

# Risky Business: Capitated Financing in the Dual Eligible Demonstration Projects

---

*Ellen Breslin Davidson and  
Tony Dreyfus*

*BD Group*



Community Catalyst, Inc.  
30 Winter St. 10<sup>th</sup> Floor  
Boston, MA 02108  
617.338.6035  
Fax: 617.451.5838  
[www.communitycatalyst.org](http://www.communitycatalyst.org)



*The national Dual Eligible Demonstration Projects aim to improve health services for low-income people with disabilities and low-income seniors by moving millions of people and billions of dollars into capitated health plans. The goals are laudable but must be supported by the right financing. Unfortunately, the capitated models under development put health plans at too much financial risk, undermining the goals of the demonstration and jeopardizing the health and well-being of vulnerable people.*

## **Introduction: A National Effort to Improve Care for Duals**

Nationwide, approximately ten million people are eligible for both Medicare and Medicaid. These “dual eligibles” are low-income people either with disabilities or age 65 and over. They include some of this country’s most ill, disabled and vulnerable people. Dual eligibles have greater health care needs and costs than any other Medicare or Medicaid population. The needs of dual eligibles may be great because of a variety of serious and chronic illnesses and disabilities.

## **Reasons for the Dual Eligible Demonstration Projects**

With their greater health problems, duals face greater negative consequences from the weaknesses of the current health care system – poor coordination of care, overuse of the hospital, overuse of nursing homes and other institutions, and little oversight of the quality of care received. With separate coverage from Medicare and Medicaid, duals have not benefitted from integrated approaches to care that weave together the best balance of primary, preventive and community care. Building such new systems could shorten periods of illness and aggravated disability; reduce unnecessary care in hospitals and institutions; and create a better quality of life for dual eligibles.

In partnership with states, the federal government has created the Dual Eligible Demonstration Projects to foster integrated health care arrangements that combine medical care and supportive services into a single program. The goals are to improve quality, outcomes and cost-effectiveness.<sup>1</sup> Participating states can use managed fee-for-service or capitated managed care plans as their care delivery model. Twenty-four states are moving forward with demonstrations, including 16 states designing capitated programs. These 16 demonstrations may soon move millions of people and billions of dollars into capitated health plans.

## **The Advantages and Dangers of Capitation**

The capitated approach may hold great promise for bringing deeper improvement to the care of dual eligibles. With capitation, health plans would receive the money and flexibility required to serve duals with more primary and preventive care and more supportive services provided in the community. But federal and state officials must carefully design the capitated approach and closely oversee care quality. The right financing and oversight can motivate plans to innovate for duals with greater needs and to create a much stronger care system – with better outcomes and without higher cost.

---

<sup>1</sup> Kaiser Commission on Medicaid and Uninsured. Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries. October 2012, available at <http://www.kff.org/medicaid/upload/8368.pdf>.

Capitation done poorly, however, can create the wrong incentives. If plans receive too little money for members' needs, if they have little protection from losses, and if they face weak quality oversight, then they may be driven in the wrong direction. Plans in such circumstances might avoid serving high-need duals and might unwisely reduce services in ways that will endanger the most vulnerable duals.

**Unfortunately, the capitated models emerging to date in the first three states to receive federal approval – Illinois, Massachusetts and Ohio – appear poorly designed. The federal government and these three states have reached agreement on approaches that unwisely put health plans at too much financial risk and increase the dangers of under-service. Other provisions reduce the capitation rates in order to guarantee savings and would exacerbate these dangers. Moving ahead to develop good integrated systems of care for duals is a laudable goal, but doing so with too much risk may squander this opportunity for improvement.**

Fortunately, the Affordable Care Act provides excellent guidance for how public officials can fix the demonstration's capitated model by limiting risk. An improved capitated model would also eliminate savings targets that are unnecessary for the demonstration's goals. Stringent consumer protections and strong consumer engagement should also accompany a more effective capitated model.

This policy brief explains why a careful approach to capitated financing is essential and presents our recommendations for improving this model for all states going forward.

## **A Cautious Approach to Capitation is Warranted**

There are three main reasons why the federal and state governments should take a cautious approach to capitation.

### **Many Dual Eligibles Depend on Continuous Access to Vital Services**

Duals include many of this nation's most vulnerable individuals who need extensive medical care and support services to maintain their health and function. Duals may experience a wide variety of physical chronic illness, physical disability, mental illness or cognitive disability, and may have combinations of disabling physical and mental conditions.<sup>2</sup> Many duals rely upon long term services and supports to live in the community. Younger duals who are disabled and older duals who experience the varied disabilities and losses of function that come with aging depend on such services.

Getting the financial incentives right is critically important to ensuring duals have continued access to services that maintain their health and their living situations in the community. If duals lose access to long-standing providers and services, or new approaches don't work well, then some duals may suffer increased disability and illness.

### **Health Plans Have Limited Experience Serving Duals**

Managing services in a comprehensive manner under a capitated arrangement will create new challenges for health plans and providers. The challenge of creating good systems of integrated care that will improve quality and outcomes for duals is considerable.

Yet few plans have significant experience in creating care systems that integrate medical care with long-term services and supports. Several states and Program for All-Inclusive Care for the Elderly (PACE) sites around the country have integrated acute and long-term care, but for very small numbers of people. Some plans have integration experience in the Medicare Advantage market including Special Needs Plans. But most health plans will come to the demonstration projects inexperienced in integrating care for high-need duals.

In addition, states will also be choosing among non-profit and for-profit plans. Concerns about the negative incentives of capitation are heightened by the inclusion of for-profit plans that are legally bound to prioritize shareholder earnings. In Massachusetts, the state is looking to non-profit plans, while in Ohio for-profit plans predominate.

### **The Government Lacks a Well-Developed Approach to Oversight of Quality**

The federal and state governments do not yet have the expertise or infrastructure to provide adequate oversight and management of the quality of care and services that will be provided to duals. A recent report by the Center for Health Care Strategies points out that quality measures for integration, for long-term services and supports and for behavioral health services are lacking, all key components of the care needs of duals, especially for younger duals.<sup>3</sup> Measures used by the National Committee on Quality Assurance to evaluate Special Needs Plans primarily

---

<sup>2</sup> Centers for Medicare and Medicaid Services. Medicare-Medicaid Enrollee State Profile: The National Summary, available at [http://www.integratedcareresourcecenter.com/PDFs/National\\_Summary\\_Final.pdf](http://www.integratedcareresourcecenter.com/PDFs/National_Summary_Final.pdf).

<sup>3</sup> Center for Health Care Strategies. Quality Measurement in Integrated Care for Medicare-Medicaid Enrollees. Technical Assistance Brief. January 2013, available at [http://www.chcs.org/usr\\_doc/Quality\\_Measurement\\_in\\_Integrated\\_Care.pdf](http://www.chcs.org/usr_doc/Quality_Measurement_in_Integrated_Care.pdf).

focus on measures for older adults. Another report, prepared by the Government Accountability Office, points to inadequacies in the framework currently used by the federal government to measure the quality of care provided by Special Needs Plans serving disabled persons.<sup>4</sup>

During this three-year demonstration period, both health plans and the state and federal governments need time to learn and consumers need significant protection from unintended harm.<sup>5</sup> The government can gain the expertise it needs, but will require time and involvement from stakeholders including beneficiaries and advocates. New frameworks for measuring the quality of care for dual eligibles must be developed to determine the success of the demonstration projects.

## **Capitated Dual Eligible Demonstrations Approved So Far Are Cause for Concern**

### **Federal and State Plans**

So far three state Dual Eligible Demonstration Projects relying on capitation have been approved in Illinois, Massachusetts and Ohio. Each state intends to enroll more than 100,000 beneficiaries. In Massachusetts the demonstration applies only to those under 65 while in Illinois and Ohio both younger adults with disabilities and low-income adults over 65 will be enrolled.<sup>6</sup>

The federal government has prepared guidance for the states on how the joint Medicare-Medicaid financing for the demonstration will work.<sup>7</sup> Medicare and Medicaid will pay health plans a capitation rate for a comprehensive set of benefits. Medicare payments will be risk adjusted using enrollees' diagnoses. Medicaid payments will be either risk adjusted or be based on rating categories.

Guidance on financing also includes provisions to capture savings and reward quality. The capitation rates will be reduced to generate savings for the government in each year of the demonstration. The payments will also be reduced by one, two and three percent of the capitation withheld in successive years to reward plans if they meet quality goals.

States may also add other provisions. Illinois and Ohio, for example, have included a minimum medical loss ratio requirement for health plans set at 85 percent.<sup>8</sup> This requirement allows the state to recoup funds from the health plan should spending on care fall below 85 percent and

---

<sup>4</sup> United States General Accountability Office. Medicare Special Needs Plans. CMS Could Improve Information Available about Dual-Eligible Plans' Performance. September 2012, available at <http://www.gao.gov/assets/650/648291.pdf>.

<sup>5</sup> Patricia Neuman, Barbara Lyon, Jennifer Rentas, and Diane Rowland. Dx For A Careful Approach to Moving Dual-Eligible Beneficiaries Into Managed Care Plans. Health Affairs. Vol. 32. No. 6. June 2012, available at <http://content.healthaffairs.org/content/31/6/1186.abstract>.

<sup>6</sup> Kaiser Commission on Medicaid and Uninsured. Massachusetts and Ohio: Capitated Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared. January 2013, available at <http://www.kff.org/medicaid/upload/8407.pdf>.

<sup>7</sup> Medicare-Medicaid Coordination Office, Joint Rate-Setting Process for the Capitated Financial Alignment Model, February 2013, available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf>

effectively limits plan expenditure on administration and profits. But if rates are inadequate, then this provision offers no protection to plans and their members.

The capitated models for Illinois, Massachusetts and Ohio fail to create the right incentives for health plans, thereby failing to offer consumers adequate protections from the dangers of capitation. Such unfortunate incentives are not just a problem for duals in these three states, since similar approaches may be approved in other states as well.

### **Primary Concern: Comprehensive Risk Mitigation Lacking**

None of the states approved thus far have adopted a strong risk mitigation program including the “Three R’s”: risk adjustment, reinsurance and risk corridors. The weaker approach adopted by the three states runs counter both to the government’s policies for the Health Insurance Exchange under the Affordable Care Act and to prior integrated care demonstrations. The Affordable Care Act includes comprehensive risk mitigation measures, including permanent risk adjustment and three years of reinsurance and risk corridors.<sup>9</sup>

**Risk adjustment for Medicaid.** *Risk adjustment is a system for adjusting payments to health plans to reflect the differing health risks or needs of enrollees. Its goal is twofold: to encourage plans to take on the challenge of innovating to serve people with greater needs; and to discourage plans from avoiding needier people in order to reap large undeserved profits.*

Risk adjustment for dual eligibles is particularly important because their needs are very diverse and it is relatively easy to identify which duals will have above-average costs on an ongoing basis because of high chronic needs.

Under the payment systems proposed by Illinois, Massachusetts and Ohio, risk adjustment by diagnoses applies only to the Medicare portion of the capitation, not to the Medicaid portion. The currently proposed method of calculating capitation rates will likely lead to some plans receiving too little payment for Medicaid services to meet their enrollees’ needs. The underpayments may particularly affect enrollees who need many long-term services and supports such as personal care attendants and home health aides that allow them to live at home and in the community.

While federal Medicare payments will be risk adjusted based on enrollee diagnosis, the demonstration so far lacks an effective method of risk adjustment for the Medicaid portion of the capitated payments to health plans. Illinois, Massachusetts and Ohio have each proposed to vary capitation rates by subgroups of duals relying upon a rating category structure in an attempt to capture differences in risk among eligible duals. The use of several rating categories, however, is not a substitute for risk adjustment, because each plan could easily enroll members in each rating category with health care costs that differ significantly from the average for the rating category.

---

<sup>9</sup> Society of Actuaries, Affordable Care Act Programs Expected to Mitigate Health Plans’ Risk in Early Years, June 2012, available at <http://www.soa.org/News-and-Publications/Newsroom/Press-Releases/Affordable-Care-Act-Programs-Expected-to-Mitigate-Health-Plans’-Risk--in-Early-Years.aspx>

It would not be too difficult for plans to avoid duals with costs exceeding the rate for their categories.<sup>10</sup>

States have little experience risk adjusting capitated payment for long-term services and supports. As described below with our recommendations, however, there are good approaches that could be implemented, one immediately and another later on in the demonstration.

**Reinsurance.** *Reinsurance is a system of paying plans for the costs of enrollees above an established threshold.*

It is particularly important for the duals, because some duals predictably have costs much higher than the average and reinsurance would lessen plans' concerns about enrolling them. Neither Illinois nor Ohio include any reinsurance. Massachusetts includes a limited form of reinsurance, covering only costs for long-term services and supports above a certain threshold – currently undefined – for the very few enrollees in two small Medicaid rating categories. Massachusetts calls this arrangement a “high-cost risk pool.” Health plans could probably not find affordable commercial reinsurance

**Risk corridors.** *Risk corridors provide a way for the government to limit health plan gains and losses. The federal government has designed sensible, protective risk corridors under the Affordable Care Act for the Health Insurance Exchanges. Plans will assume declining levels of risk as gains occur or losses mount. The first corridor will put health plans at full risk if expenses are in the range from 3 percent below to 3 percent above the capitation. In the second corridor, the plan and payer will share the risk 50-50 for the next five percent. The third corridor assigns plans only 20 percent of the risk for costs beyond eight percent above or below the capitation.*

Risk corridors are particularly important for the duals because they protect plans against inaccuracies in rate setting – especially in this program's initial years when experience to guide rate setting is limited. The lack of an adequate way to adjust risk for long-term services and supports makes the need for comprehensive corridors even greater. The federal experience with risk adjustment in the Medicare Advantage programs shows that even with good risk adjustment the overall program expenditures can mount when enrollment is voluntary.

Neither Illinois nor Ohio have risk corridors, while Massachusetts proposes them for one year only and provides limited protection against under-service that might result from large plan losses. The first corridor will put its health plans at full risk if expenses are in the range from 5 percent below to 5 percent above the capitation. In the second corridor, the plan and payer will share the risk 50-50 for the next 5 percent. The third corridor assigns health plans 100 percent of the risk for costs beyond 10 percent above or below the capitation. As a result of this weak structure, health plans will face no effective limits on gains or losses. Tighter risk corridors will offer much stronger protection for the most complex and costliest enrollees.

---

<sup>10</sup> Breslin Davidson and Dreyfus. Massachusetts Medicaid Policy Institute. Risk Adjustment for Dual Eligibles: Breaking New Ground in Massachusetts. January 2012, available at <http://bluecrossmafoundation.org/publication/risk-adjustment-dual-eligibles-breaking-new-ground-massachusetts>.



The Exchange corridors are better than the ones for the demonstration in Massachusetts, even though the duals are more vulnerable and an effective risk adjustment for long-term services and supports is lacking. Massachusetts allows health plans to achieve increasing levels of gain or suffer increasing levels of losses, as the costs diverge from the capitation. Neither set of corridors, however, place overall limits on health plans losses or gains.

**Comparison of Risk Corridors: Exchange vs. Massachusetts Dual Eligible Demonstration Project**

Exchange (3 years)		Massachusetts (1 year)	
Gain or Loss Corridors	Health Plan and Government Share	Gain or Loss Corridors	Health Plan and Government Share
Between 0 and 3 percent	100 percent health plans	Between 0 and 5 percent	100 percent health plans
Between 3 and 8 percent	50 percent health plans; 50 percent federal government	Between 5 and 10 percent	50 percent health plans; 50 percent federal and state government
Beyond 8 percent	20 percent health plans; 80 percent federal government	Beyond 10 percent	100 percent health plans

**Secondary Problem: Savings Assumed During the Demonstration Years**

The current savings targets appear to be arbitrary because neither the states nor the federal government has provided data and analysis to justify the assertion that these savings can be achieved in the relatively short course of a three-year demonstration. Indeed, a review of Medicare demonstrations prepared by the Congressional Budget Office indicates that savings from care coordination may not materialize.<sup>11</sup> Realizing savings from reductions in inpatient and emergency department use or institutionalization requires a high degree of integration health plans will develop only over time and after a significant investment in improved services and care management. Arbitrary savings targets simply increase the financial pressure on plans and put beneficiaries at unnecessary risk.

**Savings Targets in the Three Approved Capitated Demonstration Projects**

	Illinois	Massachusetts and Ohio
Year 1	1 percent	1 percent
Year 2	3 percent	2 percent
Year 3	5 percent	4 percent

<sup>11</sup> Congressional Budget Office. Lessons from Medicare’s Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment. Issue Brief. January 2012, available at <http://www.cbo.gov/publication/42860>.

## Recommendations

Capitation can be a powerful way to provide plans with the resources and incentives to create better systems of care where people may receive stronger primary and preventive care in their communities and spend less time in hospitals and other institutions. But setting the capitated rates with some accuracy and limiting the negative incentive of capitation to under-serve are critical elements of a payment policy with high hopes for success. The goal of savings should be delayed until strong evidence exists that efficiencies through improvement are achievable.

The federal and state governments should create a program that provides the protections needed for duals, following the strong standard set forth in the Affordable Care Act. The law's standard for risk adjustment, reinsurance and risk corridors in Health Insurance Exchanges is far better than those being proposed in the demonstration for a more vulnerable population. Contracts with health plans should include the following provisions:

- 1) **Risk adjustment for the Medicaid portion of the capitation.** Two approaches can be used to greatly improve the risk adjustment for the Medicaid portion of the capitation: using functional data by the end of the demonstration, and using individual prior cost information at the start of the demonstration.

The use of functional data to risk adjust for long term services and supports is feasible.<sup>12</sup> Both Wisconsin and New York use detailed functional data today. Using functional data to adjust the Medicaid portion of the capitation would complement the diagnostic risk adjustment being used for the Medicare portion of the capitation and would motivate plans to take on the challenge of serving people with high levels of disability or frailty. Most states have not yet gathered enough functional data and linked it to payment experience to implement functional adjustment immediately, but they should make such implementation a central administrative goal to achieve by the end of the demonstration. The first step for states to take is to require health plans to gather and report detailed functional data from the first day of the demonstration.

The use of individual prior expenditures found in the claims history of dual eligibles who enroll in the new plans should be used at the start of the demonstration to risk adjust the Medicaid portion of the capitation. Adjustment by prior expenditures should be used for the first year or two of the demonstration until the right levels of payment can be determined or until functional adjustment can be established. Adjustment by individual prior expenditure is very accurate – much more accurate than methods based on large rating groups – and easy to implement. Such accurate risk adjustment will greatly improve the incentives to create systems of care responsive to duals with high levels of need, and it will greatly reduce dangerous incentives for under-service.<sup>13</sup> Moreover, the temporary use of individual prior expenditure data does not perpetuate inefficient

---

<sup>12</sup> Breslin Davidson and Dreyfus. Massachusetts Medicaid Policy Institute. Risk Adjustment for Dual Eligibles: Breaking New Ground in Massachusetts. January 2012, available at <http://bluecrossmafoundation.org/publication/risk-adjustment-dual-eligibles-breaking-new-ground-massachusetts>.

<sup>13</sup> See Memorandum from Breslin-Davidson and Dreyfus to CMS and MassHealth regarding Temporary risk adjustment by individual prior expenditure for the Medicaid portion of the capitation rate for the Duals Demonstration in Massachusetts, January 2013, available at [http://www.communitycatalyst.org/doc\\_store/publications/CMSMassHealthexpenditures.pdf](http://www.communitycatalyst.org/doc_store/publications/CMSMassHealthexpenditures.pdf).

expenditure patterns of the fee-for-service experience any more than the use of aggregated data; the use of individual prior expenditure data just better identifies the health needs of the individual.

- 2) **Comprehensive reinsurance.** Plans should be protected from large losses for individuals whose annual costs exceed an appropriate threshold. For instance, this could be set at \$100,000. Such reinsurance will prevent plans from excessive losses on members with very high needs and make it more likely that health plans will not avoid individuals with very high needs as financial risks.
- 3) **Tighter risk corridors.** Tighter risk corridors should be used for all three years of the demonstration in line with MassHealth's approach to other programs. Total risk to each health plan should be strongly limited, so that none will lose or profit by more than 3 percent. Risk beyond 3 percent is not needed for the purposes of the demonstration and poses unnecessary dangers to people with severe disability or chronic illness.
- 4) **Minimum medical loss ratio.** The use of a minimum medical loss ratio might also be helpful as a complementary measure of protection against under-service, but not as a substitute for tight risk corridors and a strong approach to monitoring quality and outcomes.

Due to the uncertainty of the payment rates, states and the federal government would do well to rely upon risk corridors for capturing savings rather than assuming them from the start. Health plans that are able to achieve savings can do so through risk corridors with less likelihood of compromising care to enrollees.

## Conclusion

Integrating Medicare and Medicaid services could do much to improve the health care and support services on which some of our nation's most vulnerable people depend. The goal of fostering new approaches to integrating and improving services deserves the government's full attention. The problems of the duals are a significant part of the problems of our larger health care system – poor coordination of services, too much hospital and nursing home care, and too little emphasis on value.

In financing these new care programs, capitation could play a key role in supporting better-integrated care with the needed resources and flexibility. A rush towards integration without having the right financing and consumer protections in place would be unwise.

Public officials must take the necessary steps to offer duals better protection under the Dual Eligible Demonstration Projects and should begin by substantially improving the capitated model. Because financial incentives will drive health plan behavior, fixing the current deficient approach to capitation is essential. The imperative to make these corrections is high because duals are vulnerable, because plans have little experience with duals, and because the government lacks expertise in overseeing the quality of integrated care for duals. Beyond improvement to the capitated model, the federal and state governments should use the demonstration years wisely. In this new era of developing integrated services for duals, public officials should actively bring together the most promising tools for financing, consumer protections, and care improvement.