

Treating Behavioral Health Disorders in an Accountable Care Organization

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At completion of this activity, the participant will be able to:

- Identify challenges for treating behavioral health disorders and the gaps in an accountable care organization (ACO).
- Explore opportunities to treat behavioral health disorders by establishing partnerships within an ACO.
- Examine best practices and examples of successful incorporation of behavioral health treatment within an ACO.

Target Audience: Pharmacists, physicians, and managed care professionals

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INTRODUCTION

Mental health conditions and substance use disorders (SUDs), referred to as behavioral health conditions, are a leading cause of global disability.¹ In the United States, an estimated 1 in 3 adults suffers from one or both of these disorders.² These individuals die, on average, 25 years earlier than the general population as a result of suicide or comorbid physical conditions, such as cardiovascular disease, diabetes, respiratory distress, or infectious disease (HIV/AIDS). They also incur significantly higher medical and societal costs.³

Estimated spending on behavioral health conditions varies depending on the study. One analysis based on 41 million individuals covered under Medicare, Medicaid, or commercial health plans who were treated for a behavioral health condition in 2012 estimated a cost of \$525 billion, nearly half of the \$1.7 trillion spent that year on all health-related expenditures.⁴ Another analysis estimated a lower cost: \$201 billion in 2013.⁵ Both analyses, however, noted that spending on behavioral health conditions was the highest category of any other medical condition in the United States, topping cardiovascular disease and trauma (Figure 1⁵).

The number of people seeking services for behavioral health conditions is expected to increase over the next decade due to the Affordable Care Act, which mandates that insurance companies cover screening and other services for mental health and substance abuse conditions, and the Mental Health Parity and Addiction Equity Act, which requires that insurers provide equal coverage for behavioral and physical health conditions.^{6,7}

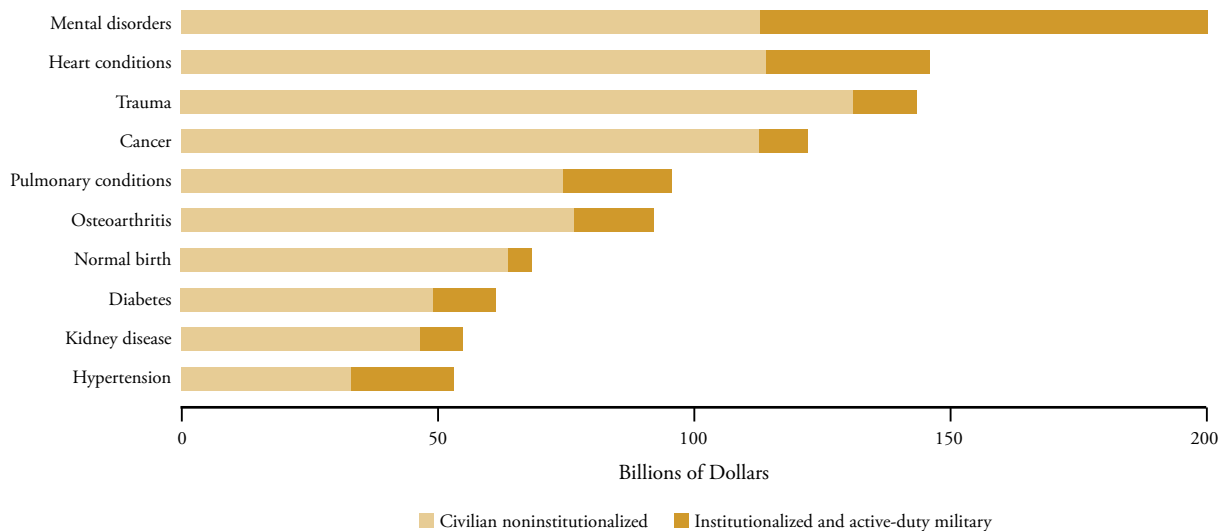
Despite the physical, economic, and societal consequences of behavioral health conditions, about one-third of individuals with these disorders receive no treatment, and the vast majority of the rest receive substandard treatment. This gap between needed care and received care increased by about two-thirds between 1997 and 2010.⁸ Indeed, 70% of Americans in a recent poll from the Kennedy Forum felt that the country needed significant changes in the way it manages behavioral health conditions.⁹

Today, many individuals with behavioral health disorders receive care in the primary care or medical specialty, not behavioral health, setting.^{10,11} Of those, up to 80% receive no treatment or substandard treatment for their behavioral health disorder.¹⁰ This includes prescribing antidepressants for mild depressive symptoms, which are relatively ineffective, and the use of psychotropic medications with no documented behavioral health diagnosis.¹² Psychosocial approaches, which studies find can be just as effective as medication, are also underutilized.^{9,13}

Prevalence of Comorbid Physical Conditions

Approximately 68% of those with behavioral health issues have comorbid physical conditions, typically chronic conditions such as asthma, low back pain, and diabetes.^{14,15} These individuals have higher morbidity and mortality rates and are more likely to be nonadherent with medication than those with only a behavioral or physical health condition.^{14,16} For instance, 21% of patients with chronic kidney disease (CKD) have comorbid depression regardless of their disease stage.¹⁷ These patients are twice as likely to be

Figure 1. Ten Medical Conditions With the Highest Estimated Spending in 2013⁵



Source: Copyrighted and published by Project HOPE/Health Affairs as Roehrig C. Mental disorders top the list of the most costly conditions in the United States: \$201 billion. *Health Aff (Millwood)*. 2016;35(6):1130-1135. doi: 10.1377/hlthaff.2015.1659. The published article is archived and available online at www.healthaffairs.org.

hospitalized and have a 41% increased risk of all-cause mortality compared with patients with CKD who do not have depression.¹⁸ Patients on hemodialysis have a 2-fold increased risk of death.¹⁹

Patients seen in the behavioral health setting who also require services for comorbid physical conditions report difficulties accessing medical care.¹⁴ In one survey of 1670 adults with mental illness, one-third had difficulties accessing primary care, with 13% attributing this to stigma around their behavioral health condition.²⁰ Further, the care received is less likely to include prevention and screening, and this limited clinician time may lead to less time spent on psychosocial issues.¹⁴ A review of the Veterans Affairs National Psychosis Registry showed poor adherence to medications for both psychiatric and medical conditions in patients with serious mental illness.¹⁴ Not surprisingly, individuals with comorbid mental and physical health conditions use more health-related services than those without, even when controlling for the higher prevalence of physical health conditions among those with behavioral disorders.¹⁶

The Need for Integrated Care

Behavioral health disorders require long-term, chronic-care management similar to that needed for chronic physical conditions such as hypertension, diabetes, and asthma.^{21,22} Such conditions respond best to management under a chronic-care model, which promotes enhanced access and care continuity, uses clinical information systems and decision support tools to identify and manage patient populations, provides self-management support to patients, and links patients to community resources. Under this model, providers also track and coordinate care and measure performance changes over time. Study results suggest this model can be implemented cost-effectively and even demonstrate some savings.^{22,23}

In the behavioral health setting, a chronic care model requires integrating mental and substance abuse treatment with physical health management. This “integrated” model is described as “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.”²⁴

Settings may involve embedding behavioral health professions in a primary care setting or primary care providers in a behavioral setting, or developing a close relationship between behavioral and primary care practices despite different physical locations, even using telemedicine (Table 1²⁵).²⁵

Despite the robust literature demonstrating the benefits of integrated care models,¹⁶ behavioral and physical healthcare delivery have traditionally operated in separate spheres.²² Bringing the two together could not only improve outcomes, but also reduce costs.²⁶ Indeed, analyses suggest that integrating medical and behavioral services in Medicaid populations could save states between \$3

and \$9 billion, while integration could save all payers (including commercial) between \$26.3 and \$48.3 billion (2012 dollars) (Table 2^{4,15}).^{4,15} Updating benefit designs to reflect these improvements needs to be part of the move to accountable care organization (ACO) behavioral health integration.

These savings are already occurring at the state level. For instance, Missouri’s Chronic Care Improvement Program, an integrative model designed for individuals with severe mental illness, such as schizophrenia, saved \$8.3 million in its first year managing 6757 members, even with a \$775,000 increase in outpatient costs.¹⁵ In addition, the state’s Community Mental Health Center healthcare homes (similar to patient-centered medical homes) for Medicaid-eligible individuals with severe and persistent mental illness, comorbid SUDs, and certain chronic health conditions reduced overall healthcare costs by 8.1% while significantly improving individual and societal outcomes.⁴ When Kaiser Sacramento integrated medical and substance use treatments in primary care clinics for individuals in an outpatient chemical dependency recovery program, per-member-per-month (PMPM) costs dropped more than 50%, with significant declines in hospitalization rates, inpatient days, and emergency department use.²⁷

Opportunities for Improvement

The Affordable Care Act created a pathway for greater integration of physical and behavioral health services when it expanded the development and use of ACOs. These integrated models of care are typically built around patient-centered medical homes. Payment is typically linked to the quality and cost of care, with value-based, rather than fee-for-service-based, reimbursement. A common reimbursement model is shared savings, in which the ACO shares in any savings with the payer over a defined timeline. In some instances, ACOs assume the risk for spending more than the financial target. Other ACOs take on even greater risk under capitation: such reimbursement models provide a financial incentive to hire case managers, social workers, pharmacists, and other allied health professionals to work with patients with comorbid behavioral health issues.²⁸

ACOs are charged with managing the health of a patient population, which requires robust data systems, predictive analytics, and coordinated care. The goal is to achieve the Triple Aim of healthcare today: improved outcomes, improved patient experience, and reduced cost.²⁹ In 2015, 70% of Americans had access to an ACO, 44% to 2 or more, and between 15% and 17% (49 to 59 million) received care from an ACO.³⁰

Integrating behavioral health management with physical health management in an ACO model could significantly improve population health management and outcomes, contributing to an ACO’s ability to survive and thrive under risk-based reimbursement models.²⁹ This approach also fits with the ACO’s team-based, coordinated care approach.³¹

Table 1. Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions: Six Levels of Collaboration/Integration²⁵

Coordinated Key Element: Communication		Co-Located Key Element: Physical Proximity		Integrated Key Element: Practice Change	
Level 1 Minimal Collaboration	Level 2 Basic Collaboration at a Distance	Level 3 Basic Collaboration Onsite	Level 4 Close Collaboration Onsite with Some System Integration	Level 5 Close Collaboration Approaching an Integrated Practice	Level 6 Full Collaboration in a Transformed/Merged Integrated Practice
Behavioral health, primary care, and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility, not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, shar- ing all practice space, where they:
<ul style="list-style-type: none"> • Have separate systems • Communicate about cases only rarely and under compelling circumstances • Communicate, driven by provider need • May never meet in person • Have limited understanding of each other's roles 	<ul style="list-style-type: none"> • Have separate systems • Communicate periodically about shared patients • Communicate, driven by specific patient issues • May meet as part of a larger community • Appreciate each other's roles as resources 	<ul style="list-style-type: none"> • Have separate systems • Communicate regularly about shared patients, by phone or e-mail • Collaborate, driven by need for each other's services and more reliable referral • Meet occasionally to discuss cases due to close proximity • Feel part of a larger yet ill-defined team 	<ul style="list-style-type: none"> • Share some systems, like scheduling or medical records • Communicate in person as needed • Collaborate, driven by need for consultation and coordinated plans for difficult patients • Have regular face-to-face interactions about some patients • Have a basic understanding of roles and culture 	<ul style="list-style-type: none"> • Actively seek system solutions together or develop work-arounds • Communicate frequently in person • Collaborate, driven by desire to be a member of the care team • Have regular team meetings to discuss overall patient care and specific patient issues • Have an in-depth understanding of roles and culture 	<ul style="list-style-type: none"> • Have resolved most or all system issues • Communicate consistently at the system, team, and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blur or blend

Source: Heath B, Wise Romero P, Reynolds K. A review and proposed standard framework for levels of integrated healthcare. Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions. http://www.integration.samhsa.gov/integrated-care-models/CIHS_Framework_Final_charts.pdf. Published March 2013.

Some ACOs are improving their delivery of behavioral health care. For example, Crystal Run Healthcare ACO in New York, which participates in the Medicare Shared Savings Program (MSSP), has 3 psychiatrists in its medical building. These psychiatrists share a waiting room with their medical colleagues and use a connected electronic health record (EHR) system. They also formed a mental health assessment team comprising of primary care and specialty physicians who meet with mental health specialists to discuss cases requiring comanagement.³²

The norm, however, is a continuation of siloed care. A survey queried 257 nationally representative Medicare, Medicaid, and commercial ACOs between 2012 and 2014, and was augmented with qualitative data from structured interviews with clinical leaders at 16 ACOs. It found that just 14% had fully integrated behavioral health and primary care teams and just 42% included behavioral health specialists among their providers.²⁹ Another

survey found that more than one-third of ACOs had no formal relationship with behavioral health providers despite the fact that

Table 2. Projected Healthcare Cost Savings Through Effective Integration^{4,15}

Payer Type	Estimated Annual Savings
Commercial	\$15.8-\$31.6 billion
Medicare	\$3.3-\$6.7 billion
Medicaid	\$7.1-\$9.9 billion
Total	\$26.3-\$48.3 billion

Source: Melek SP, Norris DT, Paulus J. Economic impact of integrated medical-behavioral healthcare: implications for psychiatry. Denver, CO: Milliman, Inc. <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Milliman-Summary-Report-Economic-Impact-Integrated-Implications-Psychiatry.pdf>. Published April 2014.

the majority of contracts included behavioral health metrics. Although 84% of ACOs had at least 1 contract with a payer that included responsibility for behavioral health services, just 66% of the largest commercial contracts included behavioral health services in the total cost of care.²⁹

In another study, researchers analyzed Medicare claims for 20% of traditional beneficiaries with a mental health condition who received care in a Pioneer or MSSP ACO between 2008 and 2013 (they could not analyze SUD claims given federal confidentiality laws). They found cost savings in 2012 for Pioneer ACOs, primarily from a reduction in hospitalization, but the savings did not continue in 2013, nor were any savings observed in the MSSP. Neither ACO program showed significant differences in outcomes.²⁸ However, the authors also found little evidence of integration between behavioral and medical management. Instead, the majority of ACOs contracted out behavioral health services. Improving outcomes for individuals with mental health issues, they concluded, required that ACOs adopt evidence-based approaches associated with greater effectiveness in this population, such as integrated services.²⁸

Even if ACOs are providing mental health services, far fewer are providing SUD services.^{21,29} A survey of 635 substance abuse treatment centers found just 15% had a signed agreement to be included in an ACO, while just 6% and 4%, respectively, planned to be connected with an ACO or were currently negotiating to be connected.²¹

Publicly owned and private nonprofit SUD treatment facilities, as well as those in more competitive markets and those accredited by the Joint Commission, were most likely to have such contracts.²¹ However, these contracts don't necessarily result in fully integrated services; they may only cover referral to behavioral health specialists. In addition, treatment centers in the Northeast were more likely than those in the Southeast and Midwest to sign contracts with an ACO, with those most likely located in states with 50 or more ACOs.²¹ The authors concluded that the results of the survey "suggest that ACOs are not effectively integrating treatment and services for individuals with SUDs into medical settings." This, in turn, continues the fragmented, suboptimal, high-cost care received by this high-risk population, most of whom suffer from multiple chronic conditions.²¹

Yet, most ACOs understand the interrelationship between behavioral and physical health on overall outcomes and costs. An analysis of data from 90 Medicare ACOs between December 2012 and June 2015, including 72 site visits, found that nearly all of the ACO staff interviewed understood that behavioral health disorders contribute to overall health outcomes and spending and that most were working to better coordinate behavioral and physical health services.³³ They were working to integrate behavioral health and primary care, increase access to social workers, and

enhance referral networks. Some embedded primary care providers in behavioral health facilities and included pharmacists and community resource specialists on treatment teams. One ACO even developed a mental health "center of excellence" for primary care referrals of complex patients who required significant behavioral and physical health services.³³ However, the study also found significant barriers to greater integration of behavioral health in an ACO, including a lack of behavioral health care providers, access to data, and sustainable financing models.³³

Successfully Integrating Behavioral and Physical Health Services in an ACO

Successful integration of behavioral and physical health services in an ACO should focus on 5 areas: financial incentives, data sharing, legislative changes, quality measures, and alignment with existing initiatives.³³

Financial Incentives

Financial incentives in any healthcare delivery system must be aligned with expected outcomes. Thus, the value of integrating behavioral and physical health services is low under a fee-for-service system, which pays for the episode of care provided regardless of outcomes and provides no reimbursement for the additional time and effort required to coordinate care.³³ The value is much higher, however, under a capitated system in which providers are essentially paid for keeping their population as healthy as possible.

Thus, value-based reimbursement models have entered the behavioral health sphere in the hope of spurring greater integration and improved outcomes. For instance, Minnesota's Medicaid program capitates Hennepin Health ACO for behavioral and medical services, which encourages greater coordination between providers.³⁴

Capitation is but one reimbursement model. States may also require that ACOs share savings with behavioral health providers or leave it up to the ACO itself to compensate behavioral health providers. For example, Maine includes behavioral health services within the total cost of care (TCOC) calculations for its ACOs, leaving it up to the organizations to determine how to financially compensate the behavioral health provider. Given that the TCOC impacts the organizations' receipt of shared savings, this is designed to promote greater accountability across settings.³⁴

Massachusetts embeds behavioral health services within its 3-tier payment system: comprehensive PMPM payments for an optional set of behavioral health services; quality incentive payments based on 23 quality measures, including 4 related to behavioral health; and shared savings payments based on cost savings on non-primary care services, including behavioral health. The higher the level, the higher the potential compensation.³⁴

Data Sharing

Successful ACOs use robust information technology systems to collect and analyze data on their patients. These systems are typically tied into scheduling and revenue cycle systems to provide a holistic view of the state of the practice and patient population at any given time.³⁴ However, medical providers have been upgrading their information technology, particularly their EHR systems, for years thanks to the Health Information Technology for Economic and Clinical Health (HITECH) Act, which offered incentives for the development and meaningful use of such systems. The act, however, excluded mental and behavioral health providers and treatment facilities from this incentive program.³⁴ Thus, behavioral health providers are far behind their physical health counterparts in the collection and use of data.³⁴

This could change if the Behavioral Health Information Technology Act and other legislations pass that are currently pending in Congress. The Behavioral Health Information Technology Act would extend incentives for meaningful use of EHRs to psychologists and mental health professionals who provide clinical care at psychiatric hospitals, mental health treatment facilities, and substance abuse treatment facilities.³⁵ In addition, the Office of the National Coordinator of Health Information Technology has released grants through the State Innovation Models Initiative to enhance IT integration into behavioral health.³⁶ ACOs could also require that their behavioral health providers participate in a joint EHR system and even offset some of the costs.

The lexicon for behavioral health diagnoses that is typically used for structured, coded information in health IT is also lacking. These structured data are required for the type of data analysis and clinical decision support necessary for successful population health management.³⁶ Just as challenging is the lack of interoperability among existing health information systems and the lack of behavioral health data fields in medical EHRs or physical health fields within behavioral health EHRs. Some states are beginning to provide support for more integrated systems, however, while larger ACOs may have the resources to modify existing systems to facilitate greater coordination.³⁴

Legislative Changes

Legislative changes in the federal regulation that prohibits sharing patient information related to alcohol and drug treatment without additional patient consent (beyond the standard HIPAA form) are needed. Without these data, ACOs are unable to provide the level of analytics required to manage the health of a population and identify patients for targeted outreach.³³

Billing issues also require changes. Just 28 state Medicaid systems allow providers to bill for primary care and behavioral health services on the same day even though there is no federal restriction. This creates a significant barrier to integrated and

coordinated care.³⁴ Some legislative actions may seem minimal, but they can send a powerful message. For instance, in Arizona, it took legislative action to strike down a law that required separate waiting rooms for patients receiving mental health services and those receiving medical care.³⁷

States should also encourage the training of additional behavioral health care specialists. A survey of 90 Medicare ACOs found that a scarcity of mental health professionals posted a significant barrier to the greater integration of behavioral and physical health. The ACOs cited poor Medicare reimbursement as one reason for the low number of providers willing to see Medicare patients.³³ Another survey of 2900 primary care providers found that 67% reported difficulties connecting their patients with behavioral health specialists because of a shortage of providers, as well as insurance barriers.³⁸ The survey was conducted in 2009, before the full impact of the Affordable Care Act and expanded access to insurance occurred. We do not yet know if this expansion changed access to providers or if benefits featuring narrow networks, behavioral health carve-outs, and high patient cost share blunted the benefit of this access.

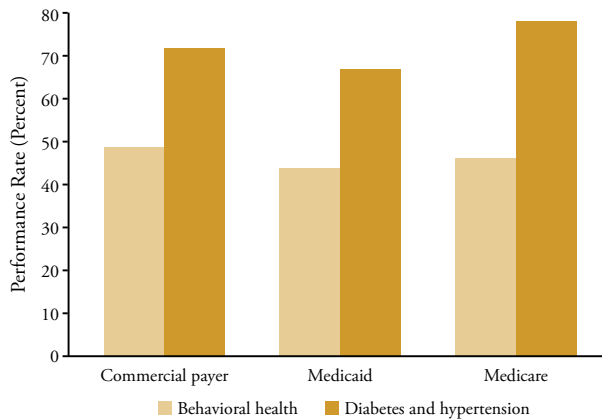
Quality Measures

Quality measures play an integral part in the effort to improve delivery of behavioral and physical healthcare services, ensure appropriate access, and align incentives under value-based reimbursement.³⁹ Although large national databases show 510 quality measures that address behavioral health, just 5% to 10% are included in major quality reporting programs, such as the Inpatient Psychiatric Facility Quality Reporting Program, the Physician Quality Reporting System, the National Quality Forum, and quality measures for Medicare and Medicaid programs maintained by the Centers for Medicare & Medicaid Services.^{39,40}

Indeed, until recently, just 1 of 33 quality measures required for Medicare ACOs, depression screening, was directly related to behavioral health.⁴¹ Yet, the depression screening is much more of a comprehensive primary care measure than measuring behavioral health performance. New measures for 2017 add rates of depression remission and response to treatment at 12 months. Measures involving screening for and treatment of SUDs are under consideration. In addition, several measures, such as shared decision making, medication reconciliation, and patient ratings of physicians, also apply.⁴²

Adherence to behavioral health-related quality measures is poor, however, with reports demonstrating that patients receive recommended care based on quality initiatives about half the time. Conversely, recommended care is provided about two-thirds of the time for other chronic conditions, including diabetes and cardiovascular disease (Figure 2³⁹).³⁹

Figure 2. Average Performance Rates on Healthcare Effectiveness Data and Information Set Quality Measures for Behavioral Health Conditions vs Diabetes and Hypertension, by Payer, 2014³⁹



Source: Copyrighted and published by Project HOPE/Health Affairs as Pincus HA, Scholle SH, Spaeth-Ruble B, Hepner KA, Brown J. Quality measures for mental health and substance use: gaps, opportunities, and challenges. *Health Aff (Millwood)*. 2016;35(6):1000-1008. doi: 10.1377/hlthaff.2016.0027. The published article is archived and available online at www.healthaffairs.org.

In a recent article in *Health Affairs*, Pincus et al highlighted 5 key areas for improvement in the realm of behavioral health quality measures³⁹:

- Expanding outcomes measurements built around the concept of “recovery” and including patients and families in their development.
- Developing structural approaches to enhance the capacity of organizations and providers to provide effective, quality care. This could include accreditation, certification, recognition, and payment programs, such as Medicaid Health Homes and the National Committee for Quality Assurance’s patient-centered medical home and specialty recognition programs, which incentivize outcome-focused care.
- Encouraging the integration of behavioral and physical health services, as described earlier in this article.
- Expanding quality measures related to the use of effective patient-centered psychosocial interventions, such as talk therapy.
- Adding quality measures around the management of SUDs.

Table 3³⁴ highlights state efforts in these areas.³⁴

Alignment With Existing Initiatives

Integrating behavioral and physical health services should build

Table 3. Behavioral Health–Related Measures Used in Medicaid Accountable Care Organization (ACO) Metrics in Select States³⁴

Program/State	Behavioral Health-Related Measures
Accountable Communities (Maine)	Shared savings are contingent on performance on 18 measures, including the following 2 related to behavioral health services: <ul style="list-style-type: none"> • Rate of initiation and engagement of alcohol and other drug dependence treatment; and • Rate of follow-up within 7 days of hospitalization for mental illness
Primary Care Payment Reform Initiative (Massachusetts)	Providers are eligible to receive an annual incentive payment based on their performance on 23 quality measures, including the following 4 behavioral health-related measures: <ul style="list-style-type: none"> • Rate of depression screening; • Rate of follow up after hospitalization for mental illness; • Rate of initiation of alcohol/drug dependence treatment; and • Attention-deficit/hyperactivity disorder medication management for children
Integrated Health Partnerships (Minnesota)	Shared savings is calculated based on a weighted score that includes performance on 8 clinical quality measures, including: <ul style="list-style-type: none"> • Depression remission at 6 months
Coordinated Care Organizations (Oregon)	Within a global budget framework, coordinated care organizations are required to track: <ul style="list-style-type: none"> • Screening and follow-up for members diagnosed with clinical depression
Medicaid ACO Shared Savings Pilot (Vermont)	Providers who demonstrate successful integration and improve behavioral and physical health care in the following 2 measures will be eligible for increased shared savings (based on total cost of care calculations): <ul style="list-style-type: none"> • Rate of depression screening by 18 years of age; and • Rate of follow-up within 7 days of hospitalization for mental illness

Source: Brown D, McGinnis T. Considerations for integrating behavioral health services within Medicaid accountable care organizations. Center for Health Care Strategies website. <http://www.chcs.org/media/ACO-LC-BH-Integration-Paper-0709141.pdf>. Published July 2014.

on existing programs within ACOs. For instance, some ACOs already employ social workers and other behavioral health specialists for short-term support. New York state is working with existing “health home” programs, which provide care for complex patients, to grow them into ACOs and is providing grants to behavioral health providers to encourage them to better collaborate with health homes. Those health homes are already required to support care management across physical and behavioral health services and create links to community support and housing.³⁴

ACOs should also investigate the numerous state and federal grants available for behavioral health integration. For instance, the SAMHSA-HRSA Center for Integrated Health Solutions has awarded more than \$26.2 million in grants to 100 community-based behavioral health organizations to support integration of primary care services into these settings.³⁴

A 2010 report from the Agency for Healthcare Research and Quality highlights several essential measures needed to facilitate an integrated mental health model in the primary care setting¹⁶:

- Normalize mental health into mainstream medical practice. This requires cultural shifts to move away from the stigma of behavioral health problems and recognize these conditions as chronic health conditions no different from diabetes and asthma. It also requires redesigning workflows and providing physicians with the technical and leadership skills they require for full integration.
- Integrate reimbursement mechanisms. This includes eliminating separate coding and billing procedures.
- Create a roadmap for implementation. This includes research that identifies the most effective and cost-effective primary care models for this population and the development of decision support tools that identify patients who require integrated services.
- Create and/or disseminate the tools providers need. This requires guidance and technical assistance for implementing integrated care, research, and valid screening, diagnostic, and monitoring instruments.

CONCLUSIONS

One in 3 individuals in this country has a behavioral health disorder, whether a mental illness, SUD, or both. These patients garner healthcare costs far higher than those without such disorders, experience greater morbidity and earlier mortality, and are more likely to experience comorbid physical health conditions. They also receive substandard care for their behavioral health disorders and experience difficulties accessing primary care for their physical health disorders. The traditional separation between behavioral and physical health services in the medical field contributes to these access and quality issues.

Integrating behavioral and physical health services within an

ACO offers a significant opportunity to address both of these problems, as well as improves outcomes and reduces costs. However, ACOs, which have traditionally focused on physical health conditions, have been slow to incorporate behavioral health within their population health focus. Barriers include a lack of quality incentives, behavioral health providers, and a robust IT infrastructure.

The value-based reimbursement model under which ACOs operate, however, should incentivize these organizations to better address behavioral health conditions in order to improve the overall health of their population. However, payers need to ensure that financial incentives are aligned to encourage this by including behavioral health outcomes and responsibilities within any capitation and/or shared savings plans. They should also support the development of interoperative information systems and legislative changes that encourage the full integration of behavioral and physical health services.

Additional Resources

The following references provide more information about integrated primary and behavioral health care:

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CE Posttest Questions

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1. Most accountable care organizations (ACOs) surveyed in recent years:

- A. Offer fully integrated behavioral health care
- B. Subcontract behavioral health care services to other providers
- C. Have taken on risk for the provision of behavioral health care services
- D. Have hired onsite psychiatrists and psychologists

2. ACOs are uniquely suited to manage behavioral health conditions because they:

- A. Operate under value-based reimbursement systems
- B. Are located in urban areas
- C. See patients with chronic medical conditions
- D. Typically employ behavioral health practitioners

3. Which of the following is true regarding the outcomes of behavioral health and current ACO models?

- A. One-third of the population currently receives no treatment.
- B. There has been an overall improvement in positive outcomes and lower cost as a result of primary care addressing behavioral health issues.
- C. There has been a vast improvement in coordination of care between primary care and behavioral health care.
- D. Over 90% of the US population has no access to behavioral health services.

4. Improving access to behavioral healthcare through ACOs requires:

- A. Having primary care providers provide more behavioral health care
- B. Greater use of quality measures related to behavioral health provision and outcomes
- C. Centralizing behavioral health services for efficiency
- D. Putting more responsibility for behavioral health visits on the patients.

5. Pioneer ACOs showed:

- A. Sustained reduction in behavioral health savings
- B. A 1-time reduction in behavioral health savings
- C. Tight integration between primary care and behavioral health
- D. Improved clinical outcomes

6. Behavioral health providers are less likely to use an electronic health record (EHR) due to:

- A. EHRs not being useful in behavioral health
- B. Lack of integration into an ACO
- C. Being excluded from the Health Information Technology for Economic and Clinical Health Act
- D. Concerns about HIPAA

- 7. Quality measures used by Centers for Medicare & Medicaid Services (CMS) to measure ACO performance had:**
- A. A robust number of behavioral health performance measures
 - B. A mix of outcome and process behavioral health measures
 - C. 1 measure aimed at depression screening
 - D. Multiple measures related to substance abuse
- 8. Improvements in outcomes and cost has been demonstrated in which of the following models:**
- A. Co-located
 - B. Coordinated
 - C. Primary Care
 - D. Integrated
- 9. Existing initiatives that can be leveraged to help integration of behavioral health services include:**
- A. New York state's health home programs
 - B. CMS' s behavioral health ACO program
 - C. Commercial payer behavioral health carve-outs
 - D. Reduction of hospital readmission rates
- 10. Tighter integration strategies for behavioral health include all of the following, except:**
- A. Removing physical barriers, such as placing behavioral health providers in primary care clinics
 - B. Adding behavioral health into a risk arrangement, such as capitation, to force primary care attention to behavioral health
 - C. Increasing access to behavioral health providers
 - D. Reducing reimbursement for behavioral health services
- 11. The Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions lists 6 levels of integrated care. At which level are most ACOs today?**
- A. Level 1
 - B. Level 2
 - C. Level 3
 - D. Level 4
- 12. Exemplary ACO behavioral health models focus on which of the following to reduce costs and improve outcomes?**
- A. Data sharing and identifying those at risk for behavioral health disorders.
 - B. Chronic care management of behavioral health similar to that of physical chronic conditions
 - C. Outsourcing behavioral health service removing burden from primary care providers
 - D. Forcing efforts on substance use disorders

Sample
Posttest