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Oregon Health Care Reform:
Potential Impacts on Independent Practice Mental Health Services

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- *As the result of healthcare reform a number of changes will directly and indirectly affect private practice fee-for-service mental health professionals in Oregon.*
- *Due to changes in public policy, mental-health services, for the first time, have a legitimate role to play in the overall healthcare delivery model.*
- *It is important that mental health professionals successfully demonstrate their effectiveness as the healthcare arena is re-designed.*
- *Mental health professionals must define their roles and adapt to the new standards in health care reform.*
- *While mental health services are relatively simple to document, many professionals do not understand essential documentation, proper coding of services, security and backups.*
- *Private practice mental health professionals should create cohesive alliances with one another, focus their limited time and adopt standards they can agree to and operate within.*

Changes in Federal and State regulation are a "game-changer" in the delivery of mental health services nationally. New regulations have changed not only Medicare and Medicaid, but have changed commercial insurance. In addition to private insurance, the statutory entities referred to as Accountable Care Organizations (ACOs) and Coordinated Care Organizations (CCOs) can or may soon provide health care for Federal, State and private employers. Furthermore, commercial insurance companies are following the lead of the Centers for Medicare and Medicaid (CMS) to provide Quality Care as well as the Oregon Health Authority. State and private employers are now asking for and buying Quality Care. Quality care is defined by (1) reasonable access and a positive patient experience, (2) services that improve the community or group's health, and (3) management or containment of costs. Quality will be demonstrated through the use of measures. This means that healthcare professionals, through patient centered and hospital 'medical homes' must measure and demonstrate the quality of mental health services.

Healthcare reform begun at the federal level has been adopted and modified by the State of Oregon to become Oregon's own healthcare reform project. It is improbable that the State of Oregon will strike down its new healthcare reform as legislators and the courts continue to struggle with national change. In response to the Supreme Court's July 28, 2012 decisions, further legislation and lawsuits may change aspects of healthcare reform. The State of Oregon's Health Authority board and administration have already changed processes affecting health care delivery. Who is covered by which kinds of health insurance may change, but the service delivery processes being put in place likely will not.

One of the anticipated and intended changes of health care reform has already taken place; the commercial insurance sector has become more interested in “keeping people healthy.” Their goal is to reduce payments for health care needs that can be prevented through increased population wellness and lower utilization of health care services. There are three primary goals in health care reform. The "triple aim" of health care reform is worthy. Most people agree that healthcare consumers should have a positive experience, reasonable access, and that the health of our communities should be improved and costs contained. Some object, suggesting that that these goals are a ruse, ways for corporate healthcare to profit by denying care or by implementing policies that are unreasonable and unjust. Whether such skepticism is valid remains to be seen, and will be seen, because health care policies and outcomes are becoming more transparent than they have been. As the result of healthcare reform a number of changes will directly and indirectly affect private practice fee-for-service mental health professionals in Oregon.

The Oregon Model

The State of Oregon has undertaken initiatives that will transform healthcare services in the public and commercial domain. This is being done by example, and more importantly, by the required creation of electronic infrastructure, transparent treatment guidelines and decision rules. There are new financial incentives and legislative demands which impact the quality, effectiveness and efficiency of care that the State of Oregon requires for tax-paid and public employee healthcare.

There are many ways to understand healthcare reform. One way is to look at it in the phase model used by the State of Oregon. The phases of healthcare reform in Oregon are sometimes referred to as transparency, transformation, and core.

To achieve ***transparency***, data that describes health care practices must be gathered and organized in a manner that allows the public, the legislature, the executive branch and healthcare leaders to set policy and to influence how healthcare services are delivered. This is beginning to happen where public health dollars are being spent. The electronic infrastructure necessary to transmit health information for such information exchanges is already happening with physician groups in Oregon.

Transmitting information creates transparency and describes what is actually happening in healthcare delivery. Transmitting details of healthcare practices and delivery (or lack of delivery) of services will increase awareness. With this developing awareness, changes are already taking place. Critical points of care, such as emergency room and physician group practices, are being connected electronically for coordination of care. Coordination of care for emergency services can prevent negative consequences when one physician is not aware of important health issues another physician is treating. In addition to connecting critical points of care, large clinics are forming collaborations and partnerships with specialty care practices that provide care beyond the specialty services in available in general practice clinics, i.e. neurology, cardiology and nephrology.

In order to bring about meaningful changes in healthcare, baselines are being established that describe how care is being delivered and the costs of care. The public and elected officials, as well as

commercial insurance providers, will soon have means to examine and evaluate our existing health care system. The transparency stage could also be called the definitional stage. The mere fact that this data is available to healthcare professionals and insurance providers will have a **transformative** effect in and of itself. Creating a reliable awareness for providers and healthcare leaders will bring about change. The baseline data will be analyzed for the purposes of profit and accountability to the public and elected officials. Data analysis will reveal trends emerging that may support improvement in community health or reveal disparities and inconsistencies with the triple aim. Analyses of baseline data and the information gained will have transformative effects, especially as healthcare providers begin to set goals with respect to specific healthcare problems in their communities. Health care givers and the public must be provided with information in a manner that is not misleading and does not create bias – always a challenge in large information systems.

The **core** stage in healthcare reform involves core or targeted health issue measurements and outcomes. Assuming that important healthcare issues are adopted as community targets for improvement, and that the focus of healthcare resources on those issues is appropriate, healthcare providers will receive financial incentives intended to improve the outcomes they produce. Meeting or exceeding core objectives will result in financial reward to healthcare provider organizations. Core issues will be the goals and objectives of healthcare from a point of care perspective.

Not all the core issues have been identified. However, there are lists that legitimize both medical and mental health services where the process of collaboration makes sense. Core issues that require both medical and mental health services include, as examples, obesity, depression, tobacco cessation, substance misuse, utilization of emergency services for urgent care issues, adverse childhood experiences, and a variety of medical procedures, including the over use of medications that have questionable benefit in relation to adverse side effects. Behavioral and mental health services are now being sought as an integrated part of medical care. The integration or coordination and referral for those services will be measured as quality and outcome elements of healthcare delivery. This is an incredible departure from the old role for mental health services, which have been "carved out" from medical care, and not considered an important medical referral. Due to changes in public policy, mental-health services, for the first time, have a legitimate role to play in the overall healthcare delivery model. Might one cynically surmise there was a hidden advantage to the medical community when untreated mental health needs increased the number of physician office visits?

Parity Impact

There is good news and bad news when behavioral and mental health services have greater parity with medical services. The good news is that mental health professionals are in a position to take a legitimate role in improving the health and well-being of patients who have behavioral and mental health problems and/or comorbid mental health and medical problems with interaction effects. The bad news is that the entire mental health profession is going to be held accountable to demonstrate that there is significant positive impact and benefit from their/our services. There are several additional problems. Medical care corporations and insurance companies have a long history of providing minimal reimbursement and contracting with or employing people who have minimal

experience and training to work with significant medical and mental health concerns. It is imperative that those mental health professionals who contract and provide collaborative and coordinated care in the new era of accountable care have appropriate experience, qualifications, and connectivity to others who provide health care. It is important that mental health professionals successfully demonstrate their effectiveness as the healthcare arena is re-designed. And regardless of the therapy approach, the course of therapy must be outcome informed.

Interoperable Systems

Electronic infrastructure is a key issue. On federal and state levels, healthcare providers, commercial insurance providers, the centers for Medicare and Medicaid and others are developing electronic infrastructure and database systems capable of providing the means to hold medical care and insurance providers accountable, systems that can support the meaningful use of healthcare information for the benefit of patients, professionals and health care system administration.

While there is no single electronic health or medical record system, there are systems that are not only interoperable, but are being connected as we speak, using interfaces that ”push and pull” data using protocols established to ensure security. Partnerships and collaborations are being established among medical provider groups within communities and electronic interfaces are being created in a manner that allows health care information to be transmitted to state and private health information exchanges and trading databases. These are the new realities included in healthcare reform in Oregon. When mental health services are integrated and coordinated with medical care they will also be expected to participate in or contribute to the electronic information exchanges and databases. Whether and how mental health professionals can “push” data to physician groups or to health insurance data bases is not yet defined. There ought to be resistance by mental health professionals if health care reform infrastructure and managers intend to pull data as *they* deem necessary. Mental health professionals value the privacy of their services. Privacy is essential; without privacy many who need services will not seek them. Mental health professionals need to define and limit what information enters the electronic systems administered by other providers, managers and payers.

The direction healthcare reform is taking in Oregon can be inferred from the social and business practice behaviors of physicians and healthcare systems. Physicians and large healthcare systems are organized and funded and taking action to define and establish their procedures and priorities in their regions and communities. They are actively responding and interacting with both the State of Oregon and commercial insurance payers.

The manner in which public and private healthcare dollars are being intermingled may have significant downstream impact on private practice mental health services. For example, commercial insurance and Medicare are becoming intertwined as more and more people are purchasing supplemental insurance to their Medicare coverage. Commercial health insurance providers have the means to manage information from Medicare claims simultaneously with information available for their commercially insured people. This is a very important signal. The electronic records systems being developed for Medicare and Medicaid patients are the electronic records systems that will be used by

healthcare providers who serve those who are commercially insured. Public and commercial dollars provide for interoperable analysis of data. Accountability requirements will emerge on the private healthcare side.

We reiterate: the electronic healthcare record systems being developed to coordinate with the centers for Medicare and Medicaid, and the State of Oregon Health Authority are being developed as the same systems used by physicians in managing care of patients with commercial insurance. One can reasonably assume that public healthcare reform will have further transformative effects on private healthcare including requirements for coordination and accountability.

The Future

The future is not clear. But there are a number of things we do know. Many changes will occur over the next several years that affect the business of fee-for-service private practice mental health. Mental health professionals will be expected to coordinate care with physicians for people who have public or commercial insurance. While mental health professionals will not become Accountable Care Organizations, they will certainly be expected to provide meaningful evidence concerning the services they provide -- to the physicians in accountable systems; and possibly to commercial and public entities that manage third-party healthcare dollars.

Independent practice fee for service mental health professionals are at a disadvantage in the accountable-care arena. Large hospital-based systems with integrated behavioral and mental health departments staffed by employees have established a standard of care and compliance with their integrated services and their electronic infrastructure intended to meet coordinated accountable care expectations. This hospital-based service pattern highlights the huge problem for the private practice sector. Private practice fee-for-service mental health professionals currently do not have the organization and electronic infrastructure to provide reliable, valid, and useful information in a manner toward which other healthcare providers are rapidly moving. Integrated behavioral and mental health services in hospital-based healthcare organizations demonstrate the level of collaboration that patients will be expected to receive.

Private Practice Cohesion

Private practice mental health has never had the cohesive organization necessary to think toward the future in a manner that could unify the profession and provide mental health professionals with a seat at the healthcare leadership table. Mental health, as a profession, has not proposed or created the standards and means to provide and manage their unique segments of health care information. By default, mental health professionals appear to be waiting for someone to give them the solution to problems involved in information exchange and accountable care. This is a challenge many mental health professionals are unaware of, have only partial understanding about, or cannot believe is imminent. And after all, this makes sense, if we consider that independent mental health professionals have preferred to work in isolation or with a few trusted colleagues; that they are trained in several related disciplines and they have little experience functioning in community.

Simple comparison between private practice mental health professionals and private practice physicians sheds light. It is easy see that private practice mental health services are well behind the standards of care-cooperation in the medical community. Most mental health professionals do not have electronic health care records systems capable of providing interoperable interfaces between mental health professionals and physicians, physician groups or to information exchanges or information trading systems. Most mental health professionals do not have electronic billing and automated internal checks and charting that insure they will be capable of surviving audits by the state, federal agencies or the commercial insurance industry. The important fact is that private practice mental-health professionals accepting third-party payment will be subjected to additional scrutiny. Private practice mental health professionals have been operating in isolation. They are not accustomed to or familiar with the simple process of self-audited practice management. It is reasonable to think that many mental health practices might not fare well during audits that focus on standards of care, clinical practices, practice administration and billing. Mental-health practitioners do not routinely audit their practices as many large physician groups do in order ensure they are compliant with their insurance contracts. While mental health services are relatively simple to document, many professionals do not understand essential documentation, proper coding of services, security and backups. Nor do they comprehend the financial penalties which can result from audits that can go back and apply penalties to many past years of services.

A simple audit of any dozen or one hundred mental health professionals would probably reveal that patient records do not have chart notes for every appointment, that session documentation and chart note are not always sufficient to justify the coding of that appointment, that many appointments are in fact coded incorrectly, that records are not sufficiently secure, and that there are significant errors in billing for services. Some insurance contracts already ask mental health professionals to affirm that they are coordinating care with the patient's physician in each case. But is this really being done, and how will mental health professionals fare when they are expected to coordinate care in a consistent, reliable and valid manner useful to physician groups?

The status quo, in which many mental health care professionals believe they are insulated or unimportant in healthcare management, is going to change whether mental health professionals are prepared to be accountable or not. As mental health services are held to have an essential role in healthcare services, it is reasonable to expect that those services will be required to become accountable in the same way that medical services are becoming accountable.

Some individual mental health professionals are attempting to anticipate and adapt to healthcare reform. At this point there are few specifics about what private practice mental health professionals will be expected to do. This is in large part because healthcare reform is being driven primarily by the overriding goals of directing medical care providers and some insurance companies that manage care to the mission of the triple aim. At a grassroots level, individual mental health practitioner's adaptations are potentially haphazard and poorly thought through in light of the trends that are happening elsewhere in the medical community. Many mental health professionals are simply waiting to see if a solution may be proposed by someone outside the private practice community. Others are simply waiting to see what everyone else might do.

The idea that mental health professionals are somehow going to collectively come up with a proactive solution to coordinate and provide accountable care seems improbable. What will most likely happen is this: when the fear and anxiety in the profession is sufficiently high, and demands for change are made as a condition of continuing to receive third-party payment, professionals will desperately attempt to change their practices as quickly as possible. This is not a healthy coping strategy!

Mental health professionals must define their roles and adapt to the new standards in health care reform. The answers to the problems mental health professionals face need to be generated from within their own profession. Private practice mental health leaders are primarily people volunteering to raise awareness and monitor what is going on in healthcare. This small and scattered cadre of concerned professionals is a far cry from the leadership roles and initiatives of other health care professions which have funded departments and employ staff to collaborate with healthcare reform leaders. Private practice mental health professionals should form cohesive alliances with one another, focus their limited time and adopt standards they can agree to and operate within. It is important to recognize that the process of transforming clinical and practice management in mental health can be relatively easy over a long transition period and incredibly difficult and expensive over a short time frame. Those who wait until they have no choice but to change or suffer dire financial consequences, risk being caught in confusion as they try to become compliant on short notice with the demands of third party payers.

The business of health care and contracting for services will change. During the transformation stage, it is possible that health care leaders and insurance companies will impose expectations and changes in contracts that reduce reimbursement for services and create reporting expectations that are potentially unethical or unprofessional. The changes may be required of mental health professionals within 30 to 90-day time frames.

It is not clear what mental health professionals, individually or as a group, believe will ensure the viability of independent practice and the culture of client privacy in which they practice. But there are important and challenging questions.

Mentor Research Institute is developing a practice viability questionnaire to examine issues of mental health practice viability and risk and liability in the Era of Accountable Care. The intent is that these questions should be reviewed, answered and revised by discussion among professionals so they will become more cogent, coherent and useful as our systems of healthcare provision change.

Conclusion

- *It is important that mental health professionals successfully demonstrate their effectiveness as the healthcare arena is re-designed.*
- *Mental health professionals must define their roles and adapt to the new standards in health care reform.*
- *Private practice mental health professionals should create cohesive alliances with one another, focus their limited time and adopt standards they can agree to and operate within.*

The future of private practice fee-for-service mental health services is not clear. There are as yet no authoritative position papers that define the likely turning points in the future of mental health practice. Mental health professionals should reflect on the issues identified in this paper and prepare themselves to be change agents in a changing system.

Mental health professionals should also consider and work toward answers to the questions raised in this paper. If these questions are not adequate or appropriate, mental health professionals should develop better questions. There are serious ramifications and consequences if the questions asked and answered about the future of mental health practice are short-sighted.

The anxiety that professionals experience as they look at legislative and corporate demands for new information sharing systems is real. Ideally, facing the anxiety will bring mental health professionals into alliance and cooperation. Allied, they can meet the new realities as mental health practice changes. They can protect patient privacy and continue to provide excellent individualized services. They can expand their practices through coordinated systems of referral from and feedback to the primary and specialist care medical community.

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