Some health care delivery issues are complicated. Here’s one that isn’t: Primary care and behavioral health care need to come together for the good of the patient, the provider and the health care system. “Only through integrating the mind with the body can we truly make a difference in the lives of patients,” says Benjamin Miller, PsyD, assistant professor and the director of the Office of Integrated Health-care Research and Policy at the University of Colorado Denver (UCD) department of family medicine.

Agreeing with the proposition is easy; it is, after all, supported by evidence and common sense. Making it happen in a sustainable way is difficult. But Colorado Beacon Consortium partner Rocky Mountain Health Plans is embarking on a three-year quest to create a sustainable model that integrates behavioral health and primary care. It is participating in an innovative pilot with the Collaborative Family Healthcare Association and the UCD department of family medicine.

Miller and his colleagues will assess how global payments may bolster the sustainability of integrated behavioral health in primary care. This approach represents a change, he explains: The current system ignores the behavioral needs of medical patients and provides disincentives for collaboration, communication and coordination among clinicians.
Traditional reimbursement reinforces this fragmented approach: Payment is made solely for psychiatric disorders and diagnoses; the payment system doesn’t recognize the role of behavioral health in improving medical outcomes.

This pilot provides practices that have (on their own initiative) taken steps toward behavioral health integration with a reliable source of funding to let them move forward, “unfettered by fee-for-service,” Miller explains, noting one of the problems with the current health care system is the fee-for-service model. Fee-for-service rewards more tests and more visits, but not necessarily better care.

Disrupting old business models and practice patterns

“It is our goal to disrupt old business models in health care by showing more effective models that offer realistic, practical, on-the-ground solutions primary care providers find valuable and useful to their practice, and rewarding to their patients,” Miller explains. If the approach works, primary care practices engaging in integrated behavioral health will achieve and maintain fiscal solvency over time, become cost neutral and, eventually, reduce overall costs. The pilot will redesign delivery structure and processes to align the medical model with the behavioral health model.

Miller and Patrick Gordon, Colorado Beacon Consortium’s program director and director of government programs at Rocky Mountain Health Plans, expect replicable case examples from the pilot that will inform long-term, sustainable transformation in the larger Colorado community and in other markets.

This effort aligns with the mission of the Colorado Beacon Consortium, which advances practice transformation by working with medical practices to improve the quality of care by helping them maximize the tools and staff they already have, while considering the practice’s patient population and surrounding community.

Testing the impact of payment reform on transformation

Up to six practices from Grand Junction and other Western Colorado communities will participate in the pilot. Miller and Gordon expect participating practices to go live by spring 2013. Researchers hope to better understand the costs and other factors essential to integration, and test the real-world application of a global payment methodology in primary care practices that have integrated behavioral health.

“We will evaluate how providers and patients view the change in how care is delivered based upon the new payment model. We hope that a new payment model will allow providers of all disciplines to better work with the patient in their own time,” Miller explains. (For evaluation details, see sidebar on page 4.) “Health care is looking for models that are more effective in how they achieve outcomes, efficient in how they deliver care, and improve the overall patient experience. Integrating behavioral health into primary care helps achieve these goals almost simultaneously.
Global payment models also foster better collaboration among providers."

The evaluation will be funded by a three-year grant from the Colorado Health Foundation and managed by the Collaborative Family Healthcare Association, a national, multidisciplinary association that promotes collaborative, integrated care. Rocky Mountain Health Plans is providing per capita, non-fee-for-service funding for the participating practices to support behavioral health services and related activities. “Partnership is the magic,” says Miller. “Without Rocky Mountain, this would be impossible to pull off.”

**Comprehensive, integrated and patient-centered**

Integrated care is whole-person care—a patient-centered model of health care delivery that engages individuals and providers in the full range of physical, psychological, social, preventive and therapeutic factors necessary for a healthy life. “What we see is a need to integrate mental health and behavioral health into primary care,” Miller says.

For years, Miller has made the case for such an approach. After all, human behavior directly affects how we deal with illness, manage chronic conditions and adhere to a care plan. It’s all part of delivering comprehensive, patient-centered, coordinated care. If the goals are to improve individual health, lower health care costs and improve the health of communities, it is imperative to understand that behavioral health is integral to physical health, and vice-versa.

Mental and physical health are deeply intertwined; the relationship between them is complex. Medical conditions may lead to psychological problems and psychological problems can place a person at risk for medical disorders.1,2 People with serious physical illnesses, such as diabetes and heart disease, are more prone to depression and anxiety; comorbid depression occurs in up to 20 percent of these patients.3 In one study, the continued presence of depression after recovery increased the risk of death to 17 percent within six months after a heart attack, versus 3 percent mortality in heart attack patients who didn’t have depression.4

When mental and medical conditions co-occur—which they do more often than not—the combination is associated with elevated symptom burden, functional impairment, decreased length and quality of life, and increased costs.5 Moreover, depression and similar conditions may make it harder for patients to take their medications, impair their ability to follow doctors’ instructions and make positive life changes such as quitting smoking, eating healthier and exercising.

Treating behavioral health and physical health separately has resulted in poorer outcomes and higher costs. As concerns about such fragmentation grow, so too does the body of evidence for integrating behavioral health into the primary care setting: Integrated care can offer better access to treatment and improved health outcomes.6,7,8

In the real, day-to-day world, behavioral health and physical health are already fully integrated. It makes no sense for the health system to segregate them, Miller says. But the current delivery system

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5Goddell S, Druss B, Reisinger Walker E. Mental Disorders and Medical Comorbidity, Robert Wood Johnson Foundation, Policy Brief, 2011.


7Goddell S, Druss B, Reisinger Walker E. op. cit.

8Kathol Rg, Butler M, McAlpine D, Kane RL. “Barriers to Physical and Mental Condition Integrated Service Delivery.” *Psychosomatic Medicine*. July/August 2010 72:511-518.
does just that: Primary care providers have not been encouraged to consult or collaborate with mental health providers because of the current system design.

What’s called for, argue Gordon and Miller, is something disruptive—integrating mental and physical care. What once was carved out will be joined. A global system of cost accountability and payment that supports both behavioral and primary care will make this possible.

The financial barrier—unit pricing and carve outs

Efforts to integrate and coordinate primary and behavioral care are expanding, but in the absence of changing how these services are paid for, sustainability is elusive, explain Miller and Gordon. What’s missing is an initiative in which advanced payment reforms, behavior change interventions and advanced value measurement are integrated on a community basis, across practices and payers. The solution is three-fold: change how you pay, change how you provide, and change traditional treatment patterns.

That’s precisely what this project plans to do. It will demonstrate the impact of evidence-based practices, integration of primary care and behavioral health, and “in-between visit care” upon quantified measures of patient health risk, morbidity and costs. It will also provide a long-needed model for other communities to consider. “A lot of eyes are on this,” says Miller.

For those who appreciate the mind/body connection, the problem of care fragmentation is old news. In fact, supporting the delivery of integrated care has been a funding priority for the Colorado Health Foundation in recent years. Despite the positive impact of such efforts, grantees consistently report it is difficult to sustain these efforts because of reimbursement and billing challenges created by traditional fee-for-service models.

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9Accountable Care Communities—Beyond Beacon Affordability and Access through Behavior Change and Health Risk Reduction: Western Colorado’s Approach to Maximize Value in Health Care through an Integrated, Multi-Payer Focus on Population Health (discussion paper).


11Ibid.
It’s the same story nationwide. Research published in 2010 indicated the greatest barrier to the creation and sustainability of such integration was related to siloed physical and mental health reimbursement practices.\textsuperscript{12}

"Because we are focusing on integrating behavioral health providers, and health behavior interventions are a central role in what they have to offer, we would hope to see an expansion of those under a new payment model," Miller explains. "We hope that once patients and providers see how they are not being paid for ‘how quickly’ and ‘how many,’ but for ‘how well,’ it will change health care for the better."

Ultimately, he says, it comes down to changing the conversation with the patient. "We hope that when a new payment model and new clinical delivery model are available, the patient will feel less rushed, more involved and more a part of the team," Miller said. “With a more comprehensive approach to payment and delivery, different priorities are placed on providers’ use of time and improving outcomes, not productivity. But to truly make this work, we must have all members of the team active and engaged, including the patient.”

Gordon and Miller are advancing a defragmented payment system that supports collaborative medical and psychological efforts. This pilot tears down the artificial wall between primary care and behavioral health. Payment will support collaborative medicine. Reimbursement will be tied to performance and quality rather than quantity.

The point of the pilot isn’t changing reimbursement for the sake of changing reimbursement, Miller explains. Rather, it is about practice transformation supported by new payment models. “Because it’s impossible to fix the problem on a per-procedure, fee-for-service basis, we are starting with fundamental redesign of the payment system,” he says. “We aren’t ‘turning on new codes’ for reimbursement.” Rather, Rocky Mountain will implement value-based payments that support the pilot’s goals. Specifically, that means prospective, population-based payment and global budgeting for physical and behavioral health services.

**What’s called for, argue Gordon and Miller, is something disruptive—integrating mental and physical care. What once was carved out will be joined. A global system of cost accountability and payment that supports both behavioral and primary care will make this possible.**

A different approach to care

Although the pilot will not evaluate specific provider skills, the evaluation will examine how providers change their behavior in response to a new payment model. Gordon and Miller emphasize they are not intervening in their clinical models, but rather studying how they respond to a global budget that includes behavioral health.

A global system of cost accountability and payment that supports both behavioral and primary care will make this possible.

Moving toward a larger vision of integration and value

Although significant on its own, this pilot is part of a larger vision of an accountable community, one that features clinical integration, value-based payments, social equity, patient engagement, care coordination and meaningful use of health IT, according to Gordon. Colorado legislation enacted in June 2012 advances that goal. H.B.12-1281 created the Medicaid payment reform and innovation pilot program to implement Medicaid payment-reform projects within the framework of the Accountable Care Collaborative, a Medicaid program to improve clients’ health and reduce costs. Rocky Mountain Health Plans is a Regional Care Collaborative Organization. Payment projects could include global payments, risk adjustment, risk sharing and aligned payment incentives. These are Medicaid projects, but the projects that emerge will serve as models for all payers and provide further evidence to bolster the value of global payment models.

\textsuperscript{12}Kathol RG, Butler M, McAlpine DD, Kane RL op. cit.
Each practice in the pilot will have considerable latitude in how it accomplishes this. “We will not be dictating what type of integrated model practices use,” Miller says. What is critical is that the behavioral health providers are present and active in the primary care setting.

**Full-throated transformation**

It has to start with reimbursement, Miller argues. “Bottom line: Any and all conversations on health reform that do not include reforming fee-for-service are non-starter conversations and will not break us from the current predicament.” He calls the pilot’s approach “the enemy of the workaround.” Other efforts underway across the country “are going at it piecemeal—perhaps a new code or a small way of transitioning care from fee-for-service and starting new types of conversations with patients.” The projects don’t succeed because they are not sustainable. “They stop short because of politics, fear, etc.,” he says. “We are not about workarounds. We are going at this full-throated. We want participants to go all in.”

That “all-in” philosophy informs the recruitment process. Miller and Gordon will recruit practices already on the path to integration and ready to expand; they will build on the current level of integration and make it sustainable. They will identify practices in Grand Junction that are integrated, and then assess whether they are appropriate for the pilot. Among the criteria: willingness of the practice to work with the project team to collect data (clinical, operational and financial). To be eligible for the pilot, practices must offer onsite behavioral health and be prepared to work as a team to collectively make an impact on patient care.

Gordon stresses this is neither an academic exercise nor a short-term fix. This approach fundamentally changes the structure of how behavioral health is handled. It’s not simply a change in reimbursement; it’s a cultural transformation. It represents a transition from a fragmented approach to a coordinated one, from a payment-centered approach to a patient-centered one.

“In Western Colorado, starting on a small scale and leveraging the power of partnership, we are going to turn the conventional approach to behavioral health on its head,” says Gordon.

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**About the Colorado Beacon Consortium**

The Colorado Beacon Consortium is made up of executive-level representation from four mission-driven, not-for-profit, Western Colorado-based organizations, all of which have nationally acknowledged track records of coordination to achieve superior outcomes. They are Mesa County Independent Physicians’ Practice Association, Quality Health Network, Rocky Mountain Health Plans and St. Mary’s Regional Medical Center. The Colorado Beacon Consortium’s mission is to optimize the efficiency, quality and performance of our health care system, and integrate the delivery of care and use of clinical information to improve community health. The geographic focus of the Consortium’s activities includes the Colorado counties of Mesa, Delta, Montrose, Garfield, Gunnison, Pitkin and Rio Blanco.
Patrick Gordon joined Rocky Mountain Health Plans (RMHP) in 2004 as the director of government programs. In addition to his current role as executive director of the Colorado Beacon Consortium, he is also leading the implementation of the Medicaid Accountable Care Collaborative project in Western Colorado. Within RMHP, he is accountable for the operational, financial and regulatory performance of the Medicaid, Dual Eligible, CHP+ and Medigap programs supported by the health plan. He has led and implemented several strategic projects for RMHP and stakeholders in Western Colorado, including: the design and implementation of a performance incentive arrangement with the State of Colorado and participating physicians to achieve Triple Aim objectives; the implementation of a Medicare Part D Prescription Drug program and targeted coverage arrangements for dual eligible beneficiaries; development of Medicare Supplemental insurance offerings; and a Medicare service area expansion in ten Wyoming counties and two Colorado counties. Prior to joining RMHP, he held various positions within the Colorado Department of Health Care Policy & Financing related to Medicaid, CHP+ and Nursing Facilities policy development and program management.

Gordon received his Master of Public Administration in Health Policy/Economics from the University of Colorado, and has received certification from America’s Health Insurance Plans Executive Leadership Program. He also serves as president of the Pinon Institute, a center for thought, leadership and culture change within long-term care.

benjamin.miller@ucdenver.edu

Benjamin F. Miller, Psy.D is an assistant professor in the Department of Family Medicine at the University of Colorado Denver School of Medicine where he is the Director of the Office of Integrated Healthcare Research and Policy. He received his doctorate degree in clinical psychology from Spalding University in Louisville, Kentucky. He completed his predoctoral internship at the University of Colorado Health Sciences Center, where he trained in primary care psychology. In addition, Miller worked as a postdoctoral fellow in primary care psychology at the University of Massachusetts Medical School in the Department of Family Medicine and Community Health.

Miller is a co-principal investigator and co-creator of the National Research Network’s Collaborative Care Research Network, and has been the principal investigator on several federal grants examining mental health and primary care integration. He has written and published on enhancing the evidence support for collaborative care models, increasing the training and education of mental health providers in primary care and the need to address specific healthcare policy for integration. He is the section editor for Health and Policy for Families, Systems and Health and reviews for several academic journals. Miller is also a 2012 expert panelist on the Agency for Healthcare Research and Quality Innovations Exchange and in the International Advisory Board of the British Journal of General Practice. Miller is the president of the Collaborative Family Healthcare Association, a national not-for-profit organization pushing for patient-centered integrated healthcare.

Miller’s research interests include models of integrating mental health and primary care, health behavior interventions, primary care practice redesign, using practice-based research networks to advance whole person healthcare, and healthcare policy. Outside of healthcare, Miller enjoys playing music, rock climbing, and running. He and his family live in Denver, Colorado.