Society of Professors of Child and Adolescent Psychiatry

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Health Care Reform: Drivers

• Extend Coverage (Social justice and efficiency)

• Cost (versus public acceptance, politics)
The Economic Picture

**Gross Federal Debt (White House Budget)**

- 2000
- 2001
- 2002
- 2003
- 2004
- 2005
- 2006
- 2007
- 2008
- 2009
- 2010
- 2011
- 2012
- 2013
- 2014

**Federal Spending as a percentage of GDP (CBO Projection)**

- Medicare & Medicaid
- Social Security
- Other Spending (Excluding Debt)
Rising health care costs have been squeezing employers and employees for years

Cumulative Increase in national Health Care Premiums, Wages and Inflation (1999 base)

“The growing costs of health insurance have absorbed a large portion of the… increase in total compensation”

- Robert D. Reischauer
Former Director of the Congressional Budget Office
Debt Growth*

* 2013-2023 based on the CBO Alternate Fiscal Scenario.
** Debt Held By The Public excludes debt that the federal government owes itself through borrowings from various trust funds like Social Security.

Despite All The Discussions, A Lot More Needs To Be Done
### Historical Comparisons

<table>
<thead>
<tr>
<th></th>
<th>Year</th>
<th>Net Debt % GDP*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revolutionary War</td>
<td>1790</td>
<td>38%</td>
</tr>
<tr>
<td>Civil War</td>
<td>1866</td>
<td>31%</td>
</tr>
<tr>
<td>World War I</td>
<td>1919</td>
<td>31%</td>
</tr>
<tr>
<td>World War II</td>
<td>1946</td>
<td>109%</td>
</tr>
<tr>
<td>Reagan Budgets</td>
<td>1993</td>
<td>49%</td>
</tr>
<tr>
<td>Today</td>
<td>2012</td>
<td>73%</td>
</tr>
</tbody>
</table>

*Debt Held By The Public excludes debt that the federal government owes itself through borrowings from various trust funds like Social Security.

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**Current Debt to GDP of 73% Eclipsed Only By World War II**
Comparison With Europe

**Budget Deficit % of GDP, 2012 (est.)**

<table>
<thead>
<tr>
<th>Country</th>
<th>% of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>2.0</td>
</tr>
<tr>
<td>Italy</td>
<td>2.5</td>
</tr>
<tr>
<td>France</td>
<td>3.0</td>
</tr>
<tr>
<td>Portugal</td>
<td>3.5</td>
</tr>
<tr>
<td>Greece</td>
<td>4.0</td>
</tr>
<tr>
<td>Spain</td>
<td>4.5</td>
</tr>
<tr>
<td>U.S.</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Accumulating Annual Debt Faster Than Spain And Greece

**Debt % of GDP, 2011**

- **Gross Debt for European Countries (which is roughly the same as their net debt) vs. Net Debt* for the U.S.**

<table>
<thead>
<tr>
<th>Country</th>
<th>2011 Actual</th>
<th>2022 Worst Case</th>
<th>2022 CBO Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spain</td>
<td>80.0</td>
<td>120.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Germany</td>
<td>100.0</td>
<td>140.0</td>
<td>120.0</td>
</tr>
<tr>
<td>France</td>
<td>120.0</td>
<td>160.0</td>
<td>140.0</td>
</tr>
<tr>
<td>Portugal</td>
<td>140.0</td>
<td>180.0</td>
<td>160.0</td>
</tr>
<tr>
<td>Italy</td>
<td>160.0</td>
<td>200.0</td>
<td>180.0</td>
</tr>
<tr>
<td>Greece</td>
<td>180.0</td>
<td>220.0</td>
<td>200.0</td>
</tr>
<tr>
<td>U.S.</td>
<td>50.0</td>
<td>90.0</td>
<td>70.0</td>
</tr>
</tbody>
</table>


* Debt Held By The Public; excludes debt that the federal government owes itself through borrowings from various trust funds like Social Security.

Comparison With Europe Not Encouraging
As predicted, society is addressing rising costs in 3 ways

<table>
<thead>
<tr>
<th>Contain rates through regulation</th>
<th>Implement payment reform</th>
<th>Turn patients into consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️ Slow or stop rate increases for Medicaid/Medicare</td>
<td>✔️ Make physicians economically sensitive; promote care integration</td>
<td>✔️ Make consumers economically sensitive</td>
</tr>
<tr>
<td>☐ Mandate lower commercial insurer or provider rates</td>
<td>✔️ Global payment by commercial insurer (Blue Cross AQC)</td>
<td>✔️ Tiered or limited provider networks</td>
</tr>
<tr>
<td>☐ Government pressure for voluntary rate reductions</td>
<td>✔️ MA payment reform commission</td>
<td>✔️ Differential co-pays and deductibles</td>
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<tr>
<td></td>
<td>✔️ Bundled payments for acute/chronic diseases</td>
<td></td>
</tr>
</tbody>
</table>
Transition

• Fee for Service (FFS) To:
  – Value Based cost/quality; outcomes
  – Risk Sharing
  – ACO
  – Capitation
  – Global Payment
Fee For Service

• Reimburse for services, face to face, volume
• Little emphasis or reward for quality
• Modest incentives for process measures
• Little focus on outcome, long-term
• No sharing of financial risk
• Silo view of EMR
• Individual incentives
• Limits reimbursement for many Child Psych Services
Likely Future

- Global budget payer for costs of care (MH, MRI)
- Focus on quality, outcome, practice guidelines, quality assurance, process improvement
- Focus on high risk, high cost, outcome, readmissions, palliative care
- Focus on coordination
- IT facilitation for broad system of care
- Carefully designed incentives, care coordination
- Sub-Populations: Medicare, Commercial, Self-insured, Medicaid and Duals; Extensive analytics
- Return on Investment (Opportunity for mental health?)
Key Concept

**FFS:** Value = Volume \( \times \) Profit

**PHM:** Value = \( \frac{\text{Quality} \times \text{Service}}{\text{Cost}} \)
## Evidence based care improvement tactics

<table>
<thead>
<tr>
<th>Access to care</th>
<th>Longitudinal Care</th>
<th>Episodic Care</th>
<th>Hospital Care</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Primary Care</td>
<td>Specialty Care</td>
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<tr>
<td></td>
<td></td>
<td>Patient portal/physician portal</td>
<td>Access program</td>
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<td></td>
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<td>Extended hours/same day appointments</td>
<td>Reduced low acuity admissions</td>
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<td></td>
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<td>Expand virtual visit options</td>
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<td></td>
<td></td>
<td>Defined process standards in priority conditions (multidisciplinary teams)</td>
<td>Re-admissions</td>
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<td></td>
<td>High risk care management</td>
<td>Shared decision making</td>
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<td></td>
<td>100% preventive services</td>
<td>Appropriateness</td>
<td></td>
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<td></td>
<td>Chronic condition management</td>
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<tr>
<td></td>
<td>EHR with decision support and order entry</td>
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<tr>
<td></td>
<td>Variance reporting/performance dashboards</td>
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<tr>
<td>Measurement</td>
<td>Quality metrics: clinical outcomes, satisfaction</td>
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<tr>
<td></td>
<td>Costs/population</td>
<td></td>
<td>Costs/episode</td>
</tr>
</tbody>
</table>

Transition Questions

- Pace of transition
- Extent → Living in 2 worlds
- Need for Capital (IT, Admin., Analysis)
- Who will hold risk (loss/gain) – Third party ins, Hospitals, Systems, Physicians
ADHD Risks and Costs

— Children with ADHD healthcare cost $775-1330 more per year and $3000 more per year as adults (mainly Psych.)

— Persistent ADHD → 3x increase nicotine and substance use (even higher with conduct disorder; Fx history of SUD not predictive of SUD or age of onset).

— ADHD → Medical and educational cost higher (about double in England and U.S.; how to include in the ROI)
ADHD OUTCOMES

- 2 ½ Years less schooling (31% vs. 4% did not finish high school)
- 16% Antisocial
- 14% Substance use
- 30% Nicotine dependence
- 24% (vs. 6%) Psychiatric Hospitalizations
Global View of Costs related to ADHD:

- Alcohol Abuse
- Tobacco Use
- Substances
- ? Adherence, chronic diseases

Does not include societal costs or opportunity costs
Child Psychiatry – To Be or Not to Be

• “Not to be” or less then we are now:
  • Impact of Managed Care
  • Stigma
  • Decrease of health care dollars devoted to Mental Health
  • Defensive Retreat into Medical Model
    – Differentiations from other mental health providers
    – MD Protection
    – Diagnosis
    – Medication
    – Demand >> supply
    – Financial and cultural comfort in 2 class system
“To be” in What Might be Coming:

• Screening of Population (Pediatric Medical Home Integration)
• Evaluation (Hierarchy by Severity)
• Team models, pediatric friendly workflows
• Functional tracking (establishing goals & baseline vs. dx)
• Protocols (Prevention of secondary issues, costs, e.g., substance use, adherence, # of ED visits, hospitalizations)
• Shared risk
• Quality Assurance (Fidelity to protocol)
• Integration into Population Health Management Tracking, IT, and analytic systems
• Use of Personnel at top of license

• Outcomes (engagement, parent groups, education, devices)

• Return on Investment

• Child Psychiatric leaders gain Power and Influence in emerging world

• Political efforts in Pediatrics, Pop Mgmt, Hospital leaders
Dealing with Primary Care and Administration

Going to where the puck will be (fast), not explaining where it was or should be.

Working with administrative leadership rather than only individual PCP

Example: Health services pilots within system
Has Anyone Done This Transformation?

Will it Really Happen?