ARTICLE

Affordable Care Act: Patient-Centered Medical Homes and Implications for Mental Health

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The Patient Protection and Affordable Care Act (ACA) is considered the largest reform of the United States' health care system since Medicare and Medicaid legislation was passed in 1965. Moreover, it is among the most significant reforms in American health care delivery, an issue that has been slow to evolve, as illustrated in Table 1 (1). The ACA was passed with goals of increasing the quality and affordability of health insurance, lowering uninsured rates, and improving insurance coverage through mandates, subsidies, and insurance exchanges. Specific to mental health services, the ACA expands on the Health Parity and Addiction Equity Act of 2008 by mandating that in addition to group health plans, individual health insurance plans provide coverage for mental health or substance use disorders that is equal to medical and surgical benefits. Another aim of the ACA is to reinvigorate primary care delivery through organizations such as patient-centered medical homes, which are collaborative patient-centered organizations responsible for the vast majority of an individual's primary and mental health care needs across the lifespan (2–5).

Most mental health treatment is provided in primary care settings, and the percentage of care provided solely in these settings is rapidly growing. Mental health problems are 2–3 times more common in patients with chronic medical illnesses, such as diabetes, arthritis, chronic pain, headache, back and neck problems, and heart disease. Mood and anxiety disorders occur in 20%–25% of patients seen in clinics serving mixed-income populations and as many as 50% of patients in clinics serving low-income populations (6). Nearly one in five older adults has at least one identified mental health concern, and depression affects more than 6.5 million of the 35 million Americans over age 65 (7). Left untreated, mental health problems are associated with functional impairment, poor treatment adherence, adverse health behaviors, and excess health care utilization (6). Strategies effective in improving management of depression in the primary care setting have been shown to involve clinician education, enhanced case management, telephone medication counseling, and integration between primary care and consultation services (8).

Even prior to implementation of the ACA, patient-centered medical homes had been proposed as integrated models to improve access to comprehensive medical care. The concept of a medical home was first introduced by the American Academy of Pediatrics (AAP) in 1967. Initially, the AAP defined the medical home as the center of a child's medical records, particularly for children with special health care needs (9). Since that time, the concept of the patient-centered medical home has expanded to include integrated care for individuals of all ages (5, 10).

The modern patient-centered medical home is defined as a partnership between the patient, family, primary provider, specialists, and community support groups whose goals are to provide comprehensive care and to minimize gaps in health care delivery. In the ideal model, seven main principles form the core of the modern patient-centered home: a personal physician, physician-directed medical practice, whole-person orientation, integrated care across the lifespan, quality and safety, enhanced access to care, and payment. Through physician-directed medical practice, the primary physician manages a team of individuals that takes responsibility for the ongoing care of patients. Whole-person centeredness involves the team of health care providers being responsible for preventive treatment, acute and chronic care, and end-of-life services. Integrated care is defined as coordinated health care delivery between all elements of the complex health system, including hospitals, subspecialty care, home health agencies, nursing homes, and community centers. To ensure quality and safety, evidence-based medicine guides clinical decision making. Finally, the payment structure should reflect the value of care management work that falls outside the face-to-face visit (5).

Multiple payment models have been described that could be used to support the patient-centered medical home in practice. These include fee-for-service payments augmented to practices recognized as patient-centered medical homes, practices being able to bill for new patient-centered medical home activities, and practices paid for meeting process measures and utilization targets. Other models involve practices paid a monthly fee in addition to typical fee-for-service billing, practices rewarded with a portion of savings if the total cost of care increases more slowly than a preset target, and comprehensive payment that accounts for the complete risk for cost of care within the practice (11).

One study found that since the ACA was passed, absolute rates of uninsured adults have declined among black, white, and Hispanic racial and ethnic groups, falling from 25.9% to 17.2% among blacks, 16.0% to 10.5% among white, and 42.8% to 31.8% among Hispanics (12). Projections have estimated

TABLE 1. Timeline of Health Care Reform in the United States[a]

1965	Medicare and Medicaid signed into law. Medicare Part A helps with hospital care, limited skill nursing, and home health care. Medicare Part B helps with physician care. Medicaid assists states in providing insurance and long-term care for poor patients.
1972	Supplemental Security Income (SSI) begins, providing cash assistance to elderly and disabled patients. Social security is amended to allow patients <65 years with end-stage renal disease and long-term disabilities to qualify for Medicare coverage.
1981	Federal budget reconciliation act requires that states make additional Medicaid payments to hospitals that serve a disproportionate number of low-income patients.
1986	Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals participating in Medicare to screen and stabilize all patients who use emergency rooms regardless of ability to pay. Consolidated Omnibus Budget Reconciliation Act (COBRA) allows employees who lose their jobs to continue with their health plan for 18 months.
1996	Health Insurance Portability and Accountability Act (HIPAA) restricts use of preexisting conditions in health insurance coverage determinants and sets standard for medical record privacy.
1997	State Children's Health Insurance Program (S-CHIP) is enacted to provide coverage of low-income children above Medicaid eligibility levels.
2006	Medicare Part D goes into effect. Massachusetts passes and implements legislation to provide health coverage to nearly all state residents. Vermont also passes legislation for near-universal health coverage.
2010	The Patient Protection and Affordable Care Act is enacted.

[a] For a more detailed history of health care reforms, see the report from the Kaiser Family Foundation (1).

that the ACA reforms could reduce the number of underinsured adults with incomes below 250% of the federal poverty level by up to 70% (13). Furthermore, with the ACA, an estimated 3.7 million more people with severe mental disorders are expected to gain access to care. In the study, severe mental disorders were defined as self-reported severe depression or other psychological distress (14).

Although limited studies exist, initial data have shown that when successfully implemented, patient-centered medical homes provide a more comprehensive, cost-effective approach to health care delivery compared with traditional practice. A 2-year follow-up at one Seattle-based clinic that adopted the patient-centered medical home model found that patients in the medical home experienced 29% fewer emergency visits and 6% fewer hospitalizations compared with patients receiving care as usual. The authors estimated a savings of $10.30 per patient per month 21 months into the study. Furthermore, patients receiving care through the patient-centered medical home received better quality care and reported improved experiences. Staff at the medical homes also reported fewer signs of burnout compared with those working in traditional clinical settings (15). Another controlled clinical trial of geriatric patients enrolled in a multidisease care management program showed that for patients with diabetes mellitus, the intervention resulted in significantly lower mortality at 1 year (6.2% for the intervention group versus 10.6% for controls) and at 2 years (12.9% versus 18.2%). Hospitalization rates were also lower at years 1 and 2 after the intervention (16).

With implementation of the patient-centered medical home, another recent study conducted in San Diego found greater increases in mental health recovery when patients with severe mental illness were provided care through the patient-centered medical home model compared with service as usual (17). In the study, 215 participants receiving services through the patient-centered medical home were compared with 22,394 clients receiving services as usual between 2011 and 2014. Severe mental illness included clients diagnosed with schizophrenia or schizoaffective disorders, bipolar disorders, major depressive disorders, dysthymia, adjustment disorders, alcohol use disorders, substance use disorders, cognitive disorders, and other depressive or psychotic disorders. Mental health recovery was assessed through client- and clinician-reported scores on the Illness Management and Recovery Scale and the Recovery Markers Questionnaire during periodic assessments over the study period. Multilevel modeling was used to explore differences in growth trends in mental health recovery scores over time between participants in the patient-centered medical home and services as usual. There were, however, several limitations of the study, including the limited generalizability of the findings, as well as the lack of randomization, as clinical judgment was ultimately used to refer participants for treatment in the patient-centered medical home (17).

Many potential barriers exist in transitioning to a patient-centered medical home. First, converting to a patient-centered medical home involves changing from individual to team-based practice. Practices must also have a systematic strategy to successfully implement whole-person centered care, as demonstrated in the National Demonstration Project, a pilot study of 36 practices that were randomized into facilitated and self-directed intervention groups that transitioned from traditional health care delivery to the patient-centered medical home model (18, 19). Physicians, physician assistants, and nurse practitioners are increasingly attracted to nonprimary care specialties because of financial and policy incentives; this has led to a deficit of primary care clinicians, which makes transition to a patient-centered medical home model difficult (10). From a mental health perspective, potential barriers include that with implementation of the ACA, states may elect to cut optional Medicaid-supported behavioral health care services, including case management, peer and vocational support services, housing,

KEY POINTS/CLINICAL PEARLS

- The Affordable Care Act (ACA) was passed with goals of increasing the quality and affordability of health insurance, lowering uninsured rates, and improving insurance coverage.
- ACA expands on the Health Parity and Addiction Equity Act of 2008 by mandating that in addition to group health plans, individual health insurance plans provide coverage for mental health or substance use disorders that is equal to medical and surgical benefits.
- Mental health problems are 2–3 times more common in patients with chronic medical illnesses, such as diabetes, arthritis, chronic pain, headache, back and neck problems, and heart disease; mood and anxiety disorders occur in 20%–25% of patients seen in clinics serving mixed-income populations and as many as 50% of patients in clinics serving low-income populations.
- When successfully implemented, patient-centered medical homes provide a more comprehensive, cost-effective approach to health care delivery compared with traditional practice.

and other psychiatric rehabilitation services, which may be essential to care coordination within the patient-centered medical home model (4).

Although only one aspect of the mandates and expansions set forth by the ACA, patient-centered medical homes have recently gained more attention. Although data are limited, pilot studies have shown that patient-centered medical homes hold promise in improving access to care and generating positive outcomes for both medical and mental health care. In practice, however, multiple barriers continue to hinder widespread transformation of traditional practices to the patient-centered medical home concept. Since enactment of the ACA, will disparities in health care access continue to narrow? Only time will tell.

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