

ADVANCING BEHAVIORAL HEALTH INTEGRATION

IN HEALTH CENTERS



NATIONAL COUNCIL
for Mental Wellbeing

 NATIONAL ASSOCIATION OF
Community Health Centers®



Health centers are well positioned to provide integrated primary and behavioral health services to medically underserved and uninsured patients nationally. Serving more than 28 million patients annually, health centers provide primary care services including screening, diagnosis and management of chronic illness such as diabetes, asthma, heart and lung disease, depression, cancer and HIV/AIDS (HRSA, 2020). Often these illnesses co-occur with mental illness and substance use disorders requiring a comprehensive and patient-centered approach to addressing both physical and behavioral health concerns.

To support health centers in expanding access to quality behavioral health services, the National Association of Community Health Centers (NACHC) launched an effort in July 2019 to define and disseminate a set of policy recommendations to reduce barriers to integrating behavioral health services in health centers. NACHC partnered with the National Council for Mental Wellbeing, the nation's largest association of mental health and addictions treatment programs serving more than 10 million adults, children and families living with behavioral health conditions, to identify opportunities to advance the integration of behavioral health services in health centers in 10 states: Colorado, Florida, Georgia, Massachusetts, New York, North Carolina, Oregon, South Dakota, Vermont and Wisconsin. Interviews with Primary Care Associations (PCAs) revealed three key recommendations: 1) increase capacity to share information about substance use, 2) identify sustainable integrated care models that align with individual state policy landscapes and 3) establish partnerships with community mental health and addiction treatment providers.

The National Council for Mental Wellbeing presented the findings to PCAs and health centers through a two-part webinar series highlighting exemplary practices. This brief summarizes the barriers, opportunities and recommendations for advancing behavioral health integration in health centers.

INCREASE THE CAPACITY TO SHARE INFORMATION ABOUT SUBSTANCE USE

Interviewees shared a common request for clarity on 42 CFR (Code of Federal Regulations) Part 2, the federal confidentiality law and regulation that protects the privacy of substance use disorder patient records. The key points of the updated Final Rule from the Department of Health and Human Services (HHS) and considerations for health centers are summarized as:

- **Covered Entity:** The updated Final Rule states that providers are considered a 42 CFR Part 2 covered entity if they “hold [themselves] out to the public” as a substance use treatment provider (HHS, 2019). HHS 42 CFR Part 2 Proposed Rule Fact Sheet.
- **Consent:** The updated Final Rule provides three new options for general designation in the consent “to whom” section of consent form. All three options are acceptable under 42 CFR Part 2, and the patient can add more restrictive options should they choose.
 - » First, a patient with a substance use disorder (SUD) may consent to disclosure of the patient’s Part 2 treatment records to an entity (for example, the Social Security Administration), without naming a specific person as the recipient for the disclosure.



“Health centers face extreme workforce shortages and are being ‘hit’ with competing demands such as human trafficking, opioids and limited capacity to treat veterans. We are expected to be the safety net for all things and have ‘tired relationships’ with mental health providers.”

— *Primary Care Association Interviewee from Key Informant Interviews*



- » Second, a patient can consent to disclose protected information that would include SUD information once. After March 2021, that information can be redisclosed among Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities to help treat the patient (or seek payment) without asking for consent again. This consent can be revoked if the request for revocation is made in writing.
- » Third, the information that can be shared must still be identified, but the patient can make broad statements such as “all substance use disorder information,” for example.
- **Re-disclosure:** The prohibition on re-disclosure of protected health information (PHI) from a covered entity remains a part of the 42 CFR Part 2 regulation; however, per the updated Final Rule, a patient can now request and receive a list of individuals or entities to whom their information has been disclosed, pursuant to a general designation consent. The entity that serves as an intermediary is responsible for complying with the List of Disclosures requirement, not the 42 CFR Part 2 program.
- **Provision of SUD Treatment:** There are two options for providing SUD treatment in compliance with 42 CFR Part 2.
 - » **Provide the SUD services as a covered entity under 42 CFR Part 2, which is necessary for organizations where SUD treatment is a major service line.** Advantages to this approach are that an organization can publicly advertise that they provide and specialize in SUD treatment and SUD treatment information cannot be used for law enforcement actions against patients.
 - » **Provide SUD treatment services while avoiding being a covered entity under 42 CFR Part 2, which is feasible when SUD services are not a major service line in an organization.** Advantages to this approach are that SUD treatment information can be handled no more restrictively than required by HIPAA, which means that tracking and reporting every disclosure is not required and an organization will avoid having to meet the criteria for being a 42 CFR Part 2 covered entity, removing many barriers to information sharing.

If an organization does not provide SUD services as a major part of their service line and they do not “hold themselves out to the public” as an SUD treatment provider by not advertising as such, there is an option to provide integrated care that includes SUD services while avoiding meeting the criteria required for being a 42 CFR Part 2 covered entity. To do this requires removing all mention of SUD diagnosis and treatment services from an organization’s website and marketing materials and never publicly stating that your organization provides these services.

Diagnosis of SUD by providers that do not hold themselves out to the public as treating SUDs are not subject to 42 CFR, Part 2 restrictions. Treatment of SUD by providers that do not hold themselves out to the public as treating SUDs are not subject to 42 CFR Part 2 restrictions. Treatment of the medical complications of SUD is not the same as treatment of SUD and does not fall under 42 CFR Part 2. If an organization chooses this option, it is also recommended that treatment of SUDs is not a primary function of any staff employed by the organization. An organization can train and formally credential a practitioner to provide SUD services, but it’s recommended that no staff spends more than 49% of their time providing SUD diagnosis and treatment services and no staff is advertised publicly solely as a SUD provider.

The final aspect of 42 CFR Part 2 that is important to consider is that an organization or individual cannot accept or request medical records directly from an organization that is a covered entity under 42 CFR Part 2. This is because self-disclosures by a patient are not protected information and may be redisclosed without violating the regulations (DHHS Publication No. (SMA) 95-3018, page 15). You can accept SUD treatment records directly from the patient or family and it does not become covered information, but providers must thoroughly document the transaction. Since this has been in effect, there are no published reports of a federal penalty under 42 CFR Part 2 for releasing SUD treatment information to another provider.



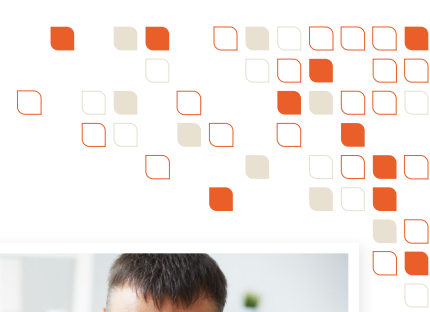
To support providers through the duration of the COVID-19 public health emergency, HHS issued guidance regarding the applicability and subsequent enforcement of federal laws and regulations pertaining to patient privacy and confidentiality. HHS announced that it will not penalize HIPAA covered health care providers or their business associates for the use and/or disclosure of protected health information when it is intended to assist in combating COVID-19 (HHS, 2020). Congress included these significant amendments to both HIPAA and 42 CFR Part 2 in the recently signed Coronavirus Aid, Relief and Economic Security (CARES) Act.

Additionally, the Substance Abuse and Mental Health Services Administrations (SAMHSA) announced 42 CFR Part 2 guidance that allows for disclosure of Part 2-protected information without patient consent during a bona fide emergency (SAMHSA, 2020). Information disclosed to medical personnel who are treating such a medical emergency may be re-disclosed for treatment purposes as needed. Part 2 requires programs to document certain information in their records after a disclosure is made pursuant to the medical emergency exception. Under the medical emergency exception, providers must make their own determinations whether a bona fide medical emergency exists for purposes of providing needed treatment to patients.

State and local laws and regulations may provide additional protections to patient records. Where a state law or regulation provides greater privacy protections or privacy rights, HIPAA covered entities and Part 2 programs must follow the state law or regulation. The guidance from HHS does not address the application and enforcement of state confidentiality laws or regulations.

IDENTIFYING SUSTAINABLE INTEGRATED CARE MODELS

Although several mechanisms exist today to promote sustainability of integrated services, each state has a different health care landscape that complicates how organizations can bill for services. The ability to bill for integrated care services is dependent on several factors including the state's Medicaid acceptance of billable services through the use of Current Procedural Terminology (CPT) codes which have been adopted and endorsed by Medicare, the state's licensure structure to provide services and the qualification and credentialing of eligible staff. State Medicaid programs are required to cover services furnished by Federally Qualified Health Centers (FQHCs) and rural health clinics (RHCs) and is a primary source of insurance for nearly half (49.2%) of patients (MACPAC, 2017). Several evidence-based approaches are sustainable in many states due to established reimbursement procedures.



Integration models such as the psychiatric Collaborative Care Model (CoCM), have been tested through numerous trials that demonstrated improved health outcomes and reduced health care costs. In a 2012 Cochrane meta-analysis that compared collaborative care with routine care, collaborative care was found to improve depression and anxiety, as well mental health related to quality of life (Archer et al., 2012). Implementation of this model ensures improved mental health, increased patient satisfaction and significant cost reduction in care. While many commercial payors have adopted payment for CoCM billing codes, only nine state Medicaid programs have adopted payment with three new states launching pilots for reimbursement in 2020 (American Psychiatric Association, 2019).



Screening, Brief Intervention and Referral to Treatment (SBIRT), an evidence-based practice used to identify, reduce and prevent problematic use of alcohol and other drugs, allows primary care providers to intervene earlier on the continuum and to identify at-risk substance use before more severe consequences occur. As a Medicare covered service and a required quality measure for FQHCs and RHCs, SBIRT offers primary care practices an effective tool with proven results in reducing health care costs, decreasing frequency and severity of alcohol and other drug use and increasing the percentage of patients who enter specialized substance use treatment (National Council for Mental Wellbeing, 2018). Although generally supported, FQHCs and RHCs still face challenges when implementing SBIRT as a billable service, mainly due to workforce capacity and the limit on the number of visits per day by an eligible provider, which may result in lost opportunities or reduced payment.

Virtual health communication services, often referred to as “telehealth,” also lend an opportunity to provide specialized behavioral health services for health centers. Telehealth services continue to move toward full adoption, but some barriers remain related to frequency, condition and reimbursement amount. In January 2019, the Centers for Medicare and Medicaid Services (CMS) issued a policy change that allows RHCs and FQHCs to receive payment for virtual communication services when at least five minutes of communication technology-based or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient who has had an RHC or FQHC billable visit within the previous year (CMS, 2019). In areas where provider shortages exist, including the 60% of U.S. counties that have no practicing psychiatrist, access to payment for virtual care could help reach the 60% of adults and 50% of children in America living with mental illness with no access to behavioral health services (Harrar, 2020; Kamal et al., 2017).

Unfortunately, the high demand for virtual care results in higher costs for care. Before the start of the current global pandemic, virtual psychiatric services cost an average of \$79 per visit across the U.S., while the newly accessible CMS billing codes for FQHCs and RHCs cover approximately 17% of the cost with a payment amount of \$13.69 per visit in 2019 (Ibarra, 2017; CMS, 2018). CMS has issued guidance that expands the coverage for providers to utilize telehealth services to continue care and minimize risk during the COVID-19 public health emergency. Under this expanded coverage, penalties will not be imposed on covered health care providers organizations that have not entered in HIPAA business associate agreements (BAAs) with video communication vendors. More detailed information about Medicare changes is available from the CMS document, [COVID-19 Frequently Asked Questions \(FAQs\) on Medicare Fee-for-Service \(FFS\) Billing](#). At the state level, Medicaid and the Children’s Health Insurance Program (CHIP) have also largely expanded the adoption of telehealth coverage for covered providers during the public health emergency. Increasingly, states are issuing guidance on changes that include:

- Allowing providers who do not have access to the technology required for video-enabled virtual session to provide telephonic sessions in a member’s home when there are concerns about COVID-19.
- Waiving face-to-face requirements to allow for telephonic or telehealth services in programs such as health homes or care coordination programs.



ESTABLISH PARTNERSHIPS WITH COMMUNITY MENTAL HEALTH AND ADDICTION TREATMENT PROVIDERS

Since most individuals visit a primary care provider at least once annually, health centers are an opportune setting to identify and treat mental illness and SUD (Blackwell et al., 2012). Researchers have found that patients presenting to health centers who screen positive for alcohol or opioid use disorder (OUD) have a high likelihood of having an alcohol use disorder (AUD) or OUD (Blackwell et al., 2014). The importance of screening in health centers is made clear in recent research, including the Health Resources and Services Administration's GO 2018 Uniform Data System (UDS) results, which demonstrated that more than 10 million (10,836,660) or 70.57% of individuals seen in health centers were screened for depression and just over 1 million (1,099,001) were screened for substance use with the SBIRT intervention (HRSA, 2018). Additionally, complexities of more severe conditions such as severe mental illness (SMI) and co-occurring SUD create intense burden on health centers making partnership with community mental health and addiction treatment providers essential to the ongoing treatment of these populations.

Community mental health and addiction treatment programs are affected by severe provider shortages in psychiatry and human services, as well as cost burdens that impact access to care. To help address the gap in treatment, Congress enacted the Certified Community Behavioral Health Clinic (CCBHC) demonstration program in 2014 to test a model to improve the quality of addiction and mental health care. This demonstration requires participating clinics to meet established criteria related to care coordination, crisis response and service delivery and to be evaluated by a common set of quality measures.

Combining the capacity of FQHCs and CCBHCs and the reimbursement mechanisms available to the two types of organizations can create a more comprehensive and flexible continuum of services for individuals with co-occurring medical and mental health conditions, including substance use. Additionally, the differing resources available to the two entities may impact the overall social landscape related to these comorbidities such as homelessness, food insecurity and low socio-economic status. Establishing formal partnerships between FQHCs and CCBHCs allows for a cross system team-based approach to care, in which the FQHC provider no longer faces the challenge of managing individuals whose mental health and substance use needs are beyond the scope of the primary care provider. In addition, due to the current Medicaid FQHC and CCBHC Prospective Payment System (PPS) structure, each entity is able to bill separately, which does not interrupt each respective organizations PPS encounter rate, which may greatly differ.

CCBHCs Provide

- **Same-day access to services.**
- **24/7/365 access to mobile crisis care.**
- **Standardized quality metrics.**
- **Coordinated care with hospitals, schools, jails, social service providers, to improve access to care and reduce use of emergency rooms (ER).**
- **Enhanced addiction services including medication-assisted treatment (MAT).**



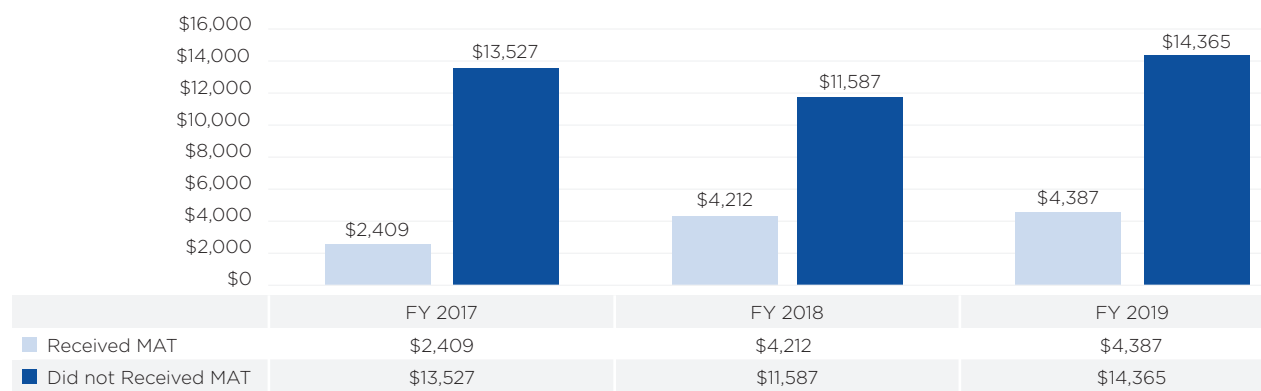
Case Highlight:



MISSOURI

Through the Medicaid Health Home State Plan initiative, the state of Missouri made significant strides to improve health, minimize disease complications and reduce Medicaid costs for individuals with chronic yet manageable conditions. Through this cross-agency state-wide collaborative, and over a six-year measurement period (2012-2017), chronic medical conditions were significantly improved, emergency room (ER) utilization dropped by 35%, high utilizing enrollees' inpatient stays decreased 85% and significant cost-savings were experienced across the cohort. Additionally, Missourians who enrolled in substance use treatment for OUD or AUD and received medication-assisted treatment (MAT) had significantly lower total Medicaid costs in the year following treatment than those that did not receive MAT.

Average Total Medicaid Cost Per OUD/AUD Consumer in the Fiscal Year After Service



POLICY CHANGE: WHAT CAN PCAS DO?

PCAs are uniquely positioned to provide technical assistance to health centers on addressing barriers to integrating behavioral health. Several recommendations for PCAs to support integrated behavioral health include:

- Partner with state mental health associations to support partnerships between health centers and behavioral health organizations and to address gaps between cost and payment for services such as virtual behavioral health and psychiatry. State and regional behavioral health associations and departments serve the interests of community behavioral health care provider organizations in their states or regions and play an important role in advancing integrated care. Value proposition experts estimate that virtual services can both expand access as well as reduce costs, primarily through diversion from costly alternative care such as ERs or hospitalization. A recent study by Philadelphia-based Jefferson Health found cost-savings ranging from \$309 to \$1,500 for each avoided emergency department visit (Nord et al., 2018).



- Review studies such as the IMPACT model study to convey the “high-value investment” integrated care models including CoCM, SBIRT and virtual health care (Unützer et al., 2002). Access resources such as [Implementing Care for Alcohol and Other Drug Use in Medical Settings: An Extension of SBIRT](#) and free technical assistance and training resources from both the HRSA-funded [Center of Excellence for Behavioral Health Technical Assistance](#) and the SAMHSA-funded [Center of Excellence for Integrated Health Solutions](#).
- Collaborate with community mental health and addiction treatment providers to identify individuals most in need of integrated care.
- Assist members in reviewing and updating patient confidentiality and health care information sharing policies and protocols to reflect the current guidelines and the ensure FQHCs take full advantage of opportunities to exchange PHI to improve care, enhance integration and ensure coordination.
- Work with health and human services to develop a standard set of performance measures necessary to evaluate outcomes and progress toward goals.
- Understand the value of CCBHCs and provide guidance to health centers on enhancing workflows and collaboration with CCBHCs. Advocate for the expansion of CCBHCs to every community across the country.
- Identify strategies to adopt alternative payment methodologies (APMs) to support integration. According to the Medicaid and FCHIP Payment and Access Commission (MACPAC), States can exercise some flexibility in the way they administer FQHC federal payment. APMs are increasingly popular in addressing gaps in reimbursement due to policy adoption. The National Association for Community Health Centers (NACHC) reported that as of 2017, more than 20 states have chosen to use an APM to reimburse health centers for services provided to Medicaid payments (NACHC, 2017). NACHC’s toolkit, the [FQHC Alternative Payment Methodology Toolkit](#), designed for state PCAs to use in developing FQHC APMs can be applied when designing the infrastructure of an integrated care model.



CONCLUSION

Barriers to integrating behavioral health in health centers vary in complexity based on individual state and federal policy. PCAs play an important role in supporting the advancement of integrated care by supporting health centers in areas such as removing barriers to information sharing, adopting evidence-based clinical practices and establishing meaningful partnerships with state mental health associations and mental health and addiction treatment providers. The Missouri case study demonstrates exemplary collaboration across associations and providers committed to achieving improved outcomes for persons with chronic conditions. Identifying best and scalable models of integrated care and partnering with behavioral health associations and providers to advance behavioral health integration will result in improved health outcomes.



REFERENCES

1. Health Resources Services Administration, Health Center Program. (2020, August). HRSA Health Center Program Fact Sheet. <https://bphc.hrsa.gov/sites/default/files/bphc/about/healthcenterfactsheet.pdf>
2. Department of Health and Human Services. (2019, August 22). HHS 42 CFR Part 2 Proposed Rule Fact Sheet. <https://www.hhs.gov/about/news/2019/08/22/hhs-42-cfr-part-2-proposed-rule-fact-sheet.html>
3. Department of Health and Human Services. (2020). 45 CFR Parts 160 and 164; Notification of Enforcement Discretion under HIPAA to Allow Uses and Disclosures of Protected Health Information by Business Associates for Public Health and Health Oversight Activities in Response to COVID-19. <https://www.hhs.gov/sites/default/files/notification-enforcement-discretion-hipaa.pdf>
4. Substance Abuse and Mental Health Services Administration. (2020). COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance. <https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf>
5. Medicaid and CHIP Payment and Access Commission. (2017, December). Medicaid Payment Policy for Federally Qualified Health Centers. <https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf>
6. Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., Coventry, P. (2012, October 17). Collaborative Care for People with Depression and Anxiety. Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD006525. DOI: 10.1002/14651858.CD006525.pub2. https://www.cochrane.org/CD006525/DEPRESSN_collaborative-care-for-people-with-depression-and-anxiety
7. American Psychiatric Association. (2019). Getting Paid in the Collaborative Care Model. <https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid>
8. National Council for Mental Wellbeing. (2018, February). Implementing Care for Alcohol and Other Drug Use In Medical Settings: An Extension of SBIRT. https://www.thenationalcouncil.org/wp-content/uploads/2018/03/021518_NCBH_ASPTReport-FINAL.pdf?dof=375ateTbd56
9. Centers for Medicare and Medicaid Services. (2019). Rural Health Clinic Center: New Virtual Communication Services. <https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center>
10. Harrar, S. (2020, March 31). Inside America's Psychiatric Shortage. PSYCOM. <https://www.psychom.net/inside-americas-psychiatrist-shortage/>
11. Kamal, R., Cox, C., Rousseau, D., et al. (2017). Costs and Outcomes of Mental Health and Substance Use Disorders in the US. The Kaiser Family Foundation. JAMA. 2017;318(5):415. doi:10.1001/jama.2017.8558. <https://jamanetwork.com/journals/jama/fullarticle/2646703>
12. Ibarra, A. (2017). Are Virtual Doctor Visits Really Cost-Effective? Not So Much, Study Says. Kaiser Health News. <https://khn.org/news/are-virtual-doctor-visits-really-cost-effective-not-so-much-study-says/>
13. Centers for Medicare and Medicaid Services. (2018, December). Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): Frequently Asked Questions. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf>
14. Blackwell, D.L., Lucas, J.W., & Clarke, T.C. (2012, February). Summary health statistics for U.S. adults: national health interview survey, 2012. Vital Health Stat 10. 2014;(260):1-161. <https://pubmed.ncbi.nlm.nih.gov/24819891/>
15. Health Resources and Services Administration (2018). National Health Center Data. <https://bphc.hrsa.gov/uds/datacenter.aspx>
16. Nord, G., Rising, K.L., Band, R.A., Carr, B.G., & Hollander, J.E. (2018, August 7). On-demand Synchronous Audio Video Telemedicine Visits Are Cost Effective. The American Journal of Emergency Medicine. DOI: <https://doi.org/10.1016/j.ajem.2018.08.017> [https://www.ajemjournal.com/article/S0735-6757\(18\)30653-3/fulltext](https://www.ajemjournal.com/article/S0735-6757(18)30653-3/fulltext)
17. Unützer, J., Katon, W., Callahan, C.M., et al. (2002, December). Collaborative Care Management of Late-Life Depression in the Primary Care Setting: A Randomized Controlled Trial JAMA. 2002;288(22):2836-2845. doi:10.1001/jama.288.22.2836. <https://pubmed.ncbi.nlm.nih.gov/12472325/>
18. National Council for Mental Wellbeing. (2018, February). Implementing Care for Alcohol and Other Drug Use in Medical Settings: An Extension of SBIRT. Substance Abuse and Mental Health Services Administration. https://www.thenationalcouncil.org/wp-content/uploads/2018/03/021518_NCBH_ASPTReport-FINAL.pdf?dof=375ateTbd56
19. The National Association of Community Health Centers. (2017, July). The FQHC Alternative Payment Methodology Toolkit: Fundamentals of Development a Capitated FQHC APM. http://www.nachc.org/wp-content/uploads/2017/08/NACHC_APMToolkit-1.pdf