



**Association for Behavioral
Health and Wellness**

*Advancing benefits and services
in mental health, substance use
and behavior change.*

HEALTHCARE INTEGRATION IN THE ERA OF THE AFFORDABLE CARE ACT

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INTRODUCTION

Changes are occurring across the healthcare landscape, with a significant focus on integration of behavioral and physical health. This paper is intended to help inform these efforts by focusing on the long history Association for Behavioral Health and Wellness (ABHW) members have with behavioral health integration. Having managed mental health benefits, substance use disorder benefits, and now integrated behavioral health benefits, managed behavioral healthcare organizations (MBHOs), whether carve-out entities or health plans with their own internal specialty organization for behavioral healthcare, are experts in blending services to meet the needs of individuals with complex behavioral and physical health conditions.

MBHOs bring substantial expertise and valuable capabilities to the current focus on integration, including strong informatics and data analytics; experience with health risk assessment and stratification; and familiarity with preventive and chronic models of care. Care management systems can serve as natural platforms for addressing co-morbid medical conditions. Because of their health and wellness orientation, MBHOs understand that the best patient approach is health literacy and patient activation within the context of recovery and peer support. With a growing focus on population health, these specialty health plans have moved from a narrow focus on behavioral health to collaboration with health plan partners and of equal or greater importance, their contracted medical providers. As behavioral health specialists, MBHOs are familiar with the mechanisms through which the science of behavior change can be consistently delivered and can therefore support providers, practitioners, and patients.

The challenge of developing provider networks that assure consumers access to treatment and recovery support while providing cost-effective care is familiar territory. Through these networks, MBHOs have incubated clinical innovation by employing evidence-based clinical guidelines and promoting care that is patient-centered and outcome-driven. Working across funding streams (e.g. Medicaid and Federal Block Grants) and across the spectrum of health and human services (e.g. housing and employment) has given them a strong appreciation for the critical need to attend to the social determinants of health as well as health services themselves. These experiences and capabilities position MBHOs to play a pivotal role in integrating behavioral and medical healthcare for their members.

Using a working definition of integration, this paper articulates the critical capabilities that specialized behavioral health organizations contribute to models and approaches to integrated care, thus enabling the improved patient outcomes that result from integration.

Certainly the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) offer significant opportunities to both improve and integrate behavioral and medical care. Health coverage offered through Medicaid Expansion and the Marketplace must cover 10 essential health benefits including mental health and substance use disorder (MH/SUD) benefits. Because of MHPAEA, these benefits must be offered “on par” with medical/surgical benefits and cannot be subject to quantitative and nonquantitative limitations that are less favorable than those applied to medical services. The result is better funding for, and availability of, behavioral health services; but the manner in which they are promoted, developed, and delivered is equally important to patient care.

DEFINITIONS OF INTEGRATION

“WHOLE PERSON CARE THAT FOCUSES ON OVERALL HEALTH; CREATES PARTNERSHIPS ACROSS ALL ASPECTS OF HEALTH; AND IS FACILITATED BY A VARIETY OF CLINICAL, STRUCTURAL, AND FINANCIAL ARRANGEMENTS AND COMMUNITY SUPPORTS THAT REMOVE BARRIERS BETWEEN PHYSICAL AND BEHAVIORAL HEALTHCARE” - ABHW

The definition of integration as it will be used in this paper is: **“whole person care that focuses on overall health; creates partnerships across all aspects of health; and is facilitated by a variety of clinical, structural, and financial arrangements and community supports that remove barriers between physical and behavioral healthcare”**.

In order to establish a context for the information presented in this paper, the authors reviewed current definitions of integration. Although there are clinical, structural, and financial dimensions of integration, the literature predominately focuses on “integrated care” or “behavioral health integration” in definitions used by the healthcare industry.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines integrated care as “the systematic coordination of general and behavioral health. Integrating mental health, substance abuse and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.”ⁱ The Agency for Healthcare Research and Quality (AHRQ) considers behavioral health integration to be “care resulting 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. This care may address mental health, substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related, physical symptoms, and ineffective patterns of healthcare utilization.”ⁱⁱ The Patient Centered Primary Care Collaborative (PCPCC) has adopted AHRQ’s definition.

The American Academy of Family Physicians’ (AAFP) Collaborative Care Research Network (CCRN) has also defined the additional term “collaborative care” which is “a term used to describe different models of behavioral health in primary care. It is also a comprehensive approach to health that sees no distinction between your mind and body, but rather focuses on your overall health. Integrating mental (behavioral) health services into primary care is one successful avenue for treating the health care of the whole person.”ⁱⁱⁱ

While the focus of integration can be clinical, structural, organizational, or financial, all efforts have one seminal objective at the core: collaborative or integrated care for the patient. However, the definitions above are generally limited to primary care based models, which is necessary but not sufficient. Further, AHRQ requires that a single practice team provide the integrated care, while AAFP is less prescriptive and accommodates a variety of models, though still limited to primary care settings. Acknowledging the diversity of practice in healthcare systems and the need for comprehensive, integrated systems of care, ABHW believes that a working definition of integration should be inclusive, rather than exclusive.

PREVALENCE OF CO-OCCURRING CONDITIONS AND THE IMPORTANCE OF INTEGRATION

Efforts to improve population health and reduce costs must adequately address behavioral health. Through extensive experience serving people with behavioral health disorders, MBHOs have witnessed the challenges that the medical system exhibits with regard to treating chronic illness among individuals with MH/SUD. This has manifested itself in increasing preventable mortality and healthcare costs. Neuropsychiatric disorders are now the number one cause of disability, surpassing other conditions such as cardiovascular disease.^{iv} Depression and other MH/SUD are associated with high health care costs.^v In fact, the top five conditions driving health care spending are: depression; obesity; arthritis; back/neck pain; and anxiety, in that order.^{vi}

Physical and behavioral health conditions have high rates of co-occurrence, with unmet behavioral health needs frequently complicating treatment for medical practitioners. One out of five patients with coronary heart disease and one out of three patients with congestive heart failure also experience depression but are not diagnosed or treated.^{vii} The interaction between a person’s psychiatric status and health is dramatic: one in three patients who go to the emergency room with chest pains is actually experiencing panic disorder or depression.^{viii} As documented in the Adverse Childhood Experiences (ACE) Study, childhood trauma (including abuse, neglect, and family dysfunction) has a dramatic and negative effect on later-life health and well-being.^{ix}

The costs of not treating co-occurring physical and behavioral health conditions are significant, both in human and financial terms. Persons with MH/SUD have two to three times the healthcare costs of those who do not.^x People with mental illness are five times more likely than the general population to have a co-morbid medical condition, most often diabetes and other metabolic disorders, heart disease, and hypertension.^{xi} Adults with serious mental illness die an average of 25 years earlier than the general population, largely because of co-occurring chronic medical conditions.^{xii} People with SUD have a range of health conditions that are directly related to those disorders, e.g. cardiomyopathy, gastritis, and liver disease, as well as a greater risk of congestive heart failure and pneumonia.^{xiii} In the United States, a baby is born with symptoms of opiate withdrawal every hour^{xiv}, with neonatal healthcare costs exceeding hundreds of thousands of dollars.

In the Medicaid population, the presence of chronic and complex comorbidities is even more pronounced, with 45% of beneficiaries with disabilities having three or more chronic conditions; almost 50% of beneficiaries with disabilities have a psychiatric illness; and psychiatric illness is represented in three of the five most prevalent pairs of diseases. Thirty-five percent of Medicaid beneficiaries have a chronic MH/SUD, and 60% of those individuals also have other chronic physical conditions and report fair or poor health status.^{xv} Healthcare spending is substantially higher for beneficiaries with chronic physical conditions who also have MH/SUD, on the order of 60% to 70% higher. Individuals with one of the five most common chronic conditions (asthma/COPD, congestive heart failure, coronary heart disease, diabetes, and hypertension) and co-occurring MH/SUD are four to five times more likely to be hospitalized.^{xvi}

The Medicaid Expansion population faces additional challenges. In some states that used waivers to enroll this group of beneficiaries before passage of the ACA, childless adults in the expansion population had three times as many MH/SUD related medical visits as adults with children.^{xvii xviii} Forty percent of persons who qualify for both Medicaid and Medicare (“dual eligibles”) have both a physical and behavioral health condition, and 60% of disabled dual eligibles have a MH/SUD.^{xix}

INTEGRATED BENEFITS MANAGEMENT MODELS

Current approaches to integrating care occur at a variety of levels: the member, his or her family or other supports, practitioners, providers, the delivery system, the manager, and the purchaser. Private and public purchasers are creating incentives for integrated care at the practice level. Health plans and MBHOs are linking primary care and behavioral health specialists to develop systems of collaborative care. Accountable Care Organizations (ACOs) and Community Care Organizations (CCOs) are creating provider networks that incorporate preventive, primary, and tertiary care, including specialties like behavioral health. Providers are independently affiliating across primary and behavioral healthcare in order to meet the behavioral health needs of medical patients and the healthcare needs of persons with serious MH/SUD. Obviously, in terms of integration, one size does not fit all, nor is it the act of a single entity.

THIS ALLIANCE HAS PRODUCED POWERFUL RESULTS: BEHAVIORAL HEALTH INPATIENT UTILIZATION DROPPED 16%; PSYCHIATRIC READMISSIONS DECREASED 8%; AND THERE WAS A 40% IMPROVEMENT IN FOLLOW-UP TREATMENT WITHIN SEVEN DAYS FOLLOWING A HOSPITALIZATION.

At the purchaser level, models for managing care are evolving. Early managed care programs in both the public and private sectors carved out behavioral health benefits for specialty management for good reasons: to rely on the behavioral health expertise of specialty health plans that are MBHOs; to protect behavioral health resources and develop special knowledge; and to manage benefits in a time of escalating costs of psychiatric care, especially acute inpatient treatment. With concern that behavioral health treatment was considered much more discretionary than medical care and that integrated arrangements would syphon spending from MH/SUD treatment to physical health, purchasers and payers carved out the benefit. MBHOs offered the advantage of singular accountability for the behavioral health benefit package, utilization management staff with behavioral health credentials, and an understanding of the role of behavioral health in recovery and wellness. Early public sector programs were able to achieve dramatic reductions in hospitalizations and high-end services and were able to substantially expand

community-based alternatives to inpatient care. Now, however, the focus of healthcare systems is the integration of primary and specialty treatment; coordination of care across hospitals and community services; and cross-institution incentives for health and wellness. In this context, integrating behavioral health and medical healthcare is as important as maintaining the integrity of the behavioral health benefit.

In the Medicaid program an increasing number of states are integrating benefits management (e.g. New Mexico, New York, Florida), but others are maintaining long-standing carve-outs (e.g. Massachusetts). Whether Medicaid carves behavioral health in or out for specialty management, states recognize the need to more closely align behavioral and medical care and are using a variety of approaches, such as: creating multi-disciplinary care teams for individuals with complex needs, including primary care clinicians, behavioral health specialists, and community health workers/peer support specialists; requiring information exchange across health and behavioral health; and aligning financial incentives that encourage collaboration.^{xx} States are also integrating physical and behavioral healthcare through different contracting arrangements.^{xxi} MBHOs are active participants in all these developments. Tennessee contracts with fully integrated health plans for all Medicaid benefits, although managed care organizations (MCOs) are able to subcontract behavioral health benefits management so long as the MBHOs operate at the same location as the MCOs. **In *TennCare*, one ABHW member supports a community plan by providing integrated management of medical and behavioral health services in three regions of the state of Tennessee through a care management approach centered around its population health model. Using risk stratification, this MBHO targets members for care coordination, complex care management, or wellness support. This alliance has produced powerful results: behavioral health inpatient utilization dropped 16%; psychiatric readmissions decreased 8%; and there was a 40% improvement in follow-up treatment within seven days following a hospitalization. The member has also created Accountable Care Communities (ACCs) that are developing integrated care delivery models across hospitals, primary care medical homes, specialists, behavioral health providers, and social supports.**

It is important to note, however, that integration is born of specific capabilities delivered through a functioning operating model – not simply the combining of funding into a single entity. These models can be present in both well-functioning carve-out models and fully integrated health plans. **In Connecticut, the state contracts with a medical Administrative Service Organization (ASO) for the Medicaid population. In this example of integration using a carve-out company, the health network partnered with an MBHO to develop a program, and it subcontracts with them for integrated care management (ICM) for high-risk members who have complex co-morbid medical conditions that are impacted by serious behavioral health problems. These members are identified through a predictive risk model or by referrals from hospitals, behavioral health organizations, or members themselves. Using one of the most effective self-management techniques, motivational interviewing (MI), an ICM nurse works with each member to identify barriers to treatment success and establish personal goals. The approach was influenced by the Kaiser Family Foundation’s five core strategies for integrating behavioral and medical healthcare for Medicaid beneficiaries^{xxii} as well as Wagner’s Chronic Care Model^{xxiii} and Rapp’s Strengths Model.^{xxiv} Early outcomes included a 50% reduction in hospital admissions and a 15% decrease in emergency room visits.**

Many states build responsibility for integration into their contracts with MBHOs. In Arizona, the largest Regional Behavioral Health Authority (RBHA), which is an MBHO, integrates all benefits for individuals with serious mental illness; this model has recently been expanded statewide. **In Massachusetts, an MBHO is now tasked with increasing integration among physical health and behavioral health providers and is eligible to receive financial incentives for doing so. This MBHO provides quality management of the state’s Primary Care Clinician Plan’s (PCCP) primary care providers (PCPs), producing a Profile Report, a Care Monitoring Registry, and a Reminder Report to assist PCPs in improving patient care. These efforts facilitate physical health and behavioral health integration by reporting measures drawn from both medical and behavioral health data sources. Consults take place with PCPs on developing quality improvement action plans; and its Integrated Care Management Program (ICMP) connects primary and behavioral healthcare practitioners around implementation of established clinical guidelines for chronic conditions such as depression, diabetes, and asthma.**

Another member’s Integration Behavioral Health Case Management program is an all-inclusive, integrated case management program supporting members and their families with complex behavioral health and comorbid

medical needs. The program provides member education, collaboration with existing community providers, and provides resources on medical and behavioral health treatment when needed. Treatment and medication compliance monitoring is offered along with support to members and their families to help the overall management of behavioral and medical health issues. A central premise to the program is to engage the member in the most clinically appropriate levels of behavioral health care and coordinate with the practitioners to set up a partnership with the community practices and the ABHW member.

When Medicare contracts with health plans for managed benefits, it uses an integrated model. In the CMS “State Demonstration to Integrate Care for Dual Eligible Individuals” program, while most states are contracting with Integrated MCOs to manage a broad range of primary, acute, and behavioral health services, as well as long-term services and supports, some will carve out the Medicaid behavioral health piece of the benefit (e.g. Arizona, California, Massachusetts).^{xxv} Even when behavioral health is carved out, however, states are including integrated features in their delivery system design. In Arizona, the program integrates physical health and behavioral treatment through the same MBHO that is also a Medicare Dual Eligible Special Needs Plan (D-SNP). California has required a Memorandum of Understanding (MOU) between county mental health and alcohol/drug plans and each Cal MediConnect plan that manages care for the dual eligibles; this MOU includes a declaration of the care coordination approaches that will create seamless care, information sharing policies, and shared performance measures. **In partnership with its affiliated specialty health plan, one plan is the Cal MediConnect plan for several California counties, providing consumers with an interdisciplinary care team (ICT) composed of experts in medical and behavioral healthcare and social services.**

Although support for integrated benefits management is growing, states will continue to utilize both carve-in and carve-out arrangements.^{xxvi} As CMS’s Technical Assistance Brief on managed care and SUD states, “there is no magic bullet” in determining the best way to achieve coordination across primary care and behavioral health or whether to carve in or carve out behavioral health services.^{xxvii} Whether in carve-in or carve-out environments, certain specifications are critical: aligned financial incentives; real time information sharing; interdisciplinary care teams; high performing provider networks; and strong quality management systems.^{xxviii} Purchasers need to create data sharing arrangements so that the health plans and specialty health plans can both utilize claims data to identify enrollees with

WHETHER IN CARVE-IN OR CARVE-OUT ENVIRONMENTS, CERTAIN SPECIFICATIONS ARE CRITICAL: ALIGNED FINANCIAL INCENTIVES; REAL TIME INFORMATION SHARING; INTERDISCIPLINARY CARE TEAMS; HIGH PERFORMING PROVIDER NETWORKS; AND STRONG QUALITY MANAGEMENT SYSTEMS.

co-morbid behavioral and medical conditions. MBHOs can and do partner with health plans to create systems of integration in order to improve health and wellness among jointly managed patients. **In Tennessee, a plan is equipping health homes, ACCs, and patient centered medical homes (PCMHs) with data to address the complex needs of members and to reduce excessive utilization and overall healthcare costs. In Maryland, another plan is creating methods for exchanging MH/SUD utilization data with Medicaid’s seven MCOs, providing access to medical, behavioral, and pharmacy data as well as integrated care plans and risk assessments.**

Purchasers using specialty health plans are incorporating features in their contracts that encourage collaborative or integrated care. For example, Maryland carves out MH/SUD through an ASO arrangement but will incorporate financial penalties in its new contract that incentivize the Healthcare Effectiveness Data and Information Set’s (HEDIS) “Engagement of Alcohol and Other Drug Dependence Treatment” measures as well as the percentage of the enrolled population with primary care visits in the previous year and all-cause hospital admissions. **In an enhancement of its existing contract with the state, the plan will incorporate a variety of activities that support integration, including training to providers on Screening, Brief Intervention, and Referral to Treatment (SBIRT); alcohol screening during pregnancy; and suicide risk assessment. They will also have a nurse care manager coordinate patient care with MCOs, establish a physician consultation line, and use an integration assessment survey to evaluate providers’ levels of integration and tie the results to practice improvement on integration measures.**

PATIENT CENTERED MEDICAL HOMES AND HEALTH HOMES

Provider-led models for integration are proliferating throughout the country, including PCMHs and health homes. These approaches are creating an ever stronger framework and infrastructure for integrated care. It is important to note that these models are not competing with those of MBHOs, but rather act as complementary agents that can reinforce the activities of the other. MBHOs have substantial experience building systems for treatment and recovery

support for persons with serious MH/SUD that address the social determinants of health, including social supports, housing, and other non-medical areas. Especially in their public sector work, these specialty health plans have managed care for persons with complex conditions and challenging living arrangements, requiring holistic and person-centered planning. These systematic approaches and the underlying analytics and processes that support them can empower an integrated provider through organized interactions with a broader, integrated system of care.

[THE MBHO] DEVELOPED ITS WELLNESS PROGRAM TO HELP RAISE THE LIFE EXPECTANCY AND IMPROVE THE QUALITY OF LIFE OF ITS MEMBERS.

PCMHs are vehicles for integrating care in either an integrated or specialty health plan model. With almost 8,400 PCMHs currently recognized by the National Committee for Quality Assurance (NCQA)^{xxix}, both public and private purchasers and payers are increasing their reliance on this model. Within PCMHs, behavioral health has gained more prominence from provisions and requirements in NCQA's 2011 and 2014 standards. Several states have initiated multi-payer PCMH initiatives (e.g. Oregon, Michigan, and Maryland). **An ABHW member has been engaged in several projects around the country that support providers in transforming their practices into PCMHs and health homes and has assisted primary care practices in achieving NCQA recognition by enhancing care management, health information technology, and value-based purchasing arrangements.**

Section 2703 of the ACA created a new State Plan Amendment (SPA) for "Health Homes that offer six core services: comprehensive care management; care coordination; health promotion; comprehensive transitional care; individual and family support; and referral to community and social support services, all linked by health information technology." The comprehensive care management function brings together a patient's physical and behavioral health needs and addresses those through care coordination. Sixteen states have approved SPAs; seven specifically target MH/SUD. Through behavioral health homes (BHHs), states are creating collaborative relationships across behavioral health and primary care practices so that persons with serious MH/SUD have access to medical care. BHHs encourage and motivate patients to access primary care, become managers of their own health, and, by doing so, improve health outcomes. Conversely, through SPAs that target primary care patients with chronic conditions, behavioral health treatment is being brought to them so that effective behavioral health interventions can improve their health status.

For persons with serious MH/SUD whose behavioral health provider serves as a health home, MBHOs are in a strong position to assist the behavioral health specialist to perform health home functions through specialized training as well as data analytics and population health management interventions to support care management and health promotion activities. **In Washington State, one plan serves as the "lead health home organization" contracting with 24 CCOs that provide the health home services.**

Another ABHW member developed its Choose Health wellness program to help raise the life expectancy and improve the quality of life for its public sector members. Recognizing the influence of social determinants on health, Choose Health offers guidance to communities about development efforts to support health and wellness for residents, provides community forums to collaborate on health and wellness initiatives, and delivers a suite of programs and services that can be individualized to help every member reach his or her health and wellness goals. Especially in their public sector work, these specialty health plans have managed care for persons with complex conditions and challenging living arrangements, requiring holistic and person-centered planning.

One plan has been an active participant in working with states in the design, development, and implementation of BHHs as well as chronic condition health homes in multiple states, including New York, Kansas, Virginia, and

Washington. It has partnered with its state and provider networks to provide unique solutions that facilitate community-based, integrated, and coordinated health services across medical, mental health, chemical dependency, and long-term services and supports to eligible members. One approach has been to focus on providing in-home or in-clinic support during point of care transition or heightened need through health home partners or other community supports. The plan identifies and verifies the need of appropriate members and then uses a variety of methods to facilitate contact between the member and the health home or other partner. The health home partner may be provided training and consultations to support targeted outcomes and appropriate coordination with other providers of care for the member.

Over the course of the last 10 years, evaluations of PCMH initiatives have indicated that quality of care, patient experiences, care coordination, and access are better than those for primary care.^{xxx} Early reviews of integrated care also show provider and patient satisfaction as key results.^{xxxi} The same hopes are held for health homes, and preliminary results from the early adopting states show promise. In New York, data for a subset of the health home population shows a 14% increase in primary care visits and a 23% drop in hospital admissions and emergency department visits. Missouri's BHHs have decreased emergency department visits by 8% and ambulatory-sensitive hospitalizations by 13%. On average, the state's health homes are saving \$52 per member per month (PMPM).^{xxxii} Like PCMHs, health homes can facilitate better preventive care for persons with serious MH/SUD and improve their access to primary care.^{xxxiii} A randomized trial conducted by Druss^{xxxiv} showed that patients served in an integrated care model that emphasized patient education were significantly more likely to have had a primary care visit and to have been screened for 15 of 17 preventive measures; they also had greater health status improvement.

COLLABORATIVE AND INTEGRATED CARE AND PATIENT ENGAGEMENT

At the practice level, MBHOs recognize that the behavioral health specialty system must extend its reach into the medical sphere, given the extent to which individuals with behavioral health needs are treated in primary care

PEER-TO-PEER CONSULTATION STAFFED BY PSYCHIATRISTS UTILIZES THE BEST AVAILABLE CLINICAL GUIDELINES TO COACH PHYSICIANS ON PRACTICE IMPROVEMENT WHILE HEALTH COACHES EDUCATE MEMBERS AND PROVIDE CARE COORDINATION. AS A RESULT OF THIS PROGRAM, HOSPITAL ADMISSIONS AND EMERGENCY ROOM VISITS DECREASED BY 30%; AND INPATIENT SPENDING WAS REDUCED BY \$90 PMPM.

settings, though often go undiagnosed or without entirely effective treatment. More than half of all behavioral health treatment occurs in the general medical system^{xxxv} and 70% of primary care visits are related to psychosocial issues.^{xxxvi} In fact, some have called primary care the “de facto mental health system”.^{xxxvii} Slightly more than 20% of all patients seen in primary care settings report that they have a co-morbid substance use disorder of some severity^{xxxviii} while 30% of

primary care patients meet diagnostic criteria for depression. Eighty-five percent of patients with a MH/SUD visit a primary care practitioner at least one time in a 12-month period.^{xxxix} Forty-five percent of people who died by suicide had contact with a primary care provider within one month of death and 75% had contact within the previous year.^{xl}

MBHOs are able to put structures and processes in place such that behavioral health providers and specialists are well positioned to consistently add value to healthcare integration, through use of case management, crisis intervention, peer supports, self-help, outreach and engagement, motivational enhancement therapy, and the stages of change. Historically, behavioral health has focused on chronic disease management; has a broader discipline and practitioner base than healthcare overall; and uses a collaborative approach to treatment and recovery support across practitioners, patients, and their families. Behavioral health specialists can develop treatment regimens for medical patients with unmanaged chronic illnesses, providing treatment as necessary but also motivational interventions to increase patient activation. Education and support on health behaviors is also a core component of the behavioral specialist's repertoire.

There are a variety of methods for clinically aligning behavioral health and primary care, including:

- Training for primary care practitioners on identification and treatment of behavioral health conditions;
 - Screening for behavioral health conditions in primary care settings;
 - Screening for medical conditions in behavioral health organizations;
 - Providing consultation services to primary care practitioners;
 - Creating strategies for increasing patients' health literacy and activation;
 - Co-locating behavioral health and primary care services; and
 - Delivering integrated team-based behavioral health and primary care.
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Training and consultation from behavioral health providers and MBHOs could assist primary care practitioners in improving their identification of behavioral health concerns and conditions. Patients under-report their mental health problems to their primary care practitioners; one study found that only 20% to 30% of patients with psychological issues told their primary care physicians about their concerns.^{xii} Other studies have shown that depression goes undetected in more than 50% primary care patients.^{xiii} Training can also increase the rate at which primary care practitioners effectively treat these conditions since only 20% of primary care patients started on antidepressants show substantial improvement.^{xiiii}

In Arkansas, an ABHW member launched a collaborative pilot focusing on members experiencing the highest complexities in both behavioral and medical disorders. The pilot is demonstrating the efficacy of partnering medical and behavioral health clinicians to conjointly provide support to the member. Structured communication channels and processes have been built into the model to ensure consistent real time collaboration between the clinicians and the member. The care managers report being much better equipped to identify and address behavioral health contributions to members' overall health challenges because of their partnership. As a result, they have reported that it is easier to engage the member with the most beneficial resource or intervention to address the behavioral need. This collaboration has demonstrated improved health outcomes for members while reducing costs. By synchronizing or combining existing behavioral health resources within chronic care management even further, gains in extending life-long wellbeing and cost reduction could be achieved. The plan intends, given the early successes of the pilot, to advance the model nationwide.

One MBHO is now piloting team-based, member-centric programs in primary care settings. The programs involve the selection of a unique type of behavioral health professional who can adapt his or her services to the pace and culture of a primary care environment. These practitioners become a member of the primary care team providing brief assessment, brief intervention, referral and case management, physician consultation, stepped care, and group work with members who have medical and behavioral comorbidities. Physicians involved in these pilot programs describe the impact as "transformational" for their practices.

Behavioral health specialists can assist primary care practices in initiating SBIRT and develop systems for warm handoffs for patients who require SUD treatment. **In Colorado, another MBHO provides training on depression screening to primary care practices and, in Maryland, they will train PCPs on SBIRT, alcohol screening for pregnant women, and suicide risk assessment.**

Similarly, primary care practices and the patients that they serve benefit from consultation and connection with behavioral health providers, as demonstrated in various psychiatric liaison and consultation programs that support pediatricians in identifying children with MU/SUD needs and in collaborating with psychiatrists on their treatment. **The long-standing Massachusetts Child Psychiatry Access Project has been so effective that it is now available in 22 states; ABHW members manage the psychiatric liaison program in several of these states.**

Since there are patients with MH/SUD who prefer to remain in medical settings for treatment, partnerships with PCPs are critical to improving health outcomes. **Based on the recognition that over 75% of all psychotropic medications are prescribed by PCPs^{xliv}, one plan's Psychotropic Drug Intervention Program uses aggregate data and scaled clinical insight to promote integration of care at the provider level. Analyzing integrated behavioral health, medical, and pharmacy claims data, this MBHO identifies target events and intervenes with members and prescribers to educate them on best practices and changes to pharmacological treatment. Evidence-based practices drive the algorithms in the technology platform that identifies prescription-related problems. Peer-to-peer consultation staffed by psychiatrists utilizes the best available clinical guidelines to coach physicians on practice improvement while health coaches educate members and provide care coordination. As a result of this program, hospital admissions and emergency room visits decreased by 30%; and inpatient spending was reduced by \$90 PMPM.**

To encourage medical-behavioral integration, an ABHW member promoted the use of the Health and Behavior Assessment and Intervention procedure codes. These codes were added to behavioral health provider fee schedules and the claim systems set up such that the codes could be submitted with a medical diagnosis. PCPs can refer patients with physical illnesses/ailments that either were being provoked by a behavioral health condition or can assist in providing psycho-educational consultation/intervention to assist members to manage and adhere to their medical condition treatment plans. In Maine, where the provider community engaged quickly with these codes, a study was done looking at members who were eligible for benefits over a three-year period and compared the baseline to year one for members with diagnoses of sleep disorders, headaches, chronic pain, and morbid obesity. While behavioral health costs increased, medical and pharmacy costs decreased with a net overall healthcare cost reduction of 3.2%.

The co-location model of coordinated care involves behavioral health specialists providing services at a primary care site or PCPs working in behavioral health settings. Co-location increases communication across practitioners and significantly increases the likelihood of referrals from primary care to behavioral health. Since two-thirds of PCPs report that they are not able to access behavioral health treatment for their patients^{xlv}, and 30% to 50% of individuals with referrals from primary care to behavioral health do not make the first appointment^{xlvi}, co-location can open access substantially. MBHOs can incentivize these activities by using contractual performance measures that encourage seamless, effective referrals from primary care to behavioral health. Many behavioral health providers host primary care clinics; and increasingly, behavioral health specialists are operating out of primary care settings. Federally qualified health centers (FQHCs) have used this model extensively, with 70% of health centers providing mental health services; 55% providing substance use disorder treatment; and 65% providing some element of integrated care.^{xlvii}

Another plan is contracting with a pediatric primary care practice that includes behavioral health clinicians. The behavioral health clinicians can be accessed in several ways: calling to make an appointment; scheduling an appointment prior to exiting the site, as a recommended follow-up to a PCP visit; meeting immediately following a PCP visit; and visiting simultaneously with a behavioral health clinician and a PCP within the exam room, in more urgent cases. The full integration of the behavioral health clinicians under one practice, which is an enhanced co-location, means full service patient needs can be met and the practice has the ease of single claims submission.

In Arizona, an ABHW member has supported the development of integrated services in several core behavioral health agencies in the state. These integrated clinics are housed in behavioral health agencies, allowing persons with severe mental illness to access physical health care in the settings where they are already comfortable. Support has included successful advocacy at the state level to change statutes/regulations that were barriers to embedding physical health services within behavioral health agencies, technical assistance to access physical health funding streams managed by other payers, and seed funding for exercise equipment, community gardens, and green space.

In Colorado, an MBHO is a partial owner of two behavioral health organizations that have carve-out contracts but are operationalizing the state's goal that 80% of Coloradans have access to co-located healthcare by 2019. This MBHO has developed a provider self-administered survey to measure movement along the integration continuum, building on the Vermont Integration Profile (VIP). The MBHO also provides targeted disease and care management

using evidence-based supports for self-care and improved health outcomes, tailoring health coaching to each member based on their response to the Patient Activation Measure (PAM).

One particularly effective model for integrated treatment is the Collaborative Care Model (CCM), developed by Unutzer and patterned after Wagner’s work on the Chronic Care Model. CCM operationalizes five principles of effective patient-centered integrated behavioral healthcare:

- Team and collaborative care so that all members of the treatment team are working in concert on whole health;
- Population-based care that identifies cohorts of patients with common clinical conditions and tracks outcomes for each group;
- Measurement-based (treatment to target) so that treatment effectiveness is continually monitored against targets and adjustments are made based on results;
- Evidence-based care that has demonstrated outcomes for specific populations; and
- Accountable care in which results are shared with patients, practitioners, and purchasers so that future treatment protocols are informed by practice-based evidence.^{xlviii}

Involving a collaborative team of a PCP, behavioral health care manager(s), and psychiatric consultant, CCM is more effective for depression and anxiety than care as usual.^{xlix} Based on Unutzer’s model, the Improving Mood—Promoting Access to Collaborative Treatment (IMPACT) model for depression treatment has had large scale implementations across health plans, community health clinics, and PCPs. Minnesota’s statewide Depression Improvement Across Minnesota—Offering A New Direction (DIAMOND) program utilizes the CCM and moves 30% of patients with depression to remission within six months.¹ Most states’ ACA health home programs are patterned after Unutzer’s work, even if they do not fully integrate care. **One plan’s program for depression treatment is based on the IMPACT model and uses depression symptom scales, behavior activation and relapse prevention to improve treatment outcomes. Training is provided to primary care practitioners on stepped care and IMPACT’s tenet of “treatment to target”. Predictive modeling allows the MBHO to identify members newly diagnosed with a chronic medical condition, to conduct depression screenings and assign targeted members to health coaches embedded within the primary care practice. Coaches assist patients to develop behavior activation plans to increase treatment adherence and improve outcomes. Preliminary data shows improvements in depression scale scores and lower emergency department and inpatient costs.**

The CCM has shown both reduced healthcare costs and improved patient functioning. In the largest trial, IMPACT participants were twice as likely as patients in usual care to have a substantial improvement in their depression over a 12-month period^{li} and to have less physical pain.^{lii} Additional studies have shown the model to be effective with adolescents with depression^{liii}, cancer patients with depression,^{liv} and patients with diabetes.^{lv} Analysis of the cost and savings of Collaborative Care produces a return on investment of \$6.50 per dollar spent.^{lvi}

One of the many ways one ABHW member has approached integration is with the Chronic Care Program. The program was developed to improve the health of the top 25% of its sickest members with chronic illness and functional impairments, while also reducing costs. Predictive Analytic Tools were used to stratify members into four quadrants of member need and utilization; types and frequency of care management intervention were designed for each quadrant. The program uses a holistic approach with a primary care manager working with an interdisciplinary team of social service professionals, nurses, pharmacists, dietitians, community health educators, and a consulting geriatrician. Individuals have had success maintaining their chronic illnesses and mental health disorders at home, hospital admissions have decreased by 51%, and the patients’ two-year odds for survival have improved by 26%.

INDIVIDUALS [...] HAVE HAD SUCCESS MAINTAINING THEIR CHRONIC ILLNESSES AND MENTAL HEALTH DISORDERS AT HOME; HOSPITAL ADMISSIONS HAVE DECREASED BY 51%, AND THE PATIENTS’ TWO-YEAR ODDS FOR SURVIVAL HAVE IMPROVED BY 26%.

PATIENT ENGAGEMENT

Behavioral health interventions can also play a pivotal role in patient engagement and increasing patients' ability to self-manage their chronic illnesses, both physical and behavioral. Self-management improves health behaviors, resulting in improved health status.^{lvii} Behavioral health interventions can effect health-related behavior change; motivational interviewing is widely used by behavioral health specialists. Several randomized clinical trials have shown that MI is superior to advice and education when helping patients manage a variety of chronic illnesses, including SUD and diabetes.^{lviii} Behavioral health providers can provide training on MI to PCPs or use MI as part of the repertoire of the

NURSE CARE MANAGERS USE MOTIVATIONAL INTERVIEWING TO HELP MEMBERS ESTABLISH PERSONAL HEALTH GOALS.

behavioral health consultants working in a collaborative care program. The behavioral health provider's regular screening and tracking of commonly co-occurring conditions like diabetes, high cholesterol, high blood pressure, and obesity can be used in conjunction with MI to increase patients' activation for self-management. **In Connecticut, an MBHO's nurse care managers use MI to help members establish personal health goals.**

The healthcare industry is increasingly recognizing the importance of engagement strategies in involving patients in the process of care and in managing their own health. Improving engagement results in greater medication adherence; reduced medical costs; and improved health status, both physical and mental.^{lix} One tool, the PAM, quantifies a patient's confidence and ability to manage his or her health; using health coaching in conjunction with the PAM has been identified as a promising practice. Patients who score high on the PAM are significantly more likely to have regular checkups, screenings, and immunizations; they're also more likely to engage in healthy behaviors.^{lx} Several studies have shown that highly activated patients had lower rates of hospitalizations and emergency department use.^{lxi} **In Washington State, the 24 health homes under contract with a plan target enrollees with complex medical conditions who are at significant risk for negative health outcomes. Care coordinators and wellness coaches use behavioral change methods to increase self-management skills, as measured by the PAM.** Employing peer specialists as navigators and health coaches improves patient activation and an individual's ability to self-manage his or her physical and behavioral health needs, resulting in increased use of primary care.^{lxii} This function is also a natural one for community behavioral health organizations, expanding the traditional role of case managers or community support workers.

PATIENTS WHO SCORE HIGH ON THE PAM ARE SIGNIFICANTLY MORE LIKELY TO HAVE REGULAR CHECKUPS, SCREENINGS AND IMMUNIZATIONS; THEY'RE ALSO MORE LIKELY TO ENGAGE IN HEALTHY BEHAVIORS.

CONCLUSION

THE RESULT OF ALL THESE ACTIVITIES EMPOWERS PROVIDERS TO MORE EFFECTIVELY ENGAGE MEMBERS IN THEIR OWN TREATMENT, AND DELIVER INTEGRATED MODELS OF CARE THAT PROMOTE OVERALL IMPROVEMENTS IN HEALTH STATUS AND OUTCOMES.

The literature is replete with research results that demonstrate the effectiveness of providing MH/SUD treatment as well as the advantage of integrating physical and behavioral healthcare. There is a growing body of evidence indicating that coordinated and integrated medical and behavioral healthcare improves outcomes and is cost-effective.^{lxiii}

Right now, in carve-in and carve-out environments, MBHOs are using their experience and expertise to make significant contributions to the growth of integrated healthcare. They are creating integrated delivery systems; managing integrated benefits for persons with serious mental illness and Medicare/Medicaid beneficiaries; and partnering with health plans on integrated management of medical and behavioral health services. MBHOs are using risk assessment

and stratification to identify members with complex medical conditions; providing access to physical health, behavioral health, and pharmacy data to health plans and behavioral health providers; and performing data analytics functions for physical and behavioral health providers. These specialty health plans are developing and managing BHHs and supporting primary care practices in their transformation to PCMHs. MBHOs provide training to primary care practices on behavioral health screening and treatment; offer consultation to primary care on quality improvement and pharmaceutical best practices; and manage highly successful psychiatric liaison programs. At the clinical level, they are implementing evidence-based collaborative care models; using health literacy tools; employing health coaches; and creating incentives for co-location of primary and behavioral healthcare. The result of all these activities empowers providers to more effectively engage members in their own treatment and deliver integrated models of care that promote overall improvements in health status and outcomes.

Through all of these innovations, MBHOs play pivotal roles in advancing integrated healthcare. As evidenced in the examples provided above as well as in ABHW member company integration programs not mentioned in this paper, ABHW and its members are committed to working with purchasers, payers, providers, legislators, regulators, and plan members to increase the scope and effectiveness of these innovations and to provide leadership to facilitate collaborative and integrated care.

ABHW MEMBERS 2015

Aetna Behavioral Health
Anthem
Beacon Health Options
Cenpatico
Cigna
Healthfirst
Humana Behavioral Health
MHN
New Directions Behavioral Health
Optum
PerformCare

END NOTES

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