



## Answers to the Most Important Questions about Health Care Reform

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**T**he Patient Protection and Affordable Care Act (ACA) is the most important piece of health care legislation at least since the founding of Medicare and Medicaid in the 1960s, and may prove even more important than that. Reactions among psychologists to the process that the ACA has instigated vary between dumbfounded anxiety, extreme skepticism, and cautious optimism. Whatever your opinion of those changes, there are some questions to which you need the answers. This article is our best effort at giving you answers to those questions. Far more change in the works than has occurred already, so read this article knowing that some of these answers will inevitably be outdated in the near future.

**Thirty years ago I was told I was doomed if I didn't join managed care. I decided against it and the apocalypse never happened. Isn't this fear about health care reform just more of the same hysteria?**

First, congratulations on surviving the last apocalypse. Second, of course it's possible that health care reform won't change things for many psychologists, but here's why we think it will. Managed care was an experiment by individual insurers that left key elements of the health care system, such as fee-for-service payment, largely intact; the ACA is a federal mandate that is intended to effect a thorough reorganization of the system. Because healthcare reform payment and structural changes will affect both private and public sector insurance, if you take insurance it is likely to affect your practice. Psychologists who accept entirely private pay for their services may be the only practitioners immune from the effects of healthcare reform, though even then referral networks may change.

Health care reform is therefore more like the introduction of Medicare and Medicaid than to the introduction of managed care, but potentially more comprehensive than either. Some of you may know that, when Medicare was established, the leadership of the American Psychological Association decided to wait and see rather than participate. Their decision to sit on the sidelines, at that time, excluded psychologists from participating for more than 25 years. Even if in the end the ACA makes little difference to psychologists, it's essential that we engage in the process of reform until that proves certain.

### What are the new concepts I need to know?

The ACA and related reform activities introduce a whole host of new terms and acronyms, but we will focus on four that are particularly important. The *health insurance exchange* and *accountable care organization* (ACO) are two structures established by the ACA that are respectively intended to reform access and service delivery. The *patient-centered medical home* (PCMH) and *integrated primary care* are not part of the ACA, but they represent service delivery systems that are potentially encouraged by the law.

### What is a health insurance exchange and why should I care?

The health insurance exchange (sometimes called the state health exchange) must be established for every state by 2014. This will be a largely on-line marketplace of health care plans sold to any willing resident of the state. Starting in 2014, individuals who do not pay for health insurance will pay a fine that escalates over the coming years. Though this condition is known as the individual mandate, the fine associated with failing to comply may not be sufficient to entice many Americans to participate. Even so, the number of individuals with health insurance is likely to expand substantially after 2014.

The exchanges will be government-regulated, so participating plans have to meet certain conditions. Policies must be *guaranteed issue*, i.e., eligibility cannot depend upon current health status; mental health parity is required; lifetime limits are prohibited as is most instances of rescission (the practice of terminating policies on technicalities once a patient becomes expensive). There are limitations set on price variation. Though cost can be adjusted based on some personal variables (age and smoking status), no policy can charge more than 4.5 times as much as the cheapest policy.

Each state is also required to identify a "benchmark plan," an existing health plan that sets the minimum standards for coverage for all plans in the state, though if the selected plan did not provide all the minimum coverages mandated under the law, the state could supplement it. So far 29 states have done so. In New Jersey, the Horizon HMO Access HSA Compatible plan was chosen with some additions, available at <<http://cciio.cms.gov/resources/EHBBenchmark/proposed-ehb-benchmark-plan-new-jersey.pdf>>. If you are interested in other states, there is a summary at <<http://statereform.org/analyses/state-progress-on-essential-health-benefits>>.

Employers are watching the development of the exchanges closely. Employers can either purchase coverage for employees through the exchange or terminate their insurance, allowing employees to purchase insurance individually through the exchange, and pay a fine (employers with less than 50 employees are exempt from these conditions) of \$2000 per employee. This is substantially less than employers currently pay per employee for health insurance, so terminating coverage will result in a cost savings while also eliminating the hassles of negotiating health care coverage. These savings can in turn be used to lift starting salaries as a recruiting tool for top job candidates. If this strategy is effective, other employers will have to follow suit, creating the possibility that employment-based health coverage will largely disappear in the foreseeable future. What impact this ultimately will have on the practice of psychology is uncertain. As the shift occurs, psychologists may see a significant reduction in their private insurance referrals. For example, many blue-collar workers that are now covered by private insurance through their worksites are likely to be shifted to Medicaid products through the exchange. This may significantly affect the referral streams of psychologists, who, due to barriers in many states to becoming Medicaid providers and low reimbursement rates, have not enrolled as providers.

Though increasing the rolls of the insured, mental health parity, and unlimited lifetime benefits are positive outcomes, it is uncertain to what extent these changes will translate into more or better care. A more important development for the future practice of all of health care is the founding of the ACOs.

### **What is an accountable care organization and why should I care?**

The ACA calls for a major reorganization of Medicare based on ACOs. An ACO is an organization that will be responsible for providing comprehensive care to Medicare patients, with contracts renewed every three years. This typically requires a consortium of provider entities, including primary care practices, hospitals, and specialty care practices, though the law suggests the ACO should be built on strong foundation of primary care. Put simply, an ACO will be responsible for providing comprehensive care to a regional population of Medicare subscribers. In the first year of the Medicare ACO Pioneer Pilot program, 33 ACOs across the country had the opportunity to participate in "sharing cost savings." Based on prior utilization and health care costs, the ACOs were given a virtual "per member per month" budget from the government. If the ACO was able to care for their patient population under this budget, they shared a percentage of the global cost savings with the government. Beginning January 1, 2013, the Pioneer ACOs had the opportunity to participate in bundled payment pilots. A bundled payment is a lump sum paid to hospitals or a group of physicians for an episode of care. The amount of the bundled payment is based on an estimate of typical costs for caring for a particular illness. If the group of providers involved in the episode of care bill less than the

bundle, they make a profit, if they bill more, then they operate at a loss. That is the incentive to provide efficient care.

"Uh-oh," you say, "here comes the managed care," and so far this does sound suspiciously like the same old wine in a new bottle. However, there is a condition placed on collecting their percentage of cost savings that potentially makes for something quite different. ACOs must collect data on 33 *Quality Performance Standards*, metrics intended to gauge the quality of the care provided. Based on the number of quality measures not met, the ACO collects an increasingly smaller percentage of their share of the savings. This is a stick that could mean surrendering tens of millions of dollars. You can see the performance standards at <<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf>>.

The system makes sense. If ACOs meet quality measures (for example, keeping patients weight, blood pressure, and blood sugars regulated, and utilizing preventative screens) then patients experience less complications of chronic illness (such as amputations in diabetes, or heart attacks and strokes) that are the exploding bombs of healthcare costs for ACOs. So, when quality measures are met, patients require fewer expensive hospitalizations, and there are more cost savings to share. These cost savings in turn are accessible to the ACOs because they have met the quality measures.

The first of several problems psychologists will have with ACOs becomes evident as you review the standards, however. Only one directly relates to mental health. Standard 18 requires screening for clinical depression and, if the screen is positive, a plan for follow-up care must be documented that same day.

While there is only one quality measure involving traditional treatment for depression, there are many quality measures that track how well ACOs do managing chronic illness. These are population-based outcomes associated with various medical issues for which behavioral health interventions can be helpful, including obesity, smoking, hypertension, and diabetes. Assisting ACOs in managing these chronic illnesses through behavioral interventions represents a major potential source of practice expansion for psychologists who are trained in behavioral medicine.

A second problem with the ACO model is that the ACA identifies the professions that can share directly in the fruits of the shared savings, and we're not on the list. Congress limited direct benefit to traditional medical disciplines, including physicians assistants and clinical nurse specialists, but excluded the allied health professions. When combined with corporate practice of medicine laws that restrict psychologists' partnering with physicians in many states, psychologists will have to look for creative solutions if we are to play a lead role in ACOs.

Third, the relationship between psychologists and the primary care physicians, who refer to us, changes profoundly in an ACO. Under the current system of independent specialty care, a physician may refer to you having no idea how long you typically see patients or how much your services cost. In the ACO, the physician is a member of—maybe even a

principal in—the organization you bill for your services and that bears the cost. In this model, physicians will be more hesitant about referring for any specialty health services, and will weigh the cost/benefit value of your care in the decision. If someone else offers approximately the same level of care that you do, in terms of patient outcomes for less, the physician has a powerful incentive to refer elsewhere.

The ACO model has one significant advantage over the current reimbursement systems in that providers should play a greater role in decision-making than is true of third party managed care organizations. That should translate to greater openness to quality of care arguments for additional services, especially when combined with the requirement of meeting quality of care standards, but in the end cost will always be a major factor.

Since many psychologists do not work with Medicare patients, it is important to know that private insurers are likely to embrace the ACO model. From the private insurance perspective, the ACO model effectively shifts financial risk and the burden of gatekeeping from the insurance companies to the providers. Massachusetts offers an early example of this shift. Thanks to its then Governor Mitt Romney, who signed comprehensive healthcare reform legislation in 2006, Massachusetts is now six years into the process, and private insurance companies have embraced the ACO model in Massachusetts. The state's largest insurer, BlueCross BlueShield Massachusetts, now has 75% of its HMO patients on "Alternative Quality Care" contracts. These are ACO structures with global payments. Specialists across many disciplines are seeing a reduction of referrals in the context of the ACO structures, as ACO professionals seek to maximize value when planning patient care. The experience there suggests that private insurance companies may follow suit across the country, although the pace of private insurance adoption of the ACO structure and bundled payments is not yet clear.

The final thing to know about ACOs is that they are likely to encourage experimentation with alternate forms of care delivery. Two in particular are worth discussing: the PCMH and integrated primary care.

### **I don't know if I can take any more, but OK, tell me about patient-centered medical homes (PCMH).**

That's not really a question, but we'll answer it anyway. The idea of the Patient Centered Medical Home (PCMH) pre-dates the ACA, and some of the description of the ACO in the act was influenced by the principles of a PCMH. The PCMH emerged out of concerns shared by the major medical associations involved in primary care such as the American Academy of Family Physicians about the bias towards specialty over primary care encouraged by the fee-for-service reimbursement model. In 2007, these associations published the *Joint Principles of the Patient-Centered Medical Home*, available at various places on-line including <<http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>>. These principles propose that every patient should have an ongoing relationship

with a personal physician, typically a primary care physician, who oversees the patient's entire care (you should be able to see the relationship to the ACO here). If the patient requires specialty care, the specialist becomes part of the patient care team led by the personal physician, and is guided by a comprehensive treatment plan overseen by the personal physician. Ideally, the PCMH even draws upon the patient's community (e.g., family, church) to help achieve positive outcomes, and uses information technology, such as shared electronic health records, to coordinate care across providers.

The concept of the PCMH has taken off. Several thousand primary care practices across the country have been recognized by the National Committee on Quality Assurance (NCQA) as PCMHs. An important part of that recognition for psychologists is the recent addition of a requirement that PCMHs must track the use of evidence-based medicine for the treatment of at least one condition related to unhealthy behaviors, mental health, or substance abuse. This is an important shift in the direction of what has come to be known as integrated care.

### **Nice segue. So, what is integrated care?**

"Integrated care" has become quite a buzzword in health care, so it's not surprising to see it used several different ways. In particular, the concept of the physician being responsible for coordinated care across providers is often referred to as integrated care. When psychologists use the term "integrated care," they usually mean the embedding of mental health and perhaps substance abuse services within the primary care team. To give a better sense of what integration means, I will start by distinguishing it from several related models.

Integrated care is distinct from co-location that refers to mental health and primary care services that are located in physical proximity. Many sites that are co-located are not integrated, as when mental health and primary care units are housed near each other but have little to do with each other. For example, each may refer to the other, and each may sometimes provide consultation to the other, but otherwise they operate independently.

Integrated care is also distinct from collaboration that occurs when mental health and primary care providers discuss a case to come up with a shared treatment plan. In most cases where such discussions occur, the providers still function independently, and each maintains complete responsibility for his or her aspect of treatment.

As noted already, integrated care is also distinct from coordination. The latter need not even involve mental health, though most of the research on coordinated care focuses on individuals with co-morbid physical and emotional conditions (McDonald et al., 2007).

Integrated care as used by mental health providers—and forward thinking primary care providers—is a model of service delivery in which mental health services are embedded within the primary care setting. The mental health provider, often known as the behavioral health consultant, is a member of the primary care team, and sees patients in a manner



consistent with primary care. The psychologist may be asked for an unscheduled "curbside consult" with a physician, may be asked into an examining room for a "warm handoff" of a patient from a physician to psychologist, may provide group medical visits for pregnant women or diabetics in collaboration with a nurse practitioner, or may work with the rest of the team on an integrated treatment plan.

This approach to care has a number of advantages, including greater patient receptivity to mental health services, increased access to psychosocial alternatives to medication for mental disorders in the primary care setting, placing mental health services where the underserved can most benefit from them, and increased use of behavioral interventions for chronic health conditions. It is not surprising then that both the Department of Veterans Affairs and Department of Defense have made a substantial commitment to integration, hiring large numbers of psychologists and social workers to serve as behavioral health consultants embedded in their primary care teams. However, it is important for the psychologist to recognize this model requires a different approach to care delivery. In the primary care setting, there is rarely more than 15-30 minutes available for patient contact. If care will require more than a few sessions, referral to specialty mental health care is appropriate, interruption during patient contacts is expected, and the focus is on establishing a sense of trust rather than of intimacy.

### Enough with the terminology, tell me how I'm going to survive?!

It is possible bundled care entities such as ACOs will not become as powerful a force in health care as we envision, and that practice will continue as is. Given the powerful economic forces agitating for change in the face of health care costs that are spiraling out of control, however, that does not seem likely. More likely is that we will see increasing consolidation within health care, reimbursement only with referral from a large health care organization, and increased emphasis on outcomes and cost containment. If that will happen, and the change is in process now, we need to engage with that process to ensure a place for ourselves at the table.

As a general principle, the solution requires demonstrating our value to other providers, with value referring to both costs and benefits. We need to ask ourselves the fundamental question: are we cost increasers in the system, or cost decreaseers? In addition to the value we provide in delivering our traditional care (e.g., relieving symptoms of depression and anxiety), psychologists need to expand our focus towards helping manage patients' basic health. Just as most psychologists consider the patient's work life, school life, and family relationships appropriate targets of inquiry and intervention, psychologists can "own" patient's basic health as well. Are patients taking medications regularly; managing their weight; exercising? Are we helping to avoid costly hospital visits that have arisen because their asthma is out of control? Because the top five chronic diseases that explode costs within ACOs are largely mediated by lifestyle factors, psychologists who put basic health on their

therapy "to do" list are arguably in the best position of any clinicians to become cost decreaseers within the system.

What follows are some specific strategies that we suggest for becoming part of the change. You will notice a few more references than has been the case till now. Those are intended as potential resources for you as you prepare to market yourself to new health care agencies.

- If a patient fails to improve in traditional psychotherapy, it is a common practice for the treatment to continue in the hope that the patient will ultimately reach a point of readiness for change. This practice will become increasingly impractical in the context of bundled care.
- Certain patients are particularly costly for the organization working under a bundled care contract. Those are the medically complex, high utilizer patients, patients who require frequent medical care, or are regularly in the emergency room or hospitalized. These patients can also be emotionally draining for medical staff. To the extent you can contribute to a treatment plan that reduces the cost and conflict associated with such patients, you can be a valuable asset to the organization. In particular, some research suggests a significant *medical cost offset* can be achieved by adding mental health services to medical care, even after accounting for the cost of those additional services (Blount et al., 2007; Bruns, Mueller, & Warren, 2012; Hunsley, 2003).

For example, when seeing a child in therapy, who has ADHD and is also asthmatic, a psychologist, in addition to helping the family manage homework time, might utilize the data they have already collected about the child's attention problems to develop an asthma care plan. Because of poor organization, Johnny might habitually forget his inhaler at soccer practice. His mother might also have ADHD symptoms, and have difficulty remembering to administer daily medications. The asthma care plan could utilize family systems dynamics and personal traits of the child to target a reduction of asthma related ER visits. In this example, the psychologist doesn't abandon their traditional role, they expand the domains in which they intervene.

- Psychologists will increasingly experiment with episode-based payments. In Massachusetts, for example, psychologists with group practices are negotiating with ACOs to provide behavioral health services to large populations of patients. This means that the psychologists hold the risk for the treatment (they negotiate a "per member per month" fee), and have significant incentives to provide targeted, effective interventions. Because treatment interventions are less bound to fee for service structures, psychologists can be more flexible and innovative in treatment strategies such as utilizing group intervention, or co-leading group interventions with physicians. Similarly, psychologists employed by hospital systems that have converted to ACO models are now being evaluated not on monthly billing, but by how well they can design targeted, effective behavioral health interven-



tions to populations of patients within the ACOs. This is a model that is likely to prove very attractive to comprehensive care organizations, but it requires a greater understanding of the costs of one's treatment than is typical for psychologists.

- An alternative that has been discussed involves episode-based payment. A patient is referred to you for diagnostic evaluation. This evaluation will need to address both the presenting complaint and complicating factors in treatment such as personality disorder, cognitive impairment, and severe psychosocial stressors. Based on the diagnosis, the psychologist will negotiate a total cost for that episode of care. The psychologist will then assume the risk if the services provided exceed expectation.
- Prescriptive authority for psychologists can also contribute to these relationships, making psychologists a one-stop shop for mental and behavioral care (McGrath & Sammons, 2011).
- Psychologists can distinguish themselves from alternate providers by the diversity of training. A single provider capable of dealing with behavioral health and mental health issues; families, couples, and individuals; personality disorders; cognitive assessment; evidence-based treatments can be a one-stop shop of services. Indeed, if psychologists are to benefit from the opportunities within the ACO structure, seeking training in behavioral medicine is critical. For example, a psychologist who seeks training in CBT strategies for insomnia can go to an ACO and provide a brief presentation on the reduction in medical complications (and therefore cost) that follow effective insomnia treatment, and contract to provide treatment to any ACO patient with insomnia.
- This approach requires increasing attention to our role as biopsychosocial providers. Specifically, enhanced preparation for dealing with behavioral issues in medical treatment, the skills that have traditionally been associated with specialization in health care psychology, should become part of the foundational knowledge of all health care psychologists. Of course, this is the direction our field is heading, regardless of healthcare reform. As cognitive and emotional neuroscience become more sophisticated, psychologists are realizing that attending to patients' physical state, for example, exercise, markedly enhances our psychological interventions.
- Whether done as part of a solo practice or a group contract, embedding a psychologist, even part-time, in the primary care team can be worthwhile even if the fee structure in effect does not allow for billing for that time. Though the majority of individuals demonstrating psychological difficulties can then be addressed efficiently within the primary care setting, a certain percentage of patients will still need referral for specialty mental health care, and research suggests a substantial increase in conversion rate resulting from an initial contact with the mental health provider in the primary care setting from which

the referral is made (e.g., Bartels et al., 2004). However, it is important for psychologists in this situation to realize that primary care is a very different setting, requiring different skill sets than those in which we are generally trained, and embedding can fail if the psychologist is not adequately prepared or flexible (Gruber, 2010). Several excellent introductory texts are available on working in integrated settings (Hunter, Goodie, Oordt, & Dobmeyer, 2007; Robinson & Reiter, 2007), as are training programs. Links to various programs, including the one the first author directs at Fairleigh Dickinson University, are available at <<http://www.integratedprimarycare.com/training>>.

- Psychologists will need to communicate more frequently and effectively with physicians. It is a common complaint among physicians that when they refer for mental health services they never hear back. The psychology consult, unlike consults with other medical specialties, often "goes into a black hole." In the future, not only should the physician know that the referral has been completed, but should have a sense of the treatment plan, expectations for treatment, and information about progress and outcomes. The psychological treatment report is an excellent opportunity to share, explicitly and concretely, how clinicians are intervening not only to improve the patient's mental health, but specific strategies they are using to address patient's physical health.
- For assessment, psychologists and neuropsychologists, the era of the 20-page report is over. Like other specialists, psychologists will need to develop the skill of writing short, high-impact reports designed to help their referral sources improve patient care. Most psychologists learned to write reports in training settings that emphasized long reports to demonstrate that clinicians were reasoning through all the variables and tying all of their clinical assertions to specific data. Many psychologists continue to write in this style long after the training benefit has ended. They spend hours of uncompensated time writing lengthy reports that referral sources neither read nor utilize. Psychologists may wish to seek advanced training in writing brief, high-impact reports through continuing education. The InterOrganizational Practice Committee (IOPC; a committee of the practice chairs of the American Academy of Clinical Neuropsychology, the National Academy of Neuropsychology, Division 40 of the American Psychological Association, and the American Board of Professional Neuropsychology) has launched a healthcare reform web-based toolkit that includes templates for writing brief assessment reports as well as advice from writing coaches in shortening reports while maintaining and improving their impact <<http://www.neuropsychologytoolkit.com>>.
- Many psychologists who work in large hospital settings already use electronic medical records (EMR). Effective use of EMR in a mental health context is a skill that can

be acquired. Psychologists must be sensitive to the information they put in those records, and they can play a role in training medical staff on the use of mental health information. Many psychologists in group practice are purchasing EMR systems. Ideally, EMR allows medical professionals to communicate freely amongst each other, and between hospital systems. In reality, EMR software developers have been allowed to create proprietary systems that cannot interact with one another. Therefore, prior to buying an EMR system, psychologists must be very cautious about whether the systems will be able to communicate with the majority of their referral sources. In some instances, large hospital systems allow outside practitioners to log onto their EMR systems, not to read patient records, but to contribute to them. The APA Practice Organization has excellent resources available to psychologists who want to learn more about EMR <<http://www.apapracticecentral.org/advocacy/state/leadership/health-records.pdf>>.

- Changes in delivery structure and payment reform create significant opportunities for psychologists with skills in behavioral health. Training opportunities for mid-career psychologists are particularly important if psychology as a profession is going to thrive in the new healthcare environment. Contacting the continuing education committee of your state psychological association is an important step. Many associations are considering pairing skill development workshops with mentoring and consultation opportunities. For example, a workshop on cognitive-behavioral therapy techniques for insomnia might conclude with a list of skilled clinicians in the area willing to provide ongoing consultation (at their regular fee) for clinicians who would like to integrate the technique in to their practices.

### That's a lot to think about. Is there anything else you would like me to know?

There are few final thoughts we'd like to share with you. We've focused here on the details, but there are some big picture issues here for you to consider, and that should create some hope that these changes will at least contribute to improving care for many people.

You may well object to the changes we've described as potentially creating a conflict in which health care providers will benefit from restricting care. That is true, but it is important to keep in mind that the current fee-for-service system creates a conflict in which health care providers benefit from offering unnecessary care. At least this new system for the first time mandates that cost containment be balanced with quality of care. As psychologists, and as advocates for our patients, we can be a voice for ensuring that this balance is maintained.

You may well be concerned about the increasing focus on data gathering, since this has traditionally been used by managed care to ration services. That is reasonable, but it is important to keep in mind the new metrics are explicitly in-

tended to force care providers to balance cost containment and quality of care. As psychologists, and as advocates for our patients, we can be a voice for ensuring the metrics are used as intended.

You may also be concerned that the emerging system will sacrifice longer term treatments for brief interventions. This is also a reasonable concern, but it is important to keep in mind that the existing mental health service that focuses on individual therapy for an extended period, with all individuals who pursue such treatment, is incapable of meeting the psychological health needs of the nation (Kazdin & Blase, 2011). As millions more people become fully integrated into the health care system, we must ensure the entire spectrum of services is available so we can match the level of service to the issues to be addressed.

Whatever the final result, the intentions of health care reform—improving access to care, and balancing cost containment with quality of care—are honorable ones. For those reasons alone, we should engage in the process. It is important we do so in a way that maintains both our own integrity and our economic viability. That is a great challenge, as well as a significant opportunity, for those willing to expand their practice skills and conceptualization of where psychologists should intervene in the healthcare system. ♦

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