Medicaid and CHIP MAC Learning Collaboratives

Continuum of New Integrated Care Models in Medicaid: Key Program Features

TECHNICAL ASSISTANCE TOOL JULY 2012

In 2012, as part of the *Medicaid and CHIP Learning Collaboratives*, the Centers for Medicare & Medicaid Services proposed a new paradigm to define emerging integrated care models in Medicaid. These new value-based purchasing models strive to shift accountability for care management, quality outcomes, and cost savings closer to the point of care. While many Medicaid programs' reimbursement policies reward providers who have a higher volume of services, there is an opportunity to pay for improved outcomes and get more value out of the health care dollar. This shift from volume to value offers the potential to reduce costs and improve care for the patient and population. Examples of these new integrated care models include: medical homes, health homes, regional networks of medical homes, and accountable care organizations (ACOs).

To date, there has been limited guidance to Medicaid agencies about how to implement these new program options. (CMS provided guidance on health homes through Section 2703 of the Affordable Care Act and also released guidance on Medicare ACOs.)

In July 2012, CMS released two State Medicaid Director letters that provided states with more guidance around these emerging integrated care models. This document provides supplemental information to the SMD letters. It presents a conceptual framework that begins to define program features of the emerging program options. The graphic on the next page illustrates the continuum of care models that shift providers toward greater accountability for quality and cost, and transition a fee-for-service reimbursement system toward one that pays for outcomes, not individual services.

The continuum includes the following program features for each care model:

- What are the characteristics of eligible providers in each model?
- What services will eligible providers be required to deliver?
- How will providers be reimbursed for the services they are providing?
- How will success be measured, at the state, program, and provider levels?

This continuum is unusual as it strives to articulate the paradigm shift occurring at the federal, state, and local levels in publicly-financed health care. It also reflects the ongoing dialogue and vibrant partnership between CMS and Medicaid agencies as they – like all payers across the country – strive to transform the health care system to achieve value-based purchasing goals. The continuum is intended as a tool to conceptualize how existing and future program levers co-exist. The various pieces are not fixed, but rather an assembly of many moving parts.

As CMS develops policy and program design considerations for these new models, it plans to release guidance to states through letters to state Medicaid directors. The guidance will help states understand CMS' expectations for how these programs should be designed, what requirements must be in place, strategies for measuring outcomes and assessing the value of these programs, and under what authorities states can implement these new models.

ABOUT THE MAC COLLABORATIVES

This document was developed for the *Value-Based Purchasing MAC Learning Collaborative*, one of five state-federal collaboratives being 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. Collaborative workgroups are focusing on: (1) early innovator information technology (IT) solutions; (2) coverage expansion; (3) data analytics and performance measurement; (4) IT efficiency and effectiveness; and (5) value-based purchasing. For more information, visit http://www.Medicaid.gov.

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Continuum of Integrated Care Models (ICM) and Features

Little/No Accountability for Quality and Cost Outcomes → *Significant Accountability for Quality and Cost Outcomes*

CARE MODELS	FFS Only	PCCM	PCCM Plus P4P	PCMH	PCMH + Health Home	Network of PCMH	ACOs	Comprehensive ACOs	Other ICMs	Full ICMs
MEASUREMENT	*Data capturing & sharing*				*Improved clinical processes*				*Improved outcomes (costs down, better patient experience)*	
PAYMENT	Made to individual PCP| Fixed $ amount: $15-service / $5-quality; Possible bonus pool; Individual Service-Focused				Made to individual providers or entity| Upfront $, savings & FFS: $10-service / $10-Quality/savings				Made to entity| $ based on savings: $5-service / $15-Quality/savings; Population-Focused	
SUCCESS INDICATORS	Process measures indicate improved care in future, yield data collection for policy development and baseline				Clinical processes and new benchmarks informed by data collection; benchmarks adjusted for continuous improvement				Improved care outcomes, not volume; patient experience	
METRICS/ VALUATION	Some MU core set; some adult/child core sets measures				Practice measurement changes and process measures that will lead to outcomes improvement				Population health, functional status, total cost of care	

MAC Collaboratives: *Federal/state partnership to support high-performing state health insurance programs. Established by the Centers for Medicare & Medicaid Services and coordinated by Mathematica Policy Research, the Center for Health Care Strategies, and Manatt Health Solutions. Visit http://www.Medicaid.gov.*