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Mental Health in ACOs: Missed Opportunities and Low Hanging Fruit

Allison N. O'Donnell, MPH[1], **Brent C. Williams, MD, MPH**[2], **Daniel Eisenberg, PhD**[3], and **Amy M. Kilbourne, PhD, MPH**[1,4]

[1]VA Ann Arbor Center for Clinical Management Research, Ann Arbor, MI

[2]Department of Internal Medicine, University of Michigan Health System, Ann Arbor, MI

[3]Department of Health Management and Policy, University of Michigan School of Public Health, Ann Arbor, MI

[4]Department of Psychiatry, University of Michigan Medical School, Ann Arbor, MI

Abstract

Accountable Care Organizations (ACOs) have potential to improve care for chronic conditions through incentives for better performance and bundled payments that promote care coordination. The Chronic Care Model (CCM) is a framework for providing health services for chronic conditions in primary care settings consistent with the organizational and financial goals of ACOs. Integrated mental health care – collaborative care by mental health and primary care providers for selected patients – improves care and is consistent with the Chronic Care Model. However, under the Medicare Shared Savings Program ACOs currently do not specify financial or organizational incentives for providing integrated mental health care through the CCM, leaving a missed opportunity to realize the full potential of ACOs to improve patient outcomes. We describe the rationale for incorporating mental health care into ACOs; how it can benefit consumers, providers, and ACOs; and what health care organizations can do to implement integrated mental health care.

Keywords

Mental health; integrated care; chronic care model; patient centered medical home; accountable care organization

Background

The Patient Protection and Affordable Care Act (ACA) has potential to transform healthcare delivery in the US, but achieving better access to and quality of care for millions of Americans who are un- or underinsured will ultimately depend on how it is implemented. A key provision of the ACA 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]

Author for Correspondence: Amy M. Kilbourne, PhD, MPH. VA Ann Arbor Center for Clinical Management Research, North Campus Research Complex, 2800 Plymouth Road, Bldg 14 Ann Arbor, MI 48109-2800. Ph: 734-845-5046, Fax: 734-222-7514, amykilbo@umich.edu.

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Mental health care warrants careful consideration in the design of ACOs. Mental disorders, including depression, anxiety disorders, and substance use disorders, are the leading causes of disability worldwide, are associated with increased medical care and employer costs, and lead to premature mortality.[4,5,6] Roughly one in four 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 health care[10] must be integrated within PCMHs.[11]

Central to operationalizing an effective patient-centered medical home model that integrates mental health care 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 (e.g., primary care), with little to no net health care costs; making it an ideal model in which to operationalize medical homes within ACOs.[14] However, the CCM and mental health care 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 health care organizations can support the implementation of integrated mental health care programs.

Low Hanging Fruit: Incentives to and Benefits of Integrated Mental Health Care in ACOs

Integrated mental health care in ACOs stands to impact consumers, providers, and ACOs in a number of ways. *Integrated mental health care* refers to a range of practice models that include direct involvement of mental health and primary care providers in collaborative, ongoing care of selected patients. Integrated mental health models have been demonstrated to improve medical[15] and mental health outcomes, particularly depression, the most-studied mental health condition.[16] In addition, the CCM has 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.

Mental health care under current ACO models – missed opportunities

Explicit incentives for improved mental health care 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 health care 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

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for improving mental health care 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 health care 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 burden[23] that primary care physicians often feel if they are expected to provide mental health care 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 co-morbid chronic illness. Due to the high financial and health costs of poorly treated chronic 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 health care 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 health care 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 set-up of a clinical registry to track patients as well as the hiring of care managers.

Financial & Organizational Models of Integrated Mental Health Care

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

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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 health care. 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 Model; and the 4) Accountable Care Organization 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 benefit carve-outs – contracts with outside providers to provide mental health care – which can present barriers to integrated mental health care.[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 health care; co-location of mental health professionals in primary care settings; disease management; reverse co-location 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 three dimensions (Figure 1): 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 (non-physician 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' Integrated Care Model (Model A) places a full time mental health social worker (MHSWs), and a one half-day per week psychiatrist, at safety net primary care sites.[33] The model focuses on enhancing skills and confidence of primary care physicians (PCPs) in providing mental health services, with on-site 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 primary care physician in a mental health setting has been utilized in the VA (Model C).[35]

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Conclusion

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 health care. It is therefore vital that decision makers across care settings include mental health care in the development of ACOs in order to realize the full potential of these emerging organizations. At the same time policymakers should consider incentivizing organizations upfront, particularly through coverage of start-up costs associated with CCM implementation such as care management in order to facilitate the adoption of integrated mental health care over the long term.

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Take-Away Points

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

- Mental health has largely been left out of the discussion and formation of the Accountable Care Organization.
- 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.

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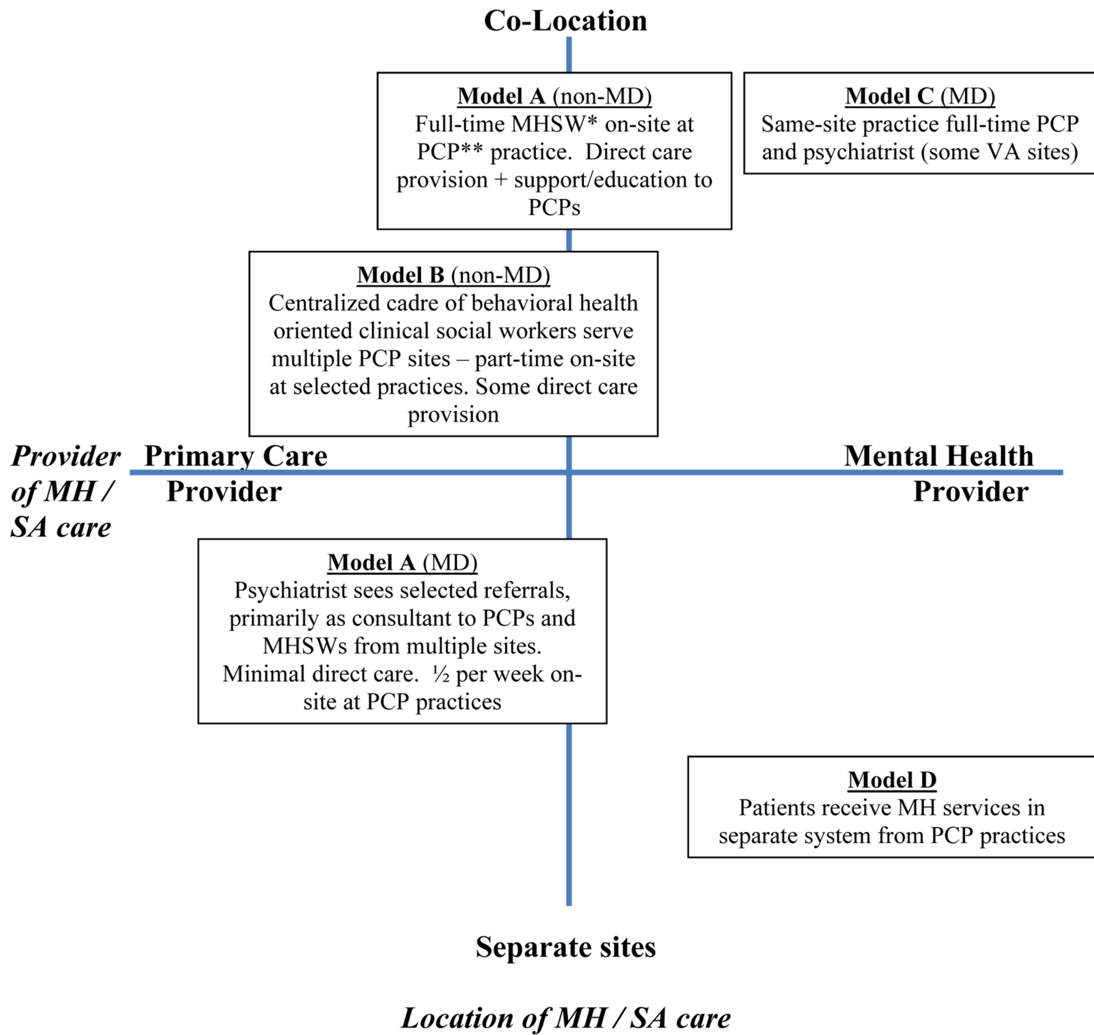

A= Washtenaw Community Health Organization Integrated Care Model[33]
B= University of Michigan Complex Care Management Program[34]
C= VA model[35]
D= Traditional model
*Mental Health Social Worker/care manager
**Primary Care Physician

Figure 1. Spectrum of Integrated Mental Health Models and Examples

A= Washtenaw Community Health Organization Integrated Care Model[33]
B= University of Michigan Complex Care Management Program[34]
C= VA model[35]
D= Traditional model
*Mental Health Social Worker/care manage
**Primary Care Physician