Budgeting for Life-Course Health

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Why Don't We Invest in Children's MH?

Not a politically contentious issue

Economics are in our favor since it saves money

What's holding us back?

Budget Neutrality Controls Policy

Both parties try to avoid increasing total spending

But prevention saves money!

CBO decides if you're right –10yr timeframe, but can also request 20yr

Example CBO Estimate

Estimated Direct Spending and Revenue Effects of H.R. 6, Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. 2018.

Estimated Direct Spending and Revenue Effects of H.R. 6, Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act

HR6-CONF-COMBO_07.XML, September 27, 2018 (2:43 p.m.) — September 27, 2018

Millions of dollars, by fiscal year.	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-2023	2019-2028

On September 27, 2018, CBO published an Estimate for H.R. 6 (version OPIOID-CONF\HR6-CONF-COMBO_04.XML, September 25, 2018). This Estimate is for an amended version of that bill (HR6-CONF-COMBO_07.XML, September 27, 2018) and includes three additional provisions (sections 4003, 4004, and 5061). On net, the additional provisions are estimated to reduce the unified-budget deficit by $46 million over the 2019-2028 period. In total, CBO estimates that H.R. 6 would reduce the unified-budget deficit by $2 million over the same period.

INCREASES OR DECREASES (-) IN DIRECT SPENDING OUTLAYS

TITLE I—MEDICAID PROVISIONS TO ADDRESS THE OPIOID CRISIS

	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-2023	2019-2028
1001. At-risk youth Medicaid protection	*	5	5	5	10	10	10	10	10	10	25	75
1002. Health insurance for former foster youth	0	0	0	0	*	10	21	33	46	61	*	171
1003. Demonstration project to increase substance use provider capacity under the Medicaid program	13	35	58	67	63	9	2	3	3	3	236	256
1004. Medicaid drug review and utilization	*	*	1	1	1	1	1	1	1	1	2	5
1006. Medicaid health homes for substance-use-disorder Medicaid enrollees	94	58	62	56	52	48	43	38	32	25	323	509
1012. Help for moms and babies	1	2	4	5	5	6	6	6	6	7	17	48

Millions of dollars, by fiscal year.	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2023	2028

INCREASES OR DECREASES (-) IN DIRECT SPENDING OUTLAYS

TITLE IV—OFFSETS

		2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2023	2028
4001.	Promoting value in Medicaid managed care	0	0	-144	-434	-305	-314	-339	-365	-390	-420	-882	-2,710
4002.	Requiring reporting by group health plans of prescription drug coverage information for purposes of identifying primary payer situations under the Medicare program	0	-5	-5	-5	-5	-5	-5	-5	-5	-5	-20	-45
4003.	Additional religious exemption from health coverage responsibility requirement (b)	-2	-3	-3	-2	-2	-2	-3	-3	-3	-3	-12	-26
4004.	Modernizing the reporting of biological and biosimilar products (b, d)												
	On-budget	0	-2	-4	-7	-5	-4	-4	-4	-5	-5	-19	-41
	Off-budget	0	*	*	*	*	*	*	*	*	*	*	*

TITLE V—OTHER MEDICAID PROVISIONS

		2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2023	2028
5042.	Medicaid providers are required to note experiences in record systems to help in-need patients	*	*	*	*	*	*	*	*	*	*	*	
5052.	State option to provide Medicaid coverage for certain individuals with substance use disorders who are patients in certain institutions for mental diseases	0	40	195	366	447	0	0	0	0	0	1,048	1,048
5061.	Medicaid Improvement Fund	0	0	22	9	0	0	0	0	0	0	31	31

TITLE VI—OTHER MEDICARE PROVISIONS[a]

6042. Opioid use disorder treatment

The Specter of Dynamic Scoring

Dynamic scoring: counting secondary effects from spending decisions

Both parties want to count macroeconomic effects of their preferred tax policies

CBO is skeptical of both, but includes some estimates when feasible, esp. after 2015 rule change

Dynamic Scoring in Preventive Health

Bipartisan support for this approach

CBO historically skeptical about prevention, but is thinking about screening and costly devices

Refused to score prevention in ACA, willing to assign CMMI cost-offsets

More recently created guiding documents

From CBO's Blog:

Estimating the Effects of Federal Policies Targeting Obesity: Challenges and Research Needs

Assessing the Budgetary Effects of Obesity Policies: Modeling Steps and Research Gaps

To determine the budgetary effects of expanding coverage under Medicare for obesity treatments, CBO would consider the following questions:

- How many beneficiaries would participate?

- How many providers, and of what types, would offer the treatment?

- What share of participants would complete the full course of treatment?

- What would be the direct costs of treatment?

- How much weight would participants lose, and how long would that weight loss be maintained?

- How would weight loss affect the health care spending of participants and the federal budget?

https://www.cbo.gov/publication/50877

Life-Course Health Doesn't Look like Example

Health promotion not a discrete behavior change

Many studies show impact on proximal mediator – not distal outcome

CBO mostly ignores prevention science literature

Wants to use single large data set for modeling – parameter estimates not well arranged like in econ

CBO Will Use Modeling Approaches

Creates simulations using multiple estimates from the literature for things like health insurance coverage

Doesn't have the time to do this for LCHD

Need to create WSIPP model for Congress

If CBO Captured Preventive Savings

Investments in LCHD would have pay-for

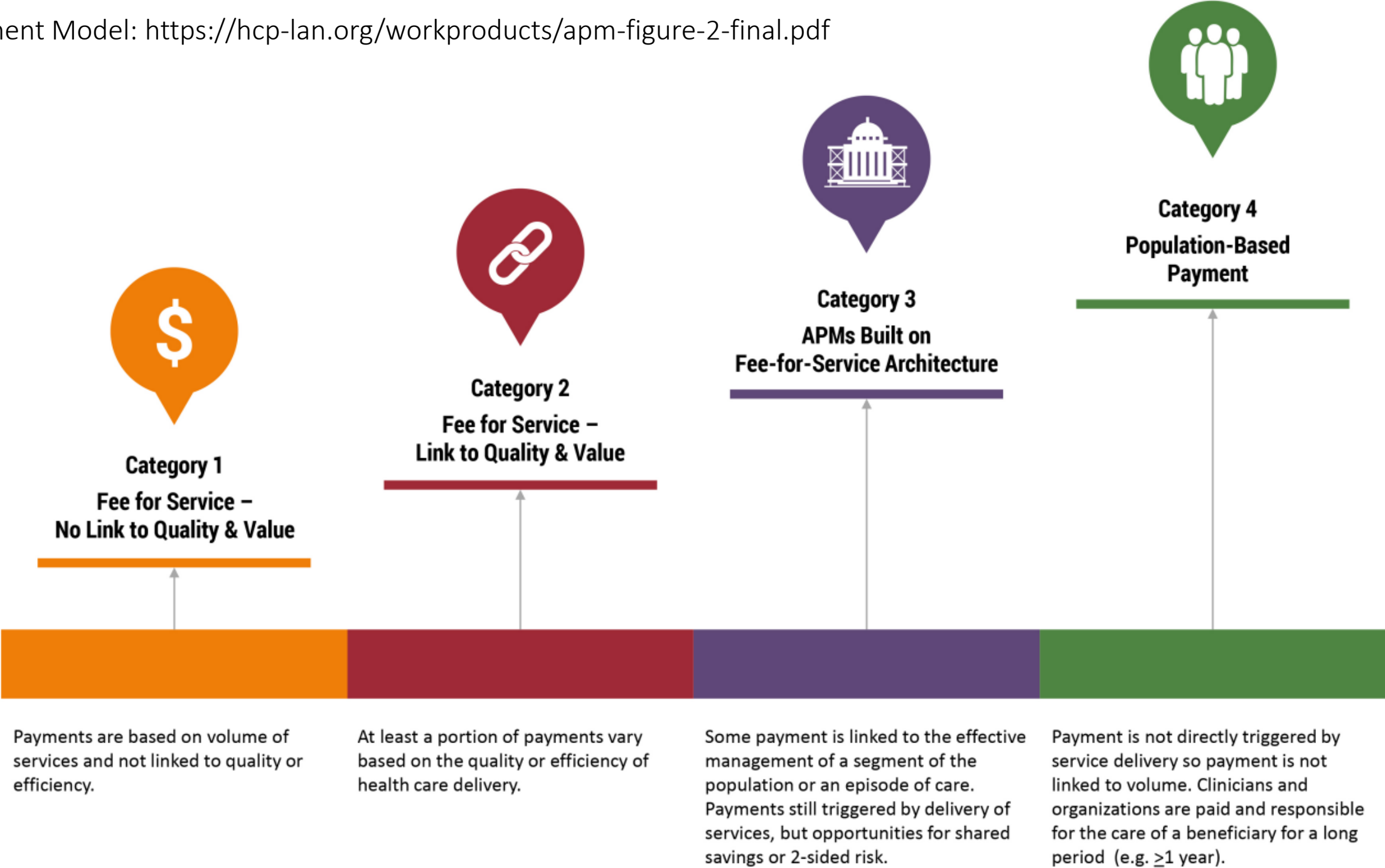Politically easy to pass LCHD enhancing policies

No more issues of scale or sustainability, and millions of kids would grow up healthier!
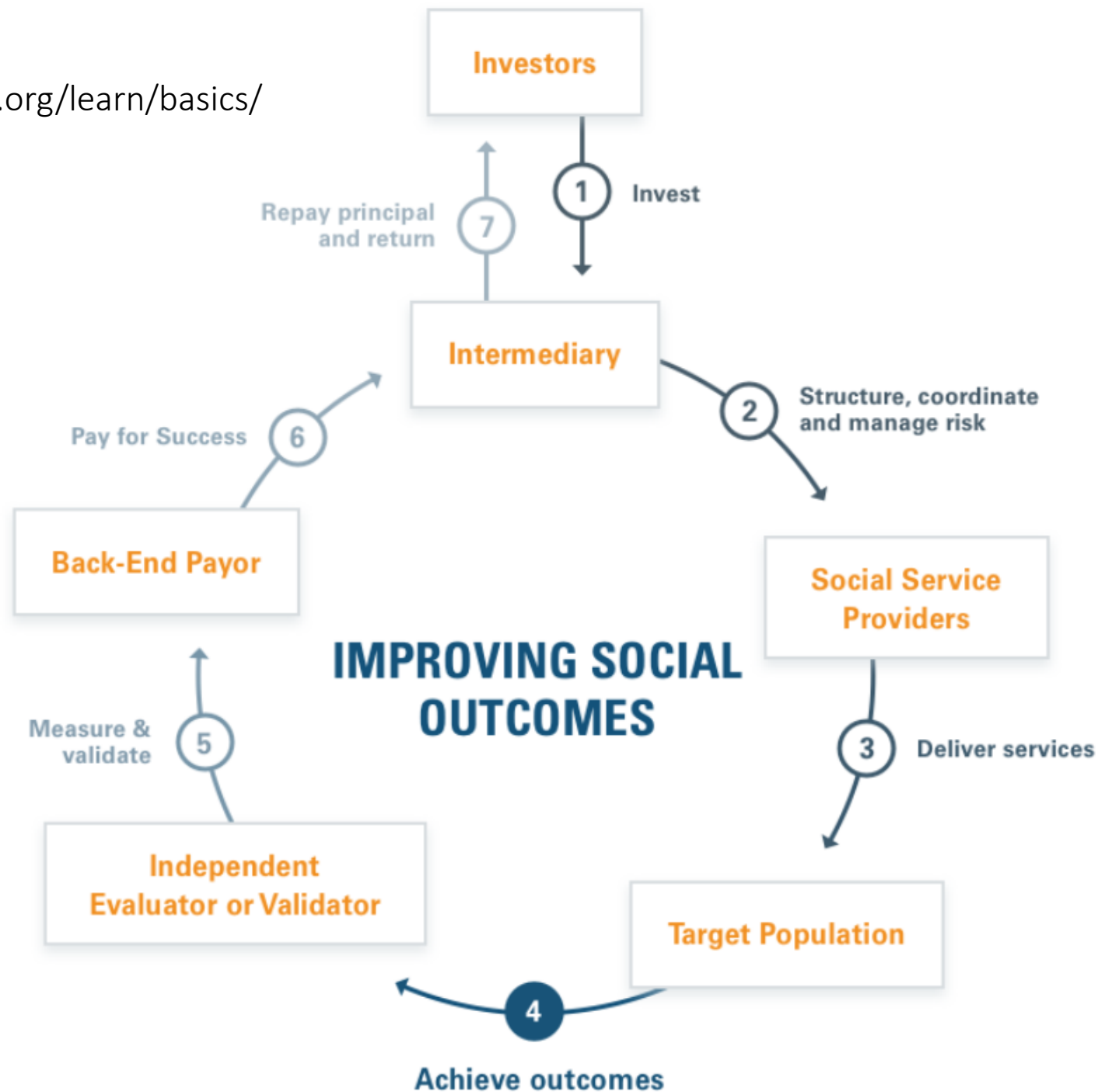
What Can You Do?

CBO has advisory panels – make sure they understand prevention science!

Talk to CBO and understand how to compile literature to make modeling LCHD easier for them

Meet with Congressional budget committee on this issue and offer to help

CMS Payment Model: https://hcp-lan.org/workproducts/apm-figure-2-final.pdf

Category 1
Fee for Service –
No Link to Quality & Value

Category 2
Fee for Service –
Link to Quality & Value

Category 3
APMs Built on
Fee-for-Service Architecture

Category 4
Population-Based
Payment

Payments are based on volume of services and not linked to quality or efficiency.

At least a portion of payments vary based on the quality or efficiency of health care delivery.

Some payment is linked to the effective management of a segment of the population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.

Payment is not directly triggered by service delivery so payment is not linked to volume. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥1 year).

IMPROVING SOCIAL OUTCOMES

Investors
1 Invest
7 Repay principal and return

Intermediary
2 Structure, coordinate and manage risk

Social Service Providers
3 Deliver services

Target Population
4 Achieve outcomes

Independent Evaluator or Validator
5 Measure & validate

Back-End Payor
6 Pay for Success

Example WSIPP Estimate

For Triple P System:
https://www.wsipp.wa.gov/BenefitCost/Program/79

Benefit-Cost Summary Statistics Per Participant

Benefits to:

Taxpayers	$503	Benefits minus costs	$1,370
Participants	$924	Benefit to cost ratio	$9.71
Others	$85	Chance the program will produce	
Indirect	$16	benefits greater than the costs	65 %
Total benefits	$1,528		
Net program cost	($157)		
Benefits minus cost	$1,370		

Detailed Monetary Benefit Estimates Per Participant

Benefits from changes to:[1]	Taxpayers	Participants	Others[2]	Indirect[3]	Total
Crime	$30	$0	$59	$15	$104
Child abuse and neglect	$16	$173	$0	$8	$198
Out-of-home placement	$62	$0	$0	$31	$92
K-12 grade repetition	$4	$0	$0	$2	$6
K-12 special education	$50	$0	$0	$25	$75
Property loss associated with alcohol abuse or dependence	$0	$0	$0	$0	$0
Health care associated with PTSD	$25	$7	$26	$12	$70
Labor market earnings associated with child abuse & neglect	$317	$744	$0	$0	$1,061
Mortality associated with child abuse and neglect	$0	$0	$0	$1	$1
Adjustment for deadweight cost of program	$0	$0	$0	($79)	($79)
Totals	**$503**	**$924**	**$85**	**$16**	**$1,528**

Conclusions

We need money to pay for the things that improve life-course health

The money is somewhere and LCH promotion has a positive ROI

Need to get creative about capturing this value at both the national and local levels