UnitedHealth®

Center for Health Reform & Modernization

Coverage for Consumers, Savings for States: *Options for Modernizing Medicaid*

Working Paper 3
April 2010

Executive Summary

1. **Medicaid is a critical safety net program for low-income Americans, and is one of the nation's largest entitlement programs. It is about to expand significantly both in numbers of beneficiaries and in size of expenditures, partly as a result of new federal health reform legislation, and partly because of the growing number of seniors who rely on Medicaid for their long-term care. All this comes at a time when states' budgets are under great pressure, with no easy fiscal solutions in sight.**

2. **This working paper provides new state-specific estimates of what those impacts will be. Drawing on the successful track records of innovative states, it also provides new national and state-specific estimates of three broad categories of savings opportunities from modernizing Medicaid. These include: the greater use of coordinated care techniques to improve access to high-quality care for low-income Americans; the greater use of managed care to support people with long-term care needs; and the upgrading of Medicaid's administrative and transactional processes. In total, the Medicaid savings options identified in this working paper could save states $149 billion in Medicaid costs over the coming decade, contributing to an overall Medicaid modernization 'dividend' estimated at $366 billion.**

Summary of Potential Medicaid Savings Identified

	Savings in billions of dollars (2011 – 2019)		
	Total	**Federal**	**State**
Increase use of coordinated care in current Medicaid population	**82**	46	35
Adopt coordinated care in Medicaid expansion population	**11**	11	1
Wider use of community-based, coordinated care in Medicaid long-term care	**140**	80	60
Administrative modernization of Medicaid programs	**133**	80	53
Total savings	**$366 billion**	**$217 billion**	**$149 billion**

Figure ES.1
Sums may not add to totals because of rounding.

3. **The federal government spent about $250 billion in 2009 supporting 70 million people in Medicaid programs,** the nation's primary source of health coverage for low-income children and families, people with disabilities and low-income seniors. Medicaid is administered by the states under federal guidelines that specify a comprehensive set of benefits. Young children and pregnant women are required to be covered, but states have substantial flexibility under the program to provide other coverage and additional benefits. About 60 percent of Medicaid spending is estimated to be at state option, which in turn has contributed to wide variability across state programs.

4. **Congress has now enacted a major expansion of health care coverage — using Medicaid as one of its two key building blocks to cover another 16 million people.** Our new modeling suggests that some states are likely to see very large increases in the absolute numbers of Medicaid-eligible residents. Florida, for example, might see an extra one million Medicaid beneficiaries, Texas an increase of nearly two million, and California more than two million additional enrollees. Other states can expect large percentage increases in their Medicaid rolls. We project that 10 states could see increases of over 50 percent, compared with what would have happened absent the new federal legislation. (Chapter One)

5. **We estimate the incremental Medicaid costs at approximately $436 billion** over the period from 2014 to 2019. We also estimate that perhaps 80 percent of the net increase in Medicaid enrollees could be adults without dependent children, a population that is older on average and tends to have higher medical costs than the typical families with children who currently use the program. (Chapter One)

6. **Coverage of health benefits is not the same as access to health care. Our new survey finds that 67 percent of primary care physicians think that new Medicaid patients will struggle to find a suitable primary care doctor, absent other policy reforms.** While the new health care reform law contains welcome increases in funding for community health centers, and provides two years of federal funding to increase primary care physicians' Medicaid reimbursement, we estimate that doing so over the rest of the decade would require an additional $50 billion, which has not been funded. (Chapter Two)

7. **There are practical actions that states can take to help solve this issue.** Providing technological and care-management support to primary care practices, promoting patient-centered medical homes, modifying the scope of practice laws, making full use of advanced nurse practitioners, and deploying innovative new primary care telemedicine models are some of the initiatives that would be likely to make a difference. Increasing Medicaid reimbursements for primary care physicians to Medicare rates was reported by about half of primary care physicians as likely to lead them to increase their Medicaid caseload. The opportunity for states to unleash substantial savings from the current Medicaid program could release resources to help increase Medicaid physician reimbursements and ensure newly-covered Medicaid beneficiaries can access high-quality care. (Chapter Two)

8. **Over the past two decades, states have been innovative and active in testing new models of care** in order to improve access and health outcomes for low-income and high-need populations. There is now a substantial evidence base which demonstrates that Medicaid managed care can improve access for underserved populations, raise the quality and appropriateness of the care they receive, and in so doing, conserve scarce public health care budgets. (Chapter Three)

9. **We estimate that states could save $36 billion from greater use of tried-and-tested Medicaid coordinated care programs for both existing and expansion populations, with additional federal savings of $57 billion over the coming decade.** (Chapter Four).

10. **About two-thirds of Medicaid's spending currently supports people with long-term care needs,** even though Medicaid is often thought of as a program for low-income women and children. These beneficiaries typically experience a lack of coordination in the dominant Medicaid fee-for-service system (which is made more complicated by the share of enrollees also eligible for Medicare), and they are exposed to the Medicaid program's current 'institutional bias,' which makes community-based care more difficult to provide. Furthermore, barriers to integrating financing and delivery

What's new in this working paper?

- New national and state-specific projections of likely increases in Medicaid enrollees as a result of the new federal health reform legislation
- New national and state-specific estimates of the associated Medicaid costs
- New national survey of primary care physicians' readiness to care for newly-covered populations, and policy options
- New estimates of potential federal and state Medicaid savings from greater use of care coordination programs and techniques
- New estimates of potential federal and state Medicaid savings from modernization of long-term care services
- Policy options for states' Medicaid administrative infrastructure modernization, and associated savings estimates

of care for enrollees dually-eligible for Medicare and Medicaid make it harder for states to be able to effectively manage the care for this population. (Chapter Five)

11. **Savings nationally from modernizing long-term care Medicaid and substituting home- and community-based care for nursing home admission could be as high as $140 billion over the coming decade, of which $60 billion would accrue to states.** Those savings could be directed toward paying for additional community-based service enrollment, could improve provider payment and access, could improve benefit structure for existing beneficiaries, and could help states with their wider fiscal challenges. (Chapter Five)

12. **Practical actions that states could take to improve delivery of Medicaid long-term care** include: adoption of managed long-term care programs with savings from nursing home diversion programs partly reinvested in community-based programs; providing consumer incentives for managed long-term care participation; requiring managed long-term care for non-dual aged and disabled populations; and leveraging their relationships with Special Needs Plans. The federal government could play its part by broadening state authority to create new long-term care models and providing financial incentives to do so; while also permitting and encouraging greater integration of Medicare and Medicaid managed long-term care. (Chapter Five)

13. **New technology and modern administrative processes could save the Medicaid program $37 billion in administrative costs between 2011 and 2019 for existing and expansion populations,** with savings equally shared between states and the federal government. Given states' expanded responsibilities arising from federal health reform, there is a need to modernize states' Medicaid administrative infrastructures. States are already experimenting with different approaches, and the ARRA stimulus legislation takes additional action to modernize health IT, including for Medicaid beneficiaries. **These initiatives would also impact Medicaid medical costs — with an estimated reduction of $96 billion in Medicaid medical spending over the 2011 – 2019 period,** of which $34 billion would accrue to the states and $61 billion to the federal government. (Chapter Six)

14. **Practical actions that states could take to help unleash these administrative savings** include: including Medicaid in state health information exchanges; making broadly available standards for encounter edits; encouraging electronic claims submission; moving to a system which validates claims prior to payment; improving capabilities for enrollment, eligibility, and retention; deploying predictive modeling analytics to identify high-cost beneficiaries; adopting rapid notification to physicians and plans of hospital admissions to permit coordinated care; including information on quality and outcomes in data systems; and employing auto-assignment based on quality. The federal government could support states in these endeavors by: creating federal standards for Medicaid administrative transactions; providing standards for Medicaid programs to share data with Medicare and other payers; establishing a multi-state database for enrollee and provider information, or developing a system of required individual patient identifiers and national provider identifiers; and including CHIP in assessing Medicaid providers' eligibility for ARRA electronic health record incentives; and other approaches. (Chapter Six)

15. **The Medicaid coverage expansion beginning in 2014 — and the federal funding to help support it — represents a major opportunity** for states to provide care to some of their neediest citizens and most underserved communities. Clearly, the scale of these increases, coupled with other expanded responsibilities for states under the federal legislation, mean that the next few years will

inevitably be a time of great pressure and challenge for states. Appendix 8 details state-by-state estimates of the areas covered by this working paper, and shows each state's expected new costs and potential savings. Releasing these savings would both allow for reinvestments in helping underserved communities get the health care they need — particularly high-quality primary care — and also help states with their own fiscal challenges. The opportunity is therefore not only for states to fulfill their new statutory responsibilities — but also to act as transformative change agents, championing the wider modernization of health care for all Americans.

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Preface

This is the third in a series of working papers produced by the UnitedHealth Center for Health Reform & Modernization.

Our first working paper 'Federal Health Care Cost Containment — How in Practice Can It Be Done?' identified $540 billion in potential medical cost savings to the federal government over the next decade. These were based on applying to traditional Medicare some of the well-tested techniques already used elsewhere in the U.S. health care system.

Our second working paper 'Health Care Cost Containment — How Technology Can Cut Red Tape and Simplify Health Care Administration' focused on practical ways in which technology can save money by modernizing the health care system's transactional 'back office.' Through 12 building blocks, it mapped out administrative savings opportunities of $332 billion in national health expenditures over the coming decade.

This new working paper, 'Coverage for Consumers, Savings for States: Options for Modernizing Medicaid,' takes up the challenge of Medicaid modernization. It does so in the belief that — in an era of new federal health reform legislation — effective management of the Medicaid program will be a critical determinant not only of how well under-served communities are able to access health care, but also of how well states are able to respond to their own significant fiscal challenges. This working paper is therefore intended to be a constructive and practical contribution to the effort to ensure these reforms succeed, both for Medicaid enrollees and for states. It draws on new data analysis, new survey research, and UnitedHealth Group's own experience through its AmeriChoice division, which is America's largest Medicaid health plan.

This report is the result of a collaborative project on the future of Medicaid, involving many experts from across UnitedHealth Group. Particular thanks go to Jeanne De Sa, and Catherine Anderson, Michael Ceballos, Jennifer Coleman, David Decker, Richard Fahel, Randy Haught, Rick Jelinek, John Kaelin, Joel Menges, Joel White, David Wichmann, and many others.

Future working papers to be published over the coming months will continue this theme of exploring practical approaches to effective health reform implementation, as well as continuing to analyze innovative techniques for tackling the underlying cost problem facing U.S. health care.

Simon Stevens
Chairman, UnitedHealth Center for Health Reform & Modernization
& Executive Vice President, UnitedHealth Group

April 2010

Chapter 1: The Challenge of Medicaid Expansion for States

The importance of Medicaid

Too many Americans lack health care coverage.[1] Medicaid, as currently structured, is a critical, but inadequate, safety net. Many millions of uninsured low-income adults are not eligible for its coverage. And perhaps up to a quarter of the uninsured are already eligible for Medicaid or the Childrens Health Insurance Program (CHIP) but do not sign up for benefits, due partly to program complexity and other related reasons.[2]

Congress has therefore now enacted a major expansion of coverage — using Medicaid as one of its two key building blocks. The new legislation is projected to expand the number of Medicaid and CHIP beneficiaries by 16 million people. This represents a major opportunity to improve the health care of millions of Americans. But it is also a major challenge — both in terms of ensuring that beneficiaries get the coordinated care they need from an adequate supply of high-quality health care providers, and in terms of states' ability to respond, given their budgets and administrative infrastructures are already under severe financial pressure.

States' current budgetary pressures

Medicaid represents a substantial share of state government spending. It is states' second largest budget line item after education, and comprises about 21 percent of states' budgets, taking account of all federal funds.[3] But unlike education spending, states find that Medicaid costs increase at precisely the point in the economic cycle where their revenues are under greatest pressure. Recent figures suggest that Medicaid enrollment increased by about 3.3 million from 2008 to 2009, a result that tracks changes in unemployment during that period.[4] (As a rule of thumb, each additional percentage point of unemployment means about one million more individuals enroll in Medicaid and 1.1 million more individuals become uninsured.)[5] Furthermore, the aging of the population is placing increasing demand on states' Medicaid budgets as funding demands grow for long-term care and related services — as we discuss in Chapter Five.

All this comes at a time when state tax revenues have declined by about 11 percent and states' combined budget shortfalls for 2010 and 2011 are projected to total at least $350 billion. Yet states — unlike the federal government — are generally required to balance their budgets. Exacerbating states' budget problems is the typical lag in the federal Medicaid funding contribution, as the Federal Medical Assistance Percentage (FMAP) is usually based on a three-year moving average of per capita spending from prior years.

Responding to those concerns, Congress periodically considers counter-cyclical funding approaches. Although no permanent 'fix' has been adopted, temporary adjustments to the FMAP have provided states with fiscal relief during recessions. For five quarters in fiscal years 2003 to 2004, all states received a 2.95 percentage point increase in their FMAP and were held harmless for decreases in their annual FMAP. This policy provided about $10 billion in extra federal funds to the states.[6] The American Recovery and Reinvestment Act of 2009 (ARRA) provided states with more extensive fiscal relief and also with additional funding targeted to those states with high unemployment. Under ARRA, all states receive a 6.2 percentage point increase in their FMAP for nine quarters (the period from October 2008 through the end of December 2010). During that time, states also will benefit from increases in

their match rate that are linked to increases in their unemployment rate. In total, the states can expect to receive an additional $88 billion in federal financial support, and Congress is considering further additions to this amount.

Additional FMAP funds help states avoid cuts in Medicaid and other parts of the state budget that otherwise would need to be directed to help fund critical Medicaid services. However, abrupt drop-offs in funding after temporary relief ends can cause disruption in states that have not emerged from periods of recession.

Funding provided through the ARRA stimulus legislation has clearly helped fill some key budget shortfalls. However, the underlying program pressures remain due to rising enrollment and continued health care cost growth. While ARRA prohibits states from cutting Medicaid eligibility as a condition of receiving the additional funding, many states nonetheless have been forced to make cuts to Medicaid physician and hospital reimbursements. This in turn can make it harder for Medicaid beneficiaries to find doctors who will treat them, as Chapter 2 discusses. States also find ways to scale back optional Medicaid benefits and restrict ease of enrollment for eligible individuals.

How large is the Medicaid expansion going to be?

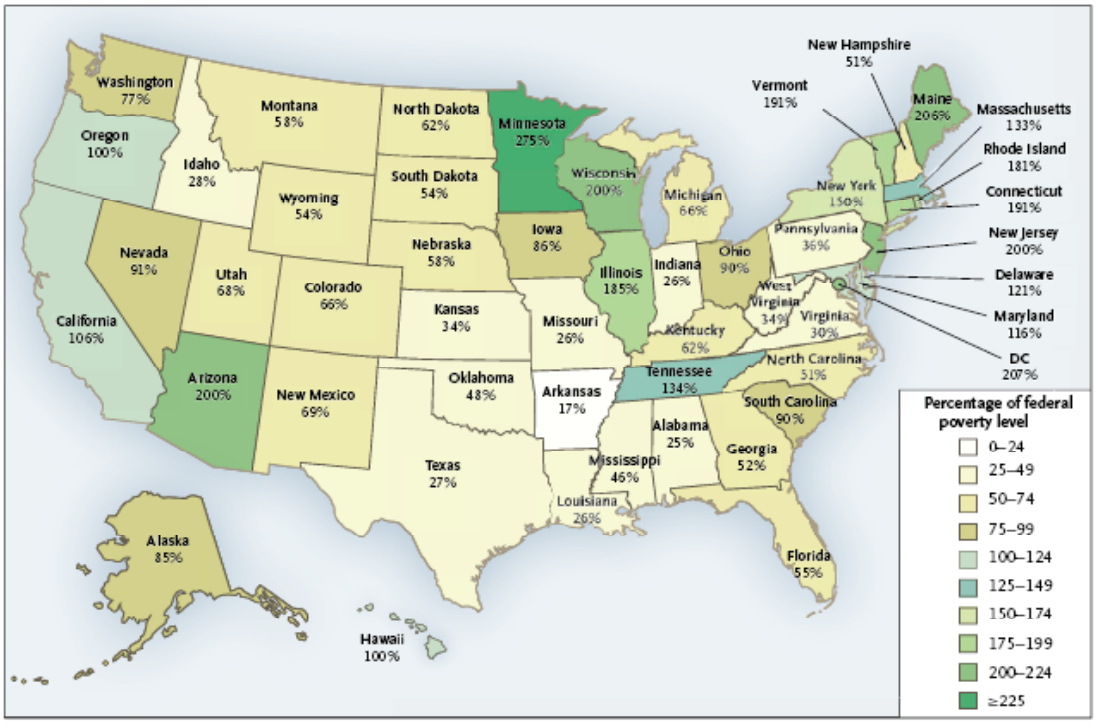
Overlaid on this situation will be the substantial expansion in Medicaid that Congress has now mandated states to implement starting in 2014. **Our analysis of Medicaid administrative data and Census data suggests that by 2019 Medicaid enrollment will grow by about 16 million under the new legislation. That would represent a 32 percent increase in the number of people otherwise served by the program in that year, on an average monthly basis.**[7]

Even before new enrollment of the expansion population begins, states will still be seeking ways to handle the increased caseload caused by the recession and increases in Medicaid and CHIP enrollment arising due to 2009 funding increases in the CHIP program, which have been estimated as increasing coverage of children by 6 million by 2013 above 2008 levels.[8] The new legislation's maintenance of effort requirements that prohibit them from reducing eligibility levels before 2014 make states' task more challenging in the run-up to implementation, even as the expected waning of the recession eases some caseload pressures.

The impact will be greatest for those states (see Figure 1.1) whose current Medicaid eligibility levels are set substantially below the new federal threshold of 133 percent of the Federal Poverty Level. The thresholds in the table reflect state program rules as they existed in January 2009. States commonly adjust income thresholds and methodologies for determining income. Some states, such as Arizona, have modified their program rules, subsequent to the date in the chart below.

Our analysis suggests that by 2019 Medicaid enrollment will grow by about 16 million under the new legislation.

Income eligibility thresholds for working parents for Medicaid programs in each state in 2009, as a percentage of the federal poverty level



Income-Eligibility Thresholds for Working Parents (Expressed as Percentages of the Federal Poverty Level) for Medicaid Programs in Each State.
Data from the Kaiser Family Foundation.

Figure 1.1; Source: Kaiser Family Foundation & NEJM 361; 21

We identified the incremental increase in each state under the new minimum federal eligibility threshold using the Lewin Group's Health Benefits Simulation Model, a microsimulation model which identifies eligible and participating individuals by analysis of income level, demographics, and current insurance status. (A further description of our methodology is discussed in Appendix 2.) We produced state-by-state shares of the projected 16 million net new Medicaid enrollees, as detailed in Figure 1.2, below.

Our estimates reveal that some states are likely to see very large increases in the absolute numbers of Medicaid-eligible residents. Florida, for example, might see an extra one million Medicaid beneficiaries, Texas an increase of nearly two million, and California more than two million additional enrollees. Other states can expect large percentage increases in their Medicaid rolls. Ten states are projected to see increases of over 50 percent, compared with what would have happened absent the new federal legislation.

Estimated 2019 net enrollment increases under new federal Medicaid eligibility thresholds, compared to absence of the new federal health reform legislation

State	Expansion Enrollment	% Increase
Alabama	372,860	46%
Alaska	44,590	46%
Arizona	334,430	45%
Arkansas	257,790	45%
California	2,033,410	27%
Colorado	271,820	57%
Connecticut	133,020	26%
Delaware	8,260	5%
District of Columbia	13,090	7%
Florida	1,050,860	42%
Georgia	598,070	40%
Hawaii	13,440	6%
Idaho	86,680	42%
Illinois	542,150	23%
Indiana	424,630	45%
Iowa	156,250	40%
Kansas	168,090	57%
Kentucky	294,930	36%
Louisiana	456,640	45%
Maine	26,060	9%
Maryland	274,430	45%
Massachusetts	-6,140	-1%
Michigan	661,800	37%
Minnesota	110,460	16%
Mississippi	290,470	47%
Missouri	396,240	45%

State	Expansion Enrollment	% Increase
Montana	76,640	84%
Nebraska	100,850	49%
Nevada	159,430	72%
New Hampshire	62,440	47%
New Jersey	376,250	41%
New Mexico	121,780	26%
New York	41,880	1%
North Carolina	583,470	40%
North Dakota	36,200	60%
Ohio	684,410	35%
Oklahoma	241,900	40%
Oregon	216,110	52%
Pennsylvania	818,470	36%
Rhode Island	42,440	23%
South Carolina	319,440	34%
South Dakota	48,040	45%
Tennessee	332,020	23%
Texas	1,904,390	56%
Utah	157,970	66%
Vermont	-7,310	-5%
Virginia	396,440	51%
Washington	328,270	32%
West Virginia	165,940	46%
Wisconsin	174,640	20%
Wyoming	33,680	52%
Total United States	**16,430,120**	**32%**

Figure 1.2; Source: UnitedHealth Center for Health Reform analytical modeling
Figures represent changes in average monthly enrollment for Medicaid population receiving comprehensive Medicaid benefits.

What are the incremental costs likely to be?

The costs of the proposed Medicaid expansion will be substantial. Excluding the CHIP component and additional funds provided to states that have already expanded Medicaid coverage to adults without dependent children, **we estimate the incremental Medicaid costs at approximately $436 billion over the period 2014 to 2019**[9], as shown in Figure 1.3 overleaf.

For the first three years of the program (2014 to 2016), states will not be required to pay for the expansion population as the federal government would cover 100 percent of program costs. States still will see their costs go up during that time as they cover new enrollment of children and parents who

would have been eligible under state eligibility standards in existence prior to the legislation's enactment. However, starting in 2017, states would be required to provide 5 percent of the cost of coverage of those newly-eligible, and in subsequent years will have to pay an increasing share of program costs. By 2020, states will bear 10 percent of the costs of coverage. See Figure 1.4.

State-specific estimated costs of proposed Medicaid expansion

(millions of dollars, 2014 – 2019) (excluding CHIP impacts)

	Total	Federal	State
Alabama	**12,215**	11,565	650
Alaska	**1,475**	1,370	105
Arizona	**5,090**	4,875	215
Arkansas	**8,425**	7,970	455
California	**34,190**	32,415	1,775
Colorado	**5,095**	4,820	275
Connecticut	**3,170**	3,035	135
Delaware	**285**	265	20
District of Columbia	**555**	530	25
Florida	**29,785**	28,060	1,725
Georgia	**19,505**	18,350	1,155
Hawaii	**410**	385	25
Idaho	**2,780**	2,665	115
Illinois	**12,560**	12,035	525
Indiana	**12,565**	12,040	525
Iowa	**2,610**	2,500	110
Kansas	**5,170**	4,785	385
Kentucky	**9,775**	9,210	565
Louisiana	**14,465**	13,660	805
Maine	**865**	830	35
Maryland	**6,065**	5,545	520
Massachusetts	**125**	120	5
Michigan	**11,170**	10,660	510
Minnesota	**3,980**	3,815	165
Mississippi	**9,290**	8,765	525
Missouri	**8,955**	8,500	455
Montana	**2,490**	2,340	150
Nebraska	**3,310**	3,140	170
Nevada	**2,815**	2,580	235
New Hampshire	**2,095**	1,960	135
New Jersey	**8,140**	7,800	340
New Mexico	**4,165**	3,900	265
New York	**2,405**	2,305	100
North Carolina	**18,900**	17,895	1,005
North Dakota	**830**	785	45
Ohio	**17,360**	16,625	735
Oklahoma	**6,510**	6,135	375
Oregon	**7,260**	6,835	425
Pennsylvania	**27,385**	26,025	1,360
Rhode Island	**1,060**	1,015	45
South Carolina	**7,745**	7,320	425
South Dakota	**1,240**	1,185	55
Tennessee	**9,080**	8,700	380
Texas	**59,520**	55,350	4,170
Utah	**2,540**	2,400	140
Vermont	**-165**	-160	-5
Virginia	**12,980**	12,160	820
Washington	**7,475**	7,070	405
West Virginia	**5,460**	5,175	285
Wisconsin	**4,255**	4,075	180
Wyoming	**975**	935	40
Total United States	**$436.4 billion**	**$412.3 billion**	**$24.1 billion**

Figure 1.3; Source: UnitedHealth Center for Health Reform analytical modeling

Summary of the effect of the Medicaid expansion on enrollment and costs by year

	Federal Fiscal Year						
	2014	2015	2016	2017	2018	2019	2014 – 19
Net changes in enrollment under Medicaid expansion[1]							
Adults without dependent children	1,881,240	6,967,930	10,876,890	12,923,770	13,051,230	13,178,700	
Parents	446,050	1,652,110	2,578,930	3,064,250	3,094,490	3,124,740	
Children[2]	18,080	66,960	104,530	124,200	125,440	126,680	
Total	**2,345,370**	**8,687,000**	**13,560,350**	**16,112,220**	**16,271,160**	**16,430,120**	
Expansion costs (in millions of dollars)							
Total	11,745	45,890	75,575	94,735	100,935	107,525	436,405
Federal	11,570	45,210	74,455	88,785	93,610	98,690	412,320
State	175	680	1,120	5,950	7,325	8,835	24,085
Effective state share[3]	**1.5%**	**1.5%**	**1.5%**	**6.3%**	**7.3%**	**8.2%**	**5.5%**

Notes:

[1] Enrollment figures represent changes in average monthly caseload in each year relative what coverage would have been under prior law in that year.

[2] Changes in enrollment of children under the new poverty threshold is net of the effect of the enrollment of already eligible children due to greater outreach under the new legislation, and the shift of some children with their families to other insurance coverage status. This effect will vary across states.

[3] States will receive the current federal match rate for coverage of children and parents who would have been eligible under current eligibility standards. The state share for the newly eligible adults rises to 10% in 2020 and stays at that level in subsequent years.

Figure 1.4; Source: UnitedHealth Center for Health Reform

We estimate that about 80 percent of the net increase in Medicaid enrollees could be adults without dependent children, a population that is older on average and tends to have higher medical costs than the typical families with children who currently use the program. Historically, the Medicaid program has not targeted this single adult population, and only a few states have covered those individuals under special waivers of federal law.

It is also possible that the Medicaid program might initially see higher-than-average per person costs as the expansion phases in. Recent analysis of newly-enrolled members conducted by UnitedHealth Group has found that these members typically have greater health care needs and use more services in their initial periods of enrollment than existing members. Sampling our data indicates individual member costs during the first six months of enrollment may average as much as 226 percent of the overall cost of existing enrollees. As shown in Figure 1.5 on page 15, costs for newly-enrolled individuals continues to exceed average cost for the existing population until they are enrolled for 8 to 12 months.[10]

New enrollees' demand for health care may initially be higher than average

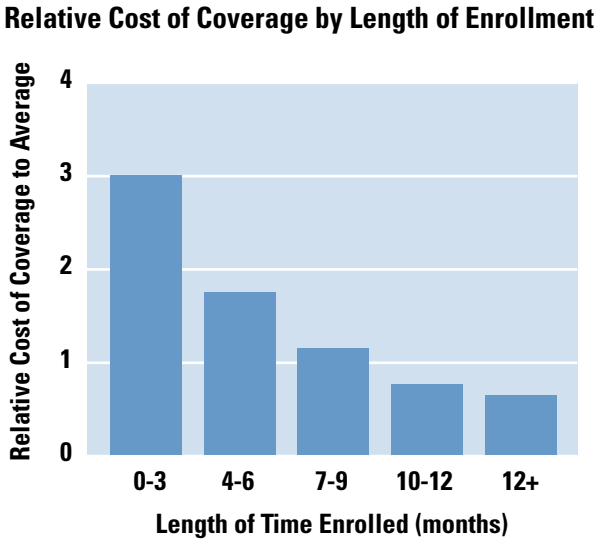


Figure 1.5; Source: Internal UnitedHealth Group AmeriChoice data, 2008

Conclusion

The 2014 Medicaid expansions and related health reforms will constitute the largest expansion in health care coverage in at least four decades. To ensure these changes are fiscally and operationally successful will require careful and diligent implementation on the part of states, health plans and many others. The rest of this Working Paper, therefore, focuses on some of the practical solutions states might adopt, so as to ensure:

- Current and new Medicaid populations actually get the high-quality health care they need
- Pressure on state budgets is reduced, and
- States' own administrative infrastructures are successfully modernized.

Chapter 2: The Challenge of Ensuring Newly Covered Medicaid Beneficiaries Can Access High Quality Care

Coverage of health benefits is not the same as access to health care. Having a Medicaid insurance card is not the same as having a primary care doctor who will treat you. Unfortunately the disconnect between benefits and access has been growing in recent years, with some estimates suggesting that nationally only half of primary care physicians are accepting new Medicaid patients.[11] And in some states that number is much lower. Partly that is because as states' Medicaid budgetary pressures have increased, they have sought to balance their books by cutting provider reimbursements. The result is that Medicaid primary care reimbursements are now estimated to average only 66 percent of Medicare levels.[12] Put differently, Medicare's rates typically average about 80 percent of commercial fees, whereas Medicaid pays only just over half of commercial fee levels.[13]

If the 16 million new Medicaid-eligible individuals are going to find health professionals to care for them regularly, this situation is going to have to change. So as part of this Working Paper, the UnitedHealth Center for Health Reform commissioned Opinion Research Corporation to undertake a national survey of primary care physicians[14] to explore what they saw as the barriers to, and solutions for, ensuring Medicaid beneficiaries get access to appropriate health care.[15]

Absent broader changes to the health care system, only 6 percent of primary care physicians reported that they expected actively to increase their Medicaid patient roster beyond current levels, and 35 percent said they expected their number to decrease. This was particularly marked for those practices only treating a small proportion of Medicaid patients, suggesting many of them were effectively looking to withdraw from the program. Those primary care physicians who were more willing to increase their Medicaid population tended to be already serving a greater share of Medicaid patients, a member of an ethnic minority, younger, and practicing at a federally-qualified health center. Of the perceived barriers to accepting more Medicaid patients, the top two factors, according to primary care physicians, were Medicaid reimbursement and Medicaid-specific paperwork and administrative burdens.

Turning to the expected increases in the Medicaid-eligible population as a result of the new national health reform legislation, primary care physicians were skeptical that — absent other changes — most of the new Medicaid patients in their area would be able to find a suitable primary care physician to serve them. Sixty-seven percent thought that patients would not be able to find a suitable primary care physician, and 10 percent thought they would, with 23 percent unsure. Larger physician groups and those already serving more Medicaid patients were likely to be more optimistic.

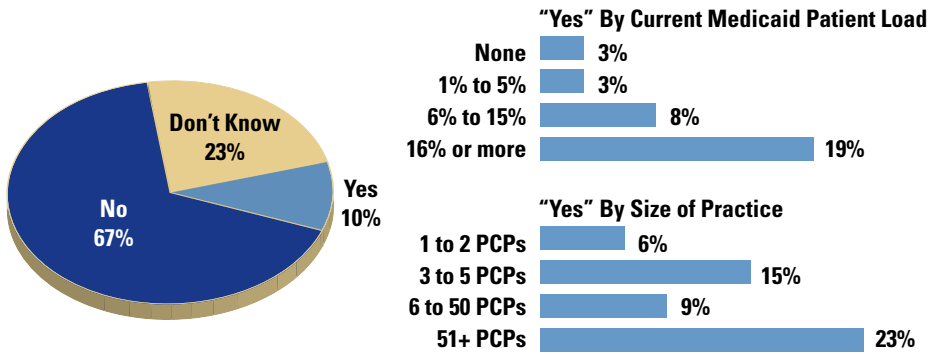


Figure 2.1; Source: ORC/ UnitedHealth Center for Health Reform Survey of Primary Care Physicians

There were also geographical differences in primary care physicians' views on the likelihood that new Medicaid enrollees would be able to get appropriate primary care, with physicians in Texas having even greater concerns than those in New York, for example. See Figure 2.2.

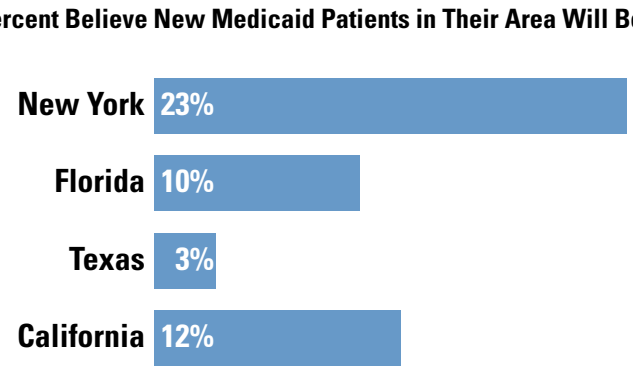


Figure 2.2; Source: ORC/UnitedHealth Center for Health Reform Survey of Primary Care Physicians

Given these concerns, Opinion Research Corporation then asked primary care physicians about a variety of policy changes that might influence their willingness to begin to care for more of the newly-eligible Medicaid patients.

Bringing primary care physicians' Medicaid reimbursements up to the same level as private health plans pay for commercially-insured individuals was the policy change that primary care physicians identified as likely to have the single biggest impact on Medicaid beneficiaries' access to primary care. Among primary care physicians, 81 percent said that this would induce them to increase their Medicaid patient rosters, with a projected increase in Medicaid patients averaging 15 percent. See Figure 2.3.

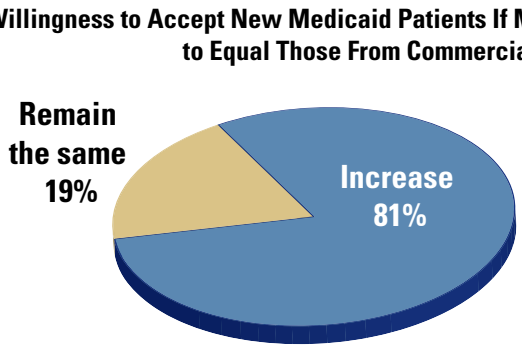


Figure 2.3; Source: ORC/UnitedHealth Center for Health Reform Survey of Primary Care Physicians

Increasing Medicaid reimbursements for primary care physicians by a lesser amount, but up to Medicare rates, was reported by about half of primary care physicians as likely to lead them to increase their Medicaid patient rosters, as shown in Figure 2.4.

Primary Care Physicians' Willingness to Accept New Medicaid Patients If Medicaid Reimbursements Increased to Equal Those From Medicare

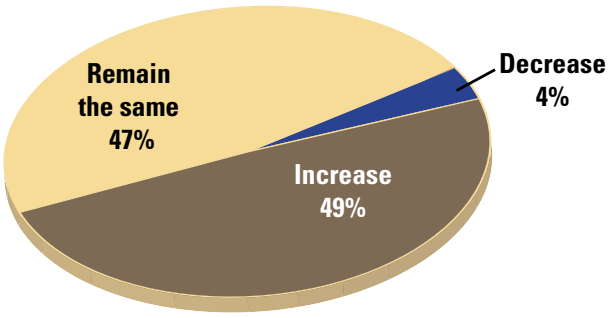


Figure 2.4; Source: ORC/UnitedHealth Center for Health Reform Survey of Primary Care Physicians

As might be expected, there likely would be a greater response from achieving parity with Medicare rates in those states where primary care physicians' Medicaid reimbursements are currently significantly below Medicare levels. In states where the Medicaid rates are less than 50 percent of Medicare, 56 percent of primary care doctors would be willing to take in more Medicaid patients if the rates were equalized, compared with 31 percent in those states where Medicaid rates are 90 percent or more of Medicare.

Other policy changes also would affect the likely availability of primary care physicians for new Medicaid patients, as shown in Figure 2.5.

Willingness to Take on More Medicaid Patients If …

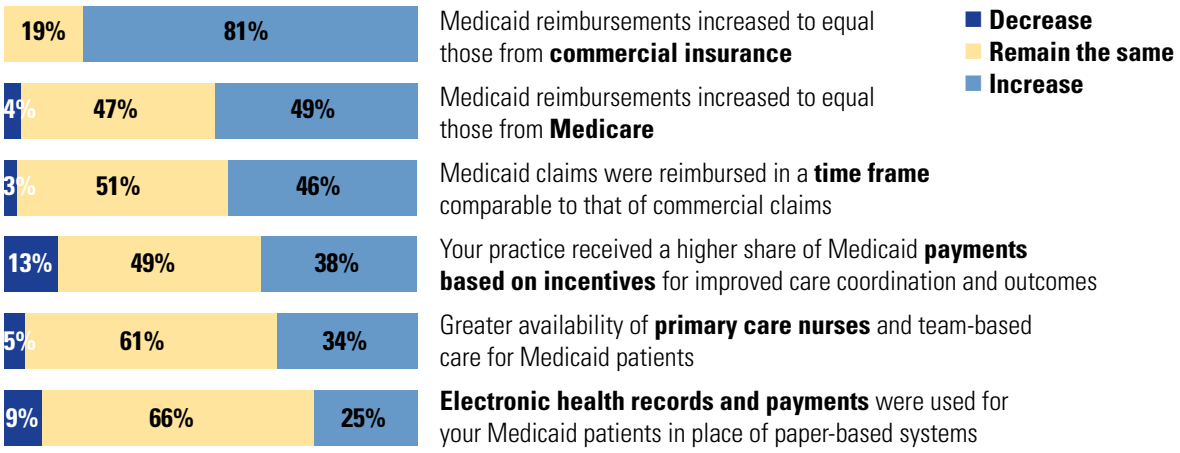


Figure 2.5; Source: ORC/UnitedHealth Center for Health Reform Survey of Primary Care Physicians

What can be done?

Increasing Medicaid reimbursements is by no means the only solution to the problem identified above. Providing technological and care management support to primary care practices, modifying scope of practice laws, making full use of advanced nurse practitioners, using pharmacists for education and medication management, and deploying innovative new primary care telemedicine models are just some of the initiatives that would be likely to make a real difference. Patient-centered medical homes and alternative approaches to payment reform could also help, if they improve the quality of care and level of utilization, with some of the resultant savings being reinvested back into stronger primary care infrastructure.

But, with all that said, it is hard to see how new Medicaid patients will be able to get access to high-quality care unless states also increase Medicaid reimbursements for primary care physicians, at least to the levels paid by Medicare.

Federal legislation seeks to make initial steps in this direction, providing funding in fiscal years 2013 and 2014 to support states in paying primary care physicians at Medicare rates. States would be reimbursed 100 percent for the cost of the amount by which the new Medicare rate exceeds the state's payment rate for those services as of July 1, 2009. Based on analysis of Medicaid administrative data, data from the American Medical Association, and internal UnitedHealth Group /AmeriChoice claims data, we estimate that the cost of that provision would be about $12 billion.[16] (About $500 million of that amount would be additional funds states would pay to cover increased volume of services attributable to the higher payment rates.) This represents an important step towards improving access, as does the additional federal funding for community health centers.

However, we further estimate that the total federal and state cost of a permanent increase in Medicaid rates to match those of Medicare would be $63 billion over the 2013 to 2019 period. The implication is that **the federal reform legislation leaves about $50 billion of a permanent reimbursement increase unfunded**. Those costs would be in addition to new state costs related to the new coverage expansion.

States clearly lack the resources to fund that kind of payment increase in their current constrained circumstances. The opportunity to unleash substantial savings from their current Medicaid programs, however, could release funding that could partly be redeployed into initiatives that would make access to care for newly-eligible Medicaid beneficiaries a reality. That opportunity is what the remaining chapters of this Working Paper seek to describe.

Chapter 3: States' Success With Medicaid Capitated Programs

Over the past two decades, states have been innovative and active in testing new models of care so as to improve access and health outcomes for low-income and high-need populations.[17] In the process, state programs have often moved beyond merely leaving their Medicaid beneficiaries to navigate a fragmented and unresponsive fee-for-service health care delivery system. Instead, states have become active purchasers of health care, and now often use many of the payment and quality techniques that were discussed in the national reform debate.

The distinctive care needs of Medicaid beneficiaries

Medicaid and other low-income populations often have complex care needs, with unique challenges in accessing care (see Figure 3.1).[18] Many enrollees also tend to "churn" into and out of Medicaid as their income or other life circumstances change, making continuous care more difficult to achieve. And significant numbers of people eligible for Medicaid fail to enroll, or delay enrollment until after the onset of illness, making preventive care tougher to provide.

Health Challenges Facing Medicaid Beneficiaries

- Health disparities are substantial, and Medicaid beneficiaries typically report poorer health status and more chronic conditions than other groups.
- Beneficiaries are sometimes transient, some lack stable home settings, and many have limited transportation options. This complicates efforts to find and communicate with potential and actual enrollees about their health needs and program eligibility.
- They often have a higher incidence of behavioral health problems, which contribute to a greater need for health care services.
- Significant communication barriers often exist, stemming from a multiplicity of languages and lower rates of literacy.
- Beneficiaries delay care, with frequent use of emergency facilities and often have no regular source of care.
- Problems taking medicine consistently and adhering to treatment regimens are common and lead to poor health.

Figure 3.1

Matters are not helped by the underlying fragmentation in the care delivery system used by beneficiaries in fee-for-service Medicaid, with a lack of coordination between care settings and care providers. So, for example, multiple drugs may be prescribed by different providers for different, or the same, conditions. Avoidable visits to the emergency room occur regularly. Behavioral health services are over-reliant on inpatient hospital care, and holistic care for physical and mental health problems is often neglected.[19] Enrollees have conditions that go untreated. All this leads to poor outcomes and higher costs later on.

What is the evidence supporting how coordinated care improves Medicaid access and care quality?

Given the particular care needs of Medicaid beneficiaries, and the documented barriers to access and quality in the Medicaid fee-for-service system, it is perhaps unsurprising that a substantial body of evidence exists to demonstrate the gains from coordinated care techniques used by managed care programs inside Medicaid.[20]

Several research studies suggest that improvements in access can be attributed to growth in access to Medicaid coordinated care programs. For example, researchers in Maryland found that the HealthChoice program was successful in improving access to ambulatory care for children.[21] A separate

study funded by Academy Health and conducted by the Urban Institute produced similar results, comparing children enrolled in Medicaid managed care plans and in fee-for-service. It found that children enrolled in Medicaid health plans were less likely to depend on an emergency room as a usual source of care, and were more likely to have visited a physician or dentist and have received preventive care.[22] Another study looked at Medicaid enrollees in Massachusetts, demonstrating the impact of care coordination on both physical and behavioral health by using case managers and nurse/social workers. Patients in the program followed treatment plans better, were higher functioning, got better access to primary care and received more targeted and integrated health services.[23]

Substantial evidence indicates the success of the managed care model in improving health outcomes and using health care services more appropriately. Most states require that Medicaid health plans operate quality assurance programs, which are evaluated based on quality metrics and standards developed by the National Committee for Quality Assurance. Increasingly, states are linking health plan financial incentives and penalties to performance. States also are required under federal law to contract with external quality review organizations.[24] As importantly, state Medicaid managed care programs have been early adopters of "pay for performance" approaches as an incentive to increase quality — often innovating at a far faster pace than the federal government's fee-for-service Medicare program. States have also begun experimenting with new Medicaid consumer incentives, aimed at improving healthy lifestyle-related behaviors and increasing the uptake of evidence-based prevention and treatment.

Managed care performs better than fee-for-service on the typical quality measures used today.[25] Below, at Figure 3.2, are results from studies conducted by the state of New York that compared its Medicaid managed care program to its fee-for-service program.[26] Managed care outperformed fee-for-service, in some cases dramatically, across a range of indicators for critical preventive services. In a managed care setting, 76 percent of enrollees received a critical test for diabetes, compared with 39 percent of fee-for-service enrollees. Similarly, 64 percent of children in managed care had immunizations in comparison to 50 percent of children in fee-for-service.

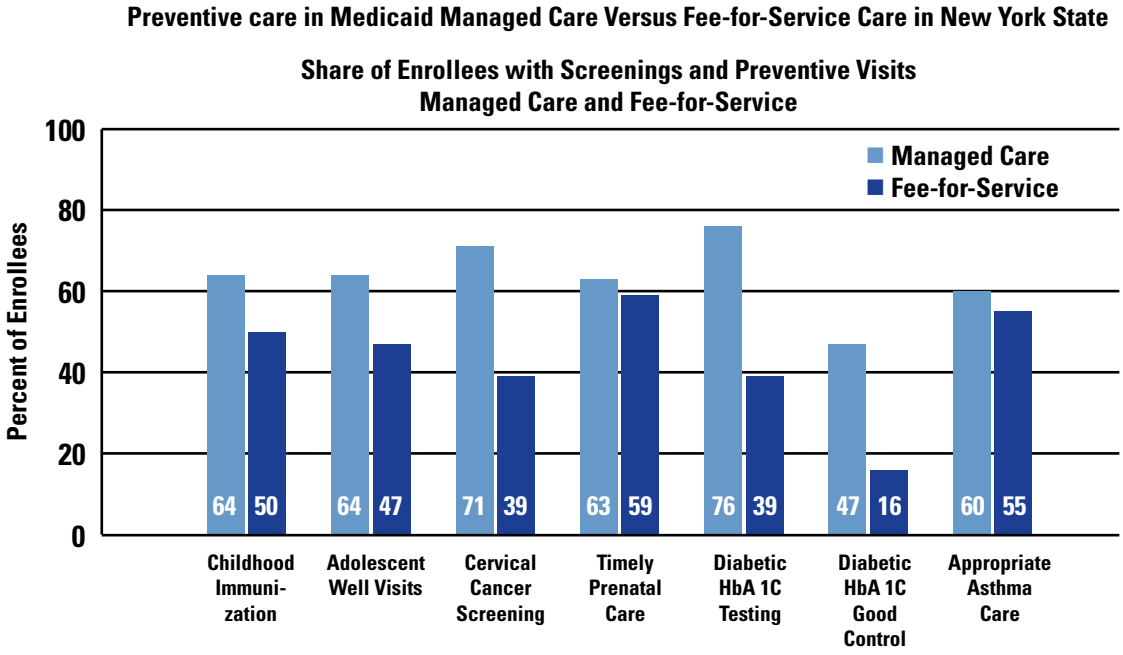
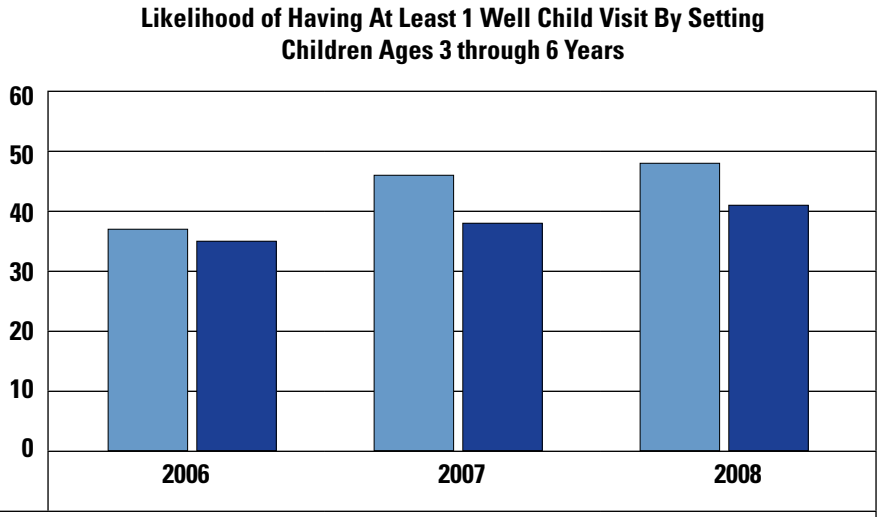


Figure 3.2; Source: New York State Department of Health, November 2008.

Other states have seen similar results. For example, in 2007 South Carolina initiated an effort to enroll Medicaid beneficiaries into managed care with the goal of improving care coordination. The state's Healthy Connections voluntary managed-care program requires that participating plans document outcomes, track quality data and meet health care benchmarks.[27] The program in which UnitedHealth Group participates has demonstrated significant quality improvements compared to the state's fee-for-service program, as shown below in Figure 3.3.[28] Other states have seen long-term improvements in the quality of care for their populations. Infant mortality rates in Rhode Island dropped significantly following the adoption of Medicaid managed care in the state in the mid-1990s, dropping over a 10-year period from 4.5 deaths per 1,000 births to 1.9 per 1,000.[29]

Well Child Visits in Medicaid Managed Care versus Medicaid Fee-For-Service in South Carolina



	2006	2007	2008
Managed Care	37	46	48
Fee-for-Service	35	38	41

Figure 3.3; Source: South Carolina, Healthy Connections program, 2008.

What is the evidence of savings from Medicaid managed care programs?

As state Medicaid programs expanded coverage in the early 1990s, managed care organizations — at that time a limited part of the program — began to offer states a way to enroll new populations in a cost-effective manner, allowing states savings relative to their fee-for-service programs. For many states, the capitated model emerged as the preferred choice because it provided a cost-effective way to connect their enrollees with the health care system, encouraged care coordination and eased the management and financial burden. Paying a set amount each year allowed for greater budgeting stability and more efficient care delivery, with payment incentives based on quality and efficiency and not simply fee-for-service or volume.

Researchers, state purchasers and other groups have extensively studied the impact of managed care programs implemented over the last 15 to 20 years. The evidence suggests that states have generally been well-served by a conversion to managed care, and that Medicaid can lead in improving care and lowering costs through effective management of high-cost populations.[30] A recent synthesis of major research in this area included analyses of federally-required independent assessments of managed care programs, state studies, and analyses by academic research institutions, consulting firms and actuarial firms. Other studies were conducted under contracts with the federal government or private foundations. This synthesis looked at managed care programs that targeted specific populations as well as broad use of managed care for state populations. Some of its highlights on the effect of managed care on rate levels and growth rates in states that have been using managed care for a long time are described below:[31]

Arizona. The state has a long history with managed care, operating its statewide program since the early 1980s. Researchers at the Government Accountability Office (GAO) estimated that the state had saved 7 percent relative to the costs a program operated under a fee-for-service system would otherwise have incurred over the 1983 to 1993 period. The researchers further estimated that the managed care program had resulted in slower program growth than otherwise would have occurred in fee-for-service (showing a 6.8 percent annual growth rate under managed care versus a 9.9 percent growth rate under fee-for-service).

Wisconsin. Another notable example of managed care savings in a state with broad coverage of its population in managed care includes Wisconsin's program. The actuarial firm Milliman estimated that the state's program saved 7.9 percent and 10.7 percent in 2001 and 2002, respectively, compared to estimates of what fee-for-service costs would have been. Savings were due to use of better tools to reduce use of emergency rooms, decrease hospital admissions and days, coordinate long-term care services, and employ chronic disease management. Use of concurrent review, discharge planning, and prescription drug management also helped the state achieve those savings.

Michigan. A study of Michigan's capitated statewide program conducted by the state's Department of Community Health examined four years of experience from 2001 through 2004. The study cited initial savings of 9 percent with growing savings in subsequent years relative to fee-for-service on a per person basis.[32]

Pennsylvania. The state's capitated managed care program that was established in the late 1990s held medical cost growth to 7.4 percent as compared to fee-for-service rates of 10.4 percent, according to a 2005 study.

Because most states now often partly rely on a managed care approach and other management controls in their programs, newer studies lack a useful measure of comparison between the two systems. However, two current examples from large states that recently implemented mandatory managed care programs for Medicaid beneficiaries provide some insight into the question of cost savings.

Florida. One recent comparison between fee-for-service and managed care was made possible due to Florida's Medicaid reform program, which was launched as a pilot in 2006.[33] At the time, the pilot was restricted to Broward and Duval counties, and participation was mandatory for certain low-income children, families, and individuals with disabilities. The University of Florida conducted an independent evaluation of the cost savings of the new reform program. The researchers created a study that compared similar groups of counties participating in reform to those that did not. According to evaluation, managed care decreased per member per month expenditures in the two study counties in the two years following implementation. Cost reductions proved the most significant for the SSI disabled population (a 3 percent reduction). Managed care reduced growth in spending for low-income families — spending per person grew at 3 percent a year instead of 8 percent a year.[34]

Georgia. The state partnered with managed care plans called Care Management Organizations (CMOs) starting in 2006 to create a lower-cost program with greater access to care for low-income families and children in its Medicaid program. Relying on a competitive procurement program to select health plans based on provider network, quality and cost criteria, the state selected three health plans. The state estimates that adoption of this new model will lower their cost trend from 7.1 percent annually to range of 3.7 percent to 6.2 percent a year (see Figure 3.4). By 2011, the state expects to save about 8 percent of costs for populations in managed care, relative to fee-for-service.[35]

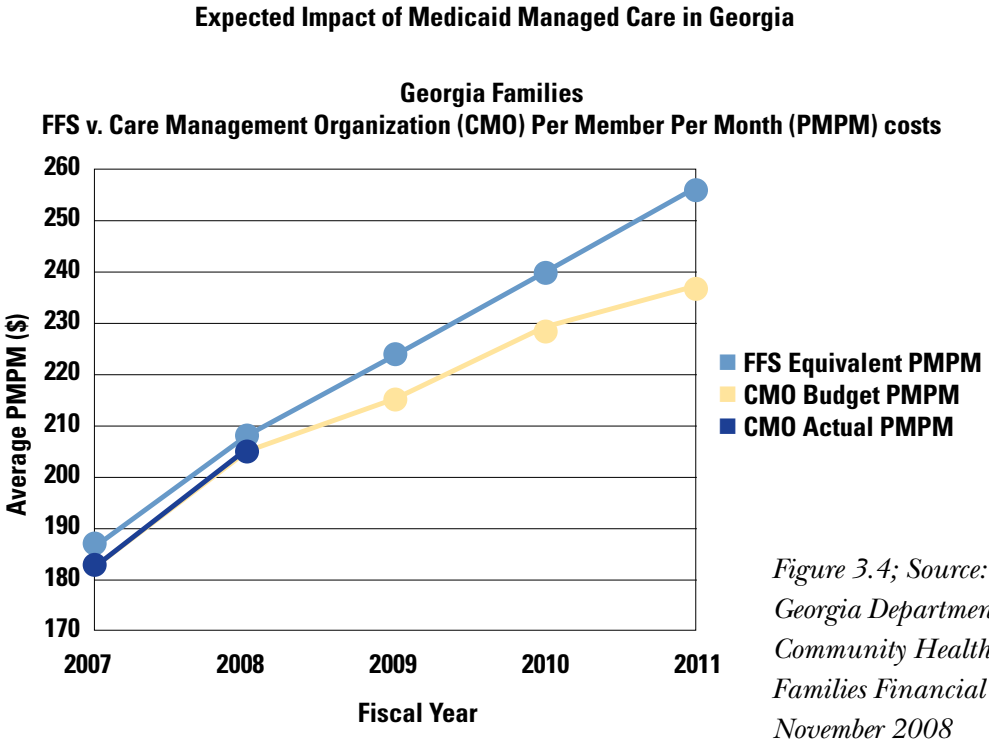


Figure 3.4; Source: Georgia Department of Community Health, Georgia Families Financial Impact, November 2008

Managed care plans can also help state Medicaid programs target specific conditions, such as high-risk pregnancies and childhood asthma, with care coordination interventions. As Medicaid covers almost half of the nation's births, this approach is a way that states can achieve savings. A health plan in Rochester, New York dramatically reduced neo-natal intensive care unit (NICU) admissions through prenatal outreach and saved about $2 for every $1 spent on the program.[36] Childhood asthma affects 12 percent of U.S. children. Care management for children with severe asthma can reduce unnecessary visits to hospitals and emergency rooms. In California, a group of 11 Medicaid health plans observed that targeted interventions to improve asthma care resulted in a 21 percent decrease in asthma-related emergency room visits and a 35 percent decrease in related hospital admissions over two years.[37]

AmeriChoice (UnitedHealth Group's Medicaid plan) helped the state of Tennessee obtain cost savings through better care coordination including a reduction in neo-natal intensive care unit (NICU) days of 12.7 percent, a reduction in bed days per 1,000 of 19 percent, and a 12 percent reduction in emergency room use.[38] This remarkable shift in NICU utilization was driven by proactive identification of individuals who may be facing higher-risk pregnancies. Following identification, AmeriChoice assigned specially trained obstetric care managers to develop personalized plans of care to address the individual member's needs and minimize the risk of NICU admissions. For instance, AmeriChoice arranged for transportation and babysitting so that their members could maintain regularly-scheduled pre-natal visits as well as ensured coordination with other services such as access to healthy foods to minimize the likelihood of complicated deliveries.

Conclusion

There is now a substantial evidence base — drawn from two decades of practical innovation by states — which demonstrates that Medicaid coordinated care can improve access for underserved populations and raise the quality and appropriateness of the care they receive. In so doing, coordinated care also conserves scarce public health care budgets.

However ***some*** states still have the opportunity to make greater use of these techniques and programs for their existing Medicaid enrollees, and ***all*** states have the opportunity to do so for their post-2014 expansion populations.

The next chapter therefore provides state-specific estimates of what these additional savings opportunities could be. Chapter Five then does the same in regard to Medicaid long-term care savings. And Chapter Six examines further savings opportunities from modernizing Medicaid's administrative infrastructure.

Chapter 4: Savings Options From Extending Medicaid Coordinated Care

States still pay for about two-thirds of Medicaid spending for their non-dual eligible Medicaid populations through uncoordinated and fragmented fee-for-service models.[39] This chapter estimates potential savings from deployment of comprehensive coordinated care, for both current state Medicaid programs, and for the federally-mandated expansion populations.

In estimating the state-by-state savings from further adoption of Medicaid managed care models, we relied primarily on state-level spending and enrollment data from the Medicaid Statistical Information System (MSIS). MSIS is the main source of administrative data on the Medicaid program and is maintained by the Centers for Medicaid and Medicare Services (CMS). Our methodology is described in greater detail in Appendix 4.

Overall, we estimated the proportion of beneficiaries that could be transitioned from fee-for-service to managed care (by state) and the amount of fee-for-service spending that would be affected by this transition. In states where Medicaid managed care has already been adopted, certain enrollees would be unlikely to benefit from expanded capitation. In states where this is not the case, we estimated the potential first-year savings of moving these new beneficiary groups to a capitated managed care model. Real-world evidence drawn from states (of the sort described in Chapter Three), from UnitedHealth Group's own results as America's largest Medicaid health plan, and from a meta-analysis of the research evidence conducted by the Lewin Group, all suggests that **states could save about five percent of fee-for-service costs by enrolling children and low-income families in managed care. Likewise, states could probably save around eight percent by transitioning enrollees with disabilities into managed care**. Because fee-for-service coverage for enrollees with disabilities is fairly fragmented, we believe this population in particular would significantly benefit from the adoption of coordinated care.

We recognize that states can implement managed care principles through programs like Primary Care Case Management (PCCM), and disease and case management programs. For some populations (e.g., individuals with developmental disabilities) or for some geographies (e.g., remote rural areas), capitated programs may not be available or easily implemented. Other approaches could be used to start to improve coordinated care management. However, those models have generally not demonstrated as much savings to states when compared to fully-capitated health plan models.

Our analysis makes downward adjustments in nearly all states' savings opportunities to reflect the state's urban/rural composition as well as the percentage of state residents enrolled in a primary care case management (PCCM) program. Implicit in our estimates are state choices with regard to carving out some benefits on a fee-for-service basis, such as prescription drugs or behavioral health services. Those average savings percentages could be higher or lower in specific states, and represent the center of a range of possible savings.

Results of analysis to estimate the savings opportunities

Based on this methodology, we estimate there would be sizable savings if states chose to either adopt a managed care approach for their enrollees now in fee-for-service or, for those that already rely on a managed care model, they increased their use of managed care. Savings would accrue to states in advance of required expansions (2014) and ramping up of the state share (2017), giving states a head start on preparing for expansions and otherwise strengthening their programs.

Potential modernization savings from wider use of Medicaid coordinated care

	Savings in billions of dollars (2011 – 2019)		
	Total	Federal	State
Increase adoption of managed care in current population	82	46	35
Adopt managed care in expansion population	11	11	1
Total	93	57	36

Figure 4.1
Sums may not add to totals because of rounding.

Figure 4.1 shows the Medicaid savings opportunity for benefits provided to children and families, and individuals with disabilities who are not dual-eligible. The estimated savings do not include reductions in institutional long-term care (covered in Chapter Five). So these Medicaid estimates primarily include savings from capitating and actively managing acute care benefits and some community-based benefits and supports, including for recipients of managed long-term care.

For children and low-income families *not* currently enrolled in managed care, we estimate there could be a combined state and federal savings of $21 billion. For coverage of disabled individuals who are eligible through their participation in the supplemental security income (SSI) program, we estimated potential cost savings of $61 billion. The total is therefore $82 billion, of which $35 billion would accrue to states and $46 billion to the federal government.

Under the forthcoming Medicaid expansion, we assume in our 'base case' that states will adopt managed care at a level similar to that used in their existing Medicaid populations. We therefore only score incremental savings in the new populations from estimating the extent to which each state could increase its managed care penetration rate over and above its adoption levels in its existing Medicaid population.

Doing so suggests there could be an additional $11 billion in feasible incremental savings for the Medicaid expansion population, which would take the form of a reduction in the currently expected new costs of the expansion. As most of these savings would accrue to the federal government, it could make sense for the federal government to share a substantial portion of those potential savings with states, so as to reward and incentivize state action.

Estimates of potential savings from wider adoption of Medicaid managed care in populations *currently* eligible for Medicaid, 2011 – 2019, millions of dollars.

State	Total	Federal	State
Alabama	800	550	260
Alaska	530	270	260
Arizona	0	0	0
Arkansas	840	610	230
California	12,220	6,110	6,110
Colorado	1,260	630	630
Connecticut	1,000	500	500
Delaware	260	130	130
District of Columbia	450	310	130
Florida	3,430	1,890	1,550
Georgia	1,220	800	430
Hawaii	160	90	80
Idaho	390	270	120
Illinois	3,790	1,900	1,890
Indiana	1,100	730	380
Iowa	870	550	320
Kansas	540	320	210
Kentucky	1,420	1,010	410
Louisiana	1,790	1,210	580
Maine	920	600	320
Maryland	1,180	590	590
Massachusetts	2,570	1,290	1,290
Michigan	1,130	720	420
Minnesota	1,730	860	860
Mississippi	1,420	1,070	350
Missouri	1,840	1,190	650
Montana	190	130	60
Nebraska	450	270	180
Nevada	580	290	290
New Hampshire	340	170	170
New Jersey	1,700	850	850
New Mexico	330	230	90
New York	11,220	5,610	5,610
North Carolina	3,050	1,990	1,060
North Dakota	90	60	30
Ohio	3,390	2,150	1,240
Oklahoma	1,490	960	530
Oregon	470	290	170
Pennsylvania	970	530	440
Rhode Island	470	250	220
South Carolina	1,540	1,080	460
South Dakota	210	130	80
Tennessee	600	390	210
Texas	5,830	3,420	2,410
Utah	610	440	170
Vermont	190	110	80
Virginia	1,100	550	550
Washington	1,960	980	980
West Virginia	770	570	200
Wisconsin	1,040	630	410
Wyoming	230	120	120
Total United States	**$81.7 billion**	**$46.4 billion**	**$35.3 billion**

Figure 4.2; Source: UnitedHealth Center for Health Reform analytical modeling

Chapter 5: Options for Improving Medicaid Long-Term Care for Seniors and People With Disabilities

Although Medicaid is often thought of as a program for low-income women and children, in fact approximately two-thirds of its spending is for supporting people with disabilities or long-term care needs. So while there are roughly 15 million aged and disabled enrollees (less than a quarter of those enrolled in Medicaid), they generate nearly 65 percent of Medicaid expenditures.[40]

And while a relatively low number of aged and disabled people are eventually placed into nursing homes (about seven percent), those placements are costly for states — with about two-thirds of nursing home revenues coming from Medicaid. As the population ages, long-term care costs will continue to take a heavy toll on state budgets, and could force states and the federal government into increasingly problematic trade-offs between support for people needing long-term care versus poor families and children.

Challenges in caring for people with long-term care

More than 80 percent of the aged and disabled have at least one chronic condition and 46 percent have more than one. Individuals with only one chronic condition are seen by an average of three physicians.[41] Individuals with seven or more chronic conditions are seen by as many as 11 physicians; for them, care is particularly fragmented and duplicative, and the predominant fee-for-service model used to pay for their care aggravates this problem. Chronic conditions are costly: on average each additional chronic condition for a disabled Medicaid beneficiary increases costs by an estimated $8,400 each year.[42] This manifests itself through increased likelihood of hospital admissions, and greater risk of nursing home placement.

In responding to these realities, states face two main challenges in caring for their long-term care populations. They experience a lack of coordination in the dominant fee-for-service system (which is made more complicated by the share of enrollees also eligible for Medicare), and they experience the program's institutional bias which makes community-based care more difficult to provide.

Lack of care coordination. Care coordination techniques are not widely used for recipients of long-term care services. Individuals who are eligible only for Medicaid are often not included in the care management programs in states for other populations. Individuals who are dual-eligible individuals are primarily covered by fee-for-service Medicare (less than 10 percent of dual spending is covered under coordinated care arrangements).[43] Funding incentives are also misaligned because many of the initial savings from investments in greater coordination accrue to the federal Medicare program. Furthermore, states' ability to coordinate and manage a comprehensive set of benefits is limited by the federal law which covers Medicare, even when they adopt Medicaid managed care for their aged and disabled populations. States must still provide wrap-around benefits and pay for beneficiary cost sharing and long-term care services leaving the program at risk for the high costs of uncoordinated care.

This lack of care coordination is made worse by the split provider payment system for dual-eligible beneficiaries. With some providers paid by Medicaid and others by Medicare, there are problematic incentives for providers to transfer patients to other settings. For instance, transfers from nursing homes

can temporarily allow the provider to gain access to much higher Medicare reimbursement. Multiple patient transfers increase the risk of medical errors, medication mismanagement, and lack of follow-up on treatment regimens.[44]

There are opportunities for states to realize savings in the short-term, but more in the long run. For those dual eligibles enrolled in Medicare coordinated care plans, proactive identification and treatment of chronic conditions helps to control some of the higher costs that states must pay for wrap-around benefits. In the case that an individual is enrolled in a Medicare Advantage plan, including a Special Needs Plan (SNP), chronic conditions may be identified and managed to avoid future long-term care needs.[45] Although SNPs designed for dual eligibles present an option for greater integration of Medicare and Medicaid services, fewer than 20 percent of states have contracted with SNPs to do so.[46] (Figure 5.1 provides additional detail on the complexities of concurrent eligibility for Medicare and Medicaid.)

Medicaid and Medicare Coverage for Dual-Eligibles
For Medicaid enrollees who are also in Medicare, care is divided between two very different systems. Medicare serves as primary payer for hospital and physician benefits, and operates a separate program providing coverage for prescription drugs. While Medicare also pays for nursing home benefits, those benefits are limited in both time and scope and are primarily for rehabilitation following an acute illness. Medicare does not offer long-term care benefits and does not support home-and community-based service options such as adult day care and personal attendants. For dually eligible individuals, Medicaid is responsible for Medicare cost sharing as well as long-term care benefits, primarily long-term care and some home and community-based services.

Figure 5.1

Bias against community and home-based care. A Medicaid long-term care bias in favor of institutional rather than community or home-based care is another challenge for states seeking ways to better provide care to their population. Many aged and disabled beneficiaries are limited in their ability to access Medicaid benefits and supports until such time that their condition becomes extremely fragile and costly and requires a nursing home stay. Because those individuals — with the exception of certain disabled beneficiaries — become eligible for Medicaid only after their condition has deteriorated to the point of needing long-term care, individuals are forced to utilize most of their available resources to become eligible through a process called "spend-down." After exhausting any Medicare coverage for sub-acute or rehabilitative care, individuals typically pay nursing homes out-of-pocket until they deplete their resources, and then, often, qualify for Medicaid coverage.

For low-income individuals with limited personal resources to support care in their homes, there are few options to help them avoid nursing home placement through substitute community and home-based services or return to the community once placed in a nursing home. Nursing home placement is then often continued unnecessarily to maintain eligibility for Medicaid benefits. In particular, every state provides frail Medicaid recipients with nursing home long-term services without service or spending limits. In contrast, because of budget constraints, most states limit access to important home services and community alternatives through enrollment caps or spending limits.

How can Medicaid managed care improve long-term care services for seniors and people with disabilities?

To date only a minority of states have developed a quality-based cost-effective approach to addressing the needs of their long-term care population, with most relying mainly on the fee-for-service system to provide care. Those that have looked to modernize their support for these beneficiaries have adopted a range of approaches including:

- Creating integrated Medicaid long-term care programs that combine acute, behavioral, nursing home, home- and community-based services, and prescription drugs;
- Integrating Medicaid and Medicare funding by either adopting program waivers with fully integrated models that combine funding from both programs — for dually eligible individuals — into one program with comprehensive benefits including acute, long-term care and home and community-based services, and behavioral care; or, on a more limited scale, working with Medicare plans such as SNPs to coordinate benefits across the programs; and
- Developing less comprehensive consumer-centered programs to encourage community placement.

Introduce integrated long-term care. To reduce the institutional bias and encourage proactive management of individuals a few states have turned to integrated long-term care programs. These models allow flexibility not otherwise found in a traditional model of care for individuals on Medicaid or who are dually eligible. Integrated long-term care encourages the early detection and ongoing management of chronic conditions with a focus on maintaining an individual's highest level of functioning in the least restrictive setting. Unlike the current fragmented models, integrated long-term care combines the many supportive programs individuals who are eligible for long-term care currently seek through a variety of agencies with highly focused care coordination to anticipate changes in condition, align resources, and ensure proactive treatment.

Through comprehensive benefit design, states can develop integrated long-term care approaches that minimize the distinction between Medicare, Medicaid, and other benefits individuals may receive. These models allow for flexibility to ensure that an individual's needs are met without the confusion of which system is responsible. Integrated long-term care also minimizes any cost shifting by providers and any incentives that would encourage treatment such as unnecessary hospitalization, outpatient services, and nursing home placement.

Comprehensive care coordination has demonstrated an ability to greatly enhance the care individuals receive. To better understand the potential of care coordination for long-term care, it is useful to look to a Medicare program where coordinated care has greatly improved utilization of costly acute care services. For instance, UnitedHealth Group's Evercare program has demonstrated an ability to reduce Medicare costs associated with high cost services such as hospitalizations by deploying nurse practitioners to coordinate care directly in the nursing homes. Under this model, nurses develop and implement an individualized care plan for the patient, including the provision of more intensive clinical support at times of heightened need. Evercare's model, which is targeted to extremely frail nursing home residents, has reduced hospitalizations and emergency room utilization by 50 percent as compared to control groups. Figure 5.2 shows results from an independent evaluation of the program.[47] This type of care coordination and individualized approach to care creates savings for Medicaid programs as it did in this Medicare example.

The Evercare Model Reduces Inappropriate Hospitalization and Emergency Admissions

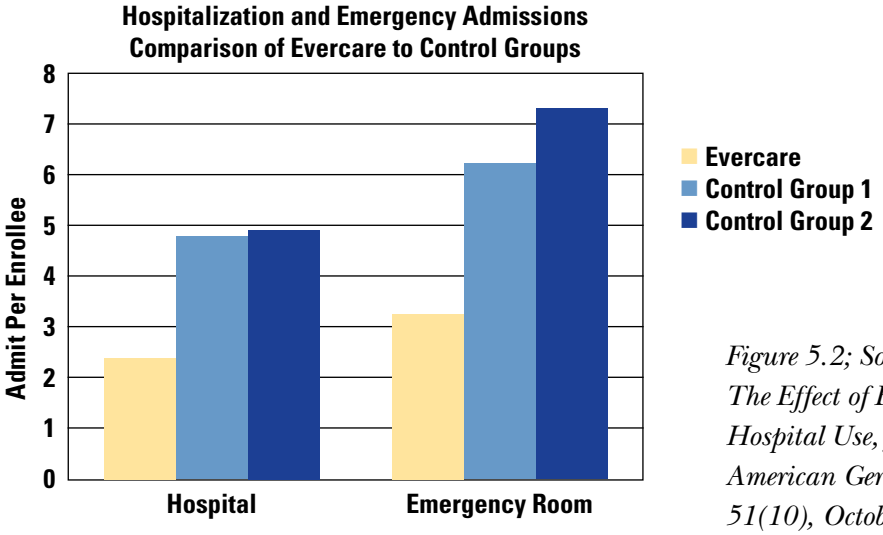


Figure 5.2; Source: Kane, R. The Effect of Evercare on Hospital Use, Journal of American Geriatrics Society 51(10), October 2003

Turning to Medicaid, effective state-based approaches have also been developed using managed care to advance care coordination of Medicaid benefits for the long-term care population. The Texas Medicaid program, STAR+PLUS, demonstrated cost savings for both non-dual and dually eligible long-term care populations using a coordinated care approach for managing chronic conditions that reduces hospitalizations.[48] It was particularly successful in urban areas, and reduced avoidable inpatient care by 22 percent, acute outpatient care by 15 percent, emergency room visits by 38 percent, and long-term care by 10 percent as compared to fee-for-service experience.[49, 50] Achievement of those goals was due to effective and comprehensive care management.[51] In one county, Texas' use of this integrated long-term care model saved the state eight percent relative to fee-for-service.[52]

Integrated long-term care promotes greater use of community-based care instead of nursing homes. All states have developed home and community-based programs through aging and disability waivers or home and community-based service waivers, which are available through approval by the Centers for Medicare & Medicaid Services (CMS). As an example, however, only a relatively small share — less than 25 percent — of individuals in need of long-term care services have access to community-based options in Tennessee, Indiana and Delaware, while 67 percent of individuals in Arizona are served in the community. The wide differences in utilization of these benefits highlights the challenges faced by states as they contemplate adoption of this model. Integrated long-term care provides more consistent utilization of less restrictive, less costly, and more desirable community-based care. Tennessee has therefore decided to embark on modernization of its long-term care program.

The Texas Medicaid program, STAR+PLUS, demonstrated cost savings for long-term care populations using a coordinated care approach for managing chronic conditions that reduces hospitalizations.

Community-based options are more cost-effective on a per person basis than institutional care. The scope of caring for someone in the community is quite broad, yet overall, the cost of caring for an

individual in a nursing home has been estimated to be 184 percent greater than the cost of caring for someone in the community with appropriate support.[53]

Integrated long-term care programs have encouraged greater use of community services rather than placement in the costly institutional settings through benefit flexibility and care management. In many cases, individual needs can be identified prior to an acute episode which results in nursing home placement. This allows for the care manager to assess an individual's needs, align access to community and social services and arrange for benefits such as personal care attendants without the need for long-term placement in a nursing home. In the instance where an individual is placed in a nursing home, integrated long-term care Medicaid programs, through comprehensive care management, can create a plan of care and align resources for safe transition back to the community following the acute episode. Unlike fee-for-service Medicaid where an individual is placed in the nursing home without any focus on moving to a less intensive level of care as the person's needs change, managed long-term care identifies individuals proactively and provides transitions to appropriate community placements.

Several state experiences with integrated long-term care have shown reductions in the cost of care not only through improvements in coordination, but in increasing the appropriateness of care setting:

Arizona created its managed long-term care program, the Arizona Long Term Care System (ALTCS), in the late 1980s to reduce the reliance of nursing homes for people in need of long-term care. At the time that ALTCS was implemented, 95 percent of people in need of long-term care were placed in nursing homes. Over the course of more than 20 years, Arizona has been able to lower the placement rate into nursing homes to 33 percent in 2008, as shown in Figure 5.3 below.

Arizona Has Reduced Use of Costly Institutions for Medicaid Long-Term Care Enrollees

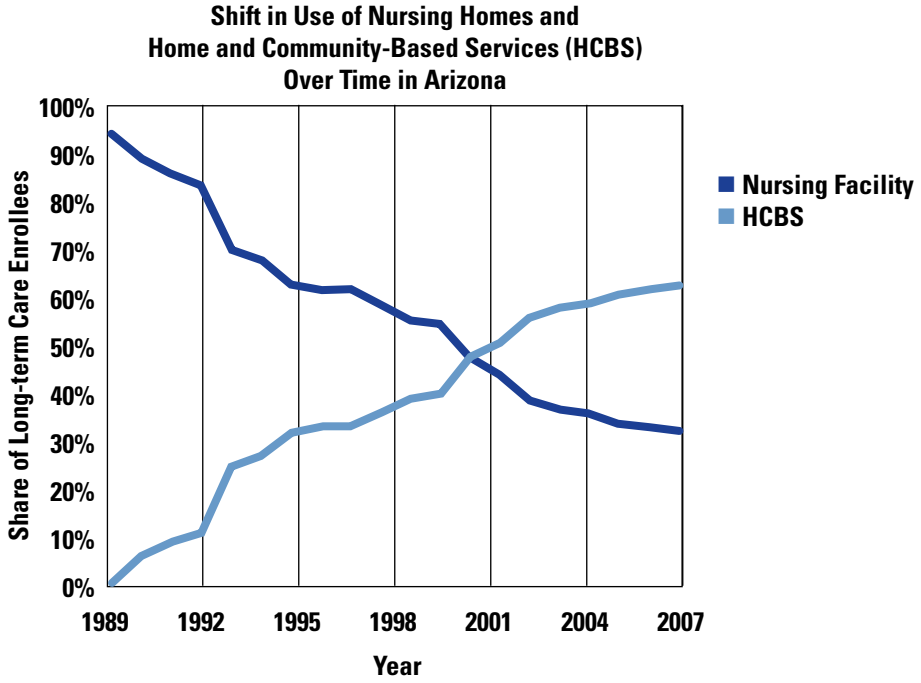


Figure 5.3; Source: Arizona Health Care Cost Containment Commission

Even with more limited enrollment, Florida's Nursing Home Diversion program has had success in using integrated long-term care for Medicaid recipients that provides a full range of acute and long-term care benefits for individuals requiring a nursing home level of care. The state relies on care management organizations to provide services to eligible individuals. Individuals who participated in the program were more likely to be able to remain in their own homes than face nursing home admission, compared to individuals who did not participate. Program participants had a 12 percent probability of entering a nursing home compared to 26 percent of fee-for-service waiver participants. Additionally, participants were four times more likely to leave nursing homes for community-based settings.[54] Figure 5.4 shows the lower probability that those enrolled in Florida's program, called a "diversion" program, will extend their stay in a nursing facility. This program successfully helped beneficiaries avoid having to move into nursing homes, and as a by-product saved Florida between $10,000 and $15,000 per beneficiary per year.[55]

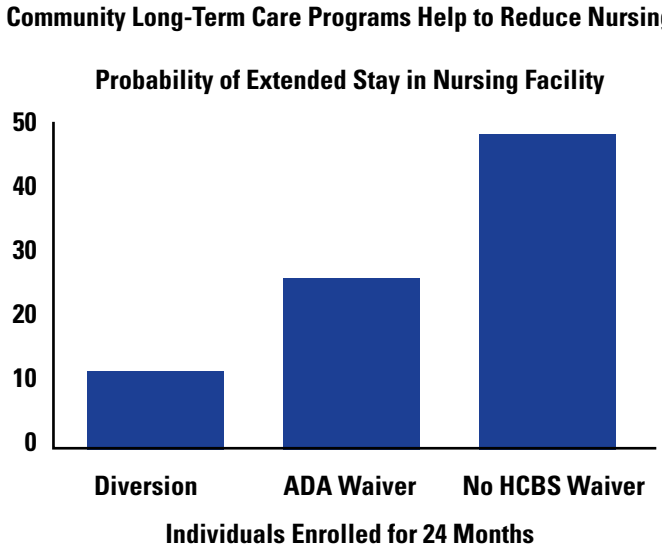


Figure 5.4; Source: Florida Office of Program and Policy Analysis & Government Accountability. The Nursing Home Diversion Program Has Successfully Delayed Nursing Home Entry. May 2006

A key consideration for integrated long-term care programs is their enrollment process. A few states, such as Minnesota, Florida and Massachusetts, have created programs using that model in which enrollment is voluntary. These programs are among other options available to eligible individuals. This approach allows for more choice but has less effect on states that choose to require enrollment into the model. More recently, states such as New Mexico, Hawaii and Tennessee have built upon the experience of Arizona and Texas and redesigned their entire system, enrolling all Medicaid individuals (including the dual-eligibles) into a single system.

Estimates of states' potential savings from modernizing Medicaid long-term care

What might be the potential savings for other states if they were able to achieve results similar to Arizona in terms of nursing home placement versus home and community-based services? Estimates can be made based on enrollment in and average costs of nursing homes and community-based waver programs under current law, and accounting for growth in per capita spending consistent with national health expenditure projections and seniors' population growth. The estimates below assume that states would take about ten years to shift enrollment from nursing homes to community placements. The estimates

are illustrative of the magnitude of the savings potential, recognizing that some savings could be offset by new costs, depending on the particular route individual states pursue.

States could expect to see reductions in nursing home enrollment of 20 percent over the course of 10 years relative to current levels.[56] At present, an estimated 56 percent of people receiving long-term care nursing or community care are in nursing homes. With concerted increases in care coordination and increased flexibility in benefits and access to community-based care the national average could fall to as low as 33 percent over ten years, dramatically changing the cost associated with long-term care.

These reforms involving stronger community-based services and alternatives to nursing home admission could therefore result in annual cost savings for long-term care of about $13 billion by the fifth year of implementation. **So, the national savings over the 2011 – 2019 period from rebalancing the entire long-term care system to ratios currently seen in the Arizona model would be $140 billion in Medicaid long-term care expenses, mainly through reduced use of nursing homes where community-based care would be more available and appropriate. Under current federal matching rates, states would see savings of $60 billion. Those savings could be directed toward paying for additional community-based service enrollment, improving provider payment and access, improving benefit structure for existing beneficiaries, and helping states with their wider fiscal challenges. State-level estimates of their share of these savings are presented in Appendix 8.**

Introduce coordination between Medicare and Medicaid. As mentioned above, in an integrated long-term care program, individuals who are eligible for Medicare and Medicaid can benefit from the reduction in fragmentation that is inherent in the current parallel program design. States can also look to leverage existing Medicare and Medicaid programs to encourage coordination between the two programs primarily through two methods:

- Rely on private organizations to offer Medicare benefits through Special Needs Plans and Medicaid services through their managed care contracts and create a simplified enrollment process, integrated acute (and sometimes long-term care) services, and simplify administration
- Seek special program waivers to integrate Medicaid and Medicare funding at the state level as is done in some of the innovative programs demonstrated in Minnesota, Wisconsin, and Massachusetts (or demonstrated in a smaller scale nationally through PACE programs).

Formally structured programs for dually eligible individuals reduce confusion and lack of coordination between the two programs for beneficiaries while streamlining administrative responsibilities for providers such as claims submission. In addition, formally aligning the two programs minimizes the risk of cost shifting that exists today.

States and CMS have begun to rely on organizations to coordinate Medicaid and Medicare benefits. One challenge is that sometimes conflicting regulations can

Over the course of ten years, the national savings from rebalancing the entire long-term care system would be $140 billion in Medicaid long-term care expenses, mainly through reduced use of nursing homes where community-based care would be more available and appropriate.

impede coordination in the areas of quality, marketing and outreach, and benefit design. Coordination can be made even more effective if individuals, who chose an organization for one program, are facilitated into the "companion" program.

For example, in states where aged and disabled beneficiaries are currently enrolled in Medicaid managed care, coordination between the Medicaid managed care plan and Medicare should be automatic. Today, if an individual is enrolled in a Medicaid managed care program, they may choose to enroll in the "companion" Medicare Special Needs plan, navigating a broad number of often similar competing Medicare plans. Without this facilitation, individuals often maintain original fee-for-service Medicare, or enroll in a Medicare Advantage or Special Needs Plan that does not coordinate with the Medicaid managed care plan. This model is highly fragmented, leading to lack of coordination between Medicare and Medicaid. In cases in which an individual has chosen a Medicare Advantage or Special Needs Plan for Medicare benefits, this may also lead to an individual having two care managers administering the two funding streams.

In the instances in which individuals are enrolled by the state in Medicaid managed care plan, the individual should be automatically enrolled in the same plan's Medicare Special Needs Plan (perhaps with the ability to opt out). This facilitation would require the health plans to offer both Medicare and Medicaid products and would greatly enhance the coordination and care received by individuals.

As an alternative, in states where aged and disabled individuals are not currently enrolled in Medicaid managed care, formal coordination between Medicare Advantage and Special Needs Plans should be created to align Medicaid benefits for those individuals. Through capitation, states can "wrap" certain Medicaid benefits around Medicare Special Needs Plans, thereby creating a single care management approach. Several states have adopted this approach (e.g., New York). This allows increased flexibility between benefits and ensures coordination between Medicare and Medicaid.

Through the recent creation of the CMS Office of Integration, states should be provided support and encouragement to create a more streamlined approaches for caring for dually eligible individuals. This will increase coordination, reduce fragmentation, and ease administrative burdens to providers and states while improving the overall treatment of individuals who are eligible for Medicare and Medicaid.

As mentioned previously, certain states have taken on a more comprehensive integration through Medicare and Medicaid program waivers. These programs have aligned funding, benefits, enrollment and quality, and provide a comprehensive set of acute, long-term care and behavioral benefits, often to frail elderly or disabled individuals at imminent risk of nursing home placement.

These programs seek to resolve one the primary challenge for integrated long-term care in that critical savings to Medicaid programs accrue over time. In the case in which the programs include dual-eligible individuals, immediate savings are typically due to changes in acute utilization such as that referenced above and are accrued to Medicare rather than Medicaid. Increasingly, however, states are working with the federal government to better integrate the financing and management of those initiatives. Some pilot programs integrate funding streams from Medicare and Medicaid and lower costs by integrating the full range of benefits for acute, behavioral health and home and community-based services offered in both programs. In Minnesota, for example, this led to a lower rate of preventable hospitalizations and ER use for program participants compared to a control group.[57] In Massachusetts' Senior Care Options (SCO) program, only 8.7 percent of clients entered a nursing home compared to the control group, and the SCO clients had a substantially higher frailty level than the control group. This result demonstrates a managed care program's ability to maintain individuals in the community much longer than in a

non-managed program and directly affects the cost of long-term care for the state of Massachusetts.[58] Similarly, in Wisconsin's Family Care program the state saved an estimated $17 million per year or 10 percent savings compared to the fee-for-service experience.[59]

Maximize consumer-centered programs. Many states have implemented programs such as Money Follows the Person (MFP), and other consumer-directed care programs. These programs, along with the recently enacted Community Living Services and Support (CLASS) insurance program, provide for improvement in consumer-focused care, increased community placement, and reduced reliance on nursing homes. While these programs hold a certain degree of promise and are attractive to individual consumers, they also pose challenges for comprehensive long-term care policy design for states.

States that have developed these consumer-centered programs have found them to be highly attractive and successful, but limited in scope. Much can be learned from these models. Individuals' ability to be actively engaged in their own care and the direction of their Medicaid resources encourages independence and community placement. These models, however, are largely limited in the ability to integrate all of the Medicare and Medicaid benefits, generally offering only a subset of home and community Medicaid benefits. The acute and long-term care Medicaid benefits and Medicare benefits, therefore, are largely uncoordinated. In addition, the programs typically require significant consumer or family involvement in finding and directing care workers and other services.

These models can be greatly enhanced by developing hybrid approaches combining these consumer-centered programs with the benefits of integrated long-term care. It is highly conceivable that these benefits can easily work alongside the fully integrated approaches previously described. For example, New Mexico and Tennessee, in their new integrated long-term care programs, both incorporated consumer-directed models as options in their broader system.

What are the barriers to adoption of managed long-term care models?

Several factors have limited adoption of models that address comprehensive, long-term care modernization.

Beneficiary enrollment and difficulty coordinating with Medicare. Provisions of Medicaid law prohibit mandatory enrollment of dual-eligible people into Medicaid managed care unless states get approval for special waver programs. Greater integration of services provided under the two programs would greatly improve care, and should be a goal for reform. Recent estimates indicate that spending on dual-eligibles in Medicare and Medicaid combined will total about $7 trillion for the 2010 to 2024 period, so even small percentage reductions in this number would produce large absolute dollar savings.[60] While the establishment of Special Needs Plans for dual-eligible beneficiaries was an important step towards a more integrated system, more can clearly be done.

Challenges in getting federal waivers to integrate benefits. Combining integrated long-term care with managed Medicare models is a promising way to help to integrate and coordinate financing for a high cost population. Yet, integration with Medicare also has proven complex, and obtaining federal waiver authority has often been slow. Enrollment in Medicare programs remains voluntary, thereby limiting the ability to truly and completely integrate care for dually eligible individuals.

Concerns about costs related to community-based care. States also have concerns about the costs of increased enrollment due to broadening the availability of community-based care as an alternative to nursing home care. Many individuals who otherwise might not pursue nursing home care might seek out new community options. Although the cost per individual is less in a community-based

setting, the number of individuals served in a community-based setting could actually increase state spending unless appropriately targeted. Additionally, investments in home- and community-based services could raise costs initially as savings from avoided nursing home stays do not occur immediately. These interventions therefore need to be carefully targeted to support those individuals who will benefit most. Advanced risk stratification techniques of the sort described in the next chapter will help accomplish this.

Spending on dual-eligibles in Medicare and Medicaid will total about $7 trillion for the 2010 to 2024 period, so even small percentage reductions in this number would produce large absolute dollar savings.

What can states do to improve effective delivery of long-term care?

States need to act now to address the looming long-term care crisis. They will need in many instances to engage the federal government to help them with funding, flexibility and technical support for integration efforts. More coordination of care within the Medicaid program for this high cost population is an important first step, and there are several ways to advance that effort. However, the ultimate integration of Medicare and Medicaid services is critical to modernization of the Medicaid long-term care system. The underlying message from state experience to date is that increased use of integrated long-term care in Medicaid and greater coordination and integration with Medicare will enable states to move from a reactive and costly model of care to one that anticipates future needs for beneficiaries, decreases institutionalization and costs, and more effectively deploys Medicaid funds.

Channel savings from nursing home diversion programs into community-based programs. As described above, shifts in long-term care placement from nursing homes to home and community-based services could reduce costs for the aged and disabled populations for states. By proactively identifying beneficiaries with a future need for long-term care services and by appropriately providing them with home and community-based services, Medicaid programs could realize the substantial savings described above.

Adopt integrated long-term care programs. States can implement integrated long-term care programs for Medicaid beneficiaries' long-term care services and acute care services covered by Medicaid. For dual-eligibles, states can develop wraparound benefits (either fully or partially capitated) for some or all of the Medicaid services associated with those enrollees. An alternative would be to develop a capitated contract with a Medicare Advantage plan or SNP for Medicaid services.

Develop short-term alternatives for coordinated care management. States seeking short-term alternatives to fully capitated managed care programs can offer robust care management programs across a broad spectrum of benefits to generate immediate savings and improve quality. Such programs would rely on experienced care management organizations under a partial-risk or full-risk arrangement to provide care management support to the fee-for-service program. These programs ensure individual care plan development, and the alignment of social, medical, and behavioral services without the fragmentation of the current Medicare and Medicaid systems and can be quickly implemented as states move to more comprehensive program design.

Adopt programs targeted to nursing home patients. States currently manage care for many individuals who already meet the nursing home level of care, and care for them in nursing homes without the benefit of managed long-term care programs. These individuals are limited in their ability to transition to home or other community settings and are subject to the fragmentation within the Medicaid and Departments of Aging systems as well as between Medicare and Medicaid. Assigning them to an integrated program specifically designed for beneficiaries with long-term care needs could ensure more effective management of chronic conditions. It can also provide incentives to avoid costly acute care and, in some instances, encourage movement to a lower level of care.

Provide consumer incentives for managed long-term care participation. In the case where participation in integrated long-term care programs or coordinated programs for dual-eligibles, states should provide strong incentives for enrollees to participate in managed long-term care. By focusing on the needs of the chronically ill, states could provide more home and community-based services as well as consumer driven care only to those individuals participating in the integrated long-term care program. By making access to community-based care and other services only available through managed models, individuals are encouraged to participate. Alternatively, states could implement Medicaid long-term "Partnership" programs that allow consumers to retain assets under Medicaid if they have previously purchased approved private long-term care insurance. These "Partnership" programs could be paired with integrated long-term care programs once individuals have qualified for Medicaid.

Require integrated long-term care for non-dual aged and disabled. Non-Medicare beneficiaries who meet a nursing home level of care could be required to enroll in an integrated long-term care program. Given the inefficiencies of a fee-for-service long-term care program, many beneficiaries are not currently given sufficient opportunities for community placement and comprehensive care management. Non-dual aged and disabled enrollees who do not meet the nursing home level of care could be included in existing Medicaid managed care programs and transitioned to Medicaid long-term care if and when a nursing home level of care is determined. In states where a Medicaid managed care program does not exist, states could be encouraged to develop either a managed care model specifically designed for aged and disabled or, at a minimum, develop a care management program that ensures appropriate utilization and anticipates the needs of enrollees.

Identify beneficiaries at risk of nursing home placement. By using available Medicaid information, such as claims data, states can identify individuals who are likely to develop high-cost conditions and develop appropriate care plans. Additionally, states could partner with Special Needs Plans to use Medicare data to identify at risk individuals. Individuals with chronic conditions often face increasing complexity as they age and their conditions deteriorate. Once illness advances, they become more dependent on the health care system.

Use relationships with Special Needs Plans to improve coordination between Medicare and Medicaid for dual-eligibles. A more comprehensive approach to these strategic partnerships, states can place certain Medicaid benefits at risk with the SNP thereby effectively leading to integration at the plan level. This improves administrative efficiencies for providers as well as reduces fragmentation for beneficiaries. Conversely, where states already employ Medicaid managed care for dual-eligible individuals, allow for automatic enrollment into a sister Medicare Advantage or Special Needs Plan to ensure coordination between Medicaid and Medicare.

What can the federal government do to help enable programs in this area?

Broaden state authority to create managed long-term care models, and provide financial incentives to do so. In order to provide incentives to states for the development of programs specifically designed for high-risk populations, the federal government should allow states to create new long-term care models at their option and eliminate the prohibition on enrolling dual eligibles in managed care on a mandatory basis. An alternative approach would be permitting states to automatically enroll dual eligible individuals in coordinated care, with an opt-out right into traditional fee-for-service coverage. CMS also could revise the state plan amendment process to make it easier.

Permit, facilitate, and encourage integration of Medicare and Medicaid benefits and coordination of care for dual-eligibles. States should be permitted to adopt integrated long-term care models that would enroll beneficiaries in a coordinated care plan that provides Medicare and Medicaid benefits. In this type of model, states would receive funding from the federal government for the expected Medicare costs of benefits. States would then combine those funds with Medicaid funds and use Medicaid health plans to provide many coordinated benefits. The states and the federal government could develop a shared savings methodology to reward both for advancing integration. This effort could be accomplished first through demonstrations, and then broadened as appropriate. CMS could develop an administrative support function to help states adopt managed long-term care models, which might include drafting model authority, removal of duplicative or conflicting regulatory requirements, and a streamlined approach to integrated benefit design.

Chapter 6: Options for Savings From Modernizing Medicaid's Administrative Systems

The current position

Today, states strive to run large Medicaid health programs on constrained budgets, often with outdated administrative infrastructures reflecting many years of under-investment in technology. Although the federal government finances 75 to 90 percent of certain technology-based activities, states still find themselves needing to commit substantial resources to administering their programs. With the substantial increases in Medicaid enrollees now expected as a result of the new federal health reform legislation, there is clearly a need to rectify that situation. Doing so will provide the opportunity not only to serve beneficiaries better, but also to use Medicaid as a vehicle for wider health care improvement, while also realizing significant savings.

Medicaid comprises 50 different state programs, as well as those in the District of Columbia and the territories, all with their own approaches to program administration. States differ in many aspects of their Medicaid administration, such as how they categorize enrollees and medical services, handle information processing, exchange data, and report to the federal government. State-specific standards for information processing methods, data exchange, and reporting do not interact across state lines. Program integrity efforts vary across states, as do the analytic systems that help states monitor quality and put in place systems to improve provider performance. As a result, there is substantial duplication of effort, with states each developing systems that perform similar activities.

The historical under-investment in health IT also has implications for safety-net providers that disproportionately care for Medicaid enrollees. There are gaps in adoption rates between hospitals and physicians that disproportionately care for the poor, and those that do not — with major implications for the quality of care. Medicaid enrollees and minority patients are less likely to see providers who use electronic health records than other patients, and may have lower quality care as a result.[61]

What is now being done?

States are already experimenting with different approaches, both in their Medicaid programs and across state health programs more generally.[62] The ARRA stimulus legislation takes additional action to modernize health IT, including for Medicaid beneficiaries. It introduces bonus payments, starting in 2011, to encourage and enable more Medicaid providers to adopt electronic health record systems. States will receive 90 percent federal funding to administer and oversee the adoption process, and are required to develop health IT plans outlining plans to do so. Grant funds are also available under ARRA to states to develop health information exchanges (HIEs) over a four-year period, and to lay the groundwork for nationwide interoperability.

The federal government is also developing a framework to improve administration of the Medicaid program by recommending data and technical standards for use across all states. This initiative, called Medicaid Information Technology Architecture (MITA), includes a technical framework as well as processes and planning guidelines for states. MITA's aim is to help states reduce wasteful spending by identifying duplicative payments and providing targeted care to individuals.

States are central in the effort to build a modernized national health infrastructure.[63] Health system improvements, therefore, need to strike a balance between national standards and the benefits of building on innovative state initiatives, avoiding disruption to effective state programs.

What can states do to modernize Medicaid's administrative processes?

Improve capabilities for enrollment, eligibility, and retention. To effectively expand coverage, states will need to improve their eligibility and enrollment systems to be able to identify and contact eligible, un-enrolled individuals, and to communicate more seamlessly with related educational and social service agencies. One proven approach is using third-party data matching instead of documentation provided by program applicants and by people renewing coverage. Third-party data may also be used to promote greater program outreach, asset identification, credentialing, and background checks.[64] Critically, states will also need administrative systems that can coordinate benefits and eligibility with other entities, such as the insurance exchanges, that are part of the comprehensive expansion of coverage under the enacted health legislation.

Adopt predictive modeling analytics to identify high-cost beneficiaries. Research has shown that fewer than five percent of Medicaid beneficiaries account for 50 percent of total expenditures. The top one percent of beneficiaries account for over 25 percent of annual Medicaid costs. While these techniques are routinely used by health plans in coordinated care programs, states can use predictive modeling in their Medicaid fee-for-service populations to identify patients who may become ill. This will allow states to target interventions, such as intense medical management.[65]

Adopt rapid notification to physicians and plans of hospital admissions to permit coordinated care. Improved data systems could establish an emergency room or urgent care notification system through a method called a standard HL7 protocol. Using this method, the system would immediately notify a payer or primary care physician of a member's admission. This process would enable better case management for patients who frequently use urgent care or emergency room settings, as well as reduce readmissions after an inpatient stay.

Include information on quality and outcomes in data systems. This information will allow states to pursue quality initiatives like medical homes and accountable care organizations, as well as pay-for-performance initiatives, all of which require cost and outcomes information to drive system improvements. One approach would be to use a system separate from the MMIS that ensures states hold to HEDIS and NCQA standards. While MMIS would process claims and perform edits, more in-depth analysis could be done in a separate data warehouse.

Employ auto-assignment in managed care based on quality. At present, the number of members that select their primary care physicians versus being auto-assigned a primary care physician varies greatly across Medicaid locations, depending on the enrollment process. In some locations, the number of enrollees being auto-assigned can be as high as 75 percent of enrollment, typically on the basis of proximity and specialty of care. For primary care case management (PCCM) programs and Medicaid managed care plans, states could establish primary care physician auto assignment rules based on quality performance measure, HEDIS scores, and specialty. States could then assign enrollees a primary care physician (PCP) that meets the highest standards and is best suited to manage their care. This would result in high performance PCPs getting the opportunity to serve more beneficiaries, increasing preventive utilization and potentially decreasing illness and extensive use of emergency rooms. Effective implementation of such a policy would depend on increases in the supply of primary care providers and improvements in payment policy for them.

Encourage electronic claims submission. Government-sponsored provider incentives to encourage electronic claims submission can result in cost savings. Paper claims add unnecessary costs to the system, for both payers and providers. We estimate providers would see a 50 to 75 percent reduction in their transaction costs, with a 20 to 50 percent reduction in processing time, 25 to 75 percent reduction in paper, and increased satisfaction from the relief of no longer having to do so much paperwork. The average industry cost to process a paper claim is $1.51 to $2.46 per claim, versus an electronic claim which costs about 50 cents. Similarly, paper check and remittance advice costs range from 50 cents to $1.50, while electronic counterparts range from 17 cents to 50 cents. Auto-adjudication of claims increases with greater use of electronic data interchange (EDI) for data submission of data. This results in increased payment accuracy and quicker payment to providers. Increasing EDI submission rates to 90 percent, from the current industry average of 65 to 80 percent, could lead to $300,000 in savings on a 100,000 member plan. If increased use of EDI is coupled with adoption of electronic funds transfer, individual providers could save between $40,000 and $100,000 annually. Congress is moving to adopt electronic funds transfer (EFT) for Medicare providers and states should now follow suit by adopting it for Medicaid remittance.

Adopt a system to validate claims prior to payment. Validating claims prior to payment through a pre-processing edit can help states simplify claims processing without slowing down payments if done electronically. The current "pay and chase" process of reconciling inappropriate payments and claims results in excessive pending encounters, recoveries and adjustments. Prospective review can help states reduce duplicate billing, fraud, waste and abuse. In recent years, health care fraud analytics firms have developed detection models that use multiple factors to score claims, predicting the likelihood that the claim is incorrect when no single factor alone would cause it to be reviewed for denial. The factors examined include intra-claim considerations, such as a high cost treatment for a diagnosis when less expensive care is often, but not always, appropriate. The models take into account provider-specific experience; claims from providers that have not had many claims denied receive lower scores relative to those who have had a larger proportion of their claims denied. Complex cross-claim factors are also examined, including evaluating sets of services that are unlikely to occur together. Identifying the probability that a claim is erroneous and then subjecting the claim to further investigation holds the potential to save billions for state Medicaid programs. In Working Paper 2, we estimated that the federal share of Medicare and Medicaid savings from a reduction in inappropriate medical costs from payment accuracy techniques would be $113 billion over a 10-year period for the current Medicaid population. The Medicaid share of those savings would be about $66 billion, with states saving $28 billion. Additional savings in administrative costs would accrue to the Medicaid program, totaling about $10 billion over the same period. States would realize about $5 billion of those savings.[66] Further savings would be realized through reductions in the cost of expanding coverage. Total benefit and administrative savings would be $90 billion, we estimate, when both current and existing populations are considered.

Make broadly available standards for encounter edits. Similar to Medicare, states should make literature and edits available to relevant payers and software vendors so that pre-payment rules engines can be appropriately developed and adopted. Program administrators would be able to utilize these tools and adjudicate claims to generate more accurate and consistent payment to providers, with reduced claim recoupment activity. By reducing half of failed encounters (through elimination of claim reworks and encounter corrections) a state Medicaid plan could reduce about 10 to 15 full time equivalents (FTEs) between encounter corrections and claims reprocessing, resulting in an annual saving of nearly $1.5 million for every one million members. Across all state programs, this could total about $65 million in annual savings.

Include Medicaid in state health information exchanges. Information exchange is both a statutory requirement for ARRA incentives in Medicaid and is fundamental to improved care delivery and outcomes. State Medicaid programs are often the largest health delivery structures within states. As such, they have an ability to drive a thoughtful and uniform exchange process for many providers that will help coordinate care across settings. Developing health information exchange (HIE) capacity will take time and involve a host of disparate stakeholders in five domains: governance, finance, technical infrastructure, business and technical operations, and legal/policy. HHS expects states to leverage existing regional and state-level efforts and resources that can advance HIE, such as master patient indexes, health information organizations (HIOs), and the Medicaid Management Information System.

Enhance Coordination of Benefits (COB) between government-sponsored and commercial health care programs. The opportunity to enhance COB across health care programs will become increasingly significant as new health care programs (e.g., exchanges) are implemented. In the past, the concept of a master eligibility database has been discussed and now could be the appropriate time to implement such a tool. An eligibility database will enable better coordination between health care programs and ensure that the appropriate parties are administering and paying for the services for which they are responsible. This could be particularly effective for administering payment for benefits typically not covered (e.g., ancillary services) by government-sponsored health care programs.

How can the federal government support the modernization of Medicaid's administrative processes?

Consider establishing federal standards for Medicaid administrative transactions and processes. Medicaid programs collect and use data to conduct basic transactions with providers and enrollees, to avoid payment errors, and to track critical information about their enrollees' medical care. Progress has been made with new billing and payment standards, but there is still significant variation for state data submission requirements and billing such as for community-based providers, non-emergent transportation outliers, room and board and other items. Establishing national standards for core information in the Medicaid program could improve the overall efficiency of the program, relieving providers, health plans, beneficiaries, fiscal intermediaries and others from non-standardized technical and transactional specifications. Existing transaction data sets could be improved through the addition of eligibility verification, benefits and prior authorization elements. Establishing and enforcing standard companion guides would produce consistent data definitions across the states. Each state also establishes its own claims editing rules that are used to evaluate appropriateness of payment for encounters. While some state-specific variation will always be necessary in this area, a national standard for determining clean claims would mean the majority of editing could be standardized and simplified across states. Each state has its own requirements, formats and data attributes for credentialing and provider submissions, and these could also be harmonized. With regulatory changes on the horizon, including switching to the HIPAA 5010 standards for electronic claims transactions and adoption of ICD-10 as a new coding system, this is an opportune time to move to greater standardization. Greater multi-state standardization of common regulatory requirements could also be considered.

Provide support and direction for standardized data sharing of Medicaid data with Medicare and private payers. Improvements to the health care system could be realized through enhanced Medicaid capabilities in data sharing with the Medicare program and other payers. While the Deficit Reduction Act of 2005 included enhanced requirements for states to require such data sharing, further action is needed to ensure the proper coordination of benefits in the overall health care payment 'matrix.'

Consider establishing a multi-state database for enrollee and provider information, or develop a system of required individual patient identifiers and national provider identifiers. The current system of state identification for Medicaid enrollees is suboptimal in terms of payment accuracy, program integrity and individual privacy, with multiple and duplicative identification numbers in circulation, as well as the occasional use of Social Security Numbers. A single Medicaid identification number could provide unique identifiers that protect against fraudulent sharing of identification cards. A multi-state database could also maintain providers' demographics, credentialing and payment information, which could lead to more rapid and accurate claims payment, fewer denials, and increased provider satisfaction. Some estimates suggest these measures could save approximately 10 percent of current Medicaid information technology costs.

Include CHIP in assessing Medicaid providers' eligibility for ARRA electronic health record incentives. Medicaid providers must meet certain thresholds to qualify for Medicaid incentive payments established under ARRA. Generally, providers must treat a certain percentage of patients enrolled in Medicaid in order to qualify for Medicaid incentives, and they are available for specialties such as pediatricians and OB/GYNs who typically do not treat Medicare patients. However, CHIP enrollees do not count against the qualifying threshold. Allowing them to do so would allow more providers who currently do not qualify for Medicare incentives to meet the Medicaid threshold, and would encourage providers to adopt and use HIT to produce better outcomes based on care coordination.

What are the savings opportunities from modernized Medicaid administrative processes?

The UnitedHealth Center for Health Reform & Modernization has estimated that the application of new technology and modern administrative processes could save the Medicaid program $37 billion in administrative costs between 2011 and 2019, with savings equally shared between states and the federal government.[67] These initiatives would also affect Medicaid medical costs — with an estimated reduction of $96 billion in medical spending over the 2011 – 2019 period, of which $34 billion would accrue to the states and $61 billion to the federal government.[68] State level estimates for these administrative savings are presented in Appendix 8.

Chapter 7: Summary: The Opportunity Ahead

Medicaid is a critical part of the U.S. health care system, and its importance is about to increase.

Practical options identified in this working paper could save states as much as $149 billion in Medicaid costs over the coming decade, contributing to an overall Medicaid modernization 'dividend' that could be as high as $366 billion.

Summary of Potential Medicaid Savings Identified in This Working Paper

	Savings in billions of dollars (2011 – 2019)		
	Total	Federal	State
Increase use of coordinated care in current Medicaid population (see Chapters 3 & 4)	**82**	46	35
Adopt coordinated care in Medicaid expansion population (see Chapters 3 & 4)	**11**	11	1
Wider use of community-based coordinated care in Medicaid long-term care (see Chapter 5)	**140**	80	60
Administrative modernization of Medicaid programs (see Chapter 6)	**133**	80	53
Predictive modeling & payment accuracy			
Administrative	**13**	7	7
Medical	**77**	49	28
Increased EMR/PHR integration			
Administrative	**3**	1	1
Medical	**19**	12	7
Greater use of electronic data interchange	**8**	4	4
Other administrative improvements	**13**	7	7
Total savings	**$366 billion**	**$217 billion**	**$149 billion**

Sums may not add to totals because of rounding.

Releasing these savings would both allow for reinvestments in helping underserved communities get the health care they need — particularly high quality primary care — but would also help states with their own fiscal challenges.

The opportunity is therefore not only for states to fulfill their new statutory responsibilities, but to act as transformative change agents, championing the wider modernization of health care for all Americans.

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Appendices

Appendix 1: How Medicaid currently works

Medicaid is the nation's primary source of health coverage for low-income children and families, people with disabilities and poor seniors. Additionally, Medicaid has an important role in financing mental health and substance abuse services, AIDS, breast and cervical cancer. However, adults without dependent children and many low-income parents do not generally qualify for Medicaid. Medicaid is jointly financed by the federal government and the states, and is one of the largest expenditures in the federal budget, totaling about $250 billion in fiscal year 2009. The federal government pays about 57 percent of program costs on average, but its contribution, known as the federal medical assistance percentage (FMAP), varies across states according to a formula based on per capita income. The program covers about 70 million individuals each year, which is greater than those covered by Medicare, and provides about $10 billion a year to hospitals each year that serve a high share of poor and uninsured (so-called disproportionate-share hospitals (DSH)). Medicaid is administered by the states, under federal guidelines that include minimum eligibility and benefit requirements.

Benefits and eligibility. States are required to provide a minimum, comprehensive set of benefits to enrollees, with other benefits permitted at state option. Federal minimum income thresholds, presented as a share of the government-defined federal poverty level (FPL) — $22,050 for a family of four in 2009 — form the basis of eligibility requirements. Young children and pregnant women are required to be covered, however states have substantial flexibility under the program to provide other coverage and optional benefits: about 60 percent of Medicaid spending is estimated to be at state option, which in turn has contributed to wide variability across state programs. Some states have had the resources to pursue broad coverage expansions as a way to address concerns about the uninsured. Indeed, some states — through federal waivers of Medicaid law — have expanded their programs well above federal minimum levels to cover families.

States are required by law to provide coverage to individuals with disabilities receiving federal Supplemental Security Income (SSI) benefits and certain individuals in institutions and, at their option, may provide coverage to disabled and aged beneficiaries with income less than poverty. Nationally, there are roughly 15 million aged and disabled enrollees, comprising under a quarter of the people enrolled Medicaid. About 40 percent of those beneficiaries are dually eligible for Medicare and Medicaid. Medicare operates as a separate, federally funded program for individuals who are over 65 as well as certain disabled individuals under 65. Individuals may be eligible for both Medicare and Medicaid — about seven million are, but there is little coordination between the two programs. Medicare is primarily responsible for hospital and physician costs and certain costs for post-acute care, but does not provide long-term care services. States maintain the responsibility for long-term care services as well as co-payments and deductibles for Medicare services.

CHIP and Medicaid. The Children's Health Insurance Program (CHIP) is a state program that provides health coverage to low-income children with incomes higher than Medicaid eligibility thresholds. Most states cover children up to 200 percent of poverty in CHIP but several have effective income thresholds at higher levels. About 10 million children are currently covered under the CHIP program, while about 34 million children are covered by Medicaid. The federal government also contributes to the cost of coverage — about 69 percent of program costs on average — yet the law caps the federal contribution for CHIP spending. Although states may provide Medicaid-level benefits, states are able to use the CHIP program's flexibility to provide children with benefits similar to those offered in the private marketplace.

When the Congress reauthorized the CHIP program in February 2009, it also expanded federal funding for the program and financial incentives to help states enroll more Medicaid and CHIP children.

Provider payment and coordinated care. States mainly rely on fee schedules to set rates for providers in fee-for-service payment systems. Over the last twenty years managed care has become an increasingly significant mode of care delivery in the Medicaid program for children and families. States pay managed care organizations set fees per enrollee to cover their services and base those fees on fee-for-service rates. Several states received federal approval to mandate substantial portions of their Medicaid population into managed care plans under waivers of Medicaid law. States sometimes choose to pay for certain benefits on a fee-for-service basis. Also, in some states that still rely primarily on fee-for-service, states may choose to use health benefit plans to provide benefits for a narrow set of services, such as behavioral health care. At their option, states may enroll (through voluntary or mandatory mechanisms) most of their populations in Medicaid managed care organizations for some or all of their benefits without a waiver from CMS. (Under Medicaid law, states may not require mandatory enrollment of dual-eligible enrollees, special needs children and Native Americans.) States comprising about 45 percent of enrollment do so, and others (state with about 15 percent of enrollment) operate primary care case management (PCCM) programs that pay organizations a fee to coordinate care for their beneficiaries. About 57 percent of children and 45 percent of adults are covered through a managed care organization. Today only 20 percent of disabled beneficiaries are enrolled in a managed care plan. The majority of high-risk aged and disabled beneficiaries remain in fee-for-service.

Administration. Administration of state programs includes a wide range of functions such as eligibility determinations and enrollment, financial management, contracting, quality oversight and provider relations. Spending for their administration was about $22 billion in fiscal year 2009, with the federal government covering about half of those costs.

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Appendix 2: Methodology for estimating enrollment and costs under the Medicaid expansion

We estimated state-specific enrollment increases and costs associated with the Medicaid expansion included in the health reform legislation. The legislation will require states starting in 2014 to enroll all individuals with income up to 133 percent of the federal poverty level (FPL) using new rules to determine how income is calculated for eligibility purposes.

The legislation will result in a large-scale expansion of Medicaid coverage — our net estimate is that the legislation will result in a 16 million increase in Medicaid enrollment by 2019 with combined federal and state costs of $436 billion through 2019. Both figures represent average annual monthly enrollment and do not include effects on the CHIP program. Comparisons to published estimates by the Congressional Budget Office are included below.

Basis of Estimate

Eligibility and enrollment. To compute eligibility and participation estimates for the Medicaid expansion, we used the Lewin Group's Health Benefits Simulation Model (HBSM), a microsimulation model that allows analysis of changes in health insurance status of different categories of individuals under different policy scenarios, such as increasing program income limits. We developed estimates of individuals who will be newly eligible for Medicaid under the proposals, including adults who are parents of Medicaid-eligible children and adults without dependent children under the new poverty thresholds. We also estimated the number of those who otherwise would be eligible for Medicaid, but not enrolled. Included in our estimates of eligibility are individuals who currently have employer-sponsored insurance and are below poverty thresholds established in each bill, as those individuals may choose to enroll in Medicaid or receive supplemental benefits from Medicaid.

Net Medicaid enrollment increases for the newly eligible population and those who would be eligible, but uninsured under prior law are shown in Figure A2.1, below. We estimate that participation rates among new eligibles will not be 100 percent. The "take-up rate," the extent to which those made eligible for Medicaid via health reform will actually come forward and enroll, was derived based on each individual and family's demographic characteristics and whether they had other health insurance coverage, or offer of coverage. Our assumptions are consistent with historical patterns in the Medicaid and CHIP programs and are about 60 percent of those eligible based on income alone. Included in those enrollment figures are individuals who otherwise would have private coverage. This phenomenon, known as "crowd-out" has been demonstrated in both Medicaid and CHIP. We estimate that about 30 percent of newly enrolled individuals otherwise would have had employer-sponsored coverage.

We assume that many of those parents and children who are eligible for Medicaid under current law, but are not enrolled, will participate under the proposals. We believe that the accompanying exchange mechanism that provides subsidies to low-income families will identify and help to enroll some of those eligible individuals in Medicaid. Our estimates also account for adults who otherwise would be covered under Medicaid who instead leave the program to enroll in the newly established exchanges or in employer-sponsored coverage, and includes some individuals with income levels above the thresholds established under the proposals. Under the legislation, we expect that states covering adults above the 133 percent of poverty threshold today will scale back that coverage starting in 2014 and that those adults will shift to the subsidized exchange created under the legislation.

Estimated Change in Medicaid Enrollment by Category, Fiscal Year 2019 (in thousands of people)

	Children	Parents	Adults w/o Children	Total
Newly eligible	0	2,940	13,130	16,070
Previously eligible, unenrolled	1,020	1,650	50	2,720
Shift to private coverage (ESI, exchange)	-890	-1,460	*	-2.350
Total	**130**	**3,130**	**13,180**	**16,430**

Figure A2.1; Note: Sums may not round to totals due to rounding
* = less than 50,000 and greater than -50,000

The expansion in Medicaid enrollment will begin to occur in 2014 under the legislation. Based on the experience of prior Medicaid expansions and the establishment of the CHIP program, we assume that full ramp-up of this enrollment will take several years, with 40 percent of the enrollment occurring by the end of the first year and increasing amounts until full ramp up by the end of the third year of the program. We indexed annual growth in the size of the expansion population to projected growth in the Medicaid population, roughly one percent annually.

Costs per person. We derived costs per person for the expansion population for each of the three demographic subgroups for which enrollment projections were made: parents, childless adults, and children. We relied on Medicaid Statistical Information System (MSIS) administrative data from the Centers for Medicare and Medicaid services which identifies spending by service and eligibility category. We used MSIS data for 2007 to calculate base per member per month (pmpm) costs for persons who were not dually eligible for Medicare and were not eligible for Medicaid due to disability. For adults required to be covered under the legislation, we relied on administrative data for the existing program's costs for a similar population and then adjusted those figures for the higher costs associated with adults without dependent children. We based our analysis on pmpm costs for men currently enrolled in Medicaid as a proxy for the costs of the expansion population adults. In part, this approach adjusted for the fact that pregnant women account for substantial pregnancy-related costs but that pregnant women are already eligible for Medicaid to 133 percent of poverty (and beyond that level in many states). To reduce variability in states with a small relative number of men enrolled in the program, we limited any states' costs for covering the new population to 30 percent above or below the nationwide pmpm cost for covering men in the program under current law. Those estimates served as our starting point for estimating the costs of covering parents under the legislation. We assumed costs for adults without dependent children will be 15 percent higher than for parents. Analysis of the Medical Expenditure Panel Survey (MEPS) shows higher utilization and costs for childless adults within this income range. We also reduced per person amounts for children to reflect the fact that children currently eligible for Medicaid, but not enrolled will have lower medical expenses relative to those who have been enrolled previously.

We inflated per member per month costs at a rate of about 5.5 percent annually, which is consistent with projected growth in per capita national health spending. For 2014, our estimated costs of annual coverage ranged from $2,800 to $5,600 per for parents, from $3,200 to $6,400 for childless adults, and from $1,400 to $3,300 for children. The variation in costs reflects local market factors, state benefit coverage, and each state's existing mix of capitation and fee-for-service approaches.

Comparison to other estimates. Our estimates are consistent with other approaches taken, as most researchers use the same public data sources for enrollment and costs in the Medicaid program. Our estimate of the increase in enrollment in 2019 is 16 million, with 2019 federal costs of $99 billion. The Congressional Budget Office (CBO) estimates a similar increase in enrollment and federal costs of $97 billion in 2019.

Our estimate of the total federal costs of the expansion over the 2014 to 2019 period is $412 billion, a figure that is lower than CBO's estimate of $424 billion. Differences are attributable to assumptions about individual decisions, such as crowd out, that we describe above, and additional federal funds for certain states that cover adults without children under current law. CBO incorporates that spending, while we do not. CBO also includes additional federal funds for CHIP in its totals.

Scope of Estimate. Given that states have not decided how they will approach the question, we did not estimate the extent to which states convert state programs for adults to Medicaid as permitted by the legislation in advance of the 2014 expansion requirement. Our estimate also does not include effects of changes to the CHIP program. The legislation provides additional funds to states for the program only in 2014 and 2015 and provides states with a higher federal match rate. While there is likely additional enrollment of CHIP children in those years, over the longer term program enrollment will decline as available funds erode.

Appendix 3: How Medicaid health plans can improve care coordination

Better care coordination is a critical need in Medicaid, and that is at the heart of what Medicaid managed care plans do, using accessible provider networks, clinical programs, member outreach and education, and other strategies to integrate care.

Access to provider networks through managed care organizations can help states reach goals of providing better health care services through ensuring network adequacy in terms of both range and qualifications of providers. An essential feature of state contracting arrangements with managed care plans and federal waiver approvals is the requirement for adequate provider networks, especially those that connect enrollees to community providers. Adequacy can be defined in several ways, including minimum numbers for health care providers, a full range of specialty providers, and geographic standards for both urban and rural settings. To better measure adequacy, states tend to require minimum ratios of providers to members, expanded hours of care, enrollee hotlines, and maximum travel time and distance requirements.

In addition to helping provide greater access to appropriate providers, managed care plans have programs that help to facilitate beneficiary access to providers through, for example, monitoring of appointment availability and feedback to customer service representatives. Tracking mechanisms employed by managed care organizations can help with appointments and follow-up reminders, accuracy of addresses and locating individuals in need of medical care through community contacts. Managed care organizations often employ personal care specialists to connect families to medical care. They also can help states with recertification and meeting goals of providing continuous care for enrollees.

Medicaid health plans deploy tailored clinical programs to enhance access to and delivery of evidence-based care. Education of enrollees about their health also contributes to improved connectivity to appropriate health care services. Programs using community health workers to ensure compliance with recommended health services, overcoming barriers such as transportation so pregnant women come in for routine prenatal care, and addressing issues such as racial and ethnic disparities and low health literacy are all components of contemporary Medicaid coordinated care programs.

Medicaid managed care frequently includes the active management of pharmacy benefits, on an integrated basis alongside medical and other benefits.

In the area of behavioral health, many states are seeking better coordination of care and to varying degrees have tried to move away from the unmanaged care prevalent in fee-for-service. Some states are pursuing full integration of behavioral with physical health benefits in full-risk managed care, while others are relying on administrative or management services organizations, care management, or disease management organizations. Those approaches can help states establish better connectivity between physical and behavioral health providers.

Policy changes that could yield further gains for beneficiaries and states include:

Upper-payment limit. Federal Medicaid policy could be changed to allow states to count managed Medicaid days in the hospital upper payment limit calculation. This would allow flexibility for states in choosing their preferred approach to providing care.

Out-of-network reimbursement. Federal Medicaid law has established an out-of-network limit for emergency services provided to Medicaid managed care enrollees in order to ensure that the state would not have to pay more than what they would otherwise pay in fee-for-service; this provision could be expanded to all out-of-network services.

Relax cumbersome waiver requirements. States pursuing managed care through certain waivers of Medicaid statute often face a complex process to adopting innovative programs.

Provide continuous care to enrollees. The managed care model can offer ways to better provide continuous medical care to enrollees and help institute longer-term programs for preventive care and behavioral improvements for better health. One way states can ensure this outcome is to adopt a policy requiring 12 months of continuous eligibility. Keeping children and families on the rolls consistently also can prevent the costs associated with churning, whereby people drop off the rolls, get sick, and then need high cost services when they re-enroll. Adoption of this state option under current Medicaid law also would allow states to more easily access federal CHIP bonus payments for enrollment of Medicaid and CHIP children.

Pursue bonuses for outreach and enrollment. The federal expansion of Medicaid could be strengthened with continued efforts to enroll all individuals that are currently eligible for Medicaid and CHIP. Bonus payments for enrolling higher than expected numbers of Medicaid children are currently available through special funding in the CHIP program. States could pursue those bonuses as they enroll more children. The federal government could also provide more support in this area in terms of incentives for states. However, finding and enrolling eligible uninsured children and families is not easy, and requires committed work in local communities. Managed care organizations can help states with statewide public awareness campaigns to enroll eligible individuals.

Appendix 4: Methodology used to estimate state-specific savings opportunities

In estimating the state-by-state savings from further adoption of Medicaid managed care models, we relied primarily on state-level spending and enrollment data from the Medicaid Statistical Information System (MSIS). MSIS is the main source of administrative data on the Medicaid program and is maintained by the Centers for Medicaid and Medicare Services (CMS). Federal rules require that all 50 states and the District of Columbia report Medicaid spending and enrollment to CMS every year, ensuring that sufficient data are available to conduct cross-state comparisons. Spending variables are broken down by provider type, (i.e., hospitals, physicians, and nursing home services). Estimates in this analysis utilize the capitated care variable, which documents risk-based payments to managed care organizations by eligibility category.

For the purposes of this analysis, we calculated savings estimates using the most recently available MSIS data. Thirty-one states provided data from fiscal year 2008. For the remaining 19 states and the District of Columbia, we relied on fiscal year 2007 data, adjusted to 2008 levels. In some cases, states expanded managed care programs after fiscal year 2008. We modified our analysis to reflect those expansions by incorporating relevant state-specific data into the existing analysis. Dual-eligibles (individuals eligible for both Medicare and Medicaid) were excluded from our estimates due to their dual-program financing and program restrictions limiting their mandatory enrollment in managed care.

We first identified the portion of total Medicaid spending allocated to fee-for-service arrangements with providers by state and by characteristics of the eligible population (i.e., children, families and non-elderly beneficiaries with disabilities). We then adjusted the fee-for-service totals by removing spending on nursing homes, programs for the medically needy, and enrollees in the retroactivity period. (Medicaid covers three months of retroactive eligibility and reimburses providers for spending incurred during that time.)

Then we estimated the proportion of beneficiaries that could be transitioned from fee-for-service to managed care (by state) and the amount of fee-for-service spending that would be affected by this transition. In states where Medicaid managed care has already been adopted, certain enrollees would be unlikely to benefit from expanded capitation. In states where this is not the case, we estimated the potential first-year savings of moving these new beneficiary groups to a capitated managed care model. Real world evidence drawn from states (of the sort described in Chapter Three), from UnitedHealth Group's own results as America's largest Medicaid health plan, and from a meta-analysis of the research evidence conducted by the Lewin Group, all suggests that states could save about five percent of fee-for-service costs by enrolling children and low-income families in managed care. Likewise, states could probably save around eight percent by transitioning enrollees with disabilities into managed care. Because fee-for-service coverage for enrollees with disabilities is fairly fragmented, we believe this population in particular would significantly benefit from the adoption of coordinated care. Those average savings percentages could be higher or lower in specific states, and represent the center of a range of possible savings.

Rural areas have particular needs and challenges. In rural states with limited managed care penetration and states that have adopted a primary care case management programs (PCCM), difficulty establishing provider networks would limit states' ability to adopt a managed care model to the fullest extent. We estimated that a capitated model would save only half as much (on a percentage basis) in rural areas as in urban areas, and only half as much for persons already enrolled in a PCCM program as it would for persons enrolled in traditional fee-for-service coverage. Consequently, our analysis makes downward adjustments in nearly all states' savings opportunities to reflect the state's urban/rural composition as well as the percentage of state residents enrolled in PCCM.

Our analysis projects the nine-year cost savings (fiscal years 2011 – 2019) for two groups of beneficiaries: (1) families and children; and (2) individuals with disabilities who are not dually eligible for Medicare. In constructing those estimates, we assumed that per capita health care costs would increase annually at about the same rate as national health expenditures and that the Medicaid enrollment would grow at rates consistent with projected population growth for the two groups of beneficiaries. We also predicted that health care savings would increase over time as managed care programs matured in each state. Specifically, we estimate that savings will grow at a quarter of a percentage point each year. We then calculated the share of the overall savings that would accrue to each state government using the federal match rates applied under current law and under the enacted legislation.

Appendix 5: U.S. health care system administrative modernization savings estimates, 2010 – 2019 (from UnitedHealth Center for Health Reform Working Paper 2)

A. Required use of common technology and information standards, with enhanced interoperability and connectivity

Option 1: Rapidly develop and adopt system-wide data and transaction standards to simplify administration and improve patients' diagnosis, treatment and outcomes. Foundational

Option 2: Use of automated cards to validate patient eligibility and benefits at the point of service. ~$18 billion

Option 3: Eliminate explanation of benefits for each transaction and replace with monthly personalized health statements, delivered through secure online portals where possible. ~$14 billion

Option 4: Eliminate paper checks and Paper Remittance Advice in favor of electronic funds transfer and electronic remittance advice. ~$109 billion

Option 5: Implement multi-payer transactional capability on Practice Management Information Systems. ~$29 billion

Option 6: Expand use of Electronic Data Interchange for claims, eligibility and coverage verification, notification/administration and claims status. ~$31 billion

Option 7: Integrate Practice Management Information Systems and payer administrative systems. ~$11 billion

Option 8: Integrate essential elements of electronic medical records and personal health records and promote information sharing and use of data to improve prevention and coordination of care. ~$13 billion

B. Use advanced system-wide techniques to improve payment speed and accuracy

Option 9: Use predictive modeling to pre-score claims for Coordination of Benefits, upcoding, subrogation, fraud and medical management prior to payment. ~$47 billion

Option 10: Create a national payment accuracy clearinghouse to settle under-payments and over-payments. ~$41 billion

C. Streamlined provider credentialing, privileging and quality designation processes

Option 11: Eliminate multiple payer credentialing and separate hospital privileging. Develop industry utility for credentialing. ~$18 billion

Option 12: Adopt common quality designation standards and create single health information database for quality determination. ~$1 billion

Potential administrative savings to the health care system by applying these selected programs are estimated at approximately $332 billion during 2010 – 2019, assuming reasonable implementation phasing.

Working Paper 2 is available at www.unitedhealthgroup.com/reform

Appendix 6: Timeline for main changes to Medicaid under federal reform legislation

2010

- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1 percent (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1 percent); increase the Medicaid rebate for non-innovator, multiple source drugs to 13 percent of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.
- Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).

2011

- Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
- Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90 percent FMAP for two years.
- Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services.
- Establish the Community First Choice Options in Medicaid to provide community-based attendant support services to certain people with disabilities.
- Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured populations.
- Improve access to care by increasing funding by $11 billion for community health centers and the National Health Service Corps over five years; establish new programs to support school-based health centers and nurse-managed health clinics.

2012

- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2010 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2010); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).
- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

2013

- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100 percent federal funding.

2014

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Expand Medicaid to all individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133 percent FPL based on modified adjusted gross income (MAGI).
- Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments.

Source: Henry J Kaiser Foundation, March 25, 2010

Appendix 7: Summary of Medicaid modernization policy options

Challenges	State Program Modernization	Federal Funding and Flexibility
Strained State Budgets *State budgets are struggling to keep pace with growing health care costs and expanding Medicaid populations. Declining tax revenue complicates state efforts to maintain and grow Medicaid programs.*	• Expand existing capitated payment models. • Create incentives to enroll new populations in coordinated care programs. • Work with health plans to design appropriate programs for state needs, including quality and oversight.	• Reward states with bonus payments for innovation and best practices. • Eliminate barriers to adoption by allowing states to count managed care days for upper-payment limit calculations and create reasonable approach to out-of-network providers.
Access to Primary Care *Systematic under-reimbursement for the services provided by primary care doctors has left many reluctant to participate in the Medicaid program. Consequently, access to primary care is limited.*	• Increase payment rates to PCPs, using some of the savings available from wider use of Medicaid coordinated care. • Modernize scope-of-practice laws to help meet demands, and use skills of nurses at full capacity. • Pilot innovative telemedicine programs, especially in underserved rural areas. • Enlist the help of experienced, Medicaid health plans to improve network access. • Use Medicaid health plans to implement medical homes.	• Incentivize states that adopt measures to improve primary care.
Fragmented Fee-for-Service Care Delivery Systems *Reactive and occasional care does not provide the quality and consistency of care necessary to address critical health disparities. Many beneficiaries suffer from persistent unmet needs.*	• Leverage managed care for greater access and quality. • Establish linkages between behavioral and physical health. • Ensure access to safety net providers. • Adopt 12 months of continuous eligibility. • Pursue bonuses for outreach and enrollment.	• Enact federal payment standards to ensure access to care through stronger enforcement of actuarial soundness. • Raise bonuses for outreach and enrollment of Medicaid children. • Ensure that policies providing insurance subsidies for low-income people interface smoothly with Medicaid.
Growing Demand and Costs for Long-Term Care *Two-thirds of Medicaid costs are comprised of services for adults with disabilities and seniors needing long-term care. Aging Baby Boomers will only increase the demand for these services.*	• Redirect savings from diversions from nursing homes to community-based programs. • Adopt managed long-term care programs, including wrap-around coverage for dual eligibles. • Develop partial-risk or care management alternatives in the short-term. • Adopt managed long-term care programs for nursing home patients. • Provide consumer incentives for greater managed long-term care participation. • Require integrated long-term care for non-dual aged and disabled. • Identify enrollees at risk for long-term care. • Use relationships with Special Needs Plans to improve coordination between Medicare and Medicaid managed long-term care.	• Broaden state authority to create managed long-term care models. • Permit, facilitate and encourage integration of Medicare and Medicaid benefits and coordination of care for dual-eligible individuals.

Challenges	State Program Modernization	Federal Funding and Flexibility
Medicaid's Administrative Infrastructure *Chronic under-investment in administrative systems can result in inefficient program operation. Modern technology is needed to improve program performance and eliminate wasteful and duplicative spending.*	• Include Medicaid in state health information exchange strategies. • Improve capabilities for enrollment, eligibility and retention. • Use a pre-processing edit to validate claims. • Encourage electronic claims submission. • Make available standardized encounter edits. • Adopt payer and medical home notification to reduce inappropriate utilization. • Employ auto-assignment based on quality. • Adopt analytics to identify high-cost beneficiaries. • Include quality and outcomes data in separate databases or align with MSIS data.	• Simplify the qualifications for electronic health records incentives. • Adopt federal standards for transactions. • Establish and enforce standards for enrollment, claims, and billing. • Enhance transaction data sets with key data elements. • Use a national standard to identify clean claims. • Create a multi-state database for individual and provider information or a system using national patient and provider identifiers. • Increase data sharing between Medicaid and Medicare and other payers.

Appendix 8: Total state-by-state costs and savings 2011 – 2019 in this Working Paper

Figures in millions of dollars

	Expansion Costs[1]			Savings Estimates											
				Capitation Savings[2]			Long-Term Care Savings[3]			Administrative Savings[4]			Total Savings		
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	**12,215**	**11,565**	**650**	-1,115	-850	-275	-2,255	-1,530	-725	-2,050	-1,410	-630	**-5,420**	**-3,790**	**-1,630**
Alaska	**1,475**	**1,370**	**105**	-620	-355	-265	0	0	0	-460	-260	-200	**-1,080**	**-615**	**-465**
Arizona	**5,090**	**4,875**	**215**	0	0	0	0	0	0	-2,460	-1,570	-890	**-2,460**	**-1,570**	**-890**
Arkansas	**8,425**	**7,970**	**455**	-1,145	-900	-245	-1,580	-1,040	-540	-1,630	-1,160	-480	**-4,355**	**-3,100**	**-1,265**
California	**34,190**	**32,415**	**1,775**	-13,400	-7,225	-6,175	-10,455	-5,225	-5,230	-15,100	-8,070	-7,020	**-38,955**	**-20,520**	**-18,425**
Colorado	**5,095**	**4,820**	**275**	-1,535	-890	-645	-455	-225	-230	-1,400	-780	-610	**-3,390**	**-1,895**	**-1,485**
Connecticut	**3,170**	**3,035**	**135**	-1,135	-630	-505	-3,815	-1,905	-1,910	-1,160	-630	-530	**-6,110**	**-3,165**	**-2,945**
Delaware	**285**	**265**	**20**	-265	-135	-130	-690	-345	-345	-510	-260	-250	**-1,465**	**-740**	**-725**
District of Columbia	**555**	**530**	**25**	-455	-315	-130	-365	-255	-110	-490	-320	-160	**-1,310**	**-890**	**-400**
Florida	**29,785**	**28,060**	**1,725**	-4,360	-2,765	-1,605	-5,880	-3,235	-2,645	-6,300	-3,830	-2,470	**-16,540**	**-9,830**	**-6,720**
Georgia	**19,505**	**18,350**	**1,155**	-1,220	-800	-430	-2,725	-1,770	-955	-4,190	-2,770	-1,420	**-8,135**	**-5,340**	**-2,805**
Hawaii	**410**	**385**	**25**	-160	-90	-80	-350	-190	-160	-420	-230	-200	**-930**	**-510**	**-440**
Idaho	**2,780**	**2,665**	**115**	-485	-360	-125	0	0	0	-660	-460	-210	**-1,145**	**-820**	**-335**
Illinois	**12,560**	**12,035**	**525**	-4,570	-2,645	-1,925	-4,475	-2,245	-2,230	-4,230	-2,330	-1,910	**-13,275**	**-7,220**	**-6,065**
Indiana	**12,565**	**12,040**	**525**	-1,210	-835	-385	-4,100	-2,705	-1,395	-2,610	-1,730	-870	**-7,920**	**-5,270**	**-2,650**
Iowa	**2,610**	**2,500**	**110**	-1,000	-675	-325	-1,770	-1,125	-645	-1,090	-670	-410	**-3,860**	**-2,470**	**-1,380**
Kansas	**5,170**	**4,785**	**385**	-580	-355	-215	-635	-385	-250	-1,010	-650	-360	**-2,225**	**-1,390**	**-825**
Kentucky	**9,775**	**9,210**	**565**	-1,730	-1,300	-430	-2,200	-1,560	-640	-2,390	-1,650	-740	**-6,320**	**-4,510**	**-1,810**
Louisiana	**14,465**	**13,660**	**805**	-2,450	-1,830	-620	-3,440	-2,325	-1,115	-2,810	-1,910	-900	**-8,700**	**-6,065**	**-2,635**
Maine	**865**	**830**	**35**	-960	-640	-320	-685	-445	-240	-1,020	-640	-370	**-2,665**	**-1,725**	**-930**
Maryland	**6,065**	**5,545**	**520**	-1,235	-640	-595	-2,715	-1,355	-1,360	-2,150	-1,180	-990	**-6,100**	**-3,175**	**-2,945**
Massachusetts	**125**	**120**	**5**	-2,575	-1,295	-1,290	-6,220	-3,110	-3,110	-3,130	-1,570	-1,570	**-11,925**	**-5,975**	**-5,970**
Michigan	**11,170**	**10,660**	**510**	-1,295	-875	-430	-4,615	-2,915	-1,700	-4,000	-2,460	-1,520	**-9,910**	**-6,250**	**-3,650**
Minnesota	**3,980**	**3,815**	**165**	-1,730	-860	-860	-1,160	-580	-580	-2,390	-1,260	-1,140	**-5,280**	**-2,700**	**-2,580**
Mississippi	**9,290**	**8,765**	**525**	-1,945	-1,565	-380	-2,000	-1,510	-490	-1,800	-1,300	-500	**-5,745**	**-4,375**	**-1,370**
Missouri	**8,955**	**8,500**	**455**	-2,000	-1,340	-660	-1,955	-1,260	-695	-2,560	-1,650	-920	**-6,515**	**-4,250**	**-2,275**
Montana	**2,490**	**2,340**	**150**	-290	-225	-65	-370	-250	-120	-350	-260	-110	**-1,010**	**-735**	**-295**
Nebraska	**3,310**	**3,140**	**170**	-600	-410	-190	-845	-515	-330	-610	-400	-220	**-2,055**	**-1,325**	**-740**
Nevada	**2,815**	**2,580**	**235**	-660	-365	-295	-385	-195	-190	-670	-390	-290	**-1,715**	**-950**	**-775**
New Hampshire	**2,095**	**1,960**	**135**	-465	-285	-180	-520	-260	-260	-400	-230	-160	**-1,385**	**-775**	**-600**
New Jersey	**8,140**	**7,800**	**340**	-1,700	-850	-850	-7,135	-3,565	-3,570	-2,750	-1,500	-1,250	**-11,585**	**-5,915**	**-5,670**

Savings Estimates – continued

	Expansion Costs[1]			Capitation Savings[2]			Long-Term Care Savings[3]			Administrative Savings[4]			Total Savings		
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State
New Mexico	**4,165**	**3,900**	**265**	-330	-230	-90	-355	-255	-100	-1,440	-990	-450	**-2,125**	**-1,475**	**-640**
New York	**2,405**	**2,305**	**100**	-11,290	-5,675	-5,615	-22,970	-11,485	-11,485	-12,680	-6,370	-6,300	**-46,940**	**-23,530**	**-23,400**
North Carolina	**18,900**	**17,895**	**1,005**	-3,785	-2,685	-1,100	-4,040	-2,630	-1,410	-4,770	-3,140	-1,630	**-12,595**	**-8,455**	**-4,140**
North Dakota	**830**	**785**	**45**	-130	-100	-30	-590	-370	-220	-150	-110	-60	**-870**	**-580**	**-310**
Ohio	**17,360**	**16,625**	**735**	-3,500	-2,255	-1,245	-8,360	-5,300	-3,060	-5,820	-3,690	-2,140	**-17,680**	**-11,245**	**-6,445**
Oklahoma	**6,510**	**6,135**	**375**	-1,850	-1,300	-550	-1,175	-755	-420	-1,680	-1,090	-600	**-4,705**	**-3,145**	**-1,570**
Oregon	**7,260**	**6,835**	**425**	-550	-365	-175	0	0	0	-1,360	-910	-470	**-1,910**	**-1,275**	**-645**
Pennsylvania	**27,385**	**26,025**	**1,360**	-970	-530	-440	-9,205	-5,045	-4,160	-6,620	-3,950	-2,670	**-16,795**	**-9,525**	**-7,270**
Rhode Island	**1,060**	**1,015**	**45**	-470	-250	-220	-1,325	-700	-625	-570	-310	-260	**-2,365**	**-1,260**	**-1,105**
South Carolina	**7,745**	**7,320**	**425**	-1,890	-1,410	-480	-885	-620	-265	-2,150	-1,440	-710	**-4,925**	**-3,470**	**-1,455**
South Dakota	**1,240**	**1,185**	**55**	-265	-180	-85	-425	-265	-160	-310	-190	-110	**-1,000**	**-635**	**-355**
Tennessee	**9,080**	**8,700**	**380**	-870	-650	-220	-3,895	-2,555	-1,340	-3,340	-2,130	-1,220	**-8,105**	**-5,335**	**-2,780**
Texas	**59,520**	**55,350**	**4,170**	-7,705	-5,160	-2,545	-7,360	-4,325	-3,035	-10,130	-6,580	-3,550	**-25,195**	**-16,065**	**-9,130**
Utah	**2,540**	**2,400**	**140**	-780	-600	-180	-405	-290	-115	-660	-440	-210	**-1,845**	**-1,330**	**-505**
Vermont	**-165**	**-160**	**-5**	-185	-105	-80	-160	-95	-65	-310	-170	-140	**-655**	**-370**	**-285**
Virginia	**12,980**	**12,160**	**820**	-1,370	-805	-565	-2,390	-1,195	-1,195	-2,460	-1,460	-1,000	**-6,220**	**-3,460**	**-2,760**
Washington	**7,475**	**7,070**	**405**	-2,040	-1,055	-985	0	0	0	-2,660	-1,450	-1,210	**-4,700**	**-2,505**	**-2,195**
West Virginia	**5,460**	**5,175**	**285**	-910	-700	-210	-995	-735	-260	-1,050	-760	-300	**-2,955**	**-2,195**	**-770**
Wisconsin	**4,255**	**4,075**	**180**	-1,090	-680	-410	-1,580	-950	-630	-1,790	-1,060	-720	**-4,460**	**-2,690**	**-1,760**
Wyoming	**975**	**935**	**40**	-290	-175	-125	-85	-45	-40	-230	-130	-100	**-605**	**-350**	**-265**
US	**436,405**	**412,320**	**24,085**	**-93,160**	**-57,215**	**-35,975**	**-139,995**	**-79,640**	**-60,355**	**-132,980**	**-79,900**	**-53,150**	**-366,135**	**-216,755**	**-149,480**

[1] Includes the costs of the new income and eligibility requirements of the program, the effects of increased enrollment of eligible uninsured, and net effects of individuals moving other coverage status under health care reform, including exchange coverage, employer-based coverage and CHIP.

[2] Figures include the potential effect of states adopting capitated managed care for existing populations in 2011 and for new expansion populations not otherwise enrolled in a managed care plan after 2014.

[3] Savings estimates assume that states reorient their long-term care systems to achieve community long-term care placement rates of about two-thirds by 2019. States showing 0 savings are already estimated to be at or below that level.

[4] Administrative saving include reductions in administrative transactional costs and reduction in medical spending attributable to more efficient program administration that results in more appropriate payment. Savings figures include spending for existing and expansion populations.

About UnitedHealth Group

UnitedHealth Group serves 70 million Americans, funding and arranging health care on behalf of individuals, employers and governments, in partnership with more than 5,000 hospitals and 650,000 physicians, nurses and other health professionals across the nation. Our core strengths are in care management, health information and technology. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers, we are also the nation's largest Medicare health plan — serving one in five seniors nationwide — and the largest Medicaid health plan, supporting underserved communities in 25 states and the District of Columbia.

UnitedHealth®

Center for Health Reform & Modernization

About the UnitedHealth Center for Health Reform & Modernization

The Center serves as a focal point for work on health care modernization and national health reform. The Center assesses and develops innovative policies and practical solutions for the health care challenges facing the nation. Drawing on UnitedHealth Group's internal expertise and extensive external partnerships, its work program falls into six priority areas:

- Practical cost containment strategies to slow the growth of U.S. health care costs
- Innovative approaches to universal coverage and health benefits, grounded in evidence-based care and consumer engagement
- Reducing health disparities, particularly in underserved communities
- Modernizing the care delivery system, including strengthening primary care
- Payment reform strategies that better support physicians, hospitals and other providers in delivering high quality patient-centered care
- Modernizing Medicare, including chronic disease management

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