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HHS Roadmap for Behavioral Health Integration

Our nation faces an unprecedented behavioral health crisis among people of all ages.

In his first State of the Union, the President outlined a bold national strategy <https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/> to prevent, treat, and provide long term recovery supports for mental illness and substance use disorders (M/SUD). The U.S. Department of Health and Human Services (HHS) has a leadership role to implement and advance the President's Strategy.

Over the course of the pandemic, self-reported symptoms of anxiety have increased </disclaimer.html>, as has the rate of overdose deaths <https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm>. Despite this apparent increased need for M/SUD care, use of such services dropped sharply at the beginning of

the pandemic and has been slower to rebound to pre-pandemic levels than other types of health care. In 2020, the past-year prevalence of any mental illness among adults in the United States (U.S.) was 21% - PDF <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/nsduhffrpdfwhtmlfiles2020/2020nsduhffr1pdfw102121.pdf>, meaning that 52.9 million adults were affected by mental illness. Substance use disorders affected 15% - PDF <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/nsduhffrpdfwhtmlfiles2020/2020nsduhffr1pdfw102121.pdf> (37.9 million) of U.S. adults, including 6.7% - PDF <https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/nsduhffrpdfwhtmlfiles2020/2020nsduhffr1pdfw102121.pdf> (17 million) of U.S. adults who were affected by both mental illness and substance use disorders. In 2019, one in three high school students and half of female students reported <https://www.cdc.gov/nchhstp/dear_colleague/2020/dcl-102320-yrbs-2009-2019-report.html> persistent feelings of sadness or hopelessness, an overall increase of 40 percent from 2009. In response, the Surgeon General issued an Advisory on youth mental health - PDF <https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf>.

On September 16, Secretary Becerra, Deputy Secretary Palm, and HHS leadership unveiled the HHS Roadmap for Behavioral Health Integration <https://aspe.hhs.gov/reports/hhs-roadmap-behavioral-health-integration> (“HHS Roadmap”) to prioritize bold policy actions that significantly advance access to care. On December 2, they further articulated this vision in a jointly authored Health Affairs Forefront Article <https://www.healthaffairs.org/content/forefront/addressing-nations-behavioral-health-crisis-hhs-roadmap-integrate-behavioral-health> </disclaimer.html>. The HHS Roadmap builds on the President’s call to action and outlines HHS’s commitment to providing the full spectrum of integrated, equitable, evidence-based, culturally appropriate, and person-centered behavioral health care to the populations it serves.

HHS calls on states, territories, tribes, and local governments, the behavioral health and medical communities, industry, individuals, including youth and families, community partners, and Congress to help move our current system of care towards an integrated and equitable model. HHS will continue to provide bold leadership to advance our nation’s behavioral health.

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HHS has identified opportunities to **expand access to behavioral health by integrating behavioral health into primary care settings**. This will increase access to care by encouraging and reimbursing primary care providers for providing behavioral health care to both adult and pediatric populations. This can also help overcome the stigma associated with receiving behavioral health services in certain communities. Examples include:

- The Centers for Medicare & Medicaid Services (CMS) recently finalized a new Medicare policy <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule> that will allow payment for integrated behavioral health care services provided by clinical psychologists and clinical social workers as part of a primary care team, where the behavioral health services furnished by a clinical psychologist or clinical social worker are serving as the focal point of care integration, starting January 1, 2023.
- The Agency for Healthcare Research and Quality's (AHRQ) Academy for Integrating Behavioral Health and Primary Care <https://www.ahrq.gov/cpi/about/otherwebsites/integrationacademy.ahrq.gov/index.html> is a national resource for integrating behavioral health and primary care, promoting and supporting the integration of behavioral health care into primary and ambulatory care settings with a key focus on providing care for patients using substances, particularly opioids, and for those with mental health conditions.

HHS has identified opportunities to **recruit, train, and support a diverse behavioral health workforce** to serve communities as providers of services to both adults and children, and to offer services that are fully integrated, culturally appropriate, accessible, and affordable. Ensuring diversity in the behavioral health workforce is key to improving long-standing inequities in service receipt. Examples include:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) will advance creation of a training pipeline from Historically Black Colleges and Universities, Minority Serving Institutions, and other institutions of higher education that reach underserved populations.

- SAMHSA will expand the Mental Health Awareness Training <https://www.samhsa.gov/mental-health-awareness-and-training> program, which prepares and trains individuals to appropriately and safely respond to persons with mental health challenges or disorders, particularly those with serious mental illness or serious emotional disturbance.
- Health Resources and Services Administration (HRSA) programs will emphasize practice in integrated settings—not just for behavioral health care providers but also for primary and specialty physical health care providers. Relevant programs may include National Health Service Corps <https://nhsc.hrsa.gov/> loan repayment programs, the Behavioral Health Workforce Education and Training Program, the Pediatric Mental Health Care Access Program <https://mchb.hrsa.gov/programs-impact/programs/pediatric-mental-health-care-access>, and the Area Health Education Centers Program.
- CMS recently approved an 1115 demonstration extension for Massachusetts <https://www.mass.gov/doc/1115-waiver-extensionfact-sheet/download> in which the state will now have new authority for behavioral health care student loan repayment, allowing for Medicaid to both advance new Medicaid providers and address the overall workforce shortage. CMS encourages other states to take up this option in their 1115 demonstrations.
- CMS recently finalized a new Medicare policy <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule> that will allow licensed marriage and family therapists, licensed professional counselors, certified addiction counselors, certified peer recovery specialists, and others who are authorized under state law to provide behavioral health services, to do so under the general supervision of a physician or non-physician practitioner, rather than under “direct” supervision, starting January 1, 2023. These behavioral health practitioners will be able to provide services without a physician or non-physician practitioner on-site, expanding access to behavioral health services for people with Medicare and enabling these behavioral health practitioners to practice near the top of their license.

- The Indian Health Service (IHS) will develop strategies to recruit, train, and support a diverse behavioral health workforce in integrated settings, including community health workers and peer support specialists, and increase the number of providers serving the American Indian/Alaska Native population through the IHS Scholarship Program <https://www.ihs.gov/scholarship/>, the Loan Repayment Program, and the American Indians into Psychology Grant Program <https://www.ihs.gov/dhps/dhpsgrants/americanindianpsychologyprogram/>.
- IHS is exploring options to significantly improve its online facility locator system for American Indian and Alaska Native patients, with more straightforward navigation for behavioral health services. The project will enable improvements in data handling and geographic analysis specific to facility locations, service catchment areas, contextual risk factors, and local continuums of care, helping IHS to concentrate on sites requiring quality improvements.

HHS has identified opportunities to **strengthen the implementation and enforcement of behavioral health parity** with an emphasis on non-quantitative treatment limits. Despite federal parity legislation, the number of people citing cost or insurance coverage as barriers to receiving behavioral health treatment remains too high. Examples include:

- CMS will strengthen parity (among financing arrangements subject to parity) by:
  - Promoting compliance and strengthening enforcement of mental health and substance use disorder parity requirements through reviews of medical management standards and other non-quantitative treatment limitations imposed by health plans.
  - Developing ways to expand timely access to behavioral health services and address the issue of “ghost” networks <https://www.ncbi.nlm.nih.gov/pmc/articles/pmc7497897/> by developing and implementing network adequacy standards based on wait times to receive behavioral health care across Medicaid and Federally facilitated Marketplaces.

HHS has identified opportunities to **engage several of the highest-risk populations**—including youth, individuals who are experiencing homelessness or are justice-involved, individuals with co-occurring disabilities, individuals involved with the child welfare system, and victims of domestic violence, trafficking, and other forms of trauma—in integrated behavioral health care through targeted outreach tailored to their needs. This is a critical component of expanding integration equitably. Examples include:

- The Administration for Children and Families (ACF) will work with the Centers for Disease Control and Prevention (CDC) and SAMHSA to leverage training tools and the evidence base on trauma-informed approaches and will develop guidance that leverages the Head Start Performance Standards to advance training of early childhood staff and issue best practices for childhood mental health consultants.
- CMS will ensure that children have access to the full range of behavioral health care as required under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in Medicaid.
- The Administration for Community Living (ACL) will expand access to behavioral health services, including crisis services, for people with co-occurring intellectual and developmental disabilities (I/DD) and behavioral health needs through its recently launched National Co-occurring Resource Center <https://acl.gov/news-and-events/announcements/acl-launches-center-improve-support-people-who-have-both-intellectual> that will build capacity among state behavioral health, developmental disabilities and Medicaid agencies; strengthen and expand the direct care workforce; and expand access to resources and opportunities for people with co-occurring I/DD and behavioral health needs.
- ACF will work with SAMHSA and other federal partners to offer mental health training and resources to parents and caregivers to address their own well-being and support their children's mental health.
- The National Institute of Mental Health (NIMH) will support research to evaluate the effectiveness of interventions to prevent or treat mental illnesses, improve the quality and outcomes of care, enhance service delivery, and communicate and implement evidence-based treatments across care settings, with the goal of optimizing how evidence-based practices can be brought to scale effectively.
- IHS is expanding its work as a trauma-informed care organization. The agency's recently released update <https://www.ihs.gov/newsroom/ihs-blog/september-2022-blogs/ihs-takes-steps-towards-becoming-a-trauma-informed-care-organization/> to its *Trauma-Informed Care* policy reflects training requirements and guidance to support IHS's efforts towards providing care that is patient-focused and driven, recovery-oriented, integrates cultural humility and provides trauma-informed services.

To address the persistent youth behavioral health crisis <https://www.cdc.gov/nchhstp/dear_colleague/2020/dcl-102320-yrbs-2009-2019-report.html>, HHS has identified opportunities to align structural supports and financing to **integrate**

promotion and prevention programs in community-based settings from early childhood to young adulthood, inclusive of schools. These settings have the promise to reach more children, promote healthy development in the environments in which children spend most of their time, prevent the occurrence of behavioral health challenges, and change the trajectory of the mental health crisis facing children. Examples include:

- The Office of the Assistant Secretary for Health (OASH) will advance the Children & Youth Resilience Challenge, a prize competition to fund innovative solutions to support resilience in children and youth.
- The National Institutes of Health (NIH), HRSA, and AHRQ will prioritize investments in strengthening the evidence base where promising interventions have an insufficient evidence base to be considered recommended preventive services.
- CMS is implementing a series of activities to support schools to deliver and claim for Medicaid services, including behavioral health services:
  - Updated guidance on Medicaid claiming for school-based administrative and direct service costs.
  - A technical assistance (TA) center in collaboration with the Department of Education to help states advance Medicaid coverage of school-based health services.
  - $50 million in grants to states to help improve Medicaid coverage of school-based services.
- CDC expanded community level programs <https://www.cdc.gov/suicide/programs/csp/index.html> that focus on preventing mental health symptoms, decreasing suicidality, and increasing resiliency.

HHS has identified opportunities to **test models of care integration facilitated through value-based payment arrangements and emerging technologies as well as an opportunity to reduce the technology gap** between behavioral health care providers and physical health care providers. To properly integrate care, providers and systems must be able to communicate with one another. While new and emerging technologies such as electronic health records can facilitate this communication, providers do not consistently receive the technical support, guidance, and reimbursement needed to leverage these tools. Establishing an electronic health record or other such health care coordination technology also often requires large up-front capital investments, which behavioral health care providers may be unable to afford. Such lack of assistance only

compounds the challenges of interoperability between physical and behavioral health care providers and non-health care systems, such as social service and early childhood systems. Examples include:

- HHS will explore new policies related to electronic care delivery platforms by reviewing the evidence and considering regulatory and payment issues.
- The Office of the National Coordinator for Health Information Technology (ONC) is leading the coordination across HHS of activities related to health information technology (health IT), including health IT activities that will support the integration of behavioral health care with other care settings. In July 2022, ONC released version 3 of the United States Core Data for Interoperability (USCDI) - PDF <https://www.healthit.gov/isa/sites/isa/files/2022-07/uscdi-version-3-july-2022-final.pdf>. The USCDI is a standardized set of health data classes and elements that can be used across care settings to aid in the coordination of care by ensuring that data is represented in an interoperable way. In version 4, ONC intends to address behavioral health integration with primary care and other physical care.
- NIMH will prioritize research that develops technology-based solutions to support the effective provision of evidence-based mental health care through its Advanced Laboratories for Accelerating the Reach and Impact of Treatments for Youth and Adults with Mental Illness (ALACRITY) Centers <https://www.nimh.nih.gov/research/research-funded-by-nimh/research-initiatives/advanced-laboratories-for-accelerating-the-reach-and-impact-of-treatments-for-youth-and-adults-with-mental-illness-alacrity> and other research programs.

HHS has identified opportunities **to drive resources into integrated care through pay-for-reporting and pay-for performance mechanisms based on integration-related quality measures.** To effectively drive resources into integrated care, the Department would need a small number of widely adopted quality measures related to integration, with a substantial share of practice revenue linked to these **measures.** Examples include:

- HHS will develop behavioral health integration measures for use across programs. Validated performance measures can not only drive meaningful improvements in the quality of behavioral health care but can also incentivize greater investment in behavioral health services and generate a sustainable revenue stream to support the delivery of behavioral health care and recruitment of providers.

For additional information regarding the HHS Roadmap for Behavioral Health Integration, please visit: https://www.aspe.hhs.gov/reports/hhs-roadmap-behavioral-health-integration <https://www.aspe.hhs.gov/reports/hhs-roadmap-behavioral-health-integration>

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