



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH  
LANSING

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DISCUSSION DRAFT – VERSION 2  
NOVEMBER 26, 2012

INTRODUCTION

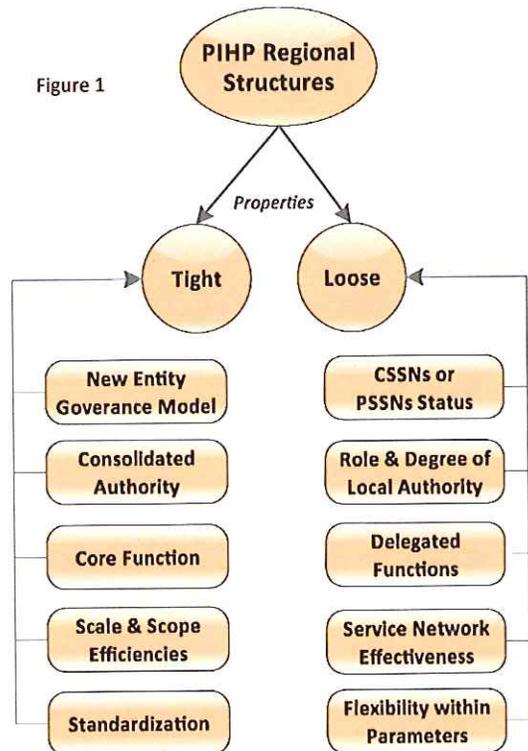
It has been over fourteen years since the launch of the Medicaid 1915(b)/(c) Concurrent Managed Specialty Services and Supports Waiver Program (hereafter referred to simply as the “waiver” or “program”). Much has transpired over these fourteen years, and many significant features of the program have been modified or significantly altered. We are now on the cusp of a new wave of change, precipitated by evolving (and still fluid) federal and state policies.

Against this backdrop of change, the Behavioral Health and Developmental Disabilities Administration (BHDDA) has been exploring, discussing and soliciting ideas regarding the next “iteration” of the waiver program and the future configuration of Prepaid Inpatient Health Plans (PIHP). This paper briefly outlines proposed and anticipated changes, and establishes the rationale for the alterations. The modifications reflect certain concepts, initiatives and directions that the BHDDA has previously (and repeatedly) emphasized as change variables and vectors.

CHANGES TO AFFILIATION FORM AND FUNCTIONS

The first and the core proposed waiver modification is the simultaneous reduction of the number of PIHPs and the creation of much larger regions. Since a primary goal of this waiver alteration is to move away from the ubiquitous “hub-and-spoke” model to tighter co-management arrangements, the ICA and ITFRA forms of intergovernmental collaboration will no longer be acceptable vehicles for affiliation. The necessity for moving beyond the early limited and perfunctory forms of collaboration, signals that the only acceptable legal arrangements for affiliation going forward will be either Urban Cooperation Act agreements or creation of a regional entity under Section 1204b of the Mental Health Code. In either case, such intergovernmental affiliation formations result in the creation of a new legal entity jointly “owned” and governed by the sponsoring CMHSPs. It is this entity that will be recognized and designated as the PIHP for the region.

The schematic (Figure 1) illustrates the concept of “polarities management.” Polarities are sets of opposites or counterpoints that can’t function well independently. The two sides of the polarity are interdependent; you cannot select one side or the polarity and ignore the other. The objective, as one author notes, is to balance and obtain the best of both opposites while avoiding the limits of each. Hence, the new regional structure must consolidate authority and core functions (tight properties), while simultaneously maintaining some “loose” aspects for local flexibility and discretion.



This change reflects current trends toward consolidation of governmental functions and the need to eliminate redundant functions and costs. While certain legal issues regarding the new forms of PIHP governance are being considered (particularly governance aspects that might infringe upon state and federal conflict of interest statutes and provisions), the CMHSPs in the new, revised, and enlarged regions are encouraged proceed with the formation of new entity (under either the UCA or the Regional Entity provisions of the Code), since further guidance on these issues is forthcoming.

EXPLOITING NEW INTEGRATED CARE MODELS AND OPPORTUNITIES

Reduction of the number of PIHPs and the pending change in affiliation arrangements from loose (ICA) agreements to the tightly structured new entity PIHP affiliation model, is a necessary – but not sufficient – condition for further state innovation. The new arrangements will allow the state to pursue some unique opportunities for coordination and integration.

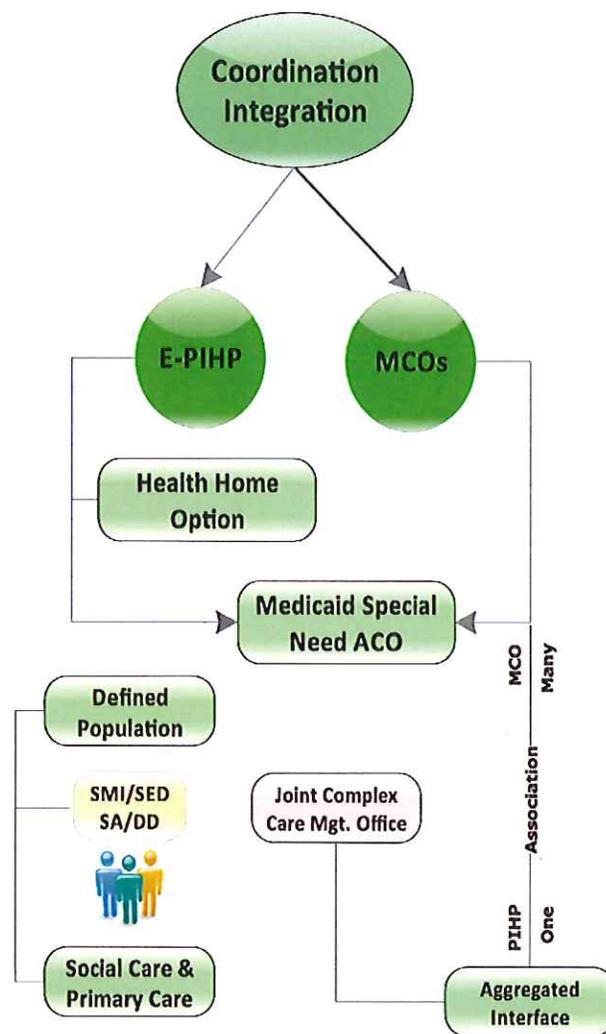
On July 10, 2012, CMS released two “State Medicaid Director Letters” (SMDL) outlining other options for integrated care models (ICM) in Medicaid. The letters focused primarily on Medicaid fee-for-service beneficiaries and possible delivery system and payment modifications to promote state integrated care models. CMS indicated that it planned to issue future guidance specifically addressing “...ICM implementation within risk-bearing managed care contracts.”

Prior to the publication of these two CMS SMDL in July, the Kaiser Commission on Medicaid and the Uninsured issued a paper entitled: “Emerging Medicaid Accountable Care Organizations: The Role of Managed Care.” In this paper, Kaiser described how Medicaid ACOs might be established in states where risk-based managed care programs are the predominant delivery and payment system. The paper described how a state could weave a Medicaid ACO within and between various managed care entities.

The diagram (Figure 2) illustrates one conceivable approach for layering a “Medicaid Special Needs ACO” within the existing PIHP and MCO structures in Michigan. It assumes that Michigan successfully pursues the “Health Home” option (2703), which would facilitate greater PIHP involvement (an Enhanced PIHP) and provide more health monitoring/promotion service options to address the significant morbidity and mortality patterns of our consumers. It should be noted that this model can still be achieved through other mechanisms should the 2703 health home not become a reality in Michigan.

The Health Home option is only a prelude to a more ambitious plan of establishing a “special need” Medicaid accountable care organization within and between the PIHPs and MCOs. Such a special need ACO establishes an “integrated care model” for our populations, without disrupting existing waivers or reigniting the PIHP-MCO wars of the past. PIHP network providers and MCO practitioners that see and treat Medicaid beneficiaries with severe mental illness or developmental disabilities would be participating partners in the special need ACO, and would share in any savings (the complexities of calculating savings from an ACO embedded in risk-bearing managed care organizations will require more detailed consideration than is possible in this paper).

Figure 2



## FINAL THOUGHTS

The concepts, connections and models describe above represent a preliminary approach to some daunting "polarities." A more detailed examination of governance issues/models still needs to be completed, as well as an analysis of possible legislative changes (e.g., permissive statutory provisions on Medicaid ACO arrangements) to facilitate the innovations described above.



Center for Medicaid and CHIP Services

SMDL# 12-001  
ICM# 1

RE: Integrated Care Models

July 10, 2012

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is initiating a series of communications intended to strengthen our collaborations with states to facilitate achieving better care, better health, and reduced expenditures in Medicaid programs. This letter is the first in this series that will describe policy considerations for creating integrated care models. These models support value-driven strategies to ensure that Medicaid reaches its fullest potential as a high performing health system and aligns with promising delivery system and payment reforms underway in the private and public sectors.

For the purposes of this letter and future communications, we are using the term “Integrated Care Models” (ICMs) to describe these initiatives, which could include (but are not limited to) medical/health homes, Accountable Care Organizations (ACO), ACO-like models, and other arrangements that emphasize person-centered, continuous, coordinated, and comprehensive care (see Attachment 3 of accompanying SMD # 12-002 for further description).

ICMs are characterized by organized and accountable care delivery and payment methodologies aligned across payers and providers to ensure effective, seamless, and coordinated care. By orienting the system around the needs and preferences of beneficiaries, successful ICMs can demonstrate improved health care outcomes and result in improved beneficiary experience, while reducing overall health care expenditures. ICMs include integration of various types of health care services such as primary, acute, specialty, dental, behavioral, and long-term support services. Various iterations of ICMs have long existed in capitated managed care, but for the purposes of this letter and the second letter in the series, we are referring to ICMs in the fee-for-service (FFS) system. We plan to issue future guidance specifically addressing ICM implementation within risk-bearing managed care contracts.

Our work with several states, which are creating delivery models that better coordinate services, reward quality achievements, and share savings with providers, has led to a focus on four areas: reform, modernization, stewardship, and collaboration.

- **Delivery System Reform:** Structural and programmatic reforms such as ICMs and new financial incentives can form the basis for high performing Medicaid systems. There is considerable flexibility under current authorities of most state Medicaid plans to achieve many of these reforms, including ICMs. In addition, the Affordable Care Act (Pub. L. 111-148, as revised by Pub. L. 111-152) provides new authorities, including a state plan option to provide health homes for enrollees with chronic conditions.

- **Modernization:** New technologies are critical to deliver the high quality, timely, accurate, and appropriate data necessary for reform. One hallmark of high performing health care systems is the use of cost, performance, quality, beneficiary, and program data to improve quality and efficiency. To that end, both states and CMS are actively engaged in major information technology improvement initiatives including multi-payer claims databases, modernized eligibility systems, expanded data reporting and analysis capabilities, and new systems supporting modernized business processes. We have also articulated new standards, modern architectures, and more specific guidance for the building of state systems with federal investments. CMS and states must also continue to ensure that electronic health record systems can support health information exchange and provide the necessary infrastructure for automated quality measurement, reporting, and continuous quality improvement that underpin important delivery and payment system reforms.
  
- **Stewardship:** New flexibilities should be accompanied by new models for accountability. A strong quality measurement infrastructure is essential for transition to a more outcomes-based accountability in Medicaid. The state and federal efforts to modernize data systems will provide us with a new opportunity to focus, standardize, and validate quality metrics reported by providers and states and allow for rapid and ongoing evaluation of the impact on the health and care of Medicaid beneficiaries. A shift from paying solely for volume towards outcomes-based accountability will also facilitate efforts to limit duplicative processes and eliminate administrative processes with little value.
  
- **Collaboration:** Broad system transformation is only achievable by partnership between CMS, states (and within state government), consumers, advocates, managed care organizations, providers, tribal organizations, and other stakeholders. These partnership efforts include the following:
  - Last year, the Center for Medicaid and CHIP Services launched special technical assistance teams to assist states in a variety of Medicaid reform efforts. Over the course of the last year, the Medicaid State Technical Assistance Teams (MSTAT) worked intensively with more than 25 states. The interest of these states reflects the broad interest in ensuring Medicaid is an active player in focusing health care systems on quality-driven care coordination resulting in lower cost through program improvement. These efforts are consistent with initiatives authorized under the Affordable Care Act, whether as part of a multi-payer initiative or new care models, and have led directly to the new ICM state plan flexibility described in the second letter in this series.
  
  - Building on the MSTAT experience, CMS is actively discussing these topics with several states participating in the Medicaid and CHIP Value-Based Learning Collaborative and providing technical assistance to states. The work and lessons learned from these collaborations will be shared widely with other states and stakeholders.

- Collaborations and strategic governance within states are important—ICMs require close partnerships across the service delivery system. Aligning the efforts of providers, managed care organizations, various payers, information technology vendors, public health, and other partners in the health system will help maximize improvements in service delivery as well as control costs. Some states are forging new ground and providing leadership to address specific challenges unique to urban or rural regions.
- CMS also recognizes the role of federal collaboration, especially in terms of aligning priorities and efforts and coordinating communication. As an example of how CMS is beginning this effort by aligning work within its own agency, we are testing new models of care and working to disseminate what we have learned to bring successful models to scale through the Centers for Medicare and Medicaid Innovation and in the Medicare-Medicaid Coordination Office. There are a myriad of other opportunities across the department and administration and we are committed to ensuring alignment across all of these efforts.
- Collaboration with consumer and consumer advocacy groups is critical. In order to achieve the important goals of better health and better care with lowered costs, we must continue to put our beneficiaries first. This is a time of significant change in the Medicaid program, and we should ensure beneficiaries' voices are heard in the design, implementation, and oversight of new initiatives.
- A state with federally-recognized Indian tribes, Indian health programs, and/or urban Indian health organizations must consult with these entities as outlined in section 1902(a)(73) of the Social Security Act and in 42 CFR 431.408(b), and consistent with other current CMS tribal consultation policy.

The second letter in this series, which we are also issuing today, describes flexibility in the Medicaid statute that supports delivery system and payment reform in FFS systems. Future communications will include methodologies for shared savings arrangements, a quality and cost measures framework, achieving results through managed care contracts, and guidance on alignment with other federal initiatives.

Sincerely,

/s/

Cindy Mann  
Director

cc:

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**Center for Medicaid and CHIP Services**

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**SMDL# 12-002  
ICM# 2**

**RE: Policy Considerations  
for Integrated Care Models**

July 10, 2012

Dear State Medicaid Director:

This letter is the second in a series that provides states with guidance on designing and implementing care delivery and payment reforms that improve health, improve care, and reduce costs within Medicaid programs. The first letter is SMD # 12-001. Catalyzed by new opportunities in the Affordable Care Act, payers and providers are embarking on ambitious delivery system reforms that move from volume-based, fee-for-service (FFS) reimbursement to integrated care models with financial incentives to improve beneficiary health outcomes. We believe that the information provided in this letter on the flexibility of federal authorities can help facilitate state innovation goals through Medicaid care models that place beneficiary health at the center of delivery systems. By placing the beneficiary's needs and outcomes first, we can work together to ensure that our systems of care are better designed to meet the needs of the millions of beneficiaries that we currently serve.

For purposes of this letter and future communications on payment and service delivery reform, we are using the term Integrated Care Models (ICMs) to describe these initiatives, which may include (but are not limited to) medical/health homes<sup>1</sup>, Accountable Care Organizations (ACOs), ACO-like models, and other health care delivery and financing models. Such care models emphasize person-centered, continuous, coordinated, and comprehensive care (see Attachment 3 for further description). The primary purpose of this guidance is to describe policy considerations and relevant statutory authorities for implementing ICMs. We are also introducing a state plan option to facilitate the efforts of states that wish to pay for quality improvement in FFS programs without a waiver. Many of the concepts describing this state plan option, however, could also apply to capitated programs. We plan to issue future guidance specifically addressing ICM implementation within risk-bearing managed care contracts.

We encourage states to refer to our guidance when exploring avenues to implement ICMs within, and outside of, the bounds of policies discussed in this letter. The discussion in this letter and associated attachments is not intended to be all-encompassing or limiting; rather, this is an

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<sup>1</sup> We are using the terms "health home" and "medical home" to generally refer to coordinated care models in a primary care setting.

effort to share the results of our initial interactions with states that have engaged us on authorities for new care models. As we approve ICMs in State Medicaid programs, we will develop resource materials and summary documents of state-based efforts that will be available on our website at: <http://www.medicaid.gov>.

## **I. PATHWAYS TO ICMs**

To implement ICMs within Medicaid programs, states may seek to explore new initiatives or enhance existing efforts under a Medicaid state plan, or use demonstration or waiver authority. Existing Medicaid authorities allow states the opportunity to implement ICMs on a statewide basis or through a more limited approach based on geographic area, individual needs, or through selective provider contracts.

The information below is an overview that describes potential ICM pathways, but as a quick reference, we include an “Examples of ICM Arrangements and Authorities” as Attachment 1 to this letter. The design and scope of a state’s ICM will inform the appropriate pathway.

### ***Implementing ICMs as a State Plan Option***

Historically, in an effort to formally coordinate a Medicaid beneficiary’s care while still paying providers fee-for-service, states have implemented primary care case management (PCCM) programs that limit a beneficiary’s “free choice of providers.” Because free choice of providers is limited, states generally must operate these programs under one of the Medicaid managed care authorities<sup>2</sup> (which means a PCCM program is considered a “managed care program” even though service payments are not capitated), or a waiver/demonstration authority under section 1115 of the Social Security Act (the Act). Under these PCCM programs, states offer additional reimbursement through contracts with primary care managers who agree to coordinate, locate, and monitor health care services above and beyond what is expected from FFS primary care providers.

More recently, we have discussed with states their option to implement ICMs that align financial incentives such as care coordination payments and/or shared savings under the Medicaid state plan without restricting beneficiary free choice of providers. After reviewing the statutory options for an appropriate pathway for ICMs, CMS is providing states the opportunity to implement ICMs furnishing services authorized under sections 1905(a)(25) and, by reference, 1905(t)(1) of the Act. These models are consistent with the statutory description of optional Medicaid state plan PCCM services. States may use the authority under section 1905(t)(1) of the Act to offer coordinating, locating and monitoring activities broadly and create incentive payments for providers who demonstrate improved performance on quality and cost measures. Under this authority, states may opt to reimburse providers through a “per member per month” (PMPM) arrangement and/or create quality incentive payments that could be calculated as a

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<sup>2</sup> Section 1905(a)(25) of the Act authorizes federal financial participation (FFP) for PCCM services. Specific requirements for implementing PCCM contracts are described in section 1932 of the Act and implementing regulations at 42 CFR 438, the rules governing managed care.

percentage of demonstrable program savings and shared with participating providers either directly or through umbrella provider network arrangements, also known as “shared savings” (i.e., ACO or ACO-like programs).

### ***Implementing ICMs through Medicaid Demonstrations and Waivers***

Depending on features of the model, some proposals for ICMs will require a combination of state plan and waiver authority. The Social Security Act requires a Medicaid state plan to include important safeguards for beneficiaries which, among other things, ensure services are comparable for all individuals eligible under the plan and that care be received by any qualified and participating provider.<sup>3</sup> States that seek to test models in specific geographical areas, limit freedom of choice, and/or vary the amount, duration, and scope of services amongst different populations may need to seek authority for a demonstration under section 1115(a) of the Act or a waiver program under section 1915(b) of the Act. A state that selectively contracts with a defined set of providers, among a broader pool of qualified providers, may do so under waiver authority of section 1915(b)(4) of the Act. State plan authority for Targeted Case Management under sections 1902(a)(19) and 1915(g) of the Act, or the state plan option for Health Homes under section 1945 of the Act (as enacted by section 2703 of the Affordable Care Act) are also potential pathways for ICMs. These options are open to states that may not be ready to adopt models on a statewide basis, but are interested in evaluating approaches on a smaller scale to integrating care before fully investing across the state to all eligible individuals. States that are interested in implementing ICMs under the state plan must take the necessary steps to issue public notice, conduct tribal consultation, and follow all other Medicaid requirements described in federal statute and regulations.

## **II. POLICY CONSIDERATIONS UNIQUE TO ICMs AS A STATE PLAN OPTION UNDER SECTION 1905(t)(1) OF THE ACT**

The following sections are considerations unique to implementing ICMs as an optional state plan service using the authority at 1905(t)(1).

*Provider Qualifications and Service Definitions:* ICMs may be implemented as a state plan option under authority at section 1905(t)(1) of the Act. Under this option, the state may identify reasonable qualifications for the case managers and related providers. Provider options for an ICM consistent with this section of the Act include:

- An individual practitioner, physicians, nurse practitioners, certified nurse-midwives, or physician assistants;
- Physician group practices, or entities employing or having arrangements with physicians to provide such services.

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<sup>3</sup> Federal regulations at 42 CFR 440.240 require that the Medicaid state plan “provide that the services available to any categorically needy recipient under the plan are not less in amount, duration, and scope than those services available to a medically needy recipient.” Under 42 CFR 431.51, Medicaid state plans must provide that a beneficiary may obtain services from any willing and qualified service provider.

ICMs using section 1905(t)(1) of the Act must comply with statutory requirements that care managers are responsible for locating, coordinating, and monitoring primary care services. But, the statute does not limit care managers to coordination of primary care. To fully achieve ICM objectives, care managers could coordinate a full range of services beyond primary care to include integration of primary, acute, and behavioral health care, as well as long-term services and supports (see Attachment 3).

ICMs using this authority must also satisfy statutory requirements that services must include twenty-four hour availability of information, referral and treatment in emergencies and the capability to arrange for, or refer to, a sufficient number of providers for the population served.

*Comparability and Freedom of Choice:* As with any state plan benefit under this authority, ICMs must include comparable services for all Medicaid populations and allow for any provider that meets defined qualifications to participate. States can, however, set forth standards that address populations or circumstances for which primary care case management is appropriate, based on medical necessity, and set payment levels stratified to distinguish patients with high case management needs from those with low case management needs. As noted above, a state seeking to target services in other ways incompatible with state plan authority may need to pursue a demonstration or waiver.

*Beneficiary Protections Under the Statute:* When a state implements ICMs under section 1905(t)(1) of the Act, the regulations at 42 CFR 438 will not apply, although some of the provisions of those regulations merely reflect applicable statutory beneficiary protections at section 1905(t)(3) of the Act. These statutory provisions contain important beneficiary protections concerning quality and access to care. States should take care to ensure ICMs align with these access to care provisions, as well as the access requirements at section 1902(a)(30)(A) of the Act.

Specifically, depending on the complexity of the integrated care model, states will need to consider the following as part of an ICM proposal:

- 1) Any marketing and/or other activities must not result in selective recruitment and enrollment of individuals with more favorable health status. Section 1905(t)(3)(D) of the Act prohibits discrimination based on health status, marketing activities included.
- 2) When there is assignment or attribution for purposes of payment calculation (see below), the state will be required to notify beneficiaries of the program, describe how personal information will be used, and disclose any correlative payment arrangements (e.g., incentives). Sections 1905(t)(3)(E) and 1905(t)(3)(F) of the Act refer to section 1932 of the Act, which allows the Centers for Medicare & Medicaid Services (CMS) to enforce this provision without applying the general 42 CFR Part 438 regulations.
- 3) States should examine the role of ICMs in ensuring beneficiary access to Medicaid services under the State plan. Specifically, section 1902(a)(30)(A) of the Act requires that services under the plan are available to beneficiaries at least to the extent they are available to the general population. The ICM model must be designed to be consistent with this basic statutory requirement.

We specified these provisions because they will require consideration by the state Medicaid Agency in program design. The goal of any successful and approvable ICM, regardless of authority, is not to lower costs through the reduction of services or access to care, but through improvement in the quality of the beneficiary experience.

*Reimbursing ICMs Under a State Plan Option:* States should decide whether reimbursement will be for a particular set of activities (what a provider “does”) or particular practice characteristics and incremental improvements in practice behavior (what a provider “is” or how the provider performs). (See Attachment 3 for examples.) For state plan amendments that reimburse for a particular set of activities, a state should clearly define a minimum expectation of activities that a provider would perform for each enrolled beneficiary within a defined period (e.g., a quarter). States may vary payments to providers based on the level of activity/service that will occur within a quarter and/or variations in the costs of delivering the care coordination activities.

State plan amendments that reimburse based on the characteristics of a provider will require a detailed description of the characteristics that trigger payments and any variations in payment levels associated with provider care coordination capabilities. For instance, since the objectives of ICMs are largely measured in quality and health outcomes, a state could implement a tiered rate methodology that pays one rate for providers who maintain a staff of care coordinators, report process-based outcome measures, and routinely use electronic health records systems, and a higher rate to providers who meet all of the first tier criteria and additionally report outcome based quality measures, offer 24 hour care, provide a free nurse hotline, etc. Payments may also be based on performance on quality metrics, achievement of savings targets (shared savings), and other indicators of high quality care.

*Per member per month (PMPM) Care Coordination Payment:* While states have the option to define ICM services as a package of discrete care coordination activities to manage beneficiaries and reimburse through traditional fee-for-service payment methods, states may find that PMPM payment structures are conducive to the types of activities provided through ICMs. PMPM rates need not require an administrative action by the provider for every coordinating event or a direct contact with a beneficiary, but may reimburse providers for direct and indirect actions (e.g. monitoring patient treatment gaps or offering extended hours of operation) that aim to improve health and outcomes for all beneficiaries.

To take this option, states must submit a comprehensive state plan reimbursement methodology that explains how the state constructs payment rates. The construction of PMPM rates for state plan ICM services will largely depend on:

- State service definitions and associated service activities;
- The qualified providers eligible to receive ICM payments;
- The extent to which providers require support in coordinating care for Medicaid beneficiaries; and
- The specific needs of the individuals who will benefit from the coordination activities.

Rates must be economical and efficient in accordance with section 1902(a)(30)(A) of the Act, which means the costs used to calculate rates are appropriately tied to the provider activities and allocated to the Medicaid program (if the costs are not exclusive to the Medicaid program). States must consider costs associated with providing ICM services (i.e., salaries, fringe benefits, supplies, equipment, and overhead) which may vary based on the qualifications of providers and the needs of beneficiaries.

CMS may consider the rates economical and efficient if the included costs are:

- In line with the nature of the care coordination activities;
- Generally reasonable;
- Appropriately allocated across beneficiaries who gain from the care coordination activities (regardless of payer); and
- Not prohibited under the Medicaid program.

We note that PMPMs in the context of this state plan option are restricted to care coordination services and may not include cost considerations for other Medicaid services categories. As part of ongoing oversight, the state plan methodology should explain the state's process for reviewing the rates for economy and efficiency based on cost and other applicable information and rebasing the rates as necessary.

*Payment for Quality Improvement and Shared Program Savings:* An additional approach to reimbursing ICMs under this state plan option is through payments to the ICM provider for improvements in health care quality. States may offer these payments as the base reimbursement methodology for the ICM provider, or as deferred compensation to a care coordination base rate. There are numerous quality measures available for states to adopt as part of payment models for quality improvement and CMS is interested in partnering with states to reward providers for quality improvement and achievement (e.g., improving patient care, focusing on person centered care, and using electronic health records). As discussed above, States could offer payments that are tiered based on a provider's improvement in process-based or outcome based measure, or both. In addition, states may calculate a payment based on shared savings and reward providers for the quality improvements or outcomes. Regardless of the outcomes or quality objectives a state promotes through the payment, the basic State Plan Amendment requirements are the same.

The State plan must comprehensively describe:

- Any eligibility restrictions for ICM providers to receive the payment;
- How incentives do not discourage the provision of medically necessary care;
- The specific method used to calculate the payment (including the quality measures that the State will use as the payment basis); and
- The timeframe and method to distribute the payments.

*Accountability of PMPM activities:* Though monthly ICM payments need not be directly tied to a distinct activity to a beneficiary under this payment arrangement, there is an expectation that practice transformation will have a positive impact on the overall care provided to, and health of, Medicaid beneficiaries. States must have a transparent process in place to review evidence of

these activities and the resulting benefit, such as regular reviews of quality measure results, provider reporting systems, and other means that demonstrate tangible benefits to the Medicaid program and beneficiaries. While states transition to reliable outcomes measurement, an intermediary process may include evaluation of documentation, audits, or submission of related claims (with or without value) in order to establish accountability of provider activities.

### **III. POLICY CONSIDERATIONS IN DEVELOPING ICMs UNDER ALL AUTHORITIES**

In selecting the appropriate pathway for an ICM, a state should consider the goals of the model and its core features. Based on our initial discussions with states, we have developed a list of considerations we believe could generally apply to all models. The questions in Attachment 2 are intended to generate ideas among states that are considering developing ICMs and help states anticipate some of the issues CMS may raise in reviewing ICM proposals. The policy topics and discussion below provide context to the attached list of questions and outline some of the programmatic boundaries that exist within each pathway. Policy continues to evolve as we move forward on these topics.

*Provider Designation:* Designation is a mechanism by which a beneficiary formally establishes a relationship with a provider or practice site that, in the case of an ICM, could serve as the beneficiary's primary care medical/health home. Because the nature of ICM activities (locating, coordinating, and monitoring care) is considered long-range endeavors, States may be interested in formalizing the relationship between Medicaid beneficiaries and providers by ensuring that the beneficiary selects an ICM provider. To be effective, ICMs generally rely upon such an established and continuous relationship between beneficiary and provider. This relationship encourages providers to develop care plans that address person-centered short and long-term needs and goals, maintain continuous outcome and quality data, and allows for payment continuity to reward efforts. It builds trust between a beneficiary and provider, which is key to coordinating effective care.

When considering provider designation policies, states should be cognizant of the "free choice of provider" regulation at 42 CFR 431.51. This requires that a Medicaid eligible individual may seek care from any willing and qualified service provider as defined under the state plan. To ensure freedom of choice within an ICM as a state plan option, states must have an effective opt-out process for beneficiaries who no longer wish to participate in the ICM program or who wish to switch ICM providers. States also need to ensure that the designated relationship does not inhibit free choice within any Medicaid service. For instance, a primary care physician who serves as a primary care medical or health home cannot restrict the beneficiary's ability to make an appointment with any other physician who is qualified and willing to provide care. Should a state seek to limit beneficiaries' enrollment or care from a particular ICM provider or program, it would need to pair the ICM state plan benefit with an authority that limits the beneficiary's choice of providers through a waiver or demonstration authority, as discussed in Section I of this letter.

*Provider Attribution Methodology:* An attribution method is a calculation that appropriately rewards providers for care coordination efforts based upon an estimation of the patients for whom he or she is most directly responsible. Attribution is particularly important in models that offer financial incentives to providers for quality achievements and methods that share program savings. When designing an ICM, states should consider the method used to attribute provider activities to outcomes that result from measures used to evaluate the model. In other words, the state should employ a method that gives reasonable assurance a provider's intervention can be connected to improved health care outcomes. Attribution methodologies must account for the possibility of beneficiaries changing care coordination providers using their free choice during designated periods in which quality achievements, and/or shared savings, are calculated.

*Connecting Incentives to Outcomes Improvement:* As states move forward with care coordination models, careful consideration should be given to appropriate financial incentives that drive change and promote quality and lower costs, regardless of whether authorized by a State plan amendment or waiver. Depending upon the state's ICM concept and the capability of providers to organize within the care coordination model, it may be in a state's interest to consider a variety of payment arrangements to encourage improvement. All methods that propose to share Medicaid savings under the ICMs (regardless of authority) will be reviewed in collaboration with our partners in the Office of the Actuary. In Attachment 4, we provide a reference to several payment methods that could be applied to state ICMs.

*Patient Engagement:* States should explain how ICMs will notify its patients of participation in an ICM and the impact of that participation on the patient's care. Such notification should include a description of any incentive payments included in the state's ICM model.

#### **IV. COORDINATION WITH OTHER CMS INITIATIVES**

A state's attribution method should be consistent with other state and CMS initiatives providing services to all eligible beneficiaries. Such methods must avoid duplication in payments and ensure Medicaid, and other CMS-funded initiatives, provides for seamless coordination while incentivizing providers to minimize or eliminate program overlap.

To the extent states are operating other care coordination or quality incentive programs through federal initiatives (e.g., the Comprehensive Primary Care Initiative, Financial Alignment Models to Integrate Care for Medicare-Medicaid Enrollees, or Health Homes for Individuals with Chronic Conditions), states should ensure programs complement each other without duplication of payment and allow for the unique impact of each intervention to be evaluated independently of any other. Additionally, federal funds may not be used to fund the state share for Medicaid payments made under ICMs or any other Medicaid service category.

We are committed to working with states to ensure states coordinate with and supplement efforts funded through other federal initiatives that aim to improve care and quality for Medicaid beneficiaries.

**V. CONCLUSION**

We look forward to working with states, individually and collectively, to provide assistance and facilitate collaboration in developing and implementing ICMs within the Medicaid program. As you continue to consider and implement transformational efforts, we are available to provide assistance in navigating the policy options and the tools available to you. If you have any questions, please contact Ms. Dianne Heffron, Director of the Financial Management Group, at 410-786-3247.

Sincerely,

/s/

Cindy Mann  
Director

Enclosures

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cc:

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