

MEDICARE AND MEDICAID:
Savings Opportunities from
Health Care Modernization

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INTRODUCTION

In 2013, the country will need to grapple with a daunting set of fiscal challenges. Although the major effects of the “fiscal cliff” have now been avoided, recent actions have done more to acknowledge the depth of the nation’s budgetary problems than to permanently address them. Complicating matters further, the ceiling on federal debt will be reached in a matter of weeks – requiring policymakers to confront more hard choices about how to proceed.

Over the course of this year, therefore, policymakers will need to consider a range of structural changes to federal policies governing both spending and revenues in order to bring the budget closer to balance and prevent the federal debt from reaching unsustainable levels. Taking into account the just-enacted legislation, federal debt is projected to increase by about \$7 trillion over the next 10 years. But those projections still reflect a number of provisions in current law that will be difficult to maintain, including a sharp drop next year in Medicare’s payment rates for doctors and substantial and continuing cuts in other Medicare rates as well as a “sequester” imposing across-the-board cuts on Medicare and a wide range of federal programs. If all current policies were extended, the Congressional Budget Office (CBO) has projected that federal debt would increase by more than \$9 trillion over the next decade.

A central focus of efforts to resolve the nation’s fiscal problems will be health care entitlements – principally Medicare and Medicaid – reflecting the fact that under either of CBO’s projections, spending on those entitlements will increase over the next 25 years from one-fourth to about 40 percent of primary federal spending (that is, spending excluding interest payments).

A consensus emerged during the recent debates on national health care reform that fee-for-service payment mechanisms are at the root of the U.S. health care system’s problems with quality and efficiency. Yet of the roughly \$1 trillion spent today on Medicare and Medicaid by federal and state governments, about 75 percent is funded in that way – including over two-thirds of Medicaid’s spending and nearly 80 percent of Medicare’s spending.

The structural problems in these programs are well documented: disparate funding streams; an inability effectively to influence geographical and other inappropriate variation; and a one-size-fits-all approach to managing costs through the crude lever of administered price controls.

We have over the last several years sought to contribute to the debate on how to modernize those programs in a series of Working Papers. The approaches we discussed were potential “win-win” options which would benefit both their enrollees and the taxpayers who fund them.

This working paper updates and combines those approaches in a single volume. In some cases, we have updated our original estimates for new developments in the policy arena. In designing these options, we have made use of our data and insights from serving one in five seniors nationwide and our overall experience serving more than 75 million Americans, many of whom work for large employers who have been at the forefront of efforts to modernize health care. We have therefore been able to contrast some of their care patterns and programs with those currently available to seniors while incorporating the external research evidence on effective cost-containing strategies and techniques. For Medicaid, the estimates also draw on the track record of some of the most innovative states, as well as our own experience as America’s largest Medicaid health plan. Some approaches presented in this paper would require beneficiary participation in new models of care while some alternative options are based on voluntary and incentive-based designs.

In the following pages, we provide 10-year estimates of the opportunities available to reduce federal and state spending, as well as background information and descriptions of the important elements policies need to achieve savings. Table 1 (page 6) offers a summary of those estimates by type of savings approach, including the total, federal and state impacts as well as the impact on the Medicare and Medicaid programs.

Taking into account overlapping effects, we estimate a strategic combination of these initiatives could yield \$542 billion in federal savings over the 2013 to 2022 period, helping to reduce Medicare and federal Medicaid spending by about 4.4 percent. Of that amount, \$437 billion would represent reductions in Medicare spending. States would also see savings from reduced Medicaid spending of \$69 billion over the decade.

While much of the recent debate on Medicare and Medicaid savings has centered on either cutting consumers’ benefits or providers’ payments, the options we assess favor a different approach: better care coordination and support for beneficiaries so as to unleash greater value from the health care system.

These estimates, while inherently uncertain, help to illustrate the size of the potential modernization dividend. We hope this paper serves as a productive basis for further discussion about how to address the nation’s fiscal challenges and how meet the country’s needs for improved health care as affordably as possible.

OPPORTUNITIES

Transforming the Medicare and Medicaid fee-for-service programs

- 1: Provide seniors in traditional Medicare with comprehensive care management services
- 2: Expand use of coordinated care for dual-eligible Medicaid and Medicare beneficiaries
- 3: Provide and strengthen coordinated care for all Medicaid beneficiaries (other than “dual-eligibles”)

Providing beneficiaries with information and incentives to use high-quality providers, improve their health, and choose appropriate care

- 4: Provide information and incentives in Medicare to help seniors choose the best health care
- 5: Use information and incentive ‘nudges’ to support Medicare and Medicaid patients’ efforts to improve their health
- 6: Deploy targeted diabetes prevention and control options in government health programs

Reducing avoidable and inappropriate care with clinical interventions

- 7: Encourage wider use of transitional case management programs to reduce readmissions
- 8: Focus interventions on beneficiaries with chronic conditions and high medical costs
- 9: Improve care in post-acute settings with interventions that reduce inappropriate care
- 10: Provide support to prevent hospitalization of patients in nursing homes
- 11: Offer comprehensive care services for patients with advanced illness

Deploying technology broadly to improve and streamline care

- 12: Use predictive modeling both to improve payment accuracy and improve care

Implementing payment reform initiatives

- 13: Encourage adoption of effective payment reforms

OPPORTUNITIES TO REDUCE SPENDING IN MEDICARE AND MEDICAID

Figures in billions of dollars, fiscal years 2013 to 2022

	Total	Federal	State	Medicare	Medicaid
Current spending on Medicare and Medicaid /1	15,050	12,450	2,600	8,150	6,900

POTENTIAL SAVINGS FROM A COMPREHENSIVE INITIATIVE THAT COMBINES ELEMENTS OF INDIVIDUAL PROPOSALS

Provide seniors (nonduals) in traditional Medicare with comprehensive care management services	-202	-202	0	-202	0
Expand use of coordinated care for dual-eligible Medicaid and Medicare beneficiaries	-189	-153	-36	-106	-83
Provide and strengthen coordinated care for all Medicaid enrollees	-48	-30	-17	0	-48
Accelerate programs to improve health, particularly diabetes initiatives	-56	-53	-3	-48	-9
Deploy suite of clinical interventions more aggressively	-47	-46	-1	-44	-4
Use predictive modeling to improve payment accuracy and improve care	-18	-15	-3	-11	-7
Accelerate payment reform initiatives	-50	-42	-8	-27	-23
Total	-611	-542	-69	-437	-174
Share of total spending	-4.1%	-4.4%	-2.6%	-5.4%	-2.5%

SUMMARY OF SAVINGS POTENTIAL FROM INDIVIDUAL OPPORTUNITIES (NON-ADDITIVE)

Transforming the Medicare and Medicaid fee-for-service programs

Provide seniors in traditional Medicare with comprehensive care management services	-307	-298	-9	-285	-21
Policies related to the dual-eligible Medicaid and Medicare beneficiaries					
Expand use of coordinated care for dual-eligible Medicaid and Medicare beneficiaries	-189	-153	-36	-106	-83
Alternative: Expand use of coordinated care for dual-eligible Medicaid benefits only	-75	-43	-32	NA	-75
Provide and strengthen coordinated care for all Medicaid enrollees (other than "dual eligibles")	-48	-30	-17	NA	-48

Providing beneficiaries with information and incentives to use high-quality providers, improve their health, and choose appropriate care

Provide information and incentives in Medicare to help seniors choose the best health care	-61	-56	-5	-49	-11
Use information and incentive 'nudges' to support Medicare and Medicaid patients' efforts to improve their health	-67	-59	-8	-45	-22
Deploy targeted diabetes prevention and control options in government health programs	-175	-167	-8	-153	-21

Reducing avoidable and inappropriate care with clinical interventions

Encourage wider use of transitional case management programs to reduce readmissions	-60	-51	-8	-37	-23
Focus interventions on beneficiaries with chronic conditions and high medical costs	-18	-16	-2	-13	-5
Improve care in post-acute settings with interventions that reduce inappropriate care	-7	-7	*	-7	*
Provide support to prevent hospitalization of patients in nursing homes	-25	-25	*	-25	*
Offer comprehensive care services for patients with advanced illness	-20	-20	*	-20	*

Deploying technology broadly to improve and streamline care

Use predictive modeling both to reduce fraud, improve payment accuracy and improve care	-72	-61	-11	-42	-30
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Implementing payment reform initiatives

Encourage adoption of effective payment reforms	-100	-83	-17	-54	-46
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/1 Includes spending for a replacement of the current physician payment system in Medicare (known as the "doc fix") with annual increases based on inflation.

Numbers may not add to totals because of rounding.

NA = Not applicable. * = effects not estimated

Table 1; Source: Analysis by UnitedHealth Center for Health Reform & Modernization, 2013.

1: PROVIDE SENIORS IN TRADITIONAL MEDICARE WITH COMPREHENSIVE CARE MANAGEMENT SERVICES

Background. Efforts to constrain cost growth in the traditional FFS Medicare program have mainly involved the use of national unit price controls, along with occasional adjustments to the scope of covered benefits. The ensuing structural weaknesses are well documented. FFS Medicare's siloed approach to funding hospital and physician services, prescription drugs, and other elements of care undermines efforts to provide coordinated care and drive optimal patient outcomes. Its inability to influence geographical and other variations in care patterns means ongoing waste and inefficiency. And a one-size-fits-all approach to managing costs through price controls can create difficulties for seniors in finding a physician to treat them and put cost pressures on other groups in the health care system.

One alternative to traditional Medicare is the Medicare Advantage program's full-risk model, offering better care coordination and clinical management. More than a quarter of seniors are now choosing to get their Medicare benefits in this way. The question arises for the seniors who are not in Medicare Advantage: what can be done to modernize traditional Medicare?

Opportunity description. One possible additional model for Medicare comes from observing the path that many of the most sophisticated and largest U.S. employers have taken to modernize how they manage their own employees' health benefits, often on an 'Administrative Services Only' (ASO) basis. This means that while they technically self-insure, those employers contract for the external expertise needed to help them manage the health care needs of their workforce. Employer sponsors generally pay their health plan partners a service fee determined on a per-employee basis for both core and additional services.

Traditional core services provided under ASO arrangements generally include claims processing, premium collection, claims review, and network access. However, health plan partners are increasingly offering other services to help employers control cost growth and improve the health of their workers, including: carefully credentialed networks of providers that provide superior outcomes; personalized health and wellness programs; nurse help lines and medical management solutions; focused disease and case management models that deploy predictive modeling; payment accuracy and integrity techniques; and the provision of actionable information and incentives for both providers and consumers, linked to the quality and appropriateness of care. In those ways, employer sponsors are able to secure for their employees many of the modern care interventions commonly provided through capitated models. More refined ASO models are emerging to serve the increasingly challenging health needs of large employer groups. In those models, health plan partners provide employers with the services of a dedicated team of professionals, such as medical

professionals and analysts, to provide a customized approach for the employer's population that relies on analysis of data and trends, evaluation of interventions and employee engagement.

In a similar vein, the TRICARE program – which provides health benefits and services to active duty and retired members of the armed services and their families – combines broad access with management of care operated in partnership with the Department of Defense (DoD) and private contractors. TRICARE provides services through a community network of providers and the DoD direct care system, an approach that optimizes the use of efficient delivery systems. This approach also provides for performance-based incentives for TRICARE's private contractors through partial-risk arrangements.

This approach would transform the traditional FFS Medicare program by adopting an ASO model similar to the one widely used by large self-insured employers – either by applying that model to all fee-for-service enrollees, or offering it as a voluntary choice for beneficiaries alongside current FFS and MA options.

- ▶ In the first scenario, Medicare beneficiaries not choosing to enroll in a Medicare Advantage plan would have their care managed by an administrative services organization. These organizations would effectively leverage networks, medical management tools, and best practices on a more integrated, comprehensive basis. Such a robust care management program could lead to significant savings, improved care, and better clinical outcomes. Application of care management tools that are based on the best clinical evidence along with targeted preventive care and patient education tools also could reduce hospital admission rates. Under this scenario, dual-eligible beneficiaries not otherwise enrolled in coordinated care plan demonstration programs also would receive their benefits through this model.
- ▶ Another scenario would be to offer the ASO model as an additional option to all Medicare enrollees, alongside the traditional FFS option and Medicare Advantage plans – with incentives to join the ASO in the form of reduced premiums or lower cost-sharing requirements when using designated providers. Dual-eligible beneficiaries not otherwise enrolled in coordinated care plan demonstration programs also could receive their benefits through this model, with states receiving incentives for using designated providers.

Under either scenario, there are various forms these new arrangements could take. For example, Medicare beneficiaries might choose between competing contractors. Or the Centers for Medicare & Medicaid Services (CMS) might contract with a single ASO for a defined geographical region – in effect instituting a much-enhanced and value-adding Medicare

Administrative Contractor (MAC) type of program, going significantly beyond the traditional and passive core functions of MACs. Beyond those core functions, the ASO contractors would operate clinical management programs, provide customer service to beneficiaries and providers, manage and develop provider networks, and offer consumer engagement with decision-support tools. Provider programs and rewards could be used to align payments with high-quality care. Enhanced payment integrity services also would help reduce costs. Opportunities for reduced cost sharing or direct rebates or benefits could provide consumers with incentives and decision-support tools to choose high-performing providers.

Rather than taking on the insurance risk of the population, Medicare ASOs would receive a per member fee that accommodates the cost of managing the core administrative functions, coordinating care for the covered population, and providing interventions. CMS could continue to set reimbursement rates that the Medicare ASOs would pay providers on an administered basis, or could base payment rates on historic Medicare FFS rates per beneficiary trended forward for expected growth in seniors' health care costs. Partial-risk arrangements for performance (where a share of the fee is at risk) or shared savings (per the Accountable Care Organization model) could be included under this approach to give contractors financial incentives to manage the overall trend of health care spending and quality for their assigned populations. Such arrangements are also often used in the large-employer ASO models and work to align incentives for the employer sponsor and the ASO provider. Flexibility in network formation and care management approaches also would add to the ability of Medicare ASOs to achieve savings.

Basis of savings estimate. Our own experience serving large national employers shows the capacity of this model to reduce costs. In making this assessment, we have been able to contrast some of their care patterns and programs with those currently available to seniors, since we are also chosen by one-in-five seniors nationwide to help manage their Medicare benefits – whether they are in Medicare Parts A and B, C or D. These comparisons lead us to believe that high-quality provider networks, thoughtful care coordination, and well-targeted case and disease management and wellness programs all could play a greater part, alongside consumer information and incentives, treatment decision support, and use of value-based benefit designs.

Of course, not all of those tools can be translated directly to traditional FFS Medicare, with its various administered prices, supplemental coverage, and other unique features. However, the main approaches can be carried over, and we estimate that applying an ASO model to the Medicare program could result in substantial savings while improving the quality of care. On balance, it is possible that migration to this model could reduce Medicare spending by about 8 percent to 10 percent (excluding fees for administering the model), if it were fully effective in all

areas of the country and beneficiaries responded similarly to its incentives as employer plan members. Fees for managing the program, operating clinical and support services, and providing any beneficiary incentives would offset a portion of those savings. Historically low fee-for-service payment rates in some parts of the country also would present challenges in driving that level of savings.

Results. Under the broad scenario for enrollment, with a five-year phase in of the ASO model across the whole Medicare FFS population, we estimate there would be close to \$300 billion in reduced federal spending over the coming decade (including a small amount of savings for dual-eligibles in the Medicaid program). Those savings would represent about 5 percent of Medicare spending by the end of the decade. In developing this estimate, we assumed that the program would not be fully effective in all regions due to different provider market dynamics, and thus accounted for a dampening effect on potential savings. Risk-based performance incentives could help to make the program more effective and also lead to greater net savings. Excluding effects for dual-eligibles (which are discussed under the next option), federal savings would be about \$200 billion.

Under a voluntary approach to enrollment, savings would understandably be more limited, for two reasons. First, only a portion of the FFS Medicare population is likely to enroll – with more limited enrollment in the initial period and growth over time as the benefits of familiarity with the administrative services option grows relative to fee-for-service. Second, attracting enrollees in a choice-based system likely would require a larger percentage of the savings to be shared with enrollees in the forms of reduced premiums and cost sharing, which would mean somewhat lower savings per enrollee for the federal government. Depending on the specific policy parameters chosen, federal savings could vary widely under a voluntary approach.

2: EXPAND USE OF COORDINATED CARE FOR DUAL-ELIGIBLE MEDICAID AND MEDICARE BENEFICIARIES

Background. About 7 million people are dually eligible for full Medicare and Medicaid benefits, with an additional 2 million low-income Medicare beneficiaries receiving support from Medicaid to pay for Medicare's cost sharing and premiums. This is typically a high-need population, with many having multiple chronic health conditions requiring high-cost services and intensive support (though some are low-income individuals with routine medical care needs). For 2013, combined Medicare and Medicaid spending on the dual-eligibles will reach an estimated \$330 billion. Of this total, we estimate that Medicare will spend about \$180 billion (including costs for prescription drugs), with Medicaid covering about \$150 billion (mainly for institutional and community-based long-term care services). *Over the next 10 years, we estimate that total spending on dual-eligible individuals could reach around \$5 trillion.*

Two structural problems undermine the efficiency of this spending:

- ▶ First, the majority of spending for dual-eligible individuals – about 90 percent of it – occurs on an unmanaged fee-for-service basis, for both Medicare and Medicaid benefits. This leads to a lack of care coordination and misaligned incentives regarding appropriate care settings.
- ▶ Second, funding for care provided to dual-eligibles comes through a tangled web of payment streams that are split between Medicaid and Medicare. The result is “siloed” care, cost-shifting, reactive rather than proactive provision of services, and wasteful duplication. Medicare serves as the primary payer for hospital and physician benefits, and operates a separate program covering prescription drugs. Medicaid is the primary payer for long-term care services, including institutional and home- and community-based services, and also covers wrap-around benefits and beneficiary cost sharing. While Medicare pays for some post-acute nursing home benefits, those benefits are limited in time and scope and provide no incentives for providers to restrain Medicaid's long-term care spending growth.

The opportunity to better coordinate care for dual-eligible individuals is therefore substantial. At present, less than 10 percent of Medicaid spending for dual-eligible beneficiaries is accounted for by those enrolled in Medicaid managed care programs that may combine acute, behavioral, nursing home, and home- and community-based services. And only about 15 percent of Medicare spending on dual-eligible individuals is for people enrolled in Medicare Advantage health plans, including Special Needs Plans (SNPs) designed for dual-eligibles.

Furthermore, those approaches are typically not integrated across Medicaid and Medicare – so Medicaid managed care enrollees often receive their Medicare benefits on a fee-for-service basis, which leaves the Medicaid program at risk for

costs associated with the lack of care coordination in the Medicare program. In fact, some of the highest cost dual eligibles – certain of those residing in nursing facilities – become eligible for Medicaid when a health crisis causes them to need institutional care and they spend down their resources to Medicaid eligibility levels. Similarly, dual-eligible enrollees in Medicare Advantage plans often have their long-term care benefits paid by Medicaid on a fee-for-service basis.

Reform in this area has historically faced a number of barriers. Medicaid law currently constrains states from enrolling dual-eligibles in managed long-term care programs, absent specific state waivers granted by the federal government – and even then, they can do so only for Medicaid benefits, not for Medicare benefits. Although historically there have been barriers to this approach, including waiver process complexity, existing support for voluntary programs, and local contracting issues, there is renewed interest in pursuing these options in order to achieve savings and improve care. Programs operated in about one-third of states that are focused on complex populations (primarily dual eligibles) are models for continued advancement in this area.

Different rules governing managed care plans in both programs – for example, regarding outreach, quality measurement and incentives, and benefit design – also serve as barriers to integration. Additionally, the health care needs of dual-eligibles vary; some with chronic conditions depend on medical services financed primarily by the Medicare program, while others in community or institutional long-term care settings primarily rely on Medicaid for their benefits. About one-third of dual-eligibles are under 65 and disabled, and they have different care needs in many instances than seniors. Those factors make it difficult to structure a single program to coordinate care in a way that serves all dual-eligibles.

Although some states have taken steps toward greater integration of Medicare and Medicaid benefits by contracting with SNPs, states cannot require dual-eligibles to enroll in Medicare Advantage plans – a constraint which limits opportunities to coordinate care and generate savings. The federal government can play a role in allowing waivers that facilitate integration of financing and benefits (as has been done in Minnesota, Wisconsin, and Massachusetts), but today cannot require that Medicare beneficiaries enroll in managed care plans, even with an opt-out provision.

CMS is currently testing innovative delivery models for greater integration of care for dual-eligibles, using a model called the Financial Alignment Demonstration. Having examined the challenges facing this population regarding the quality and cost of their care, CMS is seeking to test varying designs and compare outcomes using consistent metrics across programs

and states. States can apply to enroll their dual-eligibles in one of two models. The first is a capitated model under which states and the federal government would enter into a three-way contract with entities (such as managed care plans) to provide the combined package of Medicare and Medicaid benefits in an integrated way. The second model – known as managed fee-for-service – permits states to enroll dual-eligibles in care management programs.

Half of the states are working with CMS on developing those demonstration programs, with the majority of participants looking to the capitated models as their preferred approach. Those demonstrations are a significant departure from past policy, particularly in allowing duals to be enrolled through a passive enrollment approach in managed care for the Medicare portion of their benefits. The demonstrations are also being designed to align the two programs' rules. CMS's approach would, however, allow dual-eligibles to opt out of those plans at any time and, in the agency's current thinking, would limit total demonstration enrollment.

Opportunity description. States can take action themselves to advance greater integration, even if they are not participating in a CMS demonstration. States could fully deploy managed care models to better coordinate care and integrate *Medicaid* benefits for the dual-eligible population. Under one approach, all states would be required to enroll their dual-eligible enrollees in health plans that integrate some or all of Medicaid's acute care, home- and community-based services, nursing home care, and behavioral health services – following best practices taken by states such as Arizona, Texas, Florida, Tennessee, and New Mexico. Medicare benefits for those enrollees would generally still be paid on a fee-for-service basis, but beneficiaries also would have the option to enroll in any Medicare Advantage plan, including Special Needs Plans.

We estimate that CMS's current demonstration approach ultimately will cover about 20 percent of the full dual-eligible population. Building on that approach can further reduce costs for both programs. *In this scenario, all dual-eligible individuals would be required to enroll in a health plan providing their combined Medicare and Medicaid benefits.* This would achieve full integration of benefits and would coordinate approaches to address the complex care needs of the dual-eligible population across two payment systems. This kind of integrated model would help to ensure seamless provision of Medicare and Medicaid benefits and reduce incentives to shift costs between the two programs. Using data from both programs also would allow better targeting of preventive and 'anticipatory' care to help keep people well and support them in their own homes.

Under this model, as in CMS's capitated demonstration, a health plan or other entity (such as an ACO) could receive two payment streams which they would then blend together – one from the federal government (Medicare) and one from the states

(Medicaid). Alternatively, the federal government could provide funding directly to the states for the dual-eligible populations, which would then be topped up or offset by states' current funding contribution. Medicare and Medicaid rules regarding quality, benefit design, marketing and enrollment would need to be aligned under a single approach. Benefits under Medicare Part D (including low-income subsidies) also would be integrated into the model to ensure, for example, that medication adherence and complications are appropriately addressed through monitoring and patient engagement.

Active involvement on the part of states is essential to advancing care through this model. States have long been responsible for the long-term care needs of their dual-eligible populations – and have been innovators in designing and organizing home- and community-based service programs to meet both broad and targeted needs of their populations, with understanding at the local level of needs and resources. Additionally, states have experience contracting with health plans to manage the acute and long-term care health needs of complex populations.

Basis of savings estimate. Managed long-term care programs encourage the early detection and ongoing management of chronic and co-morbid conditions with a focus on maintaining the individual's highest level of functioning in the least restrictive setting. In our working paper, *Coverage for Consumers, Savings for States: Options for Modernizing Medicaid (April 2010)*, we described how active state programs have reduced or delayed admissions to nursing homes through better care management, resulting in savings ranging from 7.5 percent to 10 percent as compared to passive fee-for-service programs.

Full integration of Medicaid and Medicare benefits could lower costs by encouraging more rational care delivery and reduction of unnecessary hospitalizations and nursing home admissions. Research by the Lewin Group suggests a savings potential of about 8 percent in overall dual-eligible spending relative to fee-for-service through integrated Medicare and Medicaid managed care for the dual-eligibles. Potential achievable savings rates likely would range across markets, depending on historical Medicare payment rates and other local factors. An important element of those savings would be a reduction in avoidable and inappropriate inpatient hospitalizations. Because of the greater management of the Medicare portion of spending, savings also would be generated for the wrap-around benefits that Medicaid provides.

Based on our experience with a range of health plan programs providing coordinated care for seniors and individuals with disabilities and chronic care needs, we estimate that close to full implementation is viable – that is, implementation could cover nearly the entire dual-eligible population. Many examples exist across the nation of managed long-term care models in which states make entities such as managed care organizations accountable for the care and costs of dual-eligible beneficiaries. Some geographies, however, such as those in areas with

historically low Medicare payment rates, may require care management approaches more similar to those offered in CMS's managed fee-for-service model or ASO approaches.

A broad scope of implementation is necessary for the achievement of program goals. Deploying robust clinical and member-engagement tools – as well as innovative payment models oriented to quality and efficiency – requires operating at scale. In particular, achieving the full potential for savings depends upon meaningful change in care delivery, and we assume greater potential savings for policy approaches that cover broader geographies and populations and do not disrupt natural delivery system patterns. Under these scenarios, beneficiary opt-out would be limited to specific circumstances or specific periods during the year, in order to ensure care continuity, greater engagement with members, and implementation of health service models that coordinate care and improve health.

Results. Through more intensive implementation of integrated and coordinated care for the dual-eligibles, we estimate there would be additional enrollment and savings beyond those achieved through CMS's financial alignment demonstrations. The first scenario – full use of managed long-term care for the dual-eligibles in Medicaid only – could lead to \$75 billion in total federal and state savings over a 10-year period. Of those savings, \$43 billion would accrue to the federal government. That estimate reflects a ten-year phase-in that accounts for state ramp-up of infrastructure for home- and community-based services as a means of preventing future nursing home admissions.

Full integration of Medicare and Medicaid benefits for the dual-eligible population would drive even larger savings. Under that option, we estimate that \$106 billion would accrue to the Medicare program and \$83 billion to Medicaid over 10 years. Of that combined amount, \$153 billion would accrue to the federal government and \$36 billion to the states. We assumed that savings would phase-in over three years for Medicare and over a longer time frame for Medicaid, as described above. Better coordination for acute care benefits under Medicare managed care would also yield spillover savings in Medicaid above what states could generate through Medicaid managed care alone.

Discussion. In addition to the savings described above, there is further opportunity to reduce federal and state Medicaid spending on dual-eligibles by preventing chronically ill Medicare-only beneficiaries from becoming dually eligible. Those transitions could be prevented by managing beneficiaries' conditions better and maintaining the ability to live in the community. Medicaid spending for institutional dual eligibles can be very costly, so finding ways to provide high-quality, targeted interventions before individuals become eligible for Medicaid can avert high institutional costs and improve beneficiaries' quality of life. Approaches include encouraging greater enrollment of Medicare beneficiaries in coordinated care, such as dual Special Needs Plans, or formally embedding clinical interventions for Medicare beneficiaries with chronic conditions in fee-for-service Medicare.

3: PROVIDE AND STRENGTHEN COORDINATED CARE FOR ALL MEDICAID BENEFICIARIES (OTHER THAN “DUAL ELIGIBLES”)

Background. Fragmentation of care delivery in the traditional Medicaid program has led to gaps in needed preventive care, frequent visits to the emergency room, multiple and sometimes conflicting drug prescriptions, and ‘revolving door’ inpatient admissions for behavioral health problems – all of which have contributed to cost growth in the program. Efforts to control Medicaid’s spending simply by cutting back on provider reimbursements do not address inappropriate utilization and can exacerbate difficulties in accessing care for vulnerable populations.

Over the past twenty years, many states have been innovators in testing new models of care that improve access and health outcomes for low-income and high-need populations, while helping to control health care cost growth. Health plans have partnered with states to enhance care coordination, raise the quality of care, and improve the stewardship of taxpayer funding through capitated managed care models. This has been achieved partly by using accessible provider networks, carefully targeted clinical programs, member outreach and health education, and other strategies to improve prevention and integrate care. More recently, many additional states – including California, Louisiana, Kansas, Kentucky, New York, Pennsylvania and Texas – have responded to the challenging fiscal environment and pending voluntary expansion of Medicaid under the Affordable Care Act (ACA) by initiating or expanding use of proven managed care models to help preserve quality and accelerate improvements in the delivery system, while holding down cost growth. States are working with health plans to build in quality metrics and linkages between payment and plan performance.

However, about 55 percent of Medicaid spending for non-dual populations (i.e., for those beneficiaries who are receiving Medicaid benefits but not Medicare benefits) is still paid through fee-for-service mechanisms, which may include limited forms of care coordination such as primary care case management programs (which provide a small per member fee to providers to coordinate care). The figure also includes spending for individuals with disabilities and special health care needs who are not enrolled in managed care and spending for services carved out of managed care contracts, such as behavioral health and pharmaceuticals. The statewide adoption of capitated managed care by several large states, such as California and New York, will reduce the share of spending in unmanaged arrangements as those programs are implemented over the next few years.

Continued state reliance on fee-for-service payment models, including those that take the form of primary care case management, is in part a matter of history, market factors, and preferences for alternative arrangements. It also is due to challenges of deploying managed care programs to cover complex populations, services such as behavioral health, and sparsely populated rural areas. While about half of the spending

for children and low-income families is provided through capitated coordinated care arrangements, only about a fifth of spending for people with disabilities who are not dually eligible for Medicare is funded in this way – and that spending accounts for a disproportionate share of overall Medicaid costs. After current state initiatives to move toward statewide managed care systems have been fully implemented, a greater share of those with disabilities and special health care needs, including those needing behavioral health services, will be enrolled in coordinated care.

Opportunity description. In our working paper, *Coverage for Consumers, Savings for States: Options for Modernizing Medicaid (April 2010)*, we discussed the opportunity for states to enroll most of their fee-for-service Medicaid populations in coordinated / managed care programs. Since publication of that report, many states have pursued that opportunity through expansions to additional populations and geographic areas. Even so, opportunities remain for states to obtain savings and improve care by continued work with managed care plans with particular capabilities in addressing the complex care needs of non-dual beneficiaries with disabilities, those with chronic conditions, and beneficiaries in rural areas. States would partner with health plans to integrate all services, including pharmacy and behavioral health, and seek to better align case management initiatives, use of long-term care services, care coordination, medication adherence programs, and management of chronic disease.

Based on our experience operating Medicaid managed care plans, those programs are most effective when they deploy critical interventions such as comprehensive care plan development, ongoing care coordination, home visits, management of high-risk patients, and case management of care transitions and discharges to prevent hospital readmissions. Employing predictive analytics enables those services to be targeted most effectively. And integrating proven delivery reform models such as patient-centered medical homes into plan services also improves care for enrollees.

Recognizing that states would have to decide whether to adopt or expand their managed care system, the types of plans to engage, and appropriate payment rates that reflect the cost of the benefits and services provided, the federal government nevertheless could provide incentives for state participation. For example, one option would be to allow states to share more extensively in the savings from greater care coordination and improvements in the delivery system that reduce costs and improve quality – over and above what states would ordinarily share via the federal-state match rate, which can be as low as 50 percent.

Partnerships with health plans could be designed to encourage stable, long-term investments in enrollee population health and

needed reforms of the delivery system for vulnerable populations. Health plans that use medical homes, technology solutions such as telemedicine, and predictive modeling could provide states with an effective platform to drive this kind of change in the delivery system. The federal government could also streamline the waiver process to let states more rapidly deploy approaches that work to improve care provided under the program, such as those adapted from successful commercial models.

Basis of savings estimate. This option updates the modeling contained in our working papers – *Coverage for Consumers, Savings for States: Options for Modernizing Medicaid (April 2010)* and *U.S. Deficit Reduction: The Medicare and Medicaid Modernization Opportunity (October 2010)* – and accounts for the impact of the now-voluntary expansion of Medicaid under the Affordable Care Act (ACA). In those documents, we estimated the potential savings relative to fee-for-service if all states transitioned their non-dual FFS Medicaid populations to managed care.

Real-world experience drawn from states, evidence from meta-analysis of the published research, and UnitedHealth Group's own results as America's largest Medicaid health plan all suggest that Medicaid could save about 5 percent of fee-for-service costs by enrolling children and low-income families in managed care. Likewise, savings of around 6 to 7 percent could be achieved by transitioning enrollees with disabilities into managed care, because FFS coverage for this population is particularly fragmented and care needs are high. Savings of that amount may be more difficult to achieve initially for populations with highly complex care needs or in areas where states need their health plan partners to increase access to providers using higher payment rates. Our analysis also recognizes that each state starts from a different point on the "adoption curve" for managed care, and makes adjustments in states' savings opportunities to reflect each state's rural/urban composition as well as its share of Medicaid enrollees currently in primary care case management programs.

Results. We estimate that if all states adopted a comprehensive coordinated care approach for their Medicaid FFS enrollees who are not dual eligibles and are not enrolled in managed care today, then there would be total federal and state savings of about \$48 billion over the 10-year period of 2013 through 2022, with \$30 billion accruing to the federal government and the balance accruing to state governments. (Savings options for dual eligibles are discussed under Opportunity 2.) This estimate takes into account that several large states are scheduled to adopt those changes to their program in the near future.

4: PROVIDE INFORMATION AND INCENTIVES IN MEDICARE TO HELP SENIORS CHOOSE THE BEST HEALTH CARE

Background. Academic research has consistently demonstrated that the use of evidence-based care is variable, as are the resulting clinical outcomes. These variations are evident across geographies and within clinical specialties, and they persist despite the availability of evidence-based standards covering many conditions and treatments.

Profiling these variations to identify high-performing providers based on quality and resource use across episodes of care can both help health professionals continually improve the care they are able to offer, and inform the choices that patients make. Under federal law, hospitals and physicians are expected to report on quality measures, and the results for hospitals are available on a CMS web site (which will in the future also include physicians). Over the next few years, Medicare will continue to phase-in reimbursement adjustments for hospitals and physicians using budget-neutral value-based payment modifiers. These programs will pay more to high-performing providers, and less to hospitals that do poorly. And under Medicare's models for accountable care organizations (ACOs), participating providers who deliver high-quality care and reduce aggregate spending compared to a benchmark would share in the savings with taxpayers.

But there is, as yet, no federal program that specifically rewards Medicare beneficiaries for choosing high-performing providers who may deliver care more efficiently. By contrast, people who have employer-sponsored coverage are often able to share in some of the savings that come from so doing. The savings to enrollees can be substantial – as much as 20 percent reductions in their premiums – because of the quality and appropriateness of the care delivered by high-performing providers.

Opportunity description. This option would create incentives for participation in voluntary, tiered networks by Medicare beneficiaries – who could benefit from incentives such as lower cost sharing, rebates, or benefit enhancements by choosing providers who scored well on quality and efficiency standards that are clinically-led and evidence-based. States also could receive financial incentives and new authority to steer dual-eligible consumers to those high-quality provider networks. Providers also would have incentives to improve their performance.

These incentives could be deployed in FFS Medicare, with methodologies that could align across physicians' commercial and Medicare patients. In particular, health plans could use their performance data and care management programs to create virtual network 'overlays' on fee-for-service Medicare. Participation in those programs would be entirely voluntary for seniors, who nonetheless might benefit from lower Part B premiums, lower cost sharing, or rebates when they chose to use a premium-designated provider who scored better on quality and efficiency metrics. The bulk of the remaining savings would accrue directly to Medicare.

Alternatively, beneficiaries that access care through an ACO could be given incentives to choose high-quality providers. To the extent the Medicare program "shares" savings with physicians who perform well and lower costs, a portion of those savings could be given back to beneficiaries as an incentive for choosing high-performing physicians. Rebates on a beneficiary's premium or a deposit into a patient account to be used for other medical care (concurrently or in the future) could also help offset out-of-pocket costs.

Under this option, information would be provided to seniors on quality and efficiency variations to influence their choices. An optional program would then be introduced in which seniors who choose to use higher-performing providers would benefit from financial incentives equivalent to about 10 percent of cost sharing amounts. Those incentives also could accrue through Part B premium reductions or rebates, especially for those with supplemental "Medigap" coverage. For the dual-eligible population, who face little cost sharing today, the policy would provide states with incentive payments and necessary authority to enroll the duals in high-quality provider networks.

Basis of savings estimate. Estimated savings are based on the results of current UnitedHealth Group programs using our quality and efficiency measurement system, coupled with a member incentive program that promotes use of the highest quality and most cost-effective physicians. We adjusted our potential savings to account for Medicare's administered prices and practical limits on the ability to "steer" utilization based on unit price, together with adjustments for seniors' patterns of care. We made conservative assumptions about program uptake. Because the program would be voluntary, we have modeled the potential effects of only a quarter of the non-dual Medicare FFS population shifting to higher-performing providers initially. We further assumed that there would be modest growth in participation over time.

As to the question about the capacity of high-performing providers to take on new patients, it is important to note that the incentives can produce results not just from movement of patients between providers, but also from the likely community-wide improvements in provider quality and efficiency that arise as a behavioral response.

Results. This option could yield \$56 billion in federal savings over a 10-year period, assuming a phase-in of implementation over five years. Stronger incentives, with more gain-sharing with seniors, could produce more substantial savings, and would likely stimulate more substantial improvements in physician performance across the delivery system. These estimates include potential savings that could accrue to the Medicaid program as a result of dual eligibles using higher quality providers.

5: USE INFORMATION AND INCENTIVE ‘NUDGES’ TO SUPPORT MEDICARE AND MEDICAID PATIENTS’ EFFORTS TO IMPROVE THEIR HEALTH

Background. Despite advances in medical technologies that prolong life and cure disease, chronic conditions, such as diabetes and cardiovascular disease, contribute to substantial and growing health care costs. Social norms, changing living and work environments, and health habits all contribute to the growth in chronic conditions. By the time many people become Medicare-eligible, their medical conditions are already costly and advanced. The complexity of the medical system for high-cost treatments aggravates this problem.

The way the current Medicare program is structured – as a defined benefit, fee-for-service, unmanaged program – means that beneficiaries do not have consistent support or incentives or information to improve their health status. This also is evident in the Medicaid program, where enrollees may leave and join the program as their income changes and health care needs arise.

Opportunity description. Private- and public-sector employers, in partnership with their health plans, are developing and leveraging new information approaches, incentive models and wellness strategies to encourage healthy behavior, providing timely ‘nudges’ or prompts to help people make healthy lifestyle choices that reduce the likelihood of adverse health outcomes. These include financial incentives such as premium or cost-sharing reductions, rebates, or benefit enhancements for performance of certain activities or achievement of certain health goals based on credible external standards. Several different approaches have been deployed:

- ▶ **Information models** include treatment-decision support for consumers in advance of surgery or procedures (e.g., for prostate or orthopedic surgery) where clinically appropriate alternatives exist or where individuals’ preferences may differ. Counseling for members and their families can play a role in providing and supporting meaningful choices about treatment plans.
- ▶ **Activity-based incentive models** give beneficiaries rewards for performing certain health-related activities, such as completing a health risk assessment, attending a wellness seminar, getting preventive screenings, or following evidence-based care for certain chronic conditions (independent of their health outcome).
- ▶ **Results-based incentive models** are more intensive, providing benefits for individuals meeting certain health improvement goals based on credible external standards (such as reductions in their weight, blood pressure, or LDL cholesterol).

Customizing programs to the individual through personalized activity goals and targeted health outcomes encourages participation. Similarly, two-way dialogue with a health coach or counselor can help further personalize the experience, giving

participants the opportunity to ask specific questions and obtain relevant information. Effective messaging and health literacy programs are also critical in communication to participants, as health guidance and instruction needs to be clear and well-understood. Consumer-friendly language, readability, and meaningful graphics play a role in making educational materials less impersonal and more accessible.

Access to a social network can also enhance the participant experience, particularly in cases where participants have shared health concerns and health objectives. These networks provide the opportunity to share knowledge, give feedback, and encourage progress. Ultimately, regular social interaction fosters greater accountability, serving as a motivational tool. Coupled with intrinsic rewards, such as point systems, social networking tools have proven to be effective methods of engagement.

Embedding those approaches in the Medicare fee-for-service program or in Medicaid would require engagement of new kinds of health service professionals along with associated reimbursement systems as well as restructured benefit approaches. An electronic health infrastructure to monitor beneficiary health improvement also would be necessary to bring interventions to scale and ensure their success. Program materials and methods of engaging beneficiaries may need to be adapted from those used in the commercial sector, but could nonetheless lead to improvements in the health of those populations.

Basis of savings estimate. A combination of new incentive and information programs could provide substantial savings over the long run to the Medicare and Medicaid programs. Savings would come from improvements in health status, prevention of chronic conditions (such as diabetes), avoidance of unnecessary hospitalizations, and more effective use of surgical procedures and treatments. Outcomes-based programs would yield greater savings than activity-based approaches. We assumed that it would take almost a decade for savings to be fully realized, with the recognition that interventions to spur behavior change and health improvement take time to implement effectively and to yield improvements in health.

The costs of providing a range of health promotion programs would, we expect, offset about half of the savings, based on our experience in the commercial sector. We assumed that costs of the programs would phase-in more quickly than the savings, as upfront investments would be required. Our analysis was based on applications of these new information and incentive programs to the non-institutionalized population; and our estimates of their impact include effects on Medicare spending for dual eligibles. We assumed that states would share in the incentives to generate dual-eligible participation.

Savings would depend on the number of and type of initiatives deployed in the Medicare and Medicaid populations, the effectiveness of their implementation, and the willingness of beneficiaries to participate (which partly depends upon the size of the incentives). Because incentive-based programs would be new to the those populations and would represent a shift in the way they receive benefits, we assumed that only half of the eligible population would ultimately respond to activity-based incentives and that one-third of the population would respond to outcomes-based programs. For the dual-eligibles, we assumed that the policy would require states to operate health promotion programs to stimulate their participation.

Results. Our estimated net federal savings over the 10-year window as costs are phased in are around \$59 billion, with \$45 billion of that amount from the Medicare program and \$22 billion from the Medicaid program. In the tenth year, the savings would amount to a reduction of about one percent of Medicare spending, which could continue to accrue over the longer run. These estimates also include potential savings that could accrue to the Medicaid program both as a result of dual-eligibles improving their health and application of those programs for the entire Medicaid population.

6: DEPLOY TARGETED DIABETES PREVENTION AND CONTROL OPTIONS IN GOVERNMENT HEALTH PROGRAMS

Background. Diabetes is a chronic and disabling disease that currently affects nearly 26 million adults in America, and millions more worldwide. Factors contributing to the growing prevalence of diabetes include an aging population, increasing rates of obesity, and a growing share of at-risk minority populations. Assuming recent trends continue, the prevalence of diagnosed and undiagnosed diabetes is projected to rise from approximately one in 10 adults today to between one in five and one in three adults by the middle of this century.

Type 2 diabetes is typically progressive over time and yet is largely preventable through diet, weight management, and physical activity. The onset of type 2 diabetes follows a natural progression, with individuals developing prediabetes many years before the onset of diabetes. Obesity, along with increasing age, is commonly the first step in the cascade from prediabetes to diabetes.

While type 1 diabetes typically results in acute symptoms and is generally diagnosed shortly after its onset, prediabetes and type 2 diabetes are often silent health problems, without obvious signs or symptoms, and may remain undetected for many years. The vast majority of people with prediabetes (more than 90 percent) and about a quarter of people with diabetes are unaware of their health condition, and the average person with diabetes does not typically get diagnosed for four to seven years. Even so, undiagnosed individuals with diabetes are at high risk for heart disease, stroke, kidney damage, blindness, and other complications. These problems may progress more rapidly in individuals not receiving appropriate medications or pursuing lifestyle changes.

In a recent article in *Health Affairs*, entitled *Effective Interventions for Stemming the Growing Crisis of Diabetes and Prediabetes: A National Payer's Perspective (January 2012)*, we estimated that health care costs attributable to prediabetes and diabetes for U.S. adults will grow from approximately \$206 billion in 2011, or seven percent of health spending, to \$512 billion in 2021, or 10 percent of health spending. (Note that those spending figures are for costs of medical care related to prediabetes or diabetes — not total health spending by people with prediabetes or diabetes.)

Updated estimates suggest that over the next ten years, national health spending on prediabetes and diabetes will total about \$3.8 trillion. Federal health programs will bear a substantial burden of that spending. About one-third of Medicare beneficiaries, including the dual eligibles, have diabetes or prediabetes. We estimate that spending on Medicare beneficiaries with diabetes and prediabetes will be about 61 percent of total diabetes spending (\$2.3 trillion). Medicaid enrollees who are not dual-eligibles are estimated to account for an additional 4 percent of spending (\$152 billion).

Opportunity description. Effective early intervention can have a material effect on the costs associated with prediabetes and diabetes. Given the higher prevalence of prediabetes and diabetes both in the Medicare population and for some Medicaid enrollees, there is an opportunity to reduce costs and improve beneficiary health by embedding evidence-based intervention models into those programs. In our working paper, *The United States of Diabetes: Challenges and Opportunities in the Decade Ahead (November 2010)*, we described several proven intervention approaches.

In general, programs that prevent normal-weight individuals from gaining weight and encourage overweight individuals to lose weight can reduce the prevalence of prediabetes and diabetes. A specific initiative focuses on preventing progression of the disease from prediabetes to diabetes with lifestyle coaching to reduce weight. The Diabetes Prevention Program (DPP) was originally evaluated using a national controlled trial, which showed that an intensive lifestyle intervention can lead to average weight loss of 5 percent with a 58 percent reduction in the incidence of diabetes. UnitedHealth Group partnered with other stakeholders to test that model at a broader scale. Findings from that pilot program showed average weight loss consistent with published studies.

Improving compliance with diabetes medication is also an important focus for interventions. As recent studies have demonstrated, improved compliance yields better outcomes for people with diabetes. Similarly, a recent meta-analysis of data from about 2,500 patients in 16 studies using pharmacist management interventions found a significant reduction in hemoglobin A1c levels, a key measure of diabetes control. Blood cholesterol levels can also be reduced.

Other targeted lifestyle interventions can be designed to address the needs of diabetic patients with complications. A recent study showed that, on average across four years of the trial period, participants with diabetes who received an intensive lifestyle intervention had about 6 percent greater weight loss than a control group, and also saw greater improvements in their levels of hemoglobin A1c, blood pressure, HDL cholesterol, and triglycerides.

All of those models rely upon lifestyle changes and beneficiary engagement to reduce the prevalence of the disease and its complications. Testing or incorporating those models as part of a redesigned fee-for-service benefit could help to reduce disease prevalence and government spending on diabetes and prediabetes in Medicare and Medicaid. Programs could be designed to replicate elements of successful models, such as the group counseling approach underlying the DPP. Other critical components of the DPP include mobilization of social supports, providing a high number of

patient contacts, and a self-monitoring and tracking mechanism. Incentives for patient engagement in those programs can also be incorporated into their design.

Adapting interventions to the scale of the Medicare fee-for-service population or to Medicaid would require changes in those programs. For example, successful scaling up of a program like the DPP would require screening programs, a mechanism to engage and recruit people identified as being at-risk, engagement of clinical providers to refer patients to the program, organizational and contractual oversight of the delivery model, and new reimbursement systems for service providers (such as the trained “extenders” and coaches who are central to lifestyle interventions). Enlisting participating facilities could be achieved through partnerships with nonprofit and private-sector organizations. For many interventions, an electronic health infrastructure to monitor beneficiaries’ health improvement also would contribute to successful implementation and scaling efforts. The further development of lower cost ways to scale diabetes intervention programs without losing the effectiveness of the model can lead to greater savings.

Basis of savings estimates and results. We analyzed the impact of applying each of the individual interventions described above to the fee-for-service Medicare and Medicaid populations as well as an “all of the above” approach. For each scenario, we provide estimates of savings if all eligible beneficiaries participated in each type of intervention. (See Table 2. The figures update previous estimates we provided in our November 2010 working paper.)

Our savings estimates account for the net costs of providing the interventions – with the assumption, based on our experience, that those costs commonly offset about 30 percent of gross savings in the commercial sector. Depending on the nature and intensity of interventions for diabetes, the population targeted, and the scale of the effort, actual implementation costs might be higher or lower.

▶ *Preventing prediabetes and diabetes with weight-loss interventions.* Our analysis suggests that achieving five percent weight loss for people who are overweight – the target recommended by the American Heart Association – could reduce prediabetes gradually, leading to a 10 percent reduction by 2020. Some reduction in conversion to diabetes also would occur. If that happened, almost 10 million more people would not develop prediabetes or diabetes over the next 10 years, resulting in lower projected health system costs in the coming decade – and a far larger savings over their lifetimes. We estimate that the federal government would realize savings of \$28 billion.

- ▶ *Reversing prediabetes with a DPP-style intervention.* Our estimate reflects an assumption that all U.S. adults with prediabetes would be enrolled in the DPP, and that the results of that program can be replicated nationwide – which would obviously be difficult to achieve in practice but nevertheless is indicative of the opportunities involved and the costs of inaction. If such risk reduction could be achieved by all prediabetes patients, diabetes prevalence perhaps could be reduced by 8 percent by the end of the decade. About \$68 billion of savings from this approach would be realized by the federal government, reflecting reductions in Medicare and Medicaid spending and reduced costs for health insurance exchange subsidies. Medicare alone could save about \$61 billion.
- ▶ *Managing compliance intervention.* Our analysis suggests that if outcomes from improved compliance with pharmacist management interventions can be achieved and maintained, new medical complications among the diabetic population could be significantly reduced. Savings would accrue from a reduction in the number of diabetes-related complications, reflecting improved health status (as measured by reductions in HbA1c and LDL cholesterol levels) among people with diabetes who move from non-compliant to compliant status. Savings to the federal government might be \$34 billion over the period.
- ▶ *Managing complications with intensive lifestyle interventions.* If weight loss reduction could be achieved for all diabetes patients who are overweight or obese, the number of new cases of diabetic complications could come down significantly, which in turn would reduce costs. Using our model for the population with diabetes, the savings to the federal government might be \$68 billion over the period.

We also modeled an “all initiative” scenario where the best available intervention(s) were introduced to at-risk populations. For example, if overweight and obese diabetes patients received both the pharmacy management and intensive lifestyle interventions, we modeled the effects if they achieved the same glycemic improvement as participants in the former trial and the weight loss and other risk reductions achieved from the latter trial. Normal-weight diabetic patients would receive only pharmacist management since they are not at risk for weight-related problems, and would see a similar benefit from the pharmacy management scenario.

Our analysis suggests that, as compared to the status quo, the interventions have the potential to reduce diabetic-related complications by about 10 percent by the end of the decade; diabetes prevalence could be reduced by 9 percent; and prediabetes prevalence could be gradually lowered on net by 7 percent. As a result, we estimate that **if the programs we describe were fully implemented immediately and were fully effective, Medicare could save \$153 billion and Medicaid (federal and state) could save \$21 billion.**

Federal savings alone for this approach, excluding some lower costs for exchange subsidies, could be \$167 billion. New programs often take several years to implement, however, while outreach programs can face challenges in reaching beneficiaries and eligible beneficiaries may not choose to participate – so it is most reasonable to view this estimate as an upper-bound figure.

EXPECTED NET HEALTH CARE COST SAVINGS BY SOURCE OF PAYMENT

Figures in billions of dollars, fiscal years 2013 to 2022.

	Total	Federal	State	Medicare	Medicaid	Other/1
People without diabetes - lifestyle intervention	-29	-28	-1	-25	-4	-1
People with prediabetes - DPP intensive lifestyle intervention/2	-71	-68	-3	-61	-8	-1
People with diabetes - improved medication adherence	-36	-34	-2	-31	-4	-1
People with diabetes - intensive lifestyle intervention	-72	-68	-4	-58	-12	-1
All initiatives interacted (non-additive)	-178	-170	-8	-153	-21	-3

/1 Other includes federal subsidies for coverage purchased through health insurance exchanges

/2 DPP = Diabetes Prevention Plan

Table 2; Source: UnitedHealth Center for Health Reform & Modernization, 2013

7: ENCOURAGE WIDER USE OF TRANSITIONAL CASE MANAGEMENT TO REDUCE READMISSIONS

Background. The senior population has a significantly higher disease burden than the general population and has complex health and social needs. This increased risk magnifies the impact of missed preventative care and inappropriate or delayed care. Financial and logistical barriers to care can result in lost opportunities to detect and treat ailments before they become more serious. In addition, insufficient application of evidence-based standards can result in unnecessary, inappropriate, duplicative and expensive interventions.

Many hospitalizations for Medicare beneficiaries could be avoided with early interventions in their care and greater coordination of that care. Gaps in care also take place when patients leave the hospital. Patients can have difficulty remembering or following instructions from physicians, and discharge instructions are often hard for them to decipher. They also may have trouble arranging necessary follow-up visits and may not be aware of the social and community support services that are available to them. In some cases, patients may be inappropriately discharged to a setting that does not provide a sufficient level of follow-up care. Those care gaps often lead to expensive and avoidable hospital readmissions. Research has shown nearly one in five Medicare beneficiaries in the fee-for-service program will be readmitted to the hospital within 30 days.

Opportunity description. Clinical management interventions can improve health outcomes and lead to program savings through reduced hospitalization. Through our Medicare Advantage plans, we have applied a set of clinical interventions to improve the care of our senior members – starting with an initial identification of people’s health needs through predictive analytics. Our Medicaid plans pursue similar approaches. Central to those interventions are transitional case management programs that serve as a bridge between the hospital inpatient admission and discharge to home for individuals and their caregivers. Those programs begin monitoring patients from the time they are admitted and help to facilitate a safe transition for those individuals who have a high risk of being readmitted. Special attention is given to those with chronic health conditions and complex discharge plans – with a focus on ensuring that patients, caregivers, and care coordinators have a discharge plan, understand the discharge plan, and have the necessary resources to execute that plan.

At the time of discharge, case managers assist in determining the most appropriate discharge setting (e.g., a skilled nursing facility or home care). Case managers also ensure continuity of all discharge orders including medications, therapies, and wound treatments. Case managers help patients schedule appropriate follow-up visits with their primary care provider. They also connect patients with social and community service evaluations

and referrals as appropriate. The level of care coordination and clinical interventions increases with the level of complexity of follow-up care required for the patient.

Adopting a similar approach in fee-for-service programs could help drive more appropriate use of inpatient hospital services. Although such an intervention would not work as effectively as it would through a full-risk managed care plan, it nonetheless could be provided for fee-for-service beneficiaries through contracts with entities that have capabilities in care coordination and discharge planning. Clinical analytics and patient electronic health records would enhance the ability of those entities to coordinate care for fee-for-service beneficiaries.

Broader interventions for the fee-for-service population might include deployment of other programs which combine a number of elements that ultimately yield reductions in avoidable hospital usage. These programs – which have been successfully deployed by Medicare Advantage plans – include annual preventive care assessments and interventions, home visits, and benefit designs that lower member costs for appropriate care and reduce access barriers. Combined, these programs result in significantly lower inpatient admissions and reduced lengths of stay, and could be incorporated into the Medicare fee-for-service structure through the use of care coordinators who engage with beneficiaries during regular interactions with the health system, such as at their annual physical.

Basis of savings estimate. We estimate that wider use of transitional case management for the Medicare FFS population could result in more appropriate use of care and savings for the Medicare program. *Our estimate is partly based on the 30 percent lower readmission rates observed for UnitedHealthcare’s Medicare Advantage population (13.9 percent) compared with the reported readmission rates for Medicare FFS enrollees (19 to 20 percent).* One way to enhance efforts under the FFS Medicare program to reduce care gaps is to provide stronger incentives for hospitals to reduce readmissions. (Under the recent health care law, penalties have been instituted but they apply to a limited number of medical conditions.) To the extent that other reforms provide groups of primary care providers with incentives for care coordination, requirements and accountability for post-discharge care management could result in an improved savings picture for Medicare.

Results. Our analysis was based on a comparison of readmissions in UnitedHealthcare's Medicare Advantage plans versus the Medicare FFS program, standardized for geography and adjusted for differences in patients' health using the hierarchical condition category models employed by Medicare for purposes of risk adjustment. Our estimates accounted for CMS efforts currently underway to penalize hospitals for not meeting certain readmissions targets. On that basis, we estimate **the potential savings to Medicare of \$37 billion over 10 years, assuming a four year phase-in period. These estimates also include potential savings that could accrue to the Medicaid program – \$23 billion – as a result of lower wrap-around costs for dual eligibles and broader applications of readmissions programs across the Medicaid population.**

Discussion. Reducing readmissions is only part of a comprehensive approach to keep beneficiaries healthy, treat them earlier, and avert crises that can lead to emergency room visits and avoidable hospitalizations. Research has found the combined clinical approaches undertaken by Medicare Advantage plans lead to fewer preventable hospitalizations, particularly for seriously ill beneficiaries. Those approaches include increased office visits for seniors and a focus on ensuring appropriate prescribing of medication, medication adherence, and treatment for congestive heart disease and chronic obstructive pulmonary disease. Embedding similar approaches in fee-for-service Medicare, along with a comprehensive strategy to reduce readmissions could yield savings 2 to 3 times the estimated amounts for reducing readmissions alone (as discussed in *Federal Health Care Cost Containment – How in Practice Can it be Done (May 2009)*).

Additionally, research has found that adoption of managed care models in state Medicaid programs (e.g., California, Ohio, Wisconsin) has led to lower inpatient hospital spending and fewer preventable hospitalizations and ER visits relative to fee-for-service.

8: FOCUS INTERVENTIONS ON BENEFICIARIES WITH CHRONIC CONDITIONS AND HIGH MEDICAL COSTS

Background. Lack of care management – especially for beneficiaries with chronic conditions and high medical costs – can lead to poor health outcomes and avoidable use of services. This can affect patients with asthma, diabetes, and heart conditions. Many of those conditions give rise to frequent use of emergency rooms (ERs), as well as potentially avoidable hospitalizations and other outpatient services such as rehabilitation, dialysis, laboratory tests and radiological exams.

Opportunity description. Providing proactive and coordinated support services to beneficiaries with chronic health problems can help to prevent their condition from deteriorating and also avoid medical complications and hospitalizations. In such interventions – which are being applied today in Medicare Advantage plans, Medicaid plans, and employer-sponsored coverage – nurse care managers reach out to beneficiaries with chronic conditions to help them access needed services and coordinate their care. Telephonic support and coaching that helps beneficiaries lead healthier lives, including timely reminders, are another critical component. More intensive screening and data analysis combined with home visitations can prevent avoidable hospitalizations and unnecessary use of other services by proactively identifying gaps in care.

Patient engagement is key to the success of this kind of program, and the degree of intervention is tailored to the level of beneficiary engagement and the goals they set. Engaged patients can better understand and manage their illness. Collecting data from electronic health records helps to facilitate this tailored approach to care and to build a personalized care plan. Targeted communications and access to decision-support tools can further engage those patients and involve them in the intervention.

Bringing this type of targeted intervention to the Medicare fee-for-service population would require establishing a mechanism to identify the individuals who might benefit most and then to engage them through outreach programs. Medicare could develop a reimbursement approach for the kinds of nurse manager, care coordinator, and community health worker services provided through the program – for example, by paying a service fee to entities that engage those health professionals. The program further could employ or facilitate data and predictive analytics about the patient (while complying with privacy requirements), and also could provide support services like nurse lines, track patient ER visits and hospital stays, and offer feedback to primary care providers.

Basis of savings estimate. Our experience helping to manage costs for high-risk enrollees in Medicare Advantage plans, for our large employer customers and in our Medicaid plans suggests that such an intervention could reduce spending for high-cost individuals who choose to participate and improve the quality of their care along several dimensions. We base our estimate on the share of members who meet program criteria given the severity of their conditions, participation rates among those eligible, and our net savings experience per member. We adjusted our estimates about eligibility to match the characteristics of the broader Medicare fee-for-service population and assumed that this kind of intervention would be paired with an intensive outreach component. We also assumed that implementation of this kind of program would be phased in over a four-year period.

Results and discussion. We conservatively estimate that identifying and targeting high-cost Medicare beneficiaries with chronic conditions for better care management on a “stand-alone basis” could yield ten year savings of \$13 billion, with additional savings to Medicaid for reduced wrap-around costs for that population. Application of this kind of clinical approach in state Medicaid programs, primarily in fee-for-service settings, could achieve similar results for Medicaid enrollees with high-cost conditions. We estimated total and federal state Medicaid savings of \$5 billion over ten years.

9: IMPROVE CARE IN POST-ACUTE SETTINGS WITH INTERVENTIONS THAT REDUCE INAPPROPRIATE CARE

Background. After a hospital stay, many Medicare beneficiaries are transferred to a skilled nursing facility (SNF) to manage their continuing care needs. (Other post-acute services may include home health care and treatment in long-term care and inpatient rehabilitation hospitals.) Medicare pays SNFs using a prospective payment system for each day of service, and varies payment based on a patient's medical condition and functional status. Coverage extends for 100 days of SNF care per episode or "spell" of care with no beneficiary copayment required for the first 20 days of each stay. Medicare spending on SNFs in 2012 totaled about \$30 billion, with an average length of stay about 27 days and an average stay costing about \$10,000 (according to analysis by MedPAC). The Congressional Budget Office projects that SNF spending in 2022 will rise to \$64 billion.

While appropriate for many patients, transfers to SNFs also can increase the risk of illness, including infections, medication errors, and falls – and can lead to long stays or readmission to the hospital. In part, these risks arise because the transition from the hospital to the SNF may not go smoothly for seniors or their families. For example, information about the patient and their care needs, such as medication plans, may not be clearly conveyed to the new facility. Furthermore, delays in discharging patients from SNFs to community-based options are common, resulting in longer stays and sometimes depletion of patient resources that can lead them to become eligible for Medicaid. There is also wide geographic variation in the use and quality of post-acute care.

Opportunity description. Clinical interventions can help to reduce unnecessary days in a skilled nursing facility by ensuring that patients receive clinically appropriate care during their stay – and can prepare seniors and their families with tools and resources to make a smooth transition home, including the development of discharge plans and linkages to post-discharge programs.

The post-acute transition program employed by our Medicare Advantage (MA) plans manages the use of SNFs by improving the transitions process from acute facilities to SNFs and ensuring appropriate, high-quality care during the SNF stay. We employ post-acute care nurses on site in key SNF facilities to ensure a seamless transition to the receiving SNF facility and its care team – and conduct care conferences with SNF facility staff about patients' current and future needs. These nurses receive special training in beneficiary engagement and relationship development, and learn effective ways of discussing care plans with physicians and identifying patients who would benefit from the intervention. They are further aided by the care coordination and support services that MA plans have embedded in several clinical programs, such as 24/7 nurse hotlines.

Additionally, we help prepare beneficiaries and their families with tools and resources to make a smooth transition home, including: discharge planning, establishment of clear care goals and strategies to avert readmissions, steps to prevent unnecessary delays at discharge, and identification of appropriate post-discharge programs. The intervention team coordinates with local community health services to help ease the transition for beneficiaries to their homes, including coordination of outpatient care, community-based services, hospice and home health care, or transfers to long-term care facilities.

Post-acute transition interventions like the ones that Medicare plans operate also could apply to beneficiaries in the traditional fee-for-service program. For example, Medicare could pay a service fee to entities that engage post-acute nurses on-site at SNFs, employ data and predictive analytics about the patient, provide support services like nurse hotlines, and track patient hospital stays and readmission risks. Under this option, Medicare SNFs would be required to allow those programs to operate in their facilities.

Basis of savings estimate. Our experience operating a post-acute transition program for our members – including those in Dual and Chronic Special Needs Plans – since 2005 suggests that the average length of SNF stays could be reduced by about two to six days for participating patients, depending on their complexity of their case. Savings from such a program in the Medicare fee-for-service program would be partly offset by the costs of providing post-acute nurses and support infrastructure. We expect this intervention would phase-in over a four-year timeframe and would ultimately be effective for about three-quarters of SNF cases.

Results. If a post-acute transition intervention were widely adopted in the Medicare program, we estimate that it would generate savings of about \$7 billion over the 2013 to 2022 period. If this program were adopted in traditional Medicare, there would be partially offsetting increases in the cost of home health care and community services for those individuals discharged earlier from SNFs than they would be under the current system. Those additional costs might flow to the Medicare and/or Medicaid programs, depending on the type of care received and whether the individual is dually-eligible for both programs. But regardless of how the savings are allocated, total costs to the health care system would decline even as care quality was maintained or improved. Those additional impacts are not included in our estimates.

10: PROVIDE SUPPORT TO PREVENT HOSPITALIZATION OF PATIENTS IN NURSING HOMES

Background. Patients in nursing homes and other long-term care facilities are typically frail and have multiple chronic medical conditions. Such patients require complex interventions and social support if they are to avoid unnecessary hospitalizations, emergency room (ER) visits and inappropriate utilization of prescription drugs (with the associated risks of poly-pharmacy and adverse drug-drug interactions).

Opportunity description. As part of UnitedHealth Group's Evercare program, nurse practitioners are deployed in nursing homes to assist in planning and coordinating care for patients in the long-term care setting. These health professionals, along with other nurses, determine a member's preferences, clinical needs, and social support system. Coordinating closely with primary care providers and with nursing home staff, family and caregivers, the nurses develop and implement an individualized care plan for each patient, including the provision of more intensive clinical support for individuals at times of heightened need in the nursing home. Well controlled research studies have shown that this approach leads to significant reductions in avoidable hospitalizations and ER visits.

Success of broad national deployment of this model is dependent on the nurse practitioners and nurses who engage with patients in the facilities. The development of a strong and well-trained workforce is therefore critical. Additionally, an expanded model of this program would need to coordinate with the clinical model and staff of participating long-term care facilities. Scaling the program nationally also will require health information technology that can help assess patient eligibility and care needs and monitor hospital admissions and outcomes. Coordination with state Medicaid programs for dual eligibles also would increase the potential of this model to reduce costs and improve quality of care.

Basis of savings estimate. Based on actual results of our Evercare institutional special needs plans, we estimate savings from the wider application of this model. Gross savings are largely derived from reduced numbers of hospital admissions and sub-acute days for fee-for-service members living in an institution. Net savings reflect an offset for the costs of services and supports for the nurse practitioner model and additional clinical fees for skilled nursing facilities. Our experience suggests that the intervention could reduce SNF, hospital and ER costs for participating beneficiaries by about 40 percent on net; however, those savings would vary across markets. Most but not all individuals in nursing facilities could participate in this program, but our estimate accounts for individuals who otherwise will enroll in similar pilot programs funded by CMS. We assumed that the program would take five years to phase-in, after which all eligible institutionalized Medicare beneficiaries would receive similar levels of care coordination and support.

Results and discussion. We estimate that national application of this model could save the Medicare program \$25 billion over the 2013 to 2022 period. Preventing nursing home residents from being hospitalized unnecessarily would support and maintain them in a residential care setting, so we expect there could be offsetting costs to Medicaid (which pays for nursing facility care). This approach holds promise for keeping individuals in assisted-living facilities or other community-based programs from requiring nursing facility care, and thus could reduce costs to state Medicaid programs for those admissions. Although we did not estimate the Medicaid impacts of this approach, we believe that finding ways to adapt this model further could create additional opportunities for savings.

11: OFFER COMPREHENSIVE CARE SERVICES FOR PATIENTS WITH ADVANCED ILLNESS

Background. About one quarter of Medicare spending on hospital and professional benefits is for care for seniors during the last year of life, with additional spending for expensive drug therapies. There is growing evidence that in many cases, greater Medicare spending at the end of life does not necessarily result in better quality of care or patient satisfaction with care. Patients report that care delivered near the end of life often does not reflect their needs or preferences and accounts for a significant share of the large geographic variations in healthcare spending that have been observed. Whereas the vast majority of Americans would prefer to die at home, less than 40 percent actually do so. Meanwhile the median length of stay in a hospice is only 20 days, indicating that many people are not benefiting.

Inattention to control of patient discomfort leads to a lack of emphasis on important aspects of care quality for these patients. People facing decisions about end-of-life care often do not have the information necessary to make considered choices about how they would like to direct their health care.

Opportunity description. Advanced illness interventions are designed to:

- ▶ Minimize physical, psychological and spiritual distress and positively affect the lives of family and friends;
- ▶ Support alignment of the course of treatment and plan of care with individual values and goals;
- ▶ Empower patients and families to become more proactive participants in the medical care they receive; and
- ▶ Improve quality of life for patients and their family members.

Advanced Illness programs provide coordinated care for patients with advanced illnesses, and offer resources to educate patients and their families about both their condition and the benefits and quality-of-life issues surrounding treatment in the last twelve months of life. The model engages the patient and their family to assure that providers are aware of the patient's values, goals, and preferences about care.

The proposed model provides an evidence-based approach facilitating appropriate, high-quality care integrated within a community health services delivery model. Care plans would include patient education and preferences, assurance that the patient understands their medical condition, diseases, and disease trajectory, and a comprehensive assessment that addresses the patient's physical, emotional and spiritual needs and provides appropriate interventions.

This model of service coordination would provide a platform for systematic, comprehensive care that closes the gap in the treatment of advanced, chronic, co-morbid conditions and other conditions that affect health and self-care. This clinical model utilizes an individualized, whole-person approach to care that helps members navigate complex care delivery systems, stabilize

or delay progression of their illnesses or condition, and promote independence and quality of life. In validating broad application of the model, it is important to measure not just quality and resources – including reductions in avoidable hospital admissions – but also patient and family experience and understanding of their medical treatment choices.

Basis of savings estimate. We estimate that broad application of the advanced illness model for the entire Medicare FFS population could result in more appropriate use of care that better matches patients' own preferences. Using results from existing advanced illness programs, and taking into account the offsetting costs of providing services and supports to patients under the intervention, the estimates also account for an initial four-year phase in of this model as it is deployed across the Medicare fee-for-service program.

Results. We estimate a decrease in Medicare spending of \$20 billion over ten years, primarily through improved support for patients leading to reductions in inpatient hospitalizations and treatments that patients do not value. There would also be offsetting new spending for Medicare hospice services (which is not accounted for in the estimate). There might also be offsetting effects on Medicaid – through lower cost-sharing for the dual-eligibles and possible increased spending for community-based care. We did not estimate those effects in this paper.

12: USE PREDICTIVE MODELING BOTH TO IMPROVE PAYMENT ACCURACY AND IMPROVE CARE

Background. Estimates suggest that between 3 percent and 10 percent of total health care spending might be attributable to fraud, overpayments, and errors in the coordination of benefits and subrogation (which involves the proper ordering of payments that involve overlapping coverage or liability). This implies that up to \$260 billion in costs might be wasted each year, which translates into higher spending for the Medicare and Medicaid programs.

According to the National Health Care Anti-Fraud Association, approximately 70 percent of payers currently employ some form of anti-fraud system, mostly following a “pay and chase” methodology – that is, they attempt to correct the problem after it has occurred. However, payers are increasingly turning to predictive analytics to identify fraud and abuse – in particular, by monitoring and flagging claims prior to payment (pre-scoring) and identifying providers billing for services in a manner that substantially deviates from their market peers. CMS is currently engaged in efforts to deploy advanced predictive analytics in anti-fraud initiatives with the development of the Fraud Prevention System and a partnership with private payers to share information and best practices. Additionally, the agency is making structural investments in a new fraud-tracking center and in the development of new systems to detect fraudulent claim activities in collaboration with contractors.

State Medicaid programs are similarly beginning to shift away from retrospective recovery efforts toward predictive analytic and pre-payment fraud prevention tools. Additionally, state Medicaid programs have begun implementing the Recovery Audit Contractor (RAC) program that has been in use in Medicare since 2005. States have been given flexibility to design their RAC programs in order to identify and recover improper payments. States also must participate in the CMS Payment Error Rate Measurement (PERM) program and report on their estimated payment errors. Beyond these mandatory programs, state Medicaid programs vary widely in how they utilize predictive modeling and other information technology solutions to improve program integrity and reduce waste, fraud, and abuse. Many states contract with private entities to administer their fraud and abuse detection and surveillance and utilization-review functions, third-party liability programs, correct-coding initiatives, and other programs aimed at reducing inaccurate payment.

In addition to detecting fraud and abuse, predictive analytics are increasingly being used to help drive improvements in the delivery of care by reducing inappropriate and overuse of services. Payers use this technology to help identify patients at risk for hospitalization and who might benefit from higher levels of care coordination or other interventions. In health plans serving Medicare and Medicaid populations, having this technology embedded in the care model can lead to better outcomes and lower costs.

Opportunity description. Broader use of predictive analytics in the Medicare and Medicaid programs, using tools deployed in the private sector in combination with those programs’ data resources, could help to address rising costs in those programs. Not only would such a retooled system address fraud and abuse, it could help to drive greater efficiencies in the delivery of care by identifying providers who are delivering inappropriate care and identifying beneficiaries who might benefit from early interventions – which could, for example, result in reduced hospital readmissions.

Private payer experience has shown that the construction of such predictive modeling systems requires data preparation, identification of risk markers, creation of risk profiles, and calculation of future health risks. Furthermore, it is important that these systems be accurate, transparent, interoperable, and supportive of changing operational needs, and that they support the delivery of high-quality care.

Coordinating those efforts with private payer program integrity activities might drive improved efficiencies across the health care system, with benefits accruing to government payers as well. In a working paper, *How Technology Can Cut Red Tape and Simplify Health Care Administration (June 2009)*, we discussed the possible use of a national, third-party clearinghouse (or shared utility) to audit and ensure correct payments. If combined with the adoption of a single, non-variable format for all transactions, the added transparency that results would make contract compliance much easier for both providers and payers. Providers and payers would then share a common platform to address payment errors and settle credit balances, allowing for inventory management, electronic settlement, and reporting and auditing. In addition, a national predictive model pre-scoring service would actively monitor and flag questionable claims prior to payment, leading to a more robust, real-time adjudication process for most payments. This service approach, coupled with the establishment of the clearinghouse, would reduce the instances of payment error and administrative friction between payers and providers.

Today, public programs can create specific population- and community-based detection algorithms that can be integrated with prospective claims audits. These predictive modeling analytics are particularly important for helping to identify high-risk Medicare and Medicaid beneficiaries who would benefit from early clinical interventions. Predictive modeling tools and patient encounter data can be deployed to identify missed preventive care and other gaps in existing care programs and other prescribed courses of treatment. Importantly, it is critical to consider how these tools and programs can be created and refined into a more aligned, consistent, and coordinated

approach to program integrity activities. Specifically, a more unified approach across the various fraud programs and stakeholders could be further explored.

Opportunities also exist for data sharing across programs to build robust platforms that address health concerns for all individuals, regardless of their source of coverage, while tightly safeguarding individual patient confidentiality. This could help to limit “false positives” by creating a continuous feedback loop to refine approaches and create new ones; would allow sharing experiences of various inappropriate practices and fraud schemes; and would raise the visibility of fraud protection initiatives.

Basis of savings estimate. Research by the Lewin Group suggests that savings of between 2 percent and 7 percent (depending on the type of health service) may be obtainable for employer-sponsored coverage and for the Medicare and Medicaid programs, net of associated contingency and recovery costs, using predictive modeling tools. These estimates account for payment error rates and the relative proportion of reimbursable services that can be affected by prepayment policy. In addition, as the health care system becomes better at detecting fraud, waste, and abuse, the incidence of fraud is likely to decline, and we account for those improvements in our estimates. Additional savings could come from opportunities for improved beneficiary care identified using predictive analytic methods and tools. Because of the current interest in adopting predictive analytic tools, our estimate accounts for continued integration of those tools in the Medicare and Medicaid programs in the absence of additional actions.

Result. We estimate that accelerated use of predictive analytics to address fraud and abuse, and well as to drive improvements in the delivery system could reduce government health spending by an estimated \$72 billion over the 2013 to 2022 period. Of that amount, \$42 billion would accrue to the Medicare program and \$30 billion to state Medicaid programs. Furthermore, we estimate that full implementation of predictive modeling, in combination with the development of a national clearinghouse, has the potential to reduce administrative costs associated with inappropriate medical payments over the next decade, but we have not isolated that specific impact from the broader impact of clinical programs on costs.

13: ENCOURAGE ADOPTION OF EFFECTIVE PAYMENT REFORMS

Background. Spurred by ongoing cost pressures and the payment reform provisions of the Affordable Care Act, public and private payers are testing and deploying new methods of reimbursing physicians and hospitals. The precise effects of those initiatives on national and federal spending for health care are difficult to estimate, but we considered savings scenarios for the next decade, taking into account the varying degrees of readiness for reform that exists among providers and their need for support to succeed under new payment models.

Although the effects on spending will depend on a wide array of factors, these savings scenarios focus on two key dimensions: the adoption rate or share of total spending that is affected by reform initiatives; and the percentage reduction in spending that would be achieved on average by adopters, net of any gain-sharing arrangements with doctors and hospitals – that is, the net savings that might be available both to reduce insurance premiums for employers and families and to lower federal and state spending on health care. These scenarios are discussed more extensively in our recent working paper, *Farewell to Fee-for-Service? A ‘Real World’ Strategy for Health Care Payment Reform* (December 2012).

Opportunity description. How quickly and broadly will payment reforms be implemented? While some have already been adopted by a number of providers, predicting the rate of spread or ultimate adoption rate is challenging. Rather than taking an overly prescriptive approach, here we think of “adoption” as involving a set of initiatives that strongly encourage providers to deliver high-quality care more efficiently, with a mix of performance incentives, bundled payments, shared-savings and shared-risk arrangements, and capitation payments that reflects the market structure and capabilities of the local community. Based on historical precedents and judgment, a reasonable range of adoption rates for major payment reforms over 10 years might run from 20 percent at the low end to 60 percent at the high end.

Estimating the savings that reform initiatives might generate when they are adopted is also difficult, partly because many of them are still being field-tested and refined. In some cases the initial effects may be limited, but greater savings might materialize in later years once the “kinks” of these models get worked out. In other cases, significant savings might be observed early on in selected instances, but it may be hard to know whether those results can be generalized or if they reflect certain favorable characteristics of early adopters that may prove challenging to replicate. In light of those competing considerations, the scenarios presented here use a single, constant savings rate.

One way to frame the potential savings is to start with estimates about the share of health care spending in this country that appears to have little if any impact on patients’ health. Some experts have estimated that share to be in the neighborhood of 30. In theory, gross savings might be 15 to 20 percent on the higher end – down to perhaps 5 percent if reform initiatives prove less successful. And if it is further assumed that about half of the gross savings will typically accrue to providers (e.g., through bonus payments), then net savings might range between 2 percent and 10 percent.

Basis of savings and results. Using the range of assumptions described above, aggregate savings to the health system from payment reforms over 10 years could be as little as \$70 billion or as much as \$1 trillion – with more likely scenarios ranging from \$200 billion to \$600 billion, about half of which would accrue to Medicare and Medicaid (See Table 3). Implicit in these scenarios is that average savings are similar across all sectors of health care that are in scope for savings, but other combinations – with greater savings in some areas and less in other areas – would also be consistent with these estimates.

In particular, the effects may differ between Medicare and private insurance. On the one hand, the potential for gross savings may be lower in Medicare because current projections of spending already include substantial reductions in payment rate updates for providers. On the other hand, Medicare’s unmanaged fee-for-service program may present more opportunities for gains in the efficiency of health care delivery. **If the effects on Medicare’s spending were strictly proportional, it would account for about 27 percent of the savings – or \$54 billion to \$162 billion over 10 years for the more likely scenarios. Similarly, savings for Medicaid would represent about 23 percent of those totals, or \$46 billion to \$138 billion.** About 40 percent of those Medicaid savings would accrue to state governments and the remainder to the federal government.

POTENTIAL EFFECTS OF PAYMENT REFORMS ON HEALTH CARE SPENDING

Figures in billions of dollars, 2013 to 2022

Adoption Rate in 10 Years		Net Savings to the Health System			Net Savings to Medicare			Net Savings to Medicaid		
		Low (2%)	Medium (6%)	High (10%)	Low(2%)	Medium (6%)	High (10%)	Low(2%)	Medium (6%)	High (10%)
Low	20%	-70	-200	-340	-19	-54	-92	-16	-46	-78
Medium	40%	-130	-400	-670	-35	-108	-181	-30	-92	-154
High	60%	-200	-600	-1,010	-54	-162	-273	-46	-138	-232

Table 3; Source: UnitedHealth Center for Health Reform & Modernization, 2012

NOTE: About 70% of national health spending is assumed to be "in scope" for savings.

In light of recent legislation and initiatives being pursued by CMS, it may be difficult to achieve further "score-able" savings for payment reform proposals – but that again highlights the key role that health plans, health services companies, and other stakeholders can play in seeing the on-going efforts are pursued and scaled up. In particular, if implementation of successful reforms could be accelerated, the aggregate savings would be substantial. For example, assuming a net savings rate of 6 percent, raising the 10-year adoption rate from 20 percent to 40 percent or from 40 percent to 60 percent would reduce national health care spending by about \$200 billion – with \$54 billion in savings for Medicare and \$46 billion in savings for Medicaid (federal and state) if they can match the national trend.

ABOUT THE UNITEDHEALTH CENTER FOR HEALTH REFORM & MODERNIZATION

The Center is a substantial long-term commitment by UnitedHealth Group to advance sophisticated and practical approaches to health care modernization and reform. Its multi-disciplinary team of business leaders, economists, physicians and policy analysts supports the Company's strategy development and innovation agenda. The Center's public work program involves assessing and developing policies and solutions for the health care challenges facing the nation, including innovative approaches to expanding health care coverage; practical cost containment strategies to slow the growth of U.S. health care costs; and options for modernizing Medicare and Medicaid. Its published work is available at www.unitedhealthgroup.com/reform.

ABOUT UNITEDHEALTH GROUP

UnitedHealth Group is a diversified health and well-being company dedicated to helping people live healthier lives and making health care work better. With headquarters in Minnetonka, Minn., UnitedHealth Group offers a broad spectrum of products and services through two business platforms: UnitedHealthcare, which provides health care coverage and benefits services; and Optum, which provides information and technology-enabled health services. Through its businesses, UnitedHealth Group serves more than 80 million people worldwide.

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