

HEALTH CARE REFORM

A PRIMER FOR PSYCHIATRISTS

The Patient Protection and Affordable Care Act:

Analysis and Commentary from APA Publications and the APA Department of Government Relations

American Psychiatric Association

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Note: The authors have worked to ensure that all information in this book is accurate at the time of publication and consistent with general psychiatric and medical standards, and that information concerning drug dosages, schedules, and routes of administration is accurate at the time of publication and consistent with standards set by the U.S. Food and Drug Administration and the general medical community. As medical research and practice continue to advance, however, therapeutic standards may change. Moreover, specific situations may require a specific therapeutic response not included in this book. For these reasons and because human and mechanical errors sometimes occur, we recommend that readers follow the advice of physicians directly involved in their care or the care of a member of their family.

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Foreword

APA Department of Government Relations

The Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, includes many net positives for psychiatrists and their patients. Together with the 2008 mental health parity law, PPACA substantially expands the scope of comprehensive, nondiscriminatory mental health coverage that will be available to most Americans once both laws are fully implemented.

No law as wide-ranging and complex as PPACA can satisfy all of the myriad concerns of psychiatrists, other physicians, health professionals, and patients. While PPACA is not perfect, the American Psychiatric Association (APA) Board of Trustees concluded that it warranted APA's support. Among other provisions of importance to the practice of psychiatry, the law:

- Extends coverage to 32 million more Americans;
- Bars insurance companies from denying coverage based on preexisting conditions;
- Bars insurance companies from dropping coverage because of illness;
- Requires insurance companies to permit enrollees to renew coverage;
- Permits dependent children up to age 26 years to be covered by their parents' health insurance;
- Includes mental health and substance use disorder treatment as part of the basic package of benefits in health insurance sold in state-based insurance "exchanges" created by the law;
- Ultimately requires full parity for mental health and substance use disorder treatment in such insurance;
- Establishes new Centers of Excellence for Depression and Bipolar Disorder;
- Provides new research funding for postpartum depression and postpartum psychosis;
- Ensures that patients with diagnoses of mental illness will be included in "health homes";
- Boosts funding for community mental health treatment options; and
- Facilitates co-location of primary and mental health treatment centers.

The APA Department of Government Relations and the APA Office of Publishing Operations, including *Psychiatric Services*, *The American Journal of Psychiatry*, and *Psychiatric News*, have put together this booklet of information to help you better understand how the new law works and how it may affect you and your patients. We hope you find the information helpful. As always we welcome your feedback.

Introduction to the Special Section

Thomas G. McGuire, Ph.D.

Earlier this year, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the policy research arm of the U.S. Department of Health and Human Services, commissioned three papers, each addressing a key question for the organization and financing of mental health and substance abuse care under the Patient Protection and Affordable Care Act (PPACA): How should the “market” for new health insurance plans be set up? Will coverage of mental health services be adequate? Can the quality and efficiency of care be improved through better integration of mental and physical health care? Together, these papers are a primer for mental health clinicians and policy makers about what to look for, hope for, and watch out for as the rubber meets the road in health care reform.

PPACA primarily reforms health insurance, not health care. The centerpiece of PPACA, and arguably the provision with the most far-reaching implications, is creation of the new exchanges, state-run markets for individual private health insurance (that may also be accessible to small groups). The authors of the first article remind us that individual private health insurance markets have not done well by persons with mental illness (1). Persons with mental illness tend to be “bad risks” from the standpoint of the health plan, and it is in the interest of the plan to discourage them from joining. Health plans in the exchanges will have to cover mental health care at parity with general medical care; however, this regulation of the nominal benefit package provides incentives for plans to “manage” mental health care tightly. Previous experience in private health insurance implies that states should

consider policies to protect plans against drawing an “adverse selection” of the risks, so that the plans, in turn, will compete for all potential enrollees by offering high-value coverage.

Medicaid expansions to previously ineligible low-income individuals and the state-level exchanges will together extend health insurance coverage to an additional 32 million people. That’s the good news. The bad news is that the coverage for persons with mental illness may in many cases be inadequate, and it may even be less generous than the de facto coverage that is currently provided through state-funded programs for the uninsured. In the second article, Garfield and colleagues (2) review coverage of mental health services under typical commercial (employer-based) coverage as well as Medicare, Medicaid, and other publicly funded programs, and they assess the options for addressing likely gaps in coverage that will arise under reform. States are not uniform in their Medicaid and other programs, but persons with serious mental illness getting care through these payers generally have access to a wider range of services, including nontraditional medical services, than do enrollees in commercial coverage or Medicare. Under the PPACA, states can offer Medicaid “lite” to the newly covered, and indeed, there is no “maintenance of effort” clause requiring states to maintain Medicaid benefits even for the previously eligible. Coverage in state exchanges features parity, but these will be basic health insurance plans with plenty of cost sharing. It is uncertain—and even doubtful—whether these plans will cover much in the way of nontraditional benefits crucial for many with mental illnesses.

Improving quality and containing costs will ultimately require reorganization of care, and PPACA includes several provisions that aim to accelerate the reform of care. Persons with mental illness often have chronic and complex health care needs that would benefit from disease management, and they have much to gain from reorganization. Medical homes, whether these are located in primary care—or in a mental health care setting for persons whose psychiatric condition dominates their medical need—offer promising models. In the third article, Druss and Mauer (3) review the experience of integrating primary and mental health care and provide a guide to the demonstration initiatives that Medicare and Medicaid are expected to administer in the near term. In general, the focus is on payment of monthly management fees to accountable care organizations, with less reliance on procedure-based billing. Success means different things for payers, providers, and patients in these demonstrations, and it remains to be seen whether a win-win-win is possible within the constraints of existing public-payer financing structures.

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Regulating a Health Insurance Exchange: Implications for Individuals With Mental Illness

Thomas G. McGuire, Ph.D.

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Under the newly enacted health reform law, millions of lower- and middle-income Americans will purchase individual or family health insurance through state-based markets for private health insurance called insurance “exchanges,” which consolidate and regulate the market for individual and small-group health insurance. The authors consider options for structuring choice and pricing of health insurance in an exchange from the perspective of efficiently and fairly serving persons with mental illness. Exchanges are intended to foster choice and competition. However, certain features—open enrollment, individual choice, and imperfect risk adjusters—create incentives for “adverse selection,” especially in providing coverage for persons with mental illness, who have higher overall health care costs. The authors review the experience of persons with mental illness in insurance markets similar to the exchanges, such as the Massachusetts Connector and the Federal Employees Health Benefit Program, and note that competition among health plans for enrollees who are “good risks” can undermine coverage and efficiency. They review the possible approaches for contending with selection-related incentives, such as carving out all or part of mental health benefits, providing reinsurance for some mental health care costs, or their preferred option, running the exchange in the same way that an employer runs its employee benefits and addressing selection and cost control issues by choice of contractor. The authors also consider approaches an exchange could use to promote effective consumer choice, such as passive and active roles for the exchange authority. Regulation will be necessary to establish a foundation for success of the exchanges. (*Psychiatric Services* 61:1074–1080, 2010)

The Patient Protection and Affordable Care Act (PPACA), passed in March 2010, will create new state-based health insurance markets, referred to as “exchanges,” which consolidate and regulate the market for individual and small-group health insurance. A well-designed exchange has the potential to increase enrollment in health in-

urance plans, expand choice, and contain costs through competition. Federal and state policy makers’ choices about design of the new market will have important consequences for persons with mental illness.

Individual health insurance markets have historically come up short in providing coverage for treatment of mental illness; state and federal regulation

has been needed to secure improvements in coverage over the past 30 years. Recently, improved diagnostic assessment, availability of low-cost treatments, and advances in managed care have ameliorated the “moral hazard” problem of insurance in mental health care (1). However, other features of the exchanges—open enrollment, individual choice, and imperfect risk adjusters—imply that “adverse selection,” the second longstanding problem for insurance markets for mental health care, must be given careful consideration in policy decisions about choice and pricing.

This article considers options for structuring choice and pricing of health insurance in an exchange from the perspective of efficiently and fairly serving persons with mental illness. Health insurance should protect consumers against financial risk, be priced fairly for the sick and the healthy, and encourage efficient health care. By pricing fairly, we mean that lower-income groups should be subsidized and persons with worse health status should not pay more for coverage than healthy persons. Our main concern in this article is how problems related to adverse selection will be handled in an exchange. After an empirical assessment of the underlying driver of selection incentives, the higher overall costs of persons with mental illness, we review relevant experience from health insurance markets that are similar in design to the new exchanges, focusing on adverse selection. Next we discuss options for contending with selection incentives within an exchange. These options tend to limit consumer choice,

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raising the key regulatory tradeoff: are consumers better served by limiting choice to prevent a “race to the bottom” in effective coverage, or is consumer choice an essential element to promote efficiency among competing plans? We also discuss the problem of choice from the standpoint of consumer awareness of alternatives and the ability of consumers to make good choices from among the large number of alternatives that could be contained in an exchange.

Mental health and health care use among likely exchange participants

Among persons likely to participate in an exchange, the frequency of mental health care use and the relation to overall health care costs per person are fundamental to assessing the functioning of insurance markets for persons with mental illness. To illustrate the issues, we consider adults aged 18–64 with family income between 150% and 250% of the federal poverty level (FPL). Table 1 contains data from the Medical Expenditure Panel Survey (MEPS) for individuals who were either privately insured during 2006 or were uninsured all or part of the year. Figures are weighted to national estimates. (Zuvekas [2] has provided definitions of the variables in the table and a description of MEPS.) About 28.8 million people are represented in the categories reported in the table. Individuals with full-year coverage through Medicare or Medic-

aid are excluded. The groups are further divided by a single indicator of mental health status: self-rated mental health status. We group the five possible mental health status responses into two categories; fair-poor and excellent–very good–good. Overall, slightly less than 10% of the population is in the fair-poor category.

For persons in all three insurance categories, spending on mental health care during a year is much higher for persons with fair or poor mental health status compared with those with good, very good, or excellent status. Among the privately insured, for example, average mental health spending per person is \$737 for less mentally healthy persons, compared with \$111 for the group with better mental health. More relevant for incentives to health insurance plans is another result: total health spending is much higher for persons with worse self-rated mental health. In the privately insured group, average total spending per person is \$7,406 compared with \$2,778 for those with better mental health. Only \$626 of the additional \$4,628 spent each year by those with worse self-rated mental health is accounted for by mental health costs directly; the vast majority of the higher total costs is for other health care costs. Although health plans must accept all applicants, the MEPS data imply that plans will have strong incentives to offer low-quality mental health care and make access difficult (3).

Experience in Massachusetts and other insurance markets

The new exchanges will be operational as of January 1, 2014, and the Congressional Budget Office estimates that by 2019, a total of 24 million people will be insured through an exchange (4). Several key design features of the exchanges are undefined by the PPACA; for example, an exchange could be run by the state, outsourced to a private authority, or left by default to the federal government to operate (5). The exchanges are loosely based on the Massachusetts Connector (described below) and will offer plans that cover a defined minimum benefit package, which will include parity for mental health care and provide premium and cost-sharing subsidies for individuals and families in households earning up to 400% FPL. Exchange plans will be more generous than those historically offered in the individual market. For example, in 2000 only 63% of individual health insurance plans offered coverage for inpatient mental health care, and only 48% provided an outpatient benefit (6).

Previous experience in other markets for private health insurance identifies challenges for the new exchanges.

Massachusetts Connector

The Massachusetts Connector, a state agency established in 2006, operates an exchange that as of March 2010 had enrolled 177,000 individuals in a health plan (7). Eighty-six percent of

Table 1

Mental health and total health expenditures in 2006 for adults aged 18–64 with incomes 150%–250% of the federal poverty level, by mental health and insurance status^a

Self-reported mental health status and expenditure type	Private insurance for the full year	Uninsured for part of the year	Uninsured for the full year	All 3 groups
Fair or poor				
Number of adults (in thousands)	1,274.7	515.4	570.3	2,360.4
Mean mental health expenditures	\$737	\$509	\$557	\$644
Mean total health expenditures	\$7,406	\$3,847	\$2,193	\$5,370
Good, very good, or excellent				
Number of adults (in thousands)	14,851.0	4,616.0	7,004.8	26,471.8
Mean mental health expenditures	\$111	\$72	\$36	\$84
Mean total health expenditures	\$2,778	\$1,926	\$690	\$2,077
All				
Number of adults (in thousands)	16,125.7	5,131.4	7,575.1	28,832.2
Mean mental health expenditures	\$161	\$116	\$75	\$130
Mean total health expenditures	\$3,144	\$2,119	\$804	\$2,347

^a Source: Medical Expenditure Panel Survey (MEPS), 2006. For definitions of variables and a description of MEPS, see Zuvekas (2).

Table 2

Copayments for mental health and substance abuse treatment in three types of Massachusetts Connector–subsidized plans, 2010^a

Plan type ^b	Outpatient office visit	Inpatient care (per stay)	Methadone maintenance	Maximum copayment ^c
Type I	\$0	\$0	\$0	\$0
Type II	\$10	\$50	\$0	\$750
Type III	\$15	\$250	\$0	\$1,500

^a Based on information available at the Connector Web site (www.mahealthconnector.org). There are no limits on coverage for mental health and substance abuse treatment, although services may require authorization.

^b Connector-specified level of health benefits and copayments available to members on the basis of their income: type I, below 100% of the federal poverty level (FPL); type II, 100.1%–200% FPL; type III, 200.1%–300% FPL

^c Excludes prescriptions

enrollees are in subsidized plans operated directly by the Connector and open to uninsured adults who are U.S. citizens or U.S. nationals and to families earning less than 300% of FPL. All subsidized plans must meet the “minimum creditable coverage” standards determined and regulated by the Connector Authority and offer comprehensive mental health and substance abuse coverage (8). Cost-sharing requirements in the subsidized plans are determined by household income (Table 2). The plans differ across provider networks and ad-

ditional offered services (such as reimbursement for fitness memberships or telephone hotline services). As of 2010 the majority of subsidized plans carve out behavioral health services, and the Connector risk-adjusts plan payments using a calculation based on D×CG methodology that incorporates age and gender, as well as prior health claims of the enrollees for whom the Connector has this information (9).

In the unsubsidized portion of the market, the Connector is more passive, supporting the development and

offering of health insurance coverage to individuals who do not have another source of coverage and who do not qualify for a Connector-subsidized plan. The Connector operates administrative services, including a Web-based enrollment function, enrollment support, and customer service, and transfers the premiums collected from individuals through to plans on a monthly basis. In 2010 seven insurance carriers participate in the unsubsidized program. Carriers offer plan products categorized into tiers based on actuarial value of coverage (called gold, silver, bronze, and young adult); all plans offer comprehensive mental health coverage. Strategies to minimize adverse selection in the unsubsidized plans were implemented primarily through the health reform legislation, which restricts carriers to use of information on age, residence location, family size, industry, wellness program use, and tobacco use when determining premiums and requires carriers to merge the small-group and nongroup markets (10). Over the past three years, the benefits offered by plans within coverage tiers have been increasingly standardized (8). Nevertheless, premiums charged for plans in the same coverage tier and with very similar cost-sharing requirements differ by a factor of up to 1.6 to 1 for a 25-year-old and up to 1.8 to 1 for a 50-year-old in the Boston area, although somewhat less in western Massachusetts (Table 3). It is unclear whether selection or other factors are responsible for the wide range of premiums in the same market for apparently very similar products.

In fiscal year 2009 the Connector’s reported administrative expenses of \$29 million represented 3.5% of total Connector expenses, with the remaining 96.5% paid out to subsidized plans in the form of capitation payments (11). To figure total administrative costs of health insurance in the Connector, health plan expenses would need to be added to those paid by the Connector itself.

There is little available information about the experience in the Connector of people with behavioral health disorders. According to interviews we conducted with several senior staff at the Connector, the population with men-

Table 3

Premiums in 2010 for Massachusetts Connector unsubsidized plans, by geographic area^a

Plan type	Boston quotes ^b			Western Massachusetts quotes ^c		
	Low	High	Ratio of high to low	Low	High	Ratio of high to low
25-year-old enrollee						
Gold	\$369	\$554	1.5	\$387	\$465	1.2
Silver (medium)	\$316	\$452	1.4	\$345	\$410	1.2
Bronze (medium)	\$232	\$324	1.4	\$262	\$294	1.1
Young adult, with prescription coverage						
High	\$186	\$290	1.6	\$212	\$235	1.1
Low	\$174	\$232	1.3	\$180	\$208	1.2
50-year-old enrollee						
Gold	\$556	\$996	1.8	\$670	\$930	1.4
Silver (medium)	\$478	\$815	1.7	\$598	\$820	1.4
Bronze (medium)	\$348	\$584	1.7	\$445	\$575	1.3

^a Based on information available at the Connector Web site (www.mahealthconnector.org). Premiums for contracts starting March 1, 2010, quoted online on February 4, 2010. Boston, zip code 02118; Western Massachusetts, zip code 01201

^b In all but two cases, the low quote was from Neighborhood Health Plan and the high quote was from Fallon Community Health Plan.

^c Carrier offering the low quote and high quote varied across all plan types.

tal illness in these plans is higher functioning than that covered through the state's Medicaid program, and persons with mental illness in the Connector faced no special difficulty in making enrollment decisions. Connector community outreach efforts are geographically based and target specific cultural groups; no special efforts are based on disease or health status. The staff at the Connector reported few complaints from the mental health advocacy community about difficulties with enrollment.

Copayment obligations under Connector plans are potentially unlimited, and early evidence indicates that financial risk may be a serious problem for people with chronic illnesses (12). Mulvaney-Day and colleagues recently surveyed 66 persons from racial and ethnic minority groups who had received free care from a designated safety-net provider for mental health services before Massachusetts state health reform (Mulvaney-Day N, Alegría M, Nillni A, et al., unpublished manuscript, 2009). In the first year of reform, half were still receiving free care. Of those who switched from free care to a Connector plan, one-third reported difficulties with the transition and cut back on their mental health care, and an additional third reported administrative difficulty with the process of reform. An insurance-based payment system—as opposed to getting “free care” from a safety-net provider—requires patients to keep records of payments and submit forms, an unfamiliar and sometimes challenging task for this population. The generalizability of these findings is limited because the study population was primarily female, low-income, and Spanish speaking.

Federal Employees Health Benefit Program

The Federal Employees Health Benefit Program (FEHBP) has run a regulated health insurance market for federal employees (including retirees) and their families since the 1960s (13). The FEHBP evolved into the paradigm of “managed competition” proposed by Enthoven in 1980 (14), wherein enrollees choose plans annually and plans (qualified by the

Office of Personnel Management [OPM]) compete on price and benefit offerings. Plans must accept all who seek to enroll. The U.S. government, acting as an employer, pays up to 72% of the average plan premium for each plan in a market (single or family and not above 75% of the plan's premium), and the employee pays the balance. Thus the employee faces the “incremental average cost” of coverage, giving the participating plans imperfect but some incentives to balance decisions about extra coverage and cost against the higher premiums that must be charged (15; Glazer J, McGuire TG, unpublished manuscript, 2009). In 2010 there were several national plans (for example, Aetna and Blue Cross) and more than 200 local plans, largely health maintenance organizations (HMOs).

Parity for coverage of mental health and substance use disorders was successfully implemented in the FEHBP plans in 2001 and evaluated by Goldman and colleagues (16). Some plans, primarily those with more management of care, covered mental health at parity before the regulation. Among the plans studied in the evaluation, only one “unmanaged” plan experienced greater utilization after parity. Plans tended to introduce more managed care, largely in the form of “carved out” benefits after parity (17). The FEHBP evaluation confirmed the general finding from earlier research that parity for mental health benefits can be implemented at little net cost in the presence or with the addition of managed care (1).

The FEHBP's experience of mental health coverage and cost before parity is also relevant. During the early years of the FEHBP, mental health care was covered at parity in national plans (18), but generous coverage proved unviable with individual choice of coverage (19). Padgett and colleagues (20) found that use of mental health care in the Blue Cross “high option” plan was two to three times higher per person despite slight differences in coverage, leaving heavy adverse selection as the only explanation for the large observed differences in costs. Health plans reacted to the threat of enrolling an “adverse

selection” of health care risks. Foote and Jones (21) documented deterioration in coverage throughout the 1980s, in spite of OPM resistance to cutbacks. Regulation of nominal benefits cannot prevent plans from “managing” mental health costs aggressively. In 1980 behavioral health services accounted for 7.8% of total FEHBP claims costs; by 1997 this had fallen to 1.9%. Foote and Jones noted that during this period most employers, with their more limited consumer choice of health plan set-ups, were improving coverage for mental health care, and employer coverage surpassed rather than fell short of what was offered in the FEHBP.

Large employer and Medicaid contracting experience

Many large employers structure an insurance market for their employees—in effect, creating an exchange within the firm. Most “solve” the moral hazard and selection-related problems that arise with mental health care use and are able to expand financial protection through parity-like benefits by offering limited choice among plans managing care (1). In a first step, employers qualify one, two, or a small number of managed care plans from which employees may choose. These plans might be from a single insurer, eliminating the insurer's incentives to engage in risk selection. As part of this negotiation, the employer contracts with the insurer, paying an individual and family rate that is based on experience. Alternatively, the employer may bear the health insurance risk and contract only for administrative costs from the plans (possibly with some rewards or penalties related to cost and performance targets). State Medicaid programs contract with managed care plans in broadly similar fashion.

For example, employees at Harvard University choose among an HMO and point-of-service (POS) plan offered by the university itself through physicians on salary at the Harvard University Group Health Plan and an HMO, POS, and preferred-provider organization (PPO) plan offered by the independent Harvard Pilgrim Health Care. All choices include unlimited coverage of inpa-

tient and other facility care for mental health and substance use disorders and unlimited outpatient visits subject to copayments. Care is managed in all plans. Harvard decides what premiums employees should pay and subsidizes enrollment for lower-income employees more than for higher-income employees. For example, the employee premium for family coverage at the Harvard Pilgrim Health Care HMO is \$229 per month for an employee making less than \$70,000 per year and \$376 per month for an employee making more than \$95,000 per year.

From the standpoint of the average employee or Medicaid recipient, there is some but limited choice. Plans differ in degree of management and coverage for out-of-network care. Provider networks overlap. Although choice is limited, employees and their families face essentially no risk of financial adversity as a result of mental illness.

Pricing an exchange: setting plan payments and enrollee premiums

Premiums paid by enrollees and paid to plans can be judged in terms of their incentives for efficient behavior on the part of plans and enrollees and in terms of fairness. Even the simple two-way cut of the population based on self-rated mental health status (Table 1) reveals very large average total cost differences between those with higher or lower self-assessed mental health status. A health plan makes or loses money according to how premiums are related to average costs in a population. If premiums paid to the plan are roughly age-gender and geographically adjusted average costs (plus a loading fee), plans will have a strong incentive to discourage enrollment of persons with mental illness by skimping on the quality of or ease of access to mental health care.

Risk adjustment of premiums paid to health plans can move premiums toward expected costs, potentially ameliorating plans' incentives to underserve persons with mental illness. However, the power of risk adjustment to align revenues with expected costs is limited by the underlying data and by regulation. Variables available

for risk adjustment may poorly predict future health care costs, especially for some chronic illnesses such as certain mental illnesses. For example, in the California Health Insurance Purchasing Cooperative (HIPC) in the 1990s, a voluntary exchange open to small groups, the risk adjustment methodology excluded mental health experience because, in part, coding for these services was thought to be imprecise and coverage at the time was partial (22). Adverse selection in the California HIPC eliminated the more generous PPO plans from the exchange (23). Furthermore, in some versions of an exchange, premiums paid by enrollees are paid directly to plans. Risk-adjusting the premiums paid to plans thus also implies charging sicker people more to enroll.

The state-based exchanges created under health reform limit the degree to which plans can differentiate premiums paid by enrollees on the basis of expected cost-related factors, such as age and gender, and by prohibiting use of "preexisting conditions" in rate setting. Exchange authorities, as intermediaries, could play a more direct role in enrollee premiums, just as employers do in the case of employer-provided health insurance, where it is the employer, not the plan, that sets the premium for membership to the worker. For example, all persons could be charged premiums to join plans based only on age, gender, and income, but plans themselves could be paid on the basis of age, gender, and past diagnoses. Level of premiums for health plans is a powerful selection device in a managed competition environment (Glazer J, McGuire TG, unpublished manuscript, 2009), and more direct regulation of premiums should be considered. Intermediation for purposes of fairness and efficiency can be done in the subsidized and unsubsidized parts of an exchange.

Facilitating enrollment in health exchanges

Choice in health plans serves heterogeneity in "taste" for insurance among consumers and allows for static and dynamic competition among the plans. However, incentives for selection and increasing complexity as-

sociated with more choice can inhibit effective decision making. Thus the ability of exchange participants to choose plans well and navigate the enrollment and reenrollment process is important to the stability and sustainability of an exchange.

Challenges with enrollment and choice are common in exchanges. Difficulties with paperwork requirements and the enrollment and reenrollment processes have been reported among enrollees in the Massachusetts Connector (24). In Florida a survey of Medicaid enrollees who were in a demonstration project that required them to select from a set of preapproved health plans found that beneficiaries had low awareness of the program, difficulty understanding health plan information, and difficulty choosing a plan (25). In this study 11% of the overall Medicaid sample and 43% of the adult sample that received Supplemental Security Income reported a mental health condition; the authors tested for and did not find any difference in these results by health condition. In the Medicare Part D exchange, the elderly choose from among many (often more than 50) private prescription drug plans. Thus far, enrollees in the Part D exchange have not maximized their potential savings in drug spending, because most beneficiaries did not select the lowest-cost plan available to them in the first year of the program (26). In a randomized experiment, 28% of beneficiaries who received personalized information about Part D plans with lower costs switched from their current plans, compared with 17% of beneficiaries who were simply directed to a Web site where they could learn such information on their own (27).

Although these studies did not focus on populations with mental illness, this collection of evidence suggests that consumers in an exchange are not well equipped to navigate the enrollment and reenrollment process or to make choices from among a large set of plans on their own. Because of cognitive deficits or incentives related to selection, individuals with mental illness may particularly benefit from having someone in an

advisory role to assist them in navigating the exchange.

Brokers often advise small employers about health plan choice. The absence of brokers was an impediment to the success of past state-level HIPCs, which were not effective on their own at marketing products to small groups and whose customers (small groups) reported wanting help from agents in selecting plans and downstream support with issues such as claim disputes (23). However, brokers are often paid commissions by plans and have their own financial interest in customer choices. Exchange models that do not employ brokers have the potential to lower overall costs because enrollees avoid broker commissions when they purchase plans. This has not been the case in the Massachusetts Connector, where it is required that plans sold through the Connector are sold in the outside market at the same price (28).

Other parties could assist enrollees in an exchange. Providers in health care settings could help patients complete and submit eligibility and enrollment applications at the point of care. Provider payments for behavioral health from exchange plans must be adequate so that providers are willing to help their patients seek coverage through these plans. Social workers, community organizations, and the mental health advocacy community can also assist people with enrollment in exchange health plans.

An exchange's centralized administrative function can also have an important role in enrollment and plan choice. The exchange could opt to be passive, simply facilitating access to health plans via the Internet and other marketing materials that are also available through other channels. (The analogy here is an Expedia.com for health insurance.) Or an exchange can be more involved with its consumers, providing detailed quality information along with individualized decision and enrollment support. This assistance may be particularly valuable to patients with mental illness who are searching for a health plan that will cover care received from a particular provider. An exchange can selectively contract with and offer a limited

number of plans, simplifying the choice process. Finally, structuring the reenrollment process so that the default for enrollees is automatic assignment into their previous plan (and so that switching plans or dropping coverage requires an enrollee to take action) can eliminate time-consuming and challenging reenrollment paperwork and avoid unnecessary gaps in coverage.

Options for structuring choice of plan

Hard experience indicates that a passive exchange that allows free entry of private health insurance plans with discretion to determine benefits (within regulatory constraints), manage care, and set premiums (also constrained by regulation) is unlikely to lead to good insurance outcomes for persons with mental illness. Incentives to underprovide care to this population will be strong, and actions to limit de facto access and benefits will be outside the scope of the exchange authority's control. Discouraging enrollment and encouraging disenrollment—"Someone with your level of need really would be better off elsewhere"—will be difficult to prevent. We do not discuss design of the benefits themselves as part of structuring choice. Federal parity law applies to coverage in the exchanges, although interpretation of parity is not straightforward when services provided for general medical care and mental health care are not equivalent (29).

Three options for improving insurance outcomes by restricting choice are worthy of consideration. First, carve out all or part of mental health benefits. Carve-outs are part of many state Medicaid and private health insurance plans. Carve-outs limit enrollees' choice of where to turn for mental health care but permit choice of other coverage. The main advantage of carve-outs is that they diminish selection-related incentives to underserve persons in need of mental health care. An exchange authority, by use of a separate contract to the carve-out vendor, is able to directly control the resources going into mental health care and other dimensions of the quality of and access to care.

The main disadvantage of a carve-out is the more difficult coordination with general health care providers and potential cost-shifting between the two insurance contracts.

A second option is to provide reinsurance for some mental health care costs (possibly along with some reinsurance for general health care costs). Reinsurance of costs above a certain annual threshold (for example, \$2,000) or for certain types of care (such as hospital care after five days per year) can have dramatic effects on the likely gains and losses and therefore on the incentives to enroll and serve persons with mental illnesses. Reinsurance need not be 100% after a threshold but could be set to allow for some risk sharing—for example, the plan would be responsible for 30% of costs after \$2,000 and the exchange authority would be responsible for 70%. By contracting with a reinsurer, the authority absolves the basic plans of risk of high-cost mental health care, diluting incentives for selection. The disadvantage of reinsurance is the diluting of plan incentives to manage care effectively, particularly around the reinsurance boundary.

Third, and our preferred option, is to run the exchange in the same way that an employer runs its employee benefits and address selection and cost control (moral hazard) issues by choice of contractor. Employers do not rely on setting elaborate risk adjustment formulas and then allowing their employees to choose from any plan that decides to offer coverage. Employers pursue their health benefit objectives by deciding which plans (a limited number) to contract with. Active selection of plan options, rather than passive manipulation of payments and premiums to influence market outcomes, has been the route chosen by private decision makers to solve the very same problems faced by public decision makers now structuring exchanges (30). This approach would economize on administrative costs and brokers' fees. Many states contract for health insurance for their employees in ways modeled on those of private employers. In Massachusetts, for example, the widely studied Group Insurance Commission serves this function (31). This approach

models exchanges on the successful sector of the private health insurance market, not on the problematic one.

Conclusions

This article considers how the structure of plan choices and the pricing of health insurance will affect the success with which new health insurance exchanges serve people with mental illness. The role played by the exchange authority will be particularly important. Risk adjustment of plan payments is unlikely to adequately contend with selection incentives to underserve persons with mental illness. The exchange authority may need to use its intermediary position to decouple rules for setting plan payments from rules for setting enrollee premiums. The exchange authority can also assist choices and design the exchange to help consumers make efficient choices. Finally, the exchange authority should consider following the lead of private employers and limiting the number of plans offered to exchange members on the basis of quality (including quality of vulnerable services such as mental health care) and cost. Competition can be maintained as plans contend to be one of the selected products. The limitation of choice would be no worse and mostly better than that experienced by the 60% of the U.S. population covered by employer-based insurance. The main advantage, and what we think thus far outweighs the cost, is the application of a proven strategy for administering broad benefits at good quality for the full range of health care needs, including mental health.

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Health Reform and the Scope of Benefits for Mental Health and Substance Use Disorder Services

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The Patient Protection and Affordable Care Act will expand insurance coverage to millions of Americans with mental disorders. One particularly important implementation issue is the scope of mental health and substance abuse services under expanded health insurance coverage. This article examines current public and commercial insurance coverage of the range of services used by individuals with mental illnesses and substance use disorders and assesses the implications of newly mandated standards for benefit packages offered by public and private plans. The authors note that many services needed by individuals with mental or substance use disorders fall outside the scope of benefits currently covered by a typical private insurance plan. Compared with other insurers, Medicaid currently covers a broader range of behavioral health services; however, individuals moving into Medicaid under new eligibility pathways will receive “benchmark” or “benchmark-equivalent” coverage rather than full Medicaid benefits. If behavioral health benefits are set at those currently available in typical private plans or in benchmark coverage, some newly insured individuals with mental illnesses or substance use disorders who are covered by private plans or Medicaid expansions are still likely to face gaps in covered services. Policy makers have several options for addressing these likely gaps in coverage, including requiring states to maintain coverage of some support services, including certain behavioral health services in the “essential benefits package,” and expanding eligibility for full Medicaid benefits. (*Psychiatric Services* 61:1081–1086, 2010)

The Patient Protection and Affordable Care Act (PPACA), signed into law in March 2010 (PL 111-148 and see also PL 111-152), mandates that federal agencies, states, businesses, and individuals take steps to expand health insurance coverage in the United States. PPACA is a significant step in increasing access to mental health care for millions of Americans who will gain

coverage under reform, including many individuals with moderate or severe disorders.

However, the impact of coverage expansions will depend on how several operational issues are handled by state and federal agencies. One particularly important set of issues is related to the scope of mental health and substance abuse services under expanded health insurance coverage.

Individuals with mental or substance use disorders, particularly those with serious and persistent mental illnesses, may require services that are often not covered by the typical insurance plan. Thus particular attention may need to be paid to structuring these new coverage options in a way that meets the health needs of this vulnerable population.

In this article, we examine current public and commercial insurance coverage of services used by individuals with mental illnesses and substance use disorders. We then assess the implications of newly mandated standards for benefit packages offered by public and private plans. We conclude by considering implementation options for addressing some of the challenges in expanding health insurance coverage for vulnerable populations, such as individuals with mental and substance use disorders.

Coverage expansions under PPACA

PPACA expands insurance coverage through a combination of an individual mandate for coverage, penalties for employers who do not cover their workers, broadened eligibility for Medicaid, and subsidies for private insurance coverage obtained through new health benefits exchanges or marketplaces through which individuals and small employers can purchase coverage. PPACA also includes several changes to the regulation of insurance, such as the extension of dependent coverage through age 26, that aim to increase availability and affordability of coverage. The majority of coverage expansions will take

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place in 2014. Medicaid will then be available to individuals with incomes up to 133% of the federal poverty level (FPL) and will cover an additional 16 million people (1). Policy makers anticipate that 24 million nonelderly individuals will gain coverage through state health insurance exchanges (1, 2). Coverage for the elderly population will remain stable, because Medicare eligibility is unchanged under reform.

Approximately a quarter of currently uninsured adults indicate that they experienced either serious psychological distress or substance abuse or dependence (or both) in the past year; over 6% of uninsured adults show indications of having a serious mental illness (3). Similarly, more than a quarter of uninsured youths report a past-year major depressive episode, illicit drug use, or both (3). Thus coverage expansions will include millions of individuals with behavioral health needs, some quite significant. Uninsured individuals with mental illnesses or substance use disorders have relatively low incomes (4) and are likely to become newly eligible for Medicaid. Actual levels of enrollment in both private coverage and Medicaid will depend on ease of enrollment, outreach and education efforts, insurance costs relative to penalties for noncompliance, and other factors. Even when PPACA is fully implemented, policy makers estimate that approximately 40% of currently uninsured individuals will remain uninsured (1).

Current coverage of behavioral health services

Individuals with mental illnesses and substance use disorders rely on a range of services to treat or manage their illness. Some of these services overlap with service categories for general medical treatment (such as inpatient hospitalization and pharmacotherapy), but many services (such as partial hospitalization, mobile crisis services, and assertive community treatment) are unique to behavioral health. Further, mental health treatment is sometimes provided by non-medical providers, such as human service agencies or support groups. People with serious mental disorders

may require additional, nonmedical social services, such as income support, vocational training, or housing assistance.

We examined prereform coverage of behavioral health services for five types of payers: employer-based insurance, Medicare, Medicaid, other state programs, and other federal programs. Table 1, compiled from expert reports (5,6), service benefit plans for various payers (7–11), and consultation with behavioral health experts, shows how coverage of behavioral health services varies across these payers. Using the standard Blue Cross/Blue Shield plan available through the Federal Employees Health Benefit Plan as a proxy for a typical employer plan, the table indicates that private insurance covers services that fall within the traditional medical model for general medical care, such as outpatient care, inpatient care, pharmaceuticals, and diagnosis and screening. Many behavioral health services, particularly those needed by individuals with serious illnesses, fall outside this scope and are not covered by private insurance. Similarly, Medicare, which was initially modeled after private-sector insurance, covers a limited scope of behavioral health benefits.

Behavioral health services are not a specifically defined category of benefits in federal Medicaid law, and although some services used for behavioral health care are mandated by the federal government, coverage of many services is at state discretion. As a result, Medicaid coverage varies across states. However, Table 1 shows that state Medicaid programs typically cover a broader range of behavioral health services than Medicare or private insurance. In addition to general medical services, most states cover long-term services, residential care, intensive case management, and some support services. There are some notable limitations on Medicaid behavioral health services, such as the exclusion of nursing and hospital services in an institution for mental disease (IMD) for those aged 22 to 64 years (12). Further, Medicaid generally does not cover social support services, such as supportive employment or housing.

Many uninsured individuals with mental illness who receive treatment do so under non-Medicaid, state-funded services. States finance a broad range of services, many of which fall outside the traditional medical model (13). States set their own criteria regarding how to deliver these services and who may receive them. Many state-financed services are specifically targeted to individuals with serious illnesses. Services may be limited to individuals without other sources of coverage, or states may provide supplemental benefits to fill in gaps in services covered by other payers. State-financed services are supplemented by the Community Mental Health Services Block Grant (MHBG), the largest federal program dedicated to financing behavioral health services. We have limited information on the specific services provided through MHBG funds because these funds explicitly support existing programs (they do not function as stand-alone funding) (14). Other federal funds primarily finance support services, such as income and housing assistance for individuals with serious mental illnesses.

Prescription drugs play a central role in the treatment of mental disorders. In 2007 among individuals who were treated for mental illnesses or substance use disorders, 84% received pharmacotherapy (15). Payers use a variety of approaches to structure prescription drug coverage. Commercial insurers typically use tiered formularies, in which cost sharing varies for drugs within a class to encourage use of lower-cost, often generic medications (16). Less than 1% of commercial plans use prior authorization requirements (that is, requiring preapproval from the plan before coverage). In contrast, state Medicaid programs, which impose very low or no cost sharing for prescription drugs, are more likely to use utilization management tools. In 2006, a total of 25 states required prior authorization for one or more second-generation antipsychotics (17). Medicare Part D plans use a combination of cost sharing and utilization management tools to restrict use of psychiatric medications.

Table 1Prereform coverage of behavioral health services, by payer^a

Category and service ^b	Blue Cross/ Blue Shield ^c	Medicare ^d	Medicaid ^e	Other state funding ^f	Other federal funding ^g
Prevention					
Screening for alcohol misuse (USPSTF recommended) ^h	X	^	/	X	
Screening for depression (USPSTF recommended) ^h	X	X	/	X	
Screening for illicit drug use	X	^	/	X	
Screening for suicide risk			/	X	
Treatment					
Diagnostic tests, psychological testing	X	X	X	X	
Outpatient psychotherapy for mental health and substance abuse	X	X	X	X	
Inpatient hospitalization for a mental or substance use disorder	X	X	X ⁱ	X	
Partial hospitalization for a mental or substance use disorder	X	X	X	X	
Inpatient detoxification	X	X	X	X	
Outpatient detoxification	X	X	X	X	
Pharmacological therapy	X	X	X	X	
Medication management	X	X	X	X	
Opioid treatment			X	X	
Short-term residential care for a mental or substance use disorder			X	X	
Long-term residential care for a mental or substance use disorder			X	X	
Case management or intensive case management for a mental or substance use disorder			X	X	
Crisis intervention for a mental or substance use disorder			X	X	
Supportive services					
Housing assistance				X	X
Vocational training or support			Limited	X	X
Income assistance				X	X
Nonemergency transportation services			X	X	
Peer support services			X	X	
Collateral services or family support services			X	X	
Home-based support services			X	X	

^a Symbols are defined as follows: X, service is covered; ^, coverage only if for alcohol or drug abuse structured assessment and brief intervention services; /, service is covered for children under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment benefit (a minority of states covers screening for adults)

^b The service list was compiled based on expert reports (5,6), service benefit plans for various payers (7–11), and consultation with behavioral health experts.

^c Based on Blue Cross and Blue Shield standard fee-for-service, prefer-provider organization plan available under the Federal Employees Health Benefit Plan (7)

^d Column indicates coverage under traditional Medicare (Parts A and B) and Medicare Part D (prescription drug coverage). Beneficiaries enrolled in Medicare supplemental plans (Medigap or Medicare Advantage) may receive additional benefits under those plans (8).

^e Coverage varies by state. Column indicates services that are covered by most states (9).

^f Coverage varies by state. Column indicates services that are covered by most states (10).

^g Federal block grant dollars supplement the state-funded programs in the "Other state funding" column. Column indicates programs funded solely with federal dollars (11).

^h USPSTF, U.S. Preventive Services Task Force

ⁱ Excludes services in an institution for mental diseases (IMD) for persons aged 22 to 64

Behavioral health benefits under new coverage options

After reform is fully implemented, behavioral health coverage will continue to vary by coverage source (Table 2) because different rules are in place for existing and new coverage sources. PPACA does not substantially change behavioral health services offered under existing coverage (Medicare, Medicaid, and existing private plans that meet specified criteria).

For those gaining new coverage under reform, PPACA establishes standards to guarantee access to an

"essential benefits package" for individuals covered under "qualified health plans." Included in these standards is the requirement that all qualified plans cover "mental health and substance use disorder services, including behavioral health treatment." The scope of services is to be equal to that covered under a "typical" employer plan. Qualified plans must cover preventive care services recommended by the U.S. Preventive Services Task Force. Prescription drugs are specified as an "essential benefit," but the law does not specify a drug benefit structure—

that is, how tiered or incentive-based formularies and utilization management tools may be used by the plans. Furthermore, qualified health plans must comply with the Mental Health Parity and Addiction Equity Act of 2008, which obliges plans providing both general medical and behavioral health benefits to do so with similar financial requirements and treatment limitations.

Although Medicaid coverage remains as is for those meeting current eligibility requirements, individuals moving into Medicaid under new eligibility pathways will receive "bench-

Table 2Postreform behavioral health benefits under various coverage sources^a

Coverage source	Defined behavioral health benefits
Medicare	Prereform rules for Medicare benefits
Medicaid	Traditional (nonexpansion) enrollees: prereform rules for Medicaid benefits Expansion enrollees: benchmark or benchmark-equivalent coverage (must cover at least essential benefits package)
Private coverage outside an exchange ^b	Existing grandfathered plans: prereform benefits New and nongrandfathered plans: mental health and substance use disorder services, including behavioral health treatment, as defined by the essential benefits package (set at the scope of services available in a typical employer plan)
Private coverage through an exchange	Mental health and substance use disorder services, including behavioral health treatment, as defined by the essential benefits package (set at the scope of services available in a typical employer plan)

^a The table excludes some coverage pathways, such as the catastrophic plan for adults up to age 30 and coverage through temporary high-risk pools.

^b Grandfathered plans include group health plans or insurance in existence on March 23, 2010. These plans are exempt from many provisions of the Patient Protection and Affordable Care Act. To maintain grandfathered status, plans must meet certain requirements, such as maintaining current benefits and not increasing enrollees' financial burden.

mark” or “benchmark-equivalent” coverage rather than the full Medicaid benefits outlined in Table 1. As of 2014, such coverage must contain at least the essential benefits package outlined above. Federal law defines “benchmark” coverage as that equal to the Federal Employees Blue Cross/Blue Shield preferred-provider organization plan, coverage available to state employees, coverage offered by the health maintenance organization with the state's largest commercially enrolled population, or other coverage approved by the U.S Secretary of Health and Human Services. “Benchmark equivalent” coverage includes basic specified services and has an aggregate actuarial value equivalent to one of the benchmark options. PPACA stipulates that if the benchmark equivalent is used, some services (including mental health care and prescription drugs) must be offered at the actuarially equivalent value of the benefit in the benchmark plan. Health reform also specifies that federal mental health parity requirements for group health plans apply to benchmark and benchmark-equivalent plans. States may provide additional services to supplement benchmark coverage, but they are not required to do so.

Implications of scope of behavioral health benefits under PPACA

On the basis of the information in Tables 1 and 2, it appears that if behavioral health benefits available under qualified health plans are set at those currently available in typical private plans, some services needed by individuals with mental disorders (particularly those required by individuals with more severe illness) will be excluded from coverage. Thus insured individuals who have such disorders will have to rely on other payment sources for some health benefits or go without. This outcome is likely even with implementation of the federal parity law, because several behavioral health services (and providers) have no counterpart general medical service. Examples of such services include nonhospital residential treatment, partial hospitalization, or treatment provided by certified addiction counselors. Federal policy makers are still determining whether the federal parity law requires plans to cover behavioral health services or providers that have no counterpart in medical-surgical services (18). If not, plans may still impose stringent limits on such services (or not cover them at all). The final interpretation of the parity provision will be a critical determinant of access to some benefits.

Medicaid will play an even larger role in providing insurance coverage for individuals with mental illnesses and substance use disorders post-health reform than it currently does. Most state Medicaid programs already cover mental health services in accordance with at least the essential benefits package, although some states do not meet these criteria for substance use disorder services (19). Under PPACA requirements, states cannot make Medicaid eligibility more restrictive than under current rules. However, the law does not stipulate that states cannot cut services after reform is implemented. State budgets are facing significant pressure, with Medicaid accounting for a large portion of state spending obligations (20). Given the likely increase in Medicaid coverage and expenditures, some states may consider cutting behavioral health services as part of a broader effort to trim Medicaid spending. As a comparison of the first and third columns in Table 1 shows, states could significantly cut these benefits and still meet standards for coverage under a typical employer plan.

Furthermore, some newly eligible Medicaid beneficiaries with serious mental disorders may require additional services because the benchmark coverage that will be offered under the expansions is on par with private coverage. PPACA includes some provisions to address this issue. The law specifies that some newly eligible beneficiaries (those exempt from mandatory benchmark coverage under federal law) must have the option of receiving the standard (full) Medicaid package rather than benchmark coverage. Current federal regulations stipulate that this group includes (among others) those who qualify for Medicaid on the basis of being disabled, regardless of whether they are eligible for Supplemental Security Income, as well as those with “special health needs,” including children with serious emotional disturbances, individuals with disabling mental disorders, and individuals with mental disabilities that significantly impair their ability to perform one or more activities of daily living (21). Existing federal regulations do

not exempt individuals who meet the definition of a person with a serious mental illness (regardless of whether this illness is disabling), instead leaving to the states the decision to include or exclude this population. Ultimately, access for newly eligible individuals with serious illness will depend on state coverage decisions and final federal regulations on benchmark coverage under PPACA.

A final consideration regarding adequacy of services under reform is whether state-financed supportive services will continue to be available to fill in gaps for individuals with mental health needs. Currently, states finance both treatment services (which may overlap with those covered by other payers) and supportive services (which are generally not covered by private insurance, Medicare, or Medicaid). As a result of coverage expansions, fewer individuals will rely on state-financed treatment services for behavioral health because these services will be covered by other payers; however, it is not clear whether states will expand or contract their coverage of supportive services after reform. On one hand, states may redirect the resources that they currently expend to provide treatment services to expand supportive services. On the other hand, states may use those resources for other expenses, such as their share of the Medicaid match, increased payments to providers, or state expenditures in areas other than behavioral health. In the past, expansions in Medicaid, combined with tight state budgets, led to the latter outcome. That is, states decreased their overall state-only spending on mental health as the availability of matched Medicaid funds increased (22).

Policy options

Health reform provides an unprecedented opportunity for millions of individuals with behavioral health needs to gain insurance coverage for crucial services, such as psychosocial counseling and prescription drugs, to treat their illnesses. However, for many individuals, particularly those with serious illnesses, the scope of services available under new coverage options will not meet all of their serv-

ice needs. The challenge of designing benefits to meet behavioral health needs under PPACA rests in recognizing differences in the scope of services covered by different payers; understanding how well each payer's benefits match the needs of those with mild, moderate, or serious illnesses; and steering people to the most appropriate source of coverage for their need.

Policy makers have several options for addressing this challenge. First, regulations can clarify the scope of the essential health benefits package to include services that are important to improving the health of the general population with mental illnesses. For example, essential health benefits could include additional preventive services (for example, screening and counseling for substance use disorders) to help identify those with behavioral health problems. In addition, essential health benefits could include case management for people with chronic diseases, including mental illnesses and substance use disorders, to help those living with lifelong disorders manage their illnesses.

Policy makers also can draw on the experience of Medicare Part D to clarify essential health benefits. Given the importance of prescription drugs to behavioral health treatment, federal guidelines for drug formularies in qualified plans will have important implications for individuals with mental disorders. Medicare formulary guidelines require plans to list "all or substantially all" antidepressants, antipsychotics, and anticonvulsants on their formularies (plans may assign drugs in these classes to high cost-sharing tiers, impose prior authorization or step therapy, or both). This requirement was put in place in part to guard against adverse selection and inhibit plans from limiting coverage for drugs used by people with high total expected drug costs (23). Experience to date suggests that Medicare formulary guidelines have led to better coverage of psychiatric medications in Medicare than in private plans (16,24).

Second, policy makers can take steps to prevent erosion of Medicaid benefits and ensure that other payment sources (such as state or

MHBG funds) finance the services excluded from private or benchmark plans. Policy makers could consider a requirement that states not restrict Medicaid services beyond current levels to correspond to the requirement for eligibility. States could also be required to maintain their non-Medicaid mental health spending at some proportion of their prereform funding. Maintenance of these funding sources will be particularly important for individuals with mental illnesses or substance use disorders who remain uninsured after reform. In addition, these funds will be needed to pay for social support services (such as housing and vocational services) that are not covered by any health payers. These policy actions would require careful consideration of state budgets, which are expected to be both positively and negatively affected by the implementation of PPACA (25).

Finally, policy makers should consider whether special coverage provisions should be developed for individuals with serious mental illness. In contrast to traditional Medicaid coverage, private or benchmark coverage is not designed to provide the full range of acute and long-term medical and social support services needed by individuals with disabling conditions. Differences in the scope of coverage of behavioral health services across sources of insurance are likely to persist even with the implementation of parity provisions. Rather than stipulating a very broad benefits package for all individuals, policy makers can leverage the scope of services currently available under state Medicaid programs to meet the needs of individuals with serious mental illnesses and substance use disorders. For example, future PPACA regulations could specify that current exemptions to mandatory enrollment in benchmark coverage are continued, allowing individuals with disabling behavioral health problems but incomes above the limit for traditional Medicaid benefits to receive the full range of Medicaid services. Further, the regulations could extend full Medicaid coverage to persons newly eligible for Medicaid who meet the federal definition of serious mental illness.

One approach to implementing this strategy is to draw on some screening mechanism to temporarily place individuals with high needs for mental health or substance use disorder services into full Medicaid coverage, with a full determination to follow.

Conclusions

To facilitate access to needed services, expanded coverage under PPACA must provide a scope of benefits to meet enrollees' needs. If behavioral health benefits are defined as services currently available in typical private plans or benchmark coverage, some individuals with mental illnesses or substance use disorders who are insured through private coverage, Medicare, or Medicaid expansions are still likely to face gaps in covered services. It is important to note that many people with mental health needs who will gain coverage under PPACA have serious disorders and rely on the full range of behavioral health benefits to meet their needs. Policy makers will need to develop strategies to ensure adequate coverage of behavioral health services, maintain existing funding sources for wrap-around care, and steer individuals who need the full continuum of behavioral health benefits into more generous coverage options.

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Health Care Reform and Care at the Behavioral Health–Primary Care Interface

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The historic passage of the Patient Protection and Affordable Care Act in March 2010 offers the potential to address long-standing deficits in quality and integration of services at the interface between behavioral health and primary care. Many of the efforts to reform the care delivery system will come in the form of demonstration projects, which, if successful, will become models for the broader health system. This article reviews two of the programs that might have a particular impact on care on the two sides of that interface: Medicaid and Medicare patient-centered medical home demonstration projects and expansion of a Substance Abuse and Mental Health Services Administration program that colocates primary care services in community mental health settings. The authors provide an overview of key supporting factors, including new financing mechanisms, quality assessment metrics, information technology infrastructure, and technical support, that will be important for ensuring that initiatives achieve their potential for improving care. (*Psychiatric Services* 61:1087–1092, 2010)

The 2010 Patient Protection and Affordable Care Act has the potential to effect a major transformation in how health care is delivered in the United States. These changes will be driven, in part, by a series of demonstration projects and initiatives for reorienting health services to increase provider accountability and strengthen the role of primary care. If successful, these new programs are likely to be expanded within Medicaid and Medicare and eventually become a model for care delivery throughout the health care system.

This article describes how two such demonstration programs, one addressing primary care in the general medical sector and the other supporting improved primary care in specialty mental health settings, might lay

the groundwork for improvements in care at the primary care–behavioral health interface. We begin with a brief overview of the clinical processes and organizational strategies that have been demonstrated to improve care at this interface, provide an overview of the two demonstration programs, and then consider supporting factors—new financing models, better quality indicators, enhanced health information technology, and technical support for local sites—that could help ensure that these new initiatives translate into improved care.

Models for improving care

To improve outcomes, health reform initiatives need to support the evidence-based clinical processes that have been documented as improving

clinical outcomes. Multiple randomized controlled trials have found that team-based interventions improve quality of care for and outcomes of common mental health and substance use disorders in primary care (1,2) and the delivery of primary medical care in specialty behavioral settings (3). A recent Agency for Healthcare Research and Quality synthesis found that integration, defined as sharing of treatment decision making and the collocation of primary care and mental health specialists, was not in and of itself predictive of improved outcomes but that together, the elements in these models consistently resulted in improved quality and outcomes of care (4). Within the broader array of services delivered in these models, key “active ingredients” that would need to be supported include systematic screening and use of qualified care managers (5).

These clinical approaches can be delivered through a variety of organizational and structural relationships, including collocation of services, referral approaches, and partnerships between general health care providers and mental health and substance abuse treatment providers. No particular organizational approach guarantees or precludes these process elements of care. However, clinical integration is generally easier to support in structured organizational models than in more loosely organized referral relationships. The 2006 Institute of Medicine report (6) on improving the quality of care for mental health and substance use conditions recommended that sites should “transition along a continuum of evidence-based coordination models . . . adopt[ing] models to which they can most easily

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transition from their current structure, that best meet the needs of their patient populations, and that ensure accountability.” The demonstration projects outlined below and other elements of health reform have the potential to promote a spectrum of organized models of care—and with them the opportunity to support evidence-based clinical models of care improvement.

Overview of demonstration projects

Medical home initiatives

Despite the growing number of individuals treated for common mental disorders in primary care, a considerable literature has demonstrated continued quality deficits in those settings (4,7). These gaps, in part, reflect problems in the broader primary care system. Most medical practices in the United States still do not have the infrastructure or capacity to implement evidence-based, organized approaches to care delivery (8). Thus improving the structure of the primary care system overall could have considerable benefits for the treatment of mental and substance use disorders in general medical settings in the United States (9).

Among the most promising strategies for revitalizing and redefining the primary care system is the patient-centered medical home (10). This model, which was originally developed for children with chronic illnesses in the 1960s (11), was reconfigured in recent years by major purchasers, health plans, and primary care organizations, working as the Patient-Centered Primary Care Collaborative (12). The model draws on Wagner’s (13) chronic care model, which describes the environmental, structural, and community characteristics needed for multidisciplinary teams to work with patients in improving illness management. Medicare, large health plans, and state Medicaid agencies are currently conducting demonstration projects to test new payment methods (a combination of fee-for-service payments, monthly care management fees, and bonuses) on quality and costs of the patient-centered medical home model (14). Some of these demonstration projects explicitly include mental health and substance

use conditions. For instance, the State of Oregon has recently adopted standards and measures for patient-centered primary care homes that include the following measure under the standard for care coordination: “When I need to see a specialist or get a test, including help for mental health or substance use problems, help me get what I need at your clinic whenever possible and stay involved when I get care in other places”(15).

The Patient Protection and Affordable Care Act includes provisions for patient-centered medical home projects within both Medicare and Medicaid. Within Medicare, these programs will be implemented in the new Center for Medicare and Medicaid Innovation, which will test innovative payment and service delivery models designed to reduce expenditures while preserving or enhancing the quality of care (16). For Medicaid enrollees, the legislation proposes a new state plan option to permit enrollees with at least two chronic conditions, or at least one serious and persistent mental health condition, to designate a provider as a health home. States are expected to design and implement care models, track costs and avoidable hospitalizations, implement information technology, and monitor and report on quality and outcomes of care.

Primary care colocation grants

Persons with serious mental disorders treated in the specialty mental health sector face challenges in accessing appropriate primary medical services (17). This poor quality of care may, in part, contribute to excess rates of medical morbidity and mortality among persons with serious mental disorders (18). For this population, “specialty medical homes,” located in community mental health settings, may provide a strategy for delivering integrated, high-quality care (19).

In 2009, in response to growing concerns about the problem of morbidity and mortality among mental health consumers, the Substance Abuse and Mental Health Services Administration issued the first set of awards for a new grant program to provide community mental health organizations with funding to provide

primary care services and wellness and prevention services to their clients, either directly or via partnerships. A total of 13 sites were funded in 2009; these sites are using a variety of strategies, including colocation of services and partnership models to improve primary care for their clients. Eight more sites are slated to be funded in 2010.

Under health reform, Congress will expand this program considerably, with \$50 million in funding for the current fiscal year. Although this grant program will provide funding only for a small proportion of community mental health providers in the United States, it will make it possible to identify and understand a series of best practices for specialty mental health homes that can subsequently be implemented more broadly. The program evaluation will provide data about the implementation, clinical outcomes, and sustainability of these programs in real-world community settings.

Key elements needed to ensure success of these initiatives

An initial evaluation of the National Demonstration Project, a patient-centered medical home project sponsored by the American Academy of Family Physicians, recommended several supporting elements that would be essential for successfully implementing future medical home projects (20). These elements included establishment of appropriate financing models, development of appropriate quality and accreditation metrics, adaptation of health information technologies, and implementation of appropriate technical support. These echo key components described as essential for supporting quality improvement efforts in general medical populations (21) and for persons with mental or substance use disorders (6). In the section below, we discuss how each of these features is important for the demonstration projects to be successful in improving care at the primary care-behavioral health interface.

Implementing new financing models

Accountable care organizations. The Patient Protection and Affordable

Care Act has provisions for organizing hospitals, specialists, and primary care providers as accountable care organizations—collectives of providers that would take responsibility for a group of patients. Under most accountable care organization models, providers are paid bonuses based on their ability to meet quality goals and contribute to reduced costs.

Psychiatrists, like other specialists, view the possibility of joining accountable care organizations with some caution, given uncertainty about who will oversee them (for example, hospitals or primary care practices) and concerns over possible loss of revenue compared with current fee-for-service payment schemes (22,23). However, membership could also support development of the new service models, new financing models, and the measurement and quality improvement infrastructure, which has been difficult to achieve in the current system. They could provide the opportunity for mental health and substance abuse treatment providers to integrate vertically with other components of the health care system, contribute to achieving cost and quality targets, and share in the payment methods being discussed in relationship to accountable care organizations (such as fee-for-service plus shared savings, episode or case rates, and pay for performance).

Accountable care organizations and patient-centered medical homes can be mutually reinforcing, with accountable care organizations providing an organizational environment to support patient-centered medical homes and patient-centered medical homes allowing accountable care organizations to optimize quality and efficiency of care (24). They could provide economies of scale for solo practitioners as well as community-based mental health and substance abuse treatment providers, allowing them to develop virtual patient-centered medical homes (25). Accountable care organizations would not guarantee integration in and of themselves, but they could provide a structure in which integrated models could be supported and incentives for integration provided.

Both similarities and differences

exist between these approaches and the 1990s managed care experience, and lessons learned from those experiments should be applied to these new models. During the 1990s, managed behavioral health care was largely operated separately from general health insurance managed care programs, an arrangement that provided expertise in managing mental health care but raised potential challenges in coordination with general medical care (26).

In contrast, accountable care organizations would include persons with general medical conditions and those with mental health conditions in the same risk pools. Thus, although these organizations could provide incentives for better coordination of care, they might also divert resources away from populations with mental disorders and other complex comorbid conditions. Because of the high costs in the Medicaid program associated with comorbid mental health and substance use disorders (27), these populations could become targets of cost savings for accountable care organizations, as they have been under Medicaid disease management programs. More generally, pay-for-performance approaches should be applied with caution to mental health and substance use conditions, pending better indicators, risk adjustment models, and capacity to establish accountability across multiple providers and systems of care (28).

State financing innovations. Current state initiatives may also provide models for these organizational and financing approaches to supporting improved care at the primary care-behavioral health interface. In the Community Care of North Carolina (CCNC) project, Medicaid enrollees receive health care and care management through local networks made up of physicians, hospitals, social service agencies, and county health departments. Preliminary evidence suggests that these programs may help improve quality of care for chronic medical illnesses and save costs (29). The CCNC project is a primary care case management model that could be used as a prototype for accountable care organizations under health reform.

Although the CCNC itself was not designed as an integration initiative, in the past several years four CCNC networks have worked with state and regional mental health authorities to pilot a model for integrating mental health and primary care. Recently, the CCNC system began a gain-sharing demonstration with Medicare, designed to better serve persons dually eligible for Medicare and Medicaid. In the demonstration, the CCNC networks will expand current care coordination efforts for the Medicaid population to dually eligible persons and, over time, to the Medicare-only population as well. The CCNC networks will receive a per-member-per-month fee to cover care management, care transitions, and colocation of mental health services. Medicare savings beyond an established threshold will be shared with the networks and reinvested (30). Planned expansion of integrated services through CCNC-employed mental health and substance abuse treatment staff may further assist primary care practitioners in meeting the expectations for medical home management of chronic health conditions, including mental health and substance use conditions.

A key financing approach for the patient-centered medical home is a monthly care management fee paid per enrollee per month in addition to fee for service. There is an opportunity to build on this idea by combining it with a unique financing model for integrated care now under way in Minnesota. More than 90 clinics have participated in an initiative known as DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction), based on the IMPACT model (Improving Mood—Promoting Access to Collaborative Treatment) (31). By providing an organizational and financial framework to support this evidence-based approach to depression management, the DIAMOND program has been able to demonstrate initial outcomes that are superior to usual depression treatment given to patients in primary care.

Behind the clinical statistics, the DIAMOND project is applying the concept of an all-payer case rate for depression care. Minnesota health

plans are paying a monthly per-person case rate to participating clinics for a bundle of services—including a depression care manager and consulting psychiatrist—under a single case rate billing code. For some of the participating plans in Minnesota, the case rate payments are being made from the health care side of the plan, rather than the mental health side, so that any cost savings can accrue to the health plans (32). Combining the DIAMOND payment model with the patient-centered medical home care management monthly fee could facilitate the adoption of collaborative care models for common mental disorders in primary care.

Standardization of billing codes. Other changes under health reform may provide greater financial viability for integrated models of care and evidence-based strategies for quality improvement. The legislation promises to bring more standardization to Medicaid (for example, eligibility thresholds, essential benefits, and minimum payment rates to primary care providers), and it could include a requirement for state plans to incorporate the current CPT (current procedural terminology) codes that support integration (for example, Health and Behavior 96150 series and Screening and Brief Intervention 99408 and 99409) and eliminate frequently described barriers to billing (such as same-day billing prohibitions). Medicaid and Medicare demonstration projects should provide a setting in which to assess the practicality and use of these changes and the more widespread use of bundling models such as those used in the DIAMOND project, which could be valuable for improving quality and increasing incentives for coordination of care across providers.

Quality metrics

Broadening the range of quality measures. Rigorous quality assessment standards are essential for the successful implementation and evaluation of demonstration projects and other changes occurring under health reform. However, quality metrics for mental health and substance use disorders are generally more limited than those for other chronic condi-

tions (7). The National Committee for Quality Assurance is seeking to expand its quality indicators for mental health and substance use conditions. Implementing quality measures for serious mental illnesses is of particular importance for evaluating Medicaid programs and other public-sector entities under health reform.

As demonstration projects and broader reform efforts move forward, it will be important to develop and measure indicators not only for individual general medical and mental health conditions but also for the key processes associated with clinical integration—effective communication (transfer of information across providers), coordination (shared understanding of goals and roles), and continuity of care (uninterrupted delivery of services across levels of care) (33). However, there are no validated measures of coordination or clinical integration that can be used for assessing quality of care of persons with mental and substance use disorders (34). Demonstration projects for patient-centered medical homes and accountable care organizations could provide a laboratory in which to develop and test candidate measures of clinical integration that could subsequently be included in efforts to implement these models more widely.

Other quality assessment organizations will also need to be engaged in these quality assessment and improvement efforts. The Physician Quality Reporting Initiative was established in 2007 to assess quality of care among physicians; it provides incentive payments to physicians for reporting data quality measures for Medicare beneficiaries (“pay for reporting”) (35). Physicians can receive a bonus payment of 2% based on their total Medicare Part B payments if they select at least three quality measures and report data for those measures on at least 80% of applicable patient encounters. However, mental health has limited representation in these measures; of 179 indicators, only four are related to mental health (depression screening, evaluation, suicide assessment, and acute medication treatment).

The National Quality Forum, which collects and certifies quality measures

from a range of sources, is working on a consensus development project funded by the Department of Health and Human Services to develop a more robust set of outpatient indicators for mental health, including serious and persistent mental illnesses (www.qualityforum.org). Candidate measures include management of common medical comorbidities, preventive medical services, and enhanced clinical outcomes of medical illnesses, as well as measures of coordination, such as documentation of communication by an outpatient mental health clinician to the patient’s primary care clinician (36). In 2007 the National Quality Forum issued a set of evidence-based practices for the treatment of substance use conditions and is working on approaches to measuring continuing care management for those conditions. These mental health and substance use measures can be used as potential candidates for development and specification by the National Committee for Quality Assurance.

Expansion of accreditation and certification programs. The National Committee for Quality Assurance should also be supported in expanding its accreditation and certification programs to include more robust quality measures. New draft certification standards for the patient-centered medical home include references to integration of mental health and substance use screening and brief treatment. The managed behavioral health organization accreditation process needs to be strengthened to incorporate expanded quality indicators, including measures of coordination with general health care.

Supporting health information technology

Health information technology is a central feature facilitating quality improvement and better integration of services (37). In its patient-centered medical home certification standards, the National Committee for Quality Assurance includes multiple information technology features, including patient tracking and registries, electronic prescribing, and test tracking. However, mental health and substance abuse treatment systems have

historically lagged behind other areas of medicine in the development and standardization of these information technology tools. Furthermore, regulatory barriers have limited the exchange of information between primary care and mental health and substance abuse treatment settings.

The Patient Protection and Affordable Care Act explicitly requires that information technology be a part of medical home demonstration projects, and it will also be critical in facilitating the success of integration efforts. In developing these technologies, standardized templates for electronic medical records and personal health records should include the data elements needed to manage and coordinate general medical care and mental health and substance abuse care. These systems need to be carefully designed to ensure that critical information on health status and services can be extracted for measuring service patterns and performance.

The Health Information Technology for Economic and Clinical Health Act authorizes roughly \$36 billion for health information technology. Most of the funds are expected to be distributed between 2011 and 2016 as adoption incentives through Medicare and Medicaid to qualified health care providers who adopt and use electronic medical records in accordance with the act's requirements. Although mental health and substance abuse treatment providers are not eligible for these funds, legislation has recently been introduced to include them as qualified health care providers in this grant program (38).

Building capacity for technical assistance

Implementing these demonstration projects will be complex, and states and local sites will require considerable technical support if these projects are to be successful. An initial evaluation of the National Demonstration Project, a two-year patient-centered medical home practice transformation project sponsored by the American Academy of Family Physicians, described the challenges in transforming the organizational cultures and physician practice patterns in the 36 participating sites (20).

The authors described this process as a highly local developmental one requiring both top-down leadership and bottom-up engagement with physicians and other clinicians. To help current primary care practices successfully transition to medical homes, they recommended that technical support be tailored to characteristics of practices and organizational readiness.

For the new demonstration projects, technical assistance roles will similarly require a grounding in evidence-based approaches to integration practices along with a knowledge of how these clinical models work in local settings. It will require maintaining an inventory of evidence-based approaches to integrated care and to measurement and quality improvement and developing and disseminating standardized templates for electronic health records, personal health records, and the registry. Expertise will be needed not only from content experts and researchers but also from quality improvement organizations with experience in driving large-scale practice change. Practice management experts will need to work with sites in demonstration projects to make these programs financially sustainable after grants end and with other sites that do not have specific funding to underwrite quality improvement efforts.

Conclusions

These two demonstration projects—patient-centered medical home demonstration projects and expansion of the Substance Abuse and Mental Health Services Administration primary care project in community mental health centers—offer considerable potential to improve care at the primary care–behavioral health interface. Given the complexity of the problems underlying poor-quality care in safety-net settings, the success of these efforts will hinge on the ability of clinicians, managers, and policy makers from various agencies to work across traditional organizational boundaries. In anticipation of the implementation of health reform legislation, a number of these collaborations have already begun. The Health Resources and Services Ad-

ministration will be cofunding the technical assistance center for primary care colocation grants with the Substance Abuse and Mental Health Services Administration. The Assistant Secretary for Planning and Evaluation is cosponsoring the evaluation of that program, along with the Substance Abuse and Mental Health Services Administration, and working with the National Committee for Quality Assurance to develop new quality metrics that can be used in evaluating the impact of health reform. In addition, the Agency for Healthcare Research and Quality and the National Institute of Mental Health are working together in setting a research agenda for mental health information technology and comparative effectiveness research that will further inform these health reform efforts.

As these interagency collaborations move forward, many of the same elements demonstrated to be essential for improving clinical quality of care—a clear locus of accountability, long-term follow-up, effective communication, and rigorous monitoring and feedback—will also be essential to ensure that these demonstration projects, and health reform more generally, fulfill their potential to improve care at the primary care–behavioral health interface.

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TAKING ISSUE

Health Care Reform and Mental Health Care Delivery

Three articles in this issue of the journal review economic and policy implications for mental health delivery of the Patient Protection and Affordable Care Act, referred to as the ACA. The authors highlight opportunities for great improvement, as well as challenges, in the financing and delivery of mental health care in the United States. The ACA incrementally expands existing insurance, and it also creates and encourages the development and diffusion of important new institutions and organizational forms that will govern insurance markets and service provision. Garfield and colleagues describe these expansions. McGuire and Sinaiko explain the role of health insurance exchanges in restructuring the individual and small-group markets. Druss and Mauer explain the potential of new organizational forms to promote integration of mental health and other medical care, along with improved approaches to specialty care delivery.

In each case, important potential gains in social welfare are noted, with an emphasis on key choices that must be made by those implementing the blueprint set out in the ACA. Gains in coverage among people with mental and substance use disorders are intertwined with the problems of poverty, illiteracy, and social isolation. Special efforts will be required to engage and enroll this deprived and frequently costly population. McGuire and Sinaiko explain that competitive insurance markets have functioned especially poorly in providing coverage to people at elevated risk of mental health and substance use problems. They review measures that might be adopted by new health insurance exchanges to mitigate historical failures in private insurance. The analysis presented by Garfield and colleagues highlights that gaps in services will remain despite coverage expansion, particularly for social supports that are not likely to be covered by private health insurance. Funding for wraparound services will continue to be important. Finally, Druss and Mauer suggest improvements in the infrastructure to promote improved mental health care within newly created medical homes and accountable care organizations. They call for development of a broader range of quality measures in mental health and the use of information technology by specialty providers.

The ACA reinforces the place of mental health and substance use disorder care in the health care mainstream, building on the 2010 implementation of parity requirements for coverage of behavioral health care in private health insurance. Even though the field may have entered the mainstream of health care reform, it is still important to recognize and address the unique challenges to the health care system posed by individuals with mental and substance use disorders. The government and other stakeholders must redouble their commitments to craft policies that account for the sometimes exceptional circumstances presented by mental health care delivery.—VIDHYA ALAKESON, M.Sc., *Nuffield Trust*, and RICHARD G. FRANK, Ph.D., *Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services*

Psychiatric Services, established in 1950, is published monthly by the American Psychiatric Association for mental health professionals and others concerned with treatment and services for persons with mental illnesses and mental disabilities, in keeping with APA's objectives to improve care and treatment, to promote research and professional education in psychiatric and related fields, and to advance the standards of all psychiatric services and facilities.

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Additional Reading

American Psychiatric Association Resources

Psychiatric News Background Articles on Reform

Reform-Law Mandate Should Boost MH Screening in Primary Care

January 7, 2011, pp. 12–26

Private insurers and Medicaid plans will be required to cover the cost of screenings of beneficiaries for psychiatric illness, which could mean mental illnesses will be detected earlier in many more people.

<http://pn.psychiatryonline.org/content/46/1/12.2.full>

AMA Describes Principles to Guide New Care Model

December 17, 2010, pp. 1, 8

Hospital and large health systems will have an advantage in the formation of accountable care organizations and are poised to capture market share, so an important consideration is how to level the playing field for physicians in small-group or solo practices.

<http://pn.psychiatryonline.org/content/45/24/1.1.full>

Psychiatrists Can Have Key Role in Care Model

December 3, 2010, pp. 24–39

Psychiatrists interested in participating in integrated care programs—which are expected to dominate in medicine’s future—may find models emerging through large companies, insurers, or local governments.

<http://pn.psychiatryonline.org/content/45/23/24.1.full>

Health Care Law May Reduce MH Benefits in Medicaid

November 5, 2010, pp. 1, 37

Despite federal parity protections, regulators or Congress

will need to take additional steps to expand the anticipated limited Medicaid coverage for mental illness that is part of the new national health care law.

<http://pn.psychiatryonline.org/content/45/21/1.1.full>

Law Improves Insurance Coverage for Those Needing MH Care

May 7, 2010, p. 4

The new health care law is expected to benefit people with mental illness because of measures such as insurance coverage expansions and protections that should allay anxiety over possible cancellation of coverage.

<http://pn.psychiatryonline.org/content/45/9/4.2.full>

Why APA Supported Health Reform

April 16, 2010, p. 3

In his “From the President” column, APA President Alan F. Schatzberg, M.D., presents a checklist of general principles that he hopes APA members can agree on despite differences in their individual views of health care reform.

<http://pn.psychiatryonline.org/content/45/8/3.full>

People With Mental Illness Gain Benefits in New Law

April 16, 2010, p. 4

The health care reform legislation requires the new health insurance exchanges to offer mental health coverage as a basic benefit—not just equal coverage if mental health care is included—and greatly expands Medicaid, the largest payer of mental health services.

<http://pn.psychiatryonline.org/content/45/8/4.1.full>

American Journal of Psychiatry Analysis and Commentary

The Impact of National Health Care Reform on Adults With Severe Mental Disorders

Rachel L. Garfield, Ph.D., et al.

May 2011, pp. 486–494

Estimates based on analysis of 2004–2006 national data indicate that when reform is fully implemented in 2019, there will be 1.15 million more users of mental health services than currently.

<http://ajp.psychiatryonline.org/cgi/content/full/168/5/486>

Looking Into the Health Reform Crystal Ball: Seeing More Constructive, Less Expensive Management Scenarios

Susan M. Essock, Ph.D., and Michael F. Hogan, Ph.D.
May 2011, pp. 449–451

In anticipation of the huge increase in the number of newly insured individuals with severe mental illness who will need services, systems and providers must begin now to design better ways to manage care while ensuring quality.

<http://ajp.psychiatryonline.org/cgi/content/full/168/5/449>

Psychiatric Services: Analysis and Commentary

Is Health Care a Right or a Commodity? Implementing Mental Health Reform in a Recession

Neil Krishan Aggarwal, M.D., M.B.A., et al.
November 2010, pp. 1144–1145

The reform law contains elements of two seemingly contradictory positions: health care as a commodity and as a right. This essay examines these positions in light of current state fiscal crises and impending reforms. To maximize state commitments to services, the federal government should outline clear performance standards that specify minimum services.

<http://ps.psychiatryonline.org/cgi/content/full/61/11/1144>

It's Never Too Late to Do It Right: Lessons From Behavioral Health Reform in New Mexico

Cathleen E. Willging, Ph.D., and Rafael M. Semansky, M.P.P.

July 2010, pp. 646–648

An initiative to reform the public behavioral health system in New Mexico placed publicly funded services under the

management of a single for-profit private corporation. The authors discuss problems that they attribute to the state's "top-down model of planning and implementation." They call on other states to better incorporate experiences of those delivering and receiving services into the design and timing of reform initiatives.

<http://ps.psychiatryonline.org/cgi/content/full/61/7/646>

Can We Learn From History? Mental Health in Health Care Reform, Revisited

Chris Koyanagi

January 2009, pp. 17–20

A veteran of the Clinton Administration's 1993 health reform effort describes several issues that remain relevant today, such as uncoordinated public and private services, cost-shifting, and poor-quality care for people with serious mental illness. She considers the barriers to full inclusion of mental health in health care reform and proposes solutions that were identified in 1993.

<http://ps.psychiatryonline.org/cgi/content/full/60/1/17>

American Psychiatric Association, Department of Government Relations: Summaries and Explanatory Documents

Health Reform Implementation Timeline, 2010–2020

The timeline describes major reform provisions by the year they are mandated for implementation.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/HCR-Timeline.aspx?FT=.pdf>

Health Reform: Key Issues for the Practice of Psychiatry, May 2010

Summarizes key features of reform and provisions of concern.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/Final-Health-Reform-Fact-Sheet-Annual-Meeting-May-2010.aspx?FT=.pdf>

Health Reform Special Report, March 2010

The report presents bulleted lists of key mental health provisions of the reform law (e.g., parity mandates, colocation of care in community mental health settings, Centers of Excellence for depression), its impact on psychiatrists and other physicians (e.g., geographic payment differentials, the Physician Quality Reporting Initiative), and its impact on patients with private insurance and those covered by Medicaid.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/HR-Special-Report.aspx?FT=.pdf>

White Paper Summaries

Health Insurance Exchanges

By 2014 each state will provide a Health Benefit Exchange, where individuals can purchase insurance, and a Small Business Health Options Program (SHOP exchange), for employers with 100 or fewer employees to purchase insurance. This document describes key features of these exchanges.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/Health-Insurance-Exchanges.aspx?FT=.pdf>

Key Changes to Medicare

Coverage during the “doughnut hole,” Independence at Home demonstration project, Bundled Payment Pilot Program, and accountable care organizations for shared savings.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/Key-Changes-to-Medicare.aspx?FT=.pdf>

Key Changes to Medicaid

Expansion of eligibility, Community First Choice Option to provide community-based attendant support, Medicaid Health Home for Mental Illness, state incentives for home- and community-based long-term care.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/Key-Changes-to-Medicaid.aspx?FT=.pdf>

Patient Benefits in Health Care Reform

Funding for treatment of women with postpartum depression, insurance coverage for preventive health services, and school-based health centers are a few of the benefits for patients in the reform law.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/Patient-Benefits-in-Health-Care-Reform.aspx?FT=.pdf>

APA Letters to Congress and the Administration

APA Comments on Health Care Reform, March 10, 2010

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/HCR-Obama-Ltr.aspx?FT=.pdf>

Independent Payment Advisory Board

The reform law established a new Independent Payment Advisory Board (IPAB) to recommend ways to reduce Medicare spending if the increase in spending exceeds targets. The APA opposes IPAB because it allows bureaucrats who are not accountable to the public to make critical Medicare payment decisions.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/Independent-Payment-Advisory-Board.aspx?FT=.pdf>

AAMC Summary of Workforce Provisions in PPACA

AAMC summary of healthcare workforce initiatives included in health reform.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/AAMC-Summary-of-Workforce-Initiatives.aspx?FT=.pdf>

Training the Psychiatric Physician Workforce

Both reform and parity laws will mean that formerly uninsured Americans with mental health needs will require services. This document presents estimates of workforce shortages, describes underserved populations, and calls for a focus on improving collaborative care.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/Training-the-Psychiatirc-Physician-Workforce-April-2011.aspx?FT=.pdf>

Accountable Care Organizations (ACOs)

Established through the health reform law, accountable care organizations are a shared savings program under Medicare. The Administration issued a proposed rule for implementing ACOs; this document summarizes the impact of ACOs on psychiatrists and their patients based on the recently released proposed rule.

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/ACOs.aspx?FT=.pdf>

APA Supports Reconciliation Package, March 20, 2010

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/bMarch-20-2010-letter-supporting-reconciliation-package-Obama-Reid-Pelosi.aspx?FT=.pdf>

APA Priorities for Health Care Reform, January 20, 2010

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/Letter-to-Speaker-Pelosi-and-Majority-Leader-Reid-on-Health-Reform-Priorities-1-21-10.aspx?FT=.pdf>

APA on House/Senate Health Reform Agreement, January 7, 2010

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/ReidPelosi-HCR-Compromise-Letter-1-7-10.aspx?FT=.pdf>

Additional APA Communications

Press Release: APA Endorses House Health Reform Proposal, September 18, 2009

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/September-18-2009-press-release-supporting-HR-3200-as-basis-for-reform.aspx?FT=.pdf>

APA Letter to AMA Joining in Support of HR 3200, September 17, 2009

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/APA-Letter-to-AMA-in-Support-of-HR-3200.aspx?FT=.pdf>

Other Resources

Alliance for Health Reform

Acronyms and Glossary of Terms

A comprehensive, continuously updated list maintained by the Alliance for Health Reform, a nonpartisan, nonprofit group that does not lobby or take positions on legislation

Mental Health Liaison Group Letter on Health Reform Compromise, January 12, 2010

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/MHLG-ReidPelosi-Letter.aspx?FT=.pdf>

APA Member Update on Endorsing HR 3200, October 2, 2009

<http://www.psych.org/MainMenu/AdvocacyGovernmentRelations/GovernmentRelations/HealthCareReform/APA-Member-Update-From-Dr-Schatzberg-9-22-09.aspx?FT=.pdf>

and that has worked since 1991 toward the goal of affordable, quality health care for all Americans.

<http://www.allhealth.org/sourcebookcontent.asp?CHID=131>

Kaiser Family Foundation, Health Care Reform (healthreform.kff.org)

Medicaid Policy Options for Meeting the Needs of Adults With Mental Illness Under the Affordable Care Act, April 2011

<http://www.kff.org/healthreform/upload/8181.pdf>

Mental Health Financing in the United States: A Primer, April 2011

<http://www.kff.org/medicaid/upload/8182.pdf>

Video Tutorial: Health Reform: An Overview

<http://www.kaiseredu.org/Tutorials-and-Presentations/Health-Reform-Overview.aspx>

Video: Health Reform Hits Main Street

<http://healthreform.kff.org/the-animation.aspx>

HealthCare.gov, U.S Department of Health and Human Services

Health Care Providers and the Affordable Care Act: What Does the Affordable Care Act Mean for Health Care Providers?

<http://www.healthcare.gov/law/infocus/providers/index.html>

Provisions of the Affordable Care Act

<http://www.healthcare.gov/law/provisions/index.html>

Affordable Care Act Implementation FAQs

http://www.hhs.gov/ociio/regulations/implementation_faq.html

The Commonwealth Fund

Proposed Rules for Accountable Care Organizations Participating in the Medicare Shared Savings Program: What Do They Say? (April 2011)

<http://www.commonwealthfund.org/~media/Files/Publications/Other/2011/Proposed%20Rules%20for%20ACOs%20What%20Do%20They%20Say.pdf>

High Performance Accountable Care: Building on Success and Learning From Experience (April 2011)

<http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2011/Apr/High-Performance-Accountable-Care.aspx?omnicid=20>

