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Legislative and Policy Developments and Imperatives for Advancing the Primary Care Behavioral Health (PCBH) Model

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Abstract
The Primary Care Behavioral Health (PCBH) practice model continues to gain converts among primary care and behavioral health professionals as the evidence supporting its effectiveness continues to accumulate. Despite a growing number of practices and organizations using the model effectively, widespread implementation has been hampered by outmoded policies and regulatory barriers. As policymakers and legislators begin to recognize the contributions that PCBH model services make to the care of complex patients and the expansion of access to those in need of behavioral health interventions, some encouraging policy initiatives are emerging and the policy environment is becoming more favorable to implementation of the PCBH model. This article outlines the necessity for policy change, exposing the policy issues and barriers that serve to limit the practice of the PCBH model; highlights innovative approaches some states are taking to foster integrated practice; and discusses the compatibility of the PCBH model with the nation's health care reform agenda. Psychologists have emerged as leaders in the design and implementation of PCBH model integration and are encouraged to continue to advance the model through the demonstration of efficient and effective clinical practice, participation in the expansion of an appropriately trained workforce, and advocacy for the inclusion of this practice model in emerging healthcare systems and value-based payment methodologies.

Keywords Managed care · Behavioral healthcare policy · Primary care integration · Patient-centered medical home

Innovation in healthcare generally springs from the practice level. Creative providers see ways to improve the effectiveness and efficiency of the care they provide. Sensitive providers listen to their patients and hear ways to transform healthcare delivery. As they evolve how they practice, these innovators and the early adopters who follow their lead must often find a way to circumvent existing healthcare policy barriers and battle with the bureaucracies that serve and protect existing policies. Such has been the case with the PCBH model of integrated care. The PCBH model existed in clinical practice, at least in rudimentary form, several decades ago (Freeman, 2011; Strosahl, 1996), and over the years it has continued to gain traction based on evidence of improved clinical outcomes, reduced overall cost of care, and enhanced satisfaction of patients who experience PCBH model services and providers who practice in the model (Hunter et al., 2017). In more recent times, the Veteran's Administration (Kearney, Post, Pomerantz, & Zeiss, 2014) and the Department of Defense (Dobmeyer et al., 2016; Hunter, Goodie, Dobmeyer, & Dorrance, 2014) have been implementing the PCBH model in their primary care practices.

Despite the evidence in support of PCBH model services and successful, long-tenured examples of the model in place at a number of locations throughout the country, widespread implementation has yet to occur. While many primary care and behavioral health providers understand the model and verbalize their support, dissemination of a new concept, even when it clearly improves practice, (Corso et al., 2012; Gouge, Polaha, Rogers, & Harden, 2016; Lanoye et al., 2016) is often insufficient to promote widespread implementation. Policies must change in order to bring PCBH model services to scale.

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This article outlines the imperative for policy change, exposing the policy issues and barriers that serve to limit, and even prevent, the practice of the PCBH model of service delivery. Encouraging state, federal, and payer policies which point the direction for policy change are highlighted. Legislators and policy makers should consider the evidence in support of the model and take action to promote widespread implementation of PCBH model practice.

Models of Integrated Service Delivery

In recent years, the concept of bringing together the services of behavioral health professionals and medical providers has generated considerable interest throughout the healthcare industry. The interest has been generated by two prominent factors: (1) access to behavioral services is inadequate for most of the population, (2) the emerging awareness of the significant cost the presence of a psychiatric condition contributes to the total cost of care of a patient. The strategies to bring these sectors together are generally referred to as integrated care. Often these approaches are loosely defined and involve nothing more than decreasing the physical distance and increasing the communication between behavioral health and medical providers. In our experience, the co-location of providers and preferential referral relationships describe much of what currently occurs under the banner of integrated care. Generally, we have seen that these approaches do not alter the practice pattern of either behavioral or medical providers in any significant way.

The lack of a common definition of integrated care has hampered policy development. While the concept of integrated care became increasingly recognized as a promising strategy to improve care, confusion reigned as consultants, policymakers, and conference speakers spoke about the "many roads to integrated care" and the "many models of integrated care." In response to this widespread confusion, the Agency for Healthcare Research and Quality (AHRQ) in 2013 commissioned a group of thought leaders to define integrated care. They developed the following definition:

> The care that results from 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. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related physical symptoms, and ineffective patterns of health care utilization (Peek, 2013).

In our experience, this definition has proven helpful in promoting more consensus among policy makers and providers about the components and nature of integrated care practice. The description of the PCBH model as articulated below (Reiter, Dobmeyer, & Hunter, 2017) is fully compatible with the AHRQ definition of integrated care.

> The Primary Care Behavioral Health (PCBH) model is a team-based primary care approach to managing behavioral health problems and biopsychosocially-influenced health conditions. The model's main goal is to enhance the primary care team's ability to manage and treat such problems/conditions, with resulting improvements in primary care services for the entire clinic population. The model incorporates into the primary care team a behavioral health consultant (BHC), sometimes referred to as a behavioral health clinician, to extend and support the primary care provider (PCP) and team. The BHC works as a generalist and an educator who provides high volume services that are accessible, team-based, and a routine part of primary care. Specifically, the BHC assists in the care of patients of any age and with any health condition (generalist); strives to intervene with all patients on the day they are referred (accessible); shares clinic space and resources and assists the team in various ways (team-based); engages with a large percentage of the clinic population (high volume); helps improve the team's biopsychosocial assessment and intervention skills and processes (educator); and is a routine part of biopsychosocial care (routine). To accomplish these goals, BHCs use focused (15–30 minute) visits to assist with specific symptoms or functional improvement. Follow-up is based in a consultant approach in which patients are followed by the BHC and PCP until functioning or symptoms begin improving; at that point, the PCP resumes sole oversight of care but re-engages the BHC at any time, as needed. Patients not improving are referred to a higher intensity of care, though if that is not possible the BHC may continue to assist until improvements are noted. This consultant approach also aims to improve the PCP's biopsychosocial management of health conditions in general.

Obviously, the PCBH model as described above stands in distinct contrast to the co-location of specialty behavioral health services with medical providers. The broadened scope of practice, the pace of care delivery, the targeting of interventions, and the on-going collaboration and consultation with primary care colleagues and other members of the primary care team throughout the workday clearly differentiate the work of the integrated behavioral health clinician in the PCBH model from the behavioral health professional involved in a typical specialty behavioral health practice. The scope of the primary care practice can be enhanced and

the work of the primary care provider (PCP) can be better supported by the PCBH model.

The PCBH model is a unique model of integrated care with clearly defined clinical strategies and objectives. Throughout this article, we focus primarily on policies that influence the delivery of the PCBH model, but are aware that most of these issues are relevant for other models of integrated care as well.

Healthcare Reform and PCBH Model of Service Delivery

The pace of health care reform in this country is accelerating and every sector of the healthcare system is experiencing dramatic change (Orszag, 2016). The insurance industry is consolidating; healthcare organizations are restructuring; provider networks are emerging; and payment for health services is tilting towards value-based methodologies (Porter & Kaptan, 2016). Providers at the practice level experience the impact of these forces and realize the expectations placed on clinical practice now have a clearer focus on outcomes, concerning both clinical management of health conditions and the cost of care (Moses et al., 2013).

The policies driving healthcare reform are rooted primarily in the general consensus that our nation cannot afford our current level of healthcare expenditures, representing 17.1% of GDP in 2015 according to the World Bank and 50% more than any other industrialized nation (Squires & Anderson, 2015). Neither the healthcare outcomes of the US healthcare system nor the health status of the American populace justify that level of expenditure. In response to these factors, entities that pay the nation's healthcare bill, including the federal and state governments as well as commercial payers, are implementing new policies impacting not only how they pay for care but also how the system of care is organized (Obama, 2016).

Many policy initiatives are aimed at strengthening the primary care system and emphasizing the key role primary care plays in coordinating, managing, and directing patient care (Davis, Abrams, & Stremikis, 2011; Koller & Khullar, 2017). Access to behavioral health services is noted as a prominent gap in our health services system (Wang, Demler, & Kessler, 2002; Wang et al., 2005). Expanding access to behavioral health assessment and intervention in primary care could help close that gap. Data reveal psychiatric conditions as significant system cost drivers, especially when co-occurring with chronic medical conditions (Melek, Norris, & Paulus, 2014). Complex patients with multiple healthcare conditions drive much of the cost in the system and are a challenge for any independent provider. Complex care requires a team-based approach (Blumenthal & Abrams, 2016; Schottenfeld et al., 2016).

The PCBH model fits comfortably within the major policy directives guiding healthcare reform in this country. The patient and implementation outcomes of the PCBH model (Hunter et al., 2017) align with the goals these policies are initiating (Kathol, deGruy, & Rollman, 2014; Miller et al., 2017). However, widespread deployment of the model is dependent on its acknowledgement and support by policy makers and those entities that pay for care.

The Quadruple Aim

The Triple Aim, developed by the Institute for Healthcare Improvement, frames the national healthcare reform agenda by articulating three broad goals for health system improvement: improve the health of a defined population; enhance the patient care experience (including quality, access, and patient satisfaction); and reduce, or at least control, the per capita cost of care (Berwick, Nolan, & Whittington, 2008). These goals are to be realized by transforming healthcare systems. Many healthcare systems, including the US healthcare system in totality, are fragmented, inefficient and have not generated satisfactory outcomes (Bradley et al., 2016; Koh, 2016; Schneider & Squire, 2017). At the same time, costs have continued to rise (Schneider, Sarnak, Squire, Skah, & Doty, 2017).

The Triple Aim is at the core of current healthcare policies in this country and, as such, has become central to healthcare reform (McCarthy & Klein, 2010). The Triple Aim approach attempts to promote more accountability and communication within healthcare systems. The Triple Aim is driving numerous health reform innovations, such as accountable care organizations (ACOs), value-based contracting, episodes of care reimbursement, sanctions for excessive rates of hospital readmissions or infections, meaningful use of information technology, and the patient-centered medical home (PCMH) model in primary care (Whittington, Nolan, Lewis, & Torres, 2015).

The burden of achieving the lofty goals of the Triple Aim falls squarely on the shoulders of healthcare providers, especially PCPs. Noting the widespread burnout of front-line physicians, it has been suggested that in order to achieve the nation's healthcare goals, we need to embrace the Quadruple Aim (Bodenheimer & Sinsky, 2014), adding the goal of improving the work life of healthcare providers. In team-based models of care like the PCBH model and the PCMH, behavioral health professionals share the responsibilities of providing care thereby lessening the burden on the PCP.

The PCMH

The PCMH model of primary care restructures practice with the goal of achieving the Triple of Aim (Nielsen, Olayiwola, Grundy, & Shaljian, 2014). Moving to the PCMH model

requires primary care practices to incorporate an infrastructure and design workflow with patients (and families) at the center of care.

The PCMH is built on five key concepts (Agency for Healthcare Research and Quality, PCMH Resource Center, 2016):

(1) A patient-centered orientation.
(2) Comprehensive, multidisciplinary team-based care, often including physicians, advanced practice nurses, psychologists or other behavioral health professionals, care coordinators, and community-based health workers.
(3) Coordination of care across inpatient, outpatient, and community elements of the health care system.
(4) Enhanced access to care, such as increased provider capacity and extended primary care hours in order to keep patients within the primary care setting at the time patients need or want it. By doing so, the goal is to prevent unnecessary emergency department visits and/or hospitalizations and their associated costs.
(5) Ongoing quality improvements, including population health management and patient safety.

A key component of the PCMH is the active involvement of patients in their care. Patient involvement involves a strong emphasis on improved patient communications, opportunities for patient self-care, increased patient decision-making, and enhanced patient access to their electronic health record. Arguably the best practice model of primary care (Barr & Ginsberg, 2006; Martin et al., 2002), payers aggressively promote the model and frequently encourage practices, sometimes with financial incentives, to seek PCMH Recognition (a form of certification) from the National Committee on Quality Assurance (2017).

It is of interest to note that with each revision of the standards practices must pass in order to achieve Recognition, the National Committee on Quality Assurance (NCQA) adds additional elements pertaining to behavioral health care. Thus, the PCBH model is not only compatible with PCMH but synergistic as well, facilitating practices in achieving NCQA recognition as a PCMH.

Value-Based Care

Healthcare reform is driving numerous innovations in the payment for healthcare services. Most of these new payment methodologies compensate providers or provider systems, at least in part, based on improved clinical outcomes and reduction of overall health care costs for an identified population of patients (The National Commission on Physician Payment Reform, 2013). This is a dramatic departure from the way providers have been compensated for their work previously. Fee-for-service has been the primary reimbursement methodology in all of healthcare for decades (Schroeder & Frist, 2013). In a fee-for-service system of reimbursement, providers generate more revenue by seeing more patients. There are few incentives for controlling costs and maximizing quality. In many of these value-based contracts, there remains a fee-for-service base reimbursement, but there are *additional* contract provisions that provide significant bonus payments for meeting predetermined quality metrics, usually HEDIS measures. In addition, value-based contracts often contain shared savings provisions, whereby the provider and the payer split any surplus (upside risk) and/or deficit (downside risk). By aligning quality and financial incentives in value-based contracts, payers are expecting that the Triple Aim will be met.

In the rush to achieve the Triple Aim, provider contracts with value-based provisions are becoming commonplace (Institute of Medicine, 2007; McCarthy & Klein, 2010). In consulting with organizations throughout the United States, we have found that many states are requiring the managed care organizations who manage their Medicaid programs to negotiate value-based provisions in their provider contracts. As usual, Medicare is in the forefront of reimbursement policies. Based on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Medicare officials have been clear about their intent to transition payment for Medicare services from volume and intensity of service to a system that rewards providers for improving quality and managing the cost of care. Medicare's goal is to have 90% of fee-for-service payments tied to quality or value, referred to as the Merit-Based Incentive Payment System (MIPS), by 2018 (Obama, 2016). In addition, Medicare expects fully 50% of their payment for services will be through Alternative Payment Models (APMs) such as ACOs or bundled payment arrangements where providers are accountable for both the quality and cost of care (Burwell, 2015; Federal Register, 2016).

The provisions of MACRA apply to physicians who are treating 100 or more Medicare patients with at least $10,000 in Medicare charges annually beginning January 1, 2017. These low thresholds mean most physicians treating an adult population will be involved with MACRA. Although psychologists do not come under the scope of MACRA until 2019, those psychologists practicing within the PCBH model will likely experience the impact along with their PCP colleagues. The measurement and reporting of clinical outcomes and the management of overall cost of care will take on renewed import. It is anticipated the complexities of MACRA and the uncertainties associated with new APMs will accelerate the trend of corporate employment of physicians (Casalino, 2017). In the opinion of these authors,

a similar trend will occur among psychologists, especially those involved in PCBH model practice.

Policy Imperatives to Support the PCBH Model

Although the PCBH practice model fits comfortably within the nation's healthcare reform agenda and appears to serve the same objectives, there are often policy barriers at the state, federal, and payer levels that impede implementation of the model. Policy makers are often unaware of integrated approaches to care and how the work of behavioral health providers practicing in primary care differs from the work of behavioral health providers engaged in free-standing, specialty practice. Existing policies, though possibly favorable to traditional behavioral health practice, may pose barriers to integrated practice. Advocacy with legislative bodies and education of policy makers and other stakeholders is often necessary to provide the regulatory and reimbursement environment favorable to integrated practice (Kathol, Butler, McAlpine, & Kane, 2010). In our experience, the policy imperatives below are necessary to support the PCBH model practice. Table 1 summarizes these imperatives.

Revenue: Services, Coding, and Fee-for-Service Reimbursement

Fee-for-service reimbursement prevails in most of the country at this time and, consequently, healthcare services are generally reimbursed based on the American Medical Association's Current Procedural Terminology numeric codes (CPT codes). When fee-for-service is the prevailing reimbursement mechanism supporting a PCBH model practice it is vital the sustaining contracts with major payers include CPT codes that cover the care BHCs provide and rates for those codes are reasonable.

Based on our experience, there are a couple of common reimbursement barriers that challenge the viability of the PCBH model in a fee-for-service environment. Some health plans and state Medicaid programs have policies preventing payments for behavioral and medical services on the same day. Since sharing care during a patient visit and same-day care from PCPs and BHCs are core to the PCBH model, not to mention the basis of the efficiency and effectiveness of the model, the prohibition of same-day payments has served to block attempts to implement the model in some environments (Roby & Jones, 2016). When the focus of the BHC's attention is the patient's psychiatric condition, the customary psychiatry CPT codes (90792, 90832, 90834, etc.) are used. However, when a BHC sees a patient at the request of a PCP to address specific questions prompted by the patient's medical condition or address general health concerns, the psychiatric codes do not apply. Instead, the Health Behavior Assessment and Intervention CPT codes 96150–96155 apply to these services. Regrettably, some health plans and state Medicaid programs have yet to add these codes to their schedule of benefits. A fee-for-service environment without the Health and Behavior codes can limit PCBH model service financial viability.

Some components of typical PCBH model practice are usually not compensated in the fee-for-service environment. Consultations between BHCs and PCPs are essential to the PCBH model. There are not any CPT codes to use for this interaction and, consequently, there is generally not any direct reimbursement for the time spent by either provider in these consultations. Many primary care teams huddle to review the daily schedule of patients and attempt to plan the

Table 1 Policy imperatives to support PCBH

Policy domain	Barriers	Resolution
Revenue: fee-for-service	Limited coding options	Negotiate CPT codes and rates with payers
Billing behavioral and medical same day	Prohibition of same day billing	Advocate and negotiate same day billing
Revenue: care of general health concerns	Payment for care of medical conditions and general health concerns but psychiatric diagnosis is required for BHC	Contracts include Health and Behavior Assessment and Interventions CPT codes 96150–96155
Revenue: value-based payments	Selection and measurement of outcomes	Quality metrics shared with primary care team Contract negotiation, data analytics infrastructure
Electronic health record	Inappropriate for BHC workflow and documentation	EHR shared by primary care team, modification of BHC templates may be necessary
Confidentiality	Confusion over 42 CFR part 2, Confidentiality of alcohol and drug patient records	Understand scope of regulation Obtain legal review
Behavioral health carve outs	Primary care and BHC have separate payers	Advocacy for PCBH, contract negotiations
Licensure and credentialing	Government or payer regulations restrict provider type	Advocacy for PCBH, negotiate with primary care providers
Workforce	Shortage of BHCs with sufficient skills for efficient and effective primary care practice	Selection of appropriately trained BHC Utilization of evidence-based protocols

work flow of the day (Schottenfeld et al., 2016). Some PCBH model practices convene multidisciplinary provider team meetings to develop treatment plans for complex patients. This provider time is generally not reimbursed in a fee-for-service funding environment. In the experience of these authors, it has generally been possible to make the case to payers that these activities have value in and of themselves and contribute to the effectiveness of care. Often a secondary revenue stream such as a care management monthly rate or a per-member-per-month rate has been negotiated to cover the time and effort that was not billable by CPT code.

Revenue: Alternative and Value-Based Payment Models

Over the past few years, value-based payment methodologies and other alternative healthcare financing strategies are beginning to supplement, and sometimes replace, fee-for-service support of primary care (Schroeder & Frist, 2013). Since many services provided in the PCBH model do not have a corresponding CPT code, these emerging payment policies are often a better match than fee-for-service. For many years, PCPs have been reimbursed, for the most part, on a fee-for-service basis by submission of Evaluation and Management Service CPT Codes, commonly known as E&M codes. These codes are based on the time and the comprehensiveness of the visit. With the shift to alternative payments models and value-based incentives, the measurement of clinical outcomes and the management of overall healthcare cost take on greater significance for the practice. These new reimbursement models may focus on specific clinical conditions, on the cost and outcomes of caring for an episode of a specific condition or on measures related to the care of an assigned population of patients. These payment models incent the entire primary care team to provide high quality and cost efficient care. These reimbursement policies impact every member of the PCBH model practice, not just the PCP. Reimbursement is based on the outcomes the team produces rather than on the independent volume of services each team member generates. In the negotiation of alternative payment methodologies and value-based payments to support a PCBH model practice, it is necessary to account for, and cover, the cost of the entire primary care team including the BHCs.

Beyond these core services and functions, PCBH model practices may include the following service components and staff, especially if the practice is participating in value-based funding arrangements. The services provided by these additional members of the primary care team are often not reimbursed in a fee-for-service environment but these services and functions may prove critical in achieving the criteria for value-based payments (Holtrop, Luo, & Alexanders, 2015).

Clinical Pharmacists

Complex patients frequently have multiple prescriptions. Clinical pharmacists consult with other members of the treatment team and provide one-on-one counseling to patients about medication compliance and adverse medication interactions.

Care Coordinators

Care coordination is frequently performed by nursing and other support staff within the PCP office. These staff work with patients using various databases and patient registries, contacting patients to close gaps in care, arrange follow-up appointments, and schedule visits for prevention services.

Community Health Coordinators

Community health coordinators are outreach and patient engagement specialists. As contracts shift to value-based arrangements and primary care teams are assigned patient panels to manage, there is a greater emphasis on outreach, patient engagement, and community support. Community health workers help patients negotiate social determinants of heath.

Psychiatric Consultation and Management

Psychiatric consultation may be available when PCPs or BHCs have questions about medication management of a patient. In circumstances where the PCP determines that psychiatric management of the patient requires direct care from a psychiatrist, the psychiatrist may see the patient until they are psychiatrically stable and then return the patient to the PCPs to manage. Reimbursement is generally available when a psychiatrist sees a patient for evaluation or treatment. Reimbursement is less likely when a psychiatrist is providing consultation to other members of the primary care team.

It is becoming more common to find team members in PCBH model practices fulfilling the roles and functions described above. These additional personnel assist practices in achieving desired outcomes and cost targets. As policy makers and payers across the nation search for value in our health care system, they may be more likely to encourage and support expanded primary care teams (Peikes et al., 2014).

Electronic Health Record and Data Barriers

The electronic health record system is often a barrier for practices attempting to implement an integrated behavioral health and primary care practice (Cifuentes et al., 2015). Generally, EHRs are developed for a specific healthcare

specialty. Thus, there are EHR systems to support the work of a primary care practice and there are EHR systems for behavioral health practice. For team-based models of care like the PCBH model, it is imperative that all members of the team share the same EHR and all team members have access to the clinical documentation of their colleagues.

While some of the EHRs in the marketplace appropriate to support primary care practice include templates for behavioral health practice, in the experience of these authors these behavioral health templates are usually a better match for a specialty practice of psychotherapy rather than supporting the workflow of a behavioral health professional embedded in a primary care practice. At Cherokee Health Systems, we found it necessary to engage our IT department in developing templates better suited to accommodate the workflow of our BHCs.

Additionally, health information exchanges (HIEs), in which claims data are shared with and by providers, are available in some areas of the country but not others. This creates integrated care challenges when there are gaps in data availability, comprehensiveness, and accuracy.

Confidentiality and Communication Between Providers

The effectiveness of the PCBH model is based on the communication between providers about the patients they share. Some state and federal privacy requirements have been interpreted to hinder this communication. Many of these regulations and policies predate the era of integrated care and widespread utilization of EHRs and are vestiges of traditional, siloed care (Hudgins, Fifield, Rose, & Arnault, 2013). Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides for patient HIE between medical providers and practices, some behavioral health providers have remained reluctant to communicate with another provider without a very specific written release from the patient. Despite some lingering confusion about information exchange on the part of some clinicians, providers working in team-based models of care like PCBH model practices are, in general, not restricted in sharing patient information with one another.

A policy in the Code of Federal Regulations pertaining to the disclosure of patient alcohol and drug records (42 CFR Part 2) limits communication for some providers and contributes to the general confusion over restrictions on the release of information. The Department of Health and Human Services released a revision of this 30-year-old regulation that took effect in March 2017, attempting to bring it in accord with HIPAA and accommodating the regulation to new models of team-based integrated care and the sharing of electronic health records (42 CFR Part 2, 2017). The regulation states members of a treatment team are free to share information regarding the substance use of patients they are treating and attempts to address whether entities providing general medical care are covered by the regulation. However, as is often the case with complex regulations, there is confusion over the interpretation of the terms and under what circumstances the provisions of the regulation apply.

According to the revised regulation the restrictions on disclosure apply to "federally assisted" entities and providers who, in addition, "hold themselves out" to be providers of substance misuse diagnosis or treatment. While the announced intent of the regulation was to exempt general medical providers, a few months after the revised regulation went into effect many primary care practices remained confused about whether the regulation applied to them (McCarthy, Rieckmann, Baker, & McConnell, 2017). If a provider treats a Medicare enrollee are they "federally assisted"? If a primary care practice uses medication-assisted treatment for patients with opioid addiction and this becomes known throughout the community does the practice come under the jurisdiction of the regulation? Based on the prevalence of substance use disorders in every primary care practice and the impact of these disorders on medical conditions it is a foregone conclusion PCPs will be dealing with the substance misuse of their patients. Until this policy quagmire is resolved and the application of this revised regulation is better understood, it seems wise for entities to seek legal counsel to determine whether they need to comply.

Behavioral Health "Carve-Outs"

Some insurance plans "carve out" behavioral health benefits from the medical benefits. This policy encourages fragmentation of care between primary care and behavioral health services. Even if behavioral health benefits are "carved in," payers may still "carve out" the benefits through a subsidiary or wholly owned behavioral health subcontracting company. In situations where the benefits are carved out, providers are usually required to execute separate agreements, one for medical services and one for behavioral health services. In these cases, providers must shoulder the administrative burden (and costs) of two different and sometimes contradictory systems for credentialing, coding, billing procedures, and claims payment. Behavioral health "carve outs" make contracting to support PCBH model services challenging.

Licensing and Credentialing Restrictions

In most states, separate licenses or certifications are required for behavioral health providers, substance abuse providers and PCPs. In addition, states often have separate departments that oversee and regulate behavioral health, substance abuse, and PCPs. As a result of licensing and administrative structures, there can be significant barriers when a provider

delivers behavioral health, substance abuse, and primary care as a holistic, integrated provider.

Workforce Barriers

Clearly, a well-trained integrated care workforce is needed but in our experience there is a shortage of PCPs and BHCs with PCBH model training or experience in every state across the country. There is a national shortage of PCPs. The federal government as well as many states have initiatives to increase the supply of nurse practitioners, physician assistants, and physicians who practice in primary care roles (Abrams, Nuzum, Mika, & Lawlor, 2011). While efforts are being made to increase primary care residency positions, far fewer efforts are targeted at increasing capacity and training of behavioral health clinicians (Hall et al., 2015).

Professional guilds, academic training programs and licensing boards are slowly catching up to the additional, unique competencies traditionally trained mental health providers require when working on integrated care teams. Until academic programs that prepare the nation's behavioral health workforce place a greater emphasis on training the clinical competencies necessary for BHC work, PCBH model practices will struggle to recruit an appropriately skilled workforce. The American Psychological Association communicated the importance of the workforce issue by convening a workgroup to study the competencies necessary for the practice of psychology in primary care. Hopefully, the report of the workgroup, *Competencies for Psychology Practice in Primary Care* (American Psychological Association, 2015), will stimulate curriculum development in academic departments that train psychologists for clinical practice. Some good resources already exist to provide a basis of curriculum development (e.g., Hunter & Goodie, 2010 Nash, Khatri, Cubic, & Baird, 2013; Robinson & Reiter, 2016).

The Graduate Psychology Education (GPE) program funded under the Public Health Services Act [Section 756(a)(2)] and administered by the federal Bureau of Health Professions is one way to address workforce barriers. GPE grants provide support to a small number of APA-approved clinical psychology programs with the stipulation that training must occur in primary care settings. It is an encouraging sign when a federal grant program targeting the training of the psychology workforce directs those funds to prepare psychologists to work in primary care settings.

Promising Initiatives

Many states are awakening to the promise of integrated care and are taking action through legislation, regulatory changes or policy initiatives to support the integration of behavioral health and medical practice. Among the many state initiatives worthy of mention, the authors selected three states to profile. Each state has established an ecology where the PCBH model services can flourish. Although unique in some ways, each is representative of a national trend to recognize the value and support the integration of behavioral healthcare and medical care.

North Carolina

North Carolina has multi-sector engagement that moves integrated care forward. Leveraging a myriad of agendas and incentives, entities invested and working on integrated care include government officials, professional organizations, health education and higher education entities, consumers/patients and families, and private funders. These stakeholders leverage both private and public funding for integrated care projects and policy development. Two decades ago the ICARE Project, which was funded by the North Carolina Health and Wellness Trust Fund, positioned the state as an early adopter. After the ICARE funding ended, the North Carolina Center of Excellence for Integrated Care was created to continue the integrated care work across the state and was funded by grantors such as the Kate B. Reynolds Charitable Trust and the Cone Health Foundation.

In 2014, the North Carolina Department of Health and Human Services and the Center of Excellence for Integrated Care joined forces for an integrated care policy summit to continue to strengthen stakeholder input as Medicaid reform plans were being developed. As a result, the participants of the summit created the North Carolina Integrated Care Steering Committee, composed of policy and practice representatives across disciplines and interests. In addition, there are currently multiple state-level and regional taskforces and workgroups focused on some aspect of integrated care including an integrated care component. The most influential group related to moving integrated care policy forward was facilitated by the North Carolina Institute of Medicine's (NCIOM) Rural Health Taskforce in 2013. NCIOM convened 45 representatives across sectors to develop a Rural Health Plan that offers recommendations for state and regional law and policy makers in an effort to address health disparities and promote individual and community wellness. Integrated care emerged as one of the six strategies in this report.

Currently, as a result of a deep commitment to providing whole-person care and the energy given to improving health for all North Carolinians, the North Carolina Department of Health and Human services is in the process of reforming the Medicaid payment system through an 1115 Waiver, submitted to the Centers for Medicare and Medicaid (CMS). Proposed changes include moving to a value-based payment system and more support for team-based care delivery to meet Quadruple Aim goals. North Carolina is also

participating in the federal Certified Community Behavioral Health Clinic project with the hope of encouraging specialty mental health and substance abuse treatment entities to provide additional monitoring and coordination of care related to physical health conditions.

Although North Carolina has a history of funding and promoting integrated care projects, the current behavioral health managed care carve-out has maintained the division of payment and ultimately created a barrier to full integration of behavioral health and medical care. Medicaid reform efforts, under the proposed 1115 waiver plan, would maintain two separate capitated systems for physical and behavioral healthcare while identifying creative ways to pilot the integration of behavioral health services into primary care by shifting payments and accountability for whole-person care such that physical health capitation entities have more responsibility for behavioral health and vice versa.

The decision to not expand Medicaid is another challenge North Carolina faces when attempting to provide additional services to the state's most vulnerable populations. The proposed 1115 Waiver promises to address some of the disparities for individuals covered; however, there are no plans to date to help the uninsured and those unable to pay for healthcare. Charity care through safety net providers and the free clinics continue to be the only support for these individuals. Without a means to pay for behavioral health services, many uninsured will go without treatment. Programs like the Cone Health Foundation Access to Care project, which funds integrated care programs for the uninsured in Greensboro are helpful but only cover one region in the state. Some Federally Qualified Health Centers (FQHCs) have implemented integrated care services for their patient. The Rural Health Group and Gaston Family Health Services are two FQHCs who have done so successfully.

As is true of every state there are organizations and systems of care in North Carolina where integrated care is thriving and other parts of the health services sector where successful implementation has yet to occur. However, North Carolina is an interesting state to profile because of the wide array of successful policy initiatives arising from a number of coalitions and collaborations among and between state government officials, private foundations, and professional organizations.

Colorado

Colorado is one of the leading states in the integration of physical health and behavioral health services. As an early adopter of groundbreaking integrated care policies, the state was able to accelerate the clinical, operational and financial transformation of integrated care among its health care systems. This transformation occurred through an alphabet policy soup of PICS, SHAPE, and SIM.

In 2011, Colorado's General Assembly passed legislation that directed the Colorado Department of Health Care Policy and Financing to review payment and infrastructure barriers to integrated care and propose integrated care policy solutions. That same year, the Colorado Health Foundation and the Collaborative Family Healthcare Association started Promoting Integrated Care Sustainability (or PICS). PICS performed an online survey and conducted in-depth interviews with stakeholders in California, Maine, Tennessee, and Texas, all of which share advanced integrated care policies and practices.

PICS made recommendations involving same day billing, staff training/workforce development, health and behavior assessment codes (96150 series), global funding strategies and statewide data collection systems. As a result of this early implementation, Colorado has made significant strides in the integration of primary care and behavioral health services (The Colorado Health Foundation, n.d.). PICS was the impetus for Colorado's next initiative—Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE). SHAPE engaged six innovative family practices by giving them significant autonomy over practice transformation, resource allocation, and cost controls. The SHAPE objectives were:

(1) To determine if a global payment method will financially support and sustain behavioral health and primary care;
(2) To understand how different payment models will affect clinical models of integration and their related costs; and
(3) To test the real-world application of a global payment methodology for primary care practices that have integrated behavioral health with the end goal to inform policy (http://www.sustainingintegratedcare.net).

Recognizing that traditional fee-for-service payment models create incentives for quantity of services over quality of services, SHAPE was designed to create better team-based care that leads to improved quality and outcomes. As importantly, it creates a financial model through global payments that sustains the integration of primary care and behavioral health care. SHAPE's website indicates that if adequate financial support is accomplished, then state and federal governments, insurers, grant organizations, tax payers, and individuals stand to gain an abundance of fiscal healthcare savings as well as overall health gains. (Retrieved from https://www.pcpcc.org/initiative/sustaining-healthcare-across-integrated-primary-care-efforts-shape). SHAPE describes its integrated care factors as follows:

(1) Total cost of compensation for the clinical model and population interventions in order to prevent "reversion to fee-for-service."
(2) Resources matched to panel size.
(3) Risk-adjusted panel complexity.
(4) Payments contingent upon adherence to best practices and outcomes.

Colorado's integrated care policies have been influenced significantly by PICS and SHAPE to evolve towards a "non-volume, non-encounter, 'risk-adjusted'" system of care and reimbursement. SHAPE provided a foundation of integrated care concepts and financial mechanisms that the state used to apply for, and receive, a State Innovation Model (SIM) grant. Colorado's SIM grant is a 4-year, $65 million transformation grant from the Centers for Medicare and Medicaid (CMS). The Colorado plan is designed to improve healthcare services and outcomes, reform payment methods, and integrate health information technology.

Through its SIM grant, Colorado plans to integrate physical and behavioral health in over 400 primary care practices and community mental health centers, targeting nearly 1600 PCPs by 2019. Their implementation strategy enhances:

(1) Health information technology,
(2) Practice transformation that supports integration,
(3) Payment reform that incentivizes integrated care and the Triple Aim, and
(4) Consumer engagement to ensure quality and population health outcomes. (Government of Colorado, 2017)

Dr. Ben Miller at University of Colorado Denver School of Medicine who is active in numerous state health policy initiatives, including SHAPE, summarizes, "We have to look at the state policy levers that enable change and pursue them with reckless abandon" (personal communication, 2016).

New Hampshire

Rising healthcare costs and a serious crisis in access to behavioral and substance use treatment were primary drivers in New Hampshire's efforts to transform its healthcare delivery system (personal interviews, 2015). Throughout the state, stakeholders identified the need for meaningful integration of behavioral and physical health systems of care in order to manage rising healthcare costs and improve individual and population health outcomes.

The state of New Hampshire received a SIM design cooperative agreement from the Centers for Medicare and Medicaid (CMS) to develop a plan for improving health in New Hampshire. The state is basing its integrated health delivery model with the goals to:

(1) Improve the quality and efficiency of healthcare delivery.
(2) Expand the use of health information technologies.
(3) Lead local population health improvement programs.

New Hampshire established a public communication strategy using stakeholder input to define a model for regional healthcare innovation across the state. New Hampshire is building upon a robust stakeholder approach to engage policymakers, healthcare leaders, and consumers. Input is being developed through interviews, workgroups, public meetings, and data analysis (Department of Health and Human Services, New Hampshire, 2015).

In addition, New Hampshire received a Medicaid waiver for a "sustainable integrated care system." The focus of this waiver was integrated delivery of behavioral health care. A key component of the waiver allows New Hampshire to implement a delivery system reform incentive payments (DSRIP) program. In this demonstration project, New Hampshire is contracting with seven regionally based integrated delivery networks (IDNs), focusing on Medicaid beneficiaries (Oss, 2016). The DSRIP focus is on 5 key performance measures for individuals with co-occurring physical and behavioral health issues:

(1) Quality of care
(2) Total cost of care
(3) Re-hospitalization rates
(4) Wait time for Inpatient psychiatric care
(5) Wait time for Outpatient mental health appointment

A great deal of policy and implementation work around integrated care is being done by The New Hampshire Citizen's Health Initiative. Its strategy is to get stakeholders to work together.

> "Our secret sauce is to get providers, payers, stakeholders and 'real people' in a room and get agreement on what works and what doesn't, and then do what works!" says Jeanne Ryer, Director of the New Hampshire Citizen's Health Initiative, Institute for Health Policy and Practice, College of Health and Human Services, University of New Hampshire. "We overcome disconnects between payers and providers, often involving service codes and processes". Ms. Ryer continues: "Practice transformation and payment transformation have to happen together, particularly with respect to integrated care". (Personal communication, 2017).

A Vision of the Future

The future is bright for the PCBH practice model. In our view, the trends are obvious and we envision widespread policy and legislative initiatives to encourage and support the PCBH model over the coming months and years. The role of the PCP is likely to continue to gain in prominence in our reforming health care system. Behavioral health professionals who have the competencies to practice in the primary care environment will accompany their primary care colleagues into the spotlight. Frontline care will become increasingly important as our healthcare system strives to achieve the Quadruple Aim. The primary care team will not only continue to provide preventive and treatment services as usual but will also have added responsibilities for care coordination and the ongoing management of patients with complex conditions. Care provided by specialists, including traditional behavioral health services, will have an important but diminished role as more patients with co-morbid conditions are cared for by primary care teams. Payers and policymakers will assure this transition takes as they seek ways to reduce overall health care costs.

In order to provide the comprehensive care expected, the frontline primary care team will need additional personnel. The primary care team of the future will not only routinely include BHCs and care coordinators but also pharmacists, community-based outreach workers, health coaches and even dentists. NCQA will set the expectation for the practice of primary care practice by establishing the standards and defining the functions of practice. BHCs will not only provide assessment and intervention but will also be considered the experts on patient engagement and behavior change strategies.

The staff of these expanded primary care teams will be employed by large healthcare systems, many with multispecialty groups and hospitals as part of their comprehensive services network. These organizations will accept full financial risk for a defined population. Compensation for the staff of the primary care teams will be based to some extent on the achievement of clinical and financial outcomes (i.e., how well they manage the care and control the cost of care for defined population of patients). Thus, payer and provider incentives will be aligned.

Portions of the vision described above are already in place in scattered locations throughout the country. Our expectation is this vision will become the norm rather than the exception in the future.

Recommendations/Call to Action

Overall, there is momentum in the healthcare policy arena in support of the integration of primary care and behavioral health. Unfortunately, policies favorable to integration have been instituted unevenly across the country. Some states and health plans have endorsed integration as a key strategy within their approach to health care reform while others have made few, if any, policy changes to support integration.

CMS policy support of PCBH model practice is critical. CMS policies govern the healthcare benefit for 100 million Americans. Medicare payment policies usually lead the way for other payers. With each passing year Medicare recipients comprise a larger percentage of the US population. Medicaid was already the largest payer of behavioral health services in the country before the passage of the Patient Protection and Affordable Coverage Act of 2010. A majority of states have seized the opportunity the Act afforded them to expand their Medicaid programs to provide coverage to large numbers of previously uninsured individuals.

Psychologists, as early developers and key proponents of the PCBH model, are uniquely positioned to take the lead in advocating for the policy and legislative changes necessary to advance the PCBH model. In order to assure the future viability of the PCBH model regardless of the organizational structure or funding environment, the following actions are recommended:

(1) In a fee-for-service payment environment, the ability to bill for the services of a behavioral health provider and a primary care health provider on the same day is essential for integrated care. Even in value-based contracts, some reimbursement is often based on fee-for-service billing. Sometimes the payer requires CPT codes to be billed so they can track the volume of services provided. Therefore, it is imperative that policies allow primary care and behavioral health services to be billed on the same day.
(2) The availability of the Health and Behavioral Assessment and Intervention CPT codes 96150–96155 are necessary to document the provision of those services to address general medical and health concerns and, in a fee-for-service environment, for the BHC to bill for those services. The codes have been available since January 1, 2002. Certainly by now these codes should be included as billable services in every health plan.
(3) Consensus on "best practice" integrated care is emerging around the definition and the practice parameters advanced by the AHRQ. The definition of the PCBH model (Reiter et al., this issue) is in accord with the AHRQ parameters but defines a more specific approach to integrated care. Practitioners of the PCBH model should use every opportunity to educate policy makers about the definition and description of best practice.
(4) The "carve out" of behavioral health from medical care in a health plan assures the fragmentation of care. It is recommended that all policy makers and payers include behavioral health services in the core benefit design.

(5) State Medicaid agencies that contract with managed care organizations to manage their Medicaid plan should support the elements of integrated care referenced in recommendations 1–4 above.
(6) When states and the federal government provide funding streams to support the provision of behavioral health services to low-income residents, they should include PCBH model practices as eligible providers of those services.
(7) It is inefficient to attempt to remove policy barriers to integrated care for health services one state at a time, especially since the barriers are frequently the same across all states. National policy solutions should address the barriers once and for all. As an example of a federal initiative that will have nationwide implications for practitioners of PCBH model services, advocates were successful in lobbying Congress to include a provision in the CURES Act of 2016 directing CMS to clarify that the Medicaid program does not prohibit the same day billing of medical and behavioral services.
(8) While grants may infuse temporary funding to build programs and increase the competencies of clinicians at the practice level, there need to be longer-term strategies to address the shortage of psychologists prepared to practice in the PCBH model. Federal and state funding of the behavioral health workforce should be strongly encouraged to direct their funding to address this problem.
(9) Psychologists have been the leaders in the development and implementation of PCBH model practice. Psychologists are encouraged to continue to advocate for the inclusion of the PCBH practice model in emerging healthcare systems and value-based payment methodologies.

Conclusion

The PCBH model of integrated care has been successfully implemented and sustained over time in a variety of health care settings across the country. In a comprehensive review of the research support for PCBH in this issue, Hunter et al. (2017) state the evidence base is promising but knowledge gaps exist. There is evidence the primary care platform grants increased access within communities to behavioral health assessments and interventions (Brawer, Martielli, Pye, Manwarning, & Tierney, 2010). Integrating appropriately skilled BHCs on primary care teams broadens the scope of primary care practice, providing additional support for primary care patients coping with a wide range of medical and psychological concerns (Sadock, Auerbach, Rybarczyk, & Aggarwal, 2014). In our experience, the PCMH with BHCs as key members of the team is better equipped to help patients negotiate the social determinants of their health status.

The PCBH model serves the national health care reform agenda and the Quadruple Aim. As noted throughout this article, there is evidence the population of patients who receive their care in primary care practices utilizing the PCBH team-based model enjoy better clinical outcomes (Angantyr, Rimner, & Norden, 2015; Bryan et al., 2012; Goodie, Isler, Hunter, & Peterson, 2009), greater satisfaction with their care (Funderburk, Fielder, DeMartini, & Flynn, 2012; Gomez et al., 2014) and, in our experience at Cherokee Health Systems, have lower overall health care utilization and cost. The stewards of health care policy and the community of insurance companies who pay the healthcare bill are beginning to recognize the economic benefits of the model.

While there are excellent, long-tenured examples of PCBH integration in place across the country, many additional practitioners and provider organizations are advocates of the model. In our experience, however, they find implementation of the model is stymied by unfavorable practice and payment policies put in place at a time before the advantages of integration and team-based care were recognized. Legislators at both the federal and state levels and healthcare policymakers and payers should be educated on the emerging science (benefits) of the PCBH model and as the data supports, put in place policies that encourage widespread implementation. The health of the nation and the viability of our health care system would be well served.

Compliance with Ethical Standards

Conflict of interest Dennis Freeman, Cathy Hudgins, and Joel Hornberger declare that they have no conflict of interest.

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References

Abrams, M., Nuzum, R., Mika, S., & Lawlor, G. (2011). *Realizing health reform's potential: How the Affordable Care Act will strengthen primary care and benefit patients, providers, and payers. The Commonwealth Fund* (Vol. 1, p. 1466).
American Medical Association. (2018). *CPT 2018 professional edition*. Chicago: American Medical Association.
American Psychological Association. (2015). *Competencies for psychology practice in primary care*. Retrieved from http://www.apa.org/ed/resources/competencies-practice.pdf.
Angantyr, K., Rimner, A., & Norden, T. (2015). Primary care behavioral health model: Perspectives of outcome, client satisfaction and gender. *Social Behavior and Personality, 43*, 287.302.
Barr, M., & Ginsberg, J. (2006). *The advanced medical home: A patient-centered, physician guided model of health care. A policy monograph of the American College of Physicians*.

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs, 27*, 759–769. https://doi.org/10.1377/hlthaff.27.3.759.

Blumenthal, D., & Abrams, M. K. (2016). Tailoring complex care management for high-need, high-cost patients. *Journal of the American Medical Association, 316*, 1657–1658.

Bodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *Annals of Family Medicine, 12*, 573–576. https://doi.org/10.1370/afm.1713.

Bradley, E. H., Canavan, M., Rogan, E., Talbert-Slagle, K., Ndumele, C., Taylor, L., & Curry, L. A. (2016). Variations in health outcomes: The role of spending on social services, public health, and health care, 2000–09. *Health Affairs, 35*, 760–768. https://doi.org/10.1377/hlthaff.2015.0814.

Brawer, P. A., Martielli, R., Pye, P. L., Manwarning, J., & Tierney, A. (2010). St. Louis Initiative for integrated care excellence (SLI^2CE): Integrated-collaborative care on a large scale model. *Families, Systems & Health, 28*, 175–187.

Bryan, C. J., Corso, K. A., Kanzler, K. E., Corso, M. L., Morrow, C. E., & Ray-Sannerud, B. (2012). Severity of mental health impairment and trajectories of improvement in an integrated primary care clinic. *Journal of Clinical and Consulting Psychology, 80*, 396–403.

Burwell, S. M. (2015). Setting value-based payment goals: HHS efforts to improve U.S. healthcare. *New England Journal of Medicine, 372*, 897–899.

Casalino, L. P. (2017). The medicare access and CHIP reauthorization act and the corporate transformation of American medicine. *Health Affair, 36*, 865–869.

Centers for Medicare and Medicaid Services. (2016). Medicare Program; Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) incentive under the Physician Fee Schedule, and criteria for physician-focused payment models. Final rule with comment period. *Federal Register 81*, 77008–77831.

Cifuentes, M., Davis, M., Fernald, D., Gunn, R., Dickinson, P., & Cohen, D. J. (2015). Electronic health record challenges, workarounds, and solutions observed in practices integrating behavioral health and primary care. *The Journal of the American Board of Family Medicine, 28*, S63–S72. https://doi.org/10.3122/jabfm.2015.S1.150133.

Colorado.gov. (2017). Retrieved from http://www.colorado.gov/.

Corso, K. A., Bryan, C. J., Corso, M. L., Kanzler, K. E., Houghton, D. C., Ray-Sannerud, B., & Morrow, C. E. (2012). Therapeutic alliance and treatment outcome in the primary care behavioral health model. *Families, Systems & Health, 30*, 87–100.

Davis, K., Abrams, M., & Stremikis, K. (2011). How the Affordable Care Act will strengthen the nation's primary care foundation. *Journal of General Internal Medicine, 26*, 1201–1203.

Department of Health and Human Services. (2015). *State innovation model*. Retrieved from https://dhhs.nh.gov/ocom/sim.htm.

Dobmeyer, A. C., Hunter, C. L., Corso, M. L., Nielsen, M. K., Corso, K. A., Polizzi, N. C., & Earles, J. E. (2016). Primary care behavioral health provider training: Systematic development and implementation in a large medical system. *Journal of Clinical Psychology in Medical Setting, 23*, 207–224. https://doi.org/10.1007/s10880-016-9464-9.

Federal Register (Vol. 18, pp. 6052–6217). Retrieved January 18, 2017, from https://www.federalregister.gov/documents/2017/01/18/2017-00719/confidentiality-of-substance-use-disorder-patient-records.

Freeman, D. (2011). Blending behaviorists into the patient centered healthcare home. In W. O'Donohue & N. Cummings (Eds.), *Understanding the behavioral healthcare crisis: The promise of integrated care and diagnostic reform*. New York: Routledge.

Funderburk, J. S., Fielder, R. L., DeMartini, K. S., & Flynn, C. A. (2012). Integrating behavioral health services into a university health centers: Patient and provider satisfaction. *Families, Systems and Health, 30*, 130–140.

Gomez, D., Bridges, A. J., Andrews, A. R., Cavell, T. A., Pastrana, F. A., Gregus, S. J., & Ojeda, C. A. (2014). Delivering parent management training in an integrated primary care setting: Description and preliminary outcome data. *Cognitive and Behavioral Practice, 21*, 296–309.

Goodie, J. L., Isler, W. C., Hunter, C., & Peterson, A. L. (2009). Using behavioral health consultants to treat insomnia in primary care: A clinical case series. *Journal of Clinical Psychology, 65*, 294–304.

Gouge, N., Polaha, J., Rogers, R., & Harden, A. (2016). Integrating behavioral health into pediatric primary care: Implications for provider time and cost. *Southern Medical Journal, 109*, 774–778.

Hall, J., Cohen, D. J., Davis, M., Gunn, R., Blount, A., Pollack, D. A., … Miller, B. F. (2015). Preparing the workforce for behavioral health and primary care integration. *The Journal of the American Board of Family Medicine, 28*, S41–S51. https://doi.org/10.3122/jabfm.2015.S1.150054.

Holtrop, J. S., Luo, Z., & Alexanders, L. (2015). Inadequate reimbursement for care management to primary care offices. *Journal of the American Board of Family Medicine, 28*, 271–279. https://doi.org/10.3122/jabfm.2015.02.140207.

Hudgins, C., Fifield, P. Y., Rose, S., & Arnault, S. (2013). Navigating the legal and ethical foundations of informed consent and confidentiality in integrated primary care. *Family Systems, & Health, 31*, 9–19. https://doi.org/10.1037/a0031974.

Hunter, C. L., Funderburk, J. S., Polaha, J., Bauman, D., Goodie, J. L., & Hunter, C. M. (2017). Primary Care Behavioral Health (PCBH) model research: Current state of the science and a call to action. *Journal of Clinical Psychology in Medical Settings, 24*(4), this issue.

Hunter, C. L., & Goodie, J. L. (2010). Operational and clinical components for integrated-collaborative behavioral healthcare in the patient-centered medical home. *Families, Systems & Health, 28*, 308–321.

Hunter, C. L., Goodie, J. L., Dobmeyer, A. C., & Dorrance, K. A. (2014). Tipping points in the Department of Defense's experience with psychologists in primary care. *American Psychologist, 69*, 388–398. https://doi.org/10.1037/a0035806.

Institute of Medicine. (2007). *Rewarding provider performance: Aligning incentives in medicare*. Washington, DC: The National Academies Press.

Kathol, R. G., Butler, M., McAlpine, D. D., & Kane, R. L. (2010). Barriers to physical and mental condition integrated service delivery. *Psychosomatic Medicine, 72*(6), 511–518. https://doi.org/10.1097/PSY.0b013e3181e2c4a0.

Kathol, R. G., deGruy, F., & Rollman, B. L. (2014). Value based financially sustainable behavioral health components in patient centered medical homes. *Annals of Family Medicine, 12*(2), 172–175. https://doi.org/10.1370/afm.1619.

Kearney, L. K., Post, E. P., Pomerantz, A. S., & Zeiss, A. M. (2014). Applying the interprofessional patient aligned care team in the Department of Veterans Affairs. *American Psychologist, 69*, 399–408.

Koh, H. K. (2016). Improving Health and Health Care in the United States. *Journal of the American Medical Association, 316*, 1679–1681.

Koller, C. F., & Khullar, D. (2017). Primary care spending rate-a lever for encouraging investment in primary care. *New England Journal of Medicine, 337*, 1709–1711. https://doi.org/10.1056/NEJMp1709538.

Lanoye, A., Stewart, K. E., Rybarczyk, B. D., Auerbach, S. M., Sadock, E., Aggarwal, A., & Austin, K. (2016). The impact of integrated psychological services in a safety net primary care clinic

on medical utilization. *Journal of Clinical Psychology*. https://doi.org/10.1002/jclp.22367.

Martin, J. C., Avant, R. F., Bowman, M. A., Bucholtz, J. R., Dickinson, J. R., Evans, K. L., … Weber, C. W. (2002). Future of Family Medicine Project Leadership Committee. The future of family medicine: A collaborative project of the family medicine community. *Annals of Family Medicine, 2*(1 Suppl), 14.

McCarthy, D., & Klein, S. (2010). The triple aim journey: Improving population health and patients' experience of care, while reducing costs. *Commonwealth Fund, 48*, 1421.

McCarthy, D., Rieckmann, T., Baker, R. L., & McConnell, K. J. (2017). The perceived impact of 42 CFR Part 2 on coordination and integration of care: A qualitative analysis. *Psychiatric Services, 68*, 245–249.

Melek, S., Norris, D., & Paulus, J. (2014). *Economic impact of integrated behavioral medicine implications for psychiatry*. American Psychiatric Association website. Retrieved April 4, 2014, from http://www.psychiatry.org/integratedcare.

Miller, B. F., Ross, K. M., Davis, M. M., Melek, S. P., Kathol, R., & Gordon, P. (2017). Payment reform in the patient-centered medical home: Enabling and sustaining integrated behavioral health care. *American Psychologist, 72*(1), 55–68.

Moses, H. I. I. I., Matheson, D. H., Dorsey, E. R., George, B. P., Sadoff, D., & Yosimura, S. (2013). The anatomy of healthcare in the United States. *Journal of the American Medical Association, 350*, 1947–1963. https://doi.org/10.1001/jama.2013.281425.

Nash, J. M., Khatri, P., Cubic, B. A., & Baird, M. A. (2013). Essential competencies for psychologists in patient-centered medical homes. *Professional Psychology: Research and Practice, 44*, 331–342.

Nielsen, M., Olayiwola, J. N., Grundy, P., & Shaljian, M. (2014). *The patient-centered medical home's impact on cost and quality: An annual update on the evidence, 2012–2013. Patient-Centered Primary Care Collaborative*. Retrieved from https://www.pcpcc.org/resource/medical-homes-impact-cost-quality.

Obama, B. (2016). United States health care reform: Progress to date and next steps. *Journal of the American Medical Association, 315*, 525–532.

Orszag, P. R. (2016). US health care reform: Cost containment and improvement in quality. *Journal of the American Medical Association, 316*, 493–495.

Oss, M. E. (2016). *The New Hampshire integrated care Medicaid waiver: The provider perspective*. Retrieved from https://www.openminds.com/market-intelligence/executive-briefings/new-developments-integrated-care-new-hampshire/.

Peek, C. J. & the National Integration Academy Council. (2013). *Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus*. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf.

Peikes, D. N., Reid, R. J., Day, T. J., Cornwell, D. D. F., Dale, S. B., Baron, R. J., … Shapiro, R. J. (2014). Staffing patterns of primary care practices in the comprehensive primary care initiative. *The Annals of Family Medicine, 12*(2), 142–149. https://doi.org/10.1370/afm.1626.

Porter, M. E., & Kaptan, R. S. (2016). How to pay for health care. In *Harvard business review*, pp. 88–100.

Reiter, J. T., Dobmeyer, R. C., & Hunter, C. L. (2017). The primary care behavioral health (PCBH) model: An overview. *Journal of Clinical Psychology in Medical Settings, 24*(4), 1–30.

Robinson, P. J., & Reiter, J. T. (2016). Behavioral Consultation and primary care. In *A guide to integrating services*. New York: Springer.

Roby, D. H., & Jones, E. E. (2016). Limits on same-day billing in Medicaid hinders integration of behavioral health into the medical home model. *Psychological Services, 13*, 110–119. https://doi.org/10.1037/ser0000044.

Sadock, E., Auerbach, S. M., Rybarczyk, B., & Aggarwal, A. (2014). Evaluation of integrated psychological services in a university-based primary care clinic. *Journal of Clinical Psychology in Medical Settings, 21*, 19–32.

Schneider, E. C., Sarnak, D. O., Squire, O., Skah, A., & Doty, M. M. (2017). Mirror, mirror 2017: International comparison reflects flaws and opportunities for better US health care. In *The Commonwealth Fund*. Retrieved from http://www.commonweatlhfund.org/interactive/2017/july/mirror-mirror/.

Schneider, E. C., & Squire, D. (2017). From last to first-could the U.S. health care system become the best in the world? *New England Journal of Medicine, 377*, 901–904. https://doi.org/10.1056/NEJMp1708704.

Schottenfeld, L., Petersen, O., Peikes, D., Ricciardi, R., Burak, H., McNellis, R., & Genevro, J. (2016). *Creating patient-centered team-based care. Pub. No. 16-0002-EF*. Rockville, MD: Agency for Healthcare Research and Quality.

Schroeder, S. A., & Frist, W. (2013). Phasing out fee-for-service payment. *New England Journal of Medicine, 368*, 2029–2032. https://doi.org/10.1056/NEJMsb1302322.

Squires, D., & Anderson, C. (2015). U.S. Health care from a global perspective: Spending, use of services, prices and health in 13 countries. In *Commonwealth Fund*. Pub 1819 (Vol. 15, pp. 1–15). Retrieved from https://www.commonwealthfund.org/-/media/files/publications/issue-brief/2015/oct.

Strosahl, K. (1996). Confessions of a behavior therapist in primary care: The odyssey and the ecstasy. *Cognitive and Behavioral Practice, 3*, 1–28.

The Colorado Health Foundation, n.d. Retrieved from http://www.coloradohealth.org.

The National Commission on Physician Payment Reform. (2013). *Report of the National Commission on physician payment reform*. Retrieved from http://physicianpaymentcommission.org/report.

Wang, P. S., Demler, O., & Kessler, R. C. (2002). Adequacy of treatment for serious mental illness in the United States. *American Journal of Public Health, 92*(1), 92–98.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 629–640.

Whittington, J. W., Nolan, K., Lewis, N., & Torres, T. (2015). Pursuing the triple aim: The first 7 years. *The Milbank Quarterly, 93*, 263–300. https://doi.org/10.1111/1468-0009.12122.