HMA

HEALTH MANAGEMENT ASSOCIATES

Estimated Federal Costs of Behavioral Health Integration Policy Proposals

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Executive Summary

In March 2021, the Bipartisan Policy Center (BPC) published a report entitled *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration* which sets forth multiple policy recommendations to improve the integration of primary care and behavioral health (BH).

HMA was engaged to conduct an analysis of the policy recommendations to determine the federal budget impact for each over the next 10 years. We accounted for current expected enrollment and federal costs of the Medicare and Medicaid programs, including our assumed impact of the COVID-19 economic downturn. Our analysis of the proposed policy recommendations measured the broad impact that each would likely have on the federal budget, based on the best available information.

Using the details provided in the BPC report as well as discussions with BPC staff, we estimate that some of the policy recommendations would increase the federal budget while others would reduce total federal spending over the next decade. Some of the policy recommendations would not result in a federal cost, either due to the nature of the proposal or the mechanics of the federal budget scoring process. The results of our analysis are summarized in Table 1.

Table 1: Estimated Change in Federal Budget for BPC Behavioral Health Integration Policy Recommendations

BPC Policy Recommendation	Description	Estimated Change in Federal Budget ($M) FY21-FY25	FY21-FY30
A-7	Reinstate time and distance standards for Medicaid network adequacy	-$46	-$105
A-11	Include integration in the Medicare Shared Savings Program (MSSP) quality measures	-$319	-$767
A-12	Provide financial incentives for BH integration in the MSSP	-$2,027	-$3,848
A-14	Add and align network performance standards across programs	+$867	+$2,270
A-17	Create novel payment model for primary care	+$1,023	+$2,874
A-20	Remove barriers to the adoption of the collaborative care model	+$80	+$224
A-22	Incentivize CCBHCs and FQHCs through voluntary integration bonus payment	+$153	+$153
B-2	Allow social workers to bill Medicare for chronic care management services	+$48	+$113
B-5	Ensure funding for the Primary Care Extension Program	+$514	+$1,114
C-8	Remove telehealth restrictions for BH	+$49	+$145
C-9	Eliminate telehealth two-way video requirement for BH	+$28	+$66

Note: Policy recommendations were evaluated separately; there may be higher or lower costs if multiple policy recommendations are enacted.

Background and Introduction

In March 2021, the Bipartisan Policy Center (BPC) published a report entitled *Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration*[1] which set forth 43 separate policy recommendations to improve the integration of primary care and behavioral health (BH). The recommendations center around three broad domains:
(I) Transform payment and delivery to advance value-based integrated care
(II) Expand and train the integrated workforce
(III) Promote technology and telehealth to support integrated care.

BPC engaged HMA to conduct an analysis of the policy recommendations to determine the federal budget impact for each recommendation over the next 10 years. Our analysis measured the impact that each recommendation would likely have on the federal budget, based on the best available information. We identified 11 of the 43 proposals as likely changing federal spending and evaluated the effect of these policies. The remaining 32 proposals we believe would have no impact on the budget, either due to the nature of the proposed change or to generally-accepted parameters associated with budget scoring.

Many of the proposed recommendations build on existing regulatory and policy frameworks, with modifications that would encourage or incent primary care providers to better integrate with behavioral healthcare. Some of the proposals focus on regulatory or operational modifications to private Medicare or Medicaid plans, while others create payment incentives directed at individual providers or health systems. We focused on the potential impact on Medicare and Medicaid spending, given the role that the federal government plays in financing these programs.

There are two limitations to our analysis. First, some of BPC's proposed policy recommendations would require additional implementation details for legislative or regulatory action which could lead to costs or savings that we have been unable to estimate in our analysis. Second, we evaluated each recommendation independently, and did not consider any interaction effects between the various recommendations that could result in higher or lower costs compared to our estimates.

Baseline Federal Spending

Our cost estimates are driven by data from the Congressional Budget Office (CBO). These data include the expected enrollment in, and federal spending on, Medicare and Medicaid over the next 10 years. The COVID-19 pandemic has significantly impacted employment in the United States, which is expected to increase the number of people who will enroll in Medicaid in the coming years as well as increase spending in both Medicare and Medicaid. Our analyses use the most recently available CBO baselines to estimate the impact of each proposal. Given the continued uncertainty regarding the short- and long-term effects of the COVID-19 pandemic, there is a significant level of uncertainty with any projections of both baseline and adjusted spending that policymakers must consider when evaluating proposals.

[1] Available at bipartisanpolicy.org.

Estimated Federal Budget Implications for BPC Policy Recommendations

Policy Recommendation Domain A: Transform Payment and Delivery to Advance Value-Based Integrated Care

Recommendation A-7: Reinstate the time and distance-to-provider standards for Medicaid network adequacy and require two additional quantitative measures.

Table 2: Estimated Impact of Policy Recommendation A-7, in $ millions

	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	**FY22 - FY27**	**FY22 – FY31**
Est. change in federal spending	-$8	-$9	-$9	-$10	-$10	-$11	-$11	-$12	-$12	-$13	**-$46**	**-$105**

States have varying requirements for Medicaid managed care plans regarding provider network adequacy, along with different means of enforcing these requirements. Historically, BH providers have been under-represented in managed care networks, often due to perceived inadequate reimbursement by the health plan.

This proposal would institute more stringent provider network adequacy standards for states to require of each Medicaid managed care plan. The Centers for Medicare & Medicaid Services (CMS) has previously recognized that health plans may have to increase payments for certain provider types in order to meet stricter network rules, and that these higher costs would need to be reflected in higher premiums paid to the health plans. States could also assess penalties on health plans that do not meet the revised network adequacy standards.

We estimate approximately half of the states would increase premiums by approximately 0.1 percent to reflect the higher payments for BH providers, yielding an increase in total federal costs of $66 million over 10 years. In all states, some plans would likely incur new financial penalties from non-compliance of the new network standards, leading to a decrease in federal spending of $172 million over 10 years. On average, the federal government would account for 70 percent of the total change due to the joint financing mechanism of the Medicaid program, resulting in a net decrease in federal spending of $105 million over 10 years.

Recommendation A-11: Include integration in the Medicare Shared Savings Program ACO quality performance standards.

Table 3: Estimated Impact of Policy Recommendation A-11, in $ millions

	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	**FY22 - FY27**	**FY22 – FY31**
Est. change in federal spending	-$51	-$59	-$64	-$70	-$75	-$79	-$83	-$90	-$95	-$101	**-$319**	**-$767**

The Medicare Shared Savings Program (MSSP) sets spending targets for providers who form Accountable Care Organizations (ACO), and rewards ACOs that have total spending below the target with a percentage of the savings. The MSSP also uses a set of quality performance standards and requires ACOs to demonstrate high quality in order to receive the full savings. ACOs that do not achieve the full set of quality metrics receive a small portion of their savings.

This proposal would add an additional set of BH integration metrics to the existing ACO performance standards. ACOs would have to demonstrate full integration in order to receive the full portion of the annual MSSP savings.

We estimate a portion of the existing MSSP participants will not be able to meet these new BH integration performance standards, which would reduce their portion of savings. We estimate these new metrics would lower the payout ratio by approximately one percent, reducing federal spending by $767 million over 10 years as the government retained more of the total savings generated by the MSSP. Of note, we do not believe these new quality measures would have any impact on MSSP participation, either from a provider or beneficiary perspective.

Recommendation A-12: Provide financial incentives for high-performing ACOs to exceed the Medicare Shared Savings Program performance standards for behavioral health integration.

Table 4: Estimated Impact of Policy Recommendation A-12, in $ millions

	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	**FY22 - FY27**	**FY22 – FY31**
Est. change in federal spending	-$435	-$405	-$403	-$394	-$390	-$383	-$373	-$370	-$356	-$339	**-$2,027**	**-$3,848**

The MSSP allows ACOs, upon first joining the program, to elect one-sided or two-sided risk tracks. ACOs that select the one-sided risk share in any savings generated are not required to return money to the federal government if spending is above the annual target. ACOs on the two-sided risk track both share in savings but are also liable for a portion of any excess spending. ACOs on the two-sided track receive a higher portion of savings generated. In addition, an ACO that initially chooses the one-sided track must transition to the two-sided track after several years of participation in the MSSP.

This proposal would introduce new BH integration standards that ACO programs could elect to use, in exchange for two adjustments to the current MSSP. First, one-sided ACO participants would be allowed to remain in the one-sided track for an additional two years. Second, both one-sided and two-sided participants would be eligible for a higher portion of savings generated by the MSSP.

We estimate this policy would result in three effects on federal spending:

- First, we estimate additional ACOs would form and enter the MSSP due to the new incentives associated with BH integration, leading to an additional two million Medicare beneficiaries aligned with the MSSP.
- Second, we analyzed the Medicare fee-for-service data and found that individuals with one or more BH conditions account for an estimated 25 percent of total spend across an average population. With the new focus on BH by certain ACOs due to the new incentives, we estimate total spending in the MSSP would decrease by an additional two percent.
- Third, the higher payout ratios available to ACOs focused on BH health would lead to providers retaining greater savings.

The first two effects would reduce federal spending, while the third would increase spending slightly, leading to a net estimated decrease of $3.8 billion over 10 years.

Recommendation A-14: Add and align network performance standards across programs.

Table 5: Estimated Impact of Policy Recommendation A-14, in $ millions

	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	**FY22 - FY27**	**FY22 – FY31**
Est. change in federal spending	$137	$155	$174	$189	$212	$229	$255	$275	$295	$348	**$867**	**$2,270**

CMS sets and monitors network adequacy levels for all Medicare Advantage (MA) plans; it currently requires approximately 10 BH providers per 50,000 MA enrollees in the plan, although these levels can vary by geography. Despite the requirements, plans do not consistently meet these standards. The GAO found that between 15 and 30 percent of BH providers that a plan indicates are in-network are not actually in-network, leading to potential access issues for MA enrollees.

This proposal would utilize some of the new network standards developed for Medicaid managed care plans and increase monitoring of and compliance by MA plans. In an effort to address some of the incomplete provider networks, plans would likely need to increase payment rates to BH providers, which in turn would increase the amounts plans bid to provide services to Medicare beneficiaries. These higher payment rates would also lead to additional BH providers participating in MA networks, increasing access to an estimated 100-150 thousand MA enrollees.

We estimate that plans would likely need to add 800-1,000 BH providers to their networks to meet the new stands. To attract these providers, we assume that average payment rates for BH care would increase by 10 percent, although some of the additional network requirements may be met via telemedicine options. Higher spending on BH would result in MA plans raising their bids by approximately 0.1 percent, which would in turn slightly lower plan rebates. Although many plans use rebates to fund extra benefits for enrollees, we do not believe the lower rebates from this proposal would decrease participation in the MA program. Overall, we estimate this proposal would increase federal spending by approximately $2.3 billion over 10 years.

Recommendation A-17: Create a novel payment model that allows primary care providers to cover the full range of primary care and mild-to-moderate behavioral health services under enhanced risk-adjusted capitated payments in traditional Medicare.

Table 6: Estimated Impact of Policy Recommendation A-17, in $ millions

	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	**FY22 - FY27**	**FY22 – FY31**
Est. change in federal spending	$65	$135	$216	$296	$311	$330	$348	$384	$390	$398	**$1,023**	**$2,874**

Most providers in the Medicare program receive fee-for-service payments for each service provided to a beneficiary. Primary care providers, on average, represent approximately four percent of total Medicare spending, although this amount varies significantly based on the beneficiary's acuity level. Patients with moderate BH conditions have higher spending than average, although the percentage associated with primary care tends to be lower than the four percent national average.

This proposal would create a new Integrated Health Model (IHM) that gives participating primary care providers a monthly fixed amount of three percent of the total prior year healthcare costs for a panel of aligned patients. The primary care provider would then be responsible for all primary care and certain BH needs, which would be part of the covered services associated with the new monthly payment.

Patients would still be able to visit any provider, and all care other than primary care and the designated set of BH services would continue to be reimbursed to separate providers of care.

We estimate between 100 and 500 primary care physicians would choose to participate in the new IHM over the next 10 years, associated with 200,000 to 800,000 Medicare beneficiaries. Initially the average cost of these beneficiaries would be roughly 20 percent higher than the overall average cost of a Medicare enrollee, largely due to the BH conditions associated with the average beneficiary in the IHM. Over time, we anticipate that IHM beneficiary costs would move closer towards the national average, as the IHM providers focus on coordinating the care of their enrollees, contributing to lowered spending. However, since the monthly fixed payments to IHM providers does not have a shared risk component, we estimate total spending would increase by $2.9 billion over 10 years.

Recommendation A-20: Remove barriers to the adoption of the collaborative care model.

Table 7: Estimated Impact of Policy Recommendation A-20, in $ millions

	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	**FY22 - FY27**	**FY22 – FY31**
Est. change in federal spending	$19	$17	$12	$14	$16	$19	$23	$28	$34	$41	**80**	**$224**

Starting in 2017, Medicare began reimbursing providers for certain services associated with integrating BH and primary care under the collaborative care model (CoCM). These services include both direct and non-direct patient contact, and can represent a single encounter or monthly service. Total Medicare spending for CoCM services increased from $46 thousand in 2017 to $6.6 million in 2019.

This proposal creates higher initial payments for providers when they first start providing CoCM services, in an effort to cover some of the start-up costs associated with care. Over time, payment rates would decline, although remain 25 percent higher than current-law payment levels. The proposal would also eliminate beneficiary cost-sharing associated with the service, as well as adjust the billing process for Federally Qualified Health Centers (FQHCs) associated with the CoCM.

We estimate the higher CoCM payments would increase service utilization by 35 percent, generally due to the higher upfront payments. The combination of higher payments and higher utilization would increase spending on CoCM services by an estimated $257 million over 10 years. Studies have demonstrated that patients participating in a CoCM have fewer hospitalizations; we estimate this proposal would reduce spending on other benefits by $105 million over 10 years. Eliminating copays on all CoCM utilization would increase spending by $70 million, while the adjusted FQHC processes would increase spending by $2 million. In total, we estimate this proposal would increase federal spending by $224 million over 10 years.

Recommendation A-22: Incentivize CCBHCs and FQHCs to strengthen integration of behavioral health and primary care through a voluntary integration bonus payment.

Table 8: Estimated Impact of Policy Recommendation A-22, in $ millions

	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	**FY22 - FY27**	**FY22 – FY31**
Est. change in federal spending	$26	$28	$31	$34	$34						**$153**	**$153**

The Protecting Access to Medicare Act (PAMA) of 2014 created a state-led demonstration for certified community behavioral health clinics (CCBHC) to improve community BH. This demonstration has been extended several times, most recently as part of the Consolidated Appropriations Act of 2021. For purposes of our analysis, we have assumed the demonstration will last until FY 2026. Under the demonstration, CCBHCs can receive a quality bonus payment based on performance across a variety of metrics. Despite an expectation of partnership with FQHCs in the demonstration, the bonus payments are not available to FQHCs.

This proposal creates additional bonus options for CCBHCs that integrate with FQHCs, with the bonus payment available to both entities. Unlike the current demonstration where bonus payments are funded by state funds, this new bonus would come from federal funds.

We estimate this proposal would result in an additional 8 to 10 CCBHC participants, resulting in approximately 74 to 76 total entities in the demonstration. Roughly 50 percent to 65 percent of these participants would be eligible for the new bonus, and we estimate the average bonus will be approximately $1 million shared between CCBHC and FQHC locations. Overall, we estimate this proposal would increase federal spending on the demonstration by $153 million over 10 years.

Policy Recommendation Domain B: Expand and Train the Integrated Workforce

Recommendation B-2: Allow licensed social workers to bill Medicare for chronic care management services.

Table 9: Estimated Impact of Policy Recommendation B-2, in $ millions

	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	**FY22 - FY27**	**FY22 – FY31**
Est. change in federal spending	$8	$9	$10	$10	$11	$11	$12	$13	$14	$15	**$48**	**$113**

Medicare reimburses certain providers for chronic care management via a set of specific codes. Total Medicare spending on these codes increased from $114 million in 2017 to $162 million in 2019 of which roughly 10 percent was paid to physician assistants (PA) and nurse practitioners (NP).

This proposal would allow licensed social workers to also receive Medicare reimbursement when providing chronic care management services.

We estimate licensed social workers would provide these new services at rates comparable to PAs and NPs, leading to an overall four percent increase in the number of chronic care management services provided to Medicare beneficiaries. We also estimate that these new providers would be reimbursed at rates comparable to PAs and NPs, or roughly $31 to $36 per service and do not believe that care management services by them would *replace* care that would have been provided by other members of

the care team. Therefore, this proposal would lead to a net increase in federal spending of $113 million over ten years.

Recommendation B-5: Provide appropriate funding for the Primary Care Extension Program.

Table 10: Estimated Impact of Policy Recommendation B-5, in $ millions

	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	**FY22 - FY27**	**FY22 – FY31**
Est. change in federal spending	$51	$103	$120	$120	$120	$120	$120	$120	$120	$120	**$514**	**$1,114**

The Affordable Care Act created the Primary Care Extension Program (PCEP), authorizing $120 million in FY11-FY14. However, Congress did not appropriate this funding, which limited the ability of the Agency for Healthcare Research and Quality (AHRQ) to fully implement the program. Our cost estimate assumes Congress will fully fund the program starting in FY22. Given the lack of current evidence for cost savings, we have not included any potential offsets from this proposal.

Policy Recommendation Domain C: Promote Technology and Telehealth to Support Integrated Care

Recommendation C-8: Remove site of service, geographic, and established patient restrictions for telehealth services.

Table 11: Estimated Impact of Policy Recommendation C-8, in $ millions

	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	**FY22 - FY27**	**FY22 – FY31**
Est. change in federal spending	$7	$8	$10	$11	$13	$15	$16	$19	$21	$24	**$49**	**$145**

Prior to the Public Health Emergency (PHE) due to the COVID-19 pandemic, Medicare limited reimbursement for telehealth services to individuals in rural areas who had an initial face-to-face visit with the provider. CMS removed a number of these restrictions during the COVID-19 PHE, resulting in an estimated 100 percent increase in the number of beneficiaries utilizing telehealth services. Currently, CMS is expected to reinstitute the telehealth restrictions upon the expiration of the PHE.

This proposal would permanently eliminate the geographic and other telehealth restrictions for BH services. Medicare beneficiaries would be able to utilize telehealth from any location to receive BH services, and there would not be any in-person requirements to continue receiving telehealth care.

We estimate the permanent removal of telehealth restrictions for BH services will lead to a 60 to 100 percent increase in telehealth services over the next 10 years, relative to expected utilization post the PHE once the restrictions are reinstated. Prior studies have found that the majority of telehealth visits do not replace other care, leading to a net 35 to 60 percent increase in total utilization. We also assume these visits will be reimbursed at rates comparable to in-person care. Combined, we estimate total federal spending will increase by $145 million over the next 10 years due to this policy.

Recommendation C-9: Eliminate the two-way video requirement for telehealth services.

Table 12: Estimated Impact of Policy Recommendation C-9, in $ millions

	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29	FY30	FY31	**FY22 - FY27**	**FY22 – FY31**
Est. change in federal spending	$5	$5	$6	$6	$6	$7	$7	$8	$8	$9	**$28**	**$66**

Prior to the COVID-19 PHE, Medicare required providers and beneficiaries to use live two-way video in order to qualify for telehealth reimbursement. During the PHE, Medicare removed this requirement, and has allowed providers to receive reimbursement for an audio-only phone call with a beneficiary. During 2020, an estimated 190 thousand BH telehealth visits were performed via audio-only.

This proposal would permanently allow audio-only telehealth visits for BH services. Providers would qualify for reimbursement if they provided certain BH -related services via the telephone to Medicare beneficiaries.

We estimate permanently allowing audio-only telehealth BH care will shift approximately one-third of all telehealth care to this setting. We also estimate that roughly 75 percent of this care will be new, with only 25 percent replacing in-person care that would have otherwise happened. Finally, we assume these visits will be reimbursed at rates comparable to in-person care. Combined, we estimate this policy will result in an increase in total federal spending of $66 million over the next 10 years.

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