

Mental Health in ACOs: Missed Opportunities and Low-Hanging Fruit

Allison N. O'Donnell, MPH; Brent C. Williams, MD; Daniel Eisenberg, PhD;
and Amy M. Kilbourne, PhD, MPH

The Patient Protection and Affordable Care Act (PPACA) has the potential to transform health-care delivery in the US, but achieving better access to and quality of care for millions of Americans who are uninsured or underinsured will ultimately depend on how it is implemented. A key provision of the PPACA is the Medicare Shared Savings Program (MSSP), allowing the formation of accountable care organizations (ACOs),¹ which facilitate care coordination across provider settings and link reimbursement to quality improvement and reductions in healthcare costs for an assigned population of Medicare patients.² ACOs are organized around the patient-centered medical home (PCMH) model, which focuses on organizing care around patients and the use of continuous, anticipatory, team-based care that seeks to improve quality and outcomes.³

Mental healthcare warrants careful consideration in the design of ACOs. Mental disorders, including depression, anxiety disorders, and substance abuse disorders, are the leading causes of disability worldwide, are associated with increased medical care and employer costs, and lead to premature mortality.⁴⁻⁶ Roughly 1 in 4 primary care patients suffer from a mental disorder, and over two-thirds of those with mental disorders also experience general medical conditions.⁷ For many persons suffering from mental disorders, primary care is the de facto source of care because of stigma concerns and limited access to mental health providers.⁸ In order for ACOs and the medical home to achieve the “triple aim” of improved care for patients and populations at lower cost,⁹ mental healthcare¹⁰ must be integrated within PCMHs.¹¹

Central to operationalizing an effective patient-centered medical home model that integrates mental healthcare is the Chronic Care Model (CCM). The CCM was developed in response to the tendency of medical care to prioritize acute symptoms and concerns of the patient over the need to provide optimal care to properly manage chronic conditions.¹² The CCM promotes enhanced access and continuity through delivery system redesign; identification and management of patient populations through clinical information systems and measurement-based care; planning and management of

care using provider decision support guidelines; provision of self-management support, and linkages to community resources; tracking and coordination of care; and measurement and improvement of performance. Not surprisingly, the CCM is an effective model for integrating mental health in primary care settings by helping providers to identify high-risk patients quickly and provide them with access to appropriate treatments such as medications and self-management support through a care manager that works primarily by enhancing access to evidence-based treatments.¹³ A recent meta-analysis and systematic review found that the CCM improved physical and mental health outcomes across a wide range of mental health diagnoses and treatment settings (eg, primary care), with little to no net healthcare costs, making it an ideal model in which to operationalize medical homes within ACOs.¹⁴ However, the CCM and mental healthcare in general have not been specifically addressed in ACO incentives strategies.¹

The goal of this paper is to describe the potential benefits from integration of mental health services into ACOs, and how healthcare organizations can support the implementation of integrated mental healthcare programs.

Low-Hanging Fruit: Incentives to and Benefits of Integrated Mental Healthcare in ACOs

Integrated mental healthcare in ACOs stands to impact consumers, providers, and ACOs in a number of ways. *Integrated mental healthcare* refers to a range of practice models that include direct involvement of mental health and primary care physicians in collaborative, ongoing care of selected patients. Integrated mental health models have been demonstrated to improve medical¹⁵ and mental health outcomes, particularly depression, the most studied mental health condition.¹⁶ In addition, the CCM has been shown to improve treatment outcomes for patients with serious mental illness, such as bipolar depression,¹⁷ but will likely require augmentation for those with schizophrenia or more severe mental illnesses.

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Mental Healthcare Under Current ACO Models—Missed Opportunities.

Explicit incentives for improved mental healthcare under CMS regulations governing ACOs are primarily related to quality measures of depression screening and patient satisfaction.¹⁸ The only ACO performance measure under the MSSP focusing on mental healthcare requires screening for depression and documentation of a follow-up treatment plan, which may lead to improved outcomes among patients with mental illness.¹⁹ However, incentives for improving mental healthcare beyond screening across the wider range of type and severity of mental health conditions were not incorporated into the MSSP ACO final rule released in November 2011.¹ At best, it may be argued that many of the ACO quality measures, such as patient/caregiver experience via communication with physician, physician ratings, and shared decision making may improve mental healthcare delivery and patient satisfaction.²⁰ Lack of explicit regulations and incentives for mental health in the ACO rules represent a serious missed opportunity.

New Opportunities for Cost-Effective Provider Mix—Low-Hanging Fruit. While mental health was not explicitly incorporated into the ACO rules, the MSSP may facilitate key components of integrated mental healthcare by moving away from fee-for-service (FFS) reimbursement. Moving away from FFS reimbursement will allow utilization of care managers to carry out traditionally non-billable tasks. Care managers come from a variety of backgrounds and are often bachelor's degree nurses, clinical social workers, health educators, or advanced practice nurses.²¹ They are responsible for carrying out many of the components of the CCM, such as support of patient self-management and ongoing contact with patients and utilization of measurement-based care over time.²² Their incorporation will not only serve to improve patient outcomes, but also help to alleviate the burden²³ that primary care physicians (PCPs) often feel if they are expected to provide mental healthcare without adequate training, infrastructure, or assistance. However, there will likely be start-up costs associated with hiring and training care managers that will not qualify as billable services. It remains uncertain if these costs will be recuperated through savings down the line.

ACO Cost Implications. The Medicare Shared Savings Program coupled with an appropriate reimbursement model may help ACOs reduce unnecessary costs among high-risk patients with comorbid chronic illness. Due to the high financial and health costs of poorly treated chronic

Take-Away Points

Accountable care organizations (ACOs) should include integrated mental health services to achieve the goal of improved healthcare quality and outcomes.

- Mental health has largely been left out of the discussion and formation of the ACO.
- A range of successful care models integrating mental health and medical services have been developed.
- The Chronic Care Model can be used to operationalize integrated mental health in the medical home.
- The structural and financial features of ACOs provide opportunities to more effectively integrate mental health services into routine care delivery models.

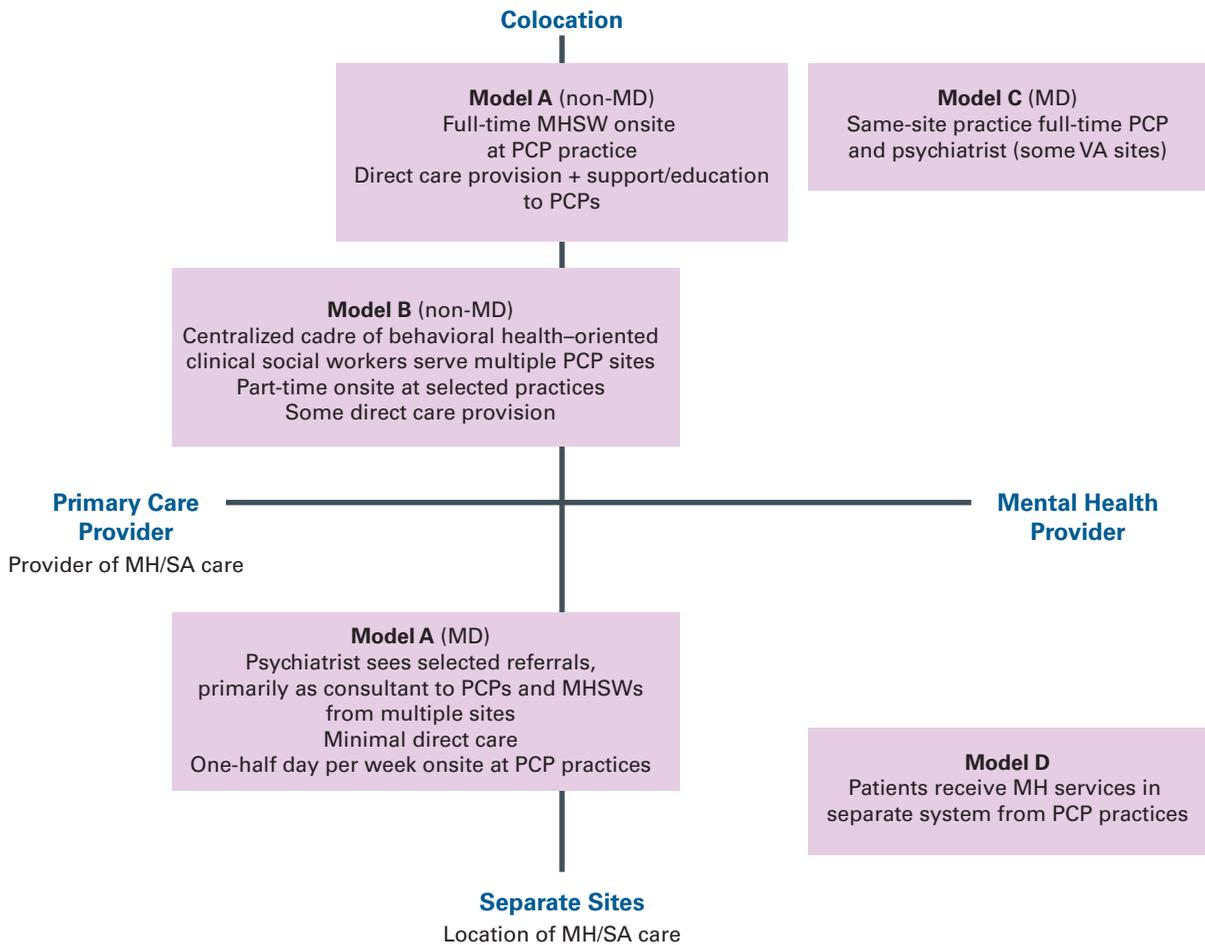
mental and physical health conditions, it is unlikely that ACOs will be able to meet quality measures, and benefit from shared savings, without adequately addressing mental health.²⁴ Given the high cost of hospital inpatient stays and the disproportionate number of patients with mental disorders who are hospitalized,^{6,25} ACOs that are able to reduce hospital admissions through better coordination of care for those with mental disorders stand to improve care and possibly reduce unnecessary costs.²⁶ However, the evidence that added investments of the CCM will lead to reduced overall healthcare costs within the MSSP has not been fully realized. Prior studies on integrated mental health based on the CCM model suggest that quality and outcomes improve, with costs either declining, remaining the same, or at worst increasing slightly.¹³ The reasons for variation in these cost outcomes have not been fully explored but most of these studies were conducted in closed healthcare systems with sufficient infrastructure already in place to adopt core complements of the CCM, including information systems. The general consensus is that the CCM costs more in the first year of implementation due to start-up costs associated with practice redesign including the setup of a clinical registry to track patients, as well as the hiring of care managers.

Financial and Organizational Models of Integrated Mental Healthcare

A lack of emphasis on mental health in the ACO final rule represents a missed opportunity to champion integrated mental healthcare. However, there are numerous models that ACOs can adopt to support integrated mental healthcare in the medical home.

Financial Models of Integration. To fully realize the potential of ACOs, the MSSP needs to be coupled with an appropriate reimbursement model to integrate mental healthcare. Potential non-FFS payment schemes are defined and discussed in depth elsewhere and have been broadly classified as: 1) fee-for-service, plus management fee, plus performance fees; 2) the Prometheus-Evidence Informed Case Rate Model; 3) the Risk-Adjusted Comprehensive Payment and Bonus

■ **Figure.** Spectrum of Integrated Mental Health Models and Examples



MH indicates mental health; SW, social worker/care manager; PCP, primary care physician; SA, substance abuse.
 Model A, Washtenaw Community Health Organization Integrated Care Model.³³
 Model B, University of Michigan Complex Care Management Program.³⁴
 Model C, VA model.³⁵
 Model D, Traditional model.

Model; and the 4) ACO model.²⁷ Various aspects of each may be more or less favorable to integrated mental healthcare. In general, models that contain FFS are arguably the most palatable because they require no extreme overhaul of the current billing system. However, continuation of the FFS model will perpetuate many of the challenges of billing for mental health in the primary care setting.²⁸ Further financial incentives exist, such as bundled payments, pay-for-performance, and gain-sharing.²⁹ The most appropriate model for any given ACO and payer partnership will vary depending on local culture and practice, and may include a combination of the models presented above or additional innovations.³⁰ While ACOs formed in the private insurance industry may have more freedom to set financial parameters than ACOs under the MSSP, the majority of private health plans use mental health ben-

efit carve-outs—contracts with outside providers to provide mental healthcare—which can present barriers to integrated mental healthcare.³¹

Organizational Models of Integration. In addition to the financial models of reimbursement, it will also be important for ACOs to consider the most appropriate organizational model of mental health integration. There are numerous structural models to support mental health integration into primary care, such as improving collaboration between separate providers; medical-provided behavioral healthcare; collocation of mental health professionals in primary care settings; disease management; reverse collocation of primary care in mental health settings; unified primary care and behavioral health; primary care behavioral health; and a collaborative system of care.³² Many of these models are based on the CCM.

The structure and function of clinical models for integrated care may be described along 3 dimensions (Figure³³⁻³⁵): a) whether practitioners work at the same practice site; b) whether mental health services are delivered by mental health professionals or primary care providers supported by mental health professionals; and c) the type of mental health professional (nonphysician vs physician). The optimal integrated care model for a given ACO will depend significantly on local configuration of providers, location of practice, communication infrastructure, and electronic medical record system.

Several programs of demonstrated feasibility are used to illustrate alternative models of integrated care (Figure 1). The Washtenaw Community Health Organization's Integrated Care Model (Model A) places a full-time mental health social worker (MHSW), and a one half-day per week psychiatrist, at safety net primary care sites.³³ The model focuses on enhancing skills and confidence of PCPs in providing mental health services, with onsite support for PCPs and short-term patient interventions by mental health providers. In a second model, implemented at the University of Michigan through its Complex Care Management Program (Model B), high-utilizing, low-income patients with complex mental health and medical needs are provided ongoing behavioral management and care coordination by a centrally located group of social work care managers with training in mental and behavioral health.³⁴ The care managers focus on directing a consistent behavioral health plan and improving coordination of mental and medical health care across providers. Finally, a model placing a full-time PCP in a mental health setting has been utilized in the VA (Model C).³⁵

CONCLUSIONS

Now is the time to effectively incorporate mental health into the general medical setting by taking advantage of the incentives offered by the ACO MSSP. Many attempts to integrate have been made in the past with little widespread and sustained success. If ACOs are to effectively live up to their promise of providing value-based care, mental health services need to be integrated into medical homes. The CCM, the key operational model under the medical home, can guide the organizational transformation of ACOs to incorporate integrated mental healthcare. It is therefore vital that decision makers across care settings include mental healthcare in the development of ACOs in order to realize the full potential of these emerging organizations. At the same time policy makers should consider incentivizing organizations up front, particularly through coverage of start-up costs associated with CCM

implementation such as care management in order to facilitate the adoption of integrated mental healthcare over the long term.

Author Affiliations: From VA Ann Arbor Center for Clinical Management Research (ANO, AMK), Ann Arbor, MI; Department of Internal Medicine (BCW), University of Michigan Health System, Ann Arbor, MI; Department of Health Management and Policy (DE), University of Michigan School of Public Health, Ann Arbor, MI; and Department of Psychiatry (AMK), University of Michigan Medical School, Ann Arbor, MI.

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Address correspondence to: Amy M. Kilbourne, PhD, MPH, VA Ann Arbor Center for Clinical Management Research, N Campus Research Complex, 2800 Plymouth Rd, Bldg 14, Ann Arbor, MI 48109-2800. E-mail: amykilbo@umich.edu.

REFERENCES

- Centers for Medicare & Medicaid Services. 42 CFR Part 425. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations. <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>. Published 2011. Accessed August 1, 2012.
- Berwick DM. Making good on ACOs' promise—the final rule for the Medicare shared savings program. *N Engl J Med*. 2011;365(19):1753-1756.
- Dickinson WP, Miller BF. Comprehensiveness and continuity of care and the inseparability of mental and behavioral health from the patient-centered medical home. *Fam Syst Health*. 2010;28(4):348-355.
- World Health Organization. Depression. http://www.who.int/mental_health/management/depression/definition/en/. Published 2010. Accessed August 1, 2012.
- Grabe HJ, Baumeister SE, John U, Freyberger HJ, Völzke H. Association of mental distress with health care utilization and costs: a 5-year observation in a general population. *Soc Psychiatry Psychiatr Epidemiol*. 2009;44(10):835-844.
- Parks J, Svendsen D, Singer P, Foti ME. *Morbidity and Mortality in People with Serious Mental Illness*. Alexandria, VA: National Association of State Mental Health Program Directors; 2006.
- Kessler RC, Berglund P, Chiu WT, et al. The US National Comorbidity Survey Replication (NCS-R): design and field procedures. *Int J Methods Psychiatr Res*. 2004;13(2):69-92.
- Wang PS, Lane M, Olfson M, Pincus HA, Wells KB, Kessler RC. Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):629-640.
- Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff (Millwood)*. 2008;27(3):759-769.
- Glied S, Herzog K, Frank R. Review: the net benefits of depression management in primary care. *Med Care Res Rev*. 2010;67(3):251-274.
- Brown Levey S, Miller B, deGruy F. Behavioral health integration: an essential element of population-based healthcare redesign. *Translational Behavioral Medicine*. 2012;2(3):364-371.
- Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. *JAMA*. 2002;288(14):1775-1779.
- Katon W, Unützer J, Wells K, Jones L. Collaborative depression care: history, evolution and ways to enhance dissemination and sustainability. *Gen Hosp Psychiatry*. 2010;32(5):456-464.

14. Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, Bauer MS. Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *Am J Psychiatry*. 2012;169(8):790-804.
15. Druss BG, Rohrbach RM, Levinson CM, Rosenheck RA. Integrated medical care for patients with serious psychiatric illness: a randomized trial. *Arch Gen Psychiatry*. 2001;58(9):861-868.
16. Badamgarav E, Weingarten SR, Henning JM, et al. Effectiveness of disease management programs in depression: a systematic review. *Am J Psychiatry*. 2003;160(12):2080-2090.
17. Kilbourne AM, Biswas K, Pirraglia PA, Sajatovic M, Williford WO, Bauer MS. Is the collaborative chronic care model effective for patients with bipolar disorder and co-occurring conditions? *J Affect Disord*. 2009;112(1-3):256-261.
18. RTI International. Accountable Care Organization 2012 Program Analysis: Quality Performance Standards, Narrative Measure Specifications. http://www.cms.gov/medicare/medicare-fee-for-service-payment/sharesavingsprogram/downloads/aco_qualitymeasures.pdf. Published 2012. Accessed May 7, 2012.
19. US Preventive Services Task Force. Screening for depression: recommendations and rationale. *Ann Intern Med*. 2002;136(10):760-764.
20. Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on outcomes. *J Fam Pract*. 2000;49(9):796-804.
21. Bachman J, Pincus HA, Houtsinger JK, Unützer J. Funding mechanisms for depression care management: opportunities and challenges. *Gen Hosp Psychiatry*. 2006;28(4):278-288.
22. Nutting PA, Gallagher K, Riley K, et al. Care management for depression in primary care practice: findings from the RESPECT-Depression trial. *Ann Fam Med*. 2008;6(1):30-37.
23. Sansone RA, Forbis JS, Sosa T. Primary care perspectives on treating bipolar disorder: a cross-sectional survey. *Prim Care Companion CNS Disord*. 2011;13(2). pii: PCC.10m01072.
24. Hunter CL, Goodie JL. Operational and clinical components for integrated-collaborative behavioral healthcare in the patient-centered medical home. *Fam Syst Health*. 2010;28(4):308-321.
25. Bryant-Comstock L, Stender M, Devercelli G. Health care utilization and costs among privately insured patients with bipolar I disorder. *Bipolar Disord*. 2002;4(6):398-405.
26. Pallak MS, Cummings NA, Dörken H, Henke CJ. Medical costs, Medicaid, and managed mental health treatment: the Hawaii study. *Manag Care Q*. 1994;2(2):64-70.
27. The Commonwealth Fund. Better to Best: Value Driving Elements of the Patient Centered Medical Home and Accountable Care Organizations. http://www.pcpcc.net/files/better_best_guide_full_2011.pdf. Published 2011. Accessed May 10, 2012.
28. Meadows T, Valleley R, Haack MK, Thorson R, Evans J. Physician "costs" in providing behavioral health in primary care. *Clin Pediatr (Phila)*. 2011;50(5):447-455.
29. Korda H, Eldridge GN. Payment incentives and integrated care delivery: levers for health system reform and cost containment. *Inquiry*. 2011-2012;48(4):277-287.
30. Devore S, Champion RW. Driving population health through accountable care organizations. *Health Aff (Millwood)*. 2011;30(1):41-50.
31. Frank RG, Garfield RL. Managed behavioral health care carve-outs: past performance and future prospects. *Annu Rev Public Health*. 2007;28:303-320.
32. Collins C, Levis Hewson D, Munger R, Wade T. Evolving Models of Behavioral Health Integration in Primary Care. New York, NY: Milbank Memorial Fund; 2010.
33. Grazier KL, Hegedus AM, Carli T, Neal D, Reynolds K. Integration of behavioral and physical health care for a medicaid population through a public-public partnership. *Psychiatr Serv*. 2003;54(11):1508-1512.
34. AHC Media, LLC. [HCM]-CM program keeps high utilizers out of hospital. <http://insurancenewsnet.com/article.aspx?id=348388>. Published June 29, 2012. Accessed August 7, 2012.
35. Druss BG, Rohrbach RM, Levinson CM, et al. Integrated medical care for patients with serious psychiatric illness: a randomized trial. *Arch Gen Psychiatry*. 2001;58(9):861-868. ■