Coordinated Care for Ohio's Dual Eligibles: Program Design Recommendations and Savings Estimates

Prepared for: Ohio Association of Health Plans

Prepared by: Special Needs Consulting Services, Inc.

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I. Executive Summary

The State of Ohio is seeking to implement a coordinated care program for persons dually covered by both Medicaid and Medicare. As evidenced by the Request for Information (RFI) document the State released on September 16, 2011, the initiative is at a critical design juncture and the State is seeking input as to how to maximize its success. Prior to the release of the State's RFI, the Ohio Association of Health Plans commissioned a report to provide program design guidance to Ohio's policymaking community. This report, prepared by Special Needs Consulting Services, was not initially intended to be a response to the RFI. However, upon conferring with ODJFS the Association has been asked to submit this as part of the RFI process. The report is also publicly available to any and all stakeholders involved in the program design effort.

The paper compares the capability and experience of Ohio's managed health care plans (MCPs), and of the capitated MCO in general – with alternative models of coordinated care for dual eligibles.

Coordinated Care Capability: The capitated MCP model adopts by far the most cost containment and quality measurement techniques – and deploys them most fully – of any coordinated care model. The MCP model scored the highest cost containment rating in all seventeen of the categories assessed. By comparison, no other model of care coordination was awarded the highest rating in more than three of the seventeen categories (18 percent). To achieve the greatest degree of cost savings from its dual eligibles coordinated care initiative, the State of Ohio will need to utilize the MCP model to the fullest degree possible. If the State seeks to work with non-MCP coordinated care contractors – in lieu of or in addition to MCPs – the State risks including entities that offer less coordinated care experience and ability. Conversely, if other contractors are required (and are in fact able) to deliver the same set of programmatic features as MCPs, there is no real point in creating a new contracting vehicle. Nothing prevents organizations who are interested in providing a comprehensive array of coordinated care services from seeking HMO licensure and competing on a level playing field with Ohio's MCPs.

Coordinated Care Experience: A similar situation exists with regard to experience. Ohio's MCPs have provided coordinated care services to Ohio's high-need Medicaid populations for years, including the State's Medicaid-only SSI beneficiaries, thousands of Ohio's dual eligible through MA SNP plans, and hundreds of thousands of dual eligibles in other states. Conversely, other types of coordinated care entities (e.g., ACOs) do not yet exist. The creation of less experienced (and perhaps non-experienced) entities to serve Ohio's complex, diverse, and highly challenging dual eligible population further diminishes the effectiveness of the initiative. Such an approach would also likely cause a considerable delay in the start date of the initiative relative to working with the already operational and highly experienced cadre of Ohio MCPs.

The report also offers several recommendations regarding optimal program design:

- <u>Select as broad a target population of dual eligibles as possible.</u> Limiting the program to subsets of Ohio's dual eligibles lowers the program's savings capability and shrinks the

size of the population that can clinically benefit from the tailored care coordination program Ohio is implementing.

- Focus the program on the "whole person." Coordinating individuals' care across the full (and highly interwoven) spectrum of Medicaid and Medicare covered services – encompassing acute health care, behavioral health care, and long term care – will optimize the program's effectiveness.

- Utilize Ohio's Existing MCPs. For the reasons identified above, the strongest program will draw upon Ohio's MCPs as the State's key contracting partners. The MCPs bring to this initiative, by a wide margin, the strongest array of capabilities and experience.

- Create a successful transition of beneficiaries. The vast majority of Ohio's dual eligibles are currently served in the traditional, unmanaged fee-for-service (FFS) setting. Moving this population into coordinated care requires a carefully designed phase-in plan that allows for (and requires) extensive outreach, education, individual assessments, preservation of certain existing provider/patient relationships, etc.

- Utilize appropriate initial and ongoing capitation rate-setting processes to ensure the program's considerable "win/win" potential is realized.

The report also prepares estimates of the savings that can be achieved through the capitated MCP model. These estimates were derived by projecting FFS costs for Ohio's duals, applying coordinated care impact factors to determine medical cost savings, then subtracting the amount projected to be needed for MCP administrative expenses and risk margins to yield net program savings. It is envisioned that a comprehensive coordinated care program would begin in January 2013 (with the remainder of 2011 and all of 2012 being needed to finalize the design features of the initiative and to conduct needed developmental tasks), and that enrollment would be phased in steadily throughout 2013.

Large-scale savings opportunities are immediately available, due to the large number of dual eligibles served in an unmanaged setting and their extremely high per capita costs. Overall savings (across Medicaid and Medicare covered services) relative to the FFS setting are projected at $6.9 billion across the ten year timeframe 2013-2022 from a statewide initiative. Single year savings are estimated at approximately $150 million in 2013, $380 million in 2014 (the first year of full enrollment), and at $1.2 billion in Year 10 (CY2022). Savings compound upwards favorably over time due to a steadily increasing number of nursing home diversions, general inflation trends, and steady population growth. Savings levels from initiatives that are less than statewide in nature are also projected.

It is envisioned that the State will share savings substantially with the Federal Government. Under an equal sharing of savings between the State and Federal governments, the State of Ohio stands to realize a savings of $3.45 billion across the first ten years of an optimally designed, statewide program.

II. Introduction

Purpose of Report:

The State of Ohio is seeking to implement a coordinated care program for persons dually covered by both Medicaid and Medicare. These persons are commonly referred to as "dual eligibles" or "duals". As evidenced by the Request for Information (RFI) document the State released on September 16, 2011, the initiative is at a critical design juncture and the State is seeking input as to how to maximize its success. Prior to the release of the State's RFI, the Ohio Association of Health Plans commissioned a report to provide program design guidance to Ohio's policymaking community. This report, prepared by Special Needs Consulting Services, was not initially intended to be a response to the RFI. However, upon conferring with ODJFS the Association has been asked to submit this as part of the RFI process. The report is also publicly available to any and all stakeholders involved in the program design effort.

Background Data on Ohio's Dual Eligibles:

A recent nationwide report, "Achieving Optimal Care Coordination for Medicaid/Medicare Dual Eligibles," contains extensive information on Ohio's dual eligibles.[1] Working with CMS MSIS data and applying typical population growth factors for duals, there are approximately 271,000 dual eligibles in Ohio during 2011. Within this group, 183,000 (67%) received the full Medicaid and Medicare benefits packages. This subgroup is often referred to as "full duals." Ohio's remaining 88,000 dual eligibles receive only partial Medicaid coverage (e.g., payments for the cost-sharing on Medicare-covered services).[2] This subgroup is commonly referred to as "partial duals." The number of dual eligibles in Ohio is expected to increase steadily by about one percent each year.[3]

Expenditures for Ohio's duals are projected to total $10.8 billion during 2011, which equates to $40,000 per dual eligible. These costs are divided 53% Medicaid and 47% Medicare. With the Federal Government paying 63.9% of Ohio's Medicaid costs and 100% of Medicare costs, the distribution of the total annual spending on Ohio's duals is approximately $8.7 billion Federal (81%) and $2.1 billion State (19%).

Long term care (LTC) services comprise the majority of existing Medicaid expenditures for Ohio's dual eligibles. While nursing home expenditures represent a large proportion of Ohio's Medicaid expenditures for dual eligibles, only 25% of Ohio's dual eligibles utilize

[1] The national report was also prepared by Special Needs Consulting Services (SNCS) and can be downloaded at no cost at the SNCS website: www.sncservices.com

[2] These population estimates represent average "point in time" eligible persons during CY2011.

[3] While the provisions of the Affordable Care Act are expected to significantly impact the number of persons eligible for and enrolled in Medicaid in Ohio, little meaningful change in the number of dual eligibles is expected to occur related to this health reform bill.

nursing home services during the year. Within the subgroup of Ohio's full benefits dual eligibles, 32% utilize nursing home services during the course of a year.[4]

Well below 10% of all spending on Ohio's dual eligibles will be paid via capitation to managed care plans (MCPs) during 2011 – almost all of which currently occurs under the Medicare Advantage program. The 2011 costs for duals via the fee-for-service (FFS) setting are estimated at $10.1 billion. Thus, *each* percentage point reduction in these FFS costs creates annual savings of $100 million.

The distribution of Ohio's expenditures for dual eligibles is summarized in Exhibit 1.

Exhibit 1. Estimated Costs for Ohio's Dual Eligibles During 2011

	Full Duals	Partial Duals	All Duals
Average Number of Eligible Persons	182,839	88,297	271,136
Medicaid Costs, PMPM			
Nursing Home	$1,010	$310	$782
Other -- Personal Support Services, Medicare Wraparound, all other	$1,194	$574	$992
Medicaid Subtotal	$2,204	$884	$1,774
Medicare Costs, PMPM			
Part A (inpatient, SNF, home health)	$492	$492	$492
Part B (outpatient, physician, other)	$431	$431	$431
Part D (pharmacy)	$625	$625	$625
Medicare Subtotal	$1,547	$1,547	$1,547
Total PMPM Costs	$3,751	$2,431	$3,321
Total Annual Costs Per Person	$45,013	$29,175	$39,855
Total Annual Costs, All Persons	$8,230,088,064	$2,576,037,216	$10,806,125,280

Ohio's duals have high average per capita costs in virtually all medical service categories. While many duals have similar needs, the array of challenges the State's program will need to capably address is extraordinarily diverse and complex. As a result, an optimal care coordination program cannot focus on a certain isolated issue (e.g., current and/or potential nursing home residents, persons with behavioral health conditions, persons with multiple chronic acute care conditions, etc.). Rather, the program will need to: a) thoroughly assess each individual's situation and needs; b) address the individual's current and emerging needs in a comprehensive, compassionate, and cost-effective manner; and c) be able to systematically implement this process across a large and diverse population.

[4] Most but not all of these persons are full-time residents of nursing facilities. Some are using a nursing home temporarily (as a "step-down" alternative to inpatient hospital care) to recover from an acute care episode.

III. Capability of Different Coordinated Care Models

A critical component of the Integrated Care Delivery System (ICDS) program design involves the model through which ICDS services are delivered. The State's February 2011 document, Ohio's Demonstration Model to Integrate Care for Dual Eligibles, indicates that "Ohio is exploring alternative models for ICDS implementation… those models include managed care plans, accountable care organizations, health homes, and other integrated care models." This section of the paper summarizes the experience and capabilities of different coordinated care approaches, beginning with a brief summary of each model.

Managed Care Plans (MCPs): MCPs accept full risk through a capitation payment model, directly pay providers for covered services, and channel patient volume towards their delivery system of contracted network providers. MCPs are often referred to as MCOs and/or HMOs. Ohio has relied extensively on MCPs to deliver coordinated care services to managed care enrollees. Currently, seven MCPs provide coordinated care services to Ohio's Medicaid beneficiaries (Amerigroup, Buckeye, CareSource, Molina, Paramount, United, and WellCare).

While the State remains open to creating and utilizing entities other than MCPs to deliver provide coordinated care services to Ohio's dual eligibles, it is not clear that additional ICDS capacity needs to be created. In conducting procurements for MCP contracts in Ohio, the State has not experienced a shortage of experienced and well-qualified applicants.

Accountable Care Organizations (ACOs): The ACO model is an emerging initiative being promoted by CMS. The key intent of the ACO approach appears to be to create additional coordinated care system capacity beyond the organizations that are willing and able to become MCPs, and to promote the proliferation of provider-sponsored coordinated care organizations. The specific coordinated care activities that ACOs will perform, and how these will differ from those performed by MCPs, are not yet clear. The degree to which new ACO entities will emerge -- and will be effective coordinated care entities -- is also unclear, as is the timeframe for ACO development and implementation. One of Ohio's existing Medicaid MCPs is a provider-sponsored entity, and nothing prevents additional provider-sponsored organizations from becoming full-service MCPs.

Health Homes: The health home model is also an emerging CMS Medicaid initiative that is independent of "home health care services" and of broader "medical home" initiatives occurring in the Medicare and other arenas. Health homes are targeted to Medicaid beneficiaries with at least two chronic conditions, including asthma, diabetes, heart disease, obesity, mental condition, and substance abuse disorder; one chronic condition and be at risk for another; or one serious and persistent mental health condition (and persons dually eligible for Medicaid and Medicare cannot be excluded). Health homes are designed to be person-centered and whole-person-focused systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. Health homes must develop a care plan for each individual that coordinates and integrates all clinical and non-clinical services and supports required to address the person's health-related needs. Health homes must use HIT to link services, facilitate communication between and among providers, the individual, and caregivers, and provide feedback to practices.

In addition, they must establish a continuous quality improvement program, and collect and report data that support evaluation efforts. The health homes requirements closely parallel the services Ohio's MCPs already provide to high-need subgroups. Therefore, a key consideration with regard to Ohio's dual eligible initiative is whether it makes the most sense for health homes to be fostered/maximized within a comprehensive MCP coordinated care structure – versus the State directly creating the health home component independently from (and perhaps in competition with) its MCPs.

Other Models: While the capitated MCP is by far the most common coordinated care approach used nationally to serve Medicaid and Medicare beneficiaries outside of the FFS setting, many states use non-MCP models to render coordinated care services to certain Medicaid subgroups. As an example in a neighboring state, since 2006 Pennsylvania has used a primary care case management program (PCCM) – which it has named ACCESSPlus -- to provide care coordination services. ACCESSPlus is used for Medicaid beneficiaries in rural counties that are not served by Pennsylvania's capitated health plans. ACCESSPlus also includes disease management and case management components for certain beneficiaries. Kentucky is another neighboring state that has extensively used a PCCM model – known as KENPAC – in its Medicaid program. However, Kentucky is currently replacing KENPAC with the fully capitated model for all non-dual beneficiaries.

A. Experience of Each Model

The relevant experience of various types of coordinated care organizations in providing coordinated care services to Ohio's dual eligibles is summarized in Exhibit 2.

Ohio's MCPs offer substantial experience in serving Ohio's high-need populations, including dual eligibles – both those at a nursing home level of care and those not yet needing long term care services. These plans' enrollment experience is summarized in the statistics below.

- More than 120,000 Ohio Aged Blind and Disabled Medicaid beneficiaries were enrolled in MCPs as of January 2011.

- 8,767 Ohio dual eligibles were enrolled in Medicare Advantage dual eligible special needs plans (D-SNPs) as of July 2011; another 2,886 Ohioans were enrolled in Medicare Advantage institutional special needs plans (I-SNPs).

- Approximately 440,000 Ohio Medicare beneficiaries were enrolled in "regular" Medicare Advantage plans during July 2011. While a small proportion of these enrollees are dually eligible for Medicaid, if even 5% of these enrollees are dual eligibles, the Ohio MCPs would collectively enroll approximately 34,000 duals (including D-SNP and I-SNP members).

- Many of Ohio's Medicaid MCPs also operate in other states. These MCPs currently serve hundreds of thousands of dual eligibles (collectively) in these other states.

The other coordinated care models – ACOs and PCCM programs -- have limited, if any, experience providing coordinated care services to dual eligibles. Neither state Medicaid programs nor the Medicare Advantage program have used non-capitated coordinated care approaches for dual eligibles on a large scale.

Exhibit 2: Experience Summary Comparison, Alternative Models for Ohio Dual Eligibles ICDS Contractors

Rating Key: ● Extensive Experience ⊙ Has Some Experience ○ No Known Experience			
Key Experience Needs	**ACO**	**Enhanced PCCM**	**MCP**
Coordinated Care Experience with High-Need Subgroups, Acute Care and Behavioral Health Services			
Organizations exist that have provided coordinated care services to high-need, impoverished subgroups in Ohio	○	○	●
Organizations exist that have provided coordinated care services to high-need, impoverished subgroups in other state(s)	○	●	●
Organizations exist that have provided coordinated care services to dual eligibles in Ohio	○	○	●
Organizations exist that have provided coordinated care services to dual eligibles in other state(s)	○	⊙	●
Managed Long Term Care Experience			
Organizations exist that have provided managed LTC services in Ohio	○	○	⊙
Organizations exist that have provided managed LTC services in other state(s)	○	○	●

B. Care Coordination Capabilities of Each Model

This section describes the medical cost management techniques used in the various coordinated care models and by the fee-for-service setting. While it is not possible to precisely quantify the cost containment impacts of any given coordinated care model, a side-by-side comparison can be made of cost containment *approaches* that occur in each setting. Exhibit 3 visually compares the three settings across a variety of cost management characteristics.

Exhibit 3: Comparison of Cost Containment Features of Various Coverage Models

Rating Key: ● Model strongly provides this attribute ⊙ Model partially provides this attribute ○ Model does not have this attribute				
Cost Containment Techniques	**FFS**	**ACO**	**Enhanced PCCM**	**MCP**
General Attributes				
Channels Patients to Low-Cost Settings and Cost-Effective Providers	○	⊙	○	●
Avoids Unnecessary Services	○	⊙	⊙	●
Creates/Uses Network of Providers	○	⊙	⊙	●
Directly Pays Providers	●	⊙	○	●
Requires Use of Lower-Cost Services	○	⊙	⊙	●
Vendor At Risk for Medical Costs	○	⊙	⊙	●
Achieves Favorable Unit Prices	●	●	●	●
Specific Attributes				
Primary Care Physician Required	○	●	●	●
Pre- Authorization for Costly Services	○	⊙	⊙	●
Referrals Required for Specialty Care	○	⊙	⊙	●
Disease Management	○	●	●	●
Case Management	○	⊙	⊙	●
Enrollee & Provider Outreach and Education	○	⊙	⊙	●
Management of Rx Mix & Usage	○	○	○	●
Can Pay for Uncovered Services on Exception Basis	○	○	○	●
Diverts Persons from Long-Term Nursing Home Institutionalization Where Possible/Appropriate	○	○	○	●
Provider Profiling/Reporting, Quality Measurement and Monitoring	○	⊙	⊙	●

From this comparison, three clear policy imperatives emerge with regard to Ohio's dual eligibles. First, it is critical to move away from the traditional FFS setting, which is currently the dominant coverage model for this high-cost, high-need subgroup. Other than underpaying providers relative to the rest of the payer community (which jeopardizes the very access to care that the Medicaid program seeks to provide to low-income persons), the Medicaid FFS setting does little or nothing to contain costs. A vast array of cost management techniques exist beyond what the FFS setting delivers, and it is important (particularly in the current fiscal situation) that Ohio move away from this model for dual eligibles to the greatest possible extent.

Second, while the "in-between" approaches create some advantages relative to FFS, the MCP model adopts by far the most cost containment techniques – and deploys them most fully – of any coordinated care model. The MCP model scored the highest cost containment rating (a dark circle) in all seventeen of the categories assessed in Exhibit 3. By comparison, no other model of care coordination was awarded a dark circle in more than three of the seventeen categories (18 percent). It is also important that the non-MCP models have little or no demonstrated capability in systematic quality measurement and reporting related to care coordination (outside of what routinely occurs in from a care delivery framework). To achieve the greatest degree of cost savings from its dual eligibles coordinated care initiative, it is essential that the State of Ohio utilize the MCP model to the fullest degree possible.

Third, the effort to maintain Ohioans in the community setting -- who would otherwise become Medicaid nursing home residents for the remainder of their lives -- is a complex and important component of this initiative. While only 25 percent of dual eligibles utilized nursing home services during 2009 (some of whom received temporary, rehabilitative care), nursing home costs represented approximately one-fourth of total spending on dual eligibles and 30 percent of spending on "full duals" (those receiving all Medicaid and Medicare covered services). While some of Ohio's MCPs have strong experience serving persons who have reached a nursing home level of care, additional work and innovation will be needed to fully meet these challenges. The State of Ohio needs to ensure it contracting partners have a sound plan to achieve success in this area – both in diverting persons from nursing homes where feasible and cost-effective, and in shoring up the capacity of community-based alternatives.

It is also possible to return some institutionalized persons to the community. As one example, an Ohio MCP's sister entity in another state has adopted a recovery-focused model. This MCP collaborated with local providers to develop a community-based alternative housing and treatment service for a group of five men who had been in long-term institutional care, some for longer than 20 years. To foster optimal recovery and resilience, the MCP placed these individuals, who had established strong social bonds over many years, in shared housing so they could continue to live in close proximity. Extensive wraparound services were coordinated for this group to assist them in remaining stable in the community. In addition to this group of men, this MCP has placed 25 other former state hospital residents in stable community settings successfully, all of whom had been hospitalized for several years. This entire group of former state hospital residents, one of whom had been hospitalized for more than 30 years, is actively involved in therapeutic activities to enhance recovery and independence whether in a group home, with family, or in the setting described above. Out of the entire group placed, only one

resident has had to return to the state hospital. This approach promotes independence as well as enhanced quality of life for the involved members.

At the same time, the State needs to enter into the coordinated care program with reasonable expectations as to what can be achieved with regard to nursing home diversions and discharges. The existing body of nursing home residents has already spent down their assets and very few of these individuals can return to community-based settings (although as demonstrated above it is worthwhile exploring these persons' circumstances and taking advantage of these opportunities). In addition, a large portion of new Medicaid nursing home residents are institutionalized *before* obtaining Medicaid coverage (then spend down to become Medicaid eligible). For these persons, little opportunity exists for the Medicaid program (or its coordinated care contractors) to retain these persons in the community.

IV. Recommended Design Features

The program design effort requires that a wide variety of decisions be made, including, fundamental, high-level matters (e.g., which duals should the program seek to serve?) and an array of highly detailed operational issues/requirements. This paper provides design suggestions on a few of the higher-level coordinated care program features, as these are deemed particularly critical/valuable to maximizing the initiative's success.

A. Select as Broad an Initial Target Population as Possible

To maximize the program's favorable clinical and financial impacts, it is recommended that the State include all Ohio dual eligibles (or at least all "full duals") in as many geographic regions as possible. Limiting the program to targeted subsets of duals will exclude many persons for whom care coordination can be beneficial and for whom cost savings can be achieved. The dual eligibles in almost any selected subset will still have a complex and diverse array of needs; thus a smaller target population will not create the advantage of focusing on persons with closely similar needs. Rather, these subsets will simply diminish the coordinated care program's administrative economies of scale and deprive many persons of the benefits of the care coordination model.

We would particularly encourage a focus on maximizing future nursing home diversions and caution against focusing the initiative too heavily on the already institutionalized subset of duals. While these individuals have the highest overall per capita costs, much of these costs are associated with nursing home institutionalization that is not going to be reversed. As discussed earlier, these individuals have already spent down and returning them to the community can realistically occur on only a limited basis. Many important positive impacts can be made with this subgroup – thus they should clearly be included in this initiative. However, it would be unwise to limit the initiative to (or focus the initiative largely on) the "already institutionalized" subgroup.

Related to this issue, we encourage that the State seek to use a mandatory enrollment approach, or to fall back on an "opt-out" enrollment model if necessary. These approaches bring the largest number of duals into the coordinated care setting, and do so without imposing marketing costs on the program to "sell" the duals into the coordinated care setting.

B. Combine Medicaid and Medicare Benefits and Funds to Serve the "Whole Person"

CMS is implementing coordinated care programs that merge together Medicaid and Medicare funds and allow the program to focus on the overall individual without regard/concern as to whether a Medicaid or Medicare benefit is being impacted. It is strongly encouraged that Ohio utilize this type of comprehensive, "whole person focused" approach. Focusing just on behavioral health services, on long-term care, or on acute care, for example, creates "silos" that will not yield optimal results. Each

individual has a unique and complex array of issues/challenges that must be discerned and addressed effectively.

Related to this issue, it is recommended that the State and CMS share equally in the savings (across the Medicaid and Medicare expenditures) that the initiative yields. Because dual eligibles' coverage status is fairly stable (once a person becomes a dual eligible, they are quite likely to remain covered by both programs for the remainder of their lives), the prior costs for most duals who enroll in the program are particularly "countable." The level of savings the program achieves can thus be quantified/estimated with a reasonable degree of accuracy, although this process will not be without challenges. CMS and the State should be able to agree on a sound methodology for estimating the program's savings, and sharing equally in the savings will create a strong motivation for the State to maximize the program's scope and success, and to devote adequate resources to the program development and ongoing monitoring efforts.

Another related issue with regard to savings is that a cash flow disadvantage to the State can occur when coverage is transferred from the FFS setting to a prepaid, capitation-based model. This challenge can negate initial program savings on a cash basis (although savings would immediately occur on an accrual basis.) However, it is not necessary for the new program to create a "cash flow winner" and a "cash flow loser." This issue can be resolved by pushing back the MCP's capitation payment date such that it is "cash flow neutral" to both parties.

C. Utilize MCPs that Already Serve Ohio's Medicaid Enrollees

Ohio has seven MCPs under contract that have significant experience providing coordinated care services to high-need subgroups in Ohio and/or other states. This experience includes enrolling and serving dual eligibles who have reached a nursing home level of care – both those residing in the community and those institutionalized in nursing homes. Contracting with these MCPs best serves the State's longer-range interests in terms of putting the strongest possible coordinated care model into place on a large scale – and also has the advantage of permitting the program to begin at the earliest possible juncture.

While it is not clear how the other types of contracting models the State is considering will add value to this endeavor beyond what MCPs can deliver, a significant potential exists for the coordinated care program and its associated savings to be considerably weakened. Utilizing alternatives to MCPs would result in less experienced (and perhaps non-experienced) contractors serving Ohio's duals on a relatively small scale. Such contracting strategies would also likely cause considerable delays in the State's efforts to get the program underway. Therefore, capitation contracting with the State's existing MCPs should be the centerpiece of the dual eligibles coordinated care effort. To the extent other contracting partners are included, they should be required to deliver the same comprehensive set of coordinated care services as the participating MCPs. Non–MCP contractors should also be held to the same level of assured savings as occurs in the MCP

capitated model, the same quality measurement and monitoring activities, and the MCPs' same level of provider payment protections in the event of insolvency.

It is also recommended that the State create a dual eligibles-tailored set of contract requirements that each participating MCP must meet, and to implement an application and site review process to ensure that the needed capabilities and commitments are in place prior to an MCP enrolling Ohio's duals in a given geographic area. Those MCPs who are unwilling to serve duals effectively would not be required to apply and participate – and those that do not successfully meet the State's contract requirements would not be permitted to participate until they do so.

D. Create a Successful Enrollment Transition of the Target Population

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 MCPs, and prohibiting direct MCP marketing activities beyond making information available for those who seek it. Ohio and many other 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 MCP when the dual eligible does not proactively make a selection.

- Providing MCPs 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 MCP 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 MCPs 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 the initial enrollment across a wide enough timeframe to enable the MCPs to conduct the needed new member orientation, education, and assessment activities effectively. An initial phase-in timeframe of 6-12 months permits the MCPs to capably provide a thorough assessment and conduct extensive education/orientation activities for all their new members.[5] A phase-in is not needed after this initial program transition

[5] If the duals program operates in concert with the Medicare Advantage program's annual enrollment and plan selection cycle, it may be useful to consider this process in establishing the timing of the phase-in.

period, however. During ongoing operations, the stream of new dual eligibles joining the program each month will be relatively small and will be manageable for the MCPs.

- 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 MCP'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 MCP to each new enrollee, who will be responsible for disseminating and updating the treatment plans, and for serving as an ongoing liaison between the MCP, the member and family, and key providers.

E. Appropriate Initial and Ongoing Capitation Rate-Setting Processes

As will be demonstrated in the ensuing savings section, it is expected that Ohio's dual eligibles coordinated care program, if optimally designed, will yield immediate and ever-growing savings across the full and combined spectrum of Medicaid and Medicare services. Effective capitation rate-setting is important to ensure that the public sector and the private MCPs each benefit from this program. Supporting the effort to set capitation rates at an appropriate "win/win" level is the fact that the baseline costs for Ohio's dual eligibles are quite "countable" across the Medicaid and Medicare Part A, B and D settings. Additionally, some of the most important risk adjustment features are relatively straightforward to make. Persons either reside in a nursing home or they do not, for example, and the residents' nursing home costs are highly predictable.

Nonetheless, there are many ways that the rate-setting could misfire at the outset. It is important, for example, not to assume significant Year 1 nursing home cost reductions will occur given that the costs in that year are largely driven by persons who will already have been institutionalized prior to enrolling in the coordinated care program and their selected MCP. The rate-setting approach also needs to address the potential for very different subgroups of duals to enroll in the different participating MCPs, which is a complex undertaking.

Whatever occurs with the rate-setting process in the initial year(s) of the program, its fairness and effectiveness can be readily assessed as the program evolves. The degree to which the overall program is yielding savings – and the degree to which the MCPs are being fairly compensated given the enrollment mix each has attracted – will become quite apparent. It will be important for the rate-setting process to fix, rather than compound or extend, any inadequacies that are found to exist.

V. Savings Estimates

This report presents estimates of savings from optimally deploying the strongest model described previously – capitation contracting with managed care plans (MCPs) with the MCPs being financially responsible for the full complement of Medicaid and Medicare covered services. Estimates have been prepared under two target population scenarios – one in which only "full duals" are targeted; another in which all Ohio dual eligibles (full and partial duals) are included. Under each of these scenarios, savings were modeled assuming that 100% of the target population is enrolled in the program (a statewide initiative); savings were also shown at various subsets of a statewide program assuming 80%, 60%, 40% and 20% of the target population was enrolled.

Savings estimates were prepared across the ten year timeframe 2013-2022, with 2013 being deemed the earliest full year in which an optimal program could reasonably be implemented. Enrollment during "Year 1" (CY2013) is assumed to include only half of the target population, given the importance of an enrollment phase-in to facilitate an effective transition of the dual eligibles into the coordinated care setting. Beginning in Year 2 (CY2014), the entire target population is assumed to be enrolled.

Large-scale savings are assumed to occur immediately. As summarized in Exhibit 4, savings in Year 1 are estimated to exceed $120 million for a statewide initiative focused on just the "full duals" subgroup. The savings shown in Exhibit 4 represent net savings across the Medicaid and Medicare benefits packages, and account for MHP administrative costs and risk margins. An enrollment phase-in is assumed to occur during Year 1 which lowers enrollment (and thus savings) by half during that year. Savings in Year 2 are also shown, and reach $300 million for Full Duals and $381 million if all dual eligibles are enrolled. Savings compound favorably in subsequent years due to population growth and ever-improving nursing home diversion volume. As of Year 10, net savings exceed 5% and reach $947 million for a statewide initiative targeted at full duals and $1.2 billion for a statewide initiative encompassing all Ohio dual eligibles. Savings across the ten-year period average more than 4%, totaling $5.6 billion for full duals and $6.9 billion for all duals.

Exhibit 4: Cost Savings Summary, Statewide Program

	Average Enrollment	Savings	Percent Savings
Full Duals			
Year 1 (phase-in year)	93,257	$123,664,545	2.6%
Year 2	188,379	$299,881,928	3.0%
Year 10	203,988	$946,567,993	5.4%
Total, Years 1-10		$5,573,064,435	4.4%
All Duals			
Year 1 (phase-in year)	138,293	$159,048,149	2.6%
Year 2	279,352	$381,664,358	2.9%
Year 10	302,498	$1,161,301,138	5.1%
Total, Years 1-10		$6,907,538,681	4.2%

The remainder of this section describes the process used to derive these savings estimates.

Baseline Costs: Medicaid baseline costs and eligibility counts for Ohio's dual eligibles were obtained from the Medical Statistical Information System (MSIS) State Summary DataMart using the FY2009 data files. Medicare costs for Ohio's dual eligibles were estimated using the following process:

- CY2009 Medicare PMPM fee-for-service costs were obtained for Part A and Part B services for aged beneficiaries from the CMS website at the county level. This data set included the number of fee-for-service beneficiaries contributing to the average PMPM costs. The county-specific information was aggregated to derive statewide average PMPM costs in Ohio. These costs for the total Medicare fee-for-service population were adjusted upwards by a factor of 1.27 to estimate Medicare PMPM costs for dual eligibles. This factor is based on dual eligibles' average risk scores derived through programming of the Medicare 5% sample data base, as reported in the "2010 SNP Alliance Profile and Advanced Practice Report" prepared by The Lewin Group.

- Part D pharmacy costs were estimated based on observed Medicaid pharmacy costs for dual eligibles in 2005 (derived from the MSIS data files), prior to the implementation of the Medicare Part D program. These 2005 PMPM costs were trended forward at 6% per year.

All derived PMPM costs were trended forward through CY2022 at a 6% annual inflation rate. The dual eligible population was trended upward at a rate of one percent per year.

The estimated baseline PMPM costs for full duals are shown in Appendix A in Table A-1. Corresponding information for all Ohio dual eligibles is shown in Appendix B, Table B-1.

Coordinated Care Impacts: Cost savings from the implementation of an optimal coordinated care program were estimated against the above-derived baseline projection. Central to this modeling effort was the derivation of coordinated care cost impact factors for each broad medical service category, which are shown in Appendix A (Table A-2). These impact factors (or closely similar factors) have been used in previous dual eligibles coordinated care savings modeling engagements.[6]

The key near-term savings opportunities are projected to occur in inpatient hospital, outpatient hospital, and pharmacy – all of which are areas where the MCO industry has a strong ability to achieve cost savings. With regard to inpatient hospital services, for example, the 2010 SNP Alliance Profile and Advanced Practice Report documents that fully integrated dual eligible MCOs achieved inpatient usage that was 16% below the rates occurring in the Medicare FFS setting for duals, despite the fact that the average acuity of these SNPs' enrollees was considerably greater than FFS dual eligibles (16% greater based on average risk scores). MCOs also implement a wide array of initiatives to transition services from the relatively costly outpatient hospital setting to less costly ambulatory settings. In the pharmacy arena, a variety of Lewin Group reports has documented Medicaid MCOs' ability to achieve savings relative to the unmanaged FFS setting through changes in the drug mix, in the volume of medications prescribed, and in the dispensing fees paid to pharmacies.[7]

A key longer-range driver of cost savings for an optimal care coordination program for dual eligibles is reductions in nursing home usage. While there are very limited opportunities to achieve immediate large-scale savings in nursing home expenditures (given that the existing group of nursing home residents has already spent down and become institutionalized), considerable opportunities exist to maintain persons in a community-based setting. These nursing home diversions accumulate favorably and sizably over time – the cost factors in Table 3 estimate more than a 10 percent savings as of Year 10.

Savings Estimates: Using the baseline costs and the cost factors described above, estimated medical costs in the coordinated care setting were derived for each year as shown in Appendices A and B (in the upper portions of Table A-3 and Table B-3).

The MCPs' administrative costs and risk margins need to be factored into the costs that will occur in the coordinated care setting. These components were estimated to represent 7.0% of total costs in the coordinated care setting for full duals. These same PMPM allocations were applied to the estimates for all dual eligibles.

Adding the MCPs' estimated PMPM medical costs and administrative allocation yields the estimated total capitation premium the State of Ohio would pay to its MCPs each year. These PMPM costs represent the State's costs in the coordinated care setting, and were compared with

[6] "Increasing Use of the Capitated Model for Dual Eligibles: Cost Savings Estimates and Public Policy Opportunities," Lewin Group, 2008. This report can be downloaded at no cost at www.communityplans.net.
[7] Examples of reports documenting MCO pharmacy savings are "Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Setting," (Lewin Group, 2003), and "Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs" (Lewin Group, 2007).

the estimated FFS baseline PMPM costs to derive the savings estimates for each year. The cost savings for full duals are presented in Appendix A, on the bottom half of Table A-3. Corresponding savings estimates for all duals are presented in Appendix B, towards the bottom of Table B-3. Savings estimates are shown for a statewide program and for various enrollment scenarios that are less than statewide.

All of the scenarios in Appendices A and B further indicate the enormity of the savings opportunity that exists through effective care coordination for Ohio's dual eligibles. Under the *smallest* savings scenario, which assumes 20% of the statewide full duals enrolling, savings across the first ten years would still exceed $1.1 billion. If the State of Ohio receives half these overall savings, annual State Fund savings across this ten-year timeframe would total $557 million and would average more than $50 million per year.

Under the *largest-scale* scenario, which would involve enrolling all of Ohio's dual eligibles, total savings across the first ten years are estimated at $6.9 billion. If the State received half these savings, State Fund savings across this ten-year timeframe would total $3.45 billion and would average more than $300 million per year.[8]

[8] Ohio uses a premium tax mechanism to secure additional Federal funds from its Medicaid MCP contracting. It is suggested that the premium tax not be applicable to the dual eligibles initiative, in the interest of creating a true 50/50 savings sharing partnership between the State and Federal government for the duals eligible program.

VI. Summary

Ohio's dual eligibles currently generate costs averaging $40,000 per person across their Medicaid and Medicare benefits. Total annual costs for Ohio's dual eligibles now approach $11 billion. The vast majority of these costs occur in the traditional FFS setting, and substantial savings opportunities exist through a well-designed and executed care coordination program. The State of Ohio is committed to implementing a program of this nature, and Ohio's Association of Health Plans commissioned this report to offer baseline data information, design input, and savings estimates.

The paper provides comparison charts on the capability and experience of Ohio's managed health care plans (MCPs), and of the capitated MCO in general – with alternative models of coordinated care for dual eligibles.

Coordinated Care Capability: The capitated MCP model adopts by far the most cost containment techniques – and deploys them most fully – of any coordinated care model. The MCP model scored the highest cost containment rating in all seventeen of the categories assessed. By comparison, no other model of care coordination was awarded the highest rating in more than three of the seventeen categories (18 percent). To achieve the greatest degree of cost savings from its dual eligibles coordinated care initiative, the State of Ohio will need to utilize the MCP model to the fullest degree possible. If the State seeks to work with non-MCP coordinated care contractors – in lieu of or in addition to MCPs – the State will be forced to work for entities that offer less coordinated care ability. Conversely, if other contractors are required (and are in fact able) to meet the same set of requirements as MCPs, there is no real point in creating a new contracting vehicle. Nothing prevents organizations who are interested in providing a comprehensive array of coordinated care services from seeking HMO licensure and competing on a level playing field with Ohio's MCPs.

Coordinated Care Experience: A similar situation exists with regard to experience. Ohio's MCPs have provided coordinated care services to Ohio's high-need Medicaid populations for years, including the State's Medicaid-only SSI beneficiaries, tens of thousands of Ohio's dual eligibles, and hundreds of thousands of dual eligibles in other states. Conversely, other types of coordinated care entities (e.g., ACOs) do not yet exist. The creation of less experienced (and perhaps non-experienced) entities to serve Ohio's complex, diverse, and highly challenging dual eligible population further diminishes the effectiveness of the initiative. Such an approach would also likely cause a considerable delay in the start date of the initiative relative to working with the already operational and highly experienced cadre of Ohio MHPs.

The report also offers several recommendations regarding optimal program design. These include the following:

- Select as broad a target population of dual eligibles as possible. Limiting the program to subsets of Ohio's dual eligibles lowers the program's savings capability and shrinks the size of the population that can clinically benefit from the tailored care coordination program Ohio is implementing.

- Focus the program on the "whole person." Coordinating individuals' care across the full (and highly interwoven) spectrum of Medicaid and Medicare covered services – encompassing acute health care, behavioral health care, and long term care – will optimize the program's effectiveness.

- Utilize Ohio's Existing MCPs. For the reasons identified above, the strongest program will draw upon Ohio's MCPs as the State's key contracting partners. The MCPs bring to this initiative, by a wide margin, the strongest array of capabilities and experience.

- Create a successful transition of beneficiaries. The vast majority of Ohio's dual eligibles are currently served in the traditional, unmanaged fee-for-service (FFS) setting. Moving this population into coordinated care requires a carefully designed phase-in plan that allows for (and requires) extensive outreach, education, individual assessments, preservation of certain existing provider/patient relationships, etc.

- Utilize appropriate initial and ongoing capitation rate-setting processes to ensure the program's considerable "win/win" potential is realized.

The report also prepares estimates of the savings that can be achieved through the capitated MCP model. These estimates were derived by projecting FFS costs for Ohio's duals, applying coordinated care impact factors to determine medical cost savings, then subtracting the amount projected to be needed for MCP administrative expenses and risk margins to yield net program savings.

It is envisioned that a comprehensive coordinated care program would begin in January 2013 (with the remainder of 2011 and all of 2012 being needed to finalize the design features of the initiative and to conduct needed developmental tasks), and that enrollment would be phased in steadily throughout 2013.

Large-scale savings opportunities are immediately available, due to the large number of dual eligibles served in an unmanaged setting and their extremely high per capita costs. Overall savings (across Medicaid and Medicare covered services) relative to the FFS setting are projected at $6.9 billion across the ten year timeframe 2013-2022 from a statewide initiative. Single year savings are estimated at approximately $150 million in 2013, $380 million in 2014 (the first year of full enrollment), and at $1.2 billion in Year 10 (CY2022). Savings compound upwards favorably over time due to a steadily increasing number of nursing home diversions, general inflation trends, and steady population growth. Savings levels from initiatives that are less than statewide in nature are also projected.

It is envisioned that the State will share savings substantially with the Federal Government. Under an equal sharing of savings between the State and Federal governments, the State of Ohio stands to realize a savings of $3.45 billion across the first ten years of an optimally designed, statewide program.

Appendix A: Cost Savings Estimates, Optimal Model for Full Duals

Table A-1. Baseline PMPM Costs for Full Dual Eligibles

PMPM Costs in FFS	Base Year 2011	Development Year 2012	Year 1 2013	Year 2 2014	Year 3 2015	Year 4 2016	Year 5 2017	Year 6 2018	Year 7 2019	Year 8 2020	Year 9 2021	Year 10 2022
Medicaid Costs, PMPM												
Nursing Home	$1,010	$1,071	$1,135	$1,203	$1,275	$1,352	$1,433	$1,519	$1,610	$1,707	$1,809	$1,917
All Other	$1,194	$1,266	$1,342	$1,422	$1,507	$1,598	$1,694	$1,795	$1,903	$2,017	$2,138	$2,266
Total	$2,204	$2,336	$2,476	$2,625	$2,783	$2,950	$3,127	$3,314	$3,513	$3,724	$3,947	$4,184
Medicare Costs, PMPM												
Part A	$492	$521	$552	$586	$621	$658	$697	$739	$784	$831	$880	$933
Part B	$431	$457	$484	$513	$544	$577	$611	$648	$687	$728	$772	$818
Part D	$625	$662	$702	$744	$788	$836	$886	$939	$995	$1,055	$1,118	$1,186
Total	$1,547	$1,640	$1,738	$1,843	$1,953	$2,070	$2,194	$2,326	$2,466	$2,614	$2,770	$2,937
Total PMPM Costs	$3,751	$3,976	$4,215	$4,468	$4,736	$5,020	$5,321	$5,640	$5,979	$6,337	$6,718	$7,121

Table A-2. Coordinated Care Cost Savings Factors

MCP Cost Factors Relative to FFS Setting	Year 1 2013	Year 2 2014	Year 3 2015	Year 4 2016	Year 5 2017	Year 6 2018	Year 7 2019	Year 8 2020	Year 9 2021	Year 10 2022
Medicaid Services										
Nursing Home	0.987	0.975	0.962	0.950	0.937	0.925	0.912	0.900	0.895	0.890
All Other	0.950	0.950	0.950	0.950	0.950	0.950	0.950	0.950	0.950	0.950
Medicare Services										
Part A	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75
Part B	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85
Part D	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85

Table A-3. Coordinated Care Savings Estimates for Full Dual Eligibles

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	
PMPM Costs in MCP Setting	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	
Medicaid Costs, PMPM											
Nursing Home	$867	$908	$950	$994	$1,039	$1,088	$1,137	$1,189	$1,253	$1,321	
All Other	$1,059	$1,123	$1,190	$1,261	$1,337	$1,417	$1,502	$1,593	$1,688	$1,789	
Total	$1,926	$2,031	$2,140	$2,256	$2,377	$2,505	$2,639	$2,782	$2,942	$3,111	
Medicare Costs, PMPM											
Part A	$414	$439	$465	$493	$523	$554	$588	$623	$660	$700	
Part B	$412	$436	$462	$490	$520	$551	$584	$619	$656	$695	
Part D	$596	$632	$670	$710	$753	$798	$846	$897	$951	$1,008	
Total	$1,422	$1,508	$1,598	$1,694	$1,796	$1,903	$2,017	$2,139	$2,267	$2,403	
Total PMPM Costs	$3,349	$3,538	$3,738	$3,950	$4,172	$4,408	$4,657	$4,920	$5,208	$5,513	
Medical Cost Savings											
Medicaid Services	$67	$82	$100	$119	$140	$163	$189	$216	$236	$257	
Medicare Services	$316	$335	$355	$376	$399	$423	$448	$475	$504	$534	
Total	$383	$417	$455	$495	$539	$586	$637	$691	$740	$791	

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Ten Year Total
Savings Projections	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2013 - 2022**
Capitation Payment in MCP Setting											
Medical Component	$3,349	$3,538	$3,738	$3,950	$4,172	$4,408	$4,657	$4,920	$5,208	$5,513	
Administration and Risk Margin	$287	$303	$320	$338	$357	$377	$398	$421	$445	$471	
Total Capitation Payment	$3,636	$3,842	$4,058	$4,288	$4,529	$4,786	$5,055	$5,341	$5,654	$5,985	
Net PMPM Savings vs. FFS Setting	$96	$114	$135	$157	$182	$208	$239	$270	$294	$320	
Percentage Savings vs. FFS Setting	2.6%	2.9%	3.2%	3.5%	3.9%	4.2%	4.5%	4.8%	4.9%	5.1%	
Enrollment (Percent of Ohio Duals in MCPs)											
100% (Statewide)	93,257	188,379	190,263	192,166	194,087	196,028	197,988	199,968	201,968	203,988	
80%	74,606	150,703	152,210	153,733	155,270	156,823	158,391	159,975	161,574	163,190	
60%	55,954	113,028	114,158	115,299	116,452	117,617	118,793	119,981	121,181	122,393	
40%	37,303	75,352	76,105	76,866	77,635	78,411	79,195	79,987	80,787	81,595	
20%	18,651	37,676	38,053	38,433	38,817	39,206	39,598	39,994	40,394	40,798	
Total Savings at Different Enrollment Levels											
100% (Statewide)	$107,253,203	$257,373,161	$307,696,843	$361,195,453	$423,549,273	$489,872,104	$566,697,890	$648,451,085	$712,853,178	$783,116,734	$4,658,058,925
80%	$85,802,563	$205,898,529	$246,157,474	$288,956,362	$338,839,419	$391,897,683	$453,358,312	$518,760,868	$570,282,543	$626,493,387	$3,726,447,140
60%	$64,351,922	$154,423,897	$184,618,106	$216,717,272	$254,129,564	$293,923,263	$340,018,734	$389,070,651	$427,711,907	$469,870,040	$2,794,835,355
40%	$42,901,281	$102,949,265	$123,078,737	$144,478,181	$169,419,709	$195,948,842	$226,679,156	$259,380,434	$285,141,271	$313,246,694	$1,863,223,570
20%	$21,450,641	$51,474,632	$61,539,369	$72,239,091	$84,709,855	$97,974,421	$113,339,578	$129,690,217	$142,570,636	$156,623,347	$931,611,785

Appendix B: Cost Savings Estimates, Optimal Model for All Ohio Dual Eligibles

Table B-1. Baseline PMPM Costs for All Ohio Dual Eligibles

	Base Year	Development Year	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
PMPM Costs in FFS	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Medicaid Costs, PMPM												
Nursing Home	$782	$829	$879	$931	$987	$1,047	$1,109	$1,176	$1,246	$1,321	$1,401	$1,485
All Other	$992	$1,052	$1,115	$1,182	$1,253	$1,328	$1,407	$1,492	$1,581	$1,676	$1,777	$1,884
Total	$1,774	$1,881	$1,994	$2,113	$2,240	$2,374	$2,517	$2,668	$2,828	$2,998	$3,177	$3,368
Medicare Costs, PMPM												
Part A	$492	$521	$552	$586	$621	$658	$697	$739	$784	$831	$880	$933
Part B	$431	$457	$484	$513	$544	$577	$611	$648	$687	$728	$772	$818
Part D	$625	$662	$702	$744	$788	$836	$886	$939	$995	$1,055	$1,118	$1,186
Total	$1,547	$1,640	$1,738	$1,843	$1,953	$2,070	$2,194	$2,326	$2,466	$2,614	$2,770	$2,937
Total PMPM Costs	$3,321	$3,521	$3,732	$3,956	$4,193	$4,445	$4,711	$4,994	$5,294	$5,611	$5,948	$6,305

Table B-2. Coordinated Care Cost Savings Factors

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
MCP Cost Factors Relative to FFS Setting	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Medicaid Services										
Nursing Home	0.987	0.975	0.962	0.950	0.937	0.925	0.912	0.900	0.895	0.890
All Other	0.950	0.950	0.950	0.950	0.950	0.950	0.950	0.950	0.950	0.950
Medicare Services										
Part A	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75	0.75
Part B	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85
Part D	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85	0.85

Table B-3. Coordinated Care Savings Estimates for All Ohio Dual Eligibles

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	
PMPM Costs in MCP Setting	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	
Medicaid Costs, PMPM											
Nursing Home	$867	$908	$950	$994	$1,039	$1,088	$1,137	$1,189	$1,253	$1,321	
All Other	$1,059	$1,123	$1,190	$1,261	$1,337	$1,417	$1,502	$1,593	$1,688	$1,789	
Total	$1,926	$2,031	$2,140	$2,256	$2,377	$2,505	$2,639	$2,782	$2,942	$3,111	
Medicare Costs, PMPM											
Part A	$414	$439	$465	$493	$523	$554	$588	$623	$660	$700	
Part B	$412	$436	$462	$490	$520	$551	$584	$619	$656	$695	
Part D	$596	$632	$670	$710	$753	$798	$846	$897	$951	$1,008	
Total	$1,422	$1,508	$1,598	$1,694	$1,796	$1,903	$2,017	$2,139	$2,267	$2,403	
Total PMPM Costs	$3,349	$3,538	$3,738	$3,950	$4,172	$4,408	$4,657	$4,920	$5,208	$5,513	
Medical Cost Savings											
Medicaid Services	$67	$82	$100	$119	$140	$163	$189	$216	$236	$257	
Medicare Services	$316	$335	$355	$376	$399	$423	$448	$475	$504	$534	
Total	$383	$417	$455	$495	$539	$586	$637	$691	$740	$791	

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Ten Year Total
Savings Projections	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2013 - 2022**
Capitation Payment in MCP Setting											
Medical Component	$3,349	$3,538	$3,738	$3,950	$4,172	$4,408	$4,657	$4,920	$5,208	$5,513	
Administration and Risk Margin	$287	$303	$320	$338	$357	$377	$398	$421	$445	$471	
Total Capitation Payment	$3,636	$3,842	$4,058	$4,288	$4,529	$4,786	$5,055	$5,341	$5,654	$5,985	
Net PMPM Savings vs. FFS Setting	$96	$114	$135	$157	$182	$208	$239	$270	$294	$320	
Percentage Savings vs. FFS Setting	2.6%	2.9%	3.2%	3.5%	3.9%	4.2%	4.5%	4.8%	4.9%	5.1%	
Enrollment (Percent of Ohio Duals in MCPs)											
100% (Statewide)	138,293	279,352	282,145	284,967	287,816	290,694	293,601	296,537	299,503	302,498	
80%	110,634	223,481	225,716	227,973	230,253	232,556	234,881	237,230	239,602	241,998	
60%	82,976	167,611	169,287	170,980	172,690	174,417	176,161	177,922	179,702	181,499	
40%	55,317	111,741	112,858	113,987	115,127	116,278	117,441	118,615	119,801	120,999	
20%	27,659	55,870	56,429	56,993	57,563	58,139	58,720	59,307	59,901	60,500	
Total Savings at Different Enrollment Levels											
100% (Statewide)	$159,048,149	$381,664,358	$456,290,458	$535,624,731	$628,090,592	$726,442,186	$840,368,845	$961,602,466	$1,057,105,756	$1,161,301,138	$6,907,538,681
80%	$127,238,519	$305,331,486	$365,032,367	$428,499,785	$502,472,474	$581,153,749	$672,295,076	$769,281,973	$845,684,605	$929,040,910	$5,526,030,944
60%	$95,428,890	$228,998,615	$273,774,275	$321,374,839	$376,854,355	$435,865,312	$504,221,307	$576,961,480	$634,263,454	$696,780,683	$4,144,523,208
40%	$63,619,260	$152,665,743	$182,516,183	$214,249,893	$251,236,237	$290,576,874	$336,147,538	$384,640,987	$422,842,303	$464,520,455	$2,763,015,472
20%	$31,809,630	$76,332,872	$91,258,092	$107,124,946	$125,618,118	$145,288,437	$168,073,769	$192,320,493	$211,421,151	$232,260,228	$1,381,507,736