2024 IHP RFP Q&A		
Question Topic **(as labeled in the RFP)**	**Question Asked**	**DHS Response**
Appendix 2: Included Services – Category of Service Table	Any possible Shaman services that could be standardize reimbursement through the DHS system?	The IHP program does not have the authority to modify the payment process for services.
Appendix A - IHP Application Template	Regarding RFP Application Section IV.B.2, Financial Plan & Experience with Risk Sharing, "Please list the initiatives, length of participation, and include a short description if the initiative is not a public initiative. Initiatives must include financial accountability, evaluation of patient experiences of care, and substantial quality performance incentives." What does initiative mean? What information is DHS expecting to receive?	Please include information about accountable care, population management, quality improvement and/or withhold, or other financial or risk-based programs the applicant IHP has participated in to date.
Appendix A - IHP Application Template	Regarding RFP Application Section IV.C.8/9, Financial Plan & Experience with Risk Sharing, "(If Track 2 Applicant) Please describe how the Applicant IHP plans to ensure payment to the State in the event of shared losses. (If Track 2 Applicant) Please describe the Applicant IHP's internal process in a potential shared losses situation." What documentation is required to prove? What level of detail is DHS requesting?	Please provide enough information to ensure that DHS is able to adequately understand and evaluate how the applicant would pay for any shared losses to the state, should that situation arise during the course of the contract. The applicant IHP has flexibility in determining how those funds will be made available if losses occur. In addition to the narrative description provided in response to the referenced question, applicants should also provide documentation to establish financial stability as directed under Section 4d of the IHP RFP.
Appendix A - IHP Application Template	Regarding RFP Application Section VII.F.2, Population Health, "If the Applicant IHPs and associated entities has a joint plan to address priority areas." Is the "associated entities" part of this question referencing an "Accountable Care Partnership"? If not, what is meant by "associated entities"?	The "associated entities" language is referring to those the IHP would be working with to address those population health needs. This may be an ACP or a less formal arrangement. The goal of the question is to better understand how the IHP is addressing the priority areas, which may or may not include one or more entities outside of the IHP Participants.
Appendix A - IHP Application Template	Regarding RFP Application Section VIII.A.1, "Any formal contracts/amendments/MOUs in place to establish community partnerships." Please explain more what types of contracts/amendments/MOUs we are expected to provide that are outside of the Accountable Care Partnership? We have lots of different community partners, are we to submit any and everything?	This question is not limited to an ACP that may be included in the IHP contract. The goal of this question is to understand how the IHP partners with other organizations to address the health of its patients. If the community partnership may be leveraged to impact the IHP attributed population, then please default to include those details.

Appendix A - IHP Application Template	In the RFP, there is a question that seems incomplete. Please see question #2 under Section V, Clinical Care Model, A. Provider Engagement. Can you tell me what that rest of the question should say? It currently states, "How will you promote and ensure the IHP's, and other associated partners' providers are delivering services that are culturally appropriate for the communities you serve? Please include details as to how you identify the culture and cultural needs of the community you serve, and how you capture and track provider cultural competency training including frequency of trainings, the population the trainings focus on, areas for"	The full question that responders should answer is, "How will you promote and ensure the IHP's and other associated partners' providers are delivering services that are culturally appropriate for the communities you serve? Please include details as to how you identify the culture and cultural needs of the community you serve, and how you capture and track provider cultural competency training including frequency of trainings, the population the trainings focus on, areas for improvement, and how gaps in trainings are addressed. "
Appendix A-1: Letter of Intent	The Letter of Intent (LOI) asks for a primary and secondary contact. Who do people usually list for these roles? Can the contacts in the LOI and Application be the same?	It is up to the IHP to determine who they would like the contacts to be; however, yes, the contacts in the LOI and the Application can be the same.
Appendix G: Sample Contract - Awarding Points for Equitable Care measures (Section 18.4.9)	The following questions all pertain to the scoring methodology for the equitable care domain as outlined in Section 18.4.9 of the Appendix G, Sample IHP Contract. A) Is each individual racial group compared to the White group?	Yes, each identified race and ethnicity group is compared to the white population. If the race or ethnicity is unknown or unidentified, then this group is not a part of the scoring process. Point assignment is focused on closing the care gap for those with care below that of the reference population.
Appendix G: Sample Contract - Awarding Points for Equitable Care measures (Section 18.4.9)	B) Regarding the language "The IHP must decrease the gap in care quality of all groups below the reference population AND either maintain or improve the quality of all other groups." Let's say in 2020, 3 groups received care above the reference population (white) and 6 received care below the reference population. Out of the 6 groups with care below, for 5 of them the care gap decreased in 2021 but care for the Native Hawaiian/Pacific Islander population, with a denominator of less than 100, did not. This group's care gap increased by 5%. Out of the 3 groups where care was better than the compare group, 2 declined, but those populations also had denominators of less than 100. Due to this – IHPs would be ineligible for any points in this entire measure. Is that correct?	The contract language states, "If the IHP's overall performance or performance for any race or ethnicity group with a denominator of a hundred (100) or greater drops more than one percent (1%) in the performance year, then the IHP will not be eligible to receive points on the measure." The denominator for the Native Hawaiian/Pacific Islander is less than 100 so the IHP would still be eligible for points on this measure but would not receive any points for this population since the rate decreased. For those groups with a denominator of 100 or more, the rate can only decrease by 1% for the measure to be eligible for point assignment for the entire measure. Please note, "Some other race" or "Multi-racial" are not included when measuring performance in this domain. Only those where the individual race or ethnicity are known and identified are included in the scoring methodology. However, IHPs should be focused on improving care for all racial and ethnic groups. DHS anticipates discussing the scoring methodology in more detail during contract conversations. DHS appreciates these contract conversations may also result in modifying the measures included in the Equitable Care domain, compared to the measures selected by the IHP in their application.
Appendix G: Sample Contract - Awarding Points for Equitable Care measures (Section 18.4.9)	C) Regarding the language, "If the IHP's overall performance or performance for any race or ethnicity group with a denominator of a hundred (100) or greater drops more than one percent (1%) in the performance year, then the IHP will not be eligible to receive points on the measure." Will this count if the group has 100 in the denominator for the measurement year, the base year, or both? As an example, the IHP has 3 groups with 100 in the base year and 4 groups with 100 in the measurement year. Does the reference population (white) count as one of the groups that cannot drop more than 1%?	All groups where a single race or ethnicity is identified are considered in the Equitable Care domain methodology; this includes the reference population.
Appendix G: Sample Contract - Awarding Points for Equitable Care measures (Section 18.4.9)	D) Regarding the language, "If the IHP does not meet these criteria, no points will be awarded for the measure. If the IHP does meet these criteria, points will be awarded based on relative change compared to the reference population for each racial and ethnic group.", does this mean the IHP needs to meet both the criteria outlined above in sub-questions B and C? But only the measurement referenced in sub-question B will be used to determine overall relative change and points, the criteria in sub-question C just needs to be met?	The criteria addressed above are paired together. Please see our responses on those sub-questions. These criteria must be met to be eligible for points for the measure, but the denominator size is an important aspect of that evaluation. If they are not met, then the IHP would not eligible for any points on that measure. If they are met, then the IHP is eligible to receive points on that measure and DHS would proceed with the relative change calculation.
Appendix G: Sample Contract - Contract 17.1 Quality Measures	How do the quality measures impact the PBP payment? And what are those thresholds? At what point does the score impact the PBP payment?	The measures included in Section 17, Population-Based Payment - Equity, Utilization, and Quality Measures, do not have an impact on the PBP payment amount. These measures are part of the consideration when determining whether to offer the IHP a new contract. Quality performance is a part of that assessment as DHS evaluates performance as a whole.
Beneficiary Eligibility and Attribution	Regarding RFP Section 7.2, Beneficiary Eligibility and Attribution, "Patients that cannot be attributed through primary care visits may be attributed to the IHP based on their E&M visits with non-primary care (specialty) providers." Specialty provider list - who is included? Are all specialties in-scope or are there select specialties?	For the "All-In Roster" (recommended), specialty providers are defined as a provider whose principal specialty is other than those listed as primary care according to Sample Contract, Appendix 1, Provider Taxonomy. For the "Billing and Treating Provider Roster" (rarely utilized), the identification of specialty providers is explained more on page 1 of Appendix A-2. Please see the IHP RFP Sample Contract for definitions of primary and specialty providers and information about how they are included in the attribution methodology, and Appendix A-2 of the IHP RFP for more information about provider rosters and the provider roster/submission process.

Bonus Points Option	We understand that the RFP includes the ability to select bonus questions on quality measures in Section 8.3. Can you please explain how this works?	IHPs will be able to obtain bonus points on the TCOC overall quality score by selecting additional measures in the following domains: •Quality improvement •Closing gaps •Equitable care Under the bonus points option, IHPs can work on up to **two additional measures**, which cannot be in the same domain. The bonus measure in each domain will be weighted consistent with other measures in that domain. For example, each measure in the quality improvement domain is worth ten percent (10%) so the bonus measure would also be worth up to 10%. IHPs will not be able to score more than 100% on the TCOC overall quality score. However, the bonus points option allows IHPs to earn more points by focusing on additional measures of interest to DHS and the IHP. The additional measures would be selected collaboratively between DHS and the IHP. If an IHP selects one or two bonus measures, those measures are then included in the TCOC quality measures in Section 18 of the contract. The weighting and point assignment methodology would remain the same. For example, if an IHP selects a bonus measure in the quality improvement domain then it would be worth 10% and the same point assignment for other measures in the quality improvement domain, focused on relative improvement, would apply. If the IHP selects an additional bonus measure in the closing gaps domain then it would be worth 5% and the same methodology for the other closing gaps measures would apply. If an IHP opts to include bonus measures then it is possible the actual TCOC overall quality score in Section 18 could be greater than 100%, but the result would be capped at 100%.
Definition of Total Cost of Care (TCOC)	In comparing our current contract to the 2024 Sample Contact, we see there is an opportunity for formal Accountable Care Partnerships (ACP) arrangements. Can you please say more on this?	The information in the contact is the standard model language. As noted in a response below, the ACP arrangement and the Health Equity Intervention measures and disparities do not have to be the same or linked. However, we typically do see a lot of success when they are linked; but again, it is not required. More information about the Accountable Care Partnership (ACP) arrangements can be found below (and on page 19 of the IHP RFP): Track 2 IHPs that formally partner with community partners and/or Track 1 IHPs may be eligible to enter into a more favorable risk arrangement with DHS. The parameters are flexible, but could include greater potential savings than potential losses or a greater share of potential savings relative to the share of potential losses. Formal partnerships could include, but are not necessarily limited to, an ongoing legally formalized relationship to provide services to address a population health goal. Eligibility for the Accountable Care Partnership risk arrangement depends on the substantiveness of the community partnership, the amount of risk involved for the IHP and the community partner, and the financial impact of the community partnership on the total cost of care. Examples of areas in which IHPs can pursue community partnerships include but are not limited to: housing, food security, social services, education, and transportation. Track 2 IHPs that are interested in Accountable Care Partnerships must include letter(s) of support from community partners with their IHP application. Accountable Care Partnerships will be monitored by DHS, through at least yearly check-ins and reporting through the Population Health Report (see Appendix H). Potential IHPs are encouraged to include details about any proposed ACP arrangement(s) in their RFP Application. IHP-specific questions can be further discussed during contract negotiations, should an organization's application be accepted for further discussion.
Definition of Total Cost of Care (TCOC)	Is having an Accountable Care Partnership (ACP) optional? What services may be provided by an ACP?	An ACP is an organization outside the IHP (community health or community benefit organization, for example) that the IHP would partner with to better serve attributed members. It is important to note that a written agreement between the IHP and ACP is required (such as a contract, memorandum of understanding (MOU)). As a Track 2 (risk bearing) IHP, you can have an ACP to help mitigate the downside risk. However, having an ACP is not required. More information about ACPs can be found in the responses to other questions in this document and in the IHP RFP.
Definition of Total Cost of Care (TCOC)	Regarding RFP Section 7.3.1, Definition of Total Cost of Care (TCOC), "This claims cap will not exceed $200,000." How often are we exceeding the $200k claim cap? Do we receive reports that outline these claims specifically?	Please note that the Claims Cap is applied to an attributed member's Total Cost of Care during a particular performance period, not at the individual claim or individual service level. Information about the number of times a claims cap is exceeded is available to IHPs in the Claim Cap Cost Distribution report, provided on a quarterly basis to IHPs via the SAS Portal. The report summarizes the number of members having total incurred claims exceeding the contracted claim cap, as well as the cap's impact on the IHP's TCOC PMPM costs. More detail on this report is available in the IHP Report Reference Documentation's TCOC Reports section.
Definition of Total Cost of Care (TCOC): Services Included in Total Cost of Care	For the cost side, does this include total claims? Or just the claims within the financial model?	We do have services that are included and excluded in the Total Cost of Care (TCOC) model. Please refer to Appendix G-Sample Contract; Appendix 2: Included Services - Category of Service Table. More information about the TCOC calculation can be fond in the IHP RFP on pages 15-17 and in the Sample Contract.
Definition of Total Cost of Care (TCOC): Shared Savings and Shared Losses Payment Distribution	How does having an ACP work with the financial model?	It allows IHPs to negotiate a more favorable risk arrangement. More information about ACPs can be found in the responses to other questions in this document and in the IHP RFP.
Introduction	We are finding that it is going to take time to shape the different criteria of the program. Will DHS be able to review the proposal draft and budgeting before final submission?	Legally we are not able to review drafts. If you are interesting in responding to the RFP, you will need to submit your letter of intent by the due date of August 28th as well as your final application by the due date of September 8th. We then will evaluate the proposal internally. If you meet the required minimum score of 60, you will then be considered to move on to contract negotiations. We encourage interested organizations to submit an application based on the best and most complete information available.
Introduction	The membership churn IHPs are facing right now is the most substantial this state has ever faced. Is there an opportunity for the model to address this significant change or to take a more proactive approach? Is there also an opportunity for IHPs to receive more frequent and/or earlier financial reporting during this period so we can better understand the effects on our population and our performance?	We understand that there are a lot of unknowns with regards to member renewals and potential population churn as a result of the PHE unwinding and that this creates uncertainty for potential IHP RFP respondents. Consistent with past calculations, changes in IHP-specific attribution, risk, and other population factors will be monitored closely. DHS will make necessary adjustments as warranted by the data. We would be happy to discuss ideas for modeling and reporting further.
Introduction	Due dates state "on August 28th by 11:59 PM" are we to submit ON that day or BY that day? Can we submit our LOI and our Application early?	Responders are to submit a letter of intent (LOI) no later than August 28, 2023 by 11:59 PM (Central Time). Responders may submit their LOI prior to that date/time. However, LOIs received after 11:59 PM (Central Time) on August 28, 2023 will not be accepted. Applications are due 11:59 PM (Central Time) on September 8, 2023. Responders may submit their application prior to that date/time. However, applications received after 11:59 PM (Central Time) on September 8, 2023 will not be accepted.

N/A	Making Care Primary (MCP) Updates	The IHP model has not been modified to incorporate any changes related to CMS' Making Care Primary (MCP). CMS' MCP model is applicable to providers who choose to apply to the MCP model under CMS' recently released Request for Applications (RFA), and is focused on Medicare FFS patients. Minnesota, through the State's Department of Human Services (DHS), is one of eight states selected by CMS' Innovation Center (CMMI) to engage in conversations with CMMI with a focus on multi-payer alignment. Minnesota DHS has not yet made any commitments to CMS with regards to modifications to programs or value-based purchasing (VBP) strategies for members served by Minnesota Health Care Programs (MHCP). Potential IHPs with organization-specific questions with regards to the CMS Medicare FFS MCP model are encouraged to contact the CMS Innovation Center (CMMI) directly at MCP@cms.hhs.gov. Potential IHPs are also welcome to include any questions or considerations related to potential future MCP alignment conversations in Minnesota as an extra section or addendum to their IHP RFP Application if they wish to.
N/A	With the IHP program expected to get a new reports portal, how does this impact payment methodology? How does this impact reports?	The new IHP Portal will not impact any aspects of the IHP model and the intent is to continue to provide the same data elements to IHPs as is available with the current Portal. We hope the new IHP Portal will enhance some of the reporting functionality and visual analytics available to IHPs (e.g., a performance dashboard).
N/A	We are currently included in an existing IHP. Are we permitted to submit an independent proposal while still a member of that existing IHP? If we want to remain a part of that existing IHP, do we still need to submit a proposal? If either case, which track would we be under?	Providers are only able to be Participants in one IHP at a time. More specifically, IHP Participating providers and systems can only participate in one IHP contract at any given time. An potential respondent that is interested in their own independent IHP contract with DHS who is currently an IHP Participant in an existing IHP contract would be able to apply, but would need to resign from the existing IHP contract prior to any new independent IHP contract going into effect. If your organization chooses to apply to this IHP RFP, please help us understand your participation plans and timing. However, if your intent is to remain a part of the existing IHP, you do not need to submit a separate application in response to this IHP RFP. The choice of tracks is dependent on the characteristics of the applicant. Responders that apply to participate as a Track 1 IHP do not have a minimum population size. Responders that apply to participate in Track 2 must meet a minimum population size of at least 5,000 attributed patients. Any applicants with a Medicaid population of over 5,000 are generally expected to participate as a Track 2 IHP. Applicants with Medicaid populations of over 5,000 that feel a Track 1 approach would be more appropriate are expected to articulate their rationale in their response. The prospective number of attributed patients is determined by the roster of providers which is submitted along with the RFP Application (Appendix A: Integrated Health Partnerships Application Template).
Payment Models, Mechanism, Risk	How much is the grant and are there different amount we can allocate to staff, fund projects, renovation or business capital?	There is not a set dollar amount allocated to IHPs under this contract. IHPs are paid a population based payment (PBP) on a quarterly basis for care coordination purposes. The PBP encourages accountability for the total cost of care of attributed patients, resource utilization, and quality of health care services provided. The total amount paid to each IHP will be based on the number of attributed members and an average base rate for each individual attributed to the IHP. The base rate will vary by the medical and social complexity of each IHP's attributed population. Each quarter, the amount of the PBP will be adjusted to reflect changes to the population attributed to the IHP. In order to encourage efficient, effective care coordination and to ensure no duplication of billing or services, the PBP will take the place of any current Health Care Home (HCH) or in-reach service coordination (IRSC) payments currently being received by the IHP for an IHP attributed member. The population-based payment (PBP) is expected to contribute to care coordination and other related investments for individuals served by the IHP. As a result, the PBP specifically replaces both Health Care Home (HCH) and In-Reach Care Coordination (in-reach) payments. The PBP-eligible population consists of IHP attributed individuals for whom the IHP is not already receiving Behavioral Health Home (BHH) care coordination payments. To ensure that an IHP doesn't receive redundant payments, DHS reconciles the population-based payments on an annual basis following the close of each performance period. More information about the PBP can be found in the IHP RFP.
Payment Models, Mechanisms, Risk	Base Period for TCOC and Quality Metrics - How is the potential loss of enrollment and/or low utilization due to the post-pandemic resumption of renewals being factored in?	Calendar Year 2023 will be the base period used for the TCOC calculation for contracts starting in January 2024. If significant changes to an IHP's attribution, risk, etc, are observed, DHS may consider adjustments, as has been standard practice of the program to date. Any adjustments will be communicated to IHPs. 2023 will also be the baseline year we use for quality improvement for the quality measurement aspects of the program. As is DHS' current practice, we will review the results to ensure improvement comparisons are appropriate. If there is a reason to make any modifications, DHS will communicate that to IHP's.
Payment Models, Mechanisms, Risk	With the Public Health Emergency (PHE) ending and membership within the IHP expected to decline next year, we are expecting to see some strange trends. What will this impact mean to the risk model?	Currently, DHS plans to utilize a similar trend development process as in previous years. We initially utilize broad trends consistent with those developed during the Managed Care Organization (MCO) rate setting process. We then take into consideration IHP specific factors and other policy or environmental factors that may impact IHPs more broadly not otherwise incorporated into the MCO trend rate setting process. The actual impact on enrollment and utilization tied to the resumption of renewal requirements taking place in 2023 and 2024. Please see response above for additional information.
Payment Models, Mechanisms, Risk	Did DHS make adjustments during the pandemic?	In 2020 DHS eliminated both upside and downside risk. In 2021, 2022, and 2023 we made adjustments to eliminate downside risk that was consistent with similar program modifications made to CMS value-based purchasing (VBP) programs. Current IHPs can find more detail on adjustments made in response to the COVID-19 Public Health Emergency (PHE) in the IHP 2021 Final and 2022 Interim Settlements memo issued June 29, 2023. Consistent with past calculations, changes in IHP-specific attribution, risk, and other population factors, DHS will continue to monitor and make adjustments as warranted.
Payment Models, Mechanisms, Risk	Is the Risk Adjustment a straight Adjusted Clinical Groups (ACG)?	The John Hopkins ACG risk adjustment grouper is currently utilized in the IHP program. We use Minnesota Medicaid specific data to develop weights.
Payment Models, Mechanisms, Risk	What will the base period for the 2024 contract be?	The base period for the 2024 contract will be 2023.

Payment Models, Mechanisms, Risk	Regarding RFP Section 7.4, Accountable Care Partnership Arrangements, what is the criteria for a partnership? What are the requirements for the partnership? How will the requirements be assessed for the partnership? What is the definition of an accountable care partnership?	Accountable Care Partnerships (ACP) are a component of the model that has a significant meaning and effect for IHPs participating in Track 2, those with a risk arrangement. For Track 2 IHPs, an ACP arrangement can allow the Track 2 to negotiate a non-reciprocal risk arrangement. Having an ACP in place does not have a technical impact on a Track 1 IHP's arrangement with DHS. A Track 2 IHP must have the ACP agreement(s) fully in place prior to the beginning of and throughout a given performance period to enable the IHP to participate in a non-reciprocal risk arrangement for that performance period. Formal partnerships could include, but are not necessarily limited to, an ongoing legally formalized relationship to provide services to address a population health goal. Eligibility for the Accountable Care Partnership risk arrangement depends on the substantiveness of the community partnership, the amount of risk involved for the IHP and the community partner, and the financial impact of the community partnership on the total cost of care. Examples of areas in which IHPs can pursue community partnerships include but are not limited to: housing, food security, social services, education, and transportation. Track 2 IHPs that are interested in Accountable Care Partnerships must include letter(s) of support from community partners with their IHP application. In terms of assessment, if the ACP and the Health Equity Intervention are aligned, then the completion of one Population Health Report (see Appendix H) will fulfill the annual reporting requirement to assess the partnership. If the IHP has an ACP arrangement that is different than the Health Equity Intervention, then the IHP would also need to complete the ACP narrative section of the Population Health Report specific to the work of the ACP. Under both scenarios, DHS will provide a template which the IHP will need to complete.
Promoting Health and Wellness Activities – Child and Teen Check-ups (C&TC)	Regarding RFP section 6.5 Promoting Health and Wellness Activities – Child and Teen Check-ups (C&TC), "Having mechanisms in place to ensure referrals are followed up on in a proper and timely manner to ensure successful outcomes for C&TC utilization." What are the expectations re: tracking and follow-up? What "mechanisms" are required and how are we expected to report this component?	It is important that IHPs maintain sufficient documentation on their C&TC outreach activities on an individual child or family basis in order to comply with federal requirements. It is up to each IHP to determine the best way to track C&TC outreach within their own systems and workflows. While DHS won't require that IHPs submit this individual level information on a regular basis, we may request this information as part of an audit, compliance check, or other accountability efforts. Specific information that should be tracked by the IHP includes: • Specific mode or manner of outreach to individual children and their families or guardians attributed to the IHP. For example, IHPs must track which families received specific mailings, text messages, or phone calls, and when. • When logistically possible, individual family responses to C&TC program participation, indicating whether a member or family (a) accepted, (b) declined, or (c) gave an undecided response or failed to respond to an outreach. On an annual basis, IHPs are to complete and submit to DHS, by March 31st, their completed C&TC Outreach report using the reporting template provided by the State. Please refer to Appendix J - Sample Child and Teen Checkups Report Template for more information. We also encourage you to refer to sections 4.5.3 "Child and Teen Checkups Outreach Report" and 4.11 "Promoting Health and Wellness Activities – Child and Teen Checkups (C&TC) Outreach" in Appendix G- Sample Contract.
Proposal Requirements	Do we have to work in partnership with another agency or can we apply on our own?	Partnership with another agency or organization is not required. Responders may apply on their own if they meet application requirements, or in partnership with another organization.
Quality and the Population-Based Payment	We noticed there is an ACP requirement in the Population Health Report. Can you please talk more about this? Isn't the Population Health Report used for the Health Equity Intervention?	The ACP arrangement and the Health Equity Intervention do not have to be the same or linked. However, we typically do see a lot of success when they are linked, but again, it is not required. IHPs are to submit a Population Health Report for each Health Equity Intervention in their contract, which includes measures specific to the intervention which are agreed to by DHS and the IHP. If the ACP and the Health Equity Intervention are the same, then the completion of one Population Health Report will fulfill the annual reporting requirement. If the IHP has an ACP arrangement that is different than the Health Equity Intervention, then the IHP would also need to complete the narrative section of the Population Health Report specific to the work of the ACP. Under both scenarios, DHS will provide a template which the IHP will need to complete.
Quality and the Population-Based Payment	The RFP contains more aggressive thresholds for earning points in both achievement and improvement in Population Based Payment Quality Measures from past RFPs. The language states that an IHP must maintain performance in order to keep receiving the PBP payments. What is the definition of "maintain"? If an IHP dips down one or two percentage points in a year will they lose PBP payments?	The measures included in Section 17, Population-Based Payment - Equity, Utilization, and Quality Measures, do not have an impact on the PBP payment amount. These measures are part of the consideration when determining whether to offer the IHP a new contract. Quality performance is a part of that assessment as DHS evaluates performance as a whole. This approach is consistent with past RFPs and contracts.
Quality and the Shared Risk Model	For the Quality Improvement domain, in looking at current performance based on the 2021 data we have, we are finding that it is hard to know where we will be two years from now. We also feel that it would be hard to maintain the same level of improvement over multiple contract years. How should we select our measures?	For selecting measures in the Quality Improvement domain, measures can be chosen from those listed in Appendix F2 - Quality Measures. We suggest the IHP analyzes their data to determine where there are gaps and how they plan to address and improve these gaps. If DHS has access to more current data during contract conversations, we will share that information with the IHP. We hope the measures selected in the Quality Improvement domain will also align with the IHP's goals for quality improvement. We are open to discussing this further with the IHP during contract conversations. While the IHP must selection measures for submission in their application, we do anticipate there will be conversations between DHS and the IHP before those are finalized for inclusion in the contract. DHS also recognizes improvement may be more difficult over the course of the contract. The scoring thresholds for the Quality Improvement domain were selected with this in mind. Those thresholds can be found in Appendix G - Sample Contract (see Section 18.4.7.).
Quality and the Shared Risk Model	Regarding RFP Section 8.3, Equitable Care Domain, "Starting with performance year 2, points will be awarded based on relative improvement (i.e., the percent change between the performance years) for each racial and ethnic group (i.e., Asian/Pacific Islander, Black, Hispanic, Native American, and Non-Hispanic White) compared to a baseline disparity gap with a reference group. In order to be eligible to receive points for a selected measure, the IHP must decrease the gap in care quality of all groups below the reference group and the IHP must either maintain or improve care quality of all other groups." How can we ensure that the program meets the needs for the population? Is DHS willing to negotiate on the equitable care component? Our demographics present unique challenges for our IHP.	The Equitable Care domain is a key component of the TCOC quality score as this domain aligns with the State's goals to eliminate health disparities and ensure equitable care across racial and ethnic groups. IHPs are asked to propose measures in their application, which DHS hopes will align with the organization's own goals for quality improvement and closing gaps in care. The methodology in this section has evolved through thoughtful feedback from IHPs and DHS would expect to continue having similar conversations during these contract negotiations with the shared goal of closing gaps in care. DHS provides several reports and other tools to help IHPs monitor their progress, such as annual quality reports and quarterly gap reports for a select set of measures.
Responder Eligibility and Participation Requirements	Our providers offer Shaman services and have a different payment process than what is typical of the Western style of payment, is this type of service a part of the IHP? Is this type of payment process allowable?	The IHP program does not have the authority to change reimbursement for Medicaid.

System Requirements	Our population is focused on limited English Proficiency and seniors. As such, we want to make sure we have the culture components necessary to meet our community's need. Can the programming of the IHP be flexible?	The IHP model does not include Medicare or dual-enrolled beneficiaries at this time. The IHP Program does have a health equity component within in it as the IHP program encourages provider organizations to be responsive to the needs of the community. As such, the IHP program is flexible in regards to the health equity component (such as food insecurity, substance use). Some examples can be found at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-8162-ENG. This list is not prescriptive based on the examples within the document. The applicant IHP should propose an intervention that is specific to the particular needs of its population. Please see Appendix E - Health Equity Measures for more details.
System Requirements	We are a Managed Care Organization based out of state. We offer a variety of healthcare services across different states. We submitted an application to become a participating group with MN Medicaid. Although the application is still in process, I'm unsure whether this would hinder us from submitting our Letter of Intent (LOI) by August 28, 2023, for the IHP?	DHS encourages organizations interested in the IHP program that believe they meet the requirements as detailed in Section 6 of the RFP to apply. Interested applicants are required to submit a letter of intent by August 28, 2023 with the completed application/proposal due by September 8, 2023 to be considered for participation in the IHP program. All health care providers included in the IHP payment model must be enrolled MHCP providers by contract execution.