STATE OF SOUTH DAKOTA
OFFICE OF PROCUREMENT MANAGEMENT
523 EAST CAPITOL AVENUE
PIERRE, SOUTH DAKOTA 57501-3182

Health Home Performance Analysis

PROPOSALS ARE DUE NO LATER THAN FEBRUARY 20, 2018 5:00 PM CT

RFP #1065 BUYER: Division of Medical Services POC: Mark Close mark.close@state.sd.us

READ CAREFULLY

FIRM NAME: _____ AUTHORIZED SIGNATURE: _____

ADDRESS: _____ TYPE OR PRINT NAME: _____

CITY/STATE: _____ TELEPHONE NO: _____

ZIP (9 DIGIT): _____ FAX NO: _____

FEDERAL TAX ID#: _____ E-MAIL: _____

PRIMARY CONTACT INFORMATION

CONTACT NAME: _____ TELEPHONE NO: _____

FAX NO: _____ E-MAIL: _____

1.0 GENERAL INFORMATION

1.1 PURPOSE OF REQUEST FOR PROPOSAL (RFP)

South Dakota is seeking a vendor to conduct an analysis that will measure and quantify the health outcome and financial impacts to Medicaid that have resulted from the provision of the Health Home core services. This analysis will include evaluating the current methodologies and recommending improvements if necessary, and then conducting analysis of program expenditures and utilization to measure the program's financial impact. This analysis will allow DSS to utilize a sound and consistent process for future Health Homes Program budget forecasting and reporting purposes.

The vendor will also maintain the established Health Home Performance Measurement data system, including performance reports and financial impact analysis data, and recommend enhancements that could support a shared savings delivery model. The vendor will maintain the outcomes measurement reporting system or recommend a more efficient reporting system that will support the review and aggregation of data for DSS and individual Health Homes

The vendor should outline the resources necessary to achieve the financial impact methodologies and Performance Measurement maintenance and enhancements DSS is seeking.

1.1.1 BACKGROUND

The South Dakota Department of Social Services (DSS) is the state agency responsible for the administration of the Health Homes Program which was implemented in July, 2013. The Health Homes Program was implemented as part of a person centered system of care to achieve improved health outcomes and experience of care for eligible Medicaid recipients and maintain at least budget neutrality for specified "High-Cost/High-Risk" Medicaid populations. There are six Core Services provided by the South Dakota Medicaid Health Homes Program:

1. Comprehensive Care Management
2. Care Coordination
3. Health Promotion
4. Comprehensive Transitional Care/Follow-up
5. Patient and Family Support
6. Referral to Community and Social Support Services

To qualify for enrollment in the Health Homes program, Medicaid recipients must:

1. Have two or more chronic conditions or one chronic condition and be at risk for another condition.
    a. Chronic Conditions Include: Asthma, COPD, Diabetes, Heart Disease, Hypertension, Substance Abuse, Obesity, Musculoskeletal and Neck/Back disorders.
    b. At-Risk Conditions Include: Pre-Diabetes, Tobacco Use, Cancer Hypercholesterolemia, Depression and Use of Multiple Medications (6 or More Classes of Drugs).
2. Have a single occurrence of a diagnosis for Severe Mental Illness or Emotional Disturbance, limited to: Schizophrenia, Bipolar, Major Depression, Mood Disorders, Ethyl Alcohol-Related Psychotic Disorder, Anxiety, Personality/Social Disorders, Attention Deficit Hyperactivity Disorder

The designated Health Homes Program provider infrastructure is as follows: Physicians, Advanced Practice Nurses, Physician Assistants working in a Clinical Group Practices, Rural Health Clinics, Federally Qualified Health Centers (FQHCs) or Indian Health Service or a Mental Health Professional working in a Community Mental Health Center. Each designated provider must sign an attestation, and take the initial Health Home training as well as meet the provider standards.

The payment methodologies for the Health Homes Program are based upon four Tiers. Each tier has an individual per member, per month (PMPM) payment for provision of the six core Health Homes services. Eligible Medicaid recipients are placed into one of four tiers based upon the prospective risk score determined by the Chronic Illness and Disability Payment System (CDPS). The CDPS score is based on historical claims and diagnoses information normed against the Medicaid population. Those in tier 1 account for approximately half of the eligible population. Tier 1 recipients have a normal prospective risk and, therefore, must opt-in to participate in the Health Homes Program. Tiers 2 through 4 see progressively higher risks of health care utilization and are automatically placed in the Health Home Program, but may opt-out of the Health Homes Program.

DSS has an established set of outcome measures that each health home must report on for each individual who received a core service on a bi-annual schedule. These measure include the standard measures required by CMS.

Please refer to the Department of Social Services website link http://dss.sd.gov//healthhome/index.asp for additional information regarding the Health Homes Program.

1.2 ISSUING OFFICE AND RFP REFERENCE NUMBER

The South Dakota Department of Social Services is the issuing office for this document and all subsequent addenda relating to it. The reference number for the transaction is RFP #1065. Refer to this number on all proposals, correspondence, and documentation relating to the RFP.

Please refer to the Department of Social Services website link http://dss.sd.gov/keyresources/rfp.aspx for the RFP, any related questions/answers, changes to schedule of activities, amendments, etc.

1.3 LETTER OF INTENT

All interested offerors are encouraged to submit a non-binding **Letter of Intent** to respond to this RFP. While preferred, a Letter of Intent is not mandatory to submit a proposal.

The letter of intent should be received by email in the Department of Social Services by no later than 12/15/2017 and must be addressed to Mark Close at mark.close@state.sd.us. Place the following exactly as written in the subject line of your email: **"Letter of Intent for RFP #1065."** Be sure to reference the RFP number in any attached letter or document.

1.4 SCHEDULE OF ACTIVITIES (SUBJECT TO CHANGE)

RFP Publication	12/01/2017
Letter of Intent to Respond Requested	12/15/2017 5:00 PM CT
Deadline for Submission of Written Inquiries	01/05/2018 5:00 PM CT
Responses to Offeror Questions	01/18/2018
Proposal Submission	02/20/2018 5:00 PM CT
Oral Presentations/Interviews/Discussions (if required)	TBD
Proposal Revisions (if required)	TBD
Anticipated Award Decision/Contract Negotiation	04/16/2018

1.5 SUBMITTING YOUR PROPOSAL

All proposals must be completed and received in the Department of Social Services by the date and time indicated in the Schedule of Activities.

Proposals received after the deadline will be late and ineligible for consideration.

An original, 6 identical copies, and 1 electronic copy of the proposal shall be submitted.

All proposals must be signed in ink by an officer of the responder legally authorized to bind the responder to the proposal, and sealed in the form intended by the respondent. Proposals that are not properly signed may be rejected. The sealed envelope must be marked with the appropriate RFP Number and Title. The words "Sealed Proposal Enclosed" must be prominently denoted on the outside of the shipping container. **Proposals must be addressed and labeled as follows:**

Request for Proposal #1065 Proposal Due 02/20/2018 5:00 PM CT
South Dakota Department of Social Services
Attention: Mark Close
700 Governors Drive
Pierre SD 57501-2291

No punctuation is used in the address. The above address as displayed should be the only information in the address field.

No proposal may be accepted from, or any contract or purchase order awarded to any person, firm or corporation that is in arrears upon any obligations to the State of South Dakota, or that otherwise may be deemed irresponsible or unreliable by the State of South Dakota.

1.6 CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION – LOWER TIER COVERED TRANSACTIONS

By signing and submitting this proposal, the offeror certifies that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation, by any Federal department or agency, from transactions involving the use of Federal funds. Where the offeror is unable to certify to any of the statements in this certification, the bidder shall attach an explanation to their offer.

1.7 NON-DISCRIMINATION STATEMENT

The State of South Dakota requires that all contractors, vendors, and suppliers doing business with any State agency, department, or institution, provide a statement of non-discrimination. By signing and submitting their proposal, the offeror certifies they do not discriminate in their employment practices with regard to race, color, creed, religion, age, sex, ancestry, national origin or disability.

1.8 MODIFICATION OR WITHDRAWAL OF PROPOSALS

Proposals may be modified or withdrawn by the offeror prior to the established due date and time.

No oral, telephonic, telegraphic or facsimile responses or modifications to informal, formal bids, or Request for Proposals will be considered.

1.9 OFFEROR INQUIRIES

Offerors may email inquiries concerning this RFP to obtain clarification of requirements. No inquiries will be accepted after 01/05/2018. Email inquiries must be sent to Mark.Close@state.sd.us with the subject line **RFP #1065 Questions**.

The Department of Social Services (DSS) will respond to offerors' inquiries by posting offeror aggregated questions and Department responses on the DSS website at http://dss.sd.gov/keyresources/rfp.aspx no later than 01/19/2018. For expediency, DSS may combine similar questions. Offerors may not rely on any other statements, either of a written or oral nature, that alter any specification or other term or condition of this RFP. Offerors will be notified in the same manner as indicated above regarding any modifications to this RFP.

1.10 PROPRIETARY INFORMATION

The proposal of the successful offeror(s) becomes public information. Proprietary information can be protected under limited circumstances such as client lists and non-public financial statements. Pricing and service elements are not considered proprietary. An entire proposal may not be marked as proprietary. Offerors must clearly identify in the Executive Summary and mark in the body of the proposal any specific proprietary information they are requesting to be protected. The Executive Summary must contain specific justification explaining why the information is to be protected. Proposals may be reviewed and evaluated by any person at the discretion of the State. All materials submitted become the property of the State of South Dakota and may be returned only at the State's option.

1.11 LENGTH OF CONTRACT

The contract resulting from this RFP will be issued for a period of one (1) year, June 1, 2018 to May 31, 2019, with the option of renewal for up to two (2), one (1) year contracts at the discretion of the state.

1.12 GOVERNING LAW

Venue for any and all legal action regarding or arising out of the transaction covered herein shall be solely in Hughes County, State of South Dakota. The laws of South Dakota shall govern this transaction.

1.13 DISCUSSIONS WITH OFFERORS (ORAL PRESENTATION/NEGOTIATIONS)

An oral presentation by an offeror to clarify a proposal may be required at the sole discretion of the State. However, the State may award a contract based on the initial proposals received without discussion with the offeror. If oral presentations are required, they will be scheduled after the submission of proposals. Oral presentations will be made at the offeror's expense.

This process is a Request for Proposal/Competitive Negotiation process. Each Proposal shall be evaluated, and each respondent shall be available for negotiation meetings at the State's request. The State reserves the right to negotiate on any and/or all components of every proposal submitted. From the time the proposals are submitted until the formal award of a contract, each proposal is considered a working document and as such, will be kept confidential. The negotiation discussions will also be held as confidential until such time as the award is completed.

2.0 STANDARD AGREEMENT TERMS AND CONDITIONS

Any contract or agreement resulting from this RFP will include, at minimum, the State's standard terms and conditions as seen in Attachment A. As part of the negotiation process, the contract terms listed in Attachment A may be altered or deleted. The Offeror should indicate in their response any issues they have with any specific contract terms. If the Offeror does not indicate any contract term issues, then the State will assume the terms are acceptable.

3.0 SCOPE OF WORK

3.1 The offeror will develop and conduct a comprehensive methodology to analyze the program expenditures and utilization to quantify the financial impact to Medicaid resulting from the provision of the Health Home core services. This method must allow DSS to review and report the impact at a variety of levels, including, but not limited to:

1. Individual Recipient
2. Health Home Chronic Condition Category
3. Designated Provider
4. Geographic locations
5. Health Home Type
6. Aggregate Data per Level of Reporting and Reporting Time Period
7. Financial Performance
8. Other Provider Groupings as Specified by the State

The offeror's proposed methodologies should consider the following:

The State defined baseline periods are as follows:
Calendar Year 2010 – January 1, 2010 through December 31, 2010
Calendar Year 2011 - January 1, 2011 through December 31, 2011
Calendar Year 2012 - January 1, 2012 through December 31, 2012
Calendar Year 2013 - January 1, 2013 through December 31, 2013

The State defined program performance periods are as follows:
Calendar Year 2014 - January 1, 2014 through December 31, 2014
Calendar Year 2015 - January 1, 2015 through December 31, 2015
Calendar Year 2016 - January 1, 2016 through December 31, 2016
Calendar Year 2017 - January 1, 2017 through December 31, 2017
Calendar Year 2018 - January 1, 2018 through December 31, 2018

The future program performance periods will adhere to the Calendar Year reporting periods and on an "as needed" basis.

Service Type Categories:
1. Inpatient Hospital (IP)
2. Emergency Room (ER)
3. Outpatient Hospital (OP)
4. Home and Community-Based Services (HCBS)
5. Pharmacy (Rx)
6. Office Visit (OV)
7. Laboratory (Lab)
8. Other

The offeror's proposal should meet the following deliverable requirements for the South Dakota Medicaid expenditures, utilization, fiscal impact, and outcome measures associated with the Health Homes (HH) Program.

3.2 The offeror will propose a method for accepting, aggregating and analyzing the Health Home Outcomes Measures. This would include:

3.2.1 Maintaining or updating all Health Home Quality file layout documents to support the outcome measure collection process from Health Homes;

3.2.2 Accepting South Dakota Medicaid Claims data and maintaining it in a secure format;

3.2.3 Accepting Outcome Measure data from the nine previous 6-month collection periods from current vendor in a secure format;

3.2.4 Facilitating outcome measures submissions from Health Homes;

3.2.5 Validating outcome measures submissions from Health Homes;

3.2.6 Generating semiannual quality reports at an aggregate level, combined provider level as identified by DSS, and individual health home level;

3.2.7 Developing reporting processes that will support quality comparisons;

3.2.8 Generating reports to assess overall Health Home performance

3.2.9 Providing DSS with the data required to meet the CMS reporting criteria.

3.2.10 Providing DSS the necessary support and information to reward Health Homes based on performance, through shared savings.

The South Dakota Health Home Outcome Measures file layouts can be found at http://dss.sd.gov/healthhome/outcomemeasures.aspx. Please note that the website contains a layout for both the CMHC and the PCP Health Homes, and a submission template. Also note that the Outcome Measures are subject to change.

3.3 The offeror shall review the existing methodologies used by the previous vendor found in Attachment B to determine the fiscal impact of the health home program and describe the continuation of the existing methodologies, improvements to the existing methodologies or an alternative to the existing methodologies.

3.3.1 The proposal will address the ability of the proposed methodologies to evaluate the fiscal impact of the health home program.

3.3.2 The proposal will identify limitations of the proposed methodologies to the current methodologies to evaluate the fiscal impact of the health home program.

3.3.3 The proposal will describe how the proposed methodologies will include a detailed future analysis and forecasting component that adjusts for fee, rate and PMPM changes and other Health Homes program variables.

3.3.4 The proposal will propose a method for managing the transition of data collection, management, and analysis of outcome measures data from the previous vendor.

3.4 Proposals should include the proposed project management techniques including a detailed description of the vendor's proposed approach and a detailed timeline for delivery of the recommended methodologies, analysis of financial impact, analysis of outcomes measures, and other proposed deliverables within the parameters of Section 1.12 Length of Contract.

3.5 The proposal should specify the elements that will be included in each of the deliverables, including but not limited to:

3.5.1 Detailed information for the recommended improvements to the current methodologies and/or alternatives analysis.

3.5.2 Tables with detailed findings, data and methods logic and any other criteria.

3.5.3 Caveats or special considerations.

3.5.4 A summary and conclusion.

3.6 The offeror will consider the reporting requirements of CMS and the South Dakota program for both the CMHC and PCP Health Homes found at http://dss.sd.gov/healthhome/outcomemeasures.aspx and the 8/30/2014 State Medicaid Director Letter regarding Shared Savings Methodologies (Attachment C).

3.7 The proposal should address how the offeror will adapt to any special project constraints, e.g. release of additional guidance or reporting specifications from CMS.

4.0 PROPOSAL REQUIREMENTS AND COMPANY QUALIFICATIONS

4.1 The offeror is cautioned that it is the offeror's sole responsibility to submit information related to the evaluation categories and that the State of South Dakota is under no obligation to solicit such information if it is not included with the proposal. The offeror's failure to submit such information may cause an adverse impact on the evaluation of the proposal.

4.2 **Offeror's Contacts**: Offerors and their agents (including subcontractors, employees, consultants, or anyone else acting on their behalf) must direct all of their questions or comments regarding the RFP, the evaluation, etc. to the point of contact of the buyer of record indicated on the first page of this RFP. Offerors and their agents may not contact any state employee other than the buyer of record regarding any of these matters during the solicitation and evaluation process. Inappropriate contacts are grounds for suspension and/or exclusion from specific procurements. Offerors and their agents who have questions regarding this matter should contact the buyer of record.

4.3 The offeror **MUST** submit a copy of their most recent independently audited financial statements.

4.4 Provide the following information related to at least three previous and current service/contracts performed by the offeror's organization which are similar to the requirements of this RFP. Provide this information for any service/contract that has been terminated, expired or not renewed in the past three years:

a. Name, address and telephone number of client/contracting agency and a representative of that agency who may be contacted for verification of all information submitted;
b. Dates of the service/contract; and
c. A brief, written description of the specific prior services performed and requirements thereof.

4.5 The offeror must submit information that demonstrates their availability and familiarity with the locale in which the project(s) are to be implemented.

4.6 The offeror must provide information about their specialized expertise, capability and technical competence as it related to the proposed approach and methodologies. Additionally, they must outlines the resources available to perform the work outlined in the RPF response.

4.7 The offeror must detail examples that document their ability and proven history in handling special project constraints.

4.8 If an offeror's proposal is not accepted by the State, the proposal will not be reviewed or evaluated.

5.0 PROPOSAL RESPONSE FORMAT

5.1 An original and 6 copies shall be submitted.

5.1.1 In addition, the offeror should provide one (1) copy of their entire proposal, including all attachments and cost proposal, in PDF electronic format. Offerors may not send the electronically formatted copy of their proposal via email.

5.1.2 The proposal should be page numbered and should have an index and/or a table of contents referencing the appropriate page number.

5.2 All proposals must be organized and tabbed with labels for the following headings:

5.2.1 **RFP Form**. The State's Request for Proposal form completed and signed.

5.2.2 **Executive Summary.** The one or two page executive summary is to briefly describe the offeror's proposal. This summary should highlight the major features of the proposal. It must indicate any requirements that cannot be met by the offeror. The reader should be able to determine the essence of the proposal by reading the executive summary. Proprietary information requests should be identified in this section.

5.2.3 **Detailed Response.** This section should constitute the major portion of the proposal and must contain at least the following information:

5.2.3.1 A complete narrative of the offeror's assessment of the work to be performed, the offeror's ability and approach, and the resources necessary to fulfill the requirements. This should demonstrate the offeror's understanding of the desired overall performance expectations.

5.2.3.2 A specific point-by-point response, in the order listed, to each requirement in the RFP as detailed in Sections 3 and 4. The response should identify each requirement being addressed as enumerated in the RFP.

5.2.3.3 A clear description of any options or alternatives proposed.

5.2.4 **Cost Proposal.** Cost will be evaluated independently from the technical proposal. Offerors may submit multiple cost proposals. All costs related to the provision of the required services must be included in each cost proposal offered.

See section 7.0 for more information related to the cost proposal.

6.0 PROPOSAL EVALUATION AND AWARD PROCESS

6.1 After determining that a proposal satisfies the mandatory requirements stated in the Request for Proposal, the evaluator(s) shall use subjective judgment in conducting a comparative assessment of the proposal by considering each of the following criteria listed in order of importance:

6.1.1 Specialized expertise, capabilities, and technical competence as demonstrated by the proposed approach and methodologies to meet the project requirements;

6.1.2 Resources available to perform the work, including any specialized services, within the specified time limits for the project;

6.1.3 Record of past performance, including price and cost data from previous projects, quality of work, ability to meet schedules, cost control, and contract administration;

6.1.4 Cost proposal;

6.1.5 Proposed project management techniques;

6.1.6 Ability and proven history in handling special project constraints,

6.1.7 Availability to the project locale; and

6.1.8 Familiarity with the project locale;

6.2 Experience and reliability of the offeror's organization are considered subjectively in the evaluation process. Therefore, the offeror is advised to submit any information which documents successful and reliable experience in past performances, especially those performances related to the requirements of this RFP.

6.3 The qualifications of the personnel proposed by the offeror to perform the requirements of this RFP, whether from the offeror's organization or from a proposed subcontractor, will be subjectively evaluated. Therefore, the offeror should submit detailed information related to the experience and qualifications, including education and training, of proposed personnel.

6.4 The State reserves the right to reject any or all proposals, waive technicalities, and make award(s) as deemed to be in the best interest of the State of South Dakota.

6.5 Award: The requesting agency and the highest ranked offeror shall mutually discuss and refine the scope of services for the project and shall negotiate terms, including compensation and performance schedule.

6.5.1 If the agency and the highest ranked offeror are unable for any reason to negotiate a contract at a compensation level that is reasonable and fair to the agency, the agency shall, either orally or in writing, terminate negotiations with the contractor. The agency may then negotiate with the next highest ranked contractor.

6.5.2 The negotiation process may continue through successive offerors, according to agency ranking, until an agreement is reached or the agency terminates the contracting process.

7.0 COST PROPOSAL

7.1 Vendor’s cost proposal should include the total contract price and a breakdown of proposed hours and staff. Payments will be made to the successful offeror based upon agreed upon project deliverables and milestones. (Attachment D)

Attachment A

DSS Purchase Order # 18SC08 _ _ _ _
Consultant Contract # 18-0800- _ _ _

STATE OF SOUTH DAKOTA
DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

Consultant Contract
For Consultant Services
Between

State of South Dakota
Department of Social Services
DIVISION OF CHILD CARE
700 Governors Drive
Pierre, SD 57501-2291

Referred to as Consultant

Referred to as State

The State hereby enters into a contract (the "Agreement" hereinafter) for consultant services with the Consultant. While performing services hereunder, Consultant is an independent contractor and not an officer, agent, or employee of the State of South Dakota.

1. CONSULTANT'S South Dakota Vendor Number is .

2. PERIOD OF PERFORMANCE:
   A. This Agreement shall be effective as of June 1, 2018 and shall end on May 31, 2019, unless sooner terminated pursuant to the terms hereof.

   B. Agreement is the result of request for proposal process, RFP #_____

3. PROVISIONS:
   A. The Purpose of this Consultant contract:
      1.

      2. Does this Agreement involve Protected Health Information (PHI)? YES (X) NO ( )
      If PHI is involved, a Business Associate Agreement must be attached and is fully incorporated herein as part of the Agreement as Exhibit A.

      3. The Consultant will use state equipment, supplies or facilities.

   B. The Consultant agrees to perform the following services (add an attachment if needed.):
      1.

   C. The State agrees to:
      1.

      2. Make payment for services upon satisfactory completion of services and receipt of bill. Payment will be in accordance with SDCL 5-26.

      3. Will the State pay Consultant expenses as a separate item?
      YES ( ) NO (X)
      If YES, expenses submitted will be reimbursed as identified in this Agreement.

D. The TOTAL CONTRACT AMOUNT will not exceed **$.**

4. BILLING:
Consultant agrees to submit a bill for services within (30) days following the month in which services were provided. Consultant will prepare and submit a monthly bill for services. Consultant agrees to submit a final bill within 30 days of the Agreement end date to receive payment for completed services. If a final bill cannot be submitted in 30 days, then a written request for extension of time and explanation must be provided to the State.

5. TECHNICAL ASSISTANCE:
The State agrees to provide technical assistance regarding Department of Social Services rules, regulations and policies to the Consultant and to assist in the correction of problem areas identified by the State's monitoring activities.

6. LICENSING AND STANDARD COMPLIANCE:
The Consultant agrees to comply in full with all licensing and other standards required by Federal, State, County, City or Tribal statute, regulation or ordinance in which the service and/or care is provided for the duration of this Agreement. The Consultant will maintain effective internal controls in managing the federal award. Liability resulting from noncompliance with licensing and other standards required by Federal, State, County, City or Tribal statute, regulation or ordinance or through the Consultant's failure to ensure the safety of all individuals served is assumed entirely by the Consultant.

7. ASSURANCE REQUIREMENTS:
The Consultant agrees to abide by all applicable provisions of the following: , Byrd Anti Lobbing Amendment (31 USC 1352), Executive orders 12549 and 12689 (Debarment and Suspension), Drug-Free Workplace, Executive Order 11246 Equal Employment Opportunity, Title VI of the Civil Rights Act of 1964, Title VIII of the Civil Rights Act of 1968, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Drug Abuse Office and Treatment Act of 1972, Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, Age Discrimination Act of 1975, Americans with Disabilities Act of 1990, Pro-Children Act of 1994, Hatch Act, Health Insurance Portability and Accountability Act (HIPAA) of 1996 as amended, Clean Air Act, Federal Water Pollution Control Act, Charitable Choice Provisions and Regulations, Equal Treatment for Faith-Based Religions at Title 28 Code of Federal Regulations Part 38, the Violence Against Women Reauthorization Act of 2013 and American Recovery and Reinvestment Act of 2009, as applicable.

8. RETENTION AND INSPECTION OF RECORDS:
The Consultant agrees to maintain or supervise the maintenance of records necessary for the proper and efficient operation of the program, including records and documents regarding applications, determination of eligibility (when applicable), the provision of services, administrative costs, statistical, fiscal, other records, and information necessary for reporting and accountability required by the State. The Consultant shall retain such records for a period of six years from the date of submission of the final expenditure report. If such records are under pending audit, the Consultant agrees to hold such records for a longer period upon notification from the State. The State, through any authorized representative, will have access to and the right to examine and copy all records, books, papers or documents related to services rendered under this Agreement. State Proprietary Information retained in Consultant's secondary and backup systems will remain fully subject to the obligations of confidentiality stated herein until such information is erased or destroyed in accordance with Consultant's established record retention policies.

All payments to the Consultant by the State are subject to site review and audit as prescribed and carried out by the State. Any over payment of this Agreement shall be returned to the State within thirty days after written notification to the Consultant.

9. WORK PRODUCT:
Consultant hereby acknowledges and agrees that all reports, plans, specifications, technical data, drawings, software system programs and documentation, procedures, files, operating instructions and procedures, source

code(s) and documentation, including those necessary to upgrade and maintain the software program, State Proprietary Information, as defined in the Confidentiality of Information paragraph herein, state data, end user data, Protected Health Information as defined in 45 CFR 160.103, and all information contained therein provided to the State by the Consultant in connection with its performance of service under this Agreement shall belong to and is the property of the State and will not be used in any way by the Consultant without the written consent of the State.

Paper, reports, forms software programs, source code(s) and other materials which are a part of the work under this Agreement will not be copyrighted without written approval of the State. In the unlikely event that any copyright does not fully belong to the State, the State none the less reserves a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, and otherwise use, and to authorize others to use, any such work for government purposes.

Consultant agrees to return all information received from the State to State's custody upon the end of the term of this Agreement, unless otherwise agreed in a writing signed by both parties.

10. TERMINATION:
This Agreement may be terminated by either party hereto upon thirty (30) days written notice. In the event the Consultant breaches any of the terms or conditions hereof, this Agreement may be terminated by the State for cause at any time, with or without notice. Upon termination of this Agreement, all accounts and payments shall be processed according to financial arrangements set forth herein for services rendered to date of termination.

11. FUNDING:
This Agreement depends upon the continued availability of appropriated funds and expenditure authority from the Legislature for this purpose. If for any reason the Legislature fails to appropriate funds or grant expenditure authority, or funds become unavailable by operation of the law or federal funds reduction, this Agreement will be terminated by the State. Termination for any of these reasons is not a default by the State nor does it give rise to a claim against the State.

12. ASSIGNMENT AND AMENDMENTS:
This Agreement may not be assigned without the express prior written consent of the State. This Agreement may not be amended except in writing, which writing shall be expressly identified as a part hereof, and be signed by an authorized representative of each of the parties hereto.

13. CONTROLLING LAW:
This Agreement shall be governed by and construed in accordance with the laws of the State of South Dakota, without regard to any conflicts of law principles, decisional law, or statutory provision which would require or permit the application of another jurisdiction's substantive law. Venue for any lawsuit pertaining to or affecting this Agreement shall be resolved in the Circuit Court, Sixth Judicial Circuit, Hughes County, South Dakota.

14. SUPERCESSION:
All prior discussions, communications and representations concerning the subject matter of this Agreement are superseded by the terms of this Agreement, and except as specifically provided herein, this Agreement constitutes the entire agreement with respect to the subject matter hereof.

15. IT STANDARDS:
Any software or hardware provided under this Agreement will comply with state standards which can be found at http://bit.sd.gov/standards/.

16. SEVERABILITY:
In the event that any provision of this Agreement shall be held unenforceable or invalid by any court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision of this Agreement, which shall remain in full force and effect.

17. NOTICE:
Any notice or other communication required under this Agreement shall be in writing and sent to the address set forth above. Notices shall be given by and to the Division being contracted with on behalf of the State, and by the Consultant, or such authorized designees as either party may from time to time designate in writing. Notices or communications to or between the parties shall be deemed to have been delivered when mailed by first class mail, provided that notice of default or termination shall be sent by registered or certified mail, or, if personally delivered, when received by such party.

18. SUBCONTRACTORS:
The Consultant may not use subcontractors to perform the services described herein without express prior written consent from the State. The State reserves the right to reject any person from the Agreement presenting insufficient skills or inappropriate behavior.

The Consultant will include provisions in its subcontracts requiring its subcontractors to comply with the applicable provisions of this Agreement, to indemnify the State, and to provide insurance coverage for the benefit of the State in a manner consistent with this Agreement. The Consultant will cause its subcontractors, agents, and employees to comply with applicable federal, state and local laws, regulations, ordinances, guidelines, permits and requirements and will adopt such review and inspection procedures as are necessary to assure such compliance. The State, at its option, may require the vetting of any subcontractors. The Consultant is required to assist in this process as needed.

19. STATE'S RIGHT TO REJECT:
The State reserves the right to reject any person or entity from performing the work or services contemplated by this Agreement, who present insufficient skills or inappropriate behavior.

20. HOLD HARMLESS:
The Consultant agrees to hold harmless and indemnify the State of South Dakota, its officers, agents and employees, from and against any and all actions, suits, damages, liability or other proceedings which may arise as the result of performing services hereunder. This section does not require the Consultant to be responsible for or defend against claims or damages arising solely from errors or omissions of the State, its officers, agents or employees.

21. INSURANCE:
Before beginning work under this Agreement, Consultant shall furnish the State with properly executed Certificates of Insurance which shall clearly evidence all insurance required in this Agreement. The Consultant, at all times during the term of this Agreement, shall obtain and maintain in force insurance coverage of the types and with the limits listed below. In the event a substantial change in insurance, issuance of a new policy, cancellation or nonrenewal of the policy, the Consultant agrees to provide immediate notice to the State and provide a new certificate of insurance showing continuous coverage in the amounts required. Consultant shall furnish copies of insurance policies if requested by the State.

A. Commercial General Liability Insurance:
Consultant shall maintain occurrence-based commercial general liability insurance or an equivalent form with a limit of not less than $1,000,000 for each occurrence. If such insurance contains a general aggregate limit, it shall apply separately to this Agreement or be no less than two times the occurrence limit.

B. Business Automobile Liability Insurance:
Consultant shall maintain business automobile liability insurance or an equivalent form with a limit of not less than $500,000 for each accident. Such insurance shall include coverage for owned, hired, and non-owned vehicles.

C. Worker's Compensation Insurance:
Consultant shall procure and maintain Workers' Compensation and employers' liability insurance as required by South Dakota law.

D. Professional Liability Insurance:
Consultant agrees to procure and maintain professional liability insurance with a limit not less than $1,000,000.

(Medical Health Professional shall maintain current general professional liability insurance with a limit of not less than one million dollars for each occurrence and three million dollars in the aggregate. Such insurance shall include South Dakota state employees as additional insureds in the event a claim, lawsuit, or other proceeding is filed against a state employee as a result of the services provided pursuant to this Agreement. If insurance provided by Medical Health Professional is provided on a claim made basis, then Medical Health Professional shall provide "tail" coverage for a period of five years after the termination of coverage.)

22. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY, AND VOLUNTARY EXCLUSION:
Consultant certifies, by signing this Agreement, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by the federal government or any state or local government department or agency. Consultant further agrees that it will immediately notify the State if during the term of this Agreement either it or its principals become subject to debarment, suspension or ineligibility from participating in transactions by the federal government, or by any state or local government department or agency.

23. CONFLICT OF INTEREST:
Consultant agrees to establish safeguards to prohibit employees or other persons from using their positions for a purpose that constitutes or presents the appearance of personal organizational conflict of interest, or personal gain as contemplated by SDCL 5-18A-17 through 5-18A-17.6. Any potential conflict of interest must be disclosed in writing. In the event of a conflict of interest, the Consultant expressly agrees to be bound by the conflict resolution process set forth in SDCL 5-18A-17 through 5-18A-17.6.

24. CONFIDENTIALITY OF INFORMATION:
For the purpose of the sub-paragraph, "State Proprietary Information" shall include all information disclosed to the Consultant by the State. Consultant acknowledges that it shall have a duty to not disclose any State Proprietary Information to any third person for any reason without the express written permission of a State officer or employee with authority to authorize the disclosure. Consultant shall not: (i) disclose any State Proprietary Information to any third person unless otherwise specifically allowed under this Agreement; (ii) make any use of State Proprietary Information except to exercise rights and perform obligations under this Agreement; (iii) make State Proprietary Information available to any of its employees, officers, agents or consultants except those who have agreed to obligations of confidentiality at least as strict as those set out in this Agreement and who have a need to know such information. Consultant is held to the same standard of care in guarding State Proprietary Information as it applies to its own confidential or proprietary information and materials of a similar nature, and no less than holding State Proprietary Information in the strictest confidence. Consultant shall protect confidentiality of the State's information from the time of receipt to the time that such information is either returned to the State or destroyed to the extent that it cannot be recalled or reproduced. State Proprietary Information shall not include information that (i) was in the public domain at the time it was disclosed to Consultant; (ii) was known to Consultant without restriction at the time of disclosure from the State; (iii) that is disclosed with the prior written approval of State's officers or employees having authority to disclose such information; (iv) was independently developed by Consultant without the benefit or influence of the State's information; (v) becomes known to Consultant without restriction from a source not connected to the State of South Dakota. State's Proprietary Information shall include names, social security numbers, employer numbers, addresses and all other data about applicants, employers or other clients to whom the State provides services of any kind. Consultant understands that this information is confidential and protected under applicable State law at SDCL 1-27-1.5, modified by SDCL 1-27-1.6, SDCL 28-1-29, SDCL 28-1-32, and SDCL 28-1-68 as applicable federal regulation and agrees to immediately notify the State if the information is disclosure, either

intentionally or inadvertently. The parties mutually agree that neither of them shall disclose the contents of the Agreement except as required by applicable law or as necessary to carry out the terms of the Agreement or to enforce that party's rights under this Agreement. Consultant acknowledges that the State and its agencies are public entities and thus are bound by South Dakota open meetings and open records laws. It is therefore not a breach of this Agreement for the State to take any action that the State reasonably believes is necessary to comply with the South Dakota open records or open meetings laws. If work assignments performed in the course of this Agreement require additional security requirements or clearance, the Consultant will be required to undergo investigation.

25. REPORTING PROVISION:
Consultant agrees to report to the State any event encountered in the course of performance of this Agreement which results in injury to any person or property, or which may otherwise subject Consultant, or the State of South Dakota or its officers, agents or employees to liability. Consultant shall report any such event to the State immediately upon discovery.

Consultant's obligation under this section shall only be to report the occurrence of any event to the State and to make any other report provided for by their duties or applicable law. Consultant's obligation to report shall not require disclosure of any information subject to privilege or confidentiality under law (e.g., attorney-client communications). Reporting to the State under this section shall not excuse or satisfy any obligation of Consultant to report any event to law enforcement or other entities under the requirements of any applicable law.

26. AUTHORIZED SIGNATURES**:**
In witness hereto, the parties signify their agreement by affixing their signatures hereto.

Consultant Signature	Date
State - DSS Division Director Virgena Wieseler	Date
State - DSS Chief Financial Officer Laurie Mikkonen	Date
State - DSS Cabinet Secretary Lynne A. Valenti	Date

State Agency Coding:

CFDA #				
Company				
Account				
Center Req				
Center User				
Dollar Total				

DSS Program Contact Person _____
Phone _____

DSS Fiscal Contact Person Contract Accountant
Phone 605 773-3586

Consultant Program Contact Person _____
Phone _____

Consultant Fiscal Contact Person _____
Phone _____
Consultant Email Address _____

SDCL 1-24A-1 states that a copy of all consulting contracts shall be filed by the State agency with the State Auditor within five days after such contract is entered into and finally approved by the contracting parties. For further information about consulting contracts, see the State Auditor's policy handbook.

DSS Purchase Order # 18SC08 _ _ _ _
Consultant Contract # 18-0800- _ _ _

STATE OF SOUTH DAKOTA

DEPARTMENT OF SOCIAL SERVICES

Exhibit A

Business Associate Agreement

1. Definitions

General definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the Provider, Consultant or entity contracting with the State of South Dakota as set forth more fully in the Agreement this Business Associate Agreement is attached.

(b) CFR. "CFR" shall mean the Code of Federal Regulations.

(c) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean South Dakota Department of Social Services.

(d) Designated Record Set. "Designated Record Set" shall have the meaning given to such term in 45 CFR 164.501.

(f) HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164 (Subparts A, C, D and E). More specifically, the "Privacy Rule" shall mean the regulations codified at 45 CFR Part 160 and Part 164 (Subparts A and E), and the "Security Rule" shall mean the regulations codified at 45 CFR Part 160 and Part 164 (Subparts A and C).

(g) Protected Health Information. "Protected Health Information" or "PHI" shall mean the term as defined in 45 C.F.R. §160.103, and is limited to the Protected Health Information received from, or received or created on behalf of Covered Entity by Business Associate pursuant to performance of the Services under the Agreement.

2. Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(c) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware within five (5) business days of receiving knowledge of such use, disclosure, breach, or security incident;

(d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;

(e) Make available protected health information in a designated record set to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR 164.524. Business associate shall cooperate with covered entity to fulfill all requests by individuals for access to the individual's protected health information that are approved by covered entity. If business associate receives a request from an individual for access to protected health information, business associate shall forward such request to covered entity within ten (10) business days. Covered entity shall be solely responsible for determining the scope of protected health information and Designated Record Set with respect to each request by an individual for access to protected health information;

(f) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526. Within ten (10) business days following any such amendment or other measure, business associate shall provide written notice to covered entity confirming that business associate has made such amendments or other measures and containing any such information as may be necessary for covered entity to provide adequate notice to the individual in accordance with 45 CFR 164.526. Should business associate receive requests to amend protected health information from an individual, Business associate shall cooperate with covered entity to fulfill all requests by individuals for such amendments to the individual's protected health information that are approved by covered entity. If business associate receives a request from an individual to amend protected health information, business associate shall forward such request to covered entity within ten (10) business days. Covered entity shall be solely responsible for determining whether to amend any protected health information with respect to each request by an individual for access to protected health information;

(g) Maintain and make available the information required to provide an accounting of disclosures to the covered entities necessary to satisfy covered entity's obligations under 45 CFR 164.528. Business associate shall cooperate with covered entity to fulfill all requests by individuals for access to an accounting of disclosures that are approved by covered entity. If business associate receives a request from an individual for an accounting of disclosures, business associate shall immediately forward such request to covered entity. Covered entity shall be solely responsible for determining whether to release any account of disclosures;

(h) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(i) Make its internal practices, books, and records available to the covered entity and / or the Secretary of the United States Department of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

3. Permitted Uses and Disclosures by Business Associate

(a) Except as otherwise limited by this Agreement, Business Associate may make any uses and disclosures of Protected Health Information necessary to perform its services to Covered Entity and otherwise meet its obligations under this Agreement, if such use or disclosure would not violate the Privacy Rule if done by the covered entity. All other uses or disclosure by Business Associate not authorized by this Agreement or by specific instruction of Covered Entity are prohibited.

(b) The business associate is authorized to use protected health information if the business associate de-identifies the information in accordance with 45 CFR 164.514(a)-(c). In order to de-identify any information, Business Associate must remove all information identifying the individual including, but not limited to, the following: names, geographic subdivisions smaller than a state, all dates related to an individual, all ages over the age of 89 (except such ages may be aggregated into a single category of age 90 or older, telephone numbers, fax numbers, electronic mail (email) addresses, medical record numbers, account numbers, certificate/ license numbers, vehicle identifiers and serial numbers (including license plate numbers, device identifiers and serial numbers, web universal resource locators (URLs), internet protocol (IP) address number, biometric identifiers (including finger and voice prints), full face photographic images (and any comparable images), any other unique identifying number, and any other characteristic or code.

(c) Business associate may use or disclose protected health information as required by law.

(d) Business associate agrees to make uses and disclosures and requests for protected health information consistent with covered entity's minimum necessary policies and procedures.

(e) Business associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity except for the specific uses and disclosures set forth in (f) and (g).

(f) Business associate may disclose protected health information for the proper management and administration of business associate or to carry out the legal responsibilities of the business associate, provided the disclosures are required by law.

(g) Business associate may provide data aggregation services relating to the health care operations of the covered entity.

4. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

(a) Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR 164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.

(b) Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.

(c) Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect business associate's use or disclosure of protected health information.

5. Term and Termination

(a) Term. The Term of this Agreement shall be effective as of and shall terminate on the dates set forth in the primary Agreement this Business Associate Agreement is attached to or on the date the primary Agreement terminates, whichever is sooner.

(b) Termination for Cause. Business associate authorizes termination of this Agreement by covered entity, if covered entity determines business associate has violated a material term of the Agreement.

(c) Obligations of Business Associate Upon Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this agreement for any reason, business associate shall return or destroy all protected health information received from, or

created or received by business associate on behalf of covered entity. This provision shall apply to protected health information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

2. In the event that business associate determines that returning or destroying the protected health information is infeasible, business associate shall provide to covered entity, within ten (10) business days, notification of the conditions that make return or destruction infeasible. Upon such determination, business associate shall extend the protections of this agreement to such protected health information and limit further uses and disclosures of such protected health information to those purposes that make the return or destruction infeasible, for so long as business associate maintains such protected health information.

(d) Survival. The obligations of business associate under this Section shall survive the termination of this Agreement.

6. Miscellaneous

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

(c) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

(d) Conflicts. In the event of a conflict in between the terms of this Business Associate Agreement and the Agreement to which it is attached, the terms of this Business Associate Agreement shall prevail to the extent such an interpretation ensures compliance with the HIPAA Rules.

Attachment B: Methodology

The Vendor's Analytic Approach

The vendor conducted analyses to answer the overarching question posed by the DSS, i.e., whether and by how much the provision of Health Home services reduced Medicaid costs for HH-enrolled recipients after the start of HH services. Part of answering this question included verifying whether cost reductions for HH patients were really due to the HH program rather than more general cost trends that were not related to provision of HH services but affected all Medicaid/non-HH patients.

The vendor conducted two sets of analyses:

1. Analyses of data that compared costs prior to HH implementation and after HH implementation;
2. Analyses of costs for a matched population, over the same time period, comparing costs of those enrolled in a HH with costs of similar individuals who were not enrolled in a HH.

These two analytic steps are not designed to produce identical numeric savings results since they are measuring different population subsets. However, each method produces a type of result, i.e., trend and relative percentage of cost reduction. Once applied to actual Medicaid costs, both methods contributed to the conclusion that the provision of HH services substantially reduced DSS Medicaid costs. These two analyses are described in more detail below.

Analytic Method 1: Comparing Costs Pre-HH Enrollment and Post-HH Enrollment
For this analysis, the vendor calculated and compared utilization (ED visits, inpatient visits, pharmacy data, e.g., number of prescriptions) and costs between the HH pre-enrollment period and the post-enrollment period. Costs for HH and non-HH recipients pre enrollment were compared to costs for HH and non-HH patients after the program started. This does not compare the same exact group of recipients but provided a macro level snapshot of HH program impact pre- and post-implementation.

Analytic Method 2: Comparison of Costs for HH Enrollees and Non-HH Enrollees
Next, the vendor created a comparison group and calculated and compared differences in utilization and costs between a specific group of Medicaid recipients enrolled in health homes and a specific comparison group of Medicaid recipients who were not enrolled in health homes but who were similar in key ways (described below) to the HH enrollees. This analysis required data about medical expenditures and demographics for a specific group of HH recipients and expenditures for a specific group of non HH-enrolled recipients who are like the HH recipients but were not enrolled in a HH – in other words, a matched comparison group.

To identify two groups to compare – one HH enrolled, and one non-HH enrolled – we identified a profile of high need/high cost Medicaid recipients who would meet the criteria for HH enrollment (e.g., characteristics of age, chronic conditions). Then, using a statistical matching procedure, the vendor selected similar subsets from among HH enrolled and non-HH enrolled recipients who were alike in their sex, age, and number of conditions and thus most suited for comparison in terms of their service utilization and costs. We refer to these two groups as the *matched* HH-enrolled recipients and the *matched* non-HH enrolled recipients. The sample size for each matched group is 4,881.

This part of the vendor's analysis followed the same subjects over the years. This approach provides more meaningful comparisons of Medicaid costs before and after HH enrollment, for the same set of recipients.

Attachment C

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMDL# 13-005
ICM# 3

August 30, 2013

RE: Shared Savings Methodologies

Dear State Medicaid Director:

This letter is the third in a series that provides states with guidance on designing and implementing care delivery and payment models that improve health, improve care, and reduce costs within state Medicaid programs. The first two letters are SMD #12-001 and 12-002. In those letters, we described the framework for Integrated Care Models (ICMs) and pathways that states may use to implement ICMs in the Medicaid state plan or, as needed, through appropriate program waivers and demonstrations. This letter focuses specifically on reimbursement methodologies that can be adopted in the context of ICMs to incentivize improved quality and outcomes and reduce costs by sharing program savings with high performing providers.

SHARED SAVINGS IN MEDICAID

Many states are interested in testing shared savings methodologies in the Medicaid program as a means to promote higher quality at an overall lower cost. CMS has had a series of discussions with states as part of the Medicaid and CHIP Value Based Purchasing Learning Collaborative about these issues. States and CMS share the goal of ensuring effective delivery system models that properly reward providers for efficiency and quality. Since shared savings methods are new and evolving, this guidance is intended to inform states' thinking as they consider developing performance incentives reimbursed through program savings, and not to prescribe just one approach to designing such incentives. Over time, we intend to offer examples of approved shared savings methodologies to share state experiences with the models and to describe practices that have proven to be effective. We will work with states to collect and make this information available. We ask that states share the results of evaluations, reports and other data that can help all interested parties understand how shared savings methodologies work to improve care and lower costs. Work along these lines is proceeding in a few states.

BACKGROUND

In previous letters we have discussed how the structure of a state's coordination and care transformation efforts will affect whether activities are implemented under a Medicaid state plan benefit or through a waiver authority. For instance, states may be interested in targeting efforts at specific populations with complex care needs or testing delivery models in targeted regions before implementing initiatives statewide. All of these decisions will affect which Medicaid authority a state uses to implement shared savings and components of the payment methodology.

We refer specifically to the second letter within this series "Policy Considerations for Integrated Care Models" (SMDL #12-002) for states that seek additional guidance on structuring ICMs.

Several states are at the forefront of driving quality improvement incentives in Medicaid fee-for-service and managed care delivery systems. Their approaches to rewarding providers that better coordinate care and improve quality through payment incentives align with similar efforts in the Medicare program as well as the private health insurance market. As state Medicaid agencies develop new incentive models that calculate payments based on Medicaid savings, they have sought guidance from CMS on Medicaid authorities and federal expectations for designing and implementing the models.

Within this letter we offer states methodological considerations that factor into any shared savings proposals, as well as technical guidance and a series of questions that CMS will expect states to answer as part of their proposals. Importantly, we expect shared savings methodologies to encourage care coordination and practice transformation activities, such as those discussed in SMDL #12-002, that improve quality and health outcomes. CMS is not interested, at this time, in partnering with states on shared savings proposals that are based only on cost savings and that do not improve quality and health outcomes or limit access to eligible beneficiaries. The services and/or activities to coordinate and transform care delivery for Medicaid beneficiaries and the quality metrics that are the basis for the shared savings payments will be defined in either the state plan or waiver documentation under a Medicaid benefit category.

METHODOLOGICAL CONSIDERATIONS

Shared savings calculations can be complex and potentially place states and CMS at risk if the calculations and trends are inaccurate or if the calculations are not routinely rebased to reflect changes to Medicaid programs and the efficiencies that have been gained through better coordination and improved quality. The analyses that informed the Medicare Physician Group Practice Demonstration, the Pioneer Accountable Care Organizations (ACO) model, and the Medicare Shared Savings Program ACOs are potential resources to help states develop similar shared savings initiatives under Medicaid programs. However, we recognize that Medicaid enrollees are often different from Medicare enrollees and states are not required to develop methodologies that mirror any of these programs. With that in mind, this letter provides information on the key structural components of a shared savings payment methodology and, as enclosures to the letter, technical design considerations and questions that states should review prior to submitting a proposal to CMS. We expect states to consider each of the methodological components described this letter as they develop a proposal for CMS to review, but we are not defining approval criteria or requiring specific standards that states will need to meet for approval. We do not foresee a "one size fits all" approach to shared savings and at this time believe it is too early to determine if there are criteria and universal standards that can apply to all Medicaid models. Our goal is to work in partnership with states to develop methodologies that mitigate risk, realize potential rewards associated with shared savings methodologies, and may be replicated nationally.

Essential Concepts of Shared Savings

A shared savings methodology typically comprises four important concepts: a total cost of care benchmark, provider payment incentives to improve care quality and lower total cost of care, a performance period that tests the changes, and an evaluation to determine the program cost savings during the performance period compared to the benchmark cost of care and to identify the improvements in care quality. In some instances the provider payment incentives in the second step will be determined through the evaluation step. We have discussed changes in care delivery at length in this and in other letters, and below we provide information on the baseline benchmark, the performance period and the evaluation components. As states design shared savings methodologies, key goals should be to ensure that:

- data analysis is used to determine that benchmark cost, performance period cost and the associated trend rates are accurate; and
- shared savings policies, such as saving thresholds, minimum savings rates, and target populations (as discussed in the attached Technical Considerations for Shared Savings) work cohesively to help ensure that shared savings payments are made only for true savings attributable to the program and not for random variations in total cost of care.
- Beneficiary access shall not be reduced and quality of care shall be improved.

Distribution of Payments

As with any Medicaid incentive payment, a state shared savings reimbursement methodology must clearly describe:

1. the criteria that providers must meet to receive incentive payments,
2. the actual payment calculation, including any caps on shared savings or risks, and
3. the methodology for distributing shared savings payments (including all of the applicable variables described within this letter).

The methodology must be comprehensive, meaning that an individual could reasonably calculate provider payments based on the information in the Medicaid state plan, waiver documentation, or contracts. Shared savings typically include the percentage of the savings (or risk) that a provider is eligible to receive and, as applicable, any tiers associated with meeting quality measures. The eligible percentage of savings that may be shared should directly link to the population attributed within the methodology and the savings and risk thresholds, which we describe in more detail below.

Actuarial Analysis

Generally, the development of a shared savings methodology will require an analysis at least as thorough as the analysis for developing capitation rates. We strongly encourage states to conduct an actuarial analysis to ensure the proposed methodologies are sound and forecast to continually improve quality and lower costs. CMS, in collaboration with our Office of the Actuary (OACT), has provided a list of considerations as an enclosure to this letter that should help position states to think through critical policy decisions. States should fully consider the

questions within this list and be prepared to provide CMS with supporting data and documentation on the benchmark calculation, trending assumptions and all other methodological components described in the enclosure. Providing this information with the submission of a shared saving methodology proposal will help expedite the review process.

Risk and Gain-sharing Arrangements

The term "shared-savings" implies that providers will receive incentive rewards for care improvements that result in Medicaid program savings. The Medicare Physician Group Practice Demonstration is an example of a program that recognized bonus payments when providers presented savings above a certain threshold and also met specific quality goals. Under the Demonstration, providers that did not achieve savings above the threshold were not penalized or placed at risk for their efforts (other than for the costs they incurred to improve care). This arrangement proved valuable even though the majority of providers within the demonstration did not demonstrate enough savings to receive a shared savings incentive because there were still measurable improvements in the quality of care provided by the demonstration providers. In the initial stages of state reform efforts, CMS supports gain-sharing arrangements that do not place providers at risk but that strive to achieve quality improvement and lower cost.

Some states may be positioned to place ICM providers at risk for some portion of the total cost of care for attributed beneficiaries if the Medicaid costs associated with the beneficiaries continue to rise beyond expectations. These types of arrangements are described within the Medicare Pioneer ACO model and the Medicare Shared Savings Program regulation. A methodology that allows for gain-sharing and risk offers states and CMS some confidence that the program will not result in unanticipated costs. Generally, risk-based provider payment arrangements may be approved in the Medicaid state plan under the conditions that: providers are not compelled to enter into a risk arrangement as a condition of delivering care coordination services, providers are made aware that they are participating in the risk arrangement, the state plan clearly articulates the basis of the risk calculation, and no provider is at risk for costs over which the provider has no affect or control.[1] To ensure that a provider is not at risk for costs that are not affected by, or over which the provider has no control, states should employ an attribution methodology that appropriately links a provider's actions to the payment methodology.[2] Additional details on attribution are described below.

Targeting Providers and Populations

As states contemplate shared savings payment methodologies within the context of their overall health reform agendas, they will need to consider the providers that will be eligible to receive incentive payments and the populations that these providers serve. We have discussed in

[1] "Risk-based arrangements can also be authorized under the state plan in conjunction with section 1932(a) authority. The conditions listed here do not apply to that authority."

[2] We note that Medicare ACO models allow groups of providers to share risk. Such arrangements are also allowable under certain Medicaid Integrated Care Models as described in SMD #12-002. In those instances, the qualified provider may be a network or organization of Medicaid providers that is responsible with providing coordinating, locating and monitoring services. Individual providers within the network or organization may share risk through agreements that are outside of the Medicaid authorized payment methodology paid directly to the network or organization (the Medicaid ICM provider). However, one network or organization may not be held at risk for the inefficiencies or another network or organization.

previous letters that states must ensure that value-based purchasing efforts do not infringe upon regulations defining free choice of providers and amount, duration and scope of services provided. We have also noted that states should ensure that there are no duplicate payments made under the Medicaid program and other federal initiatives such as the Financial Alignment Models to Integrate Care for Medicare-Medicaid Enrollees.[3] These are basic Medicaid principles that must be considered in the context of shared savings incentives and covered benefits.

The methodology for calculating shared savings incentive payments does not need to consider all of the individuals who receive care coordination or other care improvements from the providers. There is significant flexibility in how states design the incentive payment calculations in order to focus the goals of the purchasing effort and maximize value. For instance, a state could cover coordinating, locating, and monitoring services to all individuals eligible under the Medicaid state plan as an integrated care model but only calculate the shared savings incentives based on individuals with high cost and complex care needs. Note that this flexibility assumes that a state has a base methodology in the state plan to pay for care coordination with the shared savings payments functioning as a performance bonus. States should also assure that individuals who are not considered within the shared savings calculation nevertheless have sufficient access to care coordination services.

Similarly, shared savings incentive payments may be limited to providers with higher levels of qualification (such as an enhanced ability to report quality measures or an organizational capacity that coordinates care across the delivery system) that have the capability to meet care coordination or improvement goals. States will need to carefully consider and articulate the qualification of providers that are eligible to participate in shared savings payments to ensure that they can provide the accompanying care coordination or other care improvements. At this time, we anticipate that states will be interested in rewarding individual primary care practices directly, or recognizing networks of providers that are organized through a single provider entity, which will pass down savings to individual providers within the network. Either model is supportable through one or more of the implementation options described above.

State Share Requirements

Payments associated with shared savings require an appropriate source of the state share consistent with the financial partnership rules set forth in sections 1903(a) and 1905(b) of the Social Security Act. Although provider payments under a shared savings model are calculated based on achieving reductions in estimated payments that would otherwise have been made, this does not change the fact that those provider payments (whether base payments or incentive payments) are made from both state and federal funds. In order to draw down federal matching funds, the state must contribute a recognized non-federal share of state or local funds. The calculation of savings may not be counted as a "virtual" state funding source and used to draw federal financial participation (FFP). Further, the source of the state share may not be derived from other federal grant sources, so states will need to ensure that federal grant awards are

[3] CMS announced the Financial Alignment Models to Integrate Care for Medicare-Medicaid Enrollees on July 8, 2011 (SMDL 11-008), which offered states the opportunity to partner with CMS to test models for improving care and lowering cost between Medicare and Medicaid.

delinked from the permissible state or local funds that are used to draw down FFP for Medicaid expenditures.

CONCLUSION

We look forward to working with states to develop and learn from shared savings quality incentive payments within the Medicaid program. As you continue to consider and implement transformational efforts, we are available to provide assistance in navigating the policy options and the tools available to you. If you have any questions, please contact Kristin Fan, Acting Director of the Financial Management Group at: 410-786-4581.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
Division of Medicaid and Children's Health Operations

Matt Salo
Executive Director
National Association of Medicaid Directors

Alan R. Weil, J.D., M.P.P.
Executive Director
National Academy for State Health Policy

Ron Smith
Director of Legislative Affairs
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Heather E. Hogsett
Director, Committee on Health & Homeland Security
National Governors Association

Debra Miller
Director for Health Policy
Council of State Governments

Christopher Gould
Director, Government Relations
Association of State and Territorial Health Officials

Attachment A

Shared Savings Resource Materials

Information on the Medicare Shared Savings: Accountable Care Organization Program: http://innovations.cms.gov/initiatives/ACO/index.html

Pioneer Accountable Care Organization Model: http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/

Medicare Physician Group Practice Demonstration Design: Quality and Efficiency Pay-for-Performance: http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Demo_Design.pdf

Physician Group Practice Demonstration Bonus Methodology Specifications: http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Payment.pdf

Physician Group Practice Demonstration Evaluation Report to Congress: http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_RTC_Sept.pdf

Considerations for the Benchmark

The Medicaid total cost of care benchmark is established using historical data to calculate expected Medicaid expenditures for the covered populations attributed in a baseline period and then trending them into the performance period to establish a benchmark. For each Medicaid beneficiary that is counted within the methodology for a given performance period, a state should consider all of the comparable Medicaid service expenditures for those individuals from the baseline year. Typically, to establish the baseline, a state should use complete data from the year prior to the start of the performance period since prior year data reflects the most recent state Medicaid policies. The baseline data are trended forward and may be risk-adjusted to establish the benchmark. States will likely find it appropriate to segment baselines and trends based on specified population characteristics in order to account for variations in expenditures associated with each population. The resulting calculations are the benchmarks against which the performance period will be measured. The baseline should assume costs associated with the care coordination activities (or other projected new service costs) that are expected to result in savings.

Data sources: It is crucial that the baseline accurately reflect the total cost of Medicaid care and trend those costs forward using valid data sources. If the baseline or benchmark is inaccurate or founded on flawed data, the shared saving performance period may not reflect true costs savings (or risk) associated with the care model. We advise states to use paid claims data from the Medicaid Management Information System (MMIS) as the data source for the total cost of care. The MMIS paid claims data should capture all Medicaid payments for the baseline year for each beneficiary. If the MMIS does not include all necessary data, states may need to draw on other supplemental resources to calculate the full range of cost. CMS will need to understand all of data resources that states use in the baseline and benchmark calculations.

Risk Mitigation: To minimize risk avoidance based on selection bias, we advise states to incorporate appropriate risk mitigation strategies to the total cost of care to account for outliers, minimize incentives for patient selection and diagnosis or procedure up-coding, and otherwise adjust for risk between the baseline and benchmark to achieve a more confident savings measurement. This is necessary when the population used to establish the baseline is different from the population that will be in the performance period. Risk mitigation strategies could include the application of risk corridors, or adjustments to high cost and/or low cost outliers and be applied at the state or local level. We do not mandate the use of specific risk strategies as these are likely to be program specific and the adjustments may be appropriate to apply at the state or local level.

Excluded Cost: States may be interested in excluding certain costs from consideration in the payment methodology based on the design of the care coordination incentive effort. This may make sense if states are targeting improvements within certain delivery systems, in specific care settings or for certain populations. For example, if a state focuses on improving coordination in primary care with a goal of reducing higher cost inpatient admissions or emergency visits, it may not make sense to include costs related to long-term home and community based care as part of the payment incentive calculation.

Where costs are excluded from the payment calculation, there may be some risk of artificial savings due to shifts in cost to the excluded services or delivery systems. To understand this potential, we expect that states will calculate the benchmark and performance periods to include the actual total cost of care rather than only those costs that are measured and reimbursed as part of the shared savings payment methodology. States should also have an action plan to address cost-shifting through, for example, suspension of the payment methodology or adjustments to the care incentive.

Comparison Population – To best understand whether the care coordination activities are driving program savings, states may consider monitoring comparison groups that have similar characteristics to the attributed populations in the shared savings methodologies. Such an approach may be optimal if the methodology limits attribution to a particularly high-cost cohort instead of the state's general Medicaid population. For example, if assignment is triggered at discharge from a specific acute care episode or diagnosis, a comparison population may be the best available method to accurately project the cohort's expected expenditures absent the intervention. If the comparison population is an appropriate proxy for the attributed population, this measure should guard against asymmetry and anti-selection, simply stated: poor results based on incomplete information. In this regard, the comparison group, which would not receive care coordination services, provides a reasonable basis to understand whether program savings within the performance period are the result of the new care coordination effort or based on other factors.

Some states may implement care coordination on a statewide basis or with respect to individuals with chronic conditions and there may be challenges in finding comparable, non-participating populations. In those instances, states could consider the pre/post total cost of care of the attributed populations within the methodology as a suitable basis to determine that savings and quality improvement resulted from changes in care delivery that are provided to the attributed populations and that are incentivized through the model.

Trend Projections and Retrospective Analysis: Once a state establishes the total cost of care baseline, trend factors should be applied to project the cost growth that would have occurred in the absence of the new care model that the state is incentivizing. This establishes the benchmark. Considering the dynamic nature of Medicaid programs, the baseline cost data should be rebased to integrate changes associated with reform efforts or other state Medicaid program changes, such as rate increases or decreases, which were not in effect during the baseline period. If such changes are not considered within the state's methodology, the benchmark will no longer align with the performance data. A state's shared savings methodology should clearly describe the timing and basis that the state will use to rebase during the performance periods.

One approach to calculating shared savings is to rely on a retrospective analysis of the savings data. This is the preferred but not required approach. This method would likely eliminate issues related to projection errors that states may encounter in the above model, which projects the benchmark through trend data to establish a savings target, but makes no adjustments based on actual experience to calculate savings. Similar to the Medicare ACO Shared Savings Program, a state could retrospectively review the savings experience of the attributed population to a comparison population and other relevant information that may impact the performance period and make necessary adjustments to the benchmark at the end of the performance year. Since the

information is based upon actual experience, rather than projected, a more accurate benchmark can be established.

States may also opt to take a prospective approach to calculating shared savings using appropriate trends. Generally, states will be expected to develop trends that are population specific and service specific and based on actual, historic Medicaid expenditure data. The trends, in combination with targeted savings projections in the performance period, will provide states with a reasonable understanding of the cost savings target (and anticipated expenditures) related to the methodology. These trends and the benchmark should be rebased annually to consider all adjustments to the state Medicaid program that occur throughout the year. Examples of adjustments that may impact the total cost of care include: modifications to program rates and benefits and other delivery systems improvements or program expansions. In addition, states should retrospectively review the trends at a regular interval, such as annually, to determine whether the projections were in line with real cost growth. As states rebase the benchmark, the retrospective review will help determine any necessary adjustments to the trending data to account for flaws in the original projections.

Considerations for the Performance Periods

The performance period measures the impact of the new care coordination efforts against the total cost of care benchmark. To ensure that program savings are accurate, it is important that the performance period calculation include the same service package and beneficiaries that were included to establish the benchmark. States should use data to project the potential cost savings associated with the care coordination and quality efforts that are measured through the methodology, ideally incorporating such information in the design phase as the various policy options (e.g. risk adjustment, minimum savings requirements, group size requirements, sharing percentages, etc.) are modeled and chosen to maximize the probability the program will result in net savings for the state. Adjustments to the baseline, benchmark and actual performance should also be consistent to account for any program changes that impact the total cost of care.

Attribution Methodology: Attribution is the method by which a state can reasonably credit the activities of a care coordination provider to beneficiary care outcomes and program cost. States may face challenges in determining an appropriate attribution methodology because beneficiaries may lose coverage throughout the baseline and performance years or may not have consistent access to a particular care provider. Some of these issues may be addressed through a retrospective attribution methodology (required of participants in the Medicare ACO shared savings program) where final attribution is determined after each performance year. The retrospective method will likely result in more accurate beneficiary attribution and savings calculations. Retrospective attribution will also reduce risks to states because the final calculation is based on actual data instead of projections. This does create a measure of uncertainty for providers because they will be less certain of the beneficiaries attributed to them in the performance period. An alternative to retrospective attribution is a prospective approach where attribution is based on prior year data and established prior to a performance year. This method reduces risk to some providers because they know the extent of patients attributed to them and can target interventions to particular patients, but it may not result in as accurate a savings calculation and associated payments and could have unintended adverse effects on patient care.

We are not prescribing a methodology for attribution as part of this guidance. However, attribution methodologies should be statistically valid and consider a consistent set of data. CMS expects states to define the method for attribution, describe the data that will be used for the determination and the basis for evaluating the methodology. As discussed in the various Medicare shared savings initiatives, states could use a utilization statistic, such as a proportion of primary care codes rendered within the year by a particular provider, as the basis for attribution.

Minimum Savings Requirements – States may wish to implement symmetrical risk and gain-sharing thresholds to minimize the risk associated with the methodologies to both states and providers. While the objective of a shared savings methodology is to incentivize better care at lower cost, the reality is that not every provider may achieve program savings. This is particularly true when the attributed populations within a methodology are of limited size, as statistical variation in annual expenditures will generally grow as group size decreases. Minimum savings thresholds allow states to offset some of the risk associated with population variability and the difficulty states may have in accurately projecting service expenditures in the performance year. For instance, a state's methodology may not allow for shared savings (or risk) unless a provider demonstrates savings (or losses) exceeding an established percentage of the projected targeted expenditures. Generally, it is advisable that the thresholds grow as the attributed population decreases in number or as variability otherwise increasingly effects the confidence of measuring savings within the attributed population. CMS will be interested in understanding how states make this determination.

Quality Metrics

We plan to release additional guidance on quality metrics as part of this State Medicaid Director's Letter series on new Medicaid care models and payment reform initiatives. We emphasize that shared savings payment methodologies must include a quality component that ensures that savings are the result of care improvements and not due to restrictions on necessary care or some other unintended result. The quality metrics that a state includes as part of a shared savings methodology should be appropriate for the attributed populations, vigorous enough to demonstrate incremental or sustainable improvements in care, and consistent with the state's Medicaid program quality strategy. The state plan methodology should describe how the quality metrics impact the ability of providers to share in savings, such as through a tiered structure that considers quality targets to adjust the savings percentages a provider is eligible to receive.

Program Evaluation

CMS expects that all states will evaluate the effectiveness of shared savings methodologies and make any necessary adjustments to improve programs based on the result of the evaluations. Before approving the shared savings methodology, CMS is interested in understanding the criteria that states will use to measure program success, the time-frame for evaluations, and how states will use the evaluations to improve shared savings incentives. We are interested in learning from the results of evaluations so that we may help other states design effective models and develop national policy on care delivery improvements. Of particular interest to CMS are:

- whether the performance and savings determinations within the model were sufficiently accurate to result in actual net savings for the state, and description of populations for whom it was found particularly difficult to accurately measure savings,
- whether the methodology incentivized providers to alter care practices or to introduce new care practices that appear related to better quality and lower cost in order to meet savings thresholds and improve quality,
- the sustainability of shared savings models and continued quality improvement,
- the particular effects of one care coordination model as compared to another,
- the impact of poor performers on a state's overall delivery systems and strategies to address the poor performers,
- states' potential program changes if all providers achieve the quality and savings targets,
- the sufficiency of data to evaluate the incentives and quality measures,
- best practices and lessons that may help in developing replicable models.

Because of shared saving methodologies are relatively new, states must include an end date within the approved payment methodology to allow states to evaluate the success of the incentive payment based on data that has been collected on quality improvements and cost savings that have been achieved. While we expect states to provide ongoing quality, cost of care and other relevant data that demonstrates the effectiveness of their shared savings incentives, a methodology "sunset" will provide an opportunity for CMS and states to work through a formal review process to make adjustments or end programs that are not achieving desired results. States are expected to share the outcome data with CMS and explain how the findings demonstrate success or a decision to modify or discontinue the payment incentive. A "sunset" does not preclude a state from continuing to reimburse for shared saving incentives that are effective; rather, a state will simply need submit a new state plan amendment (SPA) to modify the sunset to a future date if the review results in the conclusion that the model is achieving the desired effect.

Questions States Should Consider for Medicaid Shared Savings Methodologies

Basic Program Design

1. How does the model promote better care for individuals, better health for populations, and lower costs through improved care delivery?

2. Describe how, if relevant, the model will consider Medicaid changes related to the Affordable Care Act, including the Medicaid eligibility expansion in 2014?

3. Does the model align with other changes to the state's Medicaid program? This could include modifications to payment for Medicaid providers, additional efforts to coordinate care, transform practices and/or promote quality.

4. A description of covered Medicaid services that are paid (all or in part) through the shared savings methodology is required to authorize FFP for shared savings payments under the Medicaid program.

    a. Under which Medicaid authority will the state reimburse shared savings? For guidance related to options for integrated care model implementation, see: SMDL 12-002 "Policy Considerations for Integrated Care Models."

    b. Which services or activities is the proposal requesting to be matched? (e.g. care coordination through an Integrated Care Model (ICM), Health Homes for Enrollees with Chronic Conditions, Primary Care Case Management Contracts, etc.)

5. Does the proposal describe an allowable funding source for the non-federal share of the payments per the statutory requirements of 1903(w)(6)(A) as implemented in 42 CFR 431.51?

Participating Providers

6. Which providers are eligible to receive payment under the shared savings methodology? Are certain providers within these designations targeted? (e.g. primary care practices, mental health and substance abuse providers, long-term care service and support providers, patient-centered medical homes, accountable care organizations).

7. How does a provider qualify for a payment?

8. Which activities must a provider conduct to receive payments?

9. Which quality measures will the state use as a basis to determine payment?

10. If providers are targeted:

    a. Are they targeted through provider qualifications or contracts?

    b. How will a state define eligible providers?

    c. How does the proposal address freedom of choice?

11. If there is a hierarchical structure, such as a network or ACO relationship and are the roles clearly defined to describe each entity's responsibilities and how the levels work together to coordinate care and improve quality?

12. Is provider participation mandatory or optional? If participation is mandatory, are the risk-sharing arrangements consistent with statutory requirements on reimbursement for specific provider types? (For example, the statute requires that total reimbursement to FQHCs and RHCs under an Alternative Payment Methodology may not be less than these providers would have received under the Prospective Payment System.)

13. Are participating providers required to participate in a risk sharing arrangement in order to qualify for payment? Risk sharing arrangements should be described in the proposal, along with the authority under which the state will implement the arrangement.

14. Will shareable savings or risk be determined at the statewide, carrier/network, or provider practice level (or some combination of the above)?

<u>Populations within the Model</u>

15. Are all Medicaid eligible beneficiaries included in the shared savings calculation?

    a. Is beneficiary participation mandatory?

    b. What is the process to inform beneficiaries that their health costs and information will be used in the shared savings methodology?

16. Does the shared savings methodology target specific populations?

17. How does the proposal address state-wideness when populations are targeted? Note – state plan services described under a benefit category must be available state-wide, however, as long as all eligible individuals may receive services under the benefit category, the shared savings calculation may target specific populations.

18. If the shared savings methodology accounts for costs of targeted populations, how are beneficiaries selected (e.g., by age, by condition, by event)?

Methodological Considerations

Actuarial Analysis

19. Did the state conduct an actuarial analysis to assess the validity of the shared savings structure and explain the data, assumptions, and methodology used to develop its analysis? Generally, it should be expected that the development of a shared savings methodology will require analysis at least as thorough as the analysis for developing capitation rates.

Mechanics of the Payment

20. What method will the state use to determine the shared savings amount and distribute payments to providers?

    a. How often are payments made to providers? When are these payments made (within 30 days after the end of the fiscal year, etc.)?

    b. Will provider risk be one-sided, two-sided, or both (e.g. one-sided in initial years, transitioning to two-sided in later years)?

    c. What percentage of the savings are providers and provider organizations eligible to receive?

    d. Are there limits on the amount of additional costs a provider may incur as a result of participation?

    e. How does the state plan to calculate that percentage? For instance, is the percentage tiered based on quality performance or some other factor?

    f. Will there be a minimum savings percentage that must be met in order to prevent payment due to random variation?

    g. How are the claims for the shared savings payments made? Is the MMIS or some other system used to adjudicate claims?

    h. What are the state requirements to hold providers accountable for the required activities and/or interventions paid through the shared savings methodology?

    i. On which line of the CMS-64 will the state report shared savings expenditures?

Attribution Methodology

21. What processes will be used to assign, enroll, or otherwise attribute beneficiaries to providers under the program?

    a. How many beneficiaries must be attributed, enrolled, or assigned in the program to determine statistical validity of the data and outcomes?

    b. How will the program account for beneficiaries who enter or leave Medicaid during the year? (Please note: the actuarial estimates should address this question as well.)

    c. What is the minimum number of beneficiaries required to be attributed, enrolled, or assigned per provider to determine statistical validity of the data and outcomes?

Comparison Population

22. Will the shared savings methodology compare performance to a comparable population that is not included within the methodology in order to assess whether the activities reimbursed through the model result in program savings?

    a. If so, how is this population selected?

    b. Are there potential differences in the populations that need to be considered when developing comparisons?

    c. Are there any potential anti-selection issues to consider?

Baseline Data

23. Is prior year data used as a baseline to measure the effectiveness of care coordination and practice transformation activities rewarded through the payments?

    a. With what level of confidence are the retained measured savings projected to outweigh costs from uncertainties (such as claim variation; selective participation; trend bias; etc.)?

    b. Has the data been risk adjusted for valid comparison with current performance?

24. Is the state measuring total cost of care for individuals in the delivery system or is it only measuring cost in a specific setting, such as in the PCP setting?

25. Does the baseline calculation include all program health costs within or exclude certain claims or services?

26. Does the baseline calculation account for supplemental provider payments that are made in addition to fee for services payments? How are the supplemental payments accounted for in the calculation?

27. How does the calculation treat and consider long-term services and supports?

28. What is the basis for excluding claims or services?

29. Has risk adjustment been designed to minimize the incentive for diagnosis "upcoding" by providers who might otherwise seek to influence the measurement of shared savings by adjusting their diagnosis coding practices?

30. Should the baseline data be segmented to reflect specified population characteristics?

Data Trending

31. What trending factors does the state propose to use to adjust the baseline expenditures and what underlying data were used as the basis of the trend?

    a. Will there be different trending rates based on eligibility categories?

    b. Will there be different trending rates based on service categories?

32. Should the trend data be segmented to reflect specified population characteristics?

Performance Period

33. Does the performance period calculation include all program health costs within or exclude certain claims or services? Do the included claims and services align with the benchmark calculation?

34. What is the basis for excluding claims or services? (Generally, the shared savings measurement should adjust or otherwise account for changes in covered services from the base to performance period.)

35. For the purpose of calculating program savings, would the proposal limit the inclusion of high cost claims above a certain dollar amount? Is this accounted for in the actuarial estimate of savings?

36. How does the plan account for other plan changes?

37. Are shared savings payments reconciled to the other payments made to participating providers?

    a. Are shared savings payments net of care coordination PMPMs or any other payments?

    b. How are risk sharing adjustments made in the payment to providers?

38. What strategies will the state use to minimize incentives for providers to select less costly patients?

39. What strategies will the state put in place to account for outlier patients?

Rebasing the Baseline Calculation

40. How will the baseline data be rebased after an appropriate period of time to account for any delivery system reforms that have been fully integrated?

41. How often and when will the baseline data be rebased?

Measuring Success: Components of an Evaluation

42. What evaluative measures other than cost savings will the state use to determine program success?

43. What process will the state have to evaluate the effectiveness of the shared savings payments?

44. What program modifications or corrective actions will the state implement if the program is not functioning as expected? When will the state take action to modify the program?

45. What evidence, research, or theory is the state employing to ensure that chosen quality measures are indicators of program effectiveness?

46. How is the state ensuring that costs are not being shifted to other health care settings/programs?

47. If process measures are included as performance metrics, what positive contributions to program effectiveness will the process measures indicate?

48. What data measures will be used to ensure that providers are actually transforming their method of care delivery?

49. What thresholds or other criteria are considered successful transformation?

50. How will the state address poor performers?

Attachment D: Cost Proposal Format for RFP #1065

Cost proposal for this RFP should be prepared in the following format, total amounts indicated for the fiscal analysis and outcomes data should include costs associated with up to 2 total on sight visits as deemed necessary. Rows can be added as necessary.

Task	Deliverables	Total amount
Fiscal Analysis	• Acceptance of claims data files • Completion of the data computations and analysis for CY17 claims. January – December includes data receipt, and cleaning, regression and calculations, data analysis and results • Completion of CY17 Utilization and Cost Report Interpretation and final results	
Outcomes Data	• Acceptance of existing data files • Provision of CMS Data • Facilitation of Period 10 data with data quality checks, sending data files back as necessary, creation of the individual dashboards clinics with CY16, CY17 and Period 10 comparisons. • Facilitation of Period 11 data with data quality checks, sending data files back as necessary, creation of the individual dashboards clinics with CY16, CY17 and CY18 comparisons.	
Other	• List other items as deemed necessary by the vendor here	
Total		