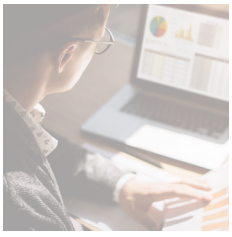
Behavioral Health Access at California's Accountable Care Organizations:

Implications for ACO Behavioral Health Across America



Authors: Patrick Gauthier, Advocates for Human Potential, Inc.;

Chris Chin and Maja Jolly, University of California, Los Angeles

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Executive Summary

This paper presents findings and recommendations resulting from a recent collaboration between Advocates for Human Potential, Inc. (AHP), and the University of California, Los Angeles (UCLA). The joint effort sought to establish a baseline of California accountable care organizations' (ACOs') level of understanding of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and of the California mental health parity law, and to determine the operational implications for those ACOs.

In the spring and summer of 2020, AHP engaged students in UCLA's Master of Public Health program to conduct research to ascertain California ACOs' familiarity with federal and state mental health parity laws. AHP and UCLA collaborated to create a survey tool to assess the breadth, depth, and accessibility of California ACOs' behavioral health services. Using the survey tool, UCLA then conducted phone interviews with key informants at ACOs across California and documented their findings and recommendations.

Background

MHPAEA was signed into law by President George W. Bush in 2008 and took comprehensive effect across the country beginning in 2013, magnified by the Affordable Care Act (ACA), which established mental health and substance use disorder (SUD) as "essential health benefits." MHPAEA applies to

- Fully insured large group commercial health insurance plans,
- Individual health insurance plans,
- Employee Retirement Income Security Act (ERISA) large, self-insured employer health insurance plans,
- Non-federal governmental self-insured employer health plans,
- Medicaid managed care plans,
- The Children's Health Insurance Program (CHIP),
- Medicaid Alternative Benefit Plans (ABPs), and
- Health Insurance Exchange small group plans (also known as Benchmark Plans) in each state.

MHPAEA is a complex law and comprehensive set of regulations whose complexity is compounded by an even more by complex ACA law and related regulations. The result of all this complexity across health insurance markets (Medicare, Medicaid, commercial insurance) and across 50 states is too often a misunderstanding of how best to finance and deliver behavioral health care.

In short, MHPAEA addresses discrimination in mental health and SUD insurance coverage or benefits by requiring that plans align mental health and SUD coverage with the predominant medical and surgical services benefits. Readers who want to better understand MHPAEA and its quantitative (financial) and non-quantitative treatment limitations (NQTLs) can learn more here.

In 2020, California Governor Gavin Newsom signed Senate Bill 855 into law to bolster MHPAEA in California beginning in January 2021. This newest parity law requires, among other things, that health plans no longer use their own medical necessity guidelines to determine what conditions are covered and what services may be provided under what circumstances. California's health insurers are now required to use standard guidelines developed locally by nonprofit clinical associations. Like MHPAEA, California's laws apply to some but not all forms of health insurance. To learn more about California's parity laws, visit this link.

ACOs were introduced to the market primarily as an innovation in system of care and financing by the ACA. Modeled after organizations like Kaiser Permanente and the Cleveland Clinic, ACOs effectively become a hybrid payer-provider. The ACO model was first developed under the auspices of the ACA for Medicare purposes in relation to the Medicare Shared Savings Program (MSSP). Notably, MHPAEA does not govern Medicare mental health and SUD benefits.

The first 32 ACOs in the country were known as Pioneer ACOs. Today, many hundreds of ACOs operate across the country and serve many different covered populations, including Medicaid managed care plan enrollees as well as ERISA self-insured employers and fully insured plans. As a consequence, some of California's ACOs that provide coverage for, authorize services for, and reimburse providers for mental health/SUD services are subject to federal and California parity laws and regulations.

Findings

More than half of the seven ACOs interviewed were not familiar with the specific requirements of MHPAEA, and five did not view behavioral health as an essential health benefit. Among those five, 95–100 percent of behavioral health services were offered out of network. Respondents cited challenges to offering behavioral health services, including the lack of interoperability between providers, unsustainable payment models, and a low supply of behavioral health providers.

Recommendations

Based on a review of the existing literature and our interviews with ACOs, we have four key recommendations to improve ACO behavioral health services.

- Educate ACOs, payers, and patients on the federal and state parity laws and make compliance tools readily available.
- Encourage MSSP, Medicaid, and commercial ACOs to add quality pay-for-performance metrics for treatment of SUDs and mental health disorders.
- Demonstrate to ACOs how the integration of behavioral health services in medical and primary care settings can further ACO financial and quality goals, especially as it relates to sharing health and behavioral health information.
- Provide technical assistance to ACOs and behavioral health providers/networks to further the cause of sustainably using non-physician providers such as social workers, recovery coaches, and behavioral health care managers in the treatment of the whole person.

Research Objectives

Advocates for Human Potential, Inc. (AHP), is a national research, technical assistance, and consulting firm headquartered in Sudbury, Massachusetts, with over 30 years of experience influencing change in health and business systems to support vulnerable populations. AHP's Director of Healthcare Solutions, Patrick Gauthier, engaged UCLA Master of Public Health practicum students to assess the breadth, depth, and accessibility of behavioral health services at accountable care organizations (ACOs) across California and make recommendations for improvements in light of the Mental Health Parity and Addiction Equity Act (MHPAEA) as well as the inclusion of medically necessary behavioral health services as essential health benefits in the Affordable Care Act (ACA).

Approach/Methods

1. Literature Review

An initial literature review was conducted to gain background knowledge of the current state of behavioral health care access in California and barriers ACOs face in providing behavioral health services.

Topics covered in the literature review included

- Background research on the emergence and objectives of ACOs,
- How ACOs are faring nationally at providing behavioral health services,
- Barriers faced by ACOs to integrating behavioral health services into their care models,
- The current state of accessibility of behavioral health services in California, and
- Recommendations for improving accessibility of behavioral health services generally and within the ACO model specifically.

2. Survey Tool Development

A survey tool was developed in close consultation with Patrick Gauthier for administration by telephone or videoconference interview with a member of each ACO's leadership. The barriers to the provision of behavioral health services identified during the literature review phase were applied as examples in the survey tool. The tool was organized into sections capturing

- Background information on each ACO, including location, population served, payer types accepted, and number of employees;
- Level of understanding of the MHPAEA law, regulations, and compliance;
- Cultural and accessibility factors, including provider comfort level with behavioral health screening, languages offered, cultural competency training requirements, and in-network vs. out-of-network availability of behavioral health services;
- Organizational prioritization of behavioral health issues;
- Barriers to providing behavioral health services; and
- Recommendations for improvements.

3. Interviews

Interviews were conducted with key informants using the survey tool as a guide. Responses were directly recorded in a form, and data was uploaded to a spreadsheet upon completion of the interview.

4. Results Analysis

For quantitative responses, statistical measures such as the mean and median were calculated to better understand the central tendency of the results. For qualitative responses, results were reviewed categorically—for example, five ACOs offered standard cultural competency training for their providers, while two ACOs did not. Results were broken down by section and analyzed to find patterns.

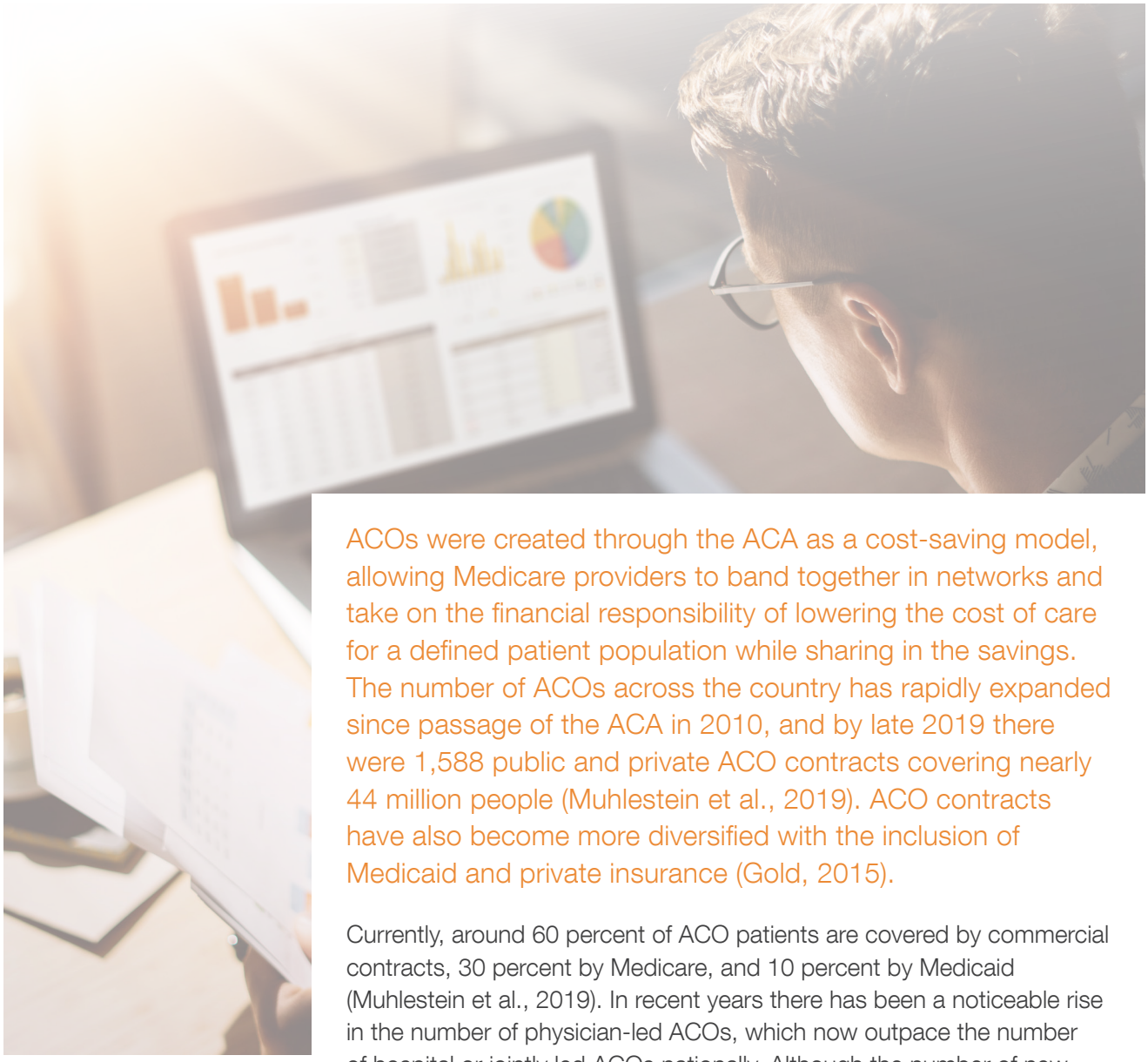
5. Additional Research

Further literature review was performed to more fully flesh out past studies' findings on barriers ACOs face in providing behavioral health services.

6. Recommendations

Recommendations were developed based on the study findings and the additional research conducted. The data was compared with other literature findings to better understand any unknowns and identify themes. These recommendations should be considered with the understanding that this data set was limited by sample size and that further research is recommended to suggest conclusions about the larger California ACO ecosystem.

Background and Literature Review



ACOs were created through the ACA as a cost-saving model, allowing Medicare providers to band together in networks and take on the financial responsibility of lowering the cost of care for a defined patient population while sharing in the savings. The number of ACOs across the country has rapidly expanded since passage of the ACA in 2010, and by late 2019 there were 1,588 public and private ACO contracts covering nearly 44 million people (Muhlestein et al., 2019). ACO contracts have also become more diversified with the inclusion of Medicaid and private insurance (Gold, 2015).

Currently, around 60 percent of ACO patients are covered by commercial contracts, 30 percent by Medicare, and 10 percent by Medicaid (Muhlestein et al., 2019). In recent years there has been a noticeable rise in the number of physician-led ACOs, which now outpace the number of hospital or jointly led ACOs nationally. Although the number of new ACOs has begun decreasing for the first time, the number of covered people continues to increase over time, in evidence of a move toward consolidation (Muhlestein et al., 2019).

For ACOs participating in the Medicare Shared Savings Program (MSSP), quality is incentivized through pay-for-performance benchmarks, including goals for patient experience, care coordination, preventive care, and at-risk populations (Centers for Medicare & Medicaid Services, 2020). Some examples of these quality metrics include patients' rating of providers, levels of care coordination, amount of risk standardized in all-condition readmission, effectiveness at controlling high blood pressure, and rates of preventive screening and intervention for tobacco use (Centers for Medicare & Medicaid Services, 2020). Of note, only 2 of the 23 quality benchmarks for the 2020–2021 year relate to behavioral health: performance of depression screening and follow-up planning, and depression remission at 12 months. Notably, there are no benchmarks related to substance use disorder (SUD) or other common behavioral health conditions, including anxiety disorders or bipolar disorder (Centers for Medicare & Medicaid Services, 2020). The addition of these pay-for-performance benchmarks would encourage ACOs to focus on providing parity in behavioral health services, a requirement for health plans under the MHPAEA.

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The MHPAEA requires that group health insurance coverage and individual plans not impose any "less favorable" benefit or treatment limitations on mental health and SUD services than those imposed on standard medical/surgical benefits). To this end, the law requires that deductibles and copayments, number of covered treatment days, and prior authorization requirements for behavioral health services be comparable and no less restrictive to those of traditional medical/surgical benefits (Centers for Medicare & Medicaid Services, 2020). The ACA greatly expanded the availability of behavioral health services when it included mental health and SUD treatment as "essential health benefits" and required coverage by insurance providers (Centers for Medicare & Medicaid Services, 2020). The designation of behavioral health services as essential health benefits, when combined with the MHPAEA requirement that behavioral health services be provided in parity with physical health services, greatly expanded the availability and accessibility of behavioral health services nationally (Frank et al., 2014).

Mental and behavioral health are key components for providing optimal integrated care, as untreated mental and behavioral health conditions are associated with chronic medical illness and markedly increased total health care costs (Kathol et al., 2015). A 2017 report by Milliman estimates that roughly $38 to $68 billion annually can be saved through the effective integration of physical and behavioral health services nationwide (Melek et al., 2019). To put this in context, the total national expenditures for mental health and SUD services were projected at around $240 billion, meaning integration could result in roughly 30 percent savings in total national mental health and SUD treatment costs. Despite this potential for enhanced care and decreased costs, the National Association of State Mental Health Program Directors has stated that "the promise that the ACO model could serve as a means of integrating behavioral and medical services in both the Medicare and Medicaid programs has not been achieved" (Gordon, 2016).

Medicare ACOs face challenges in achieving integration and parity for behavioral health, including scarcity of behavioral health workers, difficulties developing a sustainable funding model, roadblocks to sharing sensitive behavioral health data (including lack of interoperability), lack of clear referral pathways making it less likely for providers to perform screenings, and both enrollee and provider resistance to discussing behavioral health issues. Some of the labor shortages may be caused upstream by low Medicaid reimbursement (the largest single payer for mental health), limited Medicare behavioral health coverage, and lack of a sustainable fee-for-service reimbursement system (Fullerton et al., 2016).

These concerns plague ACOs nationally and at the state level. California has poor parity in behavioral health services, with some of the highest usage of out-of-network behavioral health care and low reimbursements for behavioral health visits (Melek et al., 2019). Nearly 63 percent of adult Californians did not receive mental health services or treatment even when they had an acute mental illness. Of those who did seek treatment, 17.2 percent did not receive mental health treatment due to a lack of coverage, inability to pay, or lack of available providers (California Health Care Foundation, 2018). Moreover, until very recently California did not have any regulations limiting prior authorizations for SUD medications or services. This opened the door to violations of the MHPAEA if restrictive prior authorization requirements not comparable to those for other medical services were enacted for SUD care (Legal Action Center, 2020).

California has poor parity in behavioral health services...

In September 2020, the California legislature passed Senate Bill 855 (SB 855), an update to the California Mental Health Parity Act (CMHPA) originally passed in 1999 (Wiener, 2020). SB 855 expanded the list of mental health disorders covered under the CMHPA beyond severe mental illness to include all mental health and substance use disorders, required that SUD be added as a covered condition, and defined medically necessary treatment as conforming with generally accepted standards of mental health and SUD care (Wiener, 2020). These provisions were included to help begin to address the growing SUD issues in California—including the opioid epidemic and the high number of mentally ill incarcerated and homeless individuals—and to prevent payers from creating more restrictive definitions of "medically necessary," which was left less strictly defined in the federal MHPAEA legislation, opening the door to possible parity violations (Wiener, 2020).

While we planned to recommend our own solutions to these challenges, we saw that it was appropriate to also examine recommendations and future directions suggested in the existing literature. The Legal Action Center suggested that policymakers should focus on requiring carriers to cover the costs of services (whether in-network or out-of-network, when a network

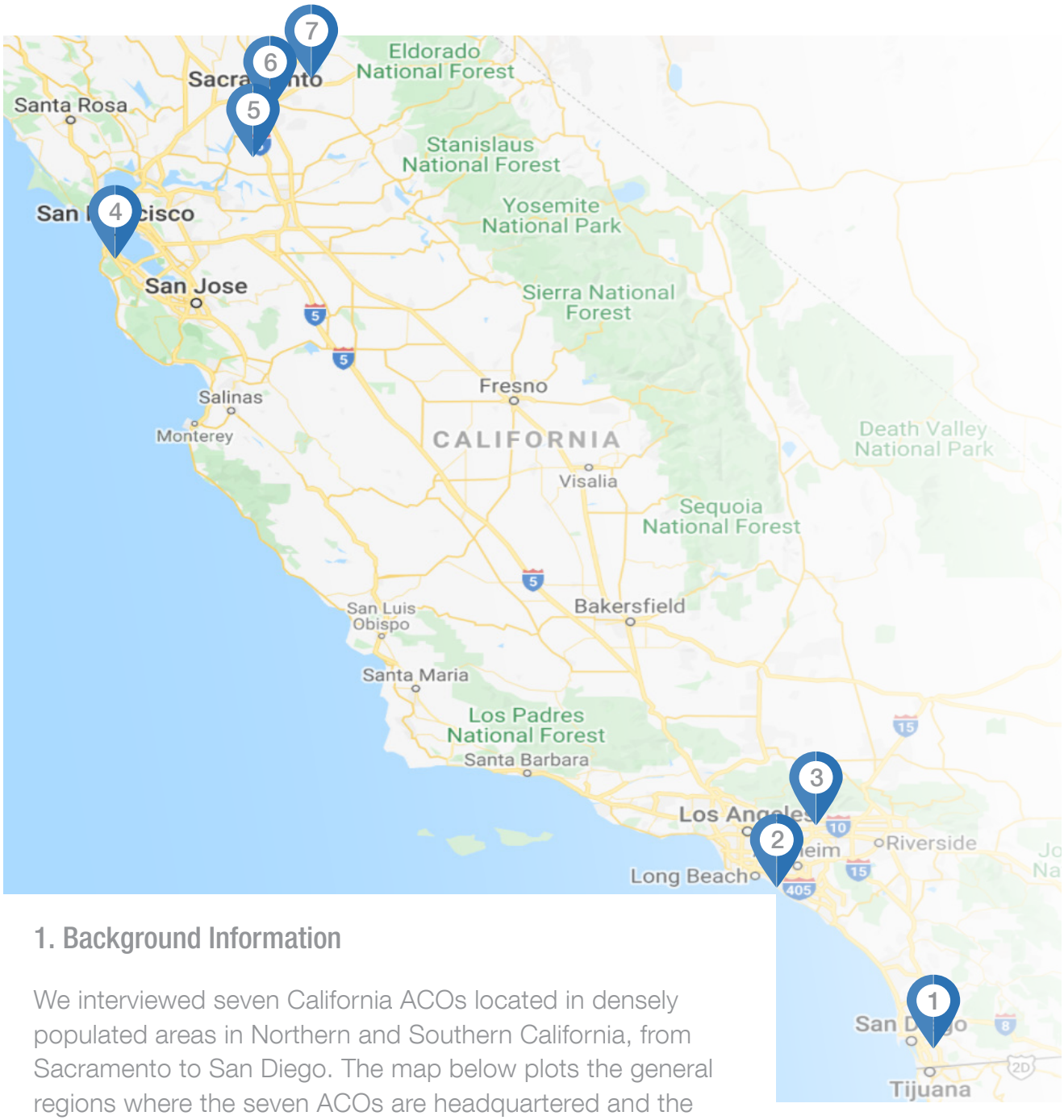
is inadequate), increase transparency of network design and compliance so that network adequacy requirements may be evaluated, improve consumer education around network adequacy, and support ongoing (not self-reported) regulatory oversight (Legal Action Center, 2020). Other recommendations for methods to improve ACOs' mental and behavioral health performance include the following:

- Building mental and behavioral health services as core ACO delivery components,
- Increasing the number of behavioral health providers in ACOs' clinician networks, and
- Entering into population risk–based contracts that include behavioral health as a standard medical benefit (Fullerton et al., 2016).

Many of the ACOs interviewed in the 2016 Fullerton study recommended that integrating behavioral health into primary care could be achieved by hiring onsite, licensed social workers and enhancing referral networks with behavioral health providers and community resources.

These findings and recommendations served as a foundation of baseline knowledge and informed the development of our survey tool. As we interviewed representatives at ACOs across California, we used this baseline understanding to determine whether they were experiencing challenges similar to those found in the literature, whether any unique challenges existed, and what specific recommendations the ACOs suggest for improvements at the organizational and policy levels.

Findings



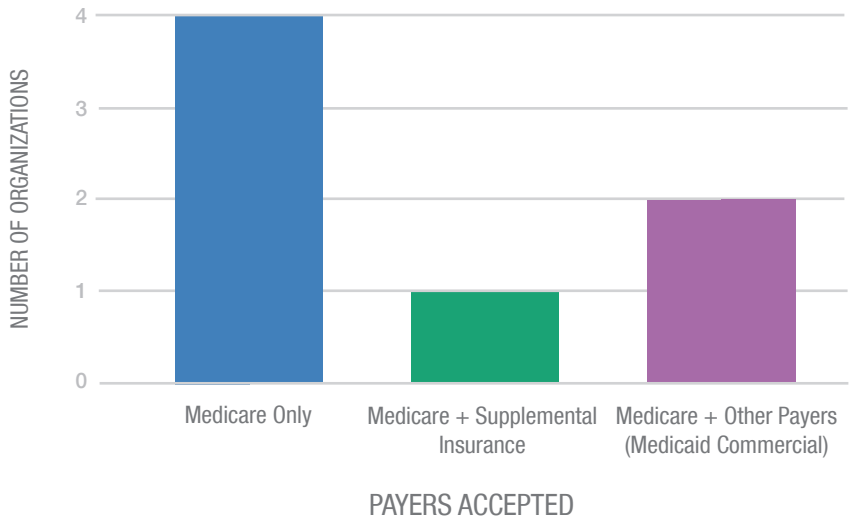
1. Background Information

We interviewed seven California ACOs located in densely populated areas in Northern and Southern California, from Sacramento to San Diego. The map below plots the general regions where the seven ACOs are headquartered and the areas they serve.

From an employer perspective, the ACOs interviewed skewed toward opposite ends of the size spectrum, with 3 sizable ACOs employing 400+ full-time employees and 4 smaller ACOs with 100 or fewer employees.

Every ACO interviewed had a large Medicare component and served the corresponding 65+ senior patient population. One ACO accepted private supplemental insurance in addition to Medicare, and three others accepted Medi-Cal and commercial payers in addition to Medicare, allowing them to serve a more diverse population of children, adults, and seniors.

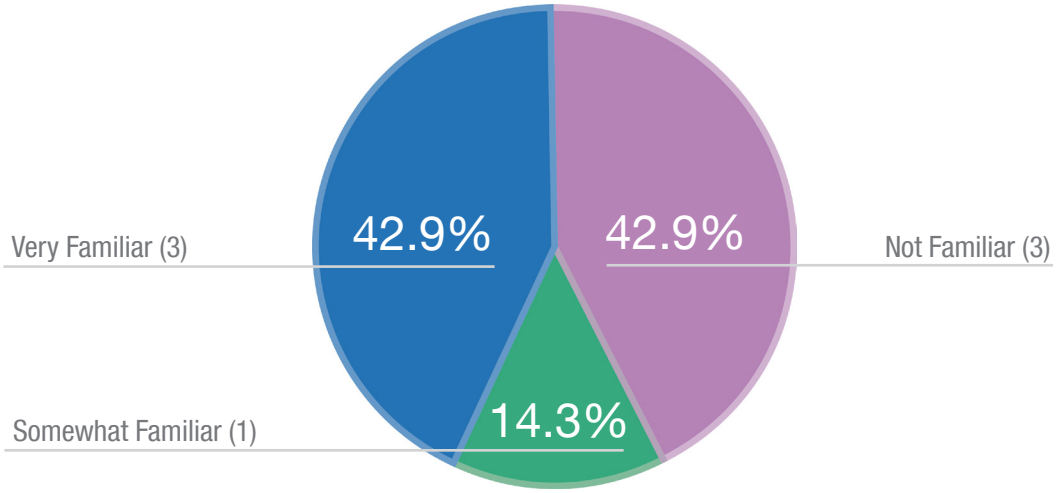
Payer Types Accepted by ACOs



2. MHPAEA and the ACOs' Behavioral Health Frameworks

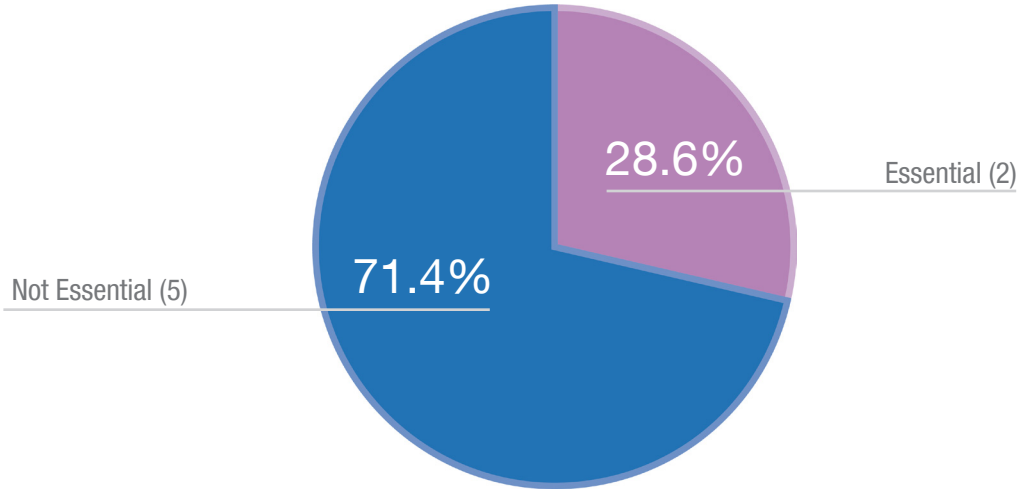
Survey respondents were asked how familiar they were with the MHPAEA, and the results were mixed: Three ACOs were not familiar at all and it was their first time hearing about it, one ACO had heard of the law but did not know its details, and three ACOs were very familiar with it. This suggests that there is a potential knowledge gap on behavioral health parity legislation among California ACOs and that there exist opportunities to educate ACO stakeholders.

ACO Familiarity with MHPAE



We also asked interviewees if their ACO viewed behavioral health as an essential health benefit, as described in the ACA. Surprisingly, five ACOs viewed behavioral health as not essential; only three viewed it as essential.

ACO Views on Behavioral Health Benefits



The differences in awareness of MHPAEA corresponded with each ACO's view of behavioral health services as essential (or non-essential) health benefits and the level of outpatient behavioral health services they offered. The ACOs that were unfamiliar with MHPAEA tended to not offer behavioral health services in line with standard medical benefits, or their interviewees were unfamiliar with the behavioral health services their organizations offered.

Two of the three ACOs that were familiar with MHPAEA were larger, public ACOs that viewed behavioral health as an essential health benefit and offered some of the most extensive behavioral health services in-network and onsite for their patients. Yet, even these ACOs struggled to provide behavioral health services in more precise parity with their medical and surgical services, often citing commercial insurance as a barrier due to specific carve-outs and prior authorization requirements for therapy and/or medications. They also cited as a barrier the lack of coverage by commercial insurance for behavioral health visits past the patient's initial visit.

To overcome these barriers, these two larger, public ACOs were progressive in creating unique programs to integrate behavioral health and primary care through collaborative care models with licensed clinical social workers, removing referral requirements in certain scenarios, and also implementing e-consults. This was consistent with some of the recommendations we came across in our initial literature review. Lastly, their primary care providers were rated as very comfortable (4 on a scale of 1 to 5, with 5 being the most comfortable and 1 being the least comfortable) discussing mental health concerns and SUDs with their patients and offered the most extensive list of interpretative services for their behavioral health visits.

For the other five ACOs, there was a heavy reliance on out-of-network behavioral health providers for mental health/SUD services, with all five stating that 95–100 percent of these services were performed out of network. However, leadership from one of these ACOs mentioned they had recently decided to implement a behavioral health service integration pilot to examine the financial viability of offering behavioral health services within their network.

3. ACO Prioritization of Behavioral Health

Organizational differences aside, the responding ACOs clearly recognized the importance of behavioral health issues and, based on mean and median scores, selected geriatric mental health needs as the first and geriatric SUDs as the second overall organizational priorities from a list of various behavioral health–focused topics that also included the opioid epidemic, vaping-related lung injury, and age-specific mental health, suicide, and so forth. Coming in third on this list was geriatric suicide. These priorities are in line with the primary population served by the ACOs we interviewed: Medicare beneficiaries. Unsurprisingly, child and adolescent mental health scored as the lowest priorities for the responding ACOs.

One topic that scored remarkably low was the opioid epidemic, with a mean of 2.28 and median of 2 on a scale of 1 to 5 (1 = least important, 5 = most important). Elderly individuals are the most susceptible group to developing opioid use disorder (OUD) as they are prescribed opioids at the highest rate, with 26.8 percent receiving opioid prescriptions over the last year (Gazelka et al., 2020). This may indicate a lack of awareness by the ACOs and could be an area for further research and potential Medicare reimbursable benchmark updates to align priorities.

4. Barriers to Providing Behavioral Health Services

Each ACO also rated specific barriers to providing more behavioral health services on a scale of 1 to 5 (1 being not a barrier and 5 being the largest barrier). Lack of data sharing between medical and behavioral health providers came in at the top of the list with a mean score of 4.2 and a median of 4.5. Respondents explained that failures in closing the referral loop and lack of proper electronic health record interoperability make it very difficult to provide behavioral health services. Often, primary care practitioners do not want to receive the behavioral health provider's full note because of the sensitive information involved. This can lead to gaps in care.

Tied for the second largest barrier with a mean score of 4 and a median of 4.5 were lack of sustainable payment models and low supply of behavioral health providers, locally and nationally. Both issues were commonly mentioned and are closely interrelated. ACOs stated that there is a significant lack of parity for behavioral health reimbursements, leading to limited sustainable payment models and lack of organizational prioritization of behavioral health efforts. This also dissuades students and future providers from pursuing behavioral health professions, leading to a shortage of behavioral health providers both locally and nationally and creating a negative feedback loop for behavioral health accessibility.

Tied for the second largest barrier...were lack of sustainable payment models and low supply of behavioral health providers...

When asked for general comments about barriers, respondents gave a wide variety of free responses. One individual said that "ACOs should be the place to integrate behavioral health but the structure of carve-out networks on the commercial side makes it difficult for patients." Another noted that there was a lack of geriatric-trained psychiatrists for their Medicare ACO patient population. Other comments mentioned large unaddressed needs due to opioids and depression and anxiety from COVID-19, negative stigma toward behavioral health issues, and particular challenges for transporting seniors to their behavioral health visits (with no direct services or payment models to support it).

There are a few notable limitations to the findings from this study, the first being the small sample size. In California alone there are over 100 ACOs, making seven a relatively small sample of that total number. An additional limitation was that responding ACOs were all located geographically in either Northern or Southern California, with no representation of the Central California region. Finally, because these interviews took place in the middle of the COVID-19 pandemic, we faced challenges scheduling interviews with ACO contacts. It is likely that ACOs had additional organizational priorities during this time and were less likely to make time for an interview regarding behavioral health even though the need for services remained great (if not greater) during the pandemic.

Recommendations

At the conclusion of the interviews, respondents were asked to share their own recommendations for mental health and SUD services. One respondent suggested that "the state of California needs to make a concerted effort around rationalizing access to behavioral health and how we support people in the right way, demystifying behavioral health issues and stigma at the primary care provider level, bringing other providers into the fold to make the most of the limited resources on the behavioral health side, and instituting continuing medical education training for providers regarding behavioral health." Another individual cited the need for "parity of reimbursement" to address the lack of behavioral health resources and attract providers to the behavioral health workforce. Several respondents related that there needs to be more integration of behavioral health in primary care.

Drawing on both our interviews and the literature review, we suggest four priority areas for improvement, two coming from a macro perspective and two from a micro perspective.

MACRO

- Educate on MHPAEA and Senate Bill 855
- Add MSSP P4P quality metrics for substance use disorder.

MICRO

- Integrate behavioral health to meet data sharing needs
- Utilize non-physician providers such as psychiatric NPs, LCWs, and care managers

Recommendation 1. Educate on MHPAEA and Senate Bill 855.

Foremost, we see a significant gap in overall understanding of and/or compliance with MHPAEA and related legislation in recent years. In 2017, commercial payers reimbursed primary care services 23.8 percent more than behavioral healthcare services, an increase from the 20.8 percent gap observed in 2015 (Melek et al., 2019). This growing disparity between reimbursements implies that health plans may be unaware of or blatantly disregarding the rules set forth in the MHPAEA. Continued education and enforcement of the laws will compel greater understanding and compliance.

Recommendation 2. Add MSSP P4P quality metrics for substance use disorder.

The need for education is not limited to health plans, as only 33 percent of patients are aware that mental health benefits should have cost-sharing and limits similar to medical benefits, and only 25 percent of patients are aware of the same for SUD benefits (California Health Care Foundation, 2019). Of the California ACOs interviewed, we see a similar trend,

with only three out of seven (43%) having knowledge and understanding of the MHPAEA. Since the recently passed SB 855 has more significant penalties for failing to provide parity, it is imperative that all parties understand the legislation. As such, we recommend educating ACOs, payers, and patients alike. We hope greater education will empower patients to demand parity from their payers.

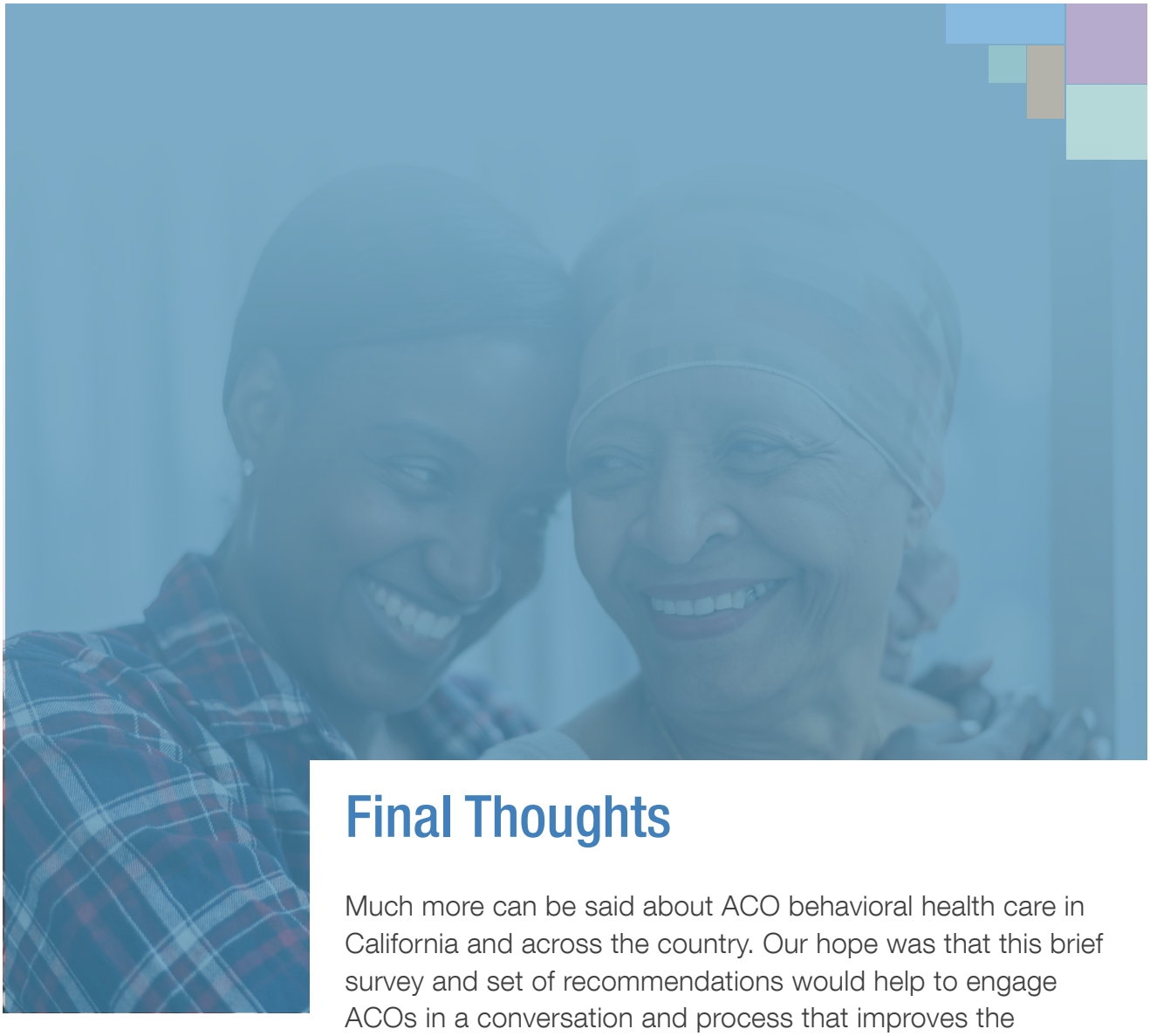
Our review of the MSSP revealed that there were not any pay-for-performance quality metrics specific to SUDs (while there were such metrics for tobacco use and depression) (Centers for Medicare & Medicaid Services, n.d.). We encourage the Centers for Medicare & Medicaid Services and the MSSP as well as commercial payers to adopt SUD-specific metrics to ensure greater ACO fidelity to SUD coverage and treatment at a time of unprecedented incidence of SUD, particularly OUD.

Recommendation 3. Integrate behavioral health to meet data sharing needs.

From a more micro, organizational perspective, we recommend ACOs adopt two best practices that we observed in a few of our respondents and the literature. The first is for ACOs to integrate behavioral health into their organizations. There are a variety of models of integration, including integration of mental health/SUD professionals in the primary care setting; integration of primary care providers in the behavioral health setting; care coordination; collaborative care models that leverage social work care managers to conduct outreach to at-risk patients; and programs that leverage recovery coaches and peer support specialists as community health workers to provide outreach, hospital diversion and continuous engagement (Joszt, 2016).

Recommendation 4. Utilize non-physician providers such as psychiatric NPs, LCSWs, and care managers.

For the other best practice, we encourage ACOs to utilize non-physician providers such as psychiatric nurse practitioners, licensed clinical social workers, and nurse care managers to provide behavioral health services as members of a common treatment team. Allowing these clinicians to operate at the top of their licensure will help to address the shortage of psychiatrists in California. A few of the ACOs we interviewed demonstrated that this is a viable method to provide behavioral health services affordably and leads to a more financially sustainable model in the long term.



Final Thoughts

Much more can be said about ACO behavioral health care in California and across the country. Our hope was that this brief survey and set of recommendations would help to engage ACOs in a conversation and process that improves the whole health of Californians and Americans, recognizing that behavioral health is central to that aim.

By uncovering the broad need for education, training, and technical assistance, we invite policymakers, regulators, payers, providers, and patient advocacy groups to join this effort. By amplifying the need for true parity and equity in behavioral health care, we will not only come to comply with the spirit and letter of the law, we will also ensure that all of our healthcare reforms produce the results they are designed to produce. We do not believe that this is a complicated effort. It will, however, require investment in education, training, and technical assistance as well as the discipline to fully implement and monitor solutions.

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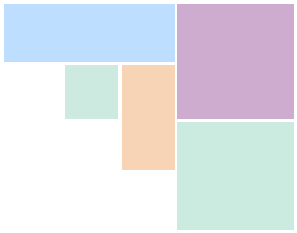

CORPORATE HEADQUARTERS

490-B Boston Post Road
Sudbury, MA 01776
Telephone: 978.443.0055

CALIFORNIA

131 N. El Molino
Suite 380
Pasadena, CA 91101
323.431.5617

ILLINOIS

1021 West Adams Street
Suite 303
Chicago, IL 60607
312.376.0595

Advocates for Human Potential, Inc.
Real World Solutions for Systems Change

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