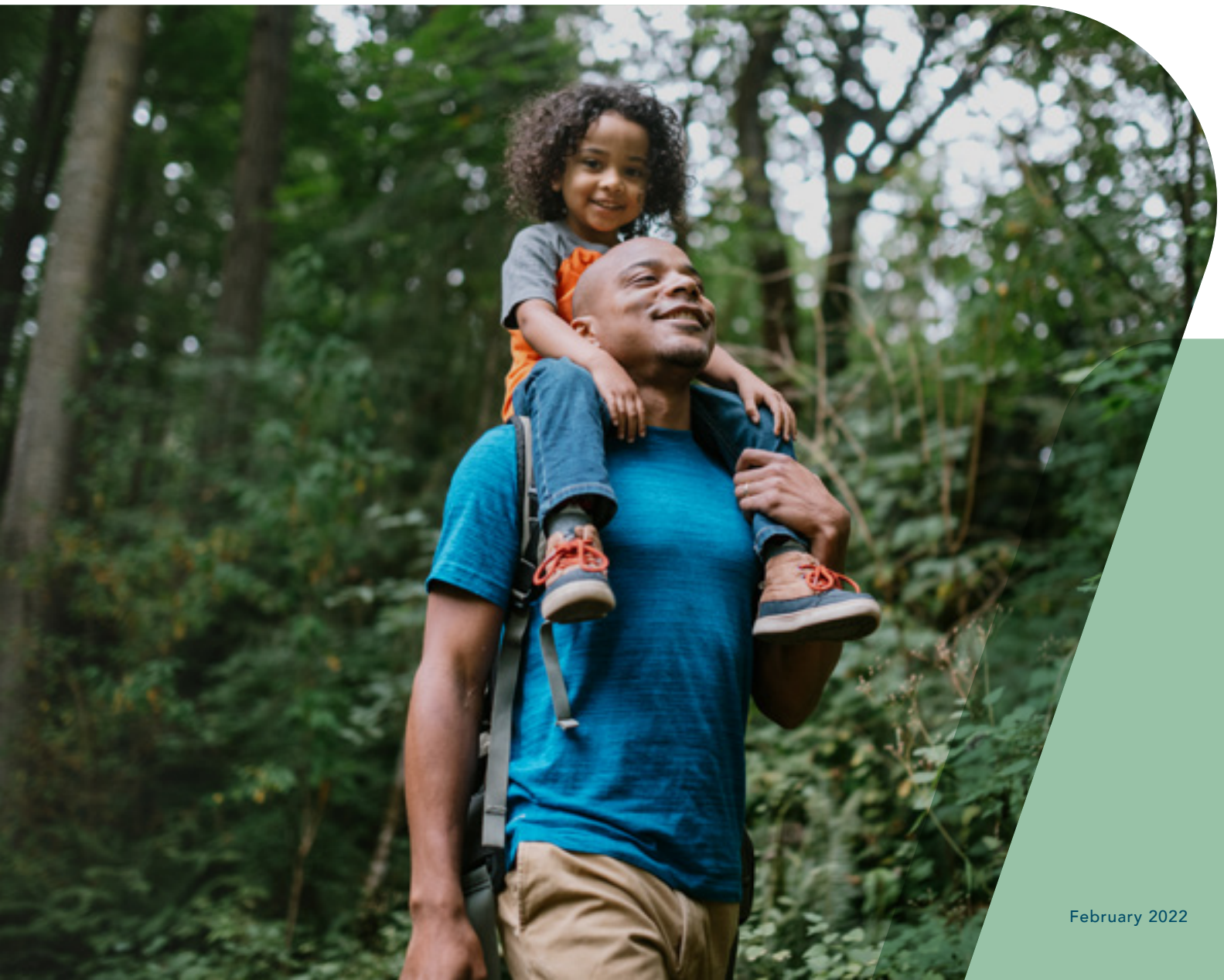


# Integrating Behavioral Health and Primary Care

BETTER CARE AND HEALTH FOR THE WHOLE PERSON



## **Everyone deserves access to the mental health and substance use disorder (MH/SUD) care they need.**

Because these services, together referred to as behavioral health services, are an important part of every person's overall health and well-being, health insurance providers are committed to ensuring access to quality, affordable behavioral health care. As part of this overall commitment, health insurance providers are leading the way, pioneering innovative programs to improve the behavioral health of their members.

These efforts extend beyond compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), which requires offering behavioral health benefits to be provided on par with medical and surgical benefits. These initiatives include raising patient awareness of the importance of behavioral health, providing resources that improve patients' behavioral health literacy, expanding access to tele-behavioral health, and investing in models of integrated, multidisciplinary care teams. Health insurance providers are also working to reduce stigma and isolation, encourage collaborations with providers, expand provider networks, and proactively identify behavioral health needs for members.

As a further extension of health insurance providers' commitment, in 2020 AHIP joined [Psych Hub](#), a Mental Health Resource Hub created to address the need for quality and engaging online education on timely and essential topics. Those topics include mental health, substance use, and suicide prevention. Psych Hub also makes information on behavioral health education and mental well-

## **Key Takeaways**

- Every American deserves access to mental health and substance use disorder treatment as an important part of their overall health.
- Health insurance providers are leading the way with many varied and innovative approaches to improve a person's behavioral health.
- Policymakers can improve access by implementing policies to expand the workforce of behavioral health clinicians, support research for evidence-based behavioral health care, and promote coordination among an integrated care team of physical and behavioral health providers.

As primary care providers for children and adolescents, pediatricians face many of the same challenges with meeting the growing demand for behavioral health services from their young patients. Yet many feel even less equipped to successfully diagnose and treat many pediatric behavioral health conditions. Multiple barriers have been identified in caring for children and adolescents with mental health conditions, such as the reluctance of parents to seek professional help, an insufficient number of specialized child and adolescent behavioral health providers to meet the demand, and additional barriers due to social or economic factors.

As with other primary care practices, approaches that integrate behavioral health into pediatric practices are accompanied by support for pediatricians. That support includes resources such as validated, age-appropriate screening tools; consultation (in-person, phone and telehealth) and referral arrangements with behavioral health specialists; and care management and coordination with behavioral health care managers.

### **Anthem's Child Psychiatry Consultation Program**

Through Beacon Health Options, Anthem has implemented the Massachusetts Child Psychiatry Access Program

(MCPAP), which improves access to behavioral health care for children by connecting primary care providers with child psychiatrists.

By promoting access to psychiatric consultations and referrals, the program encourages primary care providers to integrate behavioral health resources into their practices. It has resulted in specialized care coordination support for pediatric primary care providers in Massachusetts and numerous other states.

### **Blue Cross Blue Shield Michigan's Pediatric/Adolescent CoCM Pilot**

BCBSM launched a CoCM pilot for the pediatric/adolescent population in September 2021 in more than 20 practices. An inter-generational approach will be key to its success, including time assessing family/guardian issues and coordination between multiple systems, schools, therapy providers and often courts.

BCBSM is working with a training specialist for pediatric cases who typically have a social worker in their office practice. Additional support is also provided for offices with high adolescent case load.

being resources readily accessible to patients, providers, and other stakeholders. A number of AHIP member health insurance providers serve on Psych Hub's Scientific Advisory Board, which identifies solutions to improve behavioral health care delivery. Solutions include establishing quality metrics and integrating evidence-based practices throughout the continuum of care.

The COVID-19 pandemic has intensified the demand for behavioral health care and has further highlighted the need for better access to quality behavioral health care. The nation's youth, in particular, have experienced major disruptions as a result of pandemic mitigation measures, including school closures and social isolation. Health insurance providers have responded to this urgent need by providing additional flexibilities for patients to access their behavioral health benefits during the public health emergency. In addition, health insurance providers have been leaders in supporting increased access to telehealth. This includes tele-behavioral health services, the need for which has been accelerated by the pandemic and the pervasive national shortage of behavioral health clinicians.

We have learned a great deal about how to sustainably improve access to behavioral health care. This issue brief offers several best-practice examples from health insurance providers, and proposes several policy solutions to improve access, coordination, and adoption of best practices.

## **Behavioral Health Integration (BHI): A Strategy to Improve Access & Outcomes**

In addition to efforts to increase behavioral health providers' participation in networks, expand tele-behavioral health, and reduce stigma and isolation, health insurance providers have been exploring different ways to integrate behavioral health care with medical care. That includes leveraging collaborations with primary care providers (PCP), including pediatricians, as an effective way to enhance access to behavioral health and improve overall health outcomes.

Integrated behavioral health care blends care for medical conditions and related behavioral health factors, such as mental health and substance use disorders, life stressors and crises, or stress-related physical symptoms that affect a patient's health and well-being.<sup>1</sup> Integration of behavioral health care with primary care has been identified by many

### **Aetna's Pediatric Behavioral Health Management Program**

Recognizing that nearly half of all pediatric office visits involve behavioral, psychosocial and/or educational concerns, Aetna created a collaborative care approach to improve pediatric behavioral health care and support pediatricians in the diagnosis and treatment of behavioral health conditions.

The collaborative care program encourages pediatricians to conduct behavioral health screenings using a Pediatric Symptom Checklist. Based on the screening and assessment, the pediatrician can then manage the child's behavioral health condition, consult with a child psychiatrist, and facilitate further evaluation by the child psychiatrist if indicated. Information is shared between the pediatrician and child psychiatrist to promote seamless care coordination and management and improve patient outcomes.

### **Magellan Sees Opportunities in Integration of Pediatric Behavioral Health Care**

Workforce shortages, the scarcity of behavioral health prescribers specializing in delivering care to children and adolescents, and the recent high demand for behavioral health services for this age group, continue to present access to care challenges. However, there is an opportunity to improve access by expanding the CoCM within pediatric practices.

In addition to behavioral health providers, the pediatric care infrastructure (pediatricians and family practices) and external partners like schools and families are key players in ensuring children in need of care have regular contact with the health care system and, thus, a greater opportunity for screening, assessment, and treatment. While having a family member complete the screening can sometimes prove challenging, pediatricians are accustomed to working with a child's family. With the appropriate support and resources, pediatricians and family physicians are well-positioned to integrate behavioral health assessments into their practices, especially with the support of the CoCM model.

<sup>1</sup> <https://www.integrationacademy.ahrq.gov/about/integrated-behavioral-health>



stakeholders as a strategy not only to improve access and quality, but also to reduce disparities and promote equity:<sup>2</sup>

- Most patients have existing relationships with PCPs, and integrating behavioral health care within those practices enables easy access and “one-stop shopping” that promotes care coordination.
- While PCPs often prescribe many, if not most, medications used to treat behavioral health conditions, they may prefer consultation and/or referral with psychiatrists or clinical psychologists for certain behavioral health conditions and use of certain medications, such as atypical psychotic drugs. Consultation with behavioral health specialists are especially important for patients who may be more susceptible to greater adverse reactions from some medication and integration enables easier access to behavioral health specialists for PCPs and patients.
- For some patients, prescription drugs alone may be insufficient to improve behavioral outcomes. Integration allows for medications to be paired with psychotherapy, resulting in a more holistic approach to care for certain patients.
- Often people who have behavioral health conditions also have other chronic medical conditions. Integration promotes earlier diagnosis and better coordination of care for a patient with both behavioral health and other chronic conditions.
- PCPs are accustomed to measurement-based care and reporting quality metrics – a critical component of improving outcomes through integration.
- In addition to facilitating earlier diagnosis and treatment, care coordination, and improved outcomes, integration promotes timely information sharing between primary care and behavioral health specialists and improved patient and provider satisfaction.

Providers engaged in integrating behavioral health with medical care recognize that both health factors – medical and behavioral - are key to a person’s overall health. Better coordination and timely communication facilitate a team approach to a patient’s overall health care goals. In an integrated care model, medical and behavioral health providers often work in the same medical setting or group practice, or, if not a common site, collaborate on care plans, clinical pathways and guidelines, procedures, and information systems. This close collaboration promotes coordinated



follow-up to improve both medical and behavioral outcomes for the patient. Moreover, providing integrated behavioral care at the same time of medical care has been shown to reduce unnecessary costs in time, money and care delays.<sup>3</sup>

The Center for Health Care Strategies has developed a [continuum](#) of behavioral health integration models based on a federally developed [framework](#) for levels of integrated health care. This integration continuum includes models that emphasize coordinated care through screening and consultation, to those that supplement that care coordination with care management and co-location, to those that are more fully integrated at the health home or system-level. Along this continuum, there are several best practices for integrating behavioral health with primary care and many health insurance providers use a combination of best practices in their approaches to integration.

## Examples of Behavioral Health Integration Strategies

### The Collaborative Care Model (CoCM)<sup>4</sup>

The Collaborative Care Model (CoCM) is a model designed to promote integration that many health insurance providers have implemented with their primary care partners. This evidence-based model of integration includes care management support for patients receiving behavioral health treatment and psychiatric consultation. CoCM relies on a patient-centered team that empowers clinicians to work at the top of their license, utilizes measurement-guided care plans

2 Some examples of stakeholder resources include: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>; [https://www.chcs.org/media/PCI-Toolkit-BHI-Tool\\_090319.pdf](https://www.chcs.org/media/PCI-Toolkit-BHI-Tool_090319.pdf); and <https://www.ama-assn.org/delivering-care/public-health/behavioral-health-integration-physician-practices>

3 <https://www.integrationacademy.ahrq.gov/about/integrated-behavioral-health>

4 For examples of CoCM, see Blue Cross Blue Shield Michigan and Magellan’s case studies.

based on the latest medical evidence, and focuses on helping patients achieve clinical goals. In recent years, the Centers for Medicare & Medicaid Services (CMS) has updated its payment policies to provide reimbursement to practitioners for behavioral health integration ([BHI services](#)). As a result, there are now several codes practitioners can use to bill for BHI services under the CoCM.

In addition to Medicare, many health insurance providers in the commercial market reimburse for the CoCM codes. Some also provide technical assistance to help providers implement this model. Some health insurance providers are also partnering with technology companies that help their provider partners track and document the information necessary to implement CoCM. A number of state Medicaid programs also use the CoCM codes, though this is not universal.

While some clinicians and health systems have implemented the CoCM, uptake among providers has been relatively slow. Start-up costs, complexity, the need for technical assistance, and the inconsistent use by state Medicaid programs are often cited as barriers to widespread adoption.



## Expanded and/or Integrated Care Management<sup>5</sup>

Another approach to behavioral health integration similarly emphasizes the components of team-based care. It relies on care managers coordinating across multiple providers to align and integrate the care delivered by an array of providers to support individuals with chronic conditions, with a special focus on care management for behavioral health conditions. Under this type of model, health insurance providers and their provider partners leverage a range of specialties, including

but not limited to, primary care providers, pediatricians, experienced care managers, psychiatrists, and specialty pharmacists. These clinicians are all skilled in early diagnosis, risk assessment and needed follow-up care.

Primary care providers and care managers involved as part of the team utilize validated screening tools such as the Patient Health Questionnaire (PHQ) and health risk assessments to determine a patient's acuity and level of care needed. Based on this information, they make referrals to the appropriate clinician. Care managers serve as a bridge between primary and behavioral care. They also follow up to ensure patients see the behavioral health clinicians to whom they were referred and work with the clinician to determine the appropriate resources needed to support the patient at home or in a facility.

## Value-Based Purchasing (VBP) and Alternative Payment Models (APM)<sup>6</sup>

Value-based purchasing (VBP) and alternative payment models (APM) can improve access to quality behavioral health care by encouraging more clinicians and facilities to collaborate and coordinate care, assume responsibility for patient outcomes, and encourage behavioral health providers to join payer networks.

These arrangements can incent the integration of behavioral health care, while offering provider flexibility in delivery models and recognizing the partnerships needed to provide whole-person care. These reimbursement models offer flexibility for clinicians to invest in needed infrastructure such as health information technology and staffing. These models also offer participating providers flexibility in selecting the digital tools, most appropriate settings of care (e.g., office visits, facilities, telehealth, etc.), and community resources appropriate for their patients in order to tailor and target services to meet their patients' needs.

VBP and APMs vary based on the readiness of provider practices. They may initially begin as agreements to integrate medical and behavioral health, coordinate care, and report quality metrics to demonstrate improvement in patient care and reduction in costs. As providers advance across the VBP and APM continuum, they can include sharing financial risk for patient performance and an evolved set of applicable and evidence-based quality metrics. One challenge with this approach for use with individuals with behavioral health issues is the quality and strength of available evidence and standards for assessing behavioral health care treatment.

<sup>5</sup> For examples of expanded and/or integrated behavioral care management, see Cigna, Florida Blue, and HealthPartners case studies.

<sup>6</sup> For examples of behavioral health integration through value based payment, see Anthem, Blue Cross and Blue Shield North Carolina, and Cambia case studies.



Measures of quality in the behavioral health space trail behind those available for medical and surgical treatment. However, with experience and support from payers, providers can successfully transition to accepting more financial risk and responsibility for the total cost and quality of care.

## Recommendations for Advancing Behavioral Health Integration

Health insurance providers play a key role in advancing behavioral health integration models, including through facilitating education and training on integration best practices, helping to identify patients at risk who could benefit from referral to integrated care, assisting primary care partners and patients with referrals to behavioral health specialists, and supporting measurement-based care. However, there are several challenges to wider adoption of behavioral health integration that require broader stakeholder engagement. These challenges include the size of the existing behavioral health workforce, the strength of available evidence and standards for assessing behavioral health care treatment and the consequent state of quality measures applicable to behavioral health conditions, and the readiness of providers to implement integrated care models.

**Workforce Enhancement & Expansion.** Being able to integrate physical and behavioral health care depends greatly on having a sufficient behavioral health workforce to perform the necessary care management and specialty consultation services. It is widely recognized that we need more behavioral health clinicians to meet the growing demand for services. For example, one [estimate](#) projects that by 2030, there will be a 20% decrease in the supply of psychiatrists who care for adult patients and the number of child psychiatrists is

widely perceived to be insufficient to meet current and future demand. Shortages in clinician supply are also projected for addiction counselors.

Policies that provide incentives for individuals to enter the behavioral health field and enhance the existing behavioral health workforce could include:

- Increasing funding for loan repayment programs for providers who enter the behavioral health field, including those that specialize in children’s behavioral health care.
- Expanding the eligible provider types for National Health Service Corp (NHSC) scholarships to include behavioral health care professions, including those that specialize in children’s behavioral health care.
- Increasing the number of graduate medical education slots allotted to behavioral health providers, including those that specialize in children’s behavioral health care.
- Expanding the behavioral health provider types covered under Medicare, such as certified peer support specialists, licensed professional counselors, and licensed mental health counselors.
- Incorporating integrated behavioral health care delivery and team-based care into general medical education.
- Supporting tele-behavioral health as a means of supplementing behavioral health provider network capacity by:
  - allowing for flexibility relative to originating sites, provider types, service types, and geography.
  - supporting multi-state licensure rules.
  - supporting investments in providing broadband internet access across the country.
- Supporting hub-and-spoke models (e.g., Project ECHO) to maximize child and adult behavioral health resources.





Moreover, it is important to have diverse provider networks that reflect the communities served so that individuals can find providers that meet their preferences and needs to receive culturally competent and patient-centered care. Many of these same policy recommendations can be used to increase diversity in the behavioral health workforce, and to encourage providers to practice in underserved areas. These areas were recognized by the Administration's November 2021 announcement to invest additional funds in the NHSC and Nurse Corps to expand and diversify the health care workforce.

**Additional Research and Support for Implementation of BHI Strategies.** Despite Medicare's update to the physician fee schedule policies to improve payment for psychiatric collaborative care and care management services, provider adoption of the CoCM and use of the associated codes have been relatively low. Start-up costs, complexity, and the need for technical assistance are often cited as barriers to more widespread adoption. Moreover, many state Medicaid programs do not reimburse for the collaborative care codes, further challenging broader adoption and use. Policies to support implementation of the CoCM and other integration strategies, such as value-based/alternative payment models could include:

- Federal funding that provides practices with start-up funds and technical assistance to adopt the CoCM model.
- Additional research to build the evidence base for other models of integrated behavioral health care.
- Development of outcomes quality metrics to facilitate better assessment of behavioral health treatment

- Incentives to incorporate behavioral health integration into existing Medicare and Medicaid payment models, including through use of state Medicaid waivers to fund integration, supporting Medicaid's use of Certified Community Behavioral Health Clinics (CCBHC), and supporting Medicaid reimbursement of the CoCM codes.

**Adoption of Policies to Promote Improved Coordination and Communication.** As we work toward an interoperable health system, remaining limitations on information sharing will need to be identified, understood, and addressed. Policies to promote improved coordination and communication through health information technology systems could include:

- Removing the current exclusion of behavioral health clinicians from the Electronic Health Record (EHR) Incentive Program. Inclusion of behavioral health providers in this program would encourage greater adoption of EHRs among behavioral health clinicians and promote better information sharing among providers caring for the same patient.
- Addressing federal and/or state requirements that restrict information flow. For example, behavioral health information is often subject to more stringent privacy protections and patient consent requirements. Despite recent statutory changes, federal law continues to impose restrictions related to sharing substance use disorder (SUD) information. States, too, may have their own restrictions for information sharing from behavioral health providers. Policymakers should consider whether these requirements have an unintended effect on overall care (e.g., adverse medication reactions that result from restrictions placed on SUD information).



## Achieving Whole-Person Health for Every American

Behavioral health integration promotes timely access to whole-person care. And in removing the traditional siloes between medical and behavioral care, integration can help reduce the stigma and disparities in care that often present challenges to equitable access to quality behavioral health care.

The range of approaches currently underway underscores the importance of flexibility and recognition that physician practices are at varying stages of readiness. Some physician practices are not yet able to integrate behavioral health care based on their practice structure, such as available office space and technological capabilities. However, it is important to note that all of these approaches rely on team- and evidence-based care that includes PCPs using validated behavioral health screening and assessment tools. Such tools help identify patients in need of services, consultation and referral arrangements and partnerships with behavioral health specialists, care management by health care professionals trained to coordinate care across behavioral and medical conditions, education and training resources to support providers, and quality measurement to assess effectiveness.

Behavioral health integration is dependent on a robust behavioral health workforce. Consequently, the Department of Health and Human Services (HHS) should explore ways to increase capacity and, at the same time, make the most of the existing workforce. As they do this, policymakers should ensure that these providers have the resources and training necessary to implement integrated care models, explore what additional research might be necessary to build the evidence base for effective models of integrated behavioral health care, and support the development of measures of the quality of care based on that evidence base. Lastly, policymakers should consider removing any remaining barriers to effective communication and information sharing among providers caring for the same patients.

To learn about some of the specific behavioral health integration strategies, AHIP conducted a series of one-on-one interviews with several member plans. The case studies shared here showcase various models and partnerships with network providers to promote greater adoption of behavioral health integration and improve patient care.

Health insurance providers see firsthand the vital role that behavioral health plays in overall health. Working together, we can improve affordable access and high-quality mental health and substance use disorder care—so everyone can get the care they need, when they need it, to achieve their best health.



## Anthem

### Supporting Integration Through Collaborative Care & Value-Based Arrangements

To address physical health and mental health/substance use disorder (MH/SUD) treatment, Anthem offers a wide range of targeted interventions, education, and enhanced access to care. These approaches help ensure improved outcomes and quality of life for members. Recognizing that 80% of patients with behavioral health conditions routinely visit a PCP, yet often do not follow up to schedule initial appointments when referred to outpatient MH/SUD clinics, Anthem has focused on supporting partnerships between PCPs and MH/SUD treatment providers to improve timely access to needed behavioral health care.

For their commercial and Medicare lines of business, Anthem has been covering codes associated with the CoCM since their creation approximately 5 years ago. In addition, Anthem reimburses for various HCPC codes that support PCP engagement in behavioral health interventions. The use of these codes facilitates reimbursement for activities providers perform like assessing and screening patients for behavioral health concerns. These concerns include depression, alcohol and/or substance use, and providing counseling for patients with physical health care conditions, such as cardiovascular disease or obesity, which may contribute to their behavioral health conditions. For their Medicaid line of business, Anthem's coverage of collaborative care codes depends on state regulations that govern coverage for Medicaid enrollees.

Anthem has launched several value-based payment models for behavioral health providers and facilities serving commercial members. These alternative payment models incent health care professionals and facilities to demonstrate improved treatment outcomes and quality clinical care. Anthem is currently contracting for these value-based payment solutions with behavioral health facilities; outpatient providers; and medical providers that offer integrated behavioral health care through fully integrated, co-located, or coordinated care models. SUD facilities have an opportunity to participate in a value-based payment program for inpatient and residential treatment. Participating SUD facilities have an opportunity to earn the Blue Center of Distinction for offering quality continuum of care services.

Anthem's value-based payment solutions recognize providers who demonstrate positive treatment outcomes. PCPs earn value-based payment for delivering high quality, integrated care collaboration between a member's PCP and behavioral health provider. Integrated service delivery can expand access to care through rapid appointment offerings and transparent

quality outcomes reporting. Through these value-based solutions, Anthem connects interested PCPs with interested behavioral health providers and includes an attestation by participating providers that the PCP and behavioral health provider are engaged and will frequently communicate about their patients as needed.

Today, approximately 80 mental health providers working collaboratively with 200 PCPs and 50 substance use disorder facilities participate in Anthem's value-based payment solutions. Anthem has received great feedback from the providers currently engaged in these solutions and hopes to continue growing provider participation across its markets.

### Identifying Patient Needs

Anthem uses their claims data to provide actionable information directly to their PCPs, such as recent emergency room (ER) use for psychiatric or other behavioral health issues. PCPs have found such information helpful, enabling them to perform more in-depth screening and assessment of their patients and promote discussion about accessing behavioral health services. Additionally, claims data is used to identify members at risk for opioid and alcohol disorders and triggers referrals to clinical staff to conduct outreach to those members to offer resources and referrals as needed. Most recently, Anthem has launched a new program supporting patients with opioid use disorder that identifies people undergoing medication assisted treatment (MAT) who present in the ER. Clinical staff reach out to those patients' MAT providers within a week after the ER visits to ensure that the MAT providers are aware of the visit, resolve any issues that led to the visit, and work to intervene before a future visit to the ER is necessary.

### Assessing Quality

To assess quality for physical health and MH/SUD services, Anthem utilizes a claims-based data scorecard method, which consists of a combination of quality metrics and measures. For example, Anthem tracks what individual situations or incidents prompt outreach from their clinical teams and analyze those trends – such as whether certain triggers have increased or decreased over time. Anthem also evaluates whether an initial visit with a MH/SUD health provider occurred within 30 days of a PCP identifying a patient as having a behavioral health condition. Other metrics include the frequency of behavioral health visits, the connection of a primary care visit to a behavioral health visit based on coding, service utilization, and total cost of care. Similar to monitoring quality for physical health conditions, quality metrics will vary based on the specific behavioral health health condition.

## Spotlight: High Outreach to Promote Engagement (HOPE)

[HOPE](#) is a program that is available in designated geographical areas across multiple lines of business, including Medicaid, Medicare, commercial and federal employee health plans. The program identifies Anthem's most vulnerable populations: those with the highest rates of multiple chronic conditions, higher than average emergency room visits, and significant inpatient admissions for both behavioral and physical health. Case managers reach out to identified patients and connect them to services to assist in meeting their physical, psychological and social needs such as social services and medication schedules and offer help making follow-up appointments. Case managers work as the member's ally and provide information on plan benefits and community resources. Other members of the care team may include peer support specialists who assist members by demonstrating recovery principles and sharing their own lived experience focusing on a strength-based approach to recovery. By anticipating and supporting members' needs, Anthem has decreased major incidents such as ER visits and inpatient hospitalizations by 50%.

## Provider Training, Access to Best Practices Key to Success

Provider training and education for both PCPs and MH/SUD specialists has helped advance collaboration and integration of care that benefits patients. For example, some PCPs initially needed assistance in how to communicate and collaborate with MH/SUD specialists. Anthem and its subsidiary, Beacon Health Options, offer a range of assistance specific to provider needs in the geographic regions they serve. For example, in Massachusetts, Colorado, and Arkansas, Anthem has field-based clinicians who work with about 220 primary care practices to perform trainings, teach referral techniques, and provide technical assistance on evidence-based screenings of patients' needs.

In New York, Florida, New Hampshire and Connecticut, Anthem, through its partnership with Beacon Health Options, promotes best practices in opioid treatment by educating providers, MH/SUD and PCPs, to engage patients through Project ECHO (Extension for Community Healthcare Outcomes), an evidence-based approach to help clinicians better treat individuals with opioid use disorder.

## Practice Transformation in Medicaid

Anthem's Medicaid PCP Practice Transformation program is being implemented in 3 markets (AR, CO, AR) and consults with licensed behavioral health clinicians (e.g., social workers, psychologists, and psychiatrists) working with PCPs, to

conduct evaluations on how to manage patients' behavioral health conditions, conduct evidence-based screenings, such as use of the PHQ-9 screening tool, and access community-based programs and other internal programs. Although, there has been a limited number of psychiatrists willing to participate, there has been a significant increase over the past 2 years. In Massachusetts, for example, there has been an increase in referrals to pain management specialists and better use of shared information to help patients manage their pain more effectively. Recognizing the co-morbidity of depression and diabetes, Anthem has created a targeted program in Colorado that focuses on patients with diabetes and evaluates treatment plan compliance/adherence, testing, and mental health assessments using the PHQ 2 or 9 screening tools.

## New Strategies and Future Goals

Anthem is launching a suicide prevention program in partnership with Mindoula in specific states. Mindoula offers population health management solutions, assists health plan members with high-tech, high-touch community-based care that addresses behavioral, medical, and social determinants of health, such as homelessness and interpersonal violence, and offers community resources to help support the individual's goals and resiliency.

In addition, Anthem will be launching a new measurement-based care program with MH/SUD providers in New York focused on depression and anxiety. The program will evaluate the results of screenings (PHQ 9 and GAD 7 screening tools) administered at different times during treatment and providers will receive a financial incentive for patient screening.

Future goals for Anthem include advocating for improved metrics for behavioral health that focus on outcomes of care and not just the process of care and integrating those metrics into their quality improvement programs. In addition, Anthem will continue to seek out provider champions to help launch new value-based payment programs such as MAT and specialty medical integration and expand behavioral health integration with PCPs to better serve patient need.

In 2021, Anthem also launched a number of specific physical and behavioral health integrated case management and outreach programs utilizing predictive modeling related to comorbid conditions that include licensed clinicians and peer/wellness and recovery coaches. These programs include Cardiac Pain, Sleep Apnea, Predictive High Utilizing Alcohol and Opioid Users, and Suicide Prevention. Additional population health programs are in development for a 2022 launch.

## Cigna

### Successful Strategies Include CoCM and Integrated Case Management

Cigna's behavioral health integration strategies are founded on a deep appreciation that whole-person care is essential to drive optimal outcomes – both clinical outcomes for individual patients and affordability outcomes for their employer partners providing the health benefits. Recognizing and understanding the linkages between behavioral health conditions and medical conditions has helped Cigna identify and implement successful strategies that improve patients' access to behavioral health care and ensure that care is coordinated with their medical care in a holistic way.

Cigna has a long history of helping primary care clinics, particularly primary care ACOs, implement the CoCM. To help primary care practices get this model in place, Cigna provides a range of support, including education on the basics of behavioral health screening, what screening tools are available, and next steps for engaging patients based on the results of the screenings. Cigna also leverages existing resources by connecting primary care practices with training and other resources to support integration from the [American Psychiatric Association](#) and the [AIMS Center](#) at the University of Washington.

In addition to the CoCM, Cigna has implemented integrated case management models that build on the traditional disease management model typically associated to help patients who may have chronic medical conditions like diabetes, asthma, and cardiac disease by integrating chronic behavioral health conditions like depression. Cigna uses both behavioral health and medical case managers to coordinate and communicate with providers and patients across these types of conditions. The plan also holds joint rounds where case managers from the plan work with the behavioral health and medical specialties to develop care plans and organize provider teams to promote holistic management of patient care.

For primary care practices interested in integrating behavioral health care, Cigna offers education on the vast array of ways to integrate care, including, but not limited to the models mentioned above. Cigna incentivizes integration efforts among providers by reimbursing for collaborative care and building measures into their ACO partnerships that promote behavioral health integration. Cigna helps practices with co-locating behavioral health specialists, embedding care managers, and partnering with both local and virtual behavioral health providers to increase patient access to well-coordinated care. All of these integration approaches rely on a team of care clinicians that include primary care providers, case

managers, behavioral health specialists, and embedded care coordinators, in the case of ACOs.

### Resources on Referrals and Best Practices "Playbook"

One area of focus for Cigna has been on the referral process to make sure patients get the care they need that integrates medical and behavioral health care. For primary care groups that have integrated behavioral health specialists, the referral process is straightforward since those primary care providers will refer patients to their integrated partners. For other practices that may not have integrated behavioral health resources, Cigna has developed a referral guide that provides practices and ACOs with information on how Cigna can help them identify available behavioral health resources and what their referral options are. Part of this process is to build on the referral relationships primary care providers already have by asking which behavioral health specialists they trust for referrals and making sure those providers are part of Cigna's network.

Cigna has also developed "playbooks" on integration models that gather best practices from across the country, such as examples of partnerships with hospital emergency departments or upgrades to electronic medical records that support integration. Cigna then shares those resources with their primary care groups to help them identify integration strategies that may fit their specific characteristics and needs.

### Emphasis on Better Clinical Outcomes & Efficient Utilization

To measure the success of these integration strategies, Cigna looks at a range of metrics, such as the percentage of patients screened for conditions like depression and substance use. Cigna also tracks the time it takes for a patient with a positive screening result to see a behavioral health provider and then looks at follow-up care after that initial appointment to make sure there is ongoing provider and patient engagement as needed. And across all care, Cigna looks at measures that lead to better clinical outcomes and utilization, such as reducing unnecessary emergency room visits and unnecessary hospital admissions.

### The Added Benefits of Integration

Cigna's integration approaches not only help to improve clinical outcomes but also decrease any stigma associated with behavioral health by making care part of traditional medical care delivery. Breaking down walls between traditional silos of care also increases coordination of care across co-morbid conditions and improves communication across medical and behavioral health providers. Care managers are in frequent communication with primary care clinics to provide and receive



information to help coordinate patient care. Leveraging its claims data, Cigna plays an essential role by providing regular data reports to primary care groups on which of their patients may be at risk for behavioral health issues, based on recent hospitalizations or other health encounters.

### Supporting Physicians' Integration Efforts

Making sure physicians have the resources and support they need to integrate behavioral health care is a top priority for Cigna. Cigna is committed to providing primary care clinics with the data and support they need to address the needs of their patients who may be at risk for behavioral health issues as well as additional resources on how to promote holistic care, engage patients, and make referrals to trusted behavioral health specialists.

## Blue Cross Blue Shield of Michigan

### Behavioral Health Integration through the CoCM – An Enterprise-Wide Priority

Blue Cross Blue Shield of Michigan (BCBSM) has a long track record of working with physician organizations to explore different approaches to integrating behavioral health and primary care. BCBSM provided incentives to physician groups to identify their integration needs and pursue approaches that included co-located practices, incorporation of SUD treatment into primary care, enhanced referral arrangements, an emphasis on the social determinants of health (SDOH), and collaborative care even before any codes were adopted by CMS. This exploration resulted in a focus on the CoCM – both because of the evidence base for the model as well as the experience of the early adopters in helping to identify best practices on key aspects of the model, such as billing and tracking time. Moreover, the demonstrated evidence that treating the whole person through collaborative care helps improve quality of life and patient outcomes, addresses stigma, and reduces expenditures, was key to promoting greater adoption.

BCBSM looked at prior work done by Milliman that demonstrated that 14% of the insured population received care for primary or secondary behavioral health or SUD but accounted for 26+% of the spending. In addition, the first large, randomized control trial of collaborative care for the treatment of depression<sup>7</sup> showed both potential savings and improvement in patient outcomes. These findings helped support BCBSM's adoption of the CoCM for members in all lines of business, including 2 Medicare Advantage plans.

7 IMPACT trial – Improving Mood and Promoting Access to Collaborative

### Screening and Care Coordination under the CoCM

At BCBSM, the CoCM expands the primary care team with a behavioral health care manager and a consulting psychiatrist. Using the CoCM codes, the primary care office bills for behavioral health services and reimburses the psychiatrist. Integrated within the PCP team, the behavioral health care manager facilitates communication between the consulting psychiatrist and PCP, monitors the patient's status and experience, and refers the patient to community resources and support as needed. The PCP is still the primary treating physician, serving as the link to behavioral health specialists.

Under the CoCM, there is an incentive for PCPs to administer a PHQ-2 screening annually for their entire patient population. Depending on those scores, the PHQ-9 tool may be used as a follow up. All screening results are periodically reviewed and monitored. Based on their score, the patient may be referred to a behavioral health care manager to explain the CoCM to the patient and determine if the patient has an interest in participating. The behavioral health care manager then works with the patient to develop a treatment plan that is recommended and approved by the consulting psychiatrist and communicated back to the PCP.

Typically, under the CoCM, the behavioral health care manager is part of the PCP's office, but they are sometimes shared among multiple practices, depending on the resources available to the practices. Care managers perform a wide range of activities beyond serving as the communication bridge between the PCP and the consulting psychiatrist, including helping prepare patients to go back to work, connecting them to food resources if needed, making sure they keep a daily routine, and linking them to community programs such as a 55+ program. And, while traditional collaborative care focuses on depression and anxiety, patients often have co-morbid conditions like congestive heart failure or diabetes. If a patient is engaged in collaborative care, they are encouraged to participate in other care management programs the plan offers that focus on specific medical conditions such as congestive heart failure, chronic pulmonary disease, and diabetes. In fact, a PCP practice may have both a "boots on the ground" care manager in the practice and access to a chronic care manager from BCBSM who incorporates telephonic care management and can assist a practice with specific medical conditions such as cardiac care.

The care manager and the consulting psychiatrist perform a weekly review of all the assigned cases. This review may result in the consulting psychiatrist recommending a change in medications or the care plan, in which case the care manager would communicate these changes to the PCP who would then implement the changes with the patient.

The care manager role is critically important when a patient gets discharged from the hospital, particularly if the hospital is outside of the BCBSM provider network. The care manager plays a vital role in getting the PCP the necessary discharge information from the out of network hospital so that appropriate follow-up care can be provided.

### Exploring Expansion of the CoCM

BCBSM has found that the CoCM works well with patients whose condition is not too severe or of prolonged persistence and to date they have focused the model's use on the traditional collaborative care conditions of depression and anxiety. However, there are efforts underway to explore expanding the model to individuals with severe mental illness (SMI) and the pediatric/adolescent population (see page 2), and BCBSM has launched pilot programs to evaluate expansions.

In the SMI CoCM, an internist practice is co-located with a behavioral health provider organization, such as an outpatient center, large group practice, or a community behavioral health clinic, to facilitate providing medical care to patients receiving behavioral health care from the partnering clinic or practice. Patients have access to a case manager and a co-located psychiatrist, and there is a close relationship with the behavioral health clinic or practice in case of potential recurrence or relapse to facilitate the addition of care management services or referral to a crisis unit if needed.

### Measurement/Quality Improvement

In addition to tracking the self-reported PHQ-9 screening scores, BCBSM measures success by tracking utilization metrics such as the number of practices they have trained in the CoCM, the number of individual providers who have received CoCM training, and the number of CoCM-related claims that are being submitted.

In the future, BCBSM plans to expand its efforts to track total medical spend and total overall care spend. As the CoCM is only in year 2 of implementation, it is still too early for results. However, BCBSM has received testimonials on patient satisfaction and, while there is no definitive link to CoCM implementation, BCBSM has seen improvement in its STARS rating during the CoCM implementation period.

### Education and Training

BCBSM supports an extensive training program on the CoCM. The plan worked with 2 training partners – the University of Michigan and the Michigan Center for Clinical Systems Improvement – to develop and deliver statewide training consistent with the University of Washington AIMS Center model and provide support to expand the use of collaborative care. The plan offers ongoing provider education and continued support, such as office culture changes, for up to a full year. Since August 2020, the plan has trained approximately 180 practices in the CoCM and anticipates additional practices being trained in 2022.

BCBSM is currently working with about 40 physician organizations, each of which is assigned a training partner. The physician organizations undergo a practice assessment to make sure they have tools needed for the CoCM, such as a registry. Each practice receives a base training of 16 hours, based on the AIMS curriculum but customized for the Michigan community. PCPs and psychiatric consultants are required to do at least 4 hours of training. Training partners will sit in on case reviews to offer suggestions and support for the year following the training.

In addition, the plan offers different webinars for the physician organizations and each practice brings their entire care team to training. Webinars are offered on topics like problem solving, motivational interviews, building a systematic case review process, patient selection for the CoCM, and time management and time tracking for billing the CoCM codes. BCBSM encourages practices to participate in the training, pays for the training, and offers CMEs for participating in the training.

### Challenges and Next Steps

Several challenges remain to widespread adoption of the CoCM. For example, many behavioral health practices do not use an EHR, posing a barrier to effective and efficient electronic exchange of information between the PCP and psychiatric consultant. Additional challenges relate to necessary practice transformation and culture changes and recruitment of adequate consulting psychiatrists to meet access needs at a time of a national shortage of behavioral health providers. Provider feedback has also identified changes to the CoCM codes, such as removing the care coordination cap of 2 hours/month, that could further promote adoption and use of the CoCM.

Despite these challenges, implementation of the CoCM at BCBSM has resulted in a streamlined approach to behavioral health care, enhancing coordination among specialties,

building provider and patient communications into the treatment plan, establishing patient relationships with trusted providers, eliminating the need for additional appointments that are often missed or not scheduled, and reducing stigma and wait times. BCBSM looks forward to continued implementation, provider recruitment, expansion, and refinement of this proven model.

## HealthPartners

### Increasing Access Through Integration

HealthPartners' interest in behavioral health integration stems from its recognition that access to behavioral health care represents a big challenge – and a big opportunity for improvement in patient care and access. Based on their outreach to and engagement with providers, HealthPartners has learned that while there is significant interest in integration of behavioral health and primary care, there is also a significant need for provider education and training about how to implement and sustain these models. Minnesota has a track record of exploring behavioral health integration approaches and HealthPartners is interested in learning from those previous experiences and figuring out how best to advance these efforts.

### Learning from Previous Efforts

In 2006, Minnesota began a state-wide initiative to implement collaborative care for depression. The initiative, called DIAMOND (Depression Improvement Across Minnesota – Offering a New Direction), included a new payment from all health plans in the state with implementation of evidence-based collaborative care management for adults with depression in 75 primary care clinics. The initiative was led by the Institute for Clinical Systems Improvement (ICSI) – a regional quality improvement collaborative with membership that has historically included most of the state's medical groups, hospitals, and payers. It was effectively a precursor to what is now Medicare's CoCM and, similar to the CoCM, included a specific code that could be used to reimburse for care delivered through that model. The DIAMOND model focused on low acuity depression patients and emphasized screening and care coordination as part of its framework. Despite the model's well documented early successes, momentum has been difficult to sustain, and the reimbursement code is no longer being utilized uniquely for DIAMOND delivered services. Today, collaborative care continues to face challenges in Minnesota, with Medicaid not providing reimbursement for the CoCM codes.

### Provider Goals Driving HealthPartners' BHI Exploration

Providers' interest in integration of behavioral health care with primary care on behalf of their patients is driven by their recognition that access to behavioral health care can be a challenge, particularly for children and adolescents. Like HealthPartners, providers are interested in improving the quality of behavioral health care and decreasing the total cost of care. Both the plan and their provider partners have identified a range of potential options to improve access, including different forms of collaborative care management, leveraging tele-behavioral health, modifying current behavioral health care models, and expanding the behavioral health provider network, though the latter option is limited by the national shortage of behavioral health providers.

PCPs that use behavioral screening and assessment tools, such as the PHQ-9, will make referrals to behavioral health specialists if a need is indicated based on the screening results and patients' unique clinical situations. While the wait times for a patient to see a behavioral health specialist can be longer than the plan would like due to workforce shortages, barriers to communication between PCPs and behavioral health providers about the care being delivered has not been a commonly expressed concern. Due to the integrated nature of HealthPartners' delivery system, communication is made easier with a shared EHR that facilitates communication, coordination, and sharing of information across primary care and behavioral health providers.

### Quality Measurement

HealthPartners appreciates the importance of good quality metrics for behavioral health and sees a need for a more robust behavioral health measurement strategy across the health care system. In Minnesota, HealthPartners benefits from the MN Community Measurement initiative, which produces reports on provider performance at the individual provider level and can help plans with benchmarking and the identification of high performers.

HealthPartners is also exploring measurement strategies that improve health equity and reduce disparities, as this an area of great interest for both providers and the health plan. Enhancing data capture strategies to better allow for patient data stratification based on race and ethnicity and better match providers with patients based on race and ethnicity are two approaches being explored by the plan.

Patient experience and satisfaction surveys round out HealthPartners' quality measurement tools, as they include questions on behavioral health services and the plan is continually seeking ways to collect additional patient



feedback on their experiences with accessing their behavioral health benefits.

## Next Steps

HealthPartners is committed to not only advocating for Minnesota's Medicaid program to reimburse for the CoCM codes, but also in looking beyond the CoCM to other integration payment models, given the feedback they have received from providers regarding the implementation challenges experienced in the past related to collaborative care. HealthPartners is also interested in finding integration solutions that have buy-in across multiple payers and provider groups in order to be most effective. Through community collaboration, HealthPartners will continue to advocate for meaningful quality measurement in behavioral health, with a focus on integration and outcomes measures.

## Blue Cross and Blue Shield of North Carolina

### Value Based Arrangements and Referral Partnerships Key to Integration Strategy

Blue Cross and Blue Shield of North Carolina's (BCBS NC) behavioral health strategy prioritizes integration through its partnerships with accountable care organizations (ACO), value-based arrangements with behavioral health providers, and technology solutions that make it easier for PCPs to refer patients to behavioral health specialists and improve patient access to behavioral health care.

BCBS NC's value-based arrangements with ACOs incorporate a range of quality measures that promote integration of behavioral health into primary care for a more holistic, patient-centered experience.

In addition, the plan has implemented a value-based "pay-for-performance" (P4P) program specific to behavioral health providers, Blue Premier Behavioral Health, where providers earn incentives in addition to their fee-for-service payments. Incentives are focused on the outpatient setting and are provided for helping patients gain timely access to care, coordinate their efforts with PCPs, and help patients achieve improved outcomes. Approximately 1,300 independent behavioral providers are participating in this P4P program, which is nearing completion of its second year.

BCBS has partnered with Quartet since 2019 to help implement the enterprise-wide strategy of increased behavioral health integration. Quartet provides a platform to facilitate PCP referrals to a trusted network of local behavioral

health specialists and ongoing communication and exchange of information between the specialist and referring PCP. In addition, the platform allows for reporting of patient reported outcome measures (PROMS), and timeliness of access to care. Quartet has helped expand the plan's network of behavioral health providers at a time of national shortage as well as helped to track quality, access, and communication and when demand for behavioral health services is especially high due to the ongoing pandemic.

### PCP Flexibility to Select Validated Screening Tools

PCPs use a behavioral health screening tool of their choice to identify patients with an underlying behavioral health condition and need for services. Because there are a number of evidence-based, validated screening tools available, BCBS NC's goal is to incent PCPs to use measurement-based care, rather than specify the tool that should be used. The results of the screening are entered into Quartet's platform and Quartet reaches out to the patient, typically within 24 hours, to connect them to an appropriate behavioral health provider based on their individual care needs. PCPs still have the flexibility to request particular behavioral health specialists through Quartet platform, but in the absence of a specific request, Quartet will match the patient with a behavioral health provider that best meets the patient's need based on the information provided by the screening tool. Once the patient has seen a behavioral health specialist, that provider reports certain quality metrics and communicates information about the treatment with the referring PCP. Quartet is also equipped to provide patients with other treatment options, such as telepsychiatry, teletherapy, and computerized cognitive behavioral therapy, based on their clinical needs and preferences. Additionally, Quartet provides a "curbside consultation" service to PCPs if they have immediate questions regarding their patients.

### Type of Care Management Based on Arrangements with Providers

Care coordination and management efforts are shared depending on a patient's needs. For example, Quartet is instrumental in helping make sure referred patients access treatment. For hospitalized patients with complex needs, BCBS NC relies on its own internal care managers to be a bridge between the patient and the Quartet referral platform once the patient is discharged while ACO providers typically use their own care managers to coordinate care post-discharge. Regardless of the arrangement, care managers

are an integral part of the behavioral health care team, coordinating both care and communication across all providers caring for an individual patient.

### Measures of Quality & Access a Top Priority

As mentioned above, BCBS NC leverages Quartet's platform to track measures related to timeliness of access, PROMs, and communication with PCPs for behavioral health providers in the outpatient setting. For example, one key access metric is whether an appointment is scheduled within 14 days of a referral to a behavioral health provider. BCBS NC also uses Nuna, a quality measurement reporting platform, to provide information to clinicians engaged in value-based care programs on their performance using validated quality measures. The plan extracts the information from claims and Nuna uses that claims information to share performance information with providers. These claims-based measures include HEDIS measures focused on coordinating outpatient follow-up care, such as whether patients are receiving MAT and getting tested for hepatitis and HIV. Metrics on patient and provider satisfaction are also included based on the CAHPS Clinician and Group Survey (CG- CAPS) methodology, and BCBS NC uses ATLAS, a tool developed by Shatterproof, to help identify quality addiction treatment facilities.

### Challenges and Next Steps

Workforce shortages of behavioral health providers continues to be a major challenge to access to quality care in North Carolina. BCBS NC is actively working to expand their provider network, particularly in the areas of child/adolescent psychiatry and substance use disorder treatment. Despite this challenge, the plan has been effective at using a full range of behavioral health specialists, including masters-level therapists such as licensed clinical social workers, mental health counselors, clinical psychologists, and psychiatrists. Its partnership with Quartet has further supplemented its behavioral health provider network.

Education and information on culture change have been essential in their work with PCPs on practice transformation and inclusion of behavioral health as a core component of their practices. Information technology interoperability and data sharing challenges persist, though there is work underway to integrate providers' electronic medical records with the Quartet platform. Additionally, BCBS NC is providing targeted support for pediatric behavioral health through The Resource for Advancing Children's Mental Health (REACH) training of PCPs in rural areas.

BCBS NC has a number of initiatives in the works to further prioritize behavioral health and the importance of integrated care. One example is a value-based model for patients with severe behavioral health needs where the participating providers would be accountable for seamless, gap-free treatment, including follow-up care within 7 days of a hospitalized patient being discharged. Furthermore, there are plans to implement a separate value-based behavioral health model to hold providers accountable for the total cost of care using benchmarks based on previous years' costs. In addition, while BCBS NC has been incentivizing integration and collaborative care through its ACO and P4P models, the plan anticipates incorporating support for the CoCM codes in the near future as part of its overall strategy to promote greater adoption of behavioral health integration across the state.

BCBS NC is committed to supporting integration approaches that can be scaled quickly across the state in a variety of clinical settings. A top focus for the plan is making sure that PCPs and behavioral health providers have the information, training, and technical assistance they need to be successful in value-based and collaborative care programs that integrate behavioral health and primary care.

## Cambia

### Integration Through Collaborative Care and Value-Based Arrangements

Cambia is highly committed to meeting the needs of its members in a consumer-focused manner. This includes integrating behavioral health with primary care using a variety of approaches. These approaches include the CoCM, value-based payment models, and team-based care. They are focused on increasing patient access to quality behavioral health care that is integrated, coordinated with primary care, and delivers whole-person care.

Although Cambia reimburses providers that use the established collaborative care codes, uptake in use of the codes by PCPs has been somewhat slow. To help increase PCPs' interest and engagement in the CoCM, Cambia is exploring options to provide additional start-up resources to support CoCM implementation. In addition, Cambia is exploring the feasibility of a pilot project with one of their provider groups to help demonstrate the effectiveness of this model. Cambia will continue its education and focused outreach efforts with PCPs to try to increase adoption of the CoCM as an approach to increase patient access to behavioral health care that meets their needs.

Cambia has had more success with promoting behavioral health integration and care coordination through its value-based payment arrangements. By identifying high-quality providers who are interested in comprehensive patient care, Cambia can engage with them to track quality measures, with behavioral health integration as a key factor to improve patient care.

### **Team-Based Care a Foundation of Enterprise-Wide Effort**

Cambia has seen significant success in their use of a team-based approach to behavioral health that relies on care coordination and management between behavioral and physical health. This team-based approach involves behavioral and medical teams working closely on managing patients through joint rounds, more frequent but less formal “curbside consultations” and enhanced communication and coordination between behavioral health and med/surg medical directors on behalf of their patients.

Cambia’s care team members include internal medical directors, psychiatrists to consult on recommendations for treatment plans and medications, and specialty pharmacists – all to help inform and consult on levels of care placement, risk assessment and follow-up care. Some provider groups have their own care managers and depending on the acuity of the member, both the plan and provider care manager may be involved in the plan of care and follow-up needed for the patient.

For example, Cambia’s case managers are experienced at identifying patients who present in the ER with behavioral health conditions but have other underlying medical comorbidities. These case managers routinely call patients who have been discharged from the ER with either a behavioral health diagnosis or a combined medical and BH condition and can then refer patients to a primary care provider to make sure that both their behavioral and medical needs are being addressed in a coordinated manner. In the case of facility admissions, once a patient has been discharged, Cambia encourages the providing facility to assume responsibility for the patient’s discharge planning and identify any need for community resources once discharged. Sometimes the health plan ends up taking on this responsibility, which enables the health plan to be part of discharge planning and partner in ensuring the patient receives needed follow-up care.

In all of Cambia’s integration models, there is an expectation that PCPs will ensure that there is communication between them and their partner behavioral health specialists - either through sharing documentation or phone consultations.

While not a formal process, this communication is essential to effective care coordination and whole-person care. It is typically much easier to share clinical documentation if the providers are within the same health care system or hospital, but communication among providers and with the plan is expected to occur to promote better care management and better patient experience.

This team-based approach applies across the Cambia enterprise. Recognizing that behavioral health care is a critical component of whole-person health care, Cambia partners with national and community organizations to better integrate behavioral health and primary care. In addition, Cambia involves clinical and other leaders across the enterprise to put into effect system-wide enhancements that improve access to and quality of behavioral health care available to their members.

### **Referrals Based on Patient Needs**

Due to the COVID-19 public health emergency, Cambia has seen an increase in telehealth referrals, similar to other health insurance providers. As the majority of Cambia’s network PCPs do not have behavioral health specialists on-site, patients are typically referred to a partner group (especially if they are within the same hospital or health care system), or to the plan, to help them find an appropriate behavioral health provider after the initial patient screening and identification of a behavioral health issue has been done by the PCP.

If the patient has a severe mental illness, the patient is often referred to either an ER or a crisis team, depending on the level of severity and potential risk of patient harm. If the patient is referred to the ER, the plan is notified, and provides needed wraparound services and follow-up care to appropriately address the patient’s situation. For SUD conditions, patients are more likely to be referred by a PCP to a facility. Because these facilities are typically residential rather than inpatient, admissions can be more easily scheduled.

### **Education for Both Providers and Members**

Education is key and Cambia recognizes that not every member needs a psychiatrist. Other licensed provider types are available to patients, including PCPs skilled to identify and treat behavioral health issues and clinical therapists, who can help patients with their behavioral health needs. Members are routinely informed about the variety of clinicians available to address both their behavioral health and physical health needs. Care managers play a key role in informing both providers and members of the behavioral health services, supports, and provider options available to them and how those services and supports will be coordinated.



At least quarterly, Cambia offers education and training to providers through their provider newsletters. They have added webinars to showcase available resources, such as available new providers, new vendors, how to access them, how to refer to them, how to improve skills in early identification and screening of patients' behavioral health and other needs, and how to contact the plan to get help with accessing these resources. Cambia often partners with behavioral health providers to conduct the webinars and the training as they have found that PCPs are very receptive to hearing from other providers. Cambia also makes the webinars available for later viewing as they have found that this increases participation.

### Success Measured Through Improved Access, Quality

Cambia routinely tracks HEDIS measures and regularly reviews readmissions and medication adherence data on their members. For example, for facilities, the plan tracks the HEDIS 7-day follow-up with behavioral health provider measure, and for substance abuse, the plan monitors the number of opioids prescribed and renewed. Maintenance and stability of a condition, in addition to improvement, are key goals – as is access to the right clinician to help treat a patient's behavioral health condition. Cambia is also incorporating health equity into its measurement efforts and has formed a Health Equity Task Force that has piloted programs in 4 communities focused on reducing disparities. The programs include increased screening for patients' SDOH, addressing food insecurity, housing insecurity and ensuring appropriate availability of providers.

### Looking Ahead

Cambia continues to focus on effective ways to integrate physical and behavioral health by engaging with providers and patients. In addition to exploring the possibility of providing start-up resources for providers interested in implementing the CoCM, they are continuing to expand value-based payment arrangements that include an emphasis on behavioral health integration and coordination with primary care. Other top priorities include incentivizing EHR adoption among providers to facilitate better sharing of information between different types of providers caring for the same patient in order to promote better care coordination and management. Lastly, access issues remain a top priority, with Cambia committed to enhancing network access for patients from every entry point as much as possible given the national shortage of behavioral health clinicians and the growing demand for services.

## Florida Blue

### Offering Multiple Options for Integration

Florida Blue uses three different models for integrating medical and behavioral health to give providers and patients a range of options that best meet their needs and capabilities – the CoCM, a co-location model placing behavioral health resources on-site, and an enhanced referral model that relies on close connections and relationships between primary care providers and behavioral health specialists.

While some providers prefer using the collaborative care codes as part of the CoCM, others have found that model to be challenging to implement and have opted for other approaches. For example, many provider groups have incorporated care managers into their practices independent of the CoCM. There has also been an increase in co-location of primary care and behavioral health, where a behavioral health specialist is located at the same site as the primary care provider. In these situations, Florida Blue has made administrative changes to make co-location easier to implement. For example, the plan made administrative and billing changes to enable adult care and autism care to be delivered in a more coordinated and co-located manner. For practices that may have a behavioral health therapist credentialed in Florida Blue's behavioral health network and an occupational therapist credentialed in the plan's medical/surgical network, the providers can use the same tax ID # for billing, thereby promoting more co-located and "in the moment" care, which has been a top priority for Florida Blue. If office space is not available to enable co-location, an enhanced referral model promotes partnerships with behavioral health practices that commit to rapid access to services. For example, Florida Blue will help create "buddy practices" by matching up primary care providers with behavioral health specialists in the same neighborhood. Value-based payment arrangements also give providers flexibility to integrate care management and care coordination activities and be compensated for these services.

By making a range of integration models available to providers to increase patient access to coordinated and quality behavioral health and primary care, Florida Blue recognizes that different provider groups are at different levels of readiness in implementing these types of models. Rather than requiring any particular approach, the plan is flexible and offers support to providers through streamlined administrative processes, value-based payment arrangements, and other tools for their providers to succeed in their integration efforts and to improve patient access to the coordinated primary care and behavioral health care they need.

## Behavioral Health Screening, Referral and Treatment in Primary Care

Primary care providers use behavioral health screening and assessment tools, such as the PHQ, across all of Florida Blue's product lines. While many primary care providers are comfortable treating some behavioral health conditions, such as depression, others are not and prefer to refer patients to a behavioral health specialist. For example, PCPs are often less willing to prescribe certain medications, such as atypical psychotics, and prefer to refer to specialists if they have a patient who may need such a drug. Similarly, with severe bipolar disorder, schizophrenia, alcohol use disorder and opioid use disorder, most PCPs will refer care to behavioral health specialists. Florida Blue encourages primary care providers to deliver care they are comfortable delivering and refer patients to behavioral health specialists when needed. The three integration models Florida Blue providers use all promote easier access to behavioral health specialists when needed.

### Team-Based Care Promotes Care Coordination

The care team typically consists of physicians, care managers, clinical therapists, and psychiatrists – each with a pivotal role. For example, the physician typically focuses on the patient's physical health and co-morbid conditions, the care manager helps coordinate care and address the SDOH, the clinical therapist is primarily responsible for psychotherapy, and the psychiatrist serves as a consultant when needed.

This team-based approach relies on effective communication and sharing of information. Care managers, who are typically nurses or licensed clinical social workers, are at the center of this effort, reaching out to patients between appointments, assessing medication use, and following up on any symptoms or issues. While some of Florida Blue's network provider groups work with national vendors to help promote care coordination, most are supplementing with local care coordination capabilities, recognizing that trusted partnerships are essential to success.

### Primary Care Provider Toolkit

In partnership with New Directions Behavioral Health, Florida Blue offers an online toolkit for PCPs that includes materials to help them identify and treat behavioral health and substance abuse issues and facilitate seamless coordination of care. The toolkit provides screening tools to identify patient and referral needs; information on condition-specific topics such as suicidal thoughts, depression, anxiety, post-traumatic stress disorder, and chronic pain; and resources for patient referrals and treatment options.

In addition, Florida Blue shares information on best practices, including medication practices, screening tools, information on severity criteria, and effective ways to interact with patients. Florida Blue's pharmacists, for example, look at poly-pharmacy issues and conduct patient based/case-based learning to provide information and best practices to support clinicians. Provider support is an ongoing effort, with Florida Blue staff routinely meeting with their primary care and behavioral health specialists to identify any additional resource and/or training needs.

### Measurement & Quality Improvement

Florida Blue routinely tracks the quality of behavioral health care and uses HEDIS and other measures, such as adherence rates for antidepressants. The plan and its PCP and behavioral health specialist provider partners look at data on the number of patients seen, screening and assessment results before and after treatment, and responses to patient satisfaction surveys. Florida Blue's analytics team can create reports and provide data to practices on their specific patient populations. Sharing this information with providers helps them identify opportunities to improve the quality and value of behavioral health care being delivered and inclusion of behavioral health quality in medical value based arrangements.

### Looking Ahead

Florida Blue is committed to supporting providers in their journey to increase integration of behavioral health care. The ongoing COVID public health emergency has not only increased the need for quality behavioral health care but has also created many opportunities. For example, virtual, tele-behavioral health visits have increased dramatically and promoted vastly improved connectivity among behavioral health providers across the state. One of Florida Blue's future goals is to build on this increased connectivity and create a platform that facilitates the electronic sharing of information in real-time.

In addition, Florida Blue recently announced a collaboration with Shatterproof, a national organization dedicated to ending the devastation of addiction, to help increase access to quality addiction treatment. This collaboration offers Florida Blue members access to the ATLAS platform, an easy-to-use database that highlights high quality addiction treatment options throughout the state.

## Magellan

### Successful Strategies Leverage Patients' Existing Relationships with Primary Care Providers

Magellan recognizes the importance that PCPs play in providing for the behavioral health needs of their patients. The first presentation of a behavioral health condition is often in the primary care setting. Behavioral health medications are frequently prescribed by PCPs, many of whom do not have extensive training in mental health and substance abuse diagnosis and treatment. Primary care offices represent an opportunity for increased behavioral health screening and, in many cases, prevention of more serious conditions. In looking at national data, Magellan has observed that many patients admitted to an inpatient behavioral health facility had received no behavioral health care in the 6 months prior to their admission, but had seen their PCP – again indicating an opportunity to build on the primary care relationship as a critical point of access.

### Close Collaboration Through Care Management & the Collaborative Care Model (CoCM)

Magellan analyzes behavioral health, medical, and pharmacy claims data and uses predictive analytics to identify patients who may be at risk and could benefit from outreach and care management. Sometimes these are patients who are experiencing behavioral health issues but haven't yet generated a claim for behavioral health services. Claims for medical and pharmacy services, however, can often help predict when behavioral health services might be needed in the future. Additionally, "dual rounds" between Magellan's behavioral health care managers and health plan's disease management teams lead to enhanced communication about such patients, and provide the opportunity to share information and improve care for those patients.

The Collaborative Care Model (CoCM) promotes improved behavioral health care for patients before they ever need to see a behavioral health provider. Care managers in this model summarize patient assessment data, communicate with patients, primary care, and the consulting psychiatrist to improve outcomes and further whole person care, and coordinate care with community based resources. The CoCM's "one-to-many" approach also makes better use of a limited behavioral health workforce by enhancing the role of primary care and, in some cases, preventing the need for more intensive specialty behavioral health care.

While many PCPs have embraced the CoCM and feel more empowered to manage the behavioral health care of their patients, Magellan recognizes that there is a learning curve and not all PCPs are ready for this approach. Further, tools to streamline communication between the PCP, care manager, and psychiatrist, as well as tools to support billing collaborative care codes enhance the performance of this model. Magellan strives to meet providers and facilities where they are in terms of readiness, which can include their technological capabilities, the specific needs of their patient

population, and what other resources are available to their practices.

### Value Based Models Help Meet Providers Where They Are

Magellan has found value-based payment models to be most effective with providers and facilities serving higher levels of care, such as inpatient facilities. This is partly because there are validated, established metrics for assessing quality, such as 7-day follow-up post hospitalization rates and hospital readmission rates.

Consistent with Magellan's goal to meet providers where they are, our value-based offerings range from introducing providers to measurement-based care to sharing financial risk for patient outcomes and cost of care. Provider groups and facilities that are further along the spectrum of value-based care can benefit from these arrangements by using the resources earned through delivering better quality outcomes to invest in new programs, services, and capabilities to further improve their overall performance and benefit their patients. Regardless of where providers are on the spectrum of value-based care, improved outcomes are defined based on both patient and provider goals for improvement.

### Effective Screening and Care Coordination Rely on Good Data

Different screening tools are used for different types of behavioral health conditions, with some tools being self-administered by patients (or in the case of children, their parents) and others administered by clinicians. Magellan has found that digitally captured screening and ongoing assessment results are key to seamless care coordination across the behavioral health and physical health integrated team members caring for an individual patient. One challenge to digital capture of data is the range of technological capabilities among behavioral health providers. Larger group practices tend to have more technological capabilities and as the next generation of providers takes hold, use of digital tools is expected to increase. Magellan is rolling out screening tools to health plans and participating providers.

Like administration of screening tools, care coordination consists of activities that can be done by clinicians and, in some instances, non-clinical staff, such as helping to schedule phone consultations and/or appointments. In all instances, the objective of care coordination and management is a "warm handoff" during the transition to the next level or stage of care.

### Measuring Improvement in Care

Magellan utilizes quality measures that most providers currently report. Metrics such as readmission rates, 7-day follow-up post hospitalization, and HEDIS metrics are standardized anchor points and are used to develop performance incentives that can be used in value-based models.