

Duals Integration Fiscal Projection: Framework and Methods

Objective

The Elevance Health Public Policy Institute commissioned ATI Advisory to create a model that estimates the potential impact on state Medicaid spending of increasing Medicare–Medicaid integration for dually eligible beneficiaries. Specifically, the model allows Elevance Health to project how exclusive alignment in Special Needs Plans (SNPs) and expanding enrollment in Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) impacts state-specific Medicaid utilization and expenditures.

Conceptual Framework

The model is based on a framework in which greater integration between Medicare and Medicaid reduces fragmentation and improves care coordination, leading to changes in utilization and spending. Medicaid savings are generated by two complementary policy pathways, including increased Medicare–Medicaid integration through aligned D-SNP models and expanded enrollment in Medicaid managed care for dual eligible beneficiaries and other populations.

There are three primary mechanisms driving Medicaid savings in the model:

1. **Long-Term Services and Supports (LTSS) Rebalancing**
Integrated care models are associated with increased use of home- and community-based services (HCBS) and reduced reliance on institutional care such as nursing facilities.
2. **Improved Physical Health Management**
Better coordination through managed care expansion and/or across Medicare and Medicaid services reduces avoidable emergency department visits and hospitalizations.
3. **Reduction in Inappropriate or Duplicative Spending with Expanding Managed Care**
Alignment of financing and oversight reduces duplicate payments, inappropriate payment of cost-sharing, and other inefficiencies.

These mechanisms reflect established evidence that integrated care can reduce duplication, improve care coordination, and shift utilization toward lower-cost settings. The model does not account for any costs or savings for behavioral health services associated with integration due to the lack of evidence and data available.

Data Sources and Evidence Base

Table 1 below provides the publicly available data sources used to establish baseline conditions and estimate impacts.

Table 1. Model Data Sources

<p>Medicare enrollment and coverage data</p> <p>Used to identify full and partial dual eligible populations and baseline Medicare coverage types (e.g., Fee-for-Service (FFS), MA, D-SNPs).</p>	<ul style="list-style-type: none"> • Medicare Master Beneficiary Summary File (MBSF) • Medicare Monthly Enrollment File (MMEF) • Medicare Advantage (MA) plan enrollment and characteristics data (including D-SNP type and alignment status) • Plan Benefit Package (PBP) data (for identifying D-SNP types and benefits)
<p>Medicaid enrollment and managed care data</p> <p>Used to estimate Medicaid-only populations and baseline managed care penetration.</p>	<ul style="list-style-type: none"> • T-MSIS State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data (TAF/ADM files) • CMS Medicaid managed care enrollment reports (by state, plan, and program type) • State-level managed care program data (LTSS and Comprehensive Managed Care participation)
<p>LTSS utilization and spending data</p> <p>Primarily derived from CMS-supported datasets (e.g., LTSS Users and Expenditures reports) and used to estimate baseline trends and the effects of integration on HCBS and nursing facility use and costs.</p>	<ul style="list-style-type: none"> • CMS/Mathematica LTSS Users and Expenditures Report (2023) • HRSA Long-Term Services and Supports Demand Projections (2022–2037) • MACPAC nursing facility payment data (state-specific per diem estimates) • Bureau of Labor Statistics (BLS) price indices: <ul style="list-style-type: none"> ◦ CPI-U for home-based care (HCBS inflation) ◦ CPI-U for nursing home services • State-specific waiver and HCBS program data
<p>Physical health utilization and spending data</p> <p>Used to estimate baseline trends and the effects of integration and managed care on utilization and spending.</p>	<ul style="list-style-type: none"> • MA Encounter Data (100% MA encounter dataset, 2023) • Medical Expenditure Panel Survey (MEPS), 2023 (Medicaid spending per event) • CDC National Center for Health Statistics: <ul style="list-style-type: none"> ◦ Emergency department visit rates for Medicaid populations • Bureau of Economic Analysis: <ul style="list-style-type: none"> ◦ Regional Medical Care Price Index (state-level cost adjustments) • Elevance Health encounter data
<p>Evidence base and program integrity data</p> <p>Used to estimate the effects of integration and managed care on utilization and spending.</p>	<ul style="list-style-type: none"> • Peer-reviewed literature on Medicare–Medicaid integration (e.g., JAMA Health Forum, Journal of Aging & Social Policy) • CMS Financial Alignment Initiative and Managed LTSS (MLTSS) evaluation reports • CMS Program Integrity Reviews (managed care overpayment and recovery rates) • State-specific program evaluations (e.g., SCO, MLTSS demonstrations)

Note. See Bibliography for full list of sources.

Analytic Approach

The model projects state Medicaid spending under a baseline scenario and compares it to estimated spending under one or more integration scenarios over a 10-year period (e.g., 2026–2035). Each scenario reflects changes in enrollment into integrated D-SNPs and, where applicable, expansions in Medicaid managed care or MLTSS.

Step 1: Project Baseline Population and Spending

The model first projects the size and characteristics of key populations, including:

- Full-benefit dual eligible beneficiaries
- Partial dual beneficiaries
- Medicaid-only beneficiaries

Note. Population growth is based on federal projections (e.g., Medicare and Medicaid enrollment trends), with baseline distributions of coverage (e.g., Medicare Advantage, D-SNPs, FFS) held constant over time.

Step 2: Define Scenario(s) for Expansion of Integration

The model allows users to define integration scenarios by specifying:

- Type of integrated plan (e.g., HIDE, FIDE, or EAE D-SNPs)
- Timing of implementation
- Target enrollment levels (penetration rates)
- Source of new enrollment (e.g., Medicare FFS, MA, existing D-SNPs)

Step 3: Add Optional, Complimentary Policy Changes

- Implementation of MLTSS for dual eligible beneficiaries only or include other Medicaid populations
- Expansion of comprehensive Medicaid managed care to include dual eligible beneficiaries

Note. These optional changes are intended for states that do not currently leverage these policies.

Step 4: Estimate Utilization Changes

The model applies evidence-based estimates of how integration affects utilization across three domains:

1. LTSS Utilization

MLTSS expansion and/or integration is estimated to:

- Increase HCBS use
- Reduce nursing facility utilization

2. Physical Health Utilization

Comprehensive managed care expansion and more integrated plans are associated with:

- Fewer emergency department visits
- Fewer inpatient admissions

3. Inappropriate Payments

The model estimates reductions related to expanding managed care in:

- Duplicate Medicare–Medicaid payments
- Excess cost-sharing payments
- Fraud, waste, and abuse

Note. These effects are based on program integrity findings from CMS. As evidence in this area grows, the model includes an option for user-defined assumptions regarding avoidable spending.

Step 5: Translate Changes to Medicaid Fiscal Impact

For each scenario, changes in utilization are converted into Medicaid spending impacts:

- **LTSS spending** is calculated using per-user-per-month costs for HCBS and nursing facility care.
- **Physical health spending** is based on Medicaid's share of costs per event (e.g., ED visits, hospital admissions) with adjustments for the state-specific percentage of Medicare crossover claims that are expected to receive no Medicaid payment under the "lesser of" policy. State-specific percentages for ED and hospital admissions were estimated using Elevance Health encounter data.
- **Program integrity savings** are calculated as avoided inappropriate payments.

Key Assumptions and Limitations

The analytic approach reflects Elevance Health's inputs into the model, as described above. Additionally, this analysis is subject to several important considerations:

- **Enrollment dynamics:** Savings vary significantly depending on where new integrated enrollees come from (e.g., Medicare FFS vs existing D-SNPs).
- **Evidence variability:** Estimates of LTSS and managed care effects differ across studies and states; the model uses state-specific data and evidence where available and otherwise conservative estimates are selected to avoid overstating potential savings.
- **State variation:** Results will vary by state depending on baseline integration levels, managed care penetration, and LTSS systems.
- **Implementation resources:** The analysis does not estimate the administrative costs associated with implementing new Medicaid benefits or delivery system reforms as these costs are highly state-specific and may include systems changes, existing staffing, contract management, enrollment operations, and/or beneficiary communication activities.
- **Modeling approach:** Estimates are based on observed differences and literature rather than fully causal experimental designs.

Despite these considerations, the model provides a transparent and flexible framework for states to evaluate the potential long-term fiscal impact on state Medicaid expenditures of changes in care delivery and utilization resulting from enhancements in Medicare–Medicaid integration.

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