AHCCCS Payment Modernization
Blog # 10

High Costs and the Case for Physical and Behavioral Health Integration

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For at least ten years, it has been known that persons with serious mental illness die on average 25 years earlier than the general population. And for many years, the negative effects of behavioral health services separation from physical health services has been apparent to many policy makers, health care professionals and community advocates. Poor health outcomes, high costs, and associated social effects now serve as the impetus for integration of medical and behavioral health care, including here in Arizona. As a result, studies and analyses such as one recently issued by Millbank have been undertaken to evaluate the effectiveness of various integrated and collaborative models.

In recent months, two studies from highly respected sources have factually and emphatically underscored the financial impact behavior health conditions have on individuals' overall health and on the costs of caring for these individuals.

The Government Accountability Office (GAO) issued a study in May 2015 in which they studied the characteristics of high expenditure Medicaid-only enrollees and the distribution of expenditures, trended year to year, and which showed variation across states. High expenditure individuals were defined as the 5 percent with the highest expenditure in each state. The most expensive 1 percent of Medicaid-only enrollees nationally accounted for about one-quarter of the expenditures for this group of enrollees.

When the GAO examined high expenditure individuals by specific condition, they found that

> *less than 15 percent of all Medicaid-only enrollees had mental health conditions, while enrollees with mental health conditions consistently constituted about half of the high-expenditure group in each year; about 71 percent of high-expenditure Medicaid-only enrollees with a substance-abuse condition also had one or more mental health conditions.*

The study also presents findings on other co-occurring conditions for high expenditure Medicaid-only individuals. The highest frequency co-occurring conditions were mental health conditions and substance abuse. For example, over 65% of high expenditure individuals with asthma also had a mental health condition and over 29% had substance abuse conditions. In Arizona, of the

study's seven focus conditions, those conditions with the greatest percentage of high expenditure Medicaid –only enrollees were mental health conditions and substance abuse.

April 2015, Milliman Inc. issued a study titled Economic Impact of Medical-Behavioral Healthcare. The analysis showed that

> *Medical costs for treating those patients with chronic medical and comorbid mental health/substance use disorder (MH/SUD) conditions can be 2-3 times as high as those beneficiaries who don't have the comorbid MH/SUD conditions. The additional healthcare costs incurred by people with behavioral comorbidities are estimated to be $293 billion in 2012 across commercially-insured, Medicaid, and Medicare beneficiaries in the United States.*

Based on review of successful integrated medical and behavioral health programs, **the authors project that through effective integration, national annual savings of $26.3 to $48.3 billion** would be realized and for Medicaid alone, savings would be between $7.1 and $9.9 billion [2012 data]. These figures might actually be understated.

> *Many individuals with chronic medical conditions and co-occurring MH/SUD disorders are never diagnosed and treated for their behavioral conditions. Since this study used administrative claim data to identify illnesses and costs, these patients were not identified as suffering from these conditions. However, the establishment of evidence-based collaborative care models would likely identify many individuals with behavioral disorders that have been previously undiagnosed.*

The study presents the data several ways based on four cohorts.

A. Those with no mental health / substance use disorder diagnoses (No MH/SUD)
B. Those with mental health diagnoses, but no serious and persistent mental illness (Non-SPMI MH)
C. Those with serious and persistent mental illness (SPMI)
D. Those with substance use disorder diagnoses (SUD)

These groups were compared across various criteria such as service category [inpatient-outpatient]. Perhaps most noteworthy, are the "Comorbid Costs per Patient by Medical and Behavioral Condition".

For example, the PMPM for commercially insured persons with **asthma**:
Cohort A: $569
Cohort B: $1851
Cohort C: $1389
Cohort D: $1774

The PMPM for persons with **chronic kidney disease**:
Cohort A: $4650
Cohort B: $5664

Cohort C: $6232
Cohort D: $6901

The study goes on to calculate the "annual value opportunity" for comorbid medical and behavioral health conditions,

> *calculated as the difference in per member per month costs between those treated for MH/SUD conditions and those not treated for MH/SUD conditions, multiplied by the enrolled member months for those members who would be targets for intervention (the members with a behavioral comorbidity).*

For Medicaid, the greatest total medical condition value opportunity is for Musculoskeletal and Connective Tissue conditions [$50 million], Nutritional and Metabolic conditions [$44 million], and Ear, Nose and Throat conditions [$42 million].

> *We estimate a total annual value opportunity of $100 billion in the Medicaid market through integration of MH/SUD and medical treatments. The value opportunity was similar for most conditions on a per-patient basis.*
>
> *While high-cost conditions such as chronic kidney disease provide the most potential value on a per-patient basis, higher-prevalence conditions such as hypertension and arthritis provide the most value potential for the entire population.*

These studies factually demonstrate the potential for $26-$48 billion in annual national cost reduction through effective physical-behavioral health integration.

> *To realize this savings, it may be best to implement integration among conditions that show the highest potential for savings either per person or through the entire population.*

There are of course many models of physical health- behavioral health integration. Medicaid agencies are on the forefront of employing various models along a continuum of integration, and more will be learned about the relative effectiveness of the models. However, it is clear that significant human and economic costs can be reduced as integrated models spread.

And as providers are increasingly part of value based payment and accountable care models, many including hospital executives are embracing the need to improve access to mental health services.

As stated by Rich Umbdenstock, CEO of the American Hospital Association

> *…keeping a population healthy means keeping them healthy physically, mentally and, frankly, socially*