COMMENTARY

The Role of Behavioral Health Services in Accountable Care Organizations

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ABSTRACT

Nationally, care delivery organizations are developing accountable care organizations (ACOs), but few have an appreciation of the importance of behavioral health services or knowledge about how to include them in an ACO since their funding and delivery are currently segregated from other medical services. This commentary reviews data on the impact of patients with concurrent medical and behavioral health conditions. They indicate that three-fourths of patients with behavioral health disorders are seen in the medical setting, but are largely untreated because few medical patients choose to access the behavioral health sector, which is where behavioral health providers are paid to work. Untreated behavioral health conditions in medical patients are associated with persistent medical illness and significantly increased total medical healthcare service use and cost, especially in those with chronic medical conditions. At a national level, those with behavioral health conditions use one-third of total healthcare resources. This will not change unless at-risk ACOs can effectively correct the mismatch between behavioral health patients and behavioral healthcare delivery.

The authors suggest that ACO subcontracting for traditional segregated behavioral health services, whether from local provider groups or external vendors, will not achieve ACO-mandated access, treatment, and cost reduction goals. Rather, behavioral health specialists will need to become core ACO member providers. This will allow them to be deployed along with other member providers using value-added delivery approaches in the medical setting to integrate medical and behavioral health service delivery, and to achieve synergistic health and cost improvement.

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At their essence, accountable care organizations (ACOs) are groups of providers who are responsible for improving the total health of a population of patients while accepting financial risk for the cost of their care. Despite growing evidence that untreated behavioral health disorders (ie, mental health and substance use disorders) can result in substantially higher healthcare cost and morbidity,[1,2] many, if not most, care delivery systems do not include behavioral health professionals—including psychiatrists—as full members of their developing ACOs.[3] Including behavioral health professionals is difficult since: a) they are excluded from provider networks established by medical payers; b) they are paid through segregated behavioral health benefits (eg, carve-outs and carve-ins); c) they generally utilize independent clinical documentation systems; and d) most practice in geographically disparate clinical settings. Nevertheless, the Patient Protection and Affordable Care Act (ACA) and Mental Health Parity and Addiction Equity Act (MHPAEA) mandate that behavioral health services be included among insured services provided by ACOs.

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The logical default for ACOs is to utilize stand-alone non-network behavioral health providers as clinical "resources" for the medical population. The population is served through service agreements with behavioral health providers within their delivery system, and paid by independent behavioral health payers or by entering into subcontracts with external behavioral health vendors. The authors question whether this default is consistent with the intent of the ACA mandate: 1) that behavioral health services become available on par with medical services for all ACO patients, and 2) that ACO delivery protocols enhance quality and lower healthcare cost for ACO patients, including those with concurrent medical and behavioral health conditions. This is because in today's independently managed behavioral health delivery system, most behavioral health services are inaccessible in medical settings; thus, poor access to and coordination of care impedes health and cost outcomes.

Impact of Behavioral Health Conditions on Health Outcomes and Costs

Nearly three-fourths of patients with behavioral health conditions refuse to access care in the behavioral health sector and are seen primarily or exclusively in primary care and specialty medical settings.[4-6] Since greater than 90% of traditional behavioral health services are delivered in specialty behavioral health settings due to restrictive behavioral health payment procedures, almost two-thirds of "medical" patients with behavioral health comorbidity receive no (or non–outcome changing) assessment and treatment for their behavioral health conditions.[7] Conversely, the majority of patients seen in behavioral health settings have co-existing chronic medical conditions, yet these patients also have challenges in accessing medical services for economic and geographic reasons.[8] When present, concurrent medical and behavioral health conditions are associated with decreased patient adherence, higher complication rates, earlier mortality, doubling of the total annual cost of healthcare, and greater disability.[9-12]

Behavioral health patients consume nearly a third of total health resources. In 2012, 41 million patients covered by Medicare, Medicaid, and commercial insurance were treated for behavioral health conditions—14% of the total population, yet they accounted for $536 billion in total healthcare service use on a budget of $1.7 trillion (32%).[1] Of that, $444 billion (83%) was for medical service use. For most of these patients, access to behavioral services in the medical setting—where up to 75% are seen—and communication among medical and behavioral providers was nearly nonexistent since segregated payment procedures dictate separation of medical and behavioral service delivery.[13]

Behavioral Health Services in ACO Settings

Patients with concurrent medical and behavioral health conditions constitute an important target population for ACOs wishing to improve health and lower healthcare costs as they prepare to compete for population risk-based contracts.[2] They are a subset of marginally treated patients with high healthcare cost and poor health outcomes for whom introduction of value-added integrated medical and behavioral health services could significantly improve health and cost outcomes.[9]

This is not possible, however, when ACOs default to contracts with behavioral health providers that deliver traditional stand-alone behavioral health sector assessment and treatment. Importantly, traditional behavioral health services are all that ACOs can currently buy in the behavioral health market, whether the behavioral health specialists are located in the same clinic system or purchased from an external vendor. Traditional behavioral health professionals are driven to deliver non-integrated services by independently managed behavioral health payment procedures in order to maintain economic viability.[2,4]

Separate payment, and thus management models, does not lead to outcome change for patients with comorbid medical and behavioral health conditions. It drives the creation of segregated medical and behavioral health provider networks; discrete patient identifiers; independent provider and patient contracts; disparate coding and billing procedures and claims adjudication; noncommunicating delivery system locations; fragmented assessment and treatment; separate clinical documentation systems, success metrics, and outcome measurement procedures; and disconnected quality assessment and improvement programs. All this adds up to disjointed care delivery typified by persistent poor access to collaborative medical and behavioral health treatment, limited clinical improvement, and increased total healthcare costs,[10-12] whether in the medical or behavioral health setting (**Table**).

ACOs With Meaningful Inclusion of Behavioral Health Professionals

Based on the above discussion, a major decision that ACOs have is whether to *purchase* traditional separate behavioral health services by default, or to *build* nontraditional behavioral health services that are available to comorbid ACO patients in inpatient and outpatient medical settings since this is where most patients are seen. We suggest that the latter is the only way ACOs can achieve the desired health improvement and cost reduction that is expected with ACA and MHPAEA mandates. In fact, the ACA creates an ideal climate for ACOs to revolutionize behavioral health access and treatment by transitioning it from autonomous care delivery to becoming an integral part of medical benefits and total health.

"Built" behavioral health services in the medical setting would allow ACOs to include behavioral health professionals among ACO network providers with the same rules and expectations as other network practitioners. They would be driven by the same Triple Aim incentives and rewarded by mutually achieved health and cost successes. Importantly, recognizing that ineffectively treated behavioral health conditions in medical patients is a major source of high cost and potential loss

in the current healthcare environment, ACOs with in-network behavioral health providers could legitimately move to population risk-based contracts with health plans and government programs in which behavioral health services would be included as an integral part of medical benefits. The consolidated medical and behavioral health reimbursement process would enable ACOs to pay for deployed behavioral health providers using value-added integrated care models in medical settings—where they can bring the greatest value to patients and the ACO.

This article is intended to stimulate dialogue about the role that behavioral health professionals play for those developing ACOs. It suggests that a better way for ACOs to move from today's segregated world of behavioral health into the next generation of value-added population risk-based healthcare is to transition from stand-alone to integrated behavioral health services. This can only be accomplished when behavioral health specialists are part of the ACO's core network of providers, are paid from the same budget, and have the same quality and delivery expectations as other health professionals in ACO networks.

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Take-Away Points

Care delivery systems setting up accountable care organizations (ACOs) give little attention to the importance of behavioral health services as a part of their integrated service delivery. This article describes how ACOs can reverse predictable poor medical health outcomes and the 2 to 4 times greater total cost of care for chronic medical patients with behavioral health comorbidity by:

- Building medical setting–based behavioral health services as a core ACO medical delivery component.
- Making behavioral health providers members of the ACO's clinician network.
- Entering population risk-based contracts which include behavioral health services as standard "medical" benefits.

■ **Table.** ACO Dimensions of Care Without and With Behavioral Health Professionals as Core ACO Member Providers

ACO Dimensions of Care	Without BH Professionals as Core ACO Member Providers	With BH Professionals as Core ACO Member Providers
Cross-disciplinary access	Piecemeal: service delivery in segregated medical and BH settings; long delays in care	Uniform: co-location in medical setting; medical care availability for primary BH patients
Coordination of care	Separate medical and BH provider work processes and clinical operations	Standard medical & BH provider collaboration and information sharing
Medical health outcomes	Persistent illness, complications, and high cost, since most BH disorders not treated in medical setting and medical conditions not treated in the BH setting	Long-term health improvement linked to outcome-changing BH treatment (especially in those with chronic medical illnesses); medical stabilization of primary BH patients
Behavioral health outcomes	Persistently untreated BH comorbidity in the medical setting	Greater BH treatment prevalence and potential improvement depending on use of treat-to-target approach
Cost outcomes	Persistent doubling of total health costs (mainly due to high medical service use)	Reduced total health costs (mainly from less use of medical services)

ACO indicates accountable care organization; BH, behavioral health.