Integrated Health Partnerships
2019 Request for Proposal
Overview

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July 9, 2018
Today’s Agenda

• Overview of RFP, application and contracting process

• Overview of the Integrated Health Partnerships (IHP) 2.0 model
  • Multiple tracks
  • Payment and risk models
  • Quality measurement
  • Participant supports

• Questions?
Additional Informational Opportunities

• Optional individual **Q&A session** – contact mathew.spaan@state.mn.us by July 13th to request

• **Written questions** – submit to dhs.ihp@state.mn.us by July 13th, responses published ~July 20th

• IHP RFP **website** - [http://www.dhs.state.mn.us/DHS-293927](http://www.dhs.state.mn.us/DHS-293927)

• DHS’s IHP **listserv** - [Subscribe here](#)
• **Enhance accountability** for patients’ care, **create incentives for innovative care models** that meet IHI triple aim

• First **six (6) IHPs started in 2013**, covering ~100,000 Medicaid beneficiaries

• We now have **24 IHPs, covering over 460,000 beneficiaries**, with wide diversity and spread

• In 2018, we launched our “**IHP 2.0” model**
Current Impact of IHP

Cost savings: $276 million
People served: 460,000+
Emergency room visits: Down 7%
Hospital stays: Down 14%
Current RFP seeks provider organizations to participate in “IHP 2.0” over a three-year period starting January 1, 2019.

Core principles of model:

- Value-based payment arrangement consists of both cost/utilization and quality components
- Sustainability and innovation through modified payment arrangements, population-based payment
- Importance of non-medical health factors; need to incentivize partnerships between medical and non-medical providers to effectively address patient and population health
- Emphasis on primary care, with flexibility to include non-traditional principal care providers
- Actuarially sound benchmarks, cost estimations, and payment mechanisms
- Ability to act upon, share, and strengthen health care data and technology in timely and accurate way
- Alignment with other federal, national, and state-based value-based payment arrangements
IHP RFP Process | How to Respond

• Letter of Intent (Appendix A-1)
  • Due **July 20th, 4:30 pm** (Central), via e-mail to mathew.spaan@state.mn.us
    1. Organizational information and primary contact
    2. Past experience in value-based purchasing (ex. IHP, MSSP, other ACO or VBP programs)
    3. Certifications at the participating clinics or system level (ex. HCH, NCQA ACO, PCMH)
    4. Intended track
    5. Why interested in participating in IHP program

• Application (Appendix A)
  • **Hard copies** must be received by DHS by **August 3rd, 4:30 pm** (Central).
    
    Attention: Mathew Spaan
    Health Care Administration
    Department of Human Services
    444 Lafayette Road N.
    St. Paul, MN 55155
I. Cover Sheet

II. Application (Required questions and information can be found in Appendix A, RFP Application)
   A. Background Information/Organizational Structure
   B. Leadership & Management
   C. Financial Plan & Experience with Risk Sharing
   D. Clinical Care Model
   E. Quality Measurement
   F. Population Health
   G. Community Partnerships

III. Application Supplementary Materials (items e-g may be optional)
   A. Provider Roster (Appendix A-2)
   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)

V. Optional - Additional Materials
## IHP RFP Process | Key RFP and Contracting Dates

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter of Intent Due</td>
<td>July 20, 2018</td>
</tr>
<tr>
<td>Proposal Responses Due</td>
<td>August 3, 2018</td>
</tr>
<tr>
<td>RFP Review/Evaluation</td>
<td>~August 17, 2018</td>
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<tr>
<td>Notice of Intent to Contract</td>
<td>~August 22, 2018</td>
</tr>
<tr>
<td>Individual IHP Contract Negotiations Begin</td>
<td>~August 22 – September 29, 2018</td>
</tr>
<tr>
<td>Performance period begins</td>
<td>January 1, 2019</td>
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</table>
• Ability to provide or coordinate full scope of health care services

• Innovative care delivery model able to lower total cost of care, enhance quality of care delivered, focus on population health

• Care model includes partnerships with community-based organizations, social service agencies, counties, and public health resources

• Meaningful engagement with patients and families as partners in care delivery, quality improvement

• Ability to take on a level of financial risk/loss commensurate with potential gains

• MHCP enrolled providers able to receive and engage with health data from DHS
• DHS will not be releasing further “legacy” IHP RFPs

• Current IHPs will not automatically transition into the new model; must submit an application to enter into the new model terms

• Current IHPs may continue through current contract cycles; may choose to submit an application for new model prior to cycle ending

• IHPs in their third year will need to submit an application to continue, under the IHP 2.0 model

• DHS anticipates an annual IHP procurement process in future; however future terms may differ
## Overview of 2018 IHP Model | Multiple Tracks

<table>
<thead>
<tr>
<th>Track 1</th>
<th>Track 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Track Overview</strong></td>
<td><strong>IHP entity will receive a risk-adjusted quarterly population-based payment (PBP) tied to clinical, utilization, and social determinant metrics and adjusted for their attributed population’s medical risk and social determinants of health</strong></td>
</tr>
<tr>
<td><strong>Requirements</strong></td>
<td><strong>IHP entity will receive a risk-adjusted quarterly PBP and enter into a two-way risk model for shared savings/losses, tied to clinical, patient experience, social determinants, and HIE infrastructure metrics</strong></td>
</tr>
<tr>
<td>• <strong>Innovative care model</strong> that provide or coordinate full scope of health care services</td>
<td>Same as Track 1, plus:</td>
</tr>
<tr>
<td>• <strong>Demonstrated ability</strong> to impact TCOC, coordinate care, improve quality</td>
<td>• Ability to take on financial risk (based on multiple factors)</td>
</tr>
<tr>
<td>**<strong>Health Care Homes, NCQA cert., other evidence</strong></td>
<td>• Sufficient population to accurately calculate Total Cost of Care</td>
</tr>
<tr>
<td><strong>Applicable Provider Types</strong></td>
<td><strong>Mid or large sized integrated health systems or collaborative partnerships</strong> with ability to coordinate and provide the full scope of Medicaid services for attributed patients.</td>
</tr>
<tr>
<td>• <strong>Small, independent</strong> provider systems</td>
<td>• <strong>Specialty health care groups</strong> that coordinate care for specific groups of individuals or services</td>
</tr>
<tr>
<td>Data and Peer Learning Support</td>
<td>All participating IHPs gain access to robust data files and reports, and peer support opportunities</td>
</tr>
</tbody>
</table>
Beneficiary Eligibility and Attribution
Tracks 1 and 2
Eligibility Exclusions (Appendix C-2):
- Members dually eligible for Medicare (either Part A or Part B at any point during the past year)
- Members eligible only through programs that do not have a full benefit set
- Members with additional (third-party) coverage

Durational Exclusions:
- Members must have at least 6 continuous months or 9 non-continuous months of enrollment in an eligible program

Look Back Period:
- 12 months (plus 3 months run-out) initially, with an additional 12 months (24 total) for unattributed beneficiaries
A critical component of the process is an accurate provider roster from the IHP.

Two roster options:

- **All-in billing provider roster**: Full list of their billing NPIs included in the IHP
- **Select billing and treating provider roster**: Full list of both the billing NPIs and individual treating provider NPIs included in the IHP on a quarterly basis

Details and roster templates are available in Appendix A2 of the RFP.
Population-Based Payment
Tracks 1 and 2
IHP 2.0 | Population-based Payment (PBP)

- Available to both Track 1 and Track 2 IHPs
- Care coordination, infrastructure development, or other activities supporting innovative care delivery models for Medicaid beneficiaries
- Quarterly per member per month (PMPM) payment for attributed population, adjusted by risk, social complexity
- Tied to clinical, utilization, and social determinant metrics
- PBP replaces Health Care Home and in-reach payments
- Included in Track 2 Total Cost of Care settlement calculation
IHP 2.0 | Quarterly Population-Based Payment

- Average PMPM payment rate reflects each IHP’s attributed members’ relative medical risk, impact of social determinants of health
- Clinical risk determined using the Johns Hopkins ACG risk tool
- Social risk includes:
  - Substance use disorder
  - Severe Mental Illness (SMI)
  - Severe and Persistent Mental Illness (SPMI)
  - Deep poverty
  - Housing insecurity
  - Prior incarceration
  - Child Protection Involvement

- Examples of PBP amounts

<table>
<thead>
<tr>
<th></th>
<th>All IHPs</th>
<th>IHP A</th>
<th>IHP B</th>
<th>IHP C</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCOC PMPM</td>
<td>$403.19</td>
<td>$361.00 vs. Avg</td>
<td>$383.00 vs. Avg</td>
<td>$569.00 vs. Avg</td>
</tr>
<tr>
<td>Risk</td>
<td>1.13</td>
<td>0.92 82%</td>
<td>1.08 96%</td>
<td>1.60 142%</td>
</tr>
<tr>
<td>PBP PMPM</td>
<td>$4.50</td>
<td>$4.04 90%</td>
<td>$4.41 98%</td>
<td>$5.35 119%</td>
</tr>
<tr>
<td>Total PBP (10,000)</td>
<td>$484,654.38</td>
<td>$528,838.69</td>
<td>$641,702.02</td>
<td></td>
</tr>
</tbody>
</table>
Total Cost of Care Risk Arrangement
Track 2 Only
• **Two-sided risk** model – potential for additional revenue through shared savings, in exchange for downside risk – paid or collected following performance period

• Generally, similar **upside and downside risk levels**, with 50% share of savings or losses
  • 2% **threshold** before any shared losses or gains
  • Shared savings contingent on **quality performance**
  • Risk levels may be modified with **meaningful partnership** ("Accountable Care Partnerships")

• "Total cost of care" includes the **wide range of Medicaid covered services and PBP** for the IHP’s attributed population

• **Actual Performance vs. Estimated Target** based on **trended, risk adjusted** historical performance

• IHPs may “cap” risk through **risk corridors** (i.e. the band above and below the target for which losses or savings may be paid out)
• Track 2 IHPs may be **eligible for non-reciprocal risk** (i.e. greater upside vs. downside potential), if they enter into formal partnership

• **Ongoing legal relationship** to provide services to address a population health goal; partnerships to be evaluated on:
  • **Substantiveness and sustainability** of the community partnership
  • Amount of **risk involved** for the IHP and the community partner
  • **Impact** of the community partnership on the total cost and/or quality of care

• Must include **letter(s) of support** from partners; sample agreement

• Track 1 IHPs may also act as an “accountable care partner” with a Track 2 IHP
Basic Calculation
• TCOC target is compared to IHPs actual experience to determine the level of claim cost savings (excess cost) for risk share distribution

Target Development
• Calculate the relative risk for the attributed members for base period (i.e. CY2018)
• Calculate the TCOC for the base period
• Apply a claim/medical cost trend factor

Results Assessment
• Calculate the relative risk for the attributed members for performance period (i.e. CY2018, 2019, or 2020)
• Adjust target for the change in relative risk
• Calculate TCOC for the performance period
• Compare the adjusted target to the TCOC results
LOSS:
Savings achieved beyond the minimum threshold are shared from first dollar between the payer and delivery system at pre-negotiated levels.

GAIN:
Savings achieved beyond the minimum threshold are shared from first dollar between the payer and delivery system at pre-negotiated levels.
Quality and Population-Based Payment
• **Population-based payment** is tied to an IHP’s ability to evaluate, intervene, and improve the health of Medicaid beneficiaries.

• **Clinical quality, health equity, and utilization measures** showing improvement in health outcomes.
  
  • Determined through mutual agreement between IHP and DHS

• **Population-based quality score** - eligibility to continue participation in the program after the conclusion of each three-year cycle.
  
  • Will not impact the per member per month (PMPM) payment amount during the initial three-year cycle.
Figure 1: Social Determinants of Health, Healthy People 2020, Office of Disease Prevention and Health Promotion. (https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health)
• The RFP requires potential IHPs to propose a non-binding intervention aimed at address social determinants of health in their population.

• Potential IHPs are also required to propose quality measures tied to interventions that are intended to reduce health disparities among the IHP’s 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.
Example - Community HUB Model

Central Registration – Agencies as a Team

- Mental Health
- County agency
- Hospital
- State-funded outreach program
- Primary Health Home

Community HUB
- Schools
- Community-based agency
- Health Department

One Care Coordinator → One Outcome (Pathway)
- No duplication
- Measurable results, tied to funding
How to Design an Intervention

EQUALITY

EQUITY
Quality and Total Cost of Care Risk Model
Quality and Total Cost of Care Risk Model

The **Total Cost of Care Risk Model** is available in **Track 2 only**.

This is a **two-sided risk model** with potential for additional revenue through shared savings.

Fifty percent (50%) of an IHP’s shared savings will be contingent on overall quality measurement results.
### Core Set: Proposed Measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Key Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Quality</td>
<td>Prevention &amp; Screening</td>
</tr>
<tr>
<td></td>
<td>Effectiveness of Care for at Risk Populations</td>
</tr>
<tr>
<td></td>
<td>Behavioral Health</td>
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<tr>
<td></td>
<td>Access to Care</td>
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<tr>
<td></td>
<td>Patient-centered Care</td>
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<td></td>
<td>Patient Safety</td>
</tr>
<tr>
<td>Health Information Technology</td>
<td>Meaningful Use of Electronic Health Records (EHR)</td>
</tr>
<tr>
<td>Pilot Measures</td>
<td>For example: Patient Engagement, Care Coordination, Opioid Use, Specialty Measures</td>
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</tbody>
</table>
Care Quality Category: Alternative Measures

• 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.
Overall Quality Score: Awarding Points

- Performance is based on **improvement** or **achievement**
- MNCM measures will be assessed relative to statewide benchmarks and relative to the IHP rates from the previous performance year
- HEDIS measures will be assessed relative to Medicaid Aggregate Rate
- HIT measures will be assessed based on the percent of clinicians who achieved the Meaningful Use objectives
- Pilot measures will be credited for reporting only
### Overall Quality Score: Weights and Shared Savings

<table>
<thead>
<tr>
<th>Category</th>
<th>Key Elements</th>
<th>Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Quality</td>
<td>Prevention &amp; Screening</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>Effectiveness of Care for at Risk Populations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Behavioral Health</td>
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<td></td>
</tr>
<tr>
<td>Health Information Technology</td>
<td>Meaningful Use of Electronic Health Records (EHR)</td>
<td>20%</td>
</tr>
<tr>
<td>Pilot Measures</td>
<td>For example: Patient Engagement, Care Coordination, Opioid Use, Specialty Measures</td>
<td>10%</td>
</tr>
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</table>
Provider Supports
IHPs receive a wealth of data on their attributed populations

Data includes:

- Patient and service level detail claims, demographic data, care management reports, delivered through an IHP’s secure MN-ITS account
- Standardized monthly reports produced by DHS, delivered through a secure SAS BI portal (IHP Portal)
- Quarterly Total Cost of Care reports

Allows IHPs to gain a broader picture of both individual patients and overall attributed population
Additional Informational Opportunities

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