September 30, 2013

The Honorable Max Baucus
Chairman
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

The Honorable Orrin Hatch
Ranking Member
United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20515

Dear Chairman Baucus and Ranking Member Hatch:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) welcomes the opportunity to provide input on ways to improve our nation’s behavioral health care system.

Hospitals play a central role in the delivery of behavioral health care and are uniquely positioned to navigate the behavioral health resources that are available within communities. The AHA and its Section for Psychiatric and Substance Abuse Services work to promote the understanding and importance of behavioral health care in the continuum of care. Psychiatric and community hospitals are a vital source of care for behavioral health patients, providing treatment for a full range of psychiatric and substance abuse disorders, including mood disorders, substance-related disorders, delirium/dementia, anxiety disorders and schizophrenia. Hospitals address these and other conditions by stabilizing patients, establishing and providing quality treatment regimens and transitioning patients to outpatient and community-based services.

However, decades of discriminatory funding and the continued erosion of public financial support for behavioral care services compromises access to behavioral health care, thereby threatening advances in behavioral health care that hold the promise of improving the quality of treatment and reducing the stigma associated with behavioral health and substance use conditions. Declining reimbursements from payers and the erosion of public funding have resulted in reductions and/or eliminations of inpatient psychiatric units and/or beds in hospitals, as well as in private, free-standing and state behavioral health facilities. The lack of community-based resources, combined with a shortage of inpatient beds, has led individuals suffering from behavioral health and substance use conditions to become increasingly reliant on hospital emergency departments for care.
The AHA supports a number of policy recommendations to help increase access to and improve the quality of behavioral health care, including:

- Full implementation of the *Mental Health Parity and Addiction Equity Act*.
- Adequate behavioral health reimbursement and insurance coverage from Medicare and Medicaid to help effectively meet the health care needs of vulnerable patient populations.
- Broadening the Medicare behavioral health benefit to encompass other components of the health care continuum.
- Support from federal policymakers for innovative care delivery models, as well as quality measurement efforts, to advance the state-of-the-art in behavioral health care.
- Creating safe harbors from anti-kickback laws for clinical integration programs to help incentivize and encourage providers to collaborate across settings of care.

The *Patient Protection and Affordable Care Act*’s investments in behavioral health are worthy steps in the right direction. Expansion of health insurance, along with improved coverage of behavioral health treatment under parity laws, will broaden access to needed services. At the same time, increased provider accountability through quality measurement efforts, as well as support for new care delivery models, will spur efforts to coordinate care across currently fragmented settings to improve the efficiency and effectiveness of care delivered to individuals with behavioral health conditions. Health care organizations and providers that can effectively integrate behavioral care across treatment settings and service lines should realize gains in quality and outcomes and reduced treatment costs. Nevertheless, we will continue to need support from public partners to bolster the efforts of hospitals, behavioral health providers and others to increase access to care.

Finally, the AHA urges the Finance Committee to view behavioral health care within the context of the broader health care system, as behavioral health care needs span the full health care continuum. We are pleased to offer our responses to the thoughtful questions offered by the committee and look forward to working with you and other members of Congress on improving our nation’s behavioral health care system.

If you have any questions, please feel free to contact Carlos Jackson, AHA senior associate director of federal relations, at (202) 626-2677 or cjackson2@aha.org. Thank you again for the opportunity to comment.

Sincerely,

Rick Pollack
Executive Vice President
American Hospital Association (AHA) Responses to Senate Committee on Finance Request for Comment

1. What administrative and legislative barriers prevent Medicare and Medicaid recipients from obtaining the mental and behavioral health care they need?

FUNDING AND REIMBURSEMENT

Medicaid: As the largest payer of behavioral health services, Medicaid funds many of the community-based services and resources that are part of a complex, and often fragmented, behavioral health care system. Over the past few years, Medicaid funding has been cut dramatically as states struggle to balance their budgets. As a result, a majority of states have reduced Medicaid funding and cut rates paid to hospitals and other providers.

The Medicaid provider assessment program has allowed state governments to expand coverage, fill budget gaps and maintain access to health services by reducing proposed provider payment cuts. Despite its importance to financing state Medicaid programs, there have been recent proposals to scale back the use of provider assessments. In 2012, the House of Representatives twice passed legislation that contained a reduction in the allowable assessment from 6 percent to 5.5 percent, which would result in $11.2 billion in cuts to the Medicaid program. Any loss of funding from provider assessments would put enormous pressure on already stretched state Medicaid budgets and could potentially jeopardize this critical safety-net program, just as states prepare to expand eligibility to comply with the Patient Protection and Affordable Care Act (ACA). The AHA strongly urges Congress not to restrict the use of provider assessments by the states.

Disproportionate Share Hospital (DSH) Payments: The ACA reduces both Medicaid and Medicare DSH payments to hospitals. These payments provide vital financial support to hospitals that serve the nation’s most vulnerable populations – Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured. In light of recent data indicating that the number of Medicaid beneficiaries being admitted to hospitals for mood disorders is increasing, these actions place additional stress on hospitals. Because the ACA was estimated to expand public and private health care coverage to 32 million more Americans by 2019, Congress deemed it appropriate to cut both Medicaid and Medicare DSH payments to hospitals. However, as the president’s budget request for fiscal year (FY) 2014 reflects, with the uncertainty of state governments’ decisions on Medicaid expansion, the promise of health care coverage improvements may not be realized for some years to come. Given these factors, the AHA urges Congress to delay the DSH cuts for two years to allow for coverage expansions to be more fully realized and better data to become available.
Institutions for Mental Disease (IMD) Exclusion: The IMD exclusion originated with the enactment of the Medicaid program in 1965, at a time when state-operated psychiatric facilities were a primary setting for behavioral health care and patients were admitted for longer-term stays. The policy prohibits federal Medicaid reimbursement for inpatient care provided to individuals between the ages of 21 and 64 in IMDs, such as private freestanding psychiatric hospitals with more than 16 beds.

Advances in behavioral health care have allowed for shorter inpatient stays and more outpatient treatment options, while funding challenges have led to the closure of many state behavioral health facilities. The lack of funding and underpayment for behavioral health care services has also led to the continual decline in the number of inpatient psychiatric beds, thereby limiting access to care for many who suffer from behavioral health and substance use disorders. The AHA supports the ACA’s Medicaid Emergency Psychiatric Demonstration to examine whether eliminating or restricting the scope of the IMD exclusion can improve access to care and help reduce costs. We urge Congress to promptly review the forthcoming analysis of the demonstration and determine the necessity of the IMD exclusion.

Medicare: The AHA urges Congress to address the current inadequacies of the overall Medicare behavioral health benefit. Compared to the scope of services many private health insurers cover, the Medicare benefit is far narrower. For instance, Medicare beneficiaries are currently limited to just 190 days of inpatient psychiatric hospital care in their lifetime. No other Medicare inpatient hospital service has such a strict and arbitrary cap on benefits. The AHA has called on Congress to pass legislation to eliminate the Medicare 190-day lifetime limit.

In addition, rather than covering the full continuum of behavioral health care services, Medicare currently covers only inpatient psychiatric care, hospital-based and community mental health center-based partial hospitalization program services and office-based services. The parts of the continuum missing from the current Medicare benefit include formal coverage of intensive outpatient care, residential treatment, psychosocial rehabilitation and care management. This makes it difficult for providers to provide Medicare beneficiaries with the appropriate services at the right level and time. Telepsychiatry has been proven as an effective treatment delivery vehicle, yet Medicare does not cover telepsychiatry in the home, and limits the reimbursement for these services if the provider is in a metropolitan area. Congress should broaden the Medicare behavioral health benefit structure to encompass the other components of the continuum.

Furthermore, Congress should examine the adequacy of reimbursement levels for inpatient psychiatric units in general acute care hospitals as provided under Medicare’s inpatient psychiatric facility payment system. The lack of adequate payment is a contributing factor in the closure of inpatient psychiatric units at general hospitals. As a result, the number of inpatient beds available has declined at a time when demand for behavioral health care services in hospitals continues to grow and the value of integrating behavioral and physical health services is being demonstrated through reduced costs and improved treatment outcomes. We urge the
Finance Committee to explore how reimbursement for psychiatric services affects access to care across all settings.

**Dual-Eligible Beneficiaries:** Beneficiaries that are eligible for both the Medicare and Medicaid programs (i.e., dual-eligible) are among the sickest and poorest individuals and must navigate a system with two sets of payers and benefits to access necessary services, relying on Medicaid to pay Medicare premiums and cost sharing to cover critical benefits not covered by Medicare. Currently, care for dual eligibles is fragmented, unmanaged, and uncoordinated at the program level, based on an inefficient fee-for-service provider payment system. The current system lacks sufficient care coordination for the comprehensive services this population needs, which inhibits access to critical services and encourages cost shifting between providers and payers. All of these factors adversely affect this population’s quality of care and health outcomes, in addition to contributing to Medicare and Medicaid spending challenges.

As the Medicare Payment Advisory Commission (MedPAC) reported to Congress earlier this year, in 2009, 20 percent of all dual-eligible beneficiaries enrolled in the traditional Medicare program and one-third of dual eligibles under the age of 65 had a “severe and persistent mental illness.” Care coordination models can potentially reduce fragmentation, increase flexibility in the types of services that can be provided, enhance budget predictability, align incentives and control the costs of caring for this population. Unfortunately, the administrative complexity results in few dual eligibles participating in coordinated care models and even fewer in integrated programs that align Medicare and Medicaid. Legally, the government payers are structured to operate as two separate programs, and their interaction is complicated by 50 separate state Medicaid policies.

Financially, the current policy creates incentives to shift costs to the other payer, often hindering efforts to improve quality, increase access, and coordinate care. State-run Medicaid plans have little incentive to improve coverage of long-term and supplemental services for dual eligibles—which can reduce hospitalization, readmissions, and unnecessary ED visits—because potential savings would accrue primarily to Medicare. Better discharge planning under Medicare could help avoid a lengthy Medicaid-reimbursed residential treatment stay, but without program coordination, there is no incentive for Medicare to support this endeavor.

Hospitals are doing their part working to improve care transitions, particularly for these vulnerable populations, by better coordinating care outside the hospital’s four walls. The AHA’s 2011 report *Caring for Vulnerable Populations*, examined emerging practices in effectively coordinating care for vulnerable populations through highlighting case models of care and the development of best practices recommendations.

The way to improve both the quality and efficiency of covering the dually eligible is to develop an effective person-centered care model that is then supported by changes to both the Medicare and Medicaid programs to overcome care and coverage coordination issues and conflicting administrative requirements and financial incentives. **We urge the Committee to examine care coordinated models for the dual-eligible population.**
**Physician Payment:** Physicians specializing in behavioral health care need stable and adequate payment for services provided to Medicare beneficiaries. The most recent payment fix passed by Congress prevented a 26.5 percent cut to Medicare physician payments scheduled to take effect in 2013, and provided physicians with a zero percent update for the remainder of the year. Unfortunately, this fix, along with other provisions, was funded in part by an $11 billion reduction to hospital inpatient payments. Medicare physician payments are scheduled to be reduced by 25 percent. While averting a cut in payments to physicians is essential, it should not be financed by reducing payments to hospitals. We will continue to work with Congress to find a permanent solution to the Medicare physician payment problem, while strongly opposing additional cuts that could be harmful to hospitals’ ability to fulfill their mission of caring.

**COVERAGE**

**Mental Health Parity:** The AHA supports full implementation of the *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act* (MHPAEA). The MHPAEA ended the inequity between health insurance benefits for mental health and substance use (MH/SU) disorders and medical/surgical conditions for group health plans with more than 50 employees. Although MHPAEA is a historic policy change, further guidance is needed to ensure full parity among health conditions. Since 2010, the law has been implemented under an interim final rule. The rule states that not all treatments or treatment settings for MH/SU conditions correspond to those for medical and surgical conditions, but does not provide a formal crosswalk that links medical/surgical benefits (such as skilled-nursing facility benefits or outpatient hospital treatments) to their corresponding MH/SU benefits (such as residential treatment benefits, intensive outpatient or partial hospitalization programs). We remain hopeful that the administration will soon issue a final rule that includes such a crosswalk.

In addition, this type of crosswalk would encourage plans to integrate their MH/SU benefit and medical and surgical benefit structures into one benefit structure, where an inpatient hospitalization is simply considered an inpatient hospitalization, whether it is for psychiatric or general acute care. By no longer thinking of MH/SU and medical and surgical as two distinct types of health care benefits, we can make progress toward overcoming the stigma and discrimination often associated with MH/SU conditions.

Furthermore, the interim final rule provides that, when examining whether MH/SU benefits are being offered at parity with medical/surgical benefits, a plan must only compare benefits within the same category. The rule identified six categories of benefits: inpatient in-network; inpatient out of network; outpatient, in-network; outpatient, out of network; Emergency Care; and Prescription drugs. The AHA believes a category for post-acute care is needed. Alternatively, Congress should urge CMS to provide more instruction on which category post-acute care should fall into. Presently, it is unclear into which category, if any, certain post-acute benefits, such as skilled-nursing facility benefits, fall. More detail would help ensure that parity is provided appropriately, as well as offer protections for providers and patients alike.
Medicaid Alternative Benefit Plans and IMD Exclusion: The AHA believes that the ACA is clear that the Medicaid Alternative Benefit Plan should include the Essential Health Benefits (EHB) of hospitalization and mental health services that are included in the exchange-based coverage, thus requiring Medicaid programs to pay for IMD services provided to beneficiaries ages 21 to 64 in private psychiatric hospitals. Freestanding psychiatric hospitals play a vital role in ensuring access to community-based mental health care for those with serious mental illnesses. And the IMD restrictions present an access barrier for the Medicaid expansion population receiving coverage through the Alternative Benefit Plan.

The AHA believes that new Medicaid beneficiaries should have the same access as those who purchase health care coverage through the exchanges to choice, quality and cost-effective treatment for inpatient psychiatric care as they do for medical/surgical treatment. Accordingly, we urge the committee to consider recommending that the IMD restrictions should not apply to the coverage provided to the Medicaid expansion population through the Alternative Benefit Plan. This policy will bring Medicaid mental health coverage for the expansion population in line with the EHB requirements that apply to coverage offered through the exchanges.

WORKFORCE

Workforce Development: The expansion of health insurance coverage provided by the ACA greatly increases the demand for caregivers, including behavioral health professionals. The Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 11 million Americans who will gain access to health insurance coverage in 2014 will suffer from a behavioral health and/or substance use condition. However, the AHA is concerned that critical shortages of treatment capacity present a significant barrier to accessing behavioral health services. SAMHSA previously found that 55 percent of U.S. counties have no practicing psychiatrists, psychologists or social workers. In addition, the Bureau of Labor Statistics reports that the median age for psychiatrists and psychologists is above 50 years old, and further notes that 46 percent of psychiatrists are over the age of 65, threatening to worsen treatment capacity issues. For these reasons, the AHA continues to advocate for the highest level of appropriations for behavioral health and allied health education programs.

We also recommend Congress continue its support of the education of future physicians through the Medicare graduate medical education (GME) program. Given the current and projected shortage of physicians, especially in behavioral health, primary care and general surgery, the AHA continues to recommend that the 1996 cap on residency slots be lifted. Limits on the number of Medicare-funded residency training slots constrain the ability of hospitals to train new physicians. We support the Resident Physician Shortage Reduction Act of 2013 (S. 577/H.R. 1180), introduced by Sens. Nelson, Schumer and Reid (D-NV), and Rep. Joe Crowley (D-NY), respectively. The bill would increase the number of Medicare-supported physician training positions to at least 15,000 new resident positions, which is about a 15 percent increase in residency slots.
2. **What are the key policies that have led to improved outcomes for beneficiaries in programs that have tried integrated care models?**

Hospitals across the country have employed creative approaches to broaden access to behavioral health and substance abuse services. Hospitals and other behavioral health providers are filling the gaps in care that have grown as mental health care transitioned away from public institutions to community settings by establishing collaborative care approaches fostered by integrated care models. Integration of care can range from brief screening and intervention for comorbid conditions, to coordinated communication between medical and behavioral health providers, to full integration of care delivery across the care continuum with respect to all of the medical and behavioral health care needs of a particular patient. Integration entails both improving the screening and treatment for behavioral health care needs within primary, acute and post-acute care settings, as well as improving the medical care of people receiving services in behavioral health care settings.

Hospitals are utilizing telepsychiatry to expand availability of services in rural communities, or provide Emergency Departments (ED) with greater access to behavioral health specialists. Other effective methods include integrating behavioral health services into other settings along the care continuum, such as primary care and post-acute settings. A common theme for providers operating in an integrated manner is the focus on the total costs of care, not just the cost burden for behavioral health services, as integration has shown over and over to reduce the total cost of care. In this regard, care and case management help provide patients with the full scope of services necessary to successfully treat their conditions, including wrap around services.

The attached AHA *TrendWatch* report, *Bringing Behavioral Health Into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes* clearly demonstrates the early successes of these integrated delivery models in improving outcomes. For example, one study of an integrated care model found that 44 percent of adults with a serious mental illness who received primary care services within the behavioral health setting had diabetes and hypertension screenings, while none of the patients without integrated care were screened. Additionally, ED visits were 42 percent lower among the group that received integrated primary care services.

3. **How can Medicare and Medicaid be cost-effectively reformed to improve access to and quality of care for people with mental and behavioral health needs?**

The AHA believes that high-quality behavioral health care requires both effective care delivery models, as well as adequate resources to ensure that all patients can access appropriate care. Addressing the barriers discussed earlier would greatly enhance the resources available to the field, thereby improving access. We also recommend that Congress pursue several other strategies that have the potential to greatly enhance behavioral health care.

**Support for Innovative Care Delivery Models.** Congress should support the ongoing development and evaluation of care delivery models that integrate behavioral health care
into the broader care continuum. The delivery of and reimbursement for behavioral health services have been usually separate from and uncoordinated with the broader health care delivery system. Additionally, funding sources for psychiatric disorders have often been separate from those for substance use disorders. For individuals with comorbid behavioral and physical health conditions, this fragmentation compromises quality of care and clinical outcomes. Integration of care between the behavioral health and general medical care treatment settings and providers, can reduce costs and improve outcomes for these patients. **We urge the Finance Committee to examine methods to incentivize and encourage providers to collaborate across settings of care.** For example, Congress can create safe harbors from anti-kickback laws for clinical integration programs.

The integration of behavioral health care into the care continuum also has been integral to the success of care delivery and financing models that expanded under the ACA, such as accountable care organizations (ACOs) and medical homes. ACOs join physicians, hospitals and other providers to manage and be held accountable for the quality and costs of care for their patients. While private payers are already testing ACOs, the ACA added the model to Medicare, giving participating providers an opportunity to share in cost savings if they meet quality goals. In the Medicaid program, the ACA also created a health home program to promote integrated care for beneficiaries with chronic ailments, including behavioral health conditions. Beneficiaries with a serious and persistent mental illness, or with a mental health or substance use disorder and a comorbid chronic medical condition, are eligible to participate in the health home program. Each health home will include a team of physicians and other providers, including behavioral health care professionals. In addition to medical services, the team delivers comprehensive care management, care coordination, health promotion and other patient and family support.

**Quality Measurement and Pay-for-Performance.** The AHA believes that rigorous, publicly transparent quality measurement is an important part of improving behavioral health care. Hospitals and behavioral health care providers have long supported the need for public reporting of quality measures in order to share important and reliable quality information with the communities they serve, and identify opportunities to improve care and track improvements. The ACA expanded national measurement efforts for behavioral health care through the creation of the Inpatient Psychiatric Facility Quality Reporting (IPFQR) program. The ACA also mandates that CMS pilot a value-based purchasing program for inpatient psychiatric facilities (IPFs) by 2016, increasing the financial stakes of quality performance for behavioral health providers. We believe that a mix of public quality reporting and pay-for-performance can align the health care delivery system—including behavioral health—toward continuous quality improvement, and reward providers that improve.

However, the implementation of future quality reporting and pay-for-performance efforts related to behavioral health care must recognize the resource constraints of the field. As noted earlier, behavioral health care providers face significant resource challenges. Given the resources needed to collect and report data on quality measures, measures must be carefully selected to ensure they address the highest priority areas. Moreover, pay-for-performance
programs must be carefully implemented to ensure that they fairly assess performance, and do not impose unwarranted reductions to reimbursement.

As Congress considers the creation of additional quality measurement and pay-for-performance programs for behavioral health care in the future, we offer the following principles to guide their design. These principles are consistent with those outlined our June 2013 statement on federal quality measurement and pay-for-performance efforts in general, and our August 2013 letter on post-acute care reform.

- **Quality measurement programs for behavioral health care should be aligned with broader national quality improvement priorities for all health care providers.** Unfortunately, federal quality reporting and payment programs have proliferated without strong alignment to national priorities or a fundamental understanding of the most important changes to be made to produce better patient outcomes. Indeed, the sheer volume of measures and disparate ranking and rating efforts has become overwhelming and distracting to quality improvement efforts, with different priorities, different goals and different incentives impeding efforts to enhance coordination across the care continuum.

- **Measures in quality reporting and pay-for-performance programs must be endorsed by the National Quality Forum (NQF) to ensure they are sufficiently rigorous to use in accountability programs.** The Measure Applications Partnership (MAP) also should review the measures before being incorporated into programs to ensure they are aligned with national priorities. Rigorous measures aligned with national quality priorities would ensure focused attention on the most critical areas of improvement and promote an efficient use of limited quality improvement resources. It also would encourage coordination of efforts among all health care providers.

- **To ensure uniformity of purpose across the health care system, behavioral health quality reporting and payment programs should align with the National Quality Strategy (NQS).** The ACA directs the Department of Health and Human Services (HHS) to create an NQS that identifies critically important areas for improvement, sets goals and selects measures to be used in federal programs to encourage achievement of those goals. This plan is meant to set priorities for the health care system as a whole, and relies on input from affected stakeholders, including hospitals, patients, purchasers, insurers and public policy experts. The AHA strongly supports the premise of the NQS—that is, our nation’s health care system can be improved by focusing on aspects of care that a broad array of stakeholders believes to be important.

- **Pay-for-performance programs should assess multiple aspects of care, and use incentive structures that recognize providers for both achievement versus national benchmarks and improvement versus baseline performance.** The inclusion of multiple aspects of care within one pay-for-performance program provides a consistent evaluation mechanism and incentive structure, reducing confusion about how
performance is evaluated. We also believe this incentive structure provides greater inducement for providers to improve performance.

- **The AHA believes that measures should be added to post-acute care pay-for-performance programs in a gradual, step-wise process. This will ensure that programs assess performance accurately, and address issues of high priority.** Our guidelines are as follows:

  - Measures implemented in federal programs should be reviewed and endorsed by the NQF prior to inclusion in a federal program to ensure that each measure is important, scientifically sound, useable and feasible to collect.

  - Federal programs should require that the MAP review all measures being considered for inclusion in the program before they are formally proposed in rulemaking. As noted above, the MAP’s review should be informed by overall health care system priorities, thereby allowing an assessment of whether measures support improvement in the most important areas.

  - Before being used in a pay-for-performance program, each measure should be included in a national public reporting program for at least one year. In this manner, the results can be monitored to be sure that there is variation in performance; the causes for variation can be identified and, if related to patient characteristics (such as severity of illness), appropriate adjustments can be made to the measure; and potential unintended consequences of measurement and public reporting can be identified and addressed.

  - Monitoring of a measure’s performance should continue throughout its use in a pay-for-performance program. When there is evidence of consistent and sustained excellent performance, the measure should be retired from performance-based incentive programs and public reporting programs. This will create room for identification of additional improvement opportunities and inclusion of new measures.
One in four Americans experiences a mental illness or substance abuse disorder each year, and the majority also has a comorbid physical health condition. In 2009, more than 2 million discharges from community hospitals were for a primary diagnosis of mental illness or substance abuse disorder.

The range of effective treatment options for behavioral health disorders—which encompass both mental illness and substance abuse disorders—is expanding. Research indicates that better integration of behavioral health care services into the broader health care continuum can have a positive impact on quality, costs and outcomes.

Mental illnesses are specific, diagnosable disorders. Each is characterized by intense alterations in thinking, mood and/or behavior over time. Substance abuse disorders are conditions resulting from the inappropriate use of alcohol, prescription drugs and/or illegal drugs.

Behavioral health disorders may also include a range of addictive behaviors, such as gambling or eating disorders, characterized by an inability to abstain from the behavior and a lack of awareness of the problem.

Health reform creates new impetus and opportunity for better managing the care delivered to individuals with these conditions. Expansion of health insurance generally, along with improved coverage of behavioral health treatment under parity laws, will broaden access to needed services. At the same time, increased provider accountability will spur efforts to coordinate care across currently fragmented settings to improve the efficiency and effectiveness of care delivered to individuals with behavioral health conditions.

Many providers already are working with private payers to meet these same goals. Initiatives span value-based purchasing, accountable care organizations, patient-centered medical homes, and efforts to reduce readmissions. These initiatives will have important implications for the delivery of behavioral health care. And as the demand for behavioral health services is likely to continue to outstrip capacity, improving care integration can help to better manage this need.

Highly Prevalent, Behavioral Health Disorders Have a Significant Economic and Social Impact

Behavioral health disorders affect a substantial portion of the U.S. population. Nearly half of all Americans will develop a mental illness during their lifetime. An estimated 22.5 million Americans suffered with substance abuse or dependence in 2009, and 27 percent of Americans will suffer from a substance abuse disorder during their lifetimes.

While behavioral health disorders primarily affect adults, they also are prevalent among children. Among children, mental health conditions were the fourth most common reason for admission to the hospital in 2009. Studies reveal that approximately 17 percent of Medicare beneficiaries have a mental illness. An analysis of Medicaid beneficiaries across 13 states found that more than 11 percent of beneficiaries used behavioral health services in a year.

The economic and social costs associated with behavioral health are significant, underscoring the importance of treating these conditions. In the majority of cases, behavioral health conditions are serious enough to cause limitations in daily living and social activities. For example, behavioral health conditions hinder worker productivity and raise absenteeism, resulting in reduced income...
Behavioral health conditions are prevalent among adults in the U.S.

Chart 1: Percent of U.S. Adults Meeting Diagnostic Behavioral Health Criteria, 2007

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Within Past 12 Months</th>
<th>Ever in Lifetime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorder</td>
<td>19%</td>
<td>31%</td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>10%</td>
<td>21%</td>
</tr>
<tr>
<td>Impulse-control Disorder</td>
<td>11%</td>
<td>25%</td>
</tr>
<tr>
<td>Substance Disorder</td>
<td>13%</td>
<td>35%</td>
</tr>
<tr>
<td>Any Disorder</td>
<td>57%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Note: Anxiety disorder includes panic disorder, agoraphobia, specific phobia, social phobia, generalized anxiety disorder, post-traumatic stress disorder, obsessive compulsive disorder, and adult separation anxiety disorder. Impulse-control disorder includes oppositional defiant disorder, conduct disorder, attention deficit/hyperactivity disorder, and intermittent explosive disorder. Substance disorder includes alcohol abuse, drug abuse, and nicotine dependence.


Individuals with behavioral health disorders often have co-occurring physical health conditions. In the past year, 34 million adults—17 percent of American adults—had comorbid mental health and medical conditions. Mental health and medical conditions are risk factors for each other and the presence of one can complicate the treatment of the other. For example, a recent study found that individuals with bipolar disorder, on average, have a greater number of medical conditions than individuals without claims for mental illness. And a study of Medicaid beneficiaries in New York State determined that, among patients at high risk of hospitalization, 69 percent had a history of mental illness and 54 percent had a history of both mental illness and alcohol and substance use.

Individuals with co-occurring physical and mental health conditions present many treatment challenges. A physical condition may exacerbate a mental health condition, while a mental health condition may hinder treatment for a physical ailment. Medical conditions with a significant symptom burden, such as migraine headaches, chronic bronchitis, and back pain are associated with increased incidence of major depression. About one fifth of patients hospitalized for a heart attack suffer from major depression, which roughly triples their risk of dying from a future heart attack or other heart condition. Depressed patients also are three times more likely than non-depressed patients to be noncompliant with treatment recommendations. Moreover, individuals with mental illness more frequently have risk factors, such as smoking and obesity, which contribute to increased likelihood of chronic conditions such as stroke and diabetes.

Patients with comorbid mental health and medical conditions experience higher health care costs, with much of the difference attributable to higher medical, not mental health, expenditures. One analysis found that although the presence of comorbid depression or

or unemployment. In 2007, persons diagnosed with serious mental illness had annual earnings averaging $16,000 less than the general population. Each year, approximately 217 million days of work are lost or partially lost due to productivity decline related to mental disorders, costing United States employers $21.7 billion annually.

Behavioral health disorders also can have a profound social impact. Individuals with behavioral health conditions are more likely to live in poverty, have a lower socioeconomic status, and lower educational attainment. Lack of treatment amplifies these outcomes and increases the likelihood that individuals will end up homeless or incarcerated.

These social impacts, in conjunction with treatment costs, present a significant and growing economic burden that has made mental illness one of the five most costly conditions nationwide. In 2008, the U.S. spent nearly $60 billion on mental health services, up from $35 billion in 1996. In contrast to general health care services, in which public and private payers account for roughly equal shares of spending, public payers account for the majority of behavioral health expenditures. In 2005, Medicaid and state and local governments accounted for 61 percent of behavioral health care expenditures, compared with 46 percent for all health services.
Individuals with behavioral health conditions frequently have co-occurring physical health conditions.

Chart 2: Percentage of Adults with Mental Health Conditions and/or Medical Conditions, 2001-2003

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with Medical Conditions</td>
<td>29%</td>
</tr>
<tr>
<td>Adults with Mental Health Conditions</td>
<td>68%</td>
</tr>
</tbody>
</table>


The presence of a mental health disorder raises treatment costs for chronic medical conditions.

Chart 3: Monthly Health Care Expenditures for Chronic Conditions, with and without Comorbid Depression, 2005

<table>
<thead>
<tr>
<th>Condition</th>
<th>Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without Depression</td>
<td>$1,290</td>
</tr>
<tr>
<td>With Depression</td>
<td>$1,420</td>
</tr>
</tbody>
</table>


Anxiety boosts medical and mental health care costs, more than 80 percent of the increase stems from medical spending. Monthly costs for a patient with a chronic disease and depression are $560 more than for a person with a chronic disease without depression.30

The presence of comorbid conditions also can lead to suboptimal patient outcomes. Research indicates that individuals with mental illness die younger than people without such diagnoses, but from the same leading causes of death as occur nationwide, such as heart disease and cancer.31 Individuals with serious mental illness die, on average, 25 years earlier than the general population.32 Such poor outcomes may be linked to lack of appropriate care. One study found that almost one third of patients with schizophrenia did not receive appropriate medical treatment for their diabetes, and 62 percent and 88 percent, respectively, did not receive appropriate treatment for high blood pressure and high cholesterol.33

Individuals with comorbid conditions are at heightened risk of returning to the hospital after discharge. A Canadian study found that 37 percent of patients with mental illness discharged from acute care hospitals were readmitted within a period of one year, compared with only 27 percent of patients discharged without a mental illness.34 In addition, individuals with substance use disorders are among the highest-risk populations for medical and psychiatric rehospitalizations.35

Patients with comorbid mental and physical health conditions are readmitted for a broad range of reasons. Specifically, these patients have multiple health conditions, may lack a strong support system, and may not adhere to treatment regimens. These factors can impede recovery and increase the likelihood that patients will return to the hospital. One study found that heart attack patients who were depressed were more likely to be readmitted in the year after discharge.36 Another study concluded that patients with severe anxiety had a threefold risk of cardiac-related readmission, compared to those without anxiety.37 Among children, the risk of rehospitalization was highest during the first 30 days following a first psychiatric hospitalization and remained elevated until about 90 days post-discharge.38 This finding underscores the vulnerability of patients during the immediate post-discharge period and highlights the importance of integrated care and post-discharge support services.
Fragmented Care Delivery and Provider Shortages Impede Effective Treatment for Behavioral Health Conditions

Behavioral health care is fragmented. Individuals who seek behavioral health care often receive treatment in both the inpatient and outpatient settings from generalists and specialists, and rely on a myriad of community resources. Patients with physical health conditions can receive care from yet another group of providers who do not have linkages to those delivering behavioral health care. Even more troubling, the majority of adults with a diagnosable behavioral health disorder do not get any treatment for their behavioral health conditions.

One of the biggest barriers to accessing behavioral health services is a critical shortage of treatment capacity. Currently, 55 percent of U.S. counties have no practicing psychiatrists, psychologists or social workers. There also is a shortage of facilities formally providing behavioral health care. Only 27 percent of community hospitals have an organized, inpatient psychiatric unit, while state and county psychiatric hospitals are closing due to state budget and other funding constraints. Many states have slashed their mental health budgets. Twenty-eight states and Washington, DC reduced their mental health funding by a total of $1.6 billion between fiscal years 2009 and 2012.

Cost is a common barrier to receiving mental health care services.

Chart 4: Reasons for Not Receiving Mental Health Services, Among Adults Reporting Unmet Need, 2009

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Could Not Afford Cost</td>
<td>45.7%</td>
</tr>
<tr>
<td>Could Handle Problem Without Treatment at Time</td>
<td>26.6%</td>
</tr>
<tr>
<td>Did Not Have Time</td>
<td>16.3%</td>
</tr>
<tr>
<td>Did Not Know Where to Go For Services</td>
<td>15.3%</td>
</tr>
<tr>
<td>Health Insurance Did Not Cover Enough Treatment</td>
<td>11.7%</td>
</tr>
<tr>
<td>Treatment Would Not Help</td>
<td>10.6%</td>
</tr>
<tr>
<td>Concerned About Confidentiality</td>
<td>9.3%</td>
</tr>
<tr>
<td>Did Not Feel Need for Treatment</td>
<td>9.1%</td>
</tr>
<tr>
<td>Might Cause Others to Have Negative Opinion</td>
<td>9.0%</td>
</tr>
<tr>
<td>Might Have Negative Effect on Job</td>
<td>7.9%</td>
</tr>
</tbody>
</table>

Note: Excludes those who reported unmet need but received some services.

The health care system’s capacity to deliver mental health services has been shrinking.

Chart 5: Total Number of Psychiatric Units(1) in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals(2) in U.S., 1995-2010

Note: Includes all registered and non-registered hospitals in the U.S.
(1) Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.
(2) Freestanding psychiatric hospitals also include children's psychiatric hospitals and alcoholism/chemical dependency hospitals.
To achieve these cuts, states have eliminated or downsized emergency and long-term hospital treatment, and community mental health treatment programs, among other services. Colorado, for example, has reduced payment rates for mental health providers and cut funding for residential treatment. States are making decisions to reduce services as demand for behavioral services is increasing. Emergency department (ED) visits involving a primary diagnosis of mental illness or substance abuse disorder increased from about 4.2 million in 2006 to more than 5 million visits in 2009.

Due to this increased utilization and a shortage of beds, ED boarding—the practice in which admitted patients are held in the ED until inpatient beds become available—is growing for patients with behavioral health care needs at hospitals nationwide. In 2008, 80 percent of ED medical directors surveyed reported that their hospitals board psychiatric patients and 42 percent reported a rising trend. Boarding can adversely affect psychiatric patients by exacerbating their conditions, as patients are held in typically loud, hectic environments not conducive to their recovery.

### Treatment Settings for Behavioral Health Care

The first point of contact for individuals seeking mental health care is typically a primary care provider. In fact, primary care is the sole form of health care used by more than one third of patients receiving care for a mental health condition. Patients also may access mental health care through specialists (e.g., psychiatrists), social service providers (e.g., counselors) and informal volunteers (e.g., support groups). Mental health services are delivered at a range of locations, including hospitals, outpatient clinics and community settings. Of the 30 million adults receiving mental health services in 2009, the most common services were outpatient therapy, outpatient prescription drugs or a combination of the two.

Although mental health care is most frequently delivered on an outpatient basis, community and psychiatric hospitals remain a vital source of care for behavioral health patients. Nearly all hospitals report that they provide care to patients with mental health and substance abuse disorders. The most common behavioral health conditions treated in hospitals include mood disorders, substance-related disorders, delirium/dementia, anxiety disorders and schizophrenia. Hospitals treat these and other conditions by stabilizing patients, establishing treatment regimens and transitioning patients to outpatient and community-based services.

Overall, about 27 percent of behavioral health care expenditures in 2005 went toward hospital-based services—inpatient care provided by community and psychiatric hospitals. Psychiatric hospitals offer inpatient psychiatric and nursing services, conduct procedures and observe patients so that they do not harm themselves. Notably, the vast majority of inpatient behavioral health services are provided in community hospitals.

### Treatment for behavioral health problems is most frequently delivered on an outpatient basis.

Chart 6: Types of Mental Health Services Used in Past Year, Among Adults Receiving Treatment, 2009

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Only, Rx</td>
<td>2%</td>
</tr>
<tr>
<td>Rx Only</td>
<td>49%</td>
</tr>
<tr>
<td>Outpatient Only</td>
<td>13%</td>
</tr>
<tr>
<td>Outpatient and Rx</td>
<td>32%</td>
</tr>
<tr>
<td>Combination of Inpatient, Outpatient, and/or Rx</td>
<td>4%</td>
</tr>
</tbody>
</table>

Note: Excludes treatment for substance abuse disorders.
Treatment Works

Despite the challenges of delivering and coordinating behavioral health care within the broader health care system, effective treatment for behavioral health conditions does exist. For instance, pharmacotherapy has become an increasingly important part of behavioral health treatment. A wave of new, effective drug treatments for depression, anxiety and schizophrenia has boosted medication as a share of mental health expenditures from 7 percent in 1986 to 27 percent in 2005. Effective drug treatments also have allowed more patients to receive care in the outpatient setting, which accounted for 33 percent of mental health expenditures in 2005, up from 24 percent in 1986.58

Pharmacologic treatments, such as antidepressants have been shown to improve quality of life for mental health patients.59 Medications also are often enhanced with psychosocial treatments. Cognitive behavior therapy, in combination with psychotropic medication, has decreased symptoms of principal generalized anxiety disorder, panic disorder and social anxiety disorder.60

The relative ease of seeking treatment in ambulatory settings, along with shifting perceptions of behavioral health, may encourage more individuals to seek treatment. A survey comparing perceptions of major depression found that more individuals attribute the condition to neurobiological causes and endorse treatment for depression in 2006 than did in 1996.61

Treatment has been shown to have a positive economic impact by reducing employer costs and boosting worker productivity. In one study, work impairment of employees with mental illness (defined as when emotional distress has an impact on day-to-day functioning) was cut nearly in half after three weeks of outpatient treatment, from 31 percent to 18 percent.62 Employer-based initiatives to increase access to mental health treatment have also proven beneficial. For example, Employee Assistance Programs have been shown to reduce medical, disability, and workers’ compensation claims, improve worker productivity and decrease absenteeism.63

Treatment also has evolved to meet patient needs. Technological advances, such as telepsychiatry, have improved care for patients in rural and other underserved areas. Telepsychiatry—a form of video conferencing that can be used to provide psychiatric services—has been shown to be as effective as face-to-face communication,64 as well as to increase access and diagnosis and enhance care coordination.65

South Carolina Telepsychiatry Network

The South Carolina Department of Mental Health and the South Carolina Hospital Association received funds to develop a statewide telepsychiatry network. The program allows mental health providers to conduct psychiatric consultations via telephone and video conferencing, giving patients in 27 participating hospital EDs greater access to mental health specialists.66 The program has produced measurable results, both in terms of patient outcomes and cost savings. The statewide average length of stay for patients experiencing a behavioral crisis across participating hospitals declined from six days to three days. One hospital, Springs Memorial, reported a savings of $150,000 in the first eight months of its participation in the service.67
The Aleda E. Lutz Veterans Administration (VA) Medical Center in Saginaw, MI has been using telepsychiatry for the past five years to provide individual therapy and counseling as well as ongoing evaluation and assessment for behavioral health patients. Before initiating telepsychiatry, one onsite visit with the mental health professional is recommended to complete a psychosocial exam and establish a relationship. After that visit, patients are offered the option of receiving follow-up sessions using telepsychiatry. Before a telepsychiatry session begins, there is a reconciliation of all critical patient information from the electronic medical record and from recent tests and medication adjustments. The telepsychiatry technicians (THTs), who are onsite with the patients, and the health care provider at the remote site have protocols for how to handle specific situations or emergencies. For example, if a patient with post-traumatic stress disorder needs direct intervention during a session, the provider, who may be up to 150 miles away, may immediately call the THT (usually a nurse) on his/her cell phone and tell him/her to provide immediate hands-on care and evaluate the patient for appropriate care.

The number of VA rural sites using telepsychiatry is skyrocketing. Patients are very satisfied with the use of telepsychiatry especially because it can reduce their time spent driving to a medical care session by as much as three hours each way. Patient concerns about confidentiality of information being shared over the lines are allayed by the T3 encryption system as well as the very solid firewalls that are in place to protect their privacy.

The VA's 1,100 sites of care in the U.S., South Pacific and Puerto Rico are connected by an electronic medical record that allows health care providers to share information and coordinate care across sites. Substantial resources are required to support the technology and infrastructure as well as to train health care workers to use the equipment. The VA home telepsychiatry program served approximately 35,000 patients in 2009 and had $72 million in expenditures. By 2011, expenditures reached $163 million.

Similar to the VA experience, the Aleda E. Lutz VA Medical Center has found telepsychiatry to be a successful method for providing care to patients. The number of VA rural sites using telepsychiatry is skyrocketing. Patients are very satisfied with the use of telepsychiatry especially because it can reduce their time spent driving to a medical care session by as much as three hours each way. Patient concerns about confidentiality of information being shared over the lines are allayed by the T3 encryption system as well as the very solid firewalls that are in place to protect their privacy.

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The delivery of behavioral health services is usually separate from and uncoordinated with the broader health care delivery system. For individuals with comorbid behavioral and physical health conditions, this fragmentation compromises quality of care and clinical outcomes. Integration of care between the behavioral health and general medical care treatment settings and providers, can reduce costs and improve outcomes for these patients.

Integration of care can range from brief screening and intervention for comorbid conditions, to coordinated communication between medical and behavioral health providers, to full integration of care delivery across the care continuum with respect to all of the medical and behavioral health care needs of a particular patient. Integration entails both improving the screening and treatment for behavioral health care needs within primary, acute and post-acute care settings, as well as improving the medical care of people receiving services in behavioral health care settings.

One study of an integrated care model found that 44 percent of adults with a serious mental illness who received primary care services within the mental health setting had diabetes and hypertension screenings, while none of the patients without integrated care were screened. Additionally, ED visits were 42 percent lower among the group that received integrated primary care services.

Another study of administration of a brief screening and intervention for substance abuse among patients admitted to a large urban hospital found a nearly 50 percent reduction in re-injuries requiring an ED visit and in injuries requiring a hospital readmission within three years.

Similarly, individuals with serious mental illness enrolled in a Veterans Affairs mental health clinic who were randomized to receive integrated care were more likely to receive primary and preventive care, and demonstrated superior outcomes compared to their counterparts not receiving integrated care. Integrated care included primary care and case management given on site at the mental health clinic, patient education...
and close collaboration between physical and mental health providers.\textsuperscript{71}

A substantial body of clinical evidence has demonstrated the benefits of collaborative care for patients with depression, in particular. A literature review of 45 studies found that patients with major depressive disorder treated with collaborative care interventions experienced enhanced treatment outcomes—including reduced financial burden, substantial increases in treatment adherence, and long-term improvement in depression symptoms and functional outcomes—compared with those receiving usual care.\textsuperscript{72}

Integration of care across treatment settings can reduce readmission rates for patients with behavioral health conditions. In Florida, eight psychiatric hospitals partnered with a health plan to improve patients’ transitions to outpatient care, with the goal of reducing preventable readmissions.

### Integration of behavioral and physical health care can improve access to appropriate care.

#### Chart 8: Receipt of Preventive Care Services in 12 Months among Patients with Serious Psychiatric Illness Receiving Integrated Care vs. Patients Receiving Usual Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Integrated Care</th>
<th>Usual Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Listed in Chart</td>
<td>64%</td>
<td>86%</td>
</tr>
<tr>
<td>Educated About Smoking</td>
<td>64%</td>
<td>85%</td>
</tr>
<tr>
<td>Blood Pressure Tested</td>
<td>66%</td>
<td>85%</td>
</tr>
<tr>
<td>Educated About Nutrition</td>
<td>62%</td>
<td>83%</td>
</tr>
<tr>
<td>Educated About Exercise</td>
<td>53%</td>
<td>81%</td>
</tr>
<tr>
<td>Cholesterol Screening</td>
<td>57%</td>
<td>80%</td>
</tr>
<tr>
<td>Screened for Diabetes</td>
<td>46%</td>
<td>71%</td>
</tr>
<tr>
<td>Received Flu Vaccine</td>
<td>12%</td>
<td>32%</td>
</tr>
</tbody>
</table>


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### Mayo Clinic, Rochester, MN

The Mayo Clinic in Rochester, MN is delivering integrated primary and behavioral health care to more than 140,000 patients—including clinic employees, their dependents and other patients seen by Mayo’s primary care physicians—using a team-based approach.\textsuperscript{73} Mayo’s employed primary care physicians, clinical nurse specialists, psychiatrists, psychologists, nurses, social workers and clinic administrators make up the patient’s health care team. This team collaborates using a common patient screening tool and electronic health record to ensure the patient is receiving comprehensive primary and behavioral health care. The team also is linked with existing community-based services to ensure continuity of care for the patient.

At the initial mental health visit, patients complete self-rated scales—known as the PHQ-9 and used in a variety of health care settings nationwide—for depression, anxiety, bi-polar disorder and substance abuse which help assess the severity and urgency of the patient’s condition. The patient’s score on the PHQ-9 helps inform the health care team of the type of care the patient requires. The PHQ-9 also is completed at all follow-up visits for patients with depression. The health care team can adjust the patient’s medication, start or increase therapy and address suicide risks based on the patient’s score. Patients that receive a score of 10 or higher on the PHQ-9 are added to a registry and monitored for up to 12 months by one of Mayo’s 11 registered nurse care coordinators. The care coordinators monitor the patient’s condition, share their findings with the patient’s psychiatrist and the health care team, assist patients with referrals to other community resources and develop a relapse prevention plan with the patient. The patients also have the opportunity to participate in a depression improvement program offered in Minnesota known as DIAMOND (Depression Improvement Across Minnesota Offering a New Direction).

Mayo’s implementation of the team-based approach, the use of the PHQ-9 and the registered nurse care coordinators have significantly improved outcomes and continuity of care for patients. In 2010, two of Mayo’s clinics reported the best patient outcomes in the state.
The hospitals focused on coordinating care in the inpatient setting with support services post-discharge. Their efforts cut readmission rates at the eight hospitals. After implementing the program, the readmission rate among the participating hospitals fell from 17.7 percent to 10.4 percent.\(^74\)

Beyond improving quality of care and outcomes for patients, integrating care also can save money. In the Florida program, instituting a visit from a physician on the day of discharge reduced costs by 14 percent. Another study of a care coordination and education program, which deployed medical case managers to assist psychiatric outpatients at a community mental health center, found that participating patients had lower costs by the second year of the program than non-participating patients.\(^75\)

Further, integration has been shown to reduce health care costs in the long term. One study found that older patients with depression who received collaborative care management from both a primary care physician and a nurse or psychologist care manager had lower mean health care costs across four years compared with patients receiving usual primary care.\(^76\) Another study found that coordinating care for patients with diabetes and comorbid major depression through a nurse intervention reduced 5-year mean total medical costs by $3,907, compared with patients receiving usual primary care.\(^77\)

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**St. Anthony Hospital, Oklahoma, OK**

St. Anthony Hospital in Oklahoma City, OK is an acute care inpatient hospital that serves as a regional referral facility in behavioral medicine and also offers residential inpatient care for adolescents and children. In 2008, St. Anthony initiated a number of changes to its internal processes to address the high rates of behavioral health patients admitted through its ED and to reduce the time mentally ill patients spent in the ED in a crisis situation.\(^78\)

The hospital established a mental health admissions office in the ED and began conducting behavioral health evaluations of patients prior to bed placement in the ED. De-escalation training was conducted for all ED and security staff and the Oklahoma City Police Department was enlisted to improve and assist in the transfer of patients to the behavioral health crisis center. St. Anthony also focused on avoiding unnecessary admissions and readmissions of behavioral health patients by ensuring patients are connected with the right resources and provided the appropriate care in the appropriate setting.

As a result of these changes St. Anthony’s average wait time for patients to see a mental health professional decreased from two hours to 20 minutes, and patients now see a mental health professional before seeing an ED physician. Additionally, the average wait time for patients in the ED has decreased from 44 minutes to 28 minutes. Furthermore, the average length of stay in the ED for mental health patients has dropped from 254 minutes to 177 minutes.

Although St. Anthony has recently seen an increase in patients seeking services through the ED—on average 83 more patients a month seek care in the ED—they have experienced a 12-20 percent reduction in admissions.
Affordable Care Act Provisions Will Promote Service Integration, Quality Enhancement and Improved Access for Those with Behavioral Health Care Needs

Overall, the health care system has been shifting toward a focus on value and accountability. The Patient Protection and Affordable Care Act (ACA)\(^{79}\) furthers these efforts by promoting new care delivery models and creating new imperatives for providers to better integrate care. These ACA reforms, in addition to coverage expansion, and the previously enacted mental health parity law should facilitate the integration of behavioral health care into the broader care continuum. While many of the ACA delivery system reforms apply to Medicare and Medicaid, private insurers often adopt similar reforms once tested and found to be effective.

First, the ACA supports emerging models of care delivery—specifically accountable care organizations (ACOs) and patient-centered medical homes—that aim to coordinate and manage the full spectrum of health care needs of an individual. ACOs join physicians, hospitals and other providers to manage and be held accountable for the quality and costs of care for their patients. While ACOs are already being tested by private payers, the ACA adds the model to Medicare, giving participating providers an opportunity to share in cost savings if they meet quality goals.\(^{80}\)

In the Medicaid program, the ACA creates a health home program to promote integrated care for beneficiaries with chronic ailments, including behavioral health conditions. Beneficiaries with a serious and persistent mental illness, or with a mental health or substance abuse disorder and a comorbid chronic medical condition, are eligible to participate in the health home program. Each health home will include a team of physicians and other providers, including behavioral health care professionals. In addition to medical services, the team will deliver comprehensive care management, care coordination, health promotion and other patient and family support.\(^{81}\)

Second, the ACA creates new incentives for providers to better manage patients’ transitions among settings and providers of care and the community. The Hospital Readmissions Reduction Program lowers Medicare payment to hospitals with greater than expected readmissions. In the initial years, the program includes measures of all-cause readmissions for heart failure, heart attack and pneumonia.\(^{82}\) Given the role that behavioral health needs play in compliance with care regimens and care seeking behaviors, and the greater likelihood of readmission among patients with a comorbid behavioral health condition, identifying and addressing behavioral health needs pre-discharge will be crucial for hospitals looking to reduce their readmission rates.

Likewise, the ACA encourages the use of bundled payment rates across acute and post-acute providers for specified episodes of care in both Medicare and Medicaid.\(^{83}\) By promoting coordination across these providers, this program also could help improve care transitions for patients with behavioral health needs.

Third, the ACA sets new standards for quality of behavioral health care. The law establishes new quality measures focused on mental health care to be used in a psychiatric hospital public reporting program in Medicare. Beginning with rate year 2014, psychiatric hospitals that do not submit their data will be subject to a 2 percent payment penalty.\(^{84}\) The ACA also establishes a Psychiatric Hospital Value-based Purchasing pilot program in Medicare that will test the use of incentive payments for hospitals that meet certain performance standards.\(^{85}\) Finally, the ACA should help improve access to behavioral health services by expanding insurance coverage for all Americans\(^{86}\) and supporting workforce\(^{87}\) development grants and other efforts to expand the behavioral health care workforce. In addition to the ACA changes, the Mental Health Parity and Addiction Equity Act of 2008 also improves coverage by requiring health insurers to apply treatment limitations, enrollee financial responsibility requirements, and in-network versus out-of-network benefits equally to behavioral health and physical health care.\(^{88}\)
Conclusion

As providers take on shared accountability for health care across the continuum, they should not overlook patients’ behavioral health care needs. Behavioral health disorders are prevalent among U.S. adults, and the consequences of not addressing these conditions in a coordinated fashion are poorer physical and mental health outcomes and higher health care costs.

Health care organizations and providers that can effectively integrate care across treatment settings as well as between the behavioral and physical health care systems should realize gains in quality and outcomes, and reduced treatment costs.

ENDNOTES

3 Weighted national estimates from HCUP Nationwide Inpatient Sample (NIS), 2009, Agency for Healthcare Research and Quality (AHRQ), based on data collected by individual States and provided to AHRQ by the States. Total number of weighted discharges in the U.S. based on HCUP NIS = 39,434,956.
17 Cost was translated from 1999 to 2010 dollars using the GDP deflator as reported by the Bureau of Economic Analysis.
32 National Association of State Mental Health Program Directors. (October 2006). Morbidity and Mortality in People with Serious Mental Illness.