Provider Incentives to Improve the Quality of Mental Health Care

UNC Program on Health Outcomes

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Susan L. Ettner, Ph.D.

Professor, University of California Los Angeles

Schools of Medicine and Public Health

Overview

- Background
  - Quality of mental health care
  - Financial incentives in health care
  - Some “real-world” initiatives
- Conceptual issues in designing a financial incentives program for mental health care
- Barriers to implementation
- Application: United Behavioral Health (UBH) pilot project

The Problem

- Low-quality mental health care
- Poor diagnosis
- Poor treatment
- Both under- and over-treatment
- <1/3 of mentally ill get evidence-based care
- May be worse than medical care

WHO Data on Mismatch Between Use and Need for MHS

Type of Mental Disorder	% of U.S. pop. with disorder	% with disorder who get treated
Serious	7.7%	40.5%
Moderate	9.4%	37.2%
Mild	9.2%	23.0%
None	73.6%	14.5%

Possible Reasons for Poor Care

- Mental disorders undermine patients' ability to act as rational economic decisionmakers
- Patients with mental disorders often lack family who act as their health care agents
- Poor provider and patient knowledge about mental disorders and appropriate treatment
- Social stigma
- Organizational and financial characteristics of the health care and insurance systems

Principal-Agent Problem

- Without good information, patients rely on other players in health care system to serve as “agents”
- Principal-agent problem: providers, health plans, and purchasers each face own set of incentives, which may differ from patient’s
- Focus on providers because they directly influence quality of care

Incentivizing Healthcare Providers

- Altruism and professionalism are strong motivations for provider behavior
- Yet reimbursement incentives may discourage QI efforts, even among best-motivated professionals (IOM, 2001).
- Amount and form of financial remuneration especially likely to affect behavior when providers are poorly informed about evidence base for treatment decisions.

Two Generations of Financial Incentives in Health Care

- 'First generation': control costs rather than promoting quality or efficiency.
  - Incentives either independent of quality or actually inhibited quality
- 'Second generation': improve health care quality through 'value-based purchasing' and 'pay for performance'
  - Motivated by desire to improve clinical outcomes and perception that suboptimal care is inefficient

“Second-Generation” Incentives

- “Value-Based Purchasing”
- “Pay for Performance” Programs
- CMS Initiatives
- British National Health Service
- RWJ Demonstrations - *Depression in Primary Care: Linking Clinical and System Strategies*
- PacifiCare Behavioral Health “Honors for Outcomes”

What We Already Know

- Very little! (Randomized) interventions are only now being evaluated.
- Extant literature on impact of financial incentives is very small and focuses on:
  - Utilization/costs rather than quality
  - FFS vs. capitation methods instead of P4P, or very weak P4P incentives -> little impact
  - Immunization rates and diabetes care, nothing on mental health

What We Already Know (cont'd)

- Observational study design limits interpretation

Provider groups that care more about quality may be more likely to reward it,

or

Those with bad track record may be more motivated to change the system

Designing an incentives program to improve mental health quality

- Effectiveness of giving financial incentives to providers to improve quality depends on a number of factors
  - Who is being incentivized
  - How incentive is structured
  - Which behaviours incentivized for which patients
  - How behaviour is measured and risk-adjusted

Who do we incentivize?

- Mental disorders treated by variety of providers
- In primary care, focus on incentives to diagnose and refer patients
- In specialty sector, focus on treatment appropriateness, including duration
- In MBHOs, typically psychiatrists do medication management and master's-level psychologists do psychotherapy

What should we incentivize?

- Psychotherapy and pharmacotherapy are main psychiatric treatment modalities, yet still many aspects that could be intervened on
- Criteria for choosing behavior to target (NHCPI, 2001):
  - Number of patients likely to be affected
  - Existence of accepted performance measures
  - Clinical guidelines and potential for quality improvement

What should we incentivize? (cont'd)

- All performance measures can be gamed, so incorporate some subjectivity (K. Murphy)
  - Tradeoff: Can we get unbiased, careful assessments?

Do we incentivize process or outcome measures?

- Risk adjustment even more important when incentivizing outcomes
  - P4P may strengthen incentives to “cream-skim” and “dump”
- Importance of patient adherence in mental health care
- Principle of not rewarding/penalizing providers for something they can’t influence

Do we incentivize care for a specific condition or all conditions?

- Provider incentives generally must be tailored to a target disease, e.g., depression vs. schizophrenia
- Tradeoff: incentivizing care for a single condition may divert resources from other conditions (“crowd-out”)

What type of financial incentive?

- Models include bonuses, at-risk payment, performance fee schedules, quality grants, reimbursement for care planning, etc. (NHCPI, 2002)
- Performance-based bonuses can be paid as an add-on to the base fee per visit or as a lump-sum bonus per episode or patient

What type of incentive? (cont'd)

- Incentivize performance of individual provider or group of providers?
  - Incentivizing group dilutes incentives
  - Also adds risk -> usually have to compensate for extra risk
  - Tradeoff: ease of administration

What type of incentive? (cont'd)

- Threshold vs. bonus per patient?
- Frequency of incentive
- Changes in incentives (K. Murphy)
  - To avoid perverse incentives, use standards that do not vary over time
  - Frequent tinkering with incentive plan destroys trust -> agree up-front when and why formula will be changed

How large should the incentive be?

- Most plans account for only small part of total caseload -> small bonuses may not motivate enough
- Minimum bonus needed to motivate providers: $10-15K or 5-10% of revenue
- But large bonuses more likely to entail a take-away for somebody

Should non-financial incentives be incorporated?

- Public recognition of high-quality providers or preferential referral system
- Reduction in administrative and regulatory burden
- Receipt of continuing medical education credits
- Educational materials and/or training
- Feedback mechanisms

Barriers: Measuring Performance

- Can behavior be measured using admin data or is primary data collection required?
  - Administrative data - more feasible and sustainable but less interesting
- Medical chart review - expensive
- Electronic medical records - difficult to recoup investment

Measuring Performance (cont'd)

- Provider reports with random audits
  - Poor response rates -> selection bias?
  - Self-report bias unless auditing frequent and penalty for "cheating" high?
- Patient surveys
  - Even worse response rates?

Barriers: Provider Buy-In

- Provider buy-in depends on factors (NHCPI, 2002) such as:
  - Degree of trust between physicians and organization implementing the incentives
  - Perceived and actual accuracy of data on which incentives are based
  - Physicians' recognition of need for change
  - Support of "opinion leaders"
  - Physicians' knowledge and understanding of the incentives
  - Simplicity / directness of incentive program

Barriers: Provider Buy-In (cont'd)

Providers may not…

- agree with the practices being incentivized.
- believe adequate performance measurement and/or casemix adjustment are possible
- believe in evidence-based medicine, i.e., basing treatment decisions for individual patients on research findings.

Barriers: Sustainability

- Feasibility and sustainability depend on cost of running program
  - Cost of measuring and monitoring quality – fixed vs. variable
  - Cost of financial incentives themselves
  - Ongoing evaluation costs?
- Health plans often reluctant to engage in grant-funded studies unless possible to continue successful program

Barriers: Sustainability (cont'd)

- Theory: Programs can be cost-neutral by penalizing low-quality providers to reward high-quality
- Reality: Providers unwilling to risk pay cut for chance to get bonus.
  - Provider acceptance of NHS experiment facilitated by large increase in overall health care budget

UBH pilot project (1)

- Collaboration between UBH and UCLA/RAND researchers (Francisca Azocar, Joyce McCulloch, Robert Branstrom, Lisa Meredith, Michael Schoenbaum, Kenneth Wells)
- Pilot study to improve depression care through financial and non-financial incentives
- Early decision to focus on specialty sector
  - Existing P4P interventions focus on primary care
  - Complicated to incentivize referrals in carve-outs
- Used “participatory stakeholder process”

UBH pilot project (2)

- Chose receipt and duration of antidepressant treatment for patients needing combo therapy as the focus
- Q: Who should be incentivized to get patients onto medication?
  - Psychiatrists as prescribers?
  - Use psychologists as entry point to refer to PCPs or psychiatrists?
- Which providers do we include - only those with large UBH caseload?

UBH pilot project (3)

- How do you assign patients to a provider?
  - "Pottery Barn rule" – if you touch the patient, you own them
  - Ensure that providers understand who their denominator population is
- How do you define eligible patients and identify them using existing databases?

UBH pilot project (4)

- Which patients do we include? Only those insured entirely through United system?
  - If only have behavioral health claims, will miss many patients receiving psychotropic drugs
- Should we build onto existing intervention, or have a “stand-alone” intervention?
- Are we incentivizing providers to improve quality, or rewarding providers who are already good?

UBH Pilot Project (5)

- Are there perverse “side effects” of the incentives? Who reaps benefits?
  - P4P programs might lead providers to improve quality and lower costs, but if patients’ treatment patterns change, providers’ revenues may also drop
  - If we incentivize psychologists to refer to pharmacotherapy, will it reduce psychotherapy visits?

UBH Pilot Project (6)

- How should program be publicized?
  - Can take several years to gain provider awareness of a P4P program, even with multiple mailings, etc.
  - Anecdote: Blue Cross of CA did a P4P program and in the first year, 80 of the physicians threw away their checks

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EXTRA OVERHEADS

“Value-Based Purchasing”

- Goal: assist consumers and health care purchasers in choosing plans based on ‘value’ rather than on cost *per se.*
- Several private NFPs with such initiatives:
  - NCQA has accreditation program for MCOs and issues report cards based on HEDIS.
  - JCAHO accredits and evaluates providers and plans with respect to quality and safety.
  - NBCH uses annual survey to collect benchmark data from health plans and create performance reports.

“Pay for Performance” Programs

- Leapfrog Group for Patient Safety – consortium of public/private health care purchasers
- All financial and non-financial incentive programs in the U.S. documented through its Incentive and Reward Compendium (available online)
  - Currently 91 initiatives but not all involve explicit financial incentives
  - Performance measures include health outcomes, quality of care, patient satisfaction, investment in IT and care management tools, professional contributions, prescribing patterns, preventive screening rates.

CMS Initiatives

- The Centers for Medicare and Medicaid Services have recently funded several P4P demonstrations.
- Premier Hospital Quality Incentive Demonstration
  - Gives financial incentives to ≈300 hospitals based on 34 quality indicators related to 5 conditions.
  - Hospitals scoring in the top 10% receive a 2% bonus payment; those in next 10% receive a 1% bonus.
  - Hospitals not meeting quality standards after two years are subject to payment reductions.

CMS Initiatives (cont'd)

- 3-year Physician Group Practice Demonstration
  - Pilot-tested with 10 large physician practices
  - Physicians who reduce Medicare costs retain part of savings as bonus and earn back another part of savings if they meet quality targets.
- Other demonstrations use set-asides for quality incentive payments based on clinical performance measures in areas such as:
  - use of HIT and patient safety
  - use of culturally appropriate care
  - disease management
  - care management for high-cost beneficiaries

British National Health Service

- In 2004, UK government signed a contract with family practitioners to provide 1.8 billion pounds in bonuses over 3 years for high-quality care (planned 36% increase in budget)
- Points based on clinical and organizational indicators, patient experience and prompt access to services
- Clinical indicators are process measures and intermediate outcomes related to ten chronic conditions

British National Health Service (cont'd)

- Early results: Even more money paid out than planned (42% instead of 36% increase)
- Achieved some patient benefits and targeted improvements in care
- Currently re-pricing the contract for 2006/7 and future years
- Also bringing in 7 new clinical areas

RWJ Demonstrations

- Depression in Primary Care: Linking Clinical and System Strategies provides incentive grants to 8 projects
- Goal: overcome barriers to diagnosis and guideline-concordant depression treatment in primary care sector by supporting clinical models of QI with necessary changes in incentives and organizational arrangements.
- Financial incentives offered to providers vary widely across projects, ranging from minimal incentives to paying providers to spend an extra 15 minutes with depressed patients.

PacifiCare Behavioral Health "Honors for Outcomes"

- In 2005, PBH started an outcomes monitoring and recognition system
- Clinicians administer (Youth) Life Status Questionnaire to patients at certain visits
- Honor roll designation for providers…
  - who submitted data for at least 10 patients over three years
  - whose patients during past 3 years consistently showed "greater than average" improvement compared to others with similar baseline severity and other characteristics