



## *Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities*

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# Overview

- Opening Comments
- Study Design and Findings
- Policy Implications

## Who is ACAP?

- National trade association of safety net health plans focused primarily on Medicaid, SCHIP and Medicare
- Not-for-profit or owned by not-for-profits, such as hospitals or CHC's
- 42 plans serving over 6 million public health insurance enrollees
- ACAP plans cover 25% of all Medicaid beneficiaries in Medicaid managed care

## 42 Plans Representing 6M Lives In 23 States

*Affinity Health Plan (NY)*

Alameda Alliance for Health (CA)

AmeriHealth Mercy Health Plan (PA)

Boston Medical Center HealthNet (MA)

CalOptima (CA)

*CareOregon (OR)*

*CareSource Michigan (MI)*

CareSource (OH)

Carolina Crescent Health Plan (SC)

Children's Community Health Plan (WI)

Children's Mercy Family Health Plan (KS)

Children's Mercy Family Health Plan (MO)

*Colorado Access (CO)*

Commonwealth Care Alliance (MA)

*Community Health Network of  
Connecticut (CT)*

*Community Health Plan (WA)*

Contra Costa Health Plan (CA)

Denver Health Medical Plan (CO)

Health Plan of San Mateo (CA)

Health Plus (NY)

\*Associate Member

*Plans in Italics are original CHC plans*

*Health Right, Inc (DC)*

Health Services for Children with Special  
Needs (DC)

Horizon NJ Health (NJ)

*Hudson Health Plan (NY)*

Inland Empire Health Plan (CA)

LA Care Health Plan (CA)

Maricopa Health Plan (AZ)

Maryland Community Health Systems\* (MD)

MDwise (IN)

Metropolitan Health Plan (MN)

Monroe Plan for Medical Care, Inc. (NY)

*Neighborhood Health Plan (MA)*

*Neighborhood Health Plan of Rhode Island  
(RI)*

Network Health (MA)

Prestige Health Choice (FL)

San Francisco Health Plan (CA)

Santa Clara Family Health Plan (CA)

*Total Care (NY)*

University Family Care (AZ)

UPMC For You (PA)

Virginia Premier Health Plan, Inc (VA)

VNS CHOICE (NY)

## 21 ACAP SNP Plans

Affinity Health Plan (NY)

Alameda Alliance (CA)

CalOptima (CA)

CareOregon (OR)

Care Source (OH)

Colorado Access (CO)

Commonwealth Care Alliance (MA)

Community Health Plan (WA)

Contra Costa Health Plan (CA)

Denver Health Medical Plan (CO)

Health Plan of San Mateo (CA)

Horizon NJ Health (NJ)

Inland Empire Health Plan (CA)

LA Care (CA)

Metropolitan Health Plan (MN)

Neighborhood Health Plan of Rhode  
Island (RI)

Santa Clara Family Health Plan (CA)

Virginia Premier (VA)

University Family Care (AZ)

UPMC For You (PA)

VNS CHOICE (NY)

## CMS Integrated Care Initiative

- “The overall goal of integrated care is to provide the full array of Medicare and Medicaid benefits through a single delivery system that will provide quality of care for dual eligible beneficiaries, better care coordination and fewer administrative burdens.”

*From: CMS Integrated Care Initiative web site*

# Health Coverage for Duals

## Dominant (non)system

- Consumer acts a “general contractor” to manage these pieces:
  - Medicare FFS
  - Medicare Part D
  - Medicare Supplement or payment of cost sharing by states
  - Medicaid Acute Care (FFS or in a plan )
  - Medicaid LTC or HCBS
  - Mental Health
  - Medicaid drugs

## Integrated Care Model

- Care manager acts as the concierge or navigator within a plan that covers all services across Medicare and Medicaid and acute and long term care
- Plan ideally provides:
  - Assessment of need and individualized, chronic care plan
  - One ID, consolidated notices, appeals and grievances

# Increasing Use of the Capitated Model for Dual Eligibles

- This study by the Lewin Group is co-funded by Medicaid Health Plans of America and the Association for Community Affiliated Health Plans
- Estimates nationwide and state-by-state potential savings if dual eligibles were served in a fully integrated capitated setting
  - Managed Care Organizations would receive capitated payment from both Medicaid and Medicare and would be responsible for coordinating all services
- This study is a natural follow on to the 2006 Lewin Group report “Medicaid Capitation Expansion’s Potential Cost Savings”
  - The earlier study focused on Medicaid-only subgroups
  - This new study focuses entirely on dual eligibles



## Policy Advantages of Using a Fully Integrated Model for Dual Eligibles Are Compelling

- A well-designed integrated care model should improve dual eligibles' clinical outcomes relative to the unmanaged fee-for-service setting
  - A recent Wennberg study indicates that nearly 1/3 of spending on chronically ill populations is unnecessary, and that improving care would likely *lower* costs
- Large-scale savings are available
  - Each percentage point reduction nationwide will yield more than \$70 billion in savings across the 15 year timeframe
  - Rebalancing LTC spending may help states avoid other budget cuts

# Study Design and Findings

## Estimated CY2008 Spending On Duals: \$239 Billion This Level Of Spending Is...

- 40% of the nations' Medicaid spending
- 25% of Medicare expenditures
  - *The total spending for duals is effectively hidden in the budgets of two programs with no clear accountability for spending, access or quality of care*
- 10% of National Health Spending
- Larger than the annual revenue of all but two U.S. corporations (Wal-Mart and Exxon Mobil)
- Three times the Federal budget for the Department of Education and the Department of Energy combined
- Approximately 1.6% of GDP

# Overview of Cost Savings Estimate Methodology

- Establish CY2006 baseline of dual eligible spending in each state
  - Includes Medicaid and Medicare “sides”
  - Includes acute and long-term care spending
- Trend costs to the 15 year timeframe 2010-2024
  - Estimates costs under existing policies
- Model impacts of full reliance on capitated approach
  - Year by year
  - State by state
  - Medicare and Medicaid components, and combined total

## Baseline Costs, 2005

### Estimated Actual 2005 Expenditures, Dual Eligibles

- Medicaid: \$121.7 billion
- Medicare: \$64.5 billion
- Total: \$186.2 billion

### Adjusted figures after moving Medicaid pharmacy costs (\$23 billion) to Medicare to simulate Part D

- Medicaid: \$98.7 billion (53% of total)
- Medicare: \$87.5 billion (47% of total)
- Total: \$186.2 billion

## Cost Trending Under Existing Policies

- Dual eligibles costs will increase steadily for two reasons
  - Increase in number of eligibles – estimated growth is from 7.5 million persons in 2005 to 9.9 million in 2024 (1.5% annual growth)
  - Increase in per capita costs – annual trend of 7% assumed for both Medicare and Medicaid
- Annual spending is estimated to reach \$777 billion in 2024 – more than three times current levels
  - Across 15 year period 2010-2024, spending on dual eligibles is estimated to be *\$7 trillion*
  - Annual per capita costs estimated to rise from approximately \$25,000 in 2005 to nearly \$80,000 in 2024
  - Study presents these figures state by state, year by year

## Estimated Medical Cost Impacts of Capitation

- Inpatient per capita costs usually reduced by 20% (efforts were made to leave IGTs, federal maximization programs unaffected)
- “Impactable” nursing home costs reduced by 25%, but little nursing home spending is initially impactable (overall nursing home costs reduced 1.3% in Year 1, growing to 13.5% in Year 15)
  - Yearly home health costs assumed to *increase* by same percentage that nursing home costs decrease
- Year 1 ICF/MR costs reduced by 2%; growing to 7.5% by Year 11
- Other Medicaid costs reduced by 5%, no change assumed for personal support services
- Medicare acute care costs reduced by 15%
- Pharmacy costs reduced by 15%

## Administrative Cost Allocations

- Administration and profit are collectively assumed to represent 7% of total medical costs
- Approximate estimates are 5% of medical costs for administration, 2% for profit or operating margin
- The relatively low percentage allocation for administration is viable due to large dollar volume of “pass through” nursing home costs and the very large per capita medical cost for other services



# Summary of Nationwide Findings

National Summary of Total Savings						
Year	Medicaid Savings (Loss)		Medicare Savings (Loss)		Combined Savings (Loss)	
	Total Savings	Percentage	Total Savings	Percentage	Total Savings	Percentage
2010	-\$2,591,431,795	-2.0%	\$9,686,992,653	7.3%	\$7,095,560,857	2.7%
2011	-\$2,246,404,505	-1.6%	\$10,614,681,672	7.3%	\$8,368,277,167	2.9%
2012	-\$1,869,602,965	-1.2%	\$11,625,866,546	7.4%	\$9,756,263,582	3.2%
2013	-\$1,458,560,416	-0.9%	\$12,727,902,201	7.5%	\$11,269,341,785	3.4%
2014	-\$1,012,917,830	-0.6%	\$13,928,690,815	7.5%	\$12,915,772,985	3.6%
2015	-\$8,233,809	0.0%	\$15,258,234,821	7.6%	\$15,250,001,012	3.9%
2016	\$550,378,970	0.3%	\$16,684,793,189	7.6%	\$17,235,172,158	4.1%
2017	\$1,144,705,071	0.5%	\$18,238,186,532	7.7%	\$19,382,891,603	4.3%
2018	\$1,299,303,675	0.6%	\$19,910,010,447	7.7%	\$21,209,314,122	4.4%
2019	\$1,454,022,566	0.6%	\$21,730,215,583	7.8%	\$23,184,238,149	4.4%
2020	\$2,250,796,423	0.8%	\$23,738,052,250	7.8%	\$25,988,848,673	4.6%
2021	\$2,434,595,099	0.9%	\$25,896,401,882	7.8%	\$28,330,996,981	4.6%
2022	\$2,617,013,178	0.9%	\$28,245,640,570	7.9%	\$30,862,653,748	4.6%
2023	\$2,797,145,181	0.8%	\$30,802,458,537	7.9%	\$33,599,603,717	4.7%
2024	\$2,965,383,197	0.8%	\$33,584,644,812	7.9%	\$36,550,028,009	4.7%
5 Year Total, 2010-2014	-\$9,178,917,511	-1.2%	\$58,584,133,887	7.4%	\$49,405,216,376	3.2%
5 Year Total, 2015-2019	\$4,440,176,472	0.4%	\$91,821,440,572	7.7%	\$96,261,617,044	4.2%
5 Year Total, 2020-2024	\$13,064,933,078	0.8%	\$142,267,198,050	7.9%	\$155,332,131,129	4.6%
15 Year Total, 2010-2024	\$8,326,192,040	0.2%	\$292,672,772,509	7.7%	\$300,998,964,549	4.2%

# Summary of Nationwide Savings Findings

- Immediate savings of 2.7% for populations put into integrated capitation model (across Medicare and Medicaid funds)
- Savings entirely occur on Medicare “side” during first five years (creates policy challenges so that states can avoid Medicaid losses during this timeframe)
- Savings compound favorably over time, reaching 4.7% of baseline costs by Year 15

# Potential Savings in Five Year Increments

- 2010-2014
  - \$ 50 billion
- 2015-2019
  - An additional \$96 billion
- 2019-2024
  - An additional \$155 billion
- GRAND TOTAL: 15 year Period Exceeds \$300 Billion

## Large-Scale Dollar Savings Would Occur At State Level

- Table below summarizes savings impacts in a large state (Ohio), medium-sized state (Virginia) and a small state (South Dakota)
- The *smallest* cumulative savings across 15 years is \$327 million (Wyoming); the largest savings is \$34 *billion* in California
- Full report shows Federal and State share of project savings in each state

State	Total Savings 2010-2014	Total Savings 2015-2019	Total Savings 2020-2024
Ohio	\$1,393,584,406	\$3,501,752,472	\$5,948,592,506
Virginia	\$961,777,772	\$1,847,126,425	\$2,944,675,321
South Dakota	\$80,656,702	\$199,531,723	\$343,069,940

Figures shown represent total savings across Medicare and Medicaid

# Policy Implications

## Several Factors Limit Use of Capitation

- Comprehensive benefits in FFS setting for dual eligibles; presumption that FFS meets beneficiaries needs
- Absence of clear Medicaid policy on dual integration
- Lack of strong state, consistent leadership with an understanding of how poor chronic care management leads to premature/inappropriate use of institutional care
- Short term authorizations for Medicare Special Needs Plans creates perception of instability
- Medicare risk adjustment not refined enough for these initiatives
- Inability for states to share in overall savings
  - Early year cost savings typically accrue only to Medicare, with states not earning Medicaid savings until out-years
  - However, states determine whether capitated programs for duals are developed and implemented
  - State staff for planning are diverted to immediate budget crisis

“Payment based on capitation, rather than fee-for-service, can encourage efficiency and enable a delivery system to use savings from reduced hospitalizations or other acute-care services to offset costs of coordination and long-term care. However, capitation also can reward an organization that delivers too little service—delivering less but not better care and simply reaping greater profits... Efforts to encourage coordinated care must therefore begin with the development and assurance of effective delivery arrangements—not with payment of a capitation rate.

Testimony of Judith Feder, Ph.D. Professor of Public Policy, Georgetown University and Senior Fellow, Center for American Progress and Harriet L. Komisar, Ph.D. Research Professor, Georgetown University on Health Reform in an Aging America, Special Committee on Aging, U.S. Senate March 4, 2009

## Policy Issue: Achieving Significant Program Scale

- Model assumes all full dual populations are mandatorily enrolled for all acute and long term care services across both Medicare and Medicaid services
- “Opt-out options” may be more politically feasible than mandatory approaches; have worked well in some states
- Phase-in of populations may allow more movement towards integrated care and time to develop appropriate care management models
- Phase-in or carve-out of LTC services, especially some specialized home and community-based services, may be appropriate in some states



## Policy Issue: Incentives for States

- For states to prioritize pursuing these programs, they need access to the overall savings that occur
  - States are unlikely to “invest” in capitated model for 5 years before realizing savings on duals alone
  - Creative arrangement with CMS (e.g. 50/50 sharing of overall savings between state and federal government) is likely needed to spur significant growth of capitation
  - Grants that cover start up costs to develop rates, contracts, beneficiary education would help
  - Allocate the Medicare portion of dual eligibles’ costs to states, then allow states to implement fully integrated model with combined pool of funds (*or the reverse swap?*)

## Federal Reform Needed to Promote Integration

- Federal oversight and accountability for the cost, quality and access of dual eligibles
- Long-term reauthorization of SNP authority
- Payment appropriate to the risk of the member
- Incentives for states to increase integrated care for dual eligibles

## Contact Info

***Mary Kennedy***

***ACAP Director for Medicare Programs***

Phone: 202.701.4749

Email: [mkennedy@communityplans.net](mailto:mkennedy@communityplans.net)

See ACAP website at:

[www.communityplans.net](http://www.communityplans.net)