2025 Integrated Health Partnership (IHP) Request for Proposal (RFP) Questions and Answers (Q&A)

Note: Questions are arranged by topic as labeled in the RFP

Detail of Proposal Components

Question: What is the range of options for contract changes for a Track 1?

DHS Response: A lot of the IHP contract is boilerplate language and we do not have the authority to change it without consulting our contracts attorneys and/or the Minnesota Department of Administration. Applicants are encouraged to have their legal team review the contract prior to submitting an application and any exception requests should be noted on the Exceptions to Sample Contract and RFP Terms (DHS-7019-ENG) form as a part of the application.

Introduction

Question: Is this a competitive bid or is there only a requirement to meet contractual requirements for a Managed Care Partner?

DHS Response: The Integrated Health Partnership (IHP) demonstration is a voluntary program and the IHP Request for Proposal (RFP) is not a competitive bid. Responders must meet the system requirements detailed within Section 5 of the RFP (beginning page 11) as well as earn a minimum of 60 total points on their proposal, as detailed within section 9 of the RFP (starting on page 28). It is important to note that the IHP program (and related contract) differs significantly from our Managed Care Organization (MCO) contracts. Broadly, the IHP program entails direct contracts between the State and health care providers or their representative bodies (e.g., provider-led accountable care organizations). While MCOs can partner with provider organizations to respond to this RFP as noted in section 6.5 of the RFP (page 22), MCOs may not participate as principal Responders in the IHP program.

Question: Is there information available on the contracts that the State has with Managed Care Organizations (MCOs)?

DHS Response: Information regarding MCO Contracts can be found on the Department of Human Services (DHS) MCO website at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp

Question: Can a behavioral health program apply to be an IHP?

DHS Response: This IHP program is driven by primary care and does not have a behavioral health only option. Therefore, it is most appropriate for primary care or primary care adjacent providers. However, we welcome all those who are interested to submit a proposal.

Objective of the RFP

Question: What is the potential term of the contract? Can a contract be up to 10 years?

DHS Response: The term of any resulting contract is anticipated to be for four (4) years, from January 1, 2025, until December 31, 2028. The STATE may extend the contract one additional year, for a total of five (5) years.

Question: Is this RFP limited to only:

a. Dakota County
b. Hennepin County
c. Ramsey County
d. Washington County

DHS Response: The IHP RFP is open to all geographical areas of Minnesota and is not limited to certain counties. Please refer to the Objective of the RFP section on page 4 of the RFP for more information.

Overview of Model

Question: Is there opportunity for adjustment of quality measures – for example if there are measures where an IHP can't impact?

DHS Response: Yes, but it is important to note that for the Total Cost of Care (TCOC) quality measures for Track 2 IHPs were selected considering agency and program goals. IHPs may propose alternate measures for discussion with DHS. However, the IHP should clearly articulate why the selected measure(s) is more appropriate for the IHP patient population. Any alternative measure must meet the following criteria:

- 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.

Question: For an applicant that may be on the cusp of 5,000 attributed Medicaid lives, how does an IHP determine if it is best to apply for a Track 1 or a Track 2?

DHS Response: The minimum attributed population of 5,000 for Track 2 IHPs is intended to reduce the variability of the Total Cost of Care (TCOC) calculations from year to year merely due to changes in an IHP's

population. However, other characteristics (such as wide risk variation or a unique patient mix) also need to be taken into consideration to determine if a respondent's likely attributed population is sufficient to allow participation in a Track 2 risk arrangement. We encourage those respondents that anticipate they may be close to the 5,000 attributed lives but are interested in participating in the Track 2 IHP model to submit an application indicating their interest. If selected to move forward in the contracting process, DHS will perform a variability analysis on the anticipated attributed population to determine which Track is the best fit. Respondents that are interested in participating as a Track 2 IHP, but unable to due to excessive variability, will instead automatically be considered for Track 1 participation.

Question: Is there an opportunity to switch tracks between years?

DHS Response: In some circumstances, DHS may consider this. The technical process for executing this would be through an amendment to an IHP's contract. However, there is no guarantee an amendment will be granted. DHS and the IHP would need to have conversations as to the request to move from one track to another and determine if switching tracks makes sense given the specific situation. Other factors such as risk analysis and population size would be factored into the decision.

Question: If there are new organizations that wish to join our IHP in future contract years, would we need to submit a new application or is there an amendment process?

DHS Response: In general, existing IHPs may add or otherwise modify their participating providers through a contract amendment. However, the addition of new providers may require other changes to an IHP's contract, such as resetting the IHP's base period or modifying risk terms. An existing IHP interested in adding or modifying their participating providers should contact DHS staff to discuss the specific circumstances and changes needed.

Payment Models, Mechanisms, Risk

Question: How many Integrated Health Partnerships (IHPs) have taken on financial risk? Of those IHPs taking risk, how many have had to repay money to the Department of Human Services (DHS)?

DHS Response: There are currently 9 IHPs in a Track 2 "Risk Sharing Option." Of the 9 IHPs in a Track 2 model, 2 have had to repay money to DHS.

Question: Can an IHP propose a graduated risk scale with a capped maximum dollar exposure? For example, Year 1 = $0, Year 2 = $100K, Year 3 = $200K.

DHS Response: An IHP's risk arrangement does not necessarily have to be the same each year of the contract. However, in order to receive upside shared-savings potential, an IHP must participate in a Track 2 IHP model and have downside risk. The terms of the downside risk are assumed to be reciprocal (i.e. if an IHP wants to gain a share on the first 5% of savings they must also accept downside risk on the first 5% of any losses) unless the IHP includes the participation of an Accountable Care Partner, in which case they may enter into a 2-to-1 non-reciprocal risk arrangement. Respondents interested in a graduated risk arrangement should provide sufficient detail within their application for DHS to consider this option.

Question: What is the impact of a $200,000 claims cap adjustment versus when a claims cap is set at $100,000?

DHS Response: DHS utilizes a claims cap adjustment or truncation to minimize the impact of patient cost outliers on their overall Total Cost of Care calculations. For example, when a claims cap is set at $100K, an individual patient's costs are capped at $100K over the relevant performance period (i.e. any costs above that claims cap are not included in the Total Cost of Care calculations). If the claims cap is set at the higher $200k amount, then more of an individual patient's costs are included in the Total Cost of Care calculations.

Question: Will 2023 or 2024 be the base year for calculation for benchmarks for both TCOC and Quality for contracts starting 2025?

DHS Response: For contracts starting in 2025, the base period for the Total Cost of Care targets throughout the contract will be 2024. For quality, the base period is the year prior. For more information, please refer to Section 16: Total Cost of Care - Financial Calculation Information in the 2025 Sample Contract.

Question: Is Quality Performance only a reduction of shared savings and shared risk? For example, what would be the impact of these scenarios:

Scenario 1

* Overall quality score of 80
* Final Shared savings of $1,000,000
* Is savings split 50/50 for payment of $500,000 DHS/IHP each and then the IHP payment reduced by 20% for total payment of $400,000?

Scenario 2

* Overall quality score of 80
* Final Shared risk of $1,000,000
* Risk split 50/50 with DHS and IHP ($500,000 each)
* What is the impact of quality to the amount repaid to the state?

DHS Response: For Scenario 1: Quality's impact is on 50% of the IHP's shared savings. If the IHP's shared savings are a total of $500,000 then quality will impact 50% of that (i.e., $250,000). In this scenario that means the IHP keeps $200,000 of that $250,000 (i.e., 80% of that $250,000). The IHP total shared savings would be $450,000 (i.e., $250,000+$200,000).

For Scenario 2: If the IHP has shared loss of $500,000 quality will again have a 50% impact, but this time it is on the shared losses (i.e., $250,000). In this scenario quality mitigates the losses. If the TCOC quality score is 80% then the IHP will have to pay back 20% (i.e., $50,000 of the $250,000). The IHP total portion of the shared losses would be $300,000 (i.e., $250,000+$50,000).

Question: What is the required size for a Track 2?

DHS Response: For an IHP to be considered for a Track 2 a minimum of 5,000 attributed patients is needed.

Question: The RFP states, "Track 1 IHPs are eligible to additionally participate as an Accountable Care Partner (ACP) with a Track 2 IHP, based on agreements between the Track 1 and Track 2 IHP." Can you please explain this more?

DHS Response: A Track 2 risk bearing IHP can partner with a Track 1 non-risk bearing IHP as their Accountable Care Partner. This allows the Track 2 IHP to enter into a non-reciprocal risk arrangement with the state, as described in the "Shared Risk Model" section of the RFP. Track 1 IHPs do not take on risk; therefore, partnering with a Track 2 IHP will not modify their contract.

Question: In regards to the Risk Adjustment Model - PBP Payment, in addition to indicators, does Risk Coding flow to this?

DHS Response: Yes. The first step of determining an IHP's population-based payment (PBP) is to look at the individual and population clinical risk of the IHP's attributed population using the Johns Hopkins ACG® risk adjustment tool. We then conduct a social risk adjustment based on the IHP's population's individual social risk factors. More detail on the Patient Attribution Method can be found in Appendix C "Attribution Detail Methodology". More detail on Terms of Payment for PBP can be found in Section 5 "Payments" of the 2025 Sample Contract.

Question: Can a Track 2 IHP enter into an ACP with a behavioral health group?

DHS Response: Yes. DHS encourages collaboration with community partners.

Question: The IHP RFP indicates 'Providers that show an overall savings across their population, while maintaining or improving the quality of care, can receive a portion of that savings. Providers that cost more over time, potentially have to pay back a portion of the losses'. What is the impact of reimbursement to Indian Health Service sites that are currently eligible for reimbursement at the OMB/All Inclusive Rate?

DHS Response: Participation in the IHP program generally doesn't change the current reimbursement methodology or amounts paid to IHP participating providers, aside from the impact of the PBP on Health Care Homes and In-reach service payments. An Indian Health Services (IHS) provider would continue to be eligible for reimbursement at the OMB/All Inclusive Rate, even as an IHP participant. However, due to the nature of the All-Inclusive Rate, we believe that Indian Health Service providers would not be eligible for downside risk, and so would not be able to participate in the Track 2 IHP model. However, Indian Health Services provider <u>are</u> eligible to participate in the Track 1 IHP model, and that participation should not impact their All-Inclusive Rate reimbursements.

Question: For interim shared savings or losses, are those payments expected at the time of those determinations or do they wait for final results the following year?

DHS Response: Payments for interim shared savings (except for a portion withheld for the quality score) are made to IHPs at the time of those determinations. Payments by IHPs for interim shared losses are not made until final settlement results are calculated. Please refer to Section 5.4 "Terms of Payment for Shared Savings and Losses" of 2025 Sample Contract (Appendix G of the RFP).

Question: Questions around the alternate risk arrangements with an ACP in the program:

a. If we chose a 70/30 split with DHS, how does this apply?

i. For shared savings, the IHP would receive 70% and DHS 30%?
ii. For shared risk, is the IHP liable for 30% and DHS 70%?

b. If we chose a 2% upside/4% downside share and had a 2.9% loss (including PBP payout), is there anything payable back to DHS?

DHS Response: Track 2 IHPs that have an Accountable Care Partnership (ACP) are eligible for an alternative risk arrangement that allows for a 2-to-1 upside to downside non-reciprocal risk.

An IHP may choose to apply this 2-to-1 risk in one of two ways – either by choosing non-reciprocal *risk corridors* or non-reciprocal *shares* between their savings and losses.

In a standard Track 2 IHP model without an ACP, an IHP's upside and downside risk corridors must mirror each other. Additionally, the IHP's share of savings or losses within both the upside and the downside risk corridors are set at 50% (i.e. the IHP gets 50% of their total savings amount that falls within their upside risk corridor or must pay back 50% of total losses within their downside risk corridor). The following is an example of a standard arrangement for an IHP without an ACP that wanted potential savings up to 10% of their target:

Standard Track 2 Risk Arrangement Example

% of Adj. Target TCOC (Risk Corridors)	IHP/DHS Distribution (Risk Share)
>110%	n/a
100%-110%	50%/50%
90%-100%	50%/50%
<90%	n/a

In the first option identified above, a Track 2 IHP with an ACP may choose to modify the *risk corridors* to reflect a 2-to-1 upside advantage, while retaining the *50% share* of both savings and losses. The following table shows how this option would modify the standard arrangement example above:

Modified Risk Corridors Track 2 Risk Arrangement Example

% of Adj. Target TCOC (Risk Corridors)	IHP/DHS Distribution (Risk Share)
>105%	n/a
100%-105%	50%/50%
90%-100%	50%/50%
<90%	n/a

Note that the savings risk corridor (90% - 100% of the target TCOC) remains at 10%, while the loss risk corridor (100% - 105%) is reduces to only 5%. Across both corridors, the share of savings or losses remains the same.

In the second option, a Track 2 IHP with an ACP may choose to keep 1-to-1 upside and downside *risk corridors* and instead modify the *share* of savings and losses within those corridors. In this option, the IHP receives 70% of total shared savings that fall within the upside risk corridor while only having to pay back 35% of total losses that fall within the downside risk corridor. The following table shows how this option would modify the standard arrangement example above:

Modified Risk Share Track 2 Risk Arrangement Example

% of Adj. Target TCOC (Risk Corridors)	IHP/DHS Distribution (Risk Share)
>110%	n/a
100%-110%	*70%/30%*
90%-100%	*35%/65%*
<90%	n/a

Proposal Submission

Question: Can an application be submitted prior to the proposal due date to receive feedback from DHS in order for changes to the response to be made prior to the final submission of application?

DHS Response: Applications may be submitted at any time prior to the due date of August 14, 2024. However, due to procurement rules, we are unable to review proposals prior to the August 14, 2024, proposal due date. To be awarded an opportunity to enter into contract negotiations, successful Responders must meet the system requirements detailed within Section 5 of the RFP (beginning page 11) as well as earn a minimum of 60 total points on their proposal, as detailed within section 9 of the RFP (starting on page 28).

Quality

Question: Can an existing IHP make tweaks to their current population health measure for the next contract round?

DHS Response: Yes. When submitting your application, please be as detailed as possible in the changes you would like to make to your population health measure (also known as the Health Equity Measure). Applicant IHPs who participated in the IHP program in performance year 2024 may propose to continue the equity intervention included in that contract in response to this RFP. However, these Applicant IHPs must clearly indicate previous learnings, articulate how those learnings are incorporated into the intervention, and clearly identify changes being made to expand or enhance the intervention. These Applicant IHPs will need to consider enhancements to existing metrics or propose new metrics that more effectively capture the impact of continued interventions.

Quality and the Population-Based Payment

Question: Can an existing IHP select a new population health measure if awarded a new contract?

DHS Response: Yes, existing IHPs may select a new population health measure (also known as the Health Equity Measure) when submitting their RFP. DHS is interested in IHPs proposing interventions that are most applicable for their population. Interventions proposed by existing IHPs may be new or a continuation and expansion of the current initiative.

Quality and the Shared Risk Model

Question: Are the Total Cost of Care (TCOC) Quality Measures applicable to Track 1 IHPs? Are Track 1s required to do the equity measures report?

DHS Response: The Total Cost of Care Quality measures only apply to Track 2 IHPs. The report shown in Appendix I "Sample Equitable Care Report" is a part of the Total Cost of Care Quality Measures in the Equitable Care category, which is applicable to Track 2 IHPs, and this reporting requirement is only for performance period 1 of the contract as subsequent years will be based on quality measurement data. This reporting requirement does not apply to Track 1 IHPs.

Social Determinants of Health and Community Engagement

Question: We are in the process of working on our application, can DHS provide more detail as to the kind of activities and collaboration DHS is looking for in regards to engaging others?

DHS Response: DHS encourages collaborations with MCOs, County Based Purchasing (CBPs), counties, providers, and other community organizations. IHPs can determined the nature of the partnership based on the needs of their population and community.