Integrated Health Partnerships Request for Proposals (RFP) Q & A Document

Thank you for your interest in the Integrated Health Partnerships RFP, which was published on May 28, 2019. This document is the compilation of questions received about the RFP through July 12, 2019. Questions and responses have been made anonymous, and in some cases summarized to capture the essence of the questions. A table of contents for the submitted questions can be found below.

Overview of RFP Submission Process

Applications must be submitted via U.S. Mail in their entirety by 4:30 p.m. Central Time on Friday, August 2, 2019. 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 F-H may be optional)
   A. Provider Roster
   B. Organizational Chart with Tax Identification Numbers (TINs)
   C. Sample Agreement with Integrated Health Partnerships (IHP) participants
   D. List of Participating Clinics
   E. Equity Measures
   F. Sample of Community Partnerships Agreement
   G. Additional Proposed Quality Measures
   H. 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 and 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.)
Proposals must be physically received (not postmarked) by 4:30 p.m. Central Time on August 2, 2019 to be considered. Late proposals will not be considered and will be returned unopened to the submitting party. Faxed or emailed 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 sections 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 style of graphics, tabs, attachments, margin notes, highlights, etc., are not restricted by this RFP and their use and style are at the applicant’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 applicant 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 applicant.
Questions and Responses

Request for Proposal Process

As an existing IHP, are we required to complete the entire RFP application, or are there sections that do not apply to existing IHPs?

Existing IHPs do need to complete each section of the application. However, if you have 50 percent or more of clinics within your IHP that are Health Care Home (HCH) certified, you do not have to answer the following sections:

- Section V.D. Care Coordination and Health IT Capability
- Section VI.C (related to Quality)

If we completed an application last year but did not move forward with IHP 2.0, do we need to re-submit, or can we add to a previous application?

All applicants must submit a new application each year. However, the 2019 application is very similar to last year’s, so the information can be re-used as appropriate.

Is a hard copy of the Letter of Intent needed?

No, an email copy is acceptable.

Can we stay in the legacy IHP model?

DHS will not be releasing a Legacy RFP in 2019 for contracts beginning in 2020. Therefore, if your organization wants to continue in the IHP program, you must submit a Letter of Intent, an application, and transition to 2.0.

Can an organization be in more than one IHP?

Organizations can only be included as an IHP participant in one IHP due to member attribution methodology. However, as indicated on page 15 of the RFP, a Track 1 IHP may be considered an Accountable Care Partner for a Track 2 IHP.

Provider Requirements and Attribution

We would like to know if specialty providers would qualify for the IHP program based on scope of care.

While we are open and enthusiastic about including specialty providers in the IHP program, we have had discussions with specialty and mental health focused clinics in the past, with varying degrees of success in accommodating the specifics of certain providers to our assignment model, cost metrics, and payment methodology. We are flexible about the types of providers that can participate in the IHP program, but we do need to weigh the desire for flexibility and broad participation with consistent and replicable methodologies across all the IHPs.
Is there a way to show performance by category of Medicaid participation? Can we exclude specific populations (by eligibility) from attribution?

We can show IHP performance by category of service, but we don’t currently provide information on an IHP’s attributed population by program. There are currently no options to exclude specific populations by eligibility or other criteria from attribution.

Please describe further the difference between the Option 1 (All In) and the Option 2 (Billing andTreating Provider) Rosters.

In 2013, DHS developed attribution based on billing and treating NPIs in order to accurately capture the specific providers that IHPs wanted to include in the program. This kind of roster needs to be updated quarterly by the IHP to ensure accuracy of attribution.

In order to make roster management more efficient and effective for both the IHP and DHS, the default roster option is now a list of billing NPIs, and all treating providers billing to the listed NPIs will be included as a part of the roster. The all-in roster creates a more static list that isn’t impacted by workforce turnover, which can have a significant impact on attribution. DHS highly recommends that prospective IHPs select the all-in billing NPI roster if possible.

Some systems use a consolidated billing NPI for all of their sites, which creates a challenge if not all sites are a part of their IHP. If this is the case, then the IHP must provide a billing and treating provider roster.

Community Partnerships and Health Equity Measures

How do we come up with metrics to measure the results of our community partnerships (for example, health equity measures)?

As mentioned in Appendix F-1 of the IHP Application, IHPs will be required to propose an intervention to address social determinants of health, and will be held accountable for agreed upon health equity measures related to the proposed intervention. These health equity metrics can be primarily process measures that assess the IHP’s progress and efforts in supporting the intervention and ensuring that the reported activities are happening. These can be expressed as a rate or percentage with a numerator and denominator, or they can be milestones towards achieving a specific project goal. DHS is committed to working with applicants to develop their equity measures. The following is an example:

- An IHP has proposed a behavioral health intervention and has identified a community mental health center as a partner to provide the behavioral health services for a target set of patients.
- The proposed intervention has three steps: screen, refer and close the loop. Some example health equity measures might be:
  - Number of patients that were screened for behavioral health needs divided by the total number of patients
  - Number of patients whose screening results were positive for behavioral health needs divided by the total patients screened
- Total patients referred to services divided by the total patients that screened positive
- Total patients that received services divided by the total patients referred

What constitutes a meaningful partnership that would warrant a more favorable risk arrangement for Track 2 IHPs?

DHS has developed “Accountable Care Partnership (ACP) criteria” for IHPs interested in proposing ACP arrangements, and can provide a one-sheet guideline for this criteria upon request. Please contact Mathew Spaan (mathew.spaan@state.mn.us) to request this document.

Do we need to decide on the intervention for the health equity measures when we submit the RFP? Or can we develop it during the course of contract negotiations?

No, you do not need to have the intervention finalized at the time of the RFP submission, but must note in the application what still needs to be decided.

Do we need to screen for social determinants of health in every patient we register?

No, the IHP program does not impose specific requirements around screening for social determinants of health, although we encourage IHPs to develop strategies to address social determinants of health, and screening may be a necessary step in the development process.

Our coding department asked about codes for social determinants of health (z-codes). Are we expected to use this information and is the IHP program looking at this?

While we encourage their use, DHS does not currently have any parameters or formal expectations around the use of z-codes in the IHP program.

Financial Model

Can the level of risk vary among the three years?

Yes. Unlike the Legacy IHP model, each of the years that Track 2 IHPs under the 2.0 model participate in is looked at independently. If risk should vary each year, the IHP should be prepared to justify the reasoning behind the variability in the proposal or during contract negotiations.

Can the three-year risk be changed during the contract?

The risk corridors for each of the three IHP contract years are set during contract negotiations, prior to the beginning of the IHP contract. DHS may be open to discussing a change during the three-year contract, with some parameters. DHS must consider the possibility of IHPs attempting to maximize favorable results, fairness across all the IHPs, and reasonableness of the need for a change.
Is the population-based payment (PBP) only calculated once at the start of the contract or every quarter?

The population-based payment is calculated every quarter of the three performance periods in the IHP contract. Because the quarterly amount is based on risk and size of population for each month in the quarter, it may vary from quarter to quarter, but our methodology and analyses have shown the amount to be relatively stable.

Is the social risk adjustment to the PBP based on aggregate or individual social risk?

The social risk adjustment to the PBP is based on actual individual patients’ risk. DHS created an algorithm that assigns a lower per member per month PBP value to lower risk and non-utilizing patients, and a higher PBP value to higher risk patients. For a given patient, the presence of a social risk factor will move them to a “higher risk” band along the curve of the algorithm. However, to arrive at the final per member per month PBP for an IHP in a given quarter, DHS sums up all of the individual per member per month PBPs for the entire IHP attributed population.

What is meant by nonreciprocal risk?

Reciprocal risk means that an IHP’s financial risk arrangement in the contract with DHS reflects an equal opportunity for an IHP to obtain shared savings and also to incur shared losses for a Track 2 participant. There are a few methods available to DHS and the IHP that constitute reciprocal risk, such as: the corridors of risk, the share of the shared savings or shared losses, capped shared savings and shared loss dollar amounts.

A nonreciprocal risk arrangement is one that is more favorable to one party over the other. In the case of the IHP contract, we usually refer to nonreciprocal risk as an arrangement that’s more favorable to the IHP if there is sufficient reason to do so. It could result in one of the following arrangements:

1. Nonreciprocal risk corridors (for example, a potential of up to eight percent of shared savings can be achieved, but only up to four percent of losses incurred)
2. The IHP would receive a greater share of the shared savings and a lesser share of the losses (for example, 60 percent of the shared savings while DHS receives 40 percent)
3. The IHP could cap the shared savings at ten million dollars and the shared losses at five million dollars
4. A combination of the above three

All of the possible arrangements are subject to examination and consideration by DHS.

What is the benefit to the state for allowing nonreciprocal risk?

DHS would like to encourage IHPs to partner with community-based organizations and to invest significant resources to ensure the partnership is relevant, impactful and sustainable for both the IHP and the community-based partner. As further incentive, we offer the option of nonreciprocal risk arrangements for systems in Track 2 IHPs.
**Is it required to have a data-sharing component to partnerships with community-based organizations?**

No, it is not required to have a data-sharing component to partnerships with community-based organizations, although it is encouraged when it is relevant.

**Is the money funding the PBP coming out of another payment source that’s already coming to the IHP?**

The funding for the population-based payment comes from a number of different sources. The PBP was designed in part to help resolve the issue of the difficulty of billing for other forms of care coordination and population health management payments such as Health Care Home (HCH) claims and In-reach payments. Also, the PBP functions as a pre-payment of shared savings. The PBP will be included in the performance period’s total cost of care for determining any settlement amounts made between the state and the IHP.

**Quality**

**Is a core set of measures required for Track 2 only or both tracks?**

The core set of quality measures are only required for Track 2 IHPs. However, Track 1 IHPs are held accountable for an agreed upon set of utilization and clinical quality measures in addition to health equity measures.

**Minnesota Community Measurement (MNMC) no longer requires CAHPS data reporting. How are we expected to collect this information?**

A DHS-acquired vendor will implement Consumer Assessment of Health Plans (CAHPS) surveys for the IHP program. There is no expense or labor for the IHPs. DHS will execute the survey.

**Other Questions**

**Does the John Hopkins ACG system only consider medical risk or does a separate data point tie in the medical risk with the social risk?**

John Hopkins only includes medical risk. DHS has created algorithms to adjust individuals’ risk based on additional specific social risk factors that show an increase in actual costs over the expected costs for an individual.

**What is the relationship between IHP 2.0 and other models that use the integrated health partnership naming convention?**

IHP 2.0 is a continuation, or next iteration, of the IHP model that has been in place since 2013. IHP 2.0 is the model for this specific RFP.

In late 2017, DHS also released a “Request for Comment” on a model that is currently being called “Next Generation IHP.” That model remains in development.