Financing, Accountability and Policy:

Accountable care organizations and care of people with mental illness and substance use disorders

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NASEM Workshop on Enhancing Care and Services for Mental Health and Substance Use Disorders

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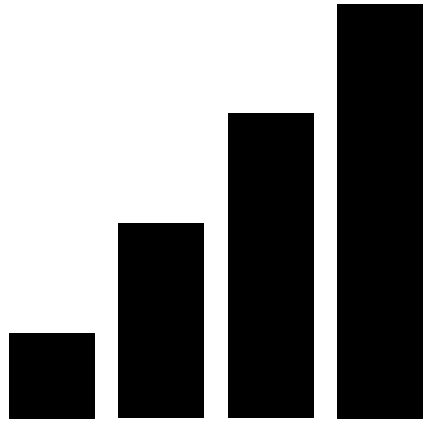
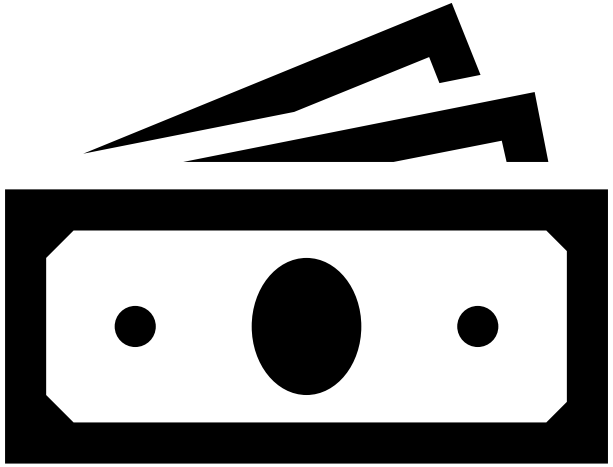
A Growing Population is Served by Clinicians in Accountable Care Organizations (ACOs)



In an ACO contract, groups of clinicians earn savings (or losses) based on quality & costs of care for a designated population.



Agenda

Why do ACOs matter for behavioral health?

Some key evidence on ACOs and behavioral health

Common themes

Why do ACOs matter for behavioral health?

This payment model could create two opposing incentives

- Invest in population health (physical, behavioral, social) vs.
- Avoid complex patients

Design issues that vary widely and may affect outcomes

- Cost categories in or out of benchmark
- Quality domains in or out of benchmark
- Models built on fee-for-service vs. managed care

Some key evidence on ACOs and behavioral health

Surveys and qualitative interviews of ACO leaders

Surveys of physician practice groups (with primary care MDs)

Claims analyses in Medicare and Medicaid

Early ACOs (2012-14) had a slow start re: behavioral health

- 14% reported integrating behavioral health in primary care

- Some early ACO leaders had engaged little with behavioral health:

"…When we looked at our top utilizers [, they are] the ones that the system is the most broken for, and it's highly chemical health and mental health driven."

"We have to pay attention to what we're being measured on [in our ACO contract], and mental health just isn't in there really."

Source: Lewis V, Colla CH, Tierney K, Van Citters AD, Fisher ES, Meara E. Few ACOs Pursue Innovative Models That Integrate Care For Mental Illness And Substance Abuse With Primary Care, *Health Affairs*, 2014 33:10, 1808-1816

Interviews with ACO leaders suggested integrating behavioral health motivated by:

Context

- Population with high burden of behavioral health needs
- Shortage of specialty providers to treat behavioral health

Payment

- Most ACO contracts include BH spending in cost of care
- Some leaders understood threat to physical health if BH poorly treated

Source: Lewis V, Colla CH, Tierney K, Van Citters AD, Fisher ES, Meara E. Few ACOs Pursue Innovative Models That Integrate Care For Mental Illness and Substance Abuse with Primary Care, *Health Affairs*, 2014 33:10, 1808-1816

ACOs reduced spending for people with serious mental illness

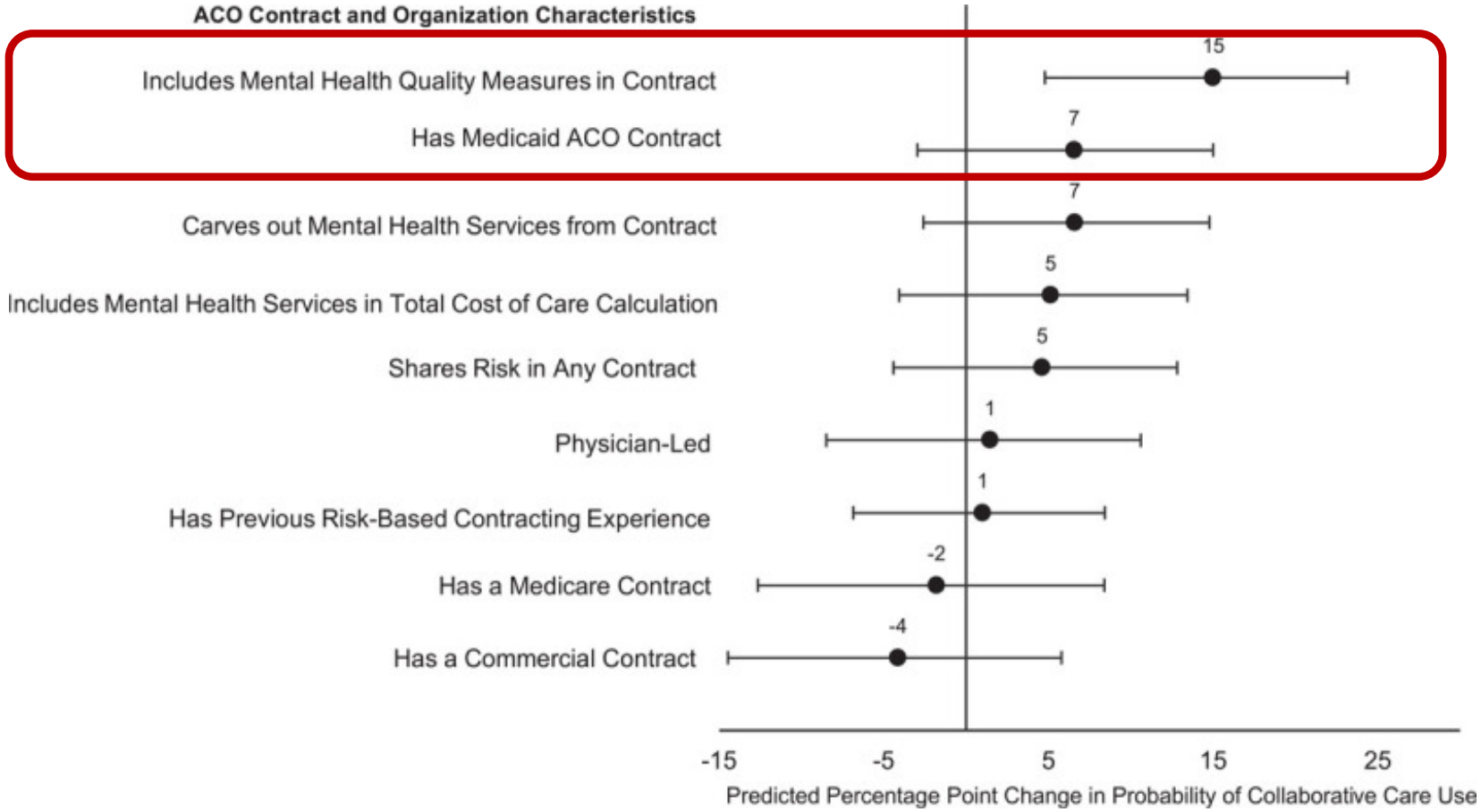
Quasi-experimental evidence comparing spending pre vs. post ACO contract start for patients served by providers in vs. not in ACO

Mental health spending & quality unchanged (2008-13)
(Busch et al. 2016)

Annual Medicare spending fell (~$233 per person) for those with SMI (2009-17)
Spending declines driven by non-mental health spending
(Figueroa et al. 2021)

Busch AB, Huskamp HA, McWilliams JM. Early Efforts By Medicare Accountable Care Organizations Have Limited Effect On Mental Illness Care And Management. Health Aff (Millwood). 2016 Jul 1;35(7):1247-56. doi: 10.1377/hlthaff.2015.1669.
Figueroa JF, Phelan J, Newton H, Orav EJ, Meara ER. ACO Participation Associated With Decreased Spending For Medicare Beneficiaries With Serious Mental Illness. Health Aff (Millwood). 2022 Aug;41(8):1182-1190. doi: 10.1377/hlthaff.2022.00096.

Behavioral health integration in primary care varies with contract features i.e. payer, quality metrics



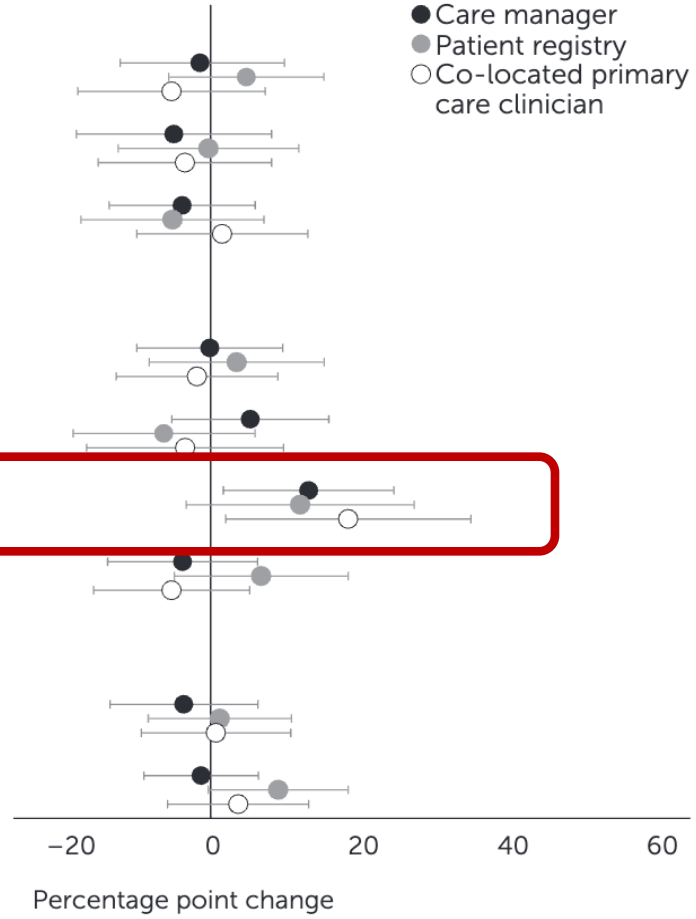
In 2017-18 national survey, 17% of ACO respondents report full implementation of 1) care manager for physical, mental, and non-medical needs; 2) consulting psychiatric clinician; 3) registry to track patient symptoms.

Newton H, Busch SH, Brunette M, Maust DT, O'Malley J, Meara ER. Implementation of Collaborative Care for Depressive Disorder Treatment among Accountable Care Organizations. *Medicine* (Baltimore). 2021 Jul 9;100(27):e26539. Doi: 10.1097/Md.0000000000026539.

Behavioral Health Integration in specialty settings also sensitive to contract features

FIGURE 2. Adjusted associations between ACO characteristics and use of integrated care strategies[a]

ACO characteristics	Coefficient (SE)		
	●	●	○
Payer			
Has a Medicare ACO contract	−.39 (.48)	.30 (.35)	−.61 (.43)
Has a Medicaid ACO contract	−.33 (.52)	−.02 (.38)	−.20 (.46)
Has a commercial ACO contract	.02 (.47)	−.31 (.38)	.40 (.46)
Largest Medicaid or largest commercial ACO contract[b]			
Includes mental health services in total cost of care	−.22 (.45)	.21 (.36)	−.32 (.44)
Includes any mental health quality measures	.79 (.49)	−.39 (.40)	.18 (.54)
Includes quality measures relevant to serious mental illness	.48 (.71)	.69 (.43)	.31 (.61)
Carves out mental health services	−.67 (.40)	.40 (.34)	−.73 (.43)
Other contract characteristics			
Shares financial risk in any contract	−.33 (.41)	.08 (.30)	−.03 (.39)
Has previous risk-based contracting experience	−.66 (.38)	.56 (.30)	−.34 (.39)

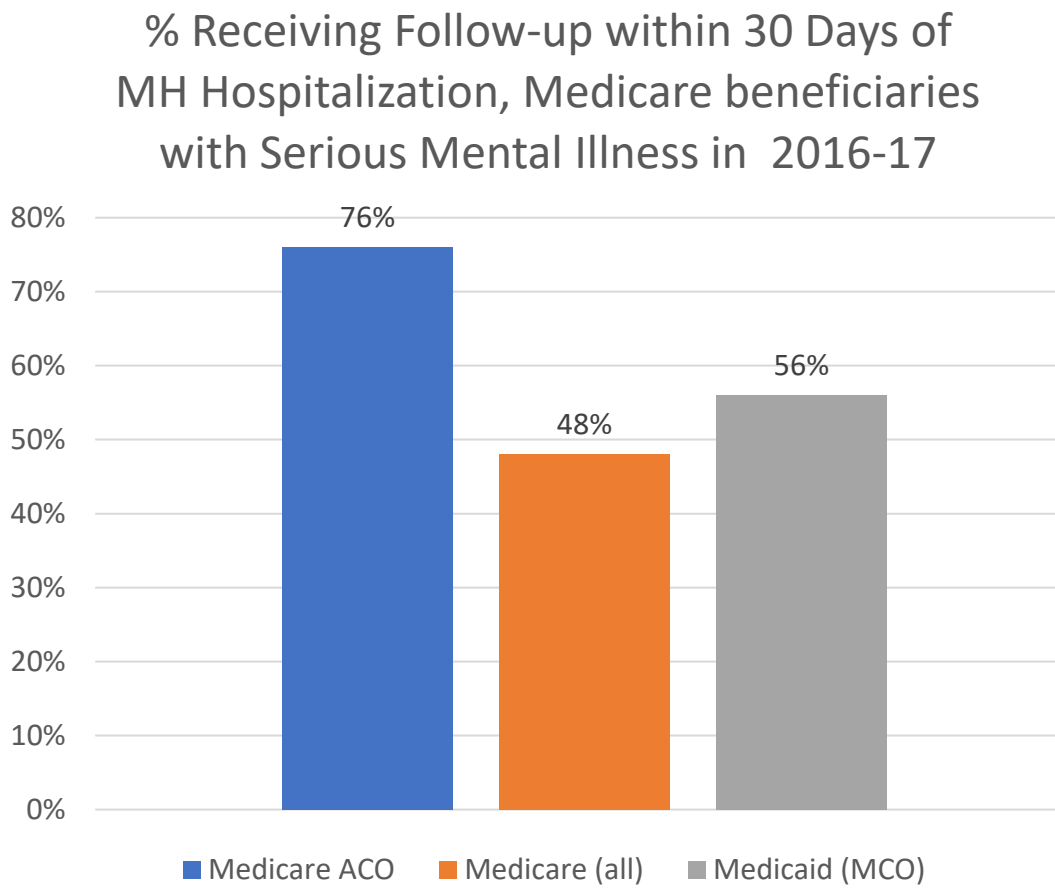


Newton H, Busch SH, Brunette MF, Maust DT, O'Malley AJ, Meara E. Psychiatric Services 2022; 73:889–896; doi: 10.1176/appi.ps.202000484

Good news – Medicare ACOs integrate physical & behavioral care & exceed national quality metrics

TABLE 1. ACO Behavioral Health Integration Index, by Component

	Full sample (%)
Behavioral Health Integration Index, mean (SD)	0.47 (0.23)
Index component (%)	
Strategies to integrate primary care into specialty mental health settings	
Care manager for physical health or nonmedical needs	73.0
Colocated PCP in specialty mental health setting	27.5
Patient registry to manage physical health conditions	36.7
Telemedicine to treat patient by phone or video	23.6
Peer support specialist	16.4
Strategies to integrate care for depression or anxiety in primary care settings	
Care manager for mental health or nonmedical needs	69.1
Mental health clinician consulting PCP	55.8
Registry to track mental health symptoms	24.5
Telemedicine to treat patient by phone or video	30.6
Peer support specialist	16.7



Newton H., Colla C , Busch S., Tomaino M., Hardy B., Brunette M., Agravat D. & Meara E. (2025). Medicare Accountable Care Organization Treatment of Serious Mental Illness. *Medical Care, 63* (2), 123-132. doi: 10.1097/MLR.0000000000002102.

Less good– Medicare ACOs reporting high vs. low integration do not deliver higher quality

Follow-up within 30 days of:
- Mental health hospitalization
- Mental health ED visit

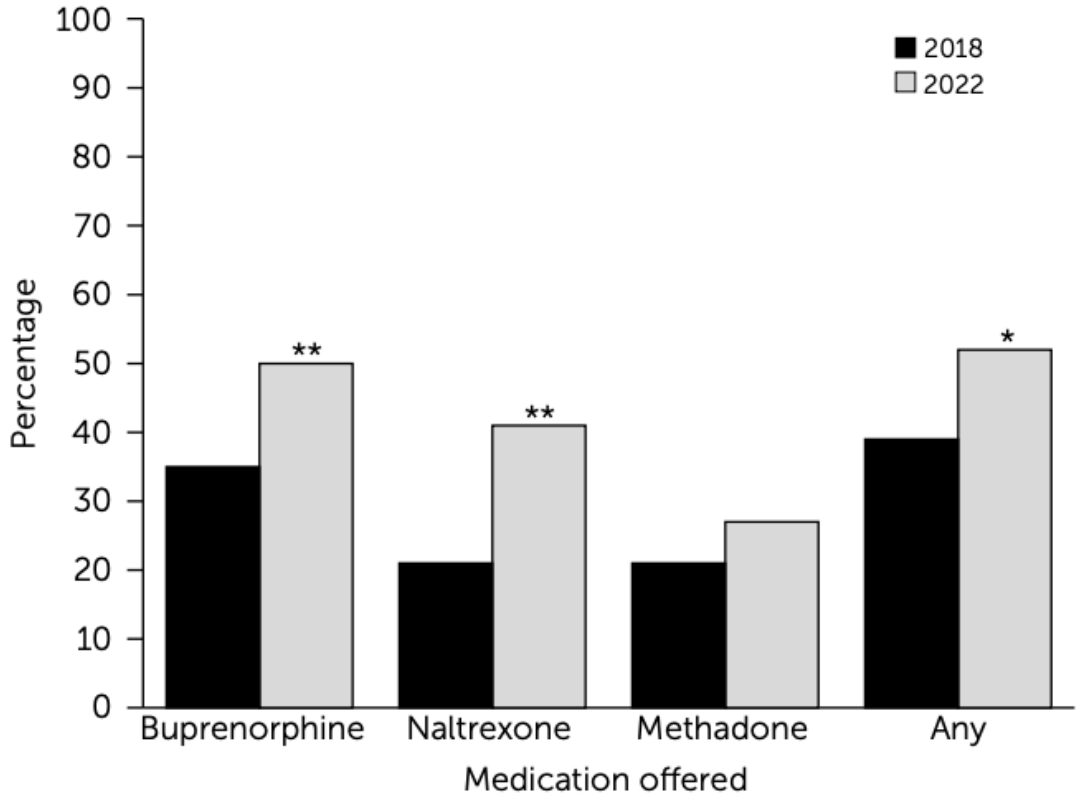
Chronic disease monitoring
- Beneficiaries with schizophrenia + diabetes
- Beneficiaries with schizophrenia + cardiovascular disease

Utilization
- Inpatient days
- ED visits
- Office visits

Newton H., Colla C , Busch S., Tomaino M., Hardy B., Brunette M., Agravat D. & Meara E. (2025). Medicare Accountable Care Organization Treatment of Serious Mental Illness. *Medical Care, 63* (2), 123-132. doi: 10.1097/MLR.0000000000002102.

Medicaid and Medicare ACO participants increased availability of MOUD over time, but MOUD availability remains low

FIGURE 1. Availability of medications for opioid use disorder offered by surveyed organizations with Medicare and Medicaid accountable care organization contracts, 2018 and 2022[a]

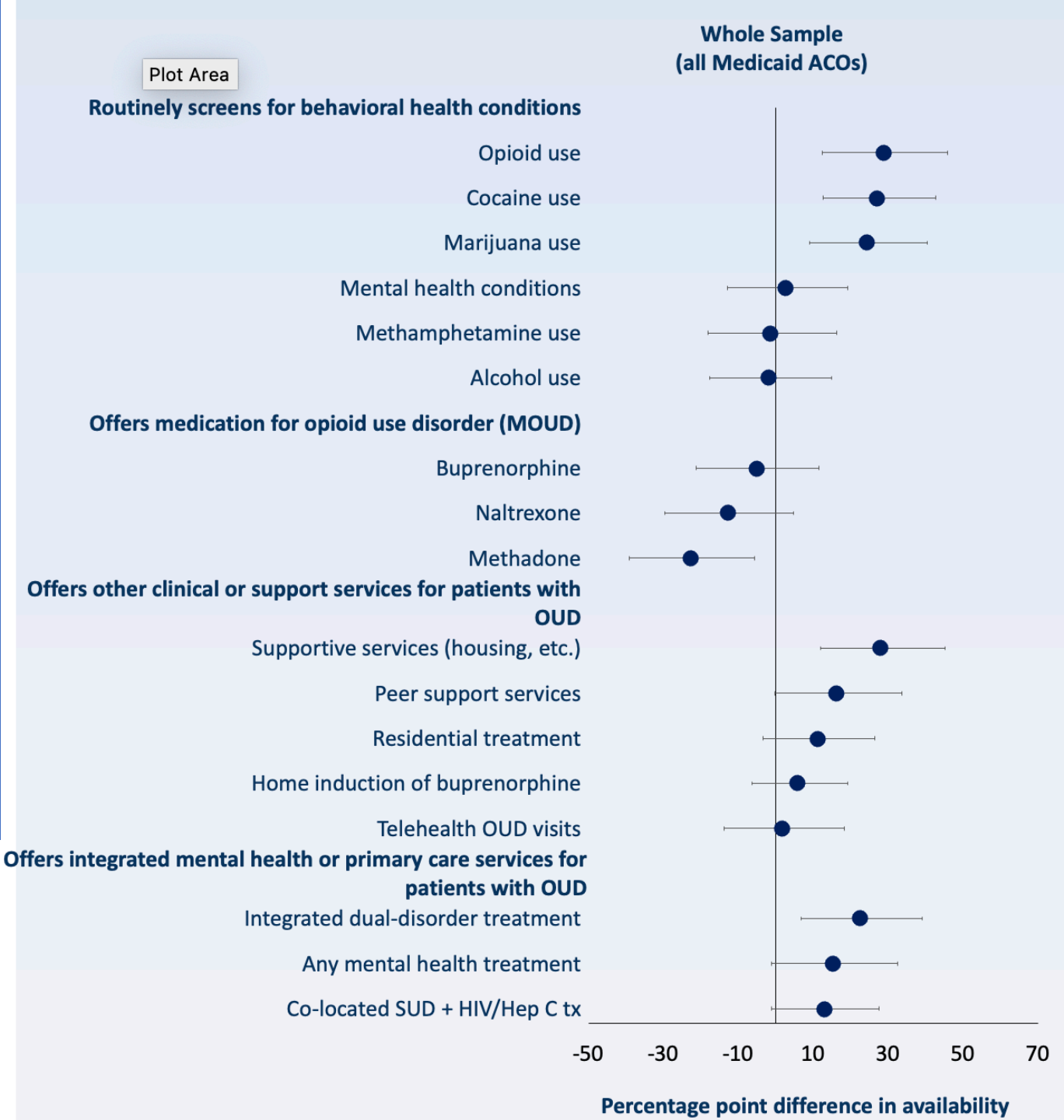


- In a survey of physician practices, those in ACO contract (vs. not) were no more likely to offer MOUD
- Environmental resources (local OUD availability) mattered little
- Information technology and BH clinicians in practice mattered more

(Miller-Rosales et al. 2023)

Newton H, Miller-Rosales C, Crawford M, Cai A, Brunette M, Meara E. Availability of Medication for Opioid Use Disorder Among Accountable Care Organizations: Evidence From a National Survey. Psychiatr Serv. 2024 Feb 1;75(2):182-185. doi: 10.1176/appi.ps.20230087. Miller-Rosales C, Busch SH, Meara ER, King A, D'Aunno TA, Colla CH. Internal and Environmental Predictors of Physician Practice Use of Screening and Medications for Opioid Use Disorders. Med Care Res Rev. 2023 Aug;80(4):410-422. doi: 10.1177/10775587231162681.

Medicaid ACOs responsible for SUD in cost of care were more likely to integrate care and address social needs but no more likely to offer MOUD.



Newton H et al. 2025, Medicaid ACO contract characteristics and availability of substance use disorder treatment: Evidence from a national survey, in progress.

% Receiving Buprenorphine after Index ED Visit in 7 Medicaid programs varied across and within states

The % of patients receiving timely buprenorphine after index ED visit was higher at hospitals that:

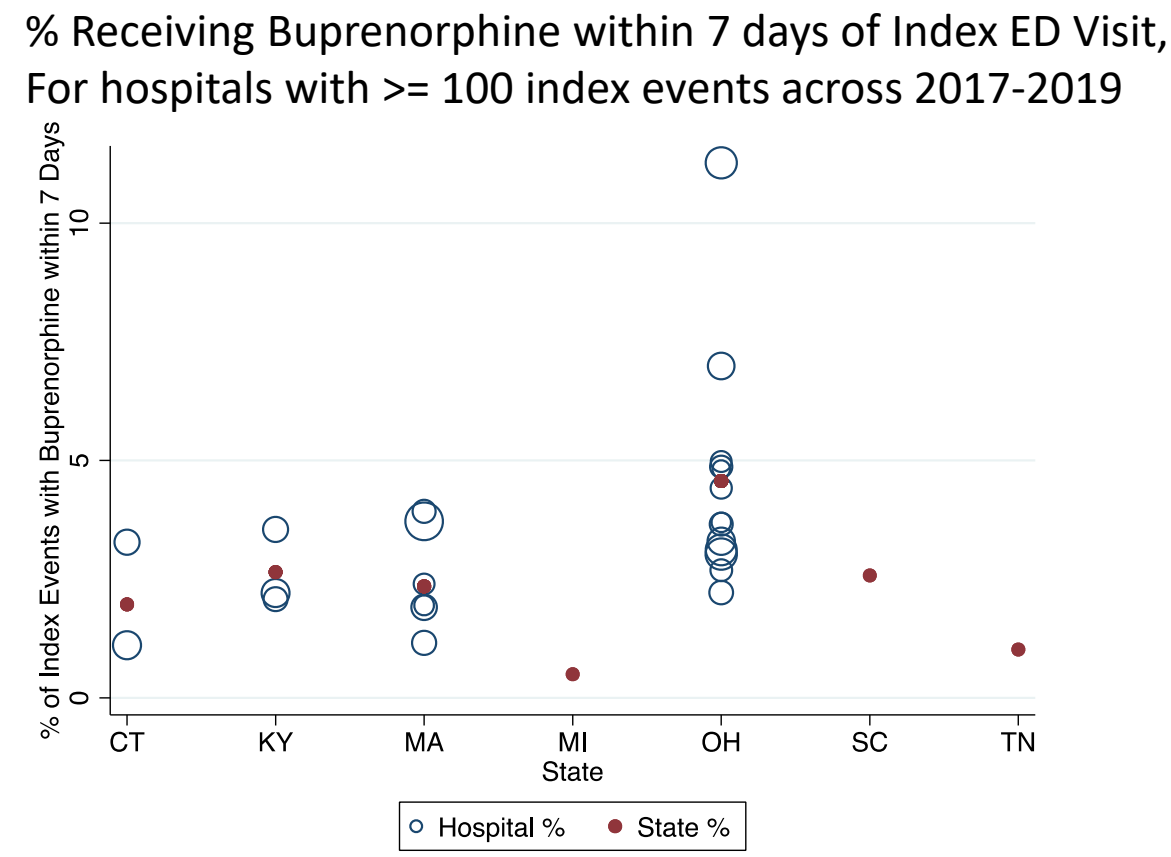
Were in Medicaid expansion states

Participated in Medicaid ACOs

But not by:

Distance to OTP or buprenorphine prescribers per capita

Integration of behavioral health



Meara et al. in progress. Based on 100,000 index ED visits with evidence of OUD and no MOUD in prior 30 days. Analysis of Medicaid TAF files. Small cells are suppressed. Each marker is a hospital (blue circle) or state (red dot).

Common Themes

Most ACO contracts do not target behavioral health, but the population health focus and variation across and within payers yields lessons

Medicaid ACO participants center behavioral health and social needs in ways others do not. They

include BH providers and social workers in ACOs,

enter contracts with robust behavioral health quality benchmarks

integrate physical and behavioral care,

address social needs

Contract features common in organizations that pursue recommended care include:

Holding providers responsible for behavioral health costs (and broader costs in general)

Robust quality metrics around mental illness and substance use disorder