



Behavioral Health Integration in Minnesota: Recommended Actions

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Introduction

Mental health leaders, medical leaders, and employers from across Minnesota resoundingly express that integrated behavioral health care in primary care, specifically the Collaborative Care Model (CoCM), is a solution that must be expanded.

Integrated behavioral health is an addition to the continuum of mental health and substance use disorder (SUD) care. Embedded in primary care, it reaches a broad population: Adults, children and families, urban and rural communities, people of varied ethnicities, socio-economic means and insurance types. Integrated behavioral health care normalizes mental health and addiction, meets people's needs before they are in crisis and require more intensive and expensive services, and facilitates transitions to specialty level care when needed. Importantly, integrated behavioral health also optimizes the mental health workforce, maximizing a severe shortage of psychiatrists and therapists to better meet a steadily increasing demand for services.

A Cochrane Systematic Review¹ of 79 randomized control trial studies shows abundant evidence that the [Collaborative Care Model](#) results in better outcomes, faster; diverting people from crisis and resulting in cost savings. For example, Mayo's experience when implementing this model showed significantly better response at three- and six months compared to usual practice.² Another study showed that for every \$1 spent on care delivered in the Collaborative Care Model, there is a \$6.50 ROI in improved health and productivity.³

With all these benefits, why hasn't this service gained more traction? As a community we've come to understand the facilitators and barriers for integrating behavioral health here in Minnesota.

A major challenge is that integration contests the status quo for how healthcare is historically delivered and paid. Historical silos exist between mental health and addiction and primary care, including different cost centers, different medical records and privacy laws. In addition, the financing of behavioral health historically and currently emphasizes fee-for-service, face-to-face visits, which has not provided sustainable reimbursement options for managing between-visit population health needs. However, Value Based Payment (VBP) is rapidly becoming a larger part of the healthcare financing equation. Healthcare systems are now at risk financially if their quality numbers are not at goal (which are harder to achieve with a growing mental health burden). The Collaborative Care Model can help meet those quality goals within Value Based Payment contracts; at the same time the model is advanced by VBP.

Four main actions are needed in order to move integrated behavioral health forward in Minnesota (more specific recommendations are found within this document):

- **Advance and support the Collaborative Care Model as a priority model**, as it has a strong evidence base with better and speedier outcomes, satisfaction, and value.
- **Recognize and support the operational and financial innovation that integration requires, as it challenges the historical structural divide between mental health/SUD, and primary care.** Two ways to do this include incorporating the model into Value Based

¹ Archer et al. Cochrane Systematic Review, 2012

² Shippee et al. Ambulatory Care Management 2013

³ Unützer et al. CMS Health Home Information Center, 2013

Payment contracts, and ensure leadership persistence to support addressing mental health in primary care, versus only in specialty mental health care.

- **Ensure financial sustainability. One clear path towards sustainability is to arrange reimbursement across all commercial and public payors and service lines for the Collaborative Care Model codes and Behavioral Health Integration codes.** This is not currently the case as it is not covered for Medicaid and MinnesotaCare patients. This hinders adoption and expansion in healthcare organizations as it is operationally too burdensome to parse out service by paper coverage, and it also puts patients and systems at risk for non-covered services provided.
- **Establish a regional center for excellence to support advancement of the Collaborative Care model.** Consider sharing of workforce (psychiatry), training, implementation support, measurement and monitoring of progress, alignment of care delivery/payor/state efforts.

Without sustained, intentional coordination on a community-wide level, as well as targeted support of resources, integrated care efforts will continue to underperform in their potential to meet our communities' mental health needs and transform Minnesota care systems.

Background

Minnesota is not new to efforts to integrate mental health in primary care. From 2008-2013 healthcare organizations, both care delivery and plans, gathered with ICSI to develop and implement the DIAMOND project, after which ICSI carried that work further in the COMPASS initiative nationally. The purchaser-led pay-for-performance program, Minnesota Bridges to Excellence, further kept momentum going for integration. (Learn more of this history in Appendix A.)

These efforts have led to progress in depression screening, however, the Minnesota Community Measurement data on depression outcomes has not shown sufficient improvement. In addition, there are significant disparities in outcomes for people of color and ethnic and culturally diverse communities, with remission rates less than half the rate than that of white patients.

In 2021 ICSI reconvened a broad stakeholder group over time to work together and learn how we have progressed in providing integrated behavioral health care in primary care. Leaders across the state report an increased need for mental health and substance use disorder care due to the pandemic. The Collaborative Care Model in primary care has risen to the top of the list as a pivotal solution in helping patients reach better outcomes more quickly, optimizing the workforce and improving value.

In addition, two distinct experiences raise the question of whether healthcare systems are substantially hampered in their efforts toward integration by not yet committing to the highly evidence-based integration program, the Collaborative Care Model:

- The momentum for payment of Collaborative Care codes has been slow, with Minnesota Medicaid still not paying for it, and the number of claims submitted to commercial insurance remains very low; and
- During the COVID pandemic a regression to older, less effective models occurred as systems were confronted with strain on their finances and mental health resources.

Why the Collaborative Care Model?

The Collaborative Care Model for Behavioral Health has been demonstrated to more effectively use the constrained resources of psychiatry and psychotherapy. Even prior to the Covid-19 pandemic, it was estimated that the country would need four times as many mental health providers as were practicing at the time in order to meet the level of need.⁴ Now, with a dramatic increase in demand for mental health services due to pandemic stressors, and with an already insufficient supply of mental health professionals, the value of the Collaborative Care Model in primary care is even more apparent.

Nationally, the Collaborative Care Model is increasingly gaining momentum as a needed solution, but is yet to be prioritized in Minnesota. [New federal legislation has been introduced specifically aimed at advancing this model of care](#), supported by multiple medical and mental health associations as well as employers; and the Collaborative Care Model in primary care has also been named as part of the solution in a new [bipartisan call for national mental health reform](#).

The [Collaborative Care Model](#) has overwhelming evidence of better outcomes, along with improved patient and provider satisfaction and potential cost savings:

- The original IMPACT trial⁵ focusing on depression (patients 65 and older) demonstrated:
 - **Double response rate at 12 months** for depressed adults (45% vs 19%)
 - Same result in all eight organizations (18 clinics total)
- Mayo's experience² when implementing the same model (age 18 and older) demonstrated:
 - **Three month and six-month response is significantly better** than usual practice
 - Six-month response (69% for intervention group vs 53% PAU)
 - Six-month remission (53% vs 31%)
- **Faster improvement for patients⁶** has been demonstrated with the Collaborative Care Model:
 - Time to depression remission was **86 days in a CoCM program vs 614 days** while in usual care
 - **A major reason for this improvement has to do with [treat to target](#)**
 - More medication adjustments are made than in practice as usual⁷
- **New research demonstrates effectiveness for people with bipolar disorder and PTSD⁸**
- **Cost savings have been demonstrated with the Collaborative Care Model:**
 - Receiving care in CoCM, employers can see a combined cost savings of \$1,815 per employee per year in health care spend and improved productivity⁹
 - For every \$1 spent on care delivered in the CoCM, there is a \$6.50 ROI in improved health and productivity³

⁴ Burke et al. BMC Health Serv Res. 2013

⁵ Unützer et al. JAMA 2002

⁶ Garrison et al. JAM Fam Med, 2016

⁷ DeJesus et al. Clinical Practice and Epidemiology in Mental Health 2013

⁸ Fortney et al. JAMA Psychiatry 2021

⁹ Unützer et al. American Journal of Managed Care 2008

- **The Collaborative Care Model for mental health is linked to better medical outcomes and cost effectiveness** for patients with diabetes, cardiovascular disease, cancer and chronic arthritis¹⁰
 - Unmanaged or ineffectively managed behavioral conditions that co-exist with other chronic illnesses undermine management of the other chronic illness and inflate overall health care spend by \$400-721 per patient per month¹¹ – an important consideration for Value Based Payment contracts

Minnesota leaders who have implemented the Collaborative Care Model have found it builds capacity in primary care to better address mental health and substance use disorders. It's also valuable in demonstrating measurable outcomes, in part because the CoCM codes are structured with fidelity to the model, and also because the service is embedded in primary care sites where measuring mental health and medical outcomes are routine.

These experiences have been echoed in other implementation efforts nationally.

Specific Needs and Opportunities in Minnesota

Through multiple group discussions, 1:1 interviews and surveys, the following needs and opportunities have been identified:

Financial

- **The financing of behavioral health must be brought in line with the shifts in payment structures occurring for the rest of healthcare organization (e.g., value-based care).** Regressing to historic expectations of care as usual (specialty care in psychiatry and/or longer therapy sessions) has long been a tension hampering integration and Collaborative Care Model innovation. Fee for service reimbursement models, as well as different cost centers for primary care and behavioral health in organizations, serve to maintain a segregation between mental health and other health needs. As an example, several Minnesota systems, when confronted with pandemic stressors, moved resources from their integration programs to services that are explicitly more recognizable as specialty care.
- **Collaborative Care Management (CoCM) codes need to be covered by Medicaid in Minnesota.** Until CoCM is covered by all payers, there will continue to be slow advancement and inequities. Of note, 22 other states do reimburse for this care, as compared to five states in 2019. Leaders at Minnesota Department of Human Services (DHS) have engaged with ICSI over time to understand the intersection of the Collaborative Care Model and Medicaid behavioral health services. (See Appendix A for more)
- **New structures and processes are needed for care delivery systems to bill for the CoCM codes.** While these codes cover non-visit time activities of the Collaborative Care Model, they are also structured in a way that the electronic health record and traditional billing systems are not designed to easily capture. Many systems are unable to invest the resources needed to establish and maintain these structures and systems.

¹⁰ Katon et al. General Psychiatry, 2012

¹¹ Melek et al. Milliman, 2014

- **Organizations need to decide internally how revenue will be distributed to cover the cost of staff such as the care manager and the psychiatrist, creating a supportive financial infrastructure.** Typically the financial infrastructure for tracking CoCM payments attributed to primary care physicians, but performed by the behavioral health care manager and psychiatrist, is lacking (or not predictable).

Operational

- **Historical structures that create silos between mental health, substance abuse, and primary care are often the undoing of the Collaborative Care Model.** Priorities, teams and workflows are misaligned, while different medical record systems hamper communication and patient care. While mental health has been identified as a key community need and a key strategy for many organizations, there is usually little focused attention on integration and strategies to bridge these historical silos.
- **Workforce limitations: There is difficulty hiring psychiatrists, care managers, and psychologists and social workers.** While integration and the Collaborative Care Model is a way to optimize the existing workforce, the shortage of workers is still a barrier. The shortage is worse for providers who see children and adolescents.
- **Telehealth can be an important addition to the model, and also has challenges to overcome.** Telehealth (and audio-only/telephone visits) during the pandemic has opened doors for patients to meet virtually with behavioral health providers regardless of location. Many systems report reduced no-shows when using virtual visits for mental health, and are experiencing advantages in optimizing the time of psychiatrists and behavioral health care managers, although telehealth alone is an insufficient solution to the behavioral health workforce shortage. Also, many clinics have not yet found ways to form effective relationships virtually across teams and departments. Ensuring effective virtual transitions for patients between the primary care and collaborative care teams also needs attention.
- **Resources to support operational changes and innovation are lacking.** Teams need further training and education on roles specific to the Collaborative Care Model including case review and team workflows. There are multiple examples of models that have been tested in randomized trials for care of people with addiction, bipolar, PTSD, etc., but practices are too busy trying to survive to test and adapt these models in their settings for improved outcomes and efficiency.

Additional insights on barriers and opportunities related to clinical practices in advancing the Collaborative Care Model in Minnesota have been gained in a 2019-2021 project funded by a Eugene B. Washington Community Engagement Award from the Patient-Centered Outcomes Research Institute (PCORI). [Read more here.](#)

Recommendations for Healthcare Organizations

Simply put, the Collaborative Care Model is systemically underutilized in Minnesota despite having the greatest amount of literature on value (cost, quality, and satisfaction) nationwide, as well as widespread support from experts nationally and here in Minnesota.

Each CEO and senior leader should consider the following:

- **How well is your organization meeting patients' mental health needs, as defined by your organization's access, satisfaction and outcome metrics?**
For example, what are your emergency department and inpatient readmission rates? What are your depression outcomes as reported by MN Community Measurement and have they improved in the past several years?
- **How robustly has your organization adopted the Collaborative Care Model as the evidence-based model to address depression and other behavioral health needs in primary care vs other strategies? How have you adjusted structures, processes and payment to support integration vs. specialty mental health care as usual?**
For example, what is your utilization of CoCM codes? Is revenue from integrated care distributed to support both primary care and collaborative care functions, e.g., care manager and psychiatrist?
- **For health plan CEOs: How does your organization support the Collaborative Care Model? How might expanding adoption align with your system's strategic intent?**
For example, are the CoCM codes turned on for all your service lines? Do you review the use of the CoCM codes submitted? Are you proactively having conversations with delivery systems to find opportunities for alignment? Do you provide training, technical support, and funding/incentives to providers to implement and expand use of the Collaborative Care Model?
- **Where might you link strategy to performance by further prioritizing integration of behavioral health and primary care, with specific measurable goals and incentives for short and intermediate term?**
For example: What is the percentage of patients achieving remission by 6 and 12 months of initiation of treatment, or how soon does a patient with depression and moderate symptoms get access to a collaborative care assessment.
- **Have you assured your organization's Balanced Score Card reflects these goals and has appropriate leadership, operational and financial support for success?**
This includes visualization of performance and alignment between the C-Suite and accountable clinical leaders (behavioral health, primary care, and other medical leaders).
- **Where do you need to dedicate the financial and other resources required to enable action?**
This will be unique to your organization, but it may include time and funds to establish systems to bill for the CoCM codes, or dedication of the specific workforce needed for the Collaborative Care Model.

Finally, the exit of ICSI from this work leaves a void for which no alternative resource has been identified. While individual organizations should proceed, without a collaborative structure for alignment, building shared metrics, payment, education, advocacy, and policy solutions will be slowed.

Recommendations for Collective Action

We recommend the following additional actions, coordinated as a Minnesota community:

- **Payors (both public and commercial) and health care delivery systems should seek and further develop a positive reinforcing feedback loop to sustain and further advance integration via the Collaborative Care Model.** Designate or create an entity to conduct and sustain the vision, coordinate and monitor activities over time.
- **Adopt and share evidence-based measurement and reporting, with an emphasis on fidelity (process measures) to start.** The CoCM codes are a good place to start as they are built on fidelity to the model. A good overview of additional potential metrics can be found at the [Integration Academy at AHRQ](#).
- **Optimize the potential expansion of the Collaborative Care Model for broader populations and conditions,** e.g., child/adolescent, mood disorders, substance use disorders, perinatal. Evidence for integration continues to evolve and is indicated for multiple populations.
- **Share resources wherever possible, including workforce.** For instance, sharing a psychiatrist among systems, and coordinating trainings for people from multiple systems and clinics to attend.
- **Learn from the experience and innovations of other states, bringing those lessons forward to all.** One example is [Penn Medicine Collaborative Care](#) at the University of Pennsylvania, where a centralized center conducts triage and assessment by telephone, allowing the mental health care managers/providers to focus on delivering interventions that improve outcomes. This is one example of a resource that could be built and shared. [Colorado](#) and [Michigan](#) are two other states who have made considerable traction in advancing integration and the Collaborative Care Model.

Summary

The need for mental health services is greater than ever, and rising. Alongside this, our mental health workforce is in severe short supply. Integrated behavioral health is a solution that addresses both issues.

The Collaborative Care Model is no longer innovative clinically and underutilized for its potential; it's a chronic condition care model with an undisputed and strong evidence base. Operationally and financially, however, Collaborative Care in primary care needs to be recognized and supported as the disruptive innovation it is for its potential to be realized.

We are starting to see a groundswell of support for integration and the Collaborative Care Model, and we now know a great deal about how to implement and sustain it. We also know that collective focus is key to driving improvement: When there was a focus by systems and health plans on improving depression screening, Minnesota's rates and performance went up.

With the undeniable need and overwhelming evidence, it's time for Minnesota to further support and advance the Collaborative Care Model. Focused action will ensure the Collaborative Care Model can reach its potential in optimizing the mental health workforce and improving outcomes for our patients, friends, and family.

Appendix A

Background on Integrated Behavioral Health in Minnesota

From 2008-2015 healthcare organizations, both care delivery and plans, gathered with ICSI to develop and implement the [DIAMOND project](#), after which ICSI carried that work further in the [COMPASS](#) initiative nationally. The purchaser-led pay-for-performance program, Minnesota Bridges to Excellence, further kept momentum for integration going.

From 2017-2020 mental health and medical leaders once again began working together as members of ICSI on integrating behavioral health in primary care. With full recognition that integration in Minnesota had stalled, the care delivery systems identified that different organizations had different models of care for integration. They adopted the [Cross-Model Framework](#)¹² to help each organization understand its program in a developmental trajectory. The ICSI group contributed to the formation of the framework, identifying the need for developing new organizational structures that support integration.

Clinics also contributed data to ICSI, reporting their implementation progress over time via a [Site Self Assessment Survey](#) instrument. A crosswalk of that data and Minnesota Community Measurement data from the same time period shows that strong organizational leadership for integrated care seems to be a key factor in better depression and chronic disease management. Clinics where personnel felt strong support for integrated care from their leadership tended to have better rates of adolescent depression screening, measurement-based care for adults with depression, and chronic disease management.

Meanwhile, leaders from both health plans and care delivery focused on sustainable funding supported by better utilization of the CMS Collaborative Care Model (CoCM) codes used in Medicare as of 2017. These codes, structured specifically with fidelity to the Collaborative Care Model, allow for reimbursement of non-visit time spent in case review and care planning and coordination. Minnesota commercial health plans have adopted the codes due to these efforts, alongside support from employers and the Minnesota Psychiatric Society.

Leaders at the Minnesota Department of Human Services (DHS) have participated in targeted conversations over time to learn more about the need and potential for the Collaborative Care Model in primary care for Medicaid patients. At this writing, DHS is working on implementing a massive spending plan for investments in community-based services, including behavioral health, and also including primary care as a place where mental health is managed. As part of this comprehensive work, they are revisiting the rate structure and conducting several studies. They see this infrastructure work as foundational to the adoption of additional potential solutions for integration such as Collaborative Care Model in future.

¹² Stephens et al. Translational Behavioral Medicine, 2020

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