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To: Third Way

From: Actuarial Research Corporation

Subject: Final Scoring Memo: Medical Homes

Date: March 11, 2015

Policy Background

Background information on the policy issue is described below and comes from Third Way's specifications for modeling the medical home proposal.[1]

> Emergency room visits often represent failure in health care. Medicare patients could avoid three of every five trips to the ER if they had better routine care. Numerous patients in the ER with an asthma attack, pneumonia, or back pain, for example, could have likely avoided costly and invasive treatment if they kept up with regular care. They would also avoid unnecessary hospitalizations. Under this proposal, Medicare and states (through multi-payer initiatives) would adopt medical homes that provide more primary care services for high-risk patients to prevent the need for expensive health care services. That would give consumers and health plans the opportunity to select providers based on quality and pricing metrics. Medicare will pay for medical homes in cases where they are cost effective like patients identified as high-risk in the GRACE study.

This analysis looks at expanding the medical homes policy to Medicaid, exchange-based and employment-based plans. Modeling specifications for expanding Medicare policies to the under 65 population are from Third Way.[2]

> For Medicaid, states would be required to adopt the same policy as Medicare's. In the private sector, doctors receiving payments for medical homes would be required to participate in multi-payer initiatives. Medicare would either lead or support these states-based initiatives. The result would be that all payers in all states would have the opportunity to participate.

The estimates of projected medical home savings are shown in Table 1. In summary, projected savings to Medicare total $89.1 billion, projected savings to Medicaid total $98.9 billion, projected savings to private health insurance (PHI) total $29.5 billion and projected savings to out-of-pocket (OOP) total $12.3 billion over the ten-year period (2015-2024).

Estimation Process and Results

Medicare

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[1] D. Kendall email communication "specs for scoring initial three Third Way proposals," August 1, 2014. Attachment: "Specs for modeling-ARC.doc."

[2] D. Kendall email communication "Re: Thoughts on specs for Bundling option," November 5, 2014. Attachment: "ARC-Extending Third Way's Medicare Policies to under-65.doc."

The total FFS Medicare enrollment estimates are derived from CMS projections. The projection of FFS high-risk beneficiaries assumes that 24% of FFS Medicare beneficiaries are high-risk, and this is constant throughout the 10-year time frame. We assume that 5% of those high-risk beneficiaries are identified and enrolled in GRACE each year, yielding a participation rate that grows to 50% of high risk beneficiaries over the ten-year period (2015-2024).

To estimate the annual projected savings per patient in GRACE, we divided the two-year savings estimate of $877 (Third Way 10Sept memo) into an annual estimate for 2004. For each subsequent year, we adjusted the annual savings estimate by the percent change in per capita national health expenditures through 2024. The total savings are calculated by taking the annual savings estimate times the high-risk beneficiaries participating in GRACE.

We included additional savings to Medicare (net of assumed overlap with GRACE intervention) from other medical home initiatives based on ARC analyses for The Commonwealth Fund. Based on participation rates and projected savings from these analyses, we assumed an overlap of 80% between the GRACE intervention and the CMWF medical home initiative with respect to the high-risk beneficiaries.

ARC developed the previous estimated impacts in two steps.[3] First, additional costs associated with the medical homes were generated, using illustrative participation rates from the specifications for some years, and interpolated values for the rest. The basic participation assumptions illustrated a case with 25 percent of Medicare enrollees designating a primary care provider within the first three years, 50 percent within five years, and 75 percent within eight years. Within these groups, the portion assumed to be in a PCMH rises from 12 percent in 2014 to 67 percent by 2023. Costs were the product of the potential population times the participation rate times the specified additional payments to be made per participant.

Second, the savings by payer were generated by applying savings rates consistent with Iowa experience[4] to the baseline spending for the assumed population in a medical home. For the population only registering with a primary care provider, the savings assumption is reduced, reflecting the substantially diminished expectations of coordination for this arrangement, relative to a medical home. The net cost change was then the savings minus the additional costs of the incentives. The savings for private payers, employers, and households were based on the implied reductions in Medicare costs, and reflected the lower cost-sharing leading to lower employer and household supplemental insurance costs.

Adding the savings generated through CMWF analyses to the illustrative estimates of the GRACE intervention expansion generates total projected savings to Medicare of $89.1 billion over ten years.

Medicaid

ARC followed a similar path for analysis to expand this policy to the under 65 population. For the Medicaid population, we utilized estimates derived from CMS projections. We assumed the percent of Medicaid enrollees that are high-risk is smaller than the percent of Medicare enrollees that are high-risk. We adjust the assumption of high-risk Medicare FFS by a factor of 0.5 and assume this is constant throughout the 10-year time frame. We

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[3] Details of the CMWF policy specifications and estimated impacts can be found here: *Mays, J., Waldo, D., Socarras, R. and Brenner, M. (2013). "Technical Report Modeling the Impact of Health Care Payment, Financing, and System Reforms." Actuarial Research Corporation prepared for The Commonwealth Fund. Access: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Jan/ARC_technical_report_modeling_impact_of_reforms.pdf*

[4] Momany, E., Flach,S., Nelson, F. and Damiano, P. (2006). A Cost Analysis of the Iowa Medicaid Primary Care Case Management Program. Health Research and Educational Trust. Health Services Research 41:4, Part 1.

kept the assumption that five percent of those high-risk beneficiaries are identified and enrolled in GRACE each year the same. This gives us a participation rate that grows to 50% of high risk Medicaid beneficiaries over the ten-year period (2015-2024). We also utilized the same savings assumption per patient from the Medicare analysis for the Medicaid population.

We included additional savings to Medicaid (net of assumed overlap with GRACE intervention) from other medical home initiatives based on ARC analyses for The Commonwealth Fund. Based on participation rates and projected savings from ARC analyses on medical homes we assumed the same overlap of 80% between the GRACE intervention and the CMWF medical home initiative with respect to the high-risk beneficiaries.

Specifically for the Medicaid population, the illustrative projected savings for the GRACE intervention expansion total $22.4 billion over the ten-year period (2015-2024), and including illustrative savings to Medicaid from other medical home initiatives produces a total projected medical home savings estimate of $98.9 billion over the ten-year period (2015-2024). We estimated the portion of Medicaid savings by the federal government and by states using the average Federal Medical Assistance Percentage (FMAP) for states in FY2015 (59%).[5] Of the $98.9 billion in savings to Medicaid, the federal share is $58.6 billion and the state share is $40.4 billion.

Private Health Insurance

For the private health insurance population, we included population estimates of ESI and exchange enrollment, which are derived from CMS projections. We adjusted the percent of the population that is high-risk by 0.25, based on the assumption that the under 65 population is healthier, with fewer high risk people to enroll in the program. The assumption that five percent of those high-risk beneficiaries are identified and enrolled in GRACE each year is kept the same in the PHI population, as it is in Medicare and Medicaid. This gives us a participation rate that grows to 50% of high risk PHI enrollees over the ten-year period (2015-2024). We also utilized the same savings assumption per patient from the Medicare analysis for the PHI population.[6]

The illustrative projected savings for the GRACE intervention expansion to PHI total $29.5 billion over the ten-year period (2015-2024).

Out-of-Pocket

To estimate the effect of the medical home policy on OOP spending, we used an estimate of how much OOP is associated with each dollar of payment through Medicare, Medicaid and PHI. The assumed distribution of OOP savings is as follows: 5% of total Medicare savings, 2% of total Medicaid savings and 20% of total PHI savings. Projected OOP savings total $12.3 billion over ten years.

Limitations

A recent policy planning to pay for the coordination of care for Medicare beneficiaries with chronic conditions is not incorporated in the baseline. Starting in January 2015, Medicare will pay providers to manage the care of beneficiaries with two or more chronic conditions. The baseline has not been adjusted to account for any effect this may have on medical home savings.

[5] Average FMAP percentage for total US (51). Accessed: http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

[6] Since the CMWF analysis did not include any savings from the PHI population, the total savings presented in Table 1 are solely from the GRACE analysis, with no assumed overlap.

ARC also explored the current multi-payer demonstrations on medical homes. Centers for Medicare and Medicaid Services (CMS) is currently implementing demonstrations supporting patient-centered medical homes. However, these initiatives are ongoing and no results have been published to date. The results of these demonstrations could impact the savings estimates and would provide updated information on the possible impacts of medical homes.[7]

[7] CMS innovation models on primary care transformation can be found here: http://innovation.cms.gov/initiatives/index.html#views=models&key=primary%20care%20transformation

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Final Estimates for Third Way

Estimated change in spending due to Medical Homes

ARC

Table 1: Estimated change in spending due to Medical Homes by payer ($ in billions, by fiscal year)

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2015-2024
Medicare	-1.8	-2.4	-3.6	-5.4	-7.1	-9.4	-11.8	-13.3	-15.7	-18.6	-89.1
Medicaid-federal	-1.7	-2.1	-3.0	-4.0	-5.0	-6.3	-7.5	-8.3	-9.6	-11.1	-58.6
total federal	-3.5	-4.6	-6.5	-9.4	-12.1	-15.7	-19.3	-21.5	-25.3	-29.7	-147.6
Medicaid-state	-1.2	-1.5	-2.0	-2.8	-3.5	-4.3	-5.2	-5.7	-6.6	-7.7	-40.4
Private health insurance	-0.4	-0.8	-1.3	-1.8	-2.4	-3.0	-3.7	-4.5	-5.4	-6.3	-29.5
Out-of-pocket spending	-0.2	-0.4	-0.5	-0.8	-1.0	-1.3	-1.6	-1.8	-2.2	-2.6	-12.3
total-Medicare, Medicaid, PHI + OOP	-5.3	-7.2	-10.4	-14.7	-19.0	-24.3	-29.9	-33.6	-39.5	-46.1	-229.8