Using restrictive payment models to control healthcare spending

A cautionary tale

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Using payment models to contain healthcare spending

• Traditional fee-for-service models can give providers incentives to spend or overspend
  – Payers use alternative payment models or access restrictions to contain costs
    • Bundled payments, prior authorization, etc.

• This is clearly efficient if care is unnecessary or wasteful
  – But can be problematic if it restricts access to necessary care
    • Particularly in the case of chronic illness
Payment models and treatment of patients with Traumatic Brain Injury

• Inpatient rehabilitation is an intensive and higher-cost option for patients with moderate/severe TBI
  – Lack of clear evidence on the cost-effectiveness
  – Makes it an attractive target for cost containment efforts

• What are the potential implications for patients?
  – Learn from other disease states
Example: Medicaid formulary restrictions for mental illness

- Prescription drugs treating mental illness are a major cost driver for Medicaid
  - Pharmaceuticals are a key component of mental health treatment
    - Not a one-size-fits-all drug class
  - Restrictions push patients towards specific medications for cost-containment purposes
    - No clinical basis for restrictions
  - What are the implications for patients?
Formulary restrictions increase the likelihood that treatment fails

In states where FR limit access to all atypicals, the likelihood of a patient resuming the same atypical after having ceased treatment for at least 30 days increases by **20.1%** relative to patients in states without restrictions.

Additionally, patients in states that impose FR on all atypicals are **11.6%** more likely to discontinue all treatments.

Formulary restrictions increase mental-illness hospitalizations

Change in MDD-related hospitalizations after the adoption of formulary restrictions

<table>
<thead>
<tr>
<th>Percent Change After Policy Adoption</th>
<th>Prior Authorization</th>
<th>Prior Authorization with Step Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Hospitalization in Year</td>
<td>5.7%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Number of Hospitalizations</td>
<td>8.8%</td>
<td>16.5%</td>
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<tr>
<td>Hospital Days</td>
<td>9.1%</td>
<td>28.0%</td>
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</tbody>
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No evidence that restrictions reduce total spending for MDD patients

Change in Annual Spending per MDD Patient after Formulary Restrictions Adopted

Policy implications

• Medicaid formulary restrictions on drugs treating mental illness have harmful effects
  – Patients more likely to fail or discontinue therapy
  – An increase in hospitalizations and hospital days
  – Increased likelihood of incarceration

• Policies don’t appear to lower costs for patients with mental illness

• Are restrictions on therapies treating mental illness an effective tool for controlling Medicaid costs?
  – Or do they worsen outcomes and drive up total costs for one of the most disadvantaged groups in the US?
What does this mean for TBI patients?

- Inpatient rehabilitation has been shown to improve outcomes for patients in other areas
  - But at comparatively high cost
- Restricting access may be able to save money in the immediate term
  - But at what cost to patients?
  - And at what long-term cost?
- We currently lack evidence on the relative cost and benefits of inpatient rehabilitation for TBI patients
  - Restricting access based on poor evidence can be bad for patients and payers