DEPARTMENT OF HUMAN SERVICES

Integrated Health Partnerships
2017 Request for Proposal
Overview

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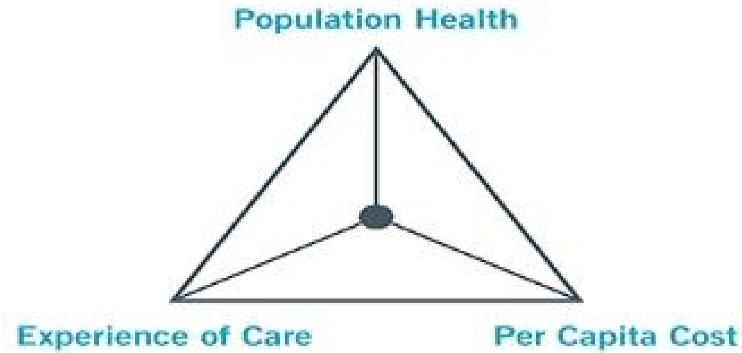
Today’s Agenda

- Overview of RFP, application and contracting process
- Overview of the Integrated Health Partnerships (IHP) 2.0 model
  - Provider Requirements Multiple tracks
  - Payment and risk models
  - Quality measurement
  - Participant supports
- Questions?

Additional Informational Opportunities

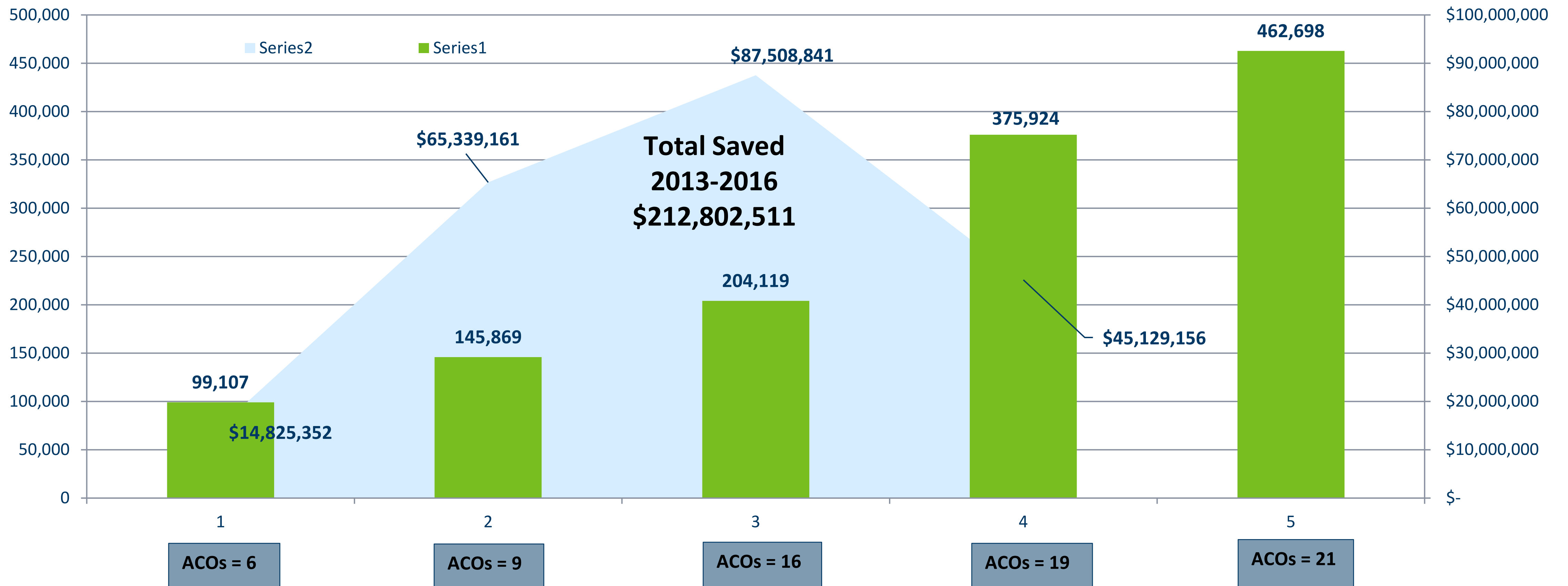
- Two additional **webinars**
  - Quality measures and methodology
    July 11, 1:30 pm to 3:00 pm (Central)
  - Payment and risk arrangements
    July 20, 9:00 am to 10:30 am (Central)
  - Registration links available at http://www.dhs.state.mn.us/DHS-293927.
- Optional individual **Q&A session** – contact mathew.spaan@state.mn.us by July 18th to request
- **Written questions** – submit to dhs.ihp@state.mn.us by July 25th, responses published ~August 1st
- IHP RFP **website** - http://www.dhs.state.mn.us/DHS-293927
- DHS's IHP **listserv** - Subscribe here

Quick History of the IHP Program



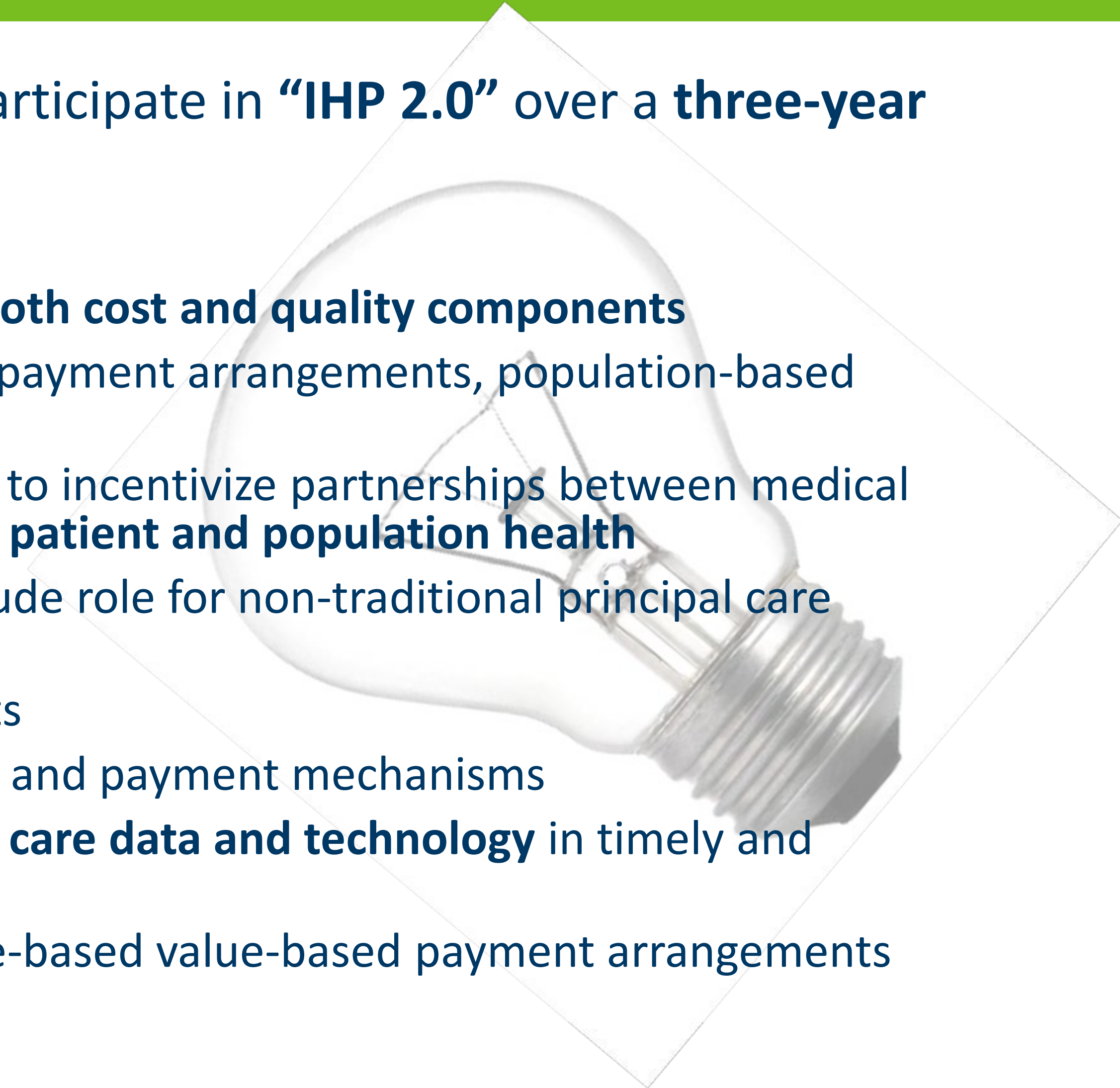
- Goal of IHP program is to directly contract with providers to **enhance accountability** for patients' care, **create incentives for innovative care models** that meet IHI triple aim
- IHP **initially authorized in 2010** by MN Statutes, 256B.0755
- First **six (6) IHPs started in 2013**, covering ~100,000 Medicaid beneficiaries
- We now have **21 IHPs, covering ~460,000** beneficiaries, with wide diversity and spread
- **Request for Information in 2016** identified current strengths and challenges of the current model; informed **IHP 2.0 model, current RFP**

Program Results to Date



IHP RFP Process | Purpose of Current Request for Proposals

- Current RFP seeks provider organizations to participate in **"IHP 2.0"** over a **three-year period** starting January 1, 2018.
- Core principles of model:
  - **Value-based payment** arrangement consists of **both cost and quality components**
  - **Sustainability and innovation** through modified payment arrangements, population-based payment
  - Importance of **non-medical health factors**; need to incentivize partnerships between medical and non-medical providers to effectively address **patient and population health**
  - Emphasis on **primary care**, with flexibility to include role for non-traditional principal care providers
  - **Expanding participation** in value-based payments
  - **Actuarially sound** benchmarks, cost estimations, and payment mechanisms
  - Ability to act upon, share, and strengthen **health care data and technology** in timely and accurate way
  - **Alignment** with other federal, national, and state-based value-based payment arrangements



IHP RFP Process | How to Respond

- Letter of Intent (Appendix A-1)
  - Due August 18th, 4:30 pm (Central), via e-mail to mathew.spaan@state.mn.us
    1. Organizational information and primary contact
    2. Past experience in value-based purchasing (ex. IHP, MSSP, other ACO or VBP programs)
    3. Certifications at the participating clinics or system level (ex. HCH, NCQA ACO, PCMH)
    4. Intended track
    5. Why interested in participating in IHP program
- Application (Appendix A)
  - Hard copies must be received by DHS by September 1st, 4:30 pm (Central).

Attention: Mathew Spaan
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Department of Human Services
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St. Paul, MN 55155

IHP RFP Process | Application Components

I. Table of Contents

II. Application (Required questions and information can be found in Appendix A, RFP Application)
   A. Background Information/Organizational Structure
   B. Leadership & Management
   C. Financial Plan & Experience with Risk Sharing
   D. Clinical Care Model
   E. Quality Measurement
   F. Community Partnerships & Social Determinants of Health

III. Application Supplementary Materials (items e-g may be optional)
   A. Provider Roster (Appendix A-2)
   B. Organizational Chart with TINs
   C. Sample Agreement with IHP Participants
   D. List of Participating Clinics
   E. Sample of Community Partnerships Agreement
   F. Additional Proposed Quality Measures
   G. Other Application Requirements, As Necessary

IV. Required Statements (See Appendix B, section I, Required Statements)

V. Optional - Additional Materials

IHP RFP Process | Key RFP and Contracting Dates

ACTIVITY	DATE
Letter of Intent Due	August 18th, 2017
Proposal Responses Due	September 1st, 2017
RFP Review/Evaluation	~September 15th, 2017
Notice of Intent to Contract	~September 21st, 2017
Potential IHP Plenary Sessions	~Sept. 18th – Sept. 30th, 2017
Individual IHP Contract Negotiations Begin	~September 25th, 2017
Individual Reports to Potential IHPs	~September 29th, 2017
2018 IHP Contracts Executed	~December 15th, 2017
Performance period begins	**January 1, 2018**

IHP RFP Process | Core System Requirements

- Ability to provide or coordinate **full scope of health care** services
- Innovative **care delivery model** able to lower total cost of care, enhance quality of care delivered, focus on population health
- Care model includes **partnerships** with community-based organizations, social service agencies, counties, and public health resources
- Meaningful engagement with **patients and families as partners** in care delivery, quality improvement
- Ability to take on level of **financial risk/loss** commensurate with potential gains
- **MHCP enrolled** providers able to receive and engage with health data from DHS

IHP RFP Process | Legacy IHP Program

- DHS will not be releasing further "legacy" IHP RFPs
- Current IHPs will not automatically transition into the new model; must submit an application to enter into the new model terms
- Current IHPs may continue through current contract cycles; may choose to submit an application for new model prior to cycle ending
- IHPs in their third year **will need to submit an application** to continue, under the IHP 2.0 model
- DHS anticipates an annual IHP procurement process in future; however future terms may differ

Overview of 2018 IHP Model | Multiple Tracks

	Track 1	Track 2
Track Overview	IHP entity will receive a **risk-adjusted quarterly population-based payment (PBP)** tied to clinical, utilization, and social determinant metrics	IHP entity will receive a **risk-adjusted quarterly PBP** *and* enter into a **two-way** risk model for **shared savings/losses**, tied to clinical, patient experience, social determinants, and HIE infrastructure metrics
Requirements	• **Innovative care model** that provide or coordinate full scope of health care services • **Demonstrated ability** to impact TCOC, coordinate care, improve quality ****Health Care Homes, NCQA cert., other evidence****	Same as Track 1, plus: • Ability to take on financial risk (based on multiple factors) • Greater than 2,000 attributed Medicaid lives
Applicable Provider Types	• **Small, independent** provider systems • **Specialty health care groups** that coordinate care for specific groups of individuals or services	• **Mid or large sized integrated health systems or collaborative partnerships** with ability to coordinate and provide the full scope of Medicaid services for attributed patients.
Data and Peer Learning Support	All participating IHPs gain access to **robust data** files and reports, and **peer support** opportunities	

Overview of 2018 IHP Model | Payment Methods

	Population-based Payment (PBP) Tracks 1 and 2	Total Cost of Care Risk Model Track 2 Only
Attribution	• Includes MA and MNCare, across PMAP and FFS. • Beneficiaries attributed based on up to 24 months look-back period	
Overview	• **Quarterly per member per month (PMPM) payment**, adjusted by risk, social complexity • Care coordination, infrastructure development • Estimated average PMPM rate across all IHPs to be ~1% of attribution eligible population's TCOC PMPM; individual IHP's average rate may differ based on population served • **PBP replaces HCH, in-reach payments**; IHPs still eligible to receive BHH, CCDHC payments	• **Two-sided risk** model –potential for additional revenue through shared savings • Performance period vs. Target based on trended, risk adjusted historical performance • Reciprocal **upside and downside risk** with 50% share of savings in each risk corridor; risk levels may be modified with meaningful partnership • **IHPs may "cap" risk** • Includes wide range of Medicaid covered services and PBP in total cost of care calculations
Quality Impact	• Multiple clinical, health disparities, and utilization measures; **determines participation** after the conclusion of each three-year cycle.	• Core set of measures across clinical, patient experience, social determinant, HIE infrastructure; **impacts 50% of IHP portion of the shared savings** amount but does not influence losses.

Overview of 2018 IHP Model | Accountable Care Partnerships

- Track 2 IHPs may be **eligible for non-reciprocal risk** (i.e. greater upside vs. downside potential), if they enter into formal partnership
- **Ongoing legal relationship** to provide services to address a population health goal; partnerships to be evaluated on:
  - **Substantiveness** of the community partnership
  - Amount of **risk involved** for the IHP and the community partner
  - **Impact** of the community partnership on the total cost and/or quality of care
- Must include **letter(s) of support** from partners; sample agreement
- Track 1 IHPs may also act as an "accountable care partner" with a Track 2 IHP

Overview of 2018 IHP Model | IHP 1.0 vs. IHP 2.0

IHP 1.0	IHP 2.0
Core Requirements	
• Innovative care model • Strong partnerships encouraged • Primary care centric	• Innovative care model • Strong partnerships *incentivized* • Primary care centric, *with potential for wider spectrum of providers*
Target Population/Attribution	
• Medical Assistance and MnCare • PMAP and FFS • Patient choice	• Medical Assistance and MnCare • PMAP and FFS • Patient choice
Payment Model	
• Accountable for total costs of care • Flexible risk options • Risk may be capped • *Upside only option*	• Accountable for total costs of care • Flexible risk options • Risk may be capped • *Ongoing support for innovation (PBP)*

Overview of 2018 IHP Model | IHP 1.0 vs. IHP 2.0

IHP 1.0	IHP 2.0
Quality	
• Includes clinical care, patient experience in multiple settings • Impacts shared savings • Can be modified based on target population	• *Includes multiple domains across patient care* • Impacts shared savings • Can be modified based on target population • *Varies based on payment (PBP vs. TCOC Risk)*
"Innovation" Cycle	
• Three year contract period, allows building on success • Ability to modify terms throughout contract period • *Ramp up built in*	• Three year contract period, allows building on success • Ability to modify terms throughout contract period • *Enhanced terms for innovative partnerships, models, metrics*
Flexibility	
• Focus on outcomes, not specific innovations • Governance, care model open	• Focus on outcomes, not specific innovations • Governance, care model open

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