

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519



July 6, 2016

Marie Zimmerman, State Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Ms. Zimmerman:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #15-0015 --Revises the section of the state plan related to Minnesota's Integrated Health Partnership (IHP) Program. This amendment clarifies the attribution process, updates the gain and loss-sharing requirements after the initial three-year contract period, and makes other technical revisions.

--Effective Date: January 1, 2016

If you have any additional questions, please have a member of your staff contact Sandra Porter at (312) 353-8310 or via e-mail at Sandra.Porter@cms.hhs.gov.

Sincerely,

/s/

Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosures

cc: Ann Berg, MDHS
 Sean Barrett, MDHS

STATE: MINNESOTA

ATTACHMENT 3.1-A

Effective: January 1, 2016

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TN: 15-15

Approved: 7/6/16

Supersedes: 13-01, 11-31

29. **Integrated Care Models (FFS Primary Care Case Management)**

~~Health Care Delivery Systems (HCDS)~~Integrated Health Partnership (IHP).

HCDSIHP entities provide FFS primary care case management services under authority of §1905(t) of the Social Security Act, which includes location, coordination and monitoring of health care services. The state ensures that it will comply with the applicable beneficiary protections in 1905(t)(3) as described below. HCDSIHP entities are under contract to share cost and savings gained or lost on the total cost of care for certain services provided on a fee-for-service basis. Medical assistance ~~enrollees~~ beneficiaries are free to choose from any qualified provider, and HCDSIHP entities are not under contract to provide medical assistance covered services for a fixed price. Providers who are participating with HCDSIHP entities will provide services and submit claims in accordance with fee-for-service requirements.

HCDSIHP entities must be under contract with the state and have demonstrated through the procurement process that:

- The delivery system includes the full scope of primary care services;
- Methods and approaches are in place to coordinate care across the spectrum of services included in the payment model;
- Partnerships are in place between the HCDSIHP entity and community-based organizations and public health resources will be in place;
- A process is in place to engage patients and their families meaningfully in the care they receive;
- The delivery system has the capacity to receive data from the state via secure electronic processes;
- The delivery system uses data provided by the state to identify opportunities for ~~recipient~~ beneficiary engagement and to stratify their population to determine the care model

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strategies needed to improve outcomes;

- The delivery system coordinates care with other medical providers who are responsible for pertinent aspects of care; and
- The delivery system participates in quality measurement activities as required by the state and engages in quality improvement activities.

The following beneficiary protections in § 1905(t) apply to this project in the following manner:

- §1905(t)(3)(A), which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment, is met because beneficiaries are afforded free choice of providers participating in Medical Assistance;
- §1905(t)(3)(B), which restricts enrollment to nearby providers, does apply to this project because there is no enrollment in the project;
- §1905(t)(3)(C), which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high quality care in a prompt manner, is met in that beneficiaries are afforded free choice of providers participating in Medical Assistance; and in that the attribution methodology ensures that only patients who have a relationship with the participating providers are attributed to the HCDSIHP entity;
- §1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment, is met because qualified HCDSIHP entities will be prohibited by contract from activities designed to result in selective recruitment and attribution of individuals with more favorable health status.

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- §1905(t)(3)(E), which provides for an ~~enrollee's~~ beneficiary's right to terminate enrollment, does not apply to this project;
- §1905(t)(3)(F), which requires compliance with § 1932, is applicable to this project as follows:
 - o §1903(d)(1), which provides for protections against fraud and abuse, is met in that all providers participating in HCDSIHP are enrolled in the Medical Assistance Program and bound by the rules of the program;
 - o §1932(d)(2), which includes restrictions on marketing by managed care entities, requires the state to monitor marketing efforts on the part of HCDSIHP entities; and
 - o §1932(e)(4) requires the states to retain the ability to terminate the contract with the HCDSIHP entities for failure to meet the terms of the contract.

Qualified HCDSIHP demonstration provider organizations are those that have submitted successful responses to the Department's request for proposals and are under contract with the state to participate in this demonstration, ending three years following the implementation date of the contract.

The state will notify Medical Assistance beneficiaries of the program, including a description of how personal information will be used, and payment incentives, through an annual mailing by May 1 of each performance year, to those ~~enrollees~~ beneficiaries who are attributed to the HCDSIHP entity at that point in time.

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The state will notify Medical Assistance beneficiaries of the program, including a description of how personal information will be used, and payment incentives, through an annual mailing by May 1 of each performance year, to those ~~enrollees~~ beneficiaries who are attributed to the HCDSIHP entity at that point in time.

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29. Integrated Care Models (FFS Primary Care Case Management)

Health Care Delivery Systems (HCDS) Integrated Health Partnership (IHP) Demonstration, Payment Adjustment.

Payment for HCDSIHP services includes a payment, made at the end of each participation year, for qualified HCDSIHP demonstration providers that have agreed to participate for the purpose of improving clinical quality and patient experience, and achieving efficiencies across the total cost of care for a broad spectrum of outpatient and inpatient care as a common financial and organization entity. Payment is distributed to participating providers through the demonstration provider entity.

"Participation year" is the first twelve-month period of participation in the HCDSIHP program by an HCDSIHP entity, and each twelve-month period thereafter. "Base year" is the twelve-month period immediately preceding the first participation year of each three-year contract period.

Payment is limited by the HCDS'IHP's performance for the participation year against identified quality measures, and these quality measures are reflective of the services provided by the HCDSIHP providers, for medical assistance enrolled patients attributed to the delivery system for the participation year. The payment for the year is based on the difference between the annual expected or target total cost of care (TCOC) and the actual, realized TCOC for the core services, plus the TCOC for additional services agreed upon by the Department and the HCDSIHP demonstration provider, for the population attributed to the demonstration provider. Gain-sharing will occur only if the HCDSIHP provider achieves a 2% or greater savings between the target total cost of care and the actual, realized total cost of care. Payment will be different between virtual and integrated delivery models. Payment for virtual delivery models includes gain-sharing, with the option to include loss-sharing only, and; payment for integrated models includes both gain-sharing and loss-sharing. For integrated models, and for virtual models in which the IHP entity elects to accept loss-sharing, payment can be positive or negative. The determination of both the base and the target TCOC includes both fee-for-service and managed care enrollees, but the

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Demonstration, Payment Adjustment (continued).

payment under this section of the state plan includes only the amount related to the providers' ratio of gain/loss for fee-for-service enrollees to the total Medicaid population attributed to the demonstration provider. Final payments/recoveries will be made no more than 15 months after all necessary data is received in final form.

Attribution, covered population, exclusions, population limits. For both the base year and for the participation year, the Department will attribute fee-for-service patients to the ~~HCDS~~IHP provider retrospectively, using fee-for-service paid claims data.

Risk score. For both the base year and the participation year, the Department will calculate a risk score based on diagnoses for ~~the participation year~~ for the population attributed to the ~~HCDS~~IHP demonstration provider. The target TCOC will be adjusted based on the increase or decrease in the risk of the attributed populations between the base year and the participation year.

Total cost of care. The TCOC for the base period and the measurement period will be calculated by the Department retrospectively, using fee-for-service claims data and encounter data from the managed care organizations. The cost in the base and participation years will include the cost of the core services and any other additional services jointly agreed upon between the Department and the demonstration provider, for the population attributed to the demonstration provider. The

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services included in the TCOC measurement for the base year and measurement year will be identical. The total cost of care will not include individual annual claims costs in excess of a catastrophic threshold of at least \$50,000.

The target TCOC will be developed using the ~~base year~~ prior years' TCOC for the IHP, plus expected trend, which will be the expected trend for the aggregate Minnesota Health Care Programs with appropriate adjustments for services not included in the base TCOC and incorporating actual ~~HCDS~~ IHP program trend as appropriate and methodologically sound.

Gain and Loss-Sharing. For the virtual model, ~~no~~ loss-sharing is not required—occurs. For all ~~three~~ participation years, the ~~HCDS~~ IHP provider shares equally with the state any gains between the target total cost of care and the realized total cost of care, ~~meaning any savings in excess from the expected total cost of care~~, and reduced by the results from the quality measures, ~~is shared equally between the state and the provider~~. A virtual IHP may accept loss-sharing within terms agreed upon between the IHP and the state.

For the integrated model, the effect of the performance measures on the gain-sharing payment is the same as for the virtual model. Loss-sharing and gain-sharing between the state and the demonstration providers ~~is~~ are as follows:

Year 1: gain-sharing only, ~~in excess of~~ when the performance threshold is met (2% savings), shared equally between the state and the demonstration provider.

Year 2: the provider must accept some risk for losses (actual cost above target TCOC), in addition to the potential for shared gains. There is no minimum amount loss-sharing threshold that the provider must accept, but the ratio of gain-sharing to loss-sharing thresholds must be two to one. All gains and losses are shared evenly with the state.

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Year 3: the provider must accept some risk for losses in addition to the potential for shared gains. There is no minimum ~~amount~~ loss-sharing threshold that the provider must accept, but the ratio of gain-sharing to loss-sharing thresholds must be ~~must be~~ symmetrical. Gains and losses are shared between the demonstration provider and the state at negotiated proportions and may not be shared evenly.

Year 4 and thereafter: the provider must accept some risk for losses, in addition to the potential for shared gains. There is no minimum loss-sharing threshold that the provider must accept, but the ratio of gain-sharing to loss-sharing thresholds must be symmetrical. Gains and losses are shared between the demonstration provider and the state at negotiated proportions. If the IHP agrees to expand the type of services included in the base year, participation year and target TCOC beyond those listed under core services below, or agrees to expand the number of participants in the IHP, then the IHP's ratio of gain-sharing to loss-sharing thresholds may be asymmetrical, with all gains and losses shared evenly with the state. An asymmetrical ratio of gain-sharing to loss-sharing is a risk corridor with a larger threshold for gain than loss. The IHP's risk arrangement for new, expanded services may differ from the IHP's risk for the core services.

Quality and Patient Experience Measures. As noted above, gain-sharing payments will be affected by quality and patient experience measures. For year 1, the measure for reporting data in accordance with requirements will have a 25% effect on the shared savings payments, meaning that 25% of the dollar amount saved shall be reducible by the percentile score calculated for this measure. For year 2, the quality and patient experience measures will have a 25% effect on the shared savings payments. For year 3, the quality and patient experience measures will have a 50% effect. For all subsequent years, the effect of the quality and patient experience measures will be negotiated between the state and the demonstration provider.

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Health Care Delivery Systems (HCDS) Integrated Health Partnership (IHP) Demonstration, Payment Adjustment (continued).

~~For all three years, t~~The state will notify ~~HCDS~~IHP entities, prior to the participation year, of the minimum attainment threshold and upper threshold scores that will result in the maximum reduction or zero reduction in the shared savings payment, by publishing the methodology on the DHS website prior to January 1 of each participation year. The measures are developed by Minnesota Community Measurement, and incorporated by reference into Minnesota Rules, Parts 4654.0100 to 4654.0800. The measures are posted on the Minnesota Department of Health website, and are updated once per year. The current measures are at:

<http://www.health.state.mn.us/healthreform/measurement/adoptedrulen/index.html>.

The updates will be incorporated into this demonstration as they occur. The measures that are in effect in this rule on the first day of each participation year will be the measures that are used for that participation year. The ~~HCDS~~IHP demonstration allows for some substitution of measures as appropriate for the population and upon DHS approval. In addition, some measures that are not applicable to the population may not be used in measuring quality in this demonstration. The state will calculate an overall quality score for each ~~HCDS~~IHP by assigning points to each measure, calculating a composite quality score for each measure category (e.g. clinical, patient experience) and assigning a weight to each measure category. The percentage of total points earned is multiplied by the shared savings amount subject to quality in the applicable participation year. The thresholds for each measure will be applied consistently amongst participating ~~HCDS~~IHP entities.

Attribution methodology: populations excluded. For purposes of both the base year and the participation year TCOC and other performance measures, attribution of patients occurs at the beginning and the end of the year using retrospective claims data. Participants will be attributed to one ~~HCDS~~IHP provider at a time. Attribution will be done using a hierarchical process as follows:

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Health Care Delivery Systems (HCDS) Integrated Health Partnership (IHP) Demonstration, Payment Adjustment (continued).

1. Participants actively participating in care coordination through a certified health care home (see item 5a of Attachments 3.1-A and 3.1-B), a behavioral health home as described in Attachment 3.1-H, or other mechanism that provides a comprehensive system of care coordination for Medicaid beneficiaries, as determined by the state.
2. Participants for whom a plurality of their evaluation and management visits/encounters are with a primary care physician participating in the ~~HCDS~~IHP demonstration;
3. ~~For the integrated models only, p~~Participants for whom a plurality of their evaluation and management visits / encounters are with a demonstration-participating non-primary care physician;

The state may modify the process identified above to ensure that participants are appropriately attributed to the IHP where most of the participant's care and/or care coordination occurs.

Participants will be attributed to the ~~HCDS~~IHP demonstration provider whether enrolled in managed care or fee-for-service. Attributed participants will be treated as a common risk pool for purpose of the total cost of care calculation and the payment model, except persons with private health coverage will not be included in the payment model, as described below. The amount of payment made to the demonstration provider for its fee-for-service patients will be the pro-rated share of the risk/gain payment described above.

The following populations are excluded from participation in the ~~HCDS~~IHP demonstration and therefore are not included in the attribution process:

1. ~~People eligible for medical assistance due to blindness or disability;~~

29. Integrated Care Models (FFS Primary Care Case Management)

Health Care Delivery Systems (HCDS) Integrated Health Partnership (IHP) Demonstration, Payment Adjustment (continued).

1. People dually eligible for Medicare and Medical Assistance for whom payment data is incomplete due to third party liability, including those with cost effective employer sponsored private health plan coverage, and those with private HMO coverage;
2. Qualified Medicare Beneficiaries who are not otherwise receiving medical assistance services;
3. Non-citizens receiving only emergency Medical Assistance;
4. Persons eligible for Medical Assistance on a spend-down basis;
5. Persons enrolled in the specialty Medical Assistance managed care product entitled the Minnesota Senior Care Plus program.

Participants for whom payment data is incomplete due to third party liability, including those with cost-effective employer-sponsored private health plan coverage and those with private HMO coverage, will be attributed to an IHP demonstration provider, but are excluded from the payment model.

Core Services. Services included in the base year, participation year and target TCOC are:

Physician services; nurse midwife; nurse practitioner; Child & Teen Check-up (EPSDT); public health nurse; rural health clinic; federally qualified health center; laboratory; radiology; chiropractic; pharmacy; vision; podiatry; physical therapy; speech therapy; occupational therapy; audiology; mental health; chemical dependency; outpatient hospital; ambulatory surgical center; inpatient hospital; anesthesia; hospice; home health (excluding personal care assistant services); and private duty nursing.

Monitoring and Reporting. The Department will monitor HCDS/IHP entities in Year One and will report to CMS, no later than 45 days after the end of the second and fourth quarters of the first demonstration year, regarding the targeted reviews of claims data, including HEDIS measures, for the purpose of ensuring

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that appropriate care is being delivered, and ensuring that potential problems are identified early. These reports will also include status updates regarding the progress of care delivery transformation, as discovered via various monitoring efforts including: participation in HCDSIHP learning collaboratives; data gathered as part of the state enforcement of health care home requirements; and tracking the progress of HCDSIHP entities' analysis of utilization and ACG output data from the state as well as their own clinical data; and updates on the progress of expansion and formation of relationships and coordination with community partners.