DEPARTMENT OF HUMAN SERVICES

FAQs: Integrated Health Partnerships (IHP) RFP

DHS received the questions in this document via email, phone, webinar and in-person during the question and comment period of May 15, 2017, to July 25, 2017. DHS has de-identified and revised all questions as appropriate for the IHP stakeholder audience.

Attribution

Is attribution criteria similar for the purposes of calculating total cost of care (TCOC) and for the population based payment (PBP)?

The attribution methodology for the purposes of calculating the total cost of care (TCOC) and the population-based payments are essentially the same. The only difference is the time period used to calculate either the TCOC or the amount of the PBP. See Appendix D of the IHP RFP, Attribution Detail Methodology.

However, for the PBP, DHS will carve out the Behavioral Health Home (BHH) and certified community behavioral health clinics (CCBHC) populations. Therefore, IHPs will not receive a PBP for the beneficiaries for whom the IHP has received a BHH or CCBHC payment. Costs for individuals attributed to an IHP via BHH or CCBHC claims will be included in the calculation of the TCOC.

When will attributed members be identified? Before or after performance period? Will attribution be on a prospective or retrospective basis?

CMS prefers that a retrospective payment take place at end of quarter, looking back at patient visits. DHS will use a retrospective attribution methodology to determine both the population-based payment and calculation of shared savings. Please see Appendix D of the RFP, Attribution Detail Methodology, for more detail on the periods used for attribution and performance.

Can a hospital be included in more than one IHP?

For the purposes of attribution, a hospital cannot be included in more than one IHP. However, for Track 2 IHPs that do not have hospitals within their system, it may be necessary to choose a hospital to use for hospital quality measures.

Payment Models

This section is divided into four subsections of questions: overall payment model, the population-based payment, risk adjustment of the population-based payment and total cost of care.

Overall Payment Model

What are the alternate risk models for Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHCs) that are alluded to in the RFP?

The federal government pays FQHCs and RHCs at an "encounter rate" to account for the costs associated with services provided by the FQHC or RHC. When a RHC or FQHC participates in the IHP program, DHS needs to ensure that the total payment(s) received by the FQHC or RHC are not less the encounter rate. Thus, these types of providers cannot take on the full scope of downside risk in a Track 2 IHP model. The current proposed model for supporting FQHC and RHC participation in the IHP program would likely be modified such that the only amount at risk is the amount of the PBP received by the IHP.

What determines if an IHP is eligible for more favorable risk arrangement for IHPs that are partly, but not entirely, made up of RHCs or FQHCs?

Within the IHP Application (see Section II: Background Information and Organization Structure, Question B), there is a place for the applicant to identify RHCs or FQHCs. This information will allow DHS to perform analyses and negotiate terms if the applicant IHP moves to the next state of contract negotiations.

Will the PBP and TCOC savings both be adjusted for social risk?

At this point in the IHP program, DHS will adjust only the PBP for social risk. We are open to discussing ways to add social risk factors (along with clinical risk) into the adjustment for total cost of care (TCOC) savings and losses, but DHS doesn't currently have a methodology for 2018.

How will health plans and DHS make the payments (of shared savings as well as PBP) to IHPs?

DHS is still weighing various factors to decide what makes the most sense – we are weighing the need for administrative simplicity with the complexity of what is already included in the managed care organization (MCO) cap rates. DHS plans to have discussions with MCOs to make a fully informed decision. IHPs, however, will receive the same amount regardless of the methodology used to administer the payments.

Will health care home (HCH) and in-reach claims be carved out from the IHP payments? Will HCH claims be skipped in attribution?

The population-based payment is meant to be a replacement for the HCH and in-reach service payments. If DHS receives a claim for HCH or in-reach services for a patient attributed to IHP, DHS will not pay these claims to the IHP.

For purposes of the PBP, HCH claims will not be "skipped" but rather eliminated from being included in the payment. As a general rule, if someone has been attributed through HCH, the individual should typically also

have evaluation and management (E&M) visits, so this should not impact attribution. We expect to see HCH claims decrease and number of people being attributed via HCH decrease over time, but the overall attribution numbers should remain the same.

Do Track 1 IHPs have to pay back PBP dollars in the event that the IHP does not meet its savings target?

Track 1 IHPs will not have a TCOC target, since the Track 1 model does not include a risk-sharing arrangement and the PBP will not be "at risk". DHS will tie eligibility to continue participating in the model and receiving the PBP after the three-year contract cycle to the Track 1 IHP's performance on a set of quality measures. See the slides from the Payment and Risk Webinar for more information.

Population-Based Payment

Will there be a recouping of the population-based payment?

For both Track 1 and Track 2 IHPs, there will be no direct recouping of the population-based payment. However, poor performance on the quality metrics tied to the population-based payment could limit an IHP's ability to participate in future contract cycles.

For Track 2 IHPs, the PBP will not be directly recouped in a shared losses situation at the end of a final settlement period during the contract. However, it is up to an IHP to decide the funding source from which the losses will be paid.

One exception applies to IHPs that fall under the FQHC and RHC exception and are subject to modified risk arrangements. One option we are considering is that the only amount subject to recouping by the state in the event of a shared losses situation is the PBP amount.

What is the amount of the PBP? When will it be determined for an individual IHP?

DHS ties the PBP amount to an IHP's attributed population, not to individual patients within the population. DHS will calculate the amount of the PBP using claims data and information about the relative risk, complexity and diverse needs of beneficiaries served by an IHP. We anticipate that the information needed to calculate the PBP is information DHS already has. PBP payment amounts will take into account subsets of patients that may drive a large portion of an IHP's costs. If, for example, an IHP's attributed members' risk is higher than average, the IHP's PBP payment will be higher to support the greater resources needed to manage that higher-risk population. Based on current modeling, an IHP with about 5,000 attributed members could receive a total annual PBP of around $200,000 to $300,000 annually and larger IHPs could receive PBP payments of $2,000,000 to $3,000,000 per year.

In the Payment webinar (July 20, 2017), DHS provided a non-binding estimate of $4.50 as a baseline amount of the PBP per individual attributed. This is an average across the average IHP's population, but doesn't incorporate the social risk factors. For purposes of IHPs performing their own analysis, $4.50 would be a good working assumption to weigh the impact of participating in the IHP program, but it may differ once DHS has finalized the methodology.

It is important to note that PBP amounts and methodology are subject to approval by CMS through the State Plan Amendment (SPA) review process. DHS is working to refine the PBP methodology as well as to determine the impact of the PBP on TCOC for Track 2 IHPs. Final decisions on a PBP methodology may take into consideration input provided by potential Track 1 and Track 2 IHPs during contract negotiations. DHS will utilize the information supplied in each potential IHP's application package to calculate an estimated PBP amount during contract negotiations.

Is the amount of the PBP negotiable?

DHS is willing to have individualized conversations about negotiating the amount downward during contract discussions, but is not able to negotiate higher PBP amounts.

Will an IHP be able to know an individual patient's contribution to the amount of the PBP, or will the IHP have to perform its own calculations based on the total amount of the PBP in order to understand this?

DHS will provide reports to help IHPs gain an understanding of the PBP, as well as the anticipated TCOC that includes the PBP. However, because DHS bases the PBP on an average per-person amount, and DHS intend it to be used by the IHP as needed to support their efforts to evaluate, intervene and improve the health of its attributed population, DHS does not intend to provide information on a specific beneficiary's contribution towards the PBP. Furthermore, DHS will base the PBP on the attributed population at a given point in time, which is meant to serve as a proxy for the IHP's population at any given point in time rather than assigning care management of a specific group of people.

How often does the PBP get calculated and distributed to providers?

DHS will distribute the PBP on a quarterly basis, but it may be calculated either on a yearly basis or a quarterly basis. There will be a uniform methodology across all IHPs, however DHS is still currently weighing the options and evaluating the tradeoff between a quarterly and yearly calculation of the PBP given IHPs need for stability, predictability and accuracy. DHS is open to suggestions from IHPs and IHP applicants during the application period and before contracts are finalized.

Does DHS intend to further define specific uses and/or limitations for how the PBP can be used for "infrastructure needs" in order to be considered appropriate for federal and state funding in this demonstration? More broadly, will IHP's be required to provide documentation on how the PBP money is used, as proof that it is used appropriately and as intended?

At this point, we anticipate that the PBP could be used fairly widely on infrastructure needs. The application process is intended to help define the organizations that are receiving the payments, along with the PBP's inclusion in TCOC (for Track 2s) and tying them to quality metrics, which should ensure their proper use. DHS reserves the right to request financial documentation, but does not expect the need to provide documentation at this time. DHS is also still completing the State Plan Amendment process. While this scenario is unlikely, CMS may impose additional requirements on DHS for DHS to receive matching federal funds for the PBP.

Population Based Payment – Risk Adjustment

How can an IHP impact the risk score of their population? Is it something that is only affected by the base period?

An IHP is limited in its ability to directly impact the risk score of their population. To assess clinical risk, DHS uses the John Hopkins Adjusted Clinical Groups (ACG), which is based on diagnostic information associated with the claims submitted, and places individuals into a "risk grouper" in any given 12-month period. For example, if there is a reduction in the diagnostic information, theoretically the risk could go down. DHS encourages IHPs to continue existing coding practices and the risk score will not fluctuate over time within an IHP. If the risk of a population changes over time from the assessment at the base period, DHS and the IHP can work together to understand and adjust to the change. To assess social risk, DHS will use a social risk adjustment methodology that is currently being developed by researchers and staff within DHS, and will be based on social risk factors already present in the IHP's population.

Will DHS use ACG risk to adjust the PBP?

Yes, DHS uses ACG risk to adjust the PBP. The adjustment will be an aggregate of the variable clinical risk levels, weighted across the entire population. However, legislation mandates DHS to adjust the population-based payment for both clinical and social risk ("chronic conditions and social determinants of health, as well as other barriers to healthcare").

What set of data is used to determine the risk?

DHS will use the Medicaid claims and enrollment data of an IHP's attributed population to determine the risk of said population.

For the population-based payment, will the social risk adjustment be applied at the individual patient level or at a more general level? (i.e. individual patient or by zip code?)

Social risk adjustment will include both individual and general factors impacting social risk. Our researchers developing the social risk adjustment methodology are looking at factors such as individual, social and family situations, as well as geography. DHS is currently in the process of weighting these factors across the IHP population and developing a functional way to associate these risk factors with appropriate additional payment to account for the complexity and difficulty of managing care for those experiencing the risk factors. The amount of adjustment for social risk factors will likely be a function of the cumulative amount of social risk factors present in the IHP population, and will result in an add-on to the entire amount of the PBP.

Is risk adjustment fixed or floating? In other words, will change in social risk of the attributed population over time result in an adjustment to the benchmark or will the benchmark remain the same?

For the TCOC calculation, DHS currently monitors and appropriately adjusts the financial benchmark according to change in clinical risk and intends to keep this the same.

We will adjust the PBP according to both clinical and social risk of the attributed population. See the answer to the question "How often does the PBP get calculated and distributed to providers" for more detail on DHS' current thinking about the frequency of calculation of the PBP (which includes risk adjustment).

Will DHS be using 3M's model of social risk adjustment [for the PBP]?

This question refers to work that 3M, as DHS' contracted data analytics vendor for the IHP program, began in 2015. The 3M model is not currently complete, so DHS cannot use it at this time. However, a DHS researcher has received funds to conduct research into social determinants of health and their impact on health outcomes and cost. We are evaluating using this promising research for purposes of this risk adjustment for 2018 payment models. Additionally, the Safety Net Coalition is developing a model that DHS may consider. DHS expects it to be available by late 2017 or early 2018.

Total Cost of Care (TCOC)

Can you confirm that the same excluded population categories as in IHP 1.0 are also excluded from TCOC in IHP 2.0?

Yes, DHS will exclude the costs associated with the populations excluded from attribution (including duals, patients receiving a limited benefit set, refugees, patients with third-party liability, etc.) from the TCOC calculation. Excluded populations are detailed in Appendix C2 of the IHP RFP.

Are drug costs included in TCOC?

Yes, pharmacy costs are included in TCOC.

Partnerships

What are the criteria for accountable care partnerships (ACP)? What is an example of an accountable care partnership?

Accountable care partnerships (ACP) are formal and ongoing relationship(s) between the IHP and a non-medical or social service organization(s) for a specific subset of your population in a way that promotes the health of the IHP population and sustainability for the partner provider. For example, an IHP has a contract with a food security social service provider, such as Second Harvest, to provide nutritious food boxes on a monthly basis. An example of an acceptable ACP arrangement could include a monthly per-member-per-month (PMPM) payment paid by the IHP to the social service organization that could help maintain ongoing costs.

Does an ACP have to be contract-driven?

No, an ACP does not need to be contract driven. However, there does need to be a formal, mutual, written and ongoing agreement. To be eligible for the terms available to IHPs with an ACP, an IHP must submit a letter of support from the social service organization (ACP) along with an IHP's application. We have seen many collaborative informal relationships that have developed within IHPs and accountable communities for health in the State Innovation Model (SIM) but DHS would like to see more resources (i.e. payments, other types of support) provided for social service organizations to ensure these relationships can be sustainable.

What are the favorable risk arrangements for IHPs that have an ACP? How would an ACP affect the risk arrangement within the contract?

Current options are: 1) Non-reciprocal risk (2:1 upside to downside) and 2) receiving greater favorable share of savings in a savings situation.

Does DHS have a list of the types of entities that DHS will consider ACPs?

No, DHS does not have a list of the types of entities that DHS will consider, but please see the overall guidelines on Slide 14 of the IHP 2.0 Overview webinar. DHS is open to the partnerships that an IHP and partner may propose as mutually beneficial to your organizations.

Would DHS expect a certain number of IHP attributed individuals to be affected by the partnership?

DHS is not necessarily expecting a certain number of IHP attributed individuals to be affected. The partnership should apply to and specifically be aimed at addressing concerns that exist in a subset of the Medicaid population or the Medicaid population as a whole.

What ways to mitigate downside risk if an IHP is Track 2?

ACPs are an opportunity for Track 2 IHPs to potentially negotiate a more favorable risk arrangement. Additionally, IHPs that include providers that are exclusively paid through an alternate payment methodology (APM) rate that covers the cost of all Medical Assistance services (i.e., FQHCs, RHCs) may also be able to negotiate modified risk arrangements.

Quality

What are the prospective quality measures for the PBP?

We are considering three or four measures that will be tied to PBP. DHS will include at least one measure from each of the following categories: utilization metrics, health equity metrics specific to an individual IHP's attributed population, and clinical quality metrics. The IHP and DHS will mutually decide on the measures during contract negotiations, but DHS is also open to IHPs' suggestions.

Is it true that quality will have a 50 percent impact on shared savings beginning in 2018 (Performance Period 1)?

Yes, this is correct.

Does the quality methodology apply to all tracks?

The quality methodology varies by the payment method in a given track, whether it is the PBP or for purposes of calculating shared savings. Because Track 1 and Track 2 IHPs both are eligible to receive the PBP, the PBP quality methodology applies to all IHPs participating. For Track 2 IHPs, the shared savings and shared losses quality methodology applies. Quality results impact the IHP's portion of the shared savings amount but do not impact shared losses.

Is the PBP linked to quality performance?

A prospective IHP must be able to meet certain quality requirements to be able to participate in the IHP program. Track 1 and Track 2 IHPs will receive the quarterly PBP for the first three years of the contract. The PBP amount an IHP receives will not be affected by the IHP's quality score. However, DHS will evaluate each IHP on clinical quality, health equity metrics specific to an individual IHP's attributed population, and utilization measures to determine eligibility for continued participation in subsequent three-year contract cycles. Therefore, it is important that all IHPs work on maintaining or improving their performance on quality measures.

Are social determinants of health, disparities efforts and community partnerships measured or incorporated into the quality measure achievement? Or is it related to the ability for IHPs to keep the population-based payment?

DHS will assess and evaluate the social determinants of health, health disparities and community partnerships of each IHP's attributed population. DHS will look at the disparities existing in each prospective IHP's patient population during the base year, and, along with the IHP, will identify appropriate clinical quality, health equity and utilization measures that will evaluate the effectiveness of efforts by the IHP to improve the health outcomes of its attributed population. DHS will discuss appropriate measures during initial contract negotiations. DHS is also open to IHPs proposing new measures in the "pilot measure" category and encourages IHPs to include these in their applications.

An IHP's performance on addressing health equity is related to the ability for IHPs to keep the PBP in the sense that if IHPs can improve upon the measure results then this puts them in a good position to participate again in the next three-year contract cycle.

Quality benchmarks were not presented in the webinars. Will performance expectations and quality benchmarks be available before contracting process?

Availability of performance expectations and quality benchmarks varies by measure, and may be impacted by upcoming changes to Statewide Quality Reporting and Measurement System (SQRMS) that are occurring as a result of 2017 legislation. More information about specific changes to SQRMS and the anticipated timing of these changes is not available at this time.

The core set of measures will generally be the same across all IHPs (with the exception of quality measures that apply to specific populations such as pediatrics), and DHS is open to incorporation of measures proposed by IHPs as appropriate to their population. DHS has already established the methodology for awarding points and determining a quality score. DHS will evaluate an IHP's performance on each quality measure against the benchmarks. More information will be available in the contract.

Will IHPs remaining in IHP 1.0 or legacy contracts have to adjust their quality as a result of IHP 2.0 quality?

No, IHPs in legacy contracts will not have to adhere to the IHP 2.0 quality measurement. However, there are often adjustments to quality as a result of measure changes, measurement system changes, etc., which should be anticipated regardless of whether an IHP is remaining in IHP 1.0 or joining IHP 2.0.

What are the sources of the quality measures used to evaluate the PBP?

DHS uses the Statewide Quality Reporting and Measurement System (SQRMS) and Minnesota Community Measurement (MNCM) measures. DHS will also consider national measurement systems (e.g., CMS' Hospital Compare, NCQA, HEDIS, etc.) when choosing quality measures. DHS is open to suggestions of other quality measures outside of nationally verified systems for pilot measures or for a specific patient population (e.g., pediatrics). IHPs can suggest alternate measures to the core set.

Process

Is the letter of intent required?

Yes, the letter of intent is very simple and gives DHS an idea of how many IHPs will be applying so that we can be prepared to do an adequate review.

Is the application different from the letter of intent?

Yes, prospective IHPs are required to fill out both the letter of intent and the application.

Do existing IHPs have a choice between the old model and the new?

Existing IHPs are given the choice of either continuing in the current contract until the contract terms are over (no later than December 31, 2019) or applying for IHP 2.0. However, DHS will not issue an RFP for the "Legacy" IHP program in 2017. Therefore, existing IHPs with contracts ending at the end of 2017 must apply for IHP 2.0 to continue participation in the program. DHS also intends to release another RFP in 2018 for contracts beginning in 2019.

DHS has stated that we will provide an estimate of PBP for each new IHP applicant. Is it possible to provide this for existing IHPs weighing the option of whether or not to apply?

DHS is not providing pre-application reports for non-applicant IHPs, which includes existing IHPs. However, feel free to reach out to DHS (mathew.spaan@state.mn.us) for further questions or individual organizational discussions.

Will there be an option for existing IHPs to elect to convert to 2.0 through the regular contracting process at the end of the year rather than submitting a proposal by the August deadline listed in the RFP?

For a January 1, 2018, start, organizations may only participate in IHP 2.0 by applying through the RFP process.

Can an IHP enter the IHP 2.0 model under Track 1 and then move to Track 2 (take on risk) during the three-year contract term?

Upon initial review, this scenario would not necessarily be a contractual issue but may likely require re-setting of the target or some other adjustment.

Since the contracts are on a three-year cycle (as in IHP 1.0) with the base period being the year prior to the first year (i.e. 2017), an IHP could potentially choose to switch only after knowing fairly well that they have "padded" the potential savings during the initial couple of non-risk years. Additionally, since the three-year period is intended to allow an IHP to build on or accrue savings across the contract cycle, if we didn't reset the target, an IHP could potentially gain shared savings that accrued in the first two years when there wasn't a risk arrangement. This would be unfair to those IHPs that took on potential downside risk in years one and two.

What data is available to a pre-applicant IHP or to applicant IHPs? Is it possible to review a report of where we are at today, and how have we been trending for the PMPM cost as well as the quality measures?

DHS is not able to provide prospective IHPs with a data report prior to submission of an application. An application does not compel prospective IHPs to enter into an IHP contract. Once DHS receives all of the applications on September 1, DHS will begin to develop several reports that are useful during contract discussions.

The reports that DHS will provide for the purposes of contract negotiation may include, but are not limited to:

- A mock attribution providing an idea of the number of beneficiaries likely attributed based on the provider roster submitted
- The aggregate risk level of the mock attributed population
- The level of the population-based payment (including clinical and social risk factors)

For Track 2 IHP applicant organizations, DHS will also provide a report on the current TCOC, as well as an analysis that shows the IHP's TCOC variability at different claims cap levels.

Other

Will monthly and quarterly reports start to include benchmark comparisons to other IHPs so we can compare IHP performance?

See the IHP RFP, Appendix G – IHP Reports and Data, for more information on what regular reports contain, as well as the IHP Portal (which contains much of the information that is updated on a quarterly and monthly basis). There is no benchmark comparison to other IHPs. The important comparison information, an IHP's TCOC performance against the benchmark, is readily available on the portal dashboard.

On a quarterly basis, we have IHP data user group meetings which provide an open forum for discussions and information between IHPs.

It seems that the DHS shares robust information with IHPs through data, reporting in the portal. Is there opportunity to share data real time?

There is currently no real-time information sharing through the IHP program. However, DHS is currently working on the Medicaid Encounter Alert Service, a real-time Medicaid notification service, and IHPs will be the first to be offered participation in this program. DHS is currently (as of end of July 2017) working to negotiate a contract and have the pilot running within six months. Please notify DHS if you are interested in this opportunity.

Can you comment on timeframe as to when the state will announce the selected vendor for the Medicaid Encounter Alert Service?

Typically, DHS makes the announcement after the contract has been executed. This is near (as of August 15) but we cannot comment as it is under jurisdiction of other state staff and because of procurement rules.

Will the social complexity methodology or social risk factor adjustment be published or available broadly, beyond the proposed IHPs?

The methodology for social risk factor adjustment is still in development, as DHS is still working with a number of different inputs and stakeholders such as the medical director's office and other departments within DHS. We hope that the methodology can be made well known and widely used at some point in the future.

If an IHP is currently in another cost-related partnership with a private or other payer, are the overlapping patients "counted" in IHP savings or losses? Will the savings or losses resulting from these partnerships get backed out of an IHP payment?

The current and planned IHP 2.0 attribution algorithm carves out duals (patients with Medicaid and Medicare claims) so there is no overlap with certain programs, such as Minnesota Senior Health Options (MSHO). However, DHS considers the IHP payment arrangement as trumping any other agreements the IHPs have with other payers. DHS requires MCOs to make payments to IHPs for shared savings.

The RFP states that "(1) DHS will develop an expected trend rate for the total cost of care based on the same unit cost and utilization trend rates used to develop the annual expected cost increases for the aggregate MHCP population." Do you have any indication as to what this has been running?

This refers to DHS' use of the base MCO rate (developed by Milliman for the full MHCP population) as the base rate for the IHP. This is consistent with what the process has been for the IHP program since early on. This "base trend" is listed in the settlement and target exhibits and is provided to the IHPs in late May or June. For 2014 to 2015, the base trend was 3.80 percent for the fee-for-service (FFS) and Special Needs Basic Care (SNBC) population, and 2.16 percent for Prepaid Medical Assistance Program (PMAP). For 2015 to 2016, the base trend was 3.12 percent and 2.35 percent respectively. For 2016 to 2017, it was 2.50 percent and 3.64 percent.