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The Affordable Care Act, Accountable Care Organizations, and Mental Health Care for Older Adults: Implications and Opportunities

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Abstract: The Patient Protection and Affordable Care Act (ACA) represents the most significant legislative change in the United States health care system in nearly half a century. Key elements of the ACA include reforms aimed at addressing high-cost, complex, vulnerable patient populations. Older adults with mental health disorders are a rapidly growing segment of the population and are among the most challenging subgroups within health care, and they account for a disproportionate amount of costs. What does the ACA mean for geriatric mental health? We address this question by highlighting opportunities for reaching older adults with mental health disorders by leveraging the diverse elements of the ACA. We describe nine relevant initiatives: (1) accountable care organizations, (2) patient-centered medical homes, (3) Medicaid-financed specialty health homes, (4) hospital readmission and health care transitions initiatives, (5) Medicare annual wellness visit, (6) quality standards and associated incentives, (7) support for health information technology and telehealth, (8) Independence at Home and 1915(i) State Plan Home and Community-Based Services program, and (9) Medicare-Medicaid Coordination Office, Center for Medicare and Medicaid Innovation, and the Patient-Centered Outcomes Research Institute. We also consider potential challenges to full implementation of the ACA and discuss novel solutions for advancing geriatric mental health in the context of projected workforce shortages and the opportunities afforded by the ACA.

Keywords: accountable care organization, geriatric psychiatry, health care reform, Medicaid, Medicare, mental health, patient-centered medical home, Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (ACA) stands as the most significant legislative change in the US health care system in nearly half a century. Even in the context of a newly elected Republican majority in Congress and a US Supreme Court challenge seeking to reverse the ACA, numerous of the act's reforms have already resulted in fundamental changes in health care delivery, with major implications for complex, high-cost patients. Included in this category would be older adults with mental health disorders, who are among the most challenging patient populations and account for a disproportionate amount of health care costs. What exactly does the ACA mean for geriatric mental health? Are there provisions within the ACA that support geriatric mental health services? What does the ACA mean for older adults with mental health conditions and for the workforce providing care to this vulnerable patient population?

About 6 to 8 million Americans aged 65 or older have a mental health or substance use disorder, and it is estimated that this number will nearly double to 10 to 14 million by the year 2030.[1] A recent Institute of Medicine report—subtitled "In Whose Hands?"—concludes that this unprecedented demographic wave will overwhelm an inadequate mental health professional workforce unless major reforms are made with respect to financing, organizing, and delivering services to this high-risk, high-cost population.[1] Innovative and effective approaches to financing and delivering mental health care are needed for this rapidly growing population if we are to overcome an alarming gap between workforce capacity, available services, and projected need.[2]

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In March 2010, President Obama signed the ACA into law, with many of its provisions going into effect in January 2014. A significant component of the ACA addresses reforms in the financing and delivery of care for high-cost Medicare and dually eligible (Medicare and Medicaid) recipients. Many of the key components of the ACA have significant implications for improving care provided to the highest-cost Medicare beneficiaries with complex conditions and, among other things, create opportunities to improve access to, and quality of, care.

In this Perspectives article we highlight these opportunities and potential solutions that may be leveraged in the ACA. It is important to note that, while many of the ACA provisions that we discuss do not explicitly address geriatric mental health conditions, the provisions in question do mention various high-risk patient groups and mental health broadly—which makes them relevant to older adults with mental disorders. First, we summarize the projected impact of geriatric mental health conditions on the health care delivery system. We then describe nine relevant initiatives in the ACA, along with the potential implications and opportunities that each component presents for advancing geriatric mental health care. We also consider potential challenges to full implementation of the ACA and discuss novel solutions for advancing geriatric mental health in the context of projected workforce shortages and the opportunities afforded by the ACA.

BACKGROUND: THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The stated primary goals of the ACA are to (1) increase the affordability of health insurance and lower the number of uninsured citizens by expanding public and private insurance coverage, and (2) implement programmatic initiatives aimed at improving quality while reducing the costs of health care. The legislation aims to achieve greater availability of health insurance through subsidies, mandates, insurance exchanges, the expansion of Medicaid, and the requirement that insurance be provided at the same rates regardless of preexisting conditions. For behavioral health services, the ACA expands on the Mental Health Parity and Addiction Equity Act, which was implemented in 2008 and requires insurers to provide the same level of coverage for mental health care or substance abuse treatment as for other medical or surgical services.[3] Treatment of mental health or substance use disorders under the ACA is considered an essential benefit and must be covered by health plans offered through insurance exchanges.[3]

Important ACA reforms related to care for older adults include restructuring Medicare reimbursements from fee-for-service to bundled payments, providing single payments to hospitals or physician groups for defined episodes of care, provisions for measuring quality, support for health information technology, and payments based on quality over quantity. In addition, the ACA provides opportunities for structural changes in health care delivery, with potential implications for behavioral health, including implementation of accountable care organizations (ACOs), patient-centered medical homes (PCMHs), programs aimed at reducing hospital readmissions, and greater emphasis on preventive health care. The ACA incentivizes care management, health promotion, patient transition care, referral to social support services, and information technology by funding health homes with a 90% federal matching rate for the first two years.[4]

ACA AND GERIATRIC MENTAL HEALTH

In this section we describe selected components of the ACA and potential implications for geriatric mental health, including (1) accountable care organizations, (2) patient-centered medical homes, (3) Medicaid-financed specialty health homes, (4) hospital readmission and health care transitions initiatives, (5) the Medicare annual wellness visit, (6) quality standards and associated incentives, (7) support for health information technology and telehealth, (8) Independence at Home and the 1915(i) State Plan Home and Community-Based Services program, and (9) the Centers for Medicare and Medicaid Services' Medicare-Medicaid Coordination Office, Center for Medicare and Medicaid Innovation, and Patient-Centered Outcomes Research Institute. See Table 1 for a summary of these initiatives.

Accountable Care Organizations

An ACO is a group of providers and hospitals that is accountable for the costs and quality of care provided to a population of patients based on pre-designated standards for payment and performance.[5] The goal of an ACO is to create a system of care coordination that links reimbursement to measures of quality and that produces opportunities for reduced costs and shared savings. ACOs promote the development of systems of care consisting of health care providers across multiple care settings, and the providers are rewarded if reductions in costs and specified quality standards are achieved. In contrast to fee-for-service care that reimburses volume (e.g., number of visits, procedures, hospital days), ACOs receive prospective payments for episodes of care or a specified reimbursement for each patient covered per month. Performance incentives are based on clinical outcomes.

There are two basic ACO models. The Medicare Shared Savings Program reimburses ACOs through a fee-for-service model in which annual expenditures are compared to a benchmark. If expenditures are lower than the benchmark, savings are shared with the ACO, provided that certain quality standards are met. By contrast, under the Medicare Pioneer ACO model, the ACO accepts full or shared risk for an identified population of Medicare beneficiaries and receives a prospective monthly payment for each patient. The ACO can generate savings if it meets specific quality standards, but it also assumes the risk that the up-front payments might not cover expenses if health care costs are high. Quality is measured in a number of areas of patient care, including those of patient and caregiver experience of care, care coordination, patient safety, preventive health, and managing complex, high-cost conditions and patients, including at-risk and frail elderly.[6]

Table 1

Summary of Selected Initiatives of the Patient Protection and Affordable Care Act and Potential Implications for Improving Geriatric Mental Health Services

Initiative	Description	Implications
Accountable Care Organizations (ACOs)	A group of providers and hospitals that are accountable for the costs and quality of health care provided to a population of patients based on pre-designated standards for payment and performance. Medicare supports two models of ACOs, which reward value (quality/cost) by payments using cost-based reimbursement with prospective payments for episodes of care or a specified reimbursement for each patient covered per month. Newly emerging Totally Accountable Care Organizations integrate physical health, behavioral health, long-term services and support, social services, and public health services. They reimburse under a global payment structure to provide financial incentives and reduce costs.	Potential to better manage older adults with mental health conditions who use more health services associated with elevated costs. Assumption of risk by Medicare ACOs and need to focus on high-cost groups will drive the need to integrate behavioral health into supported models of care.
Patient-Centered Medical Home (PCMH)	Team-based health care delivery model designed to provide coordinated, comprehensive, and timely care focused on the unique needs of individual patients. PCMHs are a core strategy for meeting the goals of improving care quality at lower per-capita costs.	Can address challenges of providing accessible mental health care for older adults through five core functions and attributes. Incentivized to offer more extensive care to those with chronic conditions, including major depression.
Medicaid-financed Specialty Health Home	Model of health care delivery for Medicaid patients with chronic conditions in which comprehensive medical care and mental health care are coordinated and delivered.	Potential for health care groups to merge and offer primary and mental health care at a single site, meeting the complex needs of older adults with co-occurring mental and physical health conditions. A similar program improved measures of diastolic blood pressure, total cholesterol, LDL cholesterol, and fasting glucose for patients with serious mental illness compared to usual care.
Hospital readmission and health care transitions	Two ACA initiatives to increase successful transitions from hospital to community settings: (1) a pilot program partnering hospitals with post-acute providers, and (2) a payment-bundling pilot program. The ACA includes a community-based care transitions program, which provides at least one transitional-care intervention to Medicare beneficiaries and $500 million to community-based organizations and hospitals with high readmission rates.	Program is limited because nonhospitalized complex older adults who are not living in regions served by these community organizations may not receive transitional services. Medicare transitions services are not required to be aligned with Medicaid, which could result in duplicate services or care fragmentation for older adults with mental health conditions.
Medicare Annual Wellness Visit	Medicare-covered, annual prevention-focused visit with a health care professional, during which patient health is assessed and necessary referrals and advice are given.	Can increase rates of screening and possible referral for treatment of depression, particularly within integrated models of care, including those in Medicare health homes.

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Table 1

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Initiative	Description	Implications
Quality standards and associated initiatives	The ACA established new quality standards for behavioral health care, specifically related to data submission. Incentives are provided based on performance measures.	Psychiatric hospitals failing to submit data will receive a 2% payment penalty. Pilot program focused on psychiatric hospital value-based purchasing to test the effectiveness of incentive payments for hospitals meeting specific performance standards. National committee for quality assurance and criteria for data practices for PCMHs. Integrated care for mental health conditions. CMS penalizes hospitals that have a higher percentage of patients readmitted within 30 days or that have a higher percentage of ambulatory care–sensitive hospitalizations.
Support for health information technology and telehealth	Technological approaches across all areas of health care offer potential to complement and support ACA objectives and quality metrics. Approaches include mobile, online, and remote technologies for delivering treatment, monitoring and tracking symptoms, promoting illness self-management, and supporting health care providers. The ACA offers incentives to increase use of health technology. The ACA aims to promote increased adoption of technological approaches in several areas using incentives and new reimbursement methods.	CMS supports research efforts to develop and evaluate technological approaches to health care delivery, including those affecting older adults with mental health conditions. Remote technological interventions have already been tested and proven to reduce emergency room visits and hospitalizations among high-risk patients with mental health conditions. CMS will support these types of technological approaches and others designed to improve care and reduce costs.
Independence at Home and the 1915(i) State Plan Home and Community-Based Services programs	Home demonstration was established under the ACA to test a service delivery and payment-incentive model. The model uses home-based primary care teams to improve health and to reduce spending on Medicare beneficiaries with multiple chronic conditions. Section 1915(i) State Plan Home and Community-Based Services are acute care medical services and long-term services offered to individuals on a need basis.	Under Section 1915(i), states may choose to extend home and community-based services to special populations, such as older adults with mental health conditions. Services for older adults with mental health conditions can include case management, psychosocial rehabilitation, clinic services, behavioral supports, health promotion, and health monitoring.
CMS Medicare-Medicaid Coordination Office, Center for Medicare and Medicaid Innovation (CMMI), and Patient-Centered Outcomes Research Institute (PCORI)	Medicare-Medicaid Coordination Office brings together Medicare and Medicaid to integrate benefits and to improve the coordination between the federal government and states in developing and supporting comprehensive quality services for dually eligibles. CMMI was created to test payment and service delivery models designed to reduce expenditures and maintain or enhance quality of care. PCORI was established to improve the quality of evidence necessary for patients and the broader health care community to make informed decisions.	Output from the Medicare-Medicaid Coordination Office targeted at individuals who are dually eligible may help older adults with mental health conditions. May develop demonstrations that require systems and services for dually eligible individuals to include coordinated models of behavioral health care. CMMI and PCORI are funding mechanisms that will continue to fund applications for implementing and evaluating service delivery models in selected areas, including vulnerable populations, care integration, transitions, and complex medical conditions.

ACA, Patient Protection and Affordable Care Act; CMS, Centers for Medicare and Medicaid Services.

In addition to ACOs under Medicare, models are also emerging under Medicaid —called totally accountable care organizations (TACOs).[7] The goal of TACOs is to provide a comprehensive array of services for Medicaid beneficiaries, to include physical health, behavioral health, long-term services and supports, social services, and public health services.[7]

Ideally, these activities will be reimbursed under a global payment to align financial incentives and reduce costs. In this respect, TACOs extend the focus beyond physical health by integrating health and social services. Although comprehensive models of care consistent with a fully developed TACO have not yet been realized, a number of Medicaid ACOs have begun to approach this goal by integrating limited long-term care supports and behavioral health services. TACOs have the potential to reduce costs and improve the quality of care for socioeconomically disadvantaged high-cost Medicaid beneficiaries with complex care needs.

Implications for geriatric mental health Although mental health care is generally included among the array of required services for ACOs, priorities for improving quality and reducing costs have largely focused on physical health conditions. Based on data from the National Survey of Accountable Care Organizations, 88% of ACOs include responsibility for mental health/substance abuse in the total costs of care in at least one of their ACO contracts.[8] However, only 13% of ACOs report significant integration of mental health/substance abuse treatment into primary care.[8] Examples of successfully integrated care include embedding behavioral health specialists into primary care teams and information sharing between providers.[9]

The initial slow adoption of integrated mental health services in ACOs is also reflected in the lack of mental health quality indicators and standards. Among the 33 quality measures used for assessing ACOs, only one addresses mental health. This indicator measures only the rates of screening for depression.[6] ACOs have largely focused, instead, on implementing care-improvement programs for chronic medical conditions such as diabetes, congestive heart failure, hypertension, asthma, and chronic obstructive pulmonary disease. Nonetheless, mental health care is likely to become a priority as health care organizations become aware of the dramatic impact of mental health conditions on health outcomes and costs. Mental health conditions such as depression are associated with poorer health outcomes, including greater long-term mortality for both acute and chronic health conditions such as myocardial infarction, congestive heart failure, arrhythmias, diabetes, and hip fracture.[10–15] Untreated mental health disorders are associated with increased severity of physical health problems, poor health behaviors, decreased adherence to recommended treatment, greater likelihood of falling, greater functional impairment, and increased health care costs.[16–25]

Mental health conditions are common among the highest-cost Medicare beneficiaries. Most (70%) of the $91.7 billion in acute care costs in the Medicare population in 2010 were for a small subset (10%) of patients.[26] This higher-cost group was associated with elevated rates of mental illness, substance abuse, heart failure, diabetes, and cancer.[26] Older adults with mental health conditions are also overrepresented among dually eligible (Medicare/Medicaid) beneficiaries who make up 21% of Medicare beneficiaries yet account for 36% of Medicare expenditures.[27] Within this group, individuals with psychiatric conditions are twice as expensive as others.[17] Due to the disproportionately high costs and complexities of the dually eligible population, the ACA created a dedicated office within the Centers for Medicare and Medicaid Services focused on innovative approaches to reforming the financing and delivery of care. As we describe later in this commentary, the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation provide special opportunities for advancing the needs and services of dually eligible individuals who have high rates of mental health conditions.

In summary, as Medicare ACOs strive to improve care outcomes and to reduce costs, the need to advance mental health care for older adults will become increasingly apparent. In addition to the cost drivers, explicit provisions of the ACA provide incentives and standards for implementing PCMHs that provide access to mental health services as a component of required comprehensive services.

The Patient-Centered Medical Home

The patient-centered medical home first emerged in the 1960s to coordinate care for complex chronic conditions in children.[28] Subsequent translation of this model into broader use by the World Health Organization in 1978 advanced the role of primary care in coordinating community resources and health care systems in conjunction with a central health information repository.[29] A 1996 Institute of Medicine study advanced the role of primary care in PCMHs to include a systematic approach to identifying patient needs and resources, followed by shared goal setting and a coordinated prevention and treatment plan.[30] Informed by the Chronic Care Model,[28] PCMHs emphasize coordination of health care across different care settings, specialty providers, and community resources; support patient illness self-management; provide decision support for clinicians and patients; and use clinical information systems to manage care and monitor outcomes.[31,32] With the passage of the ACA, PCMHs have been adopted as central to its strategy to improve care quality at lower cost.[33] In addition to its health care insurance reforms, the ACA included specific provisions supporting health care delivery initiatives and also the use of federal stimulus funds for electronic health information systems supporting medical home operations.[34]

Implications for geriatric mental health Although access to behavioral health services is generally inadequate across the lifespan, access is a particular challenge for older adults, who are much less likely than younger adults to seek mental health services from specialty providers.[1] If older adults receive any mental health care at all, it is most likely to be provided in brief visits with primary care physicians and to consist largely of medication prescriptions for antidepressants or benzodiazepines.[1,35] Among the many potential reasons for older adults' lower use of mental health care are its associated costs in the context of fixed incomes and limited resources, the lack of health care professionals trained in

geriatric mental health, the difficulty accessing mental services due to mobility or transportation limitations, and the perceived stigma associated with mental health services.[36]

Approximately one in four primary care patients has a mental health condition,[37] and over two-thirds of those with mental health conditions also have general medical conditions that affect their functioning.[1] PCMHs are designed to improve health care quality through five core functions and attributes—namely, care that is comprehensive, patient centered, coordinated, accessible, and of high quality and safety.[38] According to a report from the Agency for Healthcare Research and Quality, each of these principal components of PCMHs support the integration of mental health and primary care.[39] The delivery of *comprehensive, patient-centered, and coordinated care* for older adults recognizes that mental health and chronic physical health conditions frequently co-occur and are interrelated in older adults. An extensive research literature has established the effectiveness of integrated mental health care within primary care that provides co-located, concurrent, and coordinated care.[40–46] Improved *access* to care for older adults is addressed by embedding mental health care within the primary care setting.[45] Finally, integrated mental health care has been demonstrated to enhance overall care *quality and safety* by incorporating "key components of evidence-based models for chronic illness care," including "collaboration among primary care practitioners, patients, and specialists."[44(p 2837)]

Collaborative care plays an important role in the context of integrated mental health in primary care and PCMHs. The collaborative care model consists of an embedded depression care manager who supports routine screening, provides brief problem-solving therapy or cognitive-behavioral therapy within the primary care setting, coordinates pharmacological management, and conducts systematic follow-up in direct collaboration with the primary care prescriber.[40–46] In addition, a psychiatric consultant may meet with care managers on a weekly basis and provide consultation to the primary care provider. An extensive evidence base supports the effectiveness of collaborative models of integrated mental health in primary care.

Three randomized trials conducted in the past decade provide clear evidence specific to older adults with respect to integrated mental health in primary care. First, in the Substance Abuse and Mental Health Services Administration (SAMHSA)–supported Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E) study, older adults with depression, anxiety disorders, and at-risk alcohol use demonstrated substantially greater engagement in mental health and substance abuse treatment in co-located integrated care than in optimized referral to specialty geriatric mental health care.[45] Second, in the National Institute of Mental Health–funded Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT), the integrated collaborative care intervention was more effective than usual care in reducing suicidal ideation and depressive symptoms.[42] Finally, the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) trial demonstrated that integrated collaborative care, compared to usual care, was associated with greater reduction in depressive symptoms and greater remission of major depression.[44] The IMPACT model showed a 50% reduction in depressive symptoms compared to geriatric patients receiving usual care.[44] This trial also demonstrated that collaborative care contributes to overall reductions in total health care costs and that these reductions more than cover the costs of the intervention within four years.[47]

The IMPACT model has been widely implemented across large integrated health care systems, including Kaiser Permanente, which serves three million people in Southern California, Sutter Health, which serves over 100 communities in Northern California, and Intermountain Healthcare, which comprises 22 hospitals and over 185 physician clinics in Utah and Southeastern Idaho.[48–50] Both Kaiser Permanente and Intermountain Healthcare have reported substantial cost savings after implementing this model.[50–52] Additionally, in New York City, this collaborative care model has been implemented through the Institute for Urban Family Health, a federally qualified health center serving low-income, largely uninsured individuals,[48] and more recently through the Montefiore ACO as part of its efforts to integrate behavioral health services.[53]

The ACA includes incentives for implementing PCMHs,[54] which are eligible for enhanced federal funding for increasing their levels of care management, coordination, and clinical information technology.[55] Higher payments are also available for primary care organizations that demonstrate population-based approaches in providing care to complex patients with three or more chronic illnesses, including major depression. To meet this standard of care, primary care clinics are required to create interdisciplinary teams that include a primary care provider capable of supporting behavioral health treatments, a consulting psychiatrist, and supervision of an embedded mental health provider.

Medicaid-Financed Specialty Health Homes

With the creation of the ACA, it is estimated that up to 15 million people who were previously uninsured become eligible under Medicaid.[56,57] But, since approximately 37% of these newly eligible individuals live in states that have elected not to expand Medicaid as part of the ACA, only about 9 million people will become eligible.[58] Even though the majority of Medicaid enrollees are not elderly, Medicaid expansion is relevant to geriatric mental health care because 17% of Medicaid beneficiaries are dually eligible under Medicare and Medicare, and over 9% are low-income seniors.[59] Furthermore, Medicaid beneficiaries are getting older, and at least 10% of newly eligible individuals are between the ages of 55 and 64.[57]

In addition, the ACA includes a provision for Medicaid specialty health homes for individuals who have two chronic

health conditions, who have one chronic health condition and are at risk for a second chronic condition, or who have a persistent mental health condition.[60,61] Under this program, Medicaid state plans may support specialty health homes that provide integrated primary care within mental health settings for persons with serious mental illness. In the fully integrated model, primary and behavioral health care services are located at one site within a community mental health center or federally qualified health center. Alternatively, integrated physical and mental health care can be provided through a partnership model that closely coordinates care across the two care sectors, supported by common electronic health records, with shared outcome targets and financing.[61]

Implications for geriatric mental health The Medicaid-financed specialty health home has important implications for people with serious mental illness, who make up 4% to 6% of the population[62] and are disproportionately affected by an early-mortality health disparity.[63–66] Providing care to people with serious mental illness is particularly relevant in view of their reduced life expectancy, high medical complexity, and elevated chronic disease burden. When adults with serious mental illness reach age 65, they are disproportionately affected by chronic health conditions compared to other older adults. Furthermore, older adults who are dually eligible are more likely than Medicare-only beneficiaries to have mental health conditions (such as serious mental illness) in addition to chronic physical health conditions,[67] and their per capita health care costs are four times higher than for Medicare-only beneficiaries. Serious mental illness is associated with inadequate and highly variable medical monitoring and treatment, and with numerous barriers to preventive and routine health care, such as cost and the inability to obtain necessary medical care.[68–71] Over half of persons with psychiatric disorders (59%) report at least one barrier to health care, compared to 19% of persons without a mental illness.[72] Because of the greater risk and incidence of adverse outcomes among older adults with serious mental illness and medical comorbidity, innovative models of integrated health care are needed to address the health needs of this high-risk group.[69,73–77]

The ACA provision that supports Medicaid specialty health homes has implications for expanding and improving services for middle-aged and older adults with serious mental illness and medical comorbidity, who are among the highest-cost and highest-risk Medicaid beneficiaries.[17] Efforts to improve outcomes in this group require integrated treatment of “the whole patient” that simultaneously addresses both physical and mental health needs.[73] Community mental health organizations and other health care delivery settings that specifically target people with serious mental illness and medical comorbidity have the potential to leverage this provision of the ACA to incorporate primary health care services directly into specialty mental health settings.[60]

Within these settings, medical services are offered within a psychiatric clinic or through an integrated care arrangement with an identified primary care provider. Different options supported through the ACA include integration models that are coordinated by behavioral health organizations, managed care organizations, or primary care case-management programs. Shared financing and co-located behavioral and primary health care provide the foundation for improving access to, and quality of, care. Critical elements that are most likely to support success include the following: aligned financial incentives across physical and behavioral health; common and real-time shared electronic health information; multidisciplinary care teams accountable for coordinating the full range of supports and services (medical, behavioral, and long term); and outcome measures and metrics linked to incentives and rewards for high-quality care.[78]

In addition, a large national demonstration, the Primary Care and Behavioral Health Care Integration program, is currently attempting to implement and evaluate integrated health care for persons with serious mental illness.[61] This program, funded by SAMHSA, is a large-scale, time-limited national demonstration involving approximately 100 integrated health homes for people with serious mental illness.[79] The purpose of this program is to promote coordinated and integrated services through the co-location of primary and specialty care medical services in community-based mental and behavioral health settings. The goal is to improve the physical health status of adults with serious mental illness by improving the quality, access, and reliability of care, while achieving reduced per capita costs. An interim report on the outcomes of this innovative demonstration program found modest improvement in diastolic blood pressure, total cholesterol, LDL cholesterol, and fasting glucose.[80]

These preliminary results of the SAMHSA Primary Care and Behavioral Health Care Integration program suggest that integrated primary care has the potential to improve the delivery of primary health care and to achieve modest improvements in selected health outcomes. These findings also underscore, however, the need to more directly engage persons with mental illness as full participants in their own health care and to directly support self-management and improved health behaviors. For example, it may be possible to substantially improve engagement in primary care encounters between older adults with serious mental illness and their primary care clinicians through a program of targeted skills training. A brief program called Collaborative Activation Training can help older adults with mental illness develop the skills to prepare for primary care visits, to identify their health goals, to engage in goal setting, to discuss treatment options, and to share in decision making.[81]

Other approaches to improving outcomes for older adults with serious mental illness and comorbid health conditions include participation in training classes in community living and health management, combined with care management by medical nurses. For example, in the three-year follow-up in the Helping Older Persons Achieve Success (HOPES) program, participants, compared to those receiving usual care,

demonstrate greater long-term improvement in symptoms along with better illness self-management outcomes, community functioning, and preventive health care.[76] Illness self-management skills may also be improved through a training program for older adults with serious mental illness and co-occurring chronic health conditions—the Integrated Illness Management and Recovery program—by simultaneously supporting the acquisition of medical and psychiatric self-management skills.[82,83] The program also reduces emergency service use.[83] Finally, outcomes of integrated physical and mental health care are likely to be substantially improved with the addition of health promotion efforts aimed at risk factors such as obesity and smoking. For example, emerging evidence supports the effectiveness of health-coaching behavioral interventions in achieving clinically significant reductions in cardiovascular risk for obese persons with serious mental illness.[84,85] Health coaching (also referred to as wellness coaching) is an approach in which a health care provider (e.g., nurse, medical assistant, or trained lay health outreach worker) plays a directive role in helping an individual achieve health-related goals through support and education.[86] The ACA includes provisions that can potentially support health and wellness coaching focused on achieving those two goals under initiatives such as the 1915(i) State Plan Home and Community-Based Services program (see below).

Hospital Readmission and Health Care Transitions Initiatives

In a key initiative aimed at improving quality of care and reducing costs, the ACA provides incentives to better manage patient transitions from hospitals to the community.[87] Under this provision, the Hospital Readmissions Reduction Program reduces Medicare payments to hospitals with higher-than-expected readmission rates. Beginning in October 2013, hospitals with higher rates of readmission within 30 days of discharge are financially penalized. The ACA includes an array of initiatives aimed at complex patients at high risk of readmission. For example, the Center for Medicare and Medicaid Innovation supports proposals in which bundled payment is provided to hospitals for the total care of the patient. This program can potentially reduce costs by giving providers incentives to improve care quality and reduce rehospitalizations by better coordinating transitions to outpatient primary care provider networks and to home and community-based care. As part of the ACA efforts to measure outcomes, the National Pilot Program on Payment Bundling will analyze whether integrated care delivery and payment programs have resulted in reduced hospitalizations.[88] The ACA has made available $500 million to hospitals that have high readmission rates if they implement at least one evidence-based transitional-care intervention that targets Medicare beneficiaries. In addition, the Medicare-Medicaid Coordination Office supports pilot programs for dually eligible individuals that encourage hospitals to partner with post-acute providers to create a seamless transition from acute to post-acute care.

The ACA-supported hospital readmission and health care transitions program provides support and incentives designed to capitalize on the documented successful reduction of hospital readmissions in a series of randomized trials.[89–91] Several evidence-based transitions programs have demonstrated substantial reductions in readmissions. The common elements of these programs include the following: transitional services initiated no later than 24 hours before hospital discharge; timely post-discharge follow-up services to patients, family members, and caregivers; immediate linkage to post-acute and outpatient providers; assurance of post-discharge refill of medication prescriptions; comprehensive medication review and reconciliation; support for medication adherence and needed adjustments; and active engagement of patients and family members in self-management support.[89–91]

As part of the $10 billion invested through the Center for Medicare and Medicaid Innovation, funding was dedicated to reducing preventable hospitalizations and to improving transitional care among Medicare and Medicaid enrollees.[92] These efforts include identifying, evaluating, and disseminating these innovative and effective models of transitional care. To assess the outcomes of this program, as well as overall efforts of the Medicare Shared Savings Program, care organizations are required to report the status and outcomes of their care transitions programs. An important aim of the program is to reduce fragmentation by supporting hospitals to act as hubs for care transitions and for the implementation of these evidence-based models.[93] In a recent report from the Centers for Medicare and Medicaid Services, the first-year performance results for the 220 Medicare Shared Savings Program Accountable Care Organizations appear promising.[94] For example, 58 Shared Savings Program ACOs earned performance payments of more than $315 million as their share of total savings, resulting in a net savings to Medicare of about $383 million.[94] In addition, 60 ACOs reduced costs but did not meeting the minimum threshold to qualify for shared savings. Overall, improvements were achieved on 30 of 33 quality measures.

Implications for geriatric mental health A recent review identified nine transitional interventions in chronically ill adults that demonstrated improvement on at least one measure of readmission, with eight of the nine studies reporting reductions in all-cause readmissions.[95] The authors recommended that interventions should be chosen based on their effectiveness in achieving performance goals and that the most effective models should be incentivized to promote the adoption and continued use of transitions programs.[95] While several studies have examined transitional care in frail older adults and chronically ill elderly,[95–97] few studies have specifically explored care transitions in older adults with mental health conditions. However, the higher rates of readmission associated with mental health conditions, in general, coupled with the high rates of readmission among people with serious mental illness, in particular,[98] will likely result in

opportunities to integrate mental health providers as core members of the transition teams serving complex older adults. Nonetheless, further research is necessary to develop transitional-care interventions targeting older adults with mental health conditions, as transitions programs focused on this high-risk population could help reduce unnecessary hospitalizations and nursing home admissions.

The Medicare Annual Wellness Visit

An additional feature of the ACA is to cover annual wellness visits under Medicare. This visit requires taking a patient history, performing health assessments, reviewing the patient's functional ability, providing personalized health advice, and developing a follow-up plan.[99] The visit, which is intended to increase the use of preventive services under Medicare, covers 100 percent of payments for preventive services deemed appropriate by the US Preventive Services Task Force.[99] In addition to providing routine physical measurements, patients fill out health risk assessments. The purpose of this questionnaire is to make Medicare beneficiaries aware of their health issues and to motivate positive behavior change, while also highlighting areas where additional care or assessment is necessary.[100] Based on a review of the findings of the health risk assessment, the health care professional may recommend specific diagnostic tests, specialist referrals, or goals for positive health behavior change. Patients also have the option to discuss preparing an advance directive. At the end of the visit, patients leave with a screening schedule for five to ten years (based on individual needs) and with referrals for any other necessary services.[99]

IMPLICATIONS FOR GERIATRIC MENTAL HEALTH The Medicare annual wellness visit includes reimbursement for depression screening using the Patient Health Questionnaire (PHQ-9) and for a cognitive assessment involving the collection of information from family members using a nonspecified, evidence-based, cognitive-screening instrument. This provision may potentially increase rates of screening and referral for depression treatment within integrated models of care, including those in Medicare health homes. Unfortunately, the extent to which the annual wellness visit is used remains to be seen; both the required elements and the time necessary to complete the examination are substantial. Also, it has not been firmly established if this newly covered benefit actually improves detection and treatment.[101] Finally, other than reimbursement for depression screening, few incentives are in place for improving mental health care. Other reimbursable components of the annual wellness visit that may have relevance for individuals with mental illness include screening for tobacco dependence and obesity, and counseling for weight management and smoking cessation.

Quality Standards and Incentives

The ACA requires health plans to submit annual reports on required measures of health care delivery and outcomes. Measures of quality include patient and caregiver experience of care, care coordination, patient safety, preventive health, and management of complex, high-cost conditions.[6] For example, key quality indicators include preventing hospital readmissions and tracking use of recommended screening measures such as body mass index, blood pressure, blood glucose, and lipids. Some health plans also provide financial rewards to providers for meeting or exceeding performance standards for health homes, care coordination, case management, and medication reconciliation. Finally, some health plans provide incentives directly to patients to encourage participation in health promotion activities such as physical fitness or smoking cessation programs.

IMPLICATIONS FOR GERIATRIC MENTAL HEALTH There are few quality standards specific to behavioral health under the ACA. First, as described above, the Medicare annual wellness visit includes screening for depression and assessment of cognitive functioning. Second, quality standards for patient-centered medical homes include measures and incentives supporting integrated mental health care. Third, the requirements for psychiatric hospitals to track and report outcomes have been enhanced. Starting in 2014, psychiatric hospitals failing to submit data receive a 2% payment penalty.[102] Finally, a pilot program developed under Medicare focuses on value-based purchasing for psychiatric hospitals; the program tests the effectiveness of incentive payments for hospitals meeting specific performance standards.

The greatest implications (and opportunities) related to quality standards pertain to the ACA's priority of avoiding unnecessary hospitalizations and readmissions for *ambulatory care–sensitive conditions*. These conditions consist of medical problems that are usually treated on an outpatient basis and generally do not require hospitalization if they are managed properly, such as diabetes, chronic obstructive pulmonary disease, and hypertension.[103,104] Under the ACA, hospitals are penalized if they have a higher percentage of patients readmitted within 30 days or if they have a greater proportion of hospitalizations due to ambulatory care–sensitive conditions. Older adults with these conditions who also have comorbid mental illness have dramatically higher rates of potentially avoidable emergency room visits and hospital readmissions.[17] Integrating mental health services into ACA-supported models of care (e.g., health homes, health care transition teams, complex care management) may help to decrease ambulatory care–sensitive admissions and related health care costs.

Health Information Technology and Telehealth

With the ACA expected to expand medical coverage to tens of millions of Americans, innovative approaches are needed to alleviate already overburdened health care systems and to improve the quality and reach of services.[105] The rapid growth in technology across all areas of health care includes the use of mobile, online, and remote technologies for delivering

treatment; monitoring and tracking symptoms; illness self-management support; and decision support for health care providers. Technology spanning an array of delivery systems and content offers the potential to complement and support the ACA's objectives and quality metrics.[105] It is anticipated that, going forward, technology-based approaches to care delivery will play a key role in supporting the objectives of the ACA.[106] A strong body of evidence supports the use of various telehealth interventions and other technologies to support illness self-management and to reach high-risk populations,[107] including people with serious mental illness.[108–110] Emerging technologies have also made it possible to extend care to a large population of people, including those who live in rural areas, by overcoming geographic barriers.[111] In addition, the increasing affordability and availability of many technologies, including personal computers, mobile phones with Internet connectivity, and smartphones, make it possible to reach lower-income population groups.[112]

As technology is considered a strategy with the potential to improve access and quality, and to lower the costs of health care, proven practices for providing effective telehealth have attracted considerable attention. The ACA includes financial incentives to increase the use of health technology to support the management of population health and also incentives aimed to promote the use of telehealth practices within accountable care organizations, while the Centers for Medicare and Medicaid Services are working to establish reimbursement methods for remote monitoring by, and virtual encounters with, providers.[105]

IMPLICATIONS FOR GERIATRIC MENTAL HEALTH Among older adults with mental health disorders, technology represents a largely untapped potential to improve quality and outcomes, and to reduce costs. Consistent with the general adult population, older adults and people with mental illness are rapidly adopting and using emerging technologies. For example, extensive evidence shows that people with serious mental illness are likely to use mobile devices, social media, and online support networks,[113–116] and similar trends of increasing online and social media use have also been documented in older adults.[117,118] It may well be possible to reach older adults with mental health conditions by using emerging mobile and Web-based technologies. In particular, increasing evidence supports the use of telehealth interventions and emerging remote technologies for addressing health conditions in both older adults and people with serious mental illness. For example, automated remote technology interventions have demonstrated effectiveness in reducing emergency room visits and hospitalizations among high-risk patients with serious mental illness and chronic health conditions.[119–121] Despite the promise of emerging technologies, however, many interventions are in the early stages of development and require more rigorous evaluation among older adults with mental health conditions. In this context, the Centers for Medicare and Medicaid Services recognize the potential value of remote technologies and have supported research efforts to develop and evaluate these innovations.

Independence at Home and the 1915(i) State Plan Home and Community-Based Services Program

Through the Medicare Independence at Home Demonstration and the Medicaid 1915(i) State Plan Home and Community-Based Services, the ACA has significantly enhanced programs supporting long-term care and rehabilitative services at home and in the community for complex conditions. The Independence at Home Demonstration is a Medicare service delivery and payment incentive model being tested by the Centers for Medicare and Medicaid Services.[105] This model uses home-based, multidisciplinary primary care teams to deliver services to Medicare beneficiaries with two or more chronic conditions and who need assistance with two or more functional dependencies (e.g. walking or feeding) and have had at least one non-elective hospital admission and use of rehabilitation services in the last 12 months. Appropriate, timely care is emphasized, with the goal of improving patient health, reducing hospitalizations, and lowering costs. The Centers for Medicare and Medicaid Services award financial incentives to teams that meet quality measures and achieve lower expenditures.

The 1915(i) State Plan Home and Community-Based Services program is a Medicaid initiative that provides flexible supports and services, overcoming the highly restrictive eligibility and service requirements related to conventional long-term care provided under section 1915(c) waivers. Prior to the ACA, home and community-based long-term care services could be offered through a section 1915(c) waiver, which required that individuals be eligible for institution-based long-term care services delivered in the community.[122] The 1915(i) State Plan Home and Community-Based Services program provides the opportunity for states to move beyond skilled nursing and conventional medical care services to cover case management, health promotion, health coaching, and health monitoring for individuals on a need basis.

IMPLICATIONS FOR GERIATRIC MENTAL HEALTH The Independence at Home Demonstration is a Medicare program focusing on older adults with multiple chronic health conditions.[87] As the target population is highly likely to have comorbid mental health conditions, multidisciplinary treatment teams that directly provide or ensure mental health services will be a critical component in improving quality and reducing costs. The results of this ongoing demonstration program may have long-term implications for the financing and delivery of Medicare-supported community-based services for co-occurring physical and mental health disorders in older adults.

Under the ACA's Medicaid 1915(i) State Plan Home and Community-Based Services program, states have the option to offer home and community-based services for complex patients with chronic health conditions and mental illness, including case management, psychosocial rehabilitation,

clinic services, behavioral supports, health promotion, health coaching, and health monitoring. These services are not required to be budget neutral. By contrast, the1915(c) waiver program presented significant challenges because the most costly services such as psychiatric hospitalizations and long-term care were excluded from Medicaid coverage; expected reductions in those services would not have saved Medicaid dollars.[122]

The Centers for Medicare and Medicaid Services' Medicare-Medicaid Coordination Office, Center for Medicare and Medicaid Innovation, and the Patient-Centered Outcomes Research Institute

The purpose of developing the Medicare-Medicaid Coordination Office under the ACA was to bring together Medicare and Medicaid to effectively integrate benefits, and to improve the coordination between the federal government and states in delivering comprehensive quality services for individuals who are dually eligible.[121] Also under the ACA, the Center for Medicare and Medicaid Innovation was allocated $10 billion over ten years to identify, evaluate, and disseminate innovative care delivery models, with a special focus on care transitions.[123] This provision may also have special implications for older adults with serious mental illness who may be dually eligible. This mechanism provides opportunities to propose new approaches to financing and delivering care in response to specific requests for proposals through the Center for Medicare and Medicaid Innovation.[124] Finally, the Patient-Centered Outcomes Research Institute, also established under the ACA, is intended to improve the quality of evidence necessary for patients and the broader health care community to make informed decisions.[124] This goal is to be achieved by funding comparative clinical-effectiveness research and also research aimed at improving these research methods. The institute was appropriated $3.5 billion in funds through September 2019.[125]

Implications for geriatric mental health The Medicare-Medicaid Coordination Office is tasked with supporting state-based demonstrations addressing the specific needs of dually eligible individuals, many of whom are older adults with mental health conditions. Through this office, states have the option to conduct demonstrations for dually eligible individuals that require coordinated models of behavioral health care. Examples of state programs providing integrated physical and behavioral health care to dually eligible individuals are found in Arizona, Massachusetts, Minnesota, Tennessee, and Texas. Technical assistance and information on developing state options for integrating physical and behavioral health care can be accessed through the Integrated Care Resource Center, established by the Centers for Medicare and Medicaid Services to assist states in delivering coordinated care services to dually eligible beneficiaries.[126]

Additional opportunities to develop integrated medical, behavioral, and long-term services and supports are possible through the Dual Eligible Special Needs Plans. Although these plans vary among states, the characteristics of states with "high performing health plans" have been identified and include the following: a person- and family-centered plan of care based on assessments that capture individual needs; multidisciplinary care teams; a network with home and community-based long-term care options; and mental health assessments and services. Dual Eligible Special Needs Plans are designed to effectively manage the high-risk, high-cost population of dually eligible adults through electronic information exchange across different providers and organizations, measures of quality and performance, and alignment of incentives with the goal of achieving the "triple aim" of improving population care, improving patient experience, and reducing costs.[127]

In addition to these ongoing initiatives, the Center for Medicare and Medicaid Innovation and the Patient-Centered Outcomes Research Institute have issued requests for applications for implementing and evaluating service delivery models that target vulnerable populations, care integration, transitions, and complex medical conditions. Among the projects that the center has funded in the first two rounds of applications, at least 17 explicitly target the integration of behavioral and physical health among populations that include older adults. The institute has also funded various projects that have potential implications for older adults with mental health conditions, and it is anticipated that the institute will fund more such projects as its priorities evolve.

POTENTIAL BARRIERS TO THE FULL IMPLEMENTATION OF THE ACA

While many of the provisions within the ACA have the potential to significantly improve mental health care and outcomes for older adults, there are obstacles to the full implementation of the act. First, at the time of writing this commentary, 21 states have elected not to expand Medicaid,[128] thereby denying this benefit to roughly 37% of individuals who would have become eligible under the ACA.[58] These decisions have important implications for low-income seniors with mental health conditions who may be dually eligible. Second, the US Supreme Court has agreed to hear the challenge against the ACA provision that allows federal subsidies to help millions of Americans buy health insurance.[129] The debate, which stems from the ACA's statutory language, concerns the question whether subsidies can be provided to individuals who purchase insurance through *either* federal or state-run exchanges.[129] This question matters because only one-third of states have established health insurance exchanges,[129] and many individuals—who are mostly low- or middle-income—would potentially be left without insurance subsidies. The Supreme Court's eventual ruling has the potential to significantly undermine the ACA. Finally, Senate Republicans, who recently gained control of that chamber, have announced intentions to repeal core components of the act. Despite these potential threats to the ACA, many of the core

components have been extensively integrated into existing state policy and regional health care delivery systems. These major transformations in the financing, organization, and delivery of care may be altered, but they are likely to endure for years to come.

CONCLUSIONS

The approaching "silver tsunami" is anticipated to nearly double the number of older adults with mental health or substance use disorders by the year 2030, while current trends suggest that the total number of geriatric psychiatrists will decrease, amounting to less than one geriatric psychiatrist for every 6000 older adults in need of treatment.[1,2] With significant shortfalls also projected in other geriatric health care professions, the recent Institute of Medicine report on the mental health and substance use workforce for older adults highlights the need to provide training and support for integrated treatment of geriatric mental health conditions within primary care, as well as across the broad spectrum of acute and long-term health care and social service settings.[1] Unfortunately, state and federally funded programs with the explicit responsibility of addressing the nation's mental health needs systematically neglect older adults. According to a recent SAMHSA report, older adults (aged 65+) represent only 4.4% of those served by state mental health agencies even though they account for 13% of the population.[130] The Institute of Medicine report concluded that no government agency has been designated to assume responsibility for this rapidly growing high-cost, high-risk group that is "in no one's hands."[1] Despite the Institute of Medicine's call to action for SAMHSA to prioritize geriatric mental health, SAMHSA's recently released 2015–18 strategic plan fails to make any mention of older adults as a priority and excludes any initiatives related to geriatric mental health and substance abuse services.[3]

Despite the lack of leadership, advocacy, and accountability at the federal level for advancing geriatric mental health and substance abuse services, a number of ACA provisions create opportunities for addressing this shortfall. Screening for depression should potentially become much more common through the Medicare annual wellness visit, and improved access to care is more likely to become a reality if care systems are incentivized to implement patient-centered medical homes and specialty health homes. Novel solutions will nevertheless be needed if we are even to begin addressing the projected need for services. For example, the rapidly evolving field of health technology has the potential to extend the limited capacity and accessibility of professionals through automated self-management programs,[120,121] mobile health psychotherapy and telemedicine applications,[131,132] and virtual providers such as avatar health coaches.[133,134] These approaches have been shown to be acceptable and desirable for older adults; in addition to their capacity to be individually tailored, they can, in effect, devote the time needed to respond to complex conditions at older adults' bedsides or in their homes or communities. Access to computer-based decision support and real-time telehealth consultation also creates the potential for health outreach workers, volunteers, and peers to provide basic community-based mental health assessment, support, and counseling services. The combination of technology (high tech) and peer community health workers (high touch) has been successfully used in low- and middle-income countries that lack access to specialty mental health providers[135]—which presents the opportunity for adapting this approach for underresourced areas of health care in Western societies through "reverse innovation."[2,136]

Accountable care organizations, with the responsibility of creating systems of population-based care, have the potential to extend their clinical capacity to leverage these innovations by developing a workforce of health coaches, health outreach workers, and care transition coordinators trained to provide practical support services for complex, high-cost patients—including older adults with co-occurring mental health and chronic health conditions. The Independence at Home, Medicaid 1915(i) State Plan Home and Community-Based Services program, and Center for Medicare and Medicaid Innovation also provide opportunities to redesign conventional home and community-based long-term care services to incorporate mental health services for older adults who are at high-risk of unnecessary and inappropriate institution-based care.[137,138] Finally, provisions in the ACA supporting the implementation of electronic health information systems and opportunities for greater use of telehealth may help to leverage the potential of technology to improve care coordination and access for older adults.[105] Despite ongoing barriers to implementing the ACA, by leveraging the reforms of this law spanning Medicare and Medicaid, along with incentives and opportunities supporting integrated medical and mental health care, it may be possible to begin to address one of the major health care challenges of the coming decade: caring for the rapidly growing number of older adults with mental health conditions.[139]

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