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To: Third Way

From: Actuarial Research Corporation

Subject: Final Scoring Memo: Behavioral Health

Date: March 11, 2015

Policy Background

Background information on the policy issue is described below and comes from Third Way's analysis of estimated budgetary savings from behavioral health integration.[1]

> Mental health disorders frequently co-occur with common physical disorders. However, patients are often only treated for the physical conditions and not the accompanying mental conditions. For example, one-fifth of patients who have just had a heart attack suffer from depression. When this depression isn't treated, the chances of the patient dying from a future heart attack can triple. When primary care and behavioral health providers team up to treat patients for both their mental health and physical disorders, patients often improve substantially and this can lead to decreased health care spending and improve patient outcomes.
>
> The Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) study is one of the best examples of integrated behavioral health care that can be replicated through the three new payment models: patient-centered medical homes, bundled payments, and accountable care organizations. This treatment trial has shown great success in managing depression and comorbidity in older adults. Patients in the program had access to depression care managers who work along with the patient's primary care physician. The depression managers offer education about treatment options and subsequent treatment with either antidepressants or problem-solving treatments consisting of 6 to 8 psychotherapy sessions. Participants in the program had 12% lower total health care costs during a four-year period than patients with usual care.

This analysis estimates potential savings to Medicare, Medicaid, private health insurance (PHI) and out-of-pocket (OOP) based on a policy for integrating behavioral health into primary health care. Modeling specifications for expanding policies to the under 65 population are from Third Way.[2]

> For Medicaid, states would be required to adopt the same policy as Medicare. Coverage for integrated behavioral health and accountability for outcomes in exchange-based health plans and employment-based coverage would be linked to the adoption of medical homes, bundled payments and accountable care organizations in Medicare. To the extent that those changes proliferate outside of Medicare, so too would behavioral health integration.

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[1] Third Way. (October 29, 2014). *Estimated Budgetary Savings from Behavioral Health Integration*.

[2] D. Kendall email communication "Re: Thoughts on specs for Bundling option," November 5, 2014. Attachment: "ARC-Extending Third Way's Medicare Policies to under-65.doc."

The estimates of projected savings for Medicare, Medicaid, PHI and OOP are shown in Table 1. In summary, projected savings to Medicare total $23.2 billion over the 10-year period (2015-2024) and projected savings to Medicaid, PHI and OOP total $28.0 billion, $207.0 billion and $43.1 billion respectively.

Estimation Process and Results

The estimation process for distributing savings is based off of the methodology used in Third Way's model.[3] Additional detail on the estimation process and any deviations from the documents referenced above are described in more detail below.

Medicare

The methodology for estimating projected savings to Medicare follows the process in "behavioral health cost saving estimate.xlsx," with a minor change. ARC estimates of projected Medicare savings differ slightly from the estimates found in "Estimated Budgetary Savings from Behavioral Health Integration.docx" because of an adjustment to the Medicare non-SPMI MH member months and SPMI member months (to 23 million and 21 million, respectively). The adjustment to the Medicare non-SPMI MH member months and SPMI member months affects total spending on non-SPMI MH, giving us slightly higher savings than previously estimated.[4]

Medicaid

The estimates of projected Medicaid savings follow the same process that was done for Medicare. The baseline Medicaid enrollment data and aggregate spending are from Kaiser,[5] and projections are derived from CMS projections. The Milliman analysis[6] provides member months and the per member per month (PMPM) health care costs by presence of behavioral conditions. As noted in "behavioral health cost saving estimate.xlsx," the assumed distribution of diagnosis for Medicaid member months of serious and persistent mental illness (SPMI) and non-SPMI mental health (MH) is derived from the relationship of these conditions in the Medicare and commercial populations. Member months for Medicaid, non-SPMI MH are estimated to be 30.1 million in 2012. Projected PMPM costs for each non-SPMI/MH participant are calculated using the projected total Medicaid per capita costs and the relationship between the 2012 PMPM costs for total medical and behavioral MH/ substance use disorders (SUD) and the 2012 per capita cost. Total spending on non-SPMI MH is calculated by taking the PMPM spending times the total member months.

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[3] See Appendix A, "behavioral health cost saving estimate.xlsx" (included as a separate attachment).

[4] It also affects the assumed distribution of diagnosis for Medicaid member months of serious and persistent mental illness (SPMI) and non-SPMI mental health (MH) because it is derived from the relationship of these conditions in the Medicare and commercial populations.

[5] Kaiser Family Foundation Medicaid Enrollment: June 2012 Data Snapshot. (August 2013). Accessed: http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8050-06-medicaid-enrollment.pdf and KFF State Health Facts. Total Medicaid Spending. Accessed: http://kff.org/medicaid/state-indicator/total-medicaid-spending/

[6] Economic Impact of Integrated Medical-Behavioral Healthcare. (April 2014). Milliman American Psychiatric Association Report. Accessed: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCAQFjAA&url=http%3A%2F%2Fwww.psychiatry.org%2Ffile%2520library%2Fpractice%2Fprofessional%2520interests%2Fintegrated%2520care%2Fapa---milliman-report-final-8-13-2013.pdf&ei=9Hd_VKTkIcOHyASav4DAAw&usg=AFQjCNFOr_5Cj4yI9NOZ077BOQ5Wa9gbWg&bvm=bv.80642063,d.aWw

The distribution of non-SPMI/MH spending is spread over four years, based on the proportions estimated from the National Institute of Health (NIH) IMPACT study.[7] Year 1 assumes the entire cost of the intervention. Savings are split in equal increments over the next three years. The Milliman report provides a range for the cost impact of integration for Medicaid, and the savings rate used in this analysis (6%) takes the midpoint between the low and high estimates of cost savings as a percent of MH/SUD costs, as reported in the analysis. The savings rate is then applied to the total spending on non-SPMI MH to calculate total savings for Medicaid. We estimated the portion of Medicaid savings by the federal government and by states using the average Federal Medical Assistance Percentage (FMAP) for states in FY2015 (59%).[8] Of the $28 billion in savings to Medicaid, the federal share is $16.6 billion and the state share is $11.4 billion.

PHI

The estimates of projected PHI savings are done in a similar manner. Baseline enrollment for PHI is based off of CMS NHE enrollment data.[9,10] The enrollment and aggregate spending projections for PHI (including ESI and the exchange) are derived from CMS projections. The Milliman analysis provides member months and the per member per month (PMPM) health care costs by presence of behavioral conditions. Member months for commercial, non-SPMI MH are estimated to be 278 million in 2012. Projected PMPM costs for each non-SPMI/MH participant are calculated using the projected total PHI per capita costs and the relationship between the 2012 PMPM costs for total medical and behavioral MH/SUD and the 2012 per capita cost. Total spending on non-SPMI MH is calculated by taking the PMPM spending times the total member months.

The distribution of non-SPMI/MH spending is spread over four years, based on the proportions estimated from the NIH IMPACT study. Year 1 assumes the entire cost of the intervention. Savings are split equally over the next three years. The Milliman report provides a range for the cost impact of integration for commercial insurance, and the savings rate used in this analysis (7.5%) takes the midpoint between the low and high estimates of cost savings as a percent of MH/SUD costs, as reported in the analysis. The savings rate is then applied to the total spending on non-SPMI MH to calculate total PHI savings.

Out-of-Pocket

To estimate the effect of the behavioral health policy on OOP spending, we used an estimate of how much OOP is associated with each dollar of payment through Medicare, Medicaid and PHI. The assumed distribution of OOP savings is as follows: 5% of total Medicare savings, 2% of total Medicaid savings and 20% of total PHI savings. Projected OOP savings total $43.1 billion over ten years.

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[7] Long-term Cost Effects of Collaborative Care for Late-life Depression. National Institute of Health. Accessed: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3810022/

[8] Average FMAP percentage for total US (51). Accessed: http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

[9] Total PHI enrollment minus Medigap enrollment, based on the proportions estimated in projection data.

[10] National Health Expenditures 2013 Highlights. Accessed: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf

Final Estimates for Third Way

Estimated change in spending due to behavioral health integration

ARC

Table 1: Estimated change in spending due to behavioral health integration by payer ($ in billions, by fiscal year)

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2015-2024
Medicare	0.0	0.3	-0.4	-1.6	-2.8	-3.3	-3.5	-3.8	-4.0	-4.3	-23.2
Medicaid-federal	0.0	0.2	-0.3	-1.1	-2.0	-2.4	-2.5	-2.7	-3.0	-2.9	-16.6
total federal	0.0	0.6	-0.6	-2.7	-4.8	-5.6	-6.0	-6.5	-7.0	-7.2	-39.8
Medicaid-state	0.0	0.2	-0.2	-0.8	-1.4	-1.6	-1.7	-1.9	-2.1	-2.0	-11.4
Private health insurance	0.0	2.9	-3.1	-12.8	-23.0	-26.2	-28.4	-32.6	-44.6	-39.2	-207.0
Out-of-pocket spending	0.0	0.6	-0.7	-2.7	-4.8	-5.5	-5.9	-6.8	-9.2	-8.1	-43.1
total-Medicare, Medicaid, PHI + OOP	0.0	4.2	-4.6	-18.9	-34.0	-38.9	-42.1	-47.7	-62.9	-56.5	-301.3