Weaving Together Mental and Physical Health Care Outside the Safety Net

MAY 2020

AUTHORS
Muriel LaMois and Melora Simon, California Quality Collaborative

About the Authors

The California Quality Collaborative (CQC), a program of the Pacific Business Group on Health (PBGH), is dedicated to advancing the quality and efficiency of the health care delivery system in California. CQC creates scalable, measurable improvement in the care delivery system important to patients, purchasers, providers, and health plans. PBGH leverages the purchasing power of the country's largest and most influential private employers and public purchasers to scale market innovations that lower costs and increase quality, transform care delivery, and influence policy.

At the time of the interviews, Melora Simon was senior director, California Quality Collaborative and Care Redesign, and Muriel LaMois was a research consultant, at the Pacific Business Group on Health.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Contents

3 Introduction

4 Background

5 How Did We Get Here? Policy and Market Developments in California

6 How Current Policies and Market Arrangements Create Barriers to Integration

Provider Participation

Coordination and Communication

Reimbursement and Risk

9 Seeking Solutions

Screening

Coordination

Telehealth

Employer-Sponsored Innovations

Practice Change Through the Collaborative Care Model

12 Recommendations for Multipayer Alignment: Next Steps

13 Conclusion

14 Appendix

15 Endnotes

Introduction

Mental health issues commonly present in primary care. Twenty percent of primary care visits relate to mental health,[1] and 79% of antidepressants are prescribed by primary care providers (PCPs).[2] However, many PCPs do not have the time and expertise to diagnose and treat mental illness.[3] Depression, for example, is one of the most common conditions PCPs see, but half of patients with depression are not properly diagnosed and less than 1 in 10 is appropriately treated.[4] In addition, only 3% of psychiatrists and psychiatric nurse practitioners coordinate care with PCPs.[5]

A growing body of evidence shows that integrating mental health into primary care services can increase mental health care access and coordination, improve patient outcomes, and reduce health care costs, particularly for those with co-occurring chronic conditions.[6] Traditional safety-net providers have made strides toward offering mental health services in tandem with physical health services. In part this integration has been supported by payment systems. Yet most people covered by Medi-Cal, California's Medicaid program, receive care outside the safety net where integration has not yet taken hold.

This paper focuses on opportunities to support practice change in primary care to deliver integrated care outside the safety net. It is the result of research and interviews conducted between February and May of 2019 with 15 people at different types of entities, focused on both challenges and strategies for integration outside the safety net.

Interviewees included payers (commercial, Medicare, and Medi-Cal plans), managed behavioral health organizations, and physical and behavioral health providers (independent practice associations, medical groups, and integrated delivery systems). (See appendix for complete list.) The paper was also informed by three provider interviews conducted in late 2018 about adoption of the PHQ-9 depression screening questionnaire, as part of developing a standardized measure set in partnership with the Integrated Healthcare Association.

The Collaborative Care Model, an evidence-based care model, came up in many of the interviews, and is thus one focus of this paper.[8] Notably, this paper does not discuss the integration of primary care into specialty mental health care clinics, nor the integration of financing of specialty mental health care into managed care.

INTEGRATED CARE

Integrated care is a widely used term that can mean a host of different things. The framework from the SAMHSA-HRSA Center for Integrated Health Solutions helpfully distinguishes between coordinated, colocated, and integrated care.[7] As noted above, this paper focuses on practice change in primary care to deliver integrated care (levels 5 and 6 below).

Six Levels of Collaboration/Integration

COORDINATED *Key element:* Communication		COLOCATED *Key element:* Proximity		INTEGRATED *Key element:* Practice change	
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**	**Level 6**
Minimal collaboration	Basic collaboration at a distance	Basic collaboration on-site	Close collaboration on-site with some system integration	Close collaboration approaching an integrated practice	Full collaboration in a transformed/ merged integrated practice

Source: Bern Heath, Kathy Reynolds, and Pam Wise Romero, *A Review and Proposed Standard Framework for Levels of Integrated Healthcare*, SAMHSA-HRSA Center for Integrated Health Solutions, March 2013, www.integration.samhsa.gov.

Background

Mental health conditions disproportionately impact people with low incomes,[9] and Medi-Cal, California's Medicaid program, pays for a significant portion of mental health care in the state.[10]

Many Medi-Cal enrollees receive primary care from traditional safety-net providers — here defined as Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes, Rural Health Clinics, community health centers, and public hospital systems. California's traditional safety-net providers have made some progress in offering mental health services alongside primary care services, with 29% growth in patients receiving mental health services from 2015 to 2017.[11] As of 2018, 194 of 200 California FQHCs and Look-Alikes offered mental health services.[12] This expansion of colocated and, in some cases, integrated services has been bolstered by the FQHCs' per-visit prospective payment system, which pays more than the Medi-Cal fee-for-service fee schedule, and ensures the same level of payment regardless of payer type. This progress has also been supported through an influx of public and private grant funds to support integration.[13]

Fifty-nine percent of the Medi-Cal population, including those with behavioral health issues, receive primary care outside the traditional safety net.[14] This is particularly true in Southern California, where safety-net clinics care for only 33% of the Medi-Cal population — compared to 75% in Northern California.[15] Primary care providers outside the safety net do not have the benefit of the universality of the FQHCs' prospective payment system. Instead, if a practice wants to offer integrated behavioral health services, it needs to ensure financial viability across multiple payers, looking at the reimbursement practices of many different insurers across commercial, Medi-Cal, and Medicare lines of business.

Finding sustainable methods for funding remains one of the greatest barriers to integrating physical and behavioral health outside the safety net. Significant variation between payers in the processes for, and level of reimbursement for, behavioral health services make it difficult for providers to standardize care and invest the money and resources necessary to build out integrated care capabilities. New reimbursement mechanisms such as the Centers for Medicare & Medicaid Services' (CMS) collaborative care codes provide new avenues for reimbursing coordinated services in a fee-for-service context, and commercial plans have largely adopted these codes. However, they do not provide a solution for California's capitated medical groups, many of whom serve Medi-Cal patients.

Developing reimbursement mechanisms to support integration outside the safety net is critical to aligning incentives for behavioral health integration between public and private health care and expanding the use of collaborative care beyond the safety net and large, well-resourced health systems.

Research for this paper shows that, outside of the traditional safety net, behavioral health integration is rare. Among interviewees, it was limited to academic centers, Kaiser Permanente, and pilots or complex care management programs, usually based around a grant-funded project or an accountable care organization (ACO). An ACO is a group of hospitals, physicians, and other providers who take responsibility for the quality and cost of care for a patient population using a shared-savings model built on a fee-for-service architecture. Unlike FQHCs, providers outside the traditional safety net must reconcile the different payment policies and mechanisms that flow from Medicare, Medi-Cal, and commercial payers. Developing reimbursement mechanisms to support integration outside the safety net is critical to aligning incentives for behavioral health integration between public and private health care and expanding the use of collaborative care beyond the safety net and large, well-resourced health systems.

How Did We Get Here? Policy and Market Developments in California

Unlike some states, California does not have a single dominant payer; there are 73 distinct health insurers. Kaiser Permanente's closed integrated system has about 25% of covered lives,[16] and no other payer captures more than 18% of the insured market.[17] On the physical health side, provider organizations responded to the managed care wave of the mid-1990s and California's multipayer reality by becoming delegated medical groups, taking on financial risk along with many health plan functions.[18] Even in a fragmented payer landscape, this has simplified the physical health workflows for clinicians, as they predominantly seek prior authorization and reimbursement through their medical group, rather than from multiple payers.

In both commercial and public systems across California, physical and behavioral health care financing is fragmented. Medi-Cal is even more fragmented between Medi-Cal (physical) managed care plans, county mental health plans, and county substance use disorder plans. This fragmentation of financial and administrative responsibility has severe consequences: In addition to limiting and complicating access, fragmentation hinders incentives for each entity to invest in prevention and early intervention, inhibits coordination, and creates disruption in care that leads to poor patient outcomes and increased costs.[19]

The 1996 passage of the federal Mental Health Parity Act (P.L. 104-204) marked the beginning of systemic change for mental health care benefits, which were not historically covered health plan benefits.[20] The 2008 Mental Health Parity and Addiction Equity Act (P.L. 110-343) and the 2010 Patient Protection and Affordable Care Act (ACA) went further, requiring health plans to provide mental health and substance use disorder benefits comparable to medical and surgical benefits.[21]

To meet the requirements of these parity laws, while still controlling spending on behavioral health care, health plans began to delegate behavioral health services to specialized managed behavioral health organizations (MBHOs) that administer behavioral health benefits on their behalf. These MBHOs built specialized networks and brought expertise in managing and administering mental health benefits, from outpatient therapy to residential treatment. They reimburse almost exclusively on a fee-for-service basis in order to encourage access.

The dependence on MBHOs has meant that responsibility for behavioral health is excluded, or "carved out," of the contracts of risk-bearing delegated provider organizations.[22] For example, a contract between a health plan and a medical group that delegated professional risk would include the costs associated with all primary care and physical health specialists, but would not include the costs of psychotherapy or a visit to a psychiatrist. A full-risk contract would include professional and hospital costs for medical treatment but would exclude psychiatric hospitalization. In addition to splitting patients' needs and costs between different accountable entities, such carve-outs also create complexity for clinicians and their office staffs, who now needed to follow the processes of and coordinate with multiple payers for utilization management and care coordination of behavioral health. By contrast, as discussed above, delegated medical groups manage these processes themselves, creating a single process for frontline clinicians that is health plan agnostic. As the marketplace has evolved, many health plans have acquired or built internal MBHOs and developed processes to coordinate closely within the health plans. However, from the perspective of a delegated, risk-bearing provider organization, behavioral health benefits remain carved out, creating a significant barrier to integration of services in primary care practices.

These developments in the commercial sector came later to Medi-Cal with the implementation of the ACA in 2014. Since 1995, Medi-Cal specialty mental health services have been provided under a federal Medicaid Section 1915(b) freedom-of-choice waiver titled "Medi-Cal Specialty Mental Health Services."

Until 2014, this waiver required enrollees to access almost all mental health services through county mental health plans (MHPs), which provide specialty mental health services for adults and for children and youth who meet certain diagnostic, impairment, and intervention criteria. Consistent with the Early and Periodic Screening, Diagnostic, and Treatment mandate, California requires MHPs both to use less stringent medical necessity criteria, and to provide a broader array of services to enrollees under age 21.[23]

Until 2014, Medi-Cal managed care plans (MMCPs) were only responsible for ensuring that their PCPs offered mental health services that were within the normal scope of their practice (e.g., brief therapy, writing prescriptions). The ACA required the inclusion of behavioral health care as an essential health benefit for Medicaid Alternative Benefit Plans and qualified health plans.[24] As a result, in California, MMCPs became responsible for the delivery of non-specialty mental health services to enrollees age 21 and over with behavioral health conditions categorized as "mild to moderate."[25] (However, specialty mental health services must be provided by the MHP to children under age 21, when medically necessary, without respect to any severity test or screening tool employed by the MMCPs and MHPs.[26]) Although this change expanded the overall mental health benefit in Medi-Cal, it further fragmented financing and coordination of care, requiring recipients to move between plans based on the severity of their illness. In addition, rollout happened quite quickly, and many plans turned to MBHOs to administer the benefit. MBHO networks often differed dramatically from those of the MHPs, adding further complexity. As a result, there are county-specific processes for referral and coordination and significant variation in interpretation of the dividing line between the services covered by managed care plans and the specialty system administered by the counties.[27]

Underlying this market complexity is a severe shortage of behavioral health providers. California had over 80,000 licensed behavioral health professionals in 2016, but these professionals are unevenly spread across the state and do not reflect the diversity of the state's population.[28] The workforce shortage is likely to worsen, as 45% of psychiatrists and 37% of psychologists are over age 60 and are likely to retire or reduce their work hours within the next decade.[29]

How Current Policies and Market Arrangements Create Barriers to Integration

Stakeholders interviewed for this report repeatedly mentioned the same frustrations in achieving integration related to the policy and market structures described above, especially in these areas:

- Provider participation
- Coordination and communication
- Reimbursement and risk

Provider Participation

Because of the chronic and serious shortage in the behavioral health workforce, many behavioral health specialists are at capacity and are not taking new patients, creating a gap between "paper access" as measured by network adequacy requirements and a patient's experience in getting an appointment. In addition, many professionals in California's urban areas, in high demand and frustrated by low reimbursement and payer administrative requirements, opt out of insurance altogether, creating access and affordability challenges across payer types.[30] MBHOs have responded, often paying well in excess of the fee schedule for Medi-Cal and Medicare. For example, one medical group leader reported that a psychiatrist is paid $275 for a 20- or 30-minute visit for commercial and managed Medi-Cal patients, while Medicare pays only $70. Even with these higher reimbursement rates, access is challenging. Primary care providers interviewed for this paper described their patients' difficulties in finding in-network mental health providers with availability, and MBHOs similarly described extensive efforts to help patients find appointments

with their network mental health providers, many of whom are not accepting new patients.

Coordination and Communication

Payers' behavioral health networks can be difficult for PCPs to navigate. Each health plan has different processes around behavioral health, and while most have eliminated prior authorization, the perceived complexity of referring patients is a barrier for busy care teams.

Some PCPs said that carve-outs have damaged existing informal referral networks. Before the rise of MBHOs in the 1990s, some PCPs in delegated entities described having a sense of connection to the behavioral health providers in their area, including knowing which specialists were currently accepting new patients, or who might be a good match for a particular patient's needs. Now, PCPs often feel they have lost that connection: Instead of sending patients to a named colleague, they refer patients to an anonymous provider directory that may not be accurate or to the number of a call center on the back of an insurance card.

Further, referral frequently does not lead to care. One MBHO reported that only about 50% of patients referred by a PCP for behavioral health care end up making an appointment. Because many providers are not accepting new patients, making an appointment may require dozens of phone calls. Some of the referral "leakage" may also be due to stigma and lack of follow-through by patients, who may not perceive a need for specialty care.

Limitations in communication were among the most commonly cited frustrations among all stakeholders. Trying to normalize regular communication between entities that historically have not shared information has proved challenging. Primary care providers frequently described MBHOs as "black boxes" and did not see any differentiation in service among the MBHOs or by payer type. These providers described difficulty in getting MBHOs and their network providers to acknowledge receipt of referral to ensure patients are successfully connected to care and to share treatment plans to better improve coordination efforts.

MBHOs also expressed frustration at the current state of communication between behavioral health specialists and PCPs. They described having to "badger" PCPs for medical data, including prescriptions, lab tests, and physicals required before transcranial magnetic stimulation, for example. Conversely, MBHOs that mandate that behavioral health specialists submit treatment plans to PCPs reported that a majority of PCPs did not even look at the treatment plans included in their chart notes.

Some payers and MBHOs ended up facilitating communication between primary care clinicians and behavioral health clinicians with successful results. However, the payers described feeling caught in the middle and said they would prefer that the clinicians communicate directly with each other. All parties acknowledged that the traditional fee-for-service (FFS) reimbursement system does not provide an easy way to get paid for communication and coordination between providers.

Interviewees described tension between concern for patient privacy and effective coordination. Much of the tension stems from differing interpretations of federal and state legislation around patient privacy between PCPs and behavioral health specialists, but also between payers and MBHOs, even with the same corporate parent. Some interviewees said that requirements of privacy laws including the Health Insurance Portability and Accessibility Act (HIPAA)[31] and rules to protect the confidentiality of substance use disorder treatment records have contributed to communication challenges between MBHOs, behavioral health providers, and PCPs, adding compliance concerns to the cultural divide between behavioral health providers trained to focus on preserving patient privacy and PCPs trained to share information in service of effective coordination. Several initiatives across California have sought to improve data sharing between physical and behavioral health providers.[32] However, different requirements around gaining patient consent to share

data persist based on how individual legal counsel interpret consent requirements, and provider comfort around data sharing without first obtaining consent.[33]

Reimbursement and Risk

Insufficient funding and fragmented financing were common sources of frustration for providers. They noted that many of the activities required for integrated care (e.g., consults between providers, care management by a social worker) are not currently reimbursed under the FFS system used by MBHOs.

Interviewees said that fragmentation of financial risk limits the incentives for each entity to invest in prevention and early intervention across the continuum of needs.[34] In particular, the Knox-Keene Act (1975) was referenced as a barrier to improving coordination and integration for one particular type of organization, the behavioral health independent practice association (IPA). The act regulates and licenses managed care plans under either "full service" or "specialized" licenses. Specialized licenses are issued to entities providing only a single health care service, such as behavioral health.[35] These are limited to professional

WHAT'S A CARVE-OUT?

Three distinct but related "carve-outs" result from the policy and market developments described above, and make it more difficult to integrate physical and behavioral health care both inside and outside the safety net:

Physical and behavioral health insurance carve-out. Health insurance companies often delegate or "carve out" responsibility for mental health benefits to an internal or external MBHO. That entity develops its own provider network and has its own processes for claims, utilization management, and care coordination. Such delegation recognizes that mental health services require specialized knowledge and focus, but also complicates coordination for people who have both physical and mental health needs.

Capitated contracts that exclude behavioral health. California's health plans often delegate financial risk to provider organizations in the HMO market. In the provisions of these capitated contracts — known as the division of financial responsibility — behavioral health is often excluded, with the health plan retaining responsibility rather than delegating it to the provider groups. As a result, PCPs in delegated groups who do not typically have to interface with health plans for prior authorization of physical health services face a different situation when it comes to behavioral health services. In addition to bearing the financial costs of unmet behavioral health needs, which can result in expensive physical health crises, these groups have to develop workflows for interfacing with each payer's MBHO, a substantial and complex undertaking in California's fragmented health plan market.

Medi-Cal's mental health and substance use disorder carve-outs. In Medi-Cal, responsibility for behavioral health benefits is divided based on type of service and medical necessity. "Specialty" mental health services are provided through county mental health plans (MHPs), while non-specialty services — including individual and group psychotherapy; psychological testing; outpatient drug therapy monitoring; outpatient laboratory, drugs, supplies, and supplements; and psychiatric consultation — are the responsibility of Medi-Cal managed care plans. (These plans have only very limited responsibility for substance use disorder [SUD] treatment services; the SUD benefit in Medi-Cal is provided through a separate county system, Drug Medi-Cal.)

Fragmentation: An Extreme Example

One interviewee described the case of a Medi-Cal enrollee whose care coordination required interaction with six distinct entities:

- The county specialty mental health system that provided crisis services
- The Medi-Cal managed care plan's MBHO vendor for outpatient therapy following the resolution of the acute crisis
- A delegated medical group for primary care
- The county Drug Medi-Cal Organized Delivery System for outpatient SUD treatment
- Medi-Cal fee-for-service system for psychotropic medications
- The Medi-Cal managed care plan for durable medical equipment

risk only, however, and thus prevent a behavioral health IPA from taking on hospital risk to align revenue and incentives: This barrier is significant because the greatest savings potential in behavioral health management is in reducing hospital admissions and length of stays.

Seeking Solutions

In interviews, stakeholders expressed interest in behavioral health integration as a strategy to improve quality and patient satisfaction while reducing physician burnout and excess medical costs. They described the following activities taking place in their organizations.

Screening

Almost all provider organizations interviewed recommended that their PCPs implement universal depression screening, but outside those that had implemented integrated care, few were able to identify the degree to which it was happening and many discussed an unwillingness on the part of PCPs to screen without a reliable means of connecting patients to care after screening. Patient data from the Patient Assessment Survey administered by the Pacific Business Group on Health from 2013 to 2015 shows that primary care screening for anxiety and depression has been increasing, albeit from a low base, with one in three patients reporting being asked about anxiety and one in four being asked about depression.[36] These rates may have increased following the US Preventive Services Task Force's 2016 "B" recommendation of screening for depression among adolescents and adults who "receive care in clinical practices that have [cognitive behavioral therapy] or other evidence-based counseling available after screening."[37] This recommendation requires payers to reimburse and waive patient copayments for depression screening.

Coordination

Several provider organizations discussed implementing aspects of care integration such as hiring licensed clinical social workers to facilitate warm handoffs and care coordination for their medically complex populations. Typically, this was done without incremental revenue, with medical groups capturing cost savings through improved health outcomes and reduced acute utilization.

Telehealth

Almost all of those interviewed expressed strong interest in expanding their telehealth efforts but face challenges around reimbursement, including differing geographical restrictions, and regulations on when the remote practitioner or the originating site or both may be reimbursed. Potential telehealth applications included psychiatric evaluations, therapy, patient education, and medication management.[38] Services can be synchronous, allowing for live discussions, or asynchronous, also known as "store and forward," which includes the use of eConsults.[39] Telehealth can also be used for remote patient monitoring, either by direct video monitoring or via review of tests and images collected remotely.[40] Importantly, telehealth can help address access issues stemming from uneven distribution of the behavioral health workforce, especially in rural areas.

Employer-Sponsored Innovations

Interviews with payers said that some purchasers (e.g., large employers) recognize the potential for improved behavioral health access to lower their health care costs and improve their employees' health and productivity. A few innovative arrangements have sprung up as part of employers' directly contracted accountable care organizations, in which a group of hospitals, physicians, and other providers take responsibility for the quality and cost of care of a patient population using a shared-savings model built on a fee-for-service architecture. The service expectations in these innovative payment arrangements sometimes explicitly include behavioral health integration for a limited population. These arrangements support a variety of activities, including embedding behavioral health specialists in primary care settings, releasing authorization for data sharing, and supporting case management and care coordination. One example is Boeing's ACO

pilot program with MemorialCare.[41] Interviewees described targeted impact on hospital and emergency department utilization as well as provider satisfaction and retention and the patient experience, recognizing that the business case for these services is not based solely on the revenue they generate.

In addition, employers are expanding teleconsultation outside of traditional practices, embedding behavioral health specialists into on-site primary care locations, arranging for specialized access through employee assistance plans, and testing digital therapeutics, such as computerized cognitive behavioral therapy. These innovations are often paid for outside of traditional health plan contracts and may be paid on an encounter basis, a cost-plus basis, or a per employee per month charge. In the most novel payment arrangement, two employers, one payer, and a medical group described piloting a digital platform in which payment is based on outcomes, as measured by the patient's self-reported response.

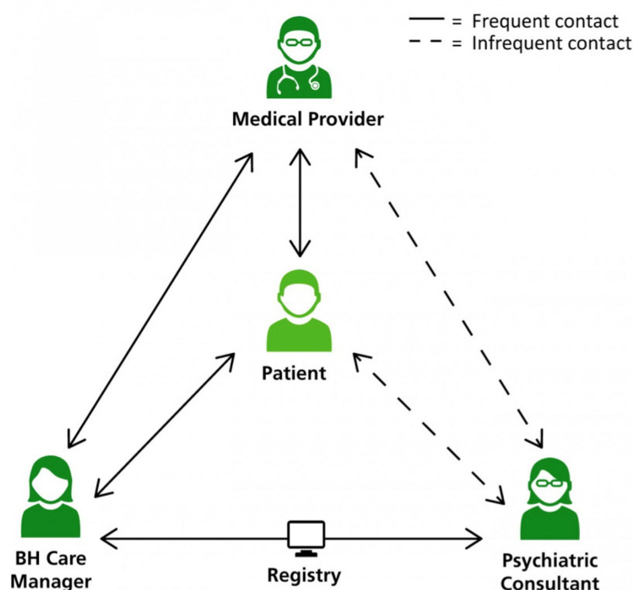
Practice Change Through the Collaborative Care Model

What Is the Collaborative Care Model?

Based on interviews, the Collaborative Care Model (CoCM) has emerged as the dominant evidence-based approach to integrating physical and behavioral health services in primary care. All interviewees who had undertaken integrated care incorporating practice change described their approach as being based on the CoCM. Other models, such as Primary Care Behaviorist, were not discussed.[42]

In CoCM, developed by Wayne Katon and colleagues at the University of Washington in the mid-1990s, a care team composed of a PCP, a behavioral health care manager, and a consulting psychiatrist work together to provide care, monitor patient progress, and adjust treatment plans.[43] It includes (1) care coordination and care management, (2) regular, proactive monitoring and treatment to target with validated clinical rating scales, and (3) regular, systematic psychiatric caseload reviews, and consultation for patients who do not show clinical improvement.[44] The CoCM has been shown to be not only an effective treatment approach but also cost-effective for common mental disorders such as depression across diverse practice settings and patient populations.[45] In California, the CoCM has been implemented in multiple care settings, including in the safety net, Kaiser Permanente, academic medical centers, and by a few pioneering delegated medical groups. Importantly, colocation is *not* a requirement of the CoCM, and telehealth has proven to be an effective option for practices to deliver the CoCM, especially where colocation is impractical or infeasible.[46]

Figure 1. Collaborative Care Team Structure



Copyright ©2017 University of Washington. All rights reserved.

Making the Economics Work

In 2017, CMS began making payments for services provided to patients receiving collaborative care services through traditional Medicare or Medicare Advantage plans.[47] These CoCM codes are billed by the primary care provider and cover the costs of the primary care provider, the behavioral health care manager, the consulting psychiatrist, and the population health registry infrastructure for treatment to target using validated rating scales. CoCM codes may be

used for patients with any behavioral health condition being addressed by the treating provider, including substance use disorders.[48] A modeling simulation that looked at likely revenues and costs associated with staffing and related infrastructure for delivery of integrated care under the CoCM codes showed positive net revenue in both FQHC and private practice settings when adopted by multiple payers.[49] There has been significant uptake of these codes among payers including Aetna, Anthem, Beacon, and United/Optum in California, and by 13 state Medicaid agencies, though it is by no means universal.[50] As of the time of publication, the authors were not aware of any MMCP that had adopted the codes.

The CMS CoCM codes are imperfect. The workflow changes required, including tracking cumulative treatment minutes and monthly code entry, were described in interviews and in the literature as challenging and arduous to implement.[51] Depending on the particular electronic health record (EHR) system, some organizations described laborious workarounds in order to use the CoCM in their EHR. In addition, the codes represent a challenge in California's delegated medical groups, where capitation and behavioral health carve-outs are the norm. As a result, providers have negotiated letters of agreement or contracted with MBHOs for FFS payment of behavioral health services delivered outside their delegated arrangements.

One particular challenge with the CoCM code implementation in California lies in the adoption of the codes by medical groups operating under delegated arrangements that exclude behavioral health. While these arrangements often specify that all activities that occur in primary care are included, the exclusion of mental health and substance use disorder services leaves CoCM services — by definition billed by PCPs — in a gray area. Some interviewees described a solution where behavioral health clinicians were credentialed by the MBHO and billed services delivered under the Collaborative Care Model to the MBHO. This ensured that collaborative care services generated incremental revenue to the practice to cover the costs of the additional mental health clinicians.

One particular challenge with the CoCM code implementation in California lies in the adoption of the codes by medical groups operating under delegated arrangements that exclude behavioral health. While these arrangements often specify that all activities that occur in primary care are included, the exclusion of mental health and substance use disorder services leaves CoCM services — by definition billed by PCPs — in a gray area.

That said, Medicare's CoCM codes have spurred action for some provider groups, who correctly anticipated that commercial insurers would follow. Not surprisingly, staff and foundation model groups with employed physicians have been the earliest adopters, as they can aggregate volume from multiple practice sites and spread the costs of behavioral health staff across all payer types.

Interviewees cited Medicare Advantage as the most common starting point for CoCM pilots, in part because delegated arrangements are more likely to include behavioral health and in part because the downstream health savings are likely to be greater due to the higher prevalence of chronic conditions among older adults.

In interviews, both payers and providers expressed excitement about these delivery and payment models. However, these arrangements are not yet common. Multipayer alignment and standardized payment models are critical to overcoming barriers to integrating care at scale.

Recommendations for Multipayer Alignment: Next Steps

The following opportunities for multipayer alignment across lines of business to support the implementation of the CoCM emerged from interviews:

- *Adoption of Collaborative Care Model codes by payers and MBHOs outside of capitated contracts.* Widespread multipayer adoption of the CoCM codes at Medicare rates would ensure sufficient revenue for providers to make the investment in integration for all their patients.
- *Development of standard payment mechanisms for Collaborative Care Model in capitated, delegated contracts.* These might include:
  - *A monthly capitation rate for CoCM that is incremental to professional or full-risk arrangements that exclude behavioral health.* While the amount may vary based on the needs of the population and be established through experience, an industry-wide agreement that the CoCM goes beyond the scope of primary care and requires additional compensation is necessary, as are studies that determine where savings accrue for shared-risk contracts.
  - *Monthly CoCM payments by MBHOs to PCPs providing team-based integrated services.* While MBHOs do not typically hold contracts with primary care providers, they could begin credentialing and reimbursing practices offering collaborative care using the CoCM codes, even if the practice is capitated for primary care.
  - *Other value-based arrangements that reward outcomes and cost savings.*

In addition to recommendations specific to the CoCM, interviewees also made the following requests for multipayer alignment:

- *Standardize and expand reimbursement for telehealth when specialty services are needed.* Many interviewees are working on expanding telehealth for behavioral health services, but face challenges around reimbursement. A standard set of approaches for telehealth reimbursement would help improve communication and access issues.[52]
- *Implement payer-agnostic hub-and-spoke models for services with very limited supply.* Providers expressed interest in a payer-agnostic method to access behavioral health from primary care. The hub-and-spoke model used in California's safety net to treat opioid use disorder[53] has demonstrated impact in connecting PCPs to behavioral health specialists and helping PCPs better meet the behavioral health needs of their patients.[54] Similarly, the Massachusetts Child Psychiatry Access Project provides telephonic child psychiatry consultations and specialized care coordination support to over 95% of the pediatric primary care providers in Massachusetts, through six regional hubs, each of which has one full-time equivalent child psychiatrist, licensed therapist, and care coordinator.[55] A similar model is being implemented in rural areas in San Diego County and has been suggested as a potential method to expand capacity by enhancing the skills of primary care physicians, improve coordination and communication, and address colocation challenges for small practices.[56]
- *Standardize consent forms and processes, and data-sharing rules.* Collective action by industry groups to standardize patient consents and normalize interpretation of HIPAA, 42 CFR Part 2, and corresponding California statutes would be a powerful tool to improve coordination. Once common standards are in place, educating payers and providers on these standards may be needed to ensure universal adoption.
- *Move toward accountability for outcomes.* Payers should consider offering additional reimbursement in exchange for providers reporting outcomes data in mental health. Paying for reporting will help provide an understanding of how integrated services are impacting patient outcomes and can serve as an important first step in moving toward paying for outcomes.

Conclusion

Outside of California's traditional health care safety net and a few large, well-resourced health systems, integration of mental health into primary care remains rare. The experience of California's FQHCs and a few other pioneers demonstrates what is possible with practice change support and standardized, near-universal reimbursement. Spurred in part by Medicare reimbursement, providers have come together around an evidence-based model, but a fragmented payment landscape makes sustainable financing one of the greatest barriers to integrating physical and behavioral health in primary care. Multipayer alignment of payment mechanisms would accelerate adoption of integrated care for all patients. This is particularly true among smaller practices that could be supported in integration activities through their IPAs. These practices serve many Medi-Cal patients and face a challenging and complex reimbursement environment.

On the current course, market movement in California will lead to integrated systems in the safety net, academic centers, Kaiser Permanente, and well-resourced foundation models that are historically closed to new Medi-Cal patients. But without collective action by payers, either voluntarily or as a result of legislative or regulatory activity, most primary care practices — including those serving a significant component of the Medi-Cal population — will be unlikely to undertake the practice change needed to provide truly integrated care.[57] This research points to potential next steps to build on the momentum created by pioneering providers and payers and create the foundation for the multipayer alignment needed to achieve widespread behavioral health integration.

Appendix. California Organizations Interviewed

Medical Groups

Brown and Toland Medical Group, Oakland

HealthCare Partners Medical Group, El Segundo

Heritage Provider Network, Northridge

Kaiser Permanente, Oakland

MemorialCare Health System, Fountain Valley

Providence St. Joseph Heritage Healthcare, Anaheim

River City Medical Group, Sacramento

Sharp Rees-Stealy Medical Group, San Diego

Payers

Blue Shield of California, Oakland

CalOptima, Orange

Cigna HealthCare of California, Glendale

Health Net, Woodland Hills

Behavioral Health Providers

Community Psychiatry, Sacramento

Windstone Health Services, Santa Ana

Managed Behavioral Health Organizations

Beacon Health Options, Cypress

Cigna Behavioral Health of California (as part of Cigna interview), Glendale

MHN (as part of HealthNet interview), San Rafael

Additional organizations interviewed as part of Integrated Health Association-Pacific Business Group on Health Commercial ACO Measurement & Benchmarking Initiative

Humboldt IPA, Eureka

University of California at Davis

University of California at Los Angeles

Endnotes

1. *Integrating Behavioral Health and Primary Care: An Actionable Framework for Advancing Integrated Care*, Eugene S. Farley, Jr. Health Policy Center at the University of Colorado Denver, February 2016, farleyhealthpolicycenter.org (PDF).

2. Andres Barkil-Oteo, "Collaborative Care for Depression in Primary Care: How Psychiatry Could 'Troubleshoot' Current Treatments and Practices," *Yale Journal of Biology and Medicine* 86, no. 2 (June 2013): 139–46, www.ncbi.nlm.nih.gov.

3. *Integrating Behavioral Health*, Eugene S. Farley, Jr., Health Policy Center.

4. James M. Ferguson, "Depression: Diagnosis and Management for the Primary Care Physician," *Primary Care Companion to the Journal of Clinical Psychiatry* 2, no. 5 (2000): 173–78, doi:10.4088/PCC.v02n0504.

5. Rick Hohner, "The Case for Collaborative Care," *Scientific American Blog*, May 29, 2019, blogs.scientificamerican.com.

6. *Evidence Base for Collaborative Care: Selected References as of 3/6/2014*, University of Washington, 2014, aims.uw.edu (PDF).

7. Bern Heath, Kathy Reynolds, and Pam Wise Romero, *A Review and Proposed Standard Framework for Levels of Integrated Healthcare*, SAMHSA-HRSA Center for Integrated Health Solutions, March 2013, www.integration.samhsa.gov (PDF).

8. Wayne Katon et al., "Collaborative Management to Achieve Treatment Guidelines: Impact on Depression in Primary Care," *JAMA* 273, no. 13 (April 5, 1995): 1026–31, doi:10.1001/jama.1995.03520370068039.

9. Julia Zur, MaryBeth Musumeci, and Rachel Garfield, "Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals," KFF, June 29, 2017, www.kff.org.

10. Margaret Tatar and Richard Chambers, *Medi-Cal Explained Fact Sheet: Medi-Cal and Behavioral Health Services*, California Health Care Foundation (CHCF), February 2019, www.chcf.org.

11. Matthew Newman and Eunice Roh, *California's Health Care Safety Net: A Patchwork of Program and Providers*, CHCF, March 2019, www.chcf.org.

12. Author analysis of California FQHCs Uniform Data System reporting from the Bureau of Primary Health Care, Healthcare Resources and Services Administration, 2018, bphc.hrsa.gov (EXCEL).

13. *Leveraging Federally Qualified Health Centers in California's Behavioral Health Care Continuum*, California Primary Care Assn., 2017, hcpsocal.org (PDF).

14. Bobbie Wunsch, Tim Reilly, and Laura Hogan, *Medi-Cal Managed Care Plans and Safety-Net Clinics Under the ACA*, CHCF, December 2015, www.chcf.org (PDF).

15. Wunsch, Reilly, and Hogan, *Managed Care Plans*.

16. "December 2019 Edition — California Health Insurance Enrollment," December 2019, CHCF, www.chcf.org.

17. Enrollment, CHCF.

18. Meredith B. Rosenthal et al., "Scale and Structure of Capitated Physician Organizations in California," *Health Affairs* 20, no. 4 (July 1, 2001): 109–19, doi:10.1377/hlthaff.20.4.109.

19. Logan Kelly, Allison Hamblin, and Stephen Kaplan, *Behavioral Health Integration in Medi-Cal: A Blueprint for California*, CHCF, February 2019, www.chcf.org.

20. Don Kingdon, Molly Brassil, and Erynne Jones, *The Circle Expands: Understanding Medi-Cal Coverage of Mild-to-Moderate Mental Health Conditions*, CHCF, August 2016, www.chcf.org.

21. John G. Kilgour, "Mental Health and Substance Use Disorder Benefits Parity," *Compensation & Benefits Review* 50, no. 2 (April 1, 2018): 95–106, doi:10.1177/0886368719828215.

22. An exception is that delegated contracts for Medicare Advantage typically include behavioral health, because risk-adjusted revenue is tied to hierarchical condition category diagnostic codes, including those related to mental health and substance use. Many of these delegated entities contract with a behavioral health independent practice association for services, though some are building their own networks or experimenting with providing their own services.

23. Kimberly Lewis and Abigail Coursolle, *Issue Brief: Mental Health Services in Medi-Cal*, National Health Law Program, January 12, 2017, healthlaw.org.

24. Kingdon, Brassil, and Jones, *The Circle Expands*.

25. Kingdon, Brassil, and Jones.

26. *Clarification on Mental Health Plan Responsibility for Providing Medi-Cal Specialty Mental Health Services to Beneficiaries Enrolled in Medi-Cal Managed Care Health Plans*, MHSUDS Information Notice No. 16-061, California Dept. of Health Care Services, December 9, 2016, www.dhcs.ca.gov (PDF).

27. Lewis and Coursolle, *Mental Health Services*.

28. Janet Coffman et al., *California's Current and Future Behavioral Health Workforce*, Healthforce Center at UCSF, February 12, 2018, healthforce.ucsf.edu.

29. Coffman et al., *Behavioral Health Workforce*.

30. Janet R. Cummings, "Declining Psychiatrist Participation in Health Insurance Networks: Where Do We Go from Here?," *JAMA* 313, no. 2 (2015): 190–91, doi:10.1001/jama.2014.12472.

31. California state laws, including the Confidentiality of Medical Information Act and the Lanterman-Petris-Short Act, largely mirror federal laws around what patient information can be shared without patient consent and when, and does not vary based on source of payment.

32. Deven McGraw, Robert Belfort, and Alex Dworkowitz, *Fine Print: Rules for Exchanging Behavioral Health Information in California*, CHCF, July 2015, www.chcf.org.

33. McGraw, Belfort, and Dworkowitz, *Fine Print*.

34. Kelly, Hamblin, and Kaplan, *Blueprint*.

35. "What Is a Restricted Knox-Keene License, Anyway?," Canopy Health, June 10, 2017, www.canopyhealth.com.

36. Personal communication, Patient Assessment Survey team. The PAS is described here: "The Patient Assessment Survey," Pacific Business Group on Health, accessed August 31, 2019, www.pbgh.org.

37. "Depression in Adults: Screening," US Preventive Services Task Force, n.d., www.uspreventiveservicestaskforce.org.

38. "What Is Telepsychiatry?," Amer. Psychiatric Assn., last reviewed January 2017, www.psychiatry.org.

39. Varsha Vimalananda et al., "Electronic Consultations (e-consults) to Improve Access to Specialty Care: A Systematic Review and Narrative Synthesis," *Journal of Telemedicine and Telecare* 21, no. 6 (Sept. 2015): 323–30, doi:10.1177/1357633X15582108.

40. Oren J. Mechanic and Alexa B. Kimball, "Telehealth Systems," *StatPearls*, last updated December 27, 2019, www.ncbi.nlm.nih.gov.

41. Samantha Masunaga, "Boeing Partners with MemorialCare to Offer Healthcare Direct to Workers," *Los Angeles Times*, June 22, 2016, www.latimes.com.

42. Mitchell D. Feldman and Saul Feldman, "The Primary Care Behaviorist: A New Approach to Medical/Behavioral Integration," *Journal of General Internal Medicine* 28, no. 3 (Mar. 2013): 331–32, doi:10.1007/s11606-012-2330-z.

43. Wayne Katon et al., "Collaborative Management to Achieve Treatment Guidelines: Impact on Depression in Primary Care," *JAMA* 273, no. 13 (Apr. 5, 1995): 1026–31, doi:10.1001/jama.1995.03520370068039; and "Learn About the Collaborative Care Model," Amer. Psychiatric Assn., n.d., www.psychiatry.org.

44. *Dissemination of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model*, Amer. Psychiatric Assn., 2016, www.psychiatry.org (PDF).

45. Jurgen Unutzer et al., "Long-Term Cost Effects of Collaborative Care for Late-Life Depression," *American Journal of Managed Care* 14, no. 2 (Feb. 2008): 95–100, www.ajmc.com; and Lydia Grypma et al., "Taking an Evidence-Based Model of Depression Care from Research to Practice: Making Lemonade out of Depression," *General Hospital Psychiatry* 28, no. 2 (Mar.–Apr. 2006): 101–7, doi:10.1016/j.genhosppsych.2005.10.008.

46. *Dissemination*, Amer. Psychiatric Assn.

47. *Cheat Sheet on Medicare Payments for Behavioral Health Integration Services*, Univ. of Washington, last updated April 4, 2019, aims.uw.edu (PDF); *FAQs for Billing the Psychiatric Collaborative Care Management (CoCM) Codes (G0502-G0504) and General Behavioral Health Intervention (BHI) Code (G0507)*, Amer. Psychiatric Assn., last updated July 2017, www.psychiatry.org (PDF); and Andrew D. Carlo et al. "Financing for Collaborative Care — a Narrative Review," *Current Treatment Options in Psychiatry* 5 (2018): 334–44, doi:10.1007/s40501-018-0150-4.

48. *Cheat Sheet*, Univ. of Washington.

49. Sanjay Basu et al., "Behavioral Health Integration into Primary Care: A Microsimulation of Financial Implications for Practices," *Journal of General Internal Medicine* 32 (2017): 1330–41, doi:10.1007/s11606-017-4177-9.

50. *Coverage for Psychiatric Collaborative Care Management (CoCM) Codes (CPT Codes 99492-99494)*, Amer. Psychiatric Assn., last updated September 2019, www.psychiatry.org (PDF).

51. Andrew D. Carlo et al., "Early Health System Experiences with Collaborative Care (CoCM) Billing Codes: A Qualitative Study of Leadership and Support Staff," *Journal of General Internal Medicine* 34 (Oct. 2019): 2150–58, doi:10.1007/s11606-019-05195-0.

52. John D. Fanburg and Jonathan J. Walzman, "Telehealth and the Law: The Challenge of Reimbursement," *Psychiatric Times* 35, no. 10 (Sept. 12, 2018), www.psychiatrictimes.com.

53. *California Medication Assisted Treatment Expansion Project: California Hub & Spoke System — Frequently Asked Questions*, California Dept. of Health Care Services, January 2018, www.californiamat.org (PDF).

54. Robert Belfort and Adam Striar, *Paying for Value in Behavioral Health: What California Can Learn from Other States' Medicaid Programs*, CHCF, February 2015, www.chcf.org.

55. John H. Strauss and Barry Sarvet, "Behavioral Health Care for Children: The Massachusetts Child Psychiatry Access Project," *Health Affairs* 33, no. 12 (Dec. 2014): 2153–61, doi:10.1377/hlthaff.2014.0896.

56. Vista Hill SmartCare BHCS (website), accessed June 10, 2019, www.smartcarebhcs.org.

57. Wunsch, Reilly, and Hogan, *Managed Care Plans*.