CMS Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees

On July 8, 2011, the Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Directors (SMD) letter providing preliminary guidance on opportunities to better align financing between Medicare and Medicaid in an effort to enhance the quality of and reduce the cost of care for individuals enrolled in both programs ("dual eligibles"). The CMS outlined two models – Capitated and Managed Fee-for-Service (FFS) – to help States overcome the financial misalignment between these two programs and to pursue the integration of primary, acute, behavioral health and long-term services and supports for dual eligibles.

On September 30, 2011, the State of Illinois submitted a letter of intent to participate in both models. Below are highlights of the two models:

Capitated Model

- This model will test a capitated payment model utilizing a three-way contract among the State, CMS, and health plans to provide integrated benefits to dual eligibles.

- Plans – selected through a competitive, joint (CMS and State) procurement process – will receive a blended capitated rate for providing the full continuum of benefits across both programs.

- Participating plans will be required to comply with all applicable Medicare and Medicaid rules and regulations as well as program specific and evaluation requirements including established quality thresholds.

- Key objectives of the initiative are to improve access to care and quality, eliminate cost shifting between the two programs, and achieve cost savings.

Managed FFS

- Under the Managed FFS model, States will ensure seamless integration and access to all necessary services, based on the individual's needs, through coordination across the Medicare and Medicaid programs.

- The Managed FFS model is designed to build upon existing FFS delivery systems and new CMS programs that offer States opportunities to improve care coordination for Medicaid beneficiaries including dual eligibles (e.g. Medicaid health homes).

- The State will be eligible to receive – based on the State meeting or exceeding established quality thresholds – a retrospective performance payment based on the level of Medicare savings achieved net of increased Medicaid costs.

- State participation in the Managed FFS model aligns with the State's Innovations Project, which offers new funding incentives and flexibilities to engage community partners in facilitating coordinated, quality care, across provider and community settings to specific Medicaid populations including dual eligibles.