Task 12: Behavioral Health Integration and State Medicaid Approaches Research Brief

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Contents

Acknowledgement

The views, opinions, and content of this report are those of the authors and do not necessarily reflect the views, opinions, or policies of the Health Resources Services Administration (HRSA), Bureau of Primary Health Care (BPHC). This material is based upon the work supported by the HRSA/BPHC and prepared by staff of JBS International, Inc under Contract No. 75R60219D00035/75R60223F34004 (P00003).

Introduction

The purpose of this report is to provide training and technical assistance (T/TA) in response to the specific needs of HRSA health centers on the topic area of Behavioral Health Integration.

The report provides a framework of the guiding elements of behavioral health integration (BHI) and the collaborative care model (CoCM), including the scope of services, workflow requirements, health care provider and patient eligibility, and reimbursement policies at the federal and state levels. Based on this framework and informed by qualitative health center data, the report discusses the barriers to integration in health center settings, describes effective, innovative integration practices in five states, and offers future considerations for expansion of BHI throughout the country to meet both medical and behavioral health needs of the patients served by federally funded health centers.

The information provided is as specific as possible to federally funded health centers and Federally Qualified Health Center (FQHC) settings, acknowledging variations in the provision and reimbursement of integrated care in these settings.

Background: Behavioral Health Integration and the Collaborative Care Model

The COVID-19 pandemic exacerbated an ongoing mental health crisis, resulting in an increased number of individuals struggling with medical, mental health and substance use disorders (e.g., depression, anxiety, opioid use disorders).[1] [2] According to the World Health Organization, during the first year of the pandemic, the global prevalence of anxiety and depression increased by 25 percent.[3] While these conditions are treatable in primary care settings by integrating care, the adoption of integrated care models and particularly of the evidence-based collaborative care approach has been slow due primarily to implementation and reimbursement challenges.[4] [5]

Behavioral Health Integration (BHI) in primary care settings is a patient-centered care strategy to improve healthy behaviors and address mental health conditions in primary care settings. BHI focuses on early screening, periodic assessments, and interventions to maximize access to behavioral health (BH) services, particularly at health centers where disease burden is high due to comorbid conditions. While several approaches are used to deliver integrated care services, this report focuses on two distinct models, each with unique payment codes—general BHI and the evidence-based psychiatric collaborative care model (CoCM)—to discuss challenges related to implementation and reimbursement and why the adoption of integrated care has been slow in primary care and health center settings.

The Improving Mood Promoting Access to Collaborative Treatment, or IMPACT trial (2002) demonstrated the effectiveness of CoCM for the treatment of depression in older adults in primary care settings.[6] BHI approaches, and particularly CoCM, have been studied for the treatment of a wide range of BH disorders in addition to depression,[6] including opioid use disorders, alcohol use disorders,[7] and anxiety.[8] While the IMPACT trial was limited to older

adults, other CoCM trials conducted between 2004 and 2014 included younger adult and adolescent patients and showed clinical effectiveness in these age groups as well.[9]

Based on the growing evidence, CoCM is now regarded as one of the most established models of integrated BH care. The American College of Physicians recommends treating depression in primary care within the context of collaborative care.[10] According to the Agency for Healthcare Research and Quality integrated BH not only improves health and patient experiences but also reduces cost and delays in treatment.[11]

Medicare and Integrated Care Models

Although growing evidence demonstrated the effectiveness of treating common BH conditions in primary care, it wasn't until 2017 that the Centers for Medicare and Medicaid Services (CMS) added two new Healthcare Common Procedure Coding System (HCPCS) billing codes for these services. These two billing codes support reimbursement for general BHI (G0511) and psychiatric CoCM (G0512) and are for use in FQHCs and Rural Health Clinics (RHCs) for eligible Medicare beneficiaries.[12]

Billing Codes

Health care providers in FQHCs and RHCs use the G0511 and G0512 billing codes to be reimbursed for general BHI and psychiatric CoCM services, respectively. The codes are allowable for monthly billing for time spent on care coordination services provided to eligible Medicare beneficiaries. General BHI and CoCM services include both direct and indirect provision of care coordination, care team communications, administration of validated rating scales, treatment planning, documentation, time tracking, and outcomes monitoring. Eligible conditions include, "any mental, behavioral health, or psychiatric condition that the billing practitioner treats, including substance use disorders that in the clinical judgment of the billing practitioner, calls for BHI services."[12] Codes G0511 and G0512 have different billing requirements and reimbursement rates.

Guiding Elements

Billed using the G0511 payment code, general BHI services include an initial assessment, administering applicable validated rating scales, systematic assessment, care planning, and continuous monitoring to facilitate and coordinate BH treatment. Billed once per calendar month for at least 20 minutes, the service may be delivered by an FQHC practitioner (e.g., a physician, nurse practitioner [NP], physician assistant [PA], or a certified nurse midwife [CNM]) or by qualified clinical staff under the direction of an FQHC practitioner. Qualified clinical staff refers to the BH care manager who is a clinician with a masters-/doctoral-level education or specialized training in behavioral health, with backgrounds in social work, psychology, or nursing. New to calendar year 2024 Medicare Physician Fee Schedule Final Rule and effective January 1, 2024, licensed Marriage and Family Therapists and licensed Mental Health Counselors will also be considered as FQHC practitioners.[13] While a psychiatric consultant can also serve on the team to

provide treatment recommendations, the presence of one is not a requirement of general BHI services.[14]

Billed using the G0512 payment code, the psychiatric CoCM also provides care coordination, assessment, planning, and monitoring, but differs from general BHI in its team member requirements, time of service, process, and billing. CoCM services are provided by a team consisting of the treating (billing) practitioner, the BH care manager, and the psychiatric consultant.

The treating (billing) practitioner is the primary care provider (PCP) and can be a physician, NP, PA, or CNM in an FQHC setting. This professional:

- initiates the service by getting the patient's consent,
- directs the BH care manager,
- oversees the patient's care, and
- remains involved throughout the episode of care.

The BH care manager, who is a clinical staff member with a masters or doctoral-level education or specialized training in behavioral health:

- maintains an ongoing relationship with the patient,
- administers applicable validated rating scales,
- collaborates with patient/care team to develop the BH care plan,
- provides brief psychosocial interventions,
- collaborates with the treating physician,
- maintains the patient registry, and
- collaborates with the psychiatric consultant during weekly caseload reviews.

The psychiatric consultant, who is the clinician trained in psychiatry and qualified to prescribe the full range of psychiatric medications is a required member of the team, is often remotely located, and is typically not expected to have direct contact with the patient. The psychiatric consultant:

- participates in the weekly caseload reviews to discuss patient clinical status and progress with the BH care manager,
- makes treatment recommendations, and
- facilitates referral for direct provision of psychiatric care when clinically indicated.

Figure 1 shows the relationships of the CoCM team members with their contact frequency while providing CoCM services.

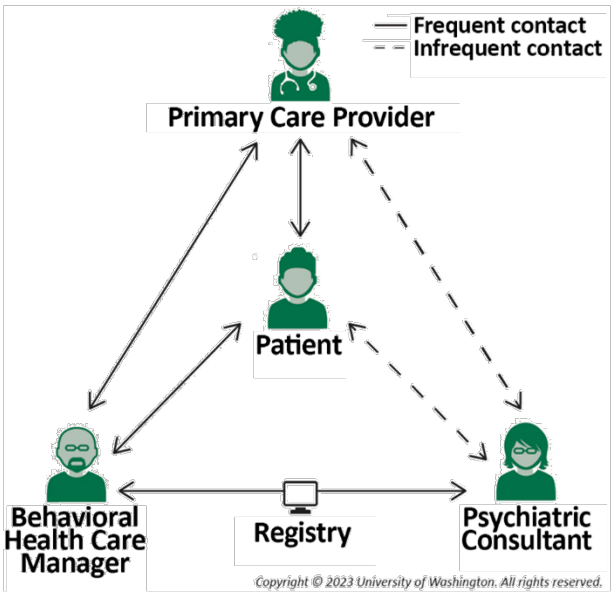

Figure 1. CoCM team member relationships *(Source: University of Washington)*

CoCM billing accounts for time spent by the BH care manager on both direct and indirect patient services such as care coordination, administering validated rating scales, team member communications, brief interventions, time tracking, and documentation in the medical record. Billing code G0512 may be submitted when at least 70 minutes of services in the initial month and 60 minutes in the subsequent months are provided. Table 1 provides a summary of the service, billing requirements, team members, billing frequencies, and reimbursement rates for general BHI and CoCM services provided in FQHC settings.

	General BHI (G0511)	CoCM (G0512)
Billing provider	FQHC practitioner	FQHC practitioner
Team members	FQHC practitioner, BH care manager	FQHC practitioner, BH care manager, psychiatric consultant
Patient registry	Optional	Required
Minutes of service (per calendar month)	20 minutes	70 minutes during initial month, 60 minutes during subsequent months
Allowable billing frequency	Once per month per beneficiary	Once per month per beneficiary
Calendar year 2024 CMS payment rates for FQHCs	$71.68	$144.07

Table 1. General BHI and CoCM services in FQHC settings

By allowing to bill for time spent in both direct and indirect services, CoCM billing offers an opportunity for reimbursement for services that are otherwise unbillable via psychotherapy or other BH services included in the FQHC qualifying visit list.[15]

Medicaid and Integrated Care

Mental health and substance use disorders are prevalent among Medicaid members. In 2020, approximately 39 percent of Medicaid members were reported to have a mental illness and/or substance use disorder.[16] Despite efforts to improve access to BH services, 35 percent of individuals living with such a disorder and covered by Medicaid report not receiving treatment.[17]

Although CMS has established guidelines for integrated care to meet the BH needs of its Medicare members, state Medicaid programs vary widely in determining coverage, delivery, and reimbursement of BHI services.

In 2020, 17 state Medicaid programs were reimbursing CoCM.[4] While this number rose to 24 states in 2023,[5] the guidance provided by states related to CoCM is inconsistent with Medicare guidelines, making it difficult for health centers to adopt and provide this service. Figure 2 shows those 24 states, including Kansas; Kansas activated the codes for individuals dually enrolled in Medicare and Medicaid.

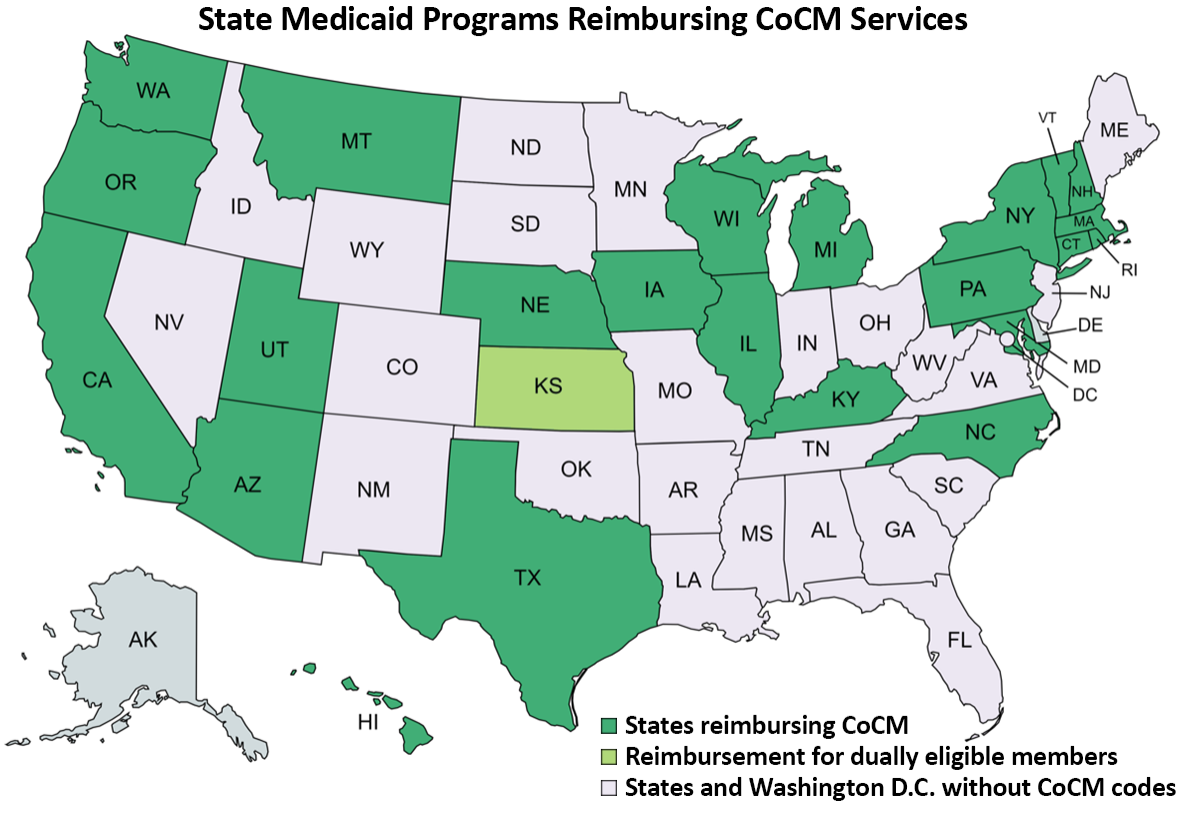

Figure 2. State Medicaid programs reimbursing CoCM services

(Source: Meadows Mental Health Policy Institute and the author's review of state Medicaid websites)

Medicaid Payment Mechanisms

FQHCs serve many people living with low income, including more than 12 million Medicaid beneficiaries[18], and largely depend on Medicaid payments for their operational revenue.[12] State Medicaid programs are required to cover FQHC services, including BH services in the state's Medicaid plan.[19]

Medicaid payment mechanisms for FQHCs are different from those of other health care providers. Under Section 1902(bb) of the Social Security Act, [20] Medicaid programs reimburse FQHCs either through the Prospective Payment System (PPS) or through a qualifying Alternative Payment Methodology (APM).

The FQHC PPS covers all qualified services provided during a visit or encounter and is determined by the state for each individual FQHC based on cost and per-visit payment rates. Under the PPS, states can and do exercise discretion as to which services are included in an encounter and how many encounters an FQHC can bill per member per day. States may also limit the number of visits they would reimburse in a year or require prior authorization if the visits exceed the allowed amount.

In addition to the PPS payment mechanism, states also have the option to use APMs to reimburse FQHCs, provided that the health center agrees to the payment method. APMs, which are value-based payment systems, must reimburse FQHCs at a rate at least as much as the PPS rate. If total payments under the APM are less than the PPS rate, states pay the difference as supplemental payments, also known as wraparound payments. States can use multiple APMs for various health centers or for the same services delivered by different providers.

Managed Care

Managed care is a health care delivery system organized to manage cost, utilization, and quality of services.[21] In recent years, most states have moved to managed care models to deliver BH care services to their Medicaid members by contracting with managed care organizations (MCOs). MCOs are health plans or health care companies that deliver health care services while limiting costs.

States pay MCOs for the contracted scope of services through either comprehensive risk-based contracts or limited benefit plans.[17] [22] Under comprehensive risk-based contracts, MCOs receive monthly capitation payments that reflect the projected monthly cost of serving each Medicaid enrollee. States make the monthly payments to the MCOs regardless of whether the Medicaid member receives services during that period. MCOs may be at financial risk if they spend more on providing services than what they are paid by the state. Under limited benefit plans, states can contract with MCOs to provide a subset of benefits or services for a particular population. Limited benefit plans are generally paid on a capitated basis and may or may not be at financial risk depending on the benefits included in the plan.

In recent years, many states have moved to carve in BH services into their MCO contracts.[17] While most states are carving these services into the MCO contracts, the carve-in status varies by

criteria such as geography, population served, and other factors. In addition, managed care networks have broad flexibility on how they reimburse for FQHC services and are not required to use PPS rates or any other alternate or cost-based payment methods.[19]

With a variety of delivery models for BH health services, the complexity of payment methodologies within states has led to ambiguities as to how Medicaid reimburses certain BH services in FQHCs. This causes inconsistencies and uncertainties in the reimbursement of BHI and CoCM services provided in FQHCs and has resulted in the slow adoption of fully integrated BH care services.

Barriers to Behavioral Health Integration and CoCM Adoption

Many challenges contribute to the slow adoption of fully integrated BH care and CoCM at health centers and FQHCs. Most challenges are related to practice transformation and financial sustainability. Based on TA activities and current literature we identified five common challenge areas that we discuss here:

1. Workforce Shortages

Fully integrated BHI and CoCM services require a team of professionals. In today's environment of workforce shortages and high staff turnover, hiring and maintaining the clinicians necessary to form the team is the most pressing structural barrier.[4] [23] [24] [25]

To overcome the staffing barrier, health center administrators often hire BH practitioners such as clinical psychologists and clinical social workers for the role of BH care managers, as they can independently bill for other BH services in addition to performing care management tasks. While CoCM does not require an independently licensed clinician to work as the BH care manager, health centers often find it more cost-effective to hire these clinicians who can also provide psychotherapy services and generate additional revenue aside from providing CoCM services.[24] This strategy constrains the health center administrators' ability to hire from a limited pool of professionals in a workforce shortage environment.

Another important barrier in forming a fully integrated team is the difficulty in hiring psychiatric practitioners with prescribing privileges. The psychiatric consultant is a required member of the CoCM team whose role includes reviewing patient progress and making treatment recommendations; however, due to staffing shortages, health centers experience difficulties hiring psychiatric consultants.

2. Technological Requirements

Integrated electronic health record (EHR) systems and patient registries are important components of integrated BH care and CoCM services. Electronic patient registries afford a highly efficient means to track time spent providing services, monitor patient progress, and facilitate weekly clinician caseload reviews. While a patient registry is a requirement of CoCM, the level of sophistication varies depending on the facility. Without an embedded patient registry in an organization's EHR, significant time is spent identifying patients as well as tracking time

spent and health outcomes. Some facilities choose to use a registry that is built into the EHR, while others choose tools such as spreadsheets that can be used alongside the medical record.

Another barrier related to technology is the lack of efficient information exchange within medical record systems. Siloed medical record systems and EHR documentation constraints due to patient confidentiality limitations often result in care fragmentation and hamper timely access to patient information and integration efforts.[26] Due to concerns of violating confidentiality requirements, some BH clinicians are reluctant to participate in Health Information Exchanges (HIEs) and share sensitive patient data.[17]

3. Workflow Design

Integrated care teams must undergo some level of workflow redesign to become integrated and meet the BH needs of their patients. Implementing and refining this process can be a barrier to successful implementation of services. Organizations must create new processes and protocols for the entire team (e.g., provide assessments and brief interventions, respond to warm handoffs, plan and conduct follow-up, and address documentation and billing requirements). Workflow design impacts clinical, billing, administrative, and management staff, requiring an organizational change mindset. The process entails the support of leadership and buy-in of all parties involved, particularly the primary care providers who initiate the service.[26] Challenges in this process result in implementation failures or the slow adoption of integration.

4. High Startup Costs and Financial Sustainability

As it is expected for any health care service, the provision of integrated care and CoCM must be financially sustainable. Staffing, technology requirements, workflow modifications, billing, and training needs contribute to the high initial cost of integrating services and require financial investment.

Varying reimbursement methodologies and payment rates across payers also stand as an important barrier to achieving financial sustainability.

Currently, less than half of the states cover CoCM as a mandated Medicaid benefit.[5] Even in states where CoCM is a mandated benefit, reimbursement rates vary significantly. They are often lower than what Medicare would reimburse for the same service, disincentivizing FQHCs to invest in the delivery of integrated care[4]. Moreover, state Medicaid programs may or may not follow the reimbursement requirements determined by Medicare. For example, some states may require attestation or prior authorization before the initiation of services or stipulate different educational and licensing requirements for the BH care manager. These requirements add additional administrative burden on providers who are trying to adopt the service and achieve financial sustainability.[5]

5. Lack of Communication, Cultural Competency, and Stigma

Language, communication barriers, lack of cultural competency among care teams, and stigma are additional barriers in mental health care access. In this setting, cultural competence is defined as a set of skills or processes that enable mental health professionals to provide services that are

culturally appropriate for the diverse populations that they serve.[27] Cultural competence allows patients to feel comfortable with their BH care provider and leads patients to continue seeking care, which is important in mental health care access especially in underrepresented minority communities.[28] Patients of different cultural backgrounds may have diverse ways of expressing symptoms of mental health disorders, resulting in miscommunications with clinicians and difficulties in diagnosing illnesses.[29] Language barriers, challenges in communication, and lack of cultural competence may also lead to patient dissatisfaction, poor comprehension of treatment plans, and negative patient outcomes.[30] Perceived discrimination and stigma in mental health care leads to reduced use of health care services. Many people suffering from mental health disorders feel the impact of stigma as being twofold: public stigma and self-stigma.[31] Public stigma is the reaction the public has to people with mental health disorders. Self-stigma is the perceived discrimination and prejudice which people with mental health disorders feel. Both lead to reduced use of mental health services.

Review of Feedback Collected From Health Centers

This section provides collective information from aggregate data gathered from Behavioral Health Technical Assistance (BH TA) events specific to documentation, coding, and billing, including Site Visits, One-to-One Coaching, Webinar satisfaction assessments, and Webinar poll submissions. During these events, health center staff reiterated the aforementioned barriers and shared insights and best practices used to overcome some of the barriers they experienced.

During the 2022-2023 contract year, JBS International conducted a Webinar titled "*Integrated Primary and Behavioral Health Documentation, Billing, and Coding*." The event attracted over 400 participants generating myriad comments and requests for additional information via the satisfaction assessment survey responses. Main themes of participant comments and requests involved challenges around implementation, workflow, workforce shortages, billing, and financial sustainability.

In response to the additional training and technical assistance (TTA) requests, JBS staff conducted 19 One-to-One Coaching calls and 9 Site Visits related to BHI documentation, coding, and billing.

During these TTA activities, health centers often voiced concerns surrounding the difficulties in effectively integrating BH into primary care. Many health center staff stated that their primary and BH services were co-located rather than fully integrated at their centers. This finding aligns with responses to polling conducted among health center participants during the 2023-2024 contract year webinar on "*Technical Assistance Opportunities to Support Integrated Primary and Behavioral Health Care*." According to the poll responses (n=30), 64 percent of participants stated that primary care and BH services were co-located and minimally or somewhat integrated at their health centers, compared to 18 percent who responded that these services were fully integrated (Figure 3). While this result may not be generalizable to all health centers, it provides an insight as to the need for better integration of BH services into primary care.

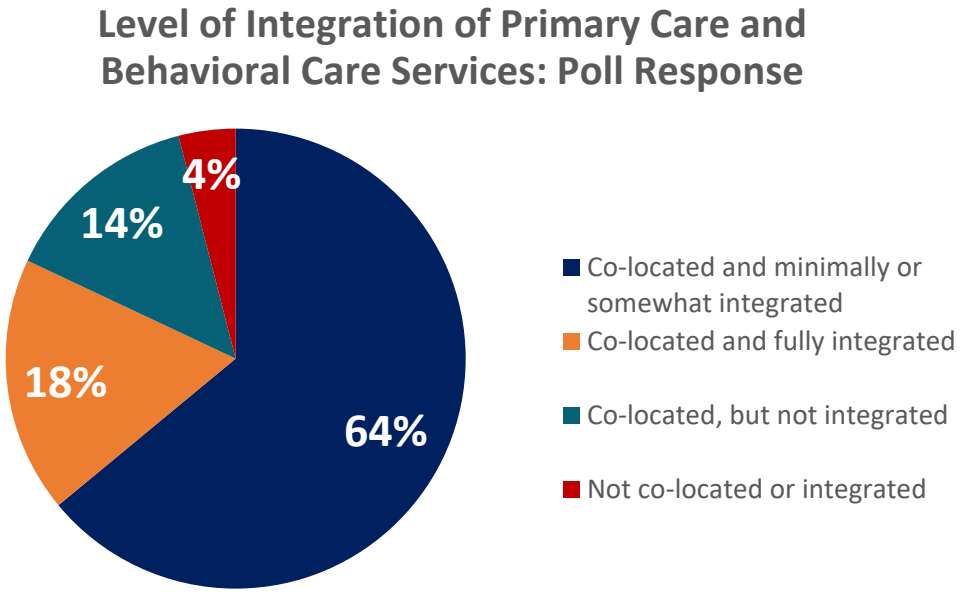

Figure 3. Level of integration of primary care and behavioral care services

During the TTA events, health center staff at the co-located level of integration discussed the challenges related to the implementation of BHI. A clinic director at a large FQHC, overseeing primary care and BH services, mentioned being a strong and resolute proponent of truly integrated care. They stated that despite their efforts, the path to integration had setbacks related to workflow which slowed the process, eventually bringing it to a standstill. This center is currently at the co-location level of integration. The director pointed out that to move forward, the center needs "a renewed focus via executive buy-in." They also mentioned the need for training to better understand the different levels of integration, the key staff involved, and the documentation and billing requirements for BHI.

Another barrier mentioned in the TA activities was the workforce shortage. The number of BH providers was not sufficient to meet the high demand. Health centers had difficulty recruiting and retaining specialty providers. High staff turnover and inadequate workforce impeded integration efforts of already overwhelmed care providers and the systems they work in.

At a Health Center Site Visit in 2023, clinic staff noted that despite practicing integrated care for the past year, the billing of BH services was not optimal. The center experiences difficulties billing for warm handoffs. In addition, ambiguous state Medicaid guidance makes it difficult to understand who the authorized billing provider is. This health center doesn't bill for risk factor reduction services, as they are not sure if those services are billable. During the visit, staff also discussed the billing challenges as a consequence of conflicting requirements of different payers.

Barriers related to EHR systems were also discussed as major impediments to integration. BH staff explained that they either could not access mental health templates in EHR systems or could not integrate their clinical notes into the medical EHR system, creating care fragmentation and

inefficiencies in timely access. In addition, most staff voiced concerns over complex documentation requirements and hoped documentation requirements would become "skinnier."

Health centers with BH providers who had prescriptive privileges had different experiences with integrating services. One center with a psychiatric nurse practitioner on staff was able to address the weekly consultations, which are part of the psychiatric CoCM requirements. Despite performing the weekly consultations and meeting the CoCM requirements, this center had yet to streamline its integration services. The BH director, who attended University of Washington's CoCM training sessions and was familiar with the service, mentioned that financial sustainability concerns were hampering their efforts to provide CoCM services. The director anticipated that their health center would lose money if they continued to provide integrated care services. Other centers reiterated this concern and stated that despite efforts, they later had to move away from BHI because the service was not financially sustainable.

Even health centers working with University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center to establish CoCM workflows struggled with implementation and documentation requirements. Some health centers experienced challenges in launching BHI and CoCM services across sites due to patient scheduling difficulties and clinicians who did not understand the service. One health center staff noted their difficulty in addressing warm handoffs in a timely manner due to their heavily booked schedules. Others noted that most warm handoffs were for patients who needed long-term specialty care and BH providers served mostly as facilitators for referrals rather than collaborators in treatments.

JBS staff also heard from some health center staff that while they were performing BHI services through warm handoffs, they were not billing for these services. Most of the time, staff cited the complexity and wide variation of the billing codes across insurance providers as reasons for not billing. Some mentioned that while they were familiar with the Medicare G codes that were specifically created for FQHCs and RHCs, they could not use these codes for their Medicaid members because their state Medicaid agencies did not recognize these codes and therefore did not reimburse for these services.

While not billing for warm handoffs and BHI services, some FQHCs recoup service costs by billing for psychotherapy when it is provided. However, frequently, centers cannot recoup the cost of other indirect services related to BHI, such as administering validated rating scales when the encounter does not involve psychotherapy. During TA events, health center staff often mentioned that administrators were uninformed about the potential of using the general BHI and CoCM codes in addition to PPS rates received for medical and mental health visits. This gap in understanding represents an opportunity for targeted training and technical assistance in this area.

Despite the challenges, health centers recognize the value of a CoCM or other integrated care model and strive for better integration. Some centers shared promising practices within this area. A health center that was at the co-located level of integration had designated one of its sites as a pilot location for integrating services. One BH clinician was working with four medical clinicians to address warm handoffs, provide assessments, and offer brief interventions. After

evaluating the pilot program, the center planned to roll out the integration at all sites. The leadership was on board with the changes, and the billing staff were working to overcome billing challenges.

Innovative State Practices

Although significant challenges remain, some state Medicaid programs and organizations are working together to bring CoCM services to Medicaid members, either by recognizing the fee-for-service codes or reimbursing through alternate payment models. This section describes how some states launched innovative strategies to facilitate the implementation and financing of CoCM.

Washington

Beginning in 2007, Washington State's Medicaid payer—Community Health Plan of Washington (CHPW)—was the first to help incentivize the implementation of CoCM through the state's Mental Health Integration Program (MHIP). In early 2017, the Washington State Legislature appropriated funds to adopt Medicare's CoCM codes to be used for CoCM services provided to Medicaid beneficiaries, intending to improve statewide access to BH care and assist practices with BHI implementation.[32] In addition, MHIP added a pay-for-performance incentive for practices to earn up to 125 percent of the case rate for demonstrating high performance and improved outcomes.[5] The program helped community practices and FQHCs defray costs of CoCM, including the incorporation of registry tools into medical record systems. To achieve this goal, CHPW contracted with the AIMS Center to support health systems in accessing the center's Care Management Tracking System registry tool.[33]

New York

New York started implementing CoCM through a statewide grant in 2012. Upon its success, the New York State Collaborative Care Medicaid Program (CCMP) was launched in 2015. The state legislature allocated funds for the treatment of depression in Medicaid patients in primary care settings, including FQHCs.[34] Similar to MHIP in Washington State, CCMP provided value-based reimbursement, which also included the pay-for-performance component designed to incentivize adoption of CoCM services.[532] In addition, the New York State Office of Mental Health provides free technical assistance and implementation support to participating providers and has partnered with the AIMS Center at the University of Washington to offer training opportunities, workflow development, and billing support. The combination of financial and training support for CoCM implementation in New York State resulted in positive outcomes for participating sites. These sites were able to demonstrate improvements in treatment outcomes of their patients with depression.[35]

North Carolina

Although North Carolina Medicaid implemented CoCM codes in 2018, the uptake of services was initially minimal. In 2021, in response to increased mental illnesses during the COVID-19 pandemic, state health care leaders formed the Collaborative Care Consortium to prioritize

expansion of CoCM across the state. Consisting of North Carolina Medicaid, academic training centers, health care systems, technical assistance groups, and medical associations, the Consortium aimed to reduce barriers to uptake. One obstacle identified by the Consortium was the pressing need for all payers to cover CoCM and adopt consistent reimbursement requirements to alleviate the administrative burden and complexity for providers. The Consortium's activities resulted in Blue Cross Blue Shield (BCBS) North Carolina, one of the state's biggest payers, starting to reimburse for CoCM and aligning its coverage requirements with Medicare. The Consortium also worked with state leadership to raise Medicaid reimbursement rates. In 2022, North Carolina Medicaid announced significant increases to CoCM Medicaid managed care rates consistent with 120 percent of the Medicare rate.[5]

Texas

Texas has been leveraging public and private funds from the American Rescue Plan Act and philanthropic grants to offset CoCM startup costs for clinical practices. In partnership with the state and various Texas-based medical schools, the Meadows Mental Health Policy Institute has provided technical and implementation support to adjust workflows and billing processes. In addition, the University of Texas Southwestern Medical Center's Center for Depression Research and Clinical Care is developing and maintaining a data repository for health systems to track their program metrics.[5]

Maryland

The Maryland legislature has also shown interest in CoCM and has requested the Department of Health and Mental Hygiene to develop a pilot program to better integrate the delivery of medical and BH services. The Maryland CoCM pilot program began in July 2020 and ended on September 30, 2023. Effective October 1, 2023, CoCM services became available to all Maryland Medicaid enrollees.[36]

Future Considerations and Recommendations for the Adoption of Behavioral Health Integration at the State Level and in Health Center Settings

Integrating BH into primary care encompasses various levels of integration and models of care. Although states and health centers have made progress in the development and adoption of integrated care, barriers related to practice transformation (workforce shortages, complex documentation requirements, payer-specific billing rules, communication barriers) and financial sustainability (startup costs, low reimbursement rates) persist. Based on a review of extant literature and qualitative feedback from clinical and administrative staff at health centers participating in BH TTA events, this section lists potential solutions to common barriers and provides future considerations and recommendations for the wider adoption of integrated BH services in health center settings.[4 5 24 25 37]

Support for Practice Transformation

- Provide ongoing logistical support to health centers to build infrastructure such as workflows, interoperable EHR tracking systems, standardized documentation templates, and time-tracking systems.
- Provide clear guidance about the licensing and educational requirements of BH providers and other types of professionals who can perform BH care manager duties. Understanding the education and licensing requirements will help health centers to hire potential staff from within the institution or a wider pool of candidates.
- Incentivize team-based services that demonstrate improved outcomes.
- Provide ongoing, individualized training and technical assistance to address the training needs of the team, including billing providers, billing and coding staff, and administrators. Clinicians who are not familiar with the consent, service, documentation, and time requirements; billers who are not aware of the full spectrum of codes; and administrators who are not familiar with the licensing and educational requirements of the BH care managers may benefit from training and technical assistance.
- Promote partnerships between health centers and external BH clinicians, psychiatrists, and psychiatric consultants to alleviate some of the workforce shortages and help address long-term treatment referrals. While the psychiatric consultant is a required member of the CoCM team, health centers do not need to have a full-time psychiatric consultant on staff and may contract with the individual to work part-time and remotely.
- Promote the continuation of telehealth. FQHCs can provide telehealth to extend care when a patient is in a different location. CMS allows patients to continue to receive behavioral or mental telehealth wherever they are located, and these telehealth services substitute for an in-person visit.[38] Telehealth services for behavioral health can help alleviate the psychiatric consultant shortage. Some states allow out-of-state physicians and other providers to practice telehealth in their state if they are already licensed in another state.[39]
- Partner with teaching facilities to allow residents in psychiatry programs to provide required weekly caseload reviews under the supervision of the teaching physician. These partnerships can help health centers meet workforce requirements. Teaching hospitals also benefit by offering real-world clinical experiences to residents in training.[40]
- Promote partnerships with industry champions of CoCM implementation such as the University of Washington AIMS Center. Some states (e.g., Washington, New York) have partnerships with the AIMS Center to support building infrastructure for integrated care services, including the use of registry tools and training about workflow and billing requirements.
- Provide ongoing cultural competency and bias training to reduce stigma and improve health equity. Training for clinicians to express patience and compassion toward patients

who are dealing with emotionally complex circumstances will improve the use of behavioral health services. Diversifying the workforce and building cultural sensitivity will enhance cultural competency among providers and have a positive impact on behavioral health utilization especially among groups of people who are otherwise not seeking help or maintaining engagement in BH services.

- Address provider wellbeing to prevent burnout. Process-related support, peer or supervisor support, and promoting professional growth opportunities will enhance staff wellbeing.
- Promote team-building activities to enhance trust and mutual respect within and across teams.
- Promote partnerships with peer support staff to help patients become and stay engaged in the recovery process.
- Promote partnerships with community organizations, providers, and social service organizations to improve information exchange. Partnerships with community organizations can also address individual and community-based behavioral health needs. The Behavioral Health Aide Program in Alaska promotes behavioral health within communities by addressing behavioral health needs of individuals related to drug, alcohol abuse, depression, and suicide.[41]

Support for Financial Sustainability

- Expand coverage of behavioral health integration services across states and insurance providers to include all public and private payers.
  - Advocate to expand Medicaid coverage of BHI and CoCM services across states as a mandated Medicaid benefit and a covered service of private insurers.
  - Promote partnerships among state officials, Medicaid programs, health systems, private insurers, and medical associations to work together to align coverage requirements. For example, North Carolina's Collaborative Care Consortium's activities helped expand coverage of behavioral health integration to include Medicaid members and privately-insured individuals.
- Align service guidelines, reimbursement requirements and rates of general BHI and CoCM with those of Medicare. Medicare provides guidance around service requirements, team member qualifications, and reimbursement codes for general BHI and CoCM services. Aligning Medicaid and private insurer requirements with those of Medicare and providing clear and consistent guidance on documentation and billing requirements will reduce the administrative burden of health centers and help them adopt services to achieve financial sustainability.
- Ensure Medicaid programs reimburse CoCM services at rates that allow financial sustainability for health centers. Low Medicaid reimbursement rates may slow the adoption of these services. In 2022, Montana and North Carolina increased their state

Medicaid reimbursement rates based on Medicaid Physician Fee Schedules by 115 percent and 120 percent respectively compared to Medicare rates.[5]

- Ensure the activation of the G0511 and G0512 billing codes for Medicaid and private insurance reimbursement. Allowing FQHCs to bill using the same codes across insurance providers will streamline the FQHC billing process and improve financial sustainability. Illinois, Massachusetts, Michigan, North Carolina, Nebraska, and Washington state Medicaid programs allow FQHCs to use the G0512 billing code for reimbursement of CoCM services.[5]
- Provide funding, especially in the early stages of BHI implementation to cover startup and maintenance costs. Provide training and technical assistance for billing before, during, and after the implementation phase. Ongoing training will ensure new knowledge and skills are applied to an ongoing learning process.
- Incentivize team-based services and health centers that demonstrate improved outcomes by implementing BHI. CMS's multi-state initiative—the Making Care Primary (MCP) Model—is intended to strengthen primary care by achieving better health outcomes and equity for people and communities. The initiative that will run for 10.5 years, from July 1, 2024, to December 31, 2034, will provide participants with additional revenue to build infrastructure, make primary care services more accessible, and improve care coordination.[42]
    - CMS's MCP Model will be tested in Colorado, Massachusetts, Minnesota, New Jersey, New Mexico, New York, North Carolina, and Washington at partnering institutions, including FQHCs. Priorities will include care management for chronic conditions, behavioral health services, and health care access for rural residents and underserved populations. CMS is working with State Medicaid agencies in these eight states to engage them in care transformation and additionally plans to engage private payers as well.

Finally, as payers are increasingly moving to value-based payment (VBP) models that incentivize quality care,[43] it is becoming evident that improved patient outcomes are the new drivers of reimbursement and financial performance. VBP models incentivize quality care by ensuring that the quality of the services and patient outcomes are monitored using validated measures in clinical settings.[44] In the context of BH, it is important to note that CoCM is the only BHI approach with a strong evidence base and validated measures for the assessment of patient outcomes. As reimbursement practices in healthcare shift to VBP, it will be crucial to promote the adoption of CoCM as an evidence-based BHI service model in health centers and other primary care settings.

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