# The Relevance of the Affordable Care Act for Improving Mental Health Care

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Annu. Rev. Clin. Psychol. 2016. 12:515–42

First published online as a Review in Advance on November 30, 2015

The *Annual Review of Clinical Psychology* is online at clinpsy.annualreviews.org

This article's doi: 10.1146/annurev-clinpsy-021815-092936



## Keywords

collaborative care, primary care, health homes, care integration, Accountable Care Organizations, severe mental illness

## Abstract

Provisions of the Affordable Care Act provide unprecedented opportunities for expanded access to behavioral health care and for redesigning the provision of services. Key to these reforms is establishing mental and substance abuse care as essential coverage, extending Medicaid eligibility and insurance parity, and protecting insurance coverage for persons with preexisting conditions and disabilities. Many provisions, including Accountable Care Organizations, health homes, and other structures, provide incentives for integrating primary care and behavioral health services and coordinating the range of services often required by persons with severe and persistent mental health conditions. Careful research and experience are required to establish the services most appropriate for primary care and effective linkage to specialty mental health services. Research providing guidance on present evidence and uncertainties is reviewed. Success in redesign will follow progress building on collaborative care and other evidence-based practices, reshaping professional incentives and practices, and reinvigorating the behavioral health workforce.

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## INTRODUCTION

The passage of the Patient Protection and Affordable Care Act of 2010 (ACA), in conjunction with implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), provides the largest potential yet to expand access to mental health and substance abuse services and to forge greater integration between behavioral and medical services. Fundamental to this opportunity is the broad extension of insurance coverage to many millions of uninsured people, the legal designation of mental health and substance abuse services as essential benefits to be included in acceptable insurance coverage, and the MHPAEA requirement that mental health services have comparable access without greater limitations than those of medical and surgical insured services. This is, of course, more easily legislated than accomplished because many behavioral health services are fundamentally different from typical medical and surgical services and resources are unequal.

The passage of the ACA and its implementation are taking place on the base of fractious and highly partisan politics with recurring efforts to sabotage many of its provisions, resulting in uncertainties as it moves forward. Thus, the ACA is best thought of more as the evolution of a framework, offering great opportunities and potential, than as a set of concrete and established changes. Its emerging shape will depend greatly on federal and state politics and policy, the clash of interests, and future policy leadership by health professionals, organizations, and advocates as well as their abilities to capitalize on incentives in the legislation.

**ACA:** conventional way of referring to the Patient Protection and Affordable Care Act of 2010

**MHPAEA:** Mental Health Parity and Addiction Equity Act of 2008

We begin with a short review of the evolution of the behavioral health services system, including a brief discussion of the efforts of health reform in the United States and—after many failures over the decades—the successful but compromised enactment of the ACA. We next focus on provisions of the ACA most relevant to mental health and substance abuse and some of the political and legal difficulties in its implementation. We then examine challenges in organizing and providing

behavioral health services in primary medical care and the specialty mental health system. We focus on persons with common mood and anxiety disorders as well as those with more severe and persistent disorders and the difficulties in providing the necessary array of services for the latter group.

Although the ACA was only recently implemented, we assess the evidence of its impact, including such issues as the numbers of new patients enrolled in Medicaid and through the health exchanges; the success in implementing Accountable Care Organizations (ACOs), patient-centered medical homes (PCMHs), health homes (HHs), and conjoint behavioral and primary care services; and the changing contours of the behavioral health professions. We also discuss the integration of behavioral and medical care services, a theme that runs through many provisions of the ACA; we investigate why these basic concerns that have existed for many decades are so difficult to resolve in practice, and we examine the potential role of promising service integration models.

**Medicaid:** a 1965 federal/state program initially providing medical care for defined vulnerable populations and subsequently modified, expanded, and significantly enlarged by the ACA

**Accountable Care Organization (ACO):** a program of incentives to organize care on a strong primary care foundation seeking to improve quality of care while reducing unnecessary costs

**Patient-centered medical home (PCMH):** a service delivery model in which treatment is coordinated through primary care physicians to ensure that patients receive needed care

**Health home (HH):** comprehensive approach to chronic care management under Medicaid for clients requiring a broad range of coordinated services

## BACKGROUND

In the early period of our nation, mental disorders were the responsibility of families and communities who did what they could to provide assistance and subsistence (Grob 1994). When persons lacked social connections or exceeded the capability or tolerance of family or friends, they were commonly confined in almshouses, poorhouses, and jails, which were the responsibility of each community and which did not differentiate among varying types of dependency and deviance including poverty, mental illness, old age, and dementia, among others. Supporting these local institutions was a burden.

By 1890, every state had established one or more institutions for the mentally ill (Natl. Inst. Health 2015). Growth of urban industrial society, changing responsibilities and weakening control of the family, and immigration, migration, and heterogeneity of increasingly dense populations required government to take on what previously were family responsibilities (Grob 1994). By 1955, when the US population was 167 million people, the population of residents in public mental hospitals reached 558,922 (Mechanic 2014). In the early years, when hospitals were small, moral treatment—a form of milieu therapy—built on the idea that considerate and kind treatment that kept patients involved in the community and encouraged their interests appeared to alleviate many patients' distress (Bockoven 1972) and helped them to leave the hospital. With changing economic and social conditions, and with increasing numbers of older patients in large, crowded, and understaffed hospitals with general paresis, the end stage of syphilis, dementias, and other incurable chronic diseases, most of these hospitals became bureaucratic custodial institutions providing abysmal care.

The development of our mental health system is as much a story about finances and payment as it is a tale of the evolution of new treatments. Throughout our history, tensions have persisted among families, communities, states, and the federal government as to who is responsible for provision of care. As responsibilities for care became too burdensome for most families, their communities (villages, cities, and counties) assumed more responsibilities, and as costs increased and maintaining decent standards became more difficult, care was increasingly transferred to the states and, in more recent times, to the federal government (Mechanic & Grob 2006). The evolution of the care system became dependent on the ability to shift costs to units of government with greater financial capacity. This tension between private provision, the role of states, and the responsibility of the federal government has persisted in the implementation of the ACA.

When World War II ended in 1945, of particular concern were the large numbers of individuals exempted by the US Selective Service from the military draft because of psychiatric disabilities and the significant numbers of troops who decompensated during their service. Techniques of

management, developed during wartime by military psychiatrists and other clinicians, contributed to optimism that much could be accomplished at the community level with appropriately organized services (Grob 1994).

**ADA:** Americans with Disabilities Act of 1990

***Olmstead v. L.C.*:** Supreme Court case granting patients the right to receive care in the least restrictive settings if possible to implement with reasonable accommodation

The introduction of chlorpromazine (Thorazine) in the 1950s calmed many psychotic patients and gave administrators and family hope that long-term patients could return to the community. Together with new optimistic social ideologies and social science studies documenting institutionalism and other deleterious effects of hospital living, these developments contributed to growing activism for change (Mechanic et al. 2013). Progress in pharmacology led to the discovery of effective antidepressants such as imipramine and a new era of psychotropic drug development. Many European refugee psychoanalysts and other psychiatrists who immigrated to the United States disseminated a range of psychodynamic and psychosocial approaches to intervention. Medical advances applied during the war contributed to the growing optimism.

The narrative, particularly from pharmaceutics representatives, was that the introduction of antipsychotic medications in the 1950s fundamentally transformed the mental hospital system and facilitated large reductions in mental hospital residents, from more than a half million in 1955 to some 35,000 to 40,000 today. The data indicate, in contrast, that between 1955 and 1965, resident patients decreased by only 15% (Mechanic 2014). A much larger decrease, 65%, came between 1965 and 1985, primarily due to social policies originating outside the mental health arena, including passage of Medicare and Medicaid in 1965. These programs provided large new incentives for the states to transform state mental health efforts. The legislation excluded federal payment for adult patients in state mental hospitals but provided Medicaid matching funding for care in general hospitals and other facilities, including nursing homes.

Although in 1965 there was relatively little nursing home capacity, the passage of Medicaid and Medicare motivated a large expansion in nursing home facilities. After 1964, as many as one-half of the elderly patients discharged from mental hospitals went directly into nursing homes (Kiesler & Sibulkin 1987). Transferring many older patients with dementia and other chronic diseases from state mental hospitals to nursing homes not only allowed states to write off at least half of their institutional costs but also permitted them to focus institutional care on less chronic patients.

As of 1974, many persons who were not eligible for Social Security Disability Insurance because they lacked the required work history became eligible for Supplemental Security Income, which provided income support to persons with disabilities including mental illness. Supplemental Security Income enrollees also became eligible for Medicaid. These federal programs and many others, such as housing assistance and food stamps, allowed patients to subsist in a range of nonhospital settings, however modest. In the 1970s, a significant social movement for the civil rights of persons with mental illness grew out of the broader civil rights movement demanding a range of new services and rights, including the right to be treated in the least restrictive environment possible (Appelbaum 1994). Although this movement did not fully live up to expectations, it established some basic civil rights protections, some of which were subsequently reinforced by the Americans with Disabilities Act of 1990 (ADA) (Mechanic et al. 2013) and the *Olmstead v. L.C.* decision by the US Supreme Court in 1999, which held that patients had the right to receive care in the least restrictive setting if such care could be implemented with "reasonable accommodations" (Rosenbaum 2000).

The Medicare and Medicaid incentives transferred most acute inpatient psychiatric care to general hospitals. Over time, with managed care seeking to contain the expensive costs of inpatient care, the average length of hospital stay substantially decreased (Mechanic et al. 1998, 2013). Although the number of persons with a primary diagnosis of mental disorder discharged from short-stay hospitals has increased in recent years, the length of stay has continued its downward trend, now averaging about six days (Mechanic et al. 2013).

Treatment in short-stay hospitals for psychiatric disorders is primarily focused on acute stabilization of the most distressing symptoms under the assumption that appropriate ongoing outpatient care will occur following hospital discharge. As compared with patients in hospital settings, however, patients in outpatient settings have greater choice and autonomy, leading to substantial variation in treatment adherence. For patients with severe and persistent behavioral disorders, discontinuities in services with resulting disruptions in treatment are quite common. In 2012, only 63.6% of Medicaid health maintenance organization psychiatric inpatients received any outpatient mental health services during the first 30 days following hospital discharge (Natl. Comm. Qual. Assur. 2013). Many of the provisions of the ACA are directed at reducing disruptions in continuity of care and improving the integration and coordination of services by encouraging a range of initiatives such as ACOs, PCMHs, and HHs.

Because many of these initiatives are intended to improve care while increasing efficiency and controlling costs, they are linked to quality-of-care incentives and, in some cases, financial penalties for failure. In the case of Medicare, for example, hospitals are now financially penalized for readmissions within 30 days of many conditions in an effort to discourage premature discharge or failure to successfully link patients to needed community services. A recent study of 11 large health maintenance organization networks found that 21.7% of patients with chronic medical conditions and psychiatric comorbidity were readmitted within 30 days compared to 16.5% without such comorbidity (Ahmedani et al. 2015).

A vigorous debate continues on the extent to which current practices and financial restraints and incentives push persons with psychiatric disorders into the criminal justice system, a common view of mental health advocates (Torrey 2014). Others believe that the criminalization hypothesis is not supported by adequate empirical evidence (Hiday & Moloney 2014). Many persons with psychiatric disorders of all kinds are found in jails and prisons, but they also are more likely to have common risk factors for incarceration such as poverty, minority racial status, unemployment, homelessness, and substance abuse (Fisher et al. 2006). A national survey of jail inmates found that recent homelessness was approximately ten times more frequent among inmates than in the general population (Greenberg & Rosenheck 2008). Several of the risk factors and life situations that encourage criminal offenses operate similarly among persons with and without severe mental illness. Drug possession and trafficking is commonly the most serious offense among inmates with mental illnesses, accounting for more than half of inmates in federal prisons (James & Glaze 2006). It is difficult to separate high rates of criminalization from the "war on drugs." Imprisonment, particularly for those with minor infractions, is increasingly challenged as harmful social policy, and many efforts are now being implemented to prevent imprisonment through diversion programs, drug and mental health courts, and better coordination between health and mental health services and the criminal justice system (Phillips 2012).

## THE STRUGGLE FOR HEALTH REFORM

On numerous occasions over the past century, serious efforts have been made to introduce a comprehensive system of health insurance and medical care provision to provide health security for the population. Strong ideological and professional interests, often with the American Medical Association in the lead, consistently opposed these efforts (Starr 1982). Mental illness was rarely explicitly part of health reform discussions.

An extensive literature has examined various efforts over the years to introduce more comprehensive health care reform (Hoffman 2012, Mechanic 2006, Quadagno 2005, Skocpol 1996, Starr 1982) and the various factors contributing to failures. The most important success was the passage in 1965 of Medicare, covering persons 65 and older and some persons with disabilities, and

Medicaid, initially covering selected poor categorical groups. These programs have been modified and expanded over the years and are substantially affected by provisions of the ACA. Passage of Medicare, initially supported by President John Kennedy prior to his assassination and carried through with Medicaid added during political negotiations, was made possible by the political skills of Lyndon Johnson and the Democratic supermajority in both houses of Congress. In the next major reform effort to provide universal health coverage, the Clinton Health Plan (Health Security Act of 1993; Skocpol 1996), Democratic control of the Congress also appeared to offer a powerful opportunity, and proposals more attentive to mental health issues than earlier efforts were included. Vigorous opposition by much of the health care sector and small businesses, the complicated and controversial process of developing the proposal, economic constraints affecting many interests, the complexity of the proposal (which the public found hard to understand), competing controversial budget and fair trade issues that captured attention, and Clinton's personal difficulties (including the effort to impeach him) all may have contributed to its failure to become law.

## THE AFFORDABLE CARE ACT STRUGGLE

President Obama began with strong numerical control in both the Senate and the House. The plan was to mandate insurance coverage of the population (an idea supported by Republicans in previous proposals seeking to emphasize the importance of personal responsibility and modeled on the successful Massachusetts plan passed under Republican Governor Romney) and to extend coverage through expansion of Medicaid to those earning up to 138% of the federal poverty level. Others who were not eligible or did not have insurance from their employers could purchase insurance on health insurance exchanges run by the states or, if they defaulted, by the federal government. The federal government would then provide subsidies for purchase of insurance for individuals and families earning up to 400% of the federal poverty level, on a sliding scale depending on income. It was initially estimated that the legislation would substantially reduce the large uninsured population, only excluding persons who could not afford insurance under the plan provisions, those who had religious objections, and undocumented persons (Jacobs & Skocpol 2010).

All such policy has significant income distributional consequences, and it was clear that the legislation would substantially redistribute resources to the poor while seeking efficiencies and reduced growth in the Medicare program. Polls showed that the Medicare population was least supportive of these reforms (Kaiser Fam. Found. Polls 2015) and Republican lawmakers uniformly exerted party influence to maintain a united opposition. It was ironic that many of the key ideas, particularly the individual mandate and competitive insurance exchanges, were built around originally popular Republican ideas. Governor Romney, who supported a similar approach in Massachusetts, strongly opposed the national plan. Some explicitly acknowledged that their strong opposition was motivated to deter President Obama from achieving a major legislative success. The legislation passed both houses of Congress without a single Republican vote.

The ACA is a large and complicated plan with interlinking and interdependent provisions. The very popular provision of prohibiting exclusion from insurance or increased premium costs because of preexisting health conditions is financially feasible because the risk pool is large and includes persons with minor as well as significant medical needs. If there were no insurance mandate, then adverse selection in acquiring health insurance together with the high costs of the sick would undermine this insurance approach. Some political opponents supported the popular preexisting condition provision but opposed the mandate, refusing to acknowledge the important connection between them.

The Senate and House bills were somewhat different, as typically occurs, requiring the legislation to return to the Senate, but in the interim Senator Ted Kennedy died and was unexpectedly

replaced by Republican Scott Brown, a vote needed by the Democrats to maintain their filibuster-proof majority. Saving the legislation required maneuvers and trades that were readily attacked by the Republican opposition and added to the acrimony surrounding the partisan legislative process.

**CMS:** Centers for Medicare and Medicaid Services

Many conservative groups mobilized to challenge various provisions of the ACA in the courts, including the penalty for not acquiring health insurance (the mandate), the threat of possibly losing Medicaid funding if states refused to expand their Medicaid programs, and the requirement to include particular birth control services in the insurance package, as well as the issue of whether exchange subsidies were legally available when states opted out of running exchanges. This major issue involved a drafting error in which two parts of the legislation were read to have different implications for such subsidies, but one of crucial significance to providing affordable coverage on the federally run exchanges. More than 85% who have enrolled on the exchanges have received subsidies. The legislative history and reports from those who worked on the legislation and chairs of the relevant Congressional committees made clear that the Congressional intent was to make financial help available to persons in state exchanges whether run by the states directly or through the federal government (Brief Health Care Policy Hist. Sch. 2015). Nevertheless, the decision remained uncertain because of differences among the Justices in interpreting provisions and the extent of literal interpretation. In June 2015, writing for the Supreme Court, Chief Justice Roberts in a 6-3 decision affirmed the right of all qualifying persons on the federal exchange as well as on state exchanges to receive subsidies. In a highly supportive opinion, the decision maintained that the intent of the legislation was to support the health marketplace, not to undermine it.

This litigation and the decisions of the Supreme Court have already complicated a number of important implementation challenges in extending insurance coverage. Although the Supreme Court by a 5-4 vote decided that the mandate and its related penalty for noncompliance was a tax and therefore constitutionally permitted under the taxing power, it ruled that the possible threat of loss of Medicaid funds for states that chose not to expand their Medicaid programs was coercive and not constitutionally permitted, allowing states to opt out of expansion. The incentives for the states to expand Medicaid are extremely large, with no cost at the start and requiring only 10% in 2020 and thereafter. The 19 states electing not to participate at this time (September 2015) are among the poorest states with large possible gains. States not yet participating are concentrated in the South, largely with Republican governors ideologically opposed to the ACA and who maintain they do not trust the federal government to keep its long-term promise of the generous 90% match. Another issue affecting Medicaid in states that do not participate in the expansion is the fate of persons under 100% of the federal poverty level who are not eligible for subsidies in the exchanges on the earlier assumption that they would be covered by Medicaid.

## MEDICAID EXPANSION UNDER THE AFFORDABLE CARE ACT

The ACA is an extensive and comprehensive law affecting insurance coverage and many aspects of the health care delivery system (Jacobs & Skocpol 2010, Kaiser Family Found. 2013). Because mental illness and substance abuse are common in the population (Kessler et al. 1994) and are especially prevalent among persons in poverty, many provisions of the ACA have important relevance for persons with these disorders. As of September 2015, 31 states, including the District of Columbia, have elected to expand Medicaid; one remains engaged in debate; and 19 states are not expanding (Kaiser Comm. Medicaid Uninsured 2015). In September 2015, the Governor of Alaska extended Medicaid, but the legislature continues to challenge his authority in the Courts. As Republican governors have expanded Medicaid or reached agreements with the Centers for Medicare and Medicaid Services (CMS), opportunities open for more Republican governors to pursue Medicaid expansion (Galewitz 2015). Nevertheless, Texas, North Carolina,

and Georgia—with high rates of uninsured—have persistently rejected expansion. Such extensions, now based solely on income, permit coverage of single, nonelderly adults in poverty without a disability. This population was not previously covered in most states. Medicaid coverage is a moving target, but as of 2014 some 8.7 million enrollees were added—7.5 million in 27 expansion states (Pear 2014). Even in nonexpansion states, increased program awareness and other changing conditions encouraged new enrollees who were eligible under preexisting criteria but had not established eligibility. The Congressional Budget Office estimated that the number of persons receiving insurance through exchanges would cover as many as 25 million in 2017 (Pear 2015a). Two recent survey reports indicated that as of mid-September 2015, the percentage of uninsured had fallen to between 9.2% and 10.4%, down by approximately one-third since the implementation of the ACA (Pear 2015b,c).

Non-Medicaid enrollees who fall between 100% and 400% of the federal poverty level are eligible for subsidies under the insurance exchanges established under the ACA, and some 7.3 million acquired insurance during the initial round in 2013–2014 (Pear 2014). Five major surveys reported significant declines among the uninsured in the prior year (Sanger-Katz 2014). Between Medicaid expansion and subsidies through the exchanges, the number of uninsured was estimated to have fallen by about one-quarter (Sanger-Katz 2014). Groups with the largest gains in insurance included blacks and Hispanics, young adults (not counting the 3 million under age 26 who were being covered by parents' insurance policies), persons with the lowest incomes, and persons from rural populations (Quealy & Sanger-Katz 2014). By early 2015, Gallop reported the uninsured adult rate as 11.9%, the lowest recorded since 2008, when Gallop tracking began (Levy 2015).

Medicaid is, of course, a large part of the story, with some 8.7 million added enrollees in the period October 2013 to approximately one year later. Of these, 7.3 million came from states that have expanded eligibility under the ACA (Pear 2014). This is of special importance for persons with behavioral disorders, and especially those with severe conditions, since they are disproportionately represented among the Medicaid population, and Medicaid offers a broader range of services to respond to chronic disabilities than is available through most private insurance plans. Medicaid is the largest behavioral health treatment and rehabilitation program in the United States, now accounting for 30% of all national behavioral health expenditures (Mechanic 2014).

Medicaid also has evolved over the years to cover essential services not typically found in private health insurance plans, such as case management, psychosocial rehabilitation, and crisis services; still other valuable services are incorporated in state plans and waivers approved by the federal government. The ACA includes a revision of section 1915(i) of the Deficit Reduction Act of 2005, which allows states to offer needed benefits for people with mental health and substance abuse disorders and makes care accessible to more people by broadening the home and community service-based waiver option (Mechanic 2012). Key to this change is that states are no longer required to have clients attain eligibility for institutional care, thus broadening the potential client population and allowing earlier interventions. As of March 2013, nine states reported that they had this option in place (Kaiser Comm. Medicaid Uninsured 2013). An increasing number of states are also taking advantage of broader Section 1115 Medicaid Delivery System Reform Incentive Payment (DSRIP) waivers to carry out delivery system reforms (Kaiser Comm. Medicaid Uninsured 2014).

## BEHAVIORAL HEALTH BENEFITS AND PROTECTIONS UNDER THE AFFORDABLE CARE ACT

The provisions of the ACA and their extensions into existing federal programs such as Medicaid and Medicare establish a basis for remaking the behavioral health care treatment system. In theory,

the opportunities for behavioral health treatment are better than ever before, but realizing greater access and a broader range of services depends on the ability of the treatment system to respond, to be accessible, to provide high quality of care, and to integrate its structures and systems in a meaningful way. It also depends on treatment personnel, their availability in different regions and localities, and their appropriate training. Thus, the gap between promise and fulfillment can be extremely challenging. The ACA greatly expands support for federally qualified health centers, making access to care more readily available to Medicaid enrollees and the uninsured.

The implementation of parity, beginning largely in 2014, suggests a significant expansion of behavioral health services. Because all health plans under the ACA must provide coverage of 10 essential benefit categories, including mental health and substance abuse disorders, the scope of parity is very much extended. The Office of the Assistant Secretary for Planning and Evaluation estimated that these added protections would affect 62 million Americans (Beronio et al. 2013). Advocates initially hoped that the Department of Health and Human Services would specify essential health benefits in detail. The Department took an alternative and politically less difficult route by shifting this responsibility to each state, but requiring that they specify essential benefits following various benchmark plans that were typical of employer plans in their state. The great majority of states selecting a benchmark chose the small group plan in their state with largest enrollment; states that failed to meet the deadline for selection were assigned the same choice (Beronio et al. 2014). Although all these plans now must offer coverage at parity, parity does not necessarily insure all of the services needed by persons with severe and persistent mental disorders, especially in the area of rehabilitation services. Advocates complain of the failure of insurers to fully comply with parity requirements.

The lack of uniformity in having each state select its own benchmark plan for defining the details of coverage for essential health benefits raises important issues going forward, particularly with respect to behavioral services that are substantially different from most medical and surgical services. A recent study (Grace et al. 2014) reviewed how these benchmark standards for pediatric coverage, another essential health benefit, defined the terms of services. The researchers found considerable variability among states, with significant exclusions, especially for services affecting children with developmental disabilities and other essential special needs.

Given the high prevalence of behavioral conditions, many of the ACA generic provisions provide coverage for a significant number of persons needing behavioral services. Following implementation, young adults ages 18 to 34 experienced the largest reduction of uninsurance of any age group, falling from almost 22% to 14% (Quealy & Sanger-Katz 2014). This reduction is significant in that the onset of many behavioral disorders is during late adolescence and early adulthood, and initiation of care typically lags for several years. Cost is only one of many barriers to seeking mental health care, but new coverage provides opportunities to close the care gap. Preventive services mandated under the ACA without cost sharing include such interventions as depression screening, alcohol abuse screening and behavioral counseling, and tobacco screening and cessation programs (Beronio et al. 2014).

Provisions of the ACA that are particularly well liked by advocates and the general public include the prohibitions on (*a*) preexisting condition denials in coverage or in acquiring insurance, (*b*) waiting periods, and (*c*) premium risk rating adjustments based on prior medical problems or risks. In the past, insurers have commonly used psychiatric disorders as a basis for these denials or restrictions. Premiums can no longer be adjusted by prior conditions or disability; the only bases for premium differences permitted are the actual plan value (i.e., platinum-, gold-, silver-, and bronze-level plans), patient age, patient tobacco use, and geography. Related protections disallow plans from dropping patients because of their high costs by prohibiting annual and lifetime expenditure limits.

## THE IMPORTANCE OF PRIMARY CARE IN AFFORDABLE CARE ACT IMPLEMENTATION

Primary medical care is an essential structural feature for implementing the intent of the ACA (Davis et al. 2011). Critical to this function is the need to redesign services both organizationally and financially to improve their effectiveness in health maintenance and prevention, to coordinate and integrate the range of needed services in an efficient and timely way, to reduce error and unnecessary services, and to provide high-quality evidence-based care. Key to these challenges is successful management of chronic disease, and of central concern are the high prevalence of psychiatric disorders and the need to improve alignment of the medical and behavioral aspects of care.

Behavioral problems are common in primary care (Olfson et al. 1997). Despite deficiencies in recognition and treatment, behavioral problems account for about one-third to one-half of outpatient medical services. These services are increasingly delivered as prescribed psychotropic medications that are commonly provided with limited attention to assessment and diagnosis and with little follow-up. Because of patient demand and financial considerations, most primary care practice is characterized by strong pressures to expedite the queue. These concerns make it unlikely that solo practitioners or small practices are equipped to provide the needed coordination within the medical system and especially across the many social welfare, rehabilitative, and other areas that are important in the overall management of people with more severe psychiatric disorders.

The need to develop greater integration between general medical care and behavioral health care has been documented over many years (Butler et al. 2008, Mechanic 1997). The academic literature on integrating mental health services into primary care has largely focused on adults with depression and anxiety disorders, but similar concerns range across a wide spectrum of challenging mental health and substance abuse disorders (Gerrity 2014).

Primary medical care has long been an important locus for behavioral health treatment. Many efforts have been made over the years to increase physician recognition and treatment as well as appropriate referral of behavioral health patients (Goldberg & Huxley 1980). Progress, however, has been uneven and inadequate. Although increasing proportions of behavioral problems of patients are recognized and receive treatment (Wang et al. 2006), primarily medication, such treatment is often not consistent with evidence-based standards (González et al. 2010). For example, patients with depression are increasingly being treated without a diagnosis and with antidepressant medications rather than psychotherapy (Mojtabai & Olfson 2011, Wiechers et al. 2013). Despite the development of several effective psychotherapies for the treatment of depression, only about one-half of outpatients who are treated for depression receive even a single counseling or psychotherapy visit (Olfson & Marcus 2010). Yet a great majority of patients express a preference for psychotherapy (McHugh et al. 2013), and treatments that align with patient preferences are associated with increased treatment retention and improved outcome (Mergl et al. 2011). Thus, an important opportunity exists to implement primary care services for depression and anxiety that provide access to evidence-based psychological treatment.

Among the many reasons for the current inadequate primary care treatment of behavioral disorders are limited knowledge and interest of physicians concerning behavioral disorders, high workload and intense pace, low reimbursement rates, and the challenging nature of many behavioral disorders, which often require more time and attention than the intensive pace of practice allows (Mechanic 2003). Nevertheless, clinical trials involving adult primary care patients with mood and anxiety disorders have found that as compared with patients who receive standard care, those who receive integrated mental health services achieve significantly improved clinical outcomes (Butler et al. 2008; Gilbody et al. 2003, 2006; Woltmann et al. 2012).

Although antidepressant medications remain the modal treatment for adult depression and several anxiety disorders in primary care, evidence also supports the efficacy of short-term (6 to 12 sessions) counseling and psychotherapy in primary care. In the United Kingdom, several high-quality randomized controlled studies comparing short-term counseling with usual primary care have demonstrated significantly greater improvement in short-term depression and anxiety symptoms as well as high levels of patient satisfaction with care, although no consistent added benefits in social function or long-term symptom severity were identified (Bower et al. 2011). A recent randomized controlled trial for adult primary care patients with depression reported that a significantly greater percentage of patients assigned to counseling (59%) than to antidepressants (45%) achieved symptomatic remission at two months (Menchetti et al. 2014). Such results support expanding access to evidence-based psychological services in primary care. As described in the following sections, the ACA seeks to restructure financing and organizational approaches to direct care toward greater coordination and higher quality through PCMHs, ACOs, and HHs.

## PATIENT-CENTERED MEDICAL HOMES

The basic concepts underlying the PCMH derive from decades of work on the effective implementation of primary care (Davis et al. 2011, Starfield 1998, Starfield et al. 2005). Although existing ventures vary a great deal in organization and size, in general physician-led teams assume responsibility for continuing and coordinated care to meet the wide range of patients' ongoing needs; the teams manage care transitions as well. PCMHs are responsible for bringing together the necessary preventive, acute, and chronic care. The ideal has been to integrate basic medical and behavioral health services in a holistic fashion, but success has been slow (Lewis et al. 2014). In larger PCMHs the intent is to encourage new tools for efficient and effective care, including multidisciplinary teams, meaningful use of information technology, and disease registries, with encouragement to move away from fee-for-service reimbursement and incentives. National surveys of PCMHs that had payment reform as an aspect of their model found a fourfold expansion between 2009 and 2013 involving 44 states with 63,011 providers and more than 20 million patients. These PCMHs varied from small pilot programs including only a few practices to multiple provider programs (Edwards et al. 2014).

Under the ACA, the primary model for PCMHs has remained fee-for-service reimbursement augmented by additional member-per-month payments and pay-for-performance bonuses. These augmented payments are higher than in the past, and 44% of programs have received shared savings reimbursements. The performance of PCMHs is quite mixed, with great variation in organization and models (Edwards et al. 2014, Friedberg et al. 2014, Hoff et al. 2012). Case studies and other investigations suggest greater success in implementation and outcomes in large and well-organized health systems that have the infrastructure and leadership to implement reforms (Alliance Community Health Plans 2015). In any case, much more research is needed to identify key determinants of success and the likelihood of achieving objectives and aspirations.

## ACCOUNTABLE CARE ORGANIZATIONS

The ACO is a related initiative that was initially under the Medicare program but was extended to Medicaid and the private sector. ACOs seek to reduce unnecessary costs by improving quality of care through a strong primary care foundation. This type of organization requires provider organizations to collectively be accountable for the care and costs of a group of patients, for whom they are held responsible. One complication is that Medicare cannot restrict or penalize patients for using services outside the ACO, which poses a greater burden for the ACO in integrating care

and reducing costs. The Medicare Shared Savings Program allows sharing of savings with ACOs of 5,000 or more Medicare patients that meet a range of quality standards. ACOs can earn larger shared savings if they also accept accountability to share in losses. Medicare also has a Pioneer ACO model that moves toward a population-based model of care with outcome-based contracts. As of 2014, an estimated 360 ACOs were covering 5.6 million Medicare recipients, and hundreds of similar arrangements existed in the private sector, some with large private insurers such as Humana, Cigna, and United Healthcare (Casalino 2014a, Cent. Medicare Medicaid Serv. 2014, Gold 2015). Because there is no agreed upon definition of an ACO, estimates of their prevalence are unreliable and vary substantially (Casalino 2014b, Shortell et al. 2014).

Depression and other mental health conditions in older adults are associated with substantially elevated health care costs, especially when there are comorbid general medical disorders (Unützer et al. 1997). Yet despite the financial burden of mental disorders in primary care, ACO quality-improvement efforts have focused almost entirely on general medical rather than mental health disorders. One exception involves screening for depression with a documented follow-up plan. However, such efforts by themselves may have little impact on care delivery and patient outcomes.

ACOs have thus far given little attention to behavioral aspects of health care. A recent national survey of 257 ACOs concluded, "Most ACOs have done little to move beyond the traditional model of fragmented primary and behavioral health care" (Lewis et al. 2014, p. 1814). More than one-third of the ACOs reported no formal relationships with behavioral health providers, and only 14% reported "nearly complete" or "full integration." Although more than one-half of the ACOs studied reported having integrated delivery systems, relatively few included behavioral health integration with primary care. Forty-two percent reported that their ACO included some behavioral health provider groups (Lewis et al. 2014). In their more intensive interview study, the investigators found the same range of primary care expansion models previously reported in the literature (Mechanic 1997), such as arrangements for primary care physicians to consult off-site psychiatrists for advice, colocation models in which primary care and specialty providers shared the same physical space, and less commonly embedded models in which behavioral health personnel were part of primary care teams and, occasionally, primary care physicians were integrated into behavioral health programs. Those more engaged in integration efforts were groups with many behavioral health clients and strong payment incentives. Unfortunately, least common were those integration approaches that the literature suggests are most effective, in which the behavioral health clinician truly becomes engaged in care.

Lewis and colleagues (2014) found that many Medicare ACOs were highly motivated to provide depression screening because depression was an ACO Medicare benchmark in evaluating performance. All these programs depend on electronic health records to facilitate communication; the electronic records share behavioral health information more widely and allow it to be incorporated into quality indicators.

Most ACOs have not focused on behavioral health issues or integration with the range of services that persons with serious and persistent mental disorders require. One important initiative in the ACA is the provision of financial incentives to the states to develop HHs.

## HEALTH HOMES

The HH is a specialized and comprehensive approach to care management that focuses on high-need, high-cost Medicaid-financed clients who require a broader range and great coordination of services than required by individuals typically served by PCMHs and ACOs. HHs care for Medicaid beneficiaries with serious mental illness and substance abuse; they also serve others with more than one chronic disease or with one chronic disease and a high risk of a second.

HHs are similar, however, to PCMHs and ACOs in terms of care management and coordination, promotion of health, linkage with needed community and social support services, and the use of health information technology to carry out care management and coordination (Nardone et al. 2014, Paradise & Nardone 2014). These objectives are pertinent to the needs of persons with serious mental illness and chronic general medical disease comorbidities. Almost all state programs give central attention to mental illness and substance abuse or other behavioral disabilities and comorbidities. An important incentive provided by the ACA to encourage states was a 90% federal match for the first two years of HH operation.

The HH approach involves mobilizing interprofessional teams including physicians, nurses, social workers, and other professionals who take responsibility for managing and coordinating the broad range of services that might be needed by persons with chronic and persistent behavioral disorders or multiple comorbidities. These approaches depend on effective electronic medical records that facilitate close communication among providers, tracking of patients and their use of services, and assessment and management of service coordination in real time. Although the HH incorporates important concepts about chronic disease management, it is more a package of ideas and expectations than a particular organizational arrangement. States are given considerable discretion as to how they organize and staff HHs, enabling them to adapt to varying cultures, medical organization and delivery methods, and payment systems.

Target populations for HHs have varied from general chronic disease programs to those directed to a particular disorder with comorbidities such as serious mental illness, substance abuse, or HIV/AIDS. States have been allowed to develop statewide programs or to restrict them to particular geographic areas. Depending on their focus and their health infrastructure, states may use teams of specialized personnel with appropriate experience, their system of primary care providers, or specialized coordination teams organized on a community or regional basis (Nardone et al. 2014). States have built payment around existing managed care programs or fee-for-service supplemented by a per-member per-month payment to compensate for the greater range and intensity of services.

As of August 2014, 15 states had at least one approved HH program, and a 50-state survey of Medicaid directors by the Kaiser Commission on Medicaid and the Uninsured reported that 21 states planned to expand existing programs or to adopt this new state opportunity (Paradise & Nardone 2014). Although positive claims are made about the performance, quality, and cost-effectiveness of HHs, there has been little rigorous evaluation. Such evaluation is difficult because the programs differ greatly, their target populations vary and are not necessarily comparable, and the states that entered the program early were already making efforts to address the challenges of chronic care management and coordination for persons with serious mental illness. Nor is it clear to what extent state programs have adhered to the guiding aspirations and principles. Underlying these coordination challenges is an array of issues concerning the quality and experience of personnel, the mix of the target population, the capacity and functioning of teams, the degree of effectiveness of the programs' health information technology systems, and the effectiveness of the integration models the state programs seek to implement.

## CLINICAL MODELS OF CARE INTEGRATION

A compelling case can be made for dedicated organizational efforts to integrate mental health care for individuals with depression, anxiety, and related disorders into the delivery of primary care. Integrated care helps to ensure that the full range of health needs will be met for adults who suffer from combinations of mental health problems and chronic general medical problems. The need for service integration arises in part from regional shortages in the availability of freestanding specialty mental health services. Two-thirds of primary care physicians report that they cannot

secure outpatient mental health referrals for their patients (Cunningham 2009). Delivering mental health services within primary care settings not only facilitates access but also can reduce stigma that might otherwise deter specialized mental health care. Moreover, integrating the treatment of common mental disorders and chronic medical conditions within primary care settings is cost effective and preferable for many patients (Katon et al. 2012, Wittink et al. 2010).

**Collaborative care:** an evidence-based model for treating depression and anxiety in primary care, including patient monitoring, education on self-management, and specialty assistance when needed

Models proposed for providing mental health services to primary care patients vary in complexity, required resources, and barriers to integration with established clinic routines. They range from care arrangements in which responsibility for treatment rests almost exclusively with primary care physicians to referral systems that are managed by mental health specialists (Gask & Khanna 2011). The simplest model involves colocation of a mental health specialist within a primary care practice. As patients are identified by primary care physicians as having mental health problems, they are referred to an on-site mental health specialist for the duration of treatment. This arrangement requires a high level of involvement from a mental health specialist in the direct provision of mental health care (Bower & Gilbody 2005).

Another approach involves training primary care physicians or other general medical staff members to provide mental health care (Gilbody et al. 2003). The goals of such educational efforts typically focus on improving psychotropic medication prescribing practices and less commonly involve teaching basic counseling and psychotherapy skills. A potential limitation of training/educational models is that they may not emphasize appropriate triage of severely ill psychiatric patients to mental health specialists. A study conducted within the Department of Veterans Affairs, for example, revealed that patients with bipolar disorder who received care exclusively within primary care were treated with less optimal pharmacotherapy than were those who also received specialized mental health services (Kilbourne et al. 2010).

Collaborative care is the most well studied model for treating depression and anxiety in primary care (Butler et al. 2008, Woltmann et al. 2012). Care managers monitor symptoms with symptom measures and advise patients on self-management. As needed, primary care physicians contact mental health specialists, who advise them on managing their patients using established treatment protocols. In some models, care managers and specialists use a stepped-care approach, in which patients who do not improve on one level of care are moved up to a more intensive level of treatment (Bower et al. 2006).

A meta-analysis of 57 randomized clinical trials confirmed that collaborative chronic care improves mental health and general medical outcomes for several mood and anxiety disorders (Woltmann et al. 2012). For adults with depression and poorly controlled diabetes or coronary heart disease, for example, collaborative care significantly increased the number of depression-free days, improved diabetes and heart disease control, and lowered outpatient health care costs (Katon et al. 2012). In the IMPACT (Improving Mood—Promoting Access to Collaborative Treatment) study, collaborative care as compared with usual primary care resulted in significantly greater reductions in depression severity and greater improvements in function and quality of life among depressed elderly primary care patients (Unützer et al. 2002).

Despite promising research findings, collaborative care has proved challenging to implement within some primary care settings (Roy-Byrne 2013) and uncertainty exists over its long-term clinical effectiveness (Oosterbaan et al. 2013). The implementation of collaborative care for depression also lags behind the implementation of chronic care models for other common medical conditions (Zafar & Mojtabai 2011). The uptake of different integrated mental health care models has been studied within 225 primary care practices operated by the Department of Veterans Affairs (Chang et al. 2013). Adoption has been far greater for the simple colocation model (47%) than for two more complex variations of collaborative care that were implemented in 17% and 8% of the practices. The low uptake of collaborative care likely reflects the burden

of the greater organizational demands imposed by implementing models of care that require fundamental changes to routine processes of care.

Collaborative care research initially focused on improving antidepressant prescribing practices and medication adherence. The model subsequently expanded to include care manager delivery of low-intensity supported self-management. Some models further allow physicians or care managers to refer patients who do not respond to antidepressants and low-intensity psychological treatments to more intensive specialized psychological interventions (Katon et al. 2010). Such high-intensity psychological therapies include cognitive behavioral therapy, interpersonal psychotherapy, and behavioral couples therapy. Despite its intuitive appeal, specialized psychological treatment as part of stepped care entails practical coordination challenges related to sequencing the care of different professionals in different settings using different treatment modalities (Richards 2012).

Implementation of collaborative care services may be most successful in practices that have an orientation toward quality improvement, a senior clinician who supports improved mental health care, financing mechanisms to reimburse collaborative care services, and an adequate medical information infrastructure. Concerns with cost containment can lead to implementation of only selected elements of collaborative care, such as screening and periodic symptom reassessments, which have not by themselves been demonstrated to improve outcomes. With the recent increase in ACOs, however, payment will be increasingly linked to patient outcomes, which in turn may create incentives to develop collaborative care models. Pay-for-performance incentives can improve patient follow-up and depression outcomes within a collaborative care framework (Unützer et al. 2012). In January 2015, Health and Human Services Secretary Sylvia Burwell announced the goal of having 85% of all Medicare fee-for-service payments linked to measures of quality or value by 2016, and a target of having 30% of Medicare payments that involve alternative payment models linked to measures of quality or value by the end of 2016, increasing to 50% by the end of 2018 (Burwell 2015).

## INTEGRATED PRIMARY CARE MODELS IN CONTEXT

As the ACA moves forward, various adaptations of collaborative care are likely to be implemented to facilitate behavioral health service access within primary care. One challenge will involve determining which patient populations can be safely and effectively treated within collaborative care and which patients will continue to require treatment that is primarily centered within the traditional specialty mental health sector.

A recent clinical trial of adults with drug and alcohol dependence underscores the limits of collaborative care for treating more severe psychiatric disorders. In the experimental group, primary care patients with substance dependence received relapse prevention counseling, treatment from onsite mental health specialists, care coordination, and other services. However, the outcomes of patients in the experimental group were not significantly different from those who received usual primary care (Saitz et al. 2013). An effort to adopt the model to the treatment of posttraumatic stress disorder in primary care also yielded disappointing results (Schnurr et al. 2013). To improve outcomes of patients with more severe mental disorders, ACOs, PCMHs, and HHs may require primary management in specialty mental health settings with consulting medical care managers to address their general medical problems and improve care transitions (Druss et al. 2010).

## SERIOUS MENTAL ILLNESS

Adults with serious mental illness often have service needs that extend across systems including general medical and behavioral health care, housing, employment, rehabilitation, education, social

and child welfare, and criminal justice (Mechanic 2014, West et al. 2015). The appropriate and adequate delivery of these services requires active and ongoing coordination that is complicated by diverse, complex, and often-inflexible funding streams. The HH offers opportunities to develop and evaluate new integrated models of care for serving many of the needs of these individuals.

**Program of Assertive Community Treatment (PACT):** an evidence-based model using interprofessional teams to support patients in the community by helping with challenges of everyday living

It has been demonstrated that the formal integration of mental health and general medical services increases access to general medical services and improves medical outcomes for individuals with severe mental illnesses and addictive disorders in a manner that is cost neutral (Druss & von Esenwein 2006). Some barriers to implementing integrated care into broader practice include primary care visit reimbursement limits, a paucity of primary care providers who are trained to care for adults with severe mental illnesses, and Medicaid prohibitions against same-day billing for primary care and specialty mental health care (Alakeson et al. 2010).

In housing, full-service partnership programs run by some government and nonprofit agencies and supported by the US Department of Housing and Urban Development and some state human services agencies in California and elsewhere provide homeless individuals with severe mental illness immediate access to permanent housing, a mental health treatment team, and community supports (O'Hara et al. 2007). In relation to standard public housing and mental health services, homeless individuals with severe mental illnesses who are enrolled in these programs significantly increase their use of outpatient mental health services and days spent in housing and report higher self-rated quality of life (Gilmer et al. 2010). Most of the direct costs of full-service housing programs are offset by lowered use of inpatient and emergency mental services.

In the area of work, several randomized controlled trials attest to the effectiveness of supported employment programs for adults with severe mental disorders (Bond et al. 2008). These programs help individuals access competitive rather than sheltered employment, attend to individual job search preferences, avoid lengthy preemployment assessment and training periods, and integrate vocational services and mental health services with ongoing individualized job support from a vocational specialist (Bond et al. 2001). Despite the availability of effective methods for implementing supported employment services (Marshall et al. 2008), widespread dissemination has been historically hindered by limited funding mechanisms in the Medicaid program. The ACA, however, includes revisions to Section 1915(i) of the Social Security Act that expand the types of services that states can provide to Medicaid beneficiaries to include key elements of supported employment programs (Siegwarth & Blyler 2014).

Although progress has been achieved in demonstrating benefits of several specific facets of service delivery for adults with severe mental illnesses, critical challenges persist in developing a general model of care that facilitates appropriate and timely access to relevant services. The best-established model, which has been widely recognized and replicated, is the Program of Assertive Community Treatment (PACT). Developed in the early 1970s, PACT uses interprofessional treatment teams to monitor and support the patient in the community, help with the challenges of everyday living, assure adherence to medication, and assist with issues that develop with respect to housing, police, and employers.

PACT is a high-intensity and expensive program, is not accessible to all who could benefit, and often fails to be implemented with fidelity. Researchers have examined PACT more than other community care programs, and although studies show that hospitalization is commonly avoided and patients benefit in a variety of social and quality-of-life aspects, benefits in terms of symptoms and functional outcomes are inconsistent. Usual care has begun to incorporate important elements of PACT, and recent studies have indicated that the differences between PACT and usual mental health care have become smaller (Killaspy et al. 2009). This raises concerns about the cost effectiveness of PACT for any but the most severely ill high-cost patients and questions about the financial feasibility of long-term PACT enrollment.

PACT staff workers tend to focus on helping patients solve problems of daily living. Few PACT workers have been formally trained to deliver evidence-based psychological and psychosocial interventions. A systematic effort to engage and maintain patients of PACT teams in such evidence-based treatments met with only limited success (Sytema et al. 2014). PACT teams also have not focused on improving access to appropriate medical care, and no studies have evaluated the role of PACT teams on the general medical care and outcomes of their patients (Gerrity 2014). Because there is substantial overlap in the infrastructure necessary to support PACT programs and PCMHs, PACT teams are well positioned to develop formal collaborations with local primary care practices and become accredited PCMHs for adults with severe and persistent mental illnesses (Vanderlip et al. 2013). Whether through PCMHs or greater flexibility in state Medicaid financing mechanisms, the ACA provides opportunities to support integrated general medical and mental health care models for adults with severe mental illness.

**Recovery:** patient-centered social movement supporting patients living a self-directed life, striving to reach their goals and potential

## THE RECOVERY PERSPECTIVE

Within the consumer and advocacy communities, the concept of recovery from severe mental illness is strongly emphasized. Although the concept means various things to different people, it was strongly endorsed by the President's New Freedom Commission (Pres. New Freedom Comm. 2003) and seen as a philosophical and pragmatic approach to mental health reform relevant to the ACA (**http://www.samhsa.gov/recovery**). The Substance Abuse and Mental Health Services Administration has formulated a working definition of recovery as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." This orientation toward service delivery and outcomes emphasizes consumer-defined goals and places patient experiences at the center of care decisions (Frese et al. 2001), consistent with the ACA's focus on patient-centered care. Examples of recovery-oriented services include peer support, shared decision-making, and consumer-directed care (Silverstein & Bellack 2008). From a personal recovery perspective, recovery tends to be viewed in highly individualized terms that involve living a satisfying life, taking responsibility, engaging in meaningful activities, and making progress toward self-defined goals within the constraints of one's illness (Mancini et al. 2005). A personal recovery perspective contrasts with a clinical recovery perspective that focuses on observer-rated improvement in predefined symptoms and functioning.

The extent to which the recovery perspective has influenced the delivery of routine community services for adults with severe mental illnesses is not known. It is likely, however, that most publicly financed mental health services for adults with severe mental illness continue to be oriented around maintenance treatment and prevention of relapse, with relatively little attention to personal recovery-oriented outcomes. Some recovery-oriented services have gained acceptance by demonstrating their value with respect to established clinical outcomes. Peer support services, for example, have been found to significantly reduce the risk of psychiatric hospital readmission (Sledge et al. 2011). In assessing the impact of the ACA, mental health advocates will be especially keen for evaluations that track delivery of recovery-oriented services and achievement of recovery-oriented outcomes.

## THE BEHAVIORAL HEALTH WORKFORCE

When the ACA is fully implemented in 2019, it is projected to result in approximately 3.7 million individuals with severe mental disorders gaining coverage (Garfield et al. 2011). Although much responsibility for the care of these individuals will fall on the primary care sector, in part as a result of patients' preferences, the demands on the specialty mental health sector will also substantially

increase. This sector is poorly prepared for the needed expansion and for adequately responding to the most severely ill population and to the growing Medicaid population.

Planning is complicated by the fact that little good information is available beyond that on physicians in the active workforce, the types of patients seen, and patterns of everyday practice. But individual surveys carried out by professional organizations are available, such as the National Survey of Counseling Center Directors (Gallagher 2012), although their results are difficult to connect with practice descriptions from the National Ambulatory Medical Care Survey and other National Health Care Surveys, which are rich sources of physician data.

Clinical access to psychiatrists is often difficult. In 2010, only 38,289 active psychiatrists were involved in patient care in the United States, a number that has not increased in recent years despite population growth (Assoc. Am. Med. Coll. 2012). Moreover, psychiatrists are highly concentrated in large urban areas, vary greatly in availability among states (from 5.2 to 24.7 per 100,000 population), and are concentrated in California and on the East Coast (Subst. Abuse Ment. Health Serv. Admin. 2013), which makes access especially difficult in rural areas.

Psychiatry remains an unpopular specialty for medical students. Each year approximately 5% of medical students enter into psychiatric residency training programs (Jolly et al. 2013). More than half of psychiatrists are age 55 or older (Bishop et al. 2014), which is a concern for the future of the psychiatric workforce. Especially pertinent to the ACA is that psychiatrists are least likely of all medical specialists to accept insurance (55% versus 86%, respectively) and especially Medicaid (43% versus 73%, respectively). Low reimbursement for psychiatric services may contribute to the low participation of psychiatrists in Medicaid. The national decline in psychiatrist provision of psychotherapy may have been driven by managed care insurers that can readily reimburse masters' level therapists at lower rates than psychiatrists (Mojtabai & Olfson 2008). Also, more than half of office-based psychiatrists are in solo practice and therefore do not have the business infrastructure to negotiate with third-party payers (Cummings 2015). Because psychiatrists are few, they depend less than other physicians on insurance reimbursements to achieve their income targets.

Overall, psychologists far outnumber psychiatrists. There are approximately two to three times as many doctorate-level clinical psychologists as psychiatrists, estimated at nearly 100,000 (Subst. Abuse Ment. Health Serv. Admin. 2013, table 93), although estimates vary depending on the range of activities used to define clinical psychologists. All states license clinical psychology practice, and most require that practitioners have two years of supervised clinical training as well as a doctorate and that they pass a state licensing examination (Mechanic et al. 2013). Doctoral-level psychologists largely function as independent professionals in office based-practice; those without doctorates often work in supervised roles in mental health agencies. Data sources are typically not comparable across health professions, although members of the clinical psychology sections of the American Psychological Association (APA) have been repeatedly surveyed (Norcross & Karpiak 2012) and studies have been conducted by the APA Center for Workforce Studies (**www.apa.org/workforce/**).

A vast majority of clinical psychologists do not participate in Medicaid, citing low reimbursement and delayed payment. Approximately one-third of psychologists have contracts with managed care mental health carve-out programs. Psychologists also do not typically serve the most severely mentally ill. Although many psychologists worked in medical and psychiatric settings in earlier years, relatively few do so now (Michalski & Kohout 2011). In 2014, only 5,560 psychologists worked in outpatient care centers, and 3,330 worked in psychiatric and substance abuse hospitals (Bur. Labor Stat. 2015). Among psychologists in the APA psychotherapy division, most are in private practice (62%) or university departments of psychology (10%), with only small percentages working in outpatient clinics (6%), general hospitals (1%), or psychiatric hospitals (1%) (Norcross & Rogan 2013).

As with psychiatrists, large disparities exist in the availability of psychologists across states, ranging from about 8 to 85 psychologists per 100,000 population (Subst. Abuse Ment. Health Serv. Admin. 2013). Only three states, Illinois, New Mexico, and Louisiana, permit some form of prescriptive authority for psychologists who complete additional training in psychopharmacology. Prescriptive authority for psychologists remains controversial both within and outside of psychology. Advocates stress the need to address local shortages of mental health specialists with prescriptive authority, whereas skeptics emphasize potential risks to patient safety and threats to psychologists' traditional professional identity (McGrath 2010).

Social workers constitute the largest profession within the mental health workforce. The Substance Abuse and Mental Health Services Administration estimates a workforce of approximately 193,000 licensed clinical social workers with the professional Masters of Social Work degree (Subst. Abuse Ment. Health Serv. Admin. 2013). Masters-trained social workers function in many settings, and most provide some direct client care in mental health centers, social agencies, or private practice. Most have worked on a salaried basis, although independent practice has become an increasingly viable option as reimbursement has become available through managed behavioral health care organizations, Medicaid and Medicare, and some private insurance. As with other independent clinicians, reimbursement is difficult in small practices lacking financial infrastructure and is usually quite modest.

Many other occupational groups provide behavioral health services. Nursing is central, although psychiatric nursing remains a relatively small specialty, with fewer than 14,000 psychiatric nurses in 2008 (Subst. Abuse Ment. Health Serv. Admin. 2013, table 93). Registered nurses are used quite flexibly, and nonspecialty nurses often are involved in behavioral health treatment. Larger numbers of behavioral health workers include counselors and case managers of various kinds, substance abuse counselors, and marriage and family therapists, including a large variety of lay therapists who have acquired skills by working in general health and mental health care settings.

Building the behavioral health professional workforce is especially difficult in relation to the most highly trained professional groups, particularly psychiatry, clinical psychology, and psychiatric nursing, which involve extended training structures and many competing opportunities. Cummings (2015), for example, suggests three alternatives for increasing the psychiatric workforce, all very challenging: (*a*) increasing reimbursement rates for psychiatric services, (*b*) increasing psychiatric training, and (*c*) developing team-based collaborative care models. Although many specialties seek enhanced reimbursement, insurers and government programs seek to constrain payment to the extent possible. Expanding psychiatric training opportunities is also unlikely because of the cost and long pipeline involved. Moreover, it is not clear that the training opportunities currently available are being fully utilized. In 2014, 14 of the 203 US psychiatric residency training programs had unfilled positions (Natl. Resid. Match. Progr. 2014). Demand for increased training remains weak among US medical students. The suggestion concerning collaborative care models and team-based care is already being aggressively pursued in many of the organizational changes encouraged by the ACA, such as PCMHs, ACOs, and HHs.

As with much in health care today, it is likely that we will muddle through with a great variety of approaches that depend on the culture of varying geographic areas and organizations, categorical programs that provide incentives to bring persons with behavioral health expertise to greatly underserved areas, increased use of telemedicine, and enhanced training programs for social workers and perhaps other professionals for expanded behavioral health practice. Although nursing may appear to be a natural solution, nurses face a richness of other opportunities that are generally perceived as preferable and are more remunerative than mental health practice. Perhaps we will see expanded efforts to train clinical psychologists to prescribe psychiatric medications and for

states to license for broader practice, although strong resistance exists both within and outside clinical psychology. Clinical social workers with enhanced training in evidence-based practices may be well positioned to fill some of the apparent gaps.

**Primary care clinicians:** general clinicians, typically seen on initial contact and for continuing care, who coordinate patients' ongoing care and specialty referrals

## OVERVIEW

Several strategies exist for improving the integration of general medical services with psychiatric and substance abuse care. In broad terms, we might think of them as models that are more and less intensive. On the less intensive side, there are models in which primary care physicians, groups, or organizations have available to them outside behavioral health consultants who can advise on the assessment and management of the patients they find challenging. The success of such consultation may depend on the interest and commitment of both parties and the incentives to invest in such care under the pressures of conflicting demands. Consultation models are facilitated when primary care and behavioral health care are located in the same premises.

An alternative model is to locate primary care clinicians, who collaborate on patient care, within behavioral health care programs; however, sufficient patient volume is needed to make this practical. Also, recruitment of primary care clinicians to these settings is difficult, as it requires finding clinicians with appropriate expertise, reimbursing them adequately, and providing them with access to diagnostic facilities and specialty networks. One intriguing model would have care provided by clinicians who have trained jointly in medicine and behavioral health. Although some such programs exist, there has thus far been little interest in them.

A common approach is to locate a behavioral health specialist, such as a nurse practitioner or a social worker, in a primary care setting to collaborate with physicians or to perform needed behavioral health services on their own. Such a person interacts more directly and intensively with primary care physicians and knows the patients; an outside consultant, in contrast, may not know either the primary care clinician who seeks guidance or the patient very well. Regardless of the details of the integration strategy, a trusting relationship between the clinician and the consultant and the direct involvement of the consultant in a collaborative care process contribute significantly to the integration effort.

The more significant integration studies have taken place within well-established organized health systems that have the infrastructure to allow many of the functions of successful integration efforts, such as good communication through a shared electronic health record, support for staff that covers a range of relevant domains, referral networks that are well established, and a reimbursement system that is based on capitation. This works better for the management of patients with depression, anxiety, and other moderately impairing conditions than for persons with more serious and severe psychiatric illnesses, who are often challenging to engage in treatment and who may not receive the priority they need in the competition for resources. For patients with the most severe psychiatric disorders, available evidence suggests that optimal treatment is primarily delivered within the specialty mental health care sector. Within specialized mental health services in the public sector, however, challenges exist in developing models of care to deliver evidence-based treatments to this patient group (Gerrity 2014).

Benefits of the ACA will give rise to myriad challenges in policy implementation. Just as changing clinical practice requires more than developing and testing new interventions, so policy implementation requires more than simply passing legislation. With the increase in service access, existing regional shortages in psychiatrists and other mental health professionals are likely to become more acute. Mental health care professionals will be forced to adjust to larger caseloads, requiring them to utilize information technology more efficiently, work more collaboratively with a wider range of health care professionals, and demonstrate a new openness to implementing more

complex but more effective evidence-based treatments that may be increasingly provided within the context of general medical care.

New financial and organizational tools to improve coordination of care, such as HHs, ACOs, PCMHs, and meaningful use of information technology incentives, offer the potential to enhance the management of people with a wide range of psychiatric disorders. To be successful, mental health care policy makers will need to focus on bringing greater coherence, integration, and emphasis to the provision of evidence-based psychosocial services to a poorly functioning system of mental health care, and mental health care professionals will need to adapt to the changing health service landscape. These are significant challenges, yet they represent a tremendous opportunity to improve the lives of young people and adults with impairing mental health and substance abuse disorders.

## SUMMARY POINTS

1. Mental health service developments have been driven by economic and other incentives and opportunities in Medicaid, Medicare, and the public welfare safety net.
2. The ACA, in conjunction with the extension of behavioral health parity, provides an unprecedented opportunity to redesign the mental health and substance abuse services systems.
3. The ACA defines mental health and substance abuse insurance coverage as essential, significantly extends Medicaid eligibility in participating states, protects access to insurance among persons with preexisting conditions, and provides incentives for improving the delivery of behavioral services.
4. ACA incentives have focused attention on care of chronic disease and persons with multiple comorbidities, but behavioral health continues to be challenging, facing financial and cultural barriers and limits of the behavioral health workforce.
5. The ACA encourages improved primary care and models to integrate and coordinate medical and behavioral care through ACOs, PCMHs, and HHs, with a focus on the array of services needed by persons with chronic disease.
6. Existing fee-for-service incentives encourage dependence on medication treatment and declining use of evidence-based psychological treatments.
7. Collaborative care is effective within primary care for persons with depression and anxiety, but little evidence supports this model for persons with severe and persistent mental illness. Persons with severe illnesses and disabilities are more appropriately treated in the specialty behavioral health sectors.
8. PCMHs and ACOs are developing rapidly and vary greatly in organizational design and capacities. Little evidence is available on improved effectiveness and efficiency, but success appears more likely in well-led integrated systems with developed infrastructures and management, including effective information technology systems.

## FUTURE ISSUES

1. Which care integration approaches work best with which patient populations needs to be established.

2. An infrastructure for improving quality and controlling cost in ACOs is required.
3. Models of staffing and care in health homes that best achieve care coordination and improve client outcomes are needed.
4. Criteria for the proper triage of clients between primary care and the specialty behavioral health systems are needed.
5. How to best accommodate significant shortages in behavioral health personnel and establish which functions can safely be transferred to more available clinicians needs to be determined.
6. Which behavioral health personnel needs are most critical, and how they can best be addressed, needs to be determined.
7. The question of how behavioral health services can best be brought to rural and other underserved areas needs to be answered.
8. The issue of how behavioral health professionals can be best prepared to adjust to new expectations, responsibilities, and constraints of emerging practice arrangements needs to be addressed.

## DISCLOSURE STATEMENT

The authors are not aware of any affiliations, memberships, funding, or financial holdings that might be perceived as affecting the objectivity of this review.

## ACKNOWLEDGMENTS

The authors thank Margaret Polansky for her outstanding coordination of the review and helpful bibliographical work.

## LITERATURE CITED

Ahmedani BK, Solberg LI, Copeland LA, Fang-Hollingsworth Y, Stewart C, et al. 2015. Psychiatric comorbidity and 30-day readmissions after hospitalization for heart failure, AMI, and pneumonia. *Psychiatr. Serv.* 66:134–40

Alakeson V, Frank RG, Katz RE. 2010. Specialty care medical homes for people with severe, persistent mental disorders. *Health Aff.* 29:867–73

Alliance Community Health Plans. 2015. Getting to more affordable care: how community health plans are leading the way. **http://www.achp.org/publications/getting-affordable-care-community-health-plans-leading-way/**

Appelbaum PS. 1994. *Almost a Revolution: Mental Health Law and the Limits of Change*. New York: Oxford Univ. Press

Assoc. Am. Med. Coll. 2012. *2012 Physician Specialty Data Book*. Washington, DC: Assoc. Am. Med. Coll. **https://www.aamc.org/download/313228/data/2012physicianspecialtydatabook.pdf**

**Beronio K, Glied S, Frank R. 2014. How the Affordable Care Act and Mental Health Parity and Addiction Equity Act greatly expand coverage of behavioral health care. *J. Behav. Health Serv. Res.* 41:410–28**

Beronio K, Po R, Skopec L, Glied S. 2013. *ASPE Issue Brief. Affordable Care Act expands mental health and substance use disorder benefits and federal parity protections for 62 million Americans.* Washington, DC: U.S. Dep. Health Hum. Serv., Off. Assist. Secr. Plan. Eval. **http://www.aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm**

**A policy analysis of provisions within ACA and MHPAEA that will expand mental health coverage.**

Bishop TF, Press MJ, Keyhani S, Pincus HA. 2014. Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA Psychiatry* 71:176–81

Bockoven JS. 1972. *Moral Treatment in Community Mental Health*. New York: Springer

Bond GR, Becker DR, Drake RE, Rapp CA, Meisler N, et al. 2001. Implementing supported employment as an evidence-based practice. *Psychiatr. Serv.* 52:313–22

**Bond GR, Drake RE, Becker DR. 2008. An update on randomized controlled trials of evidence-based supported employment. *Psychiatr. Rehabil. J.* 31:280–90**

**Comprehensive review of supported employment programs for adults with severe mental illnesses.**

Bower P, Gilbody S. 2005. Managing common mental health disorders in primary care: conceptual models and evidence base. *BMJ* 330:839–42

Bower P, Gilbody S, Richards D, Fletcher J, Sutton A. 2006. Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta-regression. *Br. J. Psychiatry* 189:484–93

Bower P, Knowles S, Coventry PA, Rowland N. 2011. Counselling for mental health and psychosocial problems in primary care. *Cochrane Database Syst. Rev.* 9:CD001025

Brief of Health Care Policy History Scholars as Amici Curiae Supporting Respondents. 2015. Re: *King et al. v. Burwell*, S. Ct. No. 14-114. Supreme Court United States. **http://www.americanbar.org/content/dam/aba/publications/supreme_court_preview/BriefsV5/14-114_amicus_resp_hcp.authcheckdam.pdf**

Bur. Labor Stat. 2015. *Occupational employment statistics, occupational employment and wages, May 2014. 19-3031 Clinical, counseling, and school psychologists.* Washington, DC: Bur. Labor Stat. **http://www.bls.gov/oes/current/oes193031.htm**

Burwell SM. 2015. Setting value-based payment goals. HHS efforts to improve U.S. health care. *N. Engl. J. Med.* 372:897–99

Butler M, Kane RL, McAlpine D, Kathol RG, Fu SS, et al. 2008. *Integration of mental health/substance abuse and primary care*. Evid. Rep./Technol. Assess. No. 173 (prep. by Minn. Evid.-Based Pract. Cent.). AHRQ Publ. No. 09-E003. Rockville, MD: Agency Healthc. Res. Qual.

Casalino LP. 2014a. Accountable Care Organizations—the risk of failure and the risks of success. *N. Engl. J. Med.* 371:1750–51

Casalino LP. 2014b. Categorizing Accountable Care Organizations: moving toward patient-centered outcomes research that compares health care delivery systems. *Health Serv. Res.* 49:1875–82

Cent. Medicare Medicaid Serv. 2014. *Fact Sheets: Medicare ACOs Continue to Succeed in Improving Care, Lowering Cost Growth.* Updated Nov. 7, 2014. Baltimore, MD: Cent. Medicare Medicaid Serv. **http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-16.html**

Chang ET, Rose DE, Yano EM, Wells KB, Metzger ME, et al. 2013. Determinants of readiness for primary care–mental health integration (PC-MHI) in the VA Health Care System. *J. Gen. Intern. Med.* 28:353–62

Cummings JR. 2015. Rates of psychiatrists' participation in health insurance networks. *JAMA* 313:190–91

Cunningham PJ. 2009. Beyond parity: primary care physicians' perspectives on access to mental health care. *Health Aff.* 28:490–501

Davis K, Abrams M, Stremikis K. 2011. How the Affordable Care Act will strengthen the nation's primary care foundation. *J. Gen. Intern. Med.* 26:1201–3

Druss BG, von Esenwein SA. 2006. Improving general medical care for persons with mental and addictive disorders: systematic review. *Gen. Hosp. Psychiatry* 28:145–53

Druss BG, von Esenwein SA, Compton MT, Rask KJ, Zhao L, Parker RM. 2010. A randomized trial of medical care management for community mental health settings: the Primary Care Access, Referral, and Evaluation (PCARE) study. *Am. J. Psychiatry* 167:151–59

Edwards ST, Bitton A, Hong J, Landon BE. 2014. Patient-centered medical home initiatives expanded in 2009–13: providers, patients, and payment incentives increased. *Health Aff.* 33:1823–31

Fisher WH, Silver E, Wolff N. 2006. Beyond criminalization: toward a criminologically informed framework for mental health policy and services research. *Adm. Policy Ment. Health* 33:544–57

Frese FJ, Stanley J, Kress K, Vogel-Scibilia S. 2001. Integrating evidence-based practices and the recovery model. *Psychiatr. Serv.* 52:1462–68

Friedberg MW, Schneider EC, Rosenthal MB, Volpp KG, Werner RM. 2014. Association between participation in a multipayer medical home intervention and changes in quality, utilization, and costs of care. *JAMA* 311:815–25

Galewitz P. 2015. Indiana Medicaid expansion may tempt other GOP-led states. *Kaiser Health News*, Jan. 28. **http://www.khn.org/news/indiana-medicaid-expansion-may-tempt-other-gop-led-states/**

Gallagher RP. 2012. Thirty years of the national survey of counseling center directors: a personal account. *J. Coll. Stud. Psychother.* 26:172–84

Garfield RL, Zuvekas SH, Lave JR, Donohue JM. 2011. The impact of national health care reform on adults with severe mental disorders. *Am. J. Psychiatry* 168:486–94

Gask L, Khanna T. 2011. Ways of working at the interface between primary and specialist mental healthcare. *Br. J. Psychiatry* 198:3–5

Gerrity, M. 2014. *Integrating primary care into behavioral health settings: what works for individuals with serious mental illness*. New York: Milbank Meml. Fund. **http://www.milbank.org/uploads/documents/papers/Integrating-Primary-Care-Report.pdf**

Gilbody S, Bower P, Fletcher J, Richards D, Sutton AJ. 2006. Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Arch. Intern. Med.* 166:2314–21

Gilbody S, Whitty P, Grimshaw J, Thomas R. 2003. Educational and organizational interventions to improve the management of depression in primary care: a systematic review. *JAMA* 289:3145–51

Gilmer TP, Stefancic A, Ettner SL, Manning WG, Tsemberis S. 2010. Effect of full-service partnerships on homelessness, use and costs of mental health services, and quality of life among adults with serious mental illness. *Arch. Gen. Psychiatry* 67:645–52

Gold J. 2015. Accountable Care Organizations, explained. *Kaiser Health News*, Sept. 14. **http://www.khn.org/news/aco-accountable-care-organization-faq**

Goldberg D, Huxley P. 1980. *Mental Illness in the Community: The Pathway to Psychiatric Care*. London: Tavistock

González HM, Vega WA, Williams DR, Tarraf W, West BT, Neighbors HW. 2010. Depression care in the United States: too little for too few. *Arch. Gen. Psychiatry* 67:37–46

Grace AM, Noonan KG, Cheng TL, Miller D, Verga B, et al. 2014. The ACA's pediatric essential health benefit has resulted in a state-by-state patchwork of coverage with exclusions. *Health Aff.* 33:2136–43

Greenberg GA, Rosenheck RA. 2008. Jail incarceration, homelessness, and mental health: a national study. *Psychiatr. Serv.* 59:170–77

**An authoritative history of the treatment of mentally ill in America from colonial days to modern times.**

**Grob GN. 1994. *The Mad Among Us: A History of the Care of America's Mentally Ill*. New York: Free Press**

Hiday VA, Moloney ME. 2014. Mental illness and the criminal justice system. In *The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society*. New York: Wiley

Hoff T, Weller W, DePuccio M. 2012. The patient-centered medical home: a review of recent research. *Med. Care Res. Rev.* 69:619–44

Hoffman B. 2012. *Health Care for Some: Rights and Rationing in the United States Since 1930*. Chicago: Univ. Chicago Press

Jacobs LR, Skocpol T. 2010. *Health Care Reform and American Politics: What Everyone Needs to Know*. New York: Oxford Univ. Press

James DJ, Glaze LE. 2006. *Mental health problems of prison and jail inmates*. Washington, DC: US Dep. Justice, Bur. Justice Stat. **http://www.bjs.gov/content/pub/pdf/mhppji.pdf**

Jolly P, Erikson C, Garrison G. 2013. US graduate medical education and physician specialty choice. *Acad. Med.* 88:468–74

Kaiser Family Found. 2013. *Summary of the Affordable Care Act*. **http://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/**

Kaiser Family Found. 2015. *Kaiser Health Tracking Poll: The Public's Views on the ACA*. **http://kff.org/interactive/tracking-opinions-aca/#?response=Favorable–Unfavorable&aRange=twoYear**

Kaiser Comm. Medicaid Uninsured. 2013. *How Is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports (LTSS) Today? State Adoption of Six LTSS Options*. **http://www.kaiserfamilyfoundation.files.wordpress.com/2013/04/8079-02.pdf**

Kaiser Comm. Medicaid Uninsured. 2014. *An Overview of Delivery System Reform Incentive Payment (DSRIP) Waivers*. **http://www.kff.org/medicaid/issue-brief/an-overview-of-delivery-system-reform-incentive-payment-waivers/**

Kaiser Comm. Medicaid Uninsured. 2015. *Status of State Action on the Medicaid Expansion Decision*. **http://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/**

**Katon WJ, Lin EHB, Von Korff M, Ciechanowski P, Ludman EJ, et al. 2010. Collaborative care for patients with depression and chronic illnesses. *N. Engl. J. Med.* 363:2611–20**

**A randomized clinical trial demonstrating collaborative care significantly improved control of medical diseases and depression.**

Katon WJ, Russo J, Lin EHB, Schmittdiel J, Ciechanowski P, et al. 2012. Cost-effectiveness of a multicondition collaborative care intervention: a randomized controlled trial. *Arch. Gen. Psychiatry* 69:506–14

Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, et al. 1994. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Arch. Gen. Psychiatry* 51:8–19

Kiesler CA, Sibulkin AE. 1987. *Mental Hospitalization: Myths and Facts About a National Crisis*. Newbury Park, CA: Sage

Kilbourne AM, Goodrich D, Miklowitz DJ, Austin K, Post EP, Bauer MS. 2010. Characteristics of patients with bipolar disorder managed in VA primary care or specialty mental health care settings. *Psychiatr. Serv.* 61:500–7

Killaspy H, Kingett S, Bebbington P, Blizard R, Johnson S, et al. 2009. Randomised evaluation of assertive community treatment: 3-year outcomes. *Br. J. Psychiatry* 195:81–82

Levy J. 2015. In U.S., uninsured rate dips to 11.9% in first quarter. **http://www.gallup.com/poll/182348/uninsured-rate-dips-first-quarter.aspx**

**Lewis VA, Colla CH, Tierney K, Van Citters AD, Fisher ES, Meara E. 2014. Few ACOs pursue innovative models that integrate care for mental illness and substance abuse with primary care. *Health Aff.* 33:1808–16**

**An evaluation of the extent to which ACOs are integrating behavioral treatment and primary care.**

Mancini MA, Hardiman ER, Lawson HA. 2005. Making sense of it all: consumer providers' theories about factors facilitating and impeding recovery from psychiatric disabilities. *Psychiatr. Rehabil. J.* 29:48–55

Marshall T, Rapp CA, Becker DR, Bond GR. 2008. Key factors for implementing supported employment. *Psychiatr. Serv.* 59:886–92

McGrath RE. 2010. Prescriptive authority for psychologists. *Annu. Rev. Clin. Psychol.* 6:21–47

McHugh RK, Whitton SW, Peckham AD, Welge JA, Otto MW. 2013. Patient preference for psychological versus pharmacologic treatment of psychiatric disorders: a meta-analytic review. *J. Clin. Psychiatry* 74:595–602

Mechanic D. 1997. Approaches for coordinating primary and specialty care for persons with mental illness. *Gen. Hosp. Psychiatry* 19:395–402

Mechanic D. 2003. Physician discontent: challenges and opportunities. *JAMA* 290:941–46

Mechanic D. 2006. *The Truth About Health Care: Why Reform Is Not Working in America*. New Brunswick, NJ: Rutgers Univ. Press

Mechanic D. 2012. Seizing opportunities under the Affordable Care Act for transforming the mental and behavioral health system. *Health Aff.* 31:376–82

Mechanic D. 2014. More people than ever before are receiving behavioral health care in the United States, but gaps and challenges remain. *Health Aff.* 33:1416–24

Mechanic D, Grob GN. 2006. Rhetoric, realities, and the plight of the mentally ill in America. In *History and Health Policy in the United States: Putting the Past Back In*, ed. RA Stevens, CE Rosenberg, LR Burns, pp. 229–49. New Brunswick, NJ: Rutgers Univ Press

Mechanic D, McAlpine DD, Olfson M. 1998. Changing patterns of psychiatric inpatient care in the United States, 1988–1994. *Arch. Gen. Psychiatry* 55:785–91

**Mechanic D, McAlpine DD, Rochefort DA. 2013. *Mental Health and Social Policy: Beyond Managed Care*. Upper Saddle River, NJ: Pearson. 6th ed.**

**Comprehensive review of mental health policy issues and the role of safety net programs.**

Menchetti M, Rucci P, Bortolotti B, Bombi A, Scocco P, et al. 2014. Moderators of remission with interpersonal counselling or drug treatment in primary care patients with depression: randomised controlled trial. *Br. J. Psychiatry* 204:144–50

Mergl R, Henkel V, Allgaier A, Kramer D, Hautzinger M, et al. 2011. Are treatment preferences relevant in response to serotonergic antidepressants and cognitive-behavioral therapy in depressed primary care patients? Results from a randomized controlled trial including a patients' choice arm. *Psychother. Psychosom.* 80:39–47

Michalski DS, Kohout JL. 2011. The state of the psychology health service provider workforce. *Am. Psychol.* 66:825–34

Mojtabai R, Olfson M. 2008. National trends in psychotherapy by office-based psychiatrists. *Arch. Gen. Psychiatry* 65:962–70

Mojtabai R, Olfson M. 2011. Proportion of antidepressants prescribed without a psychiatric diagnosis is growing. *Health Aff.* 30:1434–42

Nardone M, Snyder S, Paradise J. 2014. *Integrating physical and behavioral health care: promising Medicaid models*. Kaiser Family Found. Issue Brief, Febr. 12. **http://www.kff.org/report-section/integrating-physical-and-behavioral-health-care-promising-medicaid-models-issue-brief/**

Natl. Comm. Qual. Assur. 2013. *Improving Quality and Patient Experience: The State of Health Care Quality 2013.* **http://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web_version_report.pdf**

Natl. Inst. Health. 2015. Diseases of the mind: highlights of American psychiatry through 1900. Early psychiatric hospitals and asylums. Bethesda, MD: US Natl. Libr. Med. **http://www.nlm.nih.gov/hmd/diseases/early.html**

Natl. Resid. Matching Program. 2014. *Results and Data: 2014 Main Residency Match*. Washington, DC: Natl. Resid. Matching Program. **http://www.nrmp.org/wp-content/uploads/2014/04/Main-Match-Results-and-Data-2014.pdf**

Norcross JC, Karpiak CP. 2012. Clinical psychologists in the 2010s: 50 years of the APA Division of Clinical Psychology. *Clin. Psychol. Sci. Pract.* 19:1–12

Norcross JC, Rogan JD. 2013. Psychologists conducting psychotherapy in 2012: current practices and historical trends among division 29 members. *Psychotherapy* 50:490–95

O'Hara A. 2007. Housing for people with mental illness: update of a report to the President's New Freedom Commission. *Psychiatr. Serv.* 58:907–13

Olfson M, Fireman B, Weissman MM, Leon AC, Sheehan DV, et al. 1997. Mental disorders and disability among patients in a primary care group practice. *Am. J. Psychiatry* 154:1734–40

**A description of patterns and trends of psychotherapy use by the US general population.**

**Olfson M, Marcus SC. 2010. National trends in outpatient psychotherapy. *Am. J. Psychiatry* 167:1456–63**

Oosterbaan DB, Verbraak MJ, Terluin B, Hoogendoorn AW, Peyrot WJ, et al. 2013. Collaborative stepped care v. care as usual for common mental disorders: 8-month, cluster randomised controlled trial. *Br. J. Psychiatry* 203:132–39

Paradise J, Nardone M. 2014. Medicaid health homes: a profile of newer programs. Kaiser Family Found. Issue Brief, Aug. 6. **http://www.kff.org/report-section/medicaid-health-homes-a-profile-of-newer-programs-issue-brief/**

Pear R. 2014. Feared costs kept some states from expanding Medicaid Programs. *New York Times*, Oct. 27, p. A17

Pear R. 2015a. Budget office slashes estimated cost of health coverage. *New York Times*, Jan. 26. **http://www.nytimes.com/2015/01/27/us/politics/budget-office-slashes-estimated-cost-of-health-coverage.html**

Pear R. 2015b. Number of uninsured has declined by 15 million since 2013, administration says. *New York Times*, Aug. 12, p. A11. **http://www.nytimes.com/2015/08/12/us/number-of-uninsured-has-declined-by-15-million-since-2013-administration-says.html?_r=0**

Pear R. 2015c. Health care gains, but income remains stagnant, the White House reports. *New York Times*, Sept. 17, p. A22. **http://www.nytimes.com/2015/09/17/us/politics/census-bureau-poverty-rate-uninsured.html**

Phillips SD. 2012. *The Affordable Care Act: Implications for Public Safety and Corrections Populations*. Washington, DC: Sentencing Proj. **http://www.sentencingproject.org/doc/publications/inc_Affordable_Care_Act.pdf**

Pres. New Freedom Comm. Ment. Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America, Final Report.* DHHS Publ. No. SMA-03-3832. Rockville, MD: US Dep. Health Hum. Serv.

Quadagno J. 2005. *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*. New York: Oxford Univ. Press

Quealy K, Sanger-Katz M. 2014. Obama's health law: who was helped most. *New York Times*, Oct. 29. **http://www.nytimes.com/interactive/2014/10/29/upshot/obamacare-who-was-helped-most.html?abt=0002&abg=1**

Richards DA. 2012. Stepped care: a method to deliver increased access to psychological therapies. *Can. J. Psychiatry* 57:210–15

Rosenbaum S. 2000. Legal report: the Olmstead decision: implications for state health policy. *Health Aff.* 19:228–32

Roy-Byrne P. 2013. Collaborative care at the crossroads. *Br. J. Psychiatry* 203:86–87

Saitz R, Cheng DM, Winter M, Kim TW, Meli SM, et al. 2013. Chronic care management for dependence on alcohol and other drugs: the AHEAD randomized trial. *JAMA* 310:1156–67

Sanger-Katz M. 2014. Number of Americans without health insurance is down by about 25 percent. *New York Times*, Oct. 27, p. A16

Schnurr PP, Friedman MJ, Oxman TE, Dietrich AJ, Smith MW, et al. 2013. RESPECT-PTSD: re-engineering systems for the primary care treatment of PTSD, a randomized controlled trial. *J. Gen. Intern. Med.* 28:32–40

Shortell SM, Wu FM, Lewis VA, Colla CH, Fisher ES. 2014. A taxonomy of Accountable Care Organizations for policy and practice. *Health. Serv. Res.* 49:1883–99

Siegwarth AW, Blyler C. 2014. How the Affordable Care Act can support employment for people with mental illness. *ASPE Issue Brief*, May 2014. **http://www.aspe.hhs.gov/daltcp/reports/2014/ACAmiesIB.pdf**

Silverstein SM, Bellack AS. 2008. A scientific agenda for the concept of recovery as it applies to schizophrenia. *Clin. Psychol. Rev.* 28:1108–24

Skocpol T. 1996. *Boomerang: Health Care Reform and the Turn Against Government*. New York: Norton

Sledge WH, Lawless M, Sells D, Wieland M, O'Connell MJ, Davidson L. 2011. Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. *Psychiatr. Serv.* 62:541–44

Starfield B. 1998. *Primary Care: Balancing Health Needs, Services, and Technology*. New York: Oxford Univ. Press

Starfield B, Shi L, Macinko J. 2005. Contribution of primary care to health systems and health. *Milbank Q.* 83:457–502

Starr P. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York: Basic Books

Subst. Abuse Ment. Health Serv. Admin. 2013. *Behavioral Health, United States, 2012*. SMA 13-4797. Rockville, MD: Subst. Abuse Ment. Health Serv. Admin.

Sytema S, Jörg F, Nieboer R, Wunderink L. 2014. Adding evidence-based interventions to assertive community treatment: a feasibility study. *Psychiatr. Serv.* 65:689–92

Torrey EF. 2014. *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System*. New York: Oxford Univ Press

Unützer J, Chan YF, Hafer E, Knaster J, Shields A, et al. 2012. Quality improvement with pay-for-performance incentives in integrated behavioral health care. *Am. J. Public Health* 102:e41–45

**Unützer J, Katon W, Callahan CM, Williams JW, Hunkeler E, et al. 2002. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA* 288:2836–45**

Unützer J, Patrick DL, Simon G, Grembowski D, Walker E, et al. 1997. Depressive symptoms and the cost of health services in HMO patients aged 65 years and older: a 4-year prospective study. *JAMA* 277:1618–23

Vanderlip ER, Cerimele JM, Monroe-Devita M. 2013. A comparison of assertive community treatment fidelity measures and patient-centered medical home standards. *Psychiatr. Serv.* 64:1127–33

Wang PS, Demler O, Olfson M, Pincus HA, Wells KB, Kessler RC. 2006. Changing profiles of service sectors used for mental health care in the United States. *Am. J. Psychiatry* 163:1187–98

West JC, Rae DS, Mojtabai R, Duffy FF, Kuramoto J, et al. 2015. Planning patient-centered health homes for Medicaid psychiatric patients at greatest risk for intensive service use. *Community Ment. Health J.* 51:513–22

Wiechers IR, Leslie DL, Rosenheck RA. 2013. Prescribing of psychotropic medications to patients without a psychiatric diagnosis. *Psychiatr. Serv.* 64:1243–48

**Key clinical trial demonstrating effectiveness of collaborative care for older depressed primary care patients.**

Wittink MN, Cary M, Tenhave T, Baron J, Gallo JJ. 2010. Towards patient-centered care for depression: conjoint methods to tailor treatment based on preferences. *Patient* 3:145–57

**Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, Bauer MS. 2012. Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *Am. J. Psychiatry* 169(8):790–804**

Zafar W, Mojtabai R. 2011. Chronic disease management for depression in US medical practices: results from the Health Tracking Physician Survey. *Med. Care* 49:634–40

**A meta-analysis of clinical trials on collaborative care for several different mental disorders.**