BARRIERS TO BEHAVIORAL AND PHYSICAL HEALTH INTEGRATION IN MASSACHUSETTS

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I. INTRODUCTION

Access to behavioral health care services across the full spectrum of severity remains one of the Commonwealth's greatest health care challenges. A recent report of the Massachusetts Medicaid Policy Institute (MMPI), a program of the Blue Cross Blue Shield of Massachusetts Foundation (Foundation), found that stakeholders prioritized behavioral health reform as one of the top five MassHealth issues for the new administration to consider.[1]

A key reform initiative being undertaken by providers to increase access to behavioral health services is to implement delivery system processes that better integrate physical and behavioral health services. However, numerous state-sponsored reports (see Appendix A) have specifically identified the barriers to integrating physical and behavioral health care. Despite the attention to behavioral health integration in Massachusetts, much remains to be done. Recognizing the importance of this issue, the state has highlighted care integration among its key priorities and communicated a strong commitment to improving integration of physical and behavioral health care across the Commonwealth.

The goals of this report are to identify policy and regulatory barriers that may impede behavioral health integration and identify potential options for addressing these barriers. This list of barriers was identified through a review of reports and other secondary sources, agency regulations, and checklists, and through interviews and a focus group with key stakeholders, consisting primarily of providers. A list of considered resources is given in Appendix A, and a list of the organizations represented in the focus group is given in Appendix B. The discussion of integration barriers is divided into three sections: licensing barriers, privacy barriers, and reimbursement barriers. The licensing and privacy sections include several options for addressing the identified barriers. The reimbursement section, to the extent possible, includes identification of payers—including state Medicaid programs—that are addressing the barriers identified. A summary of the barriers and options for addressing each barrier is given in Appendix C.

While the focus of this report is on licensing, privacy, and reimbursement barriers to physical and behavioral health integration, addressing these alone does not assure effective integration of physical and behavioral health services. There are other substantive barriers to integration—including challenges around patient engagement, creating a unified organizational and team culture, organizational resistance to change, and lack of interoperability among electronic medical records (EMR)—that are beyond the purview of this report but are equally important to address in order to promote effective service integration. In addition, there are ways in which Massachusetts Department of Public Health (DPH) and MassHealth (the state's Medicaid program) regulations interface and payment rules intersect that can create barriers to behavioral and physical health integration. For example, providers report that MassHealth has separate qualifications, beyond the DPH licensing requirements, that clinics must meet before they can participate in Medicaid. Providers also reported that DPH and MassHealth requirements can be inconsistent, which creates confusion and uncertainty. Finally, we were told by focus group participants that MassHealth payment rules can also create barriers to integration. Prior-authorization requirements were identified as particularly problematic within an integrated model.

This report does not address Medicaid requirements or some of the other substantive barriers to behavioral health integration previously mentioned. Rather, this report is focused on the licensing, privacy, and reimbursement

1 "The Future of MassHealth: Five Priority Issues for the New Administration," available at http://bluecrossfoundation.org/publication/future-masshealth-five-priority-issues-new-administration.

challenges to behavioral health integration efforts that could be addressed by state action. Though stakeholders acknowledged that a broad and deep systemic review is important to enabling comprehensive, robust, and fully integrated care delivery, there was agreement that changes made in response to the barriers identified in this report can meaningfully advance behavioral and physical health integration.

This report uses the term "behavioral health" to refer to services that generally include mental health and substance use services. "Behavioral health" is also used to designate delivery models of health care that are designed to provide both physical health and mental and/or substance use health services to the patient in a coordinated, integrated, and holistic manner. The term "mental health" services means services that treat conditions that are characterized by alterations in thinking, mood, or behavior associated with distress and/or impaired functioning, for reasons other than as a result of substance use. "Substance use" treatment or programs means services targeted at treating addiction to legal or illegal substances. In the report section on licensing barriers, we are careful to use either the term "mental health" or the term "substance use" in reference to treatment services or programs, depending on which licensing requirements are being discussed.

This report begins by defining behavioral health integration so that readers will have a common understanding of the term and understand the manner in which licensing, reimbursement, and privacy requirements act as barriers to integration.

II. DEFINITION OF BEHAVIORAL HEALTH INTEGRATION

In order to understand barriers to integration of behavioral health and physical health services, it is necessary to define what constitutes behavioral health integration. For the purposes of this report, the framework published in 2013 by the Substance Abuse and Mental Health Services Administration and the Health Resources Services Administration (SAMSHA–HRSA) Center for Integrated Health Solutions (CIHS) was adopted. Under this framework, behavioral health and physical health service provision can be integrated across a continuum of levels, beginning with coordinated models with minimal collaboration to fully integrated models with shared funding, space, systems, processes, and cultures. Each of the six models varies across the integration continuum by the level of collaboration and integration it achieves, but all models share the goal of addressing physical health and behavioral health needs in a systematic manner that breaks down treatment barriers and recognizes the interrelationships between the two realms with respect to illness and treatment. The complete CIHS framework is available in Appendix D. The six models are summarized as follows:

- **Level 1 (Coordinated)**: minimum collaboration occurs between separate facilities that have separate systems and communicate only rarely and under compelling circumstances.
- **Level 2 (Coordinated)**: basic collaboration at a distance occurs between separate facilities that have separate systems but communicate periodically about shared patients and appreciate each other's roles as resources.
- **Level 3 (Co-located)**: basic collaboration on-site occurs among co-located providers who still have separate systems but communicate regularly about shared patients, by telephone or email and occasionally in meetings. They feel part of a larger, yet ill-defined, team.

- **Level 4 (Co-located)**: close collaboration on-site and some system integration occurs among co-located providers who have regular face-to-face interactions about some patients and have a basic understanding of roles and culture.
- **Level 5 (Integrated)**: close collaboration approaching an integrated practice occurs among providers who actively seek system solutions together or develop workarounds, communicate frequently in person and have regular team meetings, and have in-depth understanding of their roles and culture.
- **Level 6 (Integrated)**: full collaboration in a transformed/merged integrated practice occurs among providers that have resolved most system issues and function as one integrated system; they communicate consistently at the system, team, and individual levels and have formal and informal meetings to support an integrated model of care. They have roles and cultures that blur or blend.

While increased levels of integration are desirable, some space, infrastructure, and cultural realities make full integration not realistic for all primary care or behavioral health practices. Therefore, to promote integration, statutes, regulations, and public policy must support all levels of integration.

Throughout this report, the term "behavioral health integration" is used in a manner that includes all six integration levels. Occasionally, reference is made to a "co-located, fully integrated model," which would be Levels 5 and 6 under the CIHS framework and to a "care coordination model," which would be Levels 1 and 2 under the CIHS framework.

III. BARRIERS TO BEHAVIORAL HEALTH INTEGRATION

The discussion of integration barriers is divided into three sections: licensing barriers, reimbursement barriers, and privacy barriers. Each set of barriers will be discussed in turn.

A. LICENSING BARRIERS TO BEHAVIORAL HEALTH INTEGRATION

1. Background

The Massachusetts Department of Public Health (DPH) Division of Health Care Quality (DHCQ) regulates and licenses outpatient primary care clinics (105 CMR 140.000) and outpatient mental health clinics (105 CMR 140.500-560), and the DPH Bureau of Substance Abuse Services (BSAS) regulates and licenses substance use treatment programs (105 CMR 164.000).[2] Entities subject to licensure under 105 CMR 140.000 are organizations established for the purposes of providing ambulatory medical, surgical, dental, and physical rehabilitation or mental health services and health-care entities that use the word "clinic," "dispensary," or "institute." Generally, physicians' practices, so long as they are solely owned and controlled by one or more of the practitioners and do not need to be licensed as an ambulatory surgical center, are not included in this definition.

The regulations currently require that any regulated entity wanting to provide outpatient primary care services, outpatient mental health services, or outpatient substance use treatment services must seek and receive the ap-

2 The Department of Mental Health does not license any outpatient facilities or programs.

propriate license. For example, an existing DHCQ-licensed primary care clinic that proposes to add mental health services must apply for and obtain a mental health license and comply with the mental health services section of the regulation, 105 CMR 140.500-560. A primary care clinic that proposes to add substance use treatment services must apply for and obtain a substance use treatment program license and comply with the programmatic and staffing requirements of the substance use treatment program regulation, 105 CMR 164.000. However, if a primary care clinic has a mental health license, it may provide substance use treatment services under its mental health license. In contrast, a primary care clinic with a substance use treatment license may not provide mental health services without a mental health license.

In most cases, a community mental health clinic or freestanding substance use treatment program that proposes to add primary care services for its clients must apply for and obtain a physical health clinic license and must comply with applicable requirements of the licensure regulation. A freestanding substance use treatment clinic wanting to provide mental health services must be licensed as a mental health provider to be able to do so.

The regulations as currently written create barriers for behavioral health integration models because each set of regulations is prescriptive as to facility, program content, and staffing requirements and appears to have been written at a time when it was the norm that the programs would be operated separately and independently, even if the services are located in the same clinic space. As a result, the requirements conflict, overlap, and duplicate one another, making it very difficult to navigate among the various requirements to create an integrated program. In addition, varying interpretations of the regulations have also made it challenging to understand the specific requirements that must be met when establishing an integrated service model.

The discussion of licensing barriers is divided into two categories. The first category consists of general barriers related to issues associated with the application process and how the licensing process is implemented. The second category of barriers addresses specific regulatory provisions that are part of the licensing requirements.

2. General Licensing Barriers

The licensing process itself creates several types of barriers to integration, which are discussed below.

Burdensome Licensing Process. The licensing process, as currently implemented, was described by applicants as very time-consuming, often requiring months to assemble the necessary documentation and work with DPH to obtain the license. Merely having to complete an extensive licensing process to add services is a barrier to integration, albeit a manageable one. Providers also reported that variations in the interpretation of licensing requirements within DPH are a significant barrier to integration. Moreover, providers must undergo relicensing every two years without an opportunity to be considered in compliance based on their prior licensure and/or having accreditation from a particular national organization, and this requirement is a burden.

Triggering Licensing Requirements. Conversations with primary care and behavioral health practitioners indicated that there is no common understanding of when the need for a new license is triggered. For example, several behavioral health providers did not think that placing a single mental health provider in a primary care clinic would trigger the need for the primary care clinic to obtain a mental health license, because simply adding a mental health provider was not the mental health delivery model that "the regulations envisioned" needing licensure. On the other hand, several community health center (CHC) leaders thought that adding the mental health provider might trigger the need for a new license.

Co-locating with Separate Licensed Entity. DHCQ clinic licensing regulations have no provisions allowing CHCs to bring in a licensed mental health provider to deliver mental health services at the CHC without the CHC obtaining a mental health license. When licensed, the CHC and the mental health provider would be required to meet the specific primary care and mental health regulatory requirements discussed in the next section.

3. Specific Licensing Barriers

The following is a discussion of the specific barriers to integration that are embedded in the existing regulations as written. It is important to note that DPH has had a process in place over the past few years to review its regulations to address these issues and has begun implementing a waiver process. Providers have reported, however, that they do not now find the waiver process to be as responsive or robust as it had previously been.

a. FACILITIES

RECEPTION AREAS: The research conducted for this report did not identify any regulatory requirements that specifically mandated separate reception areas for co-located physical health and mental health clinics. Several secondary sources,[3] however, make the general statement that the regulations prohibit mental health and primary care services from sharing waiting rooms without citing any specific regulation. Section 105 CMR 140.202 requires that "each clinic" provide adequate space and equipment for reception and waiting areas. This requirement, while not explicit, might be interpreted to require separate waiting rooms for each separately licensed program, since sharing is not specifically permitted. Consistent with this regulatory language, within each separate DPH checklist developed to facilitate the license application process is the requirement for a public waiting area. The checklists for primary care facilities (OP 1) and those for outpatient mental health counseling clinics (OP 13) have different space requirements, suggesting separate reception areas.[4] However, leaders of CHCs with both a physical health and a mental health license report having integrated waiting rooms.

Section 140.1002 (A) states: "Notwithstanding general access requirements from the American Institute of Architects' *Guidelines for Design and Construction of Health Care Facilities*, a *limited services clinic* located on the premises of another entity is not required to provide separate exterior entrances or designated parking or to provide a patient waiting area or reception area that is separated from the public area of the host entity." However, primary care clinics, substance use treatment programs, and mental health clinics are expressly excluded from the definition of limited service clinics, which may have led to the belief that separate reception areas are required.

This appears to be an opportunity for DPH to clarify regulatory requirements.

ARCHITECTURAL DRAWINGS: A mental health organization trying to offer primary care services is required by DHCQ as part of the licensing process to submit the location's original architectural drawings; often these are decades old and cannot be located. In addition, providers described licensing applications that include a review of architectural drawings as being particularly burdensome and the hardest part of the licensing process because of the "rigidity" of the review process for the submitted plans. Licensees reported that because of this rigidity, they often find it necessary to use architects specializing in health care facilities in order to pass DPH review.

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3 See, for example, *CHC-CMHC Demonstration Project on Collaborative Care: Summary of Findings and Recommendations from the Evaluation of Six Demonstration Projects*, UMass Medical School, Center for Health Policy and Research, January 2008, page 22; and D. Bachrach, S. Anthony, and A. Detty, *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment*, the Commonwealth Fund, August 2014, page 15.

4 The DPH checklists are available at www.mass.gov/eohhs/gov/departments/dph/programs/hcq/healthcare-quality/health-care-facilities/plan-review/forms/outpatient-facilities-checklists.html.

ARCHITECTURAL REQUIREMENTS FOR PRIMARY CARE CLINICS: A mental health organization that wants to provide primary care services, such as changing dressings or checking vital signs or blood sugar levels, must meet the requirements of 105 CMR 140.200, which details physical plant requirements. DPH has created a subset of requirements for "Small Primary Care Outpatient Clinics" that have three or fewer exam rooms, which are less extensive than the regulatory requirements for a larger clinic. (See DPH OP3: Compliance Checklist: Small Primary Care Outpatient Clinics.) Nevertheless, the requirements are extensive regarding, for example, drug storage and pharmacy requirements, different types of lab services and maintenance, additional bathrooms/sanitation, drug shelf life, disinfection, and sterilization. Mental health providers may not have the space or plumbing to make such changes, and retrofitting an existing space is extremely costly. Moreover, clinicians have raised the question whether all the building requirements, such as pharmacy and lab services, are necessary if the physical health services are limited and will not include these services.

b. STAFFING

MULTIDISCIPLINARY CARE TEAMS: The licensing requirements for primary care clinics, mental health clinics, and substance use treatment programs include separate staffing requirements. Each of the regulations stipulates a multidisciplinary team of providers and lists different disciplinary requirements. For example, a primary care clinic must have a clinic administrator, a professional service director (who may be the same as the administrator), physician staff, nursing staff, health care staff, and social service staff. (See 105 CMR 140.310-330.) The mental health clinic must have a board-certified psychiatrist and at least two of nine separately listed mental health provider types. These regulations also specify the educational level for some of the provider types. For example, a psychiatric nurse must be an RN with a master's degree in psychiatric nursing. (See 105 CMR 140.530.) Finally, substance use treatment program regulations require a multidisciplinary care team composed of professionals with recognized expertise in a variety of areas of substance use treatment. The substance use treatment program regulations list 11 different provider types that may be members of the multidisciplinary care team. (See 105 CMR 140.164.048.)

These requirements are not compatible with any of the integration models, with the possible exception of a fully integrated, co-located model. For example, the regulations do not accommodate a model that has one or more social workers embedded in a primary care practice to screen and refer to a behavioral health program or a model of a mental health clinician providing therapy services on-site several times a week. Under current regulations, to provide any mental health services, the physical health provider would be required to meet all the staffing requirements for a mental health clinic, which are extensive.

c. SUBSTANCE USE TREATMENT PROGRAM REQUIREMENTS

The substance use treatment program regulations include very specific requirements regarding the type of services to be provided. For example, 105 CMR 164.072 requires that each patient be provided an initial assessment and stipulates the six components of the assessment and which clinicians may conduct it. Moreover, 105 CMR 164.073, 105 CMR 164.074, and 105 CMR 164.075 specify the content of a treatment plan, minimum treatment service requirements, and discharge processes, respectively. There are also associated documentation requirements. For example, if a physician sends a patient to a licensed substance use treatment program for a *lifestyle* session (e.g., smoking cessation support), the substance use treatment provider must open a case and complete about 40 pages of documentation (e.g., intake assessment, evaluation form, treatment plan, release of information

forms, and substance and nicotine and TB assessment) in order to work with that client.[5] Integrated team-based models are often structured based on brief, initial contacts, and this documentation requirement makes it challenging to collaborate with substance use treatment programs. As one CHC leader explained, the CHC had tried to establish a co-located substance use treatment program within its facility but ended up abandoning it because of the difficulties of meeting the documentation requirements within the context of a primary care clinic. Clearly, the regulations do not envision an integration model built on warm hand-offs and quick initial assessments. Meeting the substance use treatment program paperwork requirements within an integrated model, therefore, is burdensome and acts as a barrier.

d. RECORDKEEPING

The regulatory requirements for primary care clinics and mental health clinics allow for an integrated medical record, with an option of maintaining mental health records separately. (See 105 CMR 140.302.) The separately promulgated regulations for substance use treatment programs include requirements that the records be marked confidential and kept in a secure, locked location, accessible only to authorized staff. Furthermore, electronic records must be secured through a firewall and password protection and accessible only to authorized staff. Authorized staff are defined as those authorized by the administrator. (See 105 CMR 164.083 [E] and [F].) Not having the opportunity for an integrated medical record while respecting potential confidentiality concerns of patients creates logistical burdens for an integrated team.

e. OUTREACH PROGRAMS

Outreach programs are described in DPH regulations (105 CMR 140.560 [D]) as programs run by a licensed mental health provider and "may include diagnostic services and treatment services, including emergency services provided to clients in their homes or other community environments, including physicians' offices or community health centers." Mental health providers generally refer to such programs as "satellite" clinics. DPH allows licensed outpatient mental health entities to create satellite clinics as part of outreach programs under their existing license so long as the number of satellite clients and visits does not account for the majority of the clinic's clients and visits (105 CMR 140.560 [M]). Several providers interviewed indicated that the satellite site must limit the number of hours of service to 20 hours per week in order to limit volume. While this may provide an option for bringing some mental health services into a primary care clinic, it is not helpful for more robust models requiring mental health service availability on a full-time basis. This limitation has reportedly been a particular burden for clinics wanting to add mental health services to their school-based programs.

OPTIONS FOR ADDRESSING LICENSING BARRIERS

Listed below are a few short-term and longer-term options for addressing the regulatory barriers related to licensing that were identified and discussed above.

SHORT-TERM OPTIONS:

1. **Issue administrative bulletins that clarify requirements.** DPH could clarify the following issues in one or more administrative bulletins without going through a regulatory process:

5 Massachusetts Behavioral Health Integration Task Force. *Report to the Legislature and Health Policy Commission.* July 2013.

- The scope of mental health services or substance use treatment services being offered by an outpatient primary care clinic that triggers the need for the outpatient primary care clinic to obtain a mental health license.
- The scope of physical health services being offered by a mental health clinic or substance use treatment program that triggers the need for either of these clinics to obtain an outpatient primary care clinic license.
- Whether integrated behavioral health initiatives are required to have separate reception areas for physical health, mental health, and substance use treatment services.
- What service limitations are applicable to the outreach program's satellite sites operated pursuant to an outpatient mental health license.
- To what extent substance use treatment records may be integrated with mental health and physical health records.

2. **Simplify requirements for bringing physical health services into outpatient mental health clinics**. DPH might consider revising its compliance checklist for small primary care outpatient clinics to recognize a behavioral health integration model that brings minimal physical health oversight regarding the management of chronic medical conditions into the outpatient mental health clinic.
3. **Change specific regulations**. The Department could consider quickly making targeted changes to specific regulations to address several high-priority issues identified by providers and discussed in this report, including:
    - Streamlining intake and documentation requirements currently included in the substance use treatment program requirements.
    - Providing flexibility regarding substance use treatment program requirements to accommodate a broad range of integrated program models.
    - Building in flexibility regarding the staffing requirements detailed in the outpatient primary care clinic, the outpatient mental health clinic, and the substance use treatment program regulations to allow a broad range of integrated programs to be licensed.
    - Removing the requirement that *original* facility drawings must be submitted (i.e., allow current floor plan drawings to suffice) as part of a license application for an outpatient mental health clinic when the site is not new construction.
    - Allowing integration of substance use treatment records with mental health and physical health records to the extent permitted by federal law.
4. **Revitalize the waiver process**. Providers interviewed spoke very favorably about the previously existing waiver process. The Department could revitalize the waiver process and immediately publicize its availability.

OUTLINED BELOW ARE THREE LONGER-TERM OPTIONS:

1. **Collect data through the waiver process to inform permanent changes**. DPH could use the waiver process to gather information that might inform future permanent regulatory changes. For example, DPH could consider establishing a standing review panel, composed of a small number of high-level decision-makers representing program and policy leaders within the department, as well as DHCQ leaders. The panel could be responsible for receiving and acting upon requests for waivers, tracking the nature of the requests and the waiver decisions, identifying specific licensing provisions that are barriers to integration, and recommending changes to the regulations.

2. **Conduct a comprehensive review of regulatory requirements**. Within a specified time frame, such as two years, DPH could revise the licensing regulations pertaining to primary care, mental health care, and substance use treatment services to facilitate behavioral health integration. The regulations could be revised to specifically address requirements associated with integrated behavioral health models, or they could incorporate accommodations for behavioral health integration throughout. As part of the regulatory revision process, DPH should convene a multi-stakeholder advisory committee to enable it to obtain a firsthand understanding of areas of licensing concern and feedback on possible changes.

3. **Implement a "deeming" process.** There are two types of deeming processes that DPH could consider to reduce the administrative burden of seeking a DPH license. First, DPH could consider developing a deeming process for allowing an entity with one type of license to provide services on-site at another entity's facility that has a different type of license. This would enable different delivery entities to immediately work collaboratively to provide integrated services. Second, DPH could allow deemed status for licensees seeking license renewal as an outpatient primary care clinic or as a community mental health clinic if they have Commission on Accreditation of Rehabilitation Facilities (CARF) or Joint Commission accreditation and/or for licensees who recently passed a federal site visit by the HRSA Bureau of Primary Care. Massachusetts currently allows deeming for certain inpatient and residential services, as well as for substance use treatment services if the licensee has Joint Commission accreditation. This expanded deeming process would reduce the burden of completing a relicensure process every two years for CHCs and community mental health centers (CMHCs). One provider reported that currently 29 states allow some form of deemed status for outpatient providers with CARF or Joint Commission accreditation.[6]

B. PRIVACY BARRIERS TO BEHAVIORAL HEALTH INTEGRATION

Massachusetts has a panoply of laws protecting the confidentiality of personal health information (PHI), which, in concert with federal laws,[7] impact the exchange of information among behavioral health and physical health providers and among various state agencies that hold and need health care information. While identifying issues and developing recommendations, it is important to also recognize the need to protect patient privacy and confi-

6 See State Recognition Details on the Joint Commission website: www.jointcommission.org/state_recognition/state_recognition_details.aspx?ps=25&b=41

7 Two key federal laws impact the release of medical information: 1) The Health Insurance Portability and Accountability Act, which permits providers to use and disclose protected health information for treatment, payment, and health care operations without the patient's authorization so long as only the "minimum necessary" disclosure standard is met. HIPAA does require a separate written authorization from the patient, except in very limited circumstances, to disclose psychotherapy notes. 2) Federal Substance Abuse Treatment Regulations apply strict disclosure requirements to the records of "federally assisted alcohol and drug abuse programs," which generally are facilities, programs, or units that are specially licensed to provide substance abuse treatment or market themselves as providing those services. For a more detailed discussion of these two federal laws, see R. Belfort, W. Bernstein, and S. Ingargiola, *Integrating Physical and Behavioral Health: Strategies for Overcoming Legal Barriers to Health Information Exchange*, Robert Wood Johnson Foundation, January 2014.

dentiality. At the same time, the patient's interest in privacy and confidentiality must be balanced with the benefits to the patient of sharing data to improve care integration and coordination. The following is a discussion of Massachusetts privacy issues that occur in two different realms: sharing of information among treating providers and sharing of information across state agencies. This section discusses these issues and how they impact efforts to improve behavioral health integration.

1. Sharing Information Among Treating Providers

Sharing patient information among treatment team members is essential to all behavioral health integration models. As treatment teams begin to incorporate providers from multiple organizations, information sharing becomes more complicated.

a. REQUIREMENT TO MAINTAIN SEPARATE SUBSTANCE USE TREATMENT RECORDS

Substance use treatment program licensing regulations (105 CMR 164.083E) require licensed programs to maintain separate substance use treatment records, which prevents co-located programs from easily sharing information on all aspects of a patient's treatment.

b. DEFINING AUTHORIZED ACCESS TO HEALTH CARE INFORMATION

Massachusetts statutes and regulations generally allow for access to health care information by authorized persons without specific patient authorization. DPH Standards for the Protection of Personal Information of Residents of the Commonwealth (201 CMR 17.00) require all licensed providers to have in place protections against "unauthorized access to or unauthorized use of personal information." Most organizations use a well-recognized legal "need to know" standard for granting access to medical records and other personal information. Under this standard, the patient's care team would be considered providers with a need to know. In applying this standard to release information without specific patient consent, health care organizations appear to consider only individual providers within the organization as coming under the "need to know" umbrella. Any provider serving the patient who is part of a separate organization would need independent patient consent to have access to patient information. The Massachusetts regulations and organizations interpreting these regulations do not envision a multidisciplinary, multiagency care team model when considering how the "need to know" standards are applied. This can create barriers to collaborative care being provided for patients by two or more separate health care organizations.

c. RELEASE OF INFORMATION REQUIREMENTS ARE COMPLEX AND TIME-CONSUMING

Both federal and state laws establish the confidentiality of PHI and specify standards for releasing information. For example, MGL c.112, Section 129A, establishes that all communications between a licensed psychologist and the individuals with whom the psychologist engages in the practice of psychology are confidential and can be released only under certain circumstances, including upon express written consent of the patient. Massachusetts laws also provide additional protections to genetic information and reports (MGL c.111 s70g), and HIV testing results (MGL c.111 s70f), both requiring separate patient consent to release the information. Substance use records, which must be separately maintained, also need a separate consent. Under Massachusetts law, psychotherapists may provide a summary of the medical record, rather than the full record, to a requesting patient when the therapist believes that releasing the full record to the patient will adversely affect the patient's well-being. If the full record

continues to be requested, the record must be released to the patient's attorney or another psychotherapist, but only a summary is released directly to the patient. (See MGL c.112. s 12CC.)

The various Massachusetts laws in addition to the federal privacy laws have created an environment that has spawned opportunities for different interpretations of what can be released and to whom. Behavioral health providers are generally more cautious when separate consents are required as to what information is released and to whom.

The process of obtaining patient consent, sending the consent documents to the treating providers, and receiving the information from the treating provider is time-consuming and often relies on sending and receiving faxed documents. Care managers described that it can take weeks and months to get a reply. Frequently, the information is not what was expected, necessitating a follow-up request. Getting the necessary information can create serious delays in care or referrals. Providers also noted that obtaining consents regarding information for children is different than the process for adults, which adds complexity.

d. OPT-IN REQUIRED TO SHARE HEALTH CARE INFORMATION ON THE HEALTH INFORMATION EXCHANGE (HIE)—the MassHIway

Massachusetts' health information exchange offers providers a way to securely and seamlessly transmit vital data electronically. While there are technical and workflow challenges to meeting Massachusetts' privacy requirements, it represents a 21st-century means of facilitating physical health and behavioral health integration. Chapter 224, however, requires patients to affirmatively join the HIE ("opt in") in order to have their PHI shared electronically. Social psychology researchers have run experiments documenting lower rates of participation in programs with opt-in enrollment systems, compared with opt-out systems.[8] The experiences of Maine (opt-out state), which has a 98.8% patient participation rate,[9] and Rhode Island (opt-in state), which has an approximately 35% patient participation rate,[10] demonstrate the huge difference in patient health information exchange participation under the two models. The Massachusetts HIT Council is working to help providers address these regulatory and nonregulatory issues related to privacy, as the providers structure their EMR and HIE policies and practices. [11,12]

OPTIONS FOR ADDRESSING PRIVACY BARRIERS AMONG PRACTICING PROVIDERS:

In a recent issue brief developed for the Robert Wood Johnson Foundation, the authors identified six strategies that states may utilize to ease the ability of providers to share protected information.[13] The three strategies relevant to Massachusetts for the purposes of this report are:

1. **Issue a clarification of state law through agency guidance**. Of particular importance is to clarify how behavioral health providers are required to respond to patient information requests from integrated behavioral health teams. Factors to consider include the type of information being shared, what types of providers are sharing the information, how the providers are interfacing with the patients, and under what laws the providers are seeking the information.

8 D. Ariely, *Three Main Lessons of Psychology*, available at: http://danariely.com/2008/05/05/3-main-lessons-of-psychology/.

9 D. Culver, Presentation to the Maine Measure Alignment Work Group, Augusta, ME, October 30, 2014.

10 Conversations with Rhode Island Office of the Health Insurance Commissioner on or around April 20, 2015.

11 See http://healthitsecurity.com/2013/04/10/mass-hie-growing-working-on-privacy-barriers/#.

12 The MeHI toolkits which addresses privacy issues is available at http://mehi.masstech.org/education/health-it-toolkits/ehr-toolkit.

13 R. Belfort, W. Bernstein, and S. Ingargiola, *Integrating Physical and Behavioral Health: Strategies for Overcoming Legal Barrier to Health Information Exchange*, Robert Wood Johnson Foundation, January 2014.

2. **Update state legislation or regulation to streamline privacy standards governing the exchange of information**. Of particular importance is to revise Chapter 224 to permit opt-out processes for sending information electronically across the HIE. To assure adequate consumer protection, there could be a robust consumer advocacy engagement process as the opt-out process is implemented.

3. **Create a standardized consent form**. By way of example, New York State, as part of the implementation of its HIE, created a standardized consent form that covers all information exchanged by physical and behavioral health providers, including mental health, substance abuse, and HIV-related records.[14] It considers both state and federal requirements. The use of the standard form has been approved by state regulatory agencies, and its use allows providers to obtain a one-time consent. It can also be used as a multiprovider consent that allows one provider to obtain patient consent for all collaborating providers.

ADDITIONAL OPTIONS INCLUDE:

1. Ask the state's Executive Office of Health and Human Services (EOHHS) to create an internal team to develop proposed regulatory changes to reduce or remove identified barriers related to privacy. Representatives from MassHealth, DPH, the Department of Mental Health (DMH), the DPH Bureau of Substance Abuse Services, the Center for Health Information and Analysis (CHIA), the Department of Children and Families, the Department of Youth Services, the Department of Elder Affairs, and the Department of Developmental Disabilities should be asked to participate. Consideration should be given to also including the Department of Education and the Department of Public Safety. Create a multiparty stakeholder group, including consumer, provider, and payer representatives, to provide input into additional barriers not previously identified and how identified barriers can be removed. Align these activities with the recommendations of the statutorily mandated Task Force on Behavioral Health Data Policies and Long Term Stays, which is chaired by CHIA. The task force's report is due out by the end of June 2015.

2. To the extent permitted under federal law, amend substance use treatment program regulations to permit integration of substance use information as part of an integrated medical record.

2. Sharing Information Among State Agencies

In late 2014, CHIA convened the aforementioned Task Force on Behavioral Health Data Policies and Long Term Stays to identify barriers and develop ways to improve access to individually identifiable behavioral health data. As part of this process, representatives from a number of state agencies, including CHIA, the Health Policy Commission, MassHealth, DPH, DMH, the Division of Insurance (DOI), and the Attorney General's Office, were interviewed to discuss integration issues. Agencies made clear how difficult it is to share individually identifiable information among themselves. Solving this issue is important to overall integration, because many individuals with behavioral health issues are involved with multiple state agencies, and having a complete picture of their health care needs is important to the care each agency is providing separately, in order to improve coordination and reduce duplication and mixed messages. Information sharing across agencies serving the same client could significantly improve their opportunity to provide integrated, coordinated care to these patients.

14 Available at http://nyehealth.org/resources/forms/.

Each agency has a separate interagency service agreement (ISA) with every agency that requests data. Each agency's legal staff has a different interpretation of confidentiality requirements and what can be released. Reaching agreement is a time-consuming negotiation with inconsistent results. Even agencies within EOHHS have different interpretations of privacy and consent requirements.

OPTION FOR ADDRESSING INFORMATION SHARING AMONG STATE AGENCIES:

1. Recommend to the Task Force on Behavioral Health Data Policies and Long Term Stays that EOHHS create a unified privacy policy that includes standards, consent forms, and a single process for sharing confidential data among its affiliated agencies when providing services to shared individuals. Base interagency service agreements on the outcome of this initiative to unify the process within EOHHS.

C. REIMBURSEMENT BARRIERS TO BEHAVIORAL HEALTH INTEGRATION

Information regarding reimbursement barriers was collected from a variety of sources and included general information as well as very specific challenges based on payer practices. Most of the sources are provider interviews or documents reporting provider experience, and most relate to the experiences of CHCs and CMHCs, both of which are predominantly serving MassHealth beneficiaries. As a result, the reimbursement barriers identified in this section are generally associated with MassHealth. When barriers are more generally applicable to private insurers and MassHealth, the report uses the term "payers." Since many of the higher-cost MassHealth beneficiaries have both physical and behavioral health needs, efforts to remove reimbursement barriers in MassHealth could yield major benefits. The reader should note that reimbursement policies are periodically revised, and the barriers identified reflect information available as of the date of this report.

Examples of payers that are specifically addressing the barriers identified are included in this report. This report also draws from work done by the SAMHSA–HRSA Center for Integrated Health Solutions (CIHS) to develop state-specific billing worksheets to help clinic managers, integrated care project directors, and billing/coding staff at CHCs and CMHCs identify the available current procedural terminology (CPT) codes they can use in their state to bill for services related to integrated primary and behavioral health care.[15]

1. Inability to Bill and Be Paid for Two Services Provided During the Same Day

One of the hallmarks of integrated behavioral health services is the ability to provide both behavioral health and physical health services in coordination. Historically, the inability to bill for more than one service during the same visit has been a barrier to providing integrated care. Currently, MassHealth will pay for two services provided during the same visit so long as the services are not both physical health or both behavioral health services. However, providers have identified two areas where the policy's implementation has proven challenging. First, MassHealth processes a psychiatrist visit as a medical visit and when it occurs on the same day as a primary care provider (PCP) visit, it will not be paid. Second, if a medication management service, which is considered a medical visit, is provided during an office visit, the medication management service will not be paid. This occurs even if the medication management is focused on behavioral health medications. As a result, in these situations, it is to the financial advantage of the clinic to bring a patient back in for a series of services, which may impose a greater burden on the patient, rather than to provide integrated care during a single visit.

15 The worksheets may be accessed at www.integration.samhsa.gov/financing/billing-tools#billingworksheets.

EXAMPLES OF MEDICAID PROGRAMS THAT PAY FOR TWO SERVICES PROVIDED DURING ONE VISIT:

- Florida's Medicaid program allows up to three encounters (one medical, one dental, and one mental health) per recipient per day.[16]
- Washington State's Medicaid program allows providers to bill when a patient needs to be seen on the same day by different practitioners with different specialties or when the patient needs to be seen multiple times on the same day due to unrelated diagnoses.[17]

2. Inability to Bill and Be Paid for Care Management Services That Promote Behavioral Health Integration

Many behavioral health integration models include a strong care management component. Some models rely exclusively on care coordination to promote integration, such as a model being implemented by some CMHCs to use a nurse care manager with physical health training to coordinate the primary care service needs of the patients. Currently, MassHealth has not activated the complex care management and transitional care codes, which would provide payment for a wider range of care management services. At this time, MassHealth reimburses only for the time that the care manager is in direct communications with a provider or with the patient or patient's family. Payments do not cover the array of other tasks that are needed to provide integrated care, such as making referrals, informal communication with the office staff, and care and service coordination with social service agencies. One CMHC estimated that only one-fourth of the care manager's time is billable. The lack of funding mandates that providers wanting to implement an integration model with a care management component find grant funding, subsidize the service, or both. As reimbursement increasingly moves to budgeted and prospective total cost of care models, providers will have the incentive to provide these services as one strategy for managing costs—but not necessarily the funding, because there may not be any fee-for-service or other payments that expressly compensate for these services.

EXAMPLES OF PAYERS COVERING CARE MANAGEMENT SERVICES THAT PROMOTE BEHAVIORAL HEALTH INTEGRATION:

- Through the Children's Behavioral Health Initiative,[18] MassHealth pays for bachelor's-degree-level staff to provide therapeutic mentoring, which is similar to services provided by care managers, to individuals qualifying for the program. MassHealth could create a similar program to pay for care management services for dual-diagnosis high-cost patients, which would involve creating eligibility criteria, defining covered services, such as care management and care coordination services, that are beyond current MassHealth services, and creating a payment methodology for the supplemental services.

16 www.integration.samhsa.gov/financing/Florida_.pdf.

17 www.integration.samhsa.gov//financing/Washington_.pdf.

18 The Children's Behavioral Health Initiative (CBHI) is an interagency initiative of the Commonwealth's Executive Office of Health and Human Services whose mission is to strengthen, expand, and integrate Massachusetts state services into a comprehensive, community-based system of care and to ensure that families and their children with significant behavioral, emotional, and mental health needs obtain the services necessary for success in home, school, and the community. More information is available at www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/.

3. Inability to Bill and Be Paid for Community Health Workers or Peer Specialists Who Promote Behavioral Health Integration

Behavioral health integration models that serve low-income underserved populations with co-morbid physical and behavioral health issues have found the addition of community health workers to the care team to be key to addressing social needs of the patients and to engaging patients in proactive management of their chronic conditions. Currently, most payers do not reimburse for those services, and the few commercial payers that do cover the services do so for only a limited period of time. Not having a source of revenue for these services is a barrier to behavioral health integration.

Behavioral health integration models may also include peer counselors, who are people with lived experience trained to do patient outreach and engagement work with patients with serious and persistent mental illness. As with community health workers, most payers, including the MassHealth behavioral health carve-out vendors, do not generally reimburse for these services. MassHealth includes peer services in the per diem rate for very specific services (e.g., emergency series program, mobile crisis intervention, and intensive care coordination). Not having a funding source for these services to be provided within the context of an integrated behavioral health team is a barrier.

EXAMPLES OF STATE MEDICAID PROGRAMS COVERING COMMUNITY HEALTH WORKERS AND PEER SPECIALISTS THAT PROMOTE BEHAVIORAL HEALTH INTEGRATION:

- Minnesota obtained a State Plan Amendment to directly reimburse community health workers under its Medicaid program, so long as services are provided by certified workers and provided and billed under the supervision of a physician, RN, advanced practice RN, mental health professional, dentist, or public health nurse.[19]
- New Mexico Medicaid requires all contracted managed care organizations to cover community health worker services.[20]
- New Mexico Medicaid pays for peer support services and whole health and wellness coaching for both individuals and groups.[21]
- California Medicaid reimburses providers for peer support services so long as supervision requirements are met.[22]
- Texas Medicaid covers peer support services so long as the services are provided by a person in recovery who has been certified by the state and receives appropriate supervision.[23]

19 A. Burton, D. Chang, and D. Gratale, *Medicaid Funding of Community-based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models*, Nemours Foundation, June 2013, p. 9.

20 Ibid.

21 www.integration.samhsa.gov/financing/New_Mexico.pdf.

22 www.integration.samhsa.gov/financing/California.pdf.

23 www.integration.samhsa.gov/financing/Texas_.pdf.

4. Inability to Bill and Be Paid for Warm Hand-off and Consultation Activities Unless Qualifying as Therapy

Behavioral health service codes currently being reimbursed by payers do not comprehensively address the nature of services provided by behavioral health clinicians in a co-located integrated behavioral health model. An essential step in operationalizing a co-located, fully integrated model is the ability of PCPs to access behavioral health services during a primary care visit. This is often done using a "warm hand-off" process whereby the behavioral health clinician is introduced to the patient by the PCP (i.e., the "warm hand-off") and the clinician does a quick assessment and recommends next steps. Providers can receive reimbursement for a portion of these services only when the encounter can be billed as a therapy session, but this requires that the encounter process be sufficiently long, that the assessment results in a behavioral health diagnosis, and that the patient is asked to return for more in-depth therapy. Some but not all insurers also permit these types of encounters to be billed as consultations. As an example, one CHC that has operationalized a co-located fully integrated model estimates that the inability to bill for all warm hand-off encounters is equivalent to the loss of approximately 100 sessions per year, which represents between $9,000 and $10,000 in lost revenue to this center. The inability to be fully paid for time spent doing warm hand-offs and holding consultations creates a significant barrier to implementing a co-located, fully integrated model.

This failure to cover behavioral health consultations also arises in the context of a less integrated model where there is a need for PCPs and behavioral health clinicians to consult with one another. Without reimbursement for consultations, few providers are able to incorporate consultations as a regular part of their practice to improve behavioral health integration.

Finally, where an emergency department clinician wants to consult with the patient's personal behavioral health clinician, neither provider is able to bill for the consultation time. As a result, this consultation often does not occur.

EXAMPLES OF PAYERS PAYING FOR CONSULTATIONS AND WARM HAND-OFFS:

- No specific examples of payers reimbursing for warm hand-offs have been identified. However, billing experts believe that removing the prohibition against two billings for the same visit and the implementation of the Health and Behavior Codes (HABI) codes (see below) will help promote warm hand-offs.
- The Massachusetts Child Psychiatry Access Project (MCPAP) pays for psychiatric primary care clinician consultations for pediatric patients when the consultation is provided by the MCPAP-designated psychiatric regional team.[24]

5. Inability to Use Health and Behavior Codes (HABI Codes)

HABI codes are current professional terminology (CPT) codes that specified behavioral health clinicians can use when working with patients and their families on behavioral health components of physical conditions, such as smoking cessation therapy for chronic obstructive pulmonary disease patients or weight management for diabetics. The six codes cover a broad spectrum of possible patient-provider interactions, including assessments, reassessments, individual treatment, group treatment, and family sessions with and without the patient. In an integrated behavioral health model, addressing the behavioral aspects of medical conditions is a necessary part of

24 www.mcpap.com/servicesPCCs.asp.

the new delivery model. Not having the ability to bill for those types of interventions using HABI codes, and being paid only for the services that meet the standard criteria for therapy, is a barrier to providing these services. One CHC described the current reimbursement challenges associated with implementing group visits for people with diabetes that addressed both behavioral health and physical health issues. The CHC was able to cover some of the costs under MassHealth by including private one-on-one sessions with the attendees and billing for a brief office visit. MassHealth does not reimburse for medical group visits, and the CHC was not able to bill for the behavioral aspect of the group visit because the encounter did not qualify as a group therapy session. The CHC indicated that using *Diagnostic and Statistical Manual of Mental Disorders* (DSM) "V-codes" to bill for these services as a work-around was not a viable option because MassHealth will not pay for behavioral services billed with a V-code. DSM V-codes can be used to report conditions other than disease or injury (e.g., relational problems) and are used in billing to provide coding flexibility.

It is important to note that MassHealth pays for smoking cessation counseling and pharmacotherapy services provided by participating physicians and CHCs using Healthcare Common Procedure Coding System (HCPCS) service codes with modifiers.[25] This is an important benefit since smoking is a lifestyle issue associated with a number of physical health conditions, including cardiovascular disease, cancer, and chronic obstructive pulmonary disease. Moreover, tobacco cessation benefits may be billed on the same day as other medical visits. A formal evaluation of this covered service found a positive return on investment.[26] However, CMHCs are not eligible to bill for these services, even though they may be a good location to provide them to those patients who are more likely to seek care at a CMHC than at a primary care clinic.

EXAMPLES OF PAYERS PAYING HABI CODES:

- Medicare currently pays for these codes when billed by either a primary care clinic or a community mental health center, with the exception of the code covering family treatment without the patient.[27]
- California Medicaid pays for four of the six codes when billed by physicians, physician assistants, nurse practitioners, clinical psychologists, or clinical social workers.[28]
- New York Medicaid pays for all six codes when billed by any non-physician mental health practitioner.[29]

6. Inability to Bill for Telehealth Services

Currently, MassHealth does not reimburse for any telehealth services.[30] For primary care practices unable to co-locate behavioral health care in their practice space, having access to telehealth services could open up new opportunities for behavioral health integration.

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25 See "Frequently Asked Questions about the MassHealth Tobacco Cessation Benefit," available at www.mass.gov/eohhs/docs/masshealth/provlibrary/fact-sheet-providers.pdf.

26 See P. Richard, K. West, and L. Ku, "The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts," PLoS ONE 7(1): e29665. doi:10.1371/journal.pone.0029665.

27 www.integration.samhsa.gov/financing/Massachusetts.pdf.

28 www.integration.samhsa.gov/financing/California.pdf.

29 www.integration.samhsa.gov/financing/New_York_.pdf.

30 "*State Telehealth Law and Reimbursement Policies: A Comprehensive Scan of the 50 States and District of Columbia*. See the section titled "Key Findings, Medicaid Reimbursement." Center for Connected Health Policy, February 2015. The report is available at http://cchpca.org/state-laws-and-reimbursement-policies.

EXAMPLE OF PAYERS COVERING TELEHEALTH SERVICES:

- Medicare generally covers telehealth services for psychiatric evaluations with and without medical services, psychiatric therapy services, inpatient consultation, alcohol and substance abuse services with limitations, and health, obesity, and tobacco counseling.[31]
- Wyoming Medicaid offers telehealth reimbursement when provided by CMHCs or FQHCs for psychiatric evaluations with and without medical services, behavioral health therapy services, and office or other outpatient services for both mental health and physical health diagnoses.[32]

7. Complex Payment Rules That Inhibit Behavioral Health Integration

There are different payer rules about what provider types can bill for what services in various settings. The SAMHSA Center for Integrated Health Solutions and the National Council for Behavioral Health developed state-specific charts, which outline general reimbursement requirements that could support an integrated behavioral health model under state Medicaid programs and under Medicare. The chart for Massachusetts reflects state practice as of July 2014.[33] The different payer rules regarding use of various billing codes raise two issues for providers. First, they create a complex framework that providers must understand in order to receive payment for services provided. Second, providers are concerned that some of the rules do not support all integration models that maximize use of mid-level clinicians.

An assessment of a Massachusetts demonstration project to increase integration between FQHCs and CMHCs found that figuring out how to bill for integrated services was very complex:

> *"Projects spent considerable time identifying opportunities for billing maximization. Projects report funding silos, categorical funding, and having to deal with over 100 different payers each with differing billing and credentialing requirements are significant barriers to collaborative care. As a result, there is a lack of clarity surrounding who can bill for what services in various settings for individuals enrolled in the FFS, MCO, and PCC plan."*[34]

EXAMPLES OF EFFORTS TO EXPLAIN COVERAGE RULES TO FACILITATE BILLING:

Efforts to simplify billing complexities have generally taken the form of providing explanatory materials on how to bill under an integrated model. The following two examples demonstrate efforts to make billing in an integrated setting simpler through careful explanation.

- The State of California has created a website with detailed instructions on how to use billing codes to support integration. See www.ibhp.org/?section=pages&cid=141.
- The Suicide Prevention Resource Center has developed a document titled "Tips and Strategies for Billing for Mental Health Services in a Primary Care Setting." See www.sprc.org/sites/sprc.org/files/tipsandstrategiesforbilling.pdf.

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31 www.integration.samhsa.gov/financing/New_York_.pdf.

32 www.integration.samhsa.gov/financing/Wyoming.pdf.

33 www.integration.samhsa.gov/financing/Massachusetts.pdf.

34 *CHC-CMHC Demonstration Project on Collaborative Care: Summary of Findings and Recommendations from the Evaluation of Six Demonstration Projects*, UMass Medical School, Center for Health Policy and Research, January 2008, p. 19.

8. Lack of Reimbursement for Physician-Clinician Interactions Other Than Consultations and Warm Hand-offs

Practices that have implemented integrated behavioral health models all report that it is time-consuming to develop new processes, hold case conferences, and meet regularly to identify and resolve implementation issues. Currently, none of the time needed for these types of bidirectional communications is reimbursed under a traditional FFS model. As clinical leaders have noted, incorporating behaviorists on primary care teams requires redesigning workflows and defining a new culture for team-based care that may require significant training. While there will in the future be more incentives to pursue behavioral health integration and protect the time needed for these activities, at present, practices without additional grant funding do not have funding to cover these costs. Lack of funding for these activities is a significant barrier to integration.

No examples were found of payers that were specifically covering these types of communications.

IV. PRIORITIES

A key step in developing this report was to hold a focus group with key stakeholders to review the issues and barriers identified. In addition to validating that the issues identified did indeed pose meaningful challenges to integration, stakeholders were asked to identify the top three priorities that if addressed, would have the most significant impact on removing barriers to integration. The top priorities identified are as follows:

1. Reimbursement for behavioral health integration activities, including care management/care coordination activities, warm hand-offs, and behavioral health services related to physical health conditions (HABI codes).
2. Simplifying the patient consent process by developing a universal consent form that can be used by all providers across the continuum of care and by clarifying state and federal consent requirements.
3. Allowing for the integration of substance use treatment records with physical health and mental health records to facilitate treatment team communications and the provision of integrated care.

Each of these priorities is multifaceted, and changes in one area can impact activities in another. Any effort to change regulatory requirements or to provide policy clarification should not have the unintended effect of reducing behavioral and physical health integration. Providers have developed behavioral health integration models within the current framework, and efforts to remove barriers should not jeopardize current integration activities. To that end, a process for stakeholder input is critical to include in any state efforts to address the barriers to behavioral and physical health integration discussed in this report.

Stakeholders participating in the focus group noted that with the wide array of potential actions to remove barriers to integration, DPH might consider a phased approach to implementing changes—first identifying and making changes that can be implemented quickly, and second identifying changes that will involve longer time frames. For example, DPH could immediately issue a clarification regarding the requirement for separate reception areas

for co-located physical health and mental health programs. DPH could also implement a robust licensing waiver process and proactively waive the following licensing requirements with a relatively low level of effort:

- Behavioral health organizations adding physical health services to submit original architectural drawings.
- Specific staffing configurations for mental health and substance use treatment programs.
- Specific intake and documentation requirements for substance use treatment programs.
- Limiting satellite clinics to 20 hours of service per week.

More complex changes to the licensing process—including streamlining the application and review process, creating a deeming process, clarifying what services trigger licensing requirements, and permitting the integration of physical health, mental health, and substance use treatment records—could be addressed with a longer time frame.

Similarly, addressing the privacy barriers will require time-consuming but essential stakeholder involvement. The privacy barriers may be better addressed at a multiagency level, since several agencies are impacted by privacy requirements and federal laws interact with state laws in significant ways.

Following a phased approach would create momentum for change and signal to providers that the state is actively supporting physical and behavioral health integration as a priority for delivery system transformation.

V. CONCLUSION

Providers wishing to implement behavioral health integration models face multiple barriers, as the licensing, privacy, and reimbursement requirements for the most part continue to reflect a delivery system that is siloed and functions with little coordination or integration. This may be partially a function of rules and regulations that were instituted prior to the development of integrated models of care delivery. While this report highlights specific issues and challenges, it also identifies opportunities to restructure licensing and reimbursement requirements in order to foster integration, and it provides examples of payers expanding reimbursement options to support integration initiatives.

Changing privacy requirements may prove more challenging because of the need to carefully balance the legitimate concern about stigma and privacy associated with behavioral health issues and the need to provide whole-person care.

Nonetheless, this report is intended to serve as a resource summarizing some key issues and potential opportunities as the state and key stakeholders move forward in the important effort to improve integration of physical and behavioral health.

APPENDIX A: REFERENCES

REPORTS AND PRESENTATIONS

1. D. Bachrach, S. Anthony, and A. Detty, *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment,* the Commonwealth Fund, August 2014.

2. R. Belfort, W. Berstein, and S. Ingargiola, *Integrating Physical and Behavioral Health: Strategies for Overcoming Legal Barriers to Health Information Exchange,* Robert Wood Johnson Foundation, January 2014.

3. M. Brolin, A. Quinn, J. Kirkin, *et al.*, *Financing of Behavioral Health Services Within Federally Qualified Health Centers,* submitted to Substance Abuse and Mental Health Services Administration, July 23, 2012.

4. A. Burton, D. Chang, and D. Gratale, *Medicaid Funding of Community-based Prevention: Myths, State Successes Overcoming Barriers and the Promise of Integrated Payment Models,* Nemours Foundation, June 2013. Available at www.nemours.org/content/dam/nemours/wwwv2/filebox/about/Medicaid_Funding_of_Community-Based_Prevention_Final.pdf.

5. M. Coleman, S. Hedberg, D. Hurwiz, M. Johnson, *et al., CHC-CMHC Demonstration Project on Collaborative Care: Summary of Findings and Recommendations from the Evaluation of Six Demonstration Projects,* UMass Medical School, Center for Health Policy and Research, January 2008.

6. C. Collins, D.L. Hewson, R. Munger, and T. Wade, *Evolving Models of Behavioral Health Integration in Primary Care,* prepared for the Milbank Memorial Fund, 2010.

7. C.C. Cordes and N.A. Cummings, *Addressing Barriers to Integration: Successful Reimbursement Strategies for Behavioral Health Providers in Primary Care,* PowerPoint presentation available from Bailit Health Purchasing, LLC.

8. Institute for Clinical and Economic Review, *Integrating Behavioral Health into Primary Care,* prepared for the New England Comparative Effectiveness Public Advisory Council, March 23, 2015. Available at www.icer-review.org/cepac-releases-draft-report-on-integrating-behavioral-health-into-primary-care/.

9. Massachusetts Behavioral Health Integration Task Force, *Report to the Legislature and Health Policy Commission,* July 2013.

10. D. Mauch, *Reimbursement of Mental Health Services in Primary Care Settings,* DIANE Publishing, 2011.

11. K. Reynolds, *Supporting Bi-Directional Integration Through Potential Billing Opportunities: The Michigan Interim Billing Worksheets.* PowerPoint presentations available at http://c.ymcdn.com/sites/www.mpca.net/resource/resmgr/behavioral_health/supporting%20bi-directional%20integration%20through%20potential%20billing%20opportunities-the%20michigan%20interim%20billing%20worksheets.pdf.

12. *State Telehealth Law and Reimbursement Policies: A Comprehensive Scan of the 50 States and District of Columbia*. See section titled "Key Findings, Medicaid Reimbursement." Center for Connected Health Policy, February 2015. Report is available at http://cchpca.org/state-laws-and-reimbursement-policies.

WEBSITES

1. California Mental Health Services Authority, Billing, Reimbursement and Financing Behavioral Health Integration, available at www.ibhp.org/?section=pages&cid=141.
2. Massachusetts Department of Public Health, *Integration Initiative Frequently Asked Questions,* available at www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/integration-initiative-faq.html.
3. SAMHSA-HRSA Center for Integrated Health Solutions, Billing Tools: Paying for Primary Care and Behavioral Health Services Provided in Integrated Care Settings, available at www.integration.samhsa.gov/financing/billing-tools#billingworksheets.
4. Suicide Prevention Resource Center, Tips and Strategies for Billing for Mental Health Services in a Primary Care Setting, available at www.sprc.org/sites/sprc.org/files/tipsandstrategiesforbilling.pdf.

STATE OF MASSACHUSETTS REGULATIONS AND DEPARTMENT OF PUBLIC HEALTH DOCUMENTS

1. Department of Public Health: 105 CMR 140.000.
2. Department of Public Health: 105 CMR 164.000.
3. Department of Public Health: Compliance Checklist: OP1: Primary Care Facilities.
4. Department of Public Health: Compliance Checklist: OP2: Small Neighborhood Clinics.
5. Department of Public Health: Compliance Checklist: OP12: Mental Health Counseling Clinic.
6. Department of Public Health: Transmittal Letter CHC-102.
7. Office of Consumer Affairs and Business Regulation: 201 CMR 17.00: Standards for the Protection of Personal Information of Residents of the Commonwealth.
8. Center for Health Information and Analysis: 957 CMR 5.00.

OTHER

1. Massachusetts eHealth Institute, *EHR Planning and Procurement Toolkit: A Guide to First Steps in Adopting Electronic Health Records, Appendix A,* available at http://mehi.masstech.org/sites/mehi/files/documents/EHR_Toolkit/MeHI_toolkit_full_ebook_with_arrows_links3.pdf.
2. CHIA flow chart outlining data release procedure, available at http://chiamass.gov/assets/docs/p/apcd/release2/data-release-regulation-flowchart-final-pdf.pdf.

APPENDIX B: ORGANIZATIONS PARTICIPATING IN FOCUS GROUP

- Association for Behavioral Health Care
- Boston Children's Hospital
- Boston Health Care for the Homeless Program
- Brookline Community Mental Health Center
- Cambridge Health Alliance
- Center for Human Development
- Commonwealth Care Alliance
- Community Health Center of Cape Cod
- Community Healthlink
- Dimock Community Health Center
- Gosnold
- Health Law Advocates
- Health New England
- Health Policy Commission
- Institute for Clinical and Economic Review
- Lynn Community Health Center
- MA League of Community Health Centers
- Massachusetts eHealth Institute (MeHI)
- National Alliance on Mental Illness
- UMass Memorial Health Care, Inc.
- ValueOptions
- Vinfen

APPENDIX C: SUMMARY OF BARRIERS AND OPTIONS/EXAMPLES TO ADDRESS ISSUES

BARRIER CATEGORY	BRIEF ISSUE DESCRIPTION	RELEVANT STATUTE OR REGULATION	OPTIONS/EXAMPLES TO ADDRESS ISSUE
LICENSING BARRIERS			
GENERAL	Licensing process is time-consuming, requiring months to collect documentation and to work with DPH to obtain license.	N/A	• DPH could widely publicize the availability of its waiver program, create a standing review committee to render consistent decisions, identify particular problem areas, and recommend permanent resolutions. • DPH could conduct an efficiency assessment of the application process. • DPH could conduct a comprehensive review of submission requirements based on goals of licensing to eliminate arcane and unnecessary requirements.
	No consistent understanding exists about when offering new services triggers a need to obtain a new license, particularly with regard to bringing minimal behavioral health services into a CHC.	105 CMR 140.550	• DPH could provide written clarification regarding the scope of services offered by an outpatient primary care clinic that triggers either the outpatient mental health or the outpatient substance use treatment program licensing requirements.
	DPH licensing regulations do not permit CHCs to subcontract with licensed behavioral health providers without obtaining a mental health license.	105 CMR 140.500	• DPH could create a deeming process that recognizes the validity of the subcontractor's license within the contracting entity's facility, such that the contracting entity does not need to obtain its own license. • DPH could create a deeming process that deems facilities applying for a license renewal to meet licensing requirements so long as they have current CARF or Joint Commission accreditation and/or recently successfully completed a site visit by the HRSA Bureau of Primary Care.

(continued)

BARRIER CATEGORY	BRIEF ISSUE DESCRIPTION	RELEVANT STATUTE OR REGULATION	OPTIONS/EXAMPLES TO ADDRESS ISSUE
LICENSING BARRIERS *(continued)*			
FACILITIES	Regulations are interpreted to require separate reception areas for co-located physical health and mental health programs.	105 CMR 140.202; 105 CMR 140.1002 (A)	• DPH could provide written clarification of requirements. • DPH could include this requirement in its waiver process.
	A behavioral health organization wanting to add physical health services must submit the location's original architectural drawings if it is not new construction.	N/A	• DPH could eliminate this requirement. • DPH could include this requirement in its waiver process.
	A behavioral health program wanting to add physical health services must meet all requirements for small primary care outpatient clinics, regardless of how limited the physical health services are to be.	OP3: Small Primary Care Outpatient Clinics	• DPH could simplify its OP3 Compliance Checklist to allow for integration models that offer limited medical oversight focusing on chronic conditions.
STAFFING	The physical health, mental health, and substance use treatment regulations each require programs to have multidisciplinary teams, all with different composition requirements. None accommodates the full range of behavioral health integration models.	105 CMR 140.310-330; 105 CMR 140.530; 105 CMR 164.000	• DPH could revise its regulations to accommodate the full spectrum of behavioral health integration models and allow flexibility regarding staffing. • DPH could include this requirement in its waiver process.
SUBSTANCE USE TREATMENT PROGRAM SERVICE AND INTAKE REQUIREMENTS	Regulations are very prescriptive regarding types of services that must be provided and associated intake and documentation requirements. These requirements do not accommodate an integrated behavioral health model built on warm hand-offs and brief initial behavioral health assessments.	105 CMR 164.073; 105 CMR 164.074; 105 CMR 164.075	• BSAS could revise its regulations and intake and recordkeeping requirements to accommodate the full spectrum of behavioral health integration models. • DPH could include this requirement in its waiver process.
RECORDKEEPING	Substance use treatment records must be kept separately, creating barriers to information sharing among treatment team members.	105 CMR 140.302; 105 CMR 164.083	• BSAS could provide written clarification regarding the extent to which substance use treatment records may be integrated with behavioral health and physical health records. • BSAS could write regulations that allow for integrated medical records to the extent permitted by federal regulations.
OUTREACH PROGRAMS	Mental health outreach programs are limited to 20 hours of service per week under the provider's existing license.	105 CMR 140.560	• DPH could clarify the hourly limit on outreach programs to accommodate a range of integration models. • DPH could include this requirement in its waiver process.

(continued)

BARRIER CATEGORY	BRIEF ISSUE DESCRIPTION	RELEVANT STATUTE OR REGULATION	OPTIONS/EXAMPLES TO ADDRESS ISSUE
PRIVACY BARRIERS			
SHARING INFORMATION AMONG TREATING PROVIDERS	Massachusetts providers do not interpret "authorized access to medical records" to include external providers who are on the treatment team, requiring patient consent to share information or requiring the external providers to be credentialed by the organization maintaining the records.	201 CMR 17.00	• DPH could provide interpretive guidelines regarding the applicability of authorized users within the context of a multidisciplinary/ multiorganization treatment team.
	Release of information requirements are complex and time-consuming. Beyond a general consent requirement to release medical information, there are separate, additional consent requirements for genetic information, HIV testing, and substance use treatment records.	MGL c.112, Section 129A; MGL c.111 s70g; MGL c.111 s70f	• EOHHS could create a task force to develop proposed regulatory changes and could obtain input from an advisory committee. • Create a single, standard consent form. • Clarify privacy law requirements through agency-issued guidance that clarify the requirements of DPH regulations. Of particular importance is to clarify behavioral health provider obligations to release information to requesting providers.
	Separate patient consents are needed for medical information to be available on the HIE and for the information to be shared electronically among providers.	Chapter 224	• Revise Chapter 224 to permit opt-out processes for sending information electronically across the HIE.
SHARING INFORMATION AMONG STATE AGENCIES	Each agency has a separate agreement with every agency that requests data; agency legal staff interpret requirements for releasing information differently.	N/A	• EOHHS could create a unified privacy policy that includes standards, consent forms, and a single process for sharing confidential data among its affiliated agencies.

APPENDIX D: CENTER FOR INTEGRATED HEALTH SOLUTIONS BEHAVIORAL HEALTH INTEGRATION FRAMEWORK

TABLE 1. SIX LEVELS OF COLLABORATION/INTEGRATION (CORE DESCRIPTIONS)

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 **Minimal Collaboration**	**LEVEL 2** **Basic Collaboration at a Distance**	**LEVEL 3** **Basic Collaboration Onsite**	**LEVEL 4** **Close Collaboration Onsite with Some System Integration**	**LEVEL 5** **Close Collaboration Approaching an Integrated Practice**	**LEVEL 6** **Full Collaboration in a Transformed/ Merged Integrated Practice**
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
• Have separate systems • Communicate about cases only rarely and under compelling circumstances • Communicate, driven by provider need • May never meet in person • Have limited understanding of each others's roles	• Have separate systems • Communicate periodically about shared patients • Communicate, driven by specific patient issues • May meet as part of larger community • Appreciate each other's roles as resources	• Have separate systems • Communicate regularly about shared patients, by phone or email • Collaborate, driven by need for each other's services and more reliable referral • Meet occasionally to discuss cases due to close proximity • Feel part of a larger yet ill-defined team	• Share some systems, like scheduling or medical records • Communicate in person as needed • Collaborate, driven by need for consultation and coordinated plans for difficult patients • Have regular face-to-face interactions about some patients • Have a basic understanding of roles and culture	• Actively seek system solutions together or develop workarounds • Communicate frequently in person • Collaborate, driven by desire to be a member of the care team • Have regular team meetings to discuss overall patient care and specific patient issues • Have an in-depth understanding of roles and culture	• Have resolved most or all system issues, functioning as one integrated system • Communicate consistently at the system, team and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blur or blend

B. Heath, P. Wise Romero, and K. Reynolds, A Review and Proposed Standard Framework for Levels of Integrated Healthcare, Washington, D.C., SAMHSA-HRSA Center for Integrated Health Solutions, March 2013.

TABLE 2A. SIX LEVELS OF COLLABORATION/INTEGRATION (KEY DIFFERENTIATORS)

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 **Minimal Collaboration**	**LEVEL 2** **Basic Collaboration at a Distance**	**LEVEL 3** **Basic Collaboration Onsite**	**LEVEL 4** **Close Collaboration Onsite with Some System Integration**	**LEVEL 5** **Close Collaboration Approaching an Integrated Practice**	**LEVEL 6** **Full Collaboration in a Transformed/ Merged Integrated Practice**
Key Differentiator: Clinical Delivery					
• Screening and assessment done according to separate practice models • Separate treatment plans • Evidenced-based practices (EBP) implemented separately	• Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges • Separate treatment plans shared based on established relationships between specific providers • Separate responsibility for care/EBPs	• May agree on a specific or other criteria for more effective in-house referral • Separate service plans with some shared information that informs them • Some shared knowledge of each other's EBPs, especially for high utilizers	• Agree on specific screening, based on ability to respond to results • Collaborative treatment planning for specific patients • Some EBPs and some training shared, focused on interest or specific population needs	• Consistent set of agreed-upon screenings across disciplines, which guide treatment interventions • Collaborative treatment planning for all shared patients • EBPs shared across system with some joint monitoring of health conditions for some patients	• Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place • One treatment plan for all patients • EBPs are team selected, trained and implemented across disciplines as standard practice
Key Differentiator: Patient Experience					
• Patient physical and behavioral health needs are treated as separate issues • Patient must negotiate separate practices and sites on their own with varying degrees of success	• Patient health needs are treated separately, but records are shared, promoting better provider knowledge • Patients may be referred, but a variety of barriers prevent many patients from accessing care	• Patient health needs are treated separately at the same location • Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider	• Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers • Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services	• Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others • Care is responsive to identified patient needs by a team of providers as needed, which feels like a one-stop shop	• All patient health needs are treated for all patients by a team, who function effectively together • Patients experience a seamless response to all health care needs as they present, in a unified practice

TABLE 2B. SIX LEVELS OF COLLABORATION/INTEGRATION (KEY DIFFERENTIATORS) *(continued)*

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 **Minimal Collaboration**	**LEVEL 2** **Basic Collaboration at a Distance**	**LEVEL 3** **Basic Collaboration Onsite**	**LEVEL 4** **Close Collaboration Onsite with Some System Integration**	**LEVEL 5** **Close Collaboration Approaching an Integrated Practice**	**LEVEL 6** **Full Collaboration in a Transformed/ Merged Integrated Practice**
Key Differentiator: Practice/Organization					
• No coordination or management of collaborative efforts • Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow	• Some practice leadership in more systematic information sharing • Some provider buy-in to collaboration and value placed on having needed information	• Organization leaders supportive, but often co-location is viewed as a project or program • Provider buy-in to making referrals work and appreciation of onsite availability	• Organization leaders support integration through mutual problem-solving of some system barriers • More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components	• Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without changing fundamentally how disciplines are practiced • Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for providers	• Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development • Integrated care and all components embraced by all providers and active involvement in practice change
Key Differentiator: Business Model					
• Separate funding • No sharing of resources • Separate billing practices	• Separate funding • May share resources for single projects • Separate billing practices	• Separate funding • May share facility expenses • Separate billing practices	• Separate funding, but may share grants • May share office expenses, staffing costs, or infrastructure • Separate billing due to system barriers	• Blended funding based on contracts, grants or agreements • Variety of ways to structure the sharing of all expenses • Billing function combined or agreed upon process	• Integrated funding, based on multiple sources of revenue • Resources shared and allocated across whole practice • Billing maximized for integrated model and single billing structure

TABLE 3. ADVANTAGES AND WEAKNESSES AT EACH LEVEL OF COLLABORATION/INTEGRATION

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 **Minimal Collaboration**	**LEVEL 2** **Basic Collaboration at a Distance**	**LEVEL 3** **Basic Collaboration Onsite**	**LEVEL 4** **Close Collaboration Onsite with Some System Integration**	**LEVEL 5** **Close Collaboration Approaching an Integrated Practice**	**LEVEL 6** **Full Collaboration in a Transformed/ Merged Integrated Practice**
Advantages					
• Each practice can make timely and autonomous decisions about care • Readily understood as a practice model by patients and providers	• Maintains each practice's basic operating structure, so change is not a disruptive factor • Provides some coordination and information-sharing that is helpful to both patients and providers	• Co-location allows for more direct interaction and communication among professionals to impact care • Referrals more successful due to proximity • Opportunity to develop closer professional relationships	• Removal of some system barriers, like separate records, allows closer collaboration to occur • Both behavioral health and medical providers can become more well-informed about what each can provide • Patients are viewed as shared which facilitates more complete treatment plans	• High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans • Provider flexibility increases as system issues and barriers are resolved • Both provider and patient satisfaction may increase	• Opportunity to truly treat whole person • All or almost all system barriers resolved, allowing providers to practice as high-functioning team • All patient needs addressed as they occur • Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
• Services may overlap, be duplicated or even work against each other • Important aspects of care may not be addressed or take a long time to be diagnosed	• Sharing of information may not be systematic enough to effect overall patient care • No guarantee that information will change plan or strategy of each provider • Referrals may fail due to barriers, leading to patient and provider frustration	• Proximity may not lead to greater collaboration, limiting value • Effort is required to develop relationships • Limited flexibility, if traditional roles are maintained	• System issues may limit collaboration • Potential for tension and conflicting agendas among providers as practice boundaries loosen	• Practice changes may create lack of fit for some established providers • Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	• Sustainability issues may stress the practice • Few models at this level with enough experience to support value • Outcome expectations not yet established

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