



**Minnesota Department of Human Services (DHS)
Health Care Administration (HCA)
Continuing Care Administration (CCA)**

**Request for Public Input
On The Identification of Best Practices for
Development of Integrated Care System Partnerships (ICSPs)
Between MCOs and Providers to Improve Care Delivery
For People with Dual Eligibility for Medicare and Medicaid**

BACKGROUND

This document is a request for public input, comment and assistance in identification of best practices to be considered in efforts to develop innovative health care delivery systems under managed care programs serving seniors (age 65 and older) and people with disabilities (age 18-64) eligible for Medicare and Medicaid (called dual eligibles) including Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+) and Special Needs BasicCare (SNBC).

Minnesota Statutes § 256B.021, subdivision 4(i) provides authority to the Commissioner of Human Service to develop Medical Assistance Reform proposals and waivers including those designed to improve integration of Medicare and Medicaid (called Medical Assistance in Minnesota), to reduce fragmentation in the health care delivery system to improve care for people eligible for both Medicare and Medicaid, and to align fiscal incentives between primary, acute, and long-term care.

Responsibility for payment and care delivery for people with dual eligibility for Medicare and Medicaid is shared between the States and the federal government and often results in fragmented care. States have no authority over Medicare services or payments, but care delivered under Medicare has an impact on services provided under Medicaid, particularly on long-term care services. Providers may be caught between conflicting financing and delivery incentives within the two programs. Tracking of total costs of care for an individual is complicated by these conflicting incentives and unaligned payment mechanisms. For example, some services may be partially covered by both payers requiring providers to bill twice to obtain full payments. Without a role in Medicare, States have limited ability to address these Medicare issues. However, the Center for Medicare & Medicaid Services (CMS) is sponsoring new demonstration opportunities for States to improve coordination of Medicare and Medicaid services under the Affordable Care Act (ACA) through its new Medicare-Medicaid Coordination Office (MMCO). These new demonstration opportunities build upon Minnesota's long experience in developing and managing integrated Medicare and Medicaid programs.

As part of the response to the Medical Assistance Reform legislation, DHS submitted a proposal to CMS on April 26, 2012 under the CMS MMCO initiative "State Demonstrations to Integrate Care for Dual Eligible Individuals". Minnesota's submission, entitled "Re-designing Integrated Medicare

and Medicaid Financing and Delivery for People with Dual Eligibility in Minnesota” proposes to re-design existing managed care programs for dual eligibles to promote aligned incentives for accountability for the total cost of care across both payers including provider based payment reform and care delivery innovations in order to align with larger state reform initiatives and to continue to focus on person-centered individualized care coordination to achieve a seamless beneficiary experience. See Minnesota’s [Demonstration to Integrate Care for Dual Eligibles](http://www.dhs.state.mn.us/dualdemo) website: <http://www.dhs.state.mn.us/dualdemo>.

The demonstration is expected to:

- 1) Provide a role for the State in oversight of integrated Medicare and Medicaid contracting arrangements for seniors enrolled in Minnesota State Health Options (MSHO) under the current Medicare Advantage Special Needs Plans (SNP) platform in order to improve the coordination of Medicare and Medicaid services, achieve a more seamless experience for dually eligible beneficiaries and assure alignment between Medicare and Medicaid policy and operations.
- 2) Assist the State in meeting its goals for aligning programs for dual eligibles with other State provider payment and delivery reforms including promotion and development of health care home based health care delivery systems called Integrated Care System Partnerships (ICSPs) between Managed Care Organizations and Special Needs Plans (MCO/SNPs) and primary, acute, long term care and/or behavioral health providers that are designed to improve overall system performance and care outcomes for dually eligible beneficiaries. The ICSPs will build on and expand innovative contracting arrangements developed under the special needs managed care programs.
- 3) Provide access to Medicare data in order to create and maintain an integrated Medicare and Medicaid dual databases across both FFS and managed care programs that will assist in consistent measurement of the impact and result of various initiatives on dual eligibles. This database is essential to account for differences in populations served by various funders and providers so that those serving dual eligibles are treated equitably under new measurement and payment models.

Following the demonstration proposal submission to CMS, DHS has continued to negotiate terms and conditions of the demonstration with CMS, and to meet with Stakeholders to keep them informed of the process. While the Memorandum of Understanding with CMS has not been finalized, the State is moving ahead with its redesign efforts including efforts to encourage further development of Integrated Care System Partnerships between MCOs and providers. DHS has amended the 2013 MCO contracts for MSHO, MSC+ and SNBC to include provisions related to the ICSPs. Attachment 1 is a chart that illustrates ICSP Model arrangements that may be included under this redesign.

PURPOSE OF REQUEST FOR PUBLIC INPUT (RFPI)

This RFPI invites interested stakeholders to provide input to the ICSP development process and requests assistance in identification of best practices to further inform the State and its MCO contractors on several aspects of the ICSP arrangements as outlined below. Responses will not result in contractual relationships with the State or SNP/MCOs. However, responses will be shared and discussed with MCOs.

BEST PRACTICES POLICY SYMPOSIUM

Respondents are responsible for any costs associated with the preparation and submission of their responses. All responses to this RFPI will be public, according to Minnesota Statutes 13.03 unless otherwise defined by Minnesota Statutes 13.37 as "Trade Secrets". If the Responder submits information that it believes to be trade secret/confidential materials, and the Responder does not want such data used or disclosed for any purpose other than the evaluation of this response, the Responder must clearly mark every page of trade secret materials in its response at the time the response is submitted with the words "Trade Secret" or "Confidential".

In conjunction with this RFPI, DHS will sponsor a joint Health Care Administration (HCA) and Continuing Care Administration (CCA) **Best Practices Policy Symposium:**

January 28, 2013

12:30-5:00 PM

Elmer L Andersen Building
540 Cedar Street, St. Paul MN 55155
Rooms 2370-2380

The Best Practices Symposium will be open to the public, however **all attendees must pre-register** due to limitations on space. People interested in registering to attend must send an email by 4:00 p.m. Thursday, January 24, 2013, to dual.demo@state.mn.us with their name and contact information. You will be notified if your registration is declined because the Policy Symposium is filled.

The purpose of the Policy Symposium will be to provide additional information to Stakeholders and interested parties about the ICSPs, to answer questions about the ICSP initiative, to present examples of ICSP development already underway and to gather comments and additional ideas for best practices to develop additional ICSP arrangements. A Notice of Public Meeting was published in the January 7, 2013 *State Register*.

PROCEDURES AND INSTRUCTIONS FOR WRITTEN PUBLIC INPUT

Comments submitted in response to this Request for Public Input must be received at DHS **no later than 4:00 p.m. CST on Friday, February 22, 2013.**

Please email your responses, preferably in PDF format, to dual.demo@state.mn.us. Include a name, title, address, telephone number and email address for a contact person in the event there are questions regarding your submission.

DHS does not intend to publish responses to these comments. Comments will be posted on the DHS [website for the Dual Eligible Demonstration](http://www.dhs.state.mn.us/dualdemo) at www.dhs.state.mn.us/dualdemo and will be shared with MCO/SNPs and used by DHS staff in ICSP development and review activities.

Email any questions about this RFPI to dual.demo@state.mn.us.

INTEGRATED CARE SYSTEM PARTNERSHIPS (ICSPs): DESCRIPTION AND PROCESS

The 2013 contract language for MSHO/MS C+, defines ICSPs as follows:

Integrated Care System Partnership (ICSP) means relationships between MCOs and providers including long term care providers, and/or Care Systems, which are designed to coordinate and/or integrate Medicare and Medicaid primary, acute, long term care and/or mental health services in order to assist Enrollees to remain in their homes or choice of community settings, and to improve health outcomes in all settings, under contracting arrangements that include gain and/or risk sharing, performance-based payments, or other payment reforms tied to financial performance and STATE-approved quality metrics.

For the 2013 SNBC contracts, ICSPs are defined as:

Integrated Care System Partnerships means relationships between MCOs and providers including primary care providers (which may include health care homes or health homes) and behavioral health providers, which are designed to promote the integration, co-location or improve the coordination of physical and behavioral and/or chemical health, under contracting arrangements that include gain and/or risk sharing, performance-based payments or other payment reforms tied to financial performance and STATE-approved quality metrics.

Further contract requirements for ICSPs are provided in Attachments 2 and 3. SNBC contract requirements for health care delivery systems (HCDS) are provided in Attachment 4.

Each MCO participating in MSHO/MS C+ is expected to develop and maintain two or more ICSP coordination of care arrangements with primary, acute or long term care providers, at least one of which must include performance based payments with long term care providers.

MCOs participating in SNBC should have at least one ICSP arrangement to promote physical and behavioral health integration.

MCOs are required to submit descriptions of proposed ICSPs to the State on or before July 1, 2013, and must have sub-contracts for ICSPs by October 1, 2013 or within 6 months of being provided with quality and performance measures by the State. Contracts must be effective no later than January 1, 2014. Contracts must include performance metrics linked to payments based on appropriateness for the scope of services included in the ICSP contracts, the target population served, geographic utilization factors, data availability and other factors as appropriate. Existing provider contracting arrangements may qualify as ICSPs but descriptions and performance metrics must be submitted. Providers may participate in more than one ICSP and may contract with more than one MCO/SNP.

MCO/SNPs are not required to make network additions to establish an ICSP. Financial arrangements may range from pay for performance and sharing in performance incentive pools to sub-capitation with appropriate risk and/or gain sharing. (See Attachments 2 and 3.) ICSPs are encouraged to include Health Care Home (HCH) certified providers. MCOs must include HCH providers in their networks but may utilize alternative payment arrangements under the ICSP arrangements.

A clinical stakeholders workgroup has been convened to develop a range of measures appropriate for a variety of financial arrangements. Comments on the range of measures will be solicited.

Because SNP contracts remain with Medicare under the dual demonstration, ICSP contracting relationships will be negotiated between SNP/MCOs and providers. However, the State will review the proposals and will receive reports to assure that performance metrics and costs of care are identified and tracked.

BEST PRACTICE FOCUS AREAS

In order to guide implementation of ICSPs, the State is interested in soliciting information, comments and ideas for best practices on several specific topics. These topics are outlined below. Respondents are not limited to these areas, but assistance in these areas would be appreciated.

A. Best Practice Opportunities to Increase Value

1. How can primary, acute, long-term care and/or behavioral health providers and MCO/SNPs work together to improve care coordination, care outcomes, and best manage costs of care for dually eligible populations?
2. What are effective policies, strategies, mechanisms and protections for consumers that need to be in place?
3. What best practices are being used (or should be) that DHS could promote?
4. What best practices are appropriate for different cycles of care such as new enrollees, transitions between settings, end of life, etc.?
5. How does the size of the population to be served impact appropriate ICSP payment models and performance measurement and how can this be taken into consideration in the design of these arrangements?

B. What specific model of care designs, strategies or elements should be incorporated into ICSPs to address needs specific to the following?

1. Strategies for serving seniors. How would strategies consider or be modified to address differences in needs for members in the following settings? What strategies are needed to involve home and community based or residential long-term care providers in these settings? How should strategies address care transitions and end of life care?
 - Community settings
 - Residential settings
 - Rural areas
 - Urban areas
2. Strategies for serving people with disabilities. How would strategies consider or be modified to address differences in needs for members in the following settings? What strategies are needed to involve home and community based or residential providers in these settings? How should these strategies address care transitions and end of life planning?
 - Community settings
 - Residential settings
 - Rural areas
 - Urban areas
3. Strategies for increasing Behavioral/Physical Health Integration especially directed at SNBC members. How would strategies address prevention, screening, treatment and coordination and

follow-up between behavioral health and primary, specialty care and community support providers? How would strategies consider or be modified to address differences in needs for members in the following settings?

- Community settings
- Residential settings
- Rural areas
- Urban areas

C. Communication Strategies Across Provider and Service Types and Settings

1. Communications Strategies for Virtual Care System Model 1, especially in rural areas. (See Attachment 1)
 - What is needed to encourage or promote efficient day-to-day communications between unrelated MCO/SNPs, care coordinators, clinics or HCH, and long-term care or behavioral health providers?
 - How can we improve coordination of care and communications during transitions from hospital or SNF/NF to home and home based services, or from hospitals or SNF/NFs to Customized Living settings?
 - How can we use and develop efficient Electronic Health Record (EHR) or Health Information Technology (HIT) mechanisms to support and simplify communications?
 - What kind of post-discharge communication strategies should be standard for all transitions (post hospital, post SNF discharge, etc.)?
 - Other?
2. Communication Strategies for More Aligned Systems Model 2. (See Attachment 1).
 - What is needed to improve or promote more efficient day-to-day communications between MCO/SNPs, care coordinators, clinics or HCH, and long-term care or behavioral health providers?
 - How can we improve coordination of care and communications during transitions from hospital or SNF/NF to home and home based services, or from hospitals or SNF/NFs to Customized Living settings?
 - What kind of post-discharge communication strategies should be standard for all transitions (post hospital, post SNF discharge, etc.)?
 - How can you improve or modify EHR or HIT mechanisms to support and simplify communications?
 - Other?

D. Payment Models (See Attachments 2 and 3)

1. Are there specific payment models that should be considered for greater alignment of public and private payment systems, or for better alignment between Medicare and Medicaid?
2. Are there proposed payment models proposed that should be avoided? What levels of risk and gain sharing are providers interested in considering?
3. How does the size of the population to be served impact the ability to tie performance to payment? Are there some payment models that would work best for small numbers of enrollees or specific care model approaches?
4. Other?

E. Performance Measures

Identification of performance measures for the ICSPs is a complex task. While SNP/MCOs are subject to two complex and unaligned measurement systems by CMS and States, few of those measures are specific to dually eligible populations. In Minnesota, additional provider level measures are required by CMS, the Minnesota Department of Health and Minnesota Community Measurement. However, few performance measures have been tied to payment for these populations.

Attachment 5 includes a preliminary draft list of performance measures for potential use in ICSP provider payment that is being considered by the clinical workgroup. The list includes a range of measures, including specific HEDIS measures already routinely collected, new proposed measures that may require development with NCQA or CMS, Structure and Process measures, and best practice performance based protocols that would be fleshed out as part of the SNP/MCO and provider contracting process. Not all of these measures will be appropriate for all providers and services.

The list of performance measures that SNP/MCOs and the State could tie to ICSP payments is not comprehensive of all measures that would be applied to special needs managed care programs. Instead, it is a relatively short list that focuses on key areas where ICSP collaboration and performance metrics tied to payments may be most effective and where measurement is aligned with existing requirements or where additional attention is needed.

ICSPs and MCOs will choose a minimum of two measures from the final list that are appropriate to the scope of services covered in the ICSP arrangement, the target population, the geographic area, data availability, payment design and other relevant factors.

We are also seeking comments from providers on the utilization and implementation of this list of measures including the applicability of the measure set and data and information that is needed to track performance on these measures. For example:

What kinds of feedback mechanisms between SNP/MCOs and providers are important to implementing and achieving improvement on such measures?

What kind of data and analytics are needed?

What is the best way to capture what may be several disparate data sources (such as claims, care plans and care plan audits, assessment information, evidence of processes)?

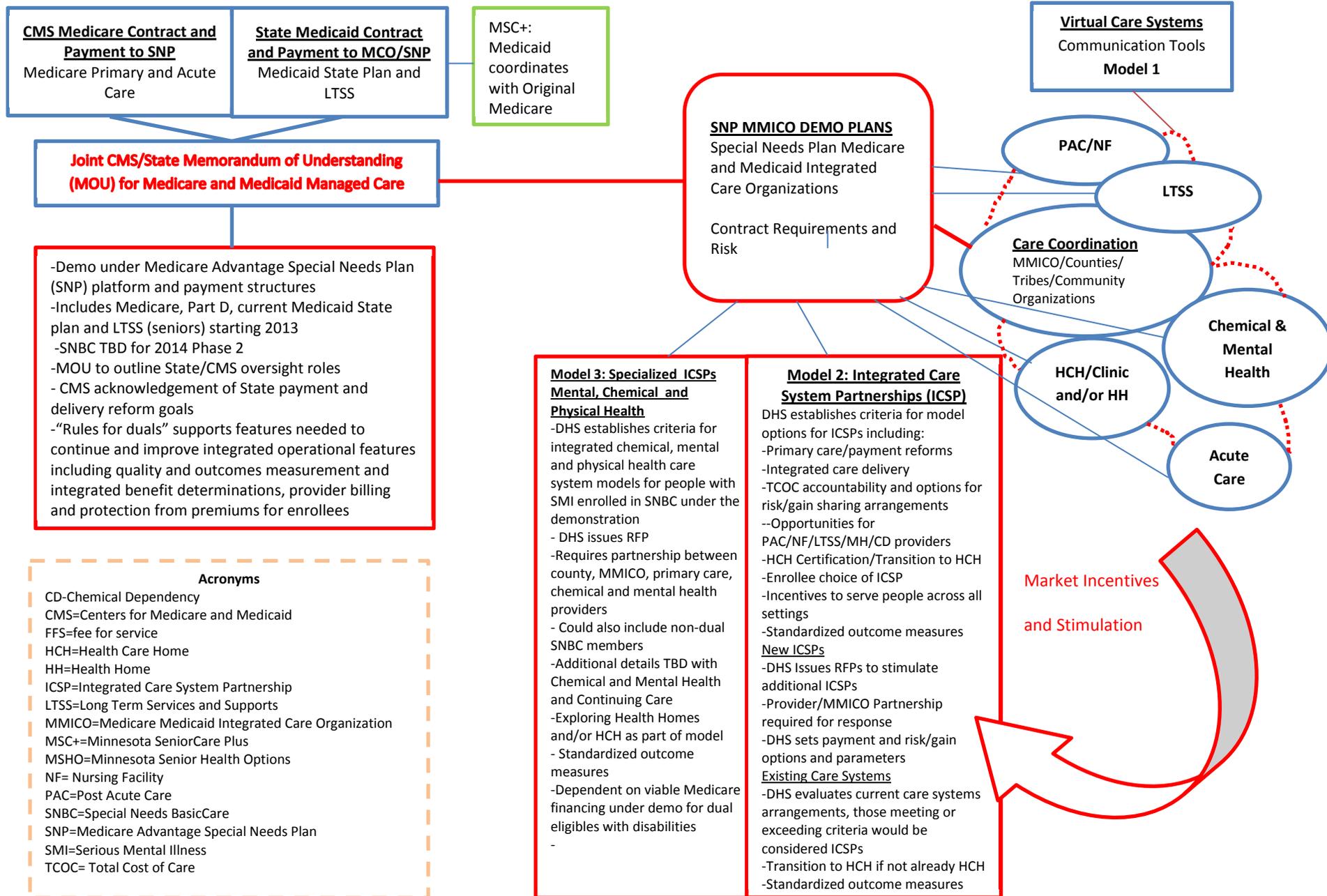
What sources of data do providers typically use in their own analyses of performance?

Please note that this list of proposed measures in Attachment 5 is still in development and will be further reviewed by stakeholder groups. However, DHS is also requesting public comments on this preliminary list through this RFPI.

ATTACHMENT 1

Revised Dual Demo Original Design Model: Special Needs Plan/Medicare Medicaid Integrated Care Organizations

8/13/2012



Attachment 2

2013 Minnesota Senior Health Options (MSHO) / Minnesota Senior Care Plus (MSC+) Contract Requirements for ICSPs

§2.68. Integrated Care System Partnership (ICSP) means relationships between MCOs and providers including long term care providers, and/or Care Systems, which are designed to coordinate and/or integrate Medicare and Medicaid primary, acute, long term care and/or mental health services in order to assist Enrollees to remain in their homes or choice of community settings, and to improve health outcomes in all settings, under contracting arrangements that include gain and/or risk sharing, performance-based payments, or other payment reforms tied to financial performance and STATE-approved quality metrics.

§3.9.1. (F) Dual Demonstration. The MCO agrees to participate in the CMS Dual Eligible Demonstration as a Fully Integrated Medicare Advantage Dual Eligible Special Needs Plan (FIDE SNP, as defined in 42 CFR § 422.2 and further defined by CMS in the 2014 SNP Application) for MSHO enrollees as outlined in the Memorandum of Understanding between CMS and the STATE. The demonstration's goals will be to improve the integration of Medicare and Medicaid through increased participation of integrated provider health care delivery systems, improve enrollee health outcomes as measured through risk adjusted quality metrics appropriate to the enrolled population, and to align administrative systems to improve efficiency and beneficiary experience.

(1) The STATE will include the MCO in regular calls between CMS and the STATE to work out details of any provisions of the demonstration affecting the MCO's Medicare SNP and Medicaid operations, provider networks, provider contracting and policies.

(2) The STATE will establish a work group for consultation with the MCOs on planning and implementation for the demonstration including development of ICSP quality metrics, and development of any Request for Information (RFI) and proposal and reporting templates for ICSP models. The initial outline of the model was published as the Minnesota Demonstration Proposal dated April 26, 2012 (see <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/minnesotaproposal.pdf>).

(G) Integrated Care System Partnerships. The MCO shall develop and maintain coordination of care and other arrangements with primary, acute and long- term care providers as outlined in Appendix V, Integrated Care System Partnerships.

3.1.2 (M) Health Care Home. The MCO Provider network must include Providers that include clinics, personal clinicians, or local trade area clinicians designated as Health Care Homes that meet the certification criteria listed in Minnesota Rules, parts 4764.0010 to 4764.0070. In addition, the MCO must:

(1) Track Enrollees with complex or chronic health conditions who are Enrolled in a certified Health Care Home; and

(2) Attribute enrollment in the Health Care Home to the clinic site, and the Enrollee specific care provided, pursuant to Minnesota Rules, Part 4764.0040.

6.1.16 Health Care Home. Enrollees with complex or chronic health conditions may access services through a Health Care Home that meets the certification criteria listed in Minnesota Rules, parts 4764.0010 through 4764.0070.

3.7.2 Other Reporting Requirements

(L) Health Care Home and Alternative Models; Integrated Care System Partnerships.

(1) Reporting for Health Care Homes. The MCO shall require that the Health Care Home provider report data to the Minnesota Department of Health as required in Minnesota Statutes, § 256B.0751, as a condition of contracting between the MCO and Health Care Home. For MSHO and MSC+, the report need not include data on pediatric care coordination.

(2) Reporting Requirement for Health Care Home, Alternative Payment Arrangements, and ICSPs. The MCO shall annually provide a description of each comprehensive payment arrangement or ICSP payment arrangement, and its proposed outcome or performance measures, that the MCO will use as an alternative to Health Care Homes payment of the standard Health Care Home coordination fee.

The descriptive report is due July 1 of the Contract Year; the summary of the performance measures and outcomes for the previous Contract Year is due at the end of the first quarter of the Contract Year. The description shall include the following:

- (a) Identify each sub-contractor for whom the MCO is paying a comprehensive payment arrangement in lieu of the standard Health Care Home coordination fee, including ICSP, and include:
- (b) Changes in the ICSP service delivery and care coordination model, if any, or indicate that no changes were made;
- (c) Service area, target population and number of Enrollees served under each arrangement;
- (d) Identify whether the Provider is certified as a Health Care Home or health home (describe if some portions of the Provider entity are and other parts are not);
- (e) Description of payment arrangements, including for ICSPs identification of which payment type and model options described in Appendix V are being used;
- (f) Describe the process for assigning or attributing Enrollees, and tracking costs of care or total costs of care as needed to implement the payment model chosen;
- (g) Describe the services included in the total cost of care arrangement (for example, whether long term care, Medicare and Medicaid costs and chemical, mental and/or behavioral health services are included, and whether any services are carved out of the arrangement);
- (h) Describe the MCO's process for overseeing the entities and evaluating their performance;
- (i) Describe quality indicators used to measure performance;
- (j) Describe the benchmarks used to determine whether the Provider entity is within the costs of care expectations.

Seniors Appendix V: Integrated Care System Partnerships

(A) Contracting Process.

(1) By October 1, 2013 or within six (6) months of the date quality and performance measures are provided by the STATE (whichever is later), the MCO will enter into subcontracts or revise current contracts with primary, acute and/or long term care providers to implement two or more Integrated Care System Partnerships (ICSPs). The ICSP must provide services designed to coordinate and/or integrate Medicare and Medicaid primary, acute and long-term care, and/or mental health services in accordance with the Contract. New or modified ICSP contracts must become effective no later than January 1, 2014.

(2) At least one ICSP arrangement must include performance-based payments with long-term care providers.

- (3) Notwithstanding section 5.3 of this Contract, the MCO's inability to establish ICSP arrangements before the Termination Date of this Contract shall not be construed as a breach if the MCO can demonstrate good faith attempts to do so.
- (4) The STATE will convene a clinical stakeholders workgroup to develop a list of quality measures appropriate for the populations to be tied to financial performance and care outcomes with the ICSPs. The STATE will make the performance measures list available by March 15, 2013. The MCO, as part of an ICSP, will choose measures from this list to link performance metrics to payments based on appropriateness for the scope of services included in its ICSP contracts, the target population served and geographic utilization factors, ability to gather data to measure performance, and other factors as appropriate.
- (5) The MCO and its existing care systems may qualify as ICSPs, provided the MCO meets these criteria or will make necessary changes to meet them within six (6) months of being provided the performance measures by the STATE.
- (6) The MCO must put into place two or more ICSPs, at least one of which must include long term care services. Providers may participate in more than one ICSP and may contract with more than one MCO. MCOs are not required to make network additions to establish an ICSP.
- (7) The MCO must conduct Care Plan audits and ICSP audits in accordance with requirements in Articles 7 and 9 of the Contract.
- (8) All services provided by the ICSP in coordination with the MCO, including individualized coordination of care, mental health targeted case management and other services, must be delivered in accordance with current applicable Contract requirements.

(B) ICSP Proposals.

- (1) On or before July 1, 2013 the MCO will submit a description of its proposed ICSPs to the STATE in a format to be determined by the STATE. The STATE will review each description and determine whether the ICSP criteria have been met prior to proposal acceptance. The description of the proposed ICSP(s) shall include:
 - a) The service delivery and care coordination model;
 - b) Target population;
 - c) Current or projected enrollment numbers;
 - d) Service area, which may be fewer counties than the MCO Service Area as defined in the Contract;
 - e) Identification of which of the providers included in the ICSP arrangements are certified as a Health Care Home or health home (describe if some portions of the Provider entity are and other parts are not);
 - f) The specified model options and payment type to be used (from the table in section 0 below; MCOs may combine model options and payment types within a single ICSP, for example 1.1-A and 1.2-B , in order to meet the ICSP criteria);
 - g) The process for assigning or attributing Enrollees;
 - h) Method that will be used for tracking cost of care or total costs of care as needed to implement the payment model chosen,;
 - i) The MCO's process for overseeing the ICSP and evaluating performance;
 - j) Choice of two or more performance measures (from the list in section (A)(4) above) appropriate to the population and appropriate to the performance payment design; and
 - k) The benchmarks or standards used to determine whether the Provider entity is effectively managing performance and costs of care.

(C) ICSP Payment Types.

- (1) The ICSP subcontracts must establish payment arrangements tied to health outcomes and costs of care. Performance results must be reported annually to the STATE as outlined in the Contract under section 3.7.2 (L) (2). The MCO will provide data necessary to verify reported results upon request as required under that section.
- (2) Care Coordination, quality metrics, financial performance measures, STATE review and acceptance, and reporting requirements are required for each payment type.
- (3) All models must support consumer choice of community and institutional settings and be designed to incent improved health outcomes.
- (4) The following table outlines ICSP model options and payment types:

MSHO/MSC+ ICSP Payment Types					
	Payment Types	Type A	Type B	Type C	Type D
<i>Model Options</i>		Performance rewards: performance pool or pay for performance	Primary Care Coordination of Care Payment; or partial sub-capitation for primary care and Care Coordination by Primary Care Provider or other Care Coordinator within ICSP	Subcapitation or Virtual Capitation for Total Cost of Care across multiple defined services including primary, acute and long term care	Alternative Proposals
<i>Model 1.1</i>	MCO contracts with LTC providers and/or Primary Care Providers.	OPTION	NA	NA	NA
<i>Model 1.2</i>	MCO contracts with Primary Care Providers or Care Systems to include payment for Care Coordination, as an alternative to Health Care Home care coordination fees.	NA	OPTION	NA	NA
<i>Model 2</i>	MCO contracts with provider Care System or a collaborative (primary care providers affiliated with long term care providers) with delegated management of care to the provider Care System or collaborative, using risk/gain/performance payment models across services.	NA	NA	OPTION	NA
<i>Model 3</i>	MCO contracts with providers under payment arrangements that can provide financial and/or performance incentives for integration / coordination of Chemical and/or Mental Health services with acute / primary care services. May include certified HCH or Health Homes.	OPTION	OPTION	OPTION	NA
<i>Model 4</i>	Alternative defined by proposal	NA	NA	NA	OPTION

Note: this table was updated 1/28/2013.

Attachment 3

2013 Special Needs BasicCare (SNBC) Model Contract Requirements for ICSPs

§2.72 Integrated Care System Partnership (ICSP) means relationships between MCOs and providers including primary care providers (which may include health care homes or health homes) and behavioral health providers, which are designed to promote the integration, co-location or improve the coordination of physical and behavioral and/or chemical health, under contracting arrangements that include gain and/or risk sharing, performance-based payments or other payment reforms tied to financial performance and STATE-approved quality metrics.

§3.7 Integrated Care System Partnerships. The MCO shall develop and maintain coordination of care and other arrangements with providers as outlined in Appendix IV, Integrated Care System Partnerships.

§3.1.2 (L) Health Care Home. The MCO Provider network must include clinics, personal clinicians, or local trade area clinicians designated as Health Care Homes that are certified under Minnesota Rules, parts 4764.0010 to 4764.0070. In addition, the MCO must:

- (1) Track Enrollees with complex or chronic health conditions who are enrolled in a certified Health Care Home; and
- (2) Attribute enrollment in the Health Care Home to the clinic site, and the Enrollee specific care provided, pursuant to Minnesota Rules, Part 4764.0040.

§3.4.2 Other Reporting Requirements.

(L) Health Care Home and Alternative Models; Integrated Care System Partnerships.

(1) Reporting for Health Care Homes. The MCO shall require that the Health Care Home provider report data to the Minnesota Department of Health as required in Minnesota Statutes, § 256B.0751 as a condition of contracting between the MCO and Health Care Home.

(2) As applicable, the STATE and MCO will work collaboratively on how to implement the collection of data on pediatric care coordination to be included in the report identified in section 3.4.2(L)(3).

(3) Reporting Requirement for Health Care Home, Alternative Payment Arrangements, and ICSPs. The MCO shall annually provide a description of each comprehensive payment arrangement or ICSP payment arrangement, and its proposed outcome or performance measures that the MCO will use as an alternative to Health Care Homes payment of the standard Health Care Home coordination fee. The descriptive report is due July 1 of the Contract Year; the summary of the performance measures and outcomes for the previous Contract Year is due at the end of the first quarter of the Contract Year. The description shall include the following:

- (a) Identify each sub-contractor for whom the MCO is paying a comprehensive payment arrangement in lieu of the standard Health Care Home coordination fee, including ICSP, and include:
 - (b) Changes in the ICSP service delivery and care coordination model, if any, or indicate that no changes were made;
 - (c) Service area, target population and number of Enrollees served under each arrangement;

- (d) Identify whether the Provider is certified as a Health Care Home or health home (describe if some portions of the Provider entity are and other parts are not);
- (e) Description of payment arrangements, including for ICSPs identification of which payment type and model options described in Appendix IV are being used;
- (f) Describe the process for assigning or attributing Enrollees, and tracking costs of care or total costs of care as needed to implement the payment model chosen;
- (g) Describe the services included in the total cost of care arrangement (for example, whether long term care, Medicare and Medicaid costs and chemical, mental and/or behavioral health services are included, and whether any services are carved out of the arrangement);
- (h) Describe the MCO's process for overseeing the entities and evaluating their performance;
- (i) Describe quality indicators used to measure performance;
- (j) Describe the benchmarks used to determine whether the Provider entity is within the costs of care expectations.

§6.1.16 Health Care Home. Enrollees with complex or chronic health conditions may access services through a Health Care Home that meets the certification criteria listed in Minnesota Rules, parts 4764.0010 to 4764.0070.

SNBC Appendix IV: Integrated Care System Partnerships

1.1 Contracting Process.

(A) By October 1, 2013 or within six (6) months of the date quality and performance measures are provided by the STATE (whichever is later), the MCO will enter into subcontracts or revise current contracts with primary care providers (which may include health care homes or health homes) and behavioral health providers to implement one or more Integrated Care System Partnerships (ICSPs). The ICSP must provide services designed to promote the integration, co-location or improve the coordination of physical and behavioral health, under contracting arrangements that include gain and/or risk sharing, performance based payments or other payment reforms tied to financial performance and STATE-approved quality metrics. New or modified ICSP contracts must become effective no later than January 1, 2014.

(B) Notwithstanding section 5.3 of this Contract, the MCO's inability to establish ICSP arrangements before the Termination Date of this Contract shall not be construed as a breach if the MCO can demonstrate good faith attempts to do so.

(C) The STATE will convene a clinical stakeholders workgroup to develop a list of quality measures appropriate for the populations to be tied to financial performance and care outcomes with the ICSPs. The STATE will make the performance measures list available by March 15, 2013. The MCO, as part of an ICSP, will choose measures from this list to link performance metrics to payments based on appropriateness for the scope of services included in its ICSP contracts, the target population served and geographic utilization factors, ability to gather data to measure performance, and other factors as appropriate.

(D) The MCO and its existing care systems may qualify as ICSPs, provided the MCO meets these criteria or will make necessary changes to meet them within six (6) months of being provided the performance measures by the STATE.

(E) The MCO must put into place one or more ICSPs. Providers may participate in more than one ICSP and may contract with more than one MCO. MCOs are not required to make network additions to establish an ICSP.

(F) The MCO must conduct Care Plan audits and ICSP audits in accordance with requirements in Articles 7 and 9 of the Contract.

(G) All services provided by the ICSP in coordination with the MCO, including coordination of care, mental health targeted case management and other services, must be delivered in accordance with current applicable Contract requirements.

1.2. ICSP Proposals.

(A) On or before July 1, 2013 the MCO will submit a description of its proposed ICSPs to the STATE in a format to be determined by the STATE. The STATE will review each description and determine whether the ICSP criteria have been met prior to proposal acceptance. The description of the proposed ICSP(s) shall include:

- (1) The service delivery and care coordination model;
- (2) Target population;
- (3) Current or projected enrollment numbers;
- (4) Service area, which may be fewer counties than the MCO Service Area as defined in the Contract;
- (5) Identification of which of the providers included in the ICSP arrangements are certified as a Health Care Home or health home (describe if some portions of the Provider entity are and other parts are not);
- (6) The specified model options and payment type to be used (from the table in section 0 below; MCOs may combine model options and payment types within a single ICSP, for example 1.1-A and 1.2-B, in order to meet the ICSP criteria);
- (7) The process for assigning or attributing Enrollees,
- (8) Method that will be used for tracking cost of care or total costs of care as needed to implement the payment model chosen;
- (9) The MCO's process for overseeing the ICSP and evaluating performance;
- (10) Choice of two or more performance measures (from the list in section 0 above) appropriate to the population and appropriate to the performance payment design; and
- (11) The benchmarks or standards used to determine whether the Provider entity is effectively managing performance and costs of care.

1.3 ICSP Payment Types.

(A) The ICSP subcontracts must establish payment arrangements tied to health outcomes and costs of care. Performance results must be reported annually to the STATE as outlined in the Contract under section 3.4.2 (L). The MCO will provide data necessary to verify reported results upon request as required under that section.

(B) Care Coordination, quality metrics, financial performance measures, STATE review and acceptance, and reporting requirements are required for each payment type.

(C) The following table outlines ICSP model options and payment types:

SNBC ICSP Payment Types					
	Payment Types	Type A	Type B	Type C	Type D
<i>Model Options</i>		Performance rewards: performance pool or pay for performance	Primary Care Coordination of Care Payment; or partial sub-capitation for primary care and Care Coordination by Primary Care Provider or other Care Coordinator within ICSP	Subcapitation or Virtual Capitation for Total Cost of Care across multiple defined services including primary and behavioral health care	Alternative Proposals
<i>Model 1.1</i>	MCO contracts with behavioral health providers and/ or Primary Care Providers.	OPTION	NA	NA	NA
<i>Model 1.2</i>	MCO contracts with Primary Care Providers or Care Systems to include payment for Care Coordination, as an alternative to Health Care Home or health home care coordination fees.	NA	OPTION	NA	NA
<i>Model 2</i>	MCO contracts with provider Care System or a collaborative (primary care providers affiliated with behavioral health providers) with delegated management of care to the provider Care System or a collaborative, using risk/gain/ performance payment models across services.	NA	NA	OPTION	NA
<i>Model 3</i>	MCO contracts with providers under payment arrangements that can provide financial and / or performance incentives for integration / coordination of behavioral health services with primary care services. May include certified HCH or Health Homes.	OPTION	OPTION	OPTION	NA
<i>Model 4</i>	Alternative defined by proposal	NA	NA	NA	OPTION

Attachment 4

2013 Special Needs BasicCare (SNBC) Model Contract Requirements for Health Care Delivery Systems (HCDS)

2.57 HCDS Entity means a health care delivery demonstration entity that has a contract with the STATE to develop alternative and innovative health care delivery methods, pursuant to Minnesota Statutes, § 256B.0755.

4.17 Health Care Delivery Systems (HCDS) Demonstration.

(A) The MCO and the STATE will participate in a shared savings and losses payment methodology through the Health Care Delivery Systems (HCDS) Demonstration with the STATE's contracted HCDS Entities in the MCO's provider network, in accordance with Minnesota Statutes, § 256B.0755.

(B) The STATE will provide the MCO with the following information:

(1) A list of the STATE's contracted HCDS Entities no later than January 1, 2013.

(2) Data identifying the MCO's Enrollees that are attributed to a particular HCDS Entity at that time. Attribution is determined by the number of visits with a Primary Care or Specialty Provider for evaluation and maintenance (E&M) codes or certified Health Care Home for care coordination codes based on twelve (12) months of FFS and encounter claims history. The attribution data will include the Enrollee's PMI number, Enrollee name, and attribution by HCDS Entity.

(a) Attribution data identifying the attributed population will be provided to the MCO quarterly, and

(b) After the calculation of

i) the base period in April 2013 for dates of service from January 1, 2012 through December 31, 2012, and

ii) after the calculation of the interim payment in May of 2014 and the final payment in May of 2015 for the performance period based on dates of service from January 1, 2013 through December 31, 2013. Additionally, the STATE will provide the MCO with a quarterly report of the attribution list of the MCO's enrollees, no later than the 15th (fifteenth) day of the month following the end of the quarter. In April of 2013, the MCO will receive the attribution data after the calculation of the base period.

(3) The STATE will provide

(a) Information on total cost of care for the MCO's attributed Enrollees to assist the MCO in developing its settlement estimates, sixty (60) days before the end of the Contract Year;

(b) An estimate of the HCDS settlement thirty (30) days after the end of the Contract Year, and

(c) Subsequently, the STATE will calculate an interim payment and a final payment for the performance periods. The base period total cost of care (TCOC) adjusted for trend and change in risk score from the base period to the performance period, will determine the interim and final adjusted targets respectively. The respective targets will then be compared to the respective interim and final HCDS actual observed performance period TCOC to calculate the interim and final payments and ensure that the HCDS has met a two percent (2%) minimum performance threshold.

(4) The STATE will notify the MCO in writing of the shared savings for the interim and final payments to be paid to the HCDS Entity or Entities. The MCO shall issue payment to the

HCDS Entity as identified by the STATE within thirty (30) days from the date of the notification from the STATE.

(C) The MCO shall work with the STATE on the development of the allocation methodology across the MCOs for the shared savings payment to the HCDS Entities.

(D) The STATE will use encounter data and the data provided in the provider payment report as required in sections 3.4.1 and 3.4.2(V) respectively, in determining TCOC. The MCO must ensure the timeliness, accuracy and completeness of the data submitted and shall comply with any actions taken to correct identified issues regarding the data submissions.

(E) If the MCO fails to make the interim or final payments within the time period established by the STATE, the STATE will take appropriate action in accordance with sections 5.5 and 5.6 of the Contract.

Attachment 5

Preliminary Proposed Integrated Care System Partnership (ICSP) Measures January 14, 2013

1. For all ICSP Populations

- Hospital Utilization (HEDIS)
- All Cause Hospital Readmissions (HEDIS)
- Emergency Department Utilization (HEDIS)

2. Especially for MSHO Community Frail Elderly (average age 80+)

- Flu/Pneumovax vaccinations (CAHPs)
- Use of High Risk Drugs (HEDIS)
- Annual Monitoring of Patients on Persistent Medications (HEDIS)
- Medication Reconciliation Post Discharge (HEDIS)
- Care of Older Adults (HEDIS)
- S&P: Reduced Risk of Falls/Falls Screenings (TBD)
- Best Practice Incentive S&P: Care Transitions (TBD)
- **Best Practice Incentive S&P: Evidence of Functional Assessment Response by PCP (TBD)*
- **Best Practice Incentive S&P: Evidence of Ongoing PCP/Care Coordinator Communication (TBD)*
- **Best Practice Incentive S&P: Evidence of Integrated Care Plan for Community Members (TBD)*

**Potential collaboration with NCQA*

3. Especially for MSHO Members in Long Term Institutional and Residential Settings

- Use of antipsychotics for people with dementia (MDS)
- Falls with fracture(s) (MDS)
- Pressure Ulcers (MDS)
- S&P: Evidence of POLST with person specific goals for residents with 90 day+ stays
- S&P: Triage Protocol followed prior to sending to Emergency Department or inpatient admission

4. Especially for People with Disabilities Ages 18-64 in SNBC (all settings)*

- Anti-depressant Monitoring (HEDIS)
- Follow Up after Hospitalization related to Mental Illness (and Substance Abuse) (HEDIS)
- Primary Care Visits (HEDIS)
- Preventive Screenings
- Substance Abuse and Mental Health screenings
- Pressure sores
- S&P: Evidence of behavioral and physical health integration, communications and care planning (TBD)

**Other measures may be proposed after consideration by the Evaluation Subcommittee of Managed Care for People with Disabilities Stakeholders Group*