Reform model not yet helping people with mental illness

December 7 2015

People who are diagnosed with mental health conditions did not see improvements in coordination and quality of care as hoped but did not experience large cuts in access as some had feared under an early alternative payment model designed to encourage coordinated health care, according to a team led by researchers from Harvard Medical School and Johns Hopkins Bloomberg School of Public Health.

The research team looked at claims data from 2006-2011 to examine whether the implementation of the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract affected mental health service use, mental health care spending, total spending and quality of care. They also interviewed providers and managers about the process of implementing the AQC and the potential for developing systems to improve coordination of care for people with mental health diagnoses.

The researchers said the interviews suggest that these organizations were not focused on mental health integration when the contract was first implemented but are now thinking creatively and innovatively about developing new programs, such as integrating social workers into treatment teams focused on non-mental health conditions like diabetes to better identify and support patients with mental health conditions who would benefit from more integration of mental health and medical care, but that it is too early to have seen results from these new programs.

The study was led by Haiden Huskamp, professor of health care policy in the Department of Health Care Policy at Harvard Medical School, and

Colleen Barry, professor and associate chair for research and practice in the Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. The findings are published in the December issue of *Health Affairs*.

"The initial effort didn't solve the problem of fragmented care for people with mental health conditions," Huskamp said. "We still need to do more to integrate the care that they get."

Payment reform experiments

While the traditional fee-for-service model provides a financial incentive for providers to perform more procedures, new payment models that provide a lump sum to cover all the costs of a person's care can motivate physicians and hospital administrators to focus on providing the highest value care and improving care coordination, although the new models could also result in reduced access to care.

Various organizational approaches to this goal—accountable care organizations, bundled payments, global budgets—are part of many public and private health care reform efforts. One early example is the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract, which began in 2009.

An earlier study of the AQC found that for the general population, the growth of overall health care spending slowed and some measures of quality of care improved.

Huskamp, Barry and colleagues at HMS, Johns Hopkins and McLean Hospital wanted to know whether the model had the same effects on people who receive mental health care.

This is a crucial population for health care reform. Mental health

disorders affect tens of millions of people in the United States each year, and the total direct and indirect costs of the most serious mental health illness are more than $300 billion per year, according to the National Institute of Mental Health.

Integrating fragmented care

Since care for mental health is even more fragmented than care in the rest of the health care system—with distinct insurance benefits for mental and behavioral health, and a separate mental health care system that is often not directly linked to primary or secondary medical care services—the researchers noted that it is an area that could benefit greatly from efforts to improve the quality and coordination of care.

Instead, they found that some AQC patients with a mental health diagnosis were slightly less likely to receive mental health services than a comparable group covered by the same insurer. They also found that for people who did use mental health services, spending did not change.

In addition, people with mental health diagnoses were less likely to benefit from improvements in quality of care.

For example, to help prevent and treat chronic illnesses, the AQC offers incentives for clinicians to increase the use of diabetes management approaches. Providers working under the AQC were more likely to adopt certain diabetes management approaches for patients in the AQC than for a comparison group of Blue Cross Blue Shield enrollees not in the AQC, but these improvements were not found among the subgroup of AQC enrollees with both diabetes and a co-occurring mental health diagnosis.

According to the researchers, as accountable care evolves, policymakers, insurance companies and providers will need to understand how these

reforms affect care for often high-cost individuals with mental health treatment needs.

"In order to take advantage of the transformative power of coordinated care," Barry said, "we need to make sure that the incentives and quality measures we use address the needs of this crucial population."

Evolution Ongoing

In addition to their quantitative analysis, the researchers also conducted interviews with providers and managers in a variety of organizations to understand the context for the complex transformations taking place.

Interview participants said that many organizations spent the first years of the contract building the basic infrastructure for collecting the data necessary to coordinate care and measure progress, and that their organizations have only recently begun to address some of the more challenging changes needed to manage mental health care delivery.

"They now have to think about the whole person, and that's changing how they do business," Huskamp said.

Provided by Harvard Medical School