



REQUEST FOR INFORMATION (RFI): INTEGRATED HEALTH PARTNERSHIPS

MINNESOTA DEPARTMENT OF HUMAN SERVICES | HEALTH CARE ADMINISTRATION

Purpose & Objective

This document is a request for comments on enhancements to the Integrated Health Partnerships (IHP) program to support innovative health care delivery systems serving Minnesota Health Care Programs (MHCP) populations authorized under Minnesota Status §256B.0755.

The IHP program has allowed the Minnesota Department of Human Services (DHS) to engage in alternative payment arrangements directly with provider organizations that serve an attributed population, in an agreed-upon total cost of care and risk/gain sharing payment arrangement. Quality of care and patient experience are measured and incorporated into the 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. A potential framework to support entry into and sustainability of the model is described below and comments are sought to help further inform options for enhancing program components.

Background

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 Request for Proposal (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. Combined, Minnesota's now nineteen (19) IHPs provide care to over 340,000 Minnesotans enrolled in MHCPs, and have achieved an estimated savings of \$76 million dollars. A portion of these savings are used by provider systems to support 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 and methodologies can be located at DHS's [Integrated Health Partnerships \(IHP\) Overview](#) webpage.

The IHP program was designed to be flexible, in order to allow for a wide variety of member and provider participants, and to integrate different potential care management strategies and operating models. For example:



- The IHP program builds off existing care and delivery systems but does not require specific or prescribed care models. This gives providers flexibility to develop innovative methods for coordinating and delivering care to improve patient health and experience with few new requirements.
- Systems with smaller regional footprints and provider groups that may not have direct affiliation with a hospital system are able to participate. Many of the payment model components (risk-share percentages, maximum per-member expenses, trend targets, etc.) allow for customization to reflect the specific circumstances or preferences of the provider participants.
- Attribution of MHCP enrollees and their TCOC calculations are done across Minnesota's Health Care Programs (MHCPs), specifically Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), and Special Needs Basic Care (SNBC), and include members enrolled under DHS fee-for-service or in any of Minnesota's Medicaid Managed Care Organizations (MCOs). Incentives are aligned across the MHCP population segments, and providers who may have small numbers of enrollees with any single MCO can participate based on the size of their aggregate Medicaid population across programs and MCOs.
- The IHP program allows for wide flexibility in the structure and governance of any participating provider organizations. Current participants range from large integrated medical groups, to collaboratives made up of independent physician groups and hospitals and rural independent physician groups.

IHP in the Future

The experience and feedback from participating stakeholders from the first three years of the IHP demonstration have highlighted many of its valuable features as well as some additional areas for potential improvements to the model. Some of these opportunities include:

- Assuring the long-term sustainability and effectiveness of the incentive structure.
 - The current model focuses on cost and quality improvements over time relative to an IHP's own historical performance. This may result in greater difficulty in realizing improvements and shared savings for systems that already perform more efficiently than their peers.
 - Care delivery and coordination improvements require providers to make upfront and on-going infrastructure investments. However, the current model's incentives are based on the potential for providers to earn future shared savings, payable at least one year after initial investments are made. This delayed and potentially unreliable revenue source may limit participation in the program. More predictable and flexible payment mechanisms with consolidated requirements related to care coordination may be needed.



- Creating a more flexible on-ramp for smaller or specialty-focused providers to enter into risk-based alternate payment arrangements, allowing for additional provider and organization types to successfully participate in the model.
 - Providers who serve smaller populations or focus on patients with more specialized or complex needs (e.g. patients with specific conditions or with behavioral health, long term care and post-acute support needs) may be unable to participate due to the difficulty in developing credible performance measurements under the existing payment model structure.
 - Additionally, smaller or specialty providers may not have the up-front funding or internal resources to meet the data and financial management requirements for participation.

- Improvements to member attribution (i.e. attaching patients to providers for the purposes of care coordination and accountability) to stabilize a provider’s attributed population and to better reflect a member’s principal care provider
 - Some members receive the majority of their care and care coordination through a specialty provider or were enrolled for only a short period of time. Currently, the IHP model prioritizes traditional primary care and requires a member be enrolled for a minimum number of months to be attributed. This methodology may result in some members not being attributed to a provider.
 - Additionally, the retrospective IHP methodology may result in “turn-over” in members attributed to a particular provider, challenging their ability to effectively manage a seamless experience of care over time.

IHP Program Track Examples and Considerations

To begin addressing the opportunities for improvement referenced above, DHS has developed several potential future IHP “tracks.” These tracks are examples provided for the purpose of facilitating feedback, and are not meant to be an exhaustive or exclusive list of the only options open for consideration. Some options included in the tracks below are similar to those laid out in CMS’ Next Generation ACO initiative¹, or changes similar to CMS’ recently proposed rule changes to the Medicare Shared Savings Program². This alignment is intentional so that providers who are currently, or are considering, participating in these programs for their Medicare population can have some level of consistency in IHP payment structure for their Minnesota Health Care Program members.

IHP Program Track Examples

In developing the following example tracks, DHS made several assumptions:

¹ More information on CMS’ Next Generation ACO initiative is available through the [CMS’s Next Generation ACO website](#).

² More information on the proposed rule changes to CMS’ Medicare Shared Savings Program is available through [CMS’s website](#).



Minnesota Department of **Human Services**

- Participation in any given track would be for a three year period with optional annual contract renewals. However, IHPs could elect to change tracks within a given contract period if system requirements are met.
- Providers will continue to be able to take on varying amounts and types of risk based on the size and complexity of the population they serve, the breadth of services they deliver, and their degree of integration across the spectrum of care.

Example Track Options

Model Component	Track 1	Track 2	Track 3
<p>Payment Structure</p>	<p>Continue to receive standard payments for services delivered plus an option for performance based shared savings payments.</p> <p>Provider also receives per member, per month (PMPM) payments for meeting care coordination and quality performance criteria.</p>	<p>Total Cost of Care (TCOC) savings payments based on a risk-adjusted performance calculation. Shared savings limits may be defined relative to the provider’s revenue or a portion of the overall savings.</p> <p>Restructured fee for service payments for meeting care coordination criteria in conjunction with an advance population infrastructure payment which is recouped as part of performance and quality reconciliation.</p> <p>Participating providers would be required to absorb risk symmetrical to their gain-share arrangement within its first participation cycle.</p>	<p>Provider organizations with sufficient financial resources to guarantee coverage of losses are able to receive a population-based payment.</p> <p>Level of savings or risk to the participating organization under the population-based arrangement may be limited.</p> <p>There are additional combined funding opportunities for providers and partners willing and able to increase joint accountability for care received by attributed IHP members.</p>
<p>Delivery System Characteristics</p>	<p>Systems specializing in a type of care, member health status or population segment that limits the number of members attributable under a standard methodology or with a limited volume of care directly under their control, but clearly defined as a patient’s predominant care manager.</p> <p>Provider organizations who meet the qualification criteria for Health Care Homes, Behavioral Health Homes or other care management programs but without sufficient attributable members to develop a fully credible TCOC performance assessment.</p>	<p>Systems with sufficient number of attributable members or controlling a sufficient percentage of attributed members’ TCOC to support a defensible and stable gain and risk share performance measurement.</p>	<p>Same as Track 2, plus:</p> <p>Provider partners are sufficient to deliver full spectrum of care services, and with sufficient administrative infrastructure to manage payments and benefits.</p>



Response Content

DHS is seeking detailed, specific, targeted, and actionable feedback on the following topics:

Sustainability and Infrastructure Needs

The current IHP total cost of care model incentivizes effective care delivery across a wide spectrum of health care system models and provider settings, and is a transition step away from fee-for-service payments. However, potential shared savings alone is not a sustainable source of operating revenue.

1. What percentage of revenue would need to be at risk or tied to care coordination services for your organization to drive meaningful changes to care delivery across your organization? What factors influence the proportion of revenue that your organization would need to receive through a reliable, consistent source, versus being contingent on your performance? Please provide sufficient details to fully understand your response.
2. DHS is considering a base, consolidated, care coordination payment to IHPs. If there was a single IHP prospective payment for care management (i.e. consolidating current care management payments received through Health Care Homes, Behavioral Health Homes, in-reach services, Targeted Case Management), what level of per patient payment would be required to cover the costs of enhanced care coordination activities. Would some portion of that payment need to be outside of any risk arrangement (i.e. not tied to cost and/or quality performance)? Please provide sufficient details to fully understand your response.
3. What infrastructure and supports need to be in place for a wider variety of providers to participate in total cost of care models?
4. Under a population-based payment structure, where a provider system takes on greater levels of risk and responsibility tied directly to the care and health outcomes of their patient population, what responsibilities would provider systems be able to take on (e.g. care management, utilization management, etc.)? Under this type of a population-based payment structure, how would the additional provider responsibilities integrate with the responsibilities of the managed care organizations, and what role would MCOs need to play to support the provider system?
5. What mechanisms could the state use to ensure the necessary infrastructure is in place and used appropriately by entities participating in either total cost of care or population-based payment arrangements?
6. As multiple payers move towards value-based payment (VBP) models providers report that maintaining multiple VBP contracts across their patient population can lead to challenges and complexity. How could the IHP program be structured, either contractually or operationally, to enable it to more effectively align with other payer's value-based payment programs? What opportunities are there to enable broad alignment across multiple payers moving towards value-based payment models?



Payment and performance on cost

Unlike insurance risk, where an entity must have sufficient reserves to guarantee solvency in catastrophic events, providers in total cost of care arrangements, like IHP, take on limited risk for their performance.

7. What factors might indicate whether a provider system has reached its maximum efficiency and can no longer expect to achieve savings compared to their own historically benchmarked targets?
8. To what extent should an IHP's TCOC targets be based on market performance rather than against their own performance over multiple years?
 - i. Should an IHP be eligible for potential savings based on **either** performance against a target **or** improvement from prior performance? Why?
 - ii. If savings or losses are based on market performance, how should the groups of providers or geographic areas be defined?
 - iii. Should performance be weighted in a way that emphasizes or de-emphasizes the impact of certain types of care or the systems' performance on specified populations? For example, should we allow for an IHP to take on more risk for a core set of services and less risk on long-term care services? Why?

Member Attachment

The retrospective use of a member's prior evaluation and management visits to determine association to a provider group is a common method of attribution that reflects the member's choice. However, many members are not included with this approach because they have not sought this type of care in the recent past, or their care is predominately provided by specialists.

9. What additional types of care or services should be considered when determining a member's principal provider for purposes of attribution? Why?
10. Should members be able to designate a principal provider system during enrollment; and if so, what criteria would determine which provider systems would be available for selection by a potential member?
11. How do we determine that a specialist is acting as a patient's principal provider, particularly for those patients with unique or complex conditions?

Integration of Services

Our health outcomes are significantly impacted by factors beyond simply the medical care we receive, including socio-economic and environmental factors. Therefore, effective health care coordination requires relationships across a broad spectrum of medical, behavioral health, and social service supports. These relationships between providers, whether medical, behavioral health, social service, or other type of provider, may be formal or informal in nature, and may or may not be embedded in the risk arrangements of an IHP.

12. How could non-primary care providers, such as behavioral health, chemical dependency, or disability service providers, participate in a risk bearing IHP-type of arrangement? What level of risk would these provider types be able to take?



13. Should IHPs be required to formally partner with non-primary care providers, such as behavioral health, chemical dependency, or disability service providers? How should these partnerships be structured? Under what circumstances would these partnerships be required (for example, in order to receive enhanced prospective payments or a population-based payment)? How would an IHP demonstrate that these partnerships are in place and adequate to fulfill any such requirements?
14. How could non-medical social service providers, such as housing services, food banks, job placement services, or other community programs, participate in a risk bearing IHP-type of arrangement? What level of risk would these provider types be able to take?
15. Should IHPs be required to formally partner with non-medical, social service providers, such as housing services, food banks, job placement services or other community programs? How should these partnerships be structured? How would an IHP demonstrate that these partnerships are in place and adequate to fulfill any such requirements?
16. In order to capture the full costs of a member's health care, should non-medical, social service costs be integrated into a cost of care model and financial arrangement? If so, how? What non-medical services should be considered for inclusion?

Quality and Patient Outcomes Measurement

One of the overt goals of the IHP program is to increase the overall quality of care that patients' receive. Currently, the IHP program ties a portion of an IHP's shared savings to performance on a sub-set of measures found in Minnesota's Statewide Quality Reporting and Measurement System.

17. Are there additional quality metrics outside of Minnesota's Statewide Quality Reporting and Measurement System that should be considered for inclusion across all IHPs?
18. What process, access or health outcomes measures related to the use of non-primary care services, such as behavioral health, chemical dependency, or disability services, could demonstrate that a patient population's health needs in those areas are being addressed or met? How can these be measured?
19. What process, access or health outcomes measures related to the use of non-medical services, such as housing services, food banks, job placement services, or other community programs, in interventions could demonstrate that a patient population's health needs are being addressed or met? How can these be measured?
20. Should a state monitor an IHP's impact on the health disparities faced by their patient population? If so, how?
21. Currently, an IHP's quality measurement results could lower the percentage of shared savings that the IHP earned through lower costs. Should quality measurement results additionally mitigate some of an IHP's responsibility for any shared losses they may end up owing? Should IHPs be able to earn above their shared savings if quality is exceptionally high?



Other

22. It's possible that some proposed enhancements will require more time to authorize and implement, for example, if they require a federal waiver. Should the state consider making incremental changes as components are authorized, or should the state wait until all components are authorized and introduce a single cohesive package?

23. Do you have any other comments, reactions, or suggested additions to the "IHP Track Options and Considerations"?

Procedure & Instructions

Submit responses by **Friday, May 27, 2016 at 5:00 pm.**

Send responses electronically in PDF format to Mat Spaan at Mathew.Spaan@state.mn.us.

If you are unable to submit your response electronically, please contact Mat Spaan at (651) 431-2495 or via email at mathew.spaan@state.mn.us for assistance. If you have additional clarifying questions regarding the contents of the RFI, please contact Mat Spaan. Components of your response may include: direct answers to questions, overall comments or feedback on the RFI, and additional perspectives. If you are responding to a specific question number in the RFI, please indicate which question for ease of review.

In the RFI response, include contact information for your respondent organization in the event that there are questions regarding your submission. Please include the following:

Name
Organization & Title (if applicable)
Telephone number
Email address

DHS will host two 90 minute stakeholder meetings to review the RFI, clarify any questions, and solicit feedback. The meetings are available to the public. Attendance at these meetings is not required in order to submit a response to this RFI.

In-person Stakeholder Meeting

Friday, April 29th, 2016, 1 – 2:30 pm
Elmer Andersen Building, Room 2380
540 Cedar Street
St. Paul, MN 55155



Minnesota Department of **Human Services**

Webinar Stakeholder Meeting

Wednesday, May 4th, 2016, 2:30 – 4 pm

Response to this RFI is completely voluntary. Responders are invited to address as many or as few of the questions as they are able. The State is seeking information that it may use for future planning and program improvement, policy development, and/or competitive contracting for services. This RFI, and responses to it, do not in any way obligate the State, nor will it provide any advantage to respondents in potential future Requests for Proposals for competitive procurement. Respondents are responsible for all costs associated with the preparation and submission of responses to this RFI.

All responses to this RFI are considered public, according to the Minnesota Statutes §13.03 unless otherwise defined by Minnesota Statutes §13.37 as “Trade Secrets.” If the Responder submits information that it believes to be trade secret/confidential materials, and the Responder does not want such data used or disclosed for any purpose other than the evaluation of this Response, the Responder must clearly mark every page of trade secret materials in its Response at the time the Response is submitted with the words “Trade Secret” or “Confidential,” and must justify the trade secret designation for each item in its Response. If the State should decide to issue an RFP and award a contract based on any information received from responses to this RFI, all public information, including the identity of the responders, will be disclosed upon request.

Thank you for taking the time to respond to this RFI. Your input is appreciated and important to the continued success of the IHP program.