

Behavioral Health Integration

Our country's healthcare system is fragmented, with physical health services, mental health services, and substance use services delivered by different providers in different locations, and often covered by different payers. This can make accessing behavioral health services challenging: as of 2018, 50% of adult Medicaid members with serious mental illness were not receiving treatment, and as of 2015, 68% of Medicaid members with an opioid use disorder were not receiving treatment.

Behavioral healthcare integration works to address these challenges by having medical providers and behavioral health providers collaborate to ensure the best possible outcomes for their patients. Often, this looks like providing assessments, treatment, and care coordination in primary care settings. Integrated care models can also include coordination with social service providers to connect patients to housing, nutrition programs, and other wrap-around services.

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Barriers to Behavioral Health Integration in Medicaid

Federal funding streams, regulations, and incentives present barriers to behavioral healthcare integration for Medicaid members. Medicaid members may benefit from services from a variety of federal agencies (like Medicaid, Medicare, and the Substance Abuse and Mental Health Services Administration, or SAMHSA) but these agencies typically have separate funding streams with different regulations and reporting requirements. This can make it difficult for states and providers to “braid” these funds into seamless, comprehensive services for patients. Integration is particularly complex for Medicaid members who are also eligible for Medicare; these “dually-eligible” members also often have the most complex care needs.

There are also federal regulations that make it difficult to provide integrated care. 42 CFR Part 2, a data sharing restriction, was initially intended to help protect the privacy of individuals with substance use disorders but has greatly hindered efforts to integrate substance use treatment. Similarly, strict regulations around the provision of medications for opioid use disorder have prevented primary care providers from prescribing these medications more broadly.

Opportunities for Federal Action

- **Fund comprehensive education on integrated models of care** for health care professionals, including physicians, registered nurses, physician assistants, psychiatric nurse practitioners, social workers, and other providers.
- **Remove regulatory barriers that restrict access to medications for opioid use disorder in primary care settings**, including strict regulations of the provision of methadone and the “X waiver” requirement for buprenorphine prescribing.
- **Promote the adoption of electronic health records/electronic medical records by behavioral health providers to facilitate care coordination.** Behavioral health providers were initially excluded from HITECH funds, which slowed the adoption of electronic health records and electronic medical records. Congress should provide additional funding to behavioral health providers and clinics to support the adoption of interoperable and integrated systems.
- **Evaluate data sharing restrictions that hinder care coordination.** Data sharing restrictions under 42 CFR Part 2 were originally intended to protect patient privacy but have greatly restricted providers’ ability to coordinate across behavioral health and physical health. Although recent legislation included provisions to better align Part 2 with HIPAA, [HHS is still developing the corresponding final regulatory rules](#), so it is unclear how these changes will impact data sharing. Regardless, many states report that providers lack a strong understanding of what data sharing is allowable even under current law. The federal government should provide clear guidance to providers on these questions.
- **Better align federal funding streams and present clear guidelines on braiding funding.** Integrated care models may draw on funding from a variety of federal agencies, including Medicaid, Medicare, and SAMHSA. The federal government could create clear guidelines for braiding this funding, and better align regulatory and data reporting requirements across these programs.
- **Launch Center for Medicare & Medicaid Innovation (CMMI) models aimed** at integrating behavioral health care and primary care for Medicaid members.

Supporting State Innovation

These changes would facilitate state efforts to integrate care for Medicaid members. As of 2021, [31 states have “carved-in” most behavioral health services into their managed care plans](#), a crucial step towards payer integration. States have used these managed care contracts to promote integration during service delivery: Washington requires its plans to submit quarterly reports on bi-directional behavioral and physical health integration, and Minnesota requires its plans to provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) in primary care clinics. However, achieving full behavioral health integration will require federal action.

You can read more about state actions to support behavioral health integration in [NAMD’s Medicaid Forward: Behavioral Health report](#).