Achieving Optimal Care Coordination for Medicaid/Medicare Dual Eligibles

Prepared by: Special Needs Consulting Services

Joel Menges
Jeremy Batt
Kaleigh Beronja
Jessica Wiecezak

August 2011

Table of Contents

I. Executive Summary

Approximately 8.4 million persons are currently covered by both the Medicaid and Medicare program. These individuals are commonly referred to in the health policy arena as dual eligibles or "duals." Current average annual health care expenditures for dual eligibles are approximately $34,000 per person across their Medicaid and Medicare benefits. Dual eligibles' health care costs are estimated to total $286 billion in 2011, representing 10.5% of all U.S. health care costs, 30% of total U.S. Medicaid expenditures, 27% of total U.S. Medicare expenditures, and 1.9% of the nation's gross domestic product. Our current annual outlays for duals' health care represents $2,486 per U.S. household, roughly equivalent to the average household's cell phone and electricity bills *combined*.

These expenditures have predominantly occurred in the traditional fee-for-service (FFS) coverage setting, where many individuals receive excellent health care services but where there is no means of (or accountability for) ensuring that duals' considerable health needs are being addressed in a cost-effective and quality manner. Coordinated care programs currently serve only a modest proportion of the nation's dual eligibles.

- As of 2008, 8.5% of nationwide Medicaid spending on dual eligibles occurred via capitation payments to managed care organizations (MCOs). As a point of reference, 43.9% of Medicaid spending on TANF and TANF-related eligibles occurred through capitation payments to MCOs.

- As of January 2011, 24% of all Medicare beneficiaries were enrolled in Medicare Advantage health plans; 12% of all dual eligibles were enrolled in Medicare Special Needs Plans specifically designed to serve duals.

Another policy issue warranting attention is that existing coordinated care programs for duals have not been designed to achieve optimal success. For example, the American taxpayer is losing – rather than saving – money from the Medicare Advantage program, where extensive marketing costs occur but where only a modest proportion of the population (18% nationwide) has elected to enroll in the coordinated care program. One of many sources of research findings on this subject is "The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to $11.4 Billion in 2009," published by The Commonwealth Fund and authored by Brian Biles, Jonah Pozen and Stuart Gutterman. The Medicare dual eligible SNPs' favorable impacts on inpatient hospital utilization are quantified in the "2010 SNP Alliance Profile and Advanced Practice Report."

It is important that public policy be shaped to both significantly increase the number of dual eligibles served in the coordinated care setting, and to ensure that the coordinated care programs into which duals are enrolled are designed to achieve the most favorable outcomes.

This Special Needs Consulting Services (SNCS) paper has three major objectives. First, it shares baseline information about each state's dual eligible population -- the number of dual eligibles with full and partial Medicaid benefits, existing spending on Medicaid and Medicare services for duals by various key components, and an estimate of the degree to which health care spending on

each state's duals occurs in the coordinated care versus the FFS setting. Second, the report quantifies the savings that would occur with each percentage point reduction in expenditures on duals in each state, along with estimates of the percentage savings that are achievable in an optimal program design situation. Third, the report delineates six key public policy "linchpins" to achieving optimal coordinated care for duals.   These linchpins, most of which involve structuring the coordinated care program more along the lines used by many successful Medicaid coordinated care programs rather than the Medicare Advantage program, are outlined below.

Linchpin #1 -- Mandatory Enrollment. The most successful programs will *require* duals to participate in a coordinated care setting, rather than *invite* them to do so. Mandatory enrollment is the only path to achieving <u>full</u> participation of a given area's dual eligible population at minimal marketing/transitional expense. This enrollment model also forces the provider community to work constructively with the MCO community if the providers desire to maintain or increase their revenues derived from serving dual eligible patients.

Linchpin #2 – Fully Integrated Model. An optimal coordinated care program will serve the "whole person" effectively, without regard to whether a Medicaid or Medicare component of the benefits package is primarily being impacted at any particular moment in time.

Linchpin #3 – Large Savings Opportunity for States. States and the Federal Government need to share significantly (perhaps equally) in the overall savings that the coordinated care program achieves – again without regard to the degree to which the savings are occurring on the Medicaid versus Medicare side of the ledger. However, since most of the baseline health care costs for duals consist of Federal funds, it is also appropriate that CMS play a large role in the design and monitoring of the programs that emerge in each state.

Linchpin #4 – Selective Contracting With MCOs. The participating MCOs in a given area should be selected through a competitive procurement process. In this way, a relatively small group consisting of roughly the 3-5 best-qualified MCOs will serve an area's dual eligible population (rather than including <u>all</u> health plans that successfully complete an application process as occurs in Medicare Advantage). The winning MCOs will be ensured considerable market share in order to operate as cost-effectively as possible, and can frame their proposed programmatic commitments accordingly.

Linchpin #5 – Effective Transition of Duals Into the Program.   A variety of program features are needed to create a successful transition of the duals into the coordinated care setting:

- Creating an objective selection process among participating MCOs (with no marketing allowed by the MCOs), with a carefully designed assignment process used for individuals who do not proactively select an MCO.

- Providing MCOs with available pre-enrollment FFS claims data for their new enrollees.

- Requiring that MCOs conduct a telephonic assessment of each new enrollee – and a face-to-face assessment in many circumstances – that encompasses the person's health care

needs, housing, social support system, weight and dietary habits, and other information that define the strengths and challenges impacting health status and future needs.

- Phasing in enrollment across a wide enough timeframe to enable the MCOs to conduct the needed new member orientation, education, and assessment activities effectively.

- Requiring that established patient/provider relationships with key front-line providers (e.g., physicians, dentists and behavioral health therapists), be allowed to continue for at least the first several months of enrollment.

- Creating an individualized care coordination plan for each new enrollee which is shared with the enrollee, key family members and/or other caregiver(s), and key physician(s).

- Assigning a care coordinator from the MCO to each enrollee, who will be responsible for disseminating and updating the treatment plans, and for serving as an ongoing liaison between the MCO, the member and family, key providers, and community resources.

Linchpin #6 – Strong Program Oversight. The initiative requires substantial program monitoring oversight which involves a variety of areas including but not limited to extensive data reporting, process and contract compliance audits, and complaint/grievance reviews. It is further suggested that an advisory body be established to provide a public forum for the initiative's key stakeholders to share information about what is working well -- and what isn't -- to help the initiative evolve as successfully as possible.

While the political process of relying more heavily on coordinated care for dual eligibles – as well as other high-need subgroups – has evolved painstakingly slowly over the past decades, there is now unprecedented momentum to replace the unmanaged fee-for-service coverage model with more effective approaches. Recent legislative and CMS initiatives represent substantial progress toward larger-scale and better-designed coordinated care programs for duals. (These CMS initiatives are summarized in the main body of this report.)

However, it is not yet clear how many dual eligibles will transition into the coordinated care setting as a result of the new partnership initiatives being permitted and developed, nor the degree to which their design will include all the features needed to achieve optimal results. Thus, a key purpose of this paper is to encourage our policymakers to not fall short of implementing – *at least on a pilot test basis* – the coordinated care models that hold the greatest promise of reducing public outlays for dual eligibles while simultaneously improving their health status and outcomes. This entails creating programs that include all six of the above-described linchpins.

The fiscal need for the most cost-effective approaches to be used is unprecedented -- at both the state and federal government levels – and a large-scale savings opportunity exists in almost every state through implementing an optimal coordinated care program for dual eligibles. The degree to which this opportunity is seized will be determined by our public policymaking outcomes. The needed care coordination techniques and capabilities exist, and the most effective program design features are largely known. The key question marks all revolve around the degree to which our knowledge base and capabilities will be permitted to be optimally deployed.

II. Compilation of Baseline Data

A. National Summary

SNCS tabulated and estimated the number of dual eligibles and their costs across the timeframe 2009 – 2021. The nationwide estimates for calendar year 2011 are summarized in Table 1 and Table 2.

Table 1: Dual Eligibles Expenditure Overview, 2011

Benefits Package Component	CY2011 Projection		
	Total Expenditures	Covered Persons	Average Costs Per Person
Medicaid Services	$137,674,866,448	8,441,180	$16,310
Medicare Services	$147,926,912,321	8,441,180	$17,524
Total	$285,601,778,769	8,441,180	$33,834

Source: SNCS Tabulations (derivation methodology described on ensuing pages)

We estimate that $286 billion will be spent on dual eligibles' health care during 2011, with these expenditures divided rather evenly between the services covered by Medicaid (48%) and Medicare (52%). The duals' expenditures represent 10.5% of national health spending, approximately 30% of Medicaid spending, approximately 27% of Medicare spending, and 1.9% of Gross Domestic Product.[1]

To translate the duals' expenditures into more personal terms, the $286 billion represents $2,486 in spending per household in the US – roughly equivalent to the average annual per household expenditures on cell phones and electricity bills *combined*.[2]

Most dual eligibles (77%) receive the full complement of Medicaid and Medicare benefits. We estimate that the "full duals" currently average $36,496 per person in health care expenditures, as

---

[1] Denominator sources used to calculate these percentages were obtained from following web addresses: http://www.cms.gov/NationalHealthExpendData/downloads/NHEProjections2009to2019.pdf and http://www.bea.gov/newsreleases/national/gdp/2011/pdf/gdp1q11_3rd.pdf

[2] Sources for number of households in the nation is U.S. Census for 2009, trended at 1% per year to derive 2011 estimate. Sources for household bills cited in this paragraph are http://www.msnbc.msn.com/id/43855530/ns/business-us_business/t/electric-bill-seem-higher-usual-well-it/ and http://communities-dominate.blogs.com/brands/2011/01/household-penetration-rates-for-technology-across-the-digital-divide.html.

shown in Table 2. The "partial duals" receive less than the full Medicaid benefits package; their costs are estimated to average $24, 685 per person.[3]

Table 2: 2011 Overview by Type of Dual Eligible

Type of Dual Eligible	CY2011 Projection				
	Medicaid	Medicare	Total Cost, Medicaid and Medicare Services	Average Number of Persons Covered	Average Cost Per Person (Across Medicaid and Medicare Services)
Full Duals	$123,857,937,965	$114,794,090,006	$238,652,027,971	6,539,209	$36,496
Partial Duals	$13,816,928,483	$33,132,822,315	$46,949,750,798	1,901,971	$24,685
All Duals	$137,674,866,448	$147,926,912,321	$285,601,778,769	8,441,180	$33,834

Source: SNCS Tabulations (derivation methodology described on ensuing pages)

B. Derivation Of Baseline Costs and Projections

The baseline costs and projections were developed through the following process.

Population: The number of dual eligibles in each state, and the distribution between full duals and partial duals, were derived using Medicaid Statistical Information System (MSIS) data maintained by CMS on the following website: http://msis.cms.hhs.gov.   Federal fiscal year 2008 is the most recent year for which data were available for all 50 states (plus the District of Columbia). The specific statistic tabulated in each state is the number of covered months for various subgroups of dual eligibles. The annual covered months were divided by 12 to yield the average population size at a given point in time during 2008.

Medicaid Costs: MSIS data files were also used to tabulate Medicaid expenditures for duals. The FY2008 base year was used to identify Medicaid expenditures for duals in each state, by type of dual eligible. Per member per month (PMPM) Medicaid costs were derived by dividing these total costs by the corresponding coverage months in each state for full and partial duals. Average annual per capita costs were derived by multiplying the PMPM costs by twelve.

Medicare Part A and Part B Costs: Medicare fee-for-service enrollment and these beneficiaries' corresponding expenditures are published annually at the county level by CMS via the following website: https://www.cms.gov/MedicareAdvtgSpecRateStats/05_FFS_Data.asp. SNCS aggregated this county level information, which is separated into Part A and Part B components, to the statewide level. The most recent available year, calendar year 2009, was used.

---

[3] Medicaid cost differences between full and partial duals were tabulated in MSIS. The Medicare data sources used did not separate full duals from partial duals and we had no basis to assume a Medicare cost difference between these two subgroups. Therefore the overall Medicare PMPM costs derived in each state were used for both full and partial duals in this report.

Medicare Part D Costs: Effective in calendar year 2006 the creation of the Medicare prescription drug benefit (Medicare Part D) resulted in a transfer of dual eligibles' pharmacy costs from the Medicaid program to Medicare. MSIS data isolated pharmacy costs for dual eligibles during FY2005 – prior to the initiation of Medicare Part D. SNCS tabulated dual eligibles' FY2005 pharmacy costs in each state using these FY2005 MSIS data. These costs were translated into PMPM format. Each state's FY2005 Medicaid PMPM pharmacy costs for dual eligibles were trended forward at 6% per year to estimate Medicare Part D costs in each state and in each ensuing year.

Trending Factors: The number of dual eligibles in each state was assumed to increase by 1% per year from 2008 through 2021. PMPM medical costs were trended at 6% per year from the base year (2008 for Medicaid benefits, 2009 for Medicare Parts A and B, and 2005 for Medicare Part D) through CY2021.

As of 2021, we project that the annual costs of health care for all dual eligibles will reach $565 billion which will equate to roughly $60,000 per dual per year.

C. State Level Projections

Table 3 presents the state-level estimates of CY2011 dual eligibles and their costs. Costs are tabulated in total dollar and cost per person terms. Table 4 presents similar estimates for CY2021, and shows the total expenditures projected to occur in each state across the 2012 – 2021 ten-year timeframe.

The degree to which capitation contracting is used for dual eligibles in each state is estimated in Table 5. This table takes into consideration the following components:

Medicare SNPs: Medicare Dual Eligible Special Needs Plan ("D-SNP") enrollment by state as of July 2011 has been tabulated using the SNP Comprehensive Report. Similar data were tabulated for Institutional SNPs ("I-SNPs"). These reports are produced monthly by CMS and posted to the following website: www.cms.gov/MCRAdvPartDEnrolData/SNP/   SNCS tabulated enrollment by state, which for the vast majority of SNPs merely involved a simple summation (since all enrollment was matched to a single state). For a few SNPs, enrollment was listed across multiple states. Each of these SNP's enrollment was apportioned across states based on the total population of each listed state.

Table 3. State-Specific Baseline Cost Estimates for Dual Eligibles, CY2011

STATE	# Duals, 2011			Costs for All Duals, 2011			Cost Per Dual Eligible, 2011		
	Full Duals	Partial Duals	All Duals	Medicaid	Medicare	Total	Medicaid	Medicare	Total
ALABAMA	94,393	98,460	192,852	$1,728,365,166	$3,013,357,676	$4,741,722,841	$8,962	$15,625	$24,587
ALASKA	12,336	260	12,596	$316,365,182	$238,447,082	$554,812,264	$25,116	$18,930	$44,046
ARIZONA	104,149	30,472	134,621	$1,817,178,118	$2,175,774,369	$3,992,952,487	$13,498	$16,162	$29,661
ARKANSAS	64,210	44,105	108,315	$1,532,463,983	$1,638,149,887	$3,170,613,870	$14,148	$15,124	$29,272
CALIFORNIA	1,113,120	22,225	1,135,345	$14,710,653,706	$19,711,596,341	$34,422,250,047	$12,957	$17,362	$30,319
COLORADO	61,336	12,851	74,187	$1,583,551,868	$1,101,591,426	$2,685,143,294	$21,345	$14,849	$36,194
CONNECTICUT	71,979	22,261	94,239	$3,803,889,331	$1,955,012,648	$5,758,901,978	$40,364	$20,745	$61,109
DELAWARE	10,241	12,015	22,256	$391,473,592	$387,486,261	$778,959,853	$17,590	$17,410	$35,000
DISTRICT OF COLUMBIA	17,394	2,854	20,248	$863,131,306	$348,532,338	$1,211,663,643	$42,628	$17,213	$59,841
FLORIDA	313,176	215,898	529,074	$7,496,494,634	$10,618,113,495	$18,114,608,129	$14,169	$20,069	$34,238
GEORGIA	135,232	106,462	241,694	$2,161,420,856	$3,836,668,009	$5,998,088,865	$8,943	$15,874	$24,817
HAWAII	27,326	2,447	29,773	$414,783,138	$339,177,185	$753,960,323	$13,931	$11,392	$25,323
IDAHO	20,110	8,400	28,511	$480,479,044	$449,284,571	$929,763,614	$16,852	$15,758	$32,611
ILLINOIS	253,334	35,533	288,866	$5,135,026,140	$5,119,386,347	$10,254,412,487	$17,776	$17,722	$35,499
INDIANA	91,229	49,544	140,773	$2,397,639,608	$2,581,430,936	$4,979,070,544	$17,032	$18,338	$35,370
IOWA	62,762	11,702	74,464	$1,469,476,523	$1,171,940,108	$2,641,416,630	$19,734	$15,738	$35,472
KANSAS	42,560	14,517	57,077	$1,105,267,316	$979,838,097	$2,085,105,413	$19,365	$17,167	$36,531
KENTUCKY	102,271	61,610	163,881	$1,736,514,866	$2,776,172,706	$4,512,687,573	$10,596	$16,940	$27,536
LOUISIANA	101,295	69,073	170,367	$2,004,743,866	$3,346,781,009	$5,351,524,875	$11,767	$19,645	$31,412
MAINE	51,027	35,137	86,165	$743,452,095	$1,328,431,384	$2,071,883,479	$8,628	$15,417	$24,046
MARYLAND	68,383	31,378	99,761	$2,137,886,677	$1,867,420,305	$4,005,306,982	$21,430	$18,719	$40,149
MASSACHUSETTS	232,258	6,138	238,396	$4,729,320,676	$4,434,003,699	$9,163,324,375	$19,838	$18,599	$38,437
MICHIGAN	214,828	26,571	241,400	$2,963,940,061	$4,509,517,038	$7,473,457,099	$12,278	$18,681	$30,959
MINNESOTA	108,652	11,009	119,662	$3,501,502,043	$1,606,678,830	$5,108,180,873	$29,262	$13,427	$42,689
MISSISSIPPI	77,888	65,114	143,001	$1,333,860,354	$2,334,758,649	$3,668,619,003	$9,328	$16,327	$25,654
MISSOURI	138,636	13,685	152,321	$2,218,384,813	$2,749,444,517	$4,967,829,330	$14,564	$18,050	$32,614
MONTANA	13,749	1,892	15,641	$305,791,321	$233,395,179	$539,186,500	$19,551	$14,922	$34,473
NEBRASKA	34,253	3,438	37,691	$745,379,016	$633,318,533	$1,378,697,549	$19,776	$16,803	$36,579
NEVADA	19,713	15,335	35,048	$369,267,468	$589,336,128	$958,603,596	$10,536	$16,815	$27,351
NEW HAMPSHIRE	18,205	6,813	25,018	$518,087,167	$423,615,967	$941,703,134	$20,708	$16,932	$37,641
NEW JERSEY	160,498	31,362	191,860	$4,426,260,589	$4,132,634,181	$8,558,894,770	$23,070	$21,540	$44,610
NEW MEXICO	37,071	14,458	51,529	$819,927,524	$563,206,675	$1,383,134,199	$15,912	$10,930	$26,842
NEW YORK	612,486	67,140	679,626	$22,453,224,886	$13,629,394,243	$36,082,619,129	$33,038	$20,054	$53,092
NORTH CAROLINA	236,183	56,173	292,356	$3,580,349,499	$4,990,277,117	$8,570,626,616	$12,247	$17,069	$29,316
NORTH DAKOTA	9,980	3,573	13,553	$377,971,403	$202,968,368	$580,939,772	$27,888	$14,976	$42,863
OHIO	182,839	88,297	271,136	$5,772,871,077	$5,034,938,036	$10,807,809,114	$21,291	$18,570	$39,861
OKLAHOMA	86,446	16,141	102,587	$1,347,463,399	$1,660,289,770	$3,007,753,169	$13,135	$16,184	$29,319
OREGON	57,164	25,266	82,430	$966,105,910	$1,020,804,563	$1,986,910,473	$11,720	$12,384	$24,104
PENNSYLVANIA	306,894	52,645	359,539	$5,243,280,350	$5,694,639,502	$10,937,919,852	$14,583	$15,839	$30,422
RHODE ISLAND	32,001	4,983	36,985	$801,995,522	$657,095,310	$1,459,090,832	$21,685	$17,767	$39,451
SOUTH CAROLINA	123,808	16,748	140,556	$2,252,372,236	$2,133,423,717	$4,385,795,953	$16,025	$15,178	$31,203
SOUTH DAKOTA	12,591	6,075	18,667	$312,680,589	$287,346,855	$600,027,444	$16,751	$15,393	$32,144
TENNESSEE	208,729	60,932	269,661	$2,379,258,010	$4,916,736,474	$7,295,994,484	$8,823	$18,233	$27,056
TEXAS	366,205	225,343	591,548	$5,950,366,586	$10,490,411,980	$16,440,778,566	$10,059	$17,734	$27,793
UTAH	25,277	2,310	27,587	$487,657,624	$453,502,831	$941,160,454	$17,677	$16,439	$34,117
VERMONT	18,430	10,859	29,289	$386,504,624	$485,153,563	$871,658,186	$13,196	$16,565	$29,761
VIRGINIA	110,738	46,735	157,473	$1,995,010,433	$2,507,460,171	$4,502,470,603	$12,669	$15,923	$28,592
WASHINGTON	104,210	30,575	134,785	$2,871,415,048	$2,088,277,896	$4,959,692,944	$21,304	$15,493	$36,797
WEST VIRGINIA	45,824	26,588	72,412	$1,308,691,573	$1,194,336,472	$2,503,028,045	$18,073	$16,494	$34,566
WISCONSIN	119,602	75,787	195,389	$2,975,778,963	$3,144,114,364	$6,119,893,327	$15,230	$16,092	$31,322
WYOMING	6,188	2,782	8,970	$249,890,666	$141,239,514	$391,130,180	$27,859	$15,746	$43,605
TOTAL	6,539,209	1,901,971	8,441,180	$137,674,866,448	$147,926,912,321	$285,601,778,769	$16,310	$17,524	$33,834

Table 4. State-Specific Baseline Cost Projections for Dual Eligibles in CY2021 and Across Ten-Year Timeframe 2012-2021

STATE	Estimated # Duals, 2021	Estimated Duals' Costs, 2021	Cost Per Dual, 2021	10 Year Costs for Duals, 2012-2021
ALABAMA	213,029	$9,380,123,489	$44,032	$70,338,126,536
ALASKA	13,914	$1,097,535,162	$78,880	$8,230,016,073
ARIZONA	148,705	$7,898,898,495	$53,118	$59,230,960,281
ARKANSAS	119,647	$6,272,140,029	$52,422	$47,032,491,581
CALIFORNIA	1,254,127	$68,094,438,882	$54,296	$510,615,373,460
COLORADO	81,949	$5,311,777,286	$64,818	$39,831,081,471
CONNECTICUT	104,099	$11,392,317,419	$109,437	$85,426,835,271
DELAWARE	24,584	$1,540,946,163	$62,680	$11,554,993,524
DISTRICT OF COLUMBIA	22,366	$2,396,925,122	$107,166	$17,973,667,697
FLORIDA	584,427	$35,834,498,746	$61,316	$268,709,842,687
GEORGIA	266,980	$11,865,479,306	$44,443	$88,974,903,778
HAWAII	32,888	$1,491,491,843	$45,350	$11,184,153,607
IDAHO	31,494	$1,839,267,669	$58,401	$13,791,997,751
ILLINOIS	319,088	$20,285,381,212	$63,573	$152,112,678,708
INDIANA	155,501	$9,849,647,086	$63,342	$73,858,912,823
IOWA	82,254	$5,225,276,763	$63,526	$39,182,445,578
KANSAS	63,048	$4,124,776,355	$65,422	$30,930,194,207
KENTUCKY	181,027	$8,927,043,633	$49,313	$66,940,645,863
LOUISIANA	188,191	$10,586,439,964	$56,254	$79,383,854,018
MAINE	95,179	$4,098,620,595	$43,062	$30,734,061,695
MARYLAND	110,198	$7,923,338,281	$71,901	$59,414,225,329
MASSACHUSETTS	263,338	$18,126,979,809	$68,836	$135,927,613,427
MICHIGAN	266,655	$14,784,067,484	$55,443	$110,860,332,559
MINNESOTA	132,181	$10,105,054,429	$76,449	$75,774,119,381
MISSISSIPPI	157,963	$7,257,298,757	$45,943	$54,419,837,745
MISSOURI	168,257	$9,827,409,604	$58,407	$73,692,162,052
MONTANA	17,277	$1,066,624,119	$61,735	$7,998,225,435
NEBRASKA	41,635	$2,727,353,264	$65,507	$20,451,427,874
NEVADA	38,714	$1,896,319,209	$48,982	$14,219,806,451
NEW HAMPSHIRE	27,636	$1,862,886,546	$67,409	$13,969,107,093
NEW JERSEY	211,933	$16,931,291,128	$79,890	$126,961,579,896
NEW MEXICO	56,920	$2,736,129,889	$48,070	$20,517,240,588
NEW YORK	750,730	$71,378,997,584	$95,079	$535,245,081,790
NORTH CAROLINA	322,943	$16,954,499,182	$52,500	$127,135,608,633
NORTH DAKOTA	14,971	$1,149,220,859	$76,761	$8,617,588,276
OHIO	299,503	$21,380,115,946	$71,385	$160,321,695,396
OKLAHOMA	113,320	$5,949,967,364	$52,506	$44,616,636,210
OREGON	91,054	$3,930,526,145	$43,167	$29,473,582,694
PENNSYLVANIA	397,155	$21,637,502,309	$54,481	$162,251,741,901
RHODE ISLAND	40,854	$2,886,388,058	$70,651	$21,643,971,819
SOUTH CAROLINA	155,262	$8,676,025,364	$55,880	$65,058,351,373
SOUTH DAKOTA	20,620	$1,186,980,284	$57,565	$8,900,732,437
TENNESSEE	297,874	$14,433,009,166	$48,453	$108,227,874,208
TEXAS	653,437	$32,523,312,383	$49,773	$243,880,463,243
UTAH	30,473	$1,861,813,012	$61,098	$13,961,057,055
VERMONT	32,353	$1,724,322,931	$53,297	$12,930,069,062
VIRGINIA	173,949	$8,906,832,322	$51,204	$66,789,088,613
WASHINGTON	148,886	$9,811,314,124	$65,898	$73,571,467,920
WEST VIRGINIA	79,988	$4,951,515,082	$61,903	$37,129,606,533
WISCONSIN	215,831	$12,106,434,110	$56,092	$90,781,736,013
WYOMING	9,908	$773,737,629	$78,090	$5,801,976,415
TOTAL	**9,324,315**	**$564,980,291,592**	**$60,592**	**$4,236,581,244,030**

Medicare Advantage: The number of persons enrolled in Medicare Advantage in each county is also published monthly by CMS (website: www.cms.gov/MCRAdvPartDEnrolData/MMAESCC). SNCS rolled this county information up to the state level, and calculated an overall penetration rate (the percentage of all Medicare beneficiaries enrolled in Medicare Advantage) as of July 2011 in each state. These percentages are shown in Table 5. Dual eligibles currently represent 18% of the overall Medicare population, but have far less incentive to enroll in a regular Medicare Advantage health plan than do other seniors for whom considerable out-of-pocket cost advantages to enrolling typically exist. We have estimated that duals comprise 5.0% of overall Medicare Advantage enrollment in each state, excluding persons enrolled in D-SNPs and I-SNPs.

Medicaid Capitation: The MSIS data files permit quantifying the degree to which capitation contracting is used for each state's dual eligible population. Table 5 shows the percentage of total Medicaid dual eligible costs paid via capitation in each state during 2008.

The overall percentage of spending on dual eligibles in each state occurring via capitation payments to Medicaid and/or Medicare MCOs is estimated in Table 5. These figures add together capitated spending occurring in Medicaid and Medicare D-SNPs along with an estimate that 5% of a state's overall Medicare Advantage enrollment comprises dual eligibles.

Based on these estimates, 12.6% of CY2011 nationwide health care spending on duals occurs via capitation payments to MCOs with the remaining 87.4% paid through the traditional unmanaged fee-for-service setting. Our estimates indicate that capitation payments account for more than 30% of overall dual eligibles' health expenditures in only one state (Arizona at 73%), with eight states between 20% and 30%. Conversely, capitation payments represent less than 5% of spending on dual eligibles in 24 states. Thus, in every state other than Arizona, an opportunity exists to substantially expand the use of coordinated care for dual eligibles.

Table 6 presents the following information for each state related to its dual eligibles:
   a) the average number of dual eligibles covered during CY2011;
   b) estimated CY2011 total costs for dual eligibles (from Table XX)
   c) estimated CY2011 total capitation costs for dual eligibles (from Table XX)
   d) estimated CY2011 fee-for-service costs for dual eligibles
   e) estimated value of *each* 1% savings in the annual FFS costs of dual eligibles

This information may be useful to states in estimating the magnitude of the savings opportunity that is available if an optimal coordinated care initiative for duals is implemented. The annual savings from each percentage point reduction in dual eligibles' fee-for-service health care expenditures (in CY2011 dollars) is greater than $100 million in six states, and is greater than $25 million in 29 states. Nationwide, each percentage point reduction in duals' current FFS expenditures will yield annual savings of approximately $2.5 billion. Additional savings can also occur on the existing body of capitated dual eligible expenses, given that the Medicare Advantage program is currently paying its MCOs at a level above underlying FFS per capita costs. An optimally designed coordinated care program for dual eligibles will yield net Medicare savings, rather than the net Medicare taxpayer costs that currently occur under Medicare Advantage.

Table 5. Magnitude of Existing Coordinated Care Programs for Dual Eligibles by State

STATE	Special Needs Plan Enrollment (from July 2011 SNP Comprehensive Report) Dual SNP	Inst. SNP	Total Medicare Advantage Enrollees, July 2011	Estimated Duals in Regular Medicare Advantage MCOs (5% of all MA enrollees)	Estimated Total Duals Enrolled in Medicare Advantage	Estimated % of Duals Enrolled in Medicare Advantage	2008 Medicaid Costs for All Duals Paid Via Capitation	% of 2008 Medicaid Costs for All Duals Paid via Capitation	Projections for All Duals, 2011 Average Enrollment	2011 Medicaid Costs	2011 Medicare Costs	2011 Total Costs	2011 Capitated Costs	2011 Percent Capitated
ALABAMA	33,349		164,874	6,576	39,925	20.7%	$126,059,217	8.7%	192,852	$1,728,365,166	$3,013,357,676	$4,741,722,841	$774,210,759	16.3%
ALASKA			142	7	7	0.1%	$0	0.0%	12,596	$316,365,182	$238,447,082	$554,812,264	$134,404	0.0%
ARIZONA	62,630	1,444	319,129	12,753	76,827	57.1%	$1,013,320,748	89.4%	134,621	$1,817,178,118	$2,175,774,369	$3,992,952,487	$2,866,726,667	71.8%
ARKANSAS	5,661		64,040	2,919	8,580	7.9%	$0	0.0%	108,315	$1,532,463,983	$1,638,149,887	$3,170,613,870	$129,762,537	4.1%
CALIFORNIA	153,250	44,532	1,596,689	69,945	267,727	23.6%	$1,871,949,869	15.6%	1,135,345	$14,710,653,706	$19,711,596,341	$34,422,250,047	$6,948,353,212	20.2%
COLORADO	8,054	2,107	211,422	10,063	20,224	27.3%	$238,185,924	19.2%	74,187	$1,583,551,868	$1,101,591,426	$2,685,143,294	$604,352,991	22.5%
CONNECTICUT	4,446	1,518	101,216	4,763	10,727	11.4%	$1,167,471	0.0%	94,239	$3,803,889,331	$1,955,012,648	$5,758,901,978	$224,195,080	3.9%
DELAWARE	1,428	893	4,560	112	2,433	10.9%	$4,578,569	1.4%	22,256	$391,473,592	$387,486,261	$778,959,853	$47,978,041	6.2%
DISTRICT OF COLUMBIA	1,425	603	7,486	273	2,301	11.4%	-$8,525,658	-1.3%	20,248	$863,131,306	$348,532,338	$1,211,663,643	$28,533,286	2.4%
FLORIDA	99,257	1,552	837,744	36,847	137,656	26.0%	$368,911,366	6.3%	529,074	$7,496,494,634	$10,618,113,495	$18,114,608,129	$3,234,851,477	17.9%
GEORGIA	7,593	1,968	222,817	10,663	20,224	8.4%	$24,856,060	1.3%	241,694	$2,161,420,856	$3,836,668,009	$5,998,088,865	$349,275,038	5.8%
HAWAII	10,189		62,551	2,618	12,807	43.0%	$1,688,174	0.5%	29,773	$414,783,138	$339,177,185	$753,960,323	$147,969,450	19.6%
IDAHO	1,608		65,934	3,216	4,824	16.9%	$9,543,512	2.3%	28,511	$480,479,044	$449,284,571	$929,763,614	$87,152,654	9.4%
ILLINOIS	5,595	379	148,859	7,144	13,118	4.5%	$4,474,777	0.1%	288,866	$5,135,026,140	$5,119,386,347	$10,254,412,487	$238,181,846	2.3%
INDIANA	2,134	163	102,246	4,997	7,294	5.2%	$9,146,446	0.5%	140,773	$2,397,639,608	$2,581,430,936	$4,979,070,544	$144,962,205	2.9%
IOWA	477		61,908	3,072	3,549	4.8%	$25,013,580	2.0%	74,464	$1,469,476,523	$1,171,940,108	$2,641,416,630	$85,510,172	3.2%
KANSAS	734	179	43,296	2,119	3,032	5.3%	$49,223,623	5.5%	57,077	$1,105,267,316	$979,838,097	$2,085,105,413	$112,959,757	5.4%
KENTUCKY	9,778		89,010	3,962	13,740	8.4%	$59,908,285	4.4%	163,881	$1,736,514,866	$2,776,172,706	$4,512,687,573	$308,477,674	6.8%
LOUISIANA	13,234		158,400	7,258	20,492	12.0%	$1,465,302	0.1%	170,367	$2,004,743,866	$3,346,781,009	$5,351,524,875	$404,337,643	7.6%
MAINE	2,847		35,909	1,653	4,500	5.2%	$0	0.0%	86,165	$743,452,095	$1,328,431,384	$2,071,883,479	$69,379,710	3.3%
MARYLAND	4,387	923	62,529	2,861	8,171	8.2%	$31,790,990	1.8%	99,761	$2,137,886,677	$1,867,420,305	$4,005,306,982	$191,353,901	4.8%
MASSACHUSETTS	16,253	1,273	150,191	6,633	24,159	10.1%	$362,227,311	9.4%	238,396	$4,729,320,676	$4,434,003,699	$9,163,324,375	$893,688,019	9.8%
MICHIGAN	9,675	795	195,966	9,275	19,745	8.2%	$1,732,104,136	39.1%	241,400	$2,963,940,061	$4,509,517,038	$7,473,457,099	$1,528,288,244	20.4%
MINNESOTA	39,470		336,260	14,840	54,310	45.4%	$593,354,579	20.3%	119,662	$3,501,502,043	$1,606,678,830	$5,108,180,873	$1,440,735,105	28.2%
MISSISSIPPI	6,554		38,225	1,584	8,138	5.7%	$0	0.0%	143,001	$1,333,860,354	$2,334,758,649	$3,668,619,003	$132,860,344	3.6%
MISSOURI	3,848		210,288	10,322	14,170	9.3%	$20,466,028	1.1%	152,321	$2,218,384,813	$2,749,444,517	$4,967,829,330	$280,878,138	5.7%
MONTANA			23,415	1,171	1,171	7.5%	$0	0.0%	15,641	$305,791,321	$233,395,179	$539,186,500	$17,469,945	3.2%
NEBRASKA	503		28,460	1,398	1,901	5.0%	$2,441,537	0.4%	37,691	$745,379,016	$633,318,533	$1,378,697,549	$34,843,914	2.5%
NEVADA		85	102,319	5,112	5,197	14.8%	$37,456	0.0%	35,048	$369,267,468	$589,336,128	$958,603,596	$87,427,296	9.1%
NEW HAMPSHIRE			12,779	639	639	2.6%	$0	0.0%	25,018	$518,087,167	$423,615,967	$941,703,134	$10,818,902	1.1%
NEW JERSEY	6,605	515	173,346	8,311	15,431	8.0%	$59,964,485	1.7%	191,860	$4,426,260,589	$4,132,634,181	$8,558,894,770	$405,638,935	4.7%
NEW MEXICO	2,835	117	81,156	3,910	6,862	13.3%	$23,281,687	2.4%	51,529	$819,927,524	$563,206,675	$1,383,134,199	$94,775,034	6.9%
NEW YORK	100,361	7,948	881,388	38,654	146,963	21.6%	$1,030,748,218	5.4%	679,626	$22,453,224,886	$13,629,394,243	$36,082,619,129	$4,149,591,713	11.5%
NORTH CAROLINA	8,236	2,211	239,927	11,474	21,921	7.5%	$33,134,416	1.1%	292,356	$3,580,349,499	$4,990,277,117	$8,570,626,616	$415,075,632	4.8%
NORTH DAKOTA			9,823	491	491	3.6%	$0	0.0%	13,553	$377,971,403	$202,968,368	$580,939,772	$7,355,222	1.3%
OHIO	8,767	2,886	451,462	21,990	33,643	12.4%	$65,955,906	1.5%	271,136	$5,772,871,077	$5,034,938,036	$10,807,809,114	$709,738,772	6.6%
OKLAHOMA	802	114	105,193	5,214	6,130	6.0%	$13,501,869	1.2%	102,587	$1,347,463,399	$1,660,289,770	$3,007,753,169	$115,245,534	3.8%
OREGON	18,645	421	176,983	7,896	26,962	32.7%	$133,712,590	16.9%	82,430	$966,105,910	$1,020,804,563	$1,986,910,473	$496,970,916	25.0%
PENNSYLVANIA	89,327	2,067	901,700	40,515	131,909	36.7%	$394,009,310	9.2%	359,539	$5,243,280,350	$5,694,639,502	$10,937,919,852	$2,572,579,404	23.5%
RHODE ISLAND		1,388	51,889	2,525	3,913	10.6%	$916,238	0.1%	36,985	$801,995,522	$657,095,310	$1,459,090,832	$70,568,058	4.8%
SOUTH CAROLINA	2,371		67,885	3,276	5,647	4.0%	$70,805,949	3.8%	140,556	$2,252,372,236	$2,133,423,717	$4,385,795,953	$171,968,634	3.9%
SOUTH DAKOTA			11,256	563	563	3.0%	$1,095,983	0.4%	18,667	$312,680,589	$287,346,855	$600,027,444	$9,994,773	1.7%
TENNESSEE	39,950	34	260,865	11,044	51,028	18.9%	$360,981,384	17.8%	269,661	$2,379,258,010	$4,916,736,474	$7,295,994,484	$1,352,908,791	18.5%
TEXAS	67,573	165	535,051	23,366	91,104	15.4%	$425,533,349	9.0%	591,548	$5,950,366,586	$10,490,411,980	$16,440,778,566	$2,148,669,578	13.1%
UTAH	6,457		95,275	4,441	10,898	39.5%	$132,541,957	17.3%	27,587	$487,657,624	$453,502,831	$941,160,454	$263,329,494	28.0%
VERMONT			3,038	152	152	0.5%	$0	0.0%	29,289	$386,504,624	$485,153,563	$871,658,186	$2,516,151	0.3%
VIRGINIA	969	696	143,605	7,097	8,762	5.6%	$16,198,033	1.0%	157,473	$1,995,010,433	$2,507,460,171	$4,502,470,603	$159,391,426	3.5%
WASHINGTON	7,438	560	222,361	10,718	18,716	13.9%	$17,901,445	0.8%	134,785	$2,871,415,048	$2,088,277,896	$4,959,692,944	$311,679,444	6.3%
WEST VIRGINIA			37,245	1,862	1,862	2.6%	$47,001,145	4.4%	72,412	$1,308,691,573	$1,194,336,472	$2,503,028,045	$88,566,849	3.5%
WISCONSIN	11,918	808	251,637	11,946	24,672	12.6%	$420,991,473	17.4%	195,389	$2,975,778,963	$3,144,114,364	$6,119,893,327	$914,144,038	14.9%
WYOMING			3,757	188	188	2.1%	$0	0.0%	8,970	$249,890,666	$141,239,514	$391,130,180	$2,957,879	0.8%
TOTAL (50 States + DC)	**876,633**	**78,344**	**10,163,506**	**460,426**	**1,415,403**	**16.8%**	**$9,791,664,739**	**8.5%**	**8,441,180**	**$137,674,866,448**	**$147,926,912,321**	**$285,601,778,769**	**$35,889,334,687**	**12.6%**

Table 6. State-Specific Estimates of Annual Fee-For-Service Costs for Dual Eligibles

STATE	2011 Total Costs	Estimated Figures for All Duals, 2011		
		2011 Capitated Costs	2011 Fee-For-Service Costs	Value of Each 1% Savings in Annual FFS Costs for Duals
ALABAMA	$4,741,722,841	$774,210,759	$3,967,512,083	$39,675,121
ALASKA	$554,812,264	$134,404	$554,677,860	$5,546,779
ARIZONA	$3,992,952,487	$2,866,726,667	$1,126,225,820	$11,262,258
ARKANSAS	$3,170,613,870	$129,762,537	$3,040,851,333	$30,408,513
CALIFORNIA	$34,422,250,047	$6,948,353,212	$27,473,896,835	$274,738,968
COLORADO	$2,685,143,294	$604,352,991	$2,080,790,303	$20,807,903
CONNECTICUT	$5,758,901,978	$224,195,080	$5,534,706,898	$55,347,069
DELAWARE	$778,959,853	$47,978,041	$730,981,813	$7,309,818
DISTRICT OF COLUMBIA	$1,211,663,643	$28,533,286	$1,183,130,358	$11,831,304
FLORIDA	$18,114,608,129	$3,234,851,477	$14,879,756,652	$148,797,567
GEORGIA	$5,998,088,865	$349,275,038	$5,648,813,827	$56,488,138
HAWAII	$753,960,323	$147,969,450	$605,990,873	$6,059,909
IDAHO	$929,763,614	$87,152,654	$842,610,960	$8,426,110
ILLINOIS	$10,254,412,487	$238,181,846	$10,016,230,642	$100,162,306
INDIANA	$4,979,070,544	$144,962,205	$4,834,108,339	$48,341,083
IOWA	$2,641,416,630	$85,510,172	$2,555,906,458	$25,559,065
KANSAS	$2,085,105,413	$112,959,757	$1,972,145,655	$19,721,457
KENTUCKY	$4,512,687,573	$308,477,674	$4,204,209,899	$42,042,099
LOUISIANA	$5,351,524,875	$404,337,643	$4,947,187,232	$49,471,872
MAINE	$2,071,883,479	$69,379,710	$2,002,503,770	$20,025,038
MARYLAND	$4,005,306,982	$191,353,901	$3,813,953,082	$38,139,531
MASSACHUSETTS	$9,163,324,375	$893,688,019	$8,269,636,356	$82,696,364
MICHIGAN	$7,473,457,099	$1,528,288,244	$5,945,168,855	$59,451,689
MINNESOTA	$5,108,180,873	$1,440,735,105	$3,667,445,769	$36,674,458
MISSISSIPPI	$3,668,619,003	$132,860,344	$3,535,758,659	$35,357,587
MISSOURI	$4,967,829,330	$280,878,138	$4,686,951,192	$46,869,512
MONTANA	$539,186,500	$17,469,945	$521,716,554	$5,217,166
NEBRASKA	$1,378,697,549	$34,843,914	$1,343,853,636	$13,438,536
NEVADA	$958,603,596	$87,427,296	$871,176,300	$8,711,763
NEW HAMPSHIRE	$941,703,134	$10,818,902	$930,884,232	$9,308,842
NEW JERSEY	$8,558,894,770	$405,638,935	$8,153,255,835	$81,532,558
NEW MEXICO	$1,383,134,199	$94,775,034	$1,288,359,165	$12,883,592
NEW YORK	$36,082,619,129	$4,149,591,713	$31,933,027,416	$319,330,274
NORTH CAROLINA	$8,570,626,616	$415,075,632	$8,155,550,984	$81,555,510
NORTH DAKOTA	$580,939,772	$7,355,222	$573,584,550	$5,735,845
OHIO	$10,807,809,114	$709,738,772	$10,098,070,341	$100,980,703
OKLAHOMA	$3,007,753,169	$115,245,534	$2,892,507,635	$28,925,076
OREGON	$1,986,910,473	$496,970,916	$1,489,939,557	$14,899,396
PENNSYLVANIA	$10,937,919,852	$2,572,579,404	$8,365,340,449	$83,653,404
RHODE ISLAND	$1,459,090,832	$70,568,058	$1,388,522,774	$13,885,228
SOUTH CAROLINA	$4,385,795,953	$171,968,634	$4,213,827,319	$42,138,273
SOUTH DAKOTA	$600,027,444	$9,994,773	$590,032,671	$5,900,327
TENNESSEE	$7,295,994,484	$1,352,908,791	$5,943,085,693	$59,430,857
TEXAS	$16,440,778,566	$2,148,669,578	$14,292,108,988	$142,921,090
UTAH	$941,160,454	$263,329,494	$677,830,960	$6,778,310
VERMONT	$871,658,186	$2,516,151	$869,142,035	$8,691,420
VIRGINIA	$4,502,470,603	$159,391,426	$4,343,079,177	$43,430,792
WASHINGTON	$4,959,692,944	$311,679,444	$4,648,013,501	$46,480,135
WEST VIRGINIA	$2,503,028,045	$88,566,849	$2,414,461,197	$24,144,612
WISCONSIN	$6,119,893,327	$914,144,038	$5,205,749,289	$52,057,493
WYOMING	$391,130,180	$2,957,879	$388,172,301	$3,881,723
Total, 50 States + DC	$285,601,778,769	$35,889,334,687	$249,712,444,082	$2,497,124,441

The *smallest* state-specific annual savings that a one percent reduction in health care spending on dual eligibles would yield is $3.9 million in Wyoming. The largest annual savings, $318 million for each percentage point cost reduction, is projected in New York.

It is important to emphasize that savings of multiple percentage points are deemed attainable through a well-designed coordinated care program targeted to dual eligibles. A 2008 report prepared by The Lewin Group, "Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities," estimated that on average a 3.7% savings was achievable on dual eligibles' overall costs across a ten-year timeframe from an optimal coordinated care program.[4] The Lewin report estimated Year 1 savings (across all Medicaid and Medicare funds for the enrolled duals, after accounting for MCO administrative costs and operating margins) at 2.7% of underlying FFS costs. These savings were projected to reach 4.4% as of Year 10 and 4.7% as of Year 15, with the increased savings percentage primarily caused by favorably compounding impacts of successful nursing home diversions.

The remainder of this paper describes and discusses the coordinated care program design features needed to achieve optimal results.

---

[4] Joel Menges served as the principal author of the Lewin Group report and is also the principal author of this SNCS report. Thus, we do not mean to imply that we are citing completely separate research/analysis in this paragraph. However, we also do not want to leave the impression that only a one percentage point savings is possible or likely, simply because the tables are showing the savings attached to each percentage point reduction.

III. Key Program Design Features Needed to Achieve Optimal Results

A. Six Linchpins to an Optimal Program Design

Our report delineates six key public policy "linchpins" to achieving optimal coordinated care for dual eligibles, as described below. Most of these design features involve structuring the coordinated care program for dual eligibles more along the lines used by many successful Medicaid coordinated care programs rather than the approaches used by the Medicare Advantage program.

Linchpin #1 -- Mandatory Enrollment. Dual eligibles should be *required* to participate in a coordinated care setting, rather than be *invited* to do so. Mandatory enrollment is the only path to achieving <u>full</u> participation of a given area's dual eligible population at minimal marketing/transitional expense. This enrollment model also forces the provider community to work constructively with the MCO community if they desire to maintain or increase their revenues from serving dual eligible patients. Where providers have an option to continue serving their existing patients in the traditional FFS setting, the cost of enlisting them to participate in an MCO network often becomes higher, thus lowering the savings the coordinated care setting can achieve on those enrolled (as well as transitioning fewer persons into the coordinated care environment).

Programmatically, mandatory enrollment models are in use for millions of high-need persons in the Medicaid managed care arena around the country. While there has certainly been some hesitation and opposition to using this approach for Medicaid beneficiaries, this model has clearly been successful and is now a fundamental component of many states' Medicaid managed care program design. Mandatory enrollment coordinated care programs for Medicaid SSI beneficiaries now occur in approximately 20 states. Several states -- California, Kentucky, Louisiana and Texas -- are currently broadening the use of mandatory enrollment for high-need Medicaid subgroups (e.g., persons with disabilities who receive Medicaid by virtue of SSI eligibility).

The fact that we have not implemented this approach for dual eligibles on the "Medicare side" of their coverage is a purely political outcome. Oddly, those opposed to using – or even testing – mandatory enrollment models for dual eligibles do not seem troubled by the widespread use of this model in the Medicaid arena. Rather, opposition to the model seems focused on simply "keeping this approach out of Medicare."

Yet it is in our *Medicaid* managed care programs, where the mandatory enrollment model has been prominently deployed, where the most programmatic success – particularly with regard to financial savings -- has been achieved.[5] A very strong case can be made that the financial savings achieved in the Medicaid coordinated care arena – and the excess costs that have occurred in the Medicare Advantage arena – are both primarily attributable to the enrollment models being used.

To achieve *optimal* success with coordinated care for dual eligibles, it is critical that the mandatory enrollment model be utilized. Alternative approaches, such as an opt-out model (whereby beneficiaries are enrolled in a coordinated care health plan unless and until they expressly select the traditional FFS setting) can also be effective in transitioning large numbers of dual eligibles into coordinated care. However, such approaches will not be as effective as the mandatory enrollment model. It is telling that while dozens of states have now implemented mandatory enrollment Medicaid coordinated care programs, none has expressed interest in "dropping back" to an opt-out enrollment model.

Another aspect of the mandatory enrollment issue involves preserving beneficiary choice. While it is clearly important that beneficiaries have choice, it is not at all clear that the unmanaged fee-for-service model deserves to be one of the choices available to dual eligibles. Under FFS, dual eligibles can obtain, at no financial cost, whatever services they desire from whatever provider(s) they desire – with taxpayers footing the bill for whatever "happens to happen" in this setting. While it is understandable that duals will select this option if it is available to them – and that providers would prefer to render care in this setting -- it is perplexing that many public policymakers would be intent on ensuring that this particular option be kept available.

As an analogy, imagine that dual eligibles were given a "food card" whereby they could obtain any groceries they desired from any grocery store at any time, without limit at no cost -- with the government paying for whatever groceries were purchased. It is readily apparent that such a policy would lead to an excessively costly volume and mix of groceries being purchased, and that this policy would also fail to best address the duals' dietary needs. It is also fairly clear that if such a "carte blanche" option existed, the vast majority of duals would prefer it to any alternative that involved necessity criteria, restrictions, etc. Yet this is essentially how the unmanaged FFS setting is structured for dual eligibles and the health care services they receive.

The choice issue for dual eligibles is best focused on permitting/requiring a selection among highly capable coordinated care organizations, all of which systematically promote access and quality and which provide a cost-effective structure. Preserving the FFS choice is an extremely costly public policy approach for dual eligibles – doing so significantly dampens the scope and the effectiveness of the coordinated care programs that are deployed.

---

[5] A May 2011 report, "An Evaluation of Medicaid Savings from Pennsylvania's HealthChoices Program," Lewin Group, estimates the savings that have occurred in that state's mandatory enrollment program. A November 2009 Lewin report, "Evaluation of New York's HIV Special Needs Program: Cost and Usage Impacts ," provides evidence that some savings can occur for high-need groups in a voluntary enrollment situation. New York's HIV coordinated care program has subsequently moved to a mandatory enrollment model. Both reports are available at no charge at the following websites:
          http://www.lewin.com/content/publications/MedicaidSavingsPAHealthChoices.pdf
          http://www.health.state.ny.us/diseases/aids/resources/snps/docs/hiv_snp_research_paper.pdf

Linchpin #2 – Fully Integrated Model. The coordinated care program needs to serve the "whole person" effectively, without regard to whether a Medicaid or Medicare component of the benefits package is primarily being impacted at any particular moment in time. Removing boundary lines between the Medicaid and Medicare portions of the benefits package fosters optimal care coordination for duals.

Available data suggest that the more fully integrated the model, the better the outcomes. Inpatient hospital usage is an important measuring point regarding the degree to which a coordinated care program is maintaining enrollees' health status and reducing overall health care costs. The statistics in Table 7, taken from the 2010 SNP Alliance Profile and Advanced Practice Report, provide evidence of this correlation. The fully integrated dual eligible SNPs (FIDESNPs) serve a particularly high-need, high-cost subgroup, as evidenced by these plans' average enrollee risk score of 1.47, which is 16% higher than the figure for all FFS dual eligibles (1.27). However, despite their relatively high average risk score the FIDESNPs' inpatient usage was 16% below the average for dual eligibles in the FFS setting. The "regular" dual eligible SNPs also had low inpatient usage rates (15% below the rate for FFS duals), although these SNPs' average risk score of 1.21 was 5% below the FFS duals' average.

Table 7. State-Specific Estimates of Annual Fee-For-Service

Coverage Setting for Dual Eligibles	Coordinated Care Description	Covered Lives	Average Risk Score	Inpatient Days Per 1,000 Persons Per Year
Fully Integrated Dual Eligible SNP (SNP Alliance Members)	High degree of integration across Medicaid and Medicare benefits packages through longstanding initiatives in Massachusetts, Minnesota and Wisconsin	34,532	1.47	2,788
"Regular" Dual Eligible SNP (SNP Alliance Members)	Strong management of Medicare benefits; typically low level of integration with Medicaid benefits	227,902	1.21	2,821
Medicare Fee-For-Service	No systematic care coordination	Approx. 330,000	1.27	3,327

Source: 2010 SNP Alliance Profile and Advanced Practice Report, Lewin Group, February 2011

Another component of full integration involves using benefits carve-outs to the least extent possible. This is an area where Medicare Advantage does tend to have a more comprehensive design than many Medicaid managed care programs, where behavioral health, long-term care, dental service, pharmacy services, and other services are sometimes excluded from a state's capitated benefits package. Such carve-outs can considerably weaken a coordinated care

system's ability to effectively address the enrollees' overall needs and minimize overall costs -- instead creating "silos" of financial accountability.

Linchpin #3 – Large Savings Opportunity for States. States and the Federal Government need to share significantly (perhaps equally) in the overall savings that the coordinated care program achieves – again without regard to the degree to which savings are occurring on the Medicaid versus Medicare benefits. However, since most of the baseline health care costs for duals consist of Federal funds, it is also appropriate that CMS play a large role in the design and monitoring of the programs that emerge in each state.

State governments are central to the proliferation of optimal care coordination programs for dual eligibles. If a program is designed such that states can share only in the savings that occur on Medicaid benefits, the initiative is unlikely to serve duals on a large scale (if it gets off the ground at all). The vast majority of the early year savings are expected to occur on the Medicare side given that coordinated care programs typically achieve much of their savings through reduced outlays for inpatient and outpatient services, and for prescription drugs relative to the FFS setting. Substantial savings in Medicaid nursing home expenditures are expected to accumulate through a comprehensive coordinated care program for duals, but such savings are limited in the initial year(s) of implementation since the existing group of nursing home residents has already spent down their assets and very few are likely to be transitioned back into a community setting. Nursing home savings in a well-coordinated setting occur slowly, but significantly, through avoiding institutionalization and maintaining at-risk persons in the community.

Linchpin #4 – Selective Contracting With MCOs. The participating MCOs in a given area are best selected through a competitive procurement process. In this way, a relatively small group consisting of roughly the 3-5 best-qualified MCOs will serve an area's dual eligible population -- rather than including all health plans that successfully complete an application process as occurs in Medicare Advantage. The winning MCOs will be ensured considerable market share in order to operate as cost-effectively as possible, and can frame their proposed programmatic commitments accordingly. The procurement process can be used to dictate a strong set of baseline programmatic requirements that all participant MCOs must meet, but can further be used to promote competition regarding the depth and breadth of the MCO outreach initiatives, price, provider network composition, and other areas the state and CMS wish to emphasize.

Linchpin #5 – Effective Transition of Duals Into the Program. A variety of program features are needed to create a successful transition of the duals into the coordinated care setting. These include:

- Using an objective process to assist dual eligibles in selecting among the available MCOs, and disallowing direct MCO marketing activities. Many states have considerable experience using an "enrollment broker" contractor for this function. It is also important that the program have a thoughtful process for assigning persons to an MCO when the dual eligible does not proactively make a selection. For example, a disproportionately high number of "auto-assignment" enrollments can be awarded to MCOs that demonstrate certain attributes (stronger network, better outreach, etc.) in their proposals.

16

- Providing MCOs with all available pre-enrollment FFS claims data for their new enrollees from at least the previous 24 months -- from the Medicaid program and for Medicare Part A, B and D services. This information enables the MCO to ascertain the enrollee's clinical conditions, provider relationships, medication regimens, etc., without having to wait for several months for their own claims to accumulate.

- Requiring that MCOs conduct at least a telephonic assessment of each new enrollee – and a face-to-face assessment in many circumstances – that encompasses the person's health care needs, housing situation, social support system, weight and dietary habits, and other information that define the strengths and challenges surrounding this individual's health status and future needs. There is tremendous variation in the duals' clinical needs – and in duals' socio-environment situations even among subgroups with similar needs. It is critical that the coordinated care model thoroughly identify *each individual's* specific circumstances.

- Phasing in enrollment across a wide enough timeframe to enable the MCOs to conduct the needed new member orientation, education, and assessment activities effectively.

- Requiring that established patient/provider relationships with key front-line providers (e.g., physicians, dentists and behavioral health therapists), be allowed to continue for at least the first several months of enrollment -- regardless of whether the provider has joined the MCO's network.

- Developing an individualized care coordination and treatment plan for each new enrollee, which is shared with the enrollee, the enrollee's key family and/or other caregiver(s), and the enrollee's key physician(s). This document also needs to be regularly reassessed and updated as appropriate, as the individual's health status and health-related circumstances evolve.

- Assigning a care coordinator from the MCO to each new enrollee, who will be responsible for disseminating and updating the treatment plans, and for serving as an ongoing liaison between the MCO, the member and family, and key providers.

Linchpin #6 – Strong Program Oversight. Any coordinated care initiative for duals requires substantial program monitoring oversight which involves a variety of areas including but not limited to extensive data reporting, process and contract compliance audits, and complaint/grievance reviews. It is further suggested that an advisory body be established to provide a public forum for the initiative's key stakeholders to share information about what is working well -- and what isn't -- to help the initiative evolve as successfully as possible.

B. A Promising Set of Federal and State Initiatives is Underway

While the political and policymaking process of relying more heavily on coordinated care for dual eligibles – as well as other high-need subgroups – has evolved painstakingly slowly over the past decades, there is now unprecedented momentum to replace the unmanaged fee-for-service coverage model with more effective approaches. Recent legislative and CMS actions represent substantial progress toward larger-scale and better-designed coordinated care programs for dual eligibles. Some of these initiatives are described briefly below:

Creation of a Medicare-Medicaid Coordination Office: The Affordable Care Act authorized creation of this Office, which is focused on improving quality and access to care for dual eligibles, simplifying processes, and eliminating regulatory conflicts and cost shifting that occur between the Medicare and Medicaid programs, States, and the Federal government.

State Demonstrations to Integrate Care for Dual Eligible Individuals: This CMS initiative, launched in April 2011, involves 15 states each of which is in the process of designing their own coordinated care program for selected dual eligibles in their respective states. These demonstrations will test new payment and financing models that strive to improve dual eligibles' care and reduce costs. The 15 states were selected through a competitive procurement process.

Testing of New Capitated Models: This would involve a three-way partnership between CMS, states, and MCOs under which Medicaid and Medicare funds for dual eligibles would be consolidated and managed. All states are eligible to apply for participation in this program.

Testing of New FFS Models: Under the FFS model, dual eligibles' care would be coordinated by the State in a manner that does not involve capitation contracting with MCOs. The State would have the opportunity to benefit financially from the savings that are achieved on both the Medicaid and Medicare costs incurred by that state's dual eligible population. All states are eligible to apply for participation in this program.

Table 8 provides a comparison chart between the six linchpins to an optimal coordinated care program (as identified in this paper), and the features of the current CMS initiatives as well as the design of the existing Medicare Special Needs Plan program.

From Table 8, while information on the new programs is all rather preliminary at this time, it does seem evident that *all* of the CMS initiatives are likely to represent a marked improvement on existing care coordination programs for dual eligibles. Enrollment of dual eligibles into a coordinated care setting most often currently occurs via the Medicare Advantage Special Needs Plan program, which includes only one of the six linchpins for optimal program design and appears to be creating net taxpayer costs rather than savings. Conversely, the new CMS initiatives all appear likely to include several of these linchpins.

Table 8. Degree to Which New CMS Initiatives Are Likely to Foster Optimal Care Coordination Programs

Linchpin for Optimal Care Coordination Program	State Demonstrations to Integrate Care for Dual Eligible Individuals	MCO Capitation Contracting Model	Managed FFS Model	Medicare Special Needs Plans
#1: Mandatory Enrollment	Unclear – not expressly part of any of the 15 states' program design documents (although seemingly desired by some state applicants)	Unclear -- initial CMS documents mention "passive enrollment" but do not mention "mandatory enrollment"	Unclear – these FFS-based initiatives might not entail actual "enrollment" into any program	No
#2: Full Integration of Medicaid and Medicare Covered Services	Yes – most state initiatives appear to be "whole person focused"	Yes	Yes	No
#3: Large-Scale State Savings Opportunity; Blended Funding	Yes	Yes	Yes	No
#4: Selective Contracting With Top-Qualified MCOs	Unclear in most states at this time; some states not planning to use MCOs	Yes	No	No
#5: Effective Transitions of Duals Into New Program	Yes (preliminary documents are unclear about this aspect, but careful transitions seem likely to occur under these demonstrations)	Yes (preliminary documents are unclear, but this seems likely to occur)	Unclear	Yes (typically)
#6: Strong Program Oversight	Yes (preliminary documents are unclear about this aspect, but strong monitoring seems likely to occur under these demonstrations)	Yes (preliminary documents are unclear, but this seems likely to occur)	Unclear	Oversight could be strengthened

C. **Summary of the Policymaking Challenge and Opportunity**

The array of CMS initiatives to support the expansion of effective coordinated programs for dual eligibles is a significant public policy accomplishment. However, it is not yet clear how many dual eligibles will transition into the coordinated care setting as a result of the new partnership initiatives being permitted/encouraged, nor the degree to which their design will include all of the features needed to achieve optimal results. Thus, a key purpose of this paper is encourage our policymakers to not fall short of implementing – *at least on a pilot test basis* – coordinated care models that include *all six* linchpins and which hold the greatest promise of reducing public outlays for dual eligibles while simultaneously improving their health status and outcomes.

The mandatory enrollment model is the most politically challenging linchpin to achieve but is particularly important to at least test during this "high water" period of innovation and demonstration activity related to coordinated care for dual eligibles. Keeping the FFS setting in place alongside a capitated initiative for duals in a given service area diminishes participation into coordinated care – but also has the further disadvantage of weakening the coordinated care program. When the FFS model is preserved, providers have extensive leverage in their dealings with participating MCOs, and the coordinated care system is often forced to deliver extra benefits to duals in order to attract and retain their participation.

The considerable successes the nation has experienced in the Medicaid managed care arena can all be traced to our political willingness to pilot test mandatory enrollment approaches decades ago. Once these pilot initiatives demonstrated the effectiveness of the approach, policymakers were then comfortable "opening up" the program to deploy the mandatory enrollment model on a more widespread basis.

Ample knowledge now exists as to how to structure a coordinated care program for dual eligibles to be highly successful -- in a manner that preserves a compassionate commitment to serving this complex and high-need population effectively, but which also provides much-needed cost containment acumen for a population that generates extraordinarily high health care costs.

The fiscal need for the most cost-effective approaches to be used is unprecedented, at both the state and federal government levels. The savings opportunities associated with optimal design and implementation of coordinated care programs for duals are large-scale in nearly every state. While a promising array of new coordinated care programs is currently being designed and implemented, the degree to which this large-scale opportunity is fully taken advantage of will be determined by our public policymaking outcomes. The key remaining question marks all revolve around the degree to which the nation's knowledge base and capabilities will be permitted to be optimally deployed.