Avalere

To: Third Way

From: Avalere Health

Date: December 16, 2014

Re: The Estimated Federal Impact of Coordinating Care for Medicare and Medicaid Dual Eligible Beneficiaries

Summary

Third Way asked Avalere Health to estimate cost or savings associated with a set of policies that would help coordinate care and integrate coverage for dual eligible beneficiaries. Specifically, this proposal would create a duals care coordination policy in which states could choose to lead the care integration efforts associated with dual eligible beneficiaries' care or leave the responsibilities to the federal government. Under either option, the state or federal government would contract with an insurance plan or plans to handle beneficiaries' Medicare and Medicaid benefits.

Savings resulting from improved care would be shared differently depending on whether the state or federal government is leading care coordination efforts. For efforts led by the states, any savings from the care coordination would be shared between the federal government and the states based on a variety of factors. Under the federal-led option, all savings would accrue to the federal government.

We estimate this proposal would reduce federal spending by $47.2 billion over the 2016-2025 federal budget window. This amount reflects a combination of an estimated $7.2 billion in new savings associated with the state-led option and an estimated $40 billion in savings from the federal-led option.

Estimated Change in Federal Spending due to Dual Eligible Care Coordination and Integration

$ in billions, by fiscal year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	**2016-2025**
State-led option	0.0	-0.1	-0.3	-0.7	-0.8	-0.8	-0.9	-1.1	-1.2	-1.2	**-7.2**
Federal-led option	0.0	-0.5	-1.6	-3.5	-4.0	-4.6	-5.4	-6.4	-6.8	-7.2	**-40.0**
Net change in spending	**0.0**	**-0.6**	**-2.0**	**-4.4**	**-4.8**	**-5.4**	**-6.4**	**-7.4**	**-7.9**	**-8.4**	**-47.2**

1350 Connecticut Avenue, NW | Suite 900 | Washington, DC 20036 | Tel 202.207.1300 | Fax 202.467.4455

Background

By 2016, there will be about 7.5 million people who are fully eligible for both Medicare and Medicaid ("full duals").[1] For these full dual eligible beneficiaries, Medicaid pays for services that Medicare does not cover, like long-term care services and dental care in some states. Medicaid also pays for full dual eligible beneficiaries' cost sharing requirements including premiums and deductibles.[2] There will also be about 1.9 million individuals who are only *partially* dually eligible for Medicare and Medicaid. These partially eligible beneficiaries only qualify for Medicaid to pay for some of the services not covered by Medicare, although Medicaid may pay for all or part their premiums or deductibles. About 82 percent of full and partial dual eligible beneficiaries are currently enrolled in Medicare FFS.[3]

The dual eligible population obtains these additional benefits because they have lower incomes and are in poorer health than the rest of the Medicare FFS population. Specifically, regarding income, dual eligible beneficiaries are economically disadvantaged—55 percent of them have annual incomes of $10,000 or less, while only six percent of other Medicare beneficiaries do.[4] Regarding health status, relative to the non-dual eligible Medicare population, they are more likely to have multiple chronic conditions, to have cognitive and functional impairments, and to be hospitalized and or to use long-term care.[5] The CBO reports that they are more than "three times as likely" as non-dual eligible Medicare beneficiaries to have a disability, thus requiring more health care services.[6]

While dually eligible beneficiaries only comprise 21 and 15 percent of the Medicare and Medicaid populations, they account for 31 and 39 percent of the costs in these programs, respectively.[7] In 2009, the average combined Medicare and Medicaid spending for full duals was $33,400; for partial duals it was $15,700, while for non-duals it was $8,300.[8]

Given the disproportionately higher spending for dual eligible beneficiaries relative to non-duals, policymakers, payers and providers have been exploring various approaches to reducing spending for this population. Achieving greater spending efficiencies for dual eligible beneficiaries has been challenging, largely because of the fragmented financing and benefit structure of Medicare and Medicaid. Specifically, while Medicare covers most acute care services and some long-term care services, Medicaid covers most long-term care services and expands coverage for certain services that are limited in Medicare, as well as beneficiary cost sharing. This division of service coverage has resulted in cost shifting, care that is siloed, and

---

[1] 2014 Medicare Trustees Report. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf.
[2] Congressional Budget Office. Glossary of Terms Related to Dual-Eligible Beneficiaries of Medicare and Medicaid. Available at http://www.cbo.gov/publication/44309.
[3] The Congressional Budget Office. Dual Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies. June 2013.
[4] The Henry J. Kaiser Family Foundation. Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries. Issue Brief. May 2011.
[5] Jacobson, G., Neuman, T., and Damico, A. "Medicare's Role for Dual Eligible Beneficiaries". Kaiser Family Foundation. Washington, DC. April 2012.
[6] The Congressional Budget Office. Dual Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies. June 2013.
[7] The Kaiser Commission on Medicaid and the Uninsured. Medicaid Facts. Dual Eligibles: Medicaid' Role for Low-Income Medicare Beneficiaries. May 2011.
[8] The Congressional Budget Office. Dual Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies. June 2013.

as a result can be duplicative. Furthermore, there is no incentive to coordinate care between Medicare and Medicaid because the majority of spending for dual eligible patients occurs on an unmanaged fee-for-service basis.

To address these issues there have been several legislative initiatives that have targeted dual eligible beneficiaries with the goals of coordinating care and integrating the financing structure through capitated payments. These programs include the Program of All-Inclusive Care for the Elderly (PACE),[9] Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP),[10] and most recently, the Financial Alignment Demonstrations (FAD).

The capitated version of the FAD involves a three-year contract between the state, the Medicare program, and health plans to promote care coordination and align financial incentives between Medicare and Medicaid. The health plans receive a prospective blended payment from Medicare and Medicaid for all primary, acute, prescription drug, behavioral health, and long-term care services. The payment is set at savings rates that are lower than what would have been paid to Medicare FFS and Medicaid in the absence of the FAD.[11] These savings targets differ by state and over time, but generally, they range between one and two percent in the first year and from three to five percent by year three.[12] By aligning Medicare and Medicaid's financial incentives, CMS' goal is to reduce cost shifting between the programs. Furthermore, states can share in the savings to Medicare under the FAD.

Currently, 17 states are pursuing the FAD (including the capitated and FFS versions) and almost 1.5 million duals are eligible for enrollment (over 20 percent of duals nationally). Eleven states are currently either participating or pursing the capitated version of the FAD. It is important to note, however that nine other states that originally pursued the FAD, decided to discontinue the program.[13] This disenrollment may speak to the program's feasibility over time, especially related to health plan's willingness to take capitated payment rates below Medicare FFS.

Given that the FAD and the other programs like PACE and D-SNPs are not available nationwide, there are many duals who are not able to access and benefit from these programs. Third Way has proposed a national care coordination program for dually eligible beneficiaries

---

[9] PACE was established as a permanent part of the Medicare benefit by the BBA of 1997. The program provides seniors with care coordination services to help them avoid long-term institutional care. Furthermore PACE insurers get capitated payments from Medicare and Medicaid, and as such, they assume the risk for beneficiary healthcare consumption. As of 2014, 31 states have PACE programs. See http://www.npaonline.org/website/article.asp?id=12&title=Who,_What_and_Where_Is_PACE?

[10] D-SNPs are special needs programs in which Medicare Advantage (MA) plans only enroll dually eligible beneficiaries with the goal of improved care coordination and continuity between Medicare and Medicaid. Medicare pays capitated payments to D-SNPs who, per the MIPPA 2008, must contract with the state to run enroll beneficiaries. FIDE-SNPs, a subset of D-SNPs, were defined in the ACA 2010. FIDE-SNPs MAs fully integrate dually eligible beneficiaries' care, by providing access to Medicare and Medicaid services under a single organization. As of 2013, there were 16 states with D-SNPs, seven of which were FIDE-SNPs. See Baty L and Radke S. Special Needs Plans Update. April 12, 2012. CMS 2012 Medicare Advantage & Prescription Drug Plan Spring Conference. Also see Woodcock C. Integrating and Coordinating Care for Dually Eligible Individuals. The Hilltop Institute, October 8, 2013, http://www.hilltopinstitute.org/publications/IntegratingAndCoordinatingCareforDuals-October2013.pdf.

[11] Avalere Health. Financial Alignment Demonstration Overview. September 2014.

[12] The Henry J. Kaiser Family Foundation. Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS. Website. See http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/.

[13] Avalere Health. Financial Alignment Demonstration Tracker. September 2014.

that is similar in many ways to the FAD. Specifically, Third Way's proposed program integrates the Medicare and Medicaid financing by requiring one entity (either the state or the federal government) to coordinate dual eligible beneficiaries' care and to receive payment for their healthcare utilization. They also propose that states share in the potential savings because of these efforts.

Third Way's proposal differs from the FAD in that there is a state-led option and a federal-led option. Under the state-led option, the state would take full responsibility for coordinating care for beneficiaries and would get a payment from the federal government for the Medicare portion of their care. Most likely, states would contract with health plans to do this. They would share in any savings to the Medicare program with the federal government according to its FMAP rate in proportion to their share of Medicaid spending. Under the federal-led option, the federal government would take responsibility for coordinating care for dual eligible beneficiaries and would receive a payment from the state for the Medicaid portion of their care. It is important to note that the state gets the right of first refusal to decide if they want to undertake the responsibility for dual eligible beneficiaries. Only if a state decides that it does not, would the federal government take over.

In the case of the federal-led option, the state does not get to share in any savings if the federal program were able to reduce spending. The shared savings in the state-led option is meant to reward states for taking the lead in financing and care coordination for the beneficiaries in their states. By overlaying the federal option, the Third Way proposal fills in the coverage gaps left by the other aforementioned dual eligible-focused initiatives, as the duals who reside in states that choose not to lead care coordination efforts can still benefit from care coordination through the federal government.

Data Sources

We used the following data sources to develop our estimate:

- Avalere Health. Financial Alignment Demonstration Tracker. September 2014.
- Brown R and Mann DR. Best Bets for Reducing Medicare Costs for Dual Eligible Beneficiaries: Assessing the Evidence. Issue Brief. Mathematica Policy Research, Inc. Prepared for the Henry J Kaiser Family Foundation. October 2012.
- The Congressional Budget Office. April 2014 Medicare Baseline. April 14, 2014.
- The Congressional Budget Office. Dual Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies. June 2013.
- Foster L, Schmitz R, and Kemper P. The Effects of PACE on Medicare and Medicaid Expenditures. Mathematica Policy Research, Inc. August 29, 2007.
- Ghosh A, Schmitz R, and Brown R. Effect of PACE on Costs, Nursing Home Admissions, and Mortality. Mathematica Policy Research, Inc. Prepared for Office of Disability, Aging and Long-Term Care Policy in the Office of the Assistant Secretary for Planning and Evaluation. January 2014.
- Musumeci, M. Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS. The Kaiser Commission on Medicaid and the Uninsured. Issue Brief. July 2014.

- The Kaiser Commission on Medicaid and the Uninsured. Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP). September 2012.
- The Henry J. Kaiser Family Foundation. Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS. Website.
- Kane R and Homyak P. Multi State Evaluation of Dual Eligibles Demonstration: Minnesota Senior Health Options Evaluation Focusing on Utilization, Cost, and Quality of Care.
- Kendall D and Garry Lampert J. Health Care: Coordinate Care for the Most Vulnerable. Third Way.
- The Lewin Group. Increasing the Use of Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities. Sponsored by the Association for Community Affiliated Plans and Medicaid Health Plans of America. November 2008.
- Thorpe KE. Estimated Federal Savings Associated with Care Coordination Model for Medicare-Medicaid Dual Eligibles. Emory University. September 2011.
- United Health Center for Health Reform and Modernization. Medicare and Medicaid: Savings Opportunities from Health Care Modernization. Working Paper 9. January 2013.

Assumptions and Methodology

Enrollment and Participation in the Dual Eligible Care Coordination Program

We estimate that in 2016, 0.9 million full dual eligible beneficiaries will participate in the care coordination program. By 2025, the program will grow to enroll 4.8 million full duals and 1.4 million partial duals. See the table below for enrollment estimates:

Table 2: Estimated Enrollment in Dual Eligible Care Coordination Program
in thousands

Enrollment Group	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Full Dual Eligible Beneficiaries	923	1904	2942	4095	4210	4325	4497	4612	4729	4849
Partial Dual Eligible Beneficiaries	0	0	0	0	311	640	998	1364	1399	1434
Total Enrollment	923	1904	2942	4095	4521	4965	5495	5976	6128	6284

We base these enrollment estimates on the following assumptions:

- In 2016, Medicare estimates that there will be 7.5 million individuals who are full duals.
- Of these full duals, approximately 1.1 million will be in the Financial Alignment Demonstration (FAD). We assume these individuals will remain in the FAD, and thus will not participate in the duals care coordination program.
- We assume that the care coordination program would only target full duals in Medicare FFS. CBO estimates that 82 percent of full duals are in Medicare FFS. As such, we adjust the approximately 6.4 million non-FAD duals downward by 18 percent.
- Of the approximately 5.3 full duals in FFS, we assume that 25 percent of this potential population, or 1.3 million, would be targeted for participation in 2016. In 2017 and 2018,

we increase these phase-in targets to 50 and 75 percent of the eligible beneficiaries, respectively. By 2019, we assume all full duals who are eligible for the program would be targeted for enrollment.

- We also assume that partial duals would start to be enrolled in these programs in 2020. We estimate that there will be about 1.7 million partial duals in Medicare FFS. We used the same 4-year phase-in assumption for the partial duals as with the full duals.
- We also assume 30 percent of full or partial duals will opt out of the care coordination program. We base this opt-out rate on the participation levels observed in the FAD and the ACA state exchanges. The opt-out rate does not differ whether the enrollee is in a state with a state-led care coordination program or in a state with a federal-led care coordination program.

We assume that 21 percent of duals (full or partial) will reside in states that choose to lead the care coordination program and the remainder would reside in states that choose to leave the care coordination activities to the federal government. We base this assumption on the state participation rates in the FAD, given the similarities of the programs.

Finally, we do not assume any drop-out rates in years after initial enrollment.

Medicare Reimbursement for Dual Eligible Care Coordination

To estimate a baseline spending level we used the published average Medicare per member per month spending (PMPMs) for full and partial duals as reported by CBO for Parts A and B services. We also used the average PMPM that CBO reported for Medicaid for full and partial duals. We trended these figures up by the projected average growth rates for Medicare Part A and B services as reported in CBO's 2014 Medicare baseline. This yields the average PMPM that the Medicare and Medicaid programs are expected to spend on dual eligible beneficiaries with no care coordination intervention.

To estimate potential savings that could be associated with dual eligible care coordination programs, as a first step, we examined other models in which researchers estimated potential savings associated with these types of programs based on utilization reductions reported from other studies as well as on their own assumptions. These models estimated savings associated with coordinating care for dual eligibles ranging from four to eight percent by the tenth year of implementation.

We also examined the outcomes and reported federal savings associated with real-world care coordination programs targeted to populations that share characteristics with duals. Specifically, we looked at the outcomes reported for the PACE program, a comprehensive care model targeted to frail and elderly people with goals of meeting their healthcare needs while integrating and coordinating care efficiently to reduce the utilization of acute care hospitalizations and long-term care services. A recent study of the PACE program found that enrollees in the programs across eight states had fewer long term care stays compared to matched controls, it also found no federal savings because the actual capitated rate for PACE enrollees was higher than the rate that would have been paid if those enrollees remained in Medicare FFS. A previous assessment of PACE was also not able to demonstrate savings, reporting similar Medicare capitation rates to FFS and higher capitated costs for Medicaid under the program relative to controls.

Another care coordination program we considered was Minnesota Senior Health Options (MSHO), a program targeted to dual eligible beneficiaries aged 65 and older in certain Minnesota counties, that combines Medicare and Medicaid financing. An assessment of this program also showed higher capitation rates under MSHO compared to controls.

In addition, in a recent report, the Government Accountability Office (GAO) assessed the potential savings associated with FIDE-SNPs. This report found that in 2013, the majority of these plans did not bid below Medicare FFS spending levels, and thus the report concluded that relatively few of these plans had the potential for Medicare savings.[14]

Lastly we considered the savings percentages included in the memorandums of understanding between CMS and the states that are participating in the FAD, as this model is the most directly comparable to the proposed program relative to the other real world examples. On average, managed care plans participating in states with FADs have agreed to capitation rates that are one, two, and four percent lower than the existing FFS payment rates in years one through three of the demonstration, respectively. Given that some states have dropped out of the demonstration, it may be unrealistic to assume these savings rates for similar duals care coordination programs. As such, we developed the savings estimates for this proposed care coordination program by considering the savings estimates in the FAD as an upper bound.

Given all of the aforementioned sources, we assume that total savings relative to current expectations would be zero percent in the first year, one percent in the second year, two percent in the third year, and three percent in years four through ten. We use the same assumptions for both the full and partial dual programs. See the table below for our estimated baseline Medicare FFS and Medicaid spending compared to estimating spending associated with the Third Way proposed dual eligible care coordination program.

Table 3: Average Per Member Per Month Expenditures for Dual Eligible Beneficiaries

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Baseline: Full Dual Eligibles	2,718	2,808	2,904	3,007	3,119	3,238	3,346	3,474	3,606	3,743
Proposal: Full Dual Eligibles	2,718	2,780	2,846	2,917	3,026	3,141	3,246	3,369	3,497	3,630
Percent Difference	*0%*	*1%*	*2%*	*3%*	*3%*	*3%*	*3%*	*3%*	*3%*	*3%*
Baseline: Partial Dual Eligibles					1,328	1,378	1,425	1,479	1,535	1,593
Program: Partial Dual Eligibles					1,328	1,365	1,396	1,434	1,489	1,545
Percent Difference (%)					*0%*	*1%*	*2%*	*3%*	*3%*	*3%*

Shared Savings Methods

Under the proposal, the savings associated with duals care coordination are shared differently depending on whether the state or federal government leads the care coordination efforts. When states lead the care coordination program, they share equally with the federal government in all savings, adjusted to the state's FMAP rate and in proportion to their

[14] The Government Accountability Office. Disabled Dual-Eligible Beneficiaries: Integration of Medicare and Medicaid Benefits May Not Lead to Expected Medicare Savings. August 2014. GAO-14-523.

contribution of total expected spending. For example, by the third year of the program for full duals, we estimate savings per full dual on an annual basis of $697. The Medicaid average contribution was 51 percent, and the average state share based on the FMAP was 43 percent. As such, the state would receive $154 per full dual on average ($697*0.51*0.43), while the federal government would receive the remaining $543 per full dual enrollee.

When states choose to leave the administration of the program to the federal government, under the proposal they would not share in any savings. The state would still pay the federal government the full amount for Medicaid portion of a dual eligible beneficiaries' care. As such, using the example above, the federal government would realize the full $697 in savings.