DEPARTMENT OF HUMAN SERVICES

Minnesota Department of Human Services Healthcare Research and Quality Division

Request for Proposals for a Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through Track 1 or Track 2 of the Integrated Health Partnerships (IHP) Demonstration.

Minnesota's Commitment to Diversity and Inclusion:

It is State of Minnesota policy to ensure equity, diversity and inclusion in making competitive grant awards. See Executive Order 19.01.

The Policy on Rating Criteria for Competitive Grant Review establishes the expectation that grant programs intentionally identify how the grant serves diverse populations, especially populations experiencing inequities and/or disparities. See OGM Policy 08-02.

Americans with Disabilities Act (ADA) Statement:
This information is available in accessible formats for people with disabilities by calling 651-431-3612 or by using your preferred relay service. For other information on disability rights and protections, contact your agency's Americans with Disabilities Act (ADA) coordinator.

1. INTRODUCTION

1.1 Objective of RFP

The Minnesota Department of Human Services, through its Healthcare Research and Quality Division (STATE or DHS), is seeking Proposals from qualified Responders to perform the tasks and services set forth in this Request for Proposal. The term of any resulting contract is anticipated to be for four (4) years, from January 1, 2025, until December 31, 2028. STATE may extend the contract up to a total of five (5) years.

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 Partnerships (IHP) program.

The IHP program allows provider organizations to voluntarily contract with DHS under a payment model that holds these organizations accountable for the total cost of care and quality of services provided to this population while providing care for Minnesota Health Care Programs (MHCP) recipients in both fee-for-service (FFS) and managed care. Within this structure, DHS seeks to expand the IHP program in different geographic regions of the state and across the full scope of care, and incentivizes the inclusion and integration of substance use and mental health services, safety net providers, social service agencies, and community-based organizations. The project includes incentives for improving quality of care, addressing health disparities, addressing social determinants of health, targeted savings, and will result in increased competition in the marketplace through direct contracting with providers.

1.2 Proposal due date

Letters of Intent must be submitted by 11:59 p.m. Central Time on Friday, August 2, 2024. Letters must be submitted on letterhead via email to Mathew Spaan, Interim Director of the Health Care Research and Quality Division, at Mathew.Spaan@state.mn.us, cc IHP.Admin.DHS@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 proposal. The Letter of Intent does not obligate the Responder to complete the proposal process. Responders that do not submit a Letter of Intent by 11:59 p.m. Central Time on Friday, August 2, 2024, will not be considered for the IHP program in 2025. A template for submission can be found in Appendix A1: Letter of Intent Template.

Proposals must be submitted by 11:59 p.m. Central Time on Wednesday, August 14, 2024. This Request for Proposal (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 Responder. Details of proposal submission can be found in Section 4: RFP Process, Section 4.6: Proposal Submission, and Appendix A: Integrated Health Partnerships Application Template.

1.3 Background

The IHP program, authorized by Min. Stat. 256B.0755, has allowed DHS to engage in alternative payment arrangements directly with provider organizations that serve an attributed population, which may include an agreed-upon total cost of care and risk/gain sharing payment arrangement. Quality of care, patient experience, utilization, and health disparities are measured and incorporated into the IHP 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. Beginning in 2018, the program expanded to include an increased focus on addressing social determinants of health, supporting community partnerships, and closing health disparity gaps within Minnesota's communities.

Combined, Minnesota's twenty-five (25) IHPs provide care to over 530,000 Minnesotans enrolled in MHCPs, and have achieved an estimated savings of more than $595 million. 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 viewed at DHS's IHP webpage (link).[1]

[1] http://www.dhs.state.mn.us/dhs16_161441.

2. SCOPE OF WORK

2.1 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, reduce health disparities, address social determinants, and improve overall patient experience. The agreements will be for a four-year contract cycle, with annual performance periods and will be conducted statewide and not limited to providers or MHCP beneficiaries in a specified geographic area. This RFP provides the detail on how a potential 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 release providers included in the IHP from the responsibility to meet all MHCP fee-for-service (FFS) and/or managed care organization (MCO) requirements including, but not limited to enrollment, reporting, claims submission, and quality measures.

2.2 Overview

This RFP provides background information and describes the services desired by STATE. It describes 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 and additional measures of performance will be defined in the final negotiated contract. Responders must be in agreement with Section 10: Required Contract Terms and Conditions.

2.3 Tasks and Deliverables

The goal of the IHP program is to allow providers to participate in value-based payment arrangements, support innovations that address social determinants and health disparities, and to continue to work towards achieving the Triple Aim of health care for patients in the State of Minnesota.

Core Principles of the program are:

- Recognition that “value-based” payment arrangements for health care consists of cost, utilization and quality components.
- Emphasis on quality and quality improvement to close gaps in care and ensure equitable care for MHCP enrollees.
- 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.

- Commitment to the identification and elimination of health disparities faced by people enrolled within an MHCP program, whether based on race, ethnicity, sexual orientation, geography, age, sex, gender, disability status, socio-economic background, or other factors.
- Claims-based attribution with an emphasis on primary care but that is flexible based on services provided and coordinated by the IHP.
- Actuarially sound benchmarks, cost estimations, and payment mechanisms, for the benefit of the payer as well as 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.

3. PROPOSAL REQUIREMENTS

3.1 Overview

Proposals must conform to all instructions, conditions, and requirements included in this RFP. Responders are expected to examine all documentation and other requirements. Failure to observe the terms and conditions in completion of the Proposal is at the Responder's risk and may, at the discretion of the STATE, result in disqualification of the Proposal for nonresponsiveness. Acceptable Proposals must offer all services identified in Section 2, "Scope of Work," agree to the contract conditions specified throughout the RFP, and include all of the items referenced in the Required Statements and Applicable Forms sections. Responder must also agree to the terms and conditions in the attached sample contract unless specifically making an exception pursuant to Required Statement "Exception to Sample Contract and RFP Terms."

3.2 Proposal Contents

Responses to this RFP must consist of all of the following components. Each of these components must be separate from the others and clearly identified.

Proposal Components	**RFP Section**
1. Table of Contents	3.3(1)
2. Application	3.3 (2)
3. Application Supplementary Materials	3.3 (3)
a. Provider Roster	
b. Organization Chart with Tax Identification Numbers (TINs)	
c. Sample Agreement with IHP Participants	
d. List of Participating Clinics	
e. Equity Measures	
f. Promoting Interoperability	
g. Other Application Requirements, As Necessary	
4. Required Statements and Forms	3.4

3.3 Detail of Proposal Components

The following will be considered minimum requirements of the Proposal. The emphasis should be on completeness and clarity of content.

1. **Table of Contents:** List each section and the accompanying page number.
2. **Application:** This component of the proposal should demonstrate the Responder's understanding of the applicant IHP's eligibility to participate in the IHP program, eligibility for Track 1 or Track 2 organizational structure, experiences and familiarity with value-based payments and risk-sharing arrangements, clinical care model, quality measurement, population health, health disparities, and community partnerships. The required questions and information can be found in Appendix A: Integrated Health Partnerships Program Application Template.
3. **Application Supplementary Materials:**
    a. Provider Roster
    b. Organizational Chart with TINs
    c. Sample Agreement with IHP Participants
    d. List of Participating Clinics
    e. Equity Measures
    f. Promoting Interoperability
    g. Other Application Requirements, As Necessary
4. **Required Statements and Forms**

    Complete the correlating forms found in **eDocs**[2] (search for the form numbers referenced below at the **eDocs** link, or paste the form file path name found in the footnotes below to your browser) and submit the completed forms in the "Required Statements and Forms" section of your Proposal. You must use the current forms found in **eDocs**. Failure to submit a Required Statement or to use the most current forms found in **eDocs** is at the Responder's risk and may, at the discretion of STATE, result in disqualification of the Proposal for nonresponsiveness.

    a. Responder Information and Declarations (DHS-7020-ENG)[3]**:** Complete the "Responder Information and Declarations" form available at the above link and submit it with the Proposal. If you are required to submit additional information as a result of the declarations, include the additional information as part of this form. Responder may fail the Required Statements Review in the event that Responder does not affirmatively warrant to any of the warranties in the Responder Information and Declarations. Additionally, STATE reserves the right to fail a Responder in the event the Responder does not make a necessary disclosure in the Responder Information and Declarations or makes a disclosure which evidences a conflict of interest.

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[2] http://mn.gov/dhs/general-public/publications-forms-resources/edocs/index.jsp
[3] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7020-ENG

b. Exceptions to Sample Contract and RFP Terms (DHS-7019-ENG)[4]: The contents of this RFP and the Proposal(s) of the successful Responder(s) may become part of the final contract if a contract is awarded. A Responder who objects to any condition of this RFP or STATE's sample contract terms and conditions (attached as **Appendix G: Sample Contract**) must note the objection(s) on the "Exceptions to Sample Contract and RFP Terms and Conditions" form available at the above link and submit it with its Proposal. Much of the language reflected in the sample contract is required by statute. **It is crucial that Responders review ALL sections, including boilerplate language, of the Sample Contract PRIOR to application submission and note any exceptions on the "Exceptions to Sample Contract and RFP Terms and Conditions" form. The State may limit negotiations or discussions to only those exceptions indicated in your response to the RFP.** Only those exceptions indicated in your response to the RFP will be available for discussion or negotiation.

Responders are cautioned that claiming either of the following may result in its Proposal being considered nonresponsive and receiving no further consideration:

1. Exceptions to the terms of the standard STATE contract that give the Responder a material advantage over other Responders;
2. Exceptions to all or substantially all boilerplate contract provisions.

c. Disclosure of Funding Form (DHS-7018-ENG)[5]:
(Applies if federal money will be used or may potentially be used to pay for all or part of the work under the contract). In order to comply with federal law, Responder is required to fill out the "Disclosure of Funding" form available at the above link and submit it with its Proposal. The form requires a Responder to provide its Unique Entity Identifier (UEI) to uniquely identify business entities. If a Responder does not already have a UEI, it may be obtained from SAM.gov.

d. Documentation to Establish Financial Stability (DHS-7896-ENG)[6]:
Minn. Stat. §16B.981/Chapter 62 - MN Laws, Article 7, Section 11 requires that a pre-award risk assessment is conducted for grant awards of $50,000 or more.

All grantees as defined in Minn. Stat. §16B.981 Subd. 1 (c) applying for grants in the state of Minnesota must undergo a financial and capacity review prior to a grant award of $50,000 and higher.

The information collected under this section will be used in STATE's determination of the award of the contract. Responder must complete the "Documentation to Establish Financial Stability" form and submit the form with its Proposal. STATE will request the

[4] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7019-ENG
[5] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7018-ENG
[6] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7896-ENG

applicable documentation upon its determination that Responder is a finalist in the solicitation process.

e. Optional – Additional Materials: Responder may include any additional information thought to be relevant as a separate document and entitle it Appendix I: Sample Equitable Care Report.

4. RFP PROCESS

4.1 Timeline

This timeline outlines the tentative RFP process for the 2025 IHP Contract:

Activity	Date
Potential Responders to contact DHS to schedule Q&A session due date	June 28, 2024
Individual 30 Minute Meetings (Optional)	July 1 - July 19, 2024
All RFP Questions Received	July 19, 2024
RFP Questions Answered and Posted on DHS Open RFPs Website	Anticipated – August 2, 2024
Letter of Intent Due	August 2, 2024
Proposal Responses Due	August 14, 2024
Notice of Intent to Contract	Anticipated - September 6, 2024

4.2 Communications

DHS may release periodic updates on the RFP as necessary. Updates and communications will occur on the IHP website at http://www.dhs.state.mn.us/IHP

4.3 Responders' Questions

Responders' questions regarding this RFP must be submitted in writing via email to Mathew Spaan Mathew.Spaan@state.mn.us, cc: IHP.Admin.DHS@state.mn.us prior to 11.59 p.m. Central Time on July 19, 2024.

Other personnel are NOT authorized to discuss this RFP with Responders before the Proposal submission deadline. **Contact regarding this RFP with any STATE personnel not listed above could result in disqualification.** STATE will not be held responsible for oral responses to Responders.

Questions will be addressed in writing and distributed to all identified prospective Responders. Every attempt will be made to provide answers timely, anticipated no later than August 2, 2024.

4.4 Optional Individual Questions and Answer Sessions

All potential Responders may request one optional 30-minute Question and Answer (Q&A) session from July 1 – July 19, 2024 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 , cc: IHP.Admin.DHS@state.mn.us before or by June 28, 2024. Oral responses provided at the conference will be non-binding. Written responses to questions asked at the Q&A session(s) will be sent to all identified known responders after the conference.

4.5 Letter of Intent

Letters of Intent must be submitted by 11:59 p.m. Central Time on August 2, 2024. Letters must be submitted on letterhead via email to Mathew Spaan, Interim Director of Health Care Research and Quality Division, at Mathew.Spaan@state.mn.us, cc IHP.Admin.DHS@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 proposal. The Letter of Intent does not obligate the applicant to complete the proposal process. Responders that do not submit a Letter of Intent by August 2, 2024 will not be considered for the IHP program in 2025. A template for submission can be found in Appendix A-1: Letter of Intent Template.

4.6 Proposal Submission

The Proposal must be submitted electronically by 11:59 p.m. Central Time on August 14, 2024 to be considered. Late Proposals will not be considered and will not be opened. Faxed Proposals will not be accepted.

Responders must ensure that the forms in Section 3.4: Required Statement and Forms meet legal signature requirements. STATE will accept e-signatures that have been authenticated by a third-party digital software, such as DocuSign and Adobe Sign, when it includes the date and time of the signature, an authentication code, and is attributable to the person intending to sign the document. Handwritten signatures on faxed or scanned documents are e-signatures and are acceptable for all purposes. Proposals must be submitted in 12-point font and single spaced. The main body of the proposal page numbers must flow continuously in numeric order. Each of the sections must be clearly identified with its own heading. 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 proposal and all correspondence related to this RFP must be delivered via email to Mathew Spaan at Mathew.Spaan@state.mn.us. Please also cc: IHP.Admin.DHS@state.mn.us on your correspondence. It is solely the responsibility of each Responder to assure that its Proposal is delivered electronically, 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.**

5. RESPONDER ELIGIBILITY AND PARTICIPATION REQUIREMENTS

5.1 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 Centers for

Medicare and Medicaid Services (CMS) or Medicaid. Accepted forms of evidence of provision of coordinated care include but are not limited to:

a. Health Care Home (HCH) Certification for the majority of clinics planning to participate in the Respondent's proposed IHP

b. National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (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 B-1: Example IHP Health System Characteristics.

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

3. Demonstrate, through the care delivery model, how the IHP will affect the total cost and quality 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 (MA) and MinnesotaCare enrollees attributed to the IHP for the performance period. See Appendix B-2: Eligible and Excluded Populations.

4. If the Respondent is interested in participating in Track 1 (non-risk bearing), they must demonstrate why they are unable to take on financial risk for the total cost of care of attributed MHCP beneficiaries. If the Respondent is interested in participating in Track 2 (upside and downside risk), they must 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. The State 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 patient's 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 the State.

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.

7. Demonstrate and/or describe efforts related to addressing social determinants of health (SDoH) and the particular risk factors present in the applicant's Medicaid patient population.

8. Demonstrate and/or describe efforts related to identifying and addressing health disparities related to race, ethnicity, geography and socio-economic background present in the Respondent's Medicaid patient population.

5.2 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 the ability to meet the requirements in Section 5.1., 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 on January 1, 2025.

5.3 Social Determinants of Health and Community Engagement

DHS is committed to advancing equity, reducing disparities, and improving access to human services for communities experiencing inequities. DHS's Equity Policy requires that DHS utilize a Health in All Policies (HiAP) approach, a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

It is important that IHPs are thoughtful about the context that creates and affects the health of individuals as well as communities, which is also known as the social determinants of health. DHS recognizes that health systems may not be the best equipped to fully address the social determinants that affect health, healthcare costs, and patient experience. However, the IHP program is an opportunity for responders and participants to innovate and advance efforts such as community partnerships, screening, referral, and care coordination for social needs, and other strategies that may already be underway.

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. More information on how the health equity measures affect payment, see Section 7.2. Quality and the Population-Based Payment.

Broadly, 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 (CBP)

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 Health Equity Intervention, documented in Appendix E, will include the target population, proposed solution, detailed intervention, historical background, and proposed equity measures.

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.

Existing IHPs wishing to continue in the IHP Program:

Responders 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 responders must clearly indicate previous learnings, articulate how those learnings are incorporated into the intervention, and whether any changes will be made to expand or enhance the intervention. These responders will need to consider enhancements to existing metrics or propose new metrics that more effectively capture the impact of continued interventions

5.4 Promoting Interoperability

Respondents must demonstrate they effectively utilize health information technology (HIT) to coordinate care and engage patients. Respondents must submit documentation with the application to provide evidence of interoperability and meet this requirement. For those respondents participating in the Merit-based Incentive Payment System (MIPS) program, DHS prefers that those respondents submit the most recent Promoting Interoperability (PI) Quality Payment Program (QPP) report submitted to CMS. Those respondents not participating in MIPS may submit an equivalent report or alternative documentation.

5.5 Promoting Health and Wellness Activities – Child and Teen Check-ups (C&TC)

Child and Teen Check-ups (C&TC) is the name for Minnesota's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. C&TC are covered services for children from birth through twenty (20) years who are enrolled in Medical Assistance (MA). For more information please visit: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/ctc.jsp

IHPs are expected to conduct C&TC outreach activities for eligible members who are attributed to the IHP. The goal of the C&TC outreach and engagement work is to increase the number of children with completed C&TC visits. In exchange, IHPs will receive a $1 per member per month (PMPM) payment for each eligible attributed member. This C&TC outreach-related PMPM payment is in addition to and separate from the IHP's population-based payment (PBP) or settlement payments noted in Section 6.4

of the RFP, and will not be considered part of an IHP's total cost of care (TCOC) calculation for settlement purposes. To fulfill this C&TC outreach requirement, applicants must currently, or within six (6) months of the execution of an IHP contract, be able to effectively ensure, provide, and document outreach activities for attributed enrollees in regard to C&TC. This includes:

- Encouraging enrollees to complete timely well-child visits in accordance with the C&TC periodicity schedule.
- Having mechanisms in place to ensure referrals are followed up on in a proper and timely manner to ensure successful outcomes for C&TC utilization.
- Having outreach methods in place for contacting enrollees who do not complete their C&TC visits.
- Having systems in place to track individual level outreach efforts and responses, where applicable.

Applicants may seek an exemption from this responsibility due to the demographics of their patient population or the nature of their provider organization. For example, if only a small portion of the Applicant's patient population is under the age of 21, they may seek an exemption from this responsibility. Applicants seeking such an exemption must include sufficient detail within their Application for DHS staff to evaluate if such an exemption is appropriate (see Appendix A – RFP Application, Section VIII).

6. MODEL DESIGN ELEMENTS

6.1 Overview of Model

IHP 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 using an executed IHP contract will be eligible for a quarterly population-based payment (PBP) for the purposes of care coordination. 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 Total Cost of Care (described in Section 6.3) 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.

STATE reserves the right upon mutual agreement with Responder to adjust final contract from Track 1 to Track 2 or vice versa and allow Responder to transition between risk tracks upon contract amendment.

Table 1: Summary of IHP 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); or a range of other health care providers subject to consideration by DHS.
Track 2	IHP entity will enter into reciprocal risk shared savings	Health systems or collaborative models with a greater level of integration between participating

Model Type	Model Aspect	Expected Provider Types
	and/or shared losses model, and receive a risk-adjusted quarterly PBP.	providers and ability to coordinate and/or provide the full scope of Medicaid services for attributed patients.

Additional requirements for participation in the Track 1 and Track 2 IHP program model can be found in Section 6.4, Payment Models, Mechanisms, Risk, and Section 7, Quality.

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 (HCH) or in-reach service coordination (IRSC) payments currently being received by the IHP for an IHP attributed member. **The population-based payment (PBP) is expected to contribute to care coordination and other related investments for individuals served by the IHP. As a result, the PBP specifically replaces both Health Care Home (HCH) and In-Reach Care Coordination (in-reach) payments. The PBP-eligible population consists of IHP attributed individuals for whom the IHP is not already receiving Behavioral Health Home (BHH) care coordination payments. To ensure that an IHP doesn't receive redundant payments, DHS reconciles the population-based payments on an annual basis following the close of each performance period.**

6.2 Beneficiary Eligibility and Attribution

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 Roster:** IHPs that select this option will be required to submit a full list of their billing National Provider Identifiers (NPIs) to be included in the IHP prior to the start of each contract year. A quarterly attestation process will determine accuracy and completion. **This is the preferred roster option for IHP attribution**, as it more accurately captures the full set of providers billing to a given clinic NPI, and there is no need to update the roster on a quarterly basis unless clinic NPIs are changing.
- **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: Integrated Health Partnerships Application Template. A list of the eligible and excluded populations for attribution to IHP can be found in Appendix B-2: Eligible and 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 C: Attribution Methodology.

Attribution is run on a monthly basis. IHPs are sent monthly reports containing information on their attributed members via both the IHP portal and MN-ITS mailbox.

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 Health Care Home (HCH) or Behavioral Health Home (BHH), as evidenced by a paid monthly care coordination claim.
2. Patients that cannot be attributed based on HCH or 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. This is how the vast majority of individuals are attributed to IHPs.
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 HCH or 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 only 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 payment model, the State and Responder will define contract terms based on subsequent analysis of which patients are likely 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).

Base and Performance Period

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 relevant calendar year.

6.3 Definition of Total Cost of Care (TCOC)

Services Included in Total Cost of Care

All Medicaid covered services will be included in the Total Cost of Care (TCOC), with a few exceptions such as Long-Term Care, Foster Care, and IEP. 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.

For a listing of categories of services (COS) included or excluded in TCOC, see Appendix G: Sample Contract Section Appendix 2: Included Services – Category of Service Table.

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.

While Track 1 IHPs are not subject to shared losses or shared savings, Total Cost of Care is calculated for Track 1 IHPs in order to provide illustrative performance results.

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. Responders that apply to participate in Track 2 must meet a minimum population size of at least 5,000 attributed patients. Any applicants with a Medicaid population of over 5,000 are generally expected to participate as a Track 2 IHP.[7] Applicants with Medicaid populations of over 5,000 that feel a Track 1 approach would be more appropriate are expected to articulate their rationale in their response. The prospective number of attributed patients is determined by the roster of providers which is submitted along with the RFP Application (Appendix A: Integrated Health Partnerships Application Template).

2. **Claim Cap Level:** To reduce the potential variability of the risk assessment and total cost of care calculations, DHS will develop the risk scores and total cost of care per-member-per-

[7] A population of 5,000 or more does not guarantee that an entity will have sufficient population to participate as a Track 2 IHP, depending on the underlying risk, demographics and cost profile of their population. During contract negotiations, the State will run an analysis to determine if the Respondent's patient population is sufficient for Track 2 participation. If the State determines that a Respondent's patient population is not sufficient for Track 2 participation, the Respondent will be considered for participation in the IHP program under a Track 1 model.

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. For Track 1 IHPs, DHS will use either a $50,000 or $100,000 claims cap threshold, which will be identified based on the IHP's population size.

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.

A summary of the above requirements for the different tracks can be found in Table 2 below.

Table 1: Total Cost of Care Specifications and Requirements by IHP Track

Model Type	Population Size	Claims Cap	Shared Savings Model
Track 1	No minimum	Maximum of $100,000	n/a
Track 2	Minimum of 5,000 attributed patients	Maximum of $200,000	Reciprocal upside and downside risk with 50% share of savings in each risk corridor. Arrangement can be modified according to demonstrated Accountable Care Partnerships (ACP)

6.4 Payment Models, Mechanisms, Risk

Payment in Track 1

Population-Based Payment

Track 1 IHPs will receive an aggregate monthly PBP, which is paid quarterly, for their respective attributed population as described in Section 6.2 above. The PBP 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 medical 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. An IHP's ability to continue participating in the IHP program and receive the PBP will be contingent on their health equity intervention and performance on quality measures as laid out in Section 7, Quality.

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. More details are available 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 an aggregate monthly PBP, paid quarterly, for their respective attributed population (attribution is 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 medical 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. An IHP's ability to continue participating in the IHP program and receive the PBP will 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 quarterly PBPs 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."[8] 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 (CY2023) 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.

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[8] For purposes of contracts beginning in 2025, the performance periods are defined as calendar Year (CY) 2025, 2026, 2027, and 2028.

The Base Period Attributed Population will be determined for each IHP using 2023 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.

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 D, 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. The parameters are flexible, but could include greater potential savings than potential losses or a greater share of potential savings relative to the share of potential losses, or other variations that are within reason and commensurate with the demonstrated resources that the IHP is investing in the partnership.

Formal partnerships could include, but are not necessarily limited to, an ongoing legally formalized 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.

Accountable Care Partnerships will be monitored by DHS, through at least yearly check-ins and reporting through the Population Health Report (see Appendix H).

6.5 Interaction with Managed Care Organizations (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 .

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 performance across both fee-for service and managed care using retrospective claims and encounter data. DHS will also calculate relevant claims-based quality measures using data applicable to each measure at the IHP level across both fee-for-service and managed care.

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

7. QUALITY

7.1 Overview

A core principle of the IHP model is that payment for health care is tied to the quality of the care provided. As explained in Section 6.2. 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, health equity, and utilization metrics. IHPs will be evaluated on quality, health equity, and utilization measures to

determine eligibility to continue participation in the IHP program after the conclusion of each contract cycle.

Table 2: The Impact of quality on payment in the 2023 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 contract cycle.
Shared Risk Model	Quality results affect the IHP portion of shared savings amount and reduce the IHP portion of shared losses.

7.2 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 health outcomes of its attributed population.

During contract discussions, the IHP likely 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 an intervention and health equity measures tied to this intervention that are intended to reduce health disparities among the IHP's population. IHPs are required to propose an intervention, based on their knowledge of the health disparities impacting their patient population. This proposal may be modified or refined during contract negotiations, based on data available and technical assistance from DHS. A template to propose an intervention is included in Appendix E: Health Equity Measures.

The IHP will be annually evaluated across a set of agreed upon measures, including clinical, utilization, and equity domains. 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 contract cycle, or intervention by DHS staff during the contract cycle, which could include a corrective action plan or termination. The equity intervention is assessed, in part, through a Population Health Report (see Appendix H) submitted by the IHP. Additionally, clinical and utilization measures are selected, in collaboration with the IHP, based on the goals of the equity intervention. Consequently, the evaluation of the intervention is based on both qualitative and quantitative metrics. The clinical and utilization measures are typically calculated or obtained by DHS for the purposes of the contract. However, DHS is open to having conversations with interested IHPs regarding measures that are meaningful to their quality improvement efforts and the intervention population, where validated results can be submitted directly to DHS.

7.3 Quality and the Shared Risk Model

In Track 2, fifty percent (50%) of an IHP's shared savings and shared losses will be contingent on overall quality measurement results. For quality measurement purposes, DHS will utilize a total cost of care quality set, aligning with statewide and Medicaid measures. In certain circumstances, an IHP may

propose additional or alternate measures, as detailed below in the Alternate Measures section. The core set of quality measures and the methodology used to calculate the overall total cost of care quality score are described below.

Total Cost of Care (TCOC) Quality Measures

The total cost of care (TCOC) set of quality measures is used for calculation of the overall total cost of care quality score, which affects an IHP's potential shared savings, and shared losses. The TCOC quality measures are organized into five domains, as listed in Table 3 below, which identify critical areas for focus and improvement: 1) quality core set, 2) care for children and adolescents, 3) quality improvement, 4) closing gaps, and 5) equitable care measures. The intent behind each domain is discussed below. Examples of the measures in each domain are listed in Appendix F-2, Quality Measures.

- The **quality core set domain** includes key measures selected from the Minnesota Department of Health (MDH) Statewide Quality Reporting and Measurement System (SQRMS), the Adult and Child Medicaid Core Measures Sets, the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA), and Patient Quality Indicators (PQI) developed by the Agency for Healthcare Quality and Research (AHRQ), as well as patient experience of care measures from AHRQ and CMS. This domain focuses on monitoring performance for a variety of conditions and aspects of care quality.
- The **care for children and adolescent domain** includes preventive health measures for those 21 years of age and younger. These measures focus on well visits and immunizations, as well as an oral health component. This domain highlights the importance of ensuring children and adolescents receive needed preventive care, which can catch items of concern early and lead to long term health benefits for this population.
- The **quality improvement domain** focuses solely on quality improvement for select measures. The measures in this domain will focus on priority area for the IHP program and the state, specifically focusing on improving quality for the selected measures. The measures of focus will be selected collaboratively between the IHP and DHS from a subset of measures. The IHP will work on three measures with the option to select one additional measure under the bonus points option (see Bonus Points Option section).
- The **closing gaps domain** focuses on reducing and eliminating disparities in care for different populations. Currently, this domain will monitor disparities in care for the MHCP population compared to that of the commercial population for select measures. The measures of focus will be selected collaboratively between the IHP and DHS from a subset of measures. The IHP will work on two measures with the option to select one additional measure under the bonus points option (see Bonus Points Option section).
- The **equitable care domain** includes an array of NCQA HEDIS measures that align with the State's goals to eliminate health disparities and ensure equitable care across racial and ethnic groups. The IHP will focus on multiple measures from this group, working toward closing gaps in care. The measures of focus will be selected collaboratively between the IHP

and DHS. The IHP may propose measures not included on this list, but in order to use other measures, DHS or the IHP would need to be able to obtain the data to assess performance for different racial and ethnic groups. The IHP will work on two measures with the option to select one additional measure under the bonus points option (see Bonus Points Option section).

Alternate Measures

An IHP may also propose alternative TCOC quality measures relevant for the IHP population of patients. However, alternative measures will only be considered for IHPs with a significantly different population from the standard IHP's attributed population, such as pediatric providers, where the current core set of measures does not fully measure the unique needs of those specific populations. Alternative TCOC quality 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 TCOC Quality Score

As explained above, DHS will compute the TCOC overall quality score using measures organized into five domains: 1) quality core set, 2) care for children and adolescents, 3) quality improvement, 4) closing gaps, and 5) equitable care. The domains will be weighted according to Table 3 below.

Table 3: Quality domains in the core measure set and proposed weights

Domain	Key Elements	Proposed Weights
Quality Core Set	Prevention & Screening for Adults (4%)	20%
	Care for at Risk Populations (4%)	
	Behavioral Health (4%)	
	Patient-centered Care (6%)	
	Quality of Outpatient Care (2%)	
	(*Category weights are noted in parenthesis next to each category above.*)	
Care for Children and Adolescents	Focus on well-visits, immunizations, and oral health (*Each measure is weighted equally*.)	20%
Quality Improvement	Quality improvement focus for selected measures (*Each measure is weighted equally*.)	30%
Closing Gaps	Closing disparities between the MHCP and commercial populations (*Each measure is weighted equally*.)	10%
Equitable Care	Improving care for racial and ethnic groups	20%

Domain	Key Elements	Proposed Weights
	(*Each measure is weighted equally*.)	

In the **quality core set and care for children and adolescent domains**, points will be awarded for achievement or for improvement as described below.

- Points for achievement will be awarded by comparing the IHP-level results to the statewide distribution of results, which uses Medicaid average rates for most measures. 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 **quality improvement** domain, points will be awarded for relative improvement (i.e., percent change between the performance years). 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.

In the **closing gaps domain**, points will be awarded for achievement or for improvement as described below.

- Points for achievement will be awarded by comparing the IHP-level results to the statewide distribution of results, which uses Commercial 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 **equitable care domain,** points will be awarded as described below.

- For performance year 1, IHPs will be allowed a ramp up period which will focus on implementing interventions aimed at closing gaps in care before performance rates will be used for scoring purposes. IHPs will be required to complete a narrative template describing the efforts they are taking to address gaps in care (see Appendix I). Point assignment will be based on the completeness of this information.

- Starting with performance year 2, points will be awarded based on relative improvement (i.e., the percent change between the performance years) for each racial and ethnic group (i.e., Asian/Pacific Islander, Black, Hispanic, Native American, and Non-Hispanic White) compared to a baseline disparity gap with a reference group. In order to be eligible to receive points for a selected measure, the IHP must decrease the gap in care quality of all groups below the reference group and the IHP must either maintain or improve care quality of all other groups.
- DHS will provide the IHP with annual information regarding gaps in care, including baseline performance for each racial and ethnic group.

Bonus Points Option

IHPs will be able to obtain bonus points on the TCOC overall quality score by selecting additional measures in the following domains:

- Quality improvement
- Closing gaps
- Equitable care

Under the bonus points option, IHPs can work on a total of two additional measures, which cannot be in the same domain. The bonus measure in each domain will be weighted consistent with other measures in that domain. For example, each measure in the quality improvement domain is worth ten percent (10%) so the bonus measure would also be worth up to 10%.

IHPs will not be able to score more than 100% on the TCOC overall quality score. However, the bonus points option allows IHPs to earn more points by focusing on additional measures of interest to DHS and the IHP. The additional measures would be selected collaboratively between DHS and the IHP.

8. DATA SHARING AND REPORTS

8.1 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 F: IHP Reports and Data. A few examples of the features and reports provided through the DHS IHP Provider Portal or other mechanisms are:

- Quarterly performance estimates

- 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 and Emergency Department (ED) Trends by Clinic, Pharmacy Utilization and Spend)
- Quality Reports (Healthcare Effectiveness Data and Information Set (HEDIS) Measures, Summary of Quality and Patient Experience Measures)

IHPs must designate, during time of application for IHP, who within their organization will be the primary administrator (PA) for the IHP Data Portal and MN-ITS Mailbox.

8.2 Learning Opportunities

IHPs will be invited and strongly encouraged to participate in learning opportunities with DHS and other IHPs via WebEx. DHS may present on data or other program related topics, answer questions, and facilitate data and program related discussions amongst IHPs. IHP peer learning events are an opportunity for IHPs to communicate and collaborate with DHS and one another.

In the future, DHS may also schedule an annual IHP Learning Day, where IHPs are strongly encouraged to attend, network with other IHPs, and discuss key issues, potential strategies, and future opportunities for IHPs. IHPs may also be invited to other learning activities and asked to present on things related to health care delivery and payment reform.

9. PROPOSAL EVALUATION AND SELECTION

9.1 Overview of Evaluation Methodology

1. 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 used to discuss a Responder's sustainability for the model, clarify questions about the Responder's ability to participate in the IHP, and to consider additional material or discussions necessitated in order to partner with the health system.

2. All responsive Proposals received by the deadline will be evaluated by STATE. Proposals will be evaluated on "best value" as specified below. The evaluation will be conducted in three phases:

a. *Phase I* Required Statements Review

b. *Phase II* Evaluation of Proposal Requirements

c. *Phase III* Selection of the Successful Responder(s)

3. During the evaluation process, all information concerning the Proposals submitted, except for the name of the Responder(s), will remain non-public and will not be disclosed to anyone whose official duties do not require such knowledge.

4. Nonselection of any Proposals will mean that either another Proposal(s) was determined to be more advantageous to STATE or that STATE exercised the right to reject any or all Proposals. At its discretion, STATE may perform an appropriate cost and pricing analysis of a Responder's Proposal, including an audit of the reasonableness of any Proposal.

Special note for Existing IHPs wishing to continue in the IHP Program:

Existing IHPs whose contract expires 12/31/2024 or earlier must submit a response to this RFP in order to be considered for participation in the IHP program for the next contract period beginning 1/1/2025. As noted earlier, existing IHPs wishing to continue in the program may propose to continue the equity intervention included in their contract in response to this RFP. Please note that **the final Population Health Report submission under their existing IHP contract will factor into whether a contract is offered under this RFP for these respondents.** Those respondents should ensure that the final Population Health Report submission is complete and clearly responds to all questions, including describing lessons learned and providing an overall assessment of the impact of the intervention

9.2 Evaluation Team

1. An evaluation team will be selected to evaluate Responder Proposals.

2. 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.

3. STATE reserves the right to alter the composition of the evaluation team and their specific responsibilities.

9.3 Evaluation Phases

At any time during the evaluation phases, STATE may, at STATE's discretion, contact Responders to (1) provide clarification of their Proposal, (2) have each Responder 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 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.

1. *Phase I*: Required Statements and Forms Review
The Required Statements will be evaluated on a pass or fail basis. Responders must "pass" each of the requirements identified in section 3 to move to Phase II.

2. *Phase II*: Evaluation of Technical Requirements of Proposals

a. Points have been assigned as follows to each of the component areas described in Section 3.2 of this RFP:

Proposal Components	Possible Points
1. Cover Sheet	**5**
2. Background Information and Organizational Structure	**10**
3. Leadership and Management	**15**
4. Financial Plan and Experience with Risk Sharing	**10**
5. Clinical Care Model	**20**
6. Quality Measurement	**15**
7. Population Health	**15**
8. Community Partnerships	**10**
Total:	**100 points**

b. 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.

c. A minimum score of 60 out of 100 total possible points will be required for Responders to be considered for acceptance into the program. A score greater than 60 does not guarantee participation in 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.

3. *Phase III*: Selection of the Successful Responder(s)

a. Only the Proposals found to be responsive under Phases I and II will be considered in Phase III.

b. The evaluation team will review the scoring in making its recommendations of the successful Responder(s).

c. STATE may submit a list of detailed comments, questions, and concerns to one or more Responders after the initial evaluation. STATE may require said response to be written, oral, or both. STATE will only use written responses for evaluation purposes. The total scores for those Responders selected to submit additional information may be revised as a result of the new information.

d. The evaluation team will make its recommendation based on the above-described evaluation process. The successful Responder(s), if any, will be selected approximately four (4) weeks after the Proposal submission due date.

9.4 Contract Negotiations and Unsuccessful Responder Notice

If a Responder(s) is selected, STATE will notify the successful Responder(s) in writing of their selection and STATE's desire to enter into contract negotiations. Contract negotiations with successful Responder(s) will include a plenary session and one optional individual IHP contract negotiation meeting.

The STATE will host a plenary session that successful Responders(s) are encouraged to attend. This session may include key information about the IHP model and contract. The plenary session is anticipated to be held on September 12, 2024.

As noted in the Exceptions to Sample Contract and RFP Terms section of this RFP, much of the language reflected in the sample contract is required by statute. **It is crucial that Responders review ALL sections, including boilerplate language, of the Sample Contract PRIOR to application submission and note any exceptions, including detailed information as to the reasoning for requesting an exception, on the "Exceptions to Sample Contract and RFP Terms and Conditions" form.**

Until STATE successfully completes negotiations with the selected Responder(s), all submitted Proposals remain eligible for selection by STATE. Data created or maintained by the STATE as part of the evaluation process (except trade secret data as defined and classified in Minn. Stat. § 13.37) will be public data when contract negotiations have been successfully completed. If the STATE determines that it is unlikely that a Responder will be selected for contract negotiations, the STATE may, as a courtesy, notify the Responder that it has not been selected for contract negotiations.

After STATE and chosen Responder(s) have successfully negotiated a contract, 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.

10. REQUIRED CONTRACT TERMS AND CONDITIONS

A. Requirements. All Responders must be willing to comply with all state and federal legal requirements regarding the performance of the grant contract. **The full requirements are set forth throughout this RFP and are contained in the attached sample grant contract in Appendix G. The attached sample grant contract should be reviewed for the terms and conditions that will likely govern any resulting contract from this RFP.** Although this RFP establishes the basis for Responder Proposals, the detailed obligations and additional measures of performance will be defined in the final negotiated contract.

B. Governing Law/Venue. This RFP and any subsequent contract must be governed by the laws of State of Minnesota. Any and all legal proceedings arising from this RFP or any resulting contract in which STATE is made a party must be brought in the State of Minnesota, District Court of Ramsey County. The venue of any federal action or proceeding arising here from in which STATE is a party must be the United States District Court for the State of Minnesota in Ramsey County.

C. Preparation Costs. STATE is not liable for any cost incurred by Responders in the preparation and production of a Proposal. Any work performed prior to the issuance of a fully executed grant contact will be done only to the extent the Responder voluntarily assumes risk of non-payment.

D. Contingency Fees Prohibited. Pursuant to Minn. Stat. § 10A.06, no person may act as or employ a lobbyist for compensation that is dependent upon the result or outcome of any legislation or administrative action.

E. Accessibility Standards. Any information systems, tools, information content, and/or work products, including the response to this solicitation/contract, applications, web sites, video, learning modules,

webinars, presentations, etc., whether commercial off-the-shelf (COTS) or custom, purchased or developed, must comply with the State of Minnesota Accessibility Standard effective September 1, 2010, as updated on June 14, 2018. This standard requires in part, compliance with the Web Content Accessibility Guidelines (WCAG) 2.0 (Level AA) and Section 508 Subparts A-D.

Information technology deliverables and services offered must comply with the State of Minnesota Accessibility Standard.[9] (The relevant requirements are contained under the "Standards" tab at the link above.) Information technology deliverables or services that do not meet the required number of standards or the specific standards required may be rejected and may not receive further consideration.

F. Insurance Requirements.

1. Responder shall not commence work under the contract until they have obtained all the insurance described below and the State of Minnesota has approved such insurance. All policies and certificates shall provide that the policies shall remain in force and effect throughout the term of the contract.

2. Responder is required to maintain and furnish satisfactory evidence of the following insurance policies:

a. Workers' Compensation Insurance: Except as provided below, Responder must provide Workers' Compensation insurance for all its employees and, in case any work is subcontracted, Responder will require the subcontractor to provide Workers' Compensation insurance in accordance with the statutory requirements of the State of Minnesota, including Coverage B, Employer's Liability. Insurance minimum amounts are as follows:

$100,000 – Bodily Injury by Disease per employee
$500,000 – Bodily Injury by Disease aggregate
$100,000 – Bodily Injury by Accident

If Minnesota Statute, section 176.041 exempts Responder from Workers' Compensation insurance or if the Responder has no employees in the State of Minnesota, Responder must provide a written statement, signed by an authorized representative, indicating the qualifying exemption that excludes Responder from the Minnesota Workers' Compensation requirements.

If during the course of the contract the Responder becomes eligible for Workers' Compensation, the Responder must comply with the Workers' Compensation Insurance requirements herein and provide the State of Minnesota with a certificate of insurance

[9] https://mn.gov/mnit/about-mnit/accessibility/

b. General Commercial Liability Insurance: Responder is required to maintain insurance protecting it from claims for damages for bodily injury, including sickness or disease, death, and for care and loss of services as well as from claims for property damage, including loss of use which may arise from operations under the contract whether the operations are by the Responder or by a subcontractor or by anyone directly or indirectly employed by the Responder under the contract. Insurance minimum amounts are as follows:

$2,000,000 – per occurrence
$2,000,000 – annual aggregate

The following coverages shall be included:

Premises and Operations Bodily Injury and Property Damage
Personal and Advertising Injury
Blanket Contractual Liability
Products and Completed Operations Liability
State of Minnesota named as an Additional Insured, to the extent permitted by law.

c. Network Security and Privacy Liability Insurance. Responder is required to keep in force a network security and privacy liability insurance policy. The coverage may be endorsed on another form of liability coverage or written on a standalone policy.

Responder shall maintain insurance to cover claims which may arise from failure of Responder's security or privacy practices resulting in, but not limited to, computer attacks, unauthorized access, Disclosure of not public data including but not limited to confidential or private information or Protected Health Information, transmission of a computer virus, or denial of service. Responder is required to carry the following **minimum** limits:

$2,000,000 per occurrence
$2,000,000 annual aggregate

d. Additional Insurance Conditions:

i. Responder's policy(ies) shall be primary insurance to any other valid and collectible insurance available to the State of Minnesota with respect to any claim arising out of Responder's performance under this IHP contract;

ii. If Responder receives a cancellation notice from an insurance carrier affording coverage herein, Responder agrees to notify the State of Minnesota within five (5) business days with a copy of the cancellation notice, unless Responder's policy(ies) contain a provision that coverage afforded under the policy(ies) will not be cancelled without at least thirty (30) days advance written notice to the
State of Minnesota;

iii. Responder is responsible for payment of IHP contract related insurance premiums and deductibles;

iv. If Responder is self-insured, a Certificate of Self-Insurance must be attached;

v. Include legal defense fees in addition to its liability policy limits, with the exception of II.G.2.d. above; and

vi. Obtain insurance policies from an insurance company having an "AM BEST" rating of A- (minus); Financial Size Category (FSC) VII or better and must be authorized to do business in the State of Minnesota; and

vii. An Umbrella or Excess Liability insurance policy may be used to supplement the Responder's policy limits to satisfy the full policy limits required by the IHP contract.

3. The State reserves the right to immediately terminate the contract if the Responder is not in compliance with the insurance requirements and retains all rights to pursue any legal remedies against the Responder. All insurance policies must be open to inspection by the State, and copies of policies must be submitted to the State's authorized representative upon written request.

4. The successful Responder is required to submit Certificates of Insurance acceptable to the State of Minnesota as evidence of insurance coverage requirements prior to commencing work under the contract.

11. STATE'S AUTHORITY

1. STATE may:

A. Reject any and all Proposals received in response to this RFP;

B. Disqualify any Responder whose conduct or Proposal fails to conform to the requirements of this RFP;

C. Have unlimited rights to duplicate all materials submitted for purposes of RFP evaluation, and duplicate all public information in response to data requests regarding the Proposal;

D. Select for contract or for negotiations a Proposal which best represents "best value" as defined in Minnesota Statutes, section 16C.02, subdivision 4 and in this RFP document;

E. Consider a late modification of a Proposal if the Proposal itself was submitted on time and if the modifications were requested by STATE, and the modifications make the terms of the Proposal more favorable to STATE, and accept such Proposal as modified;

F. At its sole discretion, reserve the right to waive any non-material deviations from the requirements and procedures of this RFP;

G. Negotiate as to any aspect of the Proposal with any Responder and negotiate with more than one Responder at the same time, including asking for Responders' "Best and Final" offers;

H. Extend the grant contract, in increments determined by STATE, not to exceed a total contract term of five years;

I. Cancel the RFP at any time and for any reason with no cost or penalty to STATE; and

J. STATE will not be liable for any errors in the RFP or other responses related to the RFP.

2. The award decisions of STATE are final and not subject to appeal.
3. If federal funds are used in funding a contract that results from this RFP, in accord with 45 C.F.R. § 92.34, for Works and Documents created and paid for under the contract, the U.S. Department of Health and Human Services will have a royalty free, non-exclusive, perpetual and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use, the Works or Documents created and paid for under a resulting contract for federal government purposes.

12.GLOSSARY OF ACRONYMS

BHH – Behavioral Health Home
C&TC – Child and Teen Check-up
CCBHC – Certified Community Behavioral Health Clinic
CMS – Center for Medicare and Medicaid Services
DHS – Department of Human Services
IHP – Integrated Health Partnerships
E&M – Evaluation & Management
EAS – Encounter Alert System
EMR – Electronic Medical Record
FFS – Fee-for-Service
HCH – Health Care Home
HiAP - Health in All Policies
HIE – Health Information Exchange
HIT – Health Information Technology
MCO – Managed Care Organization
MHCP – Minnesota Health Care Program
MPIP – Medicaid Promoting Interoperability 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
SDoH - Social Determinants of Health
TCOC – Total Cost of Care

13. APPENDICES

Appendix A: Integrated Health Partnerships Application Template
Appendix A-1: Letter of Intent Template
Appendix A-2: IHP Roster Submission Process
Appendix A-3: Sample Roster Template
Appendix B-1: Example Health System Characteristics
Appendix B-2: Eligible and Excluded Populations
Appendix C: Attribution Methodology
Appendix D: Payment Mechanism Methodology
Appendix E: Health Equity Measures Template
Appendix F: IHP Reports and Data
Appendix F2: Quality Measures
Appendix G: Sample IHP Contract
Appendix H: Sample Population Health Report
Appendix I: Sample Equitable Care Report
Appendix J: Sample Child and Teen Checkups Report