$500 TO $620 BILLION

could be saved by modernizing Medicare and Medicaid

Potential Savings From Initiatives to Modernize Medicare and Medicaid

Ten-year projected federal savings, fiscal years 2017 through 2026
Figures in billions of dollars

	Low	High
Modernize Original Medicare for non-dual FFS beneficiaries ▶ Provide beneficiaries with proven value-based care management programs ▶ Foster innovation and empower beneficiaries to engage in healthy decision-making and appropriate care ▶ Improve Original Medicare's existing infrastructure	$ 377	$468
Enroll dual-eligible beneficiaries in managed care plans that integrate their Medicare and Medicaid benefits	$ 82	$ 101
Enroll the 15% of non-dual Medicaid beneficiaries currently in FFS into managed care plans	$ 28	$ 35
Utilize predictive analytics to reduce fraud and increase payment accuracy in both Medicare and Medicaid	$ 13	$ 16
Total	$500	$620

Source: UnitedHealth Center for Health Reform & Modernization analysis of data drawn from sources including: the Congressional Budget Office, the U.S. Census Bureau, the Centers for Medicare & Medicaid Services, and the Medicare Payment Advisory Commission.

Modernize Original Medicare for Non-Dual FFS Beneficiaries

Original Medicare does not provide its beneficiaries with appropriate and scalable care management services, which have been proven to reduce costs and produce better patient outcomes among Medicare Advantage (MA) enrollees.

Original Medicare can be significantly improved to deliver quality care and better value through the infusion of value-based care management programs, greater empowerment of beneficiaries, and improved infrastructure. Modernizing Original Medicare to address the key challenges facing the program requires advancing and scaling best practices, fostering innovation, and aligning incentives to ensure beneficiaries receive high-quality care and an improved consumer experience. Strategies to modernize Original Medicare include:

- **Providing all beneficiaries with proven value-based care management programs, such as:**
  - Delivering integrated services, including disease management programs, palliative approaches, psychological care, and social services, to help beneficiaries live in the setting of their choice;

- Making patient-centered medical home models available for the program's most frail and vulnerable beneficiaries; and
- Expanding utilization of real-time predictive modeling tools and comprehensive patient encounter data to identify appropriate evidence-based interventions.

- **Fostering innovation and empowering beneficiaries to engage in healthy decision-making and appropriate care with solutions, such as:**
  - Providing proven lifestyle intervention programs and community-based activities that prevent the onset of chronic disease;
  - Authorizing consumer-friendly tools that include group sessions, coaching, robust online transparency tools, and other capabilities to help meet the needs of beneficiaries; and
  - Expanding the use of beneficiary incentives to help seniors receive appropriate preventive services, participate in wellness programs, make healthy choices, and engage with programs that identify and manage disease earlier.

- **Improving Original Medicare's existing infrastructure by:**
  - Expanding value-based payment approaches to promote quality among providers and remove the incentives to over-utilize high-cost services;
  - Providing beneficiaries with simple, consumer-friendly information to make comparisons on clinical quality and price; and
  - Authorizing Part D's utilization of innovative tools and data analytics to connect beneficiaries to appropriate clinical care.

Basis of savings estimate

With a gradual phase-in of these modernization strategies across the Original Medicare population, we estimate there would be between $377 and $468 billion in reduced federal spending over 10 years. In developing this estimate, we assumed that these solutions would not be fully effective in all regions, due to different provider market dynamics. Risk-based performance incentives could help to make the program more effective and also lead to greater net savings.

Enroll Dual-Eligible Beneficiaries in Managed Care Plans That Integrate Their Medicare and Medicaid Benefits

The majority of spending for dual-eligible Medicaid and Medicare beneficiaries – a high-need and costly population – occurs on an unmanaged fee-for-service basis in two separate programs, leading to missed opportunities for care management and misaligned incentives.

Under a modernized approach to serving dual eligibles, health plans would provide combined Medicare and Medicaid benefits, including all acute and long-term care services, thereby addressing the full range of duals' complex care needs. An integrated managed care model would not only provide needed care management to duals, but also would help ensure seamless integration of Medicare and Medicaid benefits, and eliminate incentives to shift costs between the two programs that stem from separate and misaligned Medicare and Medicaid payment policies. Specifically, managed care would lower costs by reducing avoidable hospitalizations and unnecessary nursing home admissions, as well as by ensuring ongoing long-term care is delivered in the least restricted setting possible.

Under this capitated model, states and the federal government would enter into a three-way contract with health plans or integrated provider systems, which would receive both the Medicare and Medicaid payment streams and would deliver both programs' benefits in an integrated fashion. Vesting responsibility in a single entity would allow

more effective use of data from both programs to design and target care interventions that reflect the entirety of patients' needs. This approach would require the alignment of Medicare and Medicaid regulations governing quality measurement, benefit design, marketing, and enrollment. The ability of duals to opt out of an integrated managed care approach would be limited to specific circumstances or specified disenrollment periods, in order to ensure continuity of care and support implementation of interventions that improve beneficiary health.

Basis of savings estimate

We estimate that enrolling all duals in managed care plans would produce between $82 and $101 billion in savings to the federal government over 10 years through reduced spending on Medicare and Medicaid. We assume that these savings would phase-in gradually for both Medicare and Medicaid. Separately, states would also realize substantial savings through lower Medicaid spending over the next 10 years.

Enroll the 15% of Non-Dual Medicaid Beneficiaries Currently in FFS Into Managed Care Plans

In the traditional fee-for-service Medicaid program, fragmentation of care delivery has led to a broad range of poor outcomes, including gaps in needed preventive care, frequent emergency department visits, conflicting prescriptions, and recurring inpatient admissions, including for patients with behavioral health conditions. All of these challenges have contributed to unnecessary spending and less effective care.

In a modernized approach to delivering Medicaid services, states would achieve savings and improve care through continuing and expanding their partnerships with managed care plans. Health plans have the capacity to address the complex care needs of Medicaid beneficiaries with disabilities, chronic illnesses, and behavioral health conditions. In an integrated managed care model, states would contract with health plans to deliver all services, including:

- **Primary and preventive care**
- **Pharmacy benefits and medication adherence programs**
- **Behavioral health services**
- **Case management initiatives for chronic illness**
- **Long-term care**
- **Care coordination services**

Managed care models are most effective when they deploy critical interventions, such as: comprehensive care plan development; ongoing care coordination, including home visits; high-touch management of complex, high-cost patients; and active case management of care transitions and discharges to prevent hospital and nursing home readmissions. Employing predictive analytics enables these services to be targeted to populations that will benefit the most. These partnerships with health plans can result in stable, long-term investments in beneficiaries' health and can advance delivery system reforms that benefit vulnerable populations.

Basis of savings estimate

We estimate that, if all states adopted a comprehensive managed care approach for their non-dual FFS Medicaid enrollees, the federal government would realize between $28 and $35 billion in Medicaid savings, phased in gradually. Separately, states would also realize $16 to $20 billion in savings through lower Medicaid spending over the next 10 years.

Utilize Predictive Analytics to Reduce Fraud and Increase Payment Accuracy in Both Medicare and Medicaid

Estimates suggest that between 3 percent and 10 percent of total health care spending is attributable to fraud, overpayments, and errors in the coordination of benefits and payments. Billions of dollars are wasted each year due to health care fraud, waste, and abuse, translating into higher spending for the Medicare and Medicaid programs.

Broader application of predictive analytics in the Medicare and Medicaid programs—including the use of tools deployed in the private sector in combination with the public programs' data resources—would help address unnecessary costs and increased spending in Medicare and Medicaid. Specifically, predictive analytics can help to:

- **Identify fraud and abuse by monitoring and flagging claims prior to payment;**
- **Identify providers whose billing patterns make them outliers relative to their peers; and**
- **Reduce overuse and inappropriate use of services.**

Broader and accelerated use of predictive analytics would yield greater savings for the Medicare and Medicaid programs. Once current predictive analytics tools can be designed to work with Medicare's vast repositories of data and are integrated into claims and payment systems, new program efficiencies will emerge. These information systems must be accurate, transparent, interoperable, and supportive of changing clinical priorities, and they must support the delivery of high-quality care.

Coordinating Medicare and Medicaid approaches with private payor program integrity efforts could drive additional efficiencies through the use of a national, third-party clearinghouse to audit and ensure correct payments. Providers and payors would then share a common platform to address payment errors and settle credit balances. In addition, predictive analytics would actively monitor and flag questionable claims prior to payment, leading to a more robust, real-time adjudication process.

Public programs can create specific population- and community-based detection algorithms that are integrated with prospective claims audits. These predictive analytics tools are particularly important for helping to identify Medicare and Medicaid beneficiaries who are at risk for gaps in care and would benefit from early clinical interventions and other prescribed courses of treatment. It is important to consider how these tools and programs can be refined into a more consistent and coordinated approach to pursuing program integrity.

Basis of savings estimate

We estimate that accelerated use of predictive analytics to reduce fraud, waste, and abuse, as well as to drive improvements in the delivery system, would result in $13 to $16 billion in savings to the federal government over 10 years through reduced spending on Medicare and Medicaid. Furthermore, we estimate that full implementation of predictive analytics, in combination with the clearinghouse, also would reduce administrative costs associated with inappropriate medical payments over the next decade.