

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Hess</i>	DATE <i>8-24-12</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>100059</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Mr. Teek, Singleton, Kost, Deps, CMS file</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



Center for Medicaid and CHIP Services

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ICM# 2

AUG 23 2012

Department of Health & Human Services
OFFICE OF THE DIRECTOR

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 homes¹, 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

¹ 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 authorities² (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

² 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.³ 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.

³ 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,

A handwritten signature in dark ink, appearing to read "Cindy Mann", with a stylized flourish at the end.

Cindy Mann
Director

Enclosures

Page 10 - State Medicaid Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health

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Attachment 1: Examples of ICM Arrangements and Authorities

Tool	Statutory Reference	Purpose	Policy Consideration
ICM State Plan Amendment (SPA)	Section 1905(t)(1) 42 CFR 440.168	Option to provide integrated care models to all individuals under the State plan. Ability to incentivize quality and share savings.	<ul style="list-style-type: none"> • Statewide • All Eligible Participants • All Qualified Providers
Primary Care Case Management (PCCM) Contract	Section 1905(a)(25) 42 CFR 438.6	Utilize existing PCCM contracts to reward quality. Limits providers eligible to offer services through contract. Ability to incentivize quality and share savings.	<ul style="list-style-type: none"> • Requirements at 42 CFR 438.6
Selective Contract Waiver	Section 1915(b)(4)	Limit the number of providers eligible to offer services within the model.	<ul style="list-style-type: none"> • Test for cost effectiveness and efficiency
1115 Demonstration	Section 1115	Target populations, limit geographic scope, reach target populations.	<ul style="list-style-type: none"> • Budget neutrality • Time limited

Attachment 2: Questions to Consider in Developing ICMs

General Program Description

- Is the State building off of an existing PCCM or 1115(a) demonstration program or will the model be a new Medicaid initiative?
- How will the model support better care for individuals, better health for populations and lower cost through improvement?
- What are the provider qualifications for the model?
- Will any provider that meets the established provider qualifications be able to be designated as a qualified provider?
- How do incentives from other payers support the same objectives?

Eligible Participants

- Will the model be implemented on a statewide basis? If no, what are the limiting criteria?
- May all State plan eligible beneficiaries (including those dually eligible for Medicaid and Medicare) enroll within the model?
- Are there other federally funded programs within the State serving clients with special needs who may be (or become) eligible for the expanded range of services under an Integrated Care Model?

Model Services and Activities

- Which delivery systems will the model impact (e.g. primary care, long-term care, behavioral health, etc.)?
- What services/activities will the model providers conduct through the model?
- What services will be considered for coordination in the model?
- Do these services go above and beyond any current care coordination within the State plan or waiver programs?
- What key characteristics must the providers possess or strive to achieve that are integral to implementing the model?

Beneficiary Notification

- How will beneficiaries be notified that they are enrolled within the model?
- What is included in the notification – what will be communicated to beneficiaries?
- How can beneficiaries get more information about the program?

Assignment and Attribution

- How does the program assign and attribute beneficiaries to providers?
- Are assigned beneficiaries able to opt-out of the program voluntarily? What waiver authority will form the basis for that request?

Quality Metrics

- What data measures will be used to ensure that providers are transforming their method of care delivery?
- What quality measures are proposed? Are these measures the most relevant to and measure most accurately the care coordination and quality improvements anticipated from the model?
- How do the proposed quality measures relate to other care coordination initiatives in the State (e.g. Health Homes, Medicare-Medicaid Financial Alignment Demonstrations, etc.)?
- What thresholds or improvements must be shown for a provider to meet the criteria for a quality based payment (if applicable)?

Program Oversight and Accountability

- What evaluative methods will the State use to assess whether the model is effective?
- What oversight functions will the State Medicaid agency have in place to ensure that ongoing payments are effecting better care coordination, practice transformation and quality improvement?

Payment Methodology

- Will the State reimburse providers a regular payment for care coordination activities?
- Is the payment level tiered based on provider activities, provider characteristics, or outcomes?
- What factors did the State use to determine the appropriate payment amount to reimburse provider activities under the model?
- Does the State propose to offer supplemental provider payments under the model?
- What criteria will the State use to determine provider eligibility for a supplemental payment?

- Does the State propose shared program savings as the methodology to determine supplemental provider payments?
- Did the State conduct an actuarial analysis to assess the validity of the shared savings structure?

Attachment 3: Hypothetical Integrated Care Models

<u>Model</u>	Primary Care Medical Home	Network Supported Primary Care Medical Home (e.g. network of PCMEs working together)	Accountable Care Organization
<u>Providers</u>	Physicians, Physician Directed Team, Other Designated Primary Care Provider.	Physician Groups, Network, Collaborative, and/or Partnership Organizations Composed of Individual Practices.	ACOs (adopted Medicare definition or State defined and authorized through risk-based contract).
<u>Potential Payment Models</u>	PMPM Stage One: Process-Based Quality Incentive. Stage Two: Outcome-Based Quality Incentive.	PMPM Tier One - Process-Based Quality Incentive. Tier Two – Outcome-Based Quality Incentive.	Shares Savings and Distributes Savings to Partnering Providers Based on State plan Methodology.
<u>Activities</u>	<ul style="list-style-type: none"> • Referral Management • Care Coordination • Care Management • Use of Care Plan • Beneficiary Outreach and Advocacy • Clinical Data Management • Individual and Family Supports • Development and Maintenance of Care Plans • Quality Reporting 	<p>All activities under first column, plus:</p> <ul style="list-style-type: none"> • Staff Training • Health Promotion • Quality Management • Practice Support • Promotion of Evidence-Based Medicine • Promotion of Patient Engagement • Infrastructure for Quality and Cost Measure Reporting • Promotion Coordination of Care • Quality Reporting 	<p>All activities under first column, plus:</p> <ul style="list-style-type: none"> • Staff Training • Health Promotion • Quality Management • Practice Support • Promotion of Evidence-Based Medicine • Promotion of Patient Engagement • Infrastructure for Quality and Cost Measure Reporting • Promotion Coordination of Care • Quality Reporting

<u>Model</u>	Primary Care Medical Home	Network Supported Primary Care Medical Home (e.g. network of PCMHs working together)	Accountable Care Organization
<u>Characteristics</u>	<ul style="list-style-type: none"> • Offers Extended Care Hours • Designates Hours for Patient Telephone Consultation • Ability to Report Process Quality Measures • Ability to Report Outcome Quality Measures • Demonstrates Defined Improvement in Process Measures • Meets National or State Defined Medical Home Certification Standards • Has a functional certified EHR 	<p>All activities under first column, plus:</p> <ul style="list-style-type: none"> • Offers 24 hour Nurse Advice Lines • Conducts Quarterly staff training on care coordination practices • Collects and Analyzes Practice Quality Data • Meets National or State Defined Medical Home Certification Standards • Partners with Network of Certified Medical and Health Home Providers • Process for evaluating the health needs of the population served • Partners with community stakeholders • Communicates clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them • Has written standards in place for beneficiary access and communication, and a process in place for beneficiaries to access their medical record • Engages and shares decision-making that takes into account the beneficiaries' unique needs, preferences, values, and priorities 	<p>All activities under first column, plus:</p> <ul style="list-style-type: none"> • Offers 24 hour Nurse Advice Lines • Conducts Quarterly staff training on care coordination practices • Collects and Analyzes Practice Quality Data • Meets National or State Defined Medical Home Certification Standards • Partners with Network of Certified Medical and Health Home Providers • Process for evaluating the health needs of the population served • Partners with community stakeholders • Communicates clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them • Has written standards in place for beneficiary access and communication, and a process in place for beneficiaries to access their medical record • Engages and shares decision-making that takes into account the beneficiaries' unique needs, preferences, values, and priorities

Attachment 4: Potential Payment Approaches for State Plan ICM

Payment Approach	Basis for Payment	Methodology Expectations
Base Rates	PMPMs Fee for Service	Comprehensive description of: general rate construction, effective date language, location of rate schedule, tiered payment levels, acuity adjustments.
Incentive Payment for Quality Improvement	Annual performance	Definition of quality measures and scoring criteria. Eligibility requirements for receiving payment. Methodology for calculating and distributing payment.
Medicaid Shared Savings Payment	Annual performance	Definition of quality measures and scoring criteria. Methodology for calculating and distributing payments. Specific service costs included in the calculation. Validation from CMS actuaries.