The Menges Group

Strategic Health Policy & Care Coordination Consulting

Potential Savings of Medicaid Capitated Care: National and State-by-State Estimates

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I. Executive Summary

Capitation spending is poised to become the dominant mode of Medicaid expenditures going forward. As of 2016, capitation spending represented 48.9% of national Medicaid expenditures, and this percentage has been increasing rapidly. As recently as 2010, capitation represented "only" 27.3% of Medicaid spending, for example.

We were asked by the Association for Community Affiliated Plans (ACAP) to estimate the current savings of the managed care model in Medicaid, as well as the additional savings that can occur if remaining fee-for-service (FFS) expenditures were moved into a capitated MCO setting.

Our report estimates that the MCO model delivered nationwide Medicaid savings of $7.1 billion in 2016, assuming that provider unit prices paid by Medicaid MCOs are equivalent in the aggregate to Medicaid fee-for-service (FFS) levels. The $7.1 billion figure represents an overall savings of 2.6% on all the funds paid via capitation. The 10-year savings from existing capitation programs across the 2017-2026 timeframe are projected to total $94.4 billion. The derivation of these nationwide figures is summarized in Exhibit ES-1.

Exhibit ES-1: Current Use of Capitation Model in Medicaid and Corresponding Savings (National Overview)

Jurisdiction	FFY2016 Medicaid Spending	FFY2016 Capitated Spending	Percent of Medicaid Spending Paid by Capitation, FFY2016	Estimated Savings From Existing Capitation Spending, 2016*	Estimated 10 Year Savings From Existing Capitation Spending, 2017-2026*
USA Total	**$545,794,016,573**	**$266,646,348,396**	**48.9%**	**$7,145,979,765**	**$94,375,433,823**

* Savings figures are contingent on provider unit prices negotiated by MCOs averaging at Medicaid fee-for-service levels.

In addition, we estimate that had all remaining FFS expenditures been transitioned to the capitated setting during 2017, additional nationwide savings of $5.0 billion would have occurred in that year attributable to this programmatic change. The ten-year accumulation of these savings is projected to be $63.2 billion across the 2017-2026 timeframe. The federal savings over this 10 year time period are $35.7 billion. These projected savings are also contingent on provider unit prices remaining at Medicaid FFS levels, on average. These savings are shown in Exhibit ES-2.

Exhibit ES-2: National Projected Savings (2017-2026) of Transitioning All Remaining Medicaid Fee-for-Service Costs Into Capitation Model

10 Year Total, 2017-2026					
Jurisdiction	Remaining Impactable FFS Dollars	MCO Model % Savings	MCO Model $ Savings	Federal Share of MCO Savings	State Share of MCO Savings
USA Total	$2,477,718,858,162	2.55%	$63,195,019,620	$35,712,468,167	$27,475,748,886

This analysis has not sought to assess or factor in the unit price negotiation outcomes between MCOs and the provider community. All savings estimates in this report are based on the assumption that the provider unit prices negotiated by Medicaid MCOs in the aggregate are in line with Medicaid FFS reimbursement rates. To the extent that providers are negotiating payment rates above Medicaid's base FFS prices, the savings estimated throughout this paper will be overstated. Nationwide, if currently negotiated MCO unit prices are in the aggregate more than 2.6 percentage points higher than Medicaid fee-for-service, the industry is not yielding savings and the MCO model is in fact creating additional costs to the Medicaid program relative to the FFS setting.

The projected Medicaid costs in each state are derived from a 2016 base year applying trending factors to each state and adjusting for state-specific dynamics such as whether the state implemented the ACA's Medicaid expansion, overall use of capitation programs and demonstrations, etc. MCO savings factors were derived in a nationally uniform manner. While we believe this methodology provides a reasonable estimate of current and potential Medicaid savings in each state using the capitated MCO model, many state-specific dynamics would need to be taken into consideration to develop a more precise savings estimate for a given state.

II. Introduction

The Menges Group was asked by the Association for Community Affiliated Plans (ACAP) to estimate Medicaid savings via the capitated coordinated care model. As shown in Exhibit 1, use of capitation has increased substantially during the past few years such that this model is likely to represent the majority of national Medicaid expenditures from 2017 forward.

Exhibit 1. Capitation as Percentage of All Medicaid Spending, 2013-2016

Year	% of Medicaid Expenditures Paid Via Capitation
2013	32.6%
2014	38.6%
2015	45.0%
2016	48.9%

States contract with managed care organizations (MCOs) on a capitation basis for a variety of reasons. One is that capitation creates the ability to more accurately budget upcoming Medicaid costs. MCOs also allow for clear points of accountability for facilitating access to needed health care services, effectively measuring and improving quality, benchmarking with other states to see how their populations' health compares, and attaining available cost savings.

States determine all key aspects of their Medicaid coordinated care programs:

- Whether the managed care organization (MCO) contracting model will be used. Currently, 41 states plus the District of Columbia utilize capitation contracting, while 9 states do not.
- Which populations will be enrolled in MCOs. States generally use eligibility groups, geographic areas, and health condition as factors in enrollment in MCOs.
- Whether enrollment in the MCO model is voluntary or mandatory. The vast majority of states contracting with Medicaid MCOs use a mandatory enrollment model, whereby Medicaid-covered individuals can choose from among different participating MCOs, but must enroll in an MCO. Within mandatory enrollment programs, individuals not electing a health plan will be automatically assigned to one.
- Which Medicaid services will be included in the capitated model and which services will remain in the traditional fee-for-service (FFS) setting, or "carved-out." While states are increasingly seeking to include all Medicaid covered services in the capitation program to foster an integrated, whole-person focused model of care coordination, benefit carve-outs are still common. Services that have most often been carved-out include behavioral health services, dental care, and prescription drugs.

- How the participating MCOs will be selected. In most states, a competitive procurement process is used through which the Medicaid agency contracts with a small number of top-qualified MCOs. In some states, however, an application process is used whereby all MCOs successfully meeting the state's program requirements can participate.
- A vast array of additional program design features and operating requirements are determined at the state level. These often include staffing requirements (staff to enrollee ratios, degree to which staff will be based in-state), provider network composition, payment requirements (alternative payment models), data reporting capabilities, quality measurement and monitoring, member services responsiveness, commitment to the community, etc.

The remainder of this report develops estimates of the savings that have occurred to date through Medicaid capitated care programs in addition to savings that can be achieved through use of the capitated MCO model for remaining fee-for-service expenditures. It must be noted a state cannot reach 100% MCO usage because of Medicaid's up to 90-days of retroactive coverage (e.g.., a woman gives birth in a hospital, then the hospital notifies her that she is likely Medicaid eligible rather than self-pay, so they help her enroll in coverage so that she can get her recent care paid by the Medicaid program).

III. Baseline Data Compilation

All states must submit CMS-64 reports to the federal government each quarter. These reports contain cost breakdowns in various categories for all Medicaid costs eligible for federal reimbursement. Federal reimbursement rates vary by state from a minimum of 50% to a maximum of 82%. The CMS-64 reports do not provide costs specific to Medicaid eligibility category, so our methodology has allocated the known total Medicaid costs and capitation spending by eligibility category based on known Medicaid cost distributions as of 2011 and known changes in the populations for which the capitation contracting model is being used.

This report uses five population categories:

- Duals: individuals who are eligible for both Medicaid and Medicare
- Aged, Blind, and Disabled: the supplemental security income population
- TANF Adults and Children: temporary assistance for needy families (the "typical" Medicaid population)
- All other: foster care children (who comprise roughly 1.5% of nationwide Medicaid beneficiaries) and some small groups collectively comprising 0.3% of all Medicaid beneficiaries
- Expansion: The newly eligible group under the ACA (in 31 states plus the District of Columbia)

We began with known FFY2016 expenditures in each state for:

- Overall Medicaid – all reported expenditures;
- Supplemental payments unrelated to the services rendered to a particular beneficiary (DSH, GME, Supplemental);
- Medicaid Expansion population, where applicable; and
- MCO capitation in each state.

Exhibit 2 outlines our baseline data from 2016. During 2016, 48.9% of Medicaid expenditures were paid via capitated coordinate care programs. Capitation was used most for the Expansion population (over 80%), followed by more than three quarters of the TANF group.

Exhibit 2. FFY2016 Baseline Medicaid Expenditures—National Overview

Eligibility Group	Capitated Expenditures	Fee For Service Expenditures	Total Expenditures	% of Expenditures Paid via Capitation
Duals	$42,775,454,859	$110,826,502,220	$153,601,957,079	27.8%
SSI	$49,740,249,539	$73,597,558,700	$123,337,808,239	40.3%
TANF	$104,196,103,943	$32,601,969,413	$136,798,073,356	76.2%
Other	$3,799,196,799	$5,487,187,117	$9,286,383,917	40.9%
Expansion	$66,135,343,255	$15,215,139,579	$81,350,482,834	81.3%
DSH/GME, etc.	$0	$41,419,311,148	$41,419,311,148	0.0%
Total	**$266,646,348,396**	**$279,147,668,177**	**$545,794,016,573**	**48.9%**

Using the above described data, we created estimates of spending by category and capitation within each category. We calculated spending by category to obtain an overall spending amount after excluding supplemental payments.

First, we estimated FFY2016 Medicaid expansion costs in each state that adopted the expansion, using reported enrollment and cost information.

Second, we assumed that the health expenditures by category were the same in 2016 as they were in 2011, excluding Medicaid expansion enrollees (i.e., if 25% of the non-expansion population's Medicaid medical spending in Arizona were spent on Dual Eligibles in 2011, then 25% of non-expansion population Medicaid medical spending in Arizona in 2016 were assumed to be spent on Duals).

Third, we assumed that the capitation spending by category was the same in 2016 as it was in 2011 (e.g., if Dual Eligibles accounted for 20% of the total capitation spending in New York in 2011, then they accounted for 20% of the total capitation spending in New York in 2016). We

extended the known proportion of 2011 Medicaid expenditures that were "capitated" for the TANF population to the Medicaid expansion population in the expansion-adopting states.

The above mathematical assumptions never tied exactly to the known capitation payment amounts in 2016, as a state's population mix between categories, its use of capitation between categories, and the cost growth in different categories were all assumed static in our initial modeling but were in fact fluid. We therefore adjusted the eligibility-group capitation estimates to ensure they matched – in the aggregate – the known statewide capitated spending amounts in FFY2016. In most states, the adjustments needed were minor; however, some states implemented significant changes in their Medicaid capitation programs between 2011 and 2016 (e.g., participating in the Dual Eligibles capitation demonstration), and we attempted to take those programmatic changes into account as we tied eligibility-specific capitated costs to the known statewide total.

We trended all costs—capitation and FFS expenditures forward from FFY2016 through FFY2026. We used an annual trend factor of 5% to represent increasing medical costs and general inflation. This factor is similar to the average annual increase in Medicaid spending per beneficiary that occurred from 2011-2016, which we have tabulated to be 5.0%.

IV. Savings Estimates

A. Estimated Savings from Existing MCO Capitation Programs

Our 2015 report for ACAP, "Projected Savings of Medicaid Capitated Care: National and State-by-State," developed a detailed estimate of Medicaid savings, taking into account PMPM costs by eligibility group and medical service category, the projected impacts care coordination is estimated to create for each eligibility group and service, the required administrative costs to administer the care coordination model, and the risk margin MCOs need to secure to take on capitated financial risk.

Nationwide, these projections yielded a savings of 2.61% against FFS cost levels for existing capitation contracting. We applied this savings percentage to FFY2016 capitated expenses to yield the savings of the MCO program in each state in the FFY2016 base year. These figures are shown in Exhibit 3. These savings levels are contingent on provider prices within the MCO capitation contracts averaging out at Medicaid FFS unit price levels. Exhibit 3 also estimates the savings for current capitated programs for the ten-year timeframe 2017-2026, escalating the FFY2016 savings figures by 5% per year.

Exhibit 3. Estimated Medicaid Savings from Existing MCO Contracting Programs

State	FFY2016 Medicaid Spending	FFY2016 Capitated Spending	Percent of Medicaid Spending Paid by Capitation, FFY2016	Estimated Savings From Existing Capitation Spending, 2016*	Estimated Savings From Existing Capitation Spending, 2017*
Alabama	$5,435,036,771	$0	0.0%	$0	$0
Alaska	$1,785,355,973	$0	0.0%	$0	$0
Arizona	$11,118,985,133	$9,683,119,933	87.1%	$259,502,444	$272,477,566
Arkansas	$5,955,864,929	$0	0.0%	$0	$0
California	$81,469,418,209	$41,246,812,116	50.6%	$1,105,392,542	$1,160,662,169
Colorado	$7,876,027,821	$954,543,148	12.1%	$25,581,247	$26,860,309
Connecticut	$7,344,137,284	$0	0.0%	$0	$0
Delaware	$1,883,220,982	$1,616,107,823	85.8%	$43,310,827	$45,476,368
District of Columbia	$2,761,584,285	$1,001,639,861	36.3%	$26,843,413	$28,185,584
Florida	$21,689,957,388	$15,706,906,241	72.4%	$420,936,701	$441,983,536
Georgia	$9,723,814,007	$3,798,735,856	39.1%	$101,804,093	$106,894,297
Hawaii	$2,156,012,061	$1,938,658,711	89.9%	$51,955,018	$54,552,769
Idaho	$1,689,275,323	$186,207,046	11.0%	$4,990,249	$5,239,762
Illinois	$19,178,940,763	$9,306,257,218	48.5%	$249,402,724	$261,872,861
Indiana	$10,371,904,061	$4,443,745,110	42.8%	$119,089,996	$125,044,496
Iowa	$4,716,461,091	$1,994,195,634	42.3%	$53,443,378	$56,115,547
Kansas	$3,252,725,194	$3,029,662,373	93.1%	$81,193,334	$85,253,001
Kentucky	$9,609,364,927	$6,878,104,559	71.6%	$184,329,530	$193,546,006
Louisiana	$8,536,666,882	$4,450,521,745	52.1%	$119,271,606	$125,235,187
Maine	$2,490,164,925	$0	0.0%	$0	$0
Maryland	$10,398,319,397	$4,798,061,423	46.1%	$128,585,484	$135,014,758
Massachusetts	$16,990,908,511	$6,428,905,806	37.8%	$172,291,243	$180,905,805
Michigan	$16,714,754,874	$10,963,275,584	65.6%	$293,809,932	$308,500,429
Minnesota	$10,893,812,759	$5,087,187,527	46.7%	$136,333,909	$143,150,605
Mississippi	$5,397,714,759	$2,715,086,472	50.3%	$72,762,868	$76,401,011
Missouri	$9,811,515,212	$1,315,531,229	13.4%	$35,255,535	$37,018,311
Montana	$1,361,662,906	$0	0.0%	$0	$0
Nebraska	$1,968,891,548	$692,508,343	35.2%	$18,558,854	$19,486,797
Nevada	$3,335,480,165	$1,473,758,853	44.2%	$39,495,950	$41,470,748
New Hampshire	$1,948,727,991	$801,919,923	41.2%	$21,491,026	$22,565,577
New Jersey	$14,319,021,372	$8,528,400,366	59.6%	$228,556,576	$239,984,405
New Mexico	$5,339,766,195	$4,461,697,022	83.6%	$119,571,098	$125,549,653
New York	$60,995,857,591	$32,171,587,918	52.7%	$862,181,379	$905,290,448
North Carolina	$12,157,764,904	$2,143,616,381	17.6%	$57,447,774	$60,320,163
North Dakota	$281,512,456	$88,039,406	31.3%	$2,359,409	$2,477,380
Ohio	$21,571,025,591	$11,895,433,176	55.1%	$318,791,258	$334,730,821
Oklahoma	$4,460,334,118	$57,395,260	1.3%	$1,538,162	$1,615,070
Oregon	$8,316,707,109	$5,005,544,493	60.2%	$134,145,920	$140,853,216
Pennsylvania	$27,350,279,117	$16,108,824,996	58.9%	$431,707,909	$453,293,304
Rhode Island	$2,411,382,026	$1,385,986,104	57.5%	$37,143,688	$39,000,872
South Carolina	$5,941,185,838	$2,761,241,577	46.5%	$73,999,800	$77,699,790
South Dakota	$832,399,125	$0	0.0%	$0	$0
Tennessee	$9,463,742,287	$6,119,439,351	64.7%	$163,997,707	$172,197,593
Texas	$39,563,147,154	$19,378,851,060	49.0%	$519,342,861	$545,310,004
Utah	$2,100,346,398	$1,069,616,952	50.9%	$28,665,163	$30,098,421
Vermont	$1,679,425,056	$0	0.0%	$0	$0
Virginia	$8,498,905,069	$3,364,949,339	39.6%	$90,178,846	$94,687,788
Washington	$10,787,810,275	$6,516,952,134	60.4%	$174,650,838	$183,383,379
West Virginia	$3,655,890,862	$1,399,159,482	38.3%	$37,496,727	$39,371,563
Wisconsin	$7,626,998,105	$3,678,160,845	48.2%	$98,572,747	$103,501,384
Wyoming	$573,809,794	$0	0.0%	$0	$0
USA Total	**$545,794,016,573**	**$266,646,348,396**	**48.9%**	**$7,145,979,765**	**$7,503,278,753**

The projected savings created by existing capitation programs are $7.1 billion nationwide in FFY2017. Across the ten-year period 2017-2026, this savings figure compounds to $94.4 billion.

B. Potential Savings of Additional Use of MCO Capitation Contracting Model

The 2015 Menges Group ACAP report estimated MCO model savings by eligibility category at the percentage levels shown in Exhibit 4.

The potential for additional savings of the MCO model involved applying the percentage savings figures derived above to each state's impactable fee-for-service costs. DSH, GME, and other supplemental payments unrelated to any given beneficiary's use of covered services were not deemed impactable by managed care and were removed from the savings estimates in each state. Nationwide, these costs represented 9.2% of overall FFY2016 Medicaid expenditures. Of the remaining FFS Medicaid expenditures, 10% of each state's Medicaid FFS expenditures are assumed to be un-impactable due to Medicaid's 90-days of retroactive eligibility coverage, court-mandated services, and other factors. Impactable FFS costs, then, are assumed to constitute the remaining 90% of FFS expenditures.

Exhibit 4. Estimated Capitated MCO Model Savings Versus Fee-For-Service by Eligibility Group

Capitated MCO Mature Model Savings	
Eligibility Group	**Estimated Percent Savings, MCO Model**
Duals	0.5%
SSI	6.0%
TANF	0.9%
Other	2.0%
Expansion	3.5%

Exhibit 5 presents the state-by-state savings estimates from our calculations. As with all other estimates in this report, the savings percentage and corresponding dollar figures are contingent on MCOs maintaining provider unit prices at Medicaid FFS levels in the aggregate. The average percentage savings column in Exhibit 5 varies by state based on the mix of each state's impactable FFS costs across the eligibility categories shown in in Exhibit 4.

Exhibit 5. Estimated Medicaid Savings from Transitioning Remaining Fee-For-Service Expenditures to Capitated Model, 2017-2026

10 Year Total, 2017-2026					
State	Remaining Impactable FFS Dollars	MCO Model % Savings	MCO Model $ Savings	Federal Share of MCO Savings	State Share of MCO Savings
Alabama	$54,392,247,730	2.3%	$1,253,154,707	$879,213,343	$373,941,365
Alaska	$20,945,373,055	2.1%	$440,196,848	$220,098,424	$220,098,424
Arizona	$0	0.0%	$0	$0	$0
Arkansas	$67,033,271,902	2.0%	$1,335,373,934	$930,622,095	$404,751,839
California	$348,304,235,163	3.2%	$11,246,720,844	$5,623,360,422	$5,623,360,422
Colorado	$70,468,826,212	2.0%	$1,434,315,107	$717,444,416	$716,870,690
Connecticut	$82,728,439,211	1.4%	$1,188,997,782	$594,498,891	$594,498,891
Delaware	$1,040,576,770	0.0%	$382,551	$207,342	$175,208
Dist. Of Col.	$18,955,384,461	3.5%	$658,539,858	$460,977,901	$197,561,957
Florida	$34,540,623,825	0.4%	$153,485,775	$93,779,809	$59,705,967
Georgia	$59,014,885,354	3.3%	$1,964,660,789	$1,333,808,210	$630,852,579
Hawaii	$0	0.0%	$0	$0	$0
Idaho	$17,262,775,579	2.8%	$484,685,533	$346,598,625	$138,086,908
Illinois	$83,787,679,360	2.6%	$2,159,984,017	$1,108,071,801	$1,051,912,216
Indiana	$60,165,594,062	3.0%	$1,800,387,102	$1,201,578,352	$598,808,750
Iowa	$29,020,334,943	2.1%	$613,623,547	$348,170,000	$265,453,546
Kansas	$0	0.0%	$0	$0	$0
Kentucky	$20,526,693,837	3.6%	$748,734,259	$527,558,159	$221,176,100
Louisiana	$26,446,397,821	0.6%	$160,834,182	$100,167,529	$60,666,654
Maine	$28,977,748,748	2.2%	$649,143,920	$417,918,856	$231,225,064
Maryland	$58,079,493,547	2.5%	$1,459,371,272	$729,685,636	$729,685,636
Massachusetts	$107,072,509,019	2.2%	$2,396,469,888	$1,198,234,944	$1,198,234,944
Michigan	$42,414,629,424	1.9%	$787,969,007	$513,361,808	$274,607,199
Minnesota	$60,333,928,566	3.0%	$1,831,834,755	$915,917,378	$915,917,378
Mississippi	$25,645,430,621	0.6%	$156,549,046	$116,832,553	$39,716,493
Missouri	$89,821,576,949	2.8%	$2,553,374,433	$1,613,987,979	$939,386,454
Montana	$15,051,466,750	2.0%	$294,938,121	$193,685,864	$101,252,257
Nebraska	$13,788,404,859	2.1%	$292,593,284	$151,709,618	$140,883,666
Nevada	$17,532,534,436	3.3%	$585,768,997	$378,816,810	$206,952,187
New Hampshire	$9,433,886,106	1.2%	$115,097,061	$57,548,530	$57,548,530
New Jersey	$40,927,457,565	1.0%	$413,869,934	$206,934,967	$206,934,967
New Mexico	$2,838,688,504	0.7%	$21,093,695	$15,003,945	$6,089,750
New York	$240,146,537,362	2.9%	$6,998,683,087	$3,499,341,544	$3,499,341,544
North Carolina	$104,544,361,595	2.4%	$2,475,688,917	$1,655,740,748	$819,948,169
North Dakota	$2,179,668,395	1.8%	$39,316,867	$19,658,433	$19,658,433
Ohio	$84,558,286,097	2.8%	$2,408,264,753	$1,524,913,242	$883,351,511
Oklahoma	$44,239,702,003	2.2%	$962,019,873	$576,634,712	$385,385,161
Oregon	$28,644,315,078	2.2%	$617,360,028	$398,012,010	$219,348,018
Pennsylvania	$97,512,888,789	2.0%	$1,939,146,646	$1,004,090,133	$935,056,513
Rhode Island	$8,529,945,237	1.8%	$153,960,451	$78,550,622	$75,409,829
South Carolina	$26,447,387,642	2.0%	$534,186,960	$380,875,302	$153,311,657
South Dakota	$9,842,367,160	2.2%	$216,567,387	$118,982,122	$97,585,265
Tennessee	$19,917,022,520	2.4%	$478,985,131	$311,148,741	$167,836,390
Texas	$115,721,908,017	3.6%	$4,197,759,405	$2,358,301,234	$1,839,458,171
Utah	$10,026,549,328	2.1%	$212,676,298	$148,660,733	$64,015,566
Vermont	$19,516,708,071	1.8%	$346,623,820	$188,771,332	$157,852,488
Virginia	$51,300,222,498	2.4%	$1,255,095,894	$627,547,947	$627,547,947
Washington	$37,049,240,023	3.5%	$1,288,639,055	$644,319,528	$644,319,528
West Virginia	$22,891,576,940	3.2%	$741,657,876	$532,510,355	$209,147,521
Wisconsin	$41,360,247,930	2.4%	$990,739,901	$579,681,916	$411,057,985
Wyoming	$6,738,829,100	2.0%	$135,497,023	$67,748,511	$67,748,511
Total	**$2,477,718,858,162**	**2.6%**	**$63,195,019,620**	**$35,712,468,167**	**$27,475,748,886**

The ten-year nationwide savings, if all remaining Medicaid FFS expenditures were transitioned into the capitated setting, are estimated at $63.2 billion. These nationwide savings are divided 56.5% to the Federal Government and 43.5% to state governments. The specific Federal and state share of the savings vary according to each state's Federal match rate.

V. Concluding Observations

Use of the capitated MCO model has grown substantially in the Medicaid program each of the past several years, such that capitation represented 48.9% of national Medicaid expenditures during 2016. Capitation is poised to become the dominant mode of Medicaid spending from here forward, with the traditional unmanaged fee-for-service setting playing an ever-diminishing role.

This paper shows that the existing capitated programs are achieving considerable Medicaid savings through the extensive care coordination that occurs – savings during 2017 from existing capitated programs are estimated at $7.1 billion. Across the ten-year timeframe 2017-2026, these savings are estimated at $94.4 billion. Of these ten-year savings, $53.6 billion (56.8%) are federal and $40.8 billion (43.2%) are state savings. These savings amount to 2.6% of the costs that would occur had the capitated model not been used.

Our estimates take into account the health services usage and mix impacts that the care coordination achieves, as well as the health plans' administrative costs and operating margin requirements. Our estimates did not assess—and thus did not take into account—provider unit price differences that occur in the MCO setting as a result of the contract negotiations between providers and MCOs.

We have also estimated the potential savings of transitioning remaining Medicaid fee-for-service expenditures and beneficiary subgroups into the capitated model. These costs currently represent roughly half of the nation's Medicaid spending. Transitioning these fee-for-service costs to the capitated setting to the fullest extent possible is estimated to yield care coordination savings of $63.2 billion across the 2017-2026 ten-year timeframe. The majority of these ten-year savings ($35.7 billion or 56.5% of the total) are estimated to accrue to the federal government. The savings potential for remaining non-capitated costs is lower than for existing capitation programs because some Medicaid costs—such as DSH and GME payments and coverage of retrospective eligibility periods—are not "impactable" by managed care techniques.

The value of the Medicaid MCO industry extends well beyond the level of financial savings being attained. The savings created through the Medicaid health plans' care coordination efforts occur in conjunction with substantial enhancements in the degree to which access and

quality are assessed and improved. The fee-for-service environment pays for "whatever happens out there" and offers no systematic mechanism to promote access to needed care, identify gaps in needed care, and address them. Conversely, the Medicaid MCO environment entails enormous efforts to identify enrollees' needs, identify individuals' gaps in preventive care, and work to get these gaps filled. MCO and provider performance on these access and quality fronts is being measured with ever-increasing sophistication, and these measurements are increasingly tied to performance-based payments both in state contracts with MCOs and in MCO contracts with their front-line providers. The results of these efforts are evident in the ongoing improvement in Medicaid MCOs' quality scores across time, both at the individual plan level and program-wide.

In summary, coordinated care is yielding significant savings to the Medicaid program when unit prices are held at Medicaid FFS levels—and the potential for large-scale additional savings through expansion of the Medicaid MCO model clearly exists. The capitated model has earned its emerging role as the dominant form of Medicaid coverage and Medicaid spending through its proven cost effectiveness and favorable impacts on access and quality.