Medicaid and CHIP MAC Learning Collaboratives

Integrated Care Models in Medicaid: Concept Development Toolkit

TECHNICAL ASSISTANCE TOOL JUNE 2013

To help state Medicaid agencies facilitate the design and development of new integrated care models (ICMs),* the *Value-Based Purchasing Medicaid & CHIP Learning Collaborative* worked with the Centers for Medicare & Medicaid Services (CMS) to develop this concept development toolkit. The toolkit is intended to help states conceptualize and articulate key concepts for proposed ICM programs.

While states are not required to use this toolkit as part of the formal state plan amendment or waiver process, it can assist states in thinking through ICM policy and reimbursement considerations and facilitating more efficient conversations with the state team, stakeholders as well as with CMS.

The toolkit includes two parts:

- **Part 1: Executive Summary** Through this 2-3 page summary, states can outline a brief overview of the ICM model to help the state team, stakeholders and CMS better understand the larger context of the proposed program.

- **Part 2: Program Description** States can use Part 2 to outline a detailed description of the ICM program characteristics, including: (a) Program Design; (b) Quality Strategy, and (c) Payment Methodology.

Please note:

- The toolkit incorporates questions posed in Attachment 2 of the State Medicaid Director Letter #12-002.
- Not all sections of this document will be relevant to all state ICM models. Thus, states can use the tool flexibly based on their specific ICM approach.

** For more information about ICMs, please refer to the July 10, 2012 State Medicaid Director letters, SMDL #12-001: Integrated Care Models and SMDL #12-002: Policy Considerations for Integrated Care Models, which can be found at www.medicaid.gov.*

ABOUT THE MAC COLLABORATIVES

This resource was developed for the *Value-Based Purchasing MAC Learning Collaborative*, one of a series of state-federal collaboratives coordinated through the *Medicaid and CHIP Learning Collaboratives*. The *MAC Collaboratives* were established by the Centers for Medicare & Medicaid Services to help states and their federal partners work together to achieve high-performing state health coverage programs. For more information, visit http://www.Medicaid.gov.

Integrated Care Models in Medicaid: Proposal Planning Toolkit

As states pursue Integrated Care Models (ICMs) as a part of their value-based purchasing efforts, a first step is to articulate the concept or vision for the program, whether medical homes, a network supported primary care medical homes, accountable care organizations (ACO), ACO-like entities, or other approaches. The state can use the template below to summarize its concept, briefly describing the model and what the state intends to achieve.

Part 1: Executive Summary

Instructions: Provide a 2 to 3 page general description of the proposed model. For example, if relevant and known:

Overview

- ✓ Describe the ICM model the state intends to implement.
- ✓ Detail the overall programmatic goals for the proposed ICM program, including how it will support better care for individuals, better health for populations, and lower costs through improvement.
- ✓ Describe the current Medicaid program/delivery system and how it would be changed as a result of the new model.
- ✓ Identify if there are existing program authorities/SPAs/waivers/etc. that could be relevant to/impacted by this program.

Programmatic Considerations

- ✓ Identify the eligible beneficiary population and why the state has selected this population.
- ✓ Identify the type of eligible provider entities for this program and, in general, the services and/or activities will the entities will render/provide.
- ✓ Briefly identify the type of payment methodology the state is considering, if known.

Facilitating Circumstances, Gaps and Barriers

- ✓ Describe any facilitating circumstances or existing building blocks, if any, which would be the foundation or "jumping off point" for the new model. For example, whether the state will build off an existing program, or align with an existing multi-payer program, or target existing medical homes as provider entities.
- ✓ Identify if there are any gaps in existing infrastructure that would need to be addressed for the program to be effective.
- ✓ Describe any potential barriers or obstacles to program design or implementation.

Part 2: Program Description

Instructions: To accompany the Executive Summary, provide a more detailed description of the proposed ICM model, outlining specific program components within the following areas:

I. Program Design
II. Quality Strategy
III. Payment Methodology

I. Program Design

Instructions: Develop a detailed description of the proposed model. For example, if relevant and known:

Eligible Participants/Beneficiary Population

- ✓ Identify whether the program will be statewide or targeted to specific geographic area(s) and whether or not all beneficiaries can enroll in the program.
- ✓ Describe whether beneficiary enrollment will be mandatory or voluntary.
- ✓ Describe how beneficiaries will be assigned or attributed to a provider, i.e., the process that establishes a relationship between beneficiary and provider.
- ✓ Describe how beneficiaries will be notified about the program and their enrollment status, including what information they will receive, what they will be able to access, etc.
- ✓ Specify if there are other federally-funded programs within the state serving clients with special needs who may be (or become) eligible for the expanded range of services.

Eligible Provider Entities/Provider Characteristics

- ✓ Identify whether the state will use a care management entity for this model (e.g., enhanced PCCM, networked PCCM, a managed care entity, etc.).[1]
- ✓ If certain providers will be targeted, identify whether they will be targeted by provider qualifications, selective contracts (via 1915(b) waiver), or another factor.
- ✓ Describe HIT infrastructure, population management, and data collection and exchange requirements for eligible providers.

Covered Services

- ✓ Describe any potential limitations on amount, duration and scope of services.
- ✓ Identify which delivery system(s) (e.g., primary care, long-term care, behavioral health, etc.) the new program will impact/include.
- ✓ Identify services that will be coordinated by this program and whether/how the care coordination/ care management goes beyond the coordination currently provided to the target population.

Stakeholder Input

- ✓ Briefly describe the opportunities for stakeholder (e.g., beneficiaries, advocates, health professionals, hospitals, clinics, tribes, etc.) input on the new program.

Oversight and Monitoring

- ✓ How will the state evaluate whether the program is effective?

[1] *If using a managed care or care management entity, please refer to the regulations at 42 CFR 438.2 describing risk and non-risk contracts.*

- ✓ What oversight functions will the state have to ensure that payments are improving care coordination, transforming practices, improving quality, etc.?

Timeline

- ✓ Develop a target timeline for program development, implementation, and ongoing operations. Identify inter-dependencies if possible (e.g., CMS review of a SPA or waiver, related state legislation, state budget fiscal year, staff or workforce training, health plan contract or rate-setting cycles, certification of providers, pre-implementation reviews, etc.)

II. Quality Strategy[2]

Instructions: Describe the state's proposed quality strategy for this program. For example, if relevant and known:

- ✓ Describe the state's goals and objectives for its quality strategy and how the state develops its quality strategy (e.g., whether the state was able to use data to identify those goals and objectives, how the state determines its quality goals and priorities, who at the state is driving this process and what stakeholders are involved, etc.)

- ✓ Describe the types of performance metrics that will be used (e.g., structure, process, outcomes measures; core set measures; etc.)

- ✓ Describe how the state will assess quality at the point of care, including what data will be shared back with the provider entities, how, and how often.

- ✓ Identify whether/how the strategy aligns with other quality efforts occurring in the state/region (e.g., in other Medicaid care coordination programs, with other payers).

- ✓ What data measures will be used to ensure that providers are actually transforming their method of care delivery? What thresholds or other criteria are considered successful transformation? How will the state address poor performers?

- ✓ Describe how the state will know when the eligible provider entity is rendering the required services/activities.

- ✓ Describe how the state will determine whether the program is achieving the established goals and objectives, including the evidence, research, or theory is the state employing to justify the chosen metrics as indicators of program effectiveness.

- ✓ Describe whether and how the quality strategy will be linked to payment/incentives, including what thresholds or improvements must the provider meet to receive a quality-based incentive payment.

III. Payment Methodology

Instructions: Describe the state's proposed payment methodology. For example, if relevant to the state's program and known:

- ✓ **Overview of Payment Methodology**

[2] *Note that the CMS will be providing more formal guidance on a quality strategy, so the questions in this section may be revised as a result.*

- Provide an overview of the program's payment methodology (e.g., whether the state is implementing a global payment, what kind of global payment, whether the payment will be prospective or retrospective, whether the state is pursuing shared savings, whether the state is linking payment to quality, frequency of payments, etc.)
- If using a global payment strategy, describe how the payment amount will be determined, and how the rates will be determined "economical and efficient" to comply with the statutory requirement.
- If the state is tiering rates, describe how they will be tiered (e.g., based on complex care needs, differences in care models, etc.)
- Describe what information the state used to set the rates and whether/how the payment rate will be reassessed over time.
- Describe what will trigger the provider payment, e.g., submission of a claim or an alternative trigger.

✓ **Overview of Shared Savings Methodology**

- If proposing a shared savings methodology, provide a general overview of the approach.
- If different from the general ICM program, identify the beneficiary population to be included in the shared savings program and the approximate number of beneficiaries, if available.
- Identify whether an actuarial analysis was needed/used to assess the validity of the shared savings structure and explain the assumptions used to develop its analysis.
- Provide a target number of beneficiaries who must be enrolled in the program to determine the statistical validity of the data and outcomes.
- Describe how the shared savings methodology will attribute beneficiaries to provider entities for the purposes of calculating shared savings.
- Identify how often are payments will be made to providers. Describe how the shared savings payments will be reconciled to the other payments made to participating providers, (i.e., shared savings payments net of care coordination PMPMs or any other payments)
- Describe whether the shared savings calculation includes all program health costs or excludes some claims or services. If it excludes some, describe why.
- Describe the source of the non-federal share that will be used to draw federal financial participation for claims under the model.

✓ **Shared Savings: Total Cost of Care/Baseline Cost Calculations**

- Describe how the baseline costs of the shared savings program will be calculated, including what services and/or provider activities will be included in the calculation.
- Describe whether the shared savings calculation excludes certain claims or services. If it excludes certain claims or services, describe the basis for the exclusion.
- For the purpose of calculating program savings, confirm whether the state will limit the inclusion of high cost claims above a certain dollar amount.
- If the state makes or intends to make supplemental service payments please describe how those payments are factored into the total cost of care. Supplemental payments are sometimes structured as lump sum payments so states may need to make methodological adjustments to accommodate the payments.

✓ **Shared Savings: Trend Rate Calculation**

- Describe how the trend rate will be calculated and what factors the state will use to adjust the baseline.

- Describe whether there will be different trending rates based on eligibility categories or service categories.

✓ **Shared Savings: Risk Adjustment**

- Provide an explanation of the risk adjustment methodology the state will use.
- Describe what mechanisms will be in place to protect participating entities from excessive risk. (e.g., claims caps, catastrophic risk protection, minimum savings thresholds, exclusion of certain high-risk patients, exclusion of certain services, other)

✓ **Shared Savings: Risk Sharing**

- Confirm whether participating providers will be required to participate in a risk sharing arrangement in order to qualify for payment.
- Describe any risk arrangement and the authority under which the state will implement the arrangement.
- Describe whether and how the state will recoup dollars from providers for losses.
- Describe how providers will be aware that they are participating in a risk arrangement.

✓ **Shared Savings: Calculating Savings or Losses**

- Describe how savings or losses will be calculated, including whether the state will use a pre/post methodology to assess change in costs relative to a projected budget, or will it use a control group methodology, or another approach.
- Identify the percentage of savings/losses that will be shared with participating entities and whether the amount will be tiered based on quality performance or some other factor.
- Describe if and how quality will qualify a provider for the shared savings program.

✓ **Shared Savings: Rebasing**

- Describe how benchmarking data will be rebased after an appropriate period of time to account for any delivery system reforms that have been fully integrated.

✓ **Shared Savings: Cost Shifting**

- Describe how the state will ensure that costs are not being shifted to other health care settings/programs. For instance, if the state is excluding claims from a particular delivery system, will it calculate and track expenditures associated with the excluded services to ensure that population costs savings are truly realized, rather than shifted to the excluded system?

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The Centers for Medicare & Medicaid Services (CMS) established the *Medicaid and CHIP Learning Collaboratives* to achieve high-performing state health coverage programs, a goal that requires a robust working relationship between federal and state partners. Over a two-year period, collaborative workgroups are addressing critical topics for establishing a solid health insurance infrastructure, The MAC Collaboratives are coordinated by Mathematica Policy Research, the Center for Health Care Strategies, and Manatt Health Solutions, with additional assistance from external experts and in close association with CMS. For more information, visit http://www.Medicaid.gov.