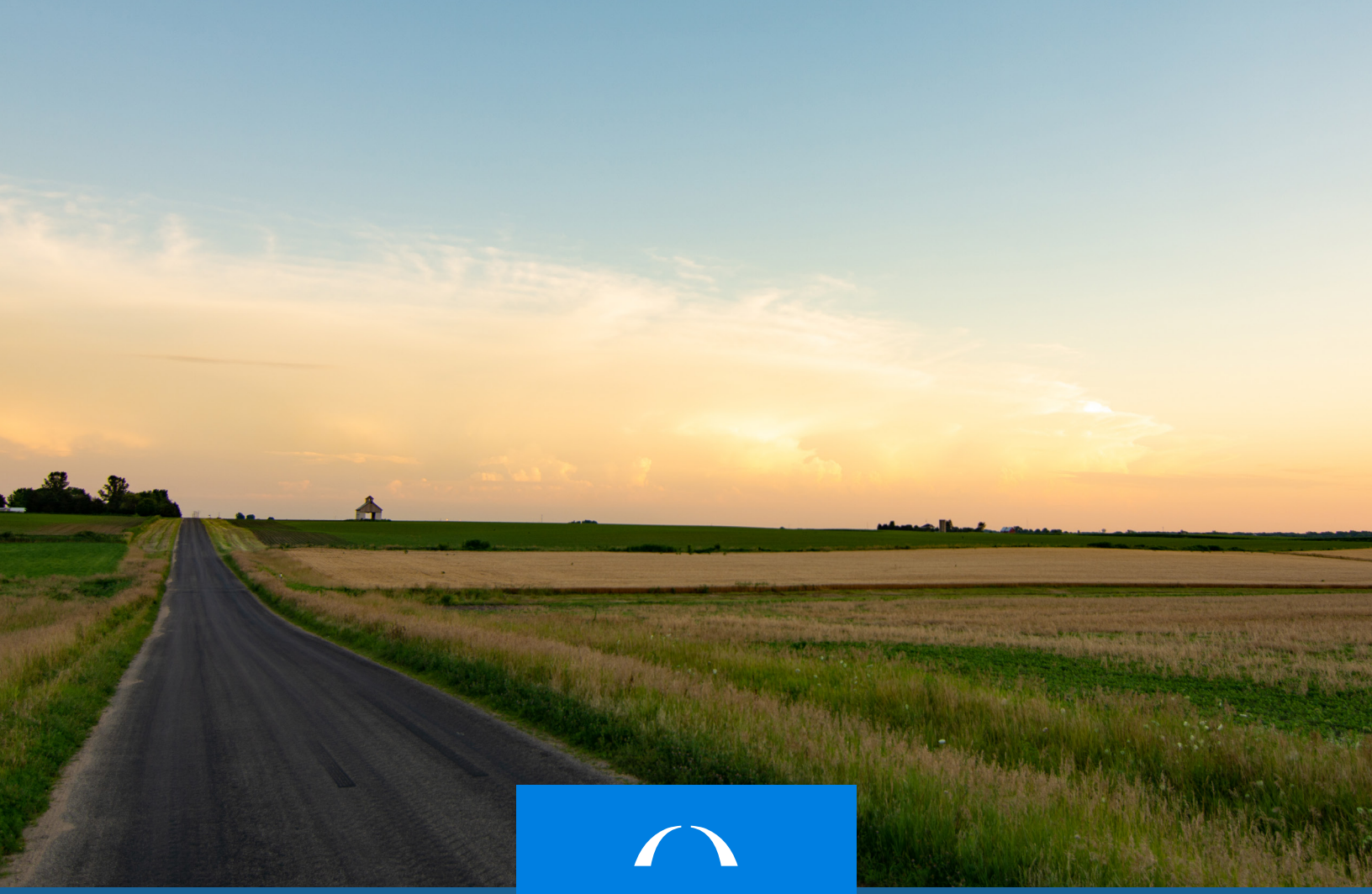

Where democracy gets to work

Achieving Behavioral Health Care Integration in Rural America

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Bipartisan Policy Center

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HEALTH PROGRAM

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Program strives to develop bipartisan policies that improve the nation's health outcomes, reduce health care costs, and make quality health care available, affordable, and accessible to all Americans. We believe the ideal health care system is one that ensures coverage for all individuals, prioritizes equity in health services, keeps people healthy, and improves care for patients. Two projects within the Health Program focus on distinct policy areas in pursuit of this ideal. The Health Project seeks solutions that improve health care quality, lower costs, and enhance coverage and delivery. The Prevention Project focuses on chronic disease prevention, social determinants of health, nutrition and obesity, and the infrastructure needed to promote healthy communities and institutions.

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DISCLAIMER

Table of Contents

Executive Summary

Integrating primary care services and treatment for mental health and substance use conditions not only enhances patients' access to needed care but also improves health outcomes in a cost-effective way. Yet the barriers to integrated care are substantial, and it is even more difficult to achieve in rural and frontier communities, which are home to 1 in 7 Americans.[1]

This report builds on the Bipartisan Policy Center's March 2021 Behavioral Health Integration Task Force report, which looked broadly at ways to achieve behavioral health and primary care integration across the United States.[2] Primary care providers already handle some of the behavioral health care needs of their patients, but they describe feeling overwhelmed, ill-equipped to handle these tasks, and underpaid. To incentivize and enable primary care providers to take on a greater role in delivering mental health and substance use treatment services, they will need training, technical assistance, adequate reimbursement, and access to a larger pool of behavioral health providers for both consultations and referrals.

Our current work focuses on breaking down the barriers to integration in rural America, where the health care infrastructure and provider composition vary in distinct ways from urban and suburban areas.

Americans in rural areas face significant shortages of psychiatrists, psychologists, clinical social workers, and other behavioral health specialists. More than 60% of nonmetropolitan counties lack a psychiatrist, and almost half of nonmetropolitan counties do not have a psychologist, compared with 27% and 19% of urban counties, respectively.[3] These gaps in specialty care force rural residents to rely heavily on primary providers for much of their care.[4]

Over the past year, BPC conducted a series of interviews with rural health policy experts, national organizations, federal and state leaders, providers, payers, consumers, and academics to gain insight into the opportunities and challenges related to delivering integrated care in rural areas.

BPC's recommendations provide a clear pathway to expand integrated primary care and behavioral health services in rural America, partially by leveraging the Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) that dominate health care delivery—particularly primary care—in these communities. The centers are key to integration in rural areas, as primary care providers often serve as a gateway into behavioral health care.

FQHCs experienced an 83% increase in patient visits for mental health and substance use disorder services between 2010 and 2016, outpacing the growth of medical visits and total visits.[5] As such, RHCs and FQHCs are critical to providing not only primary care but also behavioral health care to the populations they serve.

BPC also takes a closer look at the needs of several populations that rely heavily on alternate delivery systems for much of their care in rural areas: veterans; American Indians and Alaska Natives (AI/AN); and individuals with high behavioral health needs, including those with serious mental illness and substance use disorders. The recommendations in this report would improve the ability of rural communities to better coordinate and integrate primary care and behavioral health services for these three high-risk groups.

The policy recommendations, if implemented, would also expand the ability of primary care providers to handle the lower-acuity behavioral health needs of their patients by providing enhanced payments, training, and improved access to behavioral health providers for consultation and referral. BPC's recommendations call for the expanded use of telehealth, which took off during the COVID-19 pandemic, and new investments to ensure the delivery of integrated care in rural America.

POLICY RECOMMENDATIONS

A. Foundational to Integration

- The Department of Health and Human Services (HHS) should identify a set of standardized quality and performance metrics for delivering integrated care.
- HHS should prioritize a set of core service elements for behavioral health integration within primary care.
- The Centers for Medicare and Medicaid Services (CMS) should ensure network adequacy for Medicaid, the Children's Health Insurance Program (CHIP), and Medicare Advantage; it should also ensure there is capacity for behavioral health specialty referrals and interprofessional consultation support for primary care providers.

B. Building and Supporting the Rural Integrated Care Workforce

- Congress should incentivize behavioral health providers to practice in rural areas by allowing additional behavioral health provider types to receive bonuses through Medicare's Health Professional Shortage Area (HPSA) physician bonus program.
- To improve workforce retention, Congress should establish a federal tax credit for providers practicing in rural areas.
- To promote the training of residents in rural areas, Congress should permanently reauthorize the Teaching Health Center Graduate Medical Education (THCGME) Program and increase funding for the Health Resources Services Administration's (HRSA) Rural Residency Planning and Development Program, which supports traditional graduate medical education rotations in rural communities.

- The Substance Abuse and Mental Health Services Administration (SAMHSA), HRSA, and the Department of Veteran Affairs (VA) should incentivize medical schools to offer—and issue guidance for practicing primary care providers to receive—training for prescribing buprenorphine to patients with opioid use disorder (OUD).
- The Center for Medicaid and CHIP Services (CMCS) should provide technical assistance to state agencies regarding integration strategies, such as leveraging the use of interprofessional consultations in Medicaid and CHIP as well as weighing the expansion of Medicaid coverage of licensed professional counselor services, as Congress recently approved for Medicare.

C. Payment and Delivery System Reform

- Congress should remove the cap on RHCs that requires them to provide no more than half of their total services for behavioral health.
- CMS should clarify Medicare's same-day billing exceptions for FQHCs and RHCs to include substance use treatment in addition to mental health visits.
- To increase uptake of the Collaborative Care Model (CoCM), CMS should consider increasing reimbursement rates, rethinking beneficiary co-pays, and providing additional technical assistance or guidance to states on patient consent.
- Congress and CMS should ensure the continuation of most pandemic-era flexibilities for telehealth services delivered in rural areas, including audio-only telehealth, within the context of established patient-provider relationships.

D. Supporting Veterans, Tribal Communities, and Individuals with High Behavioral Health Needs

- VA should expand the scope of the VA Solid Start Program to provide additional support services to military members with behavioral health conditions who are transitioning from active service to veteran life, and educate veterans who might be eligible to upgrade their discharge status.
- The HHS secretary should direct departmental agencies to leverage existing grants to alleviate provider shortages among tribal communities.
- SAMHSA and CMS should increase integration within behavioral health specialty clinics by allocating grants to Community Mental Health Centers (CMHCs) and Certified Community Behavioral Health Clinics (CCBHCs); CMS should also clarify that opioid treatment programs (OTPs) can bill Medicare for primary care services.

Introduction

Since the onset of COVID-19, the need for behavioral health services has grown and become more urgent. Suicide rates rose 4% between 2020 and 2021 after two consecutive years of decline.[6] Overdose deaths reached a record in 2020, with more than 100,000 people losing their lives.[7] Additionally, the prevalence of mental health conditions tripled during peak stay-at-home orders in April 2020, as compared with just two years earlier.[8]

Although the problem is significant nationally, rural areas are often the hardest hit. For example, rural areas experience significantly higher rates of suicide—particularly among farmers, ranchers, and the American Indian and Alaskan Native populations—and drug overdose death rates surpass those of urban areas.[9,10,11,12,13,14,15] Compounding the situation is the sobering fact that 60% of rural Americans live in mental health professional shortage areas.[16] One study found that rural Medicare beneficiaries traveled twice as far as their urban counterparts to access mental health services.[17] Stakeholders interviewed by BPC also highlighted the social stigma that persists around accessing behavioral health care in rural communities, even when it is available.

Integrating behavioral health and primary care would help narrow the gap between need and care in rural areas. Yet, despite overwhelming evidence supporting its value, challenges exist to expanding its availability, and most often integration is occurring not in small, rural practices but in large urban health centers.

This report builds on BPC's 2021 Behavioral Health Integration Task Force's foundational work, *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration*, which offered a comprehensive set of recommendations for advancing primary care and behavioral health

integration nationally. This work provides a realistic assessment of the barriers to integration in rural areas and sets forth opportunities for policies that can improve access by enabling more rural providers to deliver integrated care.

THE VALUE OF INTEGRATED CARE IN RURAL AREAS

An extensive and growing body of evidence shows the benefits of delivering more behavioral health services through—and in collaboration with—primary care providers, including increasing patients' access to services, improving health outcomes, and increasing cost-effectiveness. This is particularly important in rural areas, where behavioral health specialists are in short supply and patients receive much of their care through their physician.

Access to care: Integration allows more patients to access critical mental health and substance use treatment services in a centralized location. It also reduces the chances that a patient's behavioral health needs fall through the cracks. Already, behavioral and physical health conditions are commonly diagnosed in a patient at the same time, and one study found that nearly 40% of visits to primary care physicians nationwide were for behavioral health issues.[18]

Tragically, 45% of individuals who died by suicide had seen their primary care provider in the 30 days before their death, highlighting the potential for primary care providers to intervene.[19] Rural residents already receive more of their health care through primary care settings—including care for mental health conditions—simply because specialists are fewer and farther between.[20] Moreover, primary care physicians, nationally and in rural areas, provide half of all care for mental health disorders and prescribe more medications for depression and anxiety than psychiatrists.[21]

Health outcomes: Many studies suggest that integrating care positively affects patient health outcomes. An analysis of the evidence across 34 systematic reviews and nine additional studies on integrated care programs found a 19% reduction in hospital admission rates, compared with usual care.[22] Integrated behavioral health care is also associated with reductions in emergency department visits.[23] Multiple studies found that integrated care improves the management of chronic conditions such as diabetes.[24,25] For individuals with diabetes, a systematic review found that integrated care was associated with a mean 0.5 percentage point reduction in HbA1c levels,[a] compared with usual care.[26] Additionally, integration has reduced the severity of depression and improved patients' perceptions of care.[27,28]

Cost-effectiveness: Given the high costs of and poor outcomes for patients with both physical and behavioral health conditions, integrating care can be

a HbA1c (or A1C) is a blood test that measures your average blood sugar levels over the past 3 months.

a cost-effective way to improve health outcomes.[29] Several states focused on integration have already demonstrated positive results. Illinois, Missouri, Arizona, Colorado, and Washington have lowered costs by integrating care, primarily through their Medicaid programs.[30,31,32,33,34] In Arizona, a Medicaid Managed Care Organization estimated that a collaboration to integrate care produced health care savings of up to $14.4 million in its contracts over the course of two years, and Colorado saved an estimated $178.6 million in 2016-2017 across public and private payers.[35,36]

THE INTEGRATED CARE CONTINUUM

Despite strong evidence demonstrating effectiveness, and an increasing number of programs, no standard definition for integrated care exists across private and public health programs. There also are no core service and quality standards.[37]

The Lexicon for Behavioral Health and Primary Care Integration—a document developed by the Agency for Healthcare Research and Quality (AHRQ)—provides a general statement, but this document should be built out so that it can apply to integration in various settings and degrees. According to the statement, integrated care generally consists of "a practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population."[38]

The statement serves as a useful starting point, but it does not reflect primary care providers' widely varying capabilities to screen for and deliver behavioral health services. Appendix A outlines provider types that fall along the integrated care continuum, their major activities, and the skills they need to move them further along the continuum. Indeed, activities range from screening for and coordinating patients' behavioral health needs, to co-locating care, to delivering fully integrated, seamless primary and behavioral health care.

Although many stakeholders consider system-level integration to be the gold standard of integrated care, achieving this goal is out of reach for many rural providers. Primary care providers in urban settings are significantly more likely to co-locate with behavioral health specialists than their rural counterparts. This is due to numerous barriers described in greater detail below.[39]

Wherever providers fall along the integration continuum, they can engage in valuable work to bring primary care and behavioral health services closer together. For example, independent primary care providers who are not addressing their patients' behavioral health needs can integrate more screening tools into their practice by screening patients for mental health and substance use disorders and referring them for care. Additionally, providers who already offer a more robust set of physical and behavioral health services can do even more by ensuring that all patients have a single, coordinated care plan.

INTEGRATION WILL LOOK DIFFERENT IN RURAL AMERICA

In considering the best ways to meet behavioral health needs in rural America, it is necessary to account for the populations residing there, along with their unique challenges. Compared with urban and suburban areas, rural communities are home to more American Indians and Alaska Natives, as well as more veterans. In addition, more rural residents rely on public programs, notably Medicare and Medicaid, which tend to reimburse medical providers at lower rates than private insurers.

The health care delivery infrastructure often looks different in rural areas due to workforce shortages, longer distances to services, and other challenges. It includes a heavy reliance on primary care, making RHCs and FQHCs an important component of integration efforts.

More than 5,000 RHCs and 1,400 FQHCs serve millions of Americans in rural communities, presenting major opportunities for the delivery of integrated primary care and behavioral health services.[40,41] BPC reviewed several successful models of integrated care in rural areas. For example, Cherokee Health Systems in rural Tennessee is both a federally qualified health center and a community mental health center, and it leads the nation in the delivery of evidence-based integrated care services.

Hospitals also play an important role in rural communities, yet many are at risk of losing services or closing. When a rural hospital closes, clinicians often move elsewhere, reducing the overall availability of outpatient services in a community as well.

Although federal support during the COVID-19 pandemic temporarily helped many struggling rural hospitals and slowed the rate of closures, financial challenges resumed across rural health care systems after the relief money largely ended by 2022.[42] Between January 2020 and March 2023, 33 rural hospitals have either closed or converted to other uses, in which the facility no longer provides inpatient care but continues to deliver other health services, such as emergency care, rehabilitation, or outpatient services.[43]

Rural providers disproportionately rely on Medicare and Medicaid. Today in rural areas, roughly 1 out of every 3 individuals is enrolled in Medicare and nearly 1 in 4 under age 65 relies on Medicaid.[44,45] These programs typically pay providers less than private insurers, which has implications for rural hospitals' financial security as well as the finances of other rural providers. Given the outsized role these public programs play in rural communities, this report focuses on leveraging Medicare and Medicaid to promote integrated care delivery in rural areas.

In addition to examining the important role for RHCs and FQHCs, this report also explores the potential to utilize and improve coordination within several alternate delivery systems in rural areas, including those that serve veterans, tribal communities, and individuals with significant behavioral health needs.

Veterans Affairs: Veterans disproportionately live in rural areas and often have more complex health needs, including higher rates of post-traumatic stress disorder (PTSD) and depression, than civilians.[46] The VA estimates that nearly 1 in 4 veterans—4.7 million people—settles in rural communities upon completion of their military service, and only 60% of those are enrolled in the VA system.[47,48] Drawing more veterans into the VA system would afford them access to fully integrated services. The VA has a long history of delivering integrated behavioral health care services to veterans, and research shows that this has contributed to higher patient satisfaction, improvements in health status, and quicker treatment initiation for mental health conditions.[49,50,51]

Indian Health Service: Tribal communities have high rates of mental health and substance use disorders, are disproportionately located in rural areas, and rely predominantly on the Indian Health Service (IHS) for their care. IHS provides federal health care services to approximately 2.6 million American Indians and Alaska Natives who belong to 574 federally recognized tribes in 37 states through a network of more than 600 hospitals and clinics.[52] This network remains chronically underfunded and without necessary investments, especially in the health care workforce, and falls short in the delivery of integrated care.

In 2020, Mental Health America reported that while American Indian and Alaska Native (AI/ANs) make up just 1.3% of the U.S. population, more than 19% (or roughly 827,000) reported experiencing a mental illness in the past year.[53] AI/AN youth are at especially high risk. In fact, the latest CDC data on suicide deaths indicates that the rates of completed suicides for female AI/AN adolescents is roughly four times higher than white female counterparts.[54,55]

Behavioral health specialty clinics: Individuals with serious mental illness, such as schizophrenia, bipolar disorder, or major depression, often rely on networks of specialty behavioral health clinics for much of their care and develop strong, trusting relationships with their behavioral health providers. Specialty behavioral health clinics include community mental health centers (CMHCs), certified community behavioral health clinics (CCBHCs), and opioid treatment programs (OTPs). CMHCs, CCBHCs, and OTPs reach a different patient population than typical primary care providers, and many individuals with major behavioral health needs do not receive adequate treatment in primary care settings. Thus, reverse integration, in which specialty providers bring in primary care services,

are an important mechanism for ensuring that high risk, high behavioral health need patients receive comprehensive integrated care.[56]

BARRIERS TO INTEGRATED CARE DELIVERY

Changing the way individual providers practice medicine, especially outside of large health systems, can be a slow, labor-intensive process. Unfortunately, many primary care providers—especially in rural areas—lack the training, financial incentives, technical capabilities, and staff to deliver any level of integrated services.[57] To incentivize and enable them to take on a greater role in providing behavioral health care to their patients, the federal government should take steps to minimize these challenges.

First, integrated care requires health information technology systems that enhance communication and data sharing between primary care and behavioral health providers. However, compared with other office-based providers, fewer behavioral health providers use electronic health records (EHRs). For example, 96% of cardiologists used EHRs in 2017, while only 61% of psychiatrists did.[58] Similarly, psychiatric hospitals lag in their adoption of electronic health record technology compared with general acute care hospitals (49% versus 96% in 2019).[59,60] Surprisingly, multiple recent studies confirm that overall practice-level adoption of EHRs is now significantly higher in rural areas than in urban ones—a reversal from earlier trends.[61]

As part of the American Recovery and Reinvestment Act of 2009, Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act and authorized $27 billion in funding to increase the utilization of EHRs. The act also introduced meaningful use requirements and spurred the creation of standards for HHS-certified EHRs, but it excluded behavioral health from HITECH's health technology incentives.[62]

Beyond technology, insufficient reimbursement for start-up costs, training, and technical assistance can deter integrated care delivery. Additionally, provider participation in value-based payment models has historically lagged in rural areas, hindering the ability to transform rural practices and making it difficult to sustain the integration of behavioral health care and primary care. Effective January 1, 2023, CMS implemented changes to the Medicare Shared Savings Program (MSSP) to attract rural health care providers and increase the percentage of Medicare beneficiaries in accountable care organization (ACO) arrangements.[63] Medicare rewards ACOs participating in MSSP for engaging in more coordinated care in hopes of improving outcomes and lowering costs. As part of the recent changes, CMS is allowing advanced interest payments to

support providers' investments in infrastructure and staff with no downside risk. It has also created a sliding scale for shared savings and losses, thus making financials more predictable for lower-volume providers.[64]

For primary care doctors, the lack of behavioral health providers, especially in rural areas, makes patient referrals challenging, so much so that they express concerns about identifying behavioral health conditions. Health plan networks often list participating behavioral health providers who are not accepting new patients, have long wait times for appointments, or are located far away. The lack of access to behavioral health expertise directly affects the ability and comfort-level of primary care providers to deliver integrated services.

Without appropriate training on how to handle the behavioral health needs of their patients or a strong network of behavioral health providers to refer to, many primary care providers lack the confidence needed to screen for or treat behavioral health conditions. Smaller practices, with fewer patients, can also make it harder for providers to financially maintain integrated services.[65]

Additionally, providers face numerous regulatory and licensing barriers that can create unnecessary challenges, such as prohibitions to same-day billing and scope-of-service limits.[66] In 2014, CMS launched the Innovation Accelerator Program, one area of which was to work with state Medicaid agencies to align policies in support of physical and mental health integration.[67] Drawing on lessons learned from nine states, Appendix B outlines the regulatory and licensing barriers that can hinder the delivery of integrated care.

According to the Health Resources Services Administration (HRSA), 65% (more than 31 million Americans) live in primary care health professional shortage areas, and nearly 61% (more than 37 million Americans) live in mental health HPSAs.[68] Rural patients already face outsized challenges in accessing care. Moreover, most medical schools and residencies are in urban and suburban settings, which further compounds the problem, given that providers are more likely to remain in areas where they receive their training.[69,70]

MOVING FORWARD

BPC's current work offers new policy considerations affecting rural providers and their ability to integrate primary care and behavioral health services. This report is divided into four key areas:

- Recommendations for **broad, foundational policies** at the federal level that lay the groundwork for integrated care, including defining the services that constitute behavioral health integration within primary care.

- Efforts to **support a workforce** to deliver integrated care, such as new investments in rural graduate medical education.
- Recommendations for changes to the **payment and delivery system** that can help rural providers overcome barriers to integration.
- An exploration of the needs of **veterans, tribal communities, and individuals with significant behavioral health needs**. BPC offers recommendations for how to better coordinate and integrate primary care and behavioral health services for these three high-risk groups.

Policy Recommendations

A: FOUNDATIONAL TO INTEGRATION

HHS should identify a set of standardized quality and performance metrics for delivering integrated care.

As more primary care providers and health systems design and implement integrated services, the need is growing for standardized, rigorous quality measures that are specific to integrated care. Identifying a core set of quality and performance measures could allow for greater benchmarking and accountability among providers who integrate services.[71]

Core quality measure sets already exist for behavioral health. For example, to support efforts to improve behavioral health in Medicaid and the Children's Health Insurance Program (CHIP), CMS maintains a core set of behavioral health measures for state Medicaid and CHIP agencies (reporting is voluntary). The 2023-2024 set consists of seven child-specific behavioral health measures and 11 adult-specific measures. These measures help evaluate providers' delivery of behavioral health services for individuals in Medicaid and CHIP.[72]

However, few process and outcome measures are for integrated care specifically. Those that do exist often focus on single-disease states or populations, rather than on patients with both physical and behavioral health conditions.

Building on what is already available, HHS should identify a set of standardized quality and performance metrics for practices that integrate primary care and behavioral health services.

In developing this set, HHS should build on previous efforts and seek input across CMS, the National Institute of Mental Health, the Health Resources and Service Administration, and the Substance Abuse and Mental Health Service Administration (SAMHSA). Given the unique needs of rural areas, BPC recommends that the Federal Office of Rural Health Policy (FORHP) be included. The FORHP—an office within HRSA—has played an important role in representing rural residents for more than three decades.

Bipartisan efforts to the same avail have already begun in Congress. In its November 2022 Bipartisan Mental Health Care Integration discussion draft, the Senate Finance Committee supported the development of Medicare quality measures that assess the degree to which practices are integrating behavioral health and primary care services.[73]

HHS should establish a set of core service elements for behavioral health integration within primary care.

Although federal policymakers have made some progress toward enabling integrated care, no standard definition of integrated care across private and public health exists, nor are there defined sets of core service elements and quality standards.[74] CMS, for example, has gone only as far as to call behavioral health integration "a type of care management service."[75] In contrast, the agency has established clear definitions for other service sets, such as ambulatory care, long-term care, custodial care, and emergency care.[76]

Variations in approaches to integration are necessary to account for differences in community needs, delivery system infrastructure, and populations. Nevertheless, defining a federal set of common service elements would align payer, provider, and patient expectations across primary care settings that offer integrated services.

BPC recommends that the HHS secretary clearly define the service elements of integrated behavioral health in primary care settings. HHS could then align the core elements of integrated care across agencies. Given the unique needs of rural areas, it will be critical to ensure that rural stakeholders get a say in establishing a set of service elements, evidence-based interventions, and associated workflows for behavioral health integration.

HHS could consider existing integrated care frameworks as a starting point for deliberation. For example, one framework includes the following eight domains for behavioral health integration:[77]

- Systematic screening for behavioral health conditions and referral for complex patients;
- Ongoing care management between patient and providers;
- Multidisciplinary team-based care between behavioral health and primary care providers;

- Measurement-based care—using evidence-based tools—to monitor behavioral health symptoms and adjust treatment as needed;
- Culturally adapted self-management of health conditions;
- Tracking and exchanging patient information among providers;
- Assessing social needs and providing links to services; and
- Systematic quality improvement using established integration quality metrics.

CMS should ensure network adequacy for Medicaid, CHIP, and Medicare Advantage; it should also ensure there is capacity for referrals and interprofessional consultation support for primary care providers.

Given that inadequate behavioral health networks are a key barrier to integrated care—and to providing services in general—the HHS secretary must ensure that Medicaid, CHIP, and Medicare Advantage networks are sufficient to ensure support for behavioral health specialty referrals and interprofessional consultation for primary care providers.

Achieving meaningful standards of network adequacy is challenging, as these standards must balance the need for sufficient provider participation with the ability of plans to meet those standards. However, a key enabler of integrated care is the availability of behavioral health providers for consultations and patient referrals. This is especially important for rural areas, which face an overwhelming shortage of behavioral health specialists. As such, CMS should ensure that provider networks include capacity for behavioral health specialty referrals and interprofessional consultations for primary care providers. In rural areas, this must include allowing some level of virtual care to count toward network adequacy requirements.

Interprofessional consultations ensure that primary care providers can access the psychiatric expertise they need to effectively manage their patients' mild-to-moderate mental health and substance use conditions without necessitating an on-site psychiatric provider.[b] These services help fill knowledge gaps and improve care delivery. (Later in this report, we discuss the need for primary care providers to receive additional support and technical assistance on how best to employ interprofessional consultations.)

Current methods for ensuring the adequacy of behavioral health networks vary significantly based on the type of health plan. Qualified Health Plans

b The Centers for Medicare and Medicaid Services has defined interprofessional consultations "as a situation in which the patient's treating physician or other qualified health care practitioners … requests the opinion and/or treatment advice of a physician or other qualified health care practitioner with specific specialty expertise … to assist the treating practitioner with the patient's care without patient face-to-face contact with the consulting practitioner … as long as the consultation is for the direct benefit of the beneficiary."

participating in the Affordable Care Act marketplaces, for example, are required to identify whether providers are accepting new patients. In April 2022, HHS began requiring CMS to conduct network adequacy reviews of Qualified Health Plans "for compliance with quantitative network adequacy standards based on time and distance standards."[78] Additionally, other changes mandate that HHS review additional specialists, including in behavioral health care.

Federal law requires Medicaid managed care plans to have the capacity to serve projected enrollment in their service area and to maintain a sufficient number, mix, and geographic distribution of providers. These plans must make covered services accessible to their enrollees to the same extent that such services are accessible to other state residents with Medicaid who are not enrolled with that plan.[79] In 2016, CMS required states to establish time and distance standards for specific types of providers. The Trump administration ended this requirement, allowing states to establish their own standards.

CMS is developing a rule to "assure and monitor equitable access" for Medicaid and CHIP.[80] BPC previously recommended—and continues to recommend—that HHS develop core network performance metrics, including a defined set of quantifiable measures, such as wait times, providers who are taking on new patients, and those who have not submitted a behavioral health claim during the past six months.[81] Having a core set of network adequacy standards across programs would facilitate compliance for plans subject to parity laws, and would also align and simplify requirements for insurers participating in multiple federal programs.

For Medicare Advantage plans, CMS applies time and distance standards like those for the federal marketplace. However, CMS lowered these standards in 2020, requiring that only 85% of enrollees in nonmetro areas live within time and distance standards. It further reduced the standard in all counties for Medicare Advantage plans that include telehealth providers.[82]

Given the shift to telehealth during the COVID-19 pandemic, allowing some virtual services to count toward network adequacy is critical. However, CMS should monitor the volume of telehealth providers in networks and, when determining the standard, continue to weigh such factors as broadband availability, patient choice, clinical appropriateness, and accessibility.

Health plan provider directories are often proxies for network adequacy; however, they can be inaccurate, especially for behavioral health services. To protect beneficiaries, CMS should require third-part independent audits of provider directories as well as consider using claims data to identify providers that have not billed for services over the past year or more.

B: WORKFORCE AND PROVIDER SUPPORT

Congress should expand Medicare's Health Professional Shortage Area physician bonus program by allowing additional types of behavioral health providers to receive bonuses when they practice in mental health HPSAs.

Key to increasing access to behavioral health care in rural areas is integrating services into primary care, and key to the success of integration is expanding the behavioral health and primary care workforces. The United States faces shortages of both types of workforces, and the situation is worse in rural areas, partly because providers are more likely to remain in the areas where they receive their training, and most medical schools and residencies are in urban and suburban settings.[83,84]

For behavioral health providers, more than 60% of nonmetropolitan counties lack a psychiatrist, and almost half lack a psychologist; the figures for urban counties are 27% and 19%, respectively.[85,86] And while integration can help make better use of the existing workforce, a 2017 Government Accountability Office report projects a deficit of more than 20,000 primary care physicians in rural areas by 2025.[87]

One way to keep more behavioral health providers practicing in rural areas is to financially incentivize them by expanding Medicare's Health Professional Shortage Area bonus program. Currently, CMS pays a 10% quarterly bonus when physicians deliver Medicare services within a primary care HPSA.[88] The bonus is based on the amount paid for professional services. This program

was established in 1987 and the bonus was set at 5%; it was increased to 10% in 1991. Although the size of the bonus varies with increases to providers' base reimbursement, BPC recommends that Congress direct the GAO to evaluate the size and appropriateness of Medicare's Health Professional Shortage Area bonuses to ensure their effectiveness. According to CMS data, CMS paid $144.5 million in total HPSA bonus payments in 2018 to physicians that qualified.[89]

CMS also pays bonuses to psychiatrists delivering behavioral health services in a mental health HPSA, but no other mental health provider types qualify for the incentive payment. BPC recommends that Congress expand Medicare's Health Professional Shortage Area physician bonus program by allowing additional types of behavioral health providers to receive bonuses when they practice in mental health HPSAs.

The Senate Finance Committee's Bipartisan Mental Health Workforce discussion draft, released in September 2022, included provisions to improve the distribution of the mental health workforce by expanding Medicare's Health Professional Shortage Area physician bonus program.[90] The draft proposed increasing bonus payments for psychiatrists and expanding the program to include psychologists, clinical social workers, marriage and family therapists, licensed mental health counselors, and other nonphysician practitioners.

Although the committee did not vote on this proposal in 2022, it is expected to continue pushing these issues forward.

To improve retention of the workforce, Congress should establish a federal tax credit for providers practicing in rural areas.

Retaining providers in rural areas is an ongoing challenge. Although loan repayment programs help recruit providers, they have been less effective at retaining them. Policymakers have long used tax credits and relief from income taxes as direct incentives to achieve various policy objectives.

Congress should institute a federal rural practitioner tax credit to augment the efforts of other federally administered HRSA programs. In BPC's 2022 report, *The Impact of COVID-19 on the Rural Health Care Landscape*, we urged Congress to employ federal tax incentives to bolster the rural health workforce.[91] A federal program could be modeled on several state rural workforce retention programs that leverage their state tax system: Oregon, New Mexico, Alabama, Georgia, Louisiana, and Montana.[92]

Oregon's Rural Practitioner Tax Credit, which was established in 1989, offers an average of $8.5 million annually in tax credits for providers practicing in rural areas, including dentists, physicians, nurse practitioners, physician assistants, and emergency medical service providers.[93] The $3,000, $4,000, or $5,000 annual tax credit is tiered, with those working farthest from an urban center receiving the maximum amount of $5,000. A 2016 review of relevant workforce

programs in Oregon demonstrated that although the National Health Service Corps loan repayment program attracted providers to the area, it had minimal effect on retention.[94] Conversely, the Rural Practitioner Tax Credit has a sizable effect on retention, increasing the likelihood that a provider would stay in the area, but it was not a significant tool for recruitment.[95] Notably, the report suggested that the combination of the two programs had a synergistic effect on provider recruitment and retention. New Mexico's rural health practitioner tax credit started in 2009 and functions similarly to Oregon's, with providers eligible for an income tax credit of $3,000 or $5,000 if they practice in rural areas.[96]

Drawing on the lessons of state efforts, a five-year annual federal tax credit should be offered to physicians and advanced practice clinicians who choose to work in rural HPSAs. A federal tax credit (e.g., $10,000, $15,000, or $20,000) could be tiered based on provider type or distance from a metro area. To ensure a consistently targeted benefit for underserved rural areas, the rural HPSA designation should be updated every five years. With the increase in virtual care options since COVID-19, policymakers will also have to weigh which virtual services, versus in-person services, qualify a provider for such a tax credit, if at all.

To promote the training of medical residents in rural areas, Congress should permanently reauthorize the Teaching Health Center Graduate Medical Education Program and increase funding for HRSA's Rural Residency Planning and Development Program, which supports traditional graduate medical education rotations in rural communities.

Physicians are more likely to remain in the areas in which they receive their training.[97] This reality is problematic, as only 2% of overall residencies occur in rural areas; resident training mostly takes place at teaching hospitals.[98] Although hospital-based training is imperative for medical residents, training in outpatient and nonhospital health care settings is similarly important and might better represent the kind of care most Americans receive.

The Affordable Care Act of 2010 created the Teaching Health Center Graduate Medical Education (THCGME) Program, which HRSA administers. Congress has authorized the program through various legislative packages since that time.[99] The THCGME Program reflects the importance of medical resident training in outpatient settings, such as RHCs and FQHCs. The program has also been recognized as a tool for alleviating provider shortages in HPSAs, many of which are rural areas.[100,101] THCGME supports the programs of primary care medical and dental student residents.

THCGME Program funding is set to expire at the end of fiscal year 2023. In previous extensions, Congress reauthorized the program for multiple years,

but even these extensions create fiscal cliffs and operational instabilities.[102] Although Congress is likely to reauthorize this program, uncertainty around temporary extensions keeps the program in a constant "needing to be renewed" budget cycle. This ongoing cycle can be disruptive to both rural facilities and residents. Congress should permanently reauthorize the program to ensure programmatic stability and allow programs in rural areas to expand and sustain participation.

Before being able to practice independently, physicians require graduate medical education (GME) training. The federal government primarily supports medical residency training in the form of Medicare payments to hospitals.[103]

To ensure that Medicare's GME payments build and support a robust rural workforce, Congress should devote additional resources to HRSA's Rural Residency Planning and Development Program. This program, in partnership with HRSA's Bureau of Health Workforce, offers grants for the creation of rural residency programs, also known as Rural Training Programs or Rural Track Programs. It also provides, through a Technical Assistance Center, help for rural communities to overcome some of the barriers to achieving GME accreditation.[104]

Additionally, HRSA should focus on ensuring that this help is paired with assistance for residents in becoming eligible for Medicare GME payments. The Accreditation Council for Graduate Medical Education already has an accreditation for rural tracks.[105] These rural residencies are designed to ensure that residents spend more than 50% of their time in rural settings.

SAMHSA, HRSA, and the VA should incentivize medical schools to offer—and issue guidance for practicing primary care providers to receive—training on prescribing buprenorphine to patients with OUD.

In December 2022, Congress passed the Mainstreaming Addiction Treatment (MAT) Act as part of the FY2023 omnibus bill to eliminate the Drug Addiction Treatment Act (DATA 2000) waiver, or "X waiver."[106] The X waiver was a longtime requirement for addiction providers to complete an eight-hour training course to administer buprenorphine—a form of medication-assisted treatment proven to reduce the risk of overdose, relapse, and withdrawal in patients with OUD.

Since its implementation, the X waiver has posed several problems.[107] The waiver limited the number of providers able to prescribe buprenorphine. It also affected training, keeping the content developed for the X waiver segregated from the rest of providers' clinical education. The training did not ensure mastery of addiction medicine, and it could have been better incorporated into standard provider training. Evidence also suggests that providers

who received waivers treated fewer patients so they could stay within the waiver limit, harming an already underserved, highly vulnerable group of patients.[108,109,110,111,112]

Up to this point, providers have had to complete the training needed to obtain the X waiver on top of their other credentialing requirements, making it difficult to keep up with population needs. By keeping the training requirements separate, the field has reinforced the notion that addiction treatment is not part of clinicians' routine responsibilities, perpetuating the stigma around lifesaving care. Data show that around 60% of counties nationwide lacked a waived provider.[113]

With the X waiver requirements no longer in effect as of June 2023, primary care providers have an opportunity to undertake buprenorphine treatment for even more OUD patients. Given the elimination of the X waiver, SAMHSA and HRSA should expand opportunities for current and prospective primary care professionals to receive training on how to prescribe buprenorphine to patients with OUD.

The barriers to administering medications for opioid use disorder (MOUD) are particularly troublesome in rural areas and include stigma, a lack of access to transportation, and technology.[114] A particularly large barrier is rural areas' limited workforce, which is compounded by perceived barriers (e.g., reimbursement concerns, worries about Drug Enforcement Administration intrusion) associated with OUD treatment.[115] With the end of the X waiver, primary care providers are essential in increasing access to care and closing the OUD treatment gap.[116,117,118]

The agencies should accomplish this in two ways. First, they should issue guidance instructing primary care providers to complete training for continuing medical education (CME) credits and continuing education units (CEUs). Second, they should incentivize educational institutions (e.g., medical school programs) to incorporate appropriate training into their curricula using funding from HRSA's Medical Student Education Program. This will be critically important in rural areas, where the incidence of substance use disorder (SUD) is disproportionately high compared with urban and suburban areas.

Training current primary care professionals

Primary care providers can enroll in and complete training in exchange for CEUs and CME credits, which are important for providers to maintain their state licenses.[119] Provider groups, such as the American Medical Association, generally authorize eligibility for these credits.[120,121] Thus, SAMHSA can issue guidance to state licensure boards, encouraging them to work with these groups to adopt accredited training modules or approve new training regarding buprenorphine prescribing for CEUs and CME credits.

Several promising training practices exist. For example, the American Medical Association and the American Society of Addiction Medicine developed a free training course that has been accredited and approved for continuing education credits. Building on SAMHSA's Buprenorphine Quick Start Guide, it offers an on-demand, introductory module to guide providers through buprenorphine initiation, dosing, and patient management.[122,123] SAMHSA should issue guidance to state licensure boards encouraging providers to consider this training, as it would allow them to access important resources to help them become more proficient in treating OUD patients.

SAMHSA should also include on-the-job training in its guidance. One training program leverages psychiatrists at the University of Alabama at Birmingham to virtually train primary care providers in a local Federally Qualified Health Center network (similar to Project ECHO, which has trained health care specialists).[124,125,126] This program found that through virtual mentorship, the FQHC-based providers gained confidence to administer MOUD independently within six to nine months. By incentivizing both trainers and trainees with CEUs and CME credits, primary care providers get the on-the-job training needed to expand MOUD services while also working toward their own professional development requirements.

Training new primary care professionals

Although 87% of medical schools reported offering OUD-specific curricula, one survey indicated that only around 10% of early career family medicine physicians felt they had been adequately trained and were prescribing buprenorphine.[127,128] Thus, primary care providers might need additional education and training to ensure that they are adequately prepared.

Through existing workforce development grants, HRSA can incentivize educational institutions to adjust their curricula. For example, HRSA's Medical Student Education Program provides grants to public higher education institutions to develop or expand medical school programs in states with primary care provider shortages (e.g., rural areas).[129] In 2019, HRSA awarded fewer than 10 grants, according to USASpending.gov.[130] HRSA would be able to encourage future grantees to explore adding buprenorphine training modules to their medical school curricula, and use the grant funding to develop or adapt the module.

Outside of classroom settings, educational institutions could incorporate exposure-based training into medical student intern rotations and residency training. Other evidence suggests that exposure-based training, in which students and residents learn to administer buprenorphine through practice, can help providers build confidence. One study at a RHC in Oregon found that residents who integrated into an office-based MOUD care team had more exposure to opioid cases, which may improve these residents' preparation to prescribe opioid medications. Incorporating such exposure-based training into

rotations and residency training can minimize new providers' hesitations, and further normalize and destigmatize MOUD initiation in primary care settings.

SAMHSA should issue guidance to schools offering professional degrees (e.g., medical schools, nursing schools) and residency programs to incorporate exposure-based training during students' family medicine rotations. Furthermore, residency programs—especially those in rural areas—can adapt this model to further expose entry-level primary care providers to patients with opioid use disorders.

CMCS should provide technical assistance to state agencies on integration strategies, such as leveraging the use of interprofessional consultations in Medicaid and CHIP as well as weighing the expansion of Medicaid coverage of licensed professional counselor services, as Congress recently approved for Medicare.

As discussed earlier in this report, interprofessional consultations are an important tool in the delivery of integrated care, as they allow care teams to receive guidance from behavioral health experts without the need for full referrals or to be in the same location. Such consultations can help primary care clinicians fill knowledge gaps so they can handle more mild-to-moderate problems and save referrals for more complicated treatments. Indeed, the Collaborative Care Model already embeds regular psychiatric consultations within its workflow, and these interprofessional consultations are particularly valuable for rural providers.[131]

In 2019, Medicare began paying for interprofessional consultations and established values for six Current Procedural Terminology (CPT) codes for these services. On January 5, 2023, CMS clarified its coverage policy for interprofessional consultations under Medicaid and CHIP, aligning its procedures with Medicare's policy to allow direct payment to consulting practitioners.[132]

CMS's guidance to states made clear that interprofessional consultation could proceed and be billed without the presence of a patient if the consultation was for the patient's direct benefit. Recognizing the value of interprofessional consultations for improving Medicaid and CHIP beneficiaries' access to behavioral health services, CMS also encouraged states to modify same-day billing rules that affect interprofessional consultations.

However, no federal requirement forces states to cover interprofessional consultations in Medicaid and CHIP. Expanding the number of states that cover these consultations would increase the capacity of primary care providers to deliver more services. It would also free up behavioral health specialists to handle more complex problems.

To adopt interprofessional consultations in Medicaid, states must navigate multiple hurdles, including having to submit a State Plan Amendment to enact coverage; deciding on new coverage, reimbursement, and cost-sharing policies; and training and educating qualified providers.

CMCS should also help states weigh the expansion of Medicaid coverage of licensed mental health counselor services for their state, as Congress recently approved for Medicare.

Beginning in 2024, as provided for in the Consolidated Appropriations Act, 2023, (P.L. 117-328), Medicare will cover services provided by licensed mental health counselors and marriage and family therapists. The American Counseling Association reports that there are about 160,000 mental health counselors across the country.[133] Since 2010, the VA has hired mental health counselors and the GAO reports that mental health counselors "may be easier to recruit and retain in rural settings."[134]

C: PAYMENT AND DELIVERY SYSTEM REFORM

Congress should remove the cap on RHCs that limits the provision of total services for behavioral health to no more than half.

More than 5,000 rural health clinics across the nation are in underserved, rural areas that suffer from a shortage of primary care providers.[135] These clinics provide primary care to rural residents and are critically important to the residents' receipt of behavioral health services.

Although RHCs are important to the future of behavioral health care in rural communities, they are limited to outpatient care and cannot be primarily engaged in mental health treatment.[136] RHCs' inability to provide more expansive treatment for mental health conditions dates back to 1977 and Public Law 95-210, the Rural Health Clinic Services Act. According to this law, an RHC cannot be "a rehabilitation agency or facility which is primarily for the care and treatment of mental diseases." Many interpret this statute to mean that no more than 50% of an RHC's total hours of operation (either weekly or monthly) can be dedicated to mental health treatment. The distinction is poorly understood and often results in reporting confusion. This limitation might also hinder the willingness of RHC providers to deliver integrated care.

This barrier is worrisome, as the need for behavioral health services—and especially substance use disorder services—is particularly pronounced in rural areas.[137] RHCs are often the only health care option available in rural areas, which often lack stand-alone behavioral health clinics. Moreover, many Americans—and specifically those in rural areas—already turn to their

primary care providers for behavioral health care.[138,139] One study found that nearly 40% of visits to primary care physicians nationwide were for behavioral health issues.[140] Prohibitions on the ability of providers to offer behavioral health care within an RHC, as a result, limit the ability of rural providers to meet their patients' needs.

Congress should reverse the provisions in the Rural Health Services Act that limit the ability of RHCs to treat mental illness. Policymakers could accomplish this by striking a phrase in paragraph (2) of 42 U.S.C. 1395x(aa), Section 1861(aa): "(iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases." Current bipartisan Senate legislation—the Rural Health Clinic Burden Reduction Act (S.198)—would also help rectify this issue by reversing the provision specifically for RHCs located in mental health professional shortage areas.

CMS should clarify same-day billing exceptions in Medicare for FQHCs and RHCs to include substance use treatment in addition to mental health visits.

A barrier to Federally Qualified Health Centers and rural health clinics delivering integrated primary care and behavioral health services is that both remain unable to bill Medicare for multiple visits on the same day with more than one provider (CFR Title 42, Section 405.2463). Guidance from CMS rightfully acknowledges an exception to this rule if a patient has qualified medical and mental health visits on the same day.[141,142] Unfortunately, CMS does not specify substance use treatment services as an exception.

CMS should clarify that substance use treatment services are also an exception to the same-day billing restrictions in Medicare. Such a change is especially important and opportune given the removal of the X waiver allowing more primary care providers to prescribe buprenorphine for the treatment of opioid use disorder.[143]

A Medicare exception to same-day billing restrictions for substance use treatment, as already exists for same-day mental health and primary care visits, could expand patients' access to SUD treatment and integrated services. This allowance would be especially impactful in rural and frontier communities, where the time and distance to travel to a provider can be a major burden that deters people from receiving care.

Because Medicaid is the single largest payer for mental health services in the United States, state Medicaid agencies also need to be taking steps to address this limitation.[144] As of 2017, only 32 states had amended their state Medicaid programs to allow beneficiaries to receive both medical and behavioral health services within the course of a single visit.[145] As mentioned earlier in this report, CMS issued guidance in January 2023 encouraging states to modify their remaining same-day billing restrictions that affect the integration of behavioral health and primary care services.[146]

To increase uptake of the Collaborative Care Model (CoCM), CMS should consider increasing reimbursement rates, rethinking beneficiary co-pays, and providing additional technical assistance or guidance to states on patient consent.

The Collaborative Care Model consists of care provided by a primary care provider and a health care manager working in collaboration with a psychiatric consultant to support patients receiving behavioral health care.[147] Developed by the University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center, CoCM has been increasingly adopted as an effective approach to the delivery of behavioral health integration payments and services. CMS introduced CoCM codes in the Medicare Physician Fee Schedule in 2017.

Overall uptake of CoCM codes remains low.[148] Several possible factors include provider challenges in meeting upfront costs at current reimbursement rates, beneficiary co-pays, and onerous documentation requirements related to both billing and patient consent. To increase uptake of the model, CMS should consider increasing reimbursement rates, rethinking beneficiary co-pays, and providing additional technical assistance or guidance to states on patient consent.

Five core principles define the CoCM model: patient-centered team care; population-based care tracked in a registry; measurement-based treatment; evidence-based care through psychotherapies and medication; and accountability care for quality.[149] In addition to reducing health disparities, CoCM has improved patient outcomes and increased provider confidence in offering care, while also producing cost savings.[150,151,152,153,154,155] Although studies on the adoption of collaborative care specifically in rural areas are limited, similar outcomes from the model are expected to translate to rural areas.

CMS makes payments for integrated care using the CoCM approach via CPT codes 99492, 99493, and 99494 and via HCPCS code G2214.[156] Providers can also utilize CPT code 99484 for general behavioral health integration (BHI) services (i.e., non-CoCM BHI models of care).[157] Moreover, CMS recently introduced a new HCPCS G code for care management services (G0323), which will allow for greater flexibility in care management time.[158]

According to providers, meeting upfront costs at the current CoCM reimbursement rate is a principal barrier to CoCM adoption. CMS should therefore consider increasing CoCM reimbursement rates to more adequately reflect the work and resources required to provide these services. Such an adjustment would help cover the upfront costs associated with staffing, workflows, and infrastructure changes, as well as encourage additional practices to adopt CoCM.[159] CMS could also consider a temporary increase in payment for CoCM services to promote model uptake.[160] By law, CMS is required to adhere to budget neutrality so that payment rates for individual services do not result in changes to estimated Medicare spending.[161]

An additional barrier to CoCM uptake is the burden of beneficiaries' co-pays. CMS does not currently require any cost-sharing or co-insurance for bundled opioid treatment provider services. BPC recommends that CMS apply the same policy to CoCM to encourage greater usage.

Patient consent requirements, as they exist, also stymie uptake. Among the key principles of CoCM is ensuring that patients provide consent for the billing provider to confer with a psychiatric consultant, although these requirements can differ by state and payer.[162,163] For example, Medicare does not require a patient to provide written consent, but the provider must provide documentation of consent in a patient's medical record.[164] Nonetheless, the difficulty in relaying to patients the value of a non-face-to-face service—an interprofessional consultation—might be limiting CoCM uptake.

Building on existing resources, CMS should offer additional guidance or technical assistance to states to educate providers on the best ways to communicate the value of CoCM to their patients.[165] Further clarifying—for both payers and providers—what constitutes patient consent to CoCM services might help increase the uptake of the model and improve outcomes for patients in rural areas.

Congress and CMS should ensure the continuation of most pandemic-era flexibilities for telehealth services delivered in rural areas, including audio-only services within the context of established patient-provider relationships.

Broad telehealth flexibilities afforded during the COVID-19 public health emergency substantially improved the convenience, user experience, and utility of virtual care. Less than 1% of all outpatient care before the pandemic, telehealth became a permanent fixture in care delivery almost overnight. BPC believes telehealth will continue to represent a much larger share of patient care than it did before the pandemic. This is especially important in rural areas, where access to specialty care is limited. Indeed, to widen the availability of care in rural areas, virtual care can make integrated services more possible.

Despite the lack of broadband access in many rural areas, telehealth has long improved access to care for many rural Americans. Rural communities face persistent health care worker shortages and have far fewer providers per capita than urban areas, particularly when it comes to specialists. Only 11% of physicians practice in rural areas, even though 20% of the U.S. population lives there.[166] Before COVID-19, Medicare primarily covered telehealth services for beneficiaries living in rural areas, but those patients were required to travel to designated sites, such as clinics or hospitals, to receive telehealth.

During the pandemic, Congress and the Trump administration temporarily, but drastically, changed telehealth policy, including allowing patients to access telehealth services from home, waiving two-way video requirements to permit phone calls to providers (known as audio-only telehealth), and waiving established patient requirements. These policy changes increased patients' access to mental health and substance use services and created a pathway for more primary care providers to coordinate or deliver behavioral health services. Studies have found that telehealth facilitates collaboration and consultation among behavioral health specialists and primary care as well as emergency department providers; it can also expand capacity for the treatment of mental health and substance use disorders.[167,168,169]

Yet, most pandemic-era telehealth flexibilities are set to expire after December 31, 2024. In our 2022 report, *The Future of Telehealth After COVID-19*, BPC lays out pragmatic policy recommendations for continued telehealth use. The report includes recommendations for Congress and CMS to ensure the continuation of most pandemic-era flexibilities for people living in rural areas, including access to audio-only telehealth.

Audio-only telehealth services, while more limited in their clinical utility, continue to be critical for individuals who lack broadband access, digital literacy, or the means to pay for internet access. To that end, Congress should permanently incorporate audio-only telehealth services into the definition of telehealth, and HHS should ensure that audio-only services remain accessible to Medicare beneficiaries living in rural areas, within the context of established patient-provider relationships.

D: SUPPORTING VETERANS, TRIBAL COMMUNITIES, AND INDIVIDUALS WITH HIGH BEHAVIORAL HEALTH NEEDS

The Department of Veterans Affairs should expand the scope of the VA Solid Start Program to provide additional support services to military members with behavioral health conditions who are transitioning from active service to veteran life, and educate veterans who might be eligible to upgrade their discharge status.

The VA estimates that nearly 1 in 4 veterans—4.7 million people—settle in rural communities upon completion of their military service, and only 60% of those are enrolled in the VA system.[170,171] This means that those who have served their country might be missing opportunities to access key benefits. The most recent Wounded Warrior annual survey found that more than 15% of veterans do not understand or never received information about their benefits, and nearly a quarter of veterans either find that VA providers are not sensitive to their needs or feel embarrassed about seeking behavioral health services.[172] These results point to larger issues in the transition from military service to veteran life, especially for those who left with behavioral health conditions, and pervasive stigma toward behavioral health conditions within military culture.

To address this challenge, the VA should expand the scope of VA Solid Start Program, which helps service members transition to support service members' transition to veteran life. This expansion would provide additional targeted assistance for those separating with behavioral health conditions in two ways:

connecting new veterans in rural areas with VA resources, and educating existing veterans about ways to access more VA benefits.

Because of the Pentagon's "zero tolerance" substance use policies, service members can be dishonorably discharged for failed drug tests, and therefore experience challenges accessing VA benefits.[173,174] According to the National Institutes of Health, the zero-tolerance policies have discouraged illicit drug use but also deterred service members from seeking treatment.[175] Consequences of failed drug tests can vary by service. For example, the Air National Guard's zero-tolerance policy is very strict, with the potential for any "drug use and/or prescription misuse [to] lead to criminal prosecution resulting administrative actions, such as discharge."[176]

While the latest version of the VA and Department of Defense's Clinical Practice Guidelines for SUDs outline ways to care for veterans and separating/transitioning service members, treatment plans for active-duty service members who have tested positive for illicit substances are not clearly specified.[177] This might result in a lack of continuity of care and coordination among providers. The clinical guidelines note that health care teams should assess patients and offer services to them throughout their transitions, but with multiple health systems involved—the Military Health System and TRICARE, the Veterans Health Administration, and civilian providers and payers—it is difficult to coordinate care without a designated leader.

Although zero-tolerance rules do not apply to mental illnesses, the Defense Department can still discharge service members with untreated mental illnesses, especially if they posed an immediate risk to safety or combat readiness. However, the 2020 National Defense Authorization Act (NDAA) established the Discharge Appeal Review Board (DARB), which allows veterans with PTSD, traumatic brain injury, military sexual trauma, or mental health conditions to apply for an upgraded discharge status.[c,178,179] Discharge status can affect VA benefits—including the types of jobs for which individuals can apply and the educational benefits they can receive—and other than honorable discharge is linked with higher risk of mental health conditions and health disparities.[180] This recent policy change has implications regarding efforts to expand access to behavioral health care for veterans.

Although the DoD only implemented this change in 2021, the VA had begun providing emergency mental health coverage for veterans with other than honorable discharges in 2017. In the years since, the VA began expanding the types of mental health services available for veterans (e.g., outpatient care and residential rehabilitation care), and annual visits for mental health care services among veterans with other than honorable discharge increased nearly six-fold.[181] Currently, the VA reports that 1.7 million veterans received mental health services (e.g., counseling, therapy, medication, peer support) at their facilities

c Types of discharges are the following: Honorable; Under Honorable Conditions (General); Under Other Than Honorable Conditions; Bad Conduct; Dishonorable; and Uncategorized.

in 2021.[182] The Defense Department's recent policy change to allow veterans to apply for upgraded discharges would further expand access to mental health care services.

To ensure that service members who are leaving the military because of a behavioral health issue, including illicit drug use, remain in treatment, the VA should expand the VA Solid Start Program to provide additional services and touchpoints during the transitions for these service members.[183,184] In April 2023, Congress introduced the Service Members Mental Health Improvement Act, a bipartisan bill which would support mental health for service members both "during their military careers and after they have transitioned into civilian life."[185] This bipartisan momentum shines a spotlight on the need for continuity of mental health care during the transition from the DoD to the VA system.

The goal of the VA Solid Start Program is to ensure that newly separated service members experience a smooth transition during their first year. According to the program's official description, a qualified VA representative reaches out to transitioning service members three times per year with information about resources and benefits, including mental health resources and VA coverage. The VA can clarify that, for service members who have left the military as the result of behavioral health issues, the additional touchpoints would connect these individuals with resources to initiate and sustain treatment during their transition to veteran status.

Transitioning service members in rural communities would be connected to Federally Qualified Health Centers. An estimated 400,000 veterans already seek care in FQHCs, according to data from the Uniform Data System, making the centers a logical place to coordinate care.[186] Because veterans who received other than honorable discharges might need to seek care outside of the VA system, the VA Solid Start Program can work with other VA programs, such as the Collaborative Systems of Care (CSC) Program. The CSC Program's mission is to enhance care coordination using nurses in FQHCs.[187] Thus, by expanding VA Solid Start to partner with the CSC Program, VA representatives can work with FQHCs to ensure that transitioning service members will have a greater understanding of and access to behavioral health resources.

The VA can also clarify that one role of the VA Solid Start Program would be to educate former service members—both the transitioned and those who are making the transition to veteran life—about opportunities to upgrade their discharge status. Going forward, the VA representatives would be able to review separation orders to identify individuals with behavioral health conditions and to incorporate this information into the three existing touchpoints. The VA could also expand the program to include touchpoints with qualified veterans.

Still, with the recent creation of the DARB and so many veterans eligible for this upgrade, the VA could expand the program to include qualified veterans. The expanded program would allow VA representatives to review discharge

orders for and conduct outreach to veterans with mental health diagnoses to further educate the many veterans to whom the DARB rules apply.

The HHS secretary should direct its agencies to leverage existing grants to alleviate provider shortages among tribal communities.

Indian Health Service (IHS) funding remains insufficient to meet the agency's needs, despite consistent increases. Congress appropriated $6.63 billion to the IHS in FY2022, a 57% increase over FY2012 levels. However, 40% of the budget goes toward 90 self-governance compacts, through which 350 of 574 federally recognized tribes join to gain more autonomy to manage and deliver health care programs.[188,189] According to the IHS's Congressional Justification for FY2023, the increases in discretionary spending do not sufficiently meet AI/AN health needs, and historical trauma and chronic underinvestment compound the disparities.[190] The COVID-19 pandemic, with its high rates of infection, hospitalization, and death among tribal members, further exacerbated these disparities, putting an even greater strain on existing agency resources.

According to testimony of the National Indian Health Board at a congressional hearing, a provider shortage at both IHS and tribal health facilities, especially in rural areas, is a significant barrier to quality health care. Providers are deterred by low pay, lengthy hiring processes, and high turnover.[191] To build trust and workforce capacity, academic institutions, tribal health clinics, and other organizations have partnered to train students with significant ties to AI/AN communities to become health care professionals.[192] This recruitment helps build a foundation to better address disparities in behavioral health care among AI/AN communities.

Building off existing efforts, BPC recommends that the secretary of HHS direct departmental agencies to utilize existing grants to strengthen the provider workforce in AI/AN communities. Specifically, HHS should identify existing grants to SAMHSA, HRSA, and other agencies so it can find ways to provide additional funding for workforce initiatives. The department should also evaluate grants for tribal organizations, with the goal of awarding more grants to organizations that serve tribal communities.

Eligible grants may include those that fund workforce development programs, which in turn could award money to tribal organizations. For example, HRSA invested $60 million in 2022 to strengthen the health care workforce in rural communities; that amount included $46 million from the American Rescue Plan to expand workforce capacity in rural and tribal communities.[193] The HHS secretary could direct HRSA to leverage these funds to support a greater number of tribal organizations by training primary care and behavioral health providers serving AI/AN communities.

HHS agencies might also award behavioral health grants directly to tribal health programs. For example, SAMHSA awarded $20 million in FY2020

for its Tribal Behavioral Health Grants Program. Although these awards are loosely intended to prevent suicide and SUDs, reduce the effects of trauma, and promote mental health among AI/AN youth, the emphasis on prevention could enable grantees to use these funds to pursue workforce development efforts. HHS could direct SAMHSA to leverage this money to support a greater number of workforce programs that recruit and train members of AI/AN communities to address behavioral health needs.

SAMHSA and CMS should increase integration within behavioral health specialty clinics by allocating grants to Community Mental Health Centers and Certified Community Behavioral Health Clinics; CMS should also clarify that opioid treatment programs can bill Medicare for primary care services.

SAMHSA and CMS should leverage existing grant funds to support the integration of primary care into behavioral health specialty clinics. In most instances, behavioral health integration involves enabling primary care providers and clinics to better address behavioral health conditions. However, for individuals with significant behavioral health needs, such as serious mental illness or substance use disorder, behavioral health specialty clinics are better equipped to serve their needs. Encouraging reverse integration (the enabling of behavioral health providers to deliver primary care services), might better serve these patients in a coordinated way.[194]

Although few behavioral health specialty clinics span wide geographic areas in rural America, these clinics are able to reach patients who do not often interact with traditional health care systems. Stakeholders have indicated that in specialty settings, such as harm reduction clinics, the highest risk patients, such as those with severe long-term addiction or serious mental illness, often neglect their primary care needs. Studies show that providers and patients with significant behavioral health needs share a mutual mistrust, and that pervasive stigma can affect patients' access to care, leaving their primary care needs unmet.[195,196]

There is a strong link between physical and behavioral health, and conditions in the two types are commonly diagnosed at the same time.[197] A World Health Organization report found that depression increases the risk of coronary heart disease by 1.6 to 1.9 times, and is 2 to 3 times more common in people with diabetes.[198,199,200] Individuals with SUDs are also at a higher risk for developing primary and chronic conditions, including cardiovascular and liver diseases.[201,202,203,204,205]

Although "reverse integration" is relatively uncommon, emerging evidence suggests that integrating primary care services into behavioral health specialty clinics increases the utilization of primary care services, decreases emergency department visits, raises patient engagement, and improves communication

between mental health and primary care providers.[206,207,208,209] One pilot program in Texas using a Medicaid Section 1115 waiver found that embedding pharmacies and dental services in CMHCs improved medication adherence and could improve longer-term outcomes (e.g., cardiovascular disease, smoking cessation).[210] However, a lack of sustainable funding poses challenges to these programs.

States can use enhanced federal match to integrate primary care into behavioral health specialty clinics. The Medicaid Health Home model in Missouri received funds to support the creation of a training for providers and case managers within CMHCs as part of general medicine services (e.g., screening for hypertension, diabetes and pre-diabetes, obesity, high cholesterol, and hyperlipidemia) to treat individuals with serious mental illness.[211,212] The training enables on-site primary care nurse liaisons, who are present in all CMHCs in the state, to educate behavioral health staff.[213] CMHCs often see patients multiple times per month to arrange for mental health and social services, so relationships with patients tend to be strong.

The secretary of HHS should direct SAMHSA to allocate grant funding for reverse integration through relevant existing programs. BPC identified three ways in which SAMHSA grant funds could support the integration of primary care services into behavioral health specialty clinics.

1. **Certified Community Behavioral Health Clinics.** CCBHCs are designed and required to deliver a comprehensive range of behavioral health service (e.g., integrated and crisis services) either directly or in coordination with facilities (e.g., FQHC or RHC) that offer primary care services.[214,215] A 2021 report to Congress linked CCBHCs with better overall quality of care, implying that current requirements may yield programs that better meet patients' needs.[216]

   CCBHCs received an additional $420 million in the American Rescue Plan Act in 2021 (split into two tracks to support both new and existing programs), and another $15 million in the Bipartisan Safer Communities Act in 2022.[217,218] SAMHSA could assist grantees in expanding programs that integrate primary care services into CCBHCs in future grant cycles rather than simply focusing on care coordination.

   CCBHCs can assess their own need for additional money using evidence-based assessment tools, such as the General Health Integration (GHI) Framework, and in their grant applications, they can specify when reverse integration practices are appropriate.[219,220]

2. **Community Mental Health Centers.** SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) Program awards grants to CMHCs to "improve the physical health status of adults with serious mental illness."[221] According to USA Spending, the PBHCI Program has supported more than 200 projects. An evaluation of the PBHCI revealed that many of the same

components of successful integration programs (e.g., provider education, EHR interoperability, community-based partnerships) foster successful reverse integration efforts, and that integration-specific quality measures can be adapted accordingly.[222]

The PBHCI showed improvements in access to integrated care, patient engagement, and some markers (e.g., hypertension and diabetes) of physical health. However, the program did not lead to improvements in all physical health indicators, especially those such as smoking and weight loss that require more time to see differences.[223] Despite these mixed results, this program provides access to the highest-risk patient population who may neglect their physical health needs altogether. Congress should expand the PBHCI and include provisions for enhanced technical assistance to overcome challenges, such as improving the organizational culture around integrated care and costly program sustainability, as noted in the program evaluation.

3. **Opioid Treatment Programs.** Finally, SAMHSA awards funding to opioid treatment programs. OTPs are certified and accredited to administer and dispense FDA-approved forms of MOUD—most commonly methadone—and provide counseling to prevent and screen patients for HIV.[224] OTPs should be positioned to use a portion of their grant funding from SAMHSA to ensure that primary care services—especially preventive services—are available on-site. Furthermore, SAMHSA should guide state licensing entities to revisit their facility licensure processes to allow behavioral health specialty clinics to also conduct primary care services. SAMHSA should also direct the behavioral health specialty clinics to build the data infrastructure needed to enable effective, consistent reporting, and to evaluate quality of care and patient outcomes of reverse integration practices.

In addition to support for more grants and guidance from SAMHSA around the use of grants, CMS should clarify that OTPs can bill Medicare for primary care services in the CY2024 Physician Fee Schedule. The COVID-19 federal public health emergency introduced new flexibilities for OTPs. Medicare expanded bundled rates for OTPs and office-based OUD services, allowing reimbursement for care coordination and other forms of addiction care (e.g., group psychotherapy).[225] More recently, the CY2023 Medicare Physician Fee Schedule clarified that OTPs can bill Medicare for medically reasonable and necessary services administered both in the physical locations and mobile units. Importantly, the 2023 schedule for the OTP bundle increased the reimbursement rate for methadone and nondrug therapy (e.g., psychotherapy), and allowed expanded access to MOUD via telehealth.[226]

Though OTPs receive SAMHSA grants, they have historically faced issues with reimbursement and provider attrition.[227] Medicare does not authorize or reimburse some facilities that provide SUD care—specifically, freestanding SUD treatment facilities that offer community-based care. This limits service

availability and delivery in community-based settings. Moreover, attrition among SUD providers suggests that traditional Medicare or Medicare Advantage plans use different standards to set reimbursement rates, or offer different incentives to ensure provider participation.[228] Clarification from CMS would encourage OTPs to bill Medicare for primary care services, and further enhance integration of primary care into such facilities for marginalized addiction patients.

Conclusion

Rural Americans' need for mental health and substance use treatment exceeds that of their urban and suburban counterparts, but they have fewer services available to them. The promise of integrating behavioral health services and primary care, while by no means a complete solution to the challenges weighing on rural America, could have an outsized impact.

As more providers, states, and the federal government move toward integrated care models, policymakers need to take a hard look at how the government supports providers and pays for these services to ensure that the promises of integration are realized.

Appendix A: Approaches to Integrating Physical and Behavioral Health Care

Practice type	Stand-alone primary care provider	Primary care and behavioral health providers coordinating care	Primary care provider with embedded care managers	Primary care provider co-located with behavioral health provider	System-level integration
Major activities	Primary care provider screens for patients' behavioral health needs and refers them to specialty services with patient navigation support	Primary care provider screens for patients' behavioral health needs addresses them through referral or interprofessional consult	Primary care provider screens for patients' behavioral health needs, addresses them through referral or interprofessional consult, and hires care managers to monitor patients' care plans and treatment progress, confers with specialists to ensure continuity of care collaboration	Primary care provider coordinates patients' care plans and treatment progress with behavioral health providers; at minimum there is regular communication and coordination with coordinated care plans	Primary care providers and behavioral health providers are integrated within same facility to coordinate patient care under one system; they employ unified care plans in shared medical record; with outcomes tracking, benchmarking, and Quality Improvement (QI)
Type of arrangement	Completely separate provider practices; patient sees providers from at least two practices to receive both primary and behavioral health care services	Primary care provider addresses lower acuity behavioral health needs by coordinating with or receiving advice from specialist. For more complicated needs, patient separately receives behavioral health care services	Primary care provider addresses lower acuity behavioral health needs by coordinating with specialist. For more complicated needs, patient separately receives behavioral health care services. Care managers are located in primary care practice space or are virtual	Primary care and behavioral health providers are co-located in different parts of the same building (or one is virtual) and spend some time collaborating on patients' care; patient can move easily from primary care to behavioral health services	Fully shared space; behavioral health and primary care providers typically share the same rooms, spending all or most of their time in that shared space. Capacity for both providers to see the patient in the same exam room when appropriate
Tool or skill-building needed	Provider training to use patient screening tools such as PHQ9 (depression), GAD-7 (anxiety), Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance use	Provider access to specialty referral lines or secure electronic means for provider-to-provider interprofessional consults	Communication tools; shared care planning support; tracking tools for outcomes	Communication tools; shared care planning support	QI benchmarking support and analysis

Sources: Adapted from Center for Health Care Strategies, Integrating Behavioral Health Care into Primary Care: Advancing Primary Care Innovation in Medicaid Managed Care, August 2019.

Appendix B: Regulatory and Licensing Barriers to Integrated Care Delivery

Regulatory and Licensing Area	Potential Barriers
Facility Licensing	• Conflicting or duplicative requirements across primary care and mental health clinics; multiple layers of licensing to add or deliver behavioral or physical health care in varied settings/ facilities.
Provider Licensing	• Multiple licensure types, processes, definitions, and guidance for providers to deliver behavioral health and primary care services. • Licensing or credentialing barriers that limit the types of staff who can be paid for certain functions (e.g., medical director, charge nurse) or services (e.g., for behavioral health providers to deliver primary care).
Same-Day Services	• Prohibitions on billing for two codes or encounters (e.g., one for physical health code, one behavioral health code) on the same day. • Multiple co-pays for same-day physical and behavioral health services. • Incorrect/outdated assumptions, practices, or misconceptions among providers.
Place of Service	• Medicaid and/or licensing language that limits behavioral health services or the use of certain behavioral health codes to specific facilities, such as CMHCs. • Different requirements across settings, such as use of mandatory screening tools, service documentation, and domains required in plan of care.
Clinical, Staffing Requirements	• Staffing configurations or requirements (e.g., for team-based care, specific behavioral health services, or 24-hour access) that are challenging to implement across diverse settings. • Clinical requirements, such as use of specific assessments or detailed care plans that are burdensome in diverse settings.
Facility/Physical Plant Standards	• Physical plant requirements for physical and behavioral health settings that are duplicative, conflicting, or unnecessarily burdensome (e.g., additional inspections, separate waiting rooms).
Available Billing Codes	• Ability of diverse providers to use: - Health and Behavioral Assessment codes - Screening, Brief Intervention, and Referral to Treatment codes - Chronic Care Management codes - Distinct codes for depression and other mental health/substance use screening - Codes for group therapy - Telehealth
FQHCs	• Behavioral health and integrated care services included as part of scope of services/additional services menu. • Policies regarding payment for behavioral health, either as part of the prospective payment system (PPS), or outside the PPS. • Complexity in payment for same-day services, group therapy in conjunction with encounter-based billing.

Source: Medicaid Innovation Accelerator Program, Aligning State Policies to Support Physical and Mental Health Integration, June 2018.

Glossary of Acronyms

ACO	Accountable Care Organization
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian/Alaska Native
BHI	Behavioral Health Integration
CCBHC	Certified Community Behavioral Health Clinic
CCM	Chronic Care Management
CEU	Continuing Education Unit
CHIP	Children's Health Insurance Program
CMCS	The Center for Medicaid and CHIP Services
CME	Continuing Medical Education
CMHC	Community Mental Health Center
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CoCM	Collaborative Care Model
CSC	Collaborative Systems of Care
DARB	Discharge Appeal Review Board
DoD	Department of Defense
DHS	Department of Homeland Security
EHR	Electronic Health Record
FORHP	Federal Office of Rural Health Policy
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources Services Administration
MedPAC	Medicare Payment Advisory Commission
MOUD	Medications for Opioid Use Disorder
MSSP	Medicare Shared Savings Program
NDAA	National Defense Authorization Act
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PCMH	Patient-Centered Medical Home
PHE	Public Health Emergency
PTSD	Post-traumatic Stress Disorder
RHC	Rural Health Clinic
SAMHSA	Substance Use and Mental Health Services Administration
SUD	Substance Use Disorder
THCGME	Teaching Health Center Graduate Medical Education
VA	Department of Veterans Affairs

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