

The Holistic Healthcare Safety Net System: Pennsylvania's Next Frontier

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According to The Henry J. Kaiser Family Foundation, "health insurance affects access to health care as well as a person's financial well-being. Over half of uninsured adults have no regular source of health care to go to when they are sick. Worried about high medical bills, they are more than twice as likely to delay or forgo needed care."

Since the passage of the 2010 Patient Protection and Affordable Care Act (ACA; <http://www.govtrack.us/congress/bills/111/hr3590>), millions of Americans have anticipated having enhanced access to health insurance products. The ACA has established a mandate for Americans under age 65 to purchase health insurance and offers premium subsidies to low-income Americans to help them pay for this insurance. The ACA has mandated a set of essential health benefits designed to help individuals remain healthy, overcome acute illness and improve the management of chronic health conditions. The advent of a set of essential health benefits is an important policy step toward developing a more holistic approach to health care and an effort to transform the health system from its

current focus on disease and illness to one of prevention and wellness.

The ACA established numerous opportunities to enroll uninsured Americans, to improve access to health care services, to improve the quality of care and to potentially reduce or at least better control costs. Still, the passage and implementation of the ACA has been controversial, and the recent experiences related to the initial rollout of the federal health insurance exchange have been less than positive. Yet more than 7.5 million Americans have enrolled with the knowledge that their health insurance plan will provide benefits without regard to preexisting condition exclusions.

The health delivery system, which comprises primary care practices and acute, rehabilitation and long-term care institutions, is responding to better meet the needs of the newly enrolled. New practice models are evolving, including some efforts to build so-called accountable care organizations that are designed to fully integrate a holistic approach to patient care and health care financing. These nascent efforts offer the promise of transforming health care practice, emphasizing disease prevention through a variety of patient education and wellness activities designed to improve health outcomes, earlier diagnosis of problems and perhaps less expensive solutions to patients and the system as a whole.

For patients with underlying behavioral health conditions

such as depression, anxiety and unhealthy alcohol and drug use, the essential health benefit provisions of ACA have created new opportunities for primary care providers to identify and treat patients who are experiencing these symptoms at the acute level, including offering referrals for counseling and psychotherapy when more serious conditions may require it. Still, most providers do not screen for these conditions and those that do are not currently able to invoice for these services through traditional billing methods.

Evidence-based screening tools including the Alcohol Use Disorders Identification Test and the Patient Health Questionnaire have been developed that patients can self-administer in the primary care office before or during a routine office visit. These tools help primary care practitioners better identify patients who may be experiencing these conditions at an early stage so treatment can be expedited. But screenings alone have not been shown to be effective. The new health care delivery models improve outcomes and save money compared with current practice because they change the way treatment is provided after the conditions are identified. The health care costs of patients with depression are 50 percent higher than those for patients without depression, and the societal cost of unhealthy alcohol use is \$225 billion (\$750 per person). Depression and unhealthy substance use are common and treatable, particularly if identified at an early stage.

There have been 69 randomized controlled studies of collaborative depression care management and 23 studies of screening tools and brief interventions for risky alcohol use in primary care offices. As a result, both services are recommended by the United States Preventive Services Task Force with a Grade B recommendation. For depression, the IMPACT randomized controlled trial showed a 6:1 return on investment (ROI) over four years, and a screening and brief intervention trial for unhealthy alcohol use showed a 4:1 ROI over four years. These studies describe the current system as lacking in systematic screening for mental health and substance-abuse conditions and relying upon referrals to specialists. The studies strongly suggest that the current system is not cost-effective and that opportunities exist to improve access to needed services while also saving or at least conserving the use of taxpayer money (Callahan, Nienaber, Musick, & Tierney, 1994; Katon, 2011; Katon, Lin, Russo, & Unützer, 2003; for alcohol, see <http://www.ncbi.nlm.nih.gov/pubmed/22011424>).

In Pennsylvania, there are four practice models that are integrating behavioral health with primary care. These are:

- The co-located model with primary care and behavioral health services delivered in the same location
- The coordinated care model, in which care is coordinated between two or more behavioral health

and primary care providers that are not physically co-located

- The collaborative care model, in which behavioral health and primary care confer with one another
- The integrated care model, in which behavioral health professionals provide direct consultation services within and as part of the primary care practice

While practices and communities have embraced one or more of these practice models, there remain significant barriers to realizing the goals of the ACA. These barriers include the separation of behavioral and physical health records (a current technology and practice management barrier); the separation of physical and behavioral health managed care organizational (MCO) systems that credential and establish networks of providers (a policy barrier); the separation of billing and payment systems (a policy and a business barrier); and the lack of provider education and training to incorporate a more holistic approach to patient care (a systems barrier).

Based on national surveys including all treatment settings, only 40 percent of those with a behavioral health illness receive treatment. Among those who are treated, only half receive effective treatment. Few primary care offices have the financial capital, time, staff and processes to conduct recommended screening, interventions, treatment and follow-up. Almost none are currently licensed as an outpatient behavioral health providers or are reimbursed to offer these services.

The ACA has mandated that electronic health records (EHRs) be established and used. Tablets and laptops have become commonplace inside treatment rooms. EHRs are complex, designed to incorporate patient safety protocols and evidence-based practices to improve clinical outcomes, measure practice efficiency and generate billing. EHRs are an amazing technological achievement, yet the industry has lagged behind in developing EHRs that fully integrate behavioral and physical health information and support the delivery of holistic health services.

Pennsylvania led the way in developing a model Medicaid managed care program. Its HealthChoices model is nationally recognized for its ability to improve access, improve the quality of health care services and stabilize Pennsylvania's medical assistance spending.

The Pennsylvania Department of Public Welfare's (DPW) Office of Medical Assistance is responsible for the physical HealthChoices program while the DPW Office of Mental Health and Substance Abuse Services oversees five separate behavioral health MCOs. The DPW also regulates the operations of outpatient behavioral health services and licenses each provider site. Only in the case of a federally qualified health center (FQHC) does DPW not have licensing jurisdiction over outpatient behavioral health settings. However, FQHCs are still required to submit an application to the Health Resources and Services Administration and then to DPW. Still, the MCOs

provide clinical and fiscal oversight authorizing services and administrative services such as claims processing, provider credentialing and network management.

Pennsylvania's HealthChoices participants are assisted in securing needed acute, primary and specialty services. These services are available through the MCO's network of providers supported by case management and service utilization consultants. Yet the systems are not integrated, challenging the quality, system cost-effectiveness and clinical outcomes of patients who have co-occurring physical and behavioral health conditions. In all but FQHC settings, patients must access services through separate systems, with each facility's managing clinical and financial patient information in separate recordkeeping systems.

It is also important to recognize there are significant subpopulations of special-need consumers including those living on the streets or in prisons. While there are some national models of service integration for these high-risk/high-need populations, Pennsylvania's current approach to serving these individuals divides administrative oversight, payment and service delivery among numerous state agencies. Integrated primary and behavioral health care for these subpopulations is significantly challenged by current regulatory practices and remains inefficient, fosters poor outcomes and is costly.

The ACA created an opportunity for states to expand their Medicaid program to help low-wage working adults acquire health insurance. The Corbett administration believes that the Medicaid expansion will be too costly and unsustainable for Pennsylvania and has submitted an alternative proposal that remains under review by the Centers for Medicare and Medicaid. Meanwhile, nearly 500,000 Pennsylvanians remain without an opportunity to secure affordable health insurance, creating yet another barrier to achieving full integration of physical and behavioral health care.

The opportunities of the ACA, consumer interest in access high-quality, affordable health care services and the desire of health care professionals to provide holistic, cost-effective care inspire us to consider how to best overcome the barriers that hinder or outright prevent us from achieving full integration of all health care services. The opportunity to integrate is compelling. Pennsylvania should embrace the redesign of the HealthChoices system and continue its leadership in promoting a cost-effective, high-quality system.

References

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