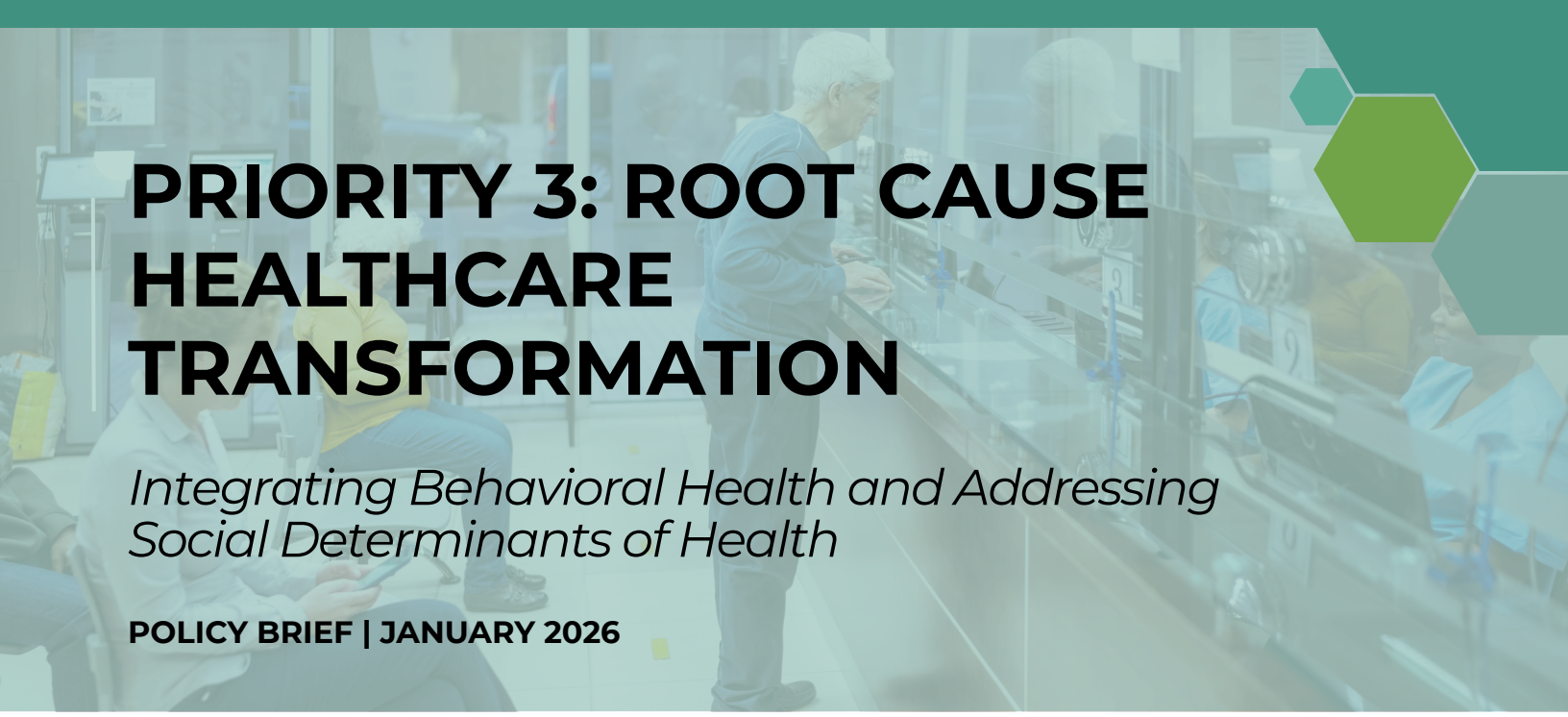

PRIORITY 3: ROOT CAUSE HEALTHCARE TRANSFORMATION

Integrating Behavioral Health and Addressing Social Determinants of Health

POLICY BRIEF | JANUARY 2026

The Policy Problem

Puerto Rico faces a convergence of chronic health crises that are placing increasing strain on a fragmented and fiscally vulnerable healthcare system. Diabetes affects 19.3% of the adult population (nearly 50% when prediabetes is included), while obesity impacts 41.5% of adults (Abartys Health & PR Diabetes Association, 2024), and Puerto Rico has the highest childhood asthma rate (16%) of any U.S. jurisdiction (CDC, BRFSS 2023, as analyzed by the American Lung Association, 2023), a disparity extensively documented in peer-reviewed literature (Lewis et al., 2020). This elevated burden of chronic disease is compounded by documented disparities in quality of care compared to the mainland United States, reflecting long-standing structural inequities in healthcare financing and infrastructure (Colón & Sánchez-Cesáreo, 2016). These conditions steadily drive healthcare costs, even as mental health services continue to operate largely in isolation from primary care. Local evidence further illustrates this fragmentation: at Damas Hospital, 61% of hospitalized patients had a mental health disorder without systematic integration of behavioral health services, and only 47% of oncologists routinely refer cancer patients to mental health care, leaving critical psychosocial needs unmet (Jiménez et al., 2013).

The scientific evidence consistently shows that fragmented care models are inadequate for addressing complex chronic conditions shaped by social, behavioral, and environmental factors. Research on integrated care demonstrates that separating physical health, mental health, and social care is associated with poorer clinical outcomes,

higher costs, and avoidable service utilization, particularly among individuals with comorbidities such as depression and noncommunicable chronic diseases (Novilla et al., 2023). In contrast, integrated care models such as the Collaborative Chronic Care Model have demonstrated significant improvements in clinical outcomes, treatment adherence, and system efficiency, supported by robust evidence from randomized controlled trials, meta-analyses, and large-scale implementation experiences (Bauer et al., 2019).

The Collaborative Care Model (CoCM) has demonstrated effectiveness in integrating behavioral health into primary care. A randomized controlled trial in Puerto Rico reported significant reductions in depressive symptoms and improvements in functional outcomes compared to usual care (Vera et al., 2010), and more recent evaluations continue to document improved symptom management and cost-effectiveness when supported by appropriate reimbursement structures (Hernández et al., 2024). Persistent disparities in behavioral health access and quality among Latino populations further highlight the need for structurally supported culturally responsive models of care (Alegría et al., 2016). Strengthening Medicare and Medicaid reimbursement for CoCM would better align financing mechanisms with integrated care delivery to reduce fragmentation and improve quality in underserved systems.

These structural limitations in the care delivery model are compounded by an impending fiscal scenario that threatens access to healthcare for low-income populations. On September 30, 2027, Puerto Rico's Federal Medical Assistance Percentage (FMAP) is scheduled to decline from 76% to 55%, while annual capped federal Medicaid funding is projected to fall from approximately $3.8 billion to about $400 million—a reduction of nearly 90% affecting more than one million beneficiaries (FOMB, 2025; CRS, 2025, CBPP, 2025; KFF, 2024). Unlike states, Puerto Rico operates under a capped financing structure that requires services to be suspended or restricted once the funding ceiling is reached, placing the stability of the healthcare infrastructure serving populations experiencing the greatest levels of vulnerability at significant risk (MACPAC, 2020).

This context is further compounded by evidence presented by the MAHA Commission, which documents that the prevalence of chronic disease in childhood has tripled since the 1960s, increasing from 12.8% to 40.3% (Make America Healthy Again Commission, 2025). This rise is linked to structural determinants such as high consumption of ultra-processed foods—accounting for nearly 70% of children's caloric intake—and exposure to more than 80,000

chemicals in the environment (Make America Healthy Again Commission, 2025). In Puerto Rico, these dynamics are intensified by an 85% dependence on imported foods, environmental vulnerabilities, and limitations in risk regulation and mitigation, reinforcing the need to transform the healthcare system through an approach that addresses the structural root causes of disease rather than only its varied clinical manifestations.

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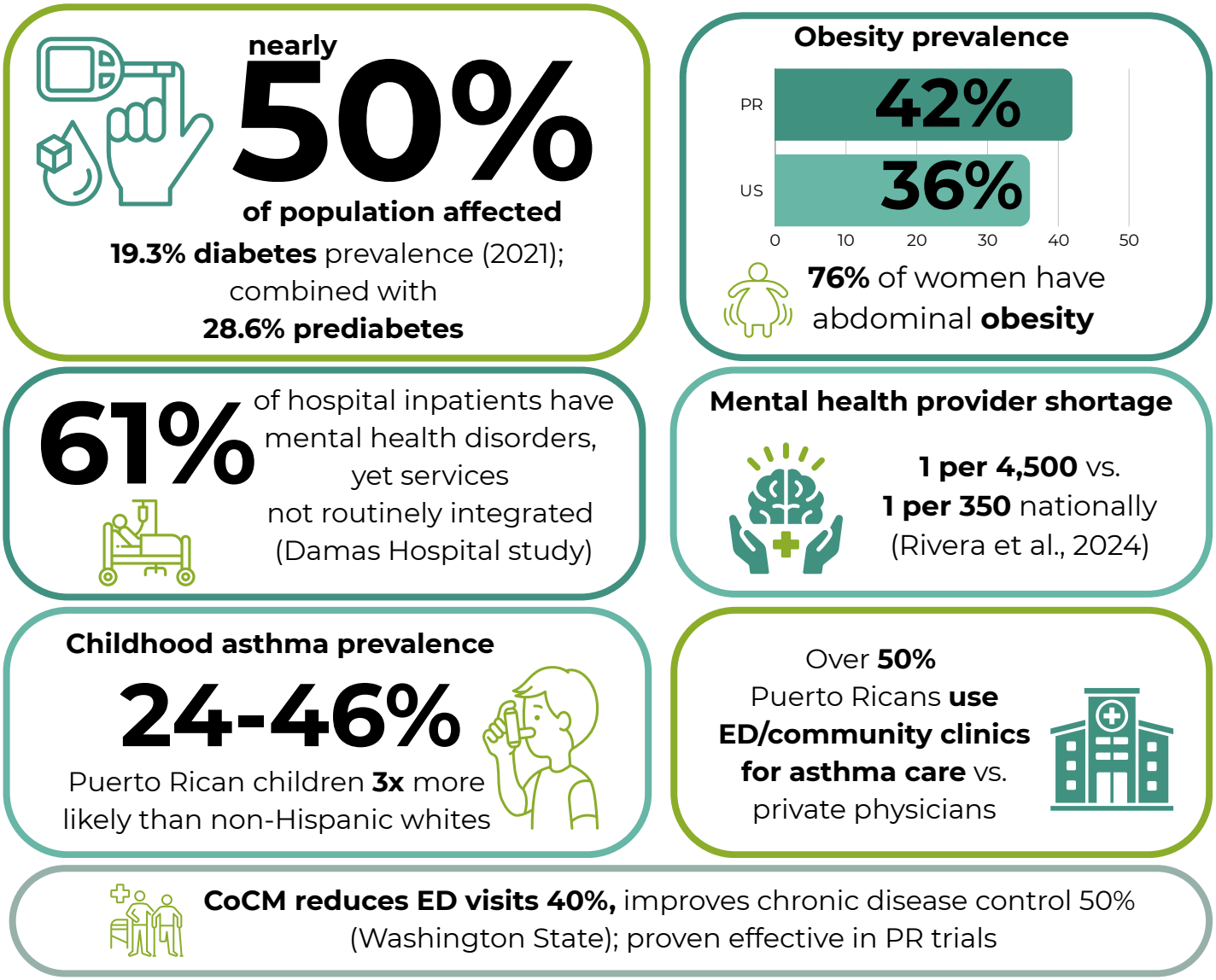
The Solution Approach

Transform healthcare by integrating behavioral health into primary care and addressing root causes—nutrition, environment, social determinants. Collaborative Care Model (CoCM) proven effective in Puerto Rico trials significantly improved outcomes for depression with chronic conditions. Certified Community Behavioral Health Clinics (CCBHCs) provide comprehensive services with sustainable prospective payment. Social determinants screening reduces ED use by 30%. Telehealth expands access across Puerto Rico's dispersed geography. Integration of MAHA priorities—whole foods nutrition programs, environmental health protections, ultra-processed food reduction—creates a comprehensive root cause approach.

Figure 1

Key Statistics



Grupo Nexos Inc.

Figure 2

Key Partners

Federal Agencies: Centers for Medicare & Medicaid Services (CMS), Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), National Institute of Mental Health (NIMH), USDA Food and Nutrition Service (MAHA nutrition programs)
Puerto Rico Partners: ASSMCA (Administración de Servicios de Salud Mental y Contra la Adicción), Puerto Rico Department of Health

Examples From Other States

- Washington State CoCM Statewide Implementation: $80M investment trained 2,000+ providers, embedded care managers in 400+ clinics serving 150K patients. Results: 60% reduction in depression, 40% decrease in ED visits, 50% improvement in chronic disease control, $3.50 saved per $1 invested.
- Minnesota CCBHC Network: 9 CCBHCs provide 24/7 crisis care, integrated primary care, peer support to 45K+ individuals. Prospective payment ensures sustainability. Results: 95% crisis stabilization without hospitalization, 50% reduction in ED use.
- Massachusetts Social Determinants Integration: MassHealth authorizes 'flexible services' addressing housing, nutrition, safety. SDOH screening in all healthcare settings links to services. Results: 30% reduction in ED use, 25% decrease in hospitalizations, 45% improvement in chronic disease control.

Table 1

Advocacy Actions

Legislative/ Administrative Action	Puerto Rico Relevance
CMS Innovation in Behavioral Health Model Expansion	Puerto Rico's own research proved CoCM works in local settings, yet infrastructure investment hasn't materialized. The IBH Model provides upfront funding for care managers, data systems, training—exactly what's needed. With 61% of inpatients having mental health disorders, integrated primary care prevents costly hospitalizations while addressing provider shortage.
Collaborative Care Model Medicare/Medicaid Reimbursement Enhancement	Research conducted in Puerto Rico proved that CoCM 'significantly improved clinical symptoms and functional status' for depression with chronic conditions. Enhanced reimbursement creates sustainable financing—primary care practices can afford care managers when adequately reimbursed. Given severe shortage (1 provider per 4,500), CoCM enables primary care to treat mental health with specialist support.

Table 1 (continued)

Advocacy Actions

Legislative/ Administrative Action	Puerto Rico Relevance
CCBHC Program Expansion	CCBHCs address fragmented care delivery (61% inpatients had mental health disorders) and severe provider shortage. CCBHC requirements mandate physical-behavioral health integration. Prospective payment provides sustainable funding independent of fee-for-service. Could transform community health centers into comprehensive integrated sites with guaranteed Medicaid reimbursement and 24/7 crisis response.
Permanent Telehealth Authorization & Parity	Puerto Rico's mountainous terrain and provider maldistribution make telehealth essential. Only 1 provider per 4,500 means in-person care impossible for most—telehealth expands reach exponentially. Critical for rural/mountain communities where provider recruitment is impossible, but telehealth delivers specialist services. Audio-only flexibility addresses digital divide and broadband limitations.
Puerto Rico Medicaid Funding Parity & Cliff Prevention	September 30, 2027: Puerto Rico's FMAP drops from 76% to 55% and capped funding plummets from $3.8B to ~$400M—a 90% reduction threatening 1+ million beneficiaries. Unlike states with uncapped funding, Puerto Rico must suspend services when cap is reached. Support permanent parity legislation treating Puerto Rico like states (uncapped funding, formula-based FMAP of 83%). Without action, entire behavioral health integration infrastructure collapses, eliminating CCBHCs, CoCM programs, and telehealth—reversing all progress toward integrated care.
Healthy Start Reauthorization Act of 2025 (H.R. 3302)	Comienzo Saludable Puerto Rico — the island's Healthy Start grantee — achieved 0% infant mortality from 2021 to 2023, a 27.2% reduction in low birth weight, and a 30.9% decrease in premature births, outcomes unmatched by any comparable program nationally. Yet these results are at risk: HHS staff terminations have destabilized federal program administration, and FY2026 funding remains uncertain. Full reauthorization at $145 million annually would protect the 627 families currently served across 24 municipalities and sustain a proven, community-based model for addressing Puerto Rico's maternal mortality rate — 57% higher than in 2000 — and infant mortality rate 40% above that of non-Hispanic whites.

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