Cite this article as:
David Mechanic
Seizing Opportunities Under The Affordable Care Act For Transforming The Mental And Behavioral Health System
Health Affairs 31, no.2 (2012):376-382

The online version of this article, along with updated information and services, is available at:
http://content.healthaffairs.org/content/31/2/376

For Reprints, Links & Permissions:
http://content.healthaffairs.org/1340_reprints.php

Email Alertings:
http://content.healthaffairs.org/subscriptions/etoc.dtl

To Subscribe:
https://fulfillment.healthaffairs.org

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.
Seizing Opportunities Under The Affordable Care Act
For Transforming The Mental And Behavioral Health System

**ABSTRACT** The Affordable Care Act, along with Medicaid expansions, offers the opportunity to redesign the nation’s highly flawed mental health system. It promotes new programs and tools, such as health homes, interdisciplinary care teams, the broadening of the Medicaid Home and Community-Based Services option, co-location of physical health and behavioral services, and collaborative care. Provisions of the act offer extraordinary opportunities, for instance, to insure many more people, reimburse previously unreimbursed services, integrate care using new information technology tools and treatment teams, confront complex chronic comorbidities, and adopt underused evidence-based interventions. The Centers for Medicare and Medicaid Services and its Center for Medicare and Medicaid Innovation should work intensively with the states to implement these new programs and other arrangements and begin to fulfill the many unmet promises of community mental health care.
Medicare and Medicaid’s coverage and payment policies, for instance, results in both major service gaps and wasteful duplication. The passage of the Affordable Care Act in 2010 raised expectations that care for people with mental illnesses will improve. An estimated 3.7 million more people with severe mental illnesses will gain access to care through provisions to expand Medicaid, subsidize private insurance for those who are not eligible for Medicaid, and require employers to offer insurance. The law will also prohibit health insurance companies from denying coverage to people with preexisting conditions. This change should benefit people with mental illnesses, who typically faced coverage denials in the past because of their existing behavioral disorders. And the law will create regulated insurance exchanges within each state, another reform that is expected to help people with mental illnesses gain access to health insurance.

Other delivery and payment innovations introduced by the Affordable Care Act could facilitate the provision of behavioral health services that are not usually reimbursable, including comprehensive care management, care coordination, social support, transition care, collaborative care, and other evidence-based interventions. Another example is supported employment programs, which encourage the most severely disabled clients to pursue competitive employment—in other words, employment in jobs that pay at least minimum wage and that are open to anyone in the community—by providing them with support for an unlimited period of time. The support includes coaching on and practice with self-presentation, forming relationships with colleagues, and identifying and resolving problems at work.

Medicaid covers a quarter of all mental health expenditures in the United States and presents policy makers with the leverage they need to improve care across the service system while restraining wasteful spending. Meanwhile, many Medicare enrollees—especially those who are eligible for both Medicare and Medicaid—have major behavioral disabilities. Also, as many as 10 percent of adults age sixty-five or older who are seen in primary care settings have clinically serious depression in addition to other chronic conditions. Depression in the elderly is commonly associated with declining function, reduced social networks, and social isolation.

This mix of issues requires integrated care and collaborative approaches that could be facilitated through medical and health homes and related approaches, such as the co-location of medical and behavioral health services that build on various provisions of the Affordable Care Act. Collaborative care models are valuable in all chronic care. But they may offer additional advantages in depression care by reducing costs over time across varying components of physical and behavioral care. Collaborative care makes seamless service provision more feasible, prevents service gaps and client dropout, and avoids duplication and inconsistencies in medication and other treatments.

Many regulations called for by the Affordable Care Act will be finalized between now and 2014. This window presents opportunities to blend various provisions to support integrated systems of care. Beyond the confines of the health reform law, coordinating newly mandated services with other programs holds promise for improving the behavioral health care landscape. Such programs include Substance Abuse and Mental Health Services Administration block grants, state-funded behavioral health programs, and initiatives supported by the Medicare-Medicaid Coordination Office to design new integrated care models.

**Reinventing Mental Health And Substance Abuse Care**

Below are five reasons why the Affordable Care Act has made reinventing mental health and substance abuse care in the United States more likely now. Following are some examples of opportunities that the Centers for Medicare and Medicaid Services (CMS), its Center for Medicare and Medicaid Innovation, and the states can continue to build on.

First, Affordable Care Act provisions enable states and federal agencies to test and evaluate improved financial and organizational tools in order to address the fragmentation of services that lead to poor quality and high cost.

Second, many provisions, such as health homes, are directed toward chronic disease co-morbidities. These provisions make it possible for care providers to be more responsive to clients who not only have serious mental illnesses but also have other serious chronic diseases or disease risks.

Third, the act allows providers to better coordinate Medicaid behavioral services with social service and housing programs that seek to prevent and manage homelessness among people with serious mental illnesses. Fourth, the act encourages the use of preventive services and substance abuse education, evaluation, and treatment, and it allows providers treating people with serious mental illnesses to pay more attention to substance abuse problems.
Fifth and finally, by extending the concepts of treatment and related supportive care to such entities as health homes, the Affordable Care Act provides new pathways for incorporating evidence-based treatments, such as supported employment, that are commonly neglected.

**Redesigning Organizational And Payment Arrangements**

Studies of the quality of mental health and substance abuse care find poor continuity and coordination of care and little adherence on the part of providers to practice standards. Typically, care is episodic and makes limited use of evidence-based medical, social, and rehabilitative interventions. This results in a very costly and inefficient pattern of care.

**PAYMENT REFORM** New forms of adjusted capitation and the related use of bundled or episode payments encourage continuity and efficiency. These new forms include fixed payments per client per time period, adjusted for age, illness severity, or other characteristics. Bundled or episode payments use a single payment for a package of services as an incentive for health providers to take greater responsibility for longer episodes of care. These payment approaches, more common to the behavioral health sector than to general medical care, offer varied opportunities to test innovative strategies aimed at improving care for patients with chronic illnesses.

Similar payment arrangements have already been used by mental health and substance abuse “carve-outs”—specified services that are organized and administered separately from the service mix—in which managed behavioral health care organizations and some community mental health centers function under various forms of capitation. Nevertheless, a great deal remains to be learned about using these payment models for populations with long-term disabilities.

Some attempts have been made to improve services and reduce wasteful spending in the behavioral health sphere and have showed promise. Unfortunately, they were rarely supported by existing organizational arrangements, incentives, and professional cultures. For example, in an early effort in Rochester, New York, the New York State Office of Mental Health provided funds to a central planning agency, Integrated Mental Health, which made a prospective fixed payment to community agencies to manage care for patients who had recently been inpatients in a state psychiatric facility. The program served as a medical home, providing not only all psychiatric care but also medical, dental, and other services necessary for community living, including housing. But the innovative aspects could not be replicated elsewhere or even sustained over time under the existing financial and organizational arrangements.

**HEALTH HOMES** There is a greater chance for successful redesign now because of the substantial commitment of CMS and its Innovation Center. The commitment is to a broader service mix, including care coordination, rehabilitative services, and assertive case management; the design of more coherent and stable organizational arrangements and payment incentives; and continuing performance evaluation.

Coordinating the management of serious chronic conditions and comorbidities and improving the transition from one type of service to another are challenging under the existing system. But Section 2703 of the Affordable Care Act encourages state Medicaid programs to offer a health home option, which is supported by a federal funding match of 90 percent for the first two years. Under this option, states can reimburse a patient-designated health home provider who provides care management, makes necessary referrals, provides individual and family support as needed, and uses health information technology to monitor and coordinate the various service providers involved.

Health homes designed for people with severe mental illnesses make it possible for community health centers and other appropriate behavioral health agencies to manage the integration of services over the full range of needs, even when a variety of providers and agencies are involved. Two of the first states approved for enhanced federal matching funds, Missouri and Rhode Island, are organizing services for people with severe mental illnesses with the help of community mental health centers.

Other states—including Iowa, New York, North Carolina, Oregon, and Washington—are
 Assertive community treatment and case management reduce hospitalization and retain patients in care.

also seeking federal matching funds, but they are not necessarily focused on severe mental illness or on behavioral health service providers. Activities in these states are not limited to this population or service mix because federal requirements for health homes allow for a range of eligible populations and design features.

Medicaid enrollees eligible for participation in health homes must have two chronic conditions, one such condition and a risk for a second, or a serious and persistent mental condition. States are considering health homes focused on a variety of chronic disease populations, but almost all states include among their target conditions mental illness and substance abuse. The Integrated Care Resource Center has produced a matrix of health home State Plan Amendments that summarizes the status of health home development as of December 1, 2011.19

The Challenge Of Comorbid Substance Abuse

A particularly challenging population at very high risk is made up of people with severe mental illnesses and comorbid substance use and abuse. Many of them suffer from other serious chronic conditions as well. Members of this population are at high risk for treatment nonadherence, hospitalization, homelessness, and incarceration. They require an integrated long-term treatment program and often need assertive case management, attention to their risk of homelessness, and interventions to prevent public disturbances and incarceration.

An appropriate care system for this population must be actively involved; accessible around the clock; and well connected to a wide array of community agencies, including those in the areas of housing and criminal justice. Some of these challenging and expensive clients may need highly specialized health homes designed specifically for them.

Well-constituted teams will be central to the successful implementation of these models. The teams must be responsible for monitoring patients and their continuing care. In addition, team members must be flexible and prepared to respond to critical events, such as a psychotic episode over a holiday weekend or an altercation requiring the team’s collaboration with police.

Assertive community treatment and case management successfully reduce hospitalization and retain patients in care, often improving their general functioning and employment and preventing them from becoming homeless.20 Policy makers could build on these approaches. The advent of improved design and organization brings new opportunities to implement cost-effective elements of care.21

The Affordable Care Act revised section 1915(i) of the Deficit Reduction Act of 2005. The revised section broadens the home and community-based services waiver option by allowing states to offer benefits specifically intended for people with mental illness and substance abuse disorders and to make care accessible to more people. The section eliminated the requirement that clients meet eligibility for institutional care, thus authorizing earlier interventions for eligible clients.

The changes in the law allow states to use home and community-based services to care for specific populations—such as people with severe mental illnesses—but those services can no longer place limits on the number of people covered, have waiting lists, or restrict coverage to specific areas of the state. In addition to usual coverage, people with chronic mental illnesses are eligible for day treatment (mental health treatment in a group setting several days a week), partial hospitalization services, psychosocial rehabilitation, and clinic services. States are permitted to propose still other services, excluding room and board, as part of their state plan amendment.

States have a further option under section 1915(k) of the Deficit Reduction Act, the Community First Choice Option. Through this approach, states can provide home and community-based services to people whose incomes are no more than 150 percent of the federal poverty level and who, in the absence of such services, would require placement in a nursing facility.

Such services are based on an individual care plan. They include community-based attendant services, including assistance with activities of daily living and the maintenance and enhancement of daily living skills; training in hiring and dismissing attendants; establishing backup systems to ensure care continuity; and selected op-
tional services. States selecting this option receive a six-percentage-point increase in their federal match for the costs of this program.

Although not specifically intended for people with profound behavioral health disabilities, the Community First Choice Option could be helpful to this population. For example, the option could provide appropriate supervision and support to allow people with serious mental illnesses, substance abuse problems, and comorbidities such as cognitive impairment to maintain their independence in the community and avoid repeated hospitalizations or placement in other institutions, such as nursing homes.

**Mental Illness And Homelessness**

Addressing the risk of homelessness and victimization and providing stable housing are critical to the effective long-term management of serious mental illness. There are a large number of programs to prevent or reduce homelessness, and seven different federal agencies administer such programs. Many homelessness programs are authorized by federal legislation designed to assist the homeless and are available to people in varying circumstances.

These programs can be coordinated with other needed behavioral health services, and the various provisions of the Affordable Care Act present an important opportunity do so in order to prevent homelessness and incarceration of people with mental illnesses.

**Integrating Mental Illness And Substance Abuse Treatments**

Organizing community treatment of mental illness is complicated by the affected population’s use and abuse of drugs and alcohol. The Affordable Care Act enables a transformation in the management of substance abuse, whether occurring along with serious mental illness or as a disorder in its own right. The act does this through its “whole person” perspective and focus on the integration of services, as well as by encouraging care coordination through health and medical homes and collaborative teams and services.

Substance abuse treatment is a mandated service under the act, which includes a provision for new workforce development and training. Substance abuse evaluation and treatment must be incorporated into the central tasks of monitoring and managing medications and educating clients about medication and illness. This is one of the most challenging areas of behavioral treatment, requiring a mix of integrated services that includes assertive case management; psychoeducation, or a combination of therapy and family-centered education; supported employment; social learning; social support; and harm-prevention orientation.

The evidence base remains undeveloped, but promising and effective approaches have been identified, such as social skills training, motivational learning, and rewards for clean urine test results. The lack of integration between mental health and substance abuse treatment has been a persistent deterrent to appropriate care, but the Affordable Care Act provides numerous opportunities to better address this issue.

**Implementing Evidence-Based Treatments**

Evidence-based social treatments that contribute to higher levels of social functioning and recovery often are not used in the care of people suffering from mental illnesses. Patients must be involved in meaningful daily activities for them to overcome their prevalent restlessness, isolation, boredom, and lack of self-regard.

Most adults define success by, and derive self-esteem from, their work and other productive activities. At least seventeen randomized controlled trials attest to the effectiveness and value of supported employment programs. Thus, the evidence affirms the value of incorporating supported employment in most programs for people with severe and persistent behavioral disorders. The Affordable Care Act provides important opportunities to overcome implementation barriers.

The population eligible for both Medicare and Medicaid, most of whom have annual incomes below $10,000 as well as more severe disabilities and greater needs than the Medicare population overall, should be an important focus of reinvented care for the mentally ill. In 2008 there
were 9.2 million people in the dual-eligibility category. Two-fifths of them had severe mental disabilities. The mentally ill dual-eligible population—16 percent of all Medicare enrollees and 15 percent of all Medicaid enrollees—accounted for approximately 27 percent and 39 percent, respectively, of the expenditures in these programs, totaling $120 billion in 2007.\(^{24}\)

CMS recently established a Medicare-Medicaid Coordination Office in an effort to ensure “full access to seamless, high quality care and to make the system as cost-effective as possible” for the dual-eligible population.\(^{11}\) CMS also provided funding to fifteen states for developing models to integrate care for this population. The goal is to create new approaches to care coordination for these people, including primary, acute, and behavioral health care and long-term supports and services. These model programs seek to identify, develop, and validate coordinated approaches to care delivery and payment.

Conclusion
Given the fiscal and other challenges faced by states and providers, it remains unclear how many will respond to the incentives and regulations associated with the new initiatives described above. Members of the behavioral health workforce will have to make many adjustments as they shoulder new responsibilities, work more collaboratively with others, increasingly depend on information technology, and reconceptualize their tasks and professional responsibilities. Major training efforts will be needed to retool the current workforce and train new personnel along the lines described.

The Institute of Medicine, two presidential commissions, and other bodies have repeatedly noted the fragmentation and disarray of our behavioral health delivery system and the suffering, disability, and homelessness that result. Attempts to address the serious challenges of access, services integration, and quality have repeatedly failed to solve these problems.

CMS, its Center for Medicare and Medicaid Innovation, and the states now have new tools to innovate in the sphere of behavioral health. Their broad agenda includes health homes, accountable care organizations, the co-location of services, health care team development, the meaningful use of information technology, and other tools of vital importance to the management of chronic disease. If they fail to seize these opportunities now, they and we will have missed the greatest chance in fifty years to address some of the largest disparities and deficiencies in our health care system and to remedy the many unfulfilled promises of community care.

NOTES

16
Medicare enrollees
The mentally ill dually eligible population—16 percent of all Medicare enrollees—accounted for 27 percent of Medicare spending in 2007. Among Medicaid enrollees, 15 percent were dually eligible, and they accounted for 39 percent of Medicaid spending in 2007.


ABOUT THE AUTHOR: DAVID MECHANIC

David Mechanic is the René Dubos University Professor of Behavioral Sciences at Rutgers University.

In this month’s Health Affairs, David Mechanic details opportunities created under the Affordable Care Act to redesign the nation’s highly imperfect mental health system. Mechanic observes that the changes create the potential to insure many more people, pay for previously unreimbursed services, integrate care using new information technology and treatment teams, confront complex chronic comorbidities, and adopt underused evidence-based interventions.

Mechanic is the René Dubos University Professor of Behavioral Sciences at Rutgers University as well as director of the Institute for Health, Health Care Policy, and Aging Research and the Mental Health Services Research Training Program, both at Rutgers. In addition, he serves as the director of the Robert Wood Johnson Foundation’s Investigator Awards in Health Policy Research Program. Mechanic is a member of the National Academy of Sciences, the American Academy of Arts and Sciences, and the Institute of Medicine. He won the Institute of Medicine’s 2009 Rhoda and Bernard Sarnat International Prize in Mental Health.

Mechanic holds both a master’s degree and a doctorate in sociology from Stanford University.