

## Barriers to Integration

Behavioral health integration is still rare, and the integration of substance abuse services even rarer, in part because there's been little or no financial incentive or administrative advantage to bringing what are now standalone medical and behavioral health operations together. Payers use separate provider networks, billing and coding practices, accreditation metrics, and record-keeping requirements. This makes a team-based approach to care difficult to finance and structure—whether it's achieved by including behavioral health professionals in primary care settings or medical practitioners in behavioral health settings. Primary care practices that seek to enhance behavioral health services face restrictions on the types of services they can bill for and reimbursement rates are often low. And sometimes there are pre-approval requirements or other restrictions that make it difficult for behavioral health care providers to work side by side with primary care clinicians. “Payment is the heart of the problem,” says Roger Kathol, M.D., president of Cartesian Solutions Inc., a Burnsville, Minn.–based consulting firm that advises health systems, health plans, and other purchasers on sustainable strategies for integrating behavioral health and physical health services.

Medical training that bifurcates physical and behavioral health care also impedes collaboration, as do privacy regulations that prevent providers from sharing information about mental health and substance abuse. There is also an enduring stigma attached to mental health problems, which discourages some patients from seeking help and some providers and other caregivers from getting involved. Education and firsthand experience can help lessen the stigma. A national program, [Mental Health First Aid](#), is training providers, schools, clergy, first responders, and

laypeople how to respond when someone has a panic attack, psychotic episode, or appears depressed or suicidal.

In addition, integration requires both primary care and behavioral health providers to change the way they work. Primary care providers—pressed for time and burdened with multiple priorities—often prefer to refer patients with mental or substance abuse problems to specialists, while behavioral health providers may be hesitant to practice in primary care settings in part because it requires a new skill set, according to Michael Hogan, Ph.D., former commissioner of mental health for New York State and former chair of George W. Bush's President's Commission on Mental Health. "As part of a team, behavioral health providers have to deal not only with depression and anxiety but also heart failure and diabetes," he says. In similar fashion, primary care providers must be comfortable talking about behavioral health issues, particularly substance abuse.

Many of the health care organizations that have made progress in integrating behavioral and primary care have either funded the initiatives themselves or relied on grants. (According to a 2011 survey, 78 percent of primary care providers who have integrated behavioral health services into their practices said they pay for them with the help of grants.<sup>11</sup>) Others have taken advantage of Medicare and Medicaid demonstration programs and waivers that enable them to accept global payments for delivering both types of services. And some health systems have been willing—at least in the short run—to absorb the costs of adding behavioral health services to primary care. For example, Boston Medical Center, an academic medical center and safety-net provider, is covering the cost of adding social workers, psychiatric nurse practitioners, and patient navigators into its family medicine practices on a trial basis.

Part of the rationale is that the investment may help the medical center succeed in future value-based contracts, or as an accountable care organization, by allowing it to share in any savings that accrue from improving outcomes and reducing costs.

Indeed, behavioral health integration is likely to grow as purchasers increasingly move away from fee-for-service payment models and providers are given responsibility for the overall health of patient populations.

### **Global Payment Initiatives**

The Colorado-based Rocky Mountain Health Plans—in partnership with the family medicine department at the University of Colorado–Denver and the Collaborative Family Healthcare Association, a nonprofit that promotes collaborative models of primary care—is testing whether a global payment model can support the provision of behavioral services in local primary care practices. Under the SHAPE pilot (Sustaining Healthcare Across integrated Primary care Efforts), which was launched in 2012, three practices in Western Colorado that have already integrated behavioral health care are receiving global payments to pay for team-based care, with three integrated practices that earn fee-for-service payments serving as the controls.

Instead of offering supplementary per-member/per-month payments to reimburse practices for delivering behavioral health care, as some insurers have done, SHAPE's leaders opted for a global payment approach in order to reimburse practices for the full costs of providing behavioral health care—taking into account staffing resources as well as the number and complexity of the patients served. The global payment also provides practices with flexibility to determine

which services will produce the best results, and to dedicate time to panel management, care coordination, and other "in-between-visit" activities that may lead to big health gains.

"We don't want behavioral health providers to be trapped by requirements to demonstrate productivity by the volume of traditional mental health services they render or to earn their 'keep' through a fee-for-service revenue model," says Patrick Gordon, associate vice president at Rocky Mountain Health Plans. "We think that pulls them away from the care team, pulls them away from activity that might add value but can't easily be coded."

Participating practices are held accountable for patients' total costs of care: they stand to lose part of their payment if they do not meet certain budgetary and quality benchmarks, and can also earn incentive payments for demonstrating improvement in health outcomes.

The long-term goal of this effort is "to show what's possible when you can actually create a global budget," Gordon says. "You can allocate resources to create value, and set up aligned gain-sharing mechanisms (for example, with community mental health centers and primary care providers). It's accountability and gain-sharing mechanisms that pull people together."

## **Roles of Medicaid and Medicare**

Medicaid is a major purchaser of behavioral health services—accounting for more than a quarter of all behavioral health spending nationally—and its beneficiaries who have behavioral health conditions on top of chronic medical conditions are much more expensive than those without such conditions.<sup>12</sup> (According to the Kaiser Family Foundation, more than one-third of Medicaid beneficiaries

have a mental illness, and of those 61 percent have a comorbid medical condition.<sup>13</sup>)

As detailed in a Commonwealth Fund [report](#), state Medicaid agencies across the country are seeking to make administrative, purchasing, and regulatory reforms in order to promote integrated care for Medicaid beneficiaries with comorbid physical and behavioral health needs. These efforts take on greater urgency in states that are expanding Medicaid under the Affordable Care Act, since many of these newly insured are at high risk for having behavioral health problems.<sup>14</sup>

Massachusetts' Medicaid program (MassHealth) is seeking to promote integrated care through payment reform. Under its Primary Care Payment Reform Initiative, primary care providers are offered a risk-adjusted capitated payment for primary care services, including behavioral care, with an annual incentive payment for meeting quality benchmarks and an opportunity to share in savings for reductions in non-primary care services, such as hospitalizations. The initiative aims to enhance coordination across providers, increase accountability for the total cost of care, and integrate behavioral health services.

Through its One Care program, Massachusetts is seeking to improve care for those under age 65 who are dually eligible for Medicaid and Medicare, including by integrating behavioral and primary care (49 percent of dual eligibles have a behavioral health diagnosis in a given year.)<sup>15</sup>

Peggy Johnson, M.D., chief of psychiatry at Commonwealth Care Alliance (CCA), a nonprofit health plan and delivery network and one of the providers contracted by the state under One Care, notes that those with a serious and

persistent mental illness tend to die 25 years earlier than the general population—not because more of them commit suicide but because more of them suffer from conditions like cardiovascular disease. "There is a compelling need for a primary care presence to be actively engaged with these patients," Johnson says. In CCA's model, social workers and psychologists conduct behavioral health assessments and provide consultation, education, and support to primary care teams regarding behavioral health treatment, resulting in individualized care plans. Care coordinators also work with hospitals to help oversee care for patients who have been admitted for mental health or substance abuse treatment.

There are also efforts being made to improve behavioral health care for Medicare beneficiaries. The Centers for Medicare and Medicaid Services has awarded a consortium of health care systems and health plans, including Kaiser Permanente Southern California and the Mayo Clinic Health System, \$18 million to test another model, Care of Mental, Physical, and Substance-Use Syndromes (COMPASS).<sup>16</sup> In the COMPASS model, which incorporates aspects of the University of Washington's Collaborative Care model of behavioral health integration and others, a primary care practice-based care manager meets weekly with a consulting psychiatrist and a consulting internist (or family practice physician) to review the care of patients with depression and diabetes and/or coronary artery disease. Together, the team makes sure it is moving toward medical as well as patient-identified goals. One-third of Medicare patients have diabetes and another 30 percent have coronary artery disease. When depression accompanies these conditions—which it does about 15 percent of the time—health care costs are about 65 percent higher.<sup>17</sup>

The care managers, who are registered nurses, social workers, psychologists, and in some case specially trained medical assistants, also address life stressors that may interfere with treatment. “We’re finding that for a lot of folks who have been disengaged in care, social challenges are a real problem,” says Claire Neely, M.D., medical director at the Institute for Clinical Systems Improvement, which is leading the COMPASS demonstration. The program’s impact on cost and utilization, including emergency department and hospital use, is still under evaluation, but very preliminary results based on a small number of patients suggest it is having a positive impact on outcomes. Among diabetic patients who have been in the program for more than four months, the percentage of patients with hemoglobin A1c levels below 8 percent increased from 28 percent at baseline to 51 percent. More than half (53%) of patients who entered the program with uncontrolled blood pressure and remained in it for at least four months have the condition under control. And among those with depression, 39 percent are in remission. The program has also been well received by doctors. “Primary care physicians say, ‘Oh, my gosh. Those are my patients who I couldn’t get to move, ever. Now they are heading in the right direction,’” Neely says.

### **"Perfect Storm" Encouraging Integration**

While there are still significant barriers to integrating behavioral health and primary care, there are also several forces encouraging it, among them: new payment policies, including models that begin to hold providers accountable for controlling overall costs, and demonstration programs led by Medicaid and Medicare. Mental health parity laws that prevent insurers from placing greater financial requirements (e.g., copayments) or treatment restrictions on mental health

or substance abuse care than they do on medical care also help, as does the fact that private health plans sold through the Affordable Care Act's health marketplaces must now include behavioral health benefits.<sup>18</sup> Convenience for patients and their desire to avoid the stigma still attached to separate psychiatric care are also factors. "All of this," says Hogan, "is creating a perfect storm to encourage integration."

*The Colorado Blueprint for Promoting Integrated Care Sustainability* (Denver, Colo.: Colorado Health Foundation, March 2012).

<sup>12</sup> Truven Health Analytics, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009*, No. SMA-13-4740 (Rockville, Md.: Substance Abuse and Mental Health Services Administration, April 2013) and C. Boyd, B. Leff, C. Weiss et al., *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations* (Hamilton, N.J.: Center for Health Care Strategies, December 2010).

<sup>13</sup> See:

[http://kaiserfamilyfoundation.files.wordpress.com/2013/01/83\\_83\\_bhc.pdf](http://kaiserfamilyfoundation.files.wordpress.com/2013/01/83_83_bhc.pdf).

<sup>14</sup> D. Bachrach, S. Anthony, and A. Detty, *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment* (New York, N.Y.: The Commonwealth Fund, August 2014).

<sup>15</sup> One Care is part of a demonstration program funded through the Affordable Care Act that aims to develop new care models for those covered by both the Medicare and Medicaid programs. Information on dual eligibles comes from: Substance Abuse and Mental Health Services

Administration, Center for Behavioral Health Statistics and Quality, The CBHSQ Report: Behavioral Health Conditions and Health Care Expenditures of Adults Aged 18 to 64 Dually Eligible for Medicaid and Medicare (Rockville, Md., July 2014).

<sup>16</sup> The COMPASS project was made possible by Grant Number 1C1CMS331048-01-00 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

<sup>17</sup> See G. S. Adler, "Diabetes in the Medicare Aged Population, 2004," *Health Care Finance Review*, Winter 2007 29(2):91–101; J. Unutzer, M. Schoenbaum, W. J. Katon et al., "Health Care Costs Associated with Depression in Medically Ill Fee-for-Service Medicare Participants," *Journal of the American Geriatric Society*, March 2009 57(3):506–10; and K. Z. Bambauer, D. G. Safran, D. Ross-Degnan et al., "Depression and Cost-Related Medication Non-Adherence in Medicare Beneficiaries," *Archives of General Psychiatry*, May 2007 64(5):602–08.