

STATE: MINNESOTA

ATTACHMENT 3.1-A

Effective: January 1, 2024

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

**Integrated Health Partnership (IHP).** IHP entities provide FFS primary care case management services under authority of § 1905(t) of the Social Security Act, which includes location, coordination and monitoring of health care services. The state ensures that it will comply with the applicable beneficiary protections in § 1905(t)(3) as described below. IHP entities are under contract to share cost and savings gained or lost on the total cost of care for certain services provided on a fee-for-service (FFS) basis. Beginning January 1, 2018, Track 1 and Track 2 IHP entities will receive population-based payments for the provision of evaluation, intervention, and health improvement activities of its attributed patients.

Medical assistance beneficiaries are free to choose from any qualified provider, and IHP entities are not under contract to provide medical assistance covered services for a fixed price. Providers who are participating with IHP entities will provide services and submit claims in accordance with fee-for-service requirements.

~~Legacy IHP entities are those with contracts that began before January 1, 2018, and include both virtual and integrated models. Track 1 and track 2 IHP entities differ from legacy IHPs based on have the following characteristics: 1) track 1 & 2 IHPs have contracts that begin January 1, 2018, or after, and 2) they have also agreed to be evaluated on utilization and health equity metrics. Additionally, both track 1 and track 2 IHP entities will receive population-based payments. a) track 2 entity differs from a track 1 entity because of its ability to manage the risk of loss. Track 2 IHP entities will share costs and savings gained or lost on the total cost of care for certain services provided on a fee-for-service basis.~~

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

- The delivery system includes or coordinates the full scope of primary care services;
- Methods and approaches are in place to coordinate care across the spectrum of services included in the payment model;
- Partnerships are in place between the IHP entity and community-based organizations and public health resources will be in place;
- A process is in place to engage patients and their families meaningfully in the care they receive;
- The delivery system has the capacity to receive data from the state via secure electronic processes;

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

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

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

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

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

**Integrated Health Partnership (IHP).** IHP entities provide FFS primary care case management services under authority of § 1905(t) of the Social Security Act, which includes location, coordination and monitoring of health care services. The state ensures that it will comply with the applicable beneficiary protections in § 1905(t)(3) as described below. IHP entities are under contract to share cost and savings gained or lost on the total cost of care for certain services provided on a fee-for-service (FFS) basis. Beginning January 1, 2018, Track 1 and Track 2 IHP entities will receive population-based payments for the provision of evaluation, intervention, and health improvement activities of its attributed patients.

Medical assistance beneficiaries are free to choose from any qualified provider, and IHP entities are not under contract to provide medical assistance covered services for a fixed price. Providers who are participating with IHP entities will provide services and submit claims in accordance with fee-for-service requirements.

~~Legacy IHP entities are those with contracts that began before January 1, 2018, and include both virtual and integrated models. Track 1 and track 2 IHP entities differ from legacy IHPs based on have the following characteristics: 1) track 1 & 2 IHPs have contracts that begin January 1, 2018, or after, and 2) they have also agreed to be evaluated on utilization and health equity metrics. Additionally, b~~Both track 1 and track 2 IHP entities will receive population-based payments.~~7 a~~A track 2 entity differs from a track 1 entity because of its ability to manage the risk of loss. Track 2 IHP entities will share costs and savings gained or lost on the total cost of care for certain services provided on a fee-for-service basis.

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

- The delivery system includes or coordinates the full scope of primary care services;
- Methods and approaches are in place to coordinate care across the spectrum of services included in the payment model;
- Partnerships are in place between the IHP entity and community-based organizations and public health resources will be in place;
- A process is in place to engage patients and their families meaningfully in the care they receive;
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29. **Integrated Care Models (FFS Primary Care Case Management)**

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  - §1903(d)(1), which provides for protections against fraud and abuse, is met in that all providers participating in IHP are enrolled in the Medical Assistance program and bound by the rules of the program;
  - §1932(d)(2), which includes restrictions on marketing by managed care entities, requires the state to monitor marketing efforts on the part of IHP entities; and
  - §1932(e)(4) requires the states to retain the ability to terminate the contract with the IHP entities for failure to meet the terms of the contract.

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

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

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

Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment.

Payment for ~~legacy and~~ track 2 IHP services includes a payment, made at the end of each participation year, for qualified IHP ~~demonstration providers~~ organizations that have agreed to participate for the purpose of improving quality and achieving efficiencies across the total cost of care for a broad spectrum of outpatient and inpatient care as a common financial and organization entity. Payment is distributed to participating providers through the ~~demonstration IHP provider~~ IHP entity.

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

Legacy IHP Entities

~~Payment is limited by the IHP's performance for the participation year against identified quality measures, and tThese quality measures are reflective of the populations, capabilities and services provided by the IHP providers, for Medical Assistance enrolled patients attributed to the delivery system for the participation year. The payment for the year is based on the difference between the annual expected, or target, total cost of care (TCOC) and the actual, realized TCOC for the core services, plus the TCOC for additional services agreed upon by the Department and the IHP demonstration provider, for the population attributed to the demonstration provider.~~

~~Gain-sharing and loss-sharing will occur only if the IHP provider achieves a 2% or greater savings or loss between the target total cost of care and the actual, realized total cost of care. Payment will be different between virtual and integrated delivery models. Payment for virtual delivery models includes gain-sharing, with the option to include loss-sharing; payment for integrated models includes both gain sharing and loss sharing. For integrated models, and for virtual models in which the IHP entity elects to accept loss-sharing, payment can be positive or negative. The determination of both the base and the target TCOC includes both fee-for-service and managed care enrollees, but the~~

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

Integrated Health Partnership (IHP) Demonstration Program, Payment Adjustment (continued).

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

Track 1 and Track 2 IHP Entities

~~Payment for track 2 IHP entities includes both gain-sharing and loss-sharing; payment can be positive or negative. Gain and loss sharing payments will be calculated using the same methodology described above for legacy IHP entities. Payment is limited by the IHP's performance for the participation year against identified quality measures. These quality measures are reflective of the populations, capabilities and services provided by the IHP providers, for Medical Assistance enrolled patients attributed to the delivery system for the participation year. The payment for the year is based on the difference between the annual expected, or target, total cost of care (TCOC) and the actual, realized TCOC for the core services, plus the TCOC for additional services agreed upon by the Department and the IHP demonstration provider, for the population attributed to the demonstration provider.~~

~~Gain-sharing and loss-sharing will occur only if the IHP achieves a 2% or greater savings or loss between the target total cost of care and the actual, realized total cost of care. Payment can be positive or negative. The determination of both the base and the target TCOC includes both fee-for-service and managed care enrollees, but the payment under this section of the state plan includes only the amount related to the providers' ratio of gain/loss for fee-for-service (FFS) enrollees to the total Medicaid population attributed to the IHP. Final payments/recoveries will be made no more than 18 months after all necessary data is received in final form.~~

**29. Integrated Care Models (FFS Primary Care Case Management) Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).**

Payment for IHP services will also include quarterly, retrospective, population-based payments for qualified IHP entities that have agreed to participate in either track 1 or track 2 of the ~~demonstration~~IHP program. The population-based payments are based on the characteristic of being an IHP entity, which includes the ability to evaluate, intervene, and improve the health of attributed patients. Payments reflect the relative risk and complexity of an IHP's attributed population. For each IHP, the Department calculates the population-based payment as follows:

1. For each attributed member in the previous quarter, the Department calculates a risk score using the Johns Hopkins ACG or other risk grouper.
2. Each attributed member is then assigned an individual per member per month payment (PMPM) based on their risk score.
3. Each attributed member's PMPM is adjusted using a social risk weight.
4. The Department then aggregates the PMPM calculated in step 3 for each attributed member, and divides the total by the number of attributed members.

This creates an average population-based payment that is paid quarterly to the IHP for each attributed member in the previous quarter.

Track 1 and track 2 IHP entities may not receive health care home payments or payments for in-reach care coordination services.

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

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

Integrated Health Partnership (IHP) ~~Demonstration~~ Program, Payment Adjustment (continued).

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

**Total cost of care.** The TCOC for the base period and the measurement period will be calculated by the Department retrospectively, using fee-for-service claims data and encounter data from the managed care organizations. The cost in the base and participation years will include the cost of the core services and any other additional services jointly agreed upon between the Department and the ~~demonstration IHP provider~~, for the population attributed to the ~~demonstration IHP provider~~. The services included in the TCOC measurement for the base year and measurement year will be identical. The total cost of care will not include individual annual claims costs in excess of a catastrophic threshold of at least \$50,000.

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

Beginning January 1, 2018, population-based payments will be included in the TCOC calculation for track 2 entities.

~~**Gain and Loss-Sharing for Legacy IHP Providers.** For the virtual model, loss-sharing is not required. For all participation years, the IHP provider shares equally with the state any gains between the target total cost of care and the realized total cost of care, reduced by the results from the quality measures. A virtual IHP may accept loss-sharing within terms agreed upon between the IHP and the state.~~



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

Integrated Health Partnership (IHP) Demonstration Program, Payment Adjustment (continued).

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

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

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

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

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

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~~25b.29.~~ **Integrated Care Models (FFS Primary Care Case Management)**

Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).

**Gain- and Loss-Sharing for Track 2 IHP Providers.** Track 2 IHP entities must accept some risk for losses, in addition to the potential for shared gains. There is no minimum loss-sharing threshold that the provider must accept. Gains and losses are shared between the ~~demonstration IHP provider~~ and the state at negotiated proportions. The state will eliminate shared losses for any month(s) where at least 20% of an IHP's attributed population resides in a county or counties that are impacted by an extreme and uncontrollable circumstance. The state will use the determination of an extreme and uncontrollable circumstance by the HHS Secretary for the Center for Medicare and Medicaid's (CMS) Quality Payment Program, including the identification of affected geographic areas and applicable time periods, for purposes of determining the applicability of the extreme and uncontrollable circumstances policies with respect to the IHP program. When at least 20% of an IHP's attributed population resides in a region that is impacted by a declared extreme and uncontrollable circumstance, then the state would reduce shared losses by an amount determined by multiplying the shared losses by the percentage of the total months in the performance year affected by the extreme and uncontrollable circumstance, and the percentage of the Integrated Health Partnership's (IHP) assigned beneficiaries who reside in an area affected by the extreme and uncontrollable circumstance.

**Quality Measures.** Gain-sharing and loss-sharing payments will be affected by quality measures. ~~For legacy IHP providers, the measure for reporting data in accordance with requirements will have a 25% effect on the shared savings payments in year 1; meaning that 25% of the dollar amount saved shall be reducible by the percentile score calculated for this measure. For year 2, the quality measures will have a 25% effect on the shared savings payments. For year 3, the quality measures will have a 50% effect. For all subsequent years, the effect of the quality measures will be negotiated between the Department and the demonstration provider.~~

For track 2 IHP providers, the effect of the quality measures will be negotiated between the Department and the ~~demonstration~~-IHP. The effect of the quality measures shall be no more than ~~50%~~100%, and no less than 25%.

For track 1 and track 2 providers, the Department shall determine each entity's ability to continue receiving population-based payments ~~in year 4 and thereafter~~ after year 3 and before entering into a future contract, based on the entity's performance on select quality measures.

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

Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).

~~The state will notify IHP entities, prior to the participation year, of the minimum attainment threshold and upper threshold scores that will result in the maximum reduction or zero reduction in the shared savings payment, by publishing the methodology on the DHS website prior to January 1 of each participation year.~~

The measures used in the calculation are consistent with the Minnesota Statewide Quality Reporting and Measurement System, which includes measures from state- and nationally-recognized sources, such as Minnesota Community Measurement, HEDIS, and other NQF-endorsed measures. The measures are posted on the Department's webpage describing Integrated Health Partnerships, and are updated once per year. The updates will be incorporated into ~~this~~ the demonstration IHP program each participation year and will be the measures used for that participation year. The IHP ~~demonstration~~ program allows for some substitution of measures as appropriate for the population and upon Department approval.

The state will calculate an overall quality score for each IHP by assigning points to each measure, calculating a composite quality score for each measure category (~~e.g. clinical, patient experience~~) and assigning a weight to each measure category. The percentage of total points earned is multiplied by the shared savings or losses amount subject to quality in the applicable participation year. The thresholds for each measure will be applied consistently amongst participating IHP entities.

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

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

Integrated Health Partnership (IHP) ~~Demonstration~~Program, Payment Adjustment (continued).

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

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

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

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

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

Integrated Health Partnership (IHP) Demonstration Program, Payment Adjustment (continued).

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

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

Integrated Health Partnership (IHP) Demonstration Program, Payment Adjustment (continued).

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

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

IHP entities may negotiate with the Department to include additional services in the TCOC calculation.