SERVING PEOPLE WITH COMPLEX NEEDS: MARKETS AND INCENTIVES

Richard G. Frank
Overview

• A Guess About the Future of Organization and Financing of Health Care
• Promoting Policy Goals: Tools and Settings
• Issues
  • Beds
  • Access to Quality Care
• Concluding Remarks
The Future

• Continued reliance on markets
  • Insurance
  • Care delivery
• Expanded use of budgeted or quasi-budgeted delivery systems
  • ACOs, Medicare Advantage, Medicaid MCOs
• Implies promoting policy goals with
  • Incentives
  • Competition
  • Market regulations
Policy Targets

- Medicaid (now 70% MMCOs)
  - MMCO regulations and contracts
  - Medicaid ACO design (payment; quality)
- Medicare Advantage SNPs
- Medicare ACOs
- Marketplaces
Issues

• Beds and market responses
  • IMD
  • Insurance expansion

• Access to quality mental health and SUD care
  • Parity Regulations (Medicaid, Private Insurance)
  • Incentives
    • Risk Adjustment
    • Performance measurement
    • Accountability
Young Adults M/SUD Admissions

Source: HCCI
Total Psychiatric Discharges per 100,000 Population by Expansion Status

![Graph showing average psychiatric discharges by expansion status from 2009 to 2014. The graph indicates a steady increase in discharges for both Non-Expansion and Expansion States over the years.](image-url)
Psychiatric Admissions (100,000) in Expansion vs. Non-Expansion States

Source: HCUPS; AHRQ
Observations

- Approximately 69,000 specialty psychiatric beds in the U.S. that fall under the IMD rule
  - 55% are in public psychiatric hospitals
  - 46% of the beds are devoted to forensic cases
  - Occupancy rates are high in private psychiatric hospitals
- Insurance expansion and parity increased inpatient use by 19% for young adults and 52% in the Medicaid program
- There is an influx of private equity money coming into the behavioral health sector
- The main driver of new investment appears to be coverage expansion
  - How much does the IMD constrain getting the mix right
  - Less cost worry with MMCO
Focusing Parity Enforcement

Figure 1. Types of Violations Found in DOL Enforcement Actions, FY 2010–2015

- NQTLs: 59%
- Cumulative requirement: 14%
- QTLs: 8%
- Other: 6%
- Not offering benefits in all classifications: 7%
- Annual dollar limits: 2%
- Lifetime dollar limits: 3%
- Disclosures to participants: 1%

Source: U.S. Department of Labor
Parity Implementation

- Enforcement on disclosure in private insurance and Medicaid will be important
- Further guidance on NQTLs will help
- Streamlined complaint filing process will also be useful
- BUT incentives to select and under supply remain
High Powered Budget Incentives: Population-Based Payment Systems

- Consolidates funding across service lines
- Moves accountability towards population focus
- Can favor prevention and early intervention approaches
  - Especially for clinical preventive services
- Challenges
  - Business case relies on savings subject to meeting quality thresholds
  - Behavioral health quality measures are under-developed
Consequences

• Potential consequences:
  • We have changed the terms of coverage, but unless we get accountability right, we risk distorting supply in a way that limits potential gains in outcomes
  • In particular, we risk undersupply of care that involves integration of behavioral health and medical care and conditions and people that are best treated using psycho-social care as a component of treatment
What to Measure and How?

• Measuring the quality of care so that it recognizes the integration and appropriate use of psycho-social care is required and difficult

• The challenge is to reward care that is likely to produce good outcomes
  • Ideally we would measure outcomes, but selection risks are high
  • Interim measures of processes that demonstrate integration and effective deployment of psycho-social care may have to be enough

• Measures must be designed to recognize the measure overload environment
Risk Adjustment

• For 50 plus years private insurance has under supplied mental health coverage and care
• Main drivers were incentives to avoid enrolling people with mental and addictive illnesses
• They cost more—both in term of behavioral health and other other medical care
• One must pay plans more for enrolling more costly people—we aren’t very good at that in the behavioral health area
Summing Up

• Markets and budgeted systems of care delivery will be with us for some time to come
• Markets for health insurance have disadvantaged people with mental illnesses and SUD for a long time
• We have improved matters through regulation (parity)
• To further advance—we must address the fundamental incentives in the main market and payment arrangements