The Potential Savings from Enhanced Chronic Care Management Policies

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Executive Summary

The chronically ill and disabled account for an estimated $635 billion, or 30 percent, of total U.S. health care spending as of 2010. About half of this amount ($304.5 billion) is spent on behalf of beneficiaries dually eligible for Medicare and Medicaid. Large amounts are also spent on Medicare beneficiaries with chronic illnesses who are not dual eligibles and on disabled individuals enrolled in Medicaid. Of the total spending on the chronically ill or disabled, $407 billion (two-thirds) was spent by the federal government for Medicaid and Medicare, with the remainder spent by states and the private sector.

This paper examines emerging evidence from efforts to redesign care, and estimates the potential of Medicare-led payment and care system initiatives to reduce spending over the next decade for Medicare and Medicaid while improving care outcomes. We estimate that a phased-in approach could save $331 billion over a decade (2014–2023), with three-quarters of this accruing to the federal government from Medicare and Medicaid and the rest to states and private payers.

The Potential of Patient-Centered Care Systems

For many of the chronically ill and disabled, care is often uncoordinated and inefficient. They often receive care from multiple clinicians across multiple sites of care. The coordination of care between Medicaid and Medicare for acute, subacute, and long-term care can be inefficient and is frequently duplicative. Further, failure to coordinate and provide appropriate care often puts the health and safety of the frail elderly and disabled at risk. This points to the need for a stronger focus on care teams, systems, and care management for chronically ill individuals, especially in the light of calls to reduce health care spending in Medicaid and Medicare. Despite the potential of better care management, the evidence on the effect of chronic care management programs is inconsistent. There have been many studies that showed little net cost savings, particularly in freestanding disease management programs where reductions in utilization of some services were offset by the cost of the care initiative.

More recently, however, a number of studies have emerged suggesting a possibility of annual net savings in the five to seven percent range when care is provided by innovative care teams operating within redesigned care systems that provide timely information and payment support, with accountability for outcomes. Shared attributes of innovations that are yielding improved health and care experiences while reducing net costs include targeting care on those most in need; fostering tightly knit teams of physicians and nurses/aides working together to provide and coordinate care across a continuum that includes long-term and home-based care; enabling multiple points of access, including after hours; engaging patients and their families to teach self-management skills; and providing care teams with access to timely information on emergency room visits, as well as hospital and nursing home admissions.

Medicare and Medicaid

The research literature also suggests that most of the savings are from acute care services such as hospital admissions and readmissions, emergency room visits, specialists, and skilled nursing facility days. For those dually eligible for Medicare and Medicaid, such services are largely paid by Medicare. Most policy discussions today center around increasing incentives to states to improve the management of these high-cost populations in Medicaid programs. But the key challenge is that most savings would accrue to Medicare, not Medicaid.

In this paper, we argue that more attention should be given to having Medicare develop or initiate chronic care management programs with incentives to support a partnership with state Medicaid programs to align incentives. In the case of duals, Medicare would likely reap most of the savings, and thus should take on the role of making the necessary investments to realize these savings. For those dually eligible, Medicaid would focus attention on efficiently managing home- and community-based long-term care services and reducing nursing home admissions. Medicare-led initiatives would stimulate the development of high-

value care systems for all the chronically ill or disabled, including those receiving Medicaid but not Medicare. We suggest a number of policy options that would establish a new partnership between Medicare and Medicaid and would address the needs of different populations—those living in nursing homes and assisted living facilities as well as those living at home. These options include providing care coordination programs with financial incentives, either through lump sum payments or higher reimbursement rates to primary care practitioners, and approaches that incorporate new ways of paying for primary care and shared savings. Many of these policy options could build on pilots, new federal support of Medicaid initiatives, and the authority to innovate that were included in the Affordable Care Act (ACA) legislation. The paper suggests ways such policies could be combined to maximize impact and spread.

Potential Savings

To illustrate the potential cost savings if the policies succeed in stimulating and supporting the spread of innovative care systems for the chronically ill and disabled, we examined total, federal, and state spending over the next decade, building on findings from several recent studies. We assumed a concentrated federal effort to institute payment reforms in support of chronic care management programs with the features documented in a range of studies. Assuming the policies would be phased in beginning in 2013 and fully implemented by 2016, we estimate that savings would amount to about $331 billion, or 0.9 percent of national health expenditures over the 2014–2023 period. The bulk of the savings would come from reductions in spending on dual eligibles with institutional and noninstitutional long-term care spending. These estimates assume that two-thirds of frail elderly or disabled long-term care users and half of other chronically ill groups participate. In general, we assumed savings of 5 percent net of management costs and financial incentives. We assumed an additional savings of 2 percent for dual eligibles because of better coordination between Medicare and Medicaid.

We estimate that the federal government would reap 76 percent of the savings, or about $252 billion over the 10-year period. The federal government not only saves from Medicare expenditure reductions, but also would reap approximately 57 percent of Medicaid savings as its share of Medicaid. States would save another $48.4 billion. We caution that these estimates are probably an upper bound because of the difficulty of replicating the most promising interventions. On the other hand, we are still learning what works well, and efforts to spread good practices could stimulate more rapid progress.

Overall, we conclude that there is a rich opportunity for Medicare to serve as a catalyst to transform care systems. As the program that services the nation's elderly and disabled, Medicare is centrally positioned to take the lead responsibility in working with providers to develop chronic care management programs. The federal government accounts for the lion's share of the spending today and therefore stands to reap most of the savings from such programs. Partnerships with states will be essential to align incentives and support for care teams, especially for those in need of long-term care. Medicare can also join state Medicaid programs that have initiated exceptional programs, but should not depend on all programs being initiated by states or spread by states without new Medicare financial incentives. Moving toward an approach that aligns the two programs with an eye toward total spending—not Medicare or Medicaid alone—has the potential for significant gains in care for very vulnerable populations and lowering the cost trajectory for both programs. At the same time, it will be critical for Medicaid and states to lead in developing policies that improve care for chronically ill children and families and that reduce institutionalization by providing options in the community, including well-coordinated home and community long-term care support services.

In an era of innovation, the emerging evidence speaks to the potential of creative teams that provide patient-centered care to reduce annual costs while improving outcomes and care experiences. There is an opportunity to move forward to build on the array of new federal support for Medicaid and authority for Medicare to innovate that is part of the ACA legislation. Combining policies with a strategic focus offers the opportunity to catalyze action. Strategic payment and information support that align incentives have the potential for rapid spread if Medicare is able to partner with care systems and state Medicaid initiatives. At the same time, the private sector stands to benefit to the extent that private insurers join with public payers to spur further innovation and improved local health care systems. **Read the entire report here**.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders.

About the Authors and Acknowledgements

John Holahan is the Center Director and Stacey McMorrow is a Research Associate in the Urban Institute's Health Policy Center. Cathy Schoen is Senior Vice President for Policy, Research and Evaluation at The Commonwealth Fund. The research in this paper was funded by the Commonwealth Fund and Urban Institute general support funds. The authors are appreciative of the comments of Robert Berenson, Judy Feder, Stuart Guterman and Stephen Zuckerman.