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Integrated Health Partnerships Demonstration

December 2018

Executive Summary

The Integrated Health Partnerships (IHP) demonstration is a health care provider direct contracting program administered by the Minnesota Department of Human Services (DHS). Under the program, DHS contracts with provider organizations called integrated health partnerships[1] to provide primary care and other covered services to Medical Assistance (MA) and MinnesotaCare enrollees.

The IHP program incorporates a value-based payment model that takes into account the cost and quality of the health care services provided. Some IHPs share savings and/or losses under a risk/gain payment arrangement, based upon how their spending for a defined set of services for enrollees attributed to them compares to spending for this set of services for a prior period. A portion of shared savings is contingent on an IHP's scores on various quality measures. Enrollees served under both fee-for-service and managed care are attributed to the IHP from which they receive the most services.

Beginning with contracts effective for 2018, all IHPs are also eligible to receive population-based payments for care coordination. A portion of payment is also contingent on an IHP's scores on quality measures.

IHPs, initially referred to as health care delivery systems, were authorized by the 2010 Legislature and first began delivering services in 2013. As of July 2018, 24 IHPs provide services to just over 450,000 state program enrollees (429,699 in MA and 25,233 in MinnesotaCare) receiving services under both the managed care and fee-for-service systems.[2] DHS estimates that total savings for the program for the five-year period from 2013 to 2017 was about $277 million, with about $92 million of this amount returned to IHPs as shared savings.

This publication describes the IHP program as it is being implemented under contracts beginning in calendar years 2018 or 2019 under recent DHS request for proposals. Many IHP requirements for these calendar years are the same or similar to requirements for previous years. Major differences between current contracts and contracts that took effect in calendar year 2017 and prior years are described in Appendix C.

[1] An integrated health partnership is a type of accountable care organizations (ACO). The federal HealthCare.gov website defines an ACO as, "a group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings."

[2] DHS IHP Summary: 2018.

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Table 2 on page 12 provides information on the number of IHPs and total enrollees over time, and also includes estimates of savings realized by state health care programs from implementation of the IHP program. Appendix A lists current IHPs and provides information on date of entry, enrollment, and main service area. Appendix B lists the services included in the total cost of care. A glossary defines key terms.

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Program Implementation

Overview

The IHP demonstration was authorized by the 2010 Legislature. The program was initially referred to as the Health Care Delivery System (HCDS) demonstration and is codified as Minnesota Statutes, section 256B.0755. This section requires the Commissioner of Human Services, through the demonstration program, "…to test alternative and innovative integrated health partnerships, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care or risk/gain sharing payment arrangement."

DHS has contracted with IHPs through a series of request for proposals (RFP). The RFP issued in 2017 made a number of significant changes to the IHP program that will apply to contracts for 2018 and future years. These changes include making population-based payments to IHPs for care coordination, modifying the risk/gain sharing payment arrangement, and making program changes to better reflect the diverse populations served by IHPs.

Request for Proposals

The authorizing law requires the commissioner to develop a RFP for participation in the demonstration project and specifies requirements for the RFP process. The commissioner, in part, is required to:[3]

[3] Minn. Stat. 2017 Supp., § 256B.0755, subd. 1.

- identify and measure key indicators of quality, access, and patient satisfaction, as well as indicators to measure cost savings;
- allow maximum flexibility in IHP structure and operation to encourage innovation and variation, so that a variety of provider collaborations are able to become IHPs, and IHPs may be customized for the special needs and barriers of patient populations experiencing health disparities;
- encourage and authorize different levels and types of financial risk;
- identify required covered services for a total cost of care model or services considered in an analysis of utilization for a risk/gain sharing model; and
- establish quality standards that are appropriate for the particular patient population to be served.

The first RFP for provider participation in the IHP program was issued in 2011. The six health care providers selected under this initial RFP began delivering services as IHPs on January 1, 2013.

Recent IHP Program Modifications – IHP 2.0

The RFP issued by DHS on May 15, 2017, for services to be provided beginning January 1, 2018, made a number of significant changes to the IHP program. These changes in part reflect findings from a request for information issued by DHS in 2016 that sought comments on improvements that could be made to the IHP program. DHS refers to this modified IHP program as "IHP 2.0." These changes included the following:[4]

- provision of population-based payments to all types of IHPs (to be used for service coordination); these payments will be risk-adjusted to reflect differences in the intensiveness of care coordination
- eliminating gain sharing (the receipt of shared savings payments) from the payment arrangement for smaller, less integrated IHPs
- providing greater incentives for IHPs to partner with community-based organizations
- adjustment of quality measures to reflect socio-economically complex patient populations
- providing greater flexibility for IHPs to be customized to serve patient populations with special needs and barriers to care due to health disparities and other factors

Transition to the IHP 2.0 Model

The most recent RFP, issued June 11, 2018, incorporates these IHP 2.0 features. Contracts awarded under this 2018 RFP will normally apply for the three-year period of January 1, 2019, through December 31, 2021.

Legacy IHPs—those IHPs that entered the program under a RFP issued prior to 2017—are not required to convert to the IHP 2.0 program, and may renew their contracts under the terms of the prior RFP for

[4] See Laws of Minnesota 2017, First Special Session chapter 6, article 4, sections 40 to 43; "Integrated Health Partnerships 2017 Request for Proposal Overview," Matthew Spaan, June 29, 2017; and "Request for Proposals for a Qualified Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration," Minnesota Department of Human Services Health Care Administration, May 15, 2017.

up to the three-year contract period.[5] Once a legacy IHP has reached the end of the three-year contract period, it must reapply under the terms of the most current RFP (i.e., convert to IHP 2.0) if it wishes to continue as an IHP.

IHP Organization and Requirements

Overview

IHPs can be established by a wide range of provider types. Managed care and county-based purchasing plans may participate in an IHP but cannot be the primary responder to an RFP. An IHP must provide or coordinate the full scope of MA services, be able to accept financial risk under a total cost of care risk arrangement (if applicable), monitor and ensure quality of care, and meet other specified requirements.

Eligible Providers

An IHP is made up of a network of providers; this may include an organizing entity and an agreement for shared governance with the providers. An IHP may be formed by the following groups:

- professionals in group practice
- networks of individual practices of professionals
- partnerships or joint ventures between hospitals and health care professionals
- hospitals employing professionals
- other groups of providers as determined by the commissioner

A managed care or county-based purchasing plan may participate in an IHP in collaboration with one or more of these groups but cannot be a primary responder to an RFP.[6]

IHP Requirements

In order to be considered for selection as an IHP, a health care provider must:[7]

- provide or coordinate the full scope of MA services. This can be demonstrated through health care home certification by DHS, recognition as a medical home by the National Committee for Quality Assurance, current or past participation as an IHP, or meeting certain health system characteristics related to the offering of primary care services, access to care, availability and use of a patient registry, and care planning and coordination;
- have all providers participating in the IHP enrolled as MA and MinnesotaCare providers;
- demonstrate how the model of care delivery used will affect the total cost of care;

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[5] This means that there is a two-year period (calendar years 2018 and 2019) during which DHS must administer two different IHP payment and quality measurement systems. IHPs that have been awarded new contracts to provide services beginning in 2018 or 2019 will operate under the IHP 2.0 requirements. IHPs that entered into contracts under prior RFPs will operate under the payment and quality measurement provisions of the prior RFP, which may differ from the IHP 2.0 requirements.

[6] Minn. Stat. 2017 Supp., § 256B.0755, subd. 1, para. (d).

[7] DHS Request for Proposals, June 11, 2018, pp. 9-10. General IHP provider contract requirements for earlier contract years are similar.

- be able to accept financial risk under the total cost of care risk arrangement agreed upon with DHS (if this payment method applies to the IHP);
- have established processes to monitor and ensure quality of care, and participate in quality measurement and quality improvement activities;
- be able to receive data electronically from DHS and use this data to engage and identify patients and improve health outcomes;
- address social determinants of health and risk factors present in the MA population served; and
- coordinate, partner with, or engage with community-based organizations, counties and local agencies, providers and county-based purchasing plans, and other entities, and engage and partner with patients and families in the provision of care and in quality improvement.

Enrollee Participation and Attribution

Overview

Most MA eligibility groups, and MinnesotaCare enrollees, are eligible to participate in the IHP program by being attributed to an IHP. Major groups specifically excluded are persons eligible for MA under a spend-down and MA enrollees who are also eligible for Medicare. The inclusion of an enrollee in the IHP program is not normally apparent to the enrollee (i.e., it is a "back-office function"). Enrollees do not choose an IHP and are instead attributed by DHS to an IHP (for purposes of population-based payments and shared risk payments) based on past provider utilization and other factors. An enrollee in fee-for-service will continue to have a choice of providers, and enrollees of a managed care organization will continue to be required to obtain services from providers who are part of the organization's provider network.

Groups Eligible for Participation

Persons eligible to be included in the IHP program for purposes of attribution to an IHP and calculations related to payment and quality measurement, are:

- MA enrollees who are pregnant women, children under age 21, parents and caretakers, adults without children, or covered through state-only funded MA;
- MA enrollees who are eligible due to blindness or a disability, who are not also eligible for Medicare; and
- MinnesotaCare enrollees.

Beginning with contracts that took effect in calendar year 2018, persons age 65 and older who are not also eligible for Medicare (i.e., are not "dual eligibles") have been eligible for the IHP program. Under contracts entered into prior to 2018, persons age 65 and older were not included in the program.

A number of groups are specifically excluded from the IHP program, including but not limited to persons eligible for MA through a spend-down, MA enrollees who are also eligible for Medicare (dual eligibles), persons with cost-effective employer coverage, and persons eligible only for MA assistance with Medicare cost-sharing.[8]

[8] Eligible and excluded populations are listed in Appendix C-2 of the DHS request for proposals, June 11, 2018.

Attribution

Attribution is the process by which DHS links an enrollee to an IHP for purposes of determining payment and measuring quality of care for that IHP. Attribution to an IHP is retrospective and is based on prior utilization. Once an individual is attributed to an IHP by DHS, all of the individual's care (for services in the total cost of care definition) will be attributed to that IHP, regardless of whether that IHP provided all of the services.

Attribution occurs on a monthly or yearly basis, depending upon the purpose. Individuals are attributed on a monthly basis using retrospective claims, for purposes of monthly patient data and care management reports, quarterly total cost of care reports, and the quarterly population-based payments (these payments are described in the next section). Individuals are attributed on a calendar year basis using retrospective claims, to determine the total cost of care and payments under the shared-risk model.

Individuals are attributed using the following hierarchical order:

1) A person enrolled in a health care home or a behavioral health home for which a monthly care coordination claim is submitted is attributed to the IHP with the greatest number of care coordination claims.
2) If item 1 does not apply, a person is attributed to the IHP from which the person has received the largest number of primary care evaluation and management visits.
3) If items 1 and 2 do not apply, a person is attributed to the IHP from which the person has received the largest number of specialty care evaluation and management visits.

Provider visits are calculated retrospectively based on a 12-month period. If there are no care coordination claims or evaluation and management visits (either primary care or specialty care) for a 12-month period, then the retrospective period is extended back an addition 12 months (24 months in total).

Payment Model

Overview

IHPs that have entered into new contracts with DHS for the 2018 and 2019 contract years participate as either Track 1 or Track 2 IHPs. Track 1 IHPs are intended to be small provider systems and specialty health care groups. Track 1 IHPs are also eligible to participate as an accountable care partner with a track 2 IHP. Track 2 IHPs are intended to be health systems with a higher level of integration and the ability to provide or coordinate the full range of MA services. Track 2 IHPs must have at least 2,000 attributed enrollees.

Both Track 1 and Track 2 IHPs will receive a quarterly population-based payment (PBP) for the attributed population. Track 2 IHPs will also be reimbursed under a shared risk model, under which savings and losses relative to a total cost of care target are shared with DHS. Track 1 IHPs are not eligible to receive payment under a shared risk model.

Track 1 and Track 2 IHPs will continue to be reimbursed as health care providers under the MA and MinnesotaCare programs, receiving payments from DHS for services provided to MA fee-for-service enrollees, and payments from managed care organizations for services provided to MA and MinnesotaCare managed care enrollees. The population-based payments will replace certain care

coordination payments that the health care provider may have previously received. The shared risk model is applied as an adjustment to payment received under MA and MinnesotaCare.

Managed care organizations are required to cooperate in the administration of the IHP program. The managed care organization and DHS each pay their portion of any shared savings payments to the IHP (and likewise receive their share of any shared loss payments from the IHP) based upon their proportion of attributed enrollees.

Population-Based Payments

Both Track 1 and Track 2 IHPs receive a quarterly population-based payment (PBP) for each attributed individual. The PBP is a new feature of IHP contracts and was first implemented beginning in 2018 for IHPs selected as part of the RFP process for that year.

The PBP was authorized by the 2017 Legislature to support care coordination services for IHP enrollees.[9] The payment is risk-adjusted to reflect "varying levels of care coordination intensiveness for enrollees with chronic conditions, limited English skills, cultural differences" or for enrollees who are homeless or experience health disparities or other barriers to care. This payment is paid quarterly to each IHP, based on the number of persons attributed to the IHP and the risk and complexity of that IHPs population, relative to the overall MA population. DHS estimated that the average PBP across all IHPs would be approximately 1 percent of the total cost of care for the attributed population; the actual payment will vary for each IHP.[10]

IHPs receiving population-based payments are not eligible to receive other care-coordination payments, such as health care home payments and care coordination fees, for any state health care program enrollee enrolled in or attributed to the IHP.

Shared Risk Model

Only Track 2 IHPs are eligible for payment under a shared risk model. Under this model, IHPs share in losses and savings with the state based on how an IHP's total cost of care for attributed individuals for a performance period compares to a target total cost of care established during a prior base period (trended forward for inflation and risk-adjusted). (See Table 1 for an example of how shared savings are calculated.)

The total cost of care is the sum of expenditures on a set of primary care and other related services, and includes population-based payments received by the IHP. These services are listed in Appendix B. All of the expenditures on these services for a patient attributed to an IHP will be counted towards that IHP, regardless of whether that IHP provided all of the services.

Performance threshold. Risk sharing does not take effect unless savings or losses meet a performance threshold, expressed as a percentage of the total cost of care. To meet the performance threshold, the performance period total cost of care must be more than 2 percent above or below the adjusted target total cost of care for the base period (i.e., above 102 percent for shared losses and below 98 percent for shared savings). Once the performance threshold is met, shared savings and

[9] See Laws 2017, 1st spec. sess., ch. 6, art. 4, sec. 42.

[10] DHS, 2017 Request for Proposal Overview, June 29, 2017 (see footnote 4 for full citation).

shared losses are calculated down to the first dollar (i.e., they include the full difference between the performance period total cost of care and the adjusted target total cost of care).

Risk-corridors. Shared savings and shared losses are limited by risk corridors negotiated between the IHP and DHS. Risk corridors are expressed as a percentage of the total cost of care, and serve as an upper and lower bound, above and below which shared savings and shared losses are not calculated. For example, under a 10 percent risk corridor, costs above 110 percent of the total cost of care are not counted when determining shared losses, and savings below 90 percent of the total cost of care are not counted when determining shared savings.

The default division for shared savings and shared losses is 50 percent for the IHP and 50 percent for DHS. This ratio can be modified based on whether an accountable care partnership arrangement exists (see discussion below).

Population floor and claims caps. DHS, in calculating the total cost of care, requires a minimum population of at least 2,000 attributed persons, and uses a per-individual claims cap of up to $200,000 (claims above this amount are not counted). The claims cap is set during the negotiation process and may vary across IHPs based on population size (since large individual claims will have a greater impact on IHPs with smaller attributed populations).

Table 1 provides an example of how shared savings will be calculated for an IHP for the calendar year 2019 contract year. The information in the table is a simplified version of the calculation from Appendix E of the June 11, 2018, DHS request for proposals.

Table 1: Example of Shared Saving Calculations for 2019

1. Base period total cost of care	$370.80	This is the average monthly cost for covered services for individuals attributed to the IHP for the base period (CY 2018), trended forward for inflation to the performance period (CY 2019)
2. Performance period total cost of care	$379.00	This is the average monthly cost for covered services for individuals attributed to the IHP for the performance period (CY 2019)
3. Target total cost of care	$387.65	This is the base period total cost of care (row 1) risk-adjusted to reflect differences in the risk and complexity of the attributed population between the base period (CY 2018) and the performance period (CY 2019)
4. Comparison of performance period total cost of care (for CY 2019) and the target total cost of care (based on CY 2018 and adjusted)	97.8	This is the ratio of the dollar values in rows 2 and 3.* This compares the total cost of care for CY 2019 performance period with the total cost of care for CY 2018 base period (trended forward to CY 2019 and risk-adjusted).
5. Shared savings/loss percentage	2.2%	This is the percentage of savings achieved during the performance period, relative to the target total cost of care. Since this exceeds the threshold of 2 percent, shared savings is calculated.**
6. Preliminary shared savings amount (not adjusted for the population-based payment)	$1,504,393	This is the product of: shared savings percentage in row 5 (2.2), times the target total cost of care in row 3 ($387.65), times the number of service months for attributed enrollees during the performance period (176,400)
7. Total population-based payment received by IHP during the performance period	$670,320	In this example, the population-based payment is $670,320, the product of the population-based payment per member per month of $3.80 and annual member months of 176,400
8. Shared savings amount, with adjustment for the population-based payment	$834,072	If the 2 percent threshold to calculate shared savings is met, the population-based payment (row 7) is subtracted from the preliminary shared savings amount (row 6), to obtain the amount that will be used to calculate the shared savings that the IHP will receive from the state.*** This is done to include the cost of the population-based payment in the total cost of care.
9. Portion of shared savings received by the IHP and by the state	$417,026	This is one-half of the amount in row 8 and reflects a 50/50 split of the shared savings amount, after the population-based payment is accounted for in row 8
10. Total revenue received by the IHP for the performance period (shared savings plus the population-based payment amount)	$1,087,356	This is the shared savings amount in row 9, with the IHP's annual population-based payment of $670,320 added back
* If the performance period total cost of care was higher than the target total cost of care, this ratio would be above 100. If the difference was greater than 2 percent (i.e., the ratio was greater than 102), then a shared loss percentage would be calculated in row 5 and a total shared loss dollar amount calculated in row 8. The IHP would then be liable to the state for one-half of the total share loss dollar amount.		

** Shared savings, or if applicable shared losses, would be calculated only up to the negotiated risk corridor, expressed as a percentage of target total cost of care (e.g., 10 percent above or below this total cost of care).
*** Alternatively, if the IHP had overspent relative to the target total cost of care and the 2 percent threshold to calculate shared losses is met, the population-based payment would be added to the preliminary shared loss amount, to obtain the amount that will be used to calculate the shared loss that the IHP will be responsible for. This is done to include the cost of the population-based payment in the total cost of care.

Accountable Care Partners

Track 2 IHPs that enter into accountable care partnerships with Track 1 IHPs or with community organizations to provide services to address health and other needs of the population served by the IHP may be eligible to enter into a more favorable risk arrangement with DHS.[11] Partnerships can address needs related to areas such as housing, food assistance, social services, education, and transportation. In evaluating partnership proposals, DHS will look at factors such as the substantiveness of the partnership, the financial risk that will be borne by the IHP and the community partner, and the impact of the partnership on total cost of care.

Role of Managed Care Organizations

DHS requires managed care organizations (e.g., managed care and county-based purchasing plans) to cooperate in administration of the IHP program and in making and receiving payments under the program. As noted earlier, an individual is attributed to an IHP regardless of whether that individual receives MA services through fee-for-service or through a managed care organization. An IHP may therefore have attributed enrollees served by both fee-for-service and managed care, and total cost of care and shared savings/shared losses are calculated for each IHP aggregating both groups of enrollees.

A managed care organization plays a role similar to that played by DHS under fee-for-service. The managed care organization and DHS each pay its portion of any shared savings payments to the IHP (and likewise would receive its share of any shared loss payments from the IHP), based upon its proportion of attributed enrollees.

Quality Measurement and Scoring

Overview

The IHP program links payment to the quality of care provided. Under contracts beginning in 2018, continued receipt of a population-based payment, and a portion of any shared savings payment, is contingent on an IHP's score on quality measures.

Population-based Payments

Continued receipt by Track 1 and Track 2 IHPs of the population-based payment following each three-year contract period is dependent on the IHP meeting measures related to quality, health equity, and service utilization. The specific measures are determined through the contract negotiation between DHS and each IHP. In addition, as part of the negotiation process, each IHP is required to propose a health

[11] This could include a nonreciprocal risk arrangement, under which there is a greater potential for shared savings (the IHP retains 60 percent), relative to shared losses (the IHP is responsible for 40 percent).

equity measure (or measures) designed to reduce health disparities within the population served by the IHP.

Shared Savings Payments

For Track 2 IHPs, 50 percent of any shared savings payment is contingent on quality measurement results. DHS uses a core set of quality measures that includes the following domains:[12]

- Care quality: includes measures selected from the Minnesota Department of Health's Statewide Quality Reporting and Measurement System (SQRMS), measures used by Medicaid, and measures from the Healthcare Effectiveness Data and Information Set (HEDIS). The proposed weight for measures in this domain in 70 percent.
- Health information technology: includes measures used by the Medicaid Electronic Health Records (EHR) incentive program. The proposed weight for these measures is 20 percent.
- Pilot measures: these are measures that cannot be fully operationalized, but which give the IHP an opportunity to propose new or innovative measures or take part in measurement efforts that target the population served. An IHP must propose at least one pilot measure. The proposed weight is 10 percent (IHPs will receive points initially just for reporting the measures).

Track 2 IHPs also may propose alternative care quality measures relevant to the populations they serve.

IHP Enrollment and Savings

Table 2 below provides information from DHS on the number of IHPs and total attributed enrollees over time, and also includes DHS estimates of savings from implementation of the IHP program. Between 2013 and 2017, the number of participating IHPs increased from six to 21 and the number of attributed enrollees increased from 96,615 to 466,460.

The table also shows that for the first five years, a majority of IHPs achieved savings. In each year except 2016, most or all of the IHPs achieving savings also met the 2 percent threshold for qualifying for shared savings.

Total savings for the five-year period from 2013 to 2017 are estimated to be $276,716,761 (2017 estimate is not final). Total savings are the dollar amount by which spending on services during the performance period is less than the target total cost of care for the base period adjusted for inflation and risk-adjusted. Of this amount, $92,489,226 was eligible to be returned to IHPs as shared savings.

The table also shows that no IHPs overspent relative to the total cost of care target for the first two years. Two IHPs in 2015, six IHPs in 2016, and three IHPs in 2017 overspent relative to this target, but the overspending did not pass the 2 percent threshold that would trigger the requirement that the IHP share in losses with DHS.

[12] Quality measures for care quality and information technology are listed in Appendix F-2 of the DHS request for proposals, June 11, 2018.

Table 2: Number of IHPs, Enrollees, and Estimated Savings

	2013	2014	2015	2016	2017*
Number IHPs**	6	9	16	19	21
Total number attributed enrollees	96,615	165,638	219,459	358,006	466,460
Number IHPs achieving savings/# meeting threshold	6/5	9/9	13/10	12/6	15/9
Estimated savings	$14,825,352	$65,339,161	$87,508,840	$48,361,582	$60,681,826
Number IHPs with losses/# meeting threshold	None	None	2/0	4/0	3/0
Estimated losses	None	None	$758,593	$4,307,703	995,683

* Interim performance results.
** The number of participating IHPs may be greater than the number of IHPs for which performance is separately reported and calculated. The performance of an IHP participating in the program may not be calculated for a variety of reasons—e.g., the IHP is too small or had too much variability in results, the results are incorporated into the results for a related IHP, or the IHP reports data to the IHP program but is not reimbursed under the program.
Source: Department of Human Services

Appendix A: Participating IHPs – 2018

IHP	Model		Attributed Population	Service Area
	Legacy	2.0	(July 2018)	
Allina Health	Integrated	—	66,462	Metro
Avera Health	—	Track 1	6,500	SW
Bluestone Physician Services	NA*	—	821	Metro
CentraCare Health System	Integrated	—	32,967	Central
Children's Health Care	—	Track 2	32,740	Metro
Community Healthcare Network	Integrated	—	28,039	Metro
Essentia Health	Integrated	—	45,974	NW, NE, W Central, Central
Fairview Health Services	Integrated	—	52,942	Metro
FQHC Urban Health Network	Virtual	—	31,516	Metro
Gillette Children's Specialty Health	NA*	—	2,055	NE, Central, Metro, S Central
Hennepin Healthcare System, Inc.	—	Track 2	37,420	Metro
Integrity Health Network	—	Track 1	4,269	NE, Central
Lake Region Healthcare	—	Track 1	4,315	W Central
Lakewood Health System	—	Track 1	4,117	Central
Mankato Clinic, LTD	—	Track 2	9,267	S Central
Mayo Clinic	Integrated	—	8,528	SE
North Memorial Health Care	—	Track 2	28,974	Metro
Northern Minnesota Network	—	Track 1	2,733	NW, NE
Northwest Alliance	Integrated	—	22,085	Metro
Perham Health	—	Track 1	1,708	W Central
Southern Prairie Community Care	Virtual	—	6,916	SW
Tri-County Health Care	—	Track 1	3,105	Central, W Central
Wilderness Health, Inc.	—	Track 1	17,392	NE
Winona Health Services	—	Track 1	4,087	SE

* Does not receive payments under the IHP program, but reports to DHS, receives data support from DHS, and participates in IHP shared learning events.
Source: Department of Human Services

Appendix B: Services Included in Total Cost of Care

The DHS RFP for the 2018 contract year lists the following care services as being included in the total cost of care:[13]

1) Physician services
2) Nurse midwife
3) Nurse practitioner
4) Child and teen check-up (EPSDT)
5) Public health nurse
6) Rural health clinic
7) Federally qualified health center
8) Laboratory
9) Radiology
10) Chiropractic
11) Pharmacy
12) Vision
13) Podiatry
14) Physical therapy
15) Speech therapy
16) Occupational therapy
17) Audiology
18) Mental health
19) Chemical dependency
20) Outpatient hospital
21) Ambulatory surgical center
22) Inpatient hospital
23) Anesthesia
24) Hospice
25) Home health (excluding personal care assistant services)
26) Private duty nursing

[13] See attachment A of the DHS RFP dated May 15, 2017. The state reserves the right to modify the services listed in the RFP.

Appendix C: The Legacy IHP Program

Overview. IHPs that entered into contracts with DHS prior to 2018 are referred to as legacy IHPs and participate as either virtual or integrated IHPs. Virtual IHPs are primary care providers and/or multi-specialty provider groups that are not formally integrated. Integrated IHPs are integrated health care delivery systems with at least 2,000 attributed enrollees. The legacy program will operate through 2019.

Both virtual and integrated IHPs are reimbursed under a shared risk model in which spending is compared to a total cost of care target. However, while integrated IHPs share in both savings and losses (“upside” and “downside” risk), virtual IHPs share only in savings (“upside” risk only). Virtual and integrated IHPs do not receive population-based payments.

Payment Model

Legacy IHPs are reimbursed only under a shared-risk model, based on total cost of care. No separate population-based payment is made.

Virtual and integrated IHPs. Legacy IHPs are classified as either virtual or integrated IHPs. *Virtual IHPs* are “primary care providers and/or multi-specialty provider groups that are not formally integrated with a hospital or integrated system via aligned financial incentives and common clinical and information systems.”[14] An example of this model is the Federally Qualified Urban Health Network (FUHN), an IHP made up of ten federally qualified health centers located in the Twin Cities. IHPs with a state program enrollee population of between 1,000 and 1,999 attributed enrollees are also classified as virtual IHPs, regardless of their level of formal integration.

An *integrated IHP* is “an integrated delivery system that provides a broad spectrum of outpatient and inpatient care as a common financial and organizational entity.” An integrated IHP must serve an attributed population of 2,000 or more.

Performance threshold. Shared savings or shared losses are not calculated unless the performance total cost of care is less than or greater than the performance threshold, expressed as a percentage of the target total cost of care. The threshold is 2 percent above or below the target total cost of care (i.e., shared losses are calculated if spending is above 102 percent of the target total cost of care, and shared savings are calculated if spending is below 98 percent). Once this threshold is met, shared savings or shared losses are calculated down to the first dollar.

Risk corridors. Integrated IHPs can propose different risk corridors to DHS, subject to specified parameters that vary with the performance period. Risk corridors are upper and lower bounds, expressed as a percentage of the total cost of care, above and below which spending is not counted when calculating shared losses or shared savings.

During the first performance period (i.e., the first calendar year of the contract), only shared savings are calculated, and the risk corridor must be within a specified percentage range of the target total cost of care. In the second performance period, the IHP is subject to both shared savings and shared losses, but

[14] DHS, Request for Proposals for Qualified Grantee(s) to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Integrated Health Partnerships (IHP) Demonstration, April 26, 2016, page 8.

the risk corridor percentages do not need to be symmetrical.[15] During the third performance period, the risk corridor percentages for shared savings and shared losses must be symmetrical. In each performance period, the IHP and the state share equally (50/50) in shared savings and shared losses.

Virtual IHPs do not have the option of proposing a risk corridor percentage schedule. Virtual IHPs also do not have the option of being paid under a shared savings/shared losses system, and are instead paid only under a shared savings system. Under this system, any savings, once the 2 percent threshold is met, are split equally (50/50) with the state for all three years of the demonstration.

Claims caps. Claims caps are applied when calculating the total cost of care. Health care spending above the cap is not counted when determining total cost of care. These claims caps varied by the size of the population served by each IHP as follows:

1) Population of 1,000 to 1,999 attributed patients: $50,000 maximum annual claims per patient
2) Population of 2,000 to 4,999 attributed patients: $100,000 maximum annual claims per patient
3) Population of more than 5,000 attributed patients: $200,000 maximum annual claims per patient

Quality Measurement and Scoring

For legacy IHPs, receipt of shared savings payments is based in part on the IHP's performance on quality measures. The DHS core set of measures is based on those already reported to the state through the Statewide Quality Reporting and Measurement System, and includes seven clinical measures and two patient experience measures. IHPs have the option, but are not required, to propose additional measures related to the population served.[16] The impact of quality measurement is phased in over the initial three-year contract period as follows:

- Year one: 25 percent of shared savings is based on the reporting of quality measures
- Year two: 25 percent of shared savings is based on performance on quality measures
- Year three and future years: 50 percent of shared savings is based on performance on quality measures

[15] A risk corridor is symmetrical if the same percentage difference applies both above and below the target total cost of care (e.g., 115 percent of the total cost of care for shared losses and 85 percent of the total cost of care for shared savings). A performance threshold is not symmetrical if the percentage above and below the target total cost of care is different—e.g., 106 percent as the threshold for shared losses and 88 percent as the threshold for shared savings. If an IHP proposes nonsymmetrical risk corridors, the ratio of the shared savings percentage and the shared losses percentage must be 2:1 (as in the example above).

[16] See DHS, "Medicaid Payment and Delivery System Innovation: Integrated Health Partnerships" Mathew Spaan, April 26, 2016; and the DHS request for proposals, April 25, 2016.

Glossary

This glossary provides informal, plain language definitions of terms used in the publication.

Attributed enrollee: An enrollee for whom spending for a set of covered services is counted towards an IHP's total cost of care or for whom quality of care is measured for purposes of determining an IHP's quality score.

Attribution: The process by which an enrollee is associated with an IHP for purposes of measuring spending and quality of care. This is normally done by examining past use of health care services, and associating the enrollee with the IHP from whom the enrollee has received the most services.

Base period total cost of care: Average monthly spending for covered services provided to an attributed enrollee during a period prior to the performance period, trended forward for inflation to the performance period.

Claims cap: This is a dollar amount above which health care spending on an enrollee is not counted for purposes of calculating the total cost of care for an IHP.

IHP 2.0: The IHP program, operating under the terms of contracts entered into beginning in CY 2018.

Integrated health partnership (IHP): A network of health care providers that directly contracts with DHS to provide services to MA and MinnesotaCare enrollees in both managed care and fee-for-service, for which payment is based in part on achieving cost savings and meeting quality goals.

Legacy IHP Program: The IHP program, operating under the terms of contracts entered into prior to CY 2018. Also sometimes referred to as IHP 1.0.

Performance period: The period during which an IHP's total cost of care is measured, for comparison with the target total cost of care and calculation of any shared losses or shared savings.

Performance threshold: A percentage above and below the target total cost of care, which the performance period total cost of care must exceed, in order for shared saving or shared losses to be calculated.

Performance period total cost of care: Average monthly spending for covered services, including the population-based payment, for individuals attributed to an IHP for the performance period.

Risk corridor: An upper and lower bound, expressed as a percentage of the target total cost of care, above and below which spending is not counted when calculating shared losses or shared savings.

Risk/gain payment arrangement: A payment method under which IHPs share with DHS in shared savings or shared losses, based upon IHP spending for a set of covered services (performance period total cost of care) compared to prior IHP adjusted spending for that set of covered services (target total cost of care).

Shared losses: The amount by which the performance period total cost of care is above the target total cost of care for an IHP.

Shared savings: The amount by which the performance period total cost of care is below the target total cost of care for an IHP.

Target total cost of care: The base period total cost of care, adjusted to reflect differences in risk and complexity between the attributed population for the base period and the attributed population for the performance period.

Total cost of care: Average monthly spending by an IHP for covered health care services for an attributed enrollee. The total cost of care can be calculated for and compared across different time periods (e.g., a base period and a performance period).

Track 1 IHP: Under IHP 2.0, an IHP composed of small provider systems and specialty health care groups.

Track 2 IHP: Under IHP 2.0, an IHP composed of a health system with a high level of integration and the ability to provide or coordinate the full range of MA services.

Integrated IHP: Under the legacy IHP program, an IHP composed of an integrated health care delivery system with at least 2,000 attributed enrollees.

Virtual IHP: Under the legacy IHP program, an IHP composed of primary care providers and/or multi-specialty provider groups that are not formally integrated.

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