# Achieving Behavioral Health Equity for Older Adults in the Affordable Care Act

**By Laurel Mildred**

According to a 2012 **report** by the Committee on the Mental Health Workforce for Geriatric Populations, “The burden of mental illness and substance use disorders in older adults in the United States borders on a crisis.” One in four adults ages 55 and older experience behavioral health disorders that are not a part of normal aging, and the majority do not receive the treatment they need.

Substance abuse, depression and anxiety are the most common disorders. Up to 17 percent of adults ages 60 and older abuse substances, including alcohol, licit and illicit drugs. Social isolation and a co-occurring mental health disorder can exacerbate these risks, and according to the Substance Abuse and Mental Health Services Administration, the U.S. healthcare system has not recognized or effectively dealt with these issues.

Between 8 percent and 20 percent of older adults within the general population experience depression, and within primary care settings the prevalence is 37 percent. Those in skilled nursing facilities show a depression rate of 50 percent. The more medications a person takes, the more likely they are to experience depression. In addition, approximately 3 percent to 14 percent of older adults each year meet the diagnostic criteria for anxiety disorder, and a much higher percentage have clinically significant symptoms of anxiety that decrease functioning. Racial, ethnic and cultural minorities, who experience higher levels of health and behavioral health disparities, are particularly impacted by a lack of appropriate screening, intervention and treatment.

There are many barriers to treatment for older adults, including stigma, misdiagnosis, isolation and a lack of coordination between physical and behavioral health providers. Another persistent barrier can be behavioral health “carve-outs” (where payers carve out mental health benefits to capitated managed behavioral healthcare organizations) with restrictive criteria excluding those with a primary diagnosis of dementia, traumatic

brain injury or other disorders. The impact of untreated behavioral health problems put older adults at high risk for poor outcomes, including suicide. In 2010, an estimated 8,618 Americans ages 60 and older committed suicide. Among these, 58 percent saw a primary care provider within their last month of life.

However, the Patient Protection and Affordable Care Act (ACA) presents unprecedented opportunities to address these conditions and increase behavioral health equity for older adults, improving access and quality, reducing disparities and improving outcomes through changes to the system that will expand services for this vulnerable population.

## Opportunities for Expanding Older Adult Behavioral Health

**Michael B. Friedman and Kimberly A. Williams** have previewed specific ways the ACA benefits older adults with behavioral health problems: it provides improved coverage of physical healthcare; improved coverage of mental health and substance use conditions, including prohibiting insurance discrimination based on preexisting conditions; it provides improved coverage of medications under Medicare Part D, including psychiatric medications; gives financial incentives for providers to enhance health and behavioral health integration; emphasizes preventive interventions; emphasizes services in the home and community instead of in institutions; and calls for enhanced long-term care coverage and service quality.

Of these, several provisions provide opportunities for change within the system:

### Parity

A key driver of change is federal parity, from the Pete Domenici and Paul Wellstone Mental Health Parity and Addiction Equity Act of 2008. Parity requires mental health and substance use disorder benefits be equal to medical–surgical benefits, prohibits annual and lifetime dollar limits on these benefits, expands covered diagnoses and includes other provisions that expand access to behavioral health services. The ACA extended these provisions even further.

Achieving parity is expected to increase access to services for all populations, but is also likely to exacerbate the existing lack of capacity within the system capacity, especially an inadequate supply of qualified behavioral health providers. Focusing on developing an adequate behavioral health workforce, especially those trained in geriatrics, is essential for realizing the potential of parity.

### Financial Incentives

The ACA set in motion three major trends in financing that can lead to expanded behavioral health services for older adults. First, its overall emphasis on bending the

healthcare cost curve has motivated policymakers to analyze the significant costs of not providing behavioral health services and align policy to expand these services to prevent greater expenses.

Second, the ACA offers various designs that assign risk linked to financial rewards, motivating providers to dispense high quality care, including appropriate behavioral healthcare, and doling out fiscal consequences when that care is not provided.

Finally, the ACA offers various financial models that permit global budgeting, which allows resources to be used for preventive care such as behavioral health services; avoiding high cost institutional care, then reinvesting savings into expanding the array of home- and community-based services, including behavioral health services, that further prevent high costs.

## Integration

Integrated models of care that require providers and systems to "re-attach the head to the body" are a key mechanism by which ACA financial incentives can be accessed. Integrated models include state Dual Eligible Demonstrations, community-based Health Homes and Accountable Care Organizations. Although each of these integrated models is unique, they have in common incentives for delivering appropriate, non-fragmented care and avoiding unnecessary costs, both of which can lead to expanded access to appropriate behavioral health services.

As states develop a better understanding of these models and their potential for reducing costs and improving care, such understanding also prompts states to consider widespread systems integration and take a second look at long-standing policies that have been chronic barriers, such as behavioral health "carve-outs." Advocates seeking to increase behavioral health equity for older adults can use the tools of the ACA—including achieving parity, harnessing financial incentives and developing integrated models—to leverage an unprecedented expansion in behavioral health services for older adults.

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