INTEGRATED CARE SYSTEM PARTNERSHIPS: FINAL REPORT AND RECOMMENDATIONS

Dedicated to working with public agencies and private purchasers to improve health care system performance.

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I. Purpose

The Minnesota Department of Human Services (DHS) contracted with Bailit Health Purchasing, LLC (Bailit Health) to evaluate the Integrated Care System Partnerships (ICSP) initiative, the state’s value-based purchasing (VBP) strategy for seniors and individuals with disabilities in Minnesota special needs programs. Payment arrangements and care delivery models that arose out of the state’s Minnesota Seniors Health Options (MSHO) program inspired the creation of the ICSP initiative.

This is the final report in a series of seven written deliverables1 that Bailit Health has prepared for the ICSP evaluation. A brief description of the other deliverables and their respective submission dates are incorporated into the report as Appendix A.

The final report describes information and insights collected throughout the duration of the evaluation, including overarching recommendations for the future of the ICSP initiative. In addition, the final report recommends next steps for improving the initiative, including:

a) opportunities for further expansion of the ICSP initiative and any related changes needed;

b) the potential for alignment of ICSPs with other related measurement and VBP initiatives in Minnesota and nationally;

c) messaging opportunities to encourage further communications between plans and providers about VBP opportunities;

d) alignment of measures within ICSP contracts with other related plan and provider requirements such as Medicare Star Ratings and state provider measurement initiatives;

e) collection methods for ICSP descriptions, results, data and information including data elements, reporting formats, and frequency of collection;

f) the potential for sharing Medicare data with plans and providers for dually eligible enrollees in non-integrated programs; and

g) communication strategies for reporting results, and how best to present information about this initiative to DHS leadership and the public.

II. Methodology

Bailit Health considered information gathered and analyzed during the course of this evaluation to prepare the final report of recommendations, including:

- an environmental scan of value-based purchasing strategies for seniors and individuals with disabilities that other states and health plans have implemented;
- interviews with MSHO/MSC+, SNBC health plans, providers and internal DHS representatives;

1 Bailit Health prepared six reports and one memo for DHS under the ICSP evaluation contract.
challenges and barriers to value-based payment models for seniors and individuals with disabilities enrolled in managed care, and
- existing ICSP projects and DHS measures and data.

III. The ICSP Initiative: Value-based Payment Model Development in MSHO, MSC+, and SNBC Programs

In 2013, DHS added a provision to its special needs program contracts (MSHO/MSC+ and SNBC) requiring that health plans implement value-based payment models with their providers, which DHS named its ICSP initiative. The ICSP initiative was inspired by partnerships between health plans and providers that previously emerged organically from the state’s MSHO program. In MSHO, health plans and providers explored new payment and delivery system models that promoted better care coordination for seniors across multiple provider types and care settings. The partnerships that arose out of the MSHO program rewarded high-performing organizations for quality improvements, health care cost management, and/or better health outcomes. A recent evaluation of the MSHO program revealed the program’s success in improving care for seniors, citing fewer hospital stays, fewer emergency department visits, more visits with primary care providers, and enrollees more likely to utilize hospice care as compared to a control group of MSC+ enrollees.

By creating the ICSP initiative, DHS sought to encourage similar partnerships in its special needs programs in an effort to improve service delivery integration, care coordination and health outcomes through payment reforms with explicit links to quality. DHS leveraged its contracting authority to direct health plans to implement value-based payment models with long-term care providers and other providers who serve seniors and individuals with disabilities.

Current value-based payment activities across the country are largely built around primary and acute care services, with little emphasis on services and service providers for seniors and individuals with disabilities. Minnesota is among a small number of states that have adopted specific value-based purchasing strategies in their programs that serve individuals with complex care needs. Other states include Arizona, Kansas, Tennessee and Texas. With long-term services and supports (LTSS) representing a large and increasing percentage of state Medicaid budgets, many states recognize the need to identify ways to incorporate value-based payment strategies into programs that serve seniors and individuals with disabilities. The table below is from Bailit Health’s Environmental Scan Report

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3 Value-based payment for health care services explicitly rewards performance relative to cost, quality, access, and/or service utilization objectives. “Payment reform” and “alternative payment models” are other terms used to describe efforts to transition from traditional fee-for-service payment of health care services, which is driven by volume, to payments that aim to improve the quality and efficiency of services rendered.
and summarizes how other states have leveraged their managed care contracts to advance payment reform for populations with complex needs.

### Arizona
- MCOs in the Arizona Long Term Care System (ALTCS) and D-SNP ALTCS plans are required to have a minimum of 15% of their total payments to providers in value-based payment arrangements.
  - The 15% threshold will increase to 35% in 2017.
  - The state withholds 1% of capitation to ALTCS plans that can be earned back for performance against five measures (see Appendix B for list of measures); however, plans that have not met the value-based payment contract requirements are not eligible to earn back any portion of the withhold.

### Kansas
- Kansas requires MCOs to increase the number of PEAK (Promoting Excellent Alternatives in Kansas Nursing Homes) facilities in their contracted networks.
  - MCOs are also accountable for increasing integration across physical, mental health and substance use disorder, long-term care, and HCBS waiver services.
  - MCOs in Kansas can earn back part or all of the 5% capitation payment that is withheld for meeting defined quality targets (see Appendix B for quality measures) for physical, behavioral health, and long-term care.

### Texas
- MCOs, including Texas “STAR+PLUS” plans for seniors and individuals with disabilities, must submit to the state proposals that encourage value-based payment arrangements with providers. Proposals must include quality incentive payments to providers.
  - A summary of the alternative payment models that were submitted by Texas plans in 2014 found that most arrangements were with primary care providers and obstetricians/gynecologists.\(^4\)
  - A review of the health plans’ 2016 value-based contracting proposals found that at least three plans were considering performance-based incentive payments for nursing facilities in the form of an additional per resident per month payment. In general, the nursing facilities would be evaluated against national (e.g., CMS MDS) and state quality measures.
  - Four percent of the capitation payment for Texas MCOs, including Texas STAR+PLUS plans for seniors and individuals with disabilities, is at risk based on performance against specified quality measures (see Appendix B for quality measures).

### IV. Impact of the ICSP Initiative

As previously reported, Bailit Health found that the ICSP initiative has been a catalyst for value-based contracting that incorporates quality into the provider payment model. We summarize the impact of the ICSP initiative below.

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• The ICSP requirement motivated some plans and providers to try new payment arrangements and may have accelerated the connection of provider payment to performance against defined measures.

• Health plans have implemented more than three times as many ICSPs with providers than what is required in their contracts with DHS. Some health plans indicated that they had implemented even more value-based payment arrangements with providers, but were not identifying them as ICSPs because of the associated reporting burden.

• The potential to earn savings or performance-based incentives led providers to invest in delivery system changes, which may benefit patients beyond those attributed to the ICSP project. Examples include funding community health workers, investments in system-wide care coordination processes, and support for a social worker embedded in an emergency department to assist in directing people to the appropriate care setting.

• The ICSP initiative has sparked an increase in communication between health plans and providers and has thereby strengthened those relationships. It has opened up a dialogue with between health plans and providers about value-based contracting that had not previously been occurring, particularly with LTSS providers. Those conversations with LTSS providers encouraged process improvements and identified training opportunities for nursing facility staff. The initiative has also helped to establish a health plan points-of-contact with which providers can discuss issues that arise and collaborate on solutions.

Minnesota is well-positioned to continue to lead reform efforts for seniors and individuals with disabilities. Minnesota has been a national leader in implementing performance-based financial incentives for nursing facilities to promote quality improvements and has been phasing in a performance improvement program for home and community-based (HCBS) providers. Through the ICSP initiative, DHS has amassed an enormous amount of descriptive information about the value-based ICSP arrangements that can inform future payment models in the state’s special needs programs. DHS has gathered insights from health plans and providers participating in the ICSP initiative, collected information about value-based payment activity for populations with complex care needs in other states, reviewed its internal ICSP operations and identified best practices in ICSP projects that could be scaled. Most importantly, this evaluation has revealed opportunities for DHS to build upon its successes and further improve upon and expand value-based payment models for seniors and individuals with disabilities through its managed care contracts, and to communicate about these activities to stakeholders.

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V. Recommendations for Future Value-based Payment Strategies in Minnesota Special Needs Programs

Bailit Health sees benefit in DHS continuing to leverage its health plan contracts to advance value-based payment strategies for individuals enrolled in the state’s special needs programs. Based on a) the value-based payment advances made by plans and providers over the past 3+ years and b) the opportunities identified during our evaluation, we recommend that DHS refine the ICSP initiative. Specifically, we recommend that DHS:

1. transition from requiring health plans to implement a set number of ICSP projects and move to establishing contractual targets for value-based payments as a percentage of all payments to providers under MSHO, MSC+, and SNBC;
2. require special focus on value-based payment for LTSS and behavioral health services, while recognizing the special technical challenges associated with such activity; and
3. provide clear guidance for health plans on what DHS considers to be a “value-based” model.

We expand upon these recommendations below, and address the other six areas of inquiry prescribed by DHS for this final report, as listed on page three.

a) Overall recommendations for the ICSP initiative, including opportunities for further expansion of the ICSP initiative and any related changes needed

- As stated above, Bailit Health recommends that DHS restructure its value-based payment strategy by implementing a target for value-based payments as a percentage of all payments in MSHO, MSC+ and SNBC, and then provide guidelines for models that would satisfy the state’s definition of a value-based payment. Representing value-based payments as a percentage of all payments is an approach that is being adopted by other states and by the Centers for Medicare and Medicaid (CMS). It may signal to plans and providers that a value-based payment strategy in special needs programs is a long-term DHS strategy. This may encourage providers on the sidelines to participate, especially since our evaluation found that some stakeholders currently perceive the ICSP initiative as a pilot program or short-term effort.

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7 Bailit Health addresses this topic first as it closely relates to the overall recommendation that DHS continue a value-based payment initiative, but refine the current the ICSP initiative design.
8 Several states have adopted this approach as both purchasing and regulatory strategies. The strategy has been applied to Medicaid populations, although to a much lesser extent for seniors and individuals with disabilities and the providers who serve them. One example of the latter can be found in Arizona which requires health plans in the Arizona Long Term Care System (ALTCS) to have a minimum of 15% of their total payments to providers in value-based arrangements in 2016 and 35% in 2017. Meeting this requirement is a prerequisite to accessing any portion of the 1% of capitation the state withholds from the plans.
A percentage-of-payments approach enables DHS to preserve a level of flexibility it has afforded to health plans (and which the plans appreciate) while continuing to direct growth in value-based payments to LTSS and behavioral health providers. Health plans are able to continue to work with providers to enter into arrangements that are consistent with provider readiness and capacity.

- DHS should establish clear guidelines on value-based payments that would apply under this framework. We recommend that the guidelines specify that a qualifying payment must create a substantive financial implication for quality performance using quality measures selected from DHS’ aligned measure set. The following list provides a starting point for acceptable value-based payment models that would count toward the target.
  - Care coordination and case management payments: Providers receive payments for care coordination and/or case management services, which are not traditionally reimbursed under FFS (e.g., care coordination/case management).
  - Episode-based payments: Fixed payments for a patient receiving a defined set of services for a specific condition across a continuum of care by multiple providers or care for a specific condition over a specified time period (e.g., a year).
  - Full capitation (e.g., global payments): Fixed dollar payments for a defined set of services paid to a provider for each person cared for by the capitated provider. Payments are based on estimated costs of most or nearly most services that the person may need (full capitation).
  - Infrastructure or capacity-building funding: This may include grants or infrastructure funding to support operational or process changes that would further position providers, especially LTSS providers, to enter into value-based contracts.9
  - Partial capitation for primary care services: Fixed dollar payments for primary care services paid to a provider for each person cared for by the capitated provider.
  - Pay-for-performance (P4P): Performance-based incentive payments for meeting specified quality or financial targets. DHS will need to be clear about the parameters for pay-for-performance models10. Some states do not consider pay-for-performance payment models value-based arrangements11, but in some cases, particularly with small populations, it may be the only statistically-viable option. For this reason, P4P might be the only realistic methodology for many LTSS providers.

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9 These entry-level investments are especially important for LTSS providers and acknowledge the role health plans play in supporting provider readiness for value-based contracts. Bailit Health acknowledges that there may not be a connection to quality associated with these payments; however, given the importance of early investments, particularly for smaller providers, we recommend that DHS count these investments toward the health plan’s target (with parameters.)

10 Researchers and other observers believe that a pay-for-performance incentive should equal 10% or more of total provider reimbursement to have a meaningful impact on quality improvement activity.

- **Shared risk (upside and downside):** Providers share savings if cost of services are below a predetermined risk-adjusted and share losses if above.

- **Shared savings (upside-only):** Providers share savings with a payer if the total cost of services is below a predetermined and risk-adjusted budget. The amount of savings the provider can receive is often linked to performance on quality measures.

- To implement this approach, DHS should incorporate the following provisions in its contracts with health plans:
  - Establish a target for value-based payments as a percentage of all payments to providers in MSHO, MSC+ and SNBC. DHS will need to begin with a baseline assessment of value-based payments in MSHO, MSC+, and SNBC in order to develop a target.
  - Require a certain percentage of value-based payments for behavioral health and LTSS providers, as value-based payments to those providers represent the greatest growth opportunity.
  - Specify a target for risk-based value-based payment contracts in order to promote movement away from pay-for-performance to more evolved value-based payment models. Initially, DHS could begin tracking the risk-based payments and phase in a target.
  - Require that health plans meet the targets in order to be eligible to earn back any of the 8% withhold.

- In addition, DHS should identify and add performance on specific quality measures related to the provision of LTSS and behavioral health services to the withhold return policy.

- To encourage alignment with approaches health plans may be taking for other insured populations, DHS should accept as a value-based payment model any approach that has satisfied the MACRA alternative payment model criteria (once finalized).

- DHS should facilitate a multi-plan and provider effort to develop value-based payment models for LTSS. As part of this effort, DHS should discuss successes, lessons learned and possible applications from related DHS internal initiatives (e.g., nursing facility and HCBS performance improvement programs). There are significant challenges to implementing value-based payment models for LTSS providers and the readiness of all providers, particularly LTSS providers, to enter into value-based contracts is highly variable. Identifying viable solutions and overcoming barriers requires collaboration and diverse perspectives. DHS can provide state resources and/or seek out grant funding opportunities for technical assistance to support collaboration.12

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12 The SCAN Foundation sponsored a program for community-based organizations in California to provide operational and infrastructure support and technical assistance to enable community-based organizations to
Finally, to support further alignment of payment and delivery of services and encourage greater coordination of care, DHS should integrate home and community-based services into the SNBC health plan capitation rate. The MSHO program spurred new payment and care models by integrating the financing and delivery of Medicaid and Medicare services under a single program and DHS has had experience integrating HCBS at the health plan level. DHS should revisit the lessons learned and best practices of previous programs (e.g., Minnesota Disability Health Options and SNBC-Preferred Integrated Network demonstration) to identify features that can be replicated in SNBC.

b) Potential for alignment of ICSPs with other related measurement and VBP initiatives in Minnesota and nationally

There is interest in and opportunity to align value-based purchasing strategies with other DHS and national initiatives.

- As indicated in the section above, Bailit Health recommends that DHS align its criteria for value-based payment models with other frameworks, and then measure plan performance. Frameworks to define value-based payment models include the approach currently under consideration within DHS criteria developed by other states, and nationally-proposed models, including the CMS-sponsored Health Care Payment Learning and Action Network Alternative Payment Model Framework and when available, the CMS MACRA definition alternative payment methodology framework.

- DHS should encourage health plans to use Minnesota’s nursing facility performance evaluation and National Core Indicators (NCI) survey data sources to structure value-based payment contracts with providers. DHS should make available the results of the NCI survey that was stratified at the health plan level. DHS should also ensure that health plans have access to nursing facility performance evaluations and continue to make available state resources to answer questions related to those evaluations.

increase their partnerships with larger health care systems. As part of the proposed DSRIP in Massachusetts, the state plans to use funds to support infrastructure development for long-term services and supports providers. Per Minnesota statute, health plans are required to follow all fee-for-service rules governing HCBS. DHS staff shared with us that IHP colleagues are currently considering a similar reporting requirement. For example, the Massachusetts Center for Health Information and Analysis annually collects information on the adoption of alternative payment methods in Massachusetts. See www.chiamass.gov/the-performance-of-the-massachusetts-health-care-system-series/#apm. DHS could also require that health plans implement selective contracting requirements to increase the number of high-performing nursing facilities in their networks and align with other internal DHS initiatives. The Kansas Medicaid agency requires MCOs to increase the number of PEAK (Promoting Excellent Alternatives in Kansas) nursing facilities in their contracted networks. The state incorporated this requirement into its performance-based withhold framework for MCOs.
DHS should consider programmatic alignment between its value-based purchasing strategies for the special needs programs and the Integrated Health Partnership (IHP) demonstration, where appropriate. While IHP is a more payer-directive strategy that has not always proven popular with plans, providers spoke of its positive attributes on multiple occasions – especially with respect to data provision and standardization of key business terms. These two strengths merit consideration for complex care population contracts. In addition, providers that contract for both IHP and ICSP populations clearly want consistent business models. Aligning ICSP and IHP to the extent possible and appropriate – without turning ICSP into IHP - could support providers and plans in streamlining operations.

c) **Messaging opportunities to encourage further communications between plans and providers about VBP opportunities**

We submit the following recommendations for ways in which DHS and health plans can further communications about value-based payment opportunities with providers. For their part, health plans should establish clear goals and appropriate expectations for moving providers along a continuum of payment models that increase the level of financial risk borne by providers and supports providers’ capacity to do so.

- DHS should share information about value-based payment models health plans and providers have implemented for the special needs programs, including descriptive details about innovative practices, challenges and successes, and factors that contributed to success. DHS can develop webinars and/or issue case study briefs\(^\text{17}\) to communicate information to health plans and providers.

- DHS should convene meetings between health plans and providers to exchange ideas and lessons learned related specific topics of interest. Following is a list of recommended discussion topics based on our evaluation of the ICSP initiative:
  - managing and applying data to improve population health, including the identification and exchange of information on high-risk members on the part of health plans to support providers’ care management activities;
  - complementary state initiatives (e.g., the nursing facility report card) that plans and their contracted networks may integrate into their agreements and/or care management processes, and

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best practices in clinical management, including greater standardization of care coordination activities, care management for individuals with complex health needs, and working across provide types to improve integration of services.

- DHS should facilitate a dialogue with health plans and providers specifically around where standardizing practices (e.g., measure alignment, standardized data formats) would be valuable and would not impede the efforts of plans and providers to innovate and experiment with different models.

- DHS should support the provision of meaningful and actionable data in a consistent format through a portal similar to what has been implemented for IHP. Many providers praised the IHP reporting platform and would welcome a similar utility for the complex care populations they serve. A structured data and information sharing process is necessary to enable providers to track against targets, particularly with respect to the status of their performance on cost and quality. This is especially critical for providers in total cost of care and full-risk arrangements. Much of the data for the special needs programs comes from health plan encounter data, which means the collection and compilation of information would take longer than it does for IHP. DHS should survey providers to understand if there is greater value in DHS developing a standardized template for health plans to adopt to report information in a more timely manner or if having a centralized portal (like IHP) is more important even if it means a delay in receiving data.

d) Alignment of measures utilized under the ICSPs with other related requirements such as Medicare Star Ratings and state provider measurement initiatives

- There is clear opportunity to address measure alignment for value-based payment activities in MSHO, MSC+ and SNBC. Because of the number of plans with which many providers interact – especially in the Metro – providers will struggle to focus on performance improvement when different plans ask for attention to different measures. This issue is not unique to value-based payment strategies for MSHO, MSC+ and SNBC. DHS should facilitate measure alignment efforts, including revisiting with health plans and providers.

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18 Several providers pointed to a lack of focus or implementation of appropriate and high-quality models of care for seniors. Providers highlighted a lack of skills in end-of-life care, caring for moderately frail elders in general population settings, and a lack of measures that are representative of care for seniors, particularly those in institutional settings. Clinical management meetings may prove especially valuable in caring for seniors, particularly for those living in the community.

19 As part of the Robert Wood Johnson Foundation’s Buying Value initiative, Bailit Health developed a Buying Value Measure Selection tool to assist states in developing health care quality measure sets. The tool facilitates a structured decision-making process for designing measure sets and incorporates data from federal, state and commercial measure sets to promote alignment. The Maine Health Management Coalition, Vermont Green Mountain Care Board, and Washington Health Alliance have used the Buying Value Measure Selection tool. More information is available at: [http://www.buyingvalue.org/resources/toolkit/](http://www.buyingvalue.org/resources/toolkit/).
contractual performance measures. DHS should also work with health plans to identify and implement measures for which the plans will be accountable under the withhold framework, as indicated above.

Other states with which we have worked have created aligned measure sets for contractual use, including Washington and Rhode Island. Rhode Island requires its Medicaid managed care plans to all use “core set” measures in their contracts, while allowing for additional measures to be selected from a “menu set.” The core and menu sets are subject to scheduled periodic review and possible revision.

- As health plans push to align with Star Ratings measures, there is urgency for DHS to work with plans and providers to identify measures that are representative of the quality of care for MSHO, MSC+, and SNBC populations and that measure quality of services paid for by Medicaid. DHS has considerable interest in ensuring that it is getting the most value out of its LTSS and behavioral health services purchases and thus orienting the measures toward those services. DHS should play a leadership role in identifying recommended measures for LTSS and behavioral health services.

**e) Collection methods for ICSP descriptions, results, data and information including data elements, reporting formats, and frequency of collection**

As detailed in the Operational Review Report (*June 2016*) for this evaluation, we recommend that DHS streamline the information collected by health plans to allow for more efficient manipulation and analysis of the data from which DHS can draw conclusions about health plan value-based purchasing activity for the special needs programs, including plan attainment of the VBP use objectives.

- DHS should require two separate reports from health plans: 1) an annual plan-level reports of all value-based payments associated with beneficiaries enrolled in MSHO, MSC+, and SNBC; and 2) individual (i.e., case study) reports of plan value-based payment arrangements specifically with LTSS and behavioral health providers. Plans would no longer be required to submit value-based payment proposals, as DHS would provide clear guidance on what would qualify toward the plan’s VBP target. DHS should provide plans with templates and clear instructions for completing the reports.
  - An example of a plan-level reporting template with data inputs is incorporated as Appendix D. This type of report should serve as the source for determining if a health plan has successfully met the target; therefore it must be signed by the Chief Financial Officer or another authorizing official.
  - An example of a case study report is incorporated as Appendix E. DHS should use the information provided by health plans to create case study briefs for public distribution.
f) Potential for sharing of Medicare data with plans and providers for dually eligible enrollees in non-integrated programs

In our interviews, Minnesota health plans indicated that access to Medicare fee-for-service (FFS) data was critical to understanding and coordinating members’ care and services. That information would support plans and providers in stratifying populations and managing risk. Health plans and providers could leverage the Medicare data to identify gaps in care, detect aberrant care-seeking behaviors, target care management efforts, and for predictive modeling. Data also enable health care purchasers to hold providers accountable for performance against established targets, including for quality, utilization, and cost. A complete picture of utilization may inform provider decisions around caseload management, care coordination, and engagement with community-based providers.

Larger provider systems have the infrastructure to comply with the federal data use and protection requirements, but smaller organizations may lack the systems or resource capabilities to accept or translate the data into actionable strategies. Developing those capabilities may be a significant undertaking for some provider organizations.

Bailit Health provided a high-level overview of approaches other states have taken with respect to Medicare data collection, analytics, and reporting in an April 8, 2016 memo to DHS. We also connected DHS with a contact in Washington to learn more about that state’s PRISM (Predictive Risk Intelligence System) system. Colorado and Washington saw value in implementing a centralized and comprehensive tool that supports multiple end-users. Those states acknowledged the variability in health information technology capabilities across health plans and providers. A common tool equalizes this so all have access to data and tools to support their populations. Both states expanded the functionality of an existing platform to integrate Medicare FFS data.

Bailit Health submits the following recommendations to DHS for increasing access to Medicare FFS data.

- DHS should leverage existing systems, or perhaps those of MDH, to create a more centralized system of collecting and reporting Medicare FFS data for individuals who are dually eligible and enrolled in managed care. DHS should aim for a centralized and comprehensive tool that supports multiple end-users, but primarily health plans and providers. A centralized platform enables providers and plans with varying data analytics capabilities access to data to support population health management and the care of individuals they serve.

- DHS should consider contracting with the Washington PRISM team, as New Mexico is doing, for assistance in creating a platform through which DHS can collect, analyze, and report
information, including Medicare FFS data, for health plans and providers serving seniors and individuals with disabilities.

g) Communication strategies for reporting results and how best to present information about this initiative to leadership and the public

- DHS should consolidate the information collected from health plans through the annual reports to prepare a summary report of value-based payment activity in the special needs programs.

- DHS should select two behavioral health and LTSS case studies to feature in the summary report and work with the health plans to ensure the information can be made publicly available.

- DHS should target completion of this report three months after health plans submit their reports. (If plans submit reports by September 30, DHS should produce a summary report for public distribution no later than the middle of January the following year.) DHS should post the summary report on its website and notify the health plans and providers when the document is published.

- To improve the visibility of plan and provider performance using value-based payment arrangements, we recommend that DHS convene an annual meeting or conference focused on its special needs programs. This could be a one-day or half-day event to present reports, introduce an outside expert speaker, and invite health plans and providers to discuss their case studies. It could also include panel discussions on topics of shared interest. Plans, providers, DHS staff, legislators, consumers, and advocates for seniors and individuals with disabilities should be invited to attend, and continuing medical education (CME) credit should be provided, as appropriate.

VI. Conclusion

DHS has demonstrated its commitment to continuously improving the quality of health care under its state programs by directing this evaluation of the ICSP initiative. Through the evaluation, DHS sought to understand opportunities to improve the management, operations and promotion of the ICSP initiative so that it may continue to provide the most value to the state, members, health plans and providers. This final report represents an analysis of the collective findings based on insights and

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20 Vermont Blueprint for Health hosts two annual events as part of the state’s system of continuous learning: a conference that highlights state, national, and international innovations in health care systems; and a meeting of Vermont’s Blueprint field staff to share learnings, best practices, and discuss future collaborations. Massachusetts implemented a provider learning collaborative as part of its Financial Alignment Demonstration. The learning collaborative incorporates webinars, online modules, and face-to-face meetings to facilitate training and information exchange. Both of those states offer continuing medical education (CME) credits.
information gathered through each stage of the evaluation and offers concrete recommendations for DHS about directing value-based strategies in its special needs programs.

We found that the ICSP did advance value-based purchasing arrangements among plans and providers, accelerating activity that would not likely have been achieved in the same timeframe without DHS’ impetus. During our evaluation we identified a number of opportunities for evolution of DHS’ VBP strategy. We anticipate that plans and providers will be eager to engage in discussions with DHS about strategy refinements, and that DHS will be able to continue to innovate to address the challenges in improving care for seniors and persons with disabilities.
Appendix A: Prior Reports Prepared by Bailit Health for the Evaluation of the ICSP Initiative

- Environmental Scan (March 2016)
- Memo re: Medicare Fee-for-Service Data Sharing (April 8, 2016)
- Report on Provider and Plan Interviews (April 2016)
- Summary of ICSP Activities and Measure Analysis (May 2016)
- Operational Review (June 2016)
- Identification of Themes and Best Practices (July 2016)
Appendix B: Quality Measures from Select State MCO Contracts

Following are the quality measures that are included in Arizona ALTCS MCO contracts, Texas STAR+PLUS MCO contracts, and Kansas MCO contracts.

<table>
<thead>
<tr>
<th>State</th>
<th>Measures</th>
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| Arizona  | ▪ Emergency department utilization;  
           ▪ Readmissions within 30 days of discharge;  
           ▪ HbA1c testing;  
           ▪ LDL-C screening;  
           ▪ Flu shots for adults 18 years and older                                           |
| Kansas   | Long-Term Care (a complete description of all measures, including behavioral health can be found at:  
           [www.kancare.ks.gov/download/Attachment_I_State_Quality_Strategy.pdf](http://www.kancare.ks.gov/download/Attachment_I_State_Quality_Strategy.pdf))  
           ▪ Nursing Facility Claim Denials: The MCO will meet or exceed the benchmark for denial of nursing facility claims.  
           ▪ Fall Risk Management: The percentage of people who have a fall with major injury will be decreased.  
           ▪ Decreased Hospital Admission after Nursing Facility Discharge: The percentage of members discharged from a nursing facility who had a hospital admission within 30 days will be decreased.  
           ▪ Decreased Nursing Facility Days of Care: The number of nursing facility days used by eligible beneficiaries will be decreased.  
           ▪ Increase in number of Person-Centered Care Home (as recognized by PEAK) providers in Network: The number of PEAK facilities is to be increased annually. |
| Texas    | ▪ Healthcare Effectiveness Data Information Set (HEDIS) Quality of Care Measures  
           1. Antidepressant medication management  
           2. HbA1c control  
           ▪ Potentially Preventable Events  
           1. Potentially preventable admissions  
           2. Potentially preventable readmissions  
           3. Potentially preventable emergency department visits  
           4. Potentially preventable complications |
Appendix C: ICSP Case Study Brief

Blue Cross and Blue Shield of Minnesota and Bluestone Physician Services

Blue Cross and Blue Shield of Minnesota contracted with Bluestone Physician Services (Bluestone) through its Blue Plus HMO. Blue Cross and Blue Shield of Minnesota has served Minnesota Health Care Programs for 23 years. Bluestone is the largest provider of residential-based care in the Twin Cities area and delivers primary care to nearly 4,000 high-risk patients through its onsite medical teams. In addition to primary care, Bluestone provides care coordination for nearly 2,000 seniors and individuals with disabilities in Minnesota. Care coordination is supported by the onsite primary care model.

Blue Cross and Blue Shield of Minnesota contracted with Bluestone to provide care coordination and case management services to more than 100 MSHO members at 15 locations, primarily in assisted living facilities. If an individual receiving care coordination services by Bluestone under the ICSP contract chooses long-term nursing home placement, those services would be transitioned to another provider.

Care coordinators are either nurses or social workers and work as part of an interdisciplinary team led by a medical director. The role of the care coordinator is to provide assistance navigating complex medical systems and overall coordination of health care needs. For members residing in assisted living settings the care coordinators work closely with facility/community staff to ensure coordination of services and care. The Bluestone care coordinator is expected to perform the following services:

- One care coordinator assigned to each member (continuity of a single care coordinator)
- Face-to-face visits
- Arrange services and obtain equipment
- Provide information regarding community resources
- Help make appointments with health care providers
- Explain benefits of health insurance plan
- Provide education on health promotion activities and medications
- Manage transitions

The payment arrangement for this ICSP is a shared savings model with the amount of gain share determined by Bluestone’s performance on the following indicators:

- Emergency room use
- All-cause readmissions (Star measure)
- High-risk medications (Star measure)
- Comprehensive medication review
Blue Cross and Blue Shield of Minnesota provides information in a quarterly report that enables Bluestone to track and monitor total cost of care.

Bluestone reported that the ICSP initiative likely accelerated value-based contracting for the organization and the opportunity to earn a share of savings on the cost of care led the provider to increase investments in its care coordination model.

Arguably, high-risk medications and comprehensive medication review measure the quality of care in care transitions, one of the key functions of the care coordinator. Readmissions could also be an indicator of the quality of care, although there are many factors associated with a readmission that are beyond the scope of a care coordinator.

Appendix D: Annual Plan-Level Reporting Template
<table>
<thead>
<tr>
<th>Value-based Payments¹: Total dollars paid to providers through²...</th>
<th>Value-based payments $</th>
<th>Percent of Grand Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care coordination and case management payments</td>
<td>$</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Episode-based payments</td>
<td>$</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Full capitation payments</td>
<td>$</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Other* value-based payments</td>
<td>$</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Partial capitation payments</td>
<td>$</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Pay-for-performance payments</td>
<td>$</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Shared risk (upside and downside) payments</td>
<td>$</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Shared savings (upside only) payments</td>
<td>$</td>
<td>#DIV/0!</td>
</tr>
<tr>
<td>Total</td>
<td>$</td>
<td>#DIV/0!</td>
</tr>
</tbody>
</table>

Percent Test #DIV/0! Must be greater than or equal to X%

I certify that this information is accurate and complete and amounts paid under value-based contracts are counted under only one model.

Chief Financial Officer or authorizing official ___________________________ Date ________________

Instructions
1 See DHS definitions for value-based payment models that are acceptable to apply to this target calculation
2 For provider contracts that incorporate more than one value-based payment, health plans should include the model of greater value
3 Behavioral health providers include mental health and substance use providers
4 LTSS providers include institutional care providers and home and community-based service providers as defined by CMS for Medicaid.
# Appendix E: Annual Case Study Report

**Minnesota Department of Human Services**  
Special Needs Programs Case Study Brief Data

<table>
<thead>
<tr>
<th>Population</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attributed lives</td>
<td></td>
</tr>
</tbody>
</table>

| Brief description of the care model |  |

<table>
<thead>
<tr>
<th>Payment model</th>
<th>Check all that apply:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Care coordination and case management payments</td>
</tr>
<tr>
<td></td>
<td>□ Episode-based payments</td>
</tr>
<tr>
<td></td>
<td>□ Full capitation</td>
</tr>
<tr>
<td></td>
<td>□ Infrastructure/capacity-building investment</td>
</tr>
<tr>
<td></td>
<td>□ Partial capitation for primary care services</td>
</tr>
<tr>
<td></td>
<td>□ Pay-for-performance (P4P)</td>
</tr>
<tr>
<td></td>
<td>□ Shared risk (upside and downside)</td>
</tr>
<tr>
<td></td>
<td>□ Shared savings (upside-only)</td>
</tr>
</tbody>
</table>

| Services included in the payment model |  |

<table>
<thead>
<tr>
<th>Provider</th>
<th>Contracting entity:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Downstream provider, if applicable:</td>
</tr>
</tbody>
</table>

| Quality measures selected |  |

| Describe how quality is integrated into the financial model |  |

| Report on performance results for the past calendar year and whether the provider achieved desired results |  |