HOW VALUE-BASED PAYMENT REFORMS CAN UNDERMINE CARE FOR THE SERIOUSLY MENTALLY ILL

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“Value-Based” Payment
Rationale for “value-based” payment

- Assumes excessive US health cost due to FFS
  - FFS financial incentive to deliver excessive “volume” of (presumably unnecessary) care
- Counter-incentive: Shift insurance risk onto providers of care.
- If providers are paid up front for:
  - An episode of care, or
  - with per-patient capitation, or
  - for care of a population, then
  - their financial incentive will be to deliver less (presumably unnecessary) care.
Rationale for “value-based” payment

• But – introduces perverse incentives –
  • Skimp on necessary as well as unnecessary care
  • Avoid sicker, more complex, and socially disadvantaged patients (“cherry picking”)

• Counter-counter-incentives –
  • pay-for-outcomes/pay-for-performance (to assure “value”)
  • risk adjustment
But:

- **Pay-for-outcomes** adds to incentive to “cherry pick”
- **Risk adjustment** is
  - Very complex
  - Difficult to capture enough relevant variables to be fair
  - Easily gamed by doctors, hospitals, health plans
  - Competitive environment = strong financial incentive to continue to “cherry pick”
- **P4O/P4P and risk adjustment both require detailed documentation and data reporting**
- **Increased administrative costs outweigh savings**

Financial incentives to “cherry-pick” affect seriously mentally ill more than any other population!
And what about the underlying assumptions?

• Does FFS really drive a lot of unnecessary care?
• What about other drivers of unnecessary care, such as lack of access to appropriate care → complications, ER, hospital?
• Are doctors primarily motivated by money?
• Does competition among risk-bearing entities (health plans, ACO’s) lead to either better plans or lower cost?
Competition in Private Health Insurance

- Administrative costs: 5-6 times that of public systems
- Incentive is to avoid risk (caring for sick people)
- “Race to the bottom” among plans
- Misguided and costly efforts to manage health care providers via bureaucracy
- No benefits for patients, providers, payers
Shifting Insurance Risk to Providers

Incentivizes them to:

- Restrict care
- "Cherry Pick" - avoid sicker, more complex patients
- Game diagnoses to beat risk adjustment
- Game documentation to improve reimbursement
- Become more focused on money at expense of patient’s welfare

Global Amnesia- Embracing Fee-For-Non-Service—Again-JGIM 01-07-14
Physician Payment & Motivation

- Behavioral Economics:
  - *intrinsic* (do right for pt) vs. *extrinsic* ($) motivation

- Consequences of pay-for-performance (P4P):
  - Measures for “performance” grossly inadequate
  - Promotes physician greed (“extrinsic” motivation)
  - Gaming documentation for payment
  - Corruption of health care data
  - Fraud and abuse

Can We Measure Quality in Health Care?

• **Estimated 25% of patients in a typical primary care practice are “complex”**

• Quality in health care is very difficult to measure due to its complexity.

• Available measures - either grossly invalid or narrowly focused on what is easy to measure (“streetlight effect”)

Quality Scores Tell More About Patients than Physicians

Harvard physicians with poorer/minority patients score low

Patient characteristics in panels of high- and low-scoring physicians

- Minority: 14% (Top Scoring) vs. 26% (Bottom Scoring)
- Non-English Speakers: 3% (Top Scoring) vs. 10% (Bottom Scoring)
- Uninsured / Medicaid: 10% (Top Scoring) vs. 17% (Bottom Scoring)
- Infrequent Visits: 29% (Top Scoring) vs. 38% (Bottom Scoring)

Escalating Administrative Burdens

- Increased utilization management by health plans
  - Prior authorizations for drugs – 8% in 2007, 23% in 2016. Also for imaging and labs.
- Much more detailed documentation (E/M, ICD-10)
  - Data reporting for pay-for-performance, risk adjustment (penalties for failure to report)
  - Increased overhead cost for staffing, computerization
- Twice as much clinic time on computer as paying attention to patients, plus 1-2 more hours charting at home (Ann Int Med, Sept 2016)
  - Loss of time for attention to patients
  - Loss of personal time and quality of life
  - Reduced cost-effectiveness of medical practice
Physician Burnout

- Emotional Exhaustion
- Loss of Meaning in Work
- Feelings of Ineffectiveness
- Tendency to view people as objects rather than human beings
Growth of Physicians and Administrators in U.S.

Growth since 1970

Managers shown as moving average of current year and two previous years

Bureau of Labor Statistics; NCHS; Himmelstein/Woolhandler analysis of CPS
Overall Administrative Costs

Dollars per capita, 2015

- USA: $3,199
- Canada: $741

Himmelstein et al. Health Aff 09/2014
Small, MD-Owned Practices, Fewer Avoidable Admissions

Public reporting appears counterproductive

<table>
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<th>Amputary Care</th>
<th>Sensitive Admission Rate per 100</th>
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Based on analysis of Medicare data, Medical Home Score, P4P Incentives, and Risk Sharing showed no effect.
HI Psychiatrist Pay vs Insurance Premiums

Kemble personal data
Effects of Health Care Reform for Psychiatry in Hawaii
Hawaii FFS Medicaid (prior to 1994)

- Weak Public MH System
  - Dept. of Health clinics run by AMHD/CAMHD
  - State Hospital – attempted closure, became forensic only
  - Ranked 51st in US, Felix Consent Decree
- But, near 100% participation by private sector psychiatrists
  - Most solo, built practices with Medicaid
- Psychiatric units in general hospitals
- Specialized SMI and substance abuse programs

- Generally good access in private sector
- Generally adequate supply of psychiatrists
  - Relative shortages on neighbor islands

- BUT, 1st for-profit psych hospital in late 1980’s
Hawaii’s Medicaid Experience – Managed Care Organizations (MCO’s)

- Converted FFS Medicaid to MCO’s - 1994, 2009
- Increased administrative hassles (and cost)
- Declining MD participation
- Worsening access problems
- Accelerated Medicaid cost increase – 2.7% > US average (Kaiser State Health Facts FY ‘90-’10)
Hawaii’s Medicaid Experience – Managed Care Organizations (MCO’s)

- Worst for mental illness – 4 yr after Medicaid managed care, > half of psychiatrists dropped out, MH ER and hospital costs increased 30%!!

  Hawaii Health Information Corp 06-26-13

- Psychiatrist participation in Hawaii Medicaid
  - 1990: 100%
  - 2009: 67%
  - 2017: 2 of 133 psychiatrists accepting new patients with either Medicaid or Medicare
Value-based reforms in Hawaii

• Almost no private practice psychiatrists willing to invest in computerization and staffing required for documentation and data reporting under new payment models → Medicare penalties

• Almost all quit accepting Medicare and Medicaid instead

• Medicare and Medicaid access now limited to CMHC’s and hospital clinics with employed psychiatrists

• Large numbers of SMI unable to obtain care at all

• Early experience with Collaborative Care model
What Would Work?
1970’s: Community Psychiatry at Cambridge Hospital

- Dept. of Psychiatry - contracted for all public sector mental health for Cambridge and Somerville
- Global budget from State (pre-Medicaid) - NO competing managed care plans
- Comprehensive services and programs
- Reach out to meet needs of patients and community
- Interdisciplinary team care, good coordination
- Professional staff paid with salaries
- High morale, low administrative cost, good care
- Care managed by delivery system, not insurance plans or government
- BUT, two-tier system
Care management by delivery system, not health plans

- **Area-based capitation** - one integrated “Accountable Care Organization” for defined geographic area
- **Optimized professional work force**
- **Cooperation and collaboration**, not competition, to improve cost-effectiveness of care
- **Comprehensive responsibility for population** and bringing as many as possible into appropriate care
- **Quality improvement** led by physicians and other health care professionals (not administrators)
  - NO pay-for-performance, bundled payments, or competing risk-bearing health plans or ACO’s
Two Incentive-Neutral MD Payment Options

1. Independent practice – Fee-for-Time
2. Employed physicians in hospitals, health centers, large groups – Salary
   • Straight salary for shift work specialties who don’t control patient volume
   • May use simple productivity incentives for physicians who can control work volume

Compared to:
• Capitation for primary care (HMSA 2016) –
  • Perverse incentives, requires P4Q and risk adjustment (high administrative burdens)
Fee-For-Time Principles

- Standardized, negotiated fee schedule
- Incentive-Neutrality –
  - Minimize perverse incentives and counter-incentives
- Minimize administrative costs and burdens
- Promote and rely on intrinsic motivation of physicians
- Quality improvement from front lines of care, not central administration
  - Intermountain model vs utilization management
Fee-For-Time Implications

- Billing vastly simplified
- No disincentive to treat complex or difficult patients
- Supports intrinsic motivation and professional ethics
- Minimizes incentives for unnecessary care
  - Minimizes need for utilization management
  - Minimizes opportunities for fraud and abuse
- Documentation for care needs, disconnected from payment
- Reduced office staffing and overhead (no need for billers, coders, scribes)
- Encourages independent practice (more cost-effective)
- No barrier to providing care in rural and underserved areas
- Computerization not absolutely required
Community-Based Specialized Services

- **Examples:**
  - SMI programs, psychosocial rehab
  - Substance abuse services
  - Collaborative Care
- **Multidisciplinary teams**
- **Funded by** global budgets (single-payer or all-payer)
- Professional staff paid with salaries
- **Available to all patients/physicians** in community based on patient need, not insurance status
Questions?

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