

Integrated Care Models

CMS Releases New Guidance for States

Over the past several months, the Centers for Medicare & Medicaid Services (CMS) has released a series of Dear State Medicaid Director letters to provide guidance on policies and implementation options for “Integrated Care Model” (ICM) initiatives. Examples of ICMs include medical/health homes, Accountable Care Organizations (ACO), ACO-like models, and other arrangements that emphasize person-centered, coordinated care. CMS makes clear that their guidance is not intended to be all-encompassing or limiting, but provides a framework of CMS’ perspective on ICMs. The following provides a summary of the CMS letters for your use in state-level advocacy and strategic planning for the creation of ICMs.

We have prepared these summaries in response to the questions that were raised at the Public Policy Committee Meeting. We also want to let you know that the National Council has engaged Dale Jarvis to write a brief paper examining the emerging alternative payment methodologies for behavioral health services that are being considered around the country. We hope these resources are helpful to you.

In their [first letter \(SMDL# 12-001\)](#), CMS defines ICMs as high performing delivery models that “better coordinate services, reward quality achievements, and share savings with providers.” They will focus around the needs and preferences of beneficiaries with the central goal of improving overall health care outcomes and consumer experiences.

As detailed in the [second letter \(SMDL# 12-002\)](#), there are four key areas of reform necessary to form effective ICMs: delivery system reform, technological modernization, stewardship, and collaboration. States may take two approaches to implement ICM payment and reimbursement systems, through either a State Plan Option or Medicaid Demonstrations and Waivers. Regardless, all state models must consider provider designation and attribution methodologies, connecting incentives to outcomes improvements, and patient engagement.

CMS’s shared savings reimbursement methodological concepts emphasize solidifying (1) a total cost of care benchmark, (2) provider payment incentives to improve care quality and lower total costs, (3) a performance period that tests changes, and (4) an evaluation to determine the program cost savings during the performance period compared to the benchmark cost of care and to identify the improvements in care quality.

Shared savings reimbursement methodologies must also follow the guidelines of other Medicaid incentive payments in that they should not reduce beneficiary access or quality of care. For the time being, CMS supports gain-sharing arrangements that strive to achieve quality improvement and lower costs without placing providers at risk. Under current guidelines, risk-based provider payment arrangements may be approved in the Medicaid state plan under specific conditions outlined in CMS’ [third letter \(SMDL# 13-005\)](#).

CMS notes that when formulating cost projections and analysis, baseline cost data should be rebased to integrate reforms or other state Medicaid program changes, such as rate increases or decreases, which were not in effect during the baseline period. Shared savings

payment methodologies must include a quality component and CMS plans to release additional quality metrics for ICMs in the future.

Other key issues covered in [most recent letter published](#) by CMS include benchmark considerations, data sources, risk mitigation, excluded cost, comparison population, and targeting providers and populations.

We would welcome updates on your state-level implementation activities pertaining to ICMs. Please contact Chuck Ingoglia, Senior Vice President of Public Policy and Practice Improvement at the National Council, at the at ChuckI@TheNationalCouncil.org or 202-684-3749 with updates or questions.