series B with Collaborative Care Network for Mental Health treatment [Internet]. Fierce Healthcare. 2022 [cited 2022Nov11]. Available from: https://www.fiercehealthcare.com/health-tech/concert-health-snags-42m-series-b-collaborative-care-network-mental-health-treatment