Six Midwestern states have submitted plans to the federal government that aim to control the costs of caring for a relatively small — but expensive — population in the Medicaid program.

The goal is to better integrate care for so-called “dual eligibles”: the more than 9 million seniors and people with disabilities who receive benefits under both the federal Medicare and state-federal Medicaid programs.

Dual eligibles account for 15 percent of Medicaid’s beneficiaries, but 38 percent of program spending, according to the Kaiser Family Foundation. That is largely due to Medicaid paying for long-term-care services.

This population includes some of the poorest and sickest people receiving public health assistance. The average cost of care is about $16,000 per year, compared with about $5,500 for a typical Medicaid enrollee.

This spring, under a program initiated by the federal Affordable Care Act, the U.S. Centers for Medicare and Medicaid Services accepted applications from 26 states to test one of two proposed new funding models: “capitated payment” or “managed fee-for-service.”

Illinois, Michigan, Minnesota, Ohio and Wisconsin have opted to try the capitated-payment model; Iowa chose managed fee-for-service.

Under the capitated-payment system, state and federal health officials would pay health plans a set “blended” rate to treat patients. In exchange for this monthly fee, the plans would provide each patient with primary, acute, behavioral health and long-term care services — which are now paid for separately by Medicare and Medicaid. The idea is to generate savings by streamlining payment systems and administrative oversight.

Under the fee-for-service model, providers would continue to be paid per service by the federal government for Medicare-eligible charges and by the state for care covered under Medicaid. But states would be responsible for coordinating care for dual eligibles — and therefore must find ways to control costs. States would receive performance bonuses for reducing the federal government’s share of costs and for meeting quality goals.
CMS is reviewing the state plans to determine which to implement. Preference will be given to plans that improve care coordination, such as relying on electronic medical records and remote monitoring devices; regularly updating patient care plans; fostering closer communication between physicians, specialists and other providers; and keeping family members and caregivers better informed about a patient’s needs and care.

In order to encourage managed-care plans to meet quality and cost-savings goals, states using the capitated-payment model can charge insurers a “withhold amount” that they could earn back each year by meeting certain goals. Illinois and Minnesota would use this type of pay-for-performance system.

In some cases, providers would also be rewarded for holding down costs. The Michigan, Ohio and Wisconsin plans all mention sharing bonus payments with health professionals.

Iowa’s managed FFS model would give providers an annual bonus of up to 20 percent for meeting certain quality-improvement goals.

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