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ORIGINAL REPORT

Care Integration in the Patient Protection and Affordable Care Act: Implications for Behavioral Health

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Abstract Individuals with co-occurring serious mental illness and substance use disorders experience a highly fragmented system of care, contributing to poor health outcomes and elevated levels of unmet treatment needs. Several elements in the health care reform law may address these issues by enhancing the integration of physical and behavioral health care systems. The purpose of this paper is to analyze these elements, which fall into three domains: increasing access, restructuring financing and reimbursement mechanisms, and enhancing infrastructure. We conclude with a consideration of the implementation challenges that lie ahead.

Keywords Integration · Co-occurring disorders · Behavioral health services

Passage of the Patient Protection and Affordable Care Act (ACA) is projected to have sweeping impacts on the provision of care for individuals with behavioral and physical health service needs who receive services in the public sector. Much is unknown regarding the ACA's impact on this vulnerable population. In this paper, we critically analyze the integration of behavioral and physical health care for people with serious mental illness and substance use disorders. We begin by briefly outlining the barriers to integrated care faced by individuals with co-occurring disorders. Next, we describe ACA elements that may increase integration in the areas of access, financing, and infrastructure. We close with some considerations of implementation challenges as the nation moves forward.

Integration enhances usual care and decision-making for people with medical and behavioral health conditions and is a critical factor in quality, patient experience, and cost (Druss et al. 2001; Peek 2009). It involves people, functions, and service sites and entails communication, collaboration, comprehensiveness, and continuity of care (Horvitz-Lennon et al. 2006). Critical elements of integrated care include quality measurement and improvement, the use of health information technology, and patient-centered care (Institute of Medicine [IOM] 2006). Clinical trials of integrated behavioral health and primary care models have demonstrated improvements in physical health (Druss et al. 2001) as well as mental health (Alexopoulos et al. 2009; Unutzer et al. 2002).

People with serious mental illness and substance use disorders have high mortality, poor health outcomes, and face significant barriers to care. They experience high incidence and prevalence of preventable physical health conditions including cardiovascular and respiratory diseases, diabetes, and HIV (Blank et al. 2002; Dausey and Desai 2003; Dickey et al. 2002; Horvitz-Lennon et al. 2006). Co-occurring disorders are associated with high levels of both emergency department use and unmet treatment needs (O'Toole et al. 2007).

Low employment rates reduce the likelihood that people with co-occurring disorders have employer-sponsored health insurance (Cook et al. 2007). They are therefore more likely to be dually eligible for both Medicare and Medicaid. Those

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dually eligible must navigate two complicated systems of care, resulting in additional administrative and logistical barriers to integration (DeJong et al. 2002). Additionally, many individuals with multiple co-occurring conditions are served through public insurance or safety net systems, which have complicated funding structures that are likely to hinder integration. For example, the publicly funded substance use treatment system operates largely outside of the traditional health system, with separate mechanisms for financing and delivering services (Buck 2011).

Due to the separation of mental health, addictions, and physical health care systems, individuals with co-occurring disorders experience a system that is difficult to navigate (Pincus et al. 2007). Restrictions on information sharing, diversity of provider types, and differently-structured financing, regulatory, and payment mechanisms contribute to a fragmented system of care in which people must seek to have their care needs met from disparate service providers who usually do not work cooperatively to either deliver or manage the individual's care (IOM 2006; Pincus et al. 2007). This fragmentation worsens the care, quality, and health outcomes for people with co-occurring disorders (Horvitz-Lennon et al. 2006). Furthermore, mental health and addictions treatment systems lag behind physical health systems in the areas of patient-centered care, quality assessment and improvement, and the use of information technology (Pincus et al. 2007). Ultimately, many individuals with co-morbid behavioral and physical health conditions face the challenge of navigating between two or more separate and complex systems, neither of which is well equipped to meet their needs (Kessler et al. 2009).

Towards Integrated Care

Care integration has been a key policy priority in major recent behavioral health reports (IOM 2006; New Freedom Commission on Mental Health 2003; U.S. Department of Health and Human Services [HHS] 1999). Numerous federal agencies, from the Substance Abuse and Mental Health Services Administration (SAMHSA) to the Department of Defense have adopted initiatives to promote the integration of primary care and mental health services for people with co-occurring disorders (SAMHSA 2008). Such initiatives range from small workgroups to research grants to system expansions. There is a small body of research that has examined the characteristics and benefits of integrated care for people with behavioral health care needs, and a growing interest in both community mental health centers and general health settings (Druss et al. 2010). However, care integration initiatives have not yet yielded the large-scale gains that are necessary to improve care for people with co-occurring disorders. These initiatives have laid the groundwork for a shift towards comprehensive integration; the behavioral health field is now primed to leverage ACA and move towards a more integrated system.

Affordable Care Act elements that may lead to greater integration are organized into three domains: increasing access, financing and reimbursement changes, and infrastructure enhancements. In each of the sections that follow, the changes that have been proposed by the ACA will be discussed and critically evaluated to explore their potential for changing the extent to which integrated care is provided to people with co-occurring disorders.

Increasing Access, a Prerequisite to Integration

The IOM defines access as "the timely use of personal health services to achieve the best possible health outcomes" (IOM 1993). The high prevalence of unmet physical (Lord et al. 2010) and behavioral health (Harris and Edlund 2005) treatment needs for this population suggest that care is neither timely nor adequate for achieving positive health outcomes. Thus access is a critical prerequisite to any discussion of integration and a necessary but not sufficient criterion for successful integration of care. The ACA could stimulate increased access in the following ways.

Medicaid Expansion

By January 2014, nearly all individuals under age 65 who have incomes below 133% of the federal poverty level will be eligible for Medicaid (Kaiser Family Foundation [KFF] 2010). Of the estimated 32 million people who will be newly eligible to obtain insurance coverage in the coming years, an estimated 5.5 million (17.5%) will have a mental illness or substance use disorder and meet the expanded criteria for Medicaid eligibility (Manderscheid 2010). Even more individuals with mental health and substance use service needs will become eligible for subsidized insurance that will be purchased through state exchanges, which are private and public health insurance marketplaces for individuals and small businesses. These expansions will increase responsibility for both physical and behavioral health care systems to meet the needs of this vulnerable population with co-occurring disorders.

Parity in Essential Benefits Packages

Consistent with the passage of mental health parity, eligibility expansions associated with the ACA must be at full parity. This provision means that insurers are prohibited from capping annual and lifetime spending for mental health and addictions treatment at levels below the caps imposed for physical health treatment. Furthermore, mental

health and addictions services will be required as essential benefits in the state exchanges. These parity requirements will ensure increased access to behavioral health services, which will promote their integration into a comprehensive package of care for individuals with co-occurring disorders.

Tracking Disparities

The ACA also includes provisions to enhance data collection related to disparities, and requires collection, analysis, and reporting access and treatment data. Populations of focus include racial and ethnic minorities, those living in rural or underserved areas, and people with disabilities. These requirements will be effective in 2012 and will be carried out by HHS (KFF 2010). This research will develop a more nuanced understanding of the specific health care barriers faced by individuals with co-occurring disorders, which will inform policy and practice changes to increase access, a necessary condition for improving integration of care.

Financing and Reimbursement Changes

Clinical integration is extremely difficult to achieve without supportive financing mechanisms. Such mechanisms include shared-risk contractual agreements, reimbursement for general health care delivered in behavioral health settings as well as behavioral health care delivered in general health settings, and meaningful reimbursement incentives for care coordination (Horvitz-Lennon et al. 2006). Several elements of the ACA have the potential to move systems towards integration through financing and reimbursement changes and incentives.

Medical Homes

In the medical home, the patient and primary care physician work collaboratively with a multi-disciplinary team to deliver comprehensive, individualized care (Fields et al. 2010). Medical homes unite four of the most compelling areas of modern health care: the value of primary care, patient-centered care, advances in chronic care, and the use of health information technology (Nutting et al. 2009). The ACA includes provisions to support and expand the medical home through pilot programs and creation of a Medicaid state plan option in which states can permit Medicaid beneficiaries with chronic conditions and serious mental health conditions to designate a provider as a health home (KFF 2010). In these programs, general and behavioral health providers will interact directly to coordinate care. A new Medicare and Medicaid Innovation Center within the Centers for Medicare and Medicaid Services (CMS) is charged with testing models like the medical home and expanding models that are shown to be effective. These initiatives will yield valuable information about the medical home for individuals with co-occurring conditions, including actionable models to guide integration efforts (Druss and Mauer 2010).

Accountable Care Organizations

A voluntary program establishing and promoting the accountable care organization model will be created through ACA legislation in 2012 (Shortell et al. 2010). Accountable care organizations are groups of health care providers that enter into collaborative agreements to share responsibility to improve quality and control costs. As of now, accountable care organizations are loosely defined, and their formal structure, including how care coordination functions are reimbursed, has yet to be articulated by CMS. Depending on how crucial details are structured regarding management, financing mechanisms, incentives, and risk sharing, behavioral health providers may be cautious about joining accountable care organizations to integrate behavioral and physical health care (Druss and Mauer 2010). Thus it is difficult to predict how widespread participation will be. If implemented optimally however, behavioral health care providers could join together with physical health providers to share savings, increase quality, and create a more integrated system of care (Druss and Mauer 2010).

Increased Reimbursement of Primary Care

In 2013 and 2014, Medicaid payments for fee-for-service and managed care for primary care providers will be increased to the Medicare reimbursement levels, which represents a mean increase of approximately 33% across the states (KFF 2010). An increase in Medicaid and Medicare payments for primary care may enhance care integration by placing greater value on the services of primary care physicians, and potentially expanding the supply of physicians who accept Medicaid. Coupled with the medical home and accountable care organization expansions discussed above, these increases could provide important incentives for care coordination.

Co-location of Primary Care and Behavioral Health Services

The ACA expands an existing SAMHSA program, allocating an additional $50 million in grants for coordinated and integrated services through the co-location of primary and specialty care in existing community-based behavioral health settings. These demonstration projects will generate

valuable information regarding best practices for primary care co-location that can be used by practitioners who are working to integrate systems in years to come (Druss and Mauer 2010).

Home and Community-based Services

Home and community-based services are flexible and individualized support services delivered to an individual in his or her home or community. Services vary widely by state, but include vocational supports, case management, peer-provided services, and other recovery support services. To target these services to people with co-occurring disorders, states must obtain waiver approval from HHS. A provision in the ACA will allow states to offer these home and community-based services through their regular state Medicaid plans, without seeking a waiver, for individuals with incomes up to 300% of the maximum SSI payment and who also have a high level of need (KFF 2010). This change could expand availability of services that can be individually tailored to address barriers to integration such as peer wellness coaches who support individuals in setting and achieving wellness goals (Swarbrick et al. 2011). Notably, in order for these expansions to take effect, each state must change its individual Medicaid plan to participate in these optional services.

Infrastructure Supports

The ACA contains several elements that may enhance the existing infrastructure that supports integrated care in community mental health centers and general health care settings.

Community-based Collaborative Care Network Program

The ACA will establish a Community-based Collaborative Care Network Program, which will support consortia of providers to coordinate and integrate services for low-income uninsured and underinsured populations (KFF 2010). Given that individuals with co-occurring disorders are over-represented amongst this population, this program has the potential to bolster behavioral health and primary care integration efforts. In order for this program to be of benefit, behavioral health service providers will need to be included in these consortia as they take shape.

Federal Coordinated Health Care Office

Approximately 60% of individuals with disabilities who are dually eligible for Medicare and Medicaid have a mental illness (Donohue et al. 2009). These individuals face elevated barriers to integrated care because they must navigate two complicated insurance systems. The ACA addresses this issue with the establishment of a new office within the HHS that has integration of these two benefit programs as its focus. Formally established in December 2010, the Federal Coordinated Health Care Office (2010) will monitor progress and provide technical assistance to states, health plans, and physicians to develop more integrated programs of care.

Workforce Development

Integrated care requires building a competent workforce composed of individuals who are effective at bridging the gaps between care systems (Druss and Mauer 2010). Doing so will require significant investments in cross-disciplinary training that draws on a common model of skills and provides the means for quick, non-disruptive communication among health professionals of different specialties (Epstein et al. 2010). The ACA has appropriated funds to support training programs that focus on medical homes, team management of chronic disease, and integration of physical and mental health services (KFF 2010). These efforts are critical first steps in establishing a workforce well suited to the delivery of integrated care.

Potential Barriers to Care Integration

Although the above elements hold promise for care integration, many implementation details remain uncertain. The volatile political environment, weak economy, and lengthy implementation timeline make the road ahead challenging for those working to integrate care for people with co-occurring disorders. Several aspects of the ACA warrant special consideration.

Improving access will require a concerted state effort to enroll newly eligible individuals. However, structuring effective outreach efforts to people with co-occurring disorders may be challenging for this difficult to reach population. Further, it is unclear if modest and time-limited federal matching funds to support increased access and home and community-based services enhancements will induce states to expand their Medicaid programs, particularly in the current protracted economic slump. It will likely be several years before states fully recover from this economic downturn, which is unlikely to catalyze states to expand access and services, due to ongoing concerns that that expansions will further strain state budgets. Additionally, states may elect to cut optional Medicaid-supported behavioral health care services to required service minimums after the ACA is implemented to contain their

spending (Garfield et al. 2010). These very services may be the ones that are most integral to care coordination: case management, peer support services, housing and vocational supports, and other psychiatric rehabilitation services.

In addition to appropriating resources to expand access, the ACA contains provisions to reduce Medicare payments to disproportionate share hospitals (DSHs) by 75% followed by a gradual increase over time based on the amount of uncompensated care provided. Medicaid DSH funding will also be gradually reduced (KFF 2010). Although ACA provisions will increase public access, it is likely that a significant number of people—an estimated 40 percent of the currently uninsured—will remain without health insurance, particularly during the early stages of implementation (Garfield et al. 2010). An unknown proportion of these individuals will have a need for care through the shrinking DSH safety net. Cutting the DSH safety net may have uniquely deleterious consequences for people with co-occurring disorders, due to the current reliance of this uninsured population on safety net services (Druss and Mauer 2010).

As financing and reimbursement systems change, policymakers must consider the consequences when vulnerable populations share the risk pool with people whose care needs are less complicated. Organizations may shift resources away from this more costly population to contain spending (Druss and Mauer 2010), with dire consequences. Similarly, any quality or cost-based payment incentive programs such as accountable care organizations must be carefully implemented to ensure that people with complicated needs do not slip through the cracks.

A final and overarching concern is the ongoing need for behavioral health system advocates and administrators to remain engaged in health care reform activities. Representatives of mental health and addictions treatment systems continue to struggle for a "seat at the table" and an effective voice in the debates about implementation in the larger health care reform movement (Pincus et al. 2007). Behavioral health service systems lag behind general health systems in terms of quality measurement and the use of information technology, both of which are critical to integration of care (IOM 2006). These current deficits will require ongoing and sustained efforts on the part of both medical and behavioral health systems, as well as the allocation of adequate resources, which poses particular challenges in the current economic environment.

As we move toward the coordination and integration of disparate health systems in the coming years, the ACA offers an exciting array of promising initiatives to promote integration of care for vulnerable individuals with co-occurring disorders. However, great challenges also loom. Many newly-insured people will have complex social service needs that extend beyond health and behavioral health. Programs supporting full community integration such as affordable housing and employment need to be sustained, supported, and promoted so individuals can live with maximum independence (Manderscheid 2010). Ideally, the support system will foster effective connections between all relevant systems, shifting the orientation from a disability or constellation of illnesses to a person-centered orientation.

The ACA's promotion of integration represents crucial initial steps toward this new orientation, although the implementation issues discussed above are daunting. In addition to promoting incentives, technical support, and increased research and development, policymakers must address accountability mechanisms, develop clear definitions of covered benefits and standards of care, and delineate effective monitoring mechanisms to ensure that this unprecedented opportunity to integrate care does not result in its intended beneficiaries continuing to receive substandard and fragmented care.

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