

Integrating Behavioral Health Under an ACO Global Budget: Barriers and Progress in Oregon

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Mental illness, substance use conditions, health behavior change, life stressors and crises, and stress-related physical symptoms—together referred to as behavioral health—are prevalent in primary care settings.^{1,2} Left untreated, behavioral health problems increase morbidity and healthcare utilization.^{3,4} Evidence suggests that patient experience and outcomes improve and costs are contained when behavioral and medical problems are addressed together.⁵⁻⁹

Under the Affordable Care Act, new organizations, such as accountable care organizations (ACOs), have emerged. ACOs are groups of doctors, hospitals, and other healthcare organizations that partner to develop contractual arrangements and innovative payment methods (eg, global budgets) that encourage integration and aim to achieve better quality, improved patient experience, and lower costs.^{10,11} Despite responsibility for behavioral health, however, fewer than 15% of ACOs have integrated behavioral health and medical care, with one-third having no formal relationship with behavioral health provider groups.¹² This suggests there may be missed opportunities for ACOs to create systems to support integrated, whole-person care.¹³

Few studies have explored how ACOs support integration.¹⁴ Here, we examine the integration experiences of Medicaid ACOs in Oregon. We focus on Oregon because integrating behavioral health and medical care was an explicit mandate in the state legislation that created Oregon's Medicaid ACOs, called coordinated care organizations (CCOs). Among CCOs, this mandate increased efforts and investment in integration over the past 2 or more years. We studied the challenges CCOs faced in financing integration and the strategies they developed to support integrated care.

METHODS

Setting

In 2012, Oregon passed legislation creating 16 CCOs across the state through its Medicaid Section 1115 demonstration waiver. This

ABSTRACT

OBJECTIVES: This study describes challenges that coordinated care organizations (CCOs), a version of accountable care organizations, experienced when attempting to finance integrated care for Medicaid recipients in Oregon and the strategies they developed to address these barriers.

STUDY DESIGN: Cross-case comparative study.

METHODS: We conducted a cross-case comparative study of 5 diverse CCOs in Oregon. We interviewed key stakeholders: CCO leaders, practice leaders, and primary care and behavioral health clinicians. A multidisciplinary team analyzed data using an immersion-crystallization approach. Financial barriers to integrating care and strategies to address them emerged from this analysis. Findings were member-checked with a CCO integration workgroup to ensure wider applicability.

RESULTS: State legislation that initiated CCOs promoted integration expansion. CCOs, however, struggled to create sustainable funding mechanisms to support integration. This was due to regulatory and financial silos that persisted despite CCO global budget formation; concerns about actuarial soundness that limited reasonable, yet creative, uses of federal funds to support integration; and billing difficulties connected to licensing and documentation requirements for behavioral and mental health providers. Despite these barriers, CCOs, with the help of the state, supported expanding integrated care in primary care by using state funds to pilot test integration models and to promote alternative payment methodologies.

CONCLUSIONS: Oregon's CCO mandate included a focus on better integrating medical and behavioral healthcare for Medicaid recipients. Despite this intention, challenges exist in the financing of integration, many of which state and federal leaders can address through payment and regulatory reform.

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TAKEAWAY POINTS

Medicaid accountable care organizations (ACOs) face financial and regulatory barriers when integrating behavioral healthcare; however, opportunities remain for supporting and expanding integration despite these constraints. This work provides organization- and practice-level details of financial ACO barriers that have not been shown before.

- ▶ States can promote behavioral health integration among Medicaid ACOs by providing technical assistance to help ACOs leverage global budgets.
- ▶ Medicaid ACOs also must promote integration by investing in early pilot projects and internally reorganizing payment models.
- ▶ Consistent integration financing regulation across payers is needed.

waiver required CCOs to operate within an annual global budget, providing medical and behavioral healthcare to Medicaid beneficiaries (the state added oral health in 2014) and mandated a reduction in the Medicaid spending growth rate without a reduction in quality. Prespecified quality benchmarks were set, with upside and downside financial risk depending on whether or not CCOs met them.^{15,16} These features were intended to create a supportive environment for integrating behavioral and primary care, and these methods resembled regulatory mechanisms and financial incentives employed in other states.^{17,18}

Sample

We purposively selected 5 of the 16 CCOs to participate in this study. The Oregon Health Authority (OHA) knew which CCOs were working on integration. With their help, we selected CCOs that were taking steps to integrate care for their region. We used an iterative sampling process, selecting 1 CCO, collecting and analyzing data, then using this information to inform subsequent CCO selection to ensure maximum variation in our sample and to monitor when saturation—the point at which no new findings emerged from the data—was reached.

Data Collection

Between April and October 2014, we conducted 1-on-1 semi-structured interviews with 4 to 10 key stakeholders at each CCO ($n = 33$). We selected stakeholders to represent a range of viewpoints on CCO activities and included CCO leaders ($n = 19$) and primary care and behavioral health clinicians ($n = 14$). A multidisciplinary research team developed the interview guide (see [eAppendix](#) [eAppendices available at [ajmc.com](#)]) and conducted 1-hour interviews, most of which were conducted in person. Eight interviews were conducted over the telephone to accommodate scheduling. Upon completing interviews at each CCO, we debriefed to formulate preliminary thinking and select the next CCO for study. We made additions to the interview guide when new topic areas emerged during the interviews.

Data Management

Interviews were audio-recorded, professionally transcribed, de-identified, and entered into Atlas.ti version 7.0 (Atlas.ti Scientific

Software Development GmbH; Berlin, Germany) for analysis. The Institutional Review Board at Oregon Health & Science University approved this study protocol.

Data Analysis

We used an immersion-crystallization approach whereby our research team analyzed the data, without a priori presuppositions of what was important and why, and continued this process until themes or a patterned set

of findings emerged.¹⁹ First, the team analyzed data for each CCO. We did this together, discussing key interview passages and, giving them a name, ultimately developed a code list. When codes and definitions were clear, and we applied them similarly during analysis (after reviewing approximately one-third of the data together), we transitioned to having 3 study team members independently code the remaining data, holding weekly meetings to ensure reliability, discuss analytical questions, and identify emerging findings.

Second, the team conducted a cross-CCO analysis, examining how themes manifested across CCOs. We developed a matrix to compare CCOs on dimensions that were emerging as important (eg, integration approach, access to psychiatry and other specialty services, challenges in financing integration). This table included characteristics of the CCO (eg, size of CCO, organizational structure, location). Finally, we prepared preliminary findings and shared them with a leadership group of clinicians and managers with hands-on experience integrating care who represented CCOs across Oregon. This allowed us to member-check and assured the transportability of findings. Stakeholders agreed that the presented findings aligned with their experience and helped us identify areas where more details were needed. We re-analyzed our data and followed up with key informants, as needed, to refine the results.

RESULTS

As shown in [Table 1](#), CCOs varied in size, organizational structure, geographic location, and experience with integration. We conducted interviews with key stakeholders at each CCO. [Table 2](#) shows the number of interviews and selected stakeholders within each CCO, with variations shaped by CCO organizational structure, size, and presence of integration infrastructure. We found that some CCOs were planning their integration efforts, while others were experimenting with fully integrated clinics and alternative payment models (APMs).

Practices within CCOs were reorganizing care delivery in several ways. As [Table 3](#) shows, CCOs were contracting with community mental health centers (CMHCs) or other mental health

TABLE 1. Coordinated Care Organization Characteristics

Organization Type ^a	CCO 1 Community Stakeholder-Led	CCO 2 Health Plan-Led	CCO 3 Community Stakeholder-Led	CCO 4 Health Plan-Led	CCO 5 IPA-Led
Membership size (2016) ^b	Medium	Large	Small	Small	Large
Geographic size ^c	Large	Medium	Small	Small	Large
Census designation	Rural	Urban	Rural	Mix ^d	Mix ^d
Multiple CCOs in the region	No	Yes	No	Yes	No
Extent of psychiatry service integration	Planned advanced integration ^e	Planned remote ^f consultation	None	Advanced integration, ^e active remote consultation ^f	Active remote ^f consultation

CCO indicates coordinated care organization; IPA, independent practice association.

^aHealth plan-led creates a new line of business from an existing health plan present in the region prior to the formation of the CCO; IPA-led primarily developed from an existing IPA in the region; community stakeholder-led brings together a group of community-based stakeholders.

^bDefinitions for small, medium, and large membership are as follows: small, <25,000 members; medium, 25,000-50,000 members; large, >50,000 members.

^cOur definitions for small, medium, and large geographic size of the CCO is as follows: small, <3000 square miles; medium, 3000-5000 square miles; large, >5000 square miles.

^dMix census designation refers to CCOs in which there is a mix of rural and urban zip codes.

^eMental health prescriber embedded into a Federally Qualified Health Center.

^fRemote consultation by primary care clinicians and/or behavioral health clinicians via either electronic health record or telephone.

organizations to embed mental health providers in regional schools; primary care clinics were bringing behavioral health clinicians (BHCs) onsite by hiring them directly or contracting with local mental health organizations; CMHCs did the same with primary care clinicians. In our interviews, stakeholders rarely described implementing specific integration models (eg, the collaborative care model); they defined behavioral health more generally, at times including mental health and substance use, and described the role of brief interventions by BHCs in primary care clinics and the delivery of basic primary care in CMHCs. With regard to access to psychiatric services, primary care stakeholders acknowledged that a small portion of their population needed these services, but psychiatric services were scarce. CCOs and practices were developing pathways to psychiatry for their patients, either through virtual connections (eg, telepsychiatry), consultation models, or by developing stronger relationships with regional mental health organizations that employed psychiatrists.

Stakeholders expressed widespread support for integration and optimism for global budgets to promote it: “What I’m hoping is that the CCO model will allow for some increased flexibility where we can just use our global budget to put the money where we think... there’ll be a payoff for the Triple Aim” (CCO 2, behavioral health director). We found, however, that CCOs’ new global budgets had not yet yielded this hoped-for flexibility to remodel care, and those CCOs and clinicians faced barriers to integration.

CCO Barriers to Integration

CCO stakeholders reported similar barriers to integrating behavioral health and medical care. These included structural financial barriers rooted in pre-CCO contracts, regulatory restrictions that affected reimbursement, and federal limitations on flexible funds, which some CCOs planned to use for integration. **Table 4** summarizes these barriers, which we describe in more detail below.

Pre-CCO contract structures and silos. Despite the introduction of global budgets, respondents described care delivery systems in which pre-CCO contract structures remained largely intact. In these structures, primary care, mental health, and substance abuse treatment organizations provided care separately, operating with independent funding sources, coding and billing systems, documentation requirements, and provider licensing and credentialing systems: “For so long it has been: ‘Here’s the funding for medical, here’s the funding for substance abuse, and here’s the funding for mental health.’ The idea was that those silos would go away. And that still has not happened. So the frustrating part is we all come to the table to coordinate care around a specific individual, and we’re still stuck in these silos” (CCO 1, CMHC clinical director).

TABLE 2. Stakeholder Interviews by Coordinated Care Organization and Role

Stakeholder Job Type	CCO 1	CCO 2	CCO 3	CCO 4	CCO 5
CCO CEO	1		1		
CCO Innovation/BH director	1	1	1		3 ^a
CCO medical director				1	
Other CCO leadership position [eg, quality improvement director, program coordinator]	3	1	1	1	1
CMHC leadership	2	1	2	2	2
Primary care practice manager					1
Primary care BHC	2	1	1	1	2
Primary care physician			1		1
Total	9	4	7	5	10

BH indicates behavioral health; BHC, behavioral health clinician; CCO, co-ordinated care organization; CEO, chief executive officer; CMHC, community mental health center.

^aThere were 3 behavioral health integration leadership positions in this CCO.

TABLE 3. Coordinated Care Organization Approaches to Integration

CCO	Approach to Integration
CCO 1	<ul style="list-style-type: none"> • Both co-located and integrated BHCs are present in primary care settings. • CCO partnership exists with a local university to integrate recent psychology graduates in primary care as BHCs. • CCO assisted with the placement of a BHC into a maternity medical home. • One CMHC embedded a NP, employed by a local FQHC,⁵ to provide primary care services for their SPMI population. • One FQHC works with a CMHC to integrate a BHC who uses the same EHR as primary care providers. These 2 organizations have a prior history of collaboration. • CCO placed QMHPs in multiple schools; the QMHPs are contracted with CMHCs and are under the supervision of a licensed provider. • For patients seen in the ED who receive a BH assessment, a BHC follows up with an appointment in the primary care office.
CCO 2	<ul style="list-style-type: none"> • BHC employed by CMHC is co-located within an FQHC to provide brief interventions, but uses the CMHC EHR. The BHC has a weekly consult with a psychiatrist to discuss complex patients. • BHC is co-located part time within a women's health center to provide brief interventions and counseling. • One FQHC hired a psychiatric NP and a LCSW prior to CCO formation. Both are integrated into the practice and use the same EHR as medical providers. • CCO 2 and another CCO collaborate to place a NP in the CMHC part time.
CCO 3	<ul style="list-style-type: none"> • Three part-time BHCs employed by a CMHC are co-located within a primary care practice and provide brief interventions and short-term counseling. • A CMHC embedded a PCP from a local primary care practice to care for their SPMI population. • A second CMHC hired and embedded a PCP, 2 nurses, a social worker, a patient coordinator, and multiple peer support specialists to work with SPMI patients. • A multispecialty physician group is working with 3 mental health organizations to embed BHCs into their practice. • A primary care practice hired a BHC who is fully integrated into the practice; the BHC has remote access to a psychiatrist who is available to assist with complex patients. • A pediatric practice hired a child psychologist and a BH care manager who work alongside a full-time child psychologist resident. • Local substance-abuse agency used CCO start-up funds to establish a primary care clinic staffed by NPs and an open-access BH clinic.
CCO 4	<ul style="list-style-type: none"> • CCO has an internal BH team co-located with physical health providers at the health plan who centrally manage patients receiving BH services across the CCO, specifically high-needs patients and high utilizers. • This CCO conducted an exploratory meeting with an in-network BH organization to explore BH integration; they are developing future plans.
CCO 5	<ul style="list-style-type: none"> • A primary care practice fully integrated 3 part-time BHCs employed by the CMHC; the BHCs use the same EHR and share physical space with the physical health providers. This practice started integration prior to the formation of the CCO. • One CMHC co-located 2 part-time BHCs into a primary care practice; they conduct mental health assessments and schedule 50-minute appointments. • A pediatric practice hired a psychiatric NP using PMPM payments to cover their costs. • One CMHC embedded a BHC into 3 primary care practices. The BHC is at each practice 1 day per week. • Two counties provide BH services in school-based programs.

BH indicates behavioral health; BHC, behavioral health clinician; CCO, coordinated care organization; CMHC, community mental health center; ED, emergency department; EHR, electronic health record; FQHC, Federally Qualified Health Center; LCSW, licensed clinical social worker; NP, nurse practitioner; PCP, primary care provider; PMPM, per member per month; QMHP, qualified mental health professional; SPMI, severe and persistent mental illness.

Other CCO stakeholders shared similar experiences. Specifically, funding earmarked for CMHCs continued, in most cases, to pass through pre-CCO structures: "Mental health is primarily provided by the county. And a large portion, like 88%, of what the CCO gets from the state for behavioral health is just passed on through to the county" (CCO 3, director of integration).

One reason historical structures remained intact was that mental health and primary care organizations had not previously worked together or built relationships to negotiate structural changes and contracts were sensitive topics and difficult to change. There was a fear that if CCOs directed more funding to primary care for behavioral health services, this would further deplete funding organizations that serve patients with more severe and persistent mental illness. For these reasons, pre-CCO contracts and structures persisted in the new system.

Licensing restrictions and reimbursement. Stakeholders trying to integrate care described a range of licensing, credentialing, and billing restrictions that made it difficult for clinics to receive reimbursement for providing integrated care. These barriers manifested differently based on the setting and integration approach.

Most primary care practices approached integration in 1 of 2 ways: hiring a BHC or contracting for their services with a CMHC. To bill for services, practices had to hire licensed BHCs. Participants reported that reimbursement rates using traditional billing codes did not cover costs: "The reimbursements are just miserable...Some of the clinics are getting [a] 30% return on the billable services" (CCO 3, behavioral health director). At the time of this study, only CCO 5 described exploring options for increasing reimbursement rates for these codes.

A second approach to integration was to contract with a CMHC to embed a BHC in a primary care practice; the BHC remained the employee of the CMHC. In this arrangement, unlicensed BHCs could bill because they operated under the remote supervision of a licensed provider at the CMHC: "We can have someone with a bachelor's degree providing

a Medicaid service. We can [bill] Medicaid on that because the assessment and the treatment plan are set up and collect a certain boatload of data, or information, and is signed off on by both a licensed clinician and a licensed healthcare provider, like a doctor, within certain timeframes” (CCO 4, CMHC director).

However, this approach limited other integration activities, such as warm hand-offs and brief interventions, because it required BHCs to complete lengthy intake assessments to satisfy CMHC documentation requirements. Diagnosis and medical justification were required for billing, and participants found these federal documentation requirements incompatible with primary care clinics’ desired integration model, which focused on brief interventions by BHCs.

Federal limitations on funding flexibility within global budgets.

The Oregon Medicaid waiver allowed CCOs to pay for nonbillable services without traditionally required encounter and billing data.¹⁵ Federal actuarial reviews, however, required these data to prove that Medicaid capitated rates were actuarially sound. CCO stakeholders were concerned about defending their use of flexible funds for integration without assurances that traditional billing codes and encounter level data would not be required: “...What really can be considered a flexible service? And that’s a real problem. And whether or not that’s going to be defensible under the actuarial soundness reviews” (CCO 3, CMHC director). Participants heard contradictory messages from the federal government regarding flexible fund use that included both a requirement to comply with actuarial regulations and an understanding that integration requires regulatory flexibility. CCO leaders feared losing funding or being penalized if they were unable to justify integrated services during these reviews.

CCO Support for Integration

In response to these barriers, stakeholders reported that CCOs were facilitating integration through financing experimentation, allowing practices to explore new care models, and mitigating the immediate need to bill for services.

Integration Financing Experimentation

CCOs were exploring ways to fund integration, which included grant funding, traditional fee-for-service billing, experimentation with APMs, and lobbying the state to “open” (reimburse for) additional billing codes to finance integration. The most common strategy for supporting integration was grant funding. CCOs relied on grants to jump-start integration efforts and circumnavigate financial barriers. Much of this funding came via state general funds allocated by the legislature in 2013, often referred to as “transformation” funds. One CCO used these funds to hire BHCs within its primary care practices. Another CCO paid for part of a psychiatrist’s salary to provide nonbillable consultation services. Participants from CCOs that used grant funding to finance

TABLE 4. Summary of Financial Challenges

CCO Financial Challenges to Behavioral Health Integration

- Pre-CCO contracts that promote siloed funding
- Continuation of pass-through funding to mental health agencies within CCO global budgets
- Requirement for BHC licensure in single-organization model
- Low FFS reimbursement rates for BHC services (single-organization model)
- Lengthy documentation requirements for reimbursement that hinder integration activities (2-organization model)
- Confusion around acceptable uses of flexible funds for integration when needing to comply with federal actuarial soundness reviews

BHC indicates behavioral health clinician; CCO, coordinated care organization; FFS, fee-for-service.

integration voiced concerns about sustainability: “We’ve got to figure out how these positions can somehow pay for themselves... The transformation grant money is going to run out at some point, and the trick is to try to show that these things are worth it in some way, to have somebody keep paying for it” (CCO 4, CCO medical director). They worried that funding would end before payment systems within CCOs adapted to support integrated care.

Stakeholders reported that CCOs were facilitating the transition from grant funding toward APMs. One CCO administrator described their role as follows: “I think people know, clinically, that [integration] is what we want and what’s best for our folks. It’s hard sometimes, though, to get the financial [aligned] with the clinical need. That’s a real big way that the CCO is empowering providers, by giving them the financial glide path to begin this process while the CCO really looks at completely revamping how Medicaid reimbursement happens” (CCO 3, director of integration).

CCOs created this “financial glide path” in different ways. One CCO used funds previously funneled back to practices as a bonus payment to pay them for unbillable integration components while asking them to collect data that could inform the transition to APMs in the future: “[The practices] will test the integration model and will test a per-member-per-month payment approach and help us move...[to] get more ready to throw that switch and say, ‘This is how we’re going to pay everyone’” (CCO 5, behavioral health director).

Another CCO created a tiered system for primary care practices. Higher-tier practices, farther along the medical home transformation process, had greater opportunity for advanced payment, while lower-tier practices received more CCO financial support. The goal of such programs was to advance clinics toward more sustainable integration models and payment structures.

DISCUSSION

ACOs offer the potential for improved care by promoting alternative payment structures that remove traditional silos between medical and behavioral healthcare. Our study demonstrates this

potential and highlights the complexities involved in executing this transformation. Global budgets, intended to provide flexibility for APMs and improve sustainability of integration efforts,¹⁶ confront numerous barriers, including preexisting contract structures, differing views about blending budgets, licensing and documentation requirements, and unclear billing rules for flexible payments. Despite differences across the CCOs, stakeholders reported experiencing similar barriers to exploring new payment models in the early years, and integration efforts relied heavily on short-term grant funding to support experimentation. These findings expand on previous work by Lewis et al, which described the lack of behavioral health integration in ACOs by providing insight into the challenges slowing adoption across ACOs in the United States.¹²

In managing ACO reform, we observed tension between promoting local autonomy and the need for state intervention or assistance. Advocacy with federal leaders may be the state's role, but our study's results suggest that to address integration barriers, ACOs must prioritize and promote integration, using their own funds to support this transition. This requires collaborating with both the state and provider groups to identify financing approaches, both gradual and expedited, to accommodate the varying levels of delivery system and alternative payment readiness among practices.

Research and policy interventions can help address integration obstacles. This includes research to understand how to expand integration within ACOs that have shown less interest, policy changes that provide technical assistance to help CCOs leverage global budgets, incentives to expand integration, and state advocacy with federal leaders to refine flexible spending requirements. In addition, leaders can shape payer policies and payment structures across payers to create consistency and minimize the extent to which ACOs responsible for Medicaid patients are not subsidizing integration for other payers.

Limitations

ACO programs and state policies are rapidly changing, and our findings represent an early view of integration that may have changed since we conducted this study. In addition, there were many simultaneous changes occurring in this environment. For instance, Federally Qualified Health Centers in Oregon were experimenting with APMs, and this shaped practices' integration efforts.

To the extent possible, we took steps to separate CCO efforts from other state innovations. The majority of CCOs in our sample were motivated to integrate care. Although this is a near-perfect sample for studying the barriers to integrating care, we need more research directed at studying ACOs that are not integrating care as quickly.

We also found that specific integration models were not being implemented by CCOs or their affiliated practices. It is likely that practices do not implement a specific integration approach; they

tend to adapt models to fit their unique circumstances and settings.²⁰ Yet, Oregon passed legislation in 2015 (S.B. 832) directing OHA to use the bill's definition of integration to develop standards for certified primary care homes and behavioral health homes integrating care, suggesting that some requirements for integration implementation are needed. Future research could examine how this legislation leads to changes in integration approaches implemented among practices.

Finally, the sample of people we interviewed did not include substance use providers, as this group was not yet centrally involved with CCO integration efforts. More research is needed to understand the silos that exist for substance use services in ACOs.

CONCLUSIONS

Oregon's CCO global budgets do not eliminate long-standing silos between behavioral and primary healthcare, nor do they create financial or organizational flexibility for clinics, where it matters most. We need systemic reform in the United States to expand alternative payment methods at the clinic level and support the provision of truly integrated whole-patient care. ■

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eAppendix

Behavioral Health Integration Scan Interview Guide

The questions below are the general topic areas we will explore with interview participants. These questions will be modified in light of what is learned during the interview and to fit the expertise of the interviewee.

Opening:

Thank you for participating in this interview. We are talking with you today because we are interested in your experiences with behavioral health integration. During the interview, we will ask you to tell us a little bit about yourself and your thoughts and experiences with behavioral health integration work in your CCO.

1. First, please tell us about yourself.

- What is your background and training?
- How long have you been working for this organization?
- What is your current role in the organization/CCO?

2. Can you tell me how you define behavioral health, mental health, and how you distinguish the two?

[Interviewer: At this point, clarify for interviewee that you will be using the term “behavior health” to refer to all behavioral and mental health, health behavior and substance use services.]

3. What is currently being done to integrate behavioral health services into your organization/the CCO?

- What activities and initiatives are happening to integrate behavioral health?
- When did these changes take place?
- What role does integrating primary care into behavioral health play?

4. What is your organization’s/the CCO’s vision for behavioral health integration?

- What does it look like at year 1? What does it look like at year 5?
- How does your organization/CCO plan to carry out this vision?

- Providers: What do you know about the CCO's vision for behavioral health integration? Who sets that vision?
- What are the next steps?
- Please describe any upcoming strategies or initiatives.

5. How has the CCO engaged providers in BH integration efforts?

- Please describe any CCO led behavioral health integration outreach efforts.
 - CCO: What outreach activities are happening?
 - CCO: Who are you engaging?
 - Providers: Who's contacted you?
 - Providers: What have you learned?

6. What are the current strengths of behavioral health integration in your organization/the CCO?

7. What are the current challenges to integrating behavioral health in your organization/the CCO?

- Please describe any challenges related to:
 - Payment
 - Documentation
 - Geography
 - Workforce
 - Data and analytics.

8. Please describe your experience with behavioral health CCO metrics.

- What other metrics/measures would be of value to you and why?

9. What type of external assistance would be helpful for delivering integrated behavioral health and primary care?

- What would you find beneficial for furthering behavioral health integration efforts?
- What would help your CCO overcome some of the challenges you described?