DEPARTMENT OF HUMAN SERVICES

RFP Questions and Answers No. 1 for Request for Proposals for a Provider 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) Program

Date of Publication: July 31, 2026

The State of Minnesota through the Minnesota Department of Human Services (DHS), Minnesota Department of Human Services Managed Care Contracting and Rates Division, issues this Questions and Answers document regarding the request for proposals identified above, which was issued on June 2, 2026. Questions are arranged by topic as labeled in the RFP.

1.1 Objective of RFP

Question: The RFP notes the contract is a 4 year option with the option of 1 year extension. Can an IHP get a 5 year contract?

DHS Response: State law allows agencies to execute contracts with a maximum duration of up to 5 years, including extensions. This is a maximum allowed for all state contracts, and is not only applicable to contracts for the Integrated Health Partnerships (IHP) Program. IHP contracts are four (4) years in length and no one (1) year extensions are planned at this time.

Question: Is there an option to rebase during the contract period?

DHS Response: Rebasing during a contract is sometimes considered and by the State based on extenuating circumstances. For example, a significant change to an IHP's participating clinics may necessitate rebasing for that IHP. The State will determine if rebasing is necessary given a specific situation. **4.5 Letter of Intent**

Question: Please clarify the due date for the Letter of Intent (LOI).

DHS Response: The Letter of Intent (LOI) must be received no later than 11:59 pm on July 31, 2026.

5. Responder Eligibility and Participation Requirements

Question: Does the program only include adults?

DHS Response: No, the IHP Program includes both children and adults. Please see appendix B2: Excluded and Included Populations for more information.

5.1 System Requirements

Question: How will the State incorporate/weigh the other factors in determining Tracks (listed on RFP p. 12)? When will the determination, if an IHP who applies for a Track 2 but is determined by the State to be a better fit for a Track 1, be made? After submitting a Letter of Intent, when will an IHP be notified of the track that they will be assigned to for this next contract period?

DHS Response: We encourage respondents that anticipate they may be close to meeting the requirements for participating as a Track 2 IHP to submit an application as a Track 2 IHP. DHS is only able to assess and take into consideration what is submitted in a responder's application. If selected to move forward in the contracting process, DHS will determine which Track is the best fit. Responders that DHS determines to not meet the criteria for Track 2 participation will instead be considered for Track 1 participation.

If selected to move forward in the contracting process, contract negotiations are anticipated to begin in October. Final Track determination will occur during the contracting phase.

5.3 Health-Related Social Needs (HRSNs) and Community Engagement

Question: Can a current IHP propose continuing the same Population Health Demonstration from their current IHP contract? How will applicant IHP know if they need to expand the intervention?

DHS Response: IHPs that meet the criteria for an Exemplary Demonstration could continue to focus on the intervention in their current contract without significant changes. As outlined in Appendix E, an Exemplary Demonstration must have immediate resources available on site, screen all patients for several health-related social needs, determine if the individual wants assistance, connect them with resources if they are interested in assistance, follow up to confirm they received what they needed, and continually improve their process using patient feedback. Please see Appendix E "Exemplary Demonstration" for a more complete description. IHPs who believe they meet this criteria must thoroughly explain how they meet each component. Please keep in mind DHS is only able to assess what is submitted in a responder's application**.**

Question: If an existing IHP scored a 2.0 on the annual population health report, does that equate to the IHP also having an exemplary equity measure?

DHS Response: No, the score related to the annual population health report for existing IHPs is related to the completion of the population health report which is used to report progress on the intervention. An exemplary demonstration is different and is specific to the *actual intervention* in the IHP contract. Please refer to Appendix E: Population Health Demonstration for more details. The components of an Exemplary Demonstration are outlined on page 3 of this appendix.

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

Question: Section 5.4 outlines strict outreach and (response) tracking requirements for C&TC. If an IHP's clinical IT infrastructure cannot support individual-level outreach response tracking, what specific alternative documentation mechanism will comply?

DHS Response: DHS does not require IHPs to utilize a specific IT tool or have specific infrastructure in place for individual level response tracking for C&TC outreach. Individual-level response tracking is a federal requirement, however. IHPs are able to utilize a variety of tools (e.g., Excel, building on the C&TC file from DHS, or other mechanisms) and/or processes to document individual-level responses.

6. Model Design Elements

Question: How will an IHP's attributed population be evaluated for track determination during both the application phase and the active performance years? Specifically, is the evaluation of the 3,000- and 8,000member thresholds based on a historical annual baseline (e.g., CY2025 or CY2026), a specific point-in-time quarterly snapshot, or is it measured dynamically throughout each performance year**?**

DHS Response: An IHP's attribution is determined based on their roster submission at the time of application. If selected to move forward in the contracting process, and a responder has changes to their roster, the attribution will be determined based on the current list of participants/roster that will be included in the executed contract. For more information on roster types, please refer to the section 6.2 Member Eligibility and Attribution in the RFP.

6.1 Overview of Model

Question: RFP p. 17 outlines " .... attribution will be determined using a retrospective model using a 24-month look back process." Does this include initial Track determination?

DHS Response: Yes, the attribution process is the same for Track 1 and Track 2 IHPs.

6.2 Member Eligibility and Attribution

Question: Who calculates attribution?

DHS Response: The State determines attribution on a monthly basis.

Question: The RFP mandates that every single provider and community partner in the IHP model must be an active, enrolled MHCP provider. Several providers are appealing disenrollments under MN Revalidate for administrative errors, but do not know the date of resolution. If a participating clinic or provider on the submitted August roster is placed into a 'pending,' 'inactive,' or 'disenrolled' status by DHS during the State's evaluation window (Phase I and II), will the IHP be notified and granted a formal 'cure period' to update or remediate our roster before a non-compliance failure is registered?

DHS Response: All health care providers included in the IHP Program must be an enrolled MHCP provider in good standing with the State.

Question: If an IHP's attributed population dynamically fluctuates across a track boundary (such as crossing the 3,000-member threshold) mid-year due to Medicaid enrollment churn outside our clinical control, will the IHP's track status and downside-risk exposure change dynamically mid-year, or is the track assignment locked for the duration of the performance year?

DHS Response: Significant changes to the IHPs' attributed population may result in changes to the contractual provisions and risk arrangements, but updates to the risk arrangements would most likely result from substantive changes to the IHP's provider roster, instead of fluctuations around the thresholds described in the RFP.

Question: Given anticipated changes to Medicaid eligibility requirements that may result in significant enrollment shifts and changes in the underlying risk profile of the Medical Assistance population, how does DHS plan to ensure that participating IHPs are not adversely impacted by factors outside of provider control?

DHS Response: Changes due to H.R.1 will be handled similar to how other significant environmental changes have occurred. In consultation with the IHP's contracted actuary, the State will use discretion on the evaluation of the change and what, if any, adjustments to the trend may be needed.

6.3 Definition of Total Cost of Care (TCOC)

Question: If an IHP's TCOC exceeds the 104% threshold, what are the specific repayment terms to the State (e.g., lump sum vs. deduction from future payments, and standard timeline)?

DHS Response: Settlement payments are not due until 120 days following the final settlement. IHPs must work directly with the MCOs the IHP owes a payment to in order to determine the best way to remit payment to that MCO. IHP settlement payment to DHS will be processed by DHS and completed via gross adjustment on a single payment warrant date at some point before the end of the 120 days. Warrant dates are scheduled to occur every other week. The IHP will need to work with DHS to identify the timing for the IHP's gross adjustment remittance. DHS will then take the necessary steps to process the gross adjustment payment.

Question: What is the threshold that an IHP needs to meet? How did the State develop the Total Cost of Care (TCOC)?

DHS Response: An IHP's performance is based on a comparison of their observed TCOC PMPM to their TCOC target. The target is based on the IHP's historical, base period PMPM, adjusted for expected trend and changes in risk from the base year to the measurement year. The threshold for shared savings is a TCOC PMPM that is 2% below the target. The threshold for shared losses is a TCOC PMPM that is 4% above the target.

The IHP program is primary care based. However, the services included in the TCOC include a broad set of services across the care continuum, including inpatient facility, outpatient surgery, mental health, pharmacy, and a variety of other services impacting member health. Certain services understood to be outside of the care systems' influence (e.g., long-term care, certain mental health services) are excluded, and some populations are not eligible for IHP attribution. Please refer to Appendix B2 for a description of the attribution-eligible populations.

Question: How are is an IHP compared for total cost of care (TCOC) purposes?

DHS Response: Because the IHP program is open to a variety of organizations serving different regions and populations, an IHP's annual TCOC performance is measured against their own historical TCOC performance, instead of peer-to-peer comparisons.

Question: Does an IHP get regular feedback on where they are sitting in regards to TCOC?

DHS Response: DHS provides quarterly performance estimates to IHPs. IHPs also receive several other reports (monthly, quarterly) intended to support their work, including a care management report, etc. DHS provides IHPs with an annual quality report and quarterly quality gap reports.

Question: What are some of the factors the actuarial group uses for trends? What is an average goal? Is a report showing 2 years of historical MCO data available? Section 6.4 states the Expected Trend rate will be based on the trend rates used to develop the annual expected cost increases for the aggregate MHCP population, with appropriate adjustments. The Appendix D settlement example applies a single Expected Trend percentage to the Base TCOC but does not specify how it is calculated.

a. To allow applicants to model expected performance, please clarify:

i. the specific data source and methodology used to set the trend (e.g., the same trend underlying MHCP capitation rate development, and if so, which components); ii. whether trend is set prospectively before the performance year, trued-up retrospectively, or a combination; iii. whether trend is differentiated by category of service, program (e.g., PMAP vs. SNBC), or eligibility group, or applied as a single composite rate; and iv. whether the adjustments for excluded services and environmental factors will be disclosed to the IHP alongside the target.

b. Is an illustrative historical trend series available so applicants can assess year-to-year variability?

DHS Response: Cost and utilization trend expectations are intended to reflect the year-to-year cost changes for the overall attribution-eligible populations. The general trends are based on the trends used by DHS' actuarial consultant, Milliman, to develop the managed care premium rates. Each year, we review the trends and adjustments developed by Milliman to ensure that the resulting cost and utilization trends continue to align with the goals of the program.

Although the cost and utilization trends Milliman uses to develop the MCO premium rates are reasonable for developing the trend rates for the IHP's TCOC targets, the differences between the projection periods and the targeted populations require adjustments to the baseline trend rates developed by Milliman. In addition, the adjustments Milliman applies to the baseline trends to reflect benefit or payment changes may need to be modified or disregarded to reflect these differences in populations or time periods. The baseline trends are also modified to reflect benefit adjustments and legislative changes effective during the performance periods.

Trends are initially developed prospectively, but adjusted based on retrospective analyses and review. The IHPs receive initial trends and targets for an individual performance year during the performance year. The initial trends and targets are updated to reflect actual experience for some trend factors and additional retrospective review after the completion of the performance year to develop an "Interim Settlement". The trends and targets are further refined after 12 months of claims runout for the performance year to develop the "Final Settlement" and reflect additional retrospective analysis and review.

Question: The methodology uses the Johns Hopkins ACG tool to develop base- and performance-period risk scores and to adjust the target for changes in relative risk. The exact mechanics of this normalization determines whether population risk-mix drift is self-correcting or whether an IHP is measured against a moving external benchmark. Please confirm the normalization reference population: is each IHP's relative risk indexed to its own base-period population (relative risk = 1.0 at base), or to a statewide or program-wide reference population?

DHS Response: In ACG risk-adjustment, members are assigned to risk categories based on their diagnostic information, age and gender. Although the ACG software contains standardized risk weights or relative costs for each category, "customized weights" can be calculated for a population based on the average expected cost incurred by the members assigned to each category.

The risk weights used to measure the year-to-year change in risk are normalized to the overall attribution eligible population. The weights are not normalized to IHP-specific populations and the same weights are used to measure year-to-year risk changes. An IHP's risk change reflects the expected cost impact of members moving to higher- and lower-risk categories, but the expected risk associated with each category does not change on a year-to-year basis.

Question: Section 6.3 sets a 2% minimum threshold for shared savings and 4% for shared losses, first-dollar calculation once a threshold is met, asymmetric sharing (50/50 up to 4%; 70% of savings and 35% of losses beyond 4%), and corridor caps of 6% (smaller Track 2) and 10% (larger Track 2). Please confirm the first-dollar reach-back is measured from the target (0%), not from the 2%/4% gate.

DHS Response: If an IHP meets the shared savings threshold of 2%, the savings-share is based on the percentage over 0% (e.g., if an IHP is 3% below target, savings-share will be based on 3%, not 1%). If an IHP meets the shared loss threshold of 4%, the loss-share is based on the percentage of losses over 0% (e.g., if an IHP is 5% above target, loss-share will be based on 5%, not 1%).

Question: Section 6.4 states the detailed methodology for the Supplemental Incentive Structure will be shared no later than twenty months following the 2027 performance period — approximately two months after final 2027 settlement, i.e., mid-to-late 2029, more than halfway through the four-year cycle. Because the initial allocation is tied to primary care utilization behavior, an incentive whose rules are unknown until after the behavior period has closed cannot shape care delivery during 2027. Would the Department consider publishing the allocation formula and eligibility criteria — even in preliminary form — before or early in the first performance year? At minimum, can DHS share the draft of the methodology, with final parameters trued up later?

DHS Response: At minimum, DHS intends to share the general anticipated methodology for eligibly and allocation in early-2027.

Question: How is DHS reflecting rehabilitator discounts for UCare payments in IHP settlements and how will that process impact benchmarks/targets go-forward? Please provide detailed information to address this concern.
DHS Response: We anticipate UCare will make all required payments. If that does not happen for some reason, the exact impact of any outstanding claim payments from UCare will need to be determined as part of the upcoming settlement calculations. In some cases where claims have been adjudicated and not paid, the data used to determine the performance results reflects the contracted claims payment. In cases where outstanding or partial claim payments artificially reduce the observed claims experience, we would plan on developing adjustments to the TCOC to reflect the impact of these cost reductions. In the event that an IHP is directly impacted by non-payment or reduced payments, we would need to determine the appropriate methodology for addressing these differences, in keeping with the current contractual provisions and goals of the shared-savings arrangements.

Question: What drove exclusion ('E') for EIDBI when it had been an Included ('I') service in a current IHP's contract? How might this change impact TCOC performance benchmarking/targets?

DHS Response: Because of the unpredictable growth and variable year-to-year impact of these services, DHS has adjusted the IHPs' annual performance targets to reflect their actual year-to-year experience since 2016. These ongoing adjustments, along with the understanding that some of these services had been "at-risk" for fraud, prompted DHS to remove them from the TCOC. The impact on the performance measurement process will be shared with the existing IHPs as part of the 2026 Target exhibit and memo.

Question: The Sample Contract shows a few services that are new (i.e. 039 Child and Teen Check-up Outreach (included), 073 Inpatient Hospital Neonatal ICU (included), 052 MHSUD-Integrated (included) and 048 EIDBI (excluded)). What were these previously listed as? What was the reasoning for each of the changes to the Included and Excluded services in TCOC, by item? Related to the Category of Service additions, will DHS be reclassifying historical claims to these new categories? Can you provide information to demonstrate impact of these changes?

DHS Response: Please refer to the updated Included Services Table below,, as an older version was inadvertently included in the published Appendix G – Sample Contract. It is also important context to note that the Categories of Service (COS) utilized by the IHP Program is an evolving catalogue of services maintained by other areas of DHS in response to changes in benefits, statutory or CMS requirements, or other billing, fiduciary, or tracking needs. We are continuing our review of categories of services information and will share a final Included Services Table with respondents who move forward into contract negotiations prior to final contract review and execution. In general, however, if a new COS is identified, it will follow a pattern consistent with

other COS in the same service class. For example, Long-Term Care Services are generally excluded from TCOC. Other COS that were asked about are noted below:

- Child and Teen Check-up Outreach has been included in the in the TCOC for many years. It will now be reflected more clearly in the Included Services table for the IHP Program. Please note that the volume of claims is very low, and it is possible that an IHP has never received reporting showing claims payments for this service category.
- Claims for Inpatient Hospital Neonatal ICU have primarily been included in service category "001 - Inpatient Hospital General" but will now listed as a separate COS.
- MHSUD-Integrated services were incorrectly labeled as included. They have been excluded from the TCOC historically and will continue to be excluded.
- EIDBI services became part of the Medicaid-eligible benefits in CY2015. Since the 2016 performance period, experience-specific adjustments were integrated into the trend rates to reflect cost changes for certain claim types. Originally, adjustments were included to reflect the actual, IHP-specific cost increases for EIDBI and Behavioral Health Home services. In effect, including the actual, IHP-specific cost changes in the annual trends removed the impact of these claims from the performance calculations. Similar adjustments were integrated for claims incurred at psychiatric residential treatment facilities (PRTF). Most recently, trend factors were added to reflect the increases in utilization for services identified as being “At-Risk” for fraud. The ongoing concerns around these “At-Risk” services have prompted DHS to exclude these claims from the TCOC for the 2026 performance period. Although DHS has been adjusting for the cost increases since 2016, EIDBI claims are also considered “At-Risk” services

and will be excluded from the TCOC. Because many claims incurred at residential treatment facilities are included in the "At-Risk" services, PRTF claims will be also excluded from the TCOC.

Appendix 2: Included Services - Category of Service Table[1]

Categories of Service Included or Excluded from IHP TCOC

Service Class	Category of Service	Included (I) / Excluded (E)
Inpatient Claims	001 - Inpatient Hospital General	I*
Inpatient Claims	006 - Inpatient Hosp Rehabilitation	I
Inpatient Claims	014 - Inpatient Hospital IMD	I*
Inpatient Claims	015 - Inpatient Long-Term Hospital	I
Inpatient Claims	074 - Inpatient Hospital Non DRG (psych contract beds)	I*
Inpatient Claims	999 - Undetermined	I*
Long Term Care Services	011 - Nursing Facility - Level I	E
Long Term Care Services	012 – Recuperative Care	E
Long Term Care Services	013 - ICF-MR	E
Long Term Care Services	017 - Nursing Facility - Level II	E
Long Term Care Services	019 - Day Training And Habilitation	E
Long Term Care Services	021 - Consumer Directed	E
Long Term Care Services	033 - Modifications And Adaptations	E
Long Term Care Services	038 - Personal Care Services	E
Long Term Care Services	084 - Swing Bed Services	E
Long Term Care Services	092 - Nutrition Services	E
Long Term Care Services	093 - Chore	E
Long Term Care Services	094 - Companion Services	E
Long Term Care Services	095 - Home Delivered Meals	E
Long Term Care Services	096 - Homemaker Services	E
Long Term Care Services	102 - Adult Day Care	E
Long Term Care Services	104 - Supported Employment Services	E
Long Term Care Services	105 - Supported Living Services	E
Long Term Care Services	106 - Structured Day Program Service	E

[1] Reviewed April 15, 2026.

Long Term Care Services	107 - Respite Care	E
Long Term Care Services	108 - Assisted Living Services	E
Long Term Care Services	109 - Independent Living Skills	E
Long Term Care Services	110 - In-Home Family Support	E
Long Term Care Services	111 - Developmental Disabilities Screening	E
Long Term Care Services	114 - Extended Home Health AIDE	E
Long Term Care Services	116 - Extended Medical Supplies / Durable Medical Equipment (DME)	E
Long Term Care Services	119 - Extended Personal Care	E
Long Term Care Services	122 - Extended Private Duty Nursing	E
Long Term Care Services	126 - Extended Transportation	E
MH/CD	029 - RTC - Mental Health	I
MH/CD	034 - Family Counseling and Training	I
MH/CD	035 - Behavioral Program Services	I
MH/CD	046 - Mental Health	I*
MH/CD	048 - Early Intensive Developmental And Behavioral Intervention (EIDBI)	E
MH/CD	062 - Chemical Dependency (aka SUD)	I*
MH/CD	063 - Chemical Dependency – Extended Care, Halfway House	I
MH/CD	071 - Case Management Mental Health	I
MH/CD	113 - PASARR - Mental Health	I
MH/CD	999 - Undetermined	I*
Other	005 - Child Welfare Targeted Case Management	I
Other	032 - Medical Supplies/DME	I
Other	036 - Transport, Special	E
Other	037 - Transport, Ambulance	E
Other	045 - Dental	I
Other	052 - IEP (Individual Education Plan for children with disabilities)	E
Other	075 - Eyeglasses/Contact Lenses	I
Other	076 - Prosthetics and Orthotics	I
Other	077 - Hearing Aids	I
Other	100 - Access Services	E
Other	103 - Foster Care	E
Outpatient Facility	007 - Outpatient Hospital Services	I*
Outpatient Facility	020 - Home Health Services	I

Outpatient Facility	025 - Birth Center Facility Fee	I
Outpatient Facility	041 - Anesthesia	I
Outpatient Facility	043 - Physician Services	I
Outpatient Facility	051 - Physical Therapy	I
Outpatient Facility	053 - Speech Therapy	I
Outpatient Facility	054 - Occupational Therapy	I
Outpatient Facility	056 - Ambulatory Surgery	I
Outpatient Facility	058 - Audiology	I
Outpatient Facility	072 - Hospice	I
Outpatient Facility	078 - Vision	I
Outpatient Facility	079 - Radiology, Technical Component	I
Outpatient Facility	080 - Laboratory	I
Outpatient Facility	082 - Fed Qualified Health Cntr Svc	I
Outpatient Facility	083 - Rural Health Clinic Services	I
Outpatient Facility	087 - End-Stage Renal Dialysis	E
Outpatient Facility	088 - Public Health Nursing	I
Outpatient Facility	089 - Private Duty Nursing	I
Outpatient Facility	118 - Extended Occupational Therapy	I
Outpatient Facility	121 - Extended Physical Therapy	I
Outpatient Facility	999 - Undetermined	I*
Pharmacy	030 - Pharmacy Services	I
Professional	020 - Home Health Services	I
Professional	022 - Transitional Services	E
Professional	040 - Child And Teen Checkup	I
Professional	041 - Anesthesia	I
Professional	043 - Physician Services	I
Professional	044 - Case Management - Other	I
Professional	051 - Physical Therapy	I
Professional	053 - Speech Therapy	I
Professional	054 - Occupational Therapy	I
Professional	055 - Podiatry	I
Professional	057 - Chiropractic	I
Professional	058 - Audiology	I
Professional	078 - Vision	I
Professional	079 - Radiology, Technical Component	I
Professional	080 - Laboratory	I

Professional	088 - Public Health Nursing	I
Professional	089 - Private Duty Nursing	I
Professional	090 - Nurse Midwife Services	I
Professional	091 - Nurse Practitioner Services	I
Professional	999 - Uncategorized	I*

* Some Categories of Service (COS) contain both included and excluded services. "I*" indicates that some claims within the category may be excluded from the TCOC. In most cases, the excluded services within these categories are ones designated as high-risk in 2025. Please see Section 16.11 for more information about how IHPs' TCOC will be impacted by services designated as high-risk.

Question: With H.R. 1 enacting 6-month renewals and work requirements, it is anticipated that significant patient churn and changes in population risk will occur. How does DHS plan to retrospectively adjust TCOC targets and risk scores in instances of sudden shifts in patient enrollment that are completely outside an IHP's clinical control?

DHS Response: Where necessary, the performance measurement process integrates the impact of broader environmental changes into the trend adjustments. This has been especially true since 2020, when the pandemic, Public Health Emergency, and other enrollment changes resulted in claim expenses that were different from the trend expectations. We expect to continually review the observed impact of environmental changes, including work requirements, and integrate appropriate trend adjustments to reflect emerging experience.

Question: Are there any patients that are excluded based on claim amounts?

DHS Response: No, claim expense thresholds are not included in the attribution criteria. However, depending on the IHP, an individual member's claims are capped at 50K, 100K, or 200K. If a member reaches the claim cap threshold, the member remains in the attributed population, but claims above the threshold are not included in the performance measurement. The claim cap is primarily based on the size of the population of the IHP, with higher claim caps for larger populations. If selected to move forward in the contracting process, the claim cap level will be determined during contract negotiations.

Question: Section 6.3 states DHS will remove the claim costs for individual members that fall above specific thresholds, with a cap not to exceed $200,000. Retaining capped costs up to the threshold — rather than removing the member entirely — preserves a larger and more stable denominator and avoids distorting the risk adjusted PMPM, and we would encourage the excess-only approach. Please confirm the mechanical treatment: when a member's total cost of care exceeds the applicable cap, is only the excess dollar amount above the threshold removed from the TCOC calculation (with the member's costs up to the cap retained in both the base and performance PMPM)? Please also confirm the cap is applied consistently across the base period and each performance period.

DHS Response: Yes. It is correct that the cost that goes above the claims cap is not included in the performance measurement calculation. It is also correct that the claims cap will be applied consistently across the base period and each performance period. Because the cap level is consistent between performance periods, an additional factor is included in the trends to reflect the leveraging impact of an untrended claims cap.

Question: We have concerns about the impact of market volatility in 2025 and beyond, and whether those impacts can be adequately addressed through actuarial adjustments alone. While we recognize that the actuarial adjustments may be methodologically sound, they do not eliminate the fundamental uncertainty created by extraordinary market events that are outside of provider control. Providers should not be penalized for volatility created by factors they have no ability to influence or manage. Providers cannot control payer insolvency, market exits, payment delays, eligibility changes, or other external disruptions that materially impact program performance, and providers should be held harmless related to these issues. We suspect we are not the only IHP with these concerns. Please address how these concerns can be mitigated in a revised model.

DHS Response: While the impact of environmental changes can be unpredictable, that does not mean that their impact cannot be measured retrospectively. Although an IHP's target is set prospectively, the performance and settlements incorporate retrospective analyses, occurring both 4-6 months and 12-18 months after the end of the performance period. Although the ongoing updates to trends can create short-term uncertainty, and some variability in shorter-term (e.g., quarterly) performance measurements, the retrospective analysis provides DHS with the opportunity to adjust the trends and targets to reflect unanticipated changes in cost expectations.

Question: We are concerned about the potential impact of future eligibility requirements and other changes to the Medicaid program. As those changes are implemented, providers need confidence that the State has mechanisms in place to identify and mitigate adverse impacts that are unrelated to provider performance.

DHS Response: Changes due to H.R.1 will be handled similar to how other significant environmental changes have occurred. In consultation with the IHP's contracted actuary, the State will use discretion on the evaluation of the change and what, if any, adjustments to the trend may be needed.

Question: Which elements of the RFP have been included by DHS in an attempt to reduce patient churn in light of the impact of H.R.1?

DHS Response: The RFP does not include specific elements to address patient churn. The attribution process does include provisions that may mitigate the impact of increases to the relative levels of patients moving in and out of eligibility (e.g., enrollment month minimums). As part of the performance measurement process, DHS reviews the impact of broader environmental changes on the attribution-eligible populations and ingrates trend adjustments to reflect unanticipated utilization changes.

Question: In the RFP, it talks about 4% and 6% savings/losses. Does this apply to Track 1 IHPs? Does the change from 4% to 6% happen automatically?

DHS Response: No, this does not apply to Track 1 IHPs, as neither shared-savings or -losses is applicable to Track 1 IHPs. The eligibility for enhanced threshold for shared-losses payments of up to 6% would be determined by DHS.

Question: The risk sharing summary table is blank in the model contract. The RFP shows Risk Sharing

Requirement model shows a 70/30 option. Is this negotiable? If a provider system is concerned about potential loss, is the downsize/upside corridors negotiable?

DHS Response: The standard risk-sharing arrangement by IHP track and size - including payment distribution - is detailed in Table 4 of the RFP. The standardized risk arrangement is something that *may* be able to be discussed further during contract negotiations, but is consistent with IHP Track 2 agreements from the past several years.

Responders who wish to seek a deviation from the standardized risk arrangement must detail their requested modification and rationale for the modification from the standardized approach that is included in the RFP in their submitted proposal. If selected to move forward in the contracting process, these details would be discussed during contract negotiations.

6.4 Payment Models, Mechanisms, Risk

Question: Reading through the RFP, can DHS help us better understand why a legal partnership with a community partner is being required for Track 2 IHPs? Many of these community partners are largely grant funded and are navigating ongoing funding instability and year-over-year reductions. Requiring a formal legal partnership seems like it may create an unnecessary barrier within our shared goal of caring for an already underserved population.

How would the IHP recommend organizations navigate situations where a community partner no longer exists during the term of the agreement due to loss of funding? Additionally, if an organization has strong, active collaboration with multiple community partners but does not currently have a formal legal partnership in place, would there be an alternative pathway that could satisfy this requirement? We would appreciate any additional context DHS can provide on the questions above as we continue evaluating the RFP.

DHS Response: DHS continues to encourage IHPs to cultivate relationships with multiple community-based organizations (CBOs). The legal agreement required in the RFP is intended to apply to the accountable care partner (ACP) organization with which the IHP has developed a relationship for purposes of the Population Health Demonstration, an organization that is often the "primary" partner CBO. This is intended to ensure that the partnership is mutually beneficial and that clear roles and responsibilities are established with regards to the IHP's Population Health Demonstration. The structure and specific approach to the legal agreement is not specified in the RFP and can be determined by the IHP and the ACP (some types of legal agreements are listed in the RFP as examples). A formal legal agreement is already common practice amongst IHPs and their primary CBO partners, and is especially important in the context of the IHP contract. Having an ACP in place has historically allowed Track 2 IHPs the ability to negotiate more favorable risk arrangements, something that was universally pursued by Track 2 IHPs. This requirement goes hand in hand with the more standardized approach to risk arrangements that has been incorporated into the current RFP for IHP Program participation. And both requirements only standardize well-established practices in the IHP Program. Additionally, IHP organizations are welcome and encouraged to establish robust and/or legal agreements with multiple partner organizations, but the requirement included in the RFP is only that one such formal legal agreement be in place with an ACP for purposes of the Population Health Demonstration intervention.

As has been the case since the IHP 2.0 model design was first implemented in 2018, DHS has expected IHPs to reach out to DHS to discuss situations like the one described in this question, where a partner organization is no longer willing or able to meet the expectations of the relationship or intervention as documented in the IHP's contract with DHS. In cases like this, we have partnered with IHPs to discuss the situation, identify a mutually agreeable solution, and have amended contracts when needed.

Question: Is it possible to get an idea of what our attribution is?

DHS Response: If selected to move forward in the contracting process, this may be something DHS can provide estimates of during contract negotiations.

Question: Section 6.4 establishes CY2026 as the single base period from which the TCOC Target is derived and then trended forward across the full four-year contract cycle. We recognize the annual risk- and trend adjustment process in Section 6.6 is designed to absorb year-to-year variation. However, that machinery adjusts the slope of the target, not the level of its starting point. Because every performance-year target is a function of the single Base TCOC (Base × cumulative trend), an anomaly in the base year — a utilization spike or dip, unusual coding, etc. — is not corrected by trend and instead continues through all four settlements. Has the Department considered a multi-year base period (e.g., a two- or three-year blended experience base) to increase stability and dampen single-year volatility in the target level? If a single base year is retained, will DHS apply any credibility weighting, outlier smoothing, or stability adjustment to the base experience, and can that methodology be shared before contract execution?

DHS Response: If an organization applies and is selected to enter into contract negotiations, the contract year would be 2027 with the base year being 2026. The State is not considering a multi-year base period.

Question: What track option would be a good fit for a Track 1 IHP who has concerns on taking on downsize risk?

DHS Response: We encourage respondents that anticipate they may be close to meeting the requirements for participating as a Track 2 IHP to submit an application as a Track 2 IHP. DHS is only able to consider what is submitted in a responder's submitted proposal. If selected to move forward in the contracting process, DHS will determine which Track is the best fit. Respondents that are interested in participating as a Track 2 IHP, but are determined by DHS as not meeting the criteria for Track 2 participation, will instead automatically be considered for Track 1 participation.

Question: Can an applicant IHP propose the same Accountable Care Partnership (ACP) as its current IHP contract?

DHS Response: The Accountable Care Partnership (ACP) must meet the requirements outlined in Section 6.4 'Payment Models, Mechanisms, Risk' of the RFP and in the 'Accountable Care Partnership' section of Appendix E. DHS is only able to assess and take into consideration what is submitted in a responder's application. The IHP's

ACP arrangement must be a part of the IHP's Population Health Demonstration and the applicant IHP must submit the required document as outlined in Appendix A: Integrated Health Partnerships Program Application Template.

Question: The share pooled component looks new this year. What is the magnitude of the shared savings pool? Should a current IHP include this information into our modeling?

DHS Response: The shared-savings incentive pool is a new component to the IHP Program. In terms of magnitude, DHS anticipates the amount of savings to be modest but meaningful. Please note that this savings opportunity is contingent on savings across the IHP Program overall and is not a guaranteed payment to IHPs.

6.5 Interaction with Managed Care Organizations (MCOs)

Question: How do managed care organizations pay the IHP?

DHS Response: Shared-savings and -losses are calculated by the State. Attribution includes both MCO-enrolled members and FFS-enrolled members. MCOs participate as a payer in the IHP settlement payment process via their contract requirement with the State. The MCO contract is handled outside of the IHP team.

6.6 Significant Changes in the Health Care Environment

Question: Section 6.6 reserves broad authority for standard and customized retrospective adjustments, including supplemental trend adjustments to reflect broader environmental factors, and anticipates further adjustment for H.R. 1 impacts. Given the size of potential H.R. 1 population effects, applicants need to understand how much of the settlement outcome rests on non-formulaic DHS judgment. Is there a governance or disclosure mechanism giving an IHP visibility into — and an opportunity to review — the discretionary adjustments applied to its specific settlement, or are these applied unilaterally by DHS?

DHS Response: Every performance year, each IHP receives detailed information on the calculation methodology and rationale for the trend factors and adjustments integrated into their settlement calculation. Since program inception, DHS has worked with the IHPs to address supplemental questions and supply additional information to assure mutual understanding and confidence in the reliability of the measurements. Typically, these discussions occur during the period between the interim and final performance calculation to allow for the integration of IHP feedback and insight into the final settlement process.

7.2 Quality and the Population-Based Payment

Question: If an IHP would like to focus on ensuring stability in enrollment and fulfilling work requirements based on the new requirements of H.R.1., would DHS consider this an acceptable population health demonstration effort?

DHS Response: The requirements for an acceptable population health demonstration are outlined in Appendix E and include efforts that are outside the scope of typical patient care. DHS would need to evaluate what is submitted as a part of the application. However, in the past, IHPs have included ensuring individuals have insurance coverage as a portion of their demonstration.

Question: Given the way our IHP is structured, we may need to utilize different measures for certain parts of our organization for the Population Health Demonstration. Is this acceptable?

DHS Response: IHPs must submit measures as outlined in Appendix E. There must be measures in different categories such as process, outcomes, patient experience, and a SMART goal. DHS will work with IHPs on refining the metrics for the Population Health Demonstration during contract negotiations. Measures may be stratified to address the IHP make up and DHS would also be able to work with IHPs who may need to report different measures for different parts of their organization.

Question: Does quality have an impact on the population based payment (PBP) amount?

DHS Response: Quality does not change the amount an IHP receives for the population based payment. Quality related to the population based payment may instead impact the IHP's ability to continue in the IHP program after the conclusion of its current contract. Please see RFP Section 7.2 'Quality and the Population-Based Payment' and Section 17 of the IHP sample contract. Quality does have an impact on any potential shared savings and can potentially mitigate losses. Please see RFP Section 7.3 'Quality and the Shared Risk Model' and Section 18 of the IHP sample contract.

7.3 Quality and the Shared Risk Model

Question: The RFP notes that for performance period 1 for the equitable care domain, IHPs will be required to complete a narrative report. If an IHP is choosing the same measure as their current contract, is a narrative report required?

DHS Response: If a current IHP is choosing to continue with the same measure as to what is in their current contract, the first performance period will not include a narrative report and will instead be scored based on the performance data. If an IHP selects a different measure, that is not in the current contract, then year one would be scored based on the completion of a narrative report explaining the steps the IHP is taking to close gaps in care for the selected measure. The goal behind the report for performance period one is to allow the IHP to put processes in place to close gaps in care and if the measure was in the prior contract then the IHP would have done that work in the previous contract.

Question: For the Closing Gaps Measures section, it is noted that four options are listed. Do IHPs have to pick measures exclusively on this list or can an applicant propose other measures not on this list?

DHS Response: The four measures listed are the measures that the State is focused on. IHPs can propose measures not on this list, but measures in this category must be from the Statewide Quality Reporting and Measurement System (SQRMS) measure set submitted to MNCM because the measures are scored based on closing gaps between the Medicaid and Commercial rates and these measures are the only ones where this data is currently available.

Question: In the Closing Gaps domain, achievement points are awarded by comparing IHP results to a statewide distribution that uses commercial rates, and the domain is framed around the MHCP-vs-commercial disparity. A substantial portion of any Medicaid-commercial gap reflects population and social-risk factors that are structural and outside the IHP's direct control rather than differences in care delivery. Please clarify:

i. whether, and how, the commercial benchmark is adjusted for population differences before comparison;
ii. given that DHS uses the greater of achievement or improvement points, whether an IHP is fully held harmless on the achievement comparison where it demonstrates year-over-year improvement, such that no IHP is penalized purely for a structural gap it did not create; and
iii. for any Medicaid-specific measures in this domain (e.g., Optimal Diabetes Care, Optimal Asthma Control), how are the targets for these measures determined?

DHS Response:

i. The closing the gaps commercial percentiles used for achievement point assignment are not risk adjusted. The intent of this category is to close gaps in care for the MHCP population and those commercial percentiles are used as the attainment thresholds for this category.
ii. The IHP has the opportunity to obtain points for achievement based on performance compared to commercial percentiles or based on relative improvement compared to the performance in the prior year. DHS does not adjust results and maintains the goal of this category is to close gaps in care. iii. The percentile distribution is calculated using the commercial performance rates for all Minnesota medical groups with a denominator of 30 or more for the given measure (e.g., Optimal Diabetes Care, etc.).

Question: We know DHS has been working with existing IHPs to update the Quality Gap Reports which provide IHPs with individual-level and summary data on patients who are in the denominator for each quality measure included in the report. The report identifies patients who received or did not receive the recommended care so that IHPs can reach out to patients to close those gaps. Will the updates to the gap reports be done by 1/1/27?

DHS Response: The feedback on the gap reports provided by existing IHPs is currently being reviewed. DHS will keep existing IHPs informed of those changes and the anticipated timeline. DHS will inform IHPs 90 days prior to making any changes.

Appendix E: Population Health Demonstration Template

Question: For Track 2 participants, the IHP must submit an MOU, BAA, or other similar agreement by November 2, 2026. Additionally, formal partnerships must demonstrate an ongoing, legally established relationship to provide services that address a population health goal within the Population Health Demonstration. Please clarify:

i. Community Partner Sustainability and Risk Mitigation: Many community-based organizations operate with grant-funded revenue streams and are currently facing significant funding uncertainty, creating challenges for long-term organizational sustainability. How does the State plan to address situations in which a community partner identified in a Population Health Demonstration dissolves or ceases operations during the demonstration period? Specifically, if a community partner listed in the approved demonstration is no longer able to operate for a substantial portion of the IHP contract period, what

flexibility, protections, or alternative pathways will be available to the IHP? Will the State allow partner substitutions, amendments to the demonstration, or other remediation strategies without negatively affecting the IHP's compliance or performance under the agreement?

ii. Recognition of Non-Formalized Community Partnerships: Has the State considered allowing nonformalized community partnerships, supported by letters of commitment or letters of support, in lieu of requiring a legal agreement at the time of proposal submission? Many IHPs maintain longstanding and effective relationships with community organizations to address health-related social needs and advance community health goals, despite not having formal legal agreements in place. How does the State intend to recognize and value these existing collaborative relationships within the Track 2 Population Health Demonstration requirements? Additionally, would the State consider allowing documentation of established collaboration, such as letters of support, as evidence of partnership where a formal MOU, BAA, or similar legal agreement does not exist?

DHS Response:

i. In cases like this, where a partner organization is no longer willing or able to meet the expectations of the relationship or intervention as documented in the IHP's contract with DHS, we have partnered with IHPs to discuss the situation, identify a mutually agreeable solution, and have amended contracts when needed. IHPs are encouraged to reach out to DHS as soon as possible if a situation like this arises. ii. DHS continues to encourage IHPs to cultivate relationships with multiple community-based organizations (CBOs). The legal agreement required in the RFP is intended to apply to the accountable care partner (ACP) organization with which the IHP has developed a relationship for purposes of the Population Health Demonstration, an organization that is often the "primary" partner CBO. This is intended to ensure that the partnership is mutually beneficial and that clear roles and responsibilities are established with regards to the IHP's Population Health Demonstration. The structure and specific approach to the legal agreement is not specified in the RFP and can be determined by the IHP and the ACP (some types of legal agreements are listed in the RFP as examples). A formal legal agreement is already common practice amongst IHPs and their primary CBO partners, and is especially important in the context of the IHP contract. Having an ACP in place has historically allowed Track 2 IHPs the ability to negotiate more favorable risk arrangements, something that was universally pursued by Track 2 IHPs. This requirement goes hand in hand with the more standardized approach to risk arrangements that has been incorporated into the current RFP for IHP Program participation. And both requirements only standardize well-established practices in the IHP Program. Additionally, IHP organizations are welcome and encouraged to establish robust and/or legal agreements with multiple partner organizations, but the requirement included in the RFP is only that one such formal legal agreement be in place with an ACP for purposes of the Population Health Demonstration intervention.

Question: If an IHP applies to carry over an existing Health Equity Measure from their current contract as the Population Health Demonstration and DHS rejects that proposal, how much time will the responder have to select a new demonstration, obtain an ACP Letter of Support, and execute the ACP legal agreement?

DHS Response: Applicants should review the requirements in Appendix E and utilize those requirements when proposing their population health demonstration. If DHS determines the applicant's intervention does not meet the specified criteria, but the applicant is selected to move forward in the contracting process, DHS and the

applicant will work together to identify a timeline for any needed modifications which must allow the parties to enter into a contract in late 2026.

Question: Is the ACP Letter of Support due along with the application on 8/26? Or can it be submitted along with the executed ACP legal agreement by the 12/1 deadline.

DHS Response: The Letter of Support must be submitted with the application. The MOU, BAA, or other similar agreement should also be submitted with the application. However, if the MOU, BAA, or other similar legal agreement is not available at the time of application then it must be submitted by November 2, 2026. Please refer to Appendix E: Population Health Demonstration Template or Appendix A: Integrated Health Partnerships Application Template for more details.

Appendix F: IHP Reports and Data

Question: Do Track 1 IHPs receive the full set of reports that Track 2 IHPs receive in order to help prepare/evaluate risk arrangement? Is DHS open to ad hoc requesting of additional information?

DHS Response: Yes, Track 1 and Track 2 IHPs receive the same reports. Yes, DHS is open to receiving ad hoc reports requests, though DHS' ability to fulfill those is entirely dependent on resource constraints. A responder may submit an ad hoc report request to DHS for consideration. Respondents are encouraged to submit any known requests with their proposal and they can also be discussed during contract negotiations if a Responder is selected to move forward in the process.

Appendix G: Sample IHP Contract

Question: Can DHS provide a current IHP with a redline version showing the difference between their current contract and what has been added to the 2027 Sample Contract?

DHS Response: DHS is unable to provide a redline version showing the changes between a current IHP's contract and the sample contract. Responders are responsible for reviewing all aspects of the contract.

Question: As a current IHP, we are in the process of making changes to our governing board. These changes may not be in place by the time a new contract is executed. Will that be an issue?

DHS Response: If selected to move forward in the contracting process, these details can be worked through during contract negotiations. If a contract is executed before the changes are finalized, a contract amendment can be completed.

Question: The model contract shows the claim cap options of $50,000/$100,000/$200,000 maximum annual claims per Patient. Does DHS anticipate any changes to these options?

DHS Response: No, DHS does not anticipate any changes to the claim cap options.

Other

Question: Can an IHP have an enablement partner present at contract negotiations?
DHS Response: Yes, an IHP can bring a subcontractor to negotiations. Information about subcontracts is included in Appendix G - Sample Contract.

Question: Can an IHP be a part of both the IHP program and apply to be a part of the Transforming Maternal Health Model (TMaH)? If a participant/responder is also participating in the TMaH program, how might that overlap with participation in the IHP program? What are the benefits and/or drawbacks to participating in both programs simultaneously? Will there be related PBP payment reconciliations?

DHS Response: Yes, an IHP can be a part of both the IHP program and apply to be a part of the Transforming Maternal Health Model (TMaH) program. Because many details of the TMaH value-based approach are still under development and because CMS is a significant collaborative partner in the TMaH model design, this is likely to be an evolving source of discussion. For example, it is likely that funding/payments for TMaH and the IHP Program will need to be evaluated to ensure there is no duplication of payment. DHS will coordinate this review internally and with CMS in order to make a determination.

Question: As a potentially new IHP, what are things we should be considering?

DHS Response: The IHP Program is a highly collaborative program with shared goals of reducing costs while providing high quality care, including better outcomes for attributed patients. There is immense value for patients and to both the IHP organization and DHS in partnering to support members and work towards those shared goals.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK