

7-1-2009

# Maine Barriers to Integration Study: The view from Maine on the barriers to integrated care and recommendations for moving forward

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## Recommended Citation

Gale, J. A., & Lambert, D. (2009). Maine barriers to integration study: The view from Maine on the barriers to integrated care and recommendations for moving forward. Portland, ME: University of Southern Maine, Muskie School of Public Service.

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July 2009

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*Prepared for*

The Maine Health Access Foundation  
Contract no. 2007CON-0010



UNIVERSITY OF  
**SOUTHERN MAINE**  
Muskie School of  
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## Acknowledgements

We would like to thank the members of the Study Team and Advisory Committee for their assistance and guidance on this project. Their assistance was invaluable in undertaking this complex study. We also thank the following Muskie School staff for their assistance with this project: Karen Pearson, Kimberly Bird, and Melanie Race for their help in editing the final report; Lisa Marie Lindenschmidt and Tedda Yeo for their assistance in organizing the meetings of the Advisory Committee; and Jennifer Lenardson and Diane Friese for their assistance in organizing the models of care and in conducting stakeholder interviews. Finally, we would like to thank William Foster, Dean of the Muskie School and Wes Davidson, Executive Director of the Aroostook Mental Health Center, for serving as the Co-Chairs of the study's Advisory Committee.

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Most importantly, we are grateful for the generous support of the Maine Health Access Foundation, which provided funding for this study and providing encouragement and advice. Dr. Wendy Wolf, President and CEO of the Foundation, and Barbara Leonard, Vice President for Programs, provided insightful comments on report drafts and materials. Ms. Leonard, Project Officer for this study, helped us to keep a steady eye on the goals of this study and engage all relevant stakeholders.



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# **Executive Summary**

## *Maine Barriers to Integration Study*

### **Introduction**

The Maine Health Access Foundation (MeHAF) has undertaken a long-term initiative to promote patient and family-centered care through the integration of behavioral and physical health services in Maine. The foundation has funded several rounds of grants to primary care, behavioral health, and specialty providers to develop integrated services. To support this work, MeHAF commissioned this study to identify barriers to integration in Maine. In Phase One, we conducted an environmental scan, which included a literature review on the clinical, financial, administrative, and regulatory barriers to integration and a review of integration initiatives in Maine, other states, and Canada. In Phase Two, we interviewed representatives from Maine's business community, payers, purchasers, professional associations, state legislators, advocacy organizations, state government, and provider organizations. The interviews provided a context to understand the barriers to integration in Maine and develop recommendations to overcome them. Our Final Report presents key findings from the study, recommendations for addressing barriers, and next steps for moving forward. This study recognizes the need for integration of behavioral and physical health services in all settings. Although most discussions of integration focus on the development of behavioral health services in primary care settings, this study acknowledges the challenges faced by individuals with chronic and/or severe behavioral health problems in obtaining vital physical and primary health care.

### **Findings and Discussion**

This study examines lessons learned from the operation of integrated programs nationally and in Maine. While these lessons support continued investment in integration, they also highlight the need for policy, regulatory, and reimbursement changes to sustain integrated services and additional data on their impact on access, quality, and effectiveness. To further integration, we must evaluate the outcomes of integrated programs, expand the range of providers participating in integrated care; enact state-specific policy, regulatory, and reimbursement changes to ensure sustainability of these services; and assist providers in enhancing their levels of integration through technical assistance and education. If successful,

access to integrated care for Maine residents with physical and behavioral health needs will improve. Four themes emerged from our work: (1) integration enjoys strong support among policymakers, providers, and consumers; (2) sustainability of integrated services remains a significant unresolved problem; (3) there are no easy solutions for sustainability; and (4) data on the impact of integration on access, quality, and effectiveness of care in Maine is needed to support change.

Low payment rates and complex reimbursement policies are primary barriers to the long-term sustainability of integrated services. Although medication management and therapy services are generally covered by payers, reimbursement rules are complicated, applied inconsistently across settings, and often do not match service delivery in primary care settings. Payers typically do not pay for care coordination and management, important elements of integrated care. As payers may believe they are adequately supporting integration by paying for direct services, we must consider how we can use existing evidence to encourage needed change and what new evidence on the impact of integration on access, quality, and effectiveness is required?

Several other issues emerged from our study. Since no one model is right for all providers and settings, integration is best viewed as a continuum, ranging from collaboration without co-location (e.g., collaborative referral relationships) to fully integrated co-located systems of care. Providers should be encouraged to assess their readiness for integration and to implement initiatives appropriate to their state of readiness, delivery setting, and market. Providers should also be encouraged, as practical, to move further along the continuum of integration.

Additional barriers in Maine include complex and often conflicting licensure, credentialing, and scope of practice regulations and the policies of some payers that exclude certain qualified clinicians, such as marriage and family therapists, from reimbursement. Addressing these barriers involves adopting changes in these areas and reconciling conflicts to support integration at the provider level. Better dissemination of data on the impact of integration initiatives in Maine and the lessons learned from these initiatives would also be of value in addressing these barriers. Greater technical assistance and educational resources would assist providers of all disciplines in overcoming provider-level barriers as they develop their own initiatives. An explicit knowledge resource on integration would support efforts to overcome barriers by serving as a coordinated repository of knowledge of current and best practices on

integration and as an “honest broker” of knowledge in integration and policy discussions. This knowledge resource would link to, draw upon, and synthesize existing knowledge and disseminate it widely to providers, policymakers, and payers to further the development of integrated care in Maine.

## **Recommendations**

An overarching priority is to develop consensus for regulatory, policy, and reimbursement changes necessary to support and advance integration in Maine. As part of this process, we should seek to realign Maine’s health care system using the Institute of Medicine’s Six Aims (e.g., care is safe, effective, patient-centered, timely, efficient, and equitable) as a guide. At the same time, it is important that we “level the integration playing field” by eliminating service delivery silos; paying consistently for integrated services regardless of setting or discipline of providers; and improving on and expanding integration by using the knowledge and skill sets of providers rather than focusing on licensure categories. We must avoid an incremental approach that builds on a broken system and does not create fundamental change. Consistent with this priority, we offer the following recommendations to promote integration in Maine:

- Address system-level barriers in Maine by reconciling conflicting regulations, reimbursement strategies, and policies; collect and disseminate data on the impact of integration initiatives; develop technical assistance and educational resources for providers interested in integration; develop continuing education resources on integration for the health care workforce; and consider implications of expanded content on integration for degree programs for physicians, physician assistants, nurse practitioners, advanced practice nurses, psychologists, social workers, nurses, and other disciplines.
- Develop and disseminate a consensus framework identifying the core elements of integrated care with which to educate policymakers, payers, and purchasers.
- Strengthen the role of the State Health Plan by incorporating stronger language related to integration and including activities focused on advancing the state of integrated health care in subsequent revisions to the Plan; encourage MeHAF’s Integration Initiative Policy Committee to provide input into the next round of revisions to the Plan; and continue financial support for depression and mental health questions and include

questions on integrated care in the Maine CDC/DHHS Behavioral Risk Factor Surveillance System telephone questionnaire (funding is only available through 2010).

- Monitor the implementation of behavioral health in the medical home pilot project; encourage participants to achieve higher levels of integration; encourage consistent participation among all payers and purchasers in Maine; include specific questions on integration in the planned evaluation of the pilot project and disseminate the results to add to the evidence base; provide technical assistance and education to pilot sites developing integrated services; and understand the implications of language on approaches to integration (e.g., the term “medical home” conveys a medically based model of integration that does not encompass integrated initiatives in other settings).
- Ensure that issues related to integration are considered in discussions of payment reform.

### **Next Steps**

To begin the change process, the study team and Advisory Committee strongly recommend that the Environmental Scan, Final Report, and Executive Summary be widely disseminated to payers, purchasers, the Maine Health Management Coalition, Quality Counts, the legislature, the Department of Health and Human Services, the Advisory Council on Health Systems Development, MeHAF’s learning community, and other stakeholders. The dissemination process should engage stakeholders in discussions to: develop consensus on integration issues; achieve critical mass for initiating needed change; secure the commitment of stakeholders to participate in the change process; identify resources stakeholders will commit to the process; and identify recommendations for priority policy, regulatory, and reimbursement changes. We further recommend that MeHAF’s Integration Initiative Policy Committee serve as the vehicle to analyze the results of these discussions, identify consensus points across stakeholders, and establish priority action steps.

## Background

Promoting patient and family-centered care is a long-term funding priority for the Maine Health Access Foundation (MeHAF). From a patient's perspective, our health care system lacks organization, integration, and coordination and is difficult to navigate, particularly for uninsured or low-income people. Consequently, MeHAF has sought to promote work that enhances patient participation and decision-making in their health care and that promotes better coordination among the different parts of our health care system. MeHAF has been particularly interested in improving the integration of primary care and behavioral health services in Maine.

MeHAF convened a steering committee to help it understand the nature and scope of integration in Maine and to establish a vision and goals for developing integration throughout the State. This effort resulted in the document, *Integrated Health Care in Maine: Visions, Principles and Values, and Goals and Objectives*<sup>1</sup>, which is designed as a general guide for integration in Maine and for MeHAF's grantmaking efforts in this area. The visioning process was followed by grants to grassroots organizations to host discussion groups with Maine residents on what patient-centered care means to them. This effort was summarized in *Maine Integrated Health Initiative: Maine People Speak About Health Care Integration*.<sup>2</sup> MeHAF has funded several rounds of grants to providers to develop or enhance integration within their settings. MeHAF also funded this study to identify barriers to integration in Maine and propose and prioritize potential solutions to these barriers.

### Maine Barriers to Integration Study

During the first phase of the study, we completed a broad environmental scan, which included an extensive literature review of the clinical, administrative, and financial barriers to integration, an analysis of different approaches to and models of integration across diverse types of providers, and a review of integration initiatives in Maine, other states, and Canada. To provide a local context for the environmental scan, we interviewed representatives of stakeholder organizations funded by MeHAF under the first round of integration grants. We also conducted a focus group with administrators and board members of some of Maine's Federally Qualified Health Centers, assembled by Kevin Lewis, Executive Director of the Maine Primary Care

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<sup>1</sup> Report available on the MeHAF web site: [http://www.mehaf.org/pictures/integration\\_vision.pdf](http://www.mehaf.org/pictures/integration_vision.pdf)

<sup>2</sup> Report available on the MeHAF web site: <http://www.mehaf.org/pictures/grassroots-feedback-2007.pdf>

Association. The results of these efforts inform the recommendations made at the end of this paper and are summarized in more detail in the *Maine Barriers to Integration Study: Environmental Scan* which is available on the Maine Health Access Foundation web site (<http://www.mehaf.org/>).

In phase two, we conducted interviews with a broad range of stakeholders in state government, the business community, third party payers, purchasers, professional and trade associations, members of the state legislature, advocacy organizations, and provider organizations. The goal of these interviews was to identify specific barriers to integration and solicit recommendations for incentives and solutions to overcoming these barriers. The results are summarized in this report as are our findings and recommendations resulting from the overall scope of work for this study.

The stakeholders we interviewed (including grantees from the first (2007) round of MeHAF's Integration Initiative funding) tended to have differing perspectives on integration, which made analyzing and reporting findings from the interviews challenging. Differences in perspective tended to reflect the manner in which the respondent is interested in integrating behavioral and physical health services, with stakeholders generally split into two groups. One group includes those who are interested in integration within an existing provider setting (e.g., co-located models). Usually, these persons are primary care providers who are interested in integrating behavioral health services into their practice settings. Increasingly, this group also includes specialty behavioral health providers interested in integrating physical health services into behavioral health settings. This interest is spurred by the evidence that patients with chronic behavioral health conditions often receive less than adequate general health care. The second group included stakeholders interested in integration across provider settings (e.g., collaboration without co-location or collaborative referral relationships). These include providers working with patients with complex needs whose service needs cannot be met within one setting; providers without the financial, physical, or staffing resources to expand their service capacity to include integrated services; and third party payers interested in ensuring that enrollees receive a full range of high-quality coordinated care based on their individual needs.

While these two groups also have common interests, it is useful to keep in mind the extent to which their interests may differ when analyzing the interviews. We also examine the results of the interviews within the framework of the barriers to integration identified in our

Environmental Scan. This helps us understand the extent to which these barriers affect providers in Maine and to identify specific actionable solutions to overcome these barriers.

### **Ongoing National and Maine Activities Related to Integration**

A challenge to studying the integration of physical and behavioral health services is that integration is a rapidly developing field with substantial ongoing activity at both the national level and in Maine. As we were completing our final work on this project in the fall of 2008, the Agency for Healthcare Research and Quality (AHRQ) released the results of a comprehensive systematic review of the evidence for integrating mental health services into primary care settings and primary care services into specialty behavioral health outpatient settings.<sup>3</sup> The AHRQ report (released after the completion of our Environmental Scan) supports our findings from both the Environmental Scan and this report. The AHRQ report found that, in general, integrated care achieved positive outcomes. It further noted that it is not possible to distinguish the positive effects of increased attention to mental health problems in general from the effects of specific integrated care models and strategies. The report confirmed our understanding of the barriers to integration nationally and in Maine and supported our findings related to sustainability, the need for greater evidence supporting the efficacy and cost savings of integrated services, the limited use of health information technology in integrated settings, and the higher level of interest in integrating behavioral health into primary care settings. The report concluded that there is a reasonably strong body of evidence to encourage integrated care, at least for depression. There is not enough evidence, however, to suggest a clearly superior integrated model. This report provides support for the continued endorsement of alternative approaches to integration in Maine and highlights the need to collect evidence to support these alternative approaches.

The concept of the patient-centered medical home (PCMH) and its potential role in supporting the integration of services is another policy issue that has gained traction and support during the course of our study. As a result, we incorporated a discussion of the PCMH in our Environmental Scan and modified our interview protocols to explore the role of the PCMH in enhancing integration. As described in the Environmental Scan, interest in and policy support for

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<sup>3</sup> Butler, M., Kane, R., McAlpine, D., Kathol, R., Fu, S., Hagedorn, H., & Wilt, T. (October 2008) *Evidence Report/Technology Assessment Number 173: Integration of Mental Health/Substance Abuse and Primary Care*. Rockville, MD: Agency for Healthcare Research and Quality.

the PCMH has grown both in Maine and nationally. More recently, third party payers, organizations such as Quality Counts, the Maine Quality Forum, and the Maine Health Management Coalition, and various employers have supported the development of a PCMH model in Maine. As a result of these discussions, Quality Counts, in partnership with the Maine Quality Forum and the Maine Health Management Coalition, is leading an effort to develop, implement, and evaluate a Maine multi-payer pilot of the PCMH model as a means for transforming health care and improving the integration of care across providers and settings of care. Funding from the Maine Health Access Foundation is helping to ensure the integration of behavioral and physical health needs in the PCMH model and support the inclusion of patients and families in shaping and implementing this new model, and. Funding from MeHAF for this effort began on January 1, 2009 and will continue for a three-year period.

### **Barriers to Integration Identified in the Environmental Scan**

In our Environmental Scan, we categorized the barriers to integration in terms of the level at which they occur:

- National- and system-level barriers
- Regulatory barriers
- Reimbursement barriers
- Practice and cultural barriers
- Patient-level barriers

A summary of these barriers follows. For a more detailed discussion of these barriers, please see our Environmental Scan report.

#### ***National and System-Level Barriers***

National- and system-level barriers include: the chronic limited supply of specialty behavioral health providers, maldistribution of behavioral health providers relative to need and geographic areas, separation of funding streams for general and behavioral health care services, and limited third party coverage of behavioral health conditions. As these barriers are rooted in national policies and systems they are not easily, or quickly, addressed by state and community policymakers and advocates.

### ***Regulatory Barriers***

The primary regulatory barriers to integration include state-level licensure laws for behavioral health clinicians, scope of practice regulations that specify the clinical services that different licensed clinicians can perform, related supervisory requirements for new professionals, and facility licensure issues governing the provision of services by behavioral health agencies. Facility licensure regulations hinder integration by establishing administrative and reporting requirements with which it is difficult for small organizations to comply, restricting Medicaid reimbursement to programs with particular types of licenses, and limiting the flexibility of agencies to work across programs/funding streams to integrate services. In addition, the separation of reimbursement policies from licensure and scope of practice laws serves as a “de facto” form of regulation by restricting reimbursement to behavioral health clinicians based on license category rather than scopes of practice.

### ***Reimbursement Barriers***

Limitations and confusion over what providers and which services may be reimbursed within different settings present significant barriers to integration. The national literature focuses on the integration of behavioral health services into primary care settings with comparatively little discussion of the integration of primary care into behavioral health settings. Accordingly, the following discussion concentrates on reimbursement barriers in primary care settings.

Integrated behavioral health programs typically include both integrative activities and direct care services. Integrative services include patient screening and engagement, consultation with primary care staff, responding to questions from patients and staff, and maintaining “walk-in” slots to accept same-day referrals. While important components of integrated programs, these activities are typically not reimbursed by third party payers. Direct care services are the one-on-one care delivered by providers to treat behavioral health conditions and are generally reimbursable by third party payers.

Coverage of integrated behavioral health services and related payment policies vary significantly across third party payers as well as Medicare, Medicaid, and commercial managed behavioral health plans, which adds administrative complexity and costs for integrated programs. A related barrier involves limitations on reimbursement for two services provided on the same day to a single patient by a provider or practice. Although Medicare and the Centers for

Medicare and Medicaid Services have resolved this problem for certain types of providers, many commercial insurers and fee-for-service Medicaid programs have not.

Limited and inconsistent reimbursement for telemental health services is another barrier to integration as these reimbursement policies restrict the use of this technology to provide needed services. Reimbursement issues for telemental health services include the inconsistent coverage of telemental health services across payers; reimbursement policies that require the use of impractical service delivery models, such as requiring both the distance consulting provider and the local-consultee provider to be present during telemental health sessions in order to invoice for them; policies that require consulting and referring providers to share the fees for a given session resulting; reimbursement policies for telemental health consults that result in rates of reimbursement for tele-consultations that are less than traditional face-to-face consultations; and the higher co-payment rates enacted by Medicare and some commercial payers for behavioral health services.<sup>4,5</sup> Telemental health services can support integration by providing both direct care as well as consultative and supervisory support to providers located in areas with a shortage of mental health professionals. Reimbursement for these services tends to be limited, varies among payers, and does not pay for many infrastructure and technology costs.<sup>6</sup>

### *Coding Issues*

Physical and behavioral health clinicians use different diagnostic and procedural coding systems to bill for services. For diagnostic coding, physical health clinicians use the *International Classification of Diseases, 9th Revision, Clinical Modification* while behavioral health clinicians use the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. While the correspondence between the two has improved over time, the two systems reflect the different diagnostic and practice styles of physical health and behavioral health clinicians. To identify services rendered, both disciplines bill for behavioral health services using the *Current Procedural Terminology* (CPT) codes maintained by the American Medical Association.

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<sup>4</sup> Novins, D, Weaver, J, and Shore, J. (2008). Telemental Health Talking Points. *Telemental Health Guide*. Available: [www.tmhguide.org](http://www.tmhguide.org).

<sup>5</sup> Health Resources and Services Administration. (2000, May). *Reimbursement/Legislative Update*. <http://www.hrsa.gov/telehealth/pubs/legis2000.htm>.

<sup>6</sup> The 124<sup>th</sup> Maine Legislature has addressed the issue of coverage of telemedicine services across payers by passing LD 1073, An Act to Provide for Insurance Coverage of Telemedicine Services. The bill was signed into law on June 11, 2009 by Governor Baldacci. The law, which goes into effect on September 12, 2009, requires carriers offering health plans in the state to provide coverage for health care services provided through telemedicine in a manner consistent with coverage for the same service provided through in-person consultation.

Physical health clinicians typically use codes from the evaluation and management or psychiatric services series while behavioral health clinicians generally use the psychiatric series codes. Behavioral health clinicians may also use the *Health and Behavioral Assessment (HBA)* codes to bill for services provided to patients with cognitive, emotional, or behavioral issues that affect the treatment and management of physical health problems. Selecting the proper code is a complex process complicated by the coding policies implemented by third party payers. Use of the wrong codes may result in lower reimbursement, denial of claims, and exposure to audits and recovery actions from third party payers.

### *Specific Medicare and Medicaid Reimbursement Issues*

Medicare imposes the highest co-payment on outpatient mental health care of any major payer (effectively 50 percent), establishes an annual cap and lifetime limits on allowable visits, and limits reimbursement to clinical social workers and doctoral-level psychologists. Medicare managed care and Part D prescription drug plans may have different benefits that increase the administrative burden on providers. Under Part D, providers are responsible for knowing each plan's formulary and manage pressure from plans to shift patients to less expensive medications. In the face of serious budgetary pressures, state Medicaid programs have reduced coverage for behavioral health services, implemented restrictions on same-day services, limited reimbursement for care and case management services, established co-payments, and implemented managed behavioral health programs to control utilization and costs. Historically, state Medicaid programs maintain the lowest reimbursement rates among third party payers.

### *Practice and Cultural Barriers*

Physical and behavioral health clinicians have different practice and diagnostic styles, which creates an ongoing challenge to integrating care. They also have different work and productivity patterns. Primary care providers typically see four to five patients per hour and will schedule walk-in appointments for patients with emergent issues. Behavioral health providers typically see patients in 20–30 minute or 45–50 minute appointments and are less likely to alter their schedules for walk-in patients. It is common for primary care providers to be interrupted for calls from other physicians or questions while with patients; behavioral health providers are typically less comfortable with such interruptions. Documentation requirements are also different. In specialty behavioral health settings, documentation is generally more extensive in

response to public funding requirements and the greater range of services provided in these settings. The documentation in primary care settings tends towards brief, immediate, problem-focused records.

#### *Lack of Information Technology*

With the growing emphasis on the integration of care within and across provider organizations, an increasingly important barrier is the limited implementation of information technology within and across provider organizations. Effective integration depends on the ability of providers to share information and communicate effectively. Sharing information is very important when patients are treated by multiple providers and very difficult to do when based on paper records or when information systems cannot “talk” to one another. Properly implemented, information technology applications such as electronic medical records can facilitate communication among providers to support the delivery of integrated care.

#### *Patient-Level Barriers*

At the patient level, barriers to integration include limited access to services, payment and reimbursement issues, staffing shortages, and negative public attitudes towards persons receiving behavioral health services (stigma). As part of its Maine Integrated Health Initiative, MeHAF, with the assistance of John Snow, Inc. surveyed Maine people about their perspectives on health care integration.<sup>7</sup> Many consumers reported that they prefer to receive behavioral health services in a primary care setting where they find services to be less “stigmatizing” than in a specialty mental health setting. Consumers have low expectations for the integration of care and they are unsure of the patient’s role in maintaining and coordinating health care.

### **The View from Maine: The Stakeholder Interview Process<sup>8</sup>**

In our Environmental Scan, we describe the barriers to integration of physical and behavioral health services as documented in the relevant literature, published studies, presentations, and reports. We were able to develop a preliminary understanding of how these barriers affect efforts to promote integration in Maine based on a focus group of administrators

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<sup>7</sup> Maine Health Access Foundation. *Maine Integrated Health Initiative*. 2007. Report available on the MeHAF web site: <http://www.mehaf.org/pictures/grassroots-feedback-2007.pdf>

<sup>8</sup> The barriers and solutions identified by individual stakeholders or groups of stakeholders are the opinions of the individual or individuals. They may not apply to all stakeholders within or across categories.

and board members from Federally Qualified Health Centers in Maine and interviews with the grantees from MeHAF's first round of Integration Initiative Grants. To develop a more thorough understanding of the barriers to integration in Maine, we conducted interviews with key stakeholders in professional associations, advocacy organizations, the legislature, the business community, third party payers, purchasers, state government, and provider organizations (Table 1).

**Table 1. Categories of Stakeholder Interviews**

- **Professional associations and advocacy organizations**
- **Legislators and other state officials**
- **Third party payers, purchasers, and managed care organizations**
- **Maine Department of Health and Human Services**
- **Practices and provider agencies including MeHAF Integration Initiative Grantees**

### **Methodology and Limitations**

To develop a list of potential interviewees, we identified the key groups of stakeholders that would be relevant to our study as described above. Within each of these groups, we identified, with input from our Advisory Committee, key individuals and organizations that should be interviewed as part of this process and scheduled calls with as many as possible. Using semi-structured protocols, the team conducted telephone interviews with these individuals.

The results of this study should be understood within the context of two limitations. First, although the study team sought to interview as wide a group of respondents as allowed by time and budget limitations, we did not interview all potential stakeholders. There may also be a subset of barriers to integration that we did not identify. We sought to minimize this possibility by interviewing a wide range of stakeholders and by triangulating our findings from the interviews with the barriers identified in our Environmental Scan. The second limitation is that the barriers and solutions identified by individual respondents may or may not be viewed as barriers or solutions by other stakeholders. We have dealt with this limitation by identifying and reporting the results of our interviews by stakeholder groups. We have further identified those

descriptions of barriers and/or solutions that may be unique to one or two respondents rather than those shared by a larger percentage of the group.

Finally, it should be noted that the “Review of Integration Barriers and Solutions” section reflects the responses and opinions of the stakeholders without interpretation and verification. The “Findings and Discussion” and “Conclusions and Recommendations” sections include the study team’s interpretation of the meaning and implications of the compiled responses.

## **Overarching Themes**

First and foremost, **there is a great deal of interest in the integration of behavioral and physical health services.** The concept of integration was endorsed by all with whom we spoke. A challenge is that there is little consensus on what is meant by the term. The use of the term integration varied both across and within categories of stakeholders. For purposes of this paper, we have identified two broad categories of integration activities (co-located services and collaborative services without co-location) as described by interview respondents. It should be noted that these two categories of integration activities are not mutually exclusive. Organizations may develop co-located services within specific settings while simultaneously pursuing collaborative (without co-location) strategies to integrate care across settings and providers. These two approaches to integration are described in greater detail in the next section.

Although there is a great deal of interest in the integration of services, **no clear and easy solutions emerged from our interviews.** Some of the proposed solutions, such as those related to workforce supply or Medicare reimbursement changes, are national in scope and require a level of system transformation that is greater in scope than Maine policymakers can address. Others, such as suggested increases in MaineCare reimbursement rates, require a commitment of scarce resources that may not be practical in the current economic environment.<sup>9</sup> Still others, such as educational programs for Federally Qualified Health Centers and/or other types of primary care providers, involve interventions that target to specific provider types and settings and may exclude providers such as licensed mental health agencies.

It is unclear how much progress we have made in securing the commitment of third party payers and purchasers to reimburse for both the direct care and integrative components of

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<sup>9</sup> MaineCare is Maine’s Medicaid program and is administered by the Office of MaineCare Services within the Maine Department of Health and Human Services.

integrated services. Despite a long history of academic and foundation interest in the delivery of integrated primary and behavioral health care, **sustainability remains an issue**. Third party payers still do not consistently reimburse providers for the integrative components of their programs such as care management and coordination, telehealth, hallway consultations, and the warm hand-off of patients from physical health to behavioral health providers. As a result, current proposals for funding integration in Maine and nationally look very similar to proposals from past years in their requests for support for care management staff and sharing of information and records. While we now know how to develop and implement the component parts of an integrated service, funding is typically not available to support these activities. Although there is evidence of the efficacy of some components of integrated care (e.g., care management and the informal role of psychiatrists as consultants to primary care providers and care managers), third party payers do not typically reimburse providers for all components of integrated behavioral and physical health services. As a policy ideal, there seems to be little disagreement with the concept of integration. On a practical level, many third party payers are not willing to support the delivery of integrated services through adequate reimbursement across provider settings.

This last point is vital to the continued improvement in the delivery of integrated services. **We must critically evaluate the delivery of integrated services in terms of patient outcomes, the effect on access to services, the cost-effective delivery of services, and the quality of care delivered by integrated programs**. In our interviews, third party payers made it clear that they have little appetite for new spending. In the absence of hard evidence documenting improved health outcomes and cost efficiencies, third party payers are unlikely to make necessary reimbursement changes. In this same vein is the reality that in our resource constrained environment, changes in delivery systems, reimbursement rates, and funding levels are likely to create short-term winners and losers as resources are redistributed across providers within the health care delivery system.

New concepts are altering the integration discussion. In particular, the emerging interest in the patient-centered medical home may complicate efforts to advance integration in Maine. A number of respondents mentioned the medical home concept and suggested that the Maine multi-payer pilot of the patient-centered medical home led by Quality Counts has the *potential* to

advance the integration of behavioral and physical health services in Maine.<sup>10</sup> Despite this potential, the integration of the two services is not explicit in the way the medical home is typically defined by its proponents. For the medical home model to advance integration, it will be necessary to require specifically that an entity include behavioral health services to be designated as a medical home, as is the case in Maine's pilot.

## **Defining Integrated Behavioral and Physical Health Services**

### ***Co-Located Models of Integration***

Co-located models of integration involve the integration of behavioral and physical health services *within* provider settings. This is the traditional model that many described when asked about the integration of behavioral health and physical health services and typically involves the placement of a behavioral health clinician in a primary care or physical health practice. It may also refer to the placement of a primary care or physical health clinician in a behavioral health provider setting. These co-located models of integration are very much facility- or site-based. The co-located model may not be appropriate for all provider settings as it involves a level of resource capacity (e.g., staffing, financial, space, and administrative) that may not be available to small private providers. This model is more commonly adopted by Federally Qualified Health Centers and larger group practices. Barriers to integration within this type of model include internal operational, financial, and workforce issues.

### ***Collaborative Models of Integration Without Co-Location***

Collaborative models of integration without co-location involve the integration of behavioral and physical health services *across* provider settings. This model of integration receives greater attention from third party payers and purchasers who are primarily concerned with their patients' ability to receive coordinated care appropriate to their needs in a timely

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<sup>10</sup> The multi-payer pilot of the PCMH in Maine has been developed with the input and participation of a wide range of stakeholders including commercial health insurance companies, the MaineCare program, employers, providers, policymakers, and organizations such as Quality Counts, the Maine Quality Forum and the Maine Health Management Coalition. With three years of funding from the Maine Health Access Foundation, the goal of the pilot project is to develop, implement, and evaluate a Maine multi-payer PCMH model as a means for transforming health care and improving integration of care across both providers and settings of care. The eventual goal of the pilot project, after the grant funding expires, is to have third party payers and purchasers provide ongoing funding and reimbursement for PCMHs. The extent to which they will be willing to do so will depend on the success of the pilot project in controlling costs, improving access to needed services, and enhancing quality of care.

fashion. There is less focus on the structural features of the delivery system. There is also a growing recognition that co-located providers are unable to provide all services needed by patients and that coordination across provider settings may enhance the level and quality of services available. Collaborative models of integration provide an option to integrate services in settings and/or markets that may not support the development co-located services due to resource availability and/or provider supply issues. Major barriers to collaborative (but not co-located) models of integration involve communication issues related to the sharing of confidential patient information, lack of integrated information systems, care coordination, and managing referral relationships.

None of our respondents explicitly framed the choice between co-location and collaboration without co-location in terms of patient perspective and need. However, a number of primary care providers are pursuing co-located strategies because they have patients within their practices would benefit from behavioral health services and they recognize that the provision of on-site behavioral health services offers a level of access, convenience, privacy, and care coordination that many patients find attractive. Providers have noted that the availability of on-site services improves the likelihood that an individual will actually follow up on the referral for behavioral health care. The trade-off is that the individual may have comparatively less choice of providers in a co-located system of care. Collaborative models without co-location may offer the opportunity for greater choice but at the cost of some convenience, coordination, and higher patient “no-show” rates. As the discussion of integration evolves, it is important to consider patient and family needs and perspectives, convenience, privacy, and choice in deciding how to structure integrated services.

## **Review of Integration Barriers and Solutions by Category of Respondents**

We conducted interviews with a wide range of representatives from professional associations, advocacy organizations, state legislators and officials, representatives from third party payer, purchaser, and managed care organizations, officials from the Maine Department of Health and Human Services (DHHS), representatives from provider organizations, and MeHAF Integration Initiative grantees. We discuss the results of our interviews for each stakeholder group.

## **Professional Associations and Advocacy Organizations**

We developed a comprehensive list of professional associations and advocacy organizations with a potential interest in the integration of behavioral and physical health services and then focused on those organizations most likely to be involved with or interested in integration. We attempted to interview representatives from as many of the group as possible within the constraints of time. We completed interviews with representatives from ten associations and organizations (Table 2).

**Table 2. Professional Association and Advocacy Organization Interviews**

- **Downeast Association of Physician Assistants**
- **Maine Association of Mental Health Services**
- **Maine Association of Psychiatric Physicians**
- **Maine Association of Substance Abuse Programs**
- **Maine Center for Public Health**
- **Maine Hospital Association**
- **Maine Medical Association**
- **Maine Osteopathic Association**
- **Maine Primary Care Association**
- **Maine Psychological Association**
- **National Alliance on Mental Illness**
- **National Association of Social Workers, Maine Chapter**

### ***Barriers Identified by Professional Association and Advocacy Organization Respondents***

#### ***State Budget Barriers***

There was substantial agreement on a number of barriers to integration. Respondents are concerned about the status of the state budget, referred to by many as a “budget crisis”, and whether or not the resources are available to support efforts to integrate services. Respondents are worried that the state’s budget crunch would limit the willingness of state officials to consider reimbursement rate changes and other financial supports necessary to encourage providers to develop integrated services.

### *Reimbursement Barriers*

There was a very consistent belief among respondents that current MaineCare reimbursement rates (as well as the reimbursement rates of some commercial insurers) are inadequate for both behavioral health and primary care services. One respondent suggested that the lengthy delays in the payment of claims from MaineCare and some private insurers were barriers to integration. Besides the cash flow problems created by delays in payment, this respondent estimated that 10 to 15% of claims for services are not paid at all.<sup>11</sup> The cash flow problems created by low reimbursement rates, delayed payments, and denied claims make it difficult for providers to develop and sustain integrated services.

Medicare payment policies for behavioral health services were also identified as a barrier to integration. The payment policies that were identified as barriers to integration included: the high co-payment rate on behavioral health services which is essentially 50%, limitations on the types of providers that are able to receive direct Medicare reimbursement (e.g., Medicare limits direct reimbursement to doctoral-level psychologists and clinical social workers), and strict lifetime payment limits on mental health services.

Across payers, reimbursement for telemedicine services is limited and often does not reflect the costs for the provision of direct and consultative services using this technology. Some payers are willing to pay for the consulting psychiatrist's time but not the time of the participating primary care provider on the other side of the screen. Respondents noted that primary care providers could see two to three patients during the time they were participating in a telemedicine-based psychiatric consultation. This discourages the use of telemedicine by primary care providers.

Respondents also identified differential payment rates and policies across settings as barriers to integration. Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes<sup>12</sup> are eligible to receive cost-based reimbursement under Medicare and cost-based prospective payments under MaineCare. FQHCs also receive Public Health Service Act Section 330 grant funds to support the provision of care to uninsured, low-income individuals. They are also eligible to apply for expansion grants from the Bureau of Primary Health Care to support the

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<sup>11</sup> This estimate of the number of unpaid claims was provided by one respondent. The authors of the study did not verify the accuracy of this statement.

<sup>12</sup> FQHC Look-Alikes are organizations that meet all FQHC requirements and receive the same reimbursement as FQHCs under Medicare and Medicaid. They do not receive Section 330 grant funding.

development of behavioral health services. Private providers are reimbursed according to more limited fee schedules under Medicare, MaineCare, and private insurers and typically have more limited access to technical assistance support to develop integrated services.

One respondent expressed the opinion that subjecting integrated services to utilization management by APS Healthcare (the Administrative Services Organization under contract to the MaineCare program) might serve as a barrier to integration as the additional administrative burden might discourage providers from developing integrated services.

#### *Workforce Barriers*

Workforce shortages were another commonly identified barrier. This was true for specialty mental health providers (psychiatrists, social workers, psychologists, and psychiatric nurse practitioners) and primary care providers (physicians, nurse practitioners, and physician assistants). Respondents stated that there are not enough providers to meet existing needs. In addition, the available pool of providers is not well distributed to address needs across the state. Rural areas have greater shortages than urban areas. Recruitment is difficult. One association representative noted that there are over 100 vacancies for primary care providers among his organization's members. It was noted that social workers, in particular, were being squeezed in the current economic climate as agencies have increased the size of their caseloads and requirements for billable hours. One respondent noted the detrimental impact on employees when agencies take over the caseloads of struggling smaller agencies. Frequently the employees of the smaller agencies are retained but converted to per diem workers without benefits.

#### *Regulatory and Licensure Barriers*

Complicated agency licensure regulations were identified as a barrier to integration, particularly for agencies that provide mental health and substance abuse services. The administrative burden and related costs can be high for smaller agencies.

#### *Provider Capacity Barriers*

A related issue is the capacity within provider organizations to develop integrated activities. Respondents noted that primary care practices are "pretty stretched" and already overburdened. The economics of primary care practices include limited reimbursement, a growing cost structure, and the need to maintain high patient volumes. Many primary care

providers must see four or more patients per hour to remain financially viable. Practices were described as “watching every dime”. Many primary care providers are seeking to become employees of their local hospitals. Given these realities, respondents questioned whether or not many primary care practices had the resources and capacity to develop integrated services.

Another barrier is the limited referral sources for specialty behavioral health services in many areas of the state. This creates a difficult challenge for primary care providers who may not have the clinical knowledge to treat a patient’s behavioral health condition effectively when it becomes more acute. The primary care provider may be placed in the difficult position of trying to continue to manage that patient’s care until appropriate care can be arranged. Fear of being unable to access needed specialty care may discourage providers from developing behavioral health services in their practices.

An additional barrier to developing integrated services identified by respondents is the lack of provider expertise and training in the delivery of integrated care. Many primary care physicians feel they lack the knowledge and time to participate in integrated services. Many behavioral health clinicians may not be comfortable (and have not been trained for) practicing in primary care settings. The administrative staff in primary care settings may have difficulty with the billing and coding requirements necessary to be paid for behavioral health services and with some of the administrative and scheduling requirements.

#### *Stigma Barriers*

Finally, the stigma surrounding behavioral health was mentioned by a limited number of respondents as a barrier to integration. Stigma often discourages patients from seeking needed services. It may also discourage providers from developing the service as either they, or their office staff, may feel uncomfortable working with behavioral health patients.

### ***Recommendations to Enhance Integration by Professional Association and Advocacy***

#### ***Organization Respondents***

##### *Reimbursement Recommendations*

All respondents recommended that attention be paid to the reimbursement rates for primary care and behavioral health services, which are inadequate to support the development of integrated services in Maine. MaineCare rates were specifically identified as a problem and it

was widely reported that primary care physicians in areas with high rates of MaineCare coverage “could not live” on MaineCare reimbursement. Suggestions included improving the reimbursement rates for evaluation and management codes typically used by primary care providers and improving coverage for and reimbursement of telemedicine service. Respondents also suggested that reimbursement rates be rationalized across practice settings and that Medicare expand coverage to include additional types of behavioral health providers and reduce the high co-payments currently levied on mental health services. Additionally, respondents recommended that MaineCare be encouraged to consistently pay for the use of health and behavioral assessment codes across different settings and provider types.

#### *Workforce Recommendations*

Respondents also recommended the development of recruitment and retention programs to assist providers in recruiting primary care, mental health, and substance abuse clinicians. These programs are particularly needed in rural and isolated communities. Related to this issue were recommendations that loan forgiveness programs be developed and enhanced to assist primary care providers and mental health clinicians with the burden of high student debt. Both areas were described as underpaid specialties and it was thought that low reimbursement rates and school debt were driving potential primary care providers and behavioral health clinicians into more lucrative specialties.

#### *Regulatory and Licensure Recommendations*

Several individuals recommended that the State simplify licensure regulations to reduce administrative burdens for providers and limit the need for dual licensures for agencies providing both mental health and substance abuse services,

#### *Provider Capacity Recommendations*

Recommendations related to training were also emphasized by respondents in this group. They believe that primary care providers and behavioral health clinicians need greater familiarity with the benefits of developing and implementing integrated services as well as training in how to implement integrated programs and how to practice in these settings. Respondents suggested that training for primary care providers include a comprehensive focus on mental health and substance abuse services, including the use of mental health and substance abuse screening tools.

A related recommendation was training to help primary care providers develop referral sources for these patients once they are identified. Respondents felt that professional associations could play a role in educating their members about the benefits of education and should participate in broad-based educational efforts.

As an additional solution to provider capacity issues, several respondents suggest that FQHCs and community mental health centers (CMHCs) reintegrate appropriate patients being treated in CMHCs back into primary care settings to reduce the demand on scarce specialty mental health resources. Others suggested that the primary care model could be established in the 12 CMHCs in Maine so that individuals treated in these settings could have their primary care needs met.

#### *Other Recommendations*

Respondents described the need for studies to collect data to support the development of integrated services. Respondents felt that it was important to take a longitudinal view of the value of delivering behavioral health services in primary care settings. Suggested studies included the collection of Maine-specific data to share with legislators, policymakers, and the public on the direct medical costs and indirect family costs of lifetime mental illness. The goal would be to provide evidence of the benefits of providing services to those that are chronically mentally ill by comparing the cost of treatment to the negative impact of failing to treat these individuals on individuals and communities. Respondents also felt that MeHAF should continue to study and evaluate integration efforts in Maine and disseminate findings to providers in Maine as well as nationally. A related suggestion was to develop a study to detail the behavioral health needs of different regions in Maine and to provide evidence of the need for integrated services. One respondent suggested that it might be useful to bring the stakeholders together to examine how behavioral health services in Maine are being delivered and to develop a structure to better promote integration. Another suggestion was to collect data and stories on the cost effectiveness of integrated services, any savings to the system that might result from the expansion of these services, and improvements in quality from the delivery of integrated services.

Respondents acknowledged that discussions of integration do not always address the same issues. Integration means different things for patients with limited or moderate behavioral health needs who are served in primary care settings compared to individuals with serious mental

illness, who generally receive services in mental health agencies and need primary care or other complex physical health services. There is a need, according to these respondents, for the field to be very clear about what it means by integration and how it is to be implemented.

Respondents also noted that leadership is needed to promote integration. Respondents suggested that advocates across the medical spectrum should be organized to keep this issue on the radar screen of policymakers, providers, and funding sources. One respondent suggested that “squeaky wheels” are needed within the state policy arena and at the practice level to support integration.

Multiple respondents encouraged support for the medical home model as an approach to enhance integration. The pilot project in Maine was thought to be very important as it contains a reimbursement component to support care management. Respondents suggested that incentives are needed to encourage primary care providers to participate in the medical home model.

### **Legislators and Other State Officials**

Our Advisory Committee helped us identify a set of legislators and state officials with a specific interest in or knowledge of integration and behavioral health issues. We completed interviews with the legislators and state officials identified in Table 3.<sup>13</sup>

**Table 3. Legislators and Other State Officials**

- **Sen. Joseph Brannigan (D- Portland)**
- **Rep. Donna Finley (R-Skowhegan)**
- **Sen. Lisa Marrache (D-Kennebec)**
- **Rep. Lisa Miller (D-Somerville)**
- **Rep. Anne Perry (D-Calais)**
- **Steven Rowe, Attorney General**

### ***Barriers Identified by Legislators and Other State Officials***

The respondents in this group focused on broad system-level barriers to integration including low coordination between different parts of the health care system, limited insurance

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<sup>13</sup> The five legislators on this list were chosen specifically for their background in behavioral health issues regardless of their party affiliations.

benefits for behavioral health services, inadequate reimbursement rates, workforce shortages, and limited behavioral health knowledge among primary care providers. There was agreement that our current “system” doesn’t function like a system in that it is very complicated with multiple parts that don’t “talk” with one another. It was noted that the referral process differs for behavioral and medical issues. For example, one respondent noted that a patient’s primary care office is likely to call and schedule an orthopedic consult for a patient with knee problems while a patient with behavioral health issues typically has to schedule his/her own appointment.

#### *Reimbursement Barriers*

Respondents noted that reimbursement rates for behavioral health services were low in Maine and that third party payers typically do not reimburse for behavioral health preventive services. Some respondents stated their belief that these reimbursement issues contribute to high turnover rates among providers in Maine. This problem is worse for child psychiatrists, which are in short supply. One respondent noted that many private practice psychiatrists in Maine will not accept MaineCare patients because of low reimbursement rates in private practice settings. This respondent also noted that it may be difficult to increase MaineCare reimbursement given the state budget crisis. Respondents also noted that people with commercial insurances have a longer wait for services than those covered by MaineCare in some sections of Maine due to MaineCare’s higher reimbursement rates for licensed agencies. Another respondent thought that our current system is too heavily focused on financial outcomes rather than on the benefits of prevention and the delivery of high-quality health care.

#### *Workforce Barriers*

Workforce shortages are another major barrier to integration. There are not enough behavioral health and primary care providers in the state to serve vulnerable populations. Workforce shortages are more extreme for child providers and in rural areas where it has been historically difficult to recruit and place psychiatrists and psychologists. There is also a shortage of nurse practitioners, registered nurses, and physician assistants with behavioral health experience. One respondent thought that these types of clinicians fit better into a primary care setting than psychologists and psychiatrists.

### *Provider Capacity Barriers*

The lack of knowledge about behavioral health care was described as significant barrier to integration. In the words of one respondent, “Many primary care clinicians skirt behavioral health issues because they don’t know enough about them. They pass out meds but provide no connection with counseling services, which are necessary to go along with the meds.” Respondents described current services as good but not accessible or coordinated. In a related discussion, one respondent noted a lack of awareness among primary care physicians of the increasing prevalence of behavioral health issues among the elderly, particularly depression and suicide. Respondents noted several other perceptions regarding mental illness. There is a social taboo among clinicians and patients that leads the not to talk about or deal with behavioral illness. Clinicians often over-diagnose or under-diagnose behavioral health problems depending on their orientation and setting. Primary care providers are likely to under-diagnose while specialty behavioral health clinicians may over-diagnose.

Primary care practice capacity was also described as a barrier to developing integrated services. Primary care providers must focus on productivity and patient flow to remain viable. They have competing priorities and the time needed to conduct a behavioral health assessment may negatively impact their productivity. One respondent questioned whether primary care providers had the “will” to pursue integration due to the additional work created for the provider in the short run and the potential drain on resources and time. In many areas, respondents noted that hospitals are taking over local primary care delivery systems as the productivity and economic challenges of private practice discourage physicians from continuing with this traditional practice model. One respondent noted an upside to this trend as hospitals may have greater capacity and resources to integrate than private practitioners thereby leading to improvement in integration at the system level.

### *Stigma and Other Barriers*

One respondent noted that stigma issues provide a disincentive for primary care providers to pursue the integration of behavioral health services in to their practices. Others respondents noted that this specific group of legislators and state officials is more knowledgeable about behavioral health issues and the impact of mental illness on society and the financial base of the state than the typical policymaker or elected official. They reported that this lack of knowledge of how the system works is a barrier to integration.

### ***Recommendations to Enhance Integration by Legislators and Other State Officials***

The individuals that we spoke to were very much aware of state budget issues and the constraints that competing demands for limited funding places on the ability to make widespread changes in MaineCare reimbursement rates and system development. That being said, they also offered a wide range of recommendations to support integration.

#### *Reimbursement Recommendations*

One respondent noted that the prior approval process is a problem in Maine. Under this process, providers treating MaineCare patients for certain behavioral health services must obtain prior approval for services in order to receive payment for those services. This adds another administrative burden to the workload of providers. This respondent suggested that a meeting be arranged between representatives from the American Psychiatric Association and the Director of MaineCare to review issues related to prior approval with the goal of making it more efficient and easier for clinicians to treat MaineCare clients.

#### *Workforce Recommendations*

The development of recruitment and retention programs for behavioral health and primary care providers was a common recommendation. Legislators cited the need to recruit psychiatrists, psychologists, social workers, and other behavioral health specialists. They also identified the need to recruit nurse practitioners and physician assistants with behavioral health experience as these types of clinicians fit well into primary care settings and can be used to relieve some of the productivity pressures on primary care physicians. Respondents suggested that recruiting counselors to work in primary care settings could supplement the medication management services provided by many physicians. They also identified the need to recruit and train additional primary care providers to support the primary care infrastructure in Maine, particularly in rural communities. Related to efforts to support recruitment and retention, respondents suggested the exploration of policies such as loan repayments for behavioral health and primary care providers as well as tax incentives for behavioral health specialists relocating to underserved areas and for clinics using telemedicine technology to expand access to services.

One respondent raised concerns about the high use of psychotropic drugs and suggested that this might be due to shortages of counseling professionals and other non-prescribing

behavioral health staff. She suggested that a research study is needed to look at this issue using data from clinical settings and through claims analysis.

#### *Provider Capacity Recommendations*

Respondents recommended the development of initiatives to enhance the knowledge base of primary care clinicians related to behavioral health and integrated services and expand their use of screening and assessment tools to improve the identification of individuals needing services. They also stated that it was necessary to improve the ability of primary care providers and counselors to work together through education and the provision of incentives to address the full range of patient needs including preventive services. This education could be provided through online or CD-based educational programs and through the development of medical staff grand rounds that focus on topics related to integration such as pharmaceutical therapy.

Respondents offered a number of recommendations to improve the functioning of the system and to break down the silos between services. One respondent suggested changing current protocols for accessing behavioral health services to allow primary care practices to coordinate the scheduling of referral appointments. Another recommended that efforts be made to increase the capacity of hospital emergency rooms to handle critical care behavioral health issues. This respondent also suggested identifying ways to reduce the need for patients in crisis to use emergency rooms to access behavioral health services. Another respondent recommended improving the stability of local behavioral health services as the high turnover rate among staff results in a loss of continuity of care for people with mental illness. This individual also suggested that improvements in communications among providers are needed as is greater feedback to primary care physicians on their patients receiving behavioral health care. Other respondents recommended support for the implementation of electronic medical records in all primary care settings to improve communication and the delivery of care.

Hospitals were identified as key players that could assume a larger role in the integration discussion due to their growing employment of primary care providers and role of hospital emergency rooms (ERs) as a safety net for individuals in crisis. Hospitals are in a position to encourage integration in their primary care clinics by hiring behavioral health staff, implementing electronic medical records, encouraging discussions between behavioral health and primary care providers, and developing the expertise to support integrated initiatives. They

(hospitals) could also improve linkages with behavioral health agencies to reduce ER use by crisis patients and streamline access to the behavioral health service system.

#### *Other Recommendations Addressing Coordination and Communication Issues*

To break down the silos in our health care system, one respondent suggested that primary care providers meet with psychiatrists, psychologists, and social workers on a regular basis at the local level. He noted that providers rarely mix and that this separation is reinforced by the fact that each profession has its own annual meeting. Another suggested that telemedicine could also play a role in further breaking down these silos by improving communications between providers and expanding access to direct services and consultations.

Respondents identified the need for leadership to advance the cause of integration and develop a consistent framework to do so. The State Health Plan was suggested as one vehicle that could help do this. They suggested that the discussion of the integration of behavioral and physical health in the State Health Plan be expanded so that it could be used as a guideline to ensure that all stakeholders are on the same page. Respondents also suggested that legislators and other policymakers need to be educated on the benefits of integration, the economics of mental illness, and issues related to mental health including substance abuse, domestic violence, and aging. Respondents further suggested that leaders of the Maine Primary Care Association, Maine Medical Association, and Maine Association of Psychiatric Physicians meet together to identify and undertake initiatives to break down silos and to further integration between the professions. One suggested that the legislature cannot advance integration in Maine on its own and that the Governor's Office of Health Policy and Finance needs to be involved in the conversation along with key staff from the DHHS Commissioner's office, the Maine Primary Care Association, the Maine Hospital Association, and MeHAF.

#### **Payers, Purchasers and Managed Care Organizations**

Given the key role of third party payers, purchasers (e.g., the Maine Chamber of Commerce and employers), and managed care organizations in Maine's health care system, we interviewed representatives from the organizations identified in Table 4. Respondents in this category are focused more on the integration of services across providers and systems (collaboration without co-location) than on integration within provider settings (co-location) as

they are primarily concerned with ensuring that the individuals for whom they are responsible receive high-quality care in a timely fashion and are less concerned with the organizational structure of the services and providers.

**Table 4. Payers, Purchasers and Managed Care Organization Interview**

- **Aetna Health/Aetna Behavioral Health**
- **Anthem Blue Cross/Blue Shield of Maine**
- **Cigna Healthcare**
- **Hannaford Brothers**
- **Maine State Chamber of Commerce**
- **Quality Care for ME — Maine ASO/APS Healthcare**
- **Shaller-Anderson**

***Barriers Identified by Payer, Purchaser, and Managed Care Organization Respondents***

Respondents identified rising costs, payment issues (including MaineCare rates and potential cuts), HIPAA and other system impediments to communication among providers, the siloed health care system, workforce shortages, the lack of transparency in the system (which makes it difficult for purchasers and consumers to understand the services that have been purchased), and difficulties in measuring quality as barriers to integration. These barriers relate primarily to the functioning of the system across providers and agencies. Stigma and prejudice against those with behavioral health illnesses and issues were also identified as barriers to integration.

***Reimbursement and Cost Barriers***

The rising costs of health care and its impact on health insurance rates are issues for third party payers and purchasers. As costs rise, premiums for employer-sponsored health insurance also rise driving employers to reduce benefits, increase co-payments and deductibles, or eliminate coverage all together. Costs are also driven by increasing utilization of services and expanding medical technology. Insurance mandates are also an expensive driver of costs in that they require health plans to pay for specific services which gives them little leeway to manage costs. Respondents are also concerned about the effect of behavioral health parity on costs. In

this environment of cost control, third party payers and purchasers were clear that they have little appetite for new health care spending unless that spending is supported by evidence that it improves quality or reduces costs. Similarly, employers are reluctant to endorse any program that increases costs. On the other hand, employers noted the high costs of untreated behavioral health issues which include absenteeism and reduced productivity.

Respondents cited Medicare and MaineCare reimbursement rates as barriers to integration. They implied that these two organizations are not paying the full costs of care for their enrollees. In addition, respondents were concerned that potential cuts to the MaineCare and DHHS budgets could have a destabilizing effect on providers in Maine and reduce access for all patients seeking services. Related to this are opinions that it is difficult for behavioral health providers to meet DHHS licensure requirements.

#### *Workforce Barriers*

Respondents identified workforce shortages and the maldistribution of behavioral health and primary care providers as a barrier to integration as there are insufficient providers to meet the demand for services. Further, existing providers are concentrated in urban areas of the state and less likely to practice in rural areas.

#### *Communication and System-Level Barriers*

The Health Insurance Portability and Accountability Act (HIPAA) and other system-level impediments to communication among providers were identified as barriers to integration. HIPAA regulations complicate communication between providers by requiring providers to obtain and maintain informed consents and releases of information before sharing clinical information. Other communication barriers included the reliance on paper health records and the limited use of electronic health records and other health information technology.

Our siloed health care system was often mentioned as a barrier by respondents who reported that individual parts of the system do not work well together. They stated that the system is confusing and difficult to navigate for patients with access problems and/or communication difficulties. They also noted that the costs of care are higher and there is limited coordination between providers. Others noted that the system focuses on sick care rather than prevention, which further increases costs. Respondents in this category are very concerned about the need to improve the functioning of our health care system.

Lack of transparency in the system and difficulties in measuring the quality of behavioral health and integrated services were also identified as barriers. Respondents thought employers and consumers did not always know what they were buying when it comes to behavioral health services. Although employers are engaged in trying to understand what they are purchasing, respondents felt that consumers were not. They acknowledged that it is difficult to measure the quality and outcomes of behavioral health and integrated services. Gaps in information make it difficult to obtain data on utilization across the system. One respondent noted that there are huge gaps in the system and offered the opinion that some primary care providers offer low-quality care, others provide high-quality care, and many provide mediocre care for depression.

The barriers to integration identified by respondents from managed care organizations were similar to those identified by third party payers and purchasers. They were, however, more narrowly focused on the communication issues across providers, the potential barrier presented by the utilization management system implemented by APS Healthcare, and the lack of access to services. The rigid interpretation of privacy issues by clinicians is a barrier to integration as behavioral health clinicians are reluctant to share information with primary care providers. Doing so requires individual releases of information and additional administrative burdens. As a result, it is difficult for providers to know what services an individual receives. This creates disjointed care and makes it difficult to manage utilization. Respondents also noted that consumers with complex issues and those living in rural areas have limited access to services. Finally, concerns were raised about the extent to which services delivered by integrated providers would be subject to utilization management by APS Healthcare under its contract with the State. Respondents suggested that the administrative burden resulting from utilization management would serve as a barrier to the development of integrated services. Respondents identified this as an issue that required additional study to understand the potential impact on the integration of services.

### ***Recommendations to Enhance Integration by Payer, Purchaser, and Managed Care Organization Respondents***

#### *Reimbursement and Cost Recommendations*

Citing the need for data to document the efficacy and cost efficiency of integrated services, respondents recommended the development of studies to collect data to demonstrate the value of these services. Suggested studies include collecting data on the costs and quality of

services, reduction in costs for employers (through increased productivity and reduced absenteeism), and improvements in patient functioning. Respondents also recommended that case studies on integrated programs and projects be conducted to provide examples of successful initiatives. The results of these case studies should be disseminated widely. Respondents also recommended that rules, regulations, and laws be studied to determine whether or not they are still appropriate in today's environment. Although it takes time to collect data, evaluate programs, and disseminate results, respondents felt this work was necessary to add to the evidence base.

Respondents also recommended consideration of reimbursement changes to support integration including the development of reimbursement protocols for care management. These go beyond simple increases in fees to focus on ways to create incentives to deliver higher quality integrated care. Suggestions included reimbursing providers for health and outcomes (e.g., pay for performance) rather than procedures or visits. Respondents also suggested sharing savings with providers could encourage collaboration. One respondent suggested the development of a primary care provider model with integrated care teams. Another suggested building reimbursable care teams around patients. A third suggested the exploration of global payment systems. One representative from the insurance industry thought that integration could support the management of behavioral and physical health services for certain conditions under a plan's overall health care budget and eliminate the need to carve out and manage behavioral health services under a separate budget. These are significant changes to the way primary care and behavioral health services have been delivered and would require broad input from affected parties to ensure buy-in and acceptance.

Respondents noted that a specific definition of integrated care is needed as well as clear operational guidelines in which evidence-based screening and treatment protocols are linked to reimbursement policies for mental health and substance abuse. Respondents recommended that providers and payers work collaboratively to develop and adapt screening and treatment protocols that are evidence-based and appropriate to specific settings. Once agreement is reached on these tools and protocols, they should be disseminated widely among providers and payers.

Respondents in this category were supportive of the medical home concept in general and the Maine PCMH pilot project specifically. They felt the medical home pilot project had the potential to improve integration in Maine by developing reimbursement mechanisms to support

the delivery of care management services. Third party payers suggested that they were willing to invest money in care management in the belief that doing so would create savings through better coordination of care, follow-through with referrals, and reductions in the use of unnecessary and/or redundant services. They also stated that they would need evidence of these savings and improvements in access and quality to continue to support the medical home pilot project.

#### *Provider Capacity Recommendations*

Respondents also recommended that educational programs on the benefits of integration and the delivery of integrated services be developed for providers, consumers, purchasers and policymakers. Education is needed to overcome concerns that integration may just be another hot policy topic and not the best approach to improving the delivery of services. They also felt that it is necessary to raise awareness that a different style of practice is needed to address both primary care and behavioral health needs in the same setting. For example, behavioral health providers may need to modify their practice styles to accommodate the demands of a primary care setting by accepting walk-in patients, scheduling shorter sessions, and tolerating interruptions to answer questions or consult with the primary care clinicians. Similarly, primary care providers may need to make adjustments in their practice styles to better function in behavioral health settings.

#### *System Change Recommendations*

Respondents noted that the changes in the system will require input from a broad range of stakeholders including employers, consumers, insurers, policymakers, and providers. They also recommended that stakeholder be at the table during those discussions. Respondents also suggested the development of physician educational workshops to help them develop integrated services and practice in integrated settings. These workshops should focus on care coordination and integration. A related recommendation involved the development of a statewide provider resource and training institute to support providers in developing and managing integrated services. Educational programs are also needed to address stigma at the community level.

At the provider level, respondents suggested the development of integrated decision support tools using health information technology to share patient information across providers in order to facilitate the integration and coordination of services. One respondent noted that it would be difficult to practice without information technology decision support. Respondents also

identified the need for care management systems at the provider level but acknowledged that there is no easy way to pay for them through the current system of reimbursement.

The managed care organizations also specifically recommended that APS Healthcare and Shaller-Anderson explore ways to work together. They further suggested that Maine learn from the efforts of other states to support integrated care. One respondent suggested that APS Healthcare’s participation in integrated initiatives in other states might have applicability in Maine. A specific example involved a contract between the State of Georgia and APS Healthcare to develop disease management programs and to coordinate behavioral health services. Although the current contract between the State of Maine and APS Healthcare contains relatively little language on integration, respondents suggested that it would be possible to establish greater expectations for integration in future contracts, particularly as it relates to the coordination between providers as outlined in treatment planning goals.

### **Maine Department of Health and Human Services**

The Maine Department of Health and Human Services (DHHS) affects efforts to promote integration in the State of Maine through its oversight role for facility licensure and regulation, its funding role under MaineCare, and through its programmatic responsibility for adult and child mental health services, substance abuse services, public health, and school-based services. We interviewed key individuals from the bureaus, divisions, and departments listed in Table 5.

**Table 5. Maine Department of Health and Human Services Interviews**

- **Adult Mental Health Services**
- **Children’s Behavioral Health Services**
- **Division of Chronic Diseases, Maine CDC**
- **Integrated Services and Quality Management**
- **Licensing and Regulatory Services**
- **MaineCare and Dirigo Health Agency**
- **Office of Substance Abuse Services**
- **Teen and Young Adult Health Program, Maine CDC**

## ***Barriers Identified by DHHS Respondents***

### *Reimbursement Recommendations*

One respondent suggested that payers, including commercial insurance and Medicaid, are reluctant to pay for integrated services, particularly the care management component of integrated care. This reluctance was thought to be related to the relatively limited evidence base for integrated services. This respondent thought that if insurers want a better system they will need to pay for it. Yet at the same time, he acknowledged that the limited evidence base, as he described it, did not encourage them to do so.

There are concerns and ongoing discussions within DHHS regarding the extent to which integrated services should be subject to utilization management under the contract with APS Healthcare to provide a behavioral health utilization management system for services purchased through MaineCare and administered by Adult Mental Health Services, Children's Behavioral Health Services, and the Office of Substance Abuse. This is a potential barrier that was identified by respondents in other categories.

### *Workforce Barriers*

Respondents identified the shortage of specialty behavioral health providers (e.g., psychiatrists, psychologists, social workers, substance abuse clinicians, etc.) and primary care providers as a barrier to integration in Maine. Concerns were raised that the shortage of primary care providers and the demands being placed on them would limit the ability of many to participate in the development of integrated services. The shortage of primary care providers is exacerbated, according to one respondent, by the fact that physicians typically receive minimal training in behavioral health issues and, as a result, have difficulties functioning in integrated settings.

### *Regulatory and Licensure Barriers*

The silos in our health care system are perpetuated in the approach to licensure and regulation in Maine. Respondents noted that credentialing and reimbursement regulations are different for physical and behavioral health providers. A related barrier was the inconsistency of rules and regulations within and across DHHS departments. Examples of these inconsistencies include MaineCare's reimbursement of social workers practicing in licensed agencies but not in independent practice and differential reimbursement rates in which MaineCare reimburses

clinicians at the rate of \$84.00 per hour in licensed settings compared to \$55.00 per hour in private practice. In identifying these inconsistencies, respondents noted the difficulty of implementing reimbursement changes in a resource scarce environment as proposed changes would place additional stress on the MaineCare budget.<sup>14</sup>

As DHHS officials identified these inconsistencies, they recognized that any changes had the potential to create competition among providers for scarce resources and funding. Respondents were concerned that vested self-interest among providers and turf issues could discourage compromise necessary to support integration. Complications created by mental health and substance abuse licensing regulations create a major administrative barrier to integration. Agencies providing both mental health and substance abuse services are often required to have two separate licenses, which creates additional administrative burdens and expenses for those agencies. To prevent these problems, officials have assembled a cross-department group of individuals to identify and reconcile these inconsistencies. DHHS is also seeking input from clinicians and stakeholders in developing its recommendations to revise reimbursement systems.

#### *Communication and System Barriers*

HIPAA was thought by some to be a barrier to integration but only if people and agencies want it to be. HIPAA has been interpreted as a barrier to communication of patient information between providers. Under HIPAA, safeguards to prevent the inappropriate release of patient information have been developed. HIPAA regulations were not designed to apply to legitimate sharing of clinical information among providers for integration and other purposes. Overly rigid interpretation has impeded communication.

One theme that arose throughout our interviews with DHHS personnel was the recognition that our siloed system of care present a significant barrier to integration in that the behavioral and physical health worlds continue to function as two separate service systems. Examples of these silos were discussed by different DHHS respondents. One respondent raised the example of the high rates of diabetes among individuals with severe and persistent mental illness. To address this issue, DHHS has implemented two separate care management systems to coordinate care for individuals with complex behavioral and physical health needs. Another example is the high rates of emergency room usage among individuals with behavioral health

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<sup>14</sup> Following the completion of our interviews in the spring and summer of 2008, MaineCare implemented changes that allow the direct reimbursement of social workers outside of licensed mental health agencies.

issues which reflects the difficulties these individuals face in receiving adequate primary care and the lack of after-hours behavioral health crisis care.

Infrastructure, workforce, and resource issues were identified as barriers to integration in Maine particularly in rural and isolated areas. As a result, the ability to develop integrated services can be more difficult in rural communities as the infrastructure and resources may not exist to provide needed services. This was mentioned specifically in reference to mental health services in school-based clinics in that the local infrastructure clearly drives what can and cannot be delivered in different parts of the state.

This was also identified as an issue at the state level. One respondent noted that the state mental health system is heavily oriented towards adults with severe mental illness as well as towards children and adolescents that are in trouble or at risk within the child welfare or juvenile justice systems. This respondent thought that the state does not adequately focus on or fund services for children and adolescents with more moderate conditions. This limits state resources available to support integrated services for the less acutely ill population of children and adolescents.

### ***Recommendations to Enhance Integration by DHHS Respondents***

The recommendations to enhance efforts to promote integration in Maine derive directly from the barriers identified in the previous section. Regardless of the specific recommendation, one clear theme emerged from our interviews: the need to include a broad range of stakeholders, including clinicians and consumers, in the discussion of changes needed to support integration. In the long run, respondents thought that changes to support integration would benefit consumers and providers alike and that our system of care would function more efficiently. In the short run, however, competition for scarce resources will likely create conflict as the system is reconfigured to support integration. As a result, respondents believe that providers and consumers need to be included in the discussions from the beginning.

### ***Reimbursement Recommendations***

A number of respondents thought that DHHS should address reimbursement issues including opening the door for master's-level clinicians to bill MaineCare directly. *(Subsequent to these interviews, this recommendation was implemented in final rules modifying the MaineCare Benefit Manual, Chapters II & III, Section 65, Behavioral Health Services, which*

became effective on October 29, 2008).<sup>15</sup> Respondents also believed that DHHS should continue the work that is underway to review facility licensing standards to reduce administrative burdens for agencies and to explore rate-setting and reimbursement standards to support integration.<sup>16</sup> This review of reimbursement rates, however, needs to take place within the context of current state budget issues. Respondents also recommended that DHHS should evaluate whether integrated care services should be subject to utilization management under the contract with APS Healthcare.

A number of DHHS respondents supported the concept of the medical home as a tool to enhance the integration of services and specifically mentioned the Maine multi-payer medical home pilot project. They believe that the medical home pilot project could enhance the integration of behavioral and physical health services by creating a way for MaineCare and commercial payers to reimburse providers that qualified as medical homes to coordinate and integrate services.

#### *Regulatory and Licensure Recommendations*

Respondents suggested that DHHS officials review different programs and licensure standards to determine what can be done to encourage integration within provider settings and licensure categories. This would be done by looking for common and obvious links for specific classes of patients and to determine appropriate treatment levels within settings.

#### *Communication and System Change Recommendations*

Respondents identified the need to define clearly what integration means and to focus on the concept of collaborative treatment rather than structural aspects of change with the goal of supporting care management and coordination. Respondents believe that it is necessary to focus on the treatment process and related outcomes rather than solely on the structural aspects and models of integration. Respondents also believed there is a need to distinguish between coordination of care (e.g., care management/coordination services), which is one component of an integrated service delivery model, and the concept of integration as a whole. This was offered

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<sup>15</sup> As described in an October 23, 2008 memo from Anthony Marple, Director of the Office of Maine Care Services on the Final Rule: MaineCare Benefits Manual, Chapters II & III, Section 65, Behavioral Health Services.

<sup>16</sup> Two DHHS staff members are currently reviewing agency regulations related to licensure (Section 65 for mental health services and Section 111 for substance abuse services) with the goal of reducing administrative burden for providers and reducing the number of billing codes needed to bill for services.

in the context of allowing multiple approaches to integration tailored to individual providers and circumstances rather than trying to identify one “best” model of integration. Finally, one respondent suggested that it would be helpful to determine where patients are currently receiving care for behavioral health issues and to evaluate the appropriateness of those treatment settings as a foundation for efforts to encourage the integration of services. This would provide important baseline information to assess the system.

In addition to these recommendations identified by a cross section of DHHS respondents, additional recommendations were made by individual respondents. These included the need to promote the use of evidence-based tools to support clinical integration such as the Substance Abuse and Mental Health Services’ SBIRT (Screening, Brief Intervention, and Referral to Treatment) program to physical health providers.<sup>17</sup> Suggesting that the substance abuse community values anonymity more than the mental health community, one respondent asserted that this difference needs to be understood and addressed in the context of integration services.

Another respondent suggested that DHHS’s prescription monitoring program could support integration by allowing providers to access individual patient’s current prescriptions through the database, thereby reducing problems with doctor shopping. This individual noted that increased training would be needed to increase use of the prescription monitoring system among providers.

Finally, one respondent suggested that DHHS needs to think about its own organization and the way in which its structure might hinder integration efforts. As part of this discussion, it was suggested that integration really needs to be examined from a population perspective rather than solely at a programmatic level. The example provided involved the coordination with chronic health program areas such as diabetes and tobacco. Although both of these program areas have links to behavioral health providers, they tend to be ad hoc rather than systematic.

### **Practices and Providers Including MeHAF’s Year One Integration Initiative Grantees**

We interviewed representatives of a wide range of physical and behavioral health providers to identify barriers to integration at the practice level (Table 6). Consistent with the national literature on integration, providers were more interested in developing and participating

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<sup>17</sup> The SBIRT program targets individuals with nondependent substance use and is designed to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

in co-located integrated models of care than in collaborative (but not co-located) integrated delivery systems. The exceptions were several MeHAF Integration Grantees who were interested in integrating services for complex patients and populations across provider settings.

**Table 6. Practice and Provider Interviews**

- **Federally Qualified Health Centers**
- **Hospital-based Practices**
- **MeHAF Integration Initiative Grantees**
- **Mental Health Agencies/Community Mental Health Centers**
- **Private Practices**
- **Rural Health Clinics**

### ***Barriers Identified by Practice and Provider Respondents***

Respondents focused heavily on operational barriers to integration including reimbursement issues, communication difficulties, space and capacity; lack of easily accessible information on developing integrated services, and lack of education related to behavioral health needs. Although the barriers identified by physical health providers and behavioral health providers are generally similar, there are enough differences to warrant a separate discussion for each group.

### ***Barriers Identified by Physical Health Provider Respondents***

#### ***Reimbursement Barriers***

Reimbursement-related barriers were frequently noted by physical health providers, including basic coding issues and limitations on the types of providers that third party payers will reimburse for the delivery of services. Respondents noted that it is difficult to stay current with the different coding and reimbursement policies implemented across third party payers. For example, Medicare will only pay for services provided by doctoral-level psychologists and clinical social workers. MaineCare pays for a wider range of providers including licensed clinical professional counselors (LCPCs) but at relatively low rates for non-licensed providers and private practitioners. Commercial insurers and managed care companies vary in the types of

providers and services they will pay for. Keeping up with these differing payment policies and credentialing standards imposes a heavy administrative burden on providers and may deter them from developing integrated services.

Respondents noted that third party payers have been slow to provide reimbursement for behavioral health clinicians using the Health and Behavioral Assessment (HBA) codes. Although these codes have been gaining acceptance, not all third party payers have chosen to recognize them. Among payers that accept these codes, there is variation in the types of provider that will be reimbursed for their use. Some commercial payers will reimburse psychologists using these codes but not licensed clinical social workers while others will reimburse either psychologists or social workers for these codes. Limiting reimbursement to psychologists for the use of HBA codes is a barrier to integration for integrated providers that may not be able to recruit a psychologist yet are serving patients with chronic illnesses such as diabetes, hypertension, and heart disease. These providers are more likely to be located in rural areas or other areas with mental health professional shortages.

A related reimbursement issue is the limited ability of primary care providers to be reimbursed for care management and coordination services. These services are an important part of integrated care and relatively few third party payers pay for them. Similarly, few payers reimburse for other components of integrated services that are important to the functioning of an integrated care program. These services include hallway consultations as well as the “warm-hand off” from a primary care provider to a behavioral health clinician in which the patient is introduced to the clinician and a “mini” mental health assessment is conducted to assess the individual’s needs, within the context of a physical health-focused encounter. Such encounters do not always meet coding standards, and therefore they are not reimbursable.

Respondents reported that high co-payments and deductibles constrain utilization of behavioral health services. Medicare, in particular, imposes very high co-payments on behavioral health services (effectively 50%) and strict lifetime limits. This is a barrier to integration for providers serving a high percentage of Medicare beneficiaries.

Fee schedules for behavioral health services implemented by commercial insurers, managed care organizations, and state Medicaid programs are also barriers to integration as payment rates may not cover the cost of providing these services. Respondents noted that private

providers may have little ability to negotiate payment rates and typically must accept payers' fee schedules.

Three other reimbursement-related barriers were identified by a smaller number of respondents. The first involved the long-term viability of integrated services. One provider noted that integrated services have a reputation as a “money loser”. This is a significant barrier when primary care providers are already working at capacity and “worried about every dime”. Another noted that community mental health agencies are biased towards MaineCare clients and that it is difficult to refer commercially insured patients for specialty services. Finally, one provider that deals primarily with homeless clients is concerned that MaineCare’s approach to presumptive eligibility for non-categorical persons made it difficult to determine eligibility for the individuals served by his agency and was a barrier to developing integrated services.<sup>18</sup>

#### *Workforce Barriers*

Recruitment and retention of behavioral health staff is another barrier to integration. Physical health providers noted that there are not enough behavioral health clinicians to fill the demand. This problem is more acute in rural and isolated areas of the state.

#### *Provider Capacity Barriers – Administrative and Communication*

Provider capacity to develop integrated services was another commonly identified barrier to integration. This included limited administrative and/or clinical time and expertise to develop and manage these services; insufficient space; high demand on limited support staff; and comparatively low interest in developing these services among some providers. A common theme that emerged was that expectations continue to grow for primary care providers to undertake different activities such as integrated services, the medical home, and

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<sup>18</sup> Under MaineCare’s presumptive eligibility provisions, qualified MaineCare providers may qualify a pregnant woman for MaineCare coverage if they determine that the pregnant woman's income meets the MaineCare guidelines. She is “presumed to be eligible” for MaineCare coverage and she can receive prenatal care beginning the day she comes for services. Once a MaineCare provider has made a presumptive determination, the coverage will last through the last day of the month following the month in which the determination is made (MaineCare Eligibility: Low Cost or Free Health Care Coverage Workshop, A Joint Project of Consumers for Affordable Health Care and Maine Equal Justice Partners, Version 1/3/08). Homeless advocates have called for the creation of presumptive eligibility for categorical MaineCare services for chronically homeless populations (Maine’s Plan to End and Prevent Homelessness, March 11, 2008 as prepared by the Maine Statewide Homelessness Council and the three Maine Regional Homeless Councils) and for homeless children and youth (Action Plan to End Homelessness in Maine: A Ten Year Plan, January 2005, developed by the Policy Academy Team).

quality/performance improvement programs, while reimbursement for primary care remains relatively stagnant.

Difficulties in sharing patient information and records between behavioral and physical health providers were identified as significant barriers to integration. Overly rigid interpretation of HIPAA regulations and confidentiality standards make sharing information difficult and increase the paperwork demands on providers by requiring them to seek and maintain separate informed consent and release of information forms for behavioral health services. It also was noted that some providers “hide behind” confidentiality issues to avoid sharing information which further reinforces the existing silos. The difficulty in sharing information is an issue within as well as across provider settings. The absence of a single patient record to record both physical and behavioral health services varies across settings and is as a barrier to both co-located and collaborative (without co-location) models of integrated care. Also complicating communication between providers is the comparatively limited implementation of electronic medical records by providers and the continued reliance on paper records.

Limited provider knowledge of the clinical, administrative, and reimbursement issues related to integration was cited as a barrier. Respondents noted that no centralized, accessible source of information existed to help providers set up integrated services, develop appropriate patient tracking systems, develop practice guidelines, code and bill for services, and assist physicians in identifying and treating behavioral health problems. This was a common theme among providers. Respondents stated that no one model of integration was right for all settings and that little support existed to help them choose the right model for their settings.

#### *Practice Culture Barriers*

Differing practice cultures and “turf” issues were also identified as barriers to integration. This was true at the provider level as primary care providers noted that it is difficult to find behavioral health clinicians that were comfortable with and could function in the primary care environment. It was also thought to be true at the system level as one provider stated his belief that the mental health world does not value integration as highly as the primary care world. Another respondent offered the opinion that state government does not really value integration. “Turf” issues were reported to be an ongoing problem, as evidenced by the different bureaucracies established to oversee the delivery of physical and behavioral health services.

### *Stigma and Other Barriers*

Stigma was identified as a barrier to integration including stigma among the public, patients, office staff, and clinicians. Travel distances and limited public transportation were identified as barriers in some areas of the state, particularly in the more isolated and rural areas. Providers noted that interest in and support for telemedicine has waxed and waned in the state. This is a barrier to integration in rural areas of the state as it limits the capacity to use the technology for the direct delivery of services and to access consultative support for primary care providers.

A final barrier to integration is the absence of well documented evidence of cost savings and effectiveness for integrated services. As a result, there has not been sufficient financial support for these services by third party payers that increasingly require an evidence base to justify paying for services. The collection of data and the time to analyze and publish the evidence is a burden to already overloaded primary care providers.

### ***Barriers Identified by Behavioral Health Provider Respondents***

Behavioral health providers identified many of the same barriers to integration as physical health providers. These include the lack of adequate reimbursement for behavioral health services; communication barriers due to confidentiality concerns; administrative burdens placed on the staff by paperwork and credentialing requirements across licensing agencies and third party payers; and the uneasiness that physical health clinicians and office staff may have in dealing with behavioral health clients (e.g., stigma). In addition, these respondents described unique ways in which some these barriers served to hinder integration efforts among behavioral health providers.

### *Reimbursement Barriers Related to Utilization Management*

The role of APS Healthcare and its utilization management system developed under the contract with the Department of Health and Human Services was identified as a barrier by behavioral health providers. Respondents were concerned about the lack of clarity regarding the extent to which integrated services would fall under the purview of APS Healthcare. Respondents suggested that it would be a barrier to integration if these services were to be

subject to utilization management as physical health providers typically do not have to deal with this issue.

#### *Workforce Barriers*

In terms of workforce barriers, behavioral health respondents identified a specific issue related to recruitment of providers that was not raised by other providers. Specifically, behavioral health providers identified the issues of “fit” and “personality” as being an important consideration in the recruitment process. Given the shortages of providers in Maine, there is a tendency to overlook issues of “fit” and “personality” when recruiting and placing providers. Respondents noted that not all providers have the personality and skills to operate in an integrated environment and that these issues must be considered when developing an integrated service. One respondent noted that personality issues can directly affect the success or failure of an integrated program and that little information exists to help providers address this issue.

#### *Provider Capacity Barriers*

The high cost and complexity of establishing physical health treatment space in behavioral health settings was identified as a barrier to integrating physical health services in behavioral health settings. The cost related to medical equipment and support staff is high and is an area in which many behavioral health organizations have little direct experience.

The final barrier practice related barrier involves the patient populations seen by many behavioral health agencies. They experience high no-show rates among their clients due to transportation difficulties, family issues, and difficulties engaging patients/clients. This can be a barrier to integration in that it reduces provider productivity, further compromising the ability of providers to develop cost-effective, self-sustaining services.

### **Recommendations to Enhance Integration by Practice and Provider Respondents**

#### ***Solutions Identified by Physical Health Provider Respondents***

##### *Provider Capacity and Operations Recommendations*

The recommendations made by physical health providers focused on the operational issues described above. A recommendation to address the limited availability of information to help providers develop integrated programs called for developing educational resources on best practice models of integration that could be replicated in other settings. Areas to be covered

included billing, coding, and reimbursement policies and protocols; sustainability issues; care coordination for complex patients; developing outcome measures and evaluation planning; using assessment and clinical tools and protocols; and licensing issues. Respondents felt that these educational resources should focus on functional issues related to integration with the goal of best meeting patients' needs. A small number of providers, including MeHAF Integration Initiative Grantees, were interested in examples of integration that were not hierarchically structured. Respondents felt that these educational resources should be centrally located and easily accessible by all providers in Maine.

Respondents from physical health practices also called for efforts to develop common understanding of confidentiality issues and charting requirements to overcome communication barriers. This would also include assistance with electronic medical records and understanding regulations related to releases of information and informed consent. They also called for simplifying standards across third party payers related to billing and coding, reporting requirements, and credentialing.

A smaller group of respondents called for providing support for grant writing and responding to requests for proposals, particularly for federal grants. Suggested areas to be covered included assistance in identifying appropriate grants and funding sources, assistance in responding to grant requirements, help in identifying appropriate outcome and evaluation measures, and access to a grant writer.

### ***Solutions Identified by Behavioral Health Provider Respondents***

#### *Regulatory and Policy Recommendations*

Recommendations to support integration identified by behavioral health providers were generally similar to those offered by physical health providers. The primary recommendation involved convening stakeholders to review paperwork, regulations, and standards related to licensing, credentialing, reimbursement, and reporting with the goal of streamlining and simplifying these requirements. The process should be inclusive with input from providers, policymakers, state officials, third party payers, and consumers. A follow-up recommendation suggested implementing these streamlined standards and regulations in a small number of sites to test and evaluate them.

### *Provider Capacity and Operations Recommendations*

Respondents also identified the need for educational programs to focus on issues related to integration and to help physical and behavioral health clinicians to understand each other's roles and needs. These educational programs should focus on billing and coding issues, practice cultures, and clinical protocols and guidelines. One respondent suggested the development of a central database of services and providers to assist patients in accessing needed services regardless of provider setting or location. This central database was referred to as a "virtual access center" that would reduce the time providers spend in making referrals by creating a comprehensive list of providers and services across the state.

## **Findings and Discussion**

Based on our work in preparing the Environmental Scan and in conducting these stakeholder interviews, a number of findings related to the integration of physical and behavioral health services have emerged.

### **How Much Progress Have We Made?**

In some ways, progress has been made in developing and implementing integrated models and in developing support among providers and policymakers. Integration has reached the status of a practice and policy ideal that has widespread support. In other ways, the state of the art in integration does not seem to have advanced very much in recent years. In general, little progress has been made in overcoming ongoing barriers to the sustainability of integrated services including limited reimbursement of key components of integrated services such as "mini" mental health assessments and ongoing care management and coordination. The process of obtaining reimbursement in integrated settings remains a labyrinthine and inconsistent mix of codes and policies that vary across payers and practice settings.

In reviewing the literature and the history of integration activities both nationally and in Maine, it is clear that current requests for funding of integrated programs and initiatives made to foundations and other funders are very similar to those made five and even ten years ago. Applicants are requesting support for care managers/coordinators to facilitate access of patients/clients to needed services and to ensure compliance by patients/clients with their treatment recommendation. Applicants are also requesting support for behavioral health

clinicians to engage in “hallway” consults, to work with primary care providers and staff to improve their understanding of behavioral health issues, and to engage patients in integrated treatment through “warm hand-offs” from their primary care providers to the behavioral health clinicians. These requests have not evolved substantially from past demonstration efforts and clearly speak to the lack of progress on ensuring the sustainability of services.

Further, the conceptualization of barriers and potential solutions does not seem to have changed significantly in recent years. As mentioned, complex and inconsistent coding, billing, and reimbursement policies across third party payers continue to be an ongoing barrier. At the same time, few payers reimburse providers for care management/coordination services and other integrative components of care. Workforce shortages and related regulatory barriers still exist as do barriers related to practice culture, knowledge base of clinicians and staff regarding integration, and complex state licensure regulations.

Given these findings, it is necessary to ask why more progress has not been made despite widespread popular support for integrated services. Among the primary reasons for this lack of progress is that policy, payment, and regulatory changes needed to support integrated services across provider settings have not been implemented by states and third party payers. Progress in adopting these needed changes is complicated by the less-than-clear definition of what is meant by integrated physical and behavioral health services. As funding has become available for integrated care, more and more applicants are bending the concept of integration to fit their proposed projects. The confusion created by this broadening of the concept of integration makes it difficult to describe what integrated care is and more difficult to convince third party payers to reimburse for the provision of integrated care.

In response to the increasing demand for limited funding for integrated care, some funders and applicants are pushing to adopt the co-located model of integrated care, (e.g., the placement of a behavioral health provider within a primary care practice) that dominated early funding applications as the preferred model of integration. While this has the advantage of simplifying the discussion of integrated care and narrowing the focus of funding requests, it does not acknowledge that co-located models of care may be more appropriate to and feasible within certain types and sizes of providers and settings and excludes those providers that do not have the capacity and resources to adopt this model. It would also exclude collaborative (without co-location) integration models in which groups of providers work to integrate services through

collaborative relationships and agreements across groups of providers rather than through the co-location of behavioral health services within specific practice settings (e.g., collaboration without co-location or basic collaboration from a distance on the continuum of Behavioral Health/Primary Care Integration Options).<sup>19</sup>

Certain types of practices such as FQHCs, hospital-based practices, and large group practices are more likely to have the administrative, financial, and clinical expertise and capacity to develop co-located services that are further along the continuum of integrated care. They are also more likely to have the resources to secure needed technical assistance and consulting support to develop their programs. FQHCs are supported by the Bureau of Primary Health Care through technical assistance and expansion grants in the development of integrated behavioral health services. Smaller practices with more limited administrative resources and capacity may find it difficult to implement more sophisticated, co-located models.

The focus on co-located models of integrated care is embodied in the prevailing expectation that the more integrated co-located practice models (e.g., those further along the continuum of integration), as measured by the five level integration scale developed by Doherty, McDaniel and Baird<sup>20</sup> or the Service Integration Scale developed by Keith Miles of Dartmouth<sup>21</sup>, are preferable to less integrated practice models that score lower on these scales. These scales focus on both the structural (e.g., ownership and employment of providers, etc.) and clinical components of integration (e.g., the way patient care is coordinated and integrated among providers and the development of clinical systems of care). They also place higher priority on co-located models of integration and tend to undervalue the potential for groups of providers to develop collaborative systems of integrated care using formal inter-organizational agreements and health information technology to achieve the functional goals of expanding access, reducing costs, and improving the quality of care provided. Instead of viewing the development of integrated services as a choice between co-located or collaborative (without co-location) services, providers should be encouraged to develop integrated services at whatever level of the continuum is appropriate for their settings and levels of resources and to move further along the continuum as appropriate.

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<sup>19</sup> Adapted from MH/Primary Care Integration Options, developed by Kathleen Reynolds, Director, Washtenaw Community Health Organization, Washtenaw County, MI; Based on Doherty, McDaniel and Baird, 1996.

<sup>20</sup> Doherty WJ, McDaniel SH, and Baird MA. Five levels of primary care/behavioral healthcare collaboration. *Behavioral Healthcare Tomorrow*. October 1996; 5:25-7.

<sup>21</sup> Service Integration Scale. Available at [http://dms.dartmouth.edu/prc/pdf/Service\\_Integration\\_Scale.pdf](http://dms.dartmouth.edu/prc/pdf/Service_Integration_Scale.pdf)

The development of more fully integrated co-located models is dependent not only on the availability of resources, space, clinical personnel, and administrative and clinical capacity, but also on market forces related to the local service infrastructure and the supply of behavioral and physical health clinicians. In some markets, limited system resources may not support the development of co-located integrated services. In these settings, collaborative systems of care may make the best use of scarce resources. The five-point scale developed by Doherty, McDaniel, and Baird, with its focus on a single organization's ownership and control of resources and staff and the delivery of clinical services within that setting as the ideal would exclude these types of collaborative models of integration from consideration.<sup>22</sup>

As mentioned above, integrated care should be viewed along a continuum of integration with practices developing integrated services using the model (either co-located or collaborative) and stage of collaboration that makes sense for their settings, resources levels, experience, and patient populations. As they gain experience with the delivery of integrated care, practices may choose to move further along the integration continuum as appropriate. In the literature on integration, the discussion too often focuses on the needs and capacity of provider organizations rather than the needs of the individuals and families they serve. While the former is important from an organizational perspective, the reality is that both perspectives are critical to the development of a sustainable integrated service. The clinical needs of individuals and families and their preferences for convenience, privacy, and choice should be placed at the forefront of the decision making-process along with organizational needs and considerations in determining the structure and delivery model of integrated services and programs.

Additional reasons behind the relative lack of progress in overcoming the barriers to integration include the choice of arguments used to promote integrated care, potential conflicts in the evidence provided by studies of integrated care models, and the failure to collect and package existing evidence in a way that encourages policymakers and third party payers to enact needed changes. Too often, advocates for integrated care cite expectations of cost offsets and savings expected to result from implementation of integrated services (e.g., patients will use fewer

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<sup>22</sup> This is not to suggest that co-located models do not have significant advantages when compared to collaborative, (without co-location) models. Co-located models allow for improved coordination between providers, improved access to behavioral health services for individuals already receiving care in primary care practices, and the preference of individuals to receive behavioral health services in primary care rather specialty mental health settings. However, the co-located model of integration may not be appropriate for all practices and markets.

physical health services as a result of treating their underlying depression and behavioral health problems). While this could be true in the long term, it is difficult to measure in the short term given the challenges of tracking the use of services by patients across various service systems. More appropriate arguments should focus on the ability of integrated programs to improve access to timely care in settings preferred by patients, better coordinate the delivery of physical and behavioral health services, and improve the quality of those services.

Although we have a great deal of experience with integrated care models, existing studies that focus on specific models may not provide sufficient evidence to encourage the development of policy, regulatory, or reimbursement changes necessary to support integration.<sup>23</sup> In its 2008 report, the Agency for Healthcare Research and Quality (AHRQ) reported on the results of a comprehensive systematic review of randomized controlled trials and high-quality experimental studies of integrated care models published between 1950 and 2007. Based on this review, the authors found that integrated care achieved positive outcomes related to improvements in symptom severity, treatment response, and remission response. They did not find evidence to suggest that outcomes improved as the levels of either provider integration or integrated processes of care increased. According to the authors, “the lack of correlation between measures of integration or specific elements of care processes and the various outcomes reinforces the underlying question about the specific effect of integrated care”. They further stated that it was not possible to “distinguish the effects of increased attention in general to mental health problems from the effects of specific strategies”.

AHRQ’s report generally reinforced our findings from interviews with third party payers in Maine who support efforts to integrate physical and behavioral health services but want evidence to document the cost effectiveness of the component parts of integrated care. According to the ARHQ report, further research is needed to identify what elements of integration are vital to producing the desired goals.<sup>24</sup> The authors suggest that “head-to-head trials to test more explicit variation in integration components and elements of care process” might help to resolve this issue. They also call for additional studies to understand who benefits from integrated care,

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<sup>23</sup>Butler, M., Kane, R., McAlpine, D., Kathol, R., Fu, S., Hagedorn, H., & Wilt, T. (October 2008) *Evidence Report/Technology Assessment Number 173: Integration of Mental Health/Substance Abuse and Primary Care*. Rockville, MD: Agency for Healthcare Research and Quality.

<sup>24</sup>Although third party payers will generally reimburse for traditional elements of behavioral health care delivered in integrated settings (e.g., medication management or individual therapy services provided by appropriately licensed clinicians), many of the costs involved in delivering services in an integrated setting are not regularly covered by a payment system based on specific in-person encounters.

demonstration projects to advance our understanding of the financial structures that best support sustainable integrated programs, and greater exploration of the business case for integrated care.

We should not, however, interpret the AHRQ report as saying that there is no evidence to support the delivery of integrated care. The authors found that integrated care achieved positive outcomes related to improvements in symptom severity, treatment response, and remission response. At the same time, a large body of literature on the benefits of integrated care and care management services has been developed over the years. We also have a great deal of experience in Maine from initiatives funded by the Maine Health Access Foundation, Robert Wood Johnson Foundation, MacArthur Foundation and others. This cumulative body of evidence provides support for claims of the effectiveness of integrated care in improving access to services and the benefits of care coordination. Our challenge is to draw upon, synthesize, and disseminate this existing evidence to support the continued investment in integrated care and to encourage policymakers and third party payers to make the necessary regulatory, reimbursement, and policy changes to support the sustainability of integrated care models.

At the same time, we should acknowledge a potential complication of the current reimbursement system for integrated care and be very clear in discussions with policymakers and third party payers. The direct service components of integrated care models (e.g., medication management and individual psychotherapy) are typically reimbursed by third party payers to providers with appropriate credentials (as defined by their reimbursement and credentialing policies) and who are approved members of their provider panels. As such, many payers may believe they are adequately supporting integrated care. We must be clear that what is needed is additional reimbursement for care management and other integrative components of care inherent in these models. Current reimbursement policies typically do not cover these services.

### ***The Role of the Medical Home in Advancing Integration***

Further complicating our understanding of integrated care is the growing interest in patient-centered medical home model. As we spoke to advocates for the patient-centered medical home model in Maine and reviewed the literature, it became clear that advocates expect that widespread adoption of the medical home model will advance the integration of services even though there is little detailed discussion of how it will do so. Most medical home discussions focus on the concepts of care management and coordination across services and do not

specifically address the integration of physical and behavioral health services. As a result, widespread adoption of the medical home will not advance the integration of services unless the models developed specifically include behavioral health services. Nationally, this is not the case. For example, the National Committee for Quality Assurance's (NCQA) definition of the medical home is very much physician focused in that it describes a model for care provided by physician practices that "seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship".<sup>25</sup> As jointly defined by the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics and American Osteopathic Association, the medical home is a model of care in which each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing for all the patient's health care needs and, when needed, arranging for appropriate care with other qualified physicians. A medical home also emphasizes enhanced care through open scheduling, expanded hours and communication between patients, physicians and staff.

In contrast, the leaders of the Primary Care Medical Home (PCMH) pilot project in Maine have adopted a more comprehensive approach and have set expectations for the integration of behavioral health for those providers seeking to be designated as medical homes. With funding from MeHAF, the Maine multi-payer PCMH pilot project has been developed with the participation of a wide range of stakeholders including third party payers, employers/purchasers, providers, Quality Counts, the Maine Quality Forum, and the Maine Health Management Coalition. Quality Counts, in partnership with the Maine Quality Forum and the Maine Health Management Coalition, is leading the pilot project which has the goal of developing, implementing, and evaluating a Maine multi-payer pilot of the PCMH model as a means for transforming health care and improving the integration of care across providers and settings of care. Foundation funding is helping to convene and coordinate the pilot project, support the inclusion of patients and families in the implementation of the new model, and ensure the integration of behavioral and physical health services in the PCMH model. MeHAF funding for this effort began on January 1, 2009 and will continue for a three-year period. The

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<sup>25</sup> NCQA. *Physician Practice Connections – Patient-Centered Medical Home Fact Sheet*. <http://www.ncqa.org/tabid/631/Default.aspx>

long-term goal for this project, after the expiration of MeHAF funding, is to have third party payers and purchasers provide ongoing funding and reimbursement for PCMHs.

### ***Competing Demands for Scarce Resources***

A clear theme emerged from our interviews related to the State's budget situation and the willingness of third party payers to develop payment for new services. In today's resource-constrained environment neither the State nor third party payers are likely to expand coverage to new services without a solid evidence base showing improved access to care, enhanced quality of care, or greater cost efficiencies and savings. As mentioned earlier, these are three common goals established for integrated services. A solid evidence base supporting these outcomes has not been developed.<sup>26</sup> There is not likely to be an infusion of new funding to support integrated services in the absence of this evidence. Since resources can be expected to remain tight, it is likely that there will be competing demands for available resources. As regulatory, reimbursement, and policy changes to support integration are considered, it is critical that policymakers and third party payers consider the differential impact of proposed changes across provider and practice settings and address and reconcile any potential conflicts prior to implementation.

### ***Training and Educational Needs***

Another major theme that emerged from our work is the absence of a centralized repository of information and technical assistance on integration that can be easily accessed by providers wishing to develop integrated services. The educational needs of providers related to integration include information on selecting the appropriate model, hiring the proper type of clinicians, billing and coding for services, developing clinical protocols and guidelines, understanding issues related to confidentiality and sharing of confidential patient information, compensation and employment issues, developing memoranda of understanding between providers, outcome measurement, evaluation, and grant writing. Currently, this information, as well as data on the outcomes of existing integrated initiatives in Maine, is scattered across individuals and organizations. It is not easy for providers to find the information they need.

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<sup>26</sup> As described earlier, this finding has been supported by AHRQ's 2008 report on the integration of mental health/substance abuse and primary care.

### ***Facility Licensure and Provider Scope of Practice Issues***

The key regulatory barrier to integration identified by a wide range of respondents is the complexity of facility licensure regulations for behavioral health services in Maine. It is widely believed that the current licensure regulations are a barrier to integration in that they limit the ability of licensed agencies to participate in integrated initiatives outside of their facilities. They also add to the administrative burden and cost to providers. Further, providers offering both mental health and substance abuse services are often required to have two licenses.

Surprisingly, regulations related to scope of practice by different types of providers were not identified as a major issue in Maine. The issue is not what services certain types of providers can offer but, rather, which third party payer will reimburse those providers for delivering particular services. Medicare, MaineCare, managed care organizations, and commercial insurers all have different policies regarding the types of providers that were eligible to provide and be reimbursed for services. This amounts to *de facto* regulation of the behavioral health workforce in that it limits reimbursement to certain types of providers and limits the willingness of those covered by different third party payers to seek services from these providers.

### ***Role of the State Health Plan in Encouraging Integration***

The final theme that arose from our interviews was the belief that the State Health Plan can play an important role in encouraging integration activities. The current State Health Plan contains the following recommendations promoting integrated patient-centered care:

- Identify resources to continue the depression and mental health questions on the Maine Center for Disease Control/DHHS' Behavioral Risk Factor Surveillance System ongoing telephone survey of Maine residents;
- Continue MaineCare's high-cost user care management benefit;
- Implement a pilot project in one public health district to improve coordination of public health and behavioral health systems;
- Implement a public-private multi-payer pilot project that pays for integrated patient-centered care (e.g., the multi-payer PCMH pilot project); and
- Support patient service integration, quality improvement, and enhanced patient safety by supporting and advocating for use of interoperable electronic health information systems

and the development of statewide health information exchange system (e.g., HealthInfoNet).

Although these are important recommendations, how they are implemented will have a direct bearing on the extent to which they truly promote the integration of physical and behavioral health services.

### **Summary of the Major Barriers to Integration**

Based on the work involved with the environmental scan, interviews with key stakeholders in the state, and the input of the project's Advisory Committee, the following are the major barriers to integration in Maine:

#### ***Barrier # 1: Sustainability Challenges***

Policymakers and purchasers have not implemented the policy, regulatory, and reimbursement changes needed to sustain the delivery of integrated care. As mentioned earlier, individual clinical components such as medication management and individual therapy are typically reimbursed by third party payers but these reimbursement rates do not cover the integrative services such as care management and care coordination. Reimbursement systems are complicated, inconsistent, and restrict service delivery. The fact that third party payers reimburse for individual service components may lead them to believe that they are adequately supporting integrated care. The key question becomes how to use existing evidence to encourage payers to reimburse for all components of integrated care and to simplify existing payment structures.

#### ***Barrier # 2: Understanding the Evidence Supporting Integration***

When viewed as a whole, the evidence from the various national and state demonstrations and projects targeting the integration of physical and behavioral health services, particularly for depression, is encouraging. Although studies may not support the selection of specific models of integration over others, they do support the continued development of integrated care. There is also strong evidence that clinicians and consumers prefer and support the receipt of services in integrated settings. Two key questions emerge in the consideration of this barrier. How do we organize and present evidence to encourage regulatory, reimbursement, and policy changes? Are

the elements of integrated depression care generalizable to anxiety and other behavioral health problems commonly seen in integrated settings?

***Barrier # 3: System Level Barriers***

The complexity of facility licensure, scope of practice regulations, and reimbursement policies are major barriers to integration as they: vary across payers and purchasers; create administrative burdens and complexity for providers; and vary across settings as to the types of services that may be reimbursed and the types of licensed professionals that may be reimbursed for services. Current payment policies of many payers also exclude certain licensed clinicians, thereby further exacerbating workforce shortages in rural and isolated areas of the state. In considering the changes necessary to support integration, it is important to recognize that changes to support some providers may conflict with the needs of others. It is important to consider and reconcile these differences to avoid the unintended consequence of encouraging the development of integrated services among some providers and discouraging it among others.

***Barrier # 4: Limited Access to Training, Educational Resources, and Knowledge from the Field***

A major barrier identified throughout our work is that providers seeking to implement integrated services have limited access to training and educational resources on integration. At the same time, the experience of funded projects (e.g., the knowledge from the field) in developing and sustaining integrated care is not easily available.

## **Conclusions and Recommendations**

Based on the full scope of work for this project, the study team has identified a set of principles and recommendations to guide and advance the integration of physical and behavioral health services in Maine. These principles and recommendations have been reviewed and approved by members of the project's Advisory Committee. The principles as developed by the study team and Advisory Committee are presented below. They provide guidance to all parties in Maine interested in the integration of physical and behavioral health services.

## **Overarching Priority: Realign Maine’s Health Care System to Ensure Integration**

An overarching priority identified by the study team and the Advisory Committee is the need to realign Maine’s health care system to ensure integration. It is very clear that our system, with its complex and conflicting mix of provider licensing, scope of practice, facility licensing and reimbursement regulations and policies, is a major barrier to integration. To guide this realignment of Maine’s health care system, we suggest the following principles:

- Develop consensus for regulatory, policy, and reimbursement changes necessary to support and advance integration in Maine. As part of this process, seek to realign Maine’s health care system using the Institute of Medicine’s Six Aims (e.g., care is safe, effective, patient-centered, timely, efficient, and equitable) as a guide.
- Level the integration playing field by eliminating service delivery silos; paying consistently for integrated services regardless of setting or discipline of providers; and improving on and expanding integration by using the knowledge and skill sets of providers rather than focusing on licensure categories.
- Avoid an incremental approach that builds on a broken system and does not create fundamental change.

Consistent with these principles, the study team and Advisory Committee present the following recommendations to support efforts to enhance integration in Maine. The Maine Health Access Foundation will consider the recommendations in its future program work and grant making and will incorporate them as appropriate with the understanding that the recommendations are too broad in scope to be the responsibility of any one organization.

### ***Recommendation # 1: Address System-Level Barriers in Maine***

We recommend that a comprehensive effort be undertaken to address and overcome system-level barriers to integration in Maine. This can be done by:

- Reconciling conflicting regulations, reimbursement strategies, and policies;
- Collecting and disseminating data on the effect of integration initiatives along with the lessons learned by the providers in developing and sustaining integrated services;
- Developing technical assistance and educational resources for providers of all disciplines interested in integration;

- Developing continuing education resources on integration for the health care workforce in Maine; and
- Exploring the implications for expanding the content of degree programs for physicians, physician assistants, nurse practitioners, other advanced practice nurses, psychologists, social workers, nurses, and other health care disciplines to include modules on developing and practicing in integrated settings.

We further recommend the development of integration knowledge resources to support providers, policymakers, third party payers, and advocates in their efforts to advance integration in Maine. As we envision them, these integration knowledge resources can support efforts to enhance integration in Maine by:

- Serving as coordinated repositories of knowledge on integration with each including a summary of the evidence supporting integration with links to the original reports and studies and a library of sample forms, documents, tools, memoranda of understanding, etc. to support integration efforts;
- Serving as “honest brokers” of knowledge in integration discussions;
- Reconciling conflicts in regulations, funding strategies, and policies;
- Collecting and disseminating data on the impact of integration initiatives and the lessons learned by the providers involved in these initiatives;
- Providing links to educational and technical assistance resources; and
- Identifying model programs and experts on integration in Maine and nationally.

In developing these knowledge resources, it will be necessary to identify an organization or organizations to undertake these tasks as well as to develop a funding and sustainability plan to support these activities over time. It will also be necessary to explore and learn from successful organizations that have undertaken similar activities such as the Integrated Behavioral Health Project in California, the ICARE Partnership North Carolina, the Hogg Foundation for Mental Health in Texas, the Integrated Primary Care program at the University of Massachusetts Medical School, and the Collaborative Family Healthcare Association in New York. Rather than reinvent the wheel, knowledge resources should build on or link to existing integration models, initiatives, and resources. These knowledge resources can also help to address stigma as an underlying barrier to the effective use of behavioral health services through education for the general public, providers, and office staff.

## ***Recommendation #2: Develop a Consensus Statement on the Elements of Integrated Care***

Early in this project, we observed that the term “integration” had begun to lose some of its specificity as applicants for funding sought to broaden the definition of integration to suit their proposed projects. In response, we observed that some funders had begun to advocate for a return to the co-located model of integrated care as the preferred model of integration. The danger in doing this is that it excludes collaborative (without co-location) models of care that may be appropriate for smaller practices and rural delivery systems.

We recognize that the need for integration exists in all settings and includes the integration of behavioral health services into physical health settings and physical health services into behavioral health settings. We also recognize that no single model is right for all providers and settings. To support the development of integrated services in Maine, we recommend that models of integration be viewed along a continuum from basic collaboration without co-location to fully integrated co-located systems of care and that providers should be encouraged to assess their readiness for integration and move along the continuum as appropriate for their organizations.

We recommend the development of a consensus statement specifying the attributes of integrated care that makes sense from the perspective of funders, payers, purchasers, providers, and consumers and facilitates the sustainability of integrated services through adequate reimbursement for all components of integrated care. We propose that the consensus statement on the elements of patient and family-centered integrated care include the following elements:

- Individuals have choice regarding preferred care setting;
- Individuals and families play meaningful and ongoing participatory roles in the care process;
- Individuals’ needs are assessed in behavioral and primary care settings for services across the spectrum of care;
- Treatment services are provided for physical and behavioral conditions (individual service components);
- Treatment is delivered by teams of physical and behavioral health providers that develop a coordinated treatment plan (care coordination);
- Providers care for a common population and use a common medical record;

- Solution-focused treatment is informed by evidence-based and promising-practice protocols;
- Physical and behavioral health providers engage in a collaborative approach to patient-centered health care (including care management);
- Links to other specialties and referral relationships are pre-arranged; and
- Care is cost-effective.

This proposed consensus statement should be distributed to a broad group of stakeholders including consumers and their families, payers, employers, purchasers, the Maine Health Management Coalition, Quality Counts, the Legislature, the Department of Health and Human Services, the Advisory Council on Health Systems Development, MeHAF’s Board, Community Advisory Committee, and Integration Learning Community; and others to generate discussion and comment. The resulting comments and suggestions should be incorporated into the consensus statement and circulated to seek consensus, if possible, from these stakeholders. Once completed, the consensus statement should be widely distributed to stakeholders and integrated programs throughout the state to guide the development of integrated services and programs.

***Recommendation #3: Monitor the Implementation of Behavioral Health in the Patient-Centered Medical Home Pilot Project***

As described earlier, the MeHAF funded multi-payer PCMH pilot project seeks specifically to incorporate activities to integrated behavioral health services into the model. We recommend that the sponsors of the pilot project:

- Monitor the extent to which behavioral health is integrated in medical homes and encourage movement towards appropriate levels of integration;
- Encourage consistent participation among all payers and purchasers in Maine;
- Include specific questions on integration in the planned evaluation of the medical home pilot project and disseminate the results to add to the evidence base;
- Provide technical assistance and education to PCMH pilot sites developing integrated services; and
- Recognize the implications of language on system-level approaches to integration (e.g., the term “medical home” conveys a very specific, medically based model of integration which does not encompass integrated initiatives in other settings).

***Recommendation # 4: Strengthen the Role of the State Health Plan in Supporting Integration***

As discussed earlier, the State Health Plan contains five recommendations that support the provision of integrated care in Maine. These recommendations are important first steps. The implementation of these recommendations must be done in such a way as to incorporate requirements that integrated physical and behavioral health services be a formal component of each of these action steps. We recommend that subsequent revisions to the 2008 State Health Plan incorporate stronger language and include activities focusing directly on advancing integrated health care in Maine. We further recommend the use of MeHAF's Integration Initiative Policy Committee to provide input into the next round of revisions to the State Health Plan and to discuss implementation issues for the tasks supporting integration in the 2008 State Health Plan. Finally, we recommend that financial support be continued (current funding is available only through 2010) for the depression and mental health questions on the Maine Center for Disease Control/DHHS Behavioral Risk Factor Surveillance System telephone questionnaire and that questions related to integrated care be incorporated into the questionnaire.

***Recommendation # 5: Elevate the Role of Integration in Payment Reform Discussions***

As discussions on payment reform occur in Maine, it is vital that the policy, regulatory, and reimbursement changes necessary to advance the integration of physical and behavioral health services are represented in the discussions of payment reform by the legislature, Department of Health and Human Services, the Advisory Council on Health Systems Development and others. We recommend the use of MeHAF's Integration Initiative Policy Committee to represent these issues in ongoing discussions of payment reform.

**Issues for Further Analysis**

We believe that the above recommendations will make a significant contribution to the integration of physical and behavioral health services in Maine. Given the complexity of the current reimbursement and budget climate, additional information will be needed to support efforts to advance the state of integration in Maine. It is important to remember that the barriers to integration identified in this paper through interviews with representatives from key stakeholder organizations are the perceptions of those barriers held by individual respondents. Although there is clear agreement across respondents on many of the barriers, the scope of this

project was such that we were not able to describe and quantify how these barriers impact different types of providers and practices nor were we to develop specific recommendations to overcome these barriers for each type of provider. Given our resource-scarce environment as well as the potential for reimbursement, regulatory, and/or licensure changes to have positive benefits for some providers and negative implications for others; it is important to carefully consider changes to avoid unintended consequences that will create additional barriers to integration among different types of providers.

As such, the following issues will require further analysis and quantification to remove or reduce these barriers:

- The impact of reimbursement, credentialing, and coding policies of third party payers as a barrier to integration across practice and provider types;
- The roles of public and private payers, commercial insurers, and managed care organizations in supporting integration activities;
- The impact of DHHS' facility licensure regulations on the integration of licensed mental health and substance abuse agencies;
- The administrative burden of inconsistent credentialing policies of third party payers and managed care on providers;
- The costs and infrastructure requirements to implement health information technology to support integration;
- The specific training needs of providers to advance integration activities within their settings; and
- The implications for including modules on integration in degree programs for physical and behavioral health disciplines.

Finally, we believe that it is important to move beyond the common conceptualization held by many policymakers and advocates for integration that a co-located model is the only way to integrate physical and behavioral health services. Given that the co-located model may not apply to all practice types and/or local delivery systems, it is important to allow for demonstrations that include collaborative (without co-location) models of integrated care that harness the collective resources and skills of groups of providers and agencies. Providers should be encouraged to develop integrated models of care at whatever stage of the integration

continuum is applicable to their resources and settings and to move further along the continuum over time as appropriate.

### **Next Steps**

To begin the change process, the study team and Advisory Committee strongly recommend that the Environmental Scan, Final Report, and Executive Summary be widely disseminated to payers, purchasers, the Maine Health Management Coalition, Quality Counts, the Legislature, the Department of Health and Human Services, the Advisory Council on Health Systems Development, MeHAF's Board, Community Advisory Committee, and Integration Learning Community; and other stakeholders. The dissemination process should engage stakeholders in discussions to: develop consensus on integration issues; achieve critical mass for initiating needed change; secure the commitment of stakeholders to participate in the change process; identify resources stakeholders will commit to the process; align resources; and identify recommendations for priority policy, regulatory, and reimbursement changes. We further recommend that MeHAF's Integration Initiative Policy Committee analyze the results of these discussions, identify consensus points across stakeholders, and establish priority action steps.

The integration of physical and behavioral health care remains an important policy ideal. It has significant potential to promote patient- and family-centered care in Maine by ensuring the coordinated delivery of physical and behavioral health services in settings preferred by patients and their families. Advancing integrated care will improve access to services and the quality of those services as well as reduce the burden of illness for patients and their families and the impact of stigma as a barrier to seeking care. Significant progress in implementing integrated programs has been made by some providers in Maine but additional work is needed to assist more providers in developing their own integrated initiatives and to refine existing integrated services. This project has been an important first step in clearly identifying and articulating the barriers to integration in Maine along with potential solutions. The recommendations outlined in this report will further the integration of behavioral and physical health services in Maine.