Minnesota Department of Human Services Health Care Administration

Request for Proposals for a Qualified Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration

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Table of Contents

I. Introduction & Background 1
A. Purpose of Request 1
B. Objective of this RFP 1
C. Background 1
D. Statutory Authority 2
II. Scope of Work & General Approach 3
A. Scope of Work 3
B. Overview of RFP 3
C. Core Principles of Model 3
III. Application Process 5
A. Overview 5
B. Timeline 5
C. Communications 5
D. Optional Individual Question and Answer Sessions 6
E. Letter of Intent 6
F. Questions 6
G. Application 6
H. Instructions for Application Submission 7
IV. Applicant Eligibility & Participation Requirements 9
A. System Requirements 9
B. Legal Entity, Governance Structure, Leadership 10
C. Community Partnerships & Patient Engagement 10
D. Transition from Legacy IHP Program 10
V. Model Design Elements 11
A. Overview of Model 11
B. Beneficiary Eligibility & Attribution 11
C. Definition of Total Cost of Care 13
D. Payment Models, Mechanisms, Risk 14
E. Interactions with MCOs 16
VI. Quality & Performance Measurement 18
A. Overview 18
B. Quality and the Population-Based Payment 18
C. Quality and the Shared Risk Model 19
VII. Data Sharing & Reports 21
A. IHP Data Portal and MN-ITs Mailbox 21
B. Learning Opportunities 21
VIII. Application Evaluation Methodology 22
A. Evaluation Methodology 22
Glossary of Acronyms 24
Appendices 24

I. Introduction & Background

A. Purpose of Request

The goal of the Integrated Health Partnerships (IHP) program is to improve the quality and value of the care provided to the citizens served by Minnesota's public health care programs. This Request for Proposal (RFP) solicits a response from organizations interested in participating in the Integrated Health Partnership program.

The Integrated Health Partnerships program allows provider organizations to voluntarily contract with the Minnesota Department of Human Services (DHS) to care for Minnesota Health Care Programs (MHCP) recipients in both fee-for-service (FFS) and managed care under a payment model that holds these organizations accountable for the total cost of care and quality of services provided to this population. Within this structure, DHS seeks to expand the IHP program in different geographic regions of the state and across different models of care delivery that will integrate health care with chemical and mental health services, safety net providers, and social service agencies. The projects will include clear incentives for quality of care and targeted savings, and will result in increased competition in the marketplace through direct contracting with providers.

B. Objective of this RFP

The objective of this RFP is to contract with a qualified Responder(s) to perform the tasks and services set forth in this RFP. The term of any resulting contract is anticipated to be three years, from January 1, 2018 through December 31, 2020.

Letters of intent must be submitted by **4:30 pm Central Time on Friday, August 18th, 2017**. Letters may be submitted via email to Mathew Spaan, Manager of Care Delivery and Payment Reform, at mathew.spaan@state.mn.us. The Letter of Intent does not obligate the State to enter into negotiations with the responder, and does not serve as a substitute for the application. The Letter of Intent does not obligate the applicant to complete the application process. Applicants that do not submit a letter of intent by Friday, August 18th, 2017 will not be considered for the IHP program in 2018. A template for submission can be found in Appendix A-1: Letter of Intent Template.

Applications must be submitted by **4:30 p.m. Central Time on Friday, September 1, 2017**. This RFP does not obligate the State to award a contract or complete the project, and the State reserves the right to cancel the solicitation if it is considered to be in its best interest. All costs incurred in responding to this RFP will be borne by the Responder. Details of application submission can be found in Section III, Application Process, and Appendix A, RFP Application.

C. Background

The IHP program has allowed the Minnesota Department of Human Services (DHS) to engage in alternative payment arrangements directly with provider organizations that serve an attributed population, in an agreed-upon total cost of care and risk/gain sharing payment arrangement. Quality of care and patient experience are measured and incorporated into the payment models alongside cost of care. DHS is interested in advancing this accountable care model to continue to

improve the quality of and reduce the cost of care provided to individuals in the state's public programs, such as Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare.

The IHP program was designed to reduce the Total Cost of Care (TCOC) for Medicaid patients while maintaining or improving the quality of care. The first IHP RFP was issued in late 2011 following input from many providers, health plans, consumers, community agencies and professional associations. Trailblazing IHPs signed contracts for their first performance year starting in 2013, and new participants have been added each subsequent year.

Combined, Minnesota's now twenty-one (21) IHPs provide care to over 462,000 Minnesotans enrolled in MHCPs, and have achieved an estimated savings of $156 million dollars. A portion of these savings are used by provider systems to achieve the Triple Aim of health care (reduce the cost of care, improve health outcomes, and improve patient experience), through strategies such as expanding use of care coordinators, extending available hours for primary care clinics, and developing partnerships with community supports that impact the health of members. Additional background on the current IHP program can be located at DHS's Integrated Health Partnerships (IHP) Overview webpage.

D. Statutory Authority

Under the authority of Minnesota Statutes, section 256B.0755, the State is soliciting proposals for Responders to participate in alternative payment arrangements for health care services on a statewide basis as an IHP. The proposed IHP will serve the population of non-dually eligible adults and children in Medical Assistance and MinnesotaCare enrolled under both fee-for-service and managed care programs.

Some aspects of the IHP program may be pending approval from state and federal authorities, which includes but is not limited to state and federal legislation, state waivers and the state plan amendment.

II. Scope of Work & General Approach

A. Scope of Work

The purpose of the IHP program is to provide opportunities for providers and other organizations to develop innovative forms of care delivery through payment arrangements that reduce the cost of care, improve health outcomes, and improve patient experience. The demonstration will be conducted over a three-year contract cycle with annual performance periods. The demonstration will be conducted statewide and is not limited to providers or MHCP beneficiaries in a specified geographic area. This RFP provides the detail of how an IHP can meet the objectives of the program.

IHPs will not administer the MHCP benefit set or pay claims under the demonstration or be required to contract for additional services outside of the services delivered by the IHP.

Nothing in the contract agreement will obviate all providers included in the IHP from meeting all MHCP fee-for-service and/or managed care organization (MCO) requirements including, but not limited to enrollment, reporting, claims submission, and quality measures.

B. Overview of RFP

This RFP provides background information and describes the services desired by the State. It delineates the requirements for this procurement and specifies the contractual conditions required by the State. Although this RFP establishes the basis for Responder Proposals, the detailed obligations, requirements and measures of performance will be defined in the final negotiated contract. Responders must be in agreement with Appendix B, section II, Required Contract Terms and Conditions.

C. Core Principles of Model

The goal of the 2018 IHP model is to introduce enhanced options for participating in value-based payment arrangements based on the past four years of experience and feedback from existing IHPs and state stakeholders, and continue to work towards achieving the Triple Aim of health care for patients in the state of Minnesota. Core principles of the Model are:

- Recognition that “value-based” payment arrangements for health care consist of both cost and quality components.
- Promoting IHP sustainability and innovation through population-based payments paid on a quarterly basis for IHP-attributed patients which will encourage IHP responsibility for patient care coordination, quality of care provided, and Total Cost of Care.
- Addressing non-medical health factors by incentivizing community partnerships between medical and non-medical providers; both recognizing the additional risk and investment required to establish and incorporate non-medical community partnerships into the health system, and rewarding non-medical providers appropriately for contribution to patient and population health.
- Claims-based attribution with an emphasis on primary care but that is flexible based on services provided and coordinated by the IHP.

- Expanding participation in value-based payments to a variety of providers by offering two different payment models that correspond to the entities' ability to bear financial risk and take on full responsibility for patients.
- Actuarially sound benchmarks, cost estimations, and payment mechanisms, for the benefit of the payer as well the provider participating in the value-based payment arrangement.
- Ability to act upon, share, and strengthen health care data and technology in a timely and accurate way.
- Alignment with other federal, national, and state-based value-based payment arrangements and/or existing initiatives to the extent possible.

III. Application Process

A. Overview

Proposals must conform to all instructions, conditions, and requirements included in the RFP. Responders are expected to examine all documentation and other requirements. Failure to observe the terms and conditions in completion of the Proposal are at the Responder's risk and may, at the discretion of the State, result in disqualification of the Proposal for nonresponsiveness. Responders may withdraw their application at any time prior to contract execution with the State. Acceptable Proposals must acknowledge IHP responsibilities and principles as detailed in Section II - Scope of Work & General Approach, meet the requirements in Section IV – Applicant Eligibility & Participation Requirements, and agree to the conditions specified throughout the RFP.

B. Timeline

This timeline outlines the tentative RFP process for the 2018 IHP Contract:

ACTIVITY	**DATE**
RFP Publication	May 15th, 2017
Additional Informational Webinars	May 29th – July 25th, 2017
Individual 30 minute meetings (Optional)	June 7th – July 25th, 2017
All RFP Questions Received	July 25th, 2017
RFP Questions Answered and Posted on DHS Website	Anticipated August 1st, 2017
Letter of Intent Due Date	August 18th, 2017
Proposal Responses Due	September 1st, 2017
RFP Review Completed	Anticipated September 15th, 2017
Notice of Intent to Contract	Anticipated September 21st, 2017
Potential IHP Plenary Sessions	Anticipated Sept. 18th – Sept. 30th, 2017
Individual IHP Contract Negotiations Begin	Anticipated September 25th, 2017
Performance period begins	January 1, 2018

C. Communications

As indicated above, additional informational webinars will be scheduled throughout the open response period prior to the application due date. The dates of these webinars will be announced through the DHS IHP Listserv and on the IHP Website no later than 10 days prior to the webinar occurring.

DHS will also be releasing periodic updates on the RFP as necessary. Communication will occur through the DHS IHP Listserv and on the IHP Website.

- To be added to the DHS IHP Listserv, please email dhs.ihp@state.mn.us or sign up at the link here: Subscribe to DHS IHP Email Listserv
- Link to the IHP Website: www.dhs.state.mn.us/IHP

D. Optional Individual Question and Answer Sessions

All potential provider responders may request one optional 30-minute Question and Answer (Q&A) session **June 7th – July 25th, 2017** either in person or via conference call. The optional Q&A sessions will serve as an opportunity for Responders to ask specific questions of State staff concerning the project. A Q&A session is not mandatory. DHS staff will record all questions and answers provided in the individual sessions and post them to the DHS website. To schedule a Q&A session for your provider organization, please contact Mathew Spaan at mathew.spaan@state.mn.us before or by **July 18, 2017.** Oral responses provided at the conference will be non-binding. Written responses to questions asked at the conference will be sent to all identified potential responders after the conference.

E. Letter of Intent

Letters of intent must be submitted by **4:30 pm Central Time on Friday, August 18th, 2017**. Letters may be submitted via email to Mathew Spaan, Manager of Care Delivery and Payment Reform, at mathew.spaan@state.mn.us. The Letter of Intent does not obligate the State to enter into negotiations with the responder, and does not serve as a substitute for the application. The Letter of Intent does not obligate the applicant to complete the application process. Applicants that do not submit a letter of intent by Friday, August 18th, 2017, will not be considered for the IHP program in 2018. A template for submission can be found in Appendix A-1: Letter of Intent Template.

F. Questions

Potential Responders and/or stakeholders may ask questions about this RFP in various forms. Questions may be sent from the date of RFP publishing until **July 25th, 2017**, to dhs.ihp@state.mn.us, at which point they will be answered, de-identified, and compiled into a final Question & Answer document to be released in early August. Questions sent via email to any other DHS staff will not be accepted or answered. Questions may also be asked in-person, via conference call, or during webinar meetings.

G. Application

Applications must be submitted in its entirety by **4:30 p.m. Central Time on Friday, September 1st, 2017**. The content must include the following:

I. Table of Contents
II. Application (Required questions and information can be found in Appendix A, RFP Application)
III. Application Supplementary Materials (items e-g may be optional)
    A. Provider Roster
    B. Organizational Chart with TINs
    C. Sample Agreement with IHP Participants
    D. List of Participating Clinics
    E. Sample of Community Partnerships Agreement
    F. Additional Proposed Quality Measures
    G. Other Application Requirements, As Necessary

IV. Required Statements (See Appendix B, section I, Required Statements)
   A. Responder Information and Declarations
   B. Exceptions to Terms and Conditions
   C. Affidavit of Noncollusion
   D. Trade Secret/Confidential Data Notification
   E. Documentation to Establish Fiscal Responsibility
   F. Disclosure of Funding Form
   G. Human Rights Compliance
      1. Affirmative Action Data Page
      2. Equal Pay Certificate
   H. Certification Regarding Lobbying

V. Optional - Additional Materials (Any additional information thought to be relevant, but not applicable to the prescribed format, may be included in the optional appendix of your Proposal.)

H. Instructions for Application Submission

Proposals must be physically received (not postmarked) by 4:30 p.m. Central Time on September 1st, 2017 to be considered. Late proposals will not be considered and will be returned unopened to the submitting party. Faxed or e-mailed proposals will not be accepted.

- One (1) original hard copy of the **full application package** must be submitted.
- Six (6) additional hard copies of the **items listed in I.–III. only** of the application package must also be submitted.
- Responder shall also include an electronic copy of the full application package and all required documents on a USB storage device or other electronic storage with the Proposal submission.

Clearly label the original "Proposal – Original" and each copy “Proposal – Copy”. All proposals, including required copies, must be submitted in a single sealed package or container. Proposals should be submitted in three-ring/spiral bound binders or folders with each section indexed with label tabs. The main body of the proposal pages must be numbered and submitted in 12-point font on 8 ½ X 11 inch paper, single spaced. The size and/or style of graphics, tabs, attachments, margin notes/highlights, etc. are not restricted by this RFP and their use and style are at the responder’s discretion.

The above-referenced packages and all correspondence related to this RFP must be delivered to:

Attention: Mathew Spaan
Health Care Administration
Department of Human Services
444 Lafayette Road N.
St. Paul, MN 55155

It is solely the responsibility of each responder to assure that their proposal is delivered at the specific place, in the specific format, and prior to the deadline for submission. **Failure to abide by these instructions for submitting proposals may result in the disqualification of any non-complying proposal.**

This RFP does not obligate the State to award a contract or complete the project, and the State reserves the right to cancel the solicitation if it is considered to be in its best interest. All costs incurred in responding to this RFP will be borne by the Responder.

IV. Applicant Eligibility & Participation Requirements

A. System Requirements

To be considered eligible to participate as an IHP for the purposes of responding to this RFP, a successful Responder must meet the following criteria:

1. Must provide or coordinate the full scope of health care services, as evidenced by provision of coordinated care, and/or prior/current participation in an outcomes-based contract with CMS or Medicaid. Accepted forms of evidence of provision of coordinated care include but are not limited to:
   a. Health Care Home (HCH) Certification
   b. NCQA PCMH Recognition
   c. Current/past participation in IHP demonstration as an IHP
   d. Additional evidence or documentation of ability to provide or coordinate full scope of health care services (See Appendix C-1: Example IHP Health System Characteristics)

2. All providers included in the IHP demonstration payment model must be enrolled MHCP providers.

3. Demonstrate, through the care delivery model, how the IHP will affect the total cost of care of its MHCP beneficiaries regardless of whether the services are delivered by the IHP. MHCP beneficiaries included in the demonstration are non-dually eligible Medical Assistance and MinnesotaCare enrollees attributed to the IHP for the performance period. (See Appendix C-2: Eligible & Excluded Populations)

4. Demonstrate the ability to take on financial risk for the total cost of care of attributed MHCP beneficiaries. IHPs will enter into variable payment arrangements (one of two IHP Tracks) with the state based on the assessed level of ability to take on financial risk. DHS will evaluate applicants' ability to take on financial risk by looking at a nexus of variables and thresholds which capture this, including but not limited to:
   a. the risk and cost variability of the attributed population,
   b. the catastrophic claims cap (i.e. maximum amount of a patients total cost of care that will be included in the IHP's total cost of care calculation) necessary to reach a stable total cost of care estimate,
   c. the percent of claim costs paid inside the applicant's system,
   d. the governance structure and geographic spread of the applicant's system,
   e. the electronic medical record (EMR) and health information exchange (HIE) environment,
   f. historical participation and/or progress in previous Integrated Health Partnership contracts, and
   g. other factors as deemed necessary by DHS.

5. Demonstrate established processes to monitor and ensure the quality of care provided. Participate in quality measurement activities as required by the State and engage in quality improvement activities.

6. Demonstrate the capacity to receive data from DHS via secure electronic processes and use it to identify opportunities for patient engagement and to stratify its population to determine the care model strategies needed to improve outcomes.

B. Legal Entity, Governance Structure, Leadership

An IHP is made up of a network of providers, and may include an organizing entity and agreement of shared governance. This may include but is not limited to a non-profit, a county or group of counties, and other group types. The IHP as a network must meet or demonstrate ability to meet the requirements in Section IV.A, System Requirements, above. All IHP payments must be provided to and/or received from an MHCP enrolled provider. The IHP organizing entity must obtain agreement from participating providers, clinics, and/or health systems in the IHP program prior to the beginning of the contract period in January 1, 2018.

C. Community Partnerships & Patient Engagement

Responders to this proposal must demonstrate how formal and informal partnerships with community-based organizations, social service agencies, counties, public health resources, etc., are included in the care delivery model.

The responder must also demonstrate how the IHP will engage and coordinate with other providers, counties, and organizations, including county-based purchasing plans that provide services to the IHP's patients on issues related to local population health, including applicable local needs, priorities, and public health goals. Responders should describe how local providers, counties, organizations, county-based purchasing plans, and other relevant purchasers were consulted in developing the application to participate in the demonstration project.

The responder must also demonstrate how the IHP will meaningfully engage patients and families as partners in the care they receive, as well as in organizational quality improvement activities and leadership roles.

D. Transition from Legacy IHP Program

The Legacy IHP Program is defined as any IHP contract originating from an IHP RFP prior to this RFP. Going into 2018, health systems that have a current, non-expiring Legacy IHP contract with DHS and that are not interested in participating in the 2018 IHP model will not be required to move into this model. Existing contracts may still be renewed up to their maximum of three years per the contract if requested, and the 90-day renewal notification terms still apply. However, **DHS will not be releasing a Legacy IHP RFP for 2018.**

IHPs whose Legacy contracts have reached their maximum three years of renewal at the end of 2017 must apply for the 2018 IHP model in order to continue participation in the program. The remaining IHPs that have a current Legacy IHP contract which is eligible for continuation through 2018 and are interested in participating in the 2018 IHP model will be required to submit a letter of intent as well as a completed IHP RFP application. Details can be found in Appendix A, RFP Application and Appendix A-1, Letter of Intent Template.

V. Model Design Elements

A. Overview of Model

The 2018 IHP Model provides the option for IHPs to participate as either Track 1 or Track 2 IHPs. All IHPs that meet the requirements and are accepted into the IHP program can be eligible for a quarterly population-based payment (PBP) for the purposes of care coordination that corresponds with its ability to manage an individual's total cost of care. Track 2 IHPs will also be eligible to receive a portion of the shared savings or pay the State a portion of the shared losses as a result of yearly performance against a TCOC target. An overview of the two tracks and the expected provider types that will participate in each model can be found in Table 1 below.

Table 1: Summary of 2018 IHP Model Track Options

Model Type	Model Aspect	Expected Provider Types
Track 1	IHP entity will receive a risk-adjusted quarterly population-based payment (PBP) for attributed population.	Small, independent provider systems, specialty health care groups that coordinate care for specific groups of individuals or a specific major portion of services (including primary care), and a range of other health care providers subject to consideration by DHS.
Track 2	IHP entity will enter into reciprocal risk shared savings and/or shared losses model, and receive a risk-adjusted quarterly PBP.	Health systems or collaborative models with a greater level of integration between participating providers, and ability to coordinate and/or provide the full scope of Medicaid services for attributed patients.

Additional requirements for participation in Track 1 and Track 2 can be found in Section V.D, Payment Models, Mechanisms, Risk, and Section VI, Quality and Performance Measurement.

In order to encourage efficient, effective care coordination and to ensure no duplication of billing or services, **the PBP will take the place of any current Health Care Home or in-reach service payments currently being received by the IHP**.

B. Beneficiary Eligibility & Attribution

For Tracks 1 and 2, attribution will be determined using a retrospective model using a 24-month look back process. Attribution will be determined by an IHP's billing and/or treating provider roster, using one of the following two methods.

- **All-in treating and billing provider roster:** IHPs that select this option will be required to submit a full list of their billing NPIs to be included in the IHP prior to the start of each contract year. A quarterly attestation process will determine accuracy and completion.
- **Select billing and treating provider roster:** IHPs that select this option will be required to submit a full list of the billing and treating provider NPIs to be included in the IHP prior to the start of each quarter. This list must be kept accurate and updated on a quarterly basis.

Submission instructions can be found in Appendix A, RFP Application. Eligible and excluded populations for attribution to IHP can be found in Appendix C-2: Eligible & Excluded Populations.

Attribution Methodology

The following describes the general process for attributing individuals to an IHP, although certain segments of the population may be carved out of the attributed population depending on the purpose for which attribution is being run, as described below. Further details are provided in Appendix D, Attribution Methodology.

Attribution is run on a monthly basis. Attribution will be done using a hierarchical process that incentivizes active outreach and retention of patients by the IHP under the following general methodology:

1. Patients actively enrolled in care coordination through a certified Behavioral Health Home (BHH) submitting a monthly care coordination claim.
2. Patients that cannot be attributed based on BHH enrollment may be attributed to the IHP based on the number of Evaluation and Management (E&M) visits (i.e., encounters) with a provider who specializes in primary care.
3. Patients that cannot be attributed through primary care visits may be attributed to the IHP based on their E&M visits with non-primary care (specialty) providers.

If a patient was not enrolled with a BHH and did not have any E&M claims within the relevant twelve (12) month period and therefore were not attributed to an IHP, then the attribution process described above will be repeated using claims occurring within an additional twelve (12) month period, for a total of twenty-four (24) months. Patients will be attributed to one IHP at a time.

Because the results of the attribution method will impact the size of the population included in each IHP's demonstration payment model, the State and Responder will define contract terms based on subsequent analysis of which patients are actually attributable.

Population-Based Payment (PBP)

As mentioned above, MHCP beneficiaries will be attributed on a monthly basis by DHS to an IHP using retrospective claims data for the purposes of determining the per-member amount and risk adjustment level of quarterly population-based payments (PBPs). For purposes of the PBP, individuals who are receiving care coordination payments through Behavioral Health Homes (BHHs) and/or Certified Community Behavioral Health Clinics (CCBHCs) will be excluded from the population used to determine the magnitude of the quarterly PBP. However, these individuals will be included in Step 1 of the process for attribution that is reported to IHPs on a monthly basis and that is used for the calculation of shared savings or losses.

Base and Performance Period (Calculation of Shared Savings/Losses)

MHCP beneficiaries will be attributed by DHS to an IHP using retrospective claims data for the purposes of determining the Total Cost of Care (TCOC) Target and actual Performance TCOC, according to the general methodology laid out above (see Attribution Methodology).

The attribution for performance measurement is calculated on an annual, calendar year basis. An IHP's target (Base Period TCOC) is based on a review of the attributed population and claims experience for the twelve months preceding contract initiation and includes additional members

that could be attributed during the additional 12 months of "look back" history. Performance Period TCOC is based on the same criteria as the Base Period TCOC, but on the attributed population for the calendar year.

C. Definition of Total Cost of Care

Services Included in Total Cost of Care

All Medicaid covered services will be included in the Total Cost of Care. The State reserves the right to and may modify the services included in the total cost of care calculation under this RFP upon further discussion and consideration. All of the attributed patients' care as provided in the total cost of care definition will be attributed to the IHP, regardless of whether the IHP delivered the services.

Calculation of Total Cost of Care: Specifications and Measurements

The risk-adjusted Total Cost of Care (TCOC) target will be calculated by DHS for all MHCP recipients in both fee-for-service and managed care attributed to the IHP for the performance period, based on the stated services included in the Total Cost of Care.

To assure that a participating IHP does not have the measurement of their performance inappropriately impacted by changes in the risk status of the membership, DHS will perform risk adjustment on the attributed populations in the base period and performance period and adjust the Target TCOC (the "Adj. Target TCOC") to reflect the changes in risk. To further refine the measurement process and reduce the potential variability inherent in any risk score methodology, DHS has developed the following specifications and requirements:

1. **Population Size:** Responders that apply to participate as a Track 1 IHP do not have a minimum population size, however, ability to enter into a Track 1 arrangement depends on the responder's overall population risk and cost profile. Responders that apply to participate in Track 2 must meet a minimum population size of at least 2,000 attributed patients. The prospective number of attributed patients is determined by the roster of providers which is submitted along with the RFP Application (Appendix A, RFP Application).

2. **Claim cap level:** To reduce the potential variability of the risk assessment process and the financial results for Track 2 IHPs, DHS will develop the risk scores and total cost of care per member per month (PMPM) by removing the claim costs for individual members that fall above specific thresholds. This claims cap will not exceed $200,000. Because of the greater impact of large claimants on the results for smaller populations, DHS will determine the claims cap for a given Responder's attributed population during contract development.

3. **Minimum Performance Threshold:** For Track 2 IHPs, DHS has established a two percent (2%) minimum performance threshold that must be met prior to the distribution of any shared savings or losses payments between the State (including its contracted MCOs, as applicable) and the IHP. Specifically, the Performance TCOC must be above 102% or below 98% of the Adjusted Target TCOC in the Integrated IHP for shared savings and losses payments to occur. Once the performance target is met, shared savings or shared losses payments are calculated back to the first dollar, i.e., any amount above or below the TCOC target.

4. **Shared Savings and Shared Losses Payment Distribution:** IHPs participating in Track 2 will enter into reciprocal upside and downside risk arrangements with DHS, within risk corridors proposed by the IHP and finalized during contract discussions. Savings and/or losses incurred will be shared at a rate of 50% by the IHP and 50% by DHS. Modifications to these risk arrangements can be made possible through demonstration of Accountable Care Partnership arrangements, as described in Section VI.C, Payment in Track 2 - Accountable Care Partnerships.

These specifications are preliminary and could be modified based on further negotiations and research prior to contract finalization. A summary of the above requirements for the different tracks can be found in Table 2 below.

Table 2: Total Cost of Care Specifications and Requirements by IHP Track

Model Type	Population Size	Claims Cap	Shared Savings Model
Track 1	No minimum	n/a	n/a
Track 2	Minimum of 2,000 attributed patients	Maximum of $200,000	Reciprocal upside and downside risk with 50% share of savings in each risk corridor, that can be modified according to Accountable Care Partnership arrangements

D. Payment Models, Mechanisms, Risk

Payment in Track 1

Population-Based Payment

Track 1 IHPs will receive a PBP for each individual attributed (as described in Section V.B above), which encourages accountability for the total cost of care of attributed patients, resource utilization, and quality of health care services provided. The total amount paid to each IHP will be based on the number of attributed members and an average base rate for each individual attributed to the IHP. The base rate will vary by the risk and social complexity of each IHP's attributed population. Each quarter, the amount of the PBP will be adjusted to reflect changes to the population attributed to the IHP, according to a schedule and process determined prior to the start of the contract. In subsequent contract years, the amount of the PBP will continue to be adjusted based on the risk and social complexity of the population attributed to the IHP. An IHP's ability to continue participating in the IHP program and receive the PBP may be contingent on cooperation with and performance on quality measures as laid out in Section VI. Quality and Performance Measurement.

Accountable Care Partnership Arrangements

Track 1 IHPs are eligible to additionally participate as an Accountable Care Partner with a Track 2 IHP, based on agreements between the Track 1 and Track 2 IHP. Read more details in the "Accountable Care Partnership Arrangements" section under "Payment in Track 2", below.

Payment in Track 2

Population-Based Payment

Track 2 IHPs will receive a PBP for each individual attributed (as described in Section V.B above), which encourages accountability for the total cost of care of attributed patients, resource utilization, and quality of health care services provided. The total amount paid to each IHP be based on the number of attributed members and an average base rate for each individual attributed to the IHP. The base rate will vary by the risk and social complexity of each IHP's attributed population. Each quarter, the amount of the PBP will be adjusted to reflect changes to the population attributed to the IHP, according to a schedule and process determined prior to the start of the contract. In subsequent contract years, the amount of the PBP will continue to be adjusted based on the risk and social complexity of the population attributed to the IHP. An IHP's ability to continue participating in the IHP program and receive the PBP may be contingent on cooperation with and performance on quality measures as laid out in Section VI. Quality and Performance Measurement.

The full value of the PBP received by the IHP will be included in their relevant performance period Total Cost of Care (TCOC) calculations for shared savings and/or losses, as described below in "Shared Risk Model".

Shared Risk Model

In Track 2, IHP performance assessment is based on a comparison of the observed TCOC for each performance period to a "TCOC Target."[1] The standard share of the savings or losses under the shared risk model is 50% to the IHP and 50% to the State/MCOs, up to a maximum savings and loss threshold agreed to between the IHP and the State (unless modified by an Accountable Care Partnership arrangement, as described below). The TCOC Target is based on a base period TCOC (CY2017) after adjusting for expected trend and changes in attributed population size and relative risk from the base period to the performance periods. The target is expressed as a "per member per month" (PMPM) value.

The Base Period Attributed Population will be determined for each IHP using 2017 claims, MCO encounter data, and the attribution process as described in this RFP. Using this attributed population, the Base Period Total Cost of Care (Base TCOC) will be developed using the full set of Medicaid covered services. Claims for an individual member that fall outside of pre-determined thresholds will be capped to adjust the PMPM results to exclude "catastrophic cases" and better reflect the IHP's target population. In addition, the Base Period Risk Score will be assessed for the assigned members, using the Johns Hopkins ACG® risk adjustment tool to determine the relative risk of the base population.

For each performance period, DHS will develop an Expected Trend rate for the total cost of care based on the trend rates used to develop the annual expected cost increases for the aggregate MHCP population, with appropriate adjustments for services excluded from the Base TCOC or other factors that are applicable to the total cost of care and goals of the program. An initial TCOC Target for the upcoming performance period will be established using the Base TCOC and Expected Trend. The target will ultimately be adjusted to reflect the relative risk of the actual population attributed to the IHP in the performance period.

[1] For purposes of contracts beginning in 2018, the performance periods are defined as calendar Year (CY) 2018, CY2019, and CY2020.

At the end of each performance period, DHS will determine the Performance Period Attributed Population using retrospective claims data and the attribution process as described in this RFP. The Performance Period Total Cost of Care (Performance TCOC) will be calculated, based on the claims incurred by the attributed population during the performance period and the PBP received by the IHP. The TCOC will reflect adjustments for any claims for an individual member that fall outside of pre-determined catastrophic case thresholds. The risk score for the measurement period's attributed population will be used to calculate the change in relative risk from the base period to the performance period. Using the change in relative risk, the Target TCOC will be adjusted based on the increase or decrease in the risk of the attributed populations. The Adjusted Target TCOC will be compared to the Performance TCOC for purposes of determining the performance results and the basis for the calculation of shared savings and losses.

Modified risk arrangements may be negotiated for IHPs that are made up of entities and/or providers that are exclusively paid through an Alternative Payment Methodology (APM) for federally qualified health centers (FQHCs) and rural health clinics (RHC) that covers the cost of all Medical Assistance services.

An example calculation of how the total cost of care target is calculated, the resulting shared savings and/or losses, and how the PBP may be calculated and/or included at the end of the year can be found in Appendix E, Payment Mechanism Methodology.

Accountable Care Partnership Arrangements

Track 2 IHPs that formally partner with community partners and/or Track 1 IHPs may be eligible to enter into a more favorable risk arrangement with DHS. Formal partnerships could include, but are not necessarily limited to, an ongoing legal relationship to provide services to address a population health goal. Eligibility for the Accountable Care Partnership risk arrangement depends on the substantiveness of the community partnership, the amount of risk involved for the IHP and the community partner, and the financial impact of the community partnership on the total cost of care. Examples of areas in which IHPs can pursue community partnerships include but are not limited to: housing, food security, social services, education, and transportation. Track 2 IHPs that are interested in Accountable Care Partnerships must include letter(s) of support from community partners with their IHP application.

E. Interactions with MCOs

The IHP demonstration will be implemented consistently at the delivery system level and for MHCP beneficiaries currently enrolled in either fee-for-service and managed care. DHS will implement and execute the IHP payment model, quality measures and methodology, patient attribution for both MHCP enrollees in fee-for-service and in MCOs under contract with the State to provide services to non-dually eligible Medical Assistance and MinnesotaCare enrollees. The MCOs will participate as a payer in the IHP payment process via their contract requirement with the State.

The State's managed care organization (MCO) contract has been modified to require cooperation with the IHP contracts. The current MCO contracts are posted on the State's public web page at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-

health-care-programs/managed-care-reporting/contracts.jsp. The MCO contract will be further modified as required to meet the objectives of the 2018 IHP model.

MHCP beneficiaries will be attributed to an IHP regardless of whether they are enrolled in fee-for-service or in an MCO. All attributed patients will be calculated together at the IHP level for the purposes of the population-based payment, the Total Cost of Care and the payment model. DHS will calculate the total population-based payments, the total cost of care targets and the shared savings or losses payment across both fee-for-service and managed care using retrospective claims and encounter data. DHS will also calculate the quality measures and overall quality score using data applicable to each measure at the IHP level across both fee-for-service and managed care. The State and its contracted MCOs, as applicable, will each pay its portion of the population-based payments and shared savings payments to the IHP (or the State and its contracted MCOs will receive shared losses payments from the IHP).

MCOs (licensed health plans or County-Based Purchasing Organizations) may not participate as principal Responders in the IHP demonstration.

VI. Quality & Performance Measurement

A. Overview

A core principle of the IHP model is that payment for health care is tied to the quality of the care provided. Responders must demonstrate established processes to monitor and ensure high quality of care provided. IHPs are also expected to participate in quality measurement activities as required by the State and engage in quality improvement activities as an entity.

As explained in Section V.A. of the RFP, Track 1 IHPs are eligible to receive the population-based payment (PBP), and Track 2 IHPs are eligible to receive both the PBP and potential shared savings through a shared risk model. The population-based payment is tied to various quality and utilization metrics. The shared savings payment is tied to the IHP core set of measures which impact how much shared savings an IHP receives. The effect of quality performance on the two types of payment is explained in Table 3 below.

Table 3: The Impact of quality on payment in the 2018 IHP model

Offered Payment Options	Quality Impact
Population-Based Payment	IHP will be evaluated on quality, health equity, and utilization measures to determine eligibility to continue participation after the conclusion of each three-year cycle.
Shared Risk Model	Quality results affect the IHP portion of the shared savings amount but do not influence losses.

B. Quality and the Population-Based Payment

Eligibility to receive the population-based payment is tied to an IHP's ability to evaluate, intervene, and improve the health of its attributed patients. The IHP will work with DHS to agree on quality, health equity, and utilization measures to evaluate the effectiveness of efforts by the IHP to improve the health outcomes of its attributed population.

During contract discussions, the IHP attributed population will be examined to determine its predominant health disparities using DHS data as well as information provided by the IHP. The IHP will be required to propose a health equity measure(s) tied to interventions that are intended to reduce health disparities among the IHP's population.

The IHP will be annually evaluated on the set of agreed upon measures to determine its progress on quality improvement. A lack of improvement or an insufficient quality performance could result in modifications or discontinuation of the population-based payment after the conclusion of an IHP's three-year contract cycle.

C. Quality and the Shared Risk Model

In Track 2, fifty percent (50%) of an IHP's shared savings will be contingent on overall quality measurement results. For quality measurement purposes, DHS will utilize a core set, aligning with statewide and Medicaid measures. An IHP may propose additional or alternate measures, as detailed below. The core set of quality measures and the methodology used to calculate the overall quality score are described below.

Core Set of Measures

The core set of measures is used for calculation of the overall quality score, which affects 50% of an IHP's potential shared savings. The core set of measures is organized into three domains, as listed in Table 4 below: care quality, health information technology and pilot measures.

- The **care quality domain** may include measures selected from the Minnesota Department of Health (MDH) Statewide Quality Reporting and Measurement System (SQRMS), the Adult and Child Medicaid Core Measures Sets, and the Healthcare Effectiveness Data and Information Set (HEDIS). Examples of measures proposed for the care quality domain are listed in Appendix F, Quality Measures.
- The **health information technology domain** will include measures selected from the Medicaid Electronic Health Records (EHR) Incentive Program. Examples of measures proposed for the health information domains are listed in Appendix F, Quality Measures.
- The **pilot measures domain** will include measures that cannot be fully operationalized for the purpose of awarding points for quality performance. Pilot measures provide an opportunity for potential IHPs to propose new or innovative measures or to join with other efforts that focus on their own target populations; IHPs will initially receive points for reporting these measures. Any IHP must propose at least one pilot measure to be included in its core set.

An IHP may also propose alternative core measures relevant for the IHP population of patients. Alternative core measures (except pilot measures) will have to meet the following requirements to be accepted:

- Must utilize a state or nationally recognized quality measure specification.
- The data must be able to be collected by a third-party using an existing data collection mechanism.
- The data must be validated and audited by a third-party.
- Must not be a measure that is impacted by high variability due to coding changes.
- Must assess health care processes and/or outcomes desirable for the IHP population of patients.

Calculation of the Overall Quality Score

DHS will compute the overall quality score using core measures organized into three domains: care quality, health information technology, and pilot measures. The domains will be weighted according to Table 4 below.

Table 4: Quality domains in the core measure set and proposed weights

Domain	Key Elements	Proposed Weights
Care Quality	Prevention & Screening	70%
	Effectiveness of Care for at Risk Populations	
	Behavioral Health	
	Access to Care	
	Patient-centered Care	
	Patient Safety	
Health Information Technology	Meaningful Use of Electronic Health Records (EHR) Technology	20%
Pilot measures	For example: Patient Engagement, Care Coordination, Opioid Use, Specialty measures.	10%

In the care quality domain, points will be awarded for achievement or for improvement.

- Points for achievement will be awarded by comparing the IHP-level results to the statewide distribution of results or Medicaid average rates. DHS will notify the IHP of the statewide distribution of results upon final calculation using the data based on the most recent quality measurement periods.
- Points for improvement will be awarded based on each measure's relative improvement– i.e. the percent change between the performance years.
- DHS will use the greater of the achievement or improvement points to calculate the overall quality score. If any IHP's participating providers do not report required quality measures, the awarded points will be reduced by the percent of IHP participants that did not report.

In the health information technology domain:

- Points will be awarded for attestation to two objectives of the Stage 3 Medicaid EHR Incentive Program: Coordination of Care through Patient Engagement (objective 6) and Health Information Exchange (objective 7). DHS is working to leverage the Minnesota EHR Incentive Program (MEIP) portal for this domain, which may require IHP providers to attest regardless of their MEIP eligibility.[2]
- Points will be awarded by comparing the percent of providers who successfully attested to the ranges agreed upon before the beginning of the demonstration. IHP providers must attest using Electronic Health Record technology certified to the 2015 Edition in order to ensure technological capacity necessary to meet the meaningful use objectives.

In the 'Pilot measures' domain, points will be awarded for reporting only. Pilot measures are those measures that are used and deemed effective by IHPs but cannot be fully operationalized for the purpose of awarding points for quality performance due to a lack of benchmarks.

[2] For the incentive payment under MEIP, health care professionals, hospitals, and critical access hospitals must meet eligibility criteria to be considered an eligible professional and eligible hospital. For purposes of determining scores under the HIT domain of the quality portion of the IHP program, these criteria may not be applicable. MEIP eligible professionals/hospitals who have participated in the Medicaid MU program since 2017 may qualify for both the incentive payment under MEIP and the relevant quality component under the IHP demonstration.

VII. Data Sharing & Reports

A. IHP Data Portal and MN-ITs Mailbox

DHS will make utilization and risk information for its attributed population available to IHP providers via DHS' IHP and MN-ITs data portals. The data will be populated by a monthly set of risk adjustment (Johns Hopkins Adjusted Clinical Groups [ACG®]) output in the DHS data warehouse, and will include both fee-for-service and MCO encounter claim data. Data will be as timely as possible given standard claims lag, and will be available via risk adjustment software output or standardized reports.

Key variables available to delivery systems will be primarily from ACG® output, and will include population-level data (such as the total cost of care and rates of inpatient and emergency department utilization) and patient-level data (such as medical and pharmacy utilization histories, predictive risk information, and indices of care coordination).

The data in the portals will be provided in raw exportable form for IHP use, but will also be provided in easily digestible reports and visual graphics. Examples can be found in Appendix G, IHP Reports and Data. A few examples of the features and reports provided through the DHS IHP Provider Portal are:

- Performance Dashboard
- Total Cost of Care Summary (Breakdowns by Category of Service, inside system vs. outside system, included versus excluded services, by member program, etc.)
- Care Coordination Reports (Care Management Reports, Chronic Condition Profile, Provider Roster Gaps, and Attribution Change Analysis)
- Utilization Reports (Inpatient & ED Trends by Clinic, Pharmacy Utilization and Spend)
- Quality Reports (HEDIS Measures, Summary of Quality and Patient Experience Measures)

A link to the full IHP Report Reference documentation can be found here: IHP Report Reference Documentation

B. Learning Opportunities

IHPs are invited to participate in Quarterly Data Users Group Meetings with DHS. DHS may present on data related topics, answer questions, and facilitate data-related discussions amongst IHPs. Data Users Group meetings are an opportunity for IHPs to communicate and collaborate with DHS and one another.

IHPs are also invited to participate in the annual IHP Learning Day. The IHP Learning Day is a forum to discuss key issues, potential strategies, and future opportunities for IHPs.

VIII. Application Evaluation Methodology

A. Evaluation Methodology

The IHP program is a non-competitive, flexible program that allows for multiple types and sizes of health systems and groups of providers to participate in order to achieve the Triple Aim of Health care for Minnesota's MHCP beneficiaries. The evaluation methodology below is mostly used to discuss an applicant's suitability for the model, clarify questions about the applicant's ability to participate in the IHP, and to consider additional material or discussions necessitated in order to partner with the health system.

At any time during the evaluation phases, the State may, at the State's discretion, contact a Responder to (1) provide further or missing information or clarification of their Proposal, (2) provide an oral presentation of their Proposal, or (3) obtain the opportunity to interview the proposed key personnel. Reference checks may also be made at this time. However, there is no guarantee that the State will look for information or clarification outside of the submitted written Proposal. Therefore, it is important that the Responder ensure that all sections of the Proposal have been completed to avoid the possibility of failing an evaluation phase or having their score reduced for lack of information.

Evaluation Team

An evaluation team will be selected to evaluate Responder Proposals. State and professional staff, other than the evaluation team, may also assist in the evaluation process. This assistance could include, but is not limited to, the initial mandatory requirements review, contacting of references, or answering technical questions from evaluators. The State reserves the right to alter the composition of the evaluation team and their specific responsibilities.

Evaluation Phases

Phase I: Required Statements Review

The Required Statements will be evaluated on a pass or fail basis. Responders must "pass" each of the requirements identified in these sections to move to Phase II.

Phase II: Evaluation of Technical Requirements of Proposals

Points have been assigned to these component areas, totaling 100 possible points. The total possible points for these component areas are as follows:

Table 5: Evaluation Methodology - RFP Point Distribution

Component Total	Possible Points
1. Cover Sheet	5
2. Background Information & Organizational Structure	15
3. Leadership & Management	15
4. Financial Plan & Experience with Risk Sharing	15
5. Clinical Care Model	20
6. Quality Measurement	15
7. Community Partnerships & Social Determinants of Health	15
Total:	100

The evaluation team will review the components of each responsive Proposal submitted. Each component will be evaluated on the Responder's understanding and the quality and completeness of the Responder's approach and solution to the problems or issues presented. All component scores will then be added together to create a proposal's total score.

A minimum score of 40 will be required for Responders to be considered for acceptance into the program. Scoring will generally be used to determine the adequacy and completeness of an IHP's proposal, but as stated above, the IHP model is flexible and supportive of emerging and/or innovative models for inclusion in the program.

Contract Negotiations and Unsuccessful Responder Notice

If a Responder(s) is selected, the State will notify the successful Responder(s) in writing of their selection and the State's desire to enter into contract negotiations. Contract negotiations may entail clarification of questions that arose from the proposal. Until the State successfully completes negotiations with the selected Responder(s), all submitted Proposals remain eligible for selection by the State.

After the State and chosen Responder(s) have been selected, the State will notify the unsuccessful Responders in writing that their Proposals have not been accepted. All public information within Proposals will then be available for Responders to review, upon request.

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APPENDICES FOLLOW.

Glossary of Acronyms

BHH – Behavioral Health Home
CCBHC – Certified Community Behavioral Health Clinic
DHS – Department of Human Services
IHP – Integrated Health Partnerships
E&M – Evaluation & Management
EMR – Electronic Medical Record
FFS – Fee-for-Service
HCH – Health Care Home
HIE – Health Information Exchange
MCO – Managed Care Organization
MHCP – Minnesota Health Care Program
NCQA – National Committee for Quality Assurance
PBP – Population-Based Payment
PCMH – Patient Centered Medical Home
PMPM – Per-Member-Per-Month
RFP – Request for Proposals
TCOC – Total Cost of Care

Appendices

Refer to the 2017 Integrated Health Partnerships (IHP) request for proposals web page to access each of the appendices individually.

Appendix A: RFP Application
- Appendix A-1: Letter of Intent Template
- Appendix A-2: Provider Roster Template
- Appendix A-3: List of Participating Clinics Template
- Appendix A-4: Quality Measures

Appendix B: Required Statements, Terms and Conditions

Appendix C-1: Example Health System Characteristics

Appendix C-2: Eligible and Excluded Populations

Appendix D: Attribution Methodology

Appendix E: Payment Mechanism Methodology

Appendix F: Quality Measures

Appendix G: IHP Reports and Data

Appendix H: Sample IHP Contract