MN HOUSE RESEARCH

Integrated Health Partnerships Program

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Executive Summary

The Integrated Health Partnerships (IHP) program is a health care provider direct contracting demonstration project administered by the Minnesota Department of Human Services (DHS). Under the program, DHS contracts with provider organizations called integrated health partnerships 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.

All IHPs are also eligible to receive population-based payments for care coordination. Continued receipt of population-based payments is contingent on an IHP's scores on quality measures.

IHPs were authorized by the 2010 Legislature and first began delivering services in 2013. As of July 2023, 28 IHPs provide services to just over 531,000 state program enrollees (497,504 in MA and 33,644 in MinnesotaCare) receiving services under both the managed care and fee-for-service systems.[1] DHS estimates that total savings for the program for the period from 2013 to 2022 was about $438 million, with about $191 million of this amount returned to IHPs as shared savings.

This publication describes the IHP program as it is being implemented under the recent DHS request for proposals for services provided beginning January 1, 2024. Table 1 on page 9 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.

[1] "IHP Attribution table," Minnesota Department of Human Services, July 2023.

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Program Implementation

Overview

The IHP demonstration project was authorized by the 2010 Legislature 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). Requirements for the RFP process are specified in section 256B.0755, subdivision 1, paragraph (b). The first RFP was issued in 2011 for services delivered beginning January 1, 2013. The most recent RFP was issued in 2023 for services to be delivered beginning January 1, 2024, through December 31, 2026.

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.[2]

IHP Requirements

In order to be considered for selection as an IHP, a health care provider must:[3]

- provide or coordinate the full scope of MA services;
- 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 and quality of care;
- 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 patients and improve health outcomes;
- address social determinants of health and risk factors present in the MA population served; and
- identify and address health disparities related to racial, ethnic, geographic, and socio-economic backgrounds present in the MA population served.

IHPs must implement an intervention to address social determinants of health and are held accountable for agreed upon health equity measures related to the intervention. IHPs are also expected to incorporate formal and informal partnerships with community-based organizations, social service agencies, counties, public health resources, and other entities in their care delivery model.

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

[3] "Request for Proposals for a Grantee to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through Track 1 or Track 2 of the Integrated Health Partnerships (IHP) Demonstration," Minnesota Department of Human Services, April 4, 2023, pp. 9-11.

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.

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.[4]

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.

[4] Eligible and excluded populations are listed in Appendix B-2 of the DHS request for proposals, April 4, 2023.

Payment Model

Overview

IHPs contract with DHS to participate as either Track 1 or Track 2 IHPs. Track 1 IHPs are generally 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 generally 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 5,000 attributed enrollees.

Both Track 1 and Track 2 IHPs receive a quarterly population-based payment (PBP) for the attributed population. Track 2 IHPs are also 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.

Both Track 1 and Track 2 IHPs also receive a $1.00 per member per month payment for each attributed enrollee, to provide child and teen checkup services to children birth through age 20.

Track 1 and Track 2 IHPs 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 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 was authorized by the 2017 Legislature to support care coordination services for IHP enrollees and was first implemented in 2018 as part of the RFP process for that year. 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.[5] 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

[5] See Minn. Stat. § 256B.0755, subd. 4, para. (d).

that the average PBP across all IHPs in 2022 was approximately 0.85 percent of the total cost of care for the attributed population; the actual payment varied for each IHP.[6]

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).

The total cost of care is the sum of expenditures on a set of primary care and other related services. Total cost of care includes population-based payments received by the IHP but excludes certain services such as long-term care, foster care, and individualized education program services. Services included in the total cost of care 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 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 for Track 2 IHPs, 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

[6] DHS email communication, August 16, 2023.

on population size (since large individual claims will have a greater impact on IHPs with smaller attributed populations).

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.[7] Partnerships can address needs related to areas such as housing, food security, social services, education, and transportation. In evaluating partnership proposals, DHS considers 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 under 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. 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 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

[7] 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).

to propose an intervention and related health equity 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:[8]

- **Quality core set:** includes but is not limited to 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 this domain is 20 percent.
- **Care for children and adolescents:** includes preventive health measures for persons age 21 and younger. The proposed weight for this domain is 20 percent.
- **Quality improvement:** focuses on quality improvement for select measures. The proposed weight for this domain is 30 percent.
- **Closing gaps:** focuses on reducing and eliminating disparities in care for different populations. The proposed weight for this domain is 10 percent.
- **Equitable care:** includes HEDIS measures related to the state's goals of eliminating health disparities and ensuring equitable care across racial and ethnic groups. The proposed weight for this domain is 20 percent.

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

IHP Enrollment and Savings

Table 1 below provides information from DHS on the number of IHPs and total attributed enrollees over time, and also includes DHS estimates of savings and losses from implementation of the IHP program. Between 2013 and 2022, the number of participating IHPs increased from six to 26 and the number of attributed enrollees increased from 96,615 to 486,788.

The table also shows that over these ten years, a majority of IHPs achieved savings. In each year except 2016, a majority (or, in 2014, all) of the IHPs achieving savings also met the 2 percent threshold for qualifying for shared savings.

Total savings for the period from 2013 to 2022 are estimated to be $438.8 million. Total savings are the dollar amount (reduced by estimated losses and population-based payments) by which spending on services during the performance period is less than the target total cost of care for

[8] Quality measures for care quality and information technology are listed in Appendix F-2 of the DHS request for proposals, April 4, 2023.

the base period adjusted for inflation and risk-adjusted. Of this amount, $191.1 million was eligible to be returned to IHPs as shared savings.[9]

The table also shows that no IHPs overspent relative to the total cost of care target for the first six years at levels above the 2 percent threshold that would trigger the requirement that the IHP share in losses with DHS. However, for 2019 and subsequent years, IHPs have overspent at levels above the 2 percent threshold for sharing of losses, and the proportion of losses to savings has increased relative to years prior to 2019.

Table 1: Number of IHPs, Enrollees, and Estimated Savings

Year	Number IHPs*	Total number attributed enrollees	Number IHPs achieving savings/ number meeting threshold	Estimated savings	Number IHPs with losses/number meeting threshold	Estimated losses
2013	6	96,615	6/5	$14,825,352	None	None
2014	9	165,638	9/9	$65,339,161	None	None
2015	16	219,459	13/11	$88,267,434	2/0	$758,593
2016	19	358,006	12/6	$53,613,374	4/0	$4,307,703
2017	21	466,460	18/15	$108,462,213	3/0	$995,683
2018	23	452,518	15/12	$111,049,603	7/0	$13,279,900
2019	25	429,354	13/11	$34,066,148	12/6	$48,204,891
2020	25	423,190	18/11	$34,720,141	4/5	$30,213,548
2021	26	467,759	14/11	$56,713,148	12/5	$42,240,658
2022	26	486,788	17/11	$61,267,201	9/5	$49,534,009

* 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

[9] DHS email communication, August 16, 2023.

Appendix A: Participating IHPs – 2023

IHP	Model Type *	Attributed Population (July 2023)	Service Area
Allina Health	Track 2	68,407	Metro
Altair ACO	Track 1	69	Metro
Astera Health (formerly Tri-County Health)	Track 1	3,301	Central, W Central
Avera Health	Track 1	11,742	SW
Breakwater Health Network (formerly Northern Minnesota Network)	Track 1	2,373	NW, NE
CentraCare Health System	Track 2	48,037	Central
Children's Minnesota	Track 2	33,713	Metro
Convergence Integrated Care (formerly MN Association of Community Mental Health Programs)	Track 1	6,991	Metro
Essentia Health	Track 2	46,893	NW, NE, W Central, Central
Face to Face Health and Counseling	Track 1	406	Metro
Fairview Physician Associates Network	Track 2	88,622	Metro
FQHC Urban Health Network	Track 1	17,758	Metro
Gillette Children's Specialty Health	Track 1	2,347	NE, Central, Metro, S Central
Hennepin Healthcare	Track 2	38,013	Metro
Integrity Health Network	Track 1	5,183	NE, Central
Lake Region Healthcare	Track 1	4,968	W Central
Lakewood Health System	Track 2	5,119	Central
Mankato Clinic, LTD	Track 2	9,755	S Central

IHP	Model Type *	Attributed Population (July 2023)	Service Area
Mayo Clinic – Rochester Area	Track 2	9,852	SE
Mayo Clinic Health System	Track 1	36,253	Greater MN
Minnesota Community Care	Track 1	11,306	E Metro
North Memorial Health Care	Track 2	29,512	Metro
Northwest Alliance	Track 2	21,065	Metro
Perham Health	Track 1	2,050	W Central
Riverwood Healthcare Center	Track 1	2,182	E Central
United Family Medicine	Track 1	2,930	Metro
Wilderness Health, Inc.	Track 1	18,602	NE
Winona Health Services	Track 1	3,699	SE

* Track 1 – nonrisk bearing; Track 2 – risk-bearing
Source: Department of Human Services

Appendix B: Services Included in Total Cost of Care

The DHS RFP for the 2024 contract year lists the following care services as being included in the total cost of care:[10]

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

[10] See Appendix G: Sample Contract, of the DHS request for proposals dated June 28, 2023. The state reserves the right to modify the services listed in the RFP.

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.

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.

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: An IHP composed of small provider systems and specialty health care groups.

Track 2 IHP: 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.