The Impact of Healthcare Reform on Psychotherapy Services

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This brief outlines and describe the reasons for healthcare reform, how this reform is transforming mental health and psychotherapy services. Patient-Centered HealthCare and the process leading to that goal are illustrated.

Healthcare reform is all around us. There is no special immunity or protection from healthcare reform. Psychotherapists are not exempt. Mental health professionals have not experienced the full impact of healthcare reform, but impacts are surfacing locally and nationally in obvious and subtle ways. Providers know something is happening, but don't see it fully or feel it yet. The impact is not unlike that of a tornado or flood in another part of the country. Many providers seem to think they are somehow shielded where they live. Perhaps providers feel shielded because their State is green, their air is clear, their fee-for-service is good or insurance payers are not auditing practices locally - yet. In many states, healthcare is changing so quickly that a great deal of time and the interaction with knowledge experts is required to understand the implications and consequences of the economic, regulatory and the legislative forces at work.

Reasons for Healthcare Reform

Healthcare reform is based on a consensus that healthcare services are often fragmented, uncoordinated and not accountable. Hence, the quality is not optimal or equitable. For many patients, satisfaction with care they receive is low. And patients who have preventable emergencies, illness, or disease are often unable to afford or obtain health and wellness care. Referrals and coordination of care practices have not been efficient, nor have there been effective means to assure that physical and mental health needs are satisfied.

In traditional healthcare services there are failures in the provision of care as well significant inefficiencies. Public health suffers as a result, the cost of healthcare goes up. Until the last decade most the focus of healthcare has been concentrated on treating serious and life threatening illness and disease rather than prevention. Improvements in quality, savings, and better patient care result when the focus shifts to collaboration and prevention. The Health Information Technology for Economics and Clinical Health Act (HITECH) and the Patient Protection and Affordable Care Act (ACA) are central to the resurgence of healthcare management by public and commercial health care payment sectors. In the mid 1980's and early 1990's, managed care meant "restricting care" based on criteria that that was not transparent or accountable. In 2013 the focus became decidedly on ensuring access, improved health and reduction is costs.

Beginning with the ACA, healthcare reform focused on the quality of care. This focus requires that healthcare be measured, accountable, transparent, affordable and available. As a result of

the ACA and the HITECH, fee-for-service mental health services will be shifting to coordinated and accountable care as illustrated in Figure 1.

The Triple Aim of healthcare reform is to (1) insure reasonable access to care and a positive patient experience, (2) improve patient and group health and well-being, and (3) to manage and contain costs. These three goals are to be implemented in a manner that is transparent and accountable. Measures of the Triple Aim are being created, evolving and beginning to be used. Both healthcare providers and payers will be accountable.

Mental Health Transformation

Insurance payers are beginning to signal that they want to contract with groups rather than individuals. Many payers are open about this preference. And it makes sense. It costs less and it requires psychotherapists to be accountable. Privately, insurance payer representatives state that it is their job to reduce the cost of care any way they legally can and that it is the providers job to assert their selves.

Groups of physicians have responded effectively to payers because they are organized, they have business consultant, data and financial resources. Mental health professionals can't respond effectively when they are in isolated private practice. Especially when they rely on paper charts. Barriers to an individual practitioner's ability to form groups is their inability to collectively gather local data to make credible arguments for their quality of care. Individual practitioners are powerless to counter the pressures that can be exerted by insurance companies and government supported insurance actions. However, by legally "grouping up", psychotherapists can create avenues for influence. Psychotherapists who form larger groups can create efficiencies of scale and consumer benefits that solo and small group practice professionals cannot.

Payers are interested in group contracts in part because single provider contracts are an economic burden to them. Further, payments to providers are shifting from "claims–based" to "inherent value", "added value" and "pay-for-performance" (P4P) criteria. Private employers, and commercial payers, are following this lead by asking for quality of care that is measurable as opposed to earlier payment models that restricted care without accountability.

Mental health services, under the ACA, have parity with medical care. Mental health services are now considered specialty care as are other points of care such as neurology, cardiology, etc. Just as for other specialty care providers; third-party paid mental health services must become coordinated and accountable. In medicine, primary medical care is becoming the care coordination center in new models called Primary Care Medical Homes (PCMH) and Patient Centered Primary Care Homes (PCPCH). Hospitals and hospital systems are purchasing medical practices and forming Hospital Medical Homes (HMH) and Accountable Healthcare System (AHS) that can manage care in communities and larger regions.

The Patient Protection and Affordable Care Act (ACA) was written to assure that health plans cover mental health services on par with physical illnesses. In Oregon, the ACA was adopted as

state law and is being implemented in Coordinated Care Organizations (CCOs) that are similar and in most ways identical to Federal Accountable Care Organizations (ACOs.) Healthcare infrastructure is adapting on a state by state basis.

While traditional solo practice fee-for-service will remain for the near term, psychotherapists will over time find it increasingly necessary to coordinate care, provide measures, and become accountable for the services they provide. Figure 1 describes the changes taking place in transformation of mental health services. In this new system of care, patient screenings, referrals, progress and outcomes will be tracked by physicians and payers. The move from fee-for-service to coordinated care will require changes in how psychotherapists practice. Psychotherapists are not specifically required to be accountable for the services they provide. Physicians, however, are directly responsible, and have financial incentives to measure and manage the quality of services that psychotherapists provide. Since physicians are required to coordinate and measure the quality of care, they are also in position to manage and direct behavioral and mental health services over time.

Figure 1.