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

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EXECUTIVE SUMMARY

Approximately 8 million Americans are simultaneously covered by Medicare and Medicaid. This population, commonly referred to as "dual eligibles," accounts for approximately 40% of the nation's Medicaid spending as well as approximately 25% of Medicare expenditures.[1] Due to steady increases in the size of the dual eligible population and assuming typical per capita cost escalation occurs, total annual spending on duals is projected to be more than $775 billion as of the year 2024, at which point annual per capita costs are expected to approach $80,000.

Notwithstanding a wide range of public sector and private sector efforts to utilize coordinated care more extensively for dual eligibles, the vast majority of current spending for dual eligibles occurs in the traditional, unmanaged FFS setting. As of 2005, 6% of Medicaid dual eligibles' spending was paid via capitation. Similarly, less than 15% of Medicare's dual eligible spending currently occurs via capitated payments.

This report estimates that large-scale savings can be achieved in transitioning the dual eligible population into a fully integrated, capitated setting. The clinical and eligibility characteristics of the dual eligibles population are exceptionally well-matched to the strengths of a fully integrated care program operated by at-risk health plans. For any given dual eligibles subgroup moved into a capitated setting, encompassing the fully benefits package of Medicare and Medicaid covered services, we estimate initial, CY2010 net savings (across the Medicare and Medicaid programs) of approximately 3% per year, growing to nearly 5% per year as of CY2024. Given the large baseline size of the per capita spending on dual eligibles (more than $7 *trillion* nationwide across the upcoming 15 years), these relatively modest percentage savings translate into rather massive dollar amounts. Nationally, each percentage point reduction in dual eligibles' spending will yield more than $70 billion in savings across the 2010-2024 timeframe.

Existing policies inhibit large-scale enrollment of dual eligibles into a fully integrated setting. One key barrier, as delineated herein, is that the early-year savings from an integrated program primarily (if not entirely) accrue to the Medicare program, which are savings that states cannot access. Conversely, states share in the net costs that initially occur on the Medicaid "side."

Another barrier is that dual eligibles themselves have little incentive to voluntarily enroll in MCOs. In the FFS setting, dual eligibles receive an extraordinarily comprehensive benefits package at essentially no cost. While dual eligibles enrolled in capitated programs value the outreach, case management and other non-financial benefits they receive, these benefits are not often readily apparent to the dual eligible population prior to enrolling. Also, while many states have used mandatory enrollment models for more than a decade to achieve large-scale

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[1] Lewin tabulations using CMS MSIS data indicate that during 2005, Medicaid spending on dual eligibles totaled $122 billion, or 44.6% of total Medicaid spending of $273 billion. With the 2006 implementation of Medicare Part D, Medicare becomes the primary payer for dual eligibles' prescription drugs. This shifts approximately $23 billion of claims expense from Medicaid to Medicare and lowers dual eligibles' share of Medicaid expenditures to 39.5%. However, states continue to contribute to the dual eligibles pharmacy costs through a financing mechanism referred to as the "clawback." When these clawback funds are included, dual eligibles represent approximately 42% of total Medicaid expenditures.

enrollment of their Medicaid populations into MCOs, it is not currently possible to mandate dual eligibles to enroll in a health plan on the Medicare "side." Medicare Advantage health plans – even those special needs plans targeting dual eligibles – have often experienced modest enrollment despite often making considerable marketing investments.

The key federal policy changes needed are summarized below:

1) Permit states to enroll all dual eligibles in targeted counties into a coordinated care setting, with a given dual eligible being enrolled in the health plan for both Medicare and Medicaid services. Enrollment would be achieved through a mandatory enrollment model or through an opt-out model as occurred on a large scale during 2006 in the Louisville, Kentucky area and in Minnesota.

2) Permit states to share 50/50 with the federal government in the net savings that occur across the Medicare and Medicaid programs. This change would motivate states to exercise their option to implement these initiatives, given that early-year savings otherwise accrue entirely to the Medicare program.

These policy changes create the opportunity for large-scale coordinated care initiatives tailored to the needs of dual eligibles. There are compelling potential financial and programmatic advantages to utilizing a fully integrated care/coverage model for dual eligibles.

I. INTRODUCTION

Approximately 8 million Americans are simultaneously covered by Medicare and Medicaid. This population, commonly referred to as "dual eligibles," accounts for approximately 40% of the nation's Medicaid spending as well as approximately 25% of Medicare expenditures.[2] Dual eligibles currently account for 10% of all national health expenditures and 1.6% of the nation's Gross Domestic Product (GDP). This population is predominantly served through the traditional fee-for-service (FFS) coverage model.

Because there is separate administration and accountability of the programs, the total cost for dual eligibles across Medicare and Medicaid and state and federal spending is seldom tallied. Also, research suggests that significant opportunities exist to simultaneously lower the costs of care for high-need subgroups and improve the clinical outcomes of the services rendered. A recent report, "The Care of Patients with Severe Chronic Illness: A Report on the Medicare Program by the Dartmouth Atlas Project," asserts that "the Medicare program could reduce current spending by at least 30%, while improving the medical care of most severely ill Americans."[3]

Dual eligibles are typically beset with multiple chronic conditions that may be best served by a coordinated approach to their health and psycho-social needs. However , while Medicaid overall enrolls more than half of its beneficiaries in managed care approaches, dual eligibles are generally excluded in these initiatives. Use of capitation contracting with managed care organizations (MCOs) currently accounts for approximately six percent of Medicaid's spending on dual eligibles, and approximately 15 percent of Medicare's spending on dual eligibles. It is often asserted that a strong care management model is used least where the need for this approach is the greatest.

This study addresses two questions. First, what are the financial implications of enrolling the dual eligible population into the capitated/integrated MCO setting on a comprehensive scale? This report estimates the cost impacts of serving dual eligibles in the capitated setting in each state across a fifteen year timeframe, demonstrating the impacts on Medicaid and Medicare spending, state and federal spending, and overall taxpayer outlays across the two programs.

Second, what are the key program design features and public policy issues that need to be addressed to achieve substantially larger-scale use of the capitated model for the dual eligible population? The report describes the barriers that have prevented more widespread enrollment of dual eligibles into MCOs, and outlines the specific policy-making opportunities to overcome these barriers.

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[2] Lewin tabulations using CMS MSIS data indicate that during 2005, Medicaid spending on dual eligibles totaled $122 billion, or 44.6% of total Medicaid spending of $273 billion. With the 2006 implementation of Medicare Part D, Medicare becomes the primary payer for dual eligibles' prescription drugs. This shifts approximately $23 billion of claims expense from Medicaid to Medicare and lowers dual eligibles' share of Medicaid expenditures to 39.5%. However, states continue to contribute to the dual eligibles pharmacy costs through a financing mechanism referred to as the "clawback." When these clawback funds are included, dual eligibles represent approximately 42% of total Medicaid expenditures.

[3] This study is available online through the following web address:
www.dartmouthatlas.org/press/2006_atlas_press_release.shtm

The Lewin Group (Lewin) has been engaged by the Association of Community Affiliated Plans (ACAP) and the Medicaid Health Plans of America (MHPA) to conduct this engagement. These two organizations co-funded a similar earlier Lewin Group report, "Medicaid Capitation Expansion's Potential Cost Savings," which quantified the savings potential for the non-dual eligible Medicaid population by state and year. Findings from this earlier report are trended to match the timeframe used in this report, and tables in Appendix A of this report present consolidated savings estimates for maximizing the use of the capitated model in the Medicaid program (for all Medicaid recipients still in the fee-for-service setting). Throughout this study, savings impacts are presented across the fifteen year timeframe 2010-2024 for each state.

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II. BACKGROUND -- DUAL ELIGIBLES AND MEDICAID MANAGED CARE

A. Attributes Of The MCO Model Relative To The Needs Of Dual Eligibles

In several fundamental respects, the dual eligible population is well-matched to being served through the capitated model in a manner that achieves clinical improvements and financial savings. These favorable dynamics are summarized below:

- Clinically, dual eligibles are typically afflicted with multiple chronic conditions. A strong, coordinated care model is particularly well-suited to serving persons with complex, chronic conditions.

- The dual eligible population experiences extremely high per capita medical costs in the areas that an integrated coverage model can favorably impact, e.g., inpatient hospital, outpatient hospital, specialist physician, pharmacy, and nursing homes.

- The dual eligible population has relatively stable Medicaid eligibility – the circumstances that lead a person to become dually eligible for Medicaid and Medicare are very unlikely to change. Thus, the MCO community is not burdened with a "revolving door" of enrollment and disenrollment as occurs with the TANF Medicaid population. (There are nonetheless issues with some dual eligibles not obtaining Medicaid eligibility recertification in a timely fashion – which can necessitate a temporary disenrollment and re-enrollment in a capitated setting.)

- Given the eligibility dynamics described above, MCOs often have the opportunity to serve dual eligible enrollees *for the remainder of these persons' lives*. This gives the MCOs a strong incentive to establish an effective working relationship with these enrollees and their caregivers, to develop an individualized care coordination plan tailored to the person's clinical and environmental situation, and to invest in outreach initiatives that can create long-term improvements in health status.

- MCOs have the financial means to make these outreach investments, due to the high baseline medical costs of the dual eligible population (and correspondingly high capitation rates when the Medicare and Medicaid "sides" of the benefits package are combined) – as long as a sizable dual eligible enrollee population enrolls with the plan in a way that minimizes marketing costs.

- Dual eligibles comprise the vast majority of Medicaid long-term care patients. While it is difficult to discharge "already institutionalized" persons back to the community, at-risk MCOs will make significant efforts to retain their enrollees in their homes and other community-based settings, such that nursing home institutionalization can be avoided where possible and appropriate.

It is very much in the MCOs' interest to establish a constructive, positive relationship with their high-need enrollees that leads to greater utilization of preventive and other "front line" health care services that detect health and behavioral problems and avoid the common problem of untreated small problems growing into full-blown health crises (which creates large-scale and unnecessary costs and which often result in tragic and other undesirable clinical outcomes).

Plans have the opportunity to engage members who may be highly motivated once they understand that the health plan's incentives are aligned with the beneficiaries' interest in leading as independent a life as possible.

B. Substantial MCO Expertise Now Exists to Serve Dual Eligibles Effectively

Many MCOs – as well as many state Medicaid agencies – now have extensive experience serving high-need populations through an integrated care model, and the "industry's" sophistication in designing, implementing and overseeing such programs has improved substantially throughout the past decade. Historically, few coordinated care programs for high-need subgroups existed, and the "coordinated care" aspects of these programs focused on assigning individuals to a "medical home" primary care provider, encouraging proper use of the MCO's provider delivery system, and deploying utilization review practices such as prior authorization for expensive services. While these techniques remain in use and of value, current Medicaid MCO programs for high-need subgroups (e.g., the Medicaid-only SSI population) typically go *far* beyond this traditional approach, as summarized below.

- For example, states now often require Medicaid MCOs to demonstrate an effective process for assessing each new high-need enrollee's health care needs, housing situation, family structure and social support system, then developing and continually adjusting individualized treatment and care coordination plans. Care coordination has advanced to provide more individualized care planning and effective approaches to identify emerging health conditions in order to avoid crisis based interventions. Such requirements and coordinated care techniques do not exist in the fee-for-service environment across the acute, chronic and long term care parts of the health system.

- States have also become increasingly adept at putting effective MCO contract requirements in place for high-need subgroups, and monitoring MCO performance aggressively.

States are also experienced at conducting competitive procurements to select those MCOs offering the best technical and price proposals, in setting capitation rates at appropriate levels, in prohibiting MCOs from engaging in individual marketing (instead utilizing objective enrollment broker contractors to facilitate sound choices between the available MCO options), and in using a mandatory enrollment model to deliver administrative economies of scale to the participating MCOs.

In turn, many MCOs have garnered valuable experience serving high need subgroups. The Medicaid MCO industry now has vast experience with the challenges of serving persons who have some or all of the following: multiple chronic conditions; unstable housing; unstable family dynamics; educational, language and cultural barriers to accessing needed care; mental disorders; addictive illnesses, etc.

C. Low MCO Enrollment Of Dual Eligibles Has Occurred To Date

Notwithstanding the favorable attributes of the MCO model with regard to dual eligibles, the emerging expertise of the industry to serve high-need subgroups effectively, and the strong

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desire on the part of MCO industry to serve dual eligibles, the dual eligible population has predominantly remained outside of the managed care setting.

A strong case can be made that, from a public policy perspective, the capitated MCO model is being relied on the least where it is most needed. Table 1 indicates that as of FY2005 only 6% of dual eligibles' Medicaid expenditures occurred through capitation. Only two states, Arizona and Oregon, "capitated" more than 20% of their dual eligibles Medicaid expenditures during 2005.

Table 1. Medicaid Spending and Capitation Spending by Subgroup, FY2005

Eligibility Cohort	Total Medicaid Spending ($ billions)	Capitated Expenditures ($ billions)	Percent Paid Via Capitation
Dual Eligibles	$121.7	$7.3	6.0%
Disabled Medicaid Only	$69.6	$9.4	13.5%
All Other (Includes TANF and TANF-Related)	$81.9	$29.7	36.3%
Total, All Medicaid Subgroups	$273.2	$46.4	17.0%

Source: Lewin tabulations from CMS MSIS Datamart

D. Reasons For Limited Role Of Capitation To Date For Dual Eligibles

There are three key barriers to expanding the role of coordinated care for dual eligibles.

1) **Comprehensive Benefits in Fee-for-Service Setting.** From a dual eligible's perspective, there is no *financial* incentive to enroll in the capitated MCO model. In the commercial and Medicare (non-dual eligible) arenas, the cost-effective attributes of the capitated HMO/MCO model enable these organizations to offer a relatively generous benefits package for a relatively low level of enrollee out-of-pocket costs. Conversely, persons with Medicaid coverage (including dual eligibles) typically receive comprehensive coverage with little or no out-of-pocket costs. Across Medicare and Medicaid coverage, dual eligibles receive an exceptional benefits package funded fully by these public programs, with no monthly premium cost, deductibles, or other out-of-pocket costs. In addition, through the Medicare "side" of their coverage dual eligibles are able to access care from most providers (unlike those covered only by Medicaid, who find many mainstream providers unwilling to accept them). Also, it is difficult for beneficiaries to appreciate, without experiencing it first, the value that care coordinators and other outreach programs can bring. Thus, there is limited incentive for dual eligibles to opt for MCO coverage that involves a restricted provider network and that does not enhance their already comprehensive benefits package.

2) **Absence Of Mandatory Enrollment from Primary Payer.** The fact that there is no financial reason for dual eligibles to switch from the FFS to the MCO setting is something that Medicaid programs have faced for decades with their non-dual eligible subgroups. In this situation, states have found that using a mandatory enrollment model is not only effective, but necessary. Voluntary enrollment models for Medicaid

recipients tend to limit plan size, making it impractical to adequately invest in the care coordination staff that are central to the model. Voluntary models also create a major (and expensive) marketing challenge for the MCO community, and even with extensive marketing Medicaid MCO enrollment has often been modest in voluntary enrollment settings. With regard to dual eligibles, some states have confronted this challenge by mandating enrollment into MCOs. However, Medicare is the primary payer for dual eligibles' acute care services, and CMS has not mandated enrollment of duals into the MCO model on the crucial Medicare "side." In the absence of mandatory enrollment of dual eligibles on *both* the Medicare and Medicaid sides, there are little grounds for optimism that a large portion of the dual eligible population will elect to transition into the capitated setting.[4] Also, when dual eligibles are enrolled in a capitated program only from the Medicaid perspective, the beneficiary still has to select a Medicare drug plan and handle the paperwork and coverage limits on the Medicare side. Medical errors and low levels of adherence are more likely to occur when drugs, for example, can be prescribed and dispensed through multiple systems. Persons who are frail or live with a disability often have a great deal of trouble understanding the benefits and options available to them in the areas most critical to their ability to live as independently as possible -- home health, physical and occupational therapy and medical supplies and equipment. And despite, the best efforts of states to offer home and community based services, vulnerable people who are hospitalized and sent to rehabilitation are often on their own in managing the transitions to and out of those facilities. The most likely pathway to a permanent nursing home placement is from the hospital or the rehab facility. Care Coordination mangers are crucial at these moments.

3) **Inability For States To Share In Overall Savings.** As depicted in detail in this report's financial projections, dual eligible MCO enrollees should create large-scale savings in overall Medicare and Medicaid expenditures. However, these savings accrue entirely to the Medicare program throughout the first several years of program implementation. On the Medicaid side, it is unlikely that savings will occur during the first several years of program implementation; conversely it is likely that states will experience initial net Medicaid losses when they transition dual eligibles into an MCO setting. States therefore have little motivation to create a managed care initiative for dual eligibles that will generate large-scale Medicare savings, but is likely to impose added costs on the state budget for several years. For states to benefit in the short term from a dual eligible capitation initiative, there needs to be a mechanism whereby the state and federal government can share in the overall (Medicare plus Medicaid) savings that the program yields.

Sections IV, V and VI present the estimated financial impacts of serving the dual eligible population in the capitated setting, demonstrating that large-scale savings are clearly possible. Section VII then describes a public policy approach to achieving these outcomes.

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[4] The absence of mandatory MCO enrollment for any Medicare subgroup is driven by political opposition to this approach from a variety of stakeholders who have skepticism – if not antipathy – about managed care. There nonetheless appears to be widespread evidence in the Medicaid arena that well-designed mandatory enrollment programs can work effectively for high-need population subgroups.

III. DUAL ELIGIBLES SAVINGS MODELING: BASELINE DATA COMPILATION

As with the previous study, Medicaid baseline costs were derived entirely through downloading and tabulating CMS website data from the Medical Statistical Information System (MSIS) State Summary Datamart.[5] For this engagement, Lewin primarily worked with the "FY2005 Quarterly Cube" database, since FY2005 was the most recent year for which the needed data fields were available for each state[6]. Baseline Medicare baseline per capita costs were also obtained from CMS website data, with Medicare Advantage demographic cost factors used to translate overall per capita costs in each state to estimate the (higher) average cost for dual eligibles.

Table 2 presents the total Medicaid dual population and Medicaid dual expenditures for each state as of FY2005, as tabulated from the above-mentioned MSIS data site. Table 2 also shows the amount and percentage of these dual expenditures that represent capitation payments, sorting the states by the percentage of FY2005 Medicaid dollars that are capitated. Several noteworthy statistics are presented in Table 2, including:

- While the dual eligible population accounts for only 15 percent of Medicaid eligibles nationally, its health care expenditures accounted for more than 44 percent of total Medicaid expenditures in FY2005. Nationwide Medicaid expenditures for dual eligibles totaled $122 billion during FY2005, averaging more than $16,000 per dual eligible and well above $1,000 per eligible per month.

- However, only 6 percent of Medicaid dual eligible spending was "capitated" (whereas, as shown in Exhibit A below, 25.8 percent of FY2005 Medicaid expenditures for non-dual eligibles were paid via capitation).

Exhibit A. Summary of FY2005 Medicaid Spending

Eligibility Group	Total Spending	Capitation Spending	Capitation as % of Total Spending
Dual Eligibles	$121,739,776,218	$7,338,726,200	6.0%
Non-Dual Eligibles	$151,462,973,954	$39,082,160,554	25.8%
Total Medicaid	$273,202,750,172	$46,420,886,754	17.0%

- In twelve states, dual eligible spending accounts for more than half of total Medicaid expenditures, while dual eligibles represent more than 30 percent of Medicaid spending in 48 of 51 states (the District of Columbia is included in this study's data tables). Dual eligibles constitute the largest share of Medicaid spending in North Dakota (almost 62 percent) and the lowest share in Alaska (28 percent).

- Arizona (86.37%) is the only state "capitating" more than half of its Medicaid dual expenditures, followed by Oregon (22.4%). Only eleven states capitate more than ten percent of their Medicaid dual expenditures. Capitation constitutes less than one percent of dual eligibles' Medicaid spending in 26 states.

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[5] The website link to the data tables is: http://msis.cms.hhs.gov
[6] The data for Maine was unavailable in the MSIS 2005 database. MSIS 2004 data was used.

Table 2. FY2005 Medicaid Costs and Use of Medicaid Capitation by State, Dual Eligibles

State	Total Dual Population	Total Medicaid Population	% Duals	Total Medicaid Spending	Total Dual Spending	Capitation Spending for Duals	% Medicaid Spending on Duals	% Capitation of Dual Spending
Arizona	115,359	1,451,207	7.9%	$4,449,323,164	$1,283,531,627	$1,108,589,794	28.8%	86.4%
Oregon	69,580	550,049	12.6%	$2,444,482,998	$872,603,048	$195,809,754	35.7%	22.4%
Pennsylvania	309,779	2,005,713	15.4%	$11,901,877,948	$5,269,575,538	$990,199,175	44.3%	18.8%
Utah	23,616	305,000	7.7%	$1,500,529,191	$765,744,328	$143,207,596	51.0%	18.7%
Alabama	167,635	948,255	17.7%	$4,154,203,745	$2,495,837,157	$411,836,561	60.1%	16.5%
Colorado	61,571	535,404	11.5%	$2,594,543,653	$1,212,518,054	$183,722,724	46.7%	15.2%
Minnesota	104,759	750,546	14.0%	$5,233,970,089	$2,572,241,865	$362,074,469	49.1%	14.1%
Michigan	209,274	1,854,408	11.3%	$7,654,273,978	$3,809,956,431	$511,336,226	49.8%	13.4%
New Mexico	43,270	528,378	8.2%	$2,415,071,607	$892,272,652	$99,183,401	36.9%	11.1%
Wisconsin	180,314	1,016,071	17.7%	$4,579,689,182	$2,502,214,920	$266,967,582	54.6%	10.7%
California	952,297	10,588,818	9.0%	$28,637,795,310	$11,914,896,446	$1,192,308,623	41.6%	10.0%
West Virginia	54,667	381,905	14.3%	$2,339,186,575	$1,179,519,791	$84,332,517	50.4%	7.1%
Florida	467,445	2,996,864	15.6%	$13,154,453,435	$6,333,530,904	$339,283,092	48.1%	5.4%
Kansas	50,098	352,314	14.2%	$2,080,259,947	$1,016,533,914	$53,827,381	48.9%	5.3%
Kentucky	132,517	845,090	15.7%	$4,043,630,633	$1,422,193,836	$69,857,241	35.2%	4.9%
Tennesse	254,778	1,614,902	15.8%	$7,698,149,236	$2,928,478,595	$135,602,100	38.0%	4.6%
New York	607,384	5,088,527	11.9%	$39,348,349,501	$18,253,091,091	$749,435,131	46.4%	4.1%
Massachusetts	199,850	1,211,742	16.5%	$8,308,261,026	$3,947,123,316	$124,268,635	47.5%	3.1%
Maryland	94,134	858,787	11.0%	$4,948,611,465	$1,764,149,661	$36,868,603	35.6%	2.1%
Delaware	17,125	177,181	9.7%	$884,667,964	$301,880,952	$5,576,736	34.1%	1.8%
Virginia	137,214	873,585	15.7%	$4,060,746,944	$1,734,436,918	$27,886,181	42.7%	1.6%
District of Columbia	18,230	165,704	11.0%	$1,315,816,541	$404,975,580	$6,242,388	30.8%	1.5%
Texas	466,943	3,987,435	11.7%	$14,365,319,650	$4,981,213,968	$75,765,029	34.7%	1.5%
Iowa	62,259	412,940	15.1%	$2,350,365,034	$1,178,518,038	$17,080,915	50.1%	1.4%
New Jersey	160,843	997,598	16.1%	$7,009,549,306	$3,784,993,441	$42,426,537	54.0%	1.1%
Mississippi	129,821	778,110	16.7%	$3,470,478,324	$1,835,636,856	$18,073,848	52.9%	1.0%
Rhode Island	33,545	219,441	15.3%	$1,637,717,916	$755,940,716	$5,111,860	46.2%	0.7%
South Carolina	157,417	996,654	15.8%	$4,247,817,505	$2,140,957,583	$14,301,985	50.4%	0.7%
Washington	113,480	1,201,010	9.4%	$5,335,471,676	$2,460,859,993	$15,433,813	46.1%	0.6%
South Dakota	15,904	126,885	12.5%	$627,071,436	$266,935,535	$1,017,311	42.6%	0.4%
North Carolina	253,562	1,566,047	16.2%	$8,414,803,162	$3,569,404,259	$13,344,136	42.4%	0.4%
Oklahoma	88,766	718,778	12.3%	$2,561,235,780	$1,073,673,794	$3,592,705	41.9%	0.3%
Hawaii	25,660	229,773	11.2%	$930,959,220	$363,086,292	$898,938	39.0%	0.2%
Nebraska	33,860	261,589	12.9%	$1,449,821,438	$679,044,984	$1,619,522	46.8%	0.2%
Missouri	152,034	1,206,971	12.6%	$5,263,004,188	$2,287,474,450	$5,208,317	43.5%	0.2%
Georgia	211,166	1,827,347	11.6%	$6,821,022,623	$2,585,564,229	$5,343,993	37.9%	0.2%
Illinois	421,823	2,393,150	17.6%	$10,787,559,126	$5,474,030,570	$11,129,528	50.7%	0.2%
Nevada	31,991	257,853	12.4%	$1,089,565,323	$398,209,146	$757,072	36.5%	0.2%
Indiana	119,285	1,019,871	11.7%	$4,780,358,965	$2,277,332,416	$2,465,020	47.6%	0.1%
Ohio	228,239	2,101,901	10.9%	$12,114,450,180	$5,308,552,490	$4,994,648	43.8%	0.1%
Connecticut	82,012	524,847	15.6%	$3,786,510,621	$2,244,455,966	$1,743,997	59.3%	0.1%
North Dakota	12,796	74,262	17.2%	$557,167,553	$344,467,541	$1,116	61.8%	0.0%
Alaska	9,993	130,250	7.7%	$1,003,770,833	$277,279,178	$0	27.6%	0.0%
Arkansas	86,143	734,959	11.7%	$2,662,444,329	$1,104,618,259	$0	41.5%	0.0%
Idaho	20,205	220,863	9.1%	$1,072,200,804	$398,814,146	$0	37.2%	0.0%
Louisiana	148,466	1,153,385	12.9%	$4,420,238,271	$1,830,903,515	$0	41.4%	0.0%
Maine*	51,194	306,397	16.7%	$2,366,282,600	$837,439,353	$0	35.4%	0.0%
Montana	16,266	115,153	14.1%	$620,998,140	$274,561,223	$0	44.2%	0.0%
New Hampshire	21,984	138,732	15.8%	$817,933,840	$446,824,630	$0	54.6%	0.0%
Vermont	26,100	161,447	16.2%	$859,143,401	$363,801,667	$0	42.3%	0.0%
Wyoming	7,984	80,833	9.9%	$397,877,396	$155,314,709	$0	39.0%	0.0%
Totals	**7,460,636**	**59,044,931**	**12.6%**	**$275,569,032,772**	**$121,739,776,218**	**$7,338,726,200**	**44.2%**	**6.0%**

Table 3 summarizes FY2005 Medicaid per capita costs by state and by service category, as well as the Medicare per capita costs as estimated by trending CY2004 Medicare spending data by an annual trending factor of 6 percent.

- For the dual eligible population in FY2005, most payments (94 percent) were delivered through the fee-for-service (FFS) payment structure. This fee-for-service expense serves as the baseline for projecting Medicaid cost impacts (no further impacts from capitation

are assumed for the 6.0% of Medicaid dual eligibles spending that were already "capitated" as of FY2005).[7]

- The largest FFS expenditure categories were Nursing Facility Care (comprising 32 percent of national dual eligible Medicaid spending), Prescription Drugs (19 percent), and Personal Support Services (9 percent). The "Other" category encompasses expenditures in Medicaid service categories not explicitly listed and which do not individually contribute heavily to per capita spending but add up incrementally to produce a large portion (20 percent) of overall Medicaid FFS expenditures.

- While Medicare is the primary payer for most health care services rendered to the dual eligible population, Medicare's per capita costs in 2005 were lower than Medicaid. This is due to Medicaid providing extensive coverage for long-term care and pharmacy services, as well as Medicaid's filling in the gaps in Medicare's coverage for acute care benefits (e.g., the inpatient deductible, Part B deductibles and coinsurance, etc.).

- Medicaid was the primary payer for prescription drug expenditures of the dual population in FY2005. However, the Medicare Modernization Act of 2003 (the MMA) shifted the responsibility of prescription drug payments for the dual population to Medicare beginning in CY2006. States continued to provide financial support for dual eligibles' pharmacy expenditures through a unique MMA payment provision commonly referred to as the "claw-back."

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[7] This document does not adjust for changes in the degree to which capitation was used for dual eligible population since the base year. Some states (e.g., Minnesota, New York and Texas) have increased the use of capitation for duals, whereas others (e.g., Pennsylvania and Tennessee) have reduced the use of capitation for dual eligibles since 2005. Most states, however, have not significantly changed the degree to which Medicaid duals are enrolled in MCOs.

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Table 3. Baseline Costs, With Medicaid Costs Shown By Category of Service, FY2005

State	Medicare	Medicaid Capitated Care	Medicaid Fee For Service							Total Dual Spending
			ICF/MR	Inpatient	Nursing Facility Care	Personal Support Services	Prescription Drugs	Home Health Services	Other FFS	
Alaska	$13,628	$0	$0	$616	$5,544	$6,559	$5,879	$10	$9,138	$27,746
Alabama	$10,337	$2,457	$132	$240	$4,304	$276	$1,674	$125	$5,681	$14,888
Arkansas	$9,827	$0	$894	$544	$4,432	$741	$2,187	$80	$3,945	$12,823
Arizona	$7,194	$9,610	$0	$142	$147	$82	$16	$2	$1,127	$11,126
California	$12,341	$1,252	$473	$528	$2,589	$2,904	$3,190	$11	$1,564	$12,512
Colorado	$10,371	$2,984	$194	$598	$6,178	$301	$2,751	$675	$6,012	$19,693
Connecticut	$14,068	$21	$2,289	$601	$12,289	$1,572	$4,116	$1,423	$5,056	$27,367
District of Columbia	$12,156	$365	$1,649	$1,695	$7,354	$40	$2,957	$1,229	$8,360	$23,648
Delaware	$10,824	$306	$985	$330	$7,902	$544	$2,108	$220	$4,164	$16,560
Florida	$12,890	$726	$399	$2,467	$4,365	$431	$3,219	$120	$1,823	$13,549
Georgia	$10,076	$25	$279	$1,015	$4,193	$460	$2,519	$10	$3,744	$12,244
Hawaii	$8,060	$35	$237	$610	$6,657	$49	$2,404	$2,596	$1,561	$14,150
Iowa	$10,585	$274	$2,348	$937	$6,138	$211	$3,599	$710	$4,713	$18,929
Idaho	$10,811	$0	$1,382	$639	$5,912	$3,713	$4,027	$53	$4,012	$19,738
Illinois	$11,479	$26	$945	$3,358	$2,987	$560	$2,591	$10	$2,501	$12,977
Indiana	$12,045	$21	$1,940	$231	$8,211	$1,123	$3,961	$264	$3,340	$19,092
Kansas	$11,857	$1,074	$933	$820	$6,127	$813	$3,799	$200	$6,524	$20,291
Kentucky	$10,569	$527	$503	$300	$4,790	$131	$2,422	$228	$1,832	$10,732
Louisiana	$13,275	$0	$1,669	$1,254	$3,763	$482	$2,943	$14	$2,207	$12,332
Massachusetts	$13,138	$622	$939	$227	$8,217	$936	$3,127	$2,730	$2,953	$19,750
Maryland	$12,846	$392	$491	$1,099	$7,499	$822	$3,049	$4,123	$1,266	$18,741
Maine*	$10,117	$0	$377	$532	$4,325	$1,205	$2,943	$30	$6,946	$16,358
Michigan	$12,169	$2,443	$75	$2,759	$6,414	$606	$3,350	-$283	$2,841	$18,206
Minnesota	$9,837	$3,456	$1,082	$502	$7,113	$8,220	$2,191	$404	$1,585	$24,554
Missouri	$12,685	$34	$507	$340	$4,634	$1,759	$4,702	$3	$3,067	$15,046
Mississippi	$12,028	$139	$859	$3,068	$4,385	$209	$2,935	$88	$2,457	$14,140
Montana	$9,867	$0	$436	$260	$8,143	$1,174	$3,524	$10	$3,332	$16,879
North Carolina	$11,705	$53	$1,010	$325	$4,156	$1,779	$3,888	$214	$2,653	$14,077
North Dakota	$10,368	$0	$3,793	$343	$12,992	$1,293	$3,315	$53	$5,132	$26,920
Nebraska	$11,691	$48	$1,350	$590	$7,232	$1,394	$3,969	$319	$5,152	$20,055
New Hampshire	$11,364	$0	$0	$337	$8,644	$198	$3,555	$43	$7,549	$20,325
New Jersey	$14,543	$264	$2,753	$668	$8,924	$1,711	$4,481	$388	$4,344	$23,532
New Mexico	$8,073	$2,292	$290	$3,804	$4,039	$2,865	$1,506	$3	$5,821	$20,621
Nevada	$10,366	$24	$338	$1,304	$4,027	$1,741	$1,919	$26	$3,069	$12,448
New York	$13,792	$1,234	$2,830	$1,613	$9,274	$3,769	$3,772	$1,363	$6,197	$30,052
Ohio	$12,446	$22	$2,011	$700	$9,526	$1,861	$4,135	$291	$4,714	$23,259
Oklahoma	$11,427	$40	$867	$476	$4,407	$357	$2,702	$5	$3,241	$12,096
Oregon	$8,985	$2,814	$124	$191	$3,020	$269	$1,860	$1	$4,261	$12,541
Pennsylvania	$11,132	$3,196	$1,405	$237	$8,578	$89	$2,033	$228	$1,244	$17,011
Rhode Island	$12,575	$152	$76	$566	$13,639	$2,361	$3,542	$678	$1,519	$22,535
South Carolina	$10,412	$91	$612	$3,703	$2,816	$621	$2,542	$30	$3,185	$13,601
South Dakota	$9,794	$64	$775	$68	$7,522	$760	$3,009	$6	$4,580	$16,785
Tennesse	$9,829	$532	$692	$130	$3,388	$96	$4,529	$1,142	$985	$11,494
Texas	$11,911	$162	$1,228	$402	$3,761	$322	$2,170	$139	$2,484	$10,668
Utah	$11,390	$6,064	$1,451	$3,610	$5,127	$484	$4,211	$97	$11,382	$32,425
Virginia	$10,251	$203	$1,150	$698	$4,322	$850	$2,998	$5	$2,415	$12,640
Vermont	$10,752	$0	$30	$263	$3,782	$113	$4,337	$114	$5,299	$13,939
Washington	$10,038	$136	$30	$425	$4,057	$3,806	$3,151	$0	$10,081	$21,685
Wisconsin	$10,225	$1,481	$792	$306	$4,478	$739	$3,041	$63	$2,978	$13,877
West Virginia	$11,187	$1,543	$692	$2,796	$6,527	$2,435	$3,122	$9	$4,452	$21,576
Wyoming	$9,913	$0	$946	$532	$7,313	$215	$2,860	$73	$7,514	$19,453
USA Total	$64,534,391,676	$7,338,726,200	$7,550,129,702	$8,127,648,203	$39,295,413,819	$10,585,390,915	$23,006,860,692	$2,897,110,854	$23,775,935,186	$121,739,776,218
Percent Share of Duals' Medicaid Spending		6.0%	6.2%	6.7%	32.3%	8.7%	18.9%	2.4%	19.5%	100.0%

IV. BASELINE COST TRENDING

Baseline costs were trended forward each year through calendar year 2024. Tables 4a, and 4b show projected Medicaid FFS per capita and Medicare expenditures in 2010 and 2024, respectively. All Medicaid and Medicare FFS baseline per capita costs were trended forward at an annual rate of 7.0 percent. The figures in Tables 4a and 4b also show the projected number of dual eligibles to grow slowly but steadily – at an annual growth of 1.5 percent.

We do not intend to imply that the single annual trend factor used in this study means that we anticipate that the rate of cost escalation will be equal in all states, nor do we intend to imply that cost escalation is likely to be constant on a yearly basis throughout the fifteen years ahead. Rather, we are simply trying to establish a reasonable inflation trend for purposes of estimating state and federal cost savings potential through full adoption of capitation for the dual eligible population.

By incorporating these trending assumptions, Lewin predicts that:

- The dual population will increase from 7.5 million in FY2005 to 9.9 million in 2024, an increase of 32%.[8]

- Despite more modest increases in the duals population, dual Medicaid FFS expenditures will more than *triple* over the next fifteen years, from $101 billion in FY2006 to $354 billion by CY2024.[9] (The switching of pharmacy costs to Medicare explains the apparent downturn in Medicaid FFS spending on dual eligibles between 2005 and 2006.)

- Medicare expenditures on behalf of dual eligibles will also roughly *quadruple* during this 15 year timeframe, increasing from $95 billion in CY2006 to $423 billion in CY2024. The CY2006 figure includes dual eligibles' pharmacy costs.

- Total spending, which includes Medicaid and Medicare expenditures, will increase from $195 billion in CY2006 to $777 billion in CY2024. Total per capita costs for dual eligibles, combining Medicare and Medicaid, are estimated to increase from $25,774 in CY2006 to $78,517 in CY2024.

- Across the 15 year timeframe 2010-2024, total expenditures on the dual eligible population are projected to be $7 *trillion*, with Medicaid comprising $3.36 trillion (47%) of these costs.

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[8] These are average "point in time" figures that estimate the number of persons covered in an average month. The number of dual eligibles that receive some Medicaid coverage *at any time* during a calendar year is much higher, since there is a continual influx of new dual eligibles (which typically more than offsets the number of dual eligibles losing Medicaid coverage due to death or relocation).

[9] While baseline data were available on a fiscal year basis, all projections in this report are made on a calendar year basis.

Table 4a. Trended Baseline Costs Estimates For CY2010, Dual Eligibles

State	Total Medicaid FFS Spending Per Eligible	Total Medicare Spending per Eligible	2010 Projected Dual Eligibles	Baseline Total Medicaid Spending	Baseline Total Medicare Spending	Projected Total Spending (Medicaid plus Medicare)
Alabama	$14,163	$14,612	180,591	$2,557,688,071	$2,638,835,889	$5,196,523,960
Alaska	$29,478	$19,217	10,766	$317,354,384	$206,882,276	$524,236,660
Arizona	$2,072	$10,185	124,274	$257,557,692	$1,265,706,804	$1,523,264,496
Arkansas	$13,966	$13,884	92,801	$1,296,034,003	$1,288,400,259	$2,584,434,263
California	$10,762	$17,429	1,025,894	$11,040,669,194	$17,880,809,927	$28,921,479,121
Colorado	$18,250	$14,647	66,329	$1,210,493,238	$971,494,466	$2,181,987,704
Connecticut	$29,941	$19,863	88,350	$2,645,271,385	$1,754,933,859	$4,400,205,244
Delaware	$18,142	$15,297	19,639	$356,292,585	$300,410,064	$656,702,649
District of Columbia	$26,929	$17,171	18,448	$496,798,953	$316,776,189	$813,575,141
Florida	$12,533	$18,206	503,571	$6,311,038,741	$9,168,163,493	$15,479,202,234
Georgia	$12,704	$14,233	227,486	$2,889,897,576	$3,237,707,258	$6,127,604,834
Hawaii	$14,994	$11,379	27,643	$414,485,208	$314,549,850	$729,035,057
Idaho	$20,766	$15,253	21,767	$452,001,794	$332,002,731	$784,004,524
Illinois	$13,889	$16,217	454,423	$6,311,294,497	$7,369,299,029	$13,680,593,526
Indiana	$19,428	$17,001	128,504	$2,496,605,448	$2,184,700,653	$4,681,306,102
Iowa	$19,798	$14,938	67,071	$1,327,889,640	$1,001,927,644	$2,329,817,284
Kansas	$20,307	$16,737	53,970	$1,095,967,447	$903,312,751	$1,999,280,198
Kentucky	$9,887	$14,931	142,758	$1,411,448,845	$2,131,494,394	$3,542,943,239
Louisiana	$12,360	$18,755	159,940	$1,976,781,732	$2,999,736,107	$4,976,517,838
Maine*	$17,886	$14,284	55,150	$986,421,070	$787,784,390	$1,774,205,460
Maryland	$19,848	$18,147	101,409	$2,012,744,688	$1,840,251,081	$3,852,995,769
Massachusetts	$20,678	$18,560	215,296	$4,451,841,028	$3,995,830,360	$8,447,671,388
Michigan	$16,030	$17,185	225,448	$3,613,998,729	$3,874,308,517	$7,488,307,246
Minnesota	$24,989	$13,898	112,855	$2,820,155,443	$1,568,445,018	$4,388,600,461
Mississippi	$14,578	$16,990	139,854	$2,038,824,274	$2,376,127,127	$4,414,951,401
Missouri	$13,465	$17,897	163,784	$2,205,272,754	$2,931,173,683	$5,136,446,437
Montana	$16,981	$13,923	17,524	$297,566,815	$243,974,958	$541,541,773
Nebraska	$20,940	$16,499	36,477	$763,810,287	$601,822,131	$1,365,632,418

State	Total Medicaid FFS Spending Per Eligible	Total Medicare Spending per Eligible	2010 Projected Dual Eligibles	Baseline Total Medicaid Spending	Baseline Total Medicare Spending	Projected Total Spending (Medicaid plus Medicare)
Nevada	$13,869	$14,650	34,463	$477,961,320	$504,895,737	$982,857,058
New Hampshire	$21,663	$16,041	23,683	$513,058,848	$379,913,060	$892,971,909
New Jersey	$24,433	$20,530	173,274	$4,233,518,681	$3,557,361,670	$7,790,880,351
New Mexico	$22,728	$11,409	46,614	$1,059,427,642	$531,842,233	$1,591,269,875
New York	$33,135	$19,476	654,325	$21,681,204,030	$12,743,863,570	$34,425,067,600
North Carolina	$13,324	$16,521	273,158	$3,639,482,815	$4,512,747,376	$8,152,230,192
North Dakota	$30,316	$14,636	13,785	$417,904,173	$201,749,445	$619,653,618
Ohio	$24,745	$17,566	245,878	$6,084,294,781	$4,319,067,324	$10,403,362,105
Oklahoma	$12,171	$16,142	95,626	$1,163,886,570	$1,543,572,819	$2,707,459,390
Oregon	$10,384	$12,696	74,958	$778,361,093	$951,648,014	$1,730,009,107
Pennsylvania	$14,681	$15,734	333,720	$4,899,197,755	$5,250,588,676	$10,149,786,431
Rhode Island	$23,494	$17,756	36,138	$849,016,949	$641,663,745	$1,490,680,694
South Carolina	$14,778	$14,707	169,583	$2,506,114,747	$2,494,089,546	$5,000,204,294
South Dakota	$17,615	$13,826	17,133	$301,783,806	$236,873,793	$538,657,599
Tennessee	$8,295	$13,855	274,468	$2,276,613,514	$3,802,861,583	$6,079,475,096
Texas	$10,883	$16,835	503,030	$5,474,409,343	$8,468,642,749	$13,943,052,092
Utah	$29,965	$16,069	25,441	$762,327,425	$408,815,294	$1,171,142,719
Vermont	$12,654	$15,165	28,117	$355,793,308	$426,389,514	$782,182,822
Virginia	$12,311	$14,473	147,818	$1,819,760,721	$2,139,435,193	$3,959,195,914
Washington	$24,934	$14,170	122,250	$3,048,136,415	$1,732,316,732	$4,780,453,148
West Virginia	$22,318	$15,798	58,892	$1,314,320,158	$930,352,146	$2,244,672,304
Wisconsin	$12,159	$14,436	194,249	$2,361,876,374	$2,804,095,335	$5,165,971,709
Wyoming	$21,701	$13,997	8,601	$186,652,534	$120,393,213	$307,045,747
TOTALS			8,037,224	$130,261,308,522	$133,190,039,677	$263,451,348,198

Table 4b. Trended Baseline Cost Estimates For CY2024, Dual Eligibles

State	Total Medicaid FFS Spending Per Eligible	Total Medicare Spending Per Eligible	2024 Projected Dual Eligibles	Baseline Total Medicaid Spending	Baseline Total Medicare Spending	Projected Total Spending (Medicaid plus Medicare)
Alabama	$31,613	$37,678	222,444	$7,032,182,400	$8,381,270,570	$15,413,452,970
Alaska	$69,691	$49,551	13,261	$924,154,003	$657,083,807	$1,581,237,810
Arizona	$5,176	$26,262	153,075	$792,387,514	$4,020,042,031	$4,812,429,545
Arkansas	$30,959	$35,799	114,308	$3,538,862,249	$4,092,119,264	$7,630,981,513
California	$24,798	$44,943	1,263,651	$31,336,462,418	$56,791,673,417	$88,128,135,835
Colorado	$40,015	$37,767	81,701	$3,269,259,136	$3,085,587,100	$6,354,846,236
Connecticut	$63,193	$51,218	108,826	$6,877,097,830	$5,573,887,927	$12,450,985,757
Delaware	$37,772	$39,443	24,190	$913,719,296	$954,139,681	$1,867,858,976
District of Columbia	$61,054	$44,276	22,724	$1,387,382,195	$1,006,120,524	$2,393,502,718
Florida	$27,340	$46,946	620,276	$16,958,264,774	$29,119,226,088	$46,077,490,862
Georgia	$27,977	$36,699	280,207	$7,839,413,031	$10,283,360,428	$18,122,773,460
Hawaii	$31,075	$29,341	34,049	$1,058,065,129	$999,049,394	$2,057,114,523
Idaho	$46,805	$39,329	26,812	$1,254,901,848	$1,054,481,913	$2,309,383,761
Illinois	$32,407	$41,816	559,738	$18,139,671,430	$23,405,809,104	$41,545,480,534
Indiana	$40,736	$43,838	158,285	$6,447,901,775	$6,938,880,650	$13,386,782,425
Iowa	$44,054	$38,519	82,615	$3,639,511,395	$3,182,246,653	$6,821,758,048
Kansas	$45,377	$43,158	66,478	$3,016,583,024	$2,869,033,502	$5,885,616,526
Kentucky	$20,034	$38,500	175,843	$3,522,832,446	$6,769,890,962	$10,292,723,408
Louisiana	$27,579	$48,361	197,007	$5,433,290,160	$9,527,534,491	$14,960,824,651
Maine*	$41,189	$36,833	67,932	$2,798,023,921	$2,502,101,077	$5,300,124,998
Maryland	$42,629	$46,792	124,911	$5,324,871,598	$5,844,866,022	$11,169,737,620
Massachusetts	$43,951	$47,857	265,192	$11,655,381,408	$12,691,253,570	$24,346,634,978
Michigan	$34,023	$44,312	277,697	$9,448,089,076	$12,305,285,102	$21,753,374,178
Minnesota	$56,326	$35,836	139,010	$7,829,953,259	$4,981,576,204	$12,811,529,463
Mississippi	$32,592	$43,810	172,265	$5,614,427,141	$7,546,874,910	$13,161,302,051
Missouri	$29,436	$46,147	201,742	$5,938,466,545	$9,309,771,716	$15,248,238,261
Montana	$34,503	$35,900	21,585	$744,739,373	$774,894,772	$1,519,634,145
Nebraska	$45,750	$42,543	44,930	$2,055,552,026	$1,911,461,844	$3,967,013,871

State	Total Medicaid FFS Spending Per Eligible	Total Medicare Spending Per Eligible	2024 Projected Dual Eligibles	Baseline Total Medicaid Spending	Baseline Total Medicare Spending	Projected Total Spending (Medicaid plus Medicare)
Nevada	$31,171	$37,777	42,450	$1,323,196,846	$1,603,611,578	$2,926,808,424
New Hampshire	$46,006	$41,363	29,172	$1,342,086,710	$1,206,651,071	$2,548,737,781
New Jersey	$52,827	$52,938	213,431	$11,274,903,452	$11,298,622,545	$22,573,525,998
New Mexico	$53,999	$29,420	57,417	$3,100,487,866	$1,689,196,994	$4,789,684,860
New York	$74,869	$50,220	805,968	$60,341,709,368	$40,476,093,694	$100,817,803,062
North Carolina	$29,618	$42,599	336,464	$9,965,391,423	$14,333,046,224	$24,298,437,648
North Dakota	$63,361	$37,738	16,980	$1,075,844,229	$640,781,299	$1,716,625,528
Ohio	$52,947	$45,294	302,861	$16,035,553,615	$13,717,894,320	$29,753,447,936
Oklahoma	$26,360	$41,622	117,787	$3,104,886,296	$4,902,579,011	$8,007,465,307
Oregon	$23,333	$32,737	92,329	$2,154,286,499	$3,022,552,302	$5,176,838,801
Pennsylvania	$28,076	$40,569	411,062	$11,540,764,349	$16,676,521,844	$28,217,286,193
Rhode Island	$45,031	$45,785	44,513	$2,004,479,176	$2,038,003,760	$4,042,482,936
South Carolina	$34,895	$37,923	208,885	$7,289,121,782	$7,921,538,206	$15,210,659,988
South Dakota	$36,845	$35,651	21,103	$777,536,826	$752,340,590	$1,529,877,416
Tennessee	$17,525	$35,727	338,078	$5,924,899,901	$12,078,360,764	$18,003,260,665
Texas	$23,775	$43,410	619,611	$14,731,140,242	$26,897,461,314	$41,628,601,555
Utah	$71,421	$41,435	31,337	$2,238,107,021	$1,298,448,157	$3,536,555,178
Vermont	$28,317	$39,103	34,634	$980,721,914	$1,354,266,061	$2,334,987,975
Virginia	$26,817	$37,320	182,076	$4,882,715,550	$6,795,111,925	$11,677,827,475
Washington	$59,667	$36,538	150,583	$8,984,811,971	$5,502,053,123	$14,486,865,094
West Virginia	$50,106	$40,735	72,540	$3,634,725,507	$2,954,913,982	$6,589,639,489
Wisconsin	$26,248	$37,223	239,268	$6,280,272,654	$8,906,155,100	$15,186,427,754
Wyoming	$47,620	$36,093	10,594	$504,503,002	$382,383,800	$886,886,802
TOTALS	$35,787	$42,731	9,899,897	$354,283,592,600	$423,028,110,387	$777,311,702,987

These large-scale baseline cost figures demonstrate the need for solutions which will free up spending to meet unmet needs. An integrated system of coverage can reduce the slope of taxpayer cost increases while providing high quality care to the beneficiaries. Each percentage point reduction in dual eligibles' per capita costs amounts to a nationwide taxpayer savings of $71 billion across the 15 year period 2010-2024. The remainder of this study estimates the level of savings that can occur through serving the dual eligible population through capitation contracts with managed care organizations (MCOs) in each state across this fifteen year timeframe. The savings figures are separately derived for the Medicaid and Medicare programs so that state and federal government impacts can be quantified.

V. CALCULATION OF CAPITATION SAVINGS FACTORS

Covering dual eligibles through an integrated MCO model would influence Medicaid and Medicare costs in many respects. This study estimates the impacts of enrolling the dual eligible population into capitated MCOs on a mandatory enrollment basis. This approach provides the largest savings opportunity; however the enormity of the overall spending on duals provides opportunities to achieve savings with more modest interventions and/or less aggressive enrollment models.

The specific assumptions used draw upon Lewin's extensive involvement in the Medicaid managed care arena encompassing more than 100 engagements over the past 15 years. These projects include capitation rate-setting on behalf of state Medicaid agencies, derivation of price bids for MCOs, analyses of existing capitated programs' impacts on cost and utilization, estimates of the cost impacts of proposed program design changes, and many other quantitative analyses.[10] The assumptions are predominantly based on anticipated in changes in *usage* between the fee-for-service and capitated settings. It is not anticipated that the health plans will negotiate lower prices with providers than those paid by Medicaid and Medicare, given that these public sector programs already typically pay providers less than providers receive for rendering the same services to commercial patients.

Medical Cost Impacts

a) **Nursing Home.** The capitated model incentivizes and equips MCOs to lower nursing home costs by helping persons with long-term care needs stay in a community-based setting as long as possible (with many persons having institutionalization delayed or avoided altogether relative to what would have occurred in the unmanaged FFS setting). However, an MCO's ability to lower nursing home costs is dampened by two dynamics. First, for the initial years after a capitated dual eligible program is implemented, Medicaid nursing home costs will be predominantly driven by persons who are already institutionalized at the program's outset. The degree to which the MCO model can discharge already institutionalized persons back into a community-based setting is limited, especially for persons of advanced age.[11] Second, the degree to which MCOs can divert new Medicaid nursing home patients is limited by the fact that many (more than 40 percent) "new" Medicaid nursing home patients are institutionalized *before* they become eligible for Medicaid, then obtain Medicaid coverage by "spending down." For this subgroup, the MCO is again in no position to prevent the institutionalization, as

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[10] For example, a 2003 Lewin Group study, "Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting," identified more than a 25% usage-related savings in PMPM Medicaid pharmacy costs in the capitated setting versus FFS, prior to taking rebate differentials into consideration. Lewin has also quantified large PMPM medical savings in various high-need population subgroups through "pre vs. post" assessments of the same persons' claims within the managed care setting. Lewin has also found the rate of cost escalation over time to be lower in mandatory enrollment Medicaid capitation settings than in the FFS environment.

[11] Executives closely involved in implementing managed long-term care programs indicate that, in their experience, persons with disabilities are often inappropriately placed in nursing homes and can still be appropriately discharged to a community based setting.

these persons have entered their nursing homes prior to attaining Medicaid eligibility and enrolling in the MCO.

To address these dynamics, Lewin has estimated the degree to which each year's baseline nursing home costs are "impactable" by the MCO model. These estimates are shown in Exhibit B below, along with our assumption that when it is possible to divert the person, MCOs will be successful 25% of the time (i.e., for every 100 MCO enrollees who would have been institutionalized in the FFS setting, only 75 persons will be institutionalized in the capitated MCO setting).

b) **Intermediate Care Facilities/Mental Retardation Facilities (ICF/MR).** These costs were estimated to be lowered by two percentage points during program years 1-5, by five percentage points during program years 6-10, and by 7.5 percentage points thereafter. These reductions assume that only a very small proportion of the lower-level cases in these facilities may be "dischargable" in the short term, but that MCOs will be successful in diverting new ICR/MR admissions as the program matures.

Exhibit B. Nursing Home Savings Estimates By Year

Year	% of FFS Nursing Home Costs Impactable by MCO Model	% MCO Savings on "Impactable" Nursing Home Costs	Overall % Savings in Baseline Nursing Home Costs
2010	5.0%	25.0%	1.3%
2011	10.0%	25.0%	2.5%
2012	15.0%	25.0%	3.8%
2013	20.0%	25.0%	5.0%
2014	25.0%	25.0%	6.3%
2015	30.0%	25.0%	7.5%
2016	35.0%	25.0%	8.8%
2017	40.0%	25.0%	10.0%
2018	42.0%	25.0%	10.5%
2019	44.0%	25.0%	11.0%
2020	46.0%	25.0%	11.5%
2021	48.0%	25.0%	12.0%
2022	50.0%	25.0%	12.5%
2023	52.0%	25.0%	13.0%
2024	54.0%	25.0%	13.5%

c) **Inpatient Hospital.** Savings of 20 percentage points against baseline Medicaid FFS costs are assumed – a smaller percentage impact than Lewin has used in several previous Medicaid analyses and reports. The Medicaid inpatient savings must accrue through reduction in admissions, since Medicaid pays for the first day deductible, as well as improved management of catastrophic cases (since Medicare coverage for inpatient hospital limits the total number of covered days, after which point Medicaid pays for the full remainder of the admission). The vast majority of overall inpatient savings for dual

eligibles that are achieved through the capitated model accrue to the Medicare program. In several states, the baseline per capita inpatient Medicaid costs seemed out of line with what was realistic for the services Medicaid pays for – these were all states that used intergovernmental transfer payment or other special mechanisms designed to maximize federal funds. It was not assumed that the MCO program would lower the amount of funding for these mechanisms. The 20 percent inpatient savings assumption was therefore limited to the first $1,000 of per capita inpatient expenses in each year (with this threshold being increased to $1,200 and then $1,400 in the outyears of the projections).[12]

d) **Pharmacy.** Baseline FFS pharmacy costs were assumed to be reduced by 15% in each year. These savings accrue to the Medicare program (and not Medicaid) due to the MAA's creation of the Part D Medicare drug benefit effective in CY2006. Regarding the specific assumption used, Lewin has conducted several studies demonstrating savings from the mix and volume of prescription drugs lead to savings of well above 20%. A Rhode Island MCO simulation, as one example, demonstrated savings of 16% would occur from MCO drug *mix* impacts alone; an additional study found utilization reduction savings (in the sheer number of prescriptions occurring) of approximately 15 percent. A more modest capitation savings of 15% is used based on an assumption that some savings in dual eligibles' pharmacy costs will likely occur through more aggressive management of the drug benefit that occurs under Medicare Part D, but that the majority of potential pharmacy savings will be attributable to the fully integrated care model that health plans offer.

e) **Personal Support Services.** The MCO model was assumed to create no change in spending on personal support services (which includes Medicaid-covered case management and several additional services). While substantial additional outreach and case management activity is expected to occur in the capitated setting, these costs are factored into the administrative allocation described below.

f) **Home Health.** Home health services were estimated to increase under the MCO model, in the same proportion as nursing home costs *decrease* in each year. This adjustment acknowledges that additional costs will occur to retain high-need dual eligibles in the community who would otherwise become institutionalized in an unmanaged FFS setting.

g) **Other Medicaid Services.** A five percent savings is assumed in all other services, which includes outpatient hospital, physician services, diagnostic providers, and an array of other providers and services. For the vast majority of these expenditures, Medicare is the primary payer and the opportunity to achieve Medicaid savings is therefore limited.

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[12] Another aspect of Medicaid costs for dual eligibles is that Medicaid programs often pay zero for a dual eligible's claim when the payment made by Medicare exceeds the Medicaid fee schedule amount. These situations contribute $0 to the baseline costs in this report; thus no savings are assumed to occur in these situations in the capitated setting.

h) **Medicare Medical Costs.** The HMO model is estimated to save 15 percent on Medicare per capita medical costs in each year. A larger percentage savings is certainly possible, as large portions of the dual eligible population have multiple chronic conditions and very high costs in the medical service categories that the capitated model is best-equipped to favorably influence. Dual eligibles experience extremely high average per capita costs for inpatient services, outpatient hospital services, and for prescription drugs, all of which are medical service categories that the fully integrated MCO model has demonstrated its ability to significantly lower utilization and per capita costs relative to the traditional FFS setting.

MCO Administrative Costs and Operating Margins

MCO administrative costs were estimated at 7% of the MCO's medical expenses (summing the projected medical costs from both the Medicaid and Medicare "sides"). This allocation includes the MCOs' risk margin or profit margin, thus actual administrative costs are estimated to be in the vicinity of 5% of medical costs with a two percent risk margin. While this is an unusually small percentage allocation, the PMPM allocation is unusually large (more than $150 in most states in CY2010) due to the large base of PMPM medical dollars. The administrative allocation was distributed 40% to Medicaid and 60% to Medicare. The larger allocation to Medicare was made because most administrative costs are associated with managing acute care needs and Medicare is the primary payer for these services.

Note that we have not factored in the state Medicaid and CMS costs for administering the MCO program – hiring enrollment broker, conducting competitive bids, rate-setting, ongoing monitoring, etc. These administrative functions create additional costs, but such costs should be largely offset by the government's savings for administrative services that the MCOs take off of the Medicare & Medicaid program's hands, particularly claims processing/payment.

VI. CAPITATION SAVINGS ESTIMATES

Summary Findings

With the above baseline costs and assumptions, the estimates of state and national savings from full use of capitation is a straightforward calculation. The derived percentage savings factors from Section III are applied to the trended baseline fee-for-service expenditures from Section II, in each state and year. Note that the Medicaid savings from the capitated model estimated herein include only savings from expansion of capitated programs -- the savings existing Medicaid capitation programs for dual eligibles (or other subgroups) are creating are not included in these figures. Two states with existing capitation initiatives that include more than half the state's dual eligible population – Arizona and Minnesota – have been removed from the modeling effort. Similarly, Hawaii impacts have not been modeled given the current implementation of the Quest Expanded Access program, through which all dual eligibles will be served through a capitated model.

Our analyses indicate that large-scale savings can occur across the Medicare and Medicaid programs when dual eligibles are enrolled in the capitated setting. Table 5 shows the estimated overall savings by year if all dual eligibles nationwide were enrolled in the capitated MCO model.

While it is of course unrealistic that all dual eligibles would be converted into the MCO model, the national totals are useful in demonstrating the average percentage savings that occur when *any* population of dual eligibles is converted from the FFS to the MCO setting.

Table 5. Summary Of Nationwide Potential Cost Savings

National Summary of Total Savings						
	Medicaid Savings (Loss)		Medicare Savings (Loss)		Combined Savings (Loss)	
Year	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%

Because the dual eligibles' per capita costs are so high, the dollar savings that can occur at the state level (or even at the county level within states) can be substantial. State-specific tables showing potential savings are summarized in Table 6. The cumulative state-level savings magnitudes – combining the impacts to Medicare and Medicaid -- are shown in Exhibit C below for a large state (Ohio), a medium-sized state (Virginia), and a small state (South Dakota). The potential savings reach more than $1 billion across the 15 year timeframe in 41 states. The *smallest* cumulative fifteen-year savings in any state is $358 million in Wyoming. The largest cumulative savings is $34 billion in California.

Exhibit C. Overall Savings Projections In Three Sample States

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

Table 6. Savings By State And By Year (Medicare and Medicaid Impacts Combined)

State	One-Year Total Savings, Medicare Plus Medicaid			Five-Year Total Savings, Medicare Plus Medicaid			15 Year Total Savings, Medicare Plus Medicaid, 2010-2024
	2010	2015	2024	2010-2014	2015-2019	2020-2024	
Alabama	$162,379,723	$334,559,998	$809,642,778	$1,122,931,962	$2,122,892,399	$3,413,545,684	$6,659,370,044
Alaska	$6,826,237	$17,291,266	$42,526,783	$53,140,259	$113,002,641	$180,210,322	$346,353,222
Arizona	$0	$0	$0	$0	$0	$0	$0
Arkansas	$77,392,923	$169,625,933	$408,933,499	$544,706,349	$1,080,871,613	$1,742,077,017	$3,367,654,978
California	$1,184,955,259	$2,133,013,848	$4,781,046,682	$7,595,572,694	$13,154,864,289	$20,467,766,987	$41,218,203,971
Colorado	$51,066,425	$119,113,378	$281,393,846	$378,466,645	$764,461,347	$1,201,257,672	$2,344,185,664
Connecticut	$44,034,911	$188,025,116	$512,266,872	$458,992,745	$1,269,100,735	$2,169,912,862	$3,898,006,342
Delaware	$13,294,112	$38,918,017	$104,846,003	$110,679,724	$258,371,205	$439,052,806	$808,103,735
District of Columbia	$13,629,212	$32,647,405	$77,916,882	$99,476,153	$206,302,287	$333,806,377	$639,584,817
Florida	$647,504,462	$1,174,806,335	$2,631,634,161	$4,176,073,545	$7,234,882,515	$11,221,147,391	$22,632,103,452
Georgia	$239,795,823	$448,508,036	$1,016,102,143	$1,571,683,790	$2,781,849,359	$4,328,155,718	$8,681,688,867
Hawaii	$0	$0	$0	$0	$0	$0	$0
Idaho	$12,056,717	$35,166,604	$90,353,179	$98,540,913	$230,067,094	$382,748,701	$711,356,707
Illinois	$480,917,515	$855,179,478	$1,901,483,447	$3,034,870,890	$5,213,218,285	$8,131,926,137	$16,380,015,312
Indiana	$87,686,592	$267,829,227	$732,034,190	$735,319,403	$1,774,209,704	$3,068,118,311	$5,577,647,418
Iowa	$50,663,154	$121,275,009	$295,029,397	$366,055,712	$762,614,580	$1,260,198,573	$2,388,868,866
Kansas	$51,296,493	$115,354,811	$275,395,799	$370,390,622	$728,847,080	$1,169,492,558	$2,268,730,260
Kentucky	$138,955,926	$289,906,955	$704,461,335	$961,460,363	$1,836,795,950	$2,972,824,328	$5,771,080,642
Louisiana	$225,035,087	$407,586,752	$924,711,447	$1,425,438,548	$2,490,632,020	$3,945,009,750	$7,861,080,318
Maine	$44,176,205	$95,860,678	$230,022,748	$312,389,989	$612,923,171	$979,485,963	$1,904,799,124
Maryland	$71,296,752	$122,183,700	$191,110,425	$452,884,925	$692,118,885	$893,694,266	$2,038,698,076
Massachusetts	$135,378,431	$334,419,565	$770,916,558	$1,027,140,590	$2,104,960,255	$3,326,308,082	$6,458,408,927
Michigan	$237,930,183	$510,697,037	$1,236,131,458	$1,682,252,160	$3,266,527,668	$5,220,523,855	$10,169,303,684
Minnesota	$0	$0	$0	$0	$0	$0	$0
Mississippi	$153,122,505	$291,317,205	$667,044,335	$1,002,960,023	$1,803,842,004	$2,842,727,563	$5,649,529,590
Missouri	$179,838,905	$366,246,039	$888,553,952	$1,228,402,728	$2,315,487,190	$3,746,055,601	$7,289,945,519
Montana	$9,490,101	$31,554,845	$87,665,198	$86,517,227	$213,810,378	$365,469,139	$665,796,745
Nebraska	$27,009,997	$73,269,244	$186,530,209	$213,232,878	$478,621,014	$790,725,959	$1,482,579,851
Nevada	$33,035,012	$62,355,600	$141,408,192	$217,198,250	$386,979,521	$602,716,892	$1,206,894,664
New Hampshire	$17,510,698	$50,291,033	$134,741,995	$147,055,402	$336,281,828	$562,806,095	$1,046,143,325

State	One-Year Total Savings, Medicare Plus Medicaid			Five-Year Total Savings, Medicare Plus Medicaid			15 Year Total Savings, Medicare Plus Medicaid, 2010-2024
	2010	2015	2024	2010-2014	2015-2019	2020-2024	
New Jersey	$154,408,649	$436,541,411	$1,126,087,581	$1,226,942,927	$2,828,474,298	$4,765,538,147	$8,820,955,373
New Mexico	$0	$0	$0	$0	$0	$0	$0
New York	$270,972,992	$1,023,115,320	$2,721,193,570	$2,510,177,418	$6,718,609,017	$11,603,343,059	$20,832,129,493
North Carolina	$259,859,180	$535,390,993	$1,300,434,900	$1,768,326,430	$3,369,130,174	$5,495,137,820	$10,632,594,423
North Dakota	$130,818	$24,627,370	$83,445,033	$38,503,095	$179,234,794	$345,370,164	$563,108,053
Ohio	$154,280,116	$530,146,662	$1,410,757,279	$1,393,584,406	$3,501,752,472	$5,948,592,506	$10,843,929,383
Oklahoma	$104,309,214	$212,553,437	$508,905,309	$708,456,052	$1,340,191,660	$2,164,987,609	$4,213,635,321
Oregon	$63,779,485	$123,518,363	$293,225,303	$426,618,811	$775,448,902	$1,237,659,042	$2,439,726,755
Pennsylvania	$245,216,279	$726,069,993	$1,965,876,462	$2,042,532,390	$4,815,875,608	$8,233,944,959	$15,092,352,956
Rhode Island	$16,347,466	$78,845,944	$221,894,214	$195,113,906	$550,463,353	$930,730,564	$1,676,307,823
South Carolina	$152,227,499	$270,204,735	$594,607,691	$963,770,876	$1,648,298,530	$2,546,537,971	$5,158,607,377
South Dakota	$8,992,852	$29,578,294	$82,222,933	$80,656,702	$199,531,723	$343,069,940	$623,258,365
Tennessee	$230,336,824	$421,316,032	$929,772,984	$1,483,951,045	$2,562,820,411	$3,988,287,807	$8,035,059,263
Texas	$584,878,583	$1,136,575,910	$2,702,384,550	$3,855,405,568	$7,075,234,895	$11,457,993,202	$22,388,633,665
Utah	$16,117,074	$38,459,289	$95,212,527	$116,690,596	$245,260,250	$404,500,565	$766,451,411
Vermont	$28,734,968	$55,439,251	$130,758,017	$192,310,047	$347,795,425	$552,359,423	$1,092,464,895
Virginia	$139,227,195	$296,686,307	$691,562,563	$961,777,772	$1,847,126,425	$2,944,675,321	$5,753,579,518
Washington	$59,470,820	$148,230,344	$378,783,956	$458,135,681	$972,291,563	$1,599,655,968	$3,030,083,213
West Virginia	$36,833,198	$95,736,035	$242,867,918	$286,086,059	$624,732,425	$1,025,926,833	$1,936,745,317
Wisconsin	$167,874,452	$364,150,460	$904,304,245	$1,177,810,799	$2,319,461,615	$3,809,368,923	$7,306,641,336
Wyoming	$5,283,831	$15,811,747	$41,827,458	$44,531,310	$105,348,487	$176,686,696	$326,566,492
USA TOTAL	$7,095,560,857	$15,250,001,012	$36,550,028,009	$49,405,216,376	$96,261,617,044	$155,332,131,129	$300,998,964,549

Note: Savings are not projected for Arizona, Hawaii, Minnesota and New Mexico due to the large-scale dual eligible Medicaid managed care initiatives that have been implemented (or are in the process of being implemented) in these states.

Medicaid Impacts

As shown in Table 5, the overall projected savings through using the capitated MCO model for dual eligibles have interesting and important components when looking separately at Medicaid and Medicare impacts. For a variety of reasons, the isolated Medicaid impacts of using MCO contractors to serve the dual eligible population are unfavorable for several years, leading to increased Medicaid spending in the initial years. The initial Medicaid "losses" are attributable to two key factors: 1) the limited ability to generate acute care Medicaid savings (since Medicare is the primary payer); and 2) the barriers to achieving sizable short-term nursing home cost savings, as described earlier. However, despite these factors working against pure Medicaid savings occurring, the dual eligibles' Medicaid costs are reduced by the MCO model in the longer term. Nationwide, a net Medicaid savings occurs in 2015, or the sixth year of program implementation. Table 7 demonstrates the net savings or costs to each State's Medicaid program in four selected years: 2010, 2015, 2020 and 2024.

Medicare Impacts

Unlike Medicaid, the Medicare program is projected to realize immediate, large-scale savings when dual eligibles are enrolled in MCOs. These large savings, shown earlier in Tables 5 and 6, occur because the enrollees have such high FFS per capita costs in the areas MCOs are best-equipped to impact (inpatient and outpatient hospital, pharmacy, etc.), because the MCOs have a clear opportunity to serve dual eligibles for the remainder of these persons' lives (thus making outreach and care coordination initiatives a cost-effective MCO investment), and because the marginal administrative costs necessary to serve dual eligibles once these persons are already enrolled in the MCO on the "Medicaid side" are relatively modest. Table 8 summarizes the projected magnitude of the Medicare savings by year and by state.

Table 7. Projected State-Specific Medicaid Cost Impacts, Selected Years
(figures include state and federal share of Medicaid spending)

State	Medicaid Cost Savings (Loss), 2010	Medicaid Cost Savings (Loss), 2015	Medicaid Cost Savings (Loss), 2020	Medicaid Cost Savings (Loss), 2024
Alabama	-$35,843,737	$23,166,180	$82,060,784	$125,685,863
Alaska	-$3,896,536	$171,839	$3,213,008	$4,362,215
Arizona	$0	$0	$0	$0
Arkansas	-$17,459,886	$19,802,170	$59,077,282	$78,597,868
California	-$408,442,863	-$316,639,073	-$287,766,763	-$466,136,345
Colorado	-$11,014,106	$19,244,157	$44,651,664	$56,952,978
Connecticut	-$48,215,304	$32,154,661	$107,621,524	$144,806,294
Delaware	-$6,512,110	$6,578,080	$20,562,361	$30,927,430
District of Columbia	-$2,487,469	$6,358,722	$14,487,241	$17,890,957
Florida	-$145,541,271	-$54,873,505	-$6,034,616	-$30,898,367
Georgia	-$14,750,005	$50,227,659	$109,946,747	$145,074,897
Hawaii	$0	$0	$0	$0
Idaho	-$7,442,937	$3,649,603	$13,991,701	$19,283,028
Illinois	-$106,359,215	-$51,855,502	-$19,764,527	-$53,268,406

State	Medicaid Cost Savings (Loss), 2010	Medicaid Cost Savings (Loss), 2015	Medicaid Cost Savings (Loss), 2020	Medicaid Cost Savings (Loss), 2024
Indiana	-$59,708,207	$28,424,996	$124,131,937	$187,930,528
Iowa	-$10,163,867	$23,170,924	$57,098,614	$73,881,748
Kansas	-$7,737,507	$21,103,490	$47,760,888	$65,255,045
Kentucky	-$47,153,777	-$1,811,480	$40,781,076	$65,339,380
Louisiana	-$38,418,530	$374,713	$38,391,860	$46,531,512
Maine	-$6,083,763	$16,203,577	$39,988,109	$53,720,946
Maryland	-$56,300,388	-$79,382,650	-$149,068,452	-$254,682,710
Massachusetts	-$137,719,204	-$102,405,068	-$121,758,886	-$207,369,446
Michigan	-$58,621,854	$41,084,314	$134,028,602	$195,688,407
Minnesota	$0	$0	$0	$0
Mississippi	-$36,009,822	-$3,422,820	$22,363,232	$25,441,907
Missouri	-$65,278,721	-$16,013,909	$30,131,691	$55,739,354
Montana	-$6,221,871	$5,599,310	$18,005,522	$27,639,109
Nebraska	-$10,719,265	$12,141,745	$35,070,591	$48,203,749
Nevada	-$5,416,614	$2,271,350	$8,312,907	$10,199,923
New Hampshire	-$5,112,363	$12,964,241	$32,256,628	$48,499,310
New Jersey	-$79,446,245	$58,535,511	$195,513,103	$273,156,268
New Mexico	$0	$0	$0	$0
New York	-$299,978,531	$70,870,125	$408,364,892	$500,300,636
North Carolina	-$107,258,924	-$37,158,608	$28,334,121	$53,203,308
North Dakota	-$5,813,882	$12,753,789	$34,679,246	$51,433,988
Ohio	-$91,279,568	$122,184,599	$329,490,315	$465,589,961
Oklahoma	-$25,046,982	$10,398,670	$48,866,695	$67,854,457
Oregon	-$13,564,311	$3,147,363	$19,698,063	$31,535,698
Pennsylvania	-$153,594,503	$78,640,591	$324,589,013	$494,827,352
Rhode Island	-$22,031,071	$13,413,915	$46,046,061	$66,160,684
South Carolina	-$31,591,517	-$14,267,382	-$6,713,558	-$19,908,837
South Dakota	-$5,747,638	$5,287,826	$17,143,744	$26,195,666
Tennessee	-$110,500,070	-$106,582,861	-$137,520,858	-$211,806,848
Texas	-$161,078,308	-$20,863,410	$126,625,011	$195,710,319
Utah	$132,235	$12,345,897	$26,048,399	$35,526,043
Vermont	-$5,648,870	$1,867,682	$9,041,343	$14,139,284
Virginia	-$31,745,386	$28,073,647	$77,787,817	$103,532,341
Washington	-$15,067,103	$27,964,104	$73,640,377	$107,251,135
West Virginia	-$16,056,780	$10,101,061	$34,703,629	$48,756,434
Wisconsin	-$56,552,853	$11,329,478	$82,330,479	$128,987,697
Wyoming	-$930,290	$5,436,470	$12,587,807	$17,640,442
USA TOTAL	-$2,591,431,795	-$8,233,809	$2,250,796,423	$2,965,383,197

Table 8. Projected Medicare Cost Impacts By State, Selected Years

State	Medicare Cost Savings (Loss), 2010	Medicare Cost Savings (Loss), 2015	Medicare Cost Savings (Loss), 2020	Medicare Cost Savings (Loss), 2024
Alabama	$198,223,460	$311,393,818	$483,591,333	$683,956,914
Alaska	$10,722,773	$17,119,427	$26,844,873	$38,164,568
Arizona	$0	$0	$0	$0
Arkansas	$94,852,809	$149,823,763	$233,477,330	$330,335,631
California	$1,593,398,123	$2,449,652,921	$3,747,259,148	$5,247,183,027
Colorado	$62,080,531	$99,869,221	$157,422,423	$224,440,868
Connecticut	$92,250,215	$155,870,455	$253,527,434	$367,460,579
Delaware	$19,806,221	$32,339,936	$51,528,114	$73,918,574
District of Columbia	$16,116,682	$26,288,683	$41,869,937	$60,025,924
Florida	$793,045,733	$1,229,679,840	$1,892,708,539	$2,662,532,529
Georgia	$254,545,829	$398,280,376	$616,878,233	$871,027,246
Hawaii	$0	$0	$0	$0
Idaho	$19,499,655	$31,517,001	$49,816,330	$71,070,152
Illinois	$587,276,731	$907,034,980	$1,392,379,494	$1,954,751,854
Indiana	$147,394,800	$239,404,231	$380,207,361	$544,103,662
Iowa	$60,827,022	$98,104,085	$155,048,271	$221,147,649
Kansas	$59,034,001	$94,251,320	$147,809,573	$210,140,754
Kentucky	$186,109,704	$291,718,435	$452,375,015	$639,121,955
Louisiana	$263,453,616	$407,212,040	$625,471,276	$878,179,936
Maine	$50,259,968	$79,657,101	$124,419,339	$176,301,802
Maryland	$127,597,140	$201,566,350	$314,294,869	$445,793,135
Massachusetts	$273,097,634	$436,824,633	$686,790,124	$978,286,004
Michigan	$296,552,038	$469,612,723	$733,279,502	$1,040,443,051
Minnesota	$0	$0	$0	$0
Mississippi	$189,132,327	$294,740,025	$455,274,544	$641,602,429
Missouri	$245,117,626	$382,259,949	$590,701,299	$832,814,598
Montana	$15,711,972	$25,955,536	$41,658,070	$60,026,089
Nebraska	$37,729,262	$61,127,498	$96,834,562	$138,326,460
Nevada	$38,451,626	$60,084,249	$92,977,858	$131,208,270
New Hampshire	$22,623,061	$37,326,792	$59,858,259	$86,242,686
New Jersey	$233,854,894	$378,005,900	$597,742,811	$852,931,313
New Mexico	$0	$0	$0	$0
New York	$570,951,523	$952,245,195	$1,538,302,777	$2,220,892,934
North Carolina	$367,118,104	$572,549,601	$884,857,509	$1,247,231,592
North Dakota	$5,944,699	$11,873,582	$21,143,550	$32,011,045
Ohio	$245,559,684	$407,962,063	$655,988,011	$945,167,319
Oklahoma	$129,356,196	$202,154,767	$312,855,941	$441,050,852
Oregon	$77,343,796	$120,371,000	$185,737,997	$261,689,605
Pennsylvania	$398,810,781	$647,429,403	$1,027,777,160	$1,471,049,110
Rhode Island	$38,378,538	$65,432,029	$107,000,756	$155,733,530
South Carolina	$183,819,016	$284,472,117	$437,291,895	$614,516,529

State	Medicare Cost Savings (Loss), 2010	Medicare Cost Savings (Loss), 2015	Medicare Cost Savings (Loss), 2020	Medicare Cost Savings (Loss), 2024
South Dakota	$14,740,490	$24,290,468	$38,927,676	$56,027,268
Tennessee	$340,836,894	$527,898,893	$811,953,103	$1,141,579,832
Texas	$745,956,891	$1,157,439,320	$1,782,475,479	$2,506,674,230
Utah	$15,984,839	$26,113,392	$41,632,365	$59,686,484
Vermont	$34,383,838	$53,571,569	$82,726,092	$116,618,733
Virginia	$170,972,582	$268,612,660	$416,485,412	$588,030,222
Washington	$74,537,923	$120,266,241	$190,125,968	$271,532,821
West Virginia	$52,889,979	$85,634,974	$135,707,855	$194,111,484
Wisconsin	$224,427,305	$352,820,982	$548,257,618	$775,316,548
Wyoming	$6,214,122	$10,375,277	$16,759,166	$24,187,016
USA TOTAL	$9,686,992,653	$15,258,234,821	$23,738,052,250	$33,584,644,812

Overall Impacts for Federal and State Government

The savings figures in the previous tables illustrate the enormous opportunity that exists with regard to achieving large-scale cost savings through better coordinating the care of dual eligibles, but the Medicaid-specific figures also illustrate the public policy challenge. Currently, for the large-scale savings shown in this report to materialize, states need to *choose* to transition their dual eligible populations into a mandatory enrollment MCO setting, and the dual eligibles themselves need to *choose* to enroll in a Medicare Advantage plan such that the health plan is responsible for all health services provided to the member and is able to utilize/enforce its coordinated care model.

As described earlier, neither of these choices is currently occurring with regularity. The dual eligible population, given the exceptional benefits package Medicare and Medicaid collectively provide, has little incentive to choose a more restrictive coverage model than the traditional fee-for-service setting. Most states elect to exclude dual eligibles from their MCO initiatives due to the adverse state-specific economics. While net savings to the federal and state government combined are compellingly favorable, states are facing several years of net cost increases by moving their dual eligible population into the capitated setting. These dynamics were illustrated in Table 5. The creation of Part D, which moves dual eligibles' pharmacy costs from Medicaid to Medicare, further limits the opportunity to achieve *Medicaid* savings through the MCO model. Pennsylvania, for example, had included dual eligibles in its capitated HealthChoices program for several years, but has now excluded dual eligibles from participating in HealthChoices with the advent of Part D Medicare.

It is important to note that some states have chosen to transition dual eligibles into a more cost-effective coverage model. Most prominently, Arizona has relied entirely upon the capitated setting for all Medicaid eligibility categories – including dual eligibles (both community-based and institutionalized subgroups) – for decades. Many additional states have had mandatory enrollment programs in place for dual eligibles in certain geographic regions, such as Texas' STAR+PLUS initiative in the Houston area. Most recently, Hawaii is currently transitioning its entire dual eligible population into the capitated setting – the Quest Expanded Access initiative

will serve all of Hawaii's dual eligibles and non-Medicare disabled adults through a coordinated care program.

Section VII discusses the public policy changes that can eliminate the disincentives that now exist for many states regarding inclusion of their dual eligibles in capitated programs. This section also presents the reconfigured savings estimates based on a 50/50 sharing of total (Medicare plus Medicaid) net savings between the state and federal government.

VII. POTENTIAL PUBLIC POLICY CHANGES TO SPUR LARGE-SCALE DUAL ELIGIBLE ENROLLMENT INTO MCOS

Because of the substantial clinical and economic advantages the MCO model can offer, many attempts have been made to facilitate increased MCO enrollment of dual eligibles. Most recently in the policy arena, this involved permitting the creation of Medicare "Special Needs Plan" licenses targeted explicitly to the dual eligible population. Notwithstanding these efforts, as noted earlier, the degree to which dual eligibles have enrolled in capitated health plans is very low. To change this situation in a more meaningful way (i.e., to pave the way for large-scale enrollment rather than modest, incremental growth of a very small enrollment baseline), the foremost need is for federal legislation that creates an opportunity for states to implement mandatory enrollment coordinated care programs for dual eligibles that combine Medicare and Medicaid funds. The key components of such legislation (and accompanying regulations) could include the following provisions:

1) Each state would have the option as to whether to participate in the program at all, as well as to select which geographic area (statewide versus any desired subset of counties or other jurisdictions) the program will be implemented in. States would have the option to expand or contract their programs geographically at any time, and would also have the option to exclude any subgroups of dual eligibles from the initiative (e.g., persons with certain clinical conditions, residential situations, etc.). This option would reduce the need for waivers, reducing the cost and time needed for implementation.

2) For all counties that a state decides to include in the new program, states would have the option to make enrollment mandatory for dual eligibles into capitated MCOs, on both the Medicare and Medicaid side, as well as the option to permit dual eligibles to "opt out" back into the FFS setting. In the latter scenario, persons who did not proactively opt out would be assigned to a health plan. States would select the implementation schedule of this enrollment transition, both within and across counties.

3) States could be required to use an objective process to assist dual eligibles in joining the most appropriate available health plan. Direct marketing to dual eligibles by the MCOs should be prohibited, but general advertising could be permitted. (The combination of mandatory enrollment and minimal marketing ensures that taxpayer funds are used for "serving" rather than for "selling" and likely provides the participating health plans with sizable enrollment and administrative economies of scale.) The legislation and regulations might also include parameters about how dual eligibles should be "auto-assigned" to MCOs when they do not proactively select a health plan.

4) States could select its dual eligible MCO contractors through a competitive procurement or establish the program requirements and allow all interested parties who demonstrate compliance with these requirements to participate. It would typically seem to be in States' best interests to ensure that their existing Medicaid MCO contractors have an opportunity to expand their operations to serve dual eligibles – but in many situations it will also be important to create opportunities for organizations not yet serving the state's Medicaid population (but with experience serving dual eligibles and other high/need subgroups) to enter the market provided that they have the capacity and local

connections necessary to integrate care across medical, social services and housing needs.

5) The legislation might require regulations that establish minimum MCO requirements regarding new member orientation, ongoing care coordination, minimum provider network composition, the degree to which enrollees can self-refer to non-network providers during the first "x" months of MCO enrollment for continuity of care purposes, minimum provider payment rates, financial solvency protections, and data reporting. The legislation and regulations might also establish a minimum required process for state and CMS oversight and monitoring of the program – strong oversight of these programs is clearly warranted.

6) If a procurement is used to select health plans, MCO capitation payments by the state (for Medicaid services) and by CMS (for Medicare services) could be determined through a competitive bidding process, subject to minimum/maximum payment amounts determined by state and CMS actuaries. Even the maximum payment amounts might build in a minimum level of overall program savings (combining Medicare and Medicaid funds), relative to continued use of the FFS coverage approach.

7) Annual Medicare and Medicaid savings from the capitated program would be objectively derived by CMS and/or its selected actuarial contractors. The total savings would be derived by projecting FFS Medicare and Medicaid costs for dual eligibles in the counties where the new program has been implemented, then comparing these costs to actual costs occurring under the capitated MCO model. A starting point for discerning savings would involve identifying three to five years of "pre-program" baseline dual eligibles' costs (in each county where the program is being implemented), combining Medicare and Medicaid funds. The multi-year baseline would also establish the year-to-year trends in dual eligibles' per capita costs. Against these baseline cost levels, the actual total per capita costs for all dual eligibles (a combination of actual FFS and capitation costs) can be quantified in each county once the managed care program is operational – and compared with an estimate of what costs would have been in the absence of the initiative. States that already have a large proportion of dual eligibles enrolled in capitated programs (e.g., Arizona and Minnesota) may find it difficult to achieve cost reductions against their existing cost baseline; these states might simply continue forward with their existing initiatives and not elect to participate in a new dual eligibles capitation program.

8) The combined (Medicare plus Medicaid) savings derived through the above process would be shared 50/50 between the state Medicaid agency and CMS. Should the calculation show that added costs occurred (as opposed to savings), the program's financial model would need to be revised to ensure that future net savings for CMS would occur. No state dual eligibles capitation initiative would be permitted to continually operate at a net loss to CMS.

Table 9 estimates the financial implications of implementing the above model without the 50/50 sharing provision, which again illustrates why so many states have been hesitant to implement capitated initiatives for dual eligibles. Table 10 presents the same total dollar savings as are shown in Table 9, but with these savings split 50/50 between the state and federal governments. The shared savings arrangement depicted in Table 10 would strongly motivate states to

implement these new initiatives, although no state would be under any obligation to do so. The federal government should also have a strong preference for the program design modeled in Table 10. Under current policy, the federal government enjoys the lion's share of the savings that occur, but achieves savings only on a rather modest volume of dual eligible MCO enrollees. Conversely, under the new policies described herein and modeled in Table 10, the federal share of the savings would be "only" 50 percent, but this savings would be applied to a much larger pool of persons and would thus yield dramatically larger overall federal expenditure reductions.

Table 10 presents the state-by-state cost savings under a 50/50 sharing of total (Medicaid plus Medicare) annual savings between the state and federal government. The magnitude of this savings opportunity seems to present a compelling public policy option for any given state as well as for the federal government. Three examples of the estimated savings at the state level are conveyed below:

- In Ohio, as a "large state" example, the *state* share of the savings are estimated to average more than $350 million per year across the first fifteen years of statewide implementation. Even during the initial five years of implementation, state savings average approximately $140 million per year.

- The corresponding figures for Virginia, a medium-sized state example, are average *state budget* savings of approximately $190 million per year across the first 15 years of statewide implementation, and approximately $100 million per year across the initial five years.

- The corresponding figures for a small state, using South Dakota as an example, are average *state budget* savings of approximately $20 million per year across the first 15 years of statewide implementation, and $8 million per year during the initial five years.

Savings of this magnitude create rather exciting opportunities for state policymakers in terms of securing funding to enhance health care coverage to otherwise uninsured persons, supporting other parts of the state budget, or providing meaningful tax relief to a state's citizens.

Another policy option seeking to enhance the role of coordinated care programs for dual eligibles was recently put forth by the Galen Institute.[13] The report, "Medi*caid* Advantage: a medical home for dual eligible beneficiaries," outlines a new program whereby states, at their option, could accept capitation payments from CMS for the Medicare portion of dual elgibles' costs. Participating states would then be at risk for the full baseline costs of covering dual eligibles and would likely transfer this risk to capitated health plans -- with states building in savings for themselves in so doing. Under the Galen Institute model, dual eligibles would retain the option to receive traditional, FFS Medicare coverage.

In the absence of new policy initiatives, states are left with a fiscally challenging path to accessing the savings that coordinated care creates for dual eligibles. As shown in Table 9, states will typically experience fiscal losses rather than savings for several years when the dual

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[13] The Galen Institute's report can be downloaded at no cost at this web address:
http://www.galen.org/component,8/action,show_content/id,7/news_id,2969/type,33/

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eligible population is transitioned into the MCO setting – unless they are able to access some of the large-scale savings that the MCO model is projected to immediately create for Medicare. In the absence of federal legislation, one option available to states that softens (and in many cases, eliminates) any short-term "losses" from transitioning the dual eligible population into MCOs is to also transition into MCOs other Medicaid eligibles who are still covered via fee-for-service. Appendix A derives the consolidated net savings (or net costs) for states to undertake this approach. In every state, this approach is estimated to create cumulative state savings within a five-year timeframe.

Table 9. Projected State Government and Federal Government Cost Impacts
(assuming all Medicare savings accrue to federal government; state impacts shared per existing match formula)

State	State Savings			Federal Savings			State and Federal Savings		
	2010-2014	2015-2019	2020-2024	2010-2014	2015-2019	2020-2024	2010-2014	2015-2019	2020-2024
Alabama	-$51,006,652	$169,754,122	$350,659,920	$1,173,938,614	$1,953,138,277	$3,062,885,764	$1,122,931,962	$2,122,892,399	$3,413,545,684
Alaska	-$6,141,800	$4,799,871	$9,546,283	$59,282,059	$108,202,770	$170,664,039	$53,140,259	$113,002,641	$180,210,322
Arizona	$0	$0	$0	$0	$0	$0	$0	$0	$0
Arkansas	-$21,583,413	$129,885,565	$249,585,021	$566,289,762	$950,986,048	$1,492,491,995	$544,706,349	$1,080,871,613	$1,742,077,017
California	-$968,986,358	-$737,126,413	-$931,068,637	$8,564,559,052	$13,891,990,702	$21,398,835,624	$7,595,572,694	$13,154,864,289	$20,467,766,987
Colorado	-$435,463	$79,640,826	$126,876,974	$378,902,108	$684,820,521	$1,074,380,698	$378,466,645	$764,461,347	$1,201,257,672
Connecticut	-$58,545,720	$155,633,050	$314,924,103	$517,538,465	$1,113,467,685	$1,854,988,759	$458,992,745	$1,269,100,735	$2,169,912,862
Delaware	-$5,555,608	$30,755,549	$63,922,771	$116,235,332	$227,615,656	$375,130,035	$110,679,724	$258,371,205	$439,052,806
District of Columbia	$336,283	$32,499,931	$56,711,605	$99,139,870	$173,802,356	$277,094,772	$99,476,153	$206,302,287	$333,806,377
Florida	-$325,479,029	-$72,098,474	-$47,778,565	$4,501,552,574	$7,306,980,989	$11,268,925,956	$4,176,073,545	$7,234,882,515	$11,221,147,391
Georgia	$23,457,695	$250,974,549	$409,639,162	$1,548,226,095	$2,530,874,810	$3,918,516,556	$1,571,683,790	$2,781,849,359	$4,328,155,718
Hawaii	$0	$0	$0	$0	$0	$0	$0	$0	$0
Idaho	-$14,470,141	$27,190,873	$57,774,348	$113,011,054	$202,876,221	$324,974,353	$98,540,913	$230,067,094	$382,748,701
Illinois	-$244,052,873	-$106,060,237	-$89,114,786	$3,278,923,763	$5,319,278,522	$8,221,040,923	$3,034,870,890	$5,213,218,285	$8,131,926,137
Indiana	-$108,145,800	$205,557,924	$497,964,645	$843,465,203	$1,568,651,780	$2,570,153,667	$735,319,403	$1,774,209,704	$3,068,118,311
Iowa	-$3,432,127	$105,481,562	$204,622,409	$369,487,839	$657,133,018	$1,055,576,164	$366,055,712	$762,614,580	$1,260,198,573
Kansas	$6,615,899	$95,806,267	$168,976,230	$363,774,723	$633,040,812	$1,000,516,328	$370,390,622	$728,847,080	$1,169,492,558
Kentucky	-$113,558,106	$58,580,835	$184,977,572	$1,075,018,469	$1,778,215,115	$2,787,846,756	$961,460,363	$1,836,795,950	$2,972,824,328
Louisiana	-$109,673,493	$39,461,478	$151,394,344	$1,535,112,041	$2,451,170,542	$3,793,615,405	$1,425,438,548	$2,490,632,020	$3,945,009,750
Maine	$4,812,745	$85,303,253	$150,193,803	$307,577,244	$527,619,918	$829,292,161	$312,389,989	$612,923,171	$979,485,963
Maryland	-$160,162,920	-$260,930,873	-$496,338,037	$613,047,845	$953,049,758	$1,390,032,303	$452,884,925	$692,118,885	$893,694,266
Massachusetts	-$318,367,370	-$268,186,870	-$402,721,848	$1,345,507,960	$2,373,147,125	$3,729,029,931	$1,027,140,590	$2,104,960,255	$3,326,308,082
Michigan	-$70,263,273	$261,468,993	$493,521,190	$1,752,515,433	$3,005,058,676	$4,727,002,665	$1,682,252,160	$3,266,527,668	$5,220,523,855
Minnesota	$0	$0	$0	$0	$0	$0	$0	$0	$0
Mississippi	-$102,660,854	$27,277,306	$91,103,470	$1,105,620,877	$1,776,564,697	$2,751,624,093	$1,002,960,023	$1,803,842,004	$2,842,727,563
Missouri	-$156,543,118	$13,766,508	$134,415,589	$1,384,945,846	$2,301,720,682	$3,611,640,011	$1,228,402,728	$2,315,487,190	$3,746,055,601
Montana	-$7,256,104	$37,554,829	$77,053,573	$93,773,332	$176,255,549	$288,415,566	$86,517,227	$213,810,378	$365,469,139
Nebraska	-$10,638,157	$64,038,361	$123,407,275	$223,871,035	$414,582,653	$667,318,684	$213,232,878	$478,621,014	$790,725,959
Nevada	-$7,287,152	$13,095,910	$23,140,189	$224,485,402	$373,883,611	$579,576,703	$217,198,250	$386,979,521	$602,716,892
New Hampshire	$3,577,703	$54,101,493	$100,204,923	$143,477,699	$282,180,334	$462,601,173	$147,055,402	$336,281,828	$562,806,095

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State	State Savings			Federal Savings			State and Federal Savings		
	2010-2014	2015-2019	2020-2024	2010-2014	2015-2019	2020-2024	2010-2014	2015-2019	2020-2024
New Jersey	-$101,551,366	$268,598,701	$583,070,763	$1,328,494,293	$2,559,875,598	$4,182,467,384	$1,226,942,927	$2,828,474,298	$4,765,538,147
New Mexico	$0	$0	$0	$0	$0	$0	$0	$0	$0
New York	-$515,168,319	$446,020,435	$1,139,651,177	$3,025,345,736	$6,272,588,582	$10,463,691,881	$2,510,177,418	$6,718,609,017	$11,603,343,059
North Carolina	-$285,463,110	-$42,329,079	$131,124,392	$2,053,789,540	$3,411,459,253	$5,364,013,428	$1,768,326,430	$3,369,130,174	$5,495,137,820
North Dakota	-$1,053,821	$65,104,968	$134,966,995	$39,556,916	$114,129,827	$210,403,168	$38,503,095	$179,234,794	$345,370,164
Ohio	-$79,297,594	$626,805,493	$1,228,525,309	$1,472,882,000	$2,874,946,979	$4,720,067,197	$1,393,584,406	$3,501,752,472	$5,948,592,506
Oklahoma	-$46,864,143	$83,402,765	$193,464,466	$755,320,195	$1,256,788,895	$1,971,523,143	$708,456,052	$1,340,191,660	$2,164,987,609
Oregon	-$24,231,460	$33,457,494	$79,352,753	$450,850,270	$741,991,408	$1,158,306,290	$426,618,811	$775,448,902	$1,237,659,042
Pennsylvania	-$219,591,621	$481,075,493	$1,109,177,810	$2,262,124,011	$4,334,800,115	$7,124,767,149	$2,042,532,390	$4,815,875,608	$8,233,944,959
Rhode Island	-$24,168,008	$77,183,645	$146,849,559	$219,281,913	$473,279,708	$783,881,006	$195,113,906	$550,463,353	$930,730,564
South Carolina	-$97,470,769	-$37,932,022	-$45,139,677	$1,061,241,645	$1,686,230,552	$2,591,677,649	$963,770,876	$1,648,298,530	$2,546,537,971
South Dakota	-$6,493,074	$32,049,441	$67,260,825	$87,149,776	$167,482,282	$275,809,115	$80,656,702	$199,531,723	$343,069,940
Tennessee	-$361,284,109	-$383,541,052	-$553,525,980	$1,845,235,154	$2,946,361,463	$4,541,813,787	$1,483,951,045	$2,562,820,411	$3,988,287,807
Texas	-$371,368,261	$85,558,006	$481,804,599	$4,226,773,829	$6,989,676,889	$10,976,188,603	$3,855,405,568	$7,075,234,895	$11,457,993,202
Utah	$13,068,141	$61,079,266	$108,291,350	$103,622,454	$184,180,984	$296,209,216	$116,690,596	$245,260,250	$404,500,565
Vermont	-$8,750,852	$15,689,384	$34,218,621	$201,060,899	$332,106,041	$518,140,803	$192,310,047	$347,795,425	$552,359,423
Virginia	-$35,412,783	$116,661,035	$225,738,536	$997,190,555	$1,730,465,390	$2,718,936,785	$961,777,772	$1,847,126,425	$2,944,675,321
Washington	$1,032,841	$123,548,890	$231,284,505	$457,102,840	$848,742,674	$1,368,371,463	$458,135,681	$972,291,563	$1,599,655,968
West Virginia	-$27,935,973	$77,213,714	$153,100,718	$314,022,032	$547,518,711	$872,826,115	$286,086,059	$624,732,425	$1,025,926,833
Wisconsin	-$105,917,887	$117,116,670	$311,390,848	$1,283,728,685	$2,202,344,945	$3,497,978,075	$1,177,810,799	$2,319,461,615	$3,809,368,923
Wyoming	$2,962,538	$20,883,853	$37,564,061	$41,568,771	$84,464,634	$139,122,635	$44,531,310	$105,348,487	$176,686,696
TOTALS	-$5,120,404,836	$2,765,873,287	$7,871,765,151	$54,525,621,213	$93,495,743,757	$147,460,365,977	$49,405,216,376	$96,261,617,044	$155,332,131,129

Table 10. Projected State Government and Federal Government Cost Impacts
(assumes state and federal government each share 50/50 in total savings)

State	State Savings at 50% of Total Savings		
	2010 - 2014	2015 - 2019	2020 - 2024
Alabama	$561,465,981	$1,061,446,199	$1,706,772,842
Alaska	$26,570,130	$56,501,320	$90,105,161
Arizona	$0	$0	$0
Arkansas	$272,353,175	$540,435,806	$871,038,508
California	$3,797,786,347	$6,577,432,145	$10,233,883,493
Colorado	$189,233,322	$382,230,674	$600,628,836
Connecticut	$229,496,372	$634,550,368	$1,084,956,431
Delaware	$55,339,862	$129,185,603	$219,526,403
District of Columbia	$49,738,077	$103,151,143	$166,903,188
Florida	$2,088,036,773	$3,617,441,258	$5,610,573,696
Georgia	$785,841,895	$1,390,924,679	$2,164,077,859
Hawaii	$0	$0	$0
Idaho	$49,270,456	$115,033,547	$191,374,350
Illinois	$1,517,435,445	$2,606,609,142	$4,065,963,069
Indiana	$367,659,701	$887,104,852	$1,534,059,156
Iowa	$183,027,856	$381,307,290	$630,099,287
Kansas	$185,195,311	$364,423,540	$584,746,279
Kentucky	$480,730,182	$918,397,975	$1,486,412,164
Louisiana	$712,719,274	$1,245,316,010	$1,972,504,875
Maine	$156,194,995	$306,461,585	$489,742,982
Maryland	$226,442,462	$346,059,443	$446,847,133
Massachusetts	$513,570,295	$1,052,480,128	$1,663,154,041
Michigan	$841,126,080	$1,633,263,834	$2,610,261,927
Minnesota	$0	$0	$0
Mississippi	$501,480,012	$901,921,002	$1,421,363,782
Missouri	$614,201,364	$1,157,743,595	$1,873,027,800
Montana	$43,258,614	$106,905,189	$182,734,570
Nebraska	$106,616,439	$239,310,507	$395,362,980
Nevada	$108,599,125	$193,489,760	$301,358,446
New Hampshire	$73,527,701	$168,140,914	$281,403,048
New Jersey	$613,471,464	$1,414,237,149	$2,382,769,073
New Mexico	$0	$0	$0
New York	$1,255,088,709	$3,359,304,508	$5,801,671,529
North Carolina	$884,163,215	$1,684,565,087	$2,747,568,910
North Dakota	$19,251,547	$89,617,397	$172,685,082
Ohio	$696,792,203	$1,750,876,236	$2,974,296,253
Oklahoma	$354,228,026	$670,095,830	$1,082,493,804
Oregon	$213,309,405	$387,724,451	$618,829,521
Pennsylvania	$1,021,266,195	$2,407,937,804	$4,116,972,479
Rhode Island	$97,556,953	$275,231,677	$465,365,282
South Carolina	$481,885,438	$824,149,265	$1,273,268,986
South Dakota	$40,328,351	$99,765,862	$171,534,970
Tennessee	$741,975,523	$1,281,410,206	$1,994,143,903
Texas	$1,927,702,784	$3,537,617,447	$5,728,996,601
Utah	$58,345,298	$122,630,125	$202,250,283

State	State Savings at 50% of Total Savings		
	2010 - 2014	2015 - 2019	2020 - 2024
Vermont	$96,155,023	$173,897,713	$276,179,712
Virginia	$480,888,886	$923,563,213	$1,472,337,661
Washington	$229,067,840	$486,145,782	$799,827,984
West Virginia	$143,043,029	$312,366,213	$512,963,416
Wisconsin	$588,905,399	$1,159,730,807	$1,904,684,461
Wyoming	$22,265,655	$52,674,243	$88,343,348
USA TOTAL	**$24,702,608,188**	**$48,130,808,522**	**$77,666,065,564**

VII. CASE EXAMPLES OF STATE-SPONSORED COORDINATED CARE INITIATIVES FOR DUAL ELIGIBLES

A. Kentucky's Passport Advantage Program

While the existing policy dynamics have posed strong barriers to serving dual eligibles in a fully integrated manner, there is one locality – the Louisville, Kentucky area -- where the vast majority of dual eligibles are enrolled in a capitated health plan on both the Medicare and Medicaid "sides." In this area, a "passive" or "opt-out" approach was used through which the dual eligibles were enrolled in an MCO for Medicare as long as they were already enrolled in the same MCO for Medicaid benefits.

The Commonwealth of Kentucky's Department for Medicaid Services (DMS) contracts with University Health Care, Inc (UHC) d/b/a Passport Health Plan to provide health care services for Medicaid members in a 16 county area that includes the city of Louisville. UHC also contracts with the Centers for Medicare and Medicaid Services (CMS) to operate Passport Advantage, a Medicare Advantage Special Needs Plan. UHC covers approximately 145,000 Medicaid lives and about 9,500 of the 145,000 are dual eligibles who are also enrolled in the Passport Advantage Special Needs Plan. UHC receives capitation from both Medicaid (from the State's Department for Medicaid Services) and Medicare (from CMS).

Passport Advantage (Medicare Advantage Special Needs Plan for dual eligibles)

The health plan is accountable for coordinating all health care services including behavioral health for its members in the Passport Advantage Medicare Special Needs Plan (PAD). An important and innovative component of the Medicare Advantage Special Needs Plan is that the dual eligibles were passively enrolled at start-up through an opt-out provision. Any person who did not wish to be enrolled in PAD could exercise his/her opt-out option, but persons who took no action were placed into PAD for their Medicare coverage.

Less than one percent of the target population of dual eligibles in the 16 county area exercised the opt-out. Thus, the Louisville, Kentucky area may be the only geographic region in the nation where essentially the population of full dual eligibles is served via a capitated managed care model for both Medicaid and Medicare services. (Note that the passive enrollment feature applied only to the program's initial implementation. Dual eligibles can move to another Medicare plan or fee-for-service Medicare plan and PDP on a monthly basis).

The initial results from the PAD initiative appear to be highly encouraging:

- During CY2007, Passport Advantage experienced 1,602 disenrollments, of which 1,085 (68%) were involuntary departures related predominantly to loss of Passport Health Plan/Medicaid eligibility or death. Of the 517 voluntary disenrollments, 203 persons (39%) re-enrolled with Passport Health Plan during the year. The net voluntary disenrollment rate among Passport Advantage's dual eligibles is thus 314 divided by roughly 9,500 persons, or 3.3% per year.

- Consistent with the favorably low disenrollment statistics cited above, member surveys indicate a high level of satisfaction with the plan. The 2007 Medicare Part D CAHPS

Survey Report, which was administered by CMS, showed the overall rating of the health plan at 8.82 on a scale of 1-10. Overall rating of care received was 8.77. Overall rating of personal doctors was 8.97. Overall rating of specialists was 8.89. Overall rating of drug coverage was 8.31. The response rate was 39%. Passport Advantage rated above the national average in overall rating of health plan and in overall rating of care received per the 2007 Medicare Part D CAHPS Survey Report.

Passport Health Plan (Medicaid)

- On the Medicaid side, the plan also experiences high satisfaction rates. In 2007, at least three-fourths of members gave high ratings for satisfaction with care received from a personal doctor, care received from a specialist, and the plan itself. Seven out of ten also gave high ratings relative to overall health care in the past six months.

- Providers also appear to be largely satisfied with Passport Health Plan. Based on provider survey results, overall provider satisfaction was 71.6% in 2005, a figure that increased to 75.4% in 2007.

- Of Passport Health Plan's revenue, 92% is used to pay providers for health care services rendered to members -- Passport Health Plan's administrative costs and operating margin combined comprise eight percent of total program costs. The "medical loss ratio" of 92%, at which Passport Health Plan is operating viably, is well above the national norm of approximately 85% (a Lewin Group assessment of 216 Medicaid MCO financial statements yielded an average medical loss ratio of 85.4%).

Qualitatively, Passport Health Plan was ranked #11 of all Medicaid plans in the country by U.S. News & World Report's America's Best Health Plans. Passport is a provider sponsored health plan. The majority owner is the University of Louisville through the University Medical Center and the Medical School Practice Association. Jewish and St. Mary's Health Care, Norton Healthcare, and the Louisville-Jefferson County Primary Care Association are also owners. The Plan is administered by AmeriHealth Mercy Health Plan.

B. Minnesota's Senior Health Options Program

The Minnesota Senior Health Options (MSHO) demonstration initiative began in 1997. The program is a fully integrated model including both the Medicare and Medicaid services, through separate capitation payments from the State of Minnesota and from CMS. The MSHO target population of approximately 46,000 persons is comprised of individuals age 65 and above who are dually eligible for Medicaid and Medicare. Another 6,000 dual eligible seniors are exempted from MSHO due to a mental illness carve-out provision.

In the early years of the demonstration three health plans participated and their collective enrollment was relatively modest, although the initiative did serve roughly 6,000 members.

The program underwent significant expansions in 2006, encompassing 83 of Minnesota's 87 counties and with the number of participating MCOs growing to nine. All 46,000 MSHO-eligible persons are required to enroll either into an MSHO health plan or into the State's "regular" capitated Medicaid managed care program. Similar to what occurred in Kentucky, a passive enrollment approach was implemented whereby persons who did not make a proactive

choice of any kind were defaulted into an MSHO health plan. Approximately 33,000 persons are currently enrolled in MSHO, thus the program serves 72% of its target population.

MSHO health plans have rigorous contract and care management requirements. As an example, each enrollee must be matched to a health plan Care Coordinator who is licensed as a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician. This individual is not typically the enrollee's primary care physician, but rather a person who coordinates the provision of health and long-term care services for their enrollee panel across various settings of care.

Some of the required elements for the health plan's Care Management system are delineated below (as excerpted from the State's contract with each MSHO health plan):

1. Procedures for the provision of an individual needs assessment, diagnostic assessment, the development of an individual treatment plan as necessary based on the needs assessment, the establishment of treatment objectives, the monitoring of outcomes, and a process to ensure that treatment plans are revised as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs of the MCO's Enrollees.

2. Protocols to facilitate annual physician visits for primary and preventive care.

3. A strategy to ensure that all Enrollees and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment.

4. A method for coordinating the medical needs of an Enrollee with his/her social service needs.

Research outcomes on MSHO are available only for the pre-2006 time period when the program operated on a much smaller scale. These evaluations showed reduced hospitalizations among nursing home residents, strong member satisfaction rates.

Voluntary disenrollment rates have been very low (and are measurable for recent months), averaging below 3% per year. Members appear attracted to MSHO and happy with the program once enrolled primarily due to the tailored care management they receive under this program – a service that does not exist in the traditional fee-for-service coverage setting.

MSHO clearly serves a highly vulnerable target population, and a key outcome of the program is that the patient advocate community has been highly supportive of the model and its performance. The largest concern with the expansion during 2006 was that due to CMS regulations, the enrollment growth took place at a single point in time, placing massive burdens on the health plans to properly educate and assess a large volume of new members. Now that the program is in a more of a "steady state" mode of operation, the health plans are adequately staffed to accommodate the program's rigorous care coordination model.

At this point in time, the MSHO program is operating smoothly and successfully. Like the Kentucky initiative, MSHO provides encouraging evidence that more aggressive policies promoting a fully integrated care coordination program for dual eligibles are warranted.

VIII. CONCLUSIONS

A. Significant Savings Opportunities Exist

Combined public spending (Medicare and Medicaid) on behalf of the nation's approximately 8 million dual eligibles currently exceeds $220 *billion* per year, an annual expense of approximately $28,000 per dual eligible. Due to steady increases in the size of the dual eligible population and assuming typical per capita cost escalation occurs, total annual spending on duals is projected to be more than $775 billion as of the year 2024, at which point annual per capita costs are expected to approach $80,000.

Notwithstanding a wide range of public sector and private sector efforts to utilize coordinated care more extensively for dual eligibles, the vast majority of current spending for dual eligibles occurs in the traditional, unmanaged FFS setting. As of 2005, 6% of Medicaid dual eligibles' spending was paid via capitation. Similarly, less than 15% of Medicare's dual eligible spending currently occurs via capitated payments.

This report estimates that large-scale savings can be achieved in transitioning the dual eligible population into a fully integrated, capitated setting. The clinical and eligibility characteristics of the dual eligibles population are exceptionally well-matched to the strengths of a fully integrated care program operated by at-risk health plans. For any given dual eligibles subgroup moved into a capitated setting, encompassing the fully benefits package of Medicare and Medicaid covered services, we estimate initial, CY2010 net savings (across the Medicare and Medicaid programs) of approximately 3% per year, growing to nearly 6% per year as of CY2024. Given the large baseline size of the per capita spending on dual eligibles, these relatively modest percentage savings translate into rather massive dollar amounts. Total savings in Ohio, as a large state example, are estimated to be more than $10 billion across the fifteen-year timeframe 2020-2024. Similar figures for Virginia (a medium-sized state example) are nearly $6 billion, and for South Dakota (a small state example) are more than $600 million. The study presents savings estimates for each state and each year across the 2010-2024 timeframe (as shown in Table 6).

The state total figures can also be prorated to provide an indication of the level of savings available if a program of this nature is implemented not on a statewide basis but rather on a regional level within a state.

B. Policy Changes Are Necessary For Larger-Scale Programs To Occur

Existing policies have inadvertently created an impasse that inhibits large-scale enrollment of dual eligibles into a fully integrated setting. One key barrier, as delineated herein, is that the early-year savings from an integrated program primarily (if not entirely) accrue to the Medicare program -- savings that states cannot access under current federal policies. Conversely, states share in the net costs that initially occur on the Medicaid "side."

Another barrier is that dual eligibles themselves have little incentive to voluntarily enroll in MCOs. In the FFS setting, dual eligibles receive an extraordinarily comprehensive benefits package at essentially no cost. While many states have used mandatory enrollment models for

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more than a decade to achieve large-scale enrollment of their Medicaid populations into MCOs, it is not currently possible to mandate dual eligibles to enroll in a health plan on the Medicare "side." Medicare Advantage participants – even those special needs plans targeting dual eligibles – have often experienced modest enrollment despite often making considerable marketing investments.

The result of these barriers is that a very small proportion of dual eligibles are served in a fully integrated MCO setting where the overall cost savings potential is the most promising. Nothing in the existing policies can be expected to "break through" and yield large-scale increases in dual eligibles enrollment into a fully integrated system of coverage.

The key policy changes needed are federal legislation that accomplishes the following:

1) Permit states to enroll all dual eligibles in targeted counties into a coordinated care setting, with a given dual eligible being enrolled in the health plan for both Medicare and Medicaid services. The health plan would be at risk for this comprehensive package, and for making the outreach and administrative investments needed to improve their enrollees' health status and lower their medical costs relative to the unmanaged FFS environment. Enrollment would be achieved through a mandatory enrollment model or through an opt-out model as was successfully implemented in the Louisville, Kentucky area. A variety of additional design features are needed, as described in Section VII. For example, the health plans entrusted to serve dual eligibles in a mandatory enrollment setting (or an "opt-out" enrollment model) will need to be carefully selected and closely monitored, and marketing activities and expenses should be minimized and handled primarily by an objective third-party contractor.

2) Permit states to share 50/50 with the federal government in the net savings that occur across the Medicare and Medicaid programs. This change is necessary to motivate states to exercise their option to implement initiatives as described above.

These policy changes create the opportunity for large-scale coordinated care initiatives tailored to the needs of dual eligibles. At a minimum, initiatives of this nature seem to deserve an opportunity to be tested more broadly than has occurred to date. There are compelling potential financial and programmatic advantages to utilizing a fully integrated care/coverage model for dual eligibles. Conversely, the cost of continuing to cover the dual eligibles predominantly in the unmanaged, fee-for-service setting imposes an ever-accumulating fiscal strain that hampers our ability to achieve other important public objectives.

APPENDIX A

An April 2006 Lewin Group report, "Medicaid Capitation Expansion's Potential Cost Savings," developed estimated savings by state for the ten-year period 2006-2015. This report updates the earlier estimates to a 15 year timeframe extending from 2010-2015. Medicaid baseline costs were derived entirely through downloading and tabulating CMS website from the Medical Statistical Information System (MSIS) State Summary Datamart.[14] Baseline per capita costs are trended at 7% per year, and all managed care impact assumptions from the earlier study are relied upon.

All savings figures assume use of the capitated model through a mandatory enrollment mechanism with minimal MCO marketing activity permitted (with enrollees selecting health plans – and being assigned to MCOs if they do not make a proactive choice – through the support of an objective "enrollment broker" contractor). Savings are derived from the pool of Medicaid fee-for-service (FFS) expenditures in each state and eligibility category that are deemed amenable to impacts from the capitated model – thus savings already occurring through existing capitated programs are not quantified or otherwise factored into the report.

Table A-1 presents the TANF savings by state, and Table A-2 presents the SSI savings. Since these tables trend forward the FFS costs from a 2003 base year, changes in the level of capitation used by a state between 2003 and 2008 are not factored in. Thus, states that have expanded the use of capitation during that timeframe (Georgia and Ohio, for example) are already on a path to achieving the savings estimated in this report. Conversely, states that have less capitation now than in 2003 (Colorado and Illinois, for example), have an opportunity to achieve larger savings than those shown in the estimates herein.

The estimates in Tables A-1 and A-2 indicate that substantial Medicaid savings are possible in most states by relying more heavily on the capitated model for the TANF and non-Medicare disabled subgroups. It is worth noting that while large proportions of the Medicaid population are served through capitated programs, only a modest proportion of Medicaid expenditures are paid via capitation.

Table A-3 combines the savings from Tables A-1 and A-2 with the net state impacts of transitioning the dual eligible population into MCOs . All these figures represent the estimated impacts in total Medicaid expenditures (including both the state and federal share of Medicaid and excluding any Medicare savings impacts).

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[14] The website link to the data tables is: http://msis.cms.hhs.gov

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TABLE A-1. ESTIMATED MEDICAID SAVINGS FROM TANF AND TANF-RELATED CAPITATION, 2010-2024
Figures shown represent total savings (Federal and State share) unless otherwise indicated

State	Year 1 Percentage Savings Estimate	FY2010 Savings (Year 1)	FY2024 Savings (Year 15)	5 Year Total Savings, 2010-2014	5 Year Total Savings, 2015-2019	5 Year Total Savings, 2020-2024	15 Year Savings As % Of Baseline FFS	State Share Of Savings
Alabama	2.40%	$17,453,248	$110,632,637	$122,690,680	$245,397,308	$447,013,701	4.5%	32.0%
Alaska	4.14%	$19,746,207	$93,974,363	$128,200,153	$227,909,710	$387,121,213	6.2%	49.5%
Arizona	4.70%	$0	$0	$0	$0	$0		34.2%
Arkansas	2.15%	$16,221,620	$110,043,860	$116,487,801	$239,587,539	$442,918,699	4.2%	27.2%
California	4.86%	$220,657,487	$978,634,711	$1,408,277,334	$2,432,835,688	$4,054,061,140	6.9%	50.0%
Colorado	4.16%	$22,283,598	$105,847,130	$144,604,864	$256,872,599	$436,094,562	6.2%	50.0%
Connecticut	4.69%	$588,770	$2,650,351	$3,770,940	$6,553,762	$10,965,971	6.8%	50.0%
Delaware	4.50%	$5,434,930	$24,907,873	$34,960,023	$61,203,165	$102,909,553	6.6%	50.0%
District of Columbia	5.00%	$6,052,496	$26,531,166	$38,521,988	$66,233,499	$110,013,237	7.1%	30.0%
Florida	3.63%	$82,154,444	$416,267,218	$541,978,982	$988,531,689	$1,706,778,973	5.7%	44.6%
Georgia	2.48%	$57,691,414	$358,585,709	$403,134,191	$799,824,225	$1,450,563,730	4.5%	35.5%
Hawaii	4.79%	$0	$0	$0	$0	$0		44.9%
Idaho	2.49%	$7,623,631	$47,278,578	$53,235,860	$105,522,619	$191,278,869	4.6%	30.2%
Illinois	4.70%	$126,629,223	$569,873,586	$810,981,509	$1,409,308,550	$2,357,932,915	6.8%	49.7%
Indiana	3.19%	$28,177,238	$152,315,483	$189,133,641	$354,261,370	$621,685,296	5.3%	35.7%
Iowa	3.09%	$11,413,701	$62,736,676	$76,965,236	$145,155,598	$255,774,203	5.2%	37.4%
Kansas	3.16%	$9,525,288	$51,732,436	$64,018,869	$120,144,040	$211,081,659	5.2%	39.9%
Kentucky	2.06%	$19,082,562	$132,946,049	$138,220,732	$287,413,025	$534,322,173	4.1%	29.9%
Louisana	2.80%	$30,184,108	$175,223,712	$206,706,108	$398,718,588	$711,824,692	4.9%	28.7%
Maine	1.48%	$14,558,622	$126,371,228	$113,936,042	$259,039,138	$502,502,144	3.5%	35.6%
Maryland	4.65%	$19,522,612	$88,216,071	$125,151,906	$217,845,601	$364,886,706	6.7%	50.0%
Massachusetts	4.78%	$50,414,268	$225,095,549	$322,264,815	$558,234,786	$931,962,663	6.8%	50.0%
Michigan	4.24%	$21,522,781	$101,313,697	$139,354,944	$246,636,404	$417,708,364	6.3%	39.7%
Minnesota	4.27%	$11,447,106	$53,689,673	$74,050,985	$130,865,123	$221,420,713	6.3%	50.0%
Mississippi	3.72%	$30,799,065	$154,151,608	$202,536,221	$367,557,947	$632,618,668	5.8%	24.2%
Missouri	4.24%	$35,305,056	$166,270,516	$228,619,081	$404,699,144	$685,494,634	6.3%	36.8%
Montana	3.85%	$7,726,600	$38,023,404	$50,589,844	$91,175,410	$156,238,579	5.9%	32.0%
Nebraska	3.65%	$15,876,608	$80,239,126	$104,669,157	$190,708,752	$329,057,708	5.7%	40.5%

State	Year 1 Percentage Savings Estimate	FY2010 Savings (Year 1)	FY2024 Savings (Year 15)	5 Year Total Savings, 2010-2014	5 Year Total Savings, 2015-2019	5 Year Total Savings, 2020-2024	15 Year Savings As % Of Baseline FFS	State Share Of Savings
Nevada	4.79%	$7,621,862	$34,021,446	$48,718,238	$84,381,306	$140,862,147	6.8%	50.0%
New Hampshire	3.98%	$10,274,664	$49,781,515	$67,007,579	$119,997,731	$204,791,999	6.0%	50.0%
New Jersey	4.86%	$20,320,356	$90,139,811	$129,694,199	$224,067,517	$373,404,446	6.9%	50.0%
New Mexico	4.37%	$3,363,194	$15,611,976	$21,701,229	$38,189,970	$64,437,217	6.4%	29.1%
New York	4.69%	$284,204,882	$1,280,042,053	$1,820,504,561	$3,164,667,733	$5,296,012,394	6.7%	50.0%
North Carolina	1.82%	$42,206,690	$317,571,665	$313,716,159	$673,197,413	$1,271,261,226	3.9%	35.4%
North Dakota	2.02%	$2,196,663	$15,493,878	$15,975,704	$33,388,012	$62,230,201	4.1%	36.9%
Ohio	4.43%	$84,100,868	$388,039,869	$541,864,675	$951,230,285	$1,602,369,535	6.5%	37.9%
Oklahoma	4.11%	$19,179,453	$91,614,300	$124,635,243	$221,905,793	$377,292,321	6.2%	34.1%
Oregon	4.43%	$15,884,636	$73,341,602	$102,362,302	$179,744,574	$302,839,985	6.5%	37.6%
Pennsylvania	4.05%	$11,700,634	$56,253,164	$76,158,505	$135,954,517	$231,551,180	6.1%	45.5%
Rhode Island	4.77%	$5,280,139	$23,598,005	$33,760,103	$58,502,788	$97,695,140	6.8%	47.4%
South Carolina	4.01%	$52,146,031	$251,751,321	$339,771,096	$607,578,220	$1,035,938,594	6.1%	29.9%
South Dakota	2.25%	$4,397,172	$29,013,301	$31,298,605	$63,643,592	$116,957,769	4.3%	37.5%
Tennessee	4.09%	$92,231,780	$441,299,370	$599,607,115	$1,068,293,925	$1,817,157,036	6.2%	35.7%
Texas	4.15%	$172,853,942	$821,763,445	$1,121,940,846	$1,993,688,545	$3,385,475,181	6.2%	40.6%
Utah	4.71%	$14,628,041	$65,774,300	$93,664,214	$162,711,003	$272,169,511	6.8%	29.3%
Vermont	1.46%	$4,349,880	$38,196,806	$34,191,598	$78,096,752	$151,809,419	3.5%	40.6%
Virginia	3.95%	$15,203,009	$73,957,314	$99,249,653	$178,030,266	$304,154,226	6.0%	50.0%
Washington	4.53%	$21,662,627	$98,972,928	$139,240,374	$243,457,882	$409,017,658	6.6%	49.1%
West Virginia	2.43%	$10,396,095	$65,402,221	$72,912,299	$145,380,286	$264,377,217	4.5%	26.3%
Wisconsin	4.21%	$10,859,944	$51,295,754	$70,375,099	$124,726,519	$211,432,318	6.3%	40.6%
Wyoming	4.13%	$5,544,217	$26,417,659	$36,006,168	$64,042,280	$108,815,638	6.2%	50.0%
USA TOTAL	4.10%	$1,798,699,460	$8,852,906,113	$11,777,417,466	$21,227,112,189	$36,376,283,122	5.9%	42.2%
Federal Share		$1,029,426,948	$5,125,580,908	$6,760,456,654	$12,242,556,799	$21,042,796,971		
State Share		$769,272,513	$3,731,714,778	$5,016,960,812	$8,947,742,948	$15,333,486,151		

Note: Maximum Year 1 savings are 5%, reduced by degree to which a state's population resides in rural areas and the degree to which the FFS eligibles were enrolled in a primary care case management program during the 2003 base year. Savings percentage increases by 0.25% in each subsequent year.

TABLE A-2. ESTIMATED MEDICAID SAVINGS FROM SSI NON-DUAL ELIGIBLE CAPITATION, 2010-2024
Figures shown represent total savings (Federal and State share) unless otherwise indicated

State	Year 1 Percentage Savings Estimate	FY2010 Savings (Year 1)	FY2024 Savings (Year 15)	5 Year Total Savings, 2010-2014	5 Year Total Savings, 2015-2019	5 Year Total Savings, 2020-2024	15 Year Savings As % Of Baseline $$ Moved to Capitation	State Share of Savings
Alabama	3.13%	$23,536,318	$128,598,994	$158,448,622	$298,097,840	$524,502,861	5.2%	32.0%
Alaska	6.62%	$17,784,623	$70,096,204	$110,518,510	$182,085,357	$293,361,628	8.7%	49.5%
Arizona	7.53%	$0	$0	$0	$0	$0		34.2%
Arkansas	3.07%	$23,403,508	$129,137,179	$157,984,392	$298,430,540	$526,349,330	5.1%	27.2%
California	7.78%	$620,858,349	$2,321,313,892	$3,815,419,160	$6,156,128,403	$9,763,070,113	9.8%	50.0%
Colorado	5.96%	$32,702,854	$133,876,302	$204,918,765	$342,764,947	$558,384,913	8.0%	50.0%
Connecticut	7.51%	$45,473,457	$171,907,475	$280,094,368	$453,902,026	$722,254,128	9.6%	50.0%
Delaware	7.20%	$10,428,814	$39,955,685	$64,416,914	$104,943,213	$167,658,751	9.3%	50.0%
District of Columbia	8.00%	$31,042,208	$115,062,377	$190,426,252	$306,204,139	$484,337,032	10.1%	30.0%
Florida	5.27%	$176,434,980	$756,889,624	$1,117,329,048	$1,904,430,875	$3,144,170,285	7.3%	44.6%
Georgia	4.07%	$70,788,885	$339,327,143	$460,417,535	$820,923,656	$1,397,064,810	6.1%	35.5%
Hawaii	7.66%	$12,993,040	$48,811,586	$79,926,323	$129,202,797	$205,200,038	9.7%	44.9%
Idaho	6.52%	$21,541,692	$85,364,099	$134,022,350	$221,284,592	$357,083,926	8.6%	30.2%
Illinois	7.23%	$183,824,284	$703,324,667	$1,135,124,080	$1,848,263,510	$2,951,609,495	9.3%	49.7%
Indiana	6.83%	$74,863,614	$291,937,098	$464,158,424	$761,490,931	$1,222,990,973	8.9%	35.7%
Iowa	3.99%	$19,425,868	$94,019,293	$126,654,186	$226,714,379	$386,809,337	6.1%	37.4%
Kansas	4.22%	$20,619,808	$97,218,866	$133,561,363	$236,537,181	$400,775,849	6.3%	39.9%
Kentucky	3.99%	$51,745,046	$250,382,724	$337,351,315	$603,810,506	$1,030,129,844	6.1%	29.9%
Louisana	4.46%	$59,151,000	$272,120,584	$380,839,397	$667,755,582	$1,123,954,757	6.5%	28.7%
Maine	5.53%	$41,965,503	$176,755,266	$264,646,371	$447,756,169	$735,402,914	7.6%	35.6%
Maryland	7.44%	$82,955,163	$314,492,448	$511,265,952	$829,450,798	$1,320,957,791	9.5%	50.0%
Massachusetts	7.65%	$132,141,150	$496,523,516	$812,897,420	$1,314,174,942	$2,087,304,415	9.7%	50.0%
Michigan	6.99%	$40,654,668	$157,348,356	$251,657,053	$411,633,552	$659,627,187	9.0%	39.7%
Minnesota	6.84%	$96,420,489	$375,880,832	$597,771,675	$980,571,246	$1,574,696,435	8.9%	50.0%
Mississippi	5.95%	$47,492,908	$194,489,243	$297,617,115	$497,888,563	$811,171,021	8.0%	24.2%
Missouri	6.78%	$84,403,099	$330,050,873	$523,614,518	$859,980,459	$1,382,305,152	8.8%	36.8%
Montana	3.13%	$4,881,853	$26,673,228	$32,864,905	$61,830,020	$108,789,361	5.2%	32.0%

State	Year 1 Percentage Savings Estimate	FY2010 Savings (Year 1)	FY2024 Savings (Year 15)	5 Year Total Savings, 2010-2014	5 Year Total Savings, 2015-2019	5 Year Total Savings, 2020-2024	15 Year Savings As % Of Baseline $$ Moved to Capitation	State Share of Savings
Nebraska	5.92%	$13,507,063	$55,413,614	$84,677,007	$141,760,635	$231,080,758	8.0%	40.5%
Nevada	7.66%	$24,703,995	$92,806,530	$151,965,877	$245,656,267	$390,151,364	9.7%	50.0%
New Hampshire	6.37%	$10,531,002	$42,072,640	$65,634,971	$108,722,192	$175,863,076	8.4%	50.0%
New Jersey	7.77%	$112,000,973	$418,817,629	$688,310,378	$1,110,642,013	$1,761,455,062	9.8%	50.0%
New Mexico	7.00%	$21,543,698	$83,335,466	$133,342,152	$218,058,512	$349,372,491	9.1%	29.1%
New York	7.50%	$744,200,988	$2,814,503,762	$4,584,301,164	$7,430,190,347	$11,824,438,403	9.6%	50.0%
North Carolina	3.41%	$77,760,198	$406,564,047	$517,262,382	$955,683,586	$1,663,257,939	5.5%	35.4%
North Dakota	6.11%	$4,370,466	$17,726,024	$27,329,430	$45,543,965	$73,994,408	8.2%	36.9%
Ohio	7.09%	$232,709,164	$896,090,594	$1,438,939,154	$2,348,910,103	$3,758,324,749	9.2%	37.9%
Oklahoma	6.58%	$27,625,569	$109,132,629	$171,757,653	$283,238,050	$456,638,733	8.6%	34.1%
Oregon	6.97%	$22,589,988	$87,506,234	$139,860,046	$228,845,616	$366,809,749	9.0%	37.6%
Pennsylvania	6.77%	$65,532,704	$256,401,454	$406,595,733	$667,936,340	$1,073,795,193	8.8%	45.5%
Rhode Island	7.64%	$30,673,010	$115,336,691	$188,720,183	$305,181,254	$484,823,827	9.7%	47.4%
South Carolina	6.42%	$60,634,232	$241,587,021	$377,683,232	$624,945,702	$1,010,077,270	8.5%	29.9%
South Dakota	4.84%	$7,494,534	$33,298,849	$47,851,908	$82,725,766	$137,922,386	6.9%	37.5%
Tennessee	6.55%	$86,500,129	$342,313,366	$538,005,583	$887,822,994	$1,432,096,941	8.6%	35.7%
Texas	6.92%	$235,211,645	$913,228,161	$1,456,964,382	$2,386,127,984	$3,827,266,406	9.0%	40.6%
Utah	7.53%	$19,539,317	$73,804,563	$120,331,697	$194,937,066	$310,107,976	9.6%	29.3%
Vermont	2.35%	$4,889,675	$31,405,263	$34,512,484	$69,404,696	$126,796,072	4.4%	40.6%
Virginia	6.13%	$41,461,507	$167,918,998	$259,184,647	$431,676,197	$701,040,964	8.2%	50.0%
Washington	7.28%	$88,731,224	$338,838,967	$547,697,632	$891,108,253	$1,422,246,704	9.3%	49.1%
West Virginia	5.34%	$39,208,511	$167,305,442	$247,995,467	$421,787,364	$695,312,575	7.4%	26.3%
Wisconsin	6.73%	$69,973,407	$274,230,622	$434,302,564	$713,922,530	$1,148,287,680	8.8%	40.6%
Wyoming	6.60%	$6,993,120	$27,587,960	$43,465,769	$71,638,435	$115,449,477	8.7%	50.0%
USA TOTAL	6.48%	$4,075,919,301	$16,128,784,086	$25,350,637,510	$41,832,722,091	$67,476,572,550	8.6%	43.8%
Federal Share		$2,277,666,709	$9,074,537,646	$14,187,156,026	$23,474,772,913	$37,940,883,521		
State Share		$1,798,252,592	$7,054,246,440	$11,163,481,484	$18,357,949,178	$29,535,689,029		

Note: Maximum Year 1 savings are 8%, reduced by degree to which a state's population resides in rural areas and the degree to which the FFS eligibles were enrolled in a primary care case management program during the 2003 base year. Savings percentage increases by 0.25% in each subsequent year.

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Table A-3. Estimated Medicaid Fiscal Impacts of Transitioning Existing TANF, SSI, and Dual Eligibles from Fee-For-Service Setting to Capitated MCOs

Figures assume states do not share in Medicare savings; figures represent total Medicaid cost impacts (federal and state share combined). although right-hand column indicates state percentage share of savings. Positive figures denote savings, negative figures denote net costs.

Cost impacts are not modeled for Arizona, Hawaii, and Minnesota due to the large-scale capitation initiatives these states are implementing for their dual eligible populations.

State	CY2010 Savings (Year 1)	CY2024 Savings (Year 15)	5 Year Total Savings, 2010-2014	5 Year Total Savings, 2015-2019	5 Year Total Savings, 2020-2024	State Share Of Savings
Alabama	$5,145,829	$364,917,494	$206,107,451	$793,207,007	$1,487,344,628	32.0%
Alaska	$33,634,294	$168,432,783	$226,563,904	$419,494,119	$699,375,149	49.5%
Arizona	$0	$0	$0	$0	$0	34.2%
Arkansas	$22,165,242	$317,778,908	$244,828,720	$716,407,812	$1,312,057,509	27.2%
California	$433,072,973	$2,833,812,258	$3,285,723,778	$7,114,711,265	$11,954,993,978	50.0%
Colorado	$43,972,345	$296,676,409	$348,652,702	$758,919,198	$1,248,233,423	50.0%
Connecticut	-$2,153,077	$319,364,119	$166,773,867	$771,721,889	$1,363,068,307	50.0%
Delaware	$9,351,634	$95,790,988	$88,265,721	$227,657,476	$398,413,846	50.0%
District of Columbia	$34,607,235	$159,484,501	$229,428,643	$418,866,112	$675,366,848	30.0%
Florida	$113,048,152	$1,142,258,474	$1,071,800,758	$2,762,820,915	$4,764,706,362	44.6%
Georgia	$113,730,294	$842,987,750	$899,925,885	$2,009,916,044	$3,482,826,495	35.5%
Hawaii	$0	$0	$0	$0	$0	44.9%
Idaho	$21,722,385	$151,925,705	$166,518,434	$365,779,366	$631,169,657	30.2%
Illinois	$204,094,292	$1,219,929,847	$1,461,103,854	$3,046,800,524	$5,132,446,253	49.7%
Indiana	$43,332,645	$632,183,108	$484,997,948	$1,435,637,026	$2,619,597,907	35.7%
Iowa	$20,675,701	$230,637,717	$198,138,542	$540,317,058	$969,351,999	37.4%
Kansas	$22,407,588	$214,206,348	$208,592,048	$516,145,715	$893,109,556	39.9%
Kentucky	$23,673,831	$448,668,153	$313,646,900	$974,755,309	$1,828,215,843	29.9%
Louisana	$50,916,578	$493,875,808	$433,747,310	$1,121,812,101	$2,048,083,957	28.7%
Maine	$50,440,362	$356,847,439	$386,054,459	$839,233,210	$1,471,089,039	35.6%
Maryland	$46,177,386	$148,025,810	$316,092,019	$525,434,652	$693,168,423	50.0%
Massachusetts	$44,836,214	$514,249,619	$498,427,495	$1,336,035,989	$2,213,823,381	50.0%
Michigan	$3,555,594	$454,350,461	$274,431,156	$1,092,099,378	$1,896,186,040	39.7%

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State	CY2010 Savings (Year 1)	CY2024 Savings (Year 15)	5 Year Total Savings, 2010-2014	5 Year Total Savings, 2015-2019	5 Year Total Savings, 2020-2024	State Share Of Savings
Minnesota	$0	$0	$0	$0	$0	50.0%
Mississippi	$42,282,151	$374,082,757	$364,788,286	$901,413,423	$1,563,915,573	24.2%
Missouri	$54,429,434	$552,060,743	$504,499,593	$1,286,465,499	$2,280,516,338	36.8%
Montana	$6,386,581	$92,335,742	$72,790,280	$208,200,653	$378,275,402	32.0%
Nebraska	$18,664,407	$183,856,489	$171,478,920	$440,024,579	$767,406,311	40.5%
Nevada	$26,909,243	$137,027,899	$186,109,811	$356,229,394	$577,293,889	50.0%
New Hampshire	$15,693,303	$140,353,465	$139,797,955	$336,922,909	$581,064,921	50.0%
New Jersey	$52,875,084	$782,113,708	$614,901,846	$1,871,906,931	$3,301,001,034	50.0%
New Mexico	$24,906,892	$98,947,443	$155,043,381	$256,248,482	$413,809,708	29.1%
New York	$728,427,339	$4,594,846,451	$5,374,469,088	$11,486,898,949	$19,399,753,152	50.0%
North Carolina	$12,707,964	$777,339,020	$389,085,181	$1,563,356,109	$3,137,498,100	35.4%
North Dakota	$753,247	$84,653,890	$41,636,375	$182,027,729	$349,949,066	36.9%
Ohio	$225,530,463	$1,749,720,424	$1,853,192,638	$4,308,839,282	$7,337,722,461	37.9%
Oklahoma	$21,758,040	$268,601,385	$225,278,871	$631,703,426	$1,127,503,839	34.1%
Oregon	$24,910,313	$192,383,534	$203,420,971	$462,165,040	$796,715,792	37.6%
Pennsylvania	-$76,361,165	$807,481,971	$79,981,639	$1,686,274,374	$3,339,788,431	45.5%
Rhode Island	$13,922,078	$205,095,380	$176,524,766	$510,448,912	$861,753,724	47.4%
South Carolina	$81,188,746	$473,429,505	$578,349,477	$1,178,389,454	$1,981,595,031	29.9%
South Dakota	$6,144,068	$88,507,816	$68,769,899	$197,607,474	$362,411,450	37.5%
Tennessee	$68,231,840	$571,805,888	$575,565,236	$1,359,444,467	$2,388,137,019	35.7%
Texas	$246,987,279	$1,930,701,925	$1,954,126,861	$4,523,756,646	$8,023,314,600	40.6%
Utah	$34,299,593	$175,104,906	$232,477,231	$444,028,023	$735,426,050	29.3%
Vermont	$3,590,685	$83,741,353	$53,984,399	$173,892,338	$336,164,147	40.6%
Virginia	$24,919,130	$345,408,652	$287,608,732	$843,028,531	$1,456,672,261	50.0%
Washington	$95,326,748	$545,063,031	$688,965,570	$1,377,104,199	$2,285,297,548	49.1%
West Virginia	$33,547,825	$281,464,097	$283,018,204	$671,892,612	$1,167,340,297	26.3%
Wisconsin	$24,280,499	$454,514,073	$326,304,665	$1,035,881,567	$1,884,123,581	40.6%
Wyoming	$11,607,047	$71,646,060	$85,397,013	$177,448,422	$299,393,237	50.0%
USA TOTAL	**$3,162,326,331**	**$27,468,691,305**	**$27,197,388,482**	**$66,259,371,586**	**$114,916,471,564**	**42.2%**

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