CITIZENS HEALTH INITIATIVE

December 2016

Integrating Behavioral Health & Primary Care in New Hampshire:

A Path Forward to Sustainable Practice & Payment Transformation

ACKNOWLEDGEMENTS

The New Hampshire Citizens Health Initiative would like to thank Co-Chairs Sharon Beaty and José Their Montero, the Leadership Advisory Board and Clinical Advisory Committee, Learning Collaborative participants, funders, consulting colleagues, and staff at the Initiative, and the University of New Hampshire Institute for Health Policy and Practice and its Center for Health Analytics for all of their contributions that have made the NH Behavioral Health Integration Learning Collaborative possible.

CONTRIBUTORS

Consultants

James Highland, PhD, Compass Health Analytics
Patrick Miller, MPH, Pero Consulting Group, LLC

Staff

New Hampshire Citizens Health Initiative
Institute for Health Policy and Practice
Jeanne Ryer, MSc
Lucy Hodder, JD
Marcy Doyle, RN, MHA, MS
Hwasun Garin
Molly O'Neil
Holly Deblois Tutko, MSc
Jo Porter, MPH
Stephanie Cameron, MPH
Janet Thomas, RN, BS

ADVISORY COMMITTEE

William Brewster, MD
David Coursin, MD
Doris Lotz, MD
Jose Montero, MD, MHCDS
Sharon Beaty, MBA, FACMPE
Yvonne Goldsberry, PhD
Alexander Blount, EdD
Amy Pepin, MSW, LCSW, CPS
William Gunn, PhD
Lisa Bujno, MSN, APRN
Stephen J. Bartels, MD, MSc
Susan Nichols, PA-C

FUNDERS

Endowment for Health
New Hampshire Charitable Foundation
We especially want to thank Kim Firth, Yvonne Goldsberry, Tym Rourke, and Deborah Schachter for their vision and leadership on these important issues.

Suggested Citation: Ryer, J., Highland, J., Hodder, L., Miller, P., Doyle, M., Garin, H., … Thomas, J. (2016). Integrating behavioral health and primary care in New Hampshire: A path forward to sustainable practice and payment. A preliminary report (White Paper). Concord NH: New Hampshire Citizens Health Initiative

Contents

Executive Summary

New Hampshire residents face challenges with behavioral and physical health conditions and the interplay between them. National studies show the costs and the burden of illness from behavioral health conditions and co-occurring chronic health conditions that are not adequately treated in either primary care or behavioral health settings. Bringing primary health and behavioral health care together in integrated care settings can improve outcomes for both behavioral and physical health conditions. Primary care integrated behavioral health works in conjunction with specialty behavioral health providers, expanding capacity, improving access, and jointly managing the care of patients with higher levels of acuity.

In its work to improve the health of NH residents and create effective and cost-effective systems of care, the NH Citizens Health Initiative (Initiative) created the NH Behavioral Health Integration Learning Collaborative (BHI Learning Collaborative) in November of 2015, as a project of its Accountable Care Learning Network (NHACLN). Bringing together more than 60 organizations, including providers of all types and sizes, all of the state's community mental health centers, all of the major private and public insurers, and government and other stakeholders, the BHI Learning Collaborative built on earlier work of a NHACLN Workgroup focused on improving care for depression and co-occurring chronic illness. The BHI Learning Collaborative design is based on the core NHACLN philosophy of "shared data and shared learning" and the importance of transparency and open conversation across all stakeholder groups.

The first year of the BHI Learning Collaborative programming included shared learning on evidence-based practice for integrated behavioral health in primary care, shared data from the NH Comprehensive Healthcare Information System (NHCHIS), and work to develop sustainable payment models to replace inadequate Fee-for-Service (FFS) revenues. Provider members joined either a Project Implementation Track working on quality improvement projects to improve their levels of integration or a Listen and Learn Track for those just learning about Behavioral Health Integration (BHI). Providers in the Project Implementation Track completed a self-assessment of levels of BHI in their practice settings and committed to submit EHR-based clinical process and outcomes data to track performance on specified measures. All providers received access to unblinded NHACLN Primary Care and Behavioral Health attributed claims data from the NHCHIS for provider organizations in the NH BHI Learning Collaborative.

Following up on prior work focused on developing a sustainable model for integrating care for depression and co-occurring chronic illness in primary care settings, the BHI Learning Collaborative engaged consulting experts and participants in understanding challenges in Health Information Technology and Exchange (HIT/HIE), privacy and confidentiality, and workforce adequacy. The BHI Learning Collaborative identified a sustainable payment model for integrated care of depression in primary care. In the process of vetting the payment model, the BHI Learning Collaborative also identified and explored challenges in payment for Substance Use Disorder Screening, Brief Intervention and Referral to Treatment (SBIRT).
New Hampshire's residents will benefit from a health care system where primary care and behavioral health are integrated to support the care of the whole person. New Hampshire's current opiate epidemic accentuates the need for better screening for behavioral health issues, prevention, and treatment referral integrated into primary care. New Hampshire providers and payers are poised to move towards greater integration of behavioral health and primary care and the Initiative looks forward to continuing to support progress in supporting a path to sustainable integrated behavioral and primary care.

Introduction

The New Hampshire Citizens Health Initiative (Initiative), a program of the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH), is a multi-stakeholder collaborative effort with a decade-long history of bringing together leaders and practitioners from health care, insurance, government, higher education, business, and the public to address compelling issues leading to health systems change in New Hampshire. The Initiative's mission is to lead New Hampshire in transforming its health and health care systems to achieve the Triple Aim of better health, better care, and lower costs for health care for all of New Hampshire's residents.[1] Achieving this aim requires that New Hampshire's providers, health systems, and payers work together to better address the health needs of the whole person. The Triple Aim cannot be achieved by focusing only on physical health without addressing the behavioral health care needs of our residents.

One in four Americans has a diagnosable behavioral health condition.[2] Roughly half of Americans will experience some kind of diagnosable mental disorder in their lifetime. Lifetime prevalence of anxiety disorders in the United States is just under 30%, with lifetime prevalence of mood disorders at just under 20%, and substance use disorders (SUD) at just under 15%.[3] Individuals with mental illness have a two- to four-fold increased risk of premature mortality; those with more severe illness may die 25 years earlier than the general population.[4] Mental illness and poor health are linked, with two-thirds of patients with mental illness having a co-occurring medical condition and nearly a third of those with a medical condition have a co-occurring mental illness.[5–9] Adequate treatment is also an issue.[10]

In a 2006, New Hampshire Behavioral Risk Factor Surveillance Survey, more than 17% of adults reported having been diagnosed with depression.[11] More than 50% of continuously-enrolled, pre-Expansion Medicaid members had a diagnosis of depression or a prescription that indicated a depression diagnosis[12] Prevalence of SUDs in New Hampshire includes an estimated 82,000 residents with alcohol dependence, and 37,000 with dependence on illicit drugs excluding prescription drugs (Table 1). New Hampshire experienced a 73.5% increase in overdose deaths from 2013 to 2014.[13] Overdose deaths increased again to 439 in 2015; 480 overdose deaths are projected for 2016.[14,15] New Hampshire's newly insured Medicaid Expansion and Marketplace populations have a higher incidence of SUD than the overall New Hampshire or national rate.[16]

TABLE 1. NH Prevalence Substance Use Disorders17

CHARACTERISTIC	NUMBER OF PERSONS	TOTAL POPULATION (%)
Alcohol Dependence	82,000	7.33
Illicit Drug Dependence[a]	37,000	3.3

[a] *Not including prescription drugs*

The impacts on the health system are significant. The research tells us what providers and patients experience on a daily basis - 25 to 30% of visits for primary medical care either originate from or have a significant related behavioral health component.[18,19] According to published reports, 12.5% of Emergency Department (ED) visits involve a mental health or substance use diagnosis; those ED visits are two and a half times more likely to result in a hospital admission.[20] Depression and anxiety with a co-occurring chronic medical condition increase costs dramatically. National studies show that in the Medicare population, costs for patients with depression were significantly higher than the general population.[21]

In New Hampshire, data from the NHACLN indicate that in the commercially insured population and traditional Medicaid population, more than 40% of under age 65 members with depression or anxiety have a co-occurring chronic condition. This number rises to more than 80% in the Medicare population. NHACLN data shows that costs for patients with depression or anxiety are roughly double these costs for patients with no behavioral health or chronic conditions; when a chronic condition is added, patient costs can double again (Table 2). While within primary care, depression, anxiety, and substance use co-occur frequently with chronic medical conditions, similar data is not available for SUD because of data limitations. It is known, however, that payment rates for SUD treatment fall below Medicare and Medicaid rates in NH.[22]

The evidence is clear that addressing behavioral health concerns, such as depression, anxiety, and SUD in primary care using a collaborative care model would improve outcomes for both the behavioral health conditions and for any co-occurring chronic medical condition, as evidenced from the IMPACT and other studies in the published literature.[21,23–27] However, it is clear from the field that connections between integrated care and payment have yet to be broadly replicated in actual practice.[28] In the Learning Collaborative first year, the focus on moving integrated care into practice highlighted two aspects of integrated care: a collaborative care model for depression and the SBIRT model for substance abuse screening and early treatment.

TABLE 2. Depression/Anxiety and Co-Morbid Chronic Illness

	COMMERCIAL*			MEDICAID*			MEDICARE		
	MEMBERS	COST PMPM*	% CM*	MEMBERS	COST PMPM*	% CM*	MEMBERS	COST PMPM*	% CM*
No Chronic or BH Condition	-	**$202**	-	-	**$241**	-	-	**$169**	-
Depression w/o Co-Morbidity**	41,632	$492	-	6,211	$531	-	5,157	$491	-
Depression w/ Co-Morbidity**	25,729	$1,001	38%	4,211	$839	40%	25,795	$1,268	83%
Mood Disorder Depressed - All	67,361	$687	-	10,422	$656	-	30,952	$1,169	-
Anxiety w/o Co-Morbidity **	32,470	$391	-	3,959	$502	-	2,357	$478	-
Anxiety w/ Co-Morbidity **	16,594	$818	34%	1,988	$694	43%	12,402	$1,041	84%
Mood Disorder Anxiety - All	49,064	$536	-	5,947	$566	-	14,759	$951	-
Members with Depression/Anxiety	**116,425**	-	-	**16,369**	-	-	**45,711**	-	-
Total members with Depression/Anxiety, Commercial, Medicaid, Medicare: 178,505									

PMPM: Per Member Per Month. %CM: % with Co-Morbidity.
*Before Medicaid and ACA Expansion **Of nine chronic conditions
Source: NH Accountable Care Project, www.nhaccountablecare.org. NH Claims Data. NH Comprehensive Health Care Information System, 2013. (Data reporting period may vary by payer.)

■ Review of Literature and Evidence-Based Practice

A review of the literature on behavioral health integration was conducted to inform the Initiative's work on integrated behavioral health. The project had the benefit of expert advisors in integrated behavioral health convening as members of its Clinical Advisory Committee, which provided counsel on learning collaborative scope and content; clinical outcomes, cost, and utilization measurement; integration assessment tools; and implementation project track options. New Hampshire benefits from a cadre of resident experts in BHI who have been generous with their advice and expertise in the development of this Learning Collaborative and in serving as faculty and clinical advisors.[18,29–37]

A review of the peer-reviewed literature to support the development of a payment model looked at the collaborative care model in four dimensions:

1 Cost effectiveness
2 Impact on behavioral health outcomes
3 Impact on medical co-morbidities
4 Workplace/productivity impacts

The literature provides support for the efficacy of the collaborative care model on both behavioral and physical health outcomes and improved workplace attendance and productivity. Cost effectiveness over the long term of the model has been established in a randomized control trial; evidence in the short term is more mixed. A key part of the wide-ranging review was inclusion of the Institute for Clinical Systems Improvement study of depression in primary care. This review is extensive and covers much of the ground that is relevant on this topic.[38]

Outcomes for depression symptoms are improved under the collaborative care model, particularly for individuals with major depression. In one of the earliest studies, improvement was shown in all four outcome measures included in the study: adherence to antidepressant medication, satisfaction with care of depression and with antidepressant treatment, and reduction of depressive symptoms over time.[39] Subsequent studies have tended to reinforce these results, as well as show improved satisfaction on the part of primary care physicians treating depression.[40]

Depression and other illnesses have a bi-directional effect on each other. Many illnesses have been associated with development of depression (e.g., cardiac events, cancer), which can make individuals more susceptible to other medical comorbidities. Therefore, patients with depression have lower compliance with treatment and poorer outcomes for those comorbidities. Evidence about improved outcomes for comorbidities resulting from treatment for depression is less clear.[38]

The results of research examining health system cost-effectiveness shows mixed results, with more supportive findings over the longer time frames. The six-month and one-year studies show increased cost to the outpatient care system. This is balanced by the accumulation of clinical and economic benefits over time. One of the factors is the decrease in the utilization of general medical services in patients with chronic medical comorbidities. The only longer-term study conducted was the IMPACT study, which analyzed the costs of performing collaborative care for one year over a four-year period. The study observed a cost savings of $3,363 per patient over the four-year period.[41]

Improved depression treatment has financial impacts outside the healthcare system, particularly in the workplace. For example, a study examining the effect of a collaborative care model on absenteeism and productivity found that "… employed patients reported 6.1% greater productivity and 22.8% less absenteeism over 2 years. Consistent with its impact on depression severity and emotional role functioning, intervention effects were more observable in consistently employed subjects where the intervention improved productivity by 8.2% over two years at an estimated annual value of $1982 per depressed full-time equivalent and reduced absenteeism by 28.4% or 12.3 days over two years at an estimated annual value of $619 per depressed full-time equivalent."[42]

■ Background: Planning a New Hampshire Response

In 2015, in response to the New Hampshire experience of this national context, the Initiative shared with its NHACLN stakeholders a preliminary analysis of All-Payer Claims Data (APCD) from NHCHIS on incidence and costs of co-morbid depression and chronic disease in New Hampshire (Table 2). Although consistent with the national literature, the number of individuals, families, and communities affected was striking to the stakeholder community, as were the costs. These insights led to the creation of the Depression + Chronic Conditions Work Group (Work Group) to examine the challenges to providers, payers, patients, and families, and to the system.

Building on the NHACLN philosophy of "shared data and shared learning," the Work Group, comprising providers and payers from throughout NH, focused on reducing disparities for patients with depression and co-occurring chronic medical conditions, and using best practices to meet the needs of the populations in New Hampshire while leveraging resources in clinical and community settings. A central component of the work was the collection and analysis of aggregate practice-level data from electronic health records and claims data. In addition, the Work Group identified billing mechanisms within the current Fee for Service (FFS) structure for reimbursement of evidence-based clinical services while working to begin to move towards value-based reimbursement. (Appendix C.)

As evidenced by the rich provider and payer discussions in the NHACLN and Depression + Chronic Conditions Work Group, current payment models constrain providers from working with patients to find optimal ways to help them manage their depression and chronic conditions. Similarly, current payment structures limit providers' time to work with patients and serve to limit treatment options to those services currently within the typical reimbursement mechanisms. For example, telephonic and mobile telehealth follow-up, care coordination, access to community resources, and other services are not typically reimbursable as distinct activities in the current FFS model.

To further the work towards value-based payment models, the Initiative developed a multi-stakeholder BHI Learning Collaborative to assist providers, payers, and other stakeholders in moving forward and sustaining evidence-based models of integrated behavioral health in primary care.

With early funding from the Endowment for Health and the New Hampshire Charitable Foundation, the NH BHI Learning Collaborative delivered focused learning, facilitated stakeholder dialogue, and provided technical assistance and practice transformation coaching on the integration of behavioral health in primary care with use of evidence-based practice and work to create a sustainable payment model.

BHI Learning Collaborative Structure and Process

The NH BHI Learning Collaborative brought together more than 60 organizations, including providers of all types and sizes, all of New Hampshire's major private and public insurers, and government and other stakeholders. The NH BHI Learning Collaborative content included shared learning on evidence-based practice for BHI in primary care, shared data from the NHCHIS, and work to develop sustainable payment models to replace inadequate FFS revenues. Providers joined either a Project Implementation Track working on quality improvement projects to improve their levels of integration or a Listen and Learn Track for those new to BHI. To establish a baseline, providers in the Implementation Project Track completed the Maine Health Access Foundation Site Self-Assessment of behavioral health integration and committed to submitting EHR-based clinical process and outcomes data to track performance on selected measures.[43] All providers received access to unblinded NHACLN Primary Care, and Behavioral Health attributed claims data from the NHCHIS for provider organizations in the NH BHI Learning Collaborative.

The first year of the NH BHI Learning Collaborative focused on increasing the BHI knowledge base and fostering a conversation on how to improve practice and payment. This conversation included explorations of how payment models for integrated behavioral health might improve practice and outcomes for patients in New Hampshire, as well as assisting provider practices with on-the-ground NH BHI Learning Collaborative implementation projects. The NH BHI Learning Collaborative worked with provider and payer members to consider alternative payment models in order to create financial sustainability for integrated practice, including payments for medical and care management.[18, 25-27] A payment model based on the collaborative care model for depression was developed with New Hampshire data inputs and presented to the NH BHI Learning Collaborative participants.

Learning Collaborative Sessions

Learning sessions provided both content from experts and an opportunity for participants to understand the landscape of BHI, understand the barriers and opportunities, and an opportunity to dialogue across sectors to move forward the process for finding solutions. Year 1 concluded with a symposium on integrated behavioral health, "NH Behavioral Health Integration: Making Sense and Moving Forward." (See Appendix A for schedule of learning events).

Facilitated Discussions

NH BHI Learning Collaborative participants participated in facilitated conversations to identify common areas where they could work together to advance integrated behavioral health care. These conversations focused on evidence practice and payment, payment models, and challenges to BHI implementation and sustainability.

Implementation Projects

The Project Implementation Track practices engaged in Quality Improvement (QI) implementation projects focused on three areas: Depression and Co-occurring Chronic Illness, Substance Use Disorders, and Complex/High-Utilizer Patients. The Project Implementation Track practices engaged in monthly QI webinars with peer sharing and coaching and were assigned a QI coach to make practice coaching visits and practice facilitation sessions.

Payment Model

A payment model for treating depression with a collaborative care model was developed, with the goal of making it administratively and financially workable for both providers and carriers, while maintaining fidelity to the model and its improved outcomes for patients. Consistent with the literature, the approach to the design of the model focused on incentivizing:

1. Prevention
2. Accuracy in diagnosing depression
3. Optimal treatment duration/intensity
4. Patient compliance

Evaluation

Evaluation plans for the BHI Learning Collaborative included administration of the Maine Health Access Foundation's Site Self-Assessment instrument at inception and six-month intervals, collection of aggregate clinical process and outcomes data from provider participants' Electronic Health Records (EHR), and review and analysis of cost and utilization data from the NHCHIS.[43]

Early Results

The NH BHI Learning Collaborative is in its early phases; however, the results of the shared conversation about practice and payment are promising. The NH BHI Learning Collaborative will continue to collect and monitor claims and clinical data over time. Several practices have begun to think about moving beyond the process measures of screening for depression and SUD and have begun to collect, aggregate, and share outcomes data. As the NH BHI Learning Collaborative moves into its second year, shared data transparency will help drive the conversation.

Learning Collaborative Sessions

The organizations participating in the NH BHI Learning Collaborative represented a range of providers, all types and sizes, major private and public insurers, and government and other stakeholders. The NH BHI Learning Collaborative design provided expert content and peer learning. Learning priorities and coaching sessions were targeted to meet provider practice needs (Appendix A).

Faculty reviewed and explored the spectrum of integration options, including enhanced referral and care coordination across practice settings, bi-directional integration (i.e., primary care to BH and BH to primary care), co-location, and true integration through on-site, embedded mental health providers credentialed to provide mental health interventions.

Discussions focused on creating a sustainable payment model and outlined payment reform options consistent with level of integration and level of patient severity. Towards this goal, the BHI Learning Collaborative discussions identified barriers to integrated care and a broad range of options to establish best practices for care and promote strategies to encourage and sustain integrated care practices.

Facilitated Discussions: Options and Barriers to Integrated Care

The NH BHI Learning Collaborative analyzed, educated, and shared information about a spectrum of options to support integrated care and identified barriers to sustainable BHI implementation.

Billing and Payment ▶

Short-term financial sustainability options identified included improving the accessibility and use of certain FFS codes matching integrated behavioral health services, as well as proposing a new payment model methodology supporting a payment rate for a value-based collaborative care model. A collaborative care payment model was

proposed that would eliminate some of the barriers associated with FFS. Conversation included proposed review of solutions to FFS coding issues and discussion of evidence-based collaborative care model of billing.

Continuum of Care and Confidentiality ►

The ability to coordinate care for patients across health care settings is often hampered by the heightened confidentiality of behavioral health records under both state law and federal regulation. Integrated and referring providers are restricted by perceived or actual limitations on their ability to share important treatment information. The lack of clarity caused by proposed changes to confidentiality rules (42 CFR Part 2) has increased uncertainty. Conversations with learning collaborative participants included education regarding the rule and examples of ways to improve continuum of care and compliance with confidentiality standards in integrated practice settings.

Billing and Coding for Screening, Brief Intervention, and Referral to Treatment (SBIRT) ►

Three key themes emerged in the dialogue around the provision of SBIRT services:

1 The lack of reliably available treatment providers for SUD care referrals
2 The disconnect between current FFS billing codes and the application of SBIRT in practice
3 Difficulty with helping patients secure coverage for services when referred for SUD treatment

The NH BHI Learning Collaborative facilitated information sharing among providers and payers on barriers and challenges to support problem-solving conversations.

Billing and Coding for Other Interventions ►

Billing and coding issues create significant barriers preventing BHI due to a variety of factors, some of which were specific to certain coverage types. Barriers included, but were not limited to:

1 Availability of Health and Behavior Assessment/ Intervention (HBAI) codes
2 Applicability of HBAI codes for necessary interventions
3 Lack of a SUD treatment for traditional Medicaid
4 Requirements that prohibit billing for a BH intervention on the same day as a physical health office visit
5 Time requirements for treatment making intervention impractical
6 Low reimbursement rates for needed treatments

Credentialing Issues ►

Providers shared that they were often not able to access billing options for necessary BHI services.
Reasons included:

1 The facility or professional was considered "out of network" for the type of BH service they provided despite being "in-network" for health services
2 The site or professional was not credentialed for the integrated service
3 The professionals trained and experienced in providing the interventions did not meet the credentialing requirements for the service according to the payer requirements (including Medicaid)
4 Professional licensing standards limit the ability of professionals to provide independent BH services
5 Licensing requirements for certain BH professionals are cumbersome and prolonged

Health Information Technology and Security ►

While electronic health records allow for significant data sharing and outcomes measurement, they are cumbersome when it comes to documenting behavioral health interventions and complying with applicable confidentiality provisions. No EHR is sufficiently adapted to allow for the management of 42 CFR Part 2 rules around confidentiality of SUD treatment records. The NH Health Information Exchange (HIE), NH Health Information Organization (NHHIO) is not widely utilized to support patient care and continuity across practice settings.

■ Implementation Projects

Seven diverse practices located across New Hampshire elected to work on one of three Project Implementation tracks. The goal was to expand upon the practice's knowledge and use of quality improvement science to begin or evaluate integration. Practices used Maine Health Access Foundation's Site Self-Assessment (SSA) tool at baseline and six-month intervals to evaluate two domains: Integrated Patient and Family Services and Practice/Organization.[43] Additional practices in the

Listen & Learn track also elected to complete the SSA. Each SSA domain has nine dimensions rated on a ten-point scale depending on the level of integration or patient-centered care achieved. Practices chose one dimension as a focus of their quality work (See Figures 1-3).

FIGURE 1. BHI Site Self-Assessment (SSA) Composite Score: Practice/Organization Domain

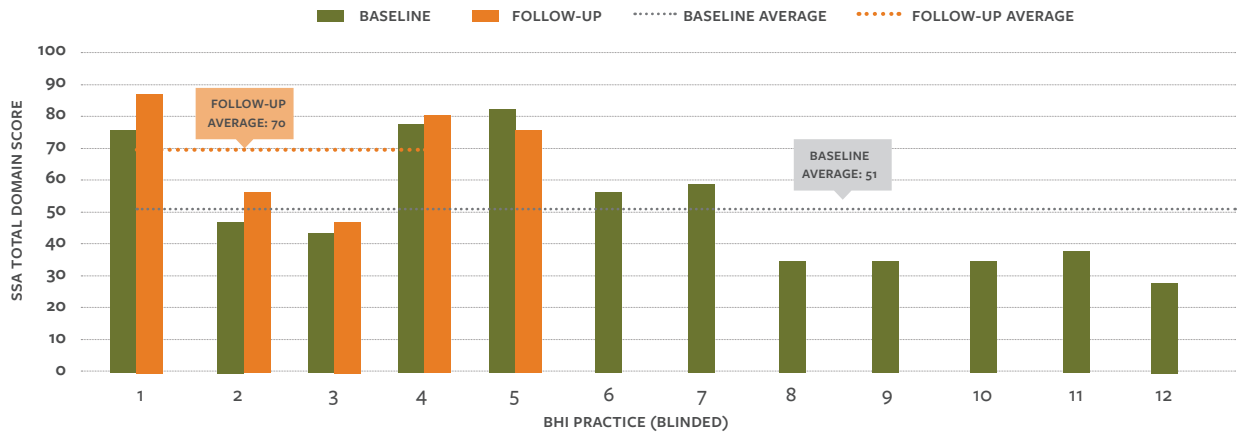


FIGURE 2. BHI Site Self-Assessment (SSA) Composite Score: Integrated Services & Patient and Family Centeredness Domain

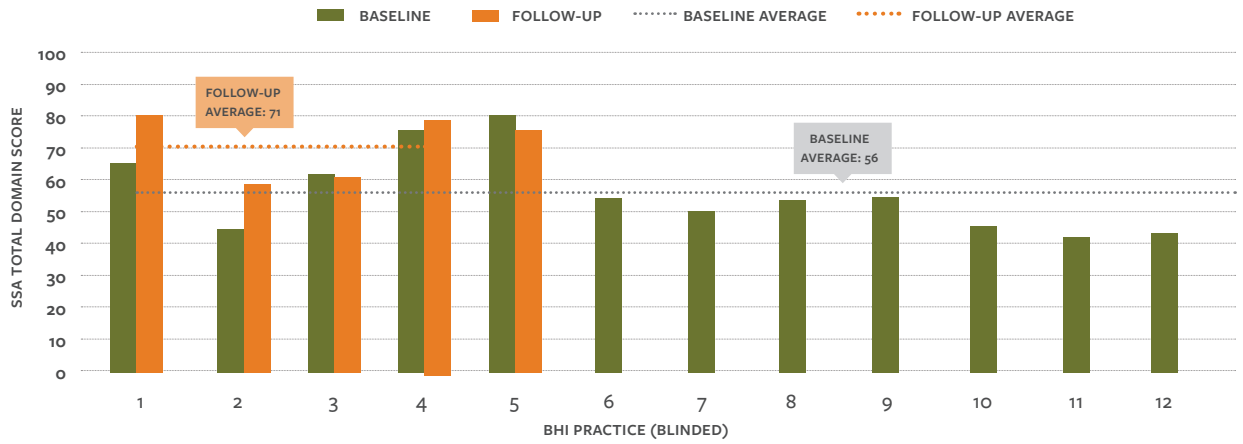
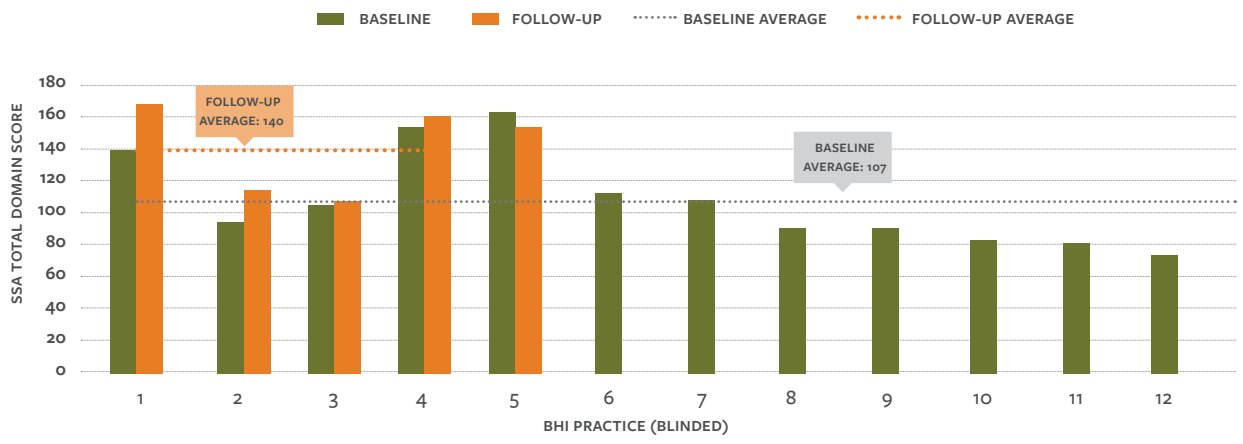


FIGURE 3. BHI Site Self-Assessment (SSA) Composite Score: Total Composite Score



All practices were able to identify a small team within their practice to begin work and develop an Aim statement for their improvement effort. Over half of the practices selected depression screening as focus area in need of improvement. At the beginning of the Learning Collaborative few practices had adopted a standardized workflow to screen for depression or rescreen for symptom remission. The shared learning environment has allowed practices to discuss possible evidence-based process workflows for depression and other processes. Each practice team is working on extracting data from the EHR, which has presented challenges for most practices. Three of the current practices are installing a new EHR, which has delayed their ability to share data both internally and externally. (See Appendix D for additional information on design, goals accomplishments, and initial lessons learned).

■ Payment Model

A key effort of the NH BHI Learning Collaborative was the exploration of a payment model focused on care for patients with depression that could serve as a test for sustainable payment for BHI. The development of the payment model was informed by the NH BHI Learning Collaborative's exploration of best practices for the integration of care for patients with depression in a primary care setting. The NH BHI Learning Collaborative engaged with Compass Health Analytics to develop a basic payment model appropriate to New Hampshire practices to serve as a point of departure for future discussion.

An effective BHI payment model needs to address the three primary parties in health care delivery: the patient, the provider, and the payer. In doing so, the model should provide incentives and benefits from following those incentives, for all three parties. Patients should be incentivized to realize good health outcomes, providers should receive sufficient resources to provide high-quality care in the most efficient manner possible, and carriers should receive value in efficient production of positive health outcomes in exchange for providing adequate resources.

To realize positive outcomes for patients, providers, and payers, the payment model for treating depression in a collaborative care setting was developed by incorporating four critical incentives:

1. Prevention
2. Accuracy in diagnosing depression (neither under- nor over-diagnosis)
3. Optimal treatment duration/intensity
4. Patient compliance

To achieve the balance required for these four factors, the model requires some basis in population health (management fee or global payment), measurement of patient outcomes, and value-based insurance design incentives for patient compliance (e.g., reduced co-pays for services that improve outcomes).

Development of a Collaborative Care Payment Model ►

The NH BHI Payment Model was based on the Collaborative Care Model for delivery of clinical services and the Institute for Clinical Systems Improvement guidelines for adult depression in primary care.[26, 38, 41] The model was developed in two steps:

1. Creating a pro forma cost to provide BHI in a primary care practice (Table 3)
2. A PMPM to support that cost to the provider and provide a return to the carrier (Table 4)

TABLE 3. NH BHI Payment Model: Practice-Level Costs of Model[a]

VARIABLE	HOURS
Example Per-Patient Time Requirements	
Initial History	2
Education	1
8 Sessions Psychotherapy (Referred)	_
Weekly Supervision by PCP/Psych	1
Phone/In Person	4
Relapse Prevention Plan	2
Total Hours Per Patient	10
Implications for Per-Staff Patient Load	
Hours Available[b]	1,740
Numbers of Patients Annually	178
Fully Loaded Salary ($)	85,000

[a] *Time period is equivalent to 1 year per patient*

[b] *Hours available for per-staff patient load are net of administrative, PTO, and training*

TABLE 4. NH BHI Payment Model: Calculation of Required Management Fee PMPM

CHARACTERISTICS	EPIDEMIOLOGICAL DATA AT OR ABOVE POVERTY (18-64)	TOTAL POPULATION (18+)	NH EXAMPLE COMMERCIAL (18+)	
No Symptoms	79.5%	76.7%	86.3%	
Mild		13.7%	15.6%	6.9%
Moderate	4.2%	4.8%	4.2%	
Severe	2.6%	3.0%	2.6%	
Total for Panel	100%	100%	100%	
Total for Practice	20.5%	23.3%	13.7%	
Patients Seen	178	178	178	
Implied Panel Size[a]	872	765	1307	
Annual Cost Per Patient	$476.29	$476.29	$476.29	
Annual Cost Per Member	$97.52	$111.16	$65.02	
Cost PMPM Over All Members	$8.13	$9.26	$5.42	

[a] *Implied Panel Size is 178 / Prevalence*

Unlike the FFS payment model, population health payment is based on per-member cost and provides a financial incentive to provide care efficiently. To balance the countervailing financial incentive to under-provide care, measurement of quality and outcomes must be a part of the payment model. One potential population-based payment method is global payment per patient model (per-member per-month cost for all medical services covered by the payer) or variants on global payment in which there is risk-sharing between the payer and the provider, based on a global payment amount.

Global payment (i.e., capitation) provides a very strong incentive to the provider to reduce services because payment is not based on the services rendered but is fixed, providing a financial incentive to address the patient's needs within the global payment budget. Global payment as the financial payment model also provides an incentive for the provider to invest in resources that can help reduce overall costs, including hiring staff to operate the collaborative care clinical delivery model. For example, if the practice needs to invest $100,000 to operate the collaborative care clinical delivery model and saves $110,000 the investment provides a net gain of $10,000. Risk-sharing models, which are based on the same global per-person budget but share gains or losses between carrier and payer relative to that budget are typically used in accountable care organization arrangements and may not have the same provider incentive to make these investments. The following examples will clarify the financial effects of operating the collaborative care clinical delivery model under various payment models.

Table 5 assumes that there is no billable service code for collaborative care and illustrates with a standardized example how various payment arrangements do or do not provide an incentive for the provider to fund the investment in collaborative care. In the first row of the table, under Fee-for-Service (FFS) payment, the provider earns nothing back from the investment and has a net loss of the investment amount of $100,000 while the insurer invests nothing and receives the benefit of the full $110,000 in savings. Under global capitation, the provider makes the investment but earns all the savings, for a net gain of $10,000. However, under a common ACO arrangement with 25% savings sharing for the provider, the $100,000 investment only earns 25% of $110,000 back to the provider, or $27,500 for a loss of $72,500. The insurer makes no investment but benefits from $82,500 in savings.

Another option for financing the collaborative care model would be to establish a service code to pay for the behavioral health worker. If this occurred and the model generated the full $110,000 in savings, the provider would not need to make an investment and (assuming an adequate payment rate) would cover their costs. The insurer would in effect make the $100,000 investment to cover the new service payments, but would net $10,000 from the savings generated. However, the service code payment model doesn't have direct incentives for the provider to follow the collaborative care model principles, and carriers could reasonably question whether they'd get the outcomes and cost savings associated with the model. If we assume that none of the benefits accrue, then the carrier would invest $100,000 and get zero return for net loss of $100,000.

In the collaborative care payment model, under which the provider would need to attain process/outcome measures consistent with a sound collaborative care clinical model, the provider would recoup their investment via the per-member-per-month management fee, and the insurer would earn $10,000 in savings after making the outlay for the management fee. This model also works well layered over a savings sharing ACO payment model, as illustrated in the last row of the table. This scenario is identical to the previous row, but the insurer pays the provider $2,500 in shared savings (25% of $10,000).

In order to make the potential savings realizable, there needs to be a reasonable financial proposition for both the payer and provider, and clearly the payer needs to invest in proportion with their degree of risk assumption. Tables 6 and 7 summarize the NH BHI Payment Model from both provider and payer perspectives. Rather than using the round numbers just discussed from the example in Table 5, these tables use actual typical values from New Hampshire.

TABLE 5. NH BHI Payment Comparison

	PROVIDER INVESTMENT ($)	PROVIDER RETURN ($)	PROVIDER NET ($)	PAYER INVESTMENT ($)	PAYER RETURN ($)	PAYER NET ($)
FFS	100,000	-	(100,000)	-	110,000	110,000
Global Capitation	100,000	110,000	10,000	-	-	-
ACO with 25% Upside	100,000	27,500	(72,500)	-	82,500	82,500
BH Fee Increase w/ Outcomes	-	-	-	100,000	110,000	10,000
BH Fee Increase w/out Outcomes	-	-	-	100,000	-	(100,000)
Payment Model	100,000	100,000	-	100,000	110,000	10,000
Mixed ACO / Payment Model	100,000	102,500	2,500	75,000	82,500	7,500

The need for patient-centered interventions to address the needs of patients with depression in a primary care setting does not lend itself to a global payment model except in experienced delivery systems with advanced and widespread integration with a broad and diverse patient base. A more carefully tailored collaborative care model provides practices with the incentive to invest in prevention, treatment interventions, and follow-up care in a way that incentivizes better outcomes and enhances quality as well as cost-savings. A per-member per-month management fee contingent on outcomes, where those outcomes reflect both high-quality care and reduction in related costs that offset the management fee, is one approach, and the approach recommended in the model proposed as part of the project. This fee would be calculated on a full-population basis (that is, all eligible members are in the denominator of the calculation), but the numerator is based on the costs associated with managing the collaborative care model.

TABLE 6. NH BHI Payment Model: Summary from Provider Perspective

	NH COMMERCIAL POPULATION 18-64	
	EPIDEMIOLOGICAL DATA	NH PROVIDER EXAMPLE
Fully Loaded Salary per Staff	$85,000	$85,000
Per-staff Patient Load	178	178
Prevalence (%)	20.5%	13.7%
Panel Size per Staff	872	1,307
Management Fee PMPM	$8.13	$5.42
Management Fee Revenue	$85,000	$85,000
Net Cost Per Panel	$0	$0

TABLE 7. NH BHI Payment Model: Net Savings to Carrier

NH COMMERCIAL POPULATION 18-64	EPIDEMIOLOGICAL DATA ($)	NH PROVIDER EXAMPLE ($)
Management Fee PMPM	8.13	5.42
Patients Per Panel		
Implied Panel Size	872	1,307
Prevalence, (%)	20.5	13.7
Number of Patients Seen	178	178
Average Medical Costs Avoided		
Year 1		
Per Patient Per Year	500	600
Per Panel Per Year	89,231	107,077
PMPM	8.53	6.83
Net Savings (Cost) PMPM	0.40	1.41
Average Medical Costs Avoided over Multiple Years (Annualized)		
Per Patient Per Year	1,000	1,200
Per Panel Per Year	178,642	214,154
PMPM	17.06	13.65
Net Savings (Cost) PMPM	8.94	8.23

Outcomes and Risk Sharing

In order to assure positive outcomes for the patient and the associated savings for the payer, it is critical that the payment model include measurement of health outcomes. Providers would be required to regularly assess patients with an evidence-based outcomes instrument agreed to by payer and provider by screening of all members (for example with the shorter PHQ-2) and follow up on patients diagnosed with depression with a more complete assessment (e.g., PHQ-9). Tying the results of this measurement process to payment helps assure provider compliance in achieving positive patient outcomes and associated cost reductions.

In order to phase the model in reasonably for the provider, the measurement process could be ramped up as follows:

1. In Year One, the provider receives the management fee in exchange for consistently providing the outcomes assessment tool results
2. In Year Two, the provider must meet the outcome standards to earn the full management fee; the fee could be prorated based on percentage of standards met
3. In Year Three, the provider could be penalized (that is, a negative management fee) for not meeting standards

Benefit Design to Support BHI

To provide full incentives for all parties, in addition to the provider and payer incentives described above, the principles of Value-Based Insurance Design (VBID) should be used to reinforce the patients' incentives. For example, patient co-pays could be waived for services related to depression management. More difficult to implement but more focused, patient cost-sharing could be waived (or other benefits provided) when patients were available and participated in their scheduled follow-up contacts and treatments for depression care.

The payment model outlined above is focused on principles that can be followed to achieve better results for the three primary participants in health care delivery: the patient, the provider, and the payer. The specifics of actual, implemented models could vary from one to the next in accordance with the needs of the participants, but in following the principles there is potential for a "win" for all involved. The implication is that by maintaining the status quo, all participants are settling for a situation that results in worse outcomes for patients. The potential to improve both behavioral and physical health without increasing overall outlays exists, and continued dialog, trial, error, and adjustment can move the system to a place that produces better outcomes for patients, improves provider satisfaction, and produces better outcomes for payers and their customers.

Summary: Barriers to Behavioral Health Integration & Opportunities for Progress

The NH BHI Learning Collaborative's learning sessions and facilitated conversations identified a number of barriers to implementation of BHI, in addition to those identified in the literature.[25, 41–46] Many of the barriers make integration difficult across practice settings, regardless of patient acuity. The collaborative focused on those barriers most applicable to the integration of behavioral health interventions in the primary care setting for those not suffering from severe or persistent behavioral health diagnoses; integration of primary care into specialty behavioral health practices is an emerging focus. Barriers include gaps in workforce capacity, insufficient reimbursement, regulatory issues relating to licensure, credentialing, privacy concerns, lack of sufficiently developed or interoperable technology, and issues related to continuity of care between providers. These are discussed in detail below.

Participants also identified differences in practice cultures, behavioral health 'stigma,' siloed practice and payment models, significant social and legal determinants of health impacting patients, and lack of transparency or communication in and among the care systems for the populations. These issues, along with others, will require ongoing dialogue.

■ Workforce

New Hampshire is facing workforce shortages of providers licensed, trained, experienced, and credentialed who can effectively provide behavioral health interventions and support in all settings, but most especially in BHI integrated into primary care. A study assessing workforce needs for BHI has recently been completed by the Center for Behavioral Health Innovation at Antioch University of New England, commissioned by the Endowment for Health.[50] This work focused on surveying safety net providers and conducting a training program asset/desire assessment. The authors offered a range of conclusions including: providers are less integrated than self-perceived, there are three roles in which to classify clinical staff working in integrated behavioral health, most staff received on-the-job training, and those positions that are in the highest demand (e.g., behavioral health clinician, substance abuse counselor, care managers) are also the hardest to find. Another study prepared by the New Hampshire Community Behavioral Health Association and presented to the Commission on Health Care and Community Support Workforce showed a year-to-date turnover rate of 19% across the Community Mental Health Centers (CMHCs), an 8% vacancy rate, and large wage gaps for multiple mental health professionals.[51] A study completed by Antal Consulting, LLC in 2016, focused on the high turnover of mental health professionals serving children in CMHCs, which resulted in disruptions in care quality and a lack of service capacity; the report offered potential retention strategies to be adopted.[52]

Barriers ▶

1 In addition to workforce shortages generally in primary care and behavioral health care, specific workforce issues present for BHI implementation in New Hampshire. Not only are providers in each licensing category and specialty in short supply, few available behavioral health providers are trained to work in integrated settings. Primary care providers are similarly not well prepared to optimize BHI providers in their practice teams. The behavioral health workforce shortage also includes serious shortages of psychiatric providers. Behavioral health providers are increasingly reluctant to take on the risk of providing therapy and other interventions to minor patients, especially forensic patients, due to associated risks.

2 Credentialing by payers of providers, especially in integrated settings, continues to be an issue. Several disciplines of Master's level therapists are not able to be directly reimbursed for patient visits and not able to be credentialed by payers. Many licensed professionals trained and experienced in the delivery of behavioral health interventions, including SUD treatments, are not able to be credentialed for the services they are trained to provide in an integrated setting.

3 The licensure process for behavioral health professionals can be slow and cumbersome. With the exception of nurses, there is no licensure reciprocity for those clinicians migrating to New Hampshire holding licenses in other states.

4 Training opportunities for the behavioral health and primary care workforce are constrained, with limited opportunities for preceptorships and residencies in New Hampshire practices. As a result, practitioners often choose to practice in other states when they complete their preparation.

5 The CMHCs have been limited in their effort to recruit and retain workforce due to below market wages and lack of loan repayment options.[50,51]

Recommendations ▶

1 Through collaboration with payers and the state licensure boards, identify barriers to credentialing and encourage streamlined credentialing options for a broad range of licensed professionals experienced and trained to provide behavioral health interventions in a primary care setting (and primary care in a behavioral health setting) and consider ways for New Hampshire to offer reciprocity to professionals credentialed elsewhere.

2 Provide accessible training opportunities for behavioral health and medical professionals on integrated behavioral health practice in primary care.

3 Develop training workshops and mentoring opportunities for professionals seeking preceptorships and residencies in New Hampshire practices with resources and centralized coordination.

4 Improve transparency to patients and employers regarding network adequacy for behavioral health providers, including the availability of information about access to and availability of providers and type of services provided. Payers should be encouraged to include integrated behavioral health as an identifiable network provider type and to cooperate with providers in order to make available transparent information to patients about the availability of behavioral health providers, including integrated delivery resources.

5 Improve the professional licensure process for behavioral health specialties, including enhanced electronic systems capacity to help speed up licensure and renewals and track practice status. Currently, New Hampshire does not have an accurate way to assess the current availability of licensed health care professionals, including practice status or location, specialty, or retirement plans. A workforce survey designed by the Department of Health and Human Services and similar to those in other states would assist the state in better understanding our current workforce and will assist with planning.

6 Analyze the licensing process for behavioral health practitioners and promote changes to ensure a more accessible and streamlined process for licenses and applicants.

■ Payment

The participants in the Learning Collaborative identified a significant lack of resources to support integrated behavioral health in primary care or community mental health settings. Providers pointed to numerous barriers preventing access to adequate or appropriately structured payments for integrated BH services, and such barriers were primary in preventing the development of integrated behavioral health care by the provider participants in the NH BHI Learning Collaborative, as well as by its forerunner group, the Initiative's Depression + Chronic Illness Work Group.

Barriers ▶

Behavioral health services have traditionally been provided and reimbursed separately from health services and in non-integrated settings. Changes in health insurance coverage requirements, as well as federal and state mental health parity and SUD equity laws, have raised questions about the availability of payment for mental health and SUD services. Movement towards a population health approach to health care delivery has emphasized the need to treat the "whole person," but payment models have not caught up to care delivery models. Payment for behavioral health services is considered by many providers to be inadequate to support the costs of care. Issues around payments for substance use disorder services was raised recently through work by Compass Health Analytics in analyzing New Hampshire SUD treatment claims data, finding that commercial payers may reimburse less than Medicare rates for certain SUD treatment services.[22] A comparable study of payments for other BH services has not been done.

1. Payment structures were perceived to be a barrier to BHI in NH. The current FFS system, combined with insurance benefits that carve out coverage and networks for medical, BH, and pharmacy, are a serious obstacle to integration. FFS codes are currently limited in paying for true integrated BH care. Payment codes for collaborative care are emerging, with CMS proposing new collaborative care codes for Medicare in 2017, but codes are limited in application.

2. Billing codes are outdated and not synchronized with integrated behavioral health modalities.

3. Payment methods do not encourage continuity of care and integration across practice settings to allow for behavioral health issues to be addressed collaboratively, regardless of the level of patient acuity, so that patients can obtain the ongoing physical and behavioral health care they need in the right setting. For example, patients diagnosed with serious mental illness will need to be treated in specialty behavioral health settings, such as community mental health centers or other specialty practices.

4. System-wide value-based payment methods, such as accountable care or global risk models, do not align incentives or support resources needed to invest in integrated behavioral health at a primary care level.

5. Resources are not available to primary care practices to support development and implementation of an integrated behavioral health model, despite the demonstrated return on investment.

Recommendations ▶

1. Encourage payers (including medical and behavioral health payers), financial managers and clinicians in a collaborative process to identify and align FFS codes with credentialed professionals available to provide integrated behavioral health in primary care settings and primary care in behavioral health settings.

2. Work to resolve persistent problems with billing for SBIRT by aligning codes with evidence-based delivery model.

3. Further develop the BHI management fee-based payment model for collaborative care and resource pilot projects in at least two primary care settings to enable review and confirmation of return on investment. [53]

4 Conduct an in-depth study of disparities in payment for behavioral health services in New Hampshire, incorporating analysis of the NHCHIS database and detailed provider surveys, and addressing relative payment levels for Medicare (addressing all Medicare payment settings/methods), Medicaid, Commercial, and self-pay.

5 Track the national review of codes for behavioral health provided in integrated settings and review New Hampshire's licensing and billing rules to ensure compatibility.

6 Continue collaborative discussions about integrated behavioral health care and value-based payment for patients diagnosed with serious mental health or SUD conditions.

■ Privacy & Confidentiality

Ensuring integrated care and continuity of care around behavioral health requires disclosure of appropriate behavioral and physical health care services and needs. Both state and federal confidentiality regulations enhance the protection of behavioral health records and limit the sharing of information, specifically about a patient's SUD diagnosis or treatment.

Barriers ▶

1 Providers are confused by 42 CFR Part 2, which provides heightened confidentiality protections to patients receiving SUD treatment or referral, because the rules are inconsistent with HIPAA. In addition, the rules have not been updated to reflect the continuity of care provided in integrated practice settings or technological changes in electronic medical records systems. Changes to the rules that have been proposed, but not finalized or clarified, impose an additional layer of uncertainty on providers. A misunderstanding of compliance options, confusion caused by the newly proposed changes to 42 CFR Part 2, and the rules incompatibility with standards of care around integrated practice settings limit collaborative care models.

2 The intensive need for SUD services in New Hampshire, the SBIRT initiative, and new coverage options available for the delivery of SUD services, have made SUD providers increasingly aware of the heightened confidentiality issues associated with SUD services, specifically 42 CFR Part 2.

3 EHR systems, including new hospital-based technology, are not compatible with confidentiality regulations and do not incorporate appropriate management tools to enable compliance.

Recommendations ▶

1 Provide education and compliance tools to providers around confidentiality issues, including 42 CFR Part 2, and include hospital systems in compliance discussions.

2 Facilitate a technical assistance forum on drafting Part 2 compliant consents once rules are final.

3 Engage EHR vendors and federal regulators around compliance needs in integrated practice and system settings.

4 Utilize learning opportunities to promote compliance options that support integrated behavioral health.

■ Health Information Technology

While EHRs allow for significant levels of data collection, workflow management, and outcomes measurement, they are often cumbersome when it comes to documenting behavioral health interventions and complying with applicable confidentiality provisions, two key issues that need to be solved in an integrated BH setting. First, agreement by New Hampshire providers on a universal consent management policy would "set the business rules" that will drive the technological requirements for HIE between primary care and behavioral health providers. Second, standardized function-

ality within the EHR would allow data elements to be released appropriately from one electronic health record system to another. New Hampshire has an opportunity to address these issues through work with NH DHHS and through the New Hampshire Health Information Organization (NHHIO). Success will be dependent on strong partnerships between providers and policy makers.

Barriers ▶

1 A lack of electronic HIE between primary care and behavioral health providers results in providers relying upon secure email, fax, and paper as the primary methods of medical records transmission. These methods result in delays, lack of accountability, higher administrative costs, lost or missing documentation, reduced information security, and potentially decreased patient outcomes.

2 A lack of Certified Electronic Health Record Technology (CEHRT) available in the Community Mental Health Centers (CMHCs) impacts the ability of providers to institute electronic HIE between primary care and behavioral health providers.

3 New Hampshire providers have not adopted a universal consent management policy, nor do all providers have the technology to support the 42 CFR Part 2 requirements, including the ability to limit the release of data elements restricted by privacy rules and consent documentation. These barriers result in lower HIE adoption rates between primary care and behavioral health providers.

4 New Hampshire lacks resources to support the infrastructure needed to enhance, promote, and pay for behavioral telehealth services.

Recommendations ▶

1 Public and private payers should adopt policies and reimbursement strategies that support the implementation of electronic HIE between primary care and behavioral health providers. These reimbursement strategies should be tied to the support of clinical quality measurement, patient satisfaction, and reduced administrative burden.

2 New Hampshire's 1115 Delivery System Reform Incentive Payment waiver, currently in Year One of a five-year implementation, should be leveraged for federal matching funds that will support electronic HIE between primary care and behavioral health providers.

3 The state should work to support policies that enable electronic HIE between primary care and behavioral health providers.

4 The state should adopt a universal consent management policy and promote local or centralized tools, which may require aggregation of patient demographic information.

5 The state should enhance New Hampshire's capacity to support behavioral telehealth through the development of telehealth networks to support clinical shortage areas. These networks may require the development of interstate compacts for clinical licensure, and they should support behavioral telehealth options for treatment of minors to enhance access and reduce risk to licensed professionals.

6 The state should review regulations, technological capacity, and resources to enhance use of behavioral telehealth applications in New Hampshire's integrated practice settings.

Conclusion

Integrating behavioral health care treatment and primary care in New Hampshire reflects the typical and often interrelated barriers that face any level of coordination of care in our complex health system. During the process of this Learning Collaborative, the opportunities and challenges of integrating behavioral health and primary care were explored in the context of practice, payment, and policy in the New Hampshire landscape. As with all of the Initiative's multi-stakeholder conversations, each perspective and voice added to our understanding of the issues and shaping of potential solutions.

The NH BHI Learning Collaborative has begun to explore the challenges and opportunities through these interdisciplinary discussions and will examine them further in Year Two. In addition, the group continues to identify the future work that needs to be done to address the health and behavioral health needs of the population that suffers from serious mental illness with co-occurring physical health needs. Our work in the year ahead will continue to focus on greater integration of practice and payment for behavioral health, including SUD, in primary care and to improve primary care access for those patients in specialty behavioral health care settings.

New Hampshire's residents will benefit from a health care system where primary care and behavioral health are integrated to support the care of the whole person. New Hampshire's current opiate epidemic accentuates the need for better screening for behavioral health issues, prevention, and treatment referral integrated into primary care. New Hampshire providers and payers are poised to move towards greater integration of behavioral health and primary care and the Initiative looks forward to continuing to support progress in supporting a path to sustainable integrated behavioral and primary care.

Citations

1. Berwick DM, Nolan TW, Whittington J. The triple aim: Care, health, and cost. *Health Aff (Millwood)*. 2008;27(3):759-769. doi:10.1377/hlthaff.27.3.759.

2. Roehrig C, Miller G, Lake C, Bryant J. National Health Spending By Medical Condition, 1996-2005. *Health Aff (Millwood)*. 2009;28(2):w358-w367. doi:10.1377/hlthaff.28.2.358.

3. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Arch Gen Psychiatry*. 2005;62(6):593-602. doi:10.1001/archpsyc.62.6.593.

4. Sharfstein SS. Integrated Care. *Am J Psychiatry*. 2011;168(11):1134-1135. doi:10.1176/appi.ajp.2011.11050766.

5. Kessler RC, Berglund P, Chiu WT, et al. The US National Comorbidity Survey Replication (NCS-R): design and field procedures. *Int J Methods Psychiatr Res.* 2004;13(2):69-92. doi:10.1002/mpr.167.

6. Kessler RC, Ormel J, Demler O, Stang PE. Comorbid mental disorders account for the role impairment of commonly occurring chronic physical disorders: Results from the National Comorbidity Survey. *J Occup Environ Med Am Coll Occup Environ Med.* 2003;45(12):1257-1266. doi:10.1097/01.jom.0000100000.70011.bb.

7. Merikangas KR, Ames M, Cui L, et al. The impact of comorbidity of mental and physical conditions on role disability in the US adult household population. *Arch Gen Psychiatry*. 2007;64(10):1180–1188.

8. Gadermann AM, Alonso J, Vilagut G, Zaslavsky AM, Kessler RC. Comorbidity and disease burden in the National Comorbidity Survey Replication (NCS-R). *Depress Anxiety*. 2012;29(9):797-806. doi:10.1002/da.21924.

9. Sareen J, Cox BJ, Clara I, Asmundson GJG. The relationship between anxiety disorders and physical disorders in the U.S. National Comorbidity Survey. *Depress Anxiety 1091-4269*. 2005;21(4):193-202. doi:10.1002/da.20072.

10. Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-Month Use of Mental Health Services in the United States: Results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):629-640. doi:10.1001/archpsyc.62.6.629.

11. McGuire C, Bratesman S. *Depression among New Hampshire Medicaid Members*. Concord NH: NH Comprehensive Health Information System, NH DHHS; 2007. www.dhhs.nh.gov/ombp/documents/depression.pdf. Accessed April 15, 2014.

12. NH Behavioral Risk Factor Surveillance System. *Depression and Anxiety Disorder among NH Adults - 2006*. Concord NH: NH Department of Health and Human Services, Division of Public Health Services; 2008. www.dhhs.state.nh.us%2Fdphs%2Fhsdm%2Fbrfss%2Fdocuments%2Fdepression.pdf. Accessed April 15, 2014.

13. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention. State Data: Drug Overdose CDC Injury Center. http://www.cdc.gov/drugoverdose/data/statedeaths.html. Published May 2016. Accessed October 9, 2016.

14. New Hampshire Information & Analysis Center. *Drug Environment Report: Unclassified June*. New Hampshire Drug Monitoring Initiative; 2016:13. http://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-may-16.pdf.

15. New Hampshire Information & Analysis Center. *Drug Environment Report: Unclassified August*. New Hampshire Drug Monitoring Initiative; 2016:13. http://www.dhhs.nh.gov/dcbcs/bdas/documents/dmi-may-16.pdf.

16. Substance Abuse and Mental Health Services Administration. Enrollment under the Medicaid Expansion and health insurance exchanges: A focus on those with behavioral health conditions in New Hampshire. July 2014. store.samhsa.gov/shin/content/PEP13-BHPREV-ACA/NSDUH_state_profile_New_Hampshire_508_final_extra.pdf. Accessed August 4, 2015.

17. Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: New Hampshire, 2014*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2015:27.

Citations (cont'd)

18. Gunn J William B, Blount A. Primary care mental health: A new frontier for psychology. *J Clin Psychol*. 2009;65(3):235-252.

19. Ansseau M, Dierick M, Buntinkx F, et al. High prevalence of mental disorders in primary care. *J Affect Disord*. 2004;78(1):49–55.

20. Owens PL, Mutter R, Stocks C. *Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007*. Rockville, MD: Agency for Healthcare Research and Quality; 2010. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf. Accessed August 4, 2015.

21. Unützer J, Schoenbaum M, Katon WJ, et al. Healthcare costs associated with depression in medically ill fee-for-service Medicare participants. *J Am Geriatr Soc*. 2009;57(3):506-510. doi:10.1111/j.1532-5415.2008.02134.x.

22. Compass Health Analytics, Inc. *Analysis of New Hampshire Commercial Insurance Claims Data Related to Substance Use Disorder: Reimbursement Rates*. Concord NH: State of New Hampshire Insurance Department; 2016:9.

23. Simon GE, Katon WJ, Lin EHB, et al. Cost-effectiveness of systematic depression treatment among people with diabetes mellitus. *Arch Gen Psychiatry*. 2007;64(1):65-72. doi:10.1001/archpsyc.64.1.65.

24. Katon WJ, Russo JE, Von Korff M, Lin EHB, Ludman E, Ciechanowski PS. Long-Term Effects on Medical Costs of Improving Depression Outcomes in Patients with Depression and Diabetes. *Diabetes Care*. 2008;31(6):1155-1159. doi:10.2337/dc08-0032.

25. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. *Cochrane Database Syst Rev. 2012*;10:CD006525. doi:10.1002/14651858.CD006525.pub2.

26. Unützer J, Katon W, Callahan CM, et al. Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial. *JAMA J Am Med Assoc*. 2002;288(22):2836-2845.

27. Katon W. Collaborative depression care models: From development to dissemination. *Am J Prev Med*. 2012;42(5):550-552.

28. Bachman J Pincus, Harold Alan, Houtsinger, Jeanie Knox, Unützer, Jürgen. Funding mechanisms for depression care management: Opportunities and challenges. *Gen Hosp Psychiatry Gen Hosp Psychiatry*. 2006;28(4):278-288.

29. Blount A. Integrated primary care: Organizing the evidence. *Fam Syst Health J Collab Fam Healthc*. 2003;21(2):121-121.

30. Fauth J, Tremblay G. Beyond dissemination and translation: Practice based participatory research. *Psychother Bull*. 2011;46(1):15–16.

31. Valeras A, Gunn W, Valeras A. An innovative model for systems-based curriculum: the complex continuity clinic. *Int J Psychiatry Med*. 2013;45(4):377-387.

32. Hudgins C, Rose S, Fifield P, Arnault S. The ethics of integration: Where policy and practice collide. In: *Medical Family Therapy*. Springer; 2014:381–401. http://link.springer.com/chapter/10.1007/978-3-319-03482-9_20. Accessed October 25, 2015.

33. Hudgins C, Rose S, Fifield PY, Arnault S. Navigating the legal and ethical foundations of informed consent and confidentiality in integrated primary care. *Fam Syst Health*. 2013;31(1):9.

34. Korsen, N. S P, Dietrick, A. J. O T. Implementing an office system to improve primary care management of depression. *Psychiatr Q*. 2003;74(1):45-60.

35. Korsen, N. K SE. Introduction to the special section on management of depression in primary care. *Psychiatr Q*. 2003;74(1):43-44.

36. Rodriguez HP, Glenn BA, Olmos TT, et al. Real-world implementation and outcomes of health behavior and mental health assessment. *J Am Board Fam Med*. 2014;27(3):356-366. doi:10.3122/jabfm.2014.03.130264.

37. Bartels SJ, Horn S, Sharkey P, Levine K. Treatment of depression in older primary care patients in health maintenance organizations. *Int J Psychiatry Med*. 1997;27(3):215–231.

38. Trangle M, Gursky J, Haight R, et al. *Adult Depression in Primary Care*. Bloomington, MN: Institute for Clinical Systems Improvement; 2016:132. https://www.icsi.org/_asset/fnhdm3/Depr.pdf.

Citations (cont'd)

39. Katon W, Robinson P, Von Korff M, et al. A multifaceted intervention to improve treatment of depression in primary care. *Arch Gen Psychiatry*. 1996;53(10):924–932.

40. Katon WJ, Seelig M. Population-based care of depression: team care approaches to improving outcomes. *J Occup Environ Med*. 2008;50(4):459–467.

41. Unützer J, Katon WJ, Fan M-Y, et al. Long-term cost effects of collaborative care for late-life depression. *Am J Manag Care*. 2008;14(2):95.

42. Rost K, Smith JL, Dickinson M. The effect of improving primary care depression management on employee absenteeism and productivity: A randomized trial. *Med Care*. 2004;42(12):1202.

43. Scheirer M, Leonard B, Ronan L, Boober B. *Site Self-Assessment Tool for the Maine Health Access Foundation Integration Initiative*. Augusta, Maine: Maine Health Access Foundation; 2015:11. http://integrationacademy.ahrq.gov/measures/C8%20Site%20Self%20assessment%20Evaluation%20Tool. Accessed May 15, 2015.

44. O'Donnell AN, Williams BC, Eisenberg D, Kilbourne AM. Mental Health in ACOs: Missed Opportunities and Low Hanging Fruit. *Am J Manag Care*. 2013;19(3):180-184.

45. Cherokee Health Systems. *The Integration of Behavioral Health and Primary Care in New Hampshire: Analysis and Recommendations.* Concord NH: Endowment for Health; 2014. http://www.endowmentforhealth.org/our-priorities/health-policy-capacity-building/behavioral-health-and-primary-care-integration-study. Accessed May 18, 2015.

46. Davis M, Balasubramanian BA, Waller E, Miller BF, Green LA, Cohen DJ. Integrating Behavioral and Physical Health Care in the Real World: Early Lessons from Advancing Care Together. *J Am Board Fam Med*. 2013;26(5):588-602. doi:10.3122/jabfm.2013.05.130028.

47. Cummings NA, O'Donohue WT, Cummings JL. The Financial Dimension of Integrated Behavioral/Primary Care. *J Clin Psychol Med Settings*. 2009;16(1):31-39. doi:10.1007/s10880-008-9139-2.

48. Blount FA, Miller BF. Addressing the workforce crisis in integrated primary care. *J Clin Psychol Med Settings*. 2009;16(1):113–119.

49. Hall J, Cohen DJ, Davis M, et al. Preparing the workforce for behavioral health and primary care integration. *J Am Board Fam Med*. 2015;28(Supplement 1):S41–S51.

50. Blount A, Fauth JM, Nordstom A, Pearson S. *Assessing the Workforce for the Integration of Behavioral Health and Primary Care in New Hampshire*. Keene, NH: Center for Behavioral Health Innovation Antioch, University New England; In press.

51. Griffin S, Miller PB. NH Community Behavioral Health Association: Workforce Trends, Impacts and Solutions. September 2016. http://www.governor.nh.gov/commissions-task-forces/health-care/documents/hc-09-27-2016-community-behavioral.pdf.

52. Antal P. *Improving Child and Community Health: Addressing Workforce Challenges in Our Community Mental Health Centers*. Concord NH: Endowment for Health; 2016.

53. Reiss-Brennan B, Brunisholz KD, Dredge C, et al. Association of integrated team-based care with health care quality, utilization, and cost. *JAMA*. 2016;316(8):826–834.

Appendices

Appendix A: NH BHI Learning Collaborative Learning Sessions and Topics

Event Date/Location	Topic	Event Date/Location	Topic
Jan 26, 2016 (Webinar)	Introduction to Behavioral Health Integration (BHI) Models and a Case Study on BHI in practice	Jan 28, 2016 (QI Web Call) Behavioral Health Integration	Quality Improvement (QI) Web Call Series: QI Essentials for
Feb 16, 2016 (Webinar)	Introduction to Health information Technology/Exchange and Privacy Considerations Surrounding BHI	Feb 18, 2016 (QI Web Call) Learning	QI Web Call Series: Interactive Calls – QI Project Help and Peer Support/
Mar 15, 2016 (Webinar)	Assessing the impact of BHI: Using Data to Track Utilization, Cost and Patient Health Outcomes	Mar 17, 2016 (QI Web Call) Learning	QI Web Call Series: Interactive Calls – QI Project Help and Peer Support/
Apr 13, 2016 (Concord, NH)	BHI In-Person Learning Session: Payment, Contractual & Financial Models	April 13, 2016 (QI In Person) Learning	QI Web Call Series: Interactive Calls – QI Project Help and Peer Support/
May 3, 2016 (Webinar)	BHI Learning Webinar: BHI for Diverse Populations; Integrating with Community Resources	May 19, 2016 (QI Web Call) Learning	QI Web Call Series: Interactive Calls – QI Project Help and Peer Support/
Jun 15, 2016 (Concord, NH)	Payment Models SUD & SBIRT Learning Collaborative Status Updates	July 21, 2016 (QI Web Call) Learning	QI Web Call Series: Interactive Calls – QI Project Help and Peer Support
Sept 14, 2016 (Bedford, NH)	New Hampshire's Citizen's Health Initiative's Behavioral Health Symposium "NH Behavioral Health Integration: Making Sense and Moving Forward" ▶ Putting NH On the Path to Primary Care and Behavioral Health Integration (Keynote) ▶ Sustainable Payment for Behavioral Health Integration ▶ Behavioral Health and Primary Care in Practice: Practice answers to your questions from regional providers and payers (Panel) ▶ Moving NH Forward to Integrate Behavioral Health: Working Lunch Discussion ▶ Screening and NH's New Opiate Prescribing Guidelines: Guidance for Primary care and Specialty Practices. (Breakout) ▶ Privacy and Confidentiality in Integrated Behavioral Health (Break Out) ▶ Understanding Proposed Medicare Physician Fee Schedule for Behavioral Health/Primary Care Integration (Breakout)		

Appendix B: NH BHI Learning Collaborative Participants

Participating Organization	Type
Aetna	Payer
Ammonoosuc Community Health Center*	Provider
Anthem	Payer
Antioch University of New England	Other
Beacon Health Options	Payer
Bi-State Primary Care Association	Other
Catholic Medical Center	Provider
Cenpatico	Payer
Centene - NH Healthy Families	Payer
Center for Life Management	Provider
Cheshire Medical Center	Provider
Child and Family Services	Other
Child Health Services	Other
Cigna	Payer
Community Partners	Provider
Compass Analytics	Other
Concord NH Hospital	Provider
Concord NH Hospital: Family Health Center *	Provider
Coos Family Health Services	Provider
Cottage Hospital/Rowe Health Center	Provider
Dartmouth-Hitchcock Health	Provider
First Choice PHO at St. Joseph Hospital	Provider
Frisbie Memorial Hospital	Provider
Geneia	Other
Genesis Behavioral Health*	Provider
Goodwin Community Health	Provider
Great Bay Mental Health Associates	Provider
Greater Nashua Mental Health Center	Provider
Harbor Homes*	Provider

Participating Organization	Type
Harvard Pilgrim Health Care	Payer
Indian Stream Health Center	Provider
Center for Excellence, Community Health Institute	Other
Lamprey Health Care	Provider
Littleton NH Regional Healthcare	Provider
LRGHealthcare	Provider
Maine Community Health Options	Payer
Mental Health Center of Greater Manchester	Provider
Mid-State Health Center	Provider
Minuteman Health	Payer
Monadnock Community Hospital	Provider
Monadnock Family Services	Provider
Moultonborough Family Health Care/LRGHealthcare*	Provider
NH Department of Health & Human Services	Gov't
NH Division of Public Health Services	Gov't
NH Home Care Association	Other
NH Medicaid	Payer
NH Medical Society	Other
Northern Human Services	Provider
OptumHealth/United Behavioral Health	Payer
Pero Group	Other
Qualidigm	Other
Riverbend Community Mental Health Center*	Provider
Seacoast Mental Health Center	Provider
Speare Memorial Hospital	Provider
University of New Hampshire	Other
Well Sense Health Plan	Payer
West Central Behavioral Health	Provider

* Practices participating in Implementation Quality Improvement Tracks

Appendix C: Current Fee-For-Service Billing Codes & Coverage Identified by Depression + Chronic Work Group as of December 2015

Clinical Intervention	Detail	Identified Billing Codes	Coverage Notes
1. Screen with PHQ-2	All patients screened with PHQ-2.	N/A	
2. Integrated PHQ-9 PHQ2	For patients with positive PHQ-2 results; follow-up with PHQ-9.	99420	**Harvard Pilgrim:** Covered **NHHF:** require pre-auth and positive **Anthem:** pts with chronic medical condition w/o BH dx can be seen by BH provider per PCP: codes 96150-96154 **Minuteman:** Covered **Beacon:** not covered **Anthem:** included in PMPM. Pts with chronic medical, w/o BH Dx covered to see BH providers per PCP (Codes 96150-96154) **Cigna:** this code is not a part of standard fee schedules for behavioral health providers; the H&B series (96150-96154 can be reimbursed for integrated behavioral services
3. Tier on PHQ-9 Results	Triage and tier care management on PHQ-9 results. Assess results and plan for care (may take place at time of visit)		
4. Patient Registry	Record of patients diagnosed with Depression + 1 or more Chronic Condition		
Care Management	Integrated care management. Coordinate and facilitate communication of care to manage both depression and chronic condition.	99495	**Harvard Pilgrim** NOTE: there is # limit; must be network NPI provider **WellSense:** Covered **Minuteman:** Covered **Anthem:** included in PMPM **NHHF/Cenpatico:** not covered; has internal CM team covering both physical & BH **Cigna:** this code that we have researched for integrated claim payment; in general we are not currently reimbursing separately for case management services through routine claim codes
		99496	**Harvard Pilgrim** NOTE: there is # limit; must be network NPI provider **WellSense:** Covered **Minuteman:** Covered **Anthem:** included in PMPM **NHHF/Cenpatico:** not covered; has internal CM team covering both physical & BH

Appendix C: CONT'D

Clinical Intervention	Detail	Identified Billing Codes	Coverage Notes
Care Management (cont'd)	Integrated care management. Coordinate and facilitate communication of care to manage both depression and chronic condition	99487 - Complex chronic care mgt, first hour physician directed, no face-to-face visit, per calendar month	**Anthem:** included in PMPM **WellSense:** not covered
		99489 - Complex chronic care mgt, add-on to code 99487, each additional 30 min of clinical staff time directed by a physician or other QHP, per calendar month	**Anthem:** included in PMPM **WellSense:** not covered
		99490 - Chronic care mgt, at least 20 min of clinical staff time directed by a physician or other QHP, per calendar month	**Anthem:** included in PMPM **WellSense:** not covered
		G9001 - coordinate care fee, initial assessment	**WellSense:** not covered
		G9002 - coordinate care fee, individual face-to-face visit	**WellSense:** not covered
		G9007 - coordinate care fee, scheduled team conference	**WellSense:** not covered
		G9008 - coordinate care fee, scheduled conference, physician oversight service	**WellSense:** not covered
Same-day BH Consult	Provide same-day consult with BH provider for patients diagnosed with depression; i.e. no need to schedule for another visit on different day at presenting & subsequent visits as needed. Allow for a "warm hand-off"/brief assessment with BH provider.	90791 - Psychiatric diagnostic evaluation	**Harvard Pilgrim:** billable by network non-BH provider **WellSense:** covered if by MD **Beacon:** AH- Clinical Psychologist AJ- Clinical Social Worker HE- Mental Health Program HO- Master's degree level SA- Nurse Practitioner TD- Registered Nurse U6- Psychiatrist **Anthem:** PCP can bill BH codes and BH can code PCP codes - covered **Minuteman:** covered **Cigna:** yes for MHSA providers

Appendix C: CONT'D

Clinical Intervention	Detail	Identified Billing Codes	Coverage Notes
Same-day BH Consult (cont'd)		90792 - Psychiatric diagnostic evaluation with medical services, must be MD	**Harvard Pilgrim:** billable by network non-BH provider **WellSense:** covered if by MD **Beacon:** SA- Nurse Practitioner U6- Psychiatrist **Anthem:** PCP can bill BH codes and BH can code PCP codes **Minuteman:** covered **Cigna:** yes for PhD-level providers
Referral	Integrate with Care Management		**NHHF:** no initial visit limit **WellSense:** initial visit limits: < 18yo = 24 visits/yr - then notification is needed (Beacon) > 18yo = 18 visits/yr - then notification is needed (Beacon) **Beacon:** 90837 covered for Beacon providers AH- Clinical Psychologist AJ- Clinical Social Worker **Anthem:** pts w/o BH Dx and sent to BH, BH can bill initial visit using E/M codes for eval, Dx and treatment planning. It does not have to be @ 1st visit.
	Integrate with Care Management		HE- Mental Health Program HO- Master's degree level SA- Nurse Practitioner TD- Registered Nurse U6- Psychiatrist **Anthem:** 12 initial visits (need to confirm) **Cigna:** For routine OP services?
BH Counseling / Therapy	As needed	90832 - Psychotherapy, 30 min with patient and/or family member	**NHHF:** by network providers **Beacon:** must be by Beacon BH provider, see notes re: initial visit limit AH- Clinical Psychologist AJ- Clinical Social Worker HE- Mental Health Program HO- Master's degree level SA- Nurse Practitioner **Minuteman:** Covered **Cigna:** yes for MHSA providers **Anthem:** pts w/o BH Dx and sent to BH, BH can bill initial visit using E/M codes for eval, Dx and treatment planning. It does not have to be @ 1st visit.
		90834 - Psychotherapy, 45 min with patient and/or family member	**NHHF:** by network providers **Beacon:** See above **Minuteman:** **Cigna:** yes for MHSA providers

Appendix C: CONT'D

Clinical Intervention	Detail	Identified Billing Codes	Coverage Notes
BH Counseling / Therapy (cont'd)		90837 - Psychotherapy, 60 min with patient and/or family member	**NHHF:** by network providers **Beacon:** See above **Minuteman:** covered **Cigna:** yes for MHSA providers **Harvard Pilgrim:** not covered
		90833 - Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service	**Beacon:** See above **Minuteman:** Covered **Cigna:** yes for MHSA providers
	As needed	90836 - Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service	**Beacon:** See above **Minuteman:** **Cigna:** yes for MHSA providers
		90838 - Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service	**Beacon:** See above **Minuteman:** **Cigna:** yes for MHSA providers
		90863 - Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	**Beacon:** See above **WellSense:** not covered **Minuteman:** not covered **Cigna:** not covered
PCP/Psych Consult (MD/APRN)	Provide access to psychiatric consultation (MD/APRN) for PCPs on diagnosis, treatment target, medications. Access to psychiatrists and psychiatric NPs is limited many parts of NH. NH pilots have shown Psych/PCP consults to be very effective in assisting PCPs with patients with BH needs and reduce need for patient psych appointments, delays, travel.	99446-99449 - Interprofessional telephone/internet assessment and management service provided by consultative physician including a verbal and written report	**Harvard Pilgrim:** billable by facilities **Harvard Pilgrim:** offers telepsych consult for HP pts via UBH. **WellSense:** offers consult for PCP with Beacon re: med mgt.; not billed, service offering for WellSense pts. **Beacon:** Code 90882 – case consultation, billable by Beacon providers **Anthem:** not covered **Minuteman:** not covered **Cigna:** tele services are available by behavioral providers utilizing routine codes in states where services are mandated
Patient/Psych Consults	Referrals as needed	90791-90863	**NHHF:** Billable codes 90791, 90832, 90834, 90837 for network providers **Beacon:** Covered **Minuteman:** Covered. Exception: 90863 not covered by WellSense, Minuteman **Cigna:** tele services are available by behavioral providers utilizing routine codes in states where services are mandated

Appendix C: CONT'D

Clinical Intervention	Detail	Identified Billing Codes	Coverage Notes
PCP/Pharmacist Consult	Patients with Depression and Co-Occurring chronic conditions may have issues with poly-pharmacy, side effects, drug interactions, costs. PCP/ Pharmacist consults can be an effective strategy.	99605-99607	Not covered **Anthem:** included in PMPM **WellSense:** offers consult for PCP with Beacon re: med mgt.; not billed, service offering for WellSense pts. **Cigna:** not a part of behavioral integration reimbursement research although consultation is available
Patient/Pharmacist Consults	As needed and available.	99605-99607	Not covered **Cigna:** not a part of behavioral integration reimbursement research although consultation is available
Chronic care group medical visits	Provide peer support, self-management support Drop-in Group Medical Appointments (DIGMA)	99078 - Group counseling with a physician	**Harvard Pilgrim:** covered if by PCP and pt seen 1:1 during visit **WellSense:** Covered **Minuteman:** not covered
		90853 - Group Psychotherapy	**Harvard Pilgrim:** covered if by PCP and pt seen 1:1 during visit **WellSense:** Covered **Beacon:** only for individual pt **Minuteman:** Covered **Cigna:** covered for behavioral health providers **Beacon:** Code H0038; peer to peer will go-live 9/1/15 for SMI, billable to org providing service
	Provide peer support, self-management support Drop-in Group Medical Appointments (DIGMA)	G0108 - Diabetes Self-Management Therapy (DSMT) [need a certified diabetic educator – CDE], Individual 30+ min	**Harvard Pilgrim:** covered if by PCP and pt seen 1:1 during visit **WellSense:** Covered **Minuteman:** Covered **Cigna:** this is not a code that we have considered so far for behavioral integration
		G0109 - DSMT, Group 2+ for 30+ min	**Harvard Pilgrim:** covered if by PCP and pt seen 1:1 during visit **WellSense:** Covered **Minuteman:** Covered **Cigna:** this is not a code that we have considered so far for behavioral integration
e-visits	Asynchronous electronic and email visits.	99444 - online medical evaluation, physician non-face-to-face E&M service to patient/ guardian or health care provider not originating from a related E&M service provided within the previous 7 days	Not covered **Anthem:** included in PMPM, captured in level of E/M visit code **Cigna:** this is not a code that we have considered so far for behavioral integration

Appendix C: CONT'D

Clinical Intervention	Detail	Identified Billing Codes	Coverage Notes
e-visits (cont'd)		98969 - Online assessment and management services provided by a qualified non-physician health care professional to an established patient, guardian, or health care provider not originating from a related assessment and management service provided within the previous 7 days, using the internet or similar electronic communications network.	Not covered **Anthem:** included in PMPM, captured in level of E/M visit code **Cigna:** this is not a code that we have considered so far for behavioral integration
Tele-visits	Synchronous electronic visits	Q3014 - Telehealth originating site facility fee (MCR)	**Harvard Pilgrim:** must be documented in EHR as would if in-person visit **WellSense:** Covered **Anthem:** covered for BH providers **Beacon:** not covered **Cigna:** this is not a code that we have considered so far for behavioral integration
		T1014 - Telehealth transmission, per minute, professional services billed	**Harvard Pilgrim:** must be documented in EHR as would if in-person visit **Anthem:** covered for BH providers **Beacon:** not covered **Cigna:** this is not a code that we have considered so far for behavioral integration

Facilitating Behavioral Health Integration Through A Quality Improvement Learning Network

OCTOBER 2015 - SEPTEMBER 2016

BACKGROUND

One in four Americans has a diagnosable mental or behavioral health condition.[1] Over 25% of adults with medical disorders have a comorbid mental health condition.[2,3] Fifty percent of all behavioral health disorders are treated in primary care.[4]

THE SOLUTION

The solution lies in integrated care - the coorination of mental health, substance abuse, and primary care services. Integrated care produces the best outcomes and is the most effective approach to caring for people with complex healthcare needs.

SAMHSA-HRSA Center for Integrated Health Solutions
NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
SAMHSA
www.integration.samhsa.gov

GOALS

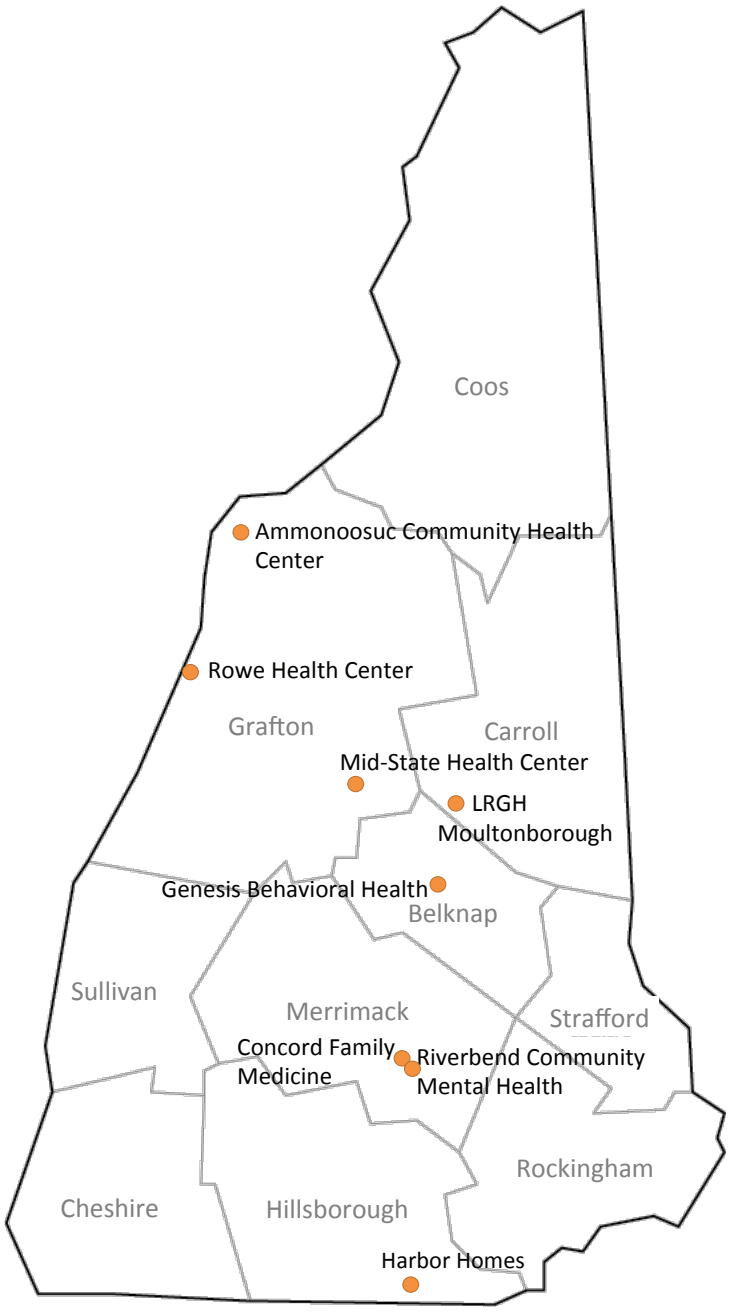
- Introduce Quality Improvement (QI) science as mechanism to pilot implementation of key functions of behavioral health integration (BHI):
  - Develop project aim statement
  - Implement first Plan-Do-Study-Act Change Cycle
  - Begin submitting data for QI work
- Facilitate cross-organizational sharing of best practices
- Adapt learning environment to meet participant needs

DESIGN

- Baseline self-assessment to determine integration status[5]
- Measures selected to track progress and minimize data burden
- Clinics chose one track
  - Depression + Chronic Illness
  - Substance Use Disorders
  - Complex Patients/High Utilizers
- Supports provided
  - QI 101 webinar (1 hr)
  - 4 shared learning sessions with all practices
  - Individual practice on-site/virtual coaching visits

PARTICIPANTS

- Federally Qualified Health Centers (3)
- Behavioral Health Practices (2)
- Hospital-Owned Primary Care Practices (3)



EMERGING FINDINGS

- 5 selected Depression Screening, 2 Complex Patients, and 1 Substance Abuse
- 5 of the 8 sustained active participation in learning network
- 7 of the 8 developed aims statements
- 4 of the 8 developed clinic work flows to integrate new process (typically screening) to support BHI
- One practice submitted baseline quarterly outcome data and others working toward it

LESSONS LEARNED & NEXT STEPS

LESSONS LEARNED

- Practices appreciated
  - Guidance
  - Coach check-ins
  - Peer-to-Peer Sharing
- Challenges
  - Over-estimated how fast practice could progress
  - Practice leadership and staff turnover also limited pace
  - Practice familiarity with QI varied significantly

NEXT STEPS

- Build understanding between the two "cultures"
- Promote awareness of BHI models
- Support practice w/initial PDSA cycles & data collection

ACKNOWLEDGEMENTS

We would like to acknowledge the staff of all participating clinics for their time and efforts advancing BHI at their clinic as well as the Endowment for Health for funding to support this work.

CITATIONS

1. Roehrig C, Miller G, Lake C, Bryant J. National Health Spending By Medical Condition, 1996-2005. *Health Aff* (Millwood). 2009;28(2):w358-w367. doi:10.1377/hlthaff.28.2.358.

2. Kessler RC, Berglund P, Chiu WT, et al. The US National Comorbidity Survey Replication (NCS-R): design and field procedures. Int J *Methods Psychiatr Res.* 2004;13(2):69-92.

3. Alegria M, Jackson JS, Kessler RC, Takeuchi D. National Comorbidity Survey Replication (NCS-R), 2001–2003. Ann Arbor: Inter-university Consortium for Political and Social Research, 2003

4. Petterson S, Miller BF, Payne-Murphy JC, Phillips RL Jr. Mental Health Treatment in the Primary Care Setting: Patterns and Pathways. *Families, Systems, & Health.* 2014;32(2):157-166 http://dx.doi.org/10.1037/fsh0000036

5. Scheirer M, Leonard B, Ronan L, Boober B. Site Self-Assessment Tool for the Maine Health Access Foundation Integration Initiative. Augusta, Maine: Maine Health Access Foundation; 2015:11. http://integrationacademy.ahrq.gov/sites/default/files/measures/8_MEHAF_SSA.pdf. Accessed May 15, 2016.

Marcy Doyle, MS, MHS, RN, CNL, Hwasun Garin, Molly O'Neil, Jeanne Ryer, MS, Holly Tutko, MS

CITIZENS
HEALTH
INITIATIVE

2 White Street | Concord, NH 03301 | 603-513-5126
www.citizenshealthinitiative.org