

BEHAVIORAL HEALTH CARE INTEGRATION: Challenges and Opportunities for Quality Measurement



Introduction

The demand for high-quality behavioral health services has never been greater. To address this demand, federal policies have incorporated behavioral health integration into primary care as a strategy to increase access to behavioral health services and reduce shortages in the behavioral health workforce. Quality measurement is an established tool for evaluating the quality of health services, creating accountability in health care and incentivizing quality improvement. In behavioral health, quality measures have focused on access to follow-up care, medication management and depression outcomes. However, compared to measures for other conditions, behavioral health quality measures have been difficult to implement and are frequently underreported. In the siloed environment of U.S. care delivery systems, measuring the quality of behavioral health care has faced special challenges, and measures have had varying success in use across the delivery system. We discuss these challenges and examine how solutions such as practice level resources, data infrastructure, data standards and the shift to digital quality measurement can improve behavioral health care quality measurement and reporting and enhance the quality of behavioral health services through integration with primary care.

BACKGROUND

Prior to the COVID-19 pandemic, treatment for mental health conditions and substance use disorders (SUD), commonly referred to as “behavioral health conditions,” was deprioritized and underfunded. In the wake of the pandemic, increased demand for behavioral health services outstripped the available workforce and extended appointment wait times with behavioral health specialists. As behavioral health care delivery and payment models evolve and incorporate alternative payment models, standards and quality measures have not kept pace. As a result, adherence to standards and performance on existing quality measures may not accurately reflect the quality of care experienced by people who receive behavioral health services.¹⁻³ Aligning quality measures in both commercial and federal measurement programs across the health care delivery system, including at the state, health plan and clinician levels, can help prioritize behavioral health quality measures and improve quality of care and patient outcomes.² Nevertheless, quality reporting remains challenging due to a largely fragmented payment and delivery system, and a lag in the adoption of electronic health records (EHRs) in behavioral health settings which has made it difficult to implement behavioral health quality measures.

Federal policymakers have identified integration of behavioral health into primary care as a crucial strategy in the effort to address a national mental health crisis.⁴ It is also a priority area in the Substance Abuse and Mental Health Services Administration’s (SAMHSA) 5-year strategic plan.⁵ Primary care practices that address co-occurring medical and behavioral health needs, such as congestive heart failure and depression, can design treatment plans that achieve whole-person care and are more likely to improve performance across the spectrum of quality measures.⁶⁻⁹ The U.S. Department of Health and Human



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Services' (HHS) Roadmap for Behavioral Health Integration cites quality measurement as a key driver for improving the quality of behavioral health care and incentivizing integration across systems that have been historically siloed.¹⁰ Still, the growing shift toward integrating behavioral health care into primary care presents unique challenges for quality measurement in this environment.

The Agency for Healthcare Research and Quality defines integrated behavioral health as “care that results from a 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.”¹¹ Although integrated behavioral health care can include providing primary care services in behavioral health care settings, or vice versa, we focus on integrating behavioral health into primary care. We refer to this model as “integrated behavioral health” throughout. Primary care and behavioral health clinicians do not need to be co-located to provide integrated behavioral health services. Care delivery can range from primary care practices screening and referring patients to behavioral health clinicians, to practices that are fully integrated and share care plans and clinical data systems with behavioral health clinicians.¹² Training primary care clinicians to deliver basic behavioral health care services is a foundational component to address the demand for these services, and can help increase the number of integrated behavioral health care settings.¹³ However, challenges to implementing behavioral health integration—establishing interoperable systems to support care coordination, payment approaches (such as fee-for-service) that fail to support integration, workforce issues¹⁰—can have adverse effects on quality measurement and reporting.

In this commentary, we explore challenges to and opportunities for behavioral health care quality measurement, focusing on integrated behavioral health care. The challenges we highlight are informed by conversations (during 2022 and 2023) facilitated by staff at the National Committee for Quality Assurance (NCQA) with stakeholders representing behavioral health clinicians and policy, payer and management experts, to identify quality measures appropriate for evaluating behavioral health care in integrated settings. Participants offered feedback about the measures that could be useful in value-based programs that use integration to achieve high-quality behavioral health care. Below, we present solutions to improve the feasibility of reporting behavioral health quality measures in integrated settings, and discuss the implications of advances in quality measurement, including the transition to digital measures that leverage standardized electronic clinical data.

The Challenge of Measuring and Supporting Integrated Behavioral Health in Primary Care

STATE OF BEHAVIORAL HEALTH CARE QUALITY MEASUREMENT

Quality measurement has become widely established in health care, enabling tracking of trends over time, providing a basis for comparison, offering incentives for high-quality care and facilitating ongoing quality improvement and alignment across the care delivery system. Quality measures are included in a broad range of state and federal programs. In the 2023 Medicaid Adult and Child Core Sets, 11 of 34 adult quality measures and 7 of 27 child quality measures are specific to behavioral health.^{14,15} HHS notes that validated performance metrics developed by a trusted measure steward can both drive meaningful improvements in the quality of behavioral health care and incentivize investment in behavioral health care by generating new, value-based revenue streams that better support care delivery and provider recruitment.¹ Driving resources to integrated care requires “a small number of widely adopted quality measures related to integration, with a substantial share of practice revenue linked to these measures.”¹⁰

Behavioral health quality measure reporting has historically been limited by data availability. Administrative claims data do not capture important evidence-based behavioral health care assessments such as results from the PHQ-9 assessment for depression screening. NCQA's Electronic Clinical Data Systems (ECDS) reporting method advanced the quality measurement field by requiring health plans to use structured electronic clinical data to report measures. Today, of 16 ECDS-reported Healthcare

Effectiveness Data and Information Set (HEDIS®) measures; 6 are behavioral health measures. However, even as health plans' ability to access and leverage standardized clinical data for reporting has steadily improved,¹⁶ the feasibility of collecting necessary data is a persistent challenge that affects various levels of the delivery system. At the practice level, for example, inadequate practice capabilities, limited data sharing and a lack of data standards have created barriers to the feasibility and utility of reporting behavioral health quality measures.¹⁷ Outdated EHRs and data systems that lack interoperability across practices are a major source of challenges to reporting behavioral health care quality measures. This technology gap contributes to inadequate practice level resources and insufficient standardized health data exchange, particularly between behavioral health care and physical health care providers. Primary care and behavioral health clinicians must be able to access and use up-to-date EHRs and data systems to mitigate underreporting for behavioral health care quality measures.

Inadequate Practice-Level Resources Create Barriers to Implementing Quality Measurement

In primary care, financing is necessary to motivate practices to integrate behavioral health. Financing must be adequate to support practice redesign (i.e., modified clinical workflows, enhanced data infrastructure and quality measurement) that supports integrated behavioral health care.¹⁸ Evidence-based, integrated care models (e.g., the Collaborative Care Model) emphasize universal screening and follow-up for conditions like depression; collaboration between physical health and behavioral health providers to create referral mechanisms for psychiatric consults; measurement-based care with validated tools (e.g., PHQ-9); and population health management that targets higher-acuity populations.¹⁹ Among primary care clinicians, including those in integrated care settings, there are persistent gaps in education and training on validated screening tools, and in population management and measurement-based care for patients with mild to moderate behavioral health conditions. Only one in three pediatricians feel they are sufficiently trained to diagnose and treat children with mental health disorders.²⁰ The primary care team's discomfort may also be a factor, particularly with screening and care management for patients with opioid use disorders, as well as the stigma of addiction.²¹

Measurement-based care complements behavioral health care quality measurement in integrated care settings. It incorporates validated screening tools into care delivery and is important for monitoring patient progress and response to treatment, informing shared decision making about care management and improving population health management.^{22,23} However, resistance to measurement-based care—from both primary care and behavioral health clinicians—has made acceptance challenging. In addition to lack of clinician training, the time required to complete a screen, administrative burden and the need to integrate outcomes into EHRs and clinical workflows are barriers to wide adoption of measurement-based care.²⁴ These challenges have implications for implementing and reporting behavioral health quality measures for practices, health plans and state Medicaid agencies that rely on validated tools to screen and monitor behavioral health conditions.

Behavioral Health Care Quality Measure Reporting Evolves, But Behavioral Health Data Collection and Exchange Remains Challenging

Measurement difficulties often stem from issues with how clinical data is documented, formatted, and exchanged. Challenges may arise due to the narrative format of treatment goals in behavioral health documentation, data collection workflow issues at the practice level, lack of interoperability across health IT data systems and limited standardization of data elements for efficient exchange of behavioral health data. Health plan quality measures have long relied on standard administrative billing data (e.g., ICD-10 codes, CPT codes). Measures requiring additional clinical information typically leverage chart-abstracted data obtained through manual medical record reviews, but data may be non-standardized (narrative clinical notes) or standardized (structured computable data elements).

Behavioral health data documentation is known to be inconsistent even when standardized data elements are available. Evidence shows that EHRs inadequately capture mental health diagnoses, visits, specialty care, hospitalizations and medications, giving an incomplete picture of a patient's behavioral health needs.²⁵ The 2009 HITECH ACT promoted use of health IT (including EHRs) but did not include incentives or requirements for behavioral health care providers to participate. The lack of oversight to ensure sufficient investment in behavioral health IT systems, and adequate resources to upgrade them, has resulted in inconsistent documentation of behavioral health data, inefficient data exchange and challenges for measure developers and measure reporting.^{17,26} Many primary care settings also use outdated EHRs and health IT systems, which limits their ability to use standardized data elements to share important behavioral health data for referral, follow-up care and quality measurement.^{27,28} As quality measurement transitions from administrative billing data and burdensome manual record review to digital measures that leverage electronic clinical data, measure developers will increasingly rely on standardized data elements.

Opportunities to Improve Quality Measurement That Supports Integrated Behavioral Health Care

INVEST IN PRACTICE TRANSFORMATION

Federal funding has helped states improve the quality of their behavioral health care services, reduce fragmentation between physical and behavioral health care and promote integration. To support high-quality behavioral health services, states must also invest in clinical transformation at the practice level to promote adoption of evidence-based integrated care models. Several states have used 1115 Medicaid Demonstration waivers, SAMHSA funding and funding from CMMI State Innovation Model (SIM) testing to provide training and technical assistance for primary care practices and behavioral health providers engaged in integrated care models.²⁹

Early SIM initiatives included states that provided resources to Medicaid programs or Accountable Care Organizations to integrate behavioral health into primary care. Oregon used SIM funds to encourage co-location of behavioral health providers in coordinated care organizations (CCO) through Medicaid contracts, and included four behavioral health performance measures in its CCO model.³⁰ SAMHSA's Promoting Integration of Primary and Behavioral Health Care program funded states to offer integrated care services for screening, diagnosis, prevention and treatment of mental health conditions, SUDs and co-occurring physical health conditions and chronic diseases.³¹ SAMHSA's Certified Community Behavioral Health Clinic model has also supported practice transformation efforts through Medicaid demonstration projects or direct funding to clinics.³²

Practice-based tools offer a prescriptive approach to enhancing primary care practice capabilities and clinical infrastructure for integrating behavioral health. For example, the Continuum-Based Framework has helped practices advance integration,³³ and includes practice readiness assessments to support a variety of practice sizes. Still, continued investment toward practice transformation is needed, especially in rural areas. The Making Care Primary (MCP) Model, set to launch in 2024 aims to help 8 state Medicaid agencies support primary care clinicians in the delivery of advanced primary care services over 10.5 years, including building the infrastructure for behavioral health integration in primary care and addressing health-related social needs.³⁴ Early evaluations of the MCP Model could be used to inform other states looking to make long-term investments in integrated behavioral health care.

DRIVE ALIGNMENT ACROSS PROGRAMS, PAYERS AND PROVIDERS TO ENHANCE DATA EXCHANGE AND QUALITY MEASUREMENT

Federal efforts that focus on alignment and reporting mandates for behavioral health measures can push states and health plans to create new systems and processes for sharing clinical data needed to report quality measures and reduce reporting burden. The Centers for Medicare & Medicaid Services (CMS) Universal Foundation focuses on aligning quality measures across federal programs, advancing equity and supporting the transition to digital quality measure reporting,³⁵ however there continues to be inconsistencies in which behavioral health quality measures to include in federal reporting programs (see **TABLE 1**). The inclusion of seven behavioral health quality measures (five pediatric and two adult) sends a strong signal to providers, health systems, health plans and states that behavioral health quality is integral to providing whole-person care.

Public reporting and the transition from voluntary to mandatory reporting are crucial to improving performance rates and encouraging adoption of interoperable health IT and a data-sharing infrastructure.³⁶ In 2024, states will be required to report the CMS Adult and Child Core Health Care Quality Measurement Sets, which include 11 Adult Core and 7 Child Core behavioral health measures assessing a variety of clinical areas such as substance use, medication management and screening and management of co-occurring chronic physical and behavioral health conditions.³⁷ While mandatory reporting of quality measures does have its challenges—availability and quality of data, ability to exchange data—technical assistance, training and clear guidance from CMS can support health plans during the transition.

States are also putting systems in place to support and promote clinical data exchange; for example, using third-party data aggregators or statewide health information exchanges (HIE) to support data sharing across the care delivery system and improve reporting for behavioral health quality measures. Arizona's plan to incorporate behavioral health data into its HIE has resulted in increased participation of behavioral health providers since the HIE's inception in 2016.³⁸ California's Health and Human Services Agency Data Exchange Framework will develop a statewide data-sharing agreement to expand exchange of health information (including behavioral health) among health care entities, government agencies and social service programs beginning in 2024.³⁹ These efforts to improve data exchange can increase the feasibility of behavioral health quality measure reporting at the state, health plan and practice levels.

Health plans are uniquely positioned to bridge the gaps that often prevent primary care practices from accessing hospitalization data and prevent behavioral health specialists from accessing social needs screening data. Health plans can collate and share data (in near real-time) with in-network integrated primary care practices at the point of care, and can hold integrated practices accountable for utilizing whole-person data to improve quality.^{40,41} This may move the needle on quality indicators that require timely response at the practice or provider level, such as the HEDIS® measures *Follow-Up After Hospitalization for Mental Illness and Social Needs Screening and Interventions*.

TABLE 1: Select Existing Behavioral Health Care Quality Measures

FOCUS AREA	MEASURE NAME	MEASURE STEWARD	DATA COLLECTION METHOD	USE IN SELECT PROGRAMS		
				2023/2024 CMS Medicaid Adult Core Set	2023/2024 CMS Medicaid Child Core Set	CMS Universal Foundation
Depression	Depression Screening and Follow Up for Adolescents and Adults	NCQA	ECDS			
	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	NCQA	ECDS			
	Postpartum Depression Screening and Follow Up	NCQA	ECDS			
	Prenatal Depression Screening and Follow Up	NCQA	ECDS			
	Depression Remission or Response for Adolescents and Adults	NCQA	ECDS			
	Screening for Depression and Follow-Up Plan	CMS	ADM or EHR	○	○	○
	Antidepressant Medication Management	NCQA	ADM	○		
Follow-up	Follow-Up After Hospitalization for Mental Illness	NCQA	ADM or EHR	○	○	
	Follow-Up After Emergency Department Visit for Mental Illness	NCQA	ADM	○	○	
	Follow-Up After Emergency Department Visit for Substance Use	NCQA	ADM	○	○	
	Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication	NCQA	ADM or EHR		○	○
Serious Mental Illness	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA	ADM	○		
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA	ADM	○		
	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%)	NCQA	ADM or HYB	○		
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	ADM		○	○
	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	ADM		○	
Substance Use	Unhealthy Alcohol Use Screening and Follow-up	NCQA	ECDS			
	Medical Assistance with Smoking and Tobacco Use Cessation	NCQA	SVY	○		
	Use of Pharmacotherapy for Opioid Use Disorder	CMS	ADM	○		
	Initiation and Engagement of Substance Use Disorder Treatment	NCQA	ADM	○		○

Note: A ○ indicates use in the program, though some measures may vary slightly across programs, e.g., different available data sources for different reporting entities. ADM= Administrative, i.e., claims data; EHR= Electronic Health Record; ECDS= Standardized data from electronic clinical data systems; includes claims; HYB= Administrative data with medical record review; SVY= Survey
 NCQA measures are part of the Healthcare Effectiveness Data and Information Set (HEDIS), a tool used by more than 90 percent of U.S. health plans to measure performance on important dimensions of care and service. NCQA’s HEDIS Electronic Clinical Data Systems (ECDS) reporting standard provides health plans a method to collect and report structured electronic clinical data for HEDIS quality measurement and quality improvement.

Funding to promote EHR adoption among behavioral health providers can address gaps in availability of data and improve the quality of shared data. Providers and health care organizations have often avoided sharing behavioral health data due to the Confidentiality of SUD Patient Records under 42 CFR part 2, which protects against unauthorized disclosure of patient records on substance abuse treatment. However, recently proposed changes to 42 CFR part 2 are intended to increase care coordination by aligning with some Health Insurance Portability and Accountability (HIPAA) privacy rules.⁴² If these changes are finalized, states, health plans and health systems should provide guidance to practices and clinicians on information that can be shared, and build up mechanisms to streamline data-sharing processes to avoid delays in care.

IMPLEMENT DATA STANDARDS TO FACILITATE INTEROPERABILITY OF BEHAVIORAL HEALTH DATA

Standardized data documentation can improve data sharing and feasibility of reporting behavioral health quality measures. Having consistent data elements and format allows aggregation across EHRs, HIEs, registries and other data sources, increasing the use of clinical data across levels of the delivery system and care continuum. Standardized and interoperable data can help providers, health plans and state and federal health agencies track longitudinal patient outcomes and develop strategies to close gaps in care.

Recent regulations like the Interoperability and Patient Access Final Rule support standardizing electronic health data for streamlined exchange across providers, including behavioral health clinicians.⁴³ Requiring EHR implementation and use of United States Core Data for Interoperability Version 3, which captures more comprehensive mental health and SUD data standards, offers an important pathway toward efficient sharing of behavioral health data. The Office of the National Coordinator for Health IT (ONC) has also identified criteria for data standards that support integration of behavioral health within primary care and other medical care.^{10,44} Since EHRs are subject to regulatory requirements,⁴⁵ standardized documentation in EHRs where behavioral health is integrated into primary care can be a path to increase data capture and improve behavioral health quality measure reporting.

PROMOTE BEHAVIORAL HEALTH MEASURE PERFORMANCE AND REPORTING THROUGH INCENTIVES

States can promote accountability and behavioral health care quality for providers, health systems and health plans by incorporating behavioral health care quality measure reporting into payment programs. Section 1115 Medicaid demonstration waivers, used to test new approaches in Medicaid, have been leveraged by at least 23 states to implement delivery system reforms,⁴⁶ integrate managed care plans and support SUD prevention and treatment.²⁹ These states use financial incentives to encourage health care systems and practices to participate in integration and value-based payment models, provide technical assistance and infrastructure development for providers and health care organizations and encourage collaboration between physical and behavioral health providers to expand behavioral health care access. In Massachusetts, ACO payments are part of their global budget-based risk contracts between payers and providers, which incentivize performance on several behavioral health quality measures such as *Screening for Clinical Depression and Follow-Up Plan and Initiation and Engagement of Substance Use Treatment*.⁴⁷ Incentivizing behavioral health quality measurement can promote high-quality behavioral health integration into primary care and broader settings where behavioral health services are provided. However, to improve behavioral health outcomes, value-based payment incentives must be coupled with clinical data-sharing capabilities and population health management interventions that address gaps in care delivery. For example, follow-up care after hospitalization for a psychotic episode might be better managed in a behavioral health care setting, but sharing follow-up data on the treatment plan with primary care clinicians in integrated behavioral health care settings can enhance care coordination and care management.

Advancing Behavioral Health Integration in the Digital Age

Advancing interoperability and health data standards can also improve quality measurement and reporting. As quality measures develop to keep pace with the rapid evolution of digital capabilities and virtual care delivery, the ability to securely query a variety of electronic clinical data sources to calculate performance on quality measures is a particularly promising facilitator of behavioral health integration. Measures that leverage electronic clinical data can align measurement priorities across the care delivery system, reducing reporting burden and incentivizing collaboration and measurement-based care. The push toward digital quality measures that use standardized electronic clinical data from a variety of sources can allow measure stewards to overcome the constraints and time lags associated with administrative and claims data, and can advance more effective and timely development of behavioral health measures. The development and growth of the Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) standard, and the United States Core Data for Interoperability (USCDI) standards that define both data models and protocols for health data exchange between settings and systems can make both clinical and administrative data available to health care organizations and providers to support care.⁴⁸



Conclusion

As behavioral health integration in primary care grows, shared accountability between medical and behavioral health clinicians at various levels of the delivery system is critical for providing high-quality behavioral health care. There is ample opportunity to leverage integrated behavioral health care to address the demand for behavioral health services and promote whole-person care. Successful integration requires up-front investment in practice capabilities, data sharing across EHRs and data standards to improve interoperability to support quality measure reporting and improve performance. Effective metrics for quality improvement are also needed.

As health care quality reporting shifts to digital measures and implementing FHIR®-based data exchange standards, behavioral health providers and facilities must embrace the health IT systems needed to support high-quality care. As the availability of clinical data increases, policies and health IT systems must continue to evolve, to improve data exchange and interoperability so data can be used to inform clinical decisions, deliver high-quality care and reduce delayed care. Expanding the availability of behavioral health data for primary care and other providers can reduce fragmentation and improve quality measurement, population health management and health care delivery.



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