The Effects of the Affordable Care Act on the Practice of Psychiatry

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CME Objective

After studying the COMMENTARY by Ebert et al, you should be able to:

- Prepare for the impending changes resulting from the Affordable Health Care Act

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The Affordable Care Act (ACA), which became law on March 23, 2010, and was upheld by the Supreme Court on June 28, 2012,[1] is a health care law intended to improve access to health care coverage in the United States and introduce protections for people who have health insurance.[2] The ACA affects providers, patients, insurance companies, and government entities, and parts of the law have already gone into effect (Table 1).[3]

Of particular importance to mental health care, a few of the policies already implemented by the ACA include prohibiting insurance companies from placing dollar limits on lifetime coverage benefits, allowing young adults to stay on their parent's health care plan up to age 26 years, providing free preventive care such as depression treatment, and prohibiting insurance companies from denying coverage to children and adults with preexisting conditions, including mental illnesses and substance use disorders.[4] The ACA also supports establishing national centers of excellence to treat depressive disorders, funding for community mental health centers, and providing preventive care for other conditions. The ACA will have a direct impact on the mentally ill as more Americans gain access to psychiatric treatment.[5]

Michael Ebert, MD, chaired a discussion among an expert panel of psychiatrists regarding how the ACA will change the practice of psychiatry and psychiatric research.

HOW WILL THE AFFORDABLE CARE ACT CHANGE THE PRACTICE OF PSYCHIATRY?

Integrated Care

Dr Ebert: Mental health care can be improved through the ACA's proposed or reinforced care delivery systems, such as community mental health centers with integrated primary and specialty care.[5] Insurers have the option to set up collaborations between primary care and mental health care.

Although the Department of Veterans Affairs (VA) is not directly impacted by the ACA, the VA has shown how the patient-centered medical home (PCMH) model can improve access to care and how chronic disease management can be facilitated through the coordinated efforts of patient-aligned care teams (PACTs; Table 2).[6] For example, a patient with posttraumatic stress disorder, chronic pain, and diabetes can receive care from a psychiatrist, a pain specialist, a rehabilitation therapist, and a primary care physician without having to coordinate the visits himself.[7]

A VA clinic, using the PCMH model and PACTs, was able to shorten wait time for appointments so that 25% of the

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The teleconference was chaired by **Michael H. Ebert, MD**, Department of Psychiatry, Yale School of Medicine, and the VA Connecticut Healthcare System, New Haven. The faculty were **Robert L. Findling, MD, MBA**, Department of Psychiatry and Behavioral Sciences, Johns Hopkins Medicine, and the Kennedy Krieger Institute, Baltimore, Maryland; **Alan J. Gelenberg, MD**, Department of Psychiatry, Penn State Hershey Milton S. Hershey Medical Center, Hershey, Pennsylvania; **John M. Kane, MD**, Department of Psychiatry, The Zucker Hillside Hospital, Glen Oaks; the Department of Psychiatry, Hofstra North Shore-Long Island Jewish School of Medicine, Uniondale; and Behavior Health Services, North Shore-Long Island Jewish Health System, New Hyde Park, New York; **Andrew A. Nierenberg, MD**, Bipolar Clinic and Research Program, Depression Clinical and Research Program, and the Department of Psychiatry, Harvard Medical School and Massachusetts General Hospital, Boston; and **Pierre N. Tariot, MD,** Banner Alzheimer's Institute, Alzheimer's Prevention Initiative, and the Department of Psychiatry, University of Arizona College of Medicine, Phoenix.

Table 1. Key Features of the Affordable Care Act[a]

Changes for Physicians	Year Implemented
Rebuild the primary care workforce (doctors, nurses, and physician assistants)	2010
Increased payments for rural health care providers	2010
Encourage integrated health systems to better coordinate care through Accountable Care Organizations	2012
Reduce paperwork and administrative costs through standardized billing and electronic health records	2012
Increased Medicaid payments for primary care doctors	2013
Pay for physicians based on value, not volume, to improve the quality of care	2015
Changes for Insurance Companies	
Put information online for consumers to compare and pick coverage	2010
Prohibit denying coverage of children based on pre-existing conditions	2010
Prohibit rescinding coverage for errors or technical mistakes on customer's applications	2010
Eliminate lifetime dollar limits on insurance coverage	2010
Regulate annual dollar limits on insurance coverage	2010
Provide free preventive care	2010
Lower health care premiums so that at least 85% of all premium dollars collected from large employer plans and 80% from individual and small employer plans are spent on health care services and health care quality improvement	2011
Prohibit discrimination due to pre-existing conditions or gender	2014
Eliminate annual dollar limits on insurance coverage	2014
Changes for Consumers	
Appeals of coverage determinations/claims with an external review process	2010
Insurance for uninsured Americans with pre-existing conditions	2010
Extended coverage on parents' plans for young adults up to age 26 years	2010
Expanded coverage for early retirees (55–65 years old)	2010
Coverage for children with pre-existing conditions	2010
Coverage for individuals participating in clinical trials	2014
Affordable care through tax credits that lower premiums	2014
Affordable and qualified health benefit plans available at the Health Insurance Marketplace for individuals and small businesses	2014
Individual responsibility to obtain basic health insurance coverage	2014
Changes for Medicare & Medicaid	
Offer relief for seniors who reach the Medicare prescription drug gap in coverage	2010
Allow states to cover more people on Medicaid through federal matching funds	2010
Offer prescription drug discounts to seniors who reach the coverage gap	2011
Provide free preventive care for seniors on Medicare	2011
Improve health care quality and efficiency through the new Center for Medicare & Medicaid Innovation	2011
Improve care for seniors after they leave the hospital to avoid readmissions	2011
Introduce new innovations to lower Medicare costs, reduce waste, improve health outcomes, and expand access to high-quality care	2011
Increase access to services at home and in the community to disabled individuals through Medicaid	2011
Address overpayments to big insurance companies and strengthen Medicare Advantage	2011
Link payment to quality outcomes through a hospital Value-Based Purchasing program in traditional Medicare	2012
Improve preventive health coverage through funding to state Medicaid programs	2013
Increase access to Medicaid to Americans who earn less than 133% of the poverty level	2014
Changes for Government	
Establish consumer assistance programs in states that apply for federal grants	2010
Provide small business health insurance tax credits	2010
Prevent disease and illness through funded prevention and public health programs	2010
Reduce health care fraud through new resources and new screening procedures	2010
Require insurance companies to justify increases on premiums	2010
Strengthen community health centers	2010
Understand and reduce health disparities using racial, ethnic, and language data	2012
Expand authority to bundle payments to improve coordination and quality of patient care	2013
Provide additional funding for the Children's Health Insurance Program	2013
Increase the small business tax credit for providing health insurance to employees	2014

[a]Based on the US Department of Health and Human Services.[3]

schedule was available for same-day visits. This approach diminished inappropriate emergency department visits from 52% to 12% and improved the care of patients with poorly-controlled diabetes.[6] Issues to address when applying the PCMH model at the national level, outside of the VA, include flexibility in meeting training needs for different employees, the need for funding, and the recognition that training and implementation take longer than expected, meaning that long-term support for the teams is needed.[6]

Dr Tariot: The VA medical home model for integrated care is based on the examples of several care delivery systems, including that of the nonprofit health care organization Kaiser Permanente.[6] Kaiser developed a cost-effective system with primary, secondary, and tertiary clinicians sharing the budget and responsibility for all care.[8] Kaiser's multispecialty health centers enable primary care doctors, nurses, specialists, and pharmacists to coordinate care, focus on prevention, and minimize hospital visits.

Severe Mental Illness

Dr Gelenberg: The ACA could hurt psychiatric care in some ways, particularly in caring for the chronically mentally ill, because many services that have been previously paid for by states are not regulated or paid for under the new legislation.[9]

Dr Tariot: Centers for Medicare & Medicaid Services (CMS) is interested in following research from the National Institute of Mental Health because CMS needs some models to ensure that people with illnesses like schizophrenia receive evidence-based care. Although the ACA plans to reimburse certain institutions for emergency inpatient psychiatric care for Medicaid patients,[5] other evidence-based practices for treating severe and persistent mental disorders are not usually covered by health insurance.[9]

Solo Practices

Dr Ebert: Someone who practices psychotherapy in an urban area can probably maintain a solo practice with direct payment outside the insurance system, but anything beyond that will be hard to maintain under the new legislation.

Dr Tariot: Psychiatrists who do not take insurance will likely keep practicing.

Dr Ebert: Although there will always be practitioners providing services for those who can pay out of pocket, solo practitioners will be rare in the new, integrated organizational structure if they want to be involved with an insurance network. Concierge practices increased 30% from 2011 to 2012.[10]

Dr Nierenberg: The future with the ACA is no more fee for service; by 2015, physicians will be paid by value rather than volume. Virtually all physicians are going to be employed. Specialists, like psychiatrists, will function more in a team setting, supervising less expensive personnel to take care of most of the health problems, similar to the community mental health center model.

Dr Kane: I agree. A number of people of all ages will get insurance who did not have insurance before, including those who are mentally ill. The same number of physicians will soon serve more patients, making team care crucial. Specialists are going to move into consultative roles and stop keeping a stable of patients.

Clinical Points

- The ACA's expanded coverage will create an influx of new patients.
- Psychiatry practice is shifting toward patient-centered medical homes and collaborative treatment teams.
- New technologies will expand access to and increase efficiency of health care.

Table 2. Principles of the Veterans Affairs' (VA) Patient-Aligned Care Teams (PACT)[a]

Patient-Driven
The primary care team is focused on the whole person Patient preferences guide the care provided to the patient
Team-Based
Primary care is delivered by an interdisciplinary team led by a primary care provider using facilitative leadership skills
Efficient
Patients receive the care they need at the time they need it from an interdisciplinary team functioning at the highest level of their competency
Comprehensive
Primary care is the point of first contact for a range of medical, behavioral, and psychosocial needs and is fully integrated with other VA health services and community resources
Continuous
Every patient has an established and continuous relationship with a personal primary care provider
Communication
The communication between the patient and other team members is honest, respectful, reliable, and culturally sensitive
Coordinated
The PACT coordinates care for the patient across and between the health care system including the private sector

[a]Reprinted with permission from Klein.[6]

Use of Technology

Dr Kane: To be able to help a larger number of patients, psychiatrists will need to make use not only of the integrated team approach but also of new technologies.[11] Technology is going to create more efficiencies and better access through the use of smart phones with apps for disease management and Web-based interventions and psychoeducation. In many places in the country, patients with schizophrenia cannot find someone to give cognitive-behavioral therapy, but if they could go online for a well-developed program, it would be a huge advantage.

Similarly, telemedicine gives clinicians the ability to communicate with patients via 2-way, in-home video, which reduces office visits. There are far fewer reasons for patients to go to a clinic or hospital these days, even with primary care, because physicians do not necessarily have to see them face to face.[10] Telemedicine is less expensive and more convenient than office visits.

Table 3. Results of the Massachusetts General Hospital Medicare Demonstration Project: Phase 1[a]

Successful Enrollment and Satisfaction
Enrolled 87% of eligible beneficiaries
Improved communication between patients and health care team
Yielded high patient and physician satisfaction
Improved Patient Outcomes
Hospitalization rate among enrolled patients was 20% lower than comparison group
Emergency department visit rates were 13% lower for enrolled patients
Annual mortality was 16% among enrolled group versus 20% among comparison group
Achieved Savings Target
12.1% in gross savings among enrolled patients
7% in annual net savings among enrolled patients after accounting for the management fee paid by Centers for Medicare & Medicaid to Massachusetts General Hospital
For every $1 spent, the program saved at least $2.65

[a]Adapted with permission from Massachusetts General Hospital.[12]

Dr Tariot: Telemedicine does not appear to have caught on yet in many residency programs, but it is going to happen.

Dr Gelenberg: Payment for telemedicine sessions is complicated. The telepsychiatry program in the VA is growing fast, but everybody is on salary.

Dr Nierenberg: At Massachusetts General Hospital (MGH), a health information technology system provides support for treatment teams via electronic health records (EHR), patient tracking, and monitoring from home. An experiment between MGH and CMS was designed to improve the coordination of services for high-cost Medicare patients. The project demonstrated reduced costs and improved care in areas including fewer emergency department visits, decreased annual mortality rates, and lower hospitalization rates (Table 3).[12]

Dr Tariot: There are revenue advantages for using electronic medical records, such as the Medicare and Medicaid EHR incentive programs for eligible professionals and hospitals.[13]

Dr Nierenberg: The ACA is going to have a huge effect on practice, and current medical school students will not practice like we have in the past.

Dr Kane: Access to care and delivery of care are both big areas of change. Medical students will have different training and practicing methods than we did. It is going to be a different world.

Dr Gelenberg: However, psychiatry is taking an optimistic turn as it explores public health questions and works in tandem with primary care doctors.

HOW WILL PSYCHIATRIC RESEARCH CHANGE?

Dr Tariot: We will certainly have greater opportunities to do effectiveness research, outcomes research, and cost-effectiveness research because we will have larger pools of patients.

Dr Gelenberg: There may be a broader balance of payers for research besides the pharmaceutical companies, such as other agencies and the federal government.

Dr Nierenberg: Studying interventions for high-risk patients remains a problem.

Dr Findling: Getting an at-risk intervention protocol through an institutional review board review has been one of the most difficult things I have ever done. For some people, it is anathema to treat someone who does not yet have an illness; conversely, others cannot understand why you would want to do a controlled study in people who are at risk for developing a condition that could be prevented.

Dr Nierenberg: The kind of research that is going to be done will have endless resources available. As a result of the ACA and other legislation, the CMS Center for Innovation is investing heavily in the development and testing of new service delivery and payment models to find better, more cost-effective ways to take care of people.[14]

I think that pharmaceutical companies may conduct fewer drug studies and get involved in more partnerships with systems that are studying the effectiveness of care.

Dr Kane: Yes, I think we will have more focus on delivery systems, experiments in innovation, and partnering. New technology, like a chip in a pill to time-stamp when a patient swallows it, will facilitate monitoring. Companies are going to be linking their drug studies to these and other opportunities.

Dr Ebert: Companies are going to be thinking past the traditional "swallow a pill" model to more creative therapeutic concepts like new devices and nanotechnology. There will be tremendous pressure on drug pricing, which is already happening in Germany and other western European countries.[15] The efficacy must justify the cost or else a new product will be assigned a generic cost.

Dr Nierenberg: Cost-effectiveness requirements will make the payers (ie, insurers) the larger determiners of what comes from pharmaceutical companies.[15]

Dr Ebert: There will be tension in government regulation as the US health care system evolves.

Dr Tariot: Occasionally, an agency will fund research, but it is hard to do studies in nonpharmacologic research, which leads to a lot of missed opportunities.

CONCLUSION

The ACA will affect several areas of psychiatry and the care of patients with mental health disorders as more Americans have access to health insurance. Patients with mental illnesses should be able to receive better care because they cannot be denied coverage based on their preexisting condition. As health care shifts to community-based models, specialists and primary care physicians will work together in a collaborative environment to provide comprehensive treatment in a coordinated care setting. Advances in technology and better care coordination will enable specialists to consult with other clinicians, caregivers, and patients in remote locations, bypassing face-to-face visits when possible. Research into care delivery systems and preventive medicine will continue to advance. Clinicians face many decisions as the ACA continues to be implemented, but understanding the upcoming changes will help them prepare for the future.

Disclosure of off-label usage: Dr Ebert has determined that, to the best of his knowledge, no investigational information about pharmaceutical agents that is outside US Food and Drug Administration–approved labeling has been presented in this activity.

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For the CME Posttest, see next page.

Posttest

To obtain credit, go to PSYCHIATRIST.COM (Keyword: April) to take this Posttest and complete the Evaluation online.

1. **Which one of the following physicians is most likely to be affected by the Affordable Care Act (ACA)?**
   a. A psychiatrist who has a solo practice in a large city and does not take insurance
   b. A psychiatrist who has an office with 1 staff member and who takes insurance
   c. A primary care physician who is a partner in a concierge practice
   d. A psychiatrist who works as part of a team in a Veterans Affairs (VA) hospital
2. **Which of the following entities does the ACA support?**
   a. National telemedicine centers
   b. Concierge clinics
   c. Community mental health centers
   d. VA hospitals
3. **A female patient presents with depression, diabetes, and back pain. At a facility using the patient-aligned care team model, she could receive treatment from a psychiatrist, primary care physician, and pain specialist at one location without having to coordinate the visits herself.**
   a. True
   b. False
4. **Which statement best describes changes in the ACA?**
   a. Specialists are responsible for coordinating care and leading the care teams
   b. Physicians are paid by volume (fee for service)
   c. It will reduce the primary care workforce
   d. Integrated health care teams are focused on the whole person, and technology is used to increase efficiency within teams