

Request for Comment:

Outcomes-Based Purchasing Redesign and Next Generation IHP

November 15, 2017

Purpose and Objective

The Minnesota Department of Human Services (DHS) is requesting public comment on the redesign and reform of DHS' purchasing and delivery strategies for Medicaid and MinnesotaCare (our state's basic health program or BHP).

Background

Minnesota is nationally recognized for its leadership in improving how the state purchases, pays for and delivers health care through its public health care programs. Currently, DHS purchases coverage for families and children--in the state's Medicaid program, Medical Assistance--and for adults in MinnesotaCare through a managed care system, with both health maintenance organizations (HMOs) and county-based purchasing (CBPs) plans serving as managed care organizations (MCOs). Over the last six years, Minnesota has taken steps to improve its managed care system. For example, in 2011, to better contain costs and improve quality, the state began applying a competitive price bidding process to establish rates for participating MCOs. This process expanded across the state in 2015, as did changes to the evaluation process to assess managed care organizations on their ability to deliver reforms, to support health care priorities (like improving access to mental health services and dental care) and to comply with additional quality oversight and data security. In addition to these purchasing reforms in managed care, Minnesota has made great strides in transitioning its delivery system to an accountable care model, through its Integrated Health Partnership (IHP) program. This program currently functions alongside managed care organizations and the state's fee-for-service system and serves about 462,000 Minnesotans.

All told, Minnesota has experienced overall savings of \$1 billion through these reform efforts. More than \$212 million of this savings has occurred in the last three years with the state's successful IHP program, which has resulted in lower spending on the total cost of care. Moreover, IHP providers have experienced better health outcomes for their managed care populations, reducing inpatient admissions by 14 percent and emergency room visits by 7 percent. IHPs are also highly ranked on statewide quality benchmarks.

This request for public comment (RFC) reflects the state's continued commitment to redesign and reform DHS' purchasing and delivery strategies for public health care programs. From the beginning, the state has actively sought and incorporated community input on the design and implementation of these reforms. For example, DHS published the first Request for Information (RFI) in 2011. This RFI resulted in the first iteration of the IHP program, which was implemented on January 1, 2013. In 2016, DHS published another RFI seeking stakeholder input on how the state's payment and delivery reform efforts

should evolve over time. The experience of participating stakeholders in the IHP demonstration, as well as the feedback from stakeholders who have not yet chosen to participate in the model, has highlighted many opportunities to continue refining the IHP model along with the features that have been fundamental to the success of the program. This feedback has also highlighted ways that the department can modify MCO contracts to better align the incentives between this IHP model and traditional managed care organizations.

Based on the feedback, DHS has developed specific advancements for the program many of which were included in the Governor's 2017 budget proposal to enhance the program to the "IHP 2.0." This new IHP track includes an enhanced payment mechanism and increased capacity for data sharing among providers. This RFC reflects the state's efforts to respond to stakeholder recommendations to better align the purchasing strategies of managed care with the "advanced track" IHPs that have increased capacity from their participation in the early stages of the program. This new model for purchasing and delivery reform is referred to as the "Next Generation IHP."

The success of participating providers and health plans under this new purchasing and delivery model will greatly depend on their ability to improve health outcomes for their enrollee populations without increasing costs. Depending on enrollee needs, providers and managed care entities may seek to address certain risk factors that they believe are likely contributing to poor health outcomes within a population or community (e.g., social determinants of health, racial disparities and behavioral health risk factors). In designing this new payment policy, DHS has initially identified four key domains for evaluating the impact and quality of a delivery and purchasing system on a population. These are: (1) enrollee experiences with care; (2) health outcomes for enrollee population; (3) health care costs to the system and program; and (4) work satisfaction among providers.

The Next Generation IHP and further refinements to the managed care model will be developed together, based on outcomes and through the Department's overarching purchasing-redesign strategy. The objectives of this strategy include, but are not limited to:

- Purchasing for health care services should be client-focused and outcome-based, placing a higher value on those providers that achieve better health outcomes at a reasonable cost.
- Enrollees should have meaningful choice in providers and understand the differences between the various provider networks. Networks should value providers that coordinate care across the continuum of services and work with the community to improve outcomes.
- Enrollees and providers should have a similar experience across the programs, regardless of where they are enrolled and who they are contracted with. This means common administration that allows enrollees to access these services when they change providers without significant disruption to their care. For example, this model proposes a single Preferred Drug List, which will minimize these types of disruptions. It should also reduce provider burden in understanding and administering program rules.
- Providers participating in outcome-based purchasing, whether directly with DHS or through a contracted health plan, should have accountability for cost and quality while maintaining an appropriate amount of flexibility in their organizational structure, contracts, partnerships and management of provider activities such as prescribing practices.
- Administration and financial functions should be simplified and efficient across the purchasing strategy and should look to reduce overlapping administrative functions (e.g., enrollee

materials, other consumer protection functions and financial reporting) and should be accomplished by improving understanding and ease for the enrollee at the best value for the taxpayer.

- Entities participating in outcome-based purchasing should have increased financial accountability over time with a proportional level of risk relative to their responsibility for services provided.
- Participating entities and taxpayers should benefit from savings accrued to the system. Enrollees will benefit from the reinvestment from these savings.

The Next Generation Integrated Health Partnerships (IHP) Model

Building on the success of the original IHP program and stakeholder feedback, the launch of the IHP 2.0 track addresses many of the suggested improvements to the IHP program. This RFC reflects DHS’ efforts to further develop and align its purchasing and delivery reforms toward what the state is referring to as “the Next Generation IHP” model, which will include overall reforms to the state’s managed care system.

This initial design framework is intended to support a future Request for Proposals (RFP) for a demonstration in the seven-county metropolitan area only. This model does not propose to replace the existing IHP program; instead, it proposes to allow for additional advancement and opportunity for the existing IHP program. Providers can choose to remain in the current IHP model, or participate in the Next Generation IHP.

Next Generation IHP Model, Aligned MCO Contract Modification Component Considerations

The table below highlights the state’s proposed demonstration for the Next Generation IHP, which includes future modifications to the MCO contracting process. The intent, at this time, is for the state to release a single RFP in order to conduct a new procurement in the seven-county, metropolitan area which will allow proposals for both Next Generation IHPs and managed care organizations that choose to participate in the demonstration. The components, as described below, are provided to facilitate feedback from interested stakeholders and are not meant to be an exhaustive or final set of features or standards for this new purchasing model.

Table 1. Model Components

Model Component	Next Generation IHP	Modified MCO Contract
Timing	RFP in 2018 for contracts beginning in 2019 Demonstration would last up to 5 years	RFP in 2018 for contracts beginning in 2019 Demonstration would last up to 5 years
Geographic demonstration area	Seven-county metropolitan area Potential Next Generation IHPs would need to apply to serve a	Seven-county metropolitan area Health plans must propose in all counties in which they are licensed.

Model Component	Next Generation IHP	Modified MCO Contract
	<p>limited subset of counties or all 7 metro area counties.</p> <p>If selected, a Next Generation IHP must participate in all counties in which they have a primary care presence.</p>	
Populations included	<p>Medical Assistance (MA) and MinnesotaCare non-dual parents, children and adults without dependent children, who are currently included in managed care</p> <p>Additional MA and MinnesotaCare populations may elect to enroll in a Next Generation IHP, including those that are excluded from mandatory participation in managed care.</p>	<p>Medical Assistance and MinnesotaCare non-dual parents, children and adults without dependent children, who are currently included in managed care</p>
Eligible entities to hold a contract with DHS	<p>Provider organizations and/or networks of providers</p> <p>IHPs</p>	<p>Non-profit/for profit HMOs licensed in the state of Minnesota</p>
Network requirements	<p>Next Generation enrollees will have access to the full scope of health care services utilizing the IHP and DHS Fee For Service (FFS) network.</p> <p>Next Generation IHP networks must meet current network adequacy standards for a core set of services. The Next Generation IHP networks will be supplemented with the current DHS FFS network.</p> <p>Next Generation IHPs will develop a network of primary care clinics from which enrollees can select their main primary care clinic.</p> <p>A primary care clinic may only be included as a selection choice for one Next Generation IHP or one or more MCOs.</p>	<p>MCO enrollees will have to access the full scope of health care services utilizing the MCO network.</p> <p>MCO networks must meet current network adequacy standards.</p> <p>MCOs will develop a network of primary care clinics from which enrollees can select their main primary care clinic.</p> <p>A primary care clinic may only be included as a selection choice for one Next Generation IHP or one or more MCOs.</p>
Functions	<p>To align with the payment model and to capture different types of services involved in accountable care,</p>	<p>No changes anticipated, however DHS is considering a similar breakout of the three activities.</p>

Model Component	Next Generation IHP	Modified MCO Contract
	<p>activities are broken out into three categories: direct health care services, administration and medical management and care coordination</p> <p>Each is outlined further below</p>	
<p>Health care services</p>	<ul style="list-style-type: none"> • Inpatient and outpatient hospital services • Outpatient and professional services • Mental health and substance use disorder • Emergency and ambulance services • Rehabilitative services • Lab and radiology • Interpreter services • Home health services • Prosthetics and orthotics • Child & Teen Checkup • Possible considerations: FQHC services, and rural health clinic services <p>The following services are included for beneficiaries, but managed by DHS or a subcontractor: PCA, NEMT, Medical supply/durable medical equipment (DME), eyeglasses/contacts, hearing aids, pharmacy and dental</p> <p>DHS is proposing to administer a single Preferred Drug List (PDL) across the fee-for-service, managed care and Next Generation IHP models</p>	<p>No changes anticipated</p> <p>The MCO will be responsible for the health care services reflected in the current MCO contract, however, DHS is proposing to administer a single Preferred Drug List (PDL) across the fee-for-service, managed care and Next Generation IHP models.</p>
<p>Administrative services</p>	<p>Next Generation IHPs will contract with DHS to provide (or provided by a subcontractor) a portion of the administrative services on behalf of</p>	<p>The MCO will be responsible for the full scope of administrative services reflected in the current MCO contract.</p> <p>MCOs must demonstrate administrative efficiency within a range achieved by the</p>

Model Component	Next Generation IHP	Modified MCO Contract
	<p>the Next Generation IHP, including such things as:</p> <ul style="list-style-type: none"> • Claims payments • Customer service system • Member materials and enrollee notices related to benefit determination and formulary changes • Provider enrollment • Initial enrollee screening and health risk assessment • Utilization review (e.g., prior authorization, utilization limits, provider standards, etc.) • Reports on behalf of Next Generation IHP (e.g., Child & Teen Checkup reporting, state monitoring report, etc.) • Integrity program • Grievance and appeals • Supply data on cost, quality, prescribing patterns, etc. <p>The Next Generation IHP will be responsible for the following remaining administrative services:</p> <ul style="list-style-type: none"> • Training and orientation for counties and tribes • Contracting with/among providers and community partners • Management of performance and other payments to providers and other community partners • Utilization review (e.g., retrospective review to determine medical necessity) • Receive data from (e.g., electronic enrollment data) and submit data 	<p>DHS (or subcontracted) services. If an MCO cannot meet this requirement, DHS will perform the administrative function in the same manner as the Next Generation IHP administrative services contract.</p>

Model Component	Next Generation IHP	Modified MCO Contract
	<p>to DHS (e.g., claims, financial data, IMD placements, quality reporting, Limited English Proficiency (LEP) plan)</p> <ul style="list-style-type: none"> • Enrollee notices related to member communication, service delivery plan changes • Grievance and appeals hearings participation • Readiness review participation • Audits by CMS and DHS • Integrity program, coordination of restriction 	
<p>Medical management and care coordination</p>	<ul style="list-style-type: none"> • Coordination and management of primary and specialty health care services and, where relevant, community and social services • Disease registry and management • Population health programs • Identification of high-risk members/identification of outliers • Concurrent review (e.g., hospitalizations) • Discharge planning • Use data to analyze, review, and report on costs, quality and other factors (e.g., prescribing patterns, etc.) • Decision-support tools/shared-decision making • Medication utilization review: additional analysis, review, action (i.e., using the data) • Coordination of benefits 	<p>MCOs will be expected to provide support for providers in their network participating in similar outcome-based payment arrangements.</p>
<p>Member enrollment and</p>	<p>Enrollees, including those populations described above as “voluntary,” will select their primary care clinic upon initial enrollment and annually during open</p>	

Model Component	Next Generation IHP	Modified MCO Contract
selection processes	<p>enrollment; they will either be enrolled in an Next Generation IHP or an MCO, whichever has the selected primary care clinic included in its network.</p> <p>For enrollees who take no action or those who do not complete the primary care clinic selection process, DHS will use historical utilization data or geography to determine a primary care clinic (and associated Next Generation IHP or MCO).</p> <p>DHS will also extend the existing process that allows enrollees to change their selection and change primary care clinics (and their Next Generation IHP or MCO) within 60 days of initial determination, a first year change option, and a process for changing for cause. Enrollees may change their primary care clinic within a Next Generation IHP or MCO as often as once per month.</p>	
Social Determinants of Health	<p>Both Next Generation IHPs and MCOs may use partial-cap or capitated funds to pay for non-covered services that are improving health and reducing costs and addressing social determinants of health (SDOH).</p>	
Data provided by DHS	<p>As is the current practice, DHS will provide available utilization and risk data to Next Generation IHPs and providers for their participating populations. The data will be populated by a monthly set of risk adjustment output. Data will be as timely as possible given standard claims lag, and will be available via risk adjustment software output or standardized reports.</p> <p>Key variables available to delivery systems will include population-level data (such as the total cost of care and rates of inpatient and emergency department utilization) and enrollee-level data (such as medical and pharmacy utilization histories, predictive risk information, and indices of care coordination).</p> <p>DHS also anticipates being able to provide additional claims detail to providers in the Next Generation IHP model.</p>	<p>DHS will consider providing some additional data to MCOs, particularly if an enrollee is new to the MCO. Current claims information will still be processed by the MCO and therefore available to the MCO. If the MCO chooses to use DHS (or its subcontractor) for claims processing, then DHS would provide similar data to the MCO.</p> <p>MCOs are expected to provide similar data feedback to support to their own network providers participating in outcome-based payment arrangements.</p>
Quality and Demonstrating Value	<p>Next Generation IHPs will be evaluated on a core set of measures organized into six categories. The Medical Management per member per month (PMPM) will be positively</p>	<p>MCOs will be evaluated on a core set of measures organized into six categories. The Medical Management PMPM will be positively or negatively adjusted based on the entity's performance.</p>

Model Component	Next Generation IHP	Modified MCO Contract
	or negatively adjusted based on the entity’s performance.	MCOs would be required to have at least 30% of their payments in an outcome-based arrangement. Shared savings payments to providers participating in the current IHP program would be considered toward that total.

The Next Generation IHP Rate Setting Process

As previously mentioned, the new proposed purchasing and delivery model in this RFC will be implemented only in the seven-county metropolitan area, which includes Hennepin, Ramsey, Anoka, Dakota, Washington, Carver and Scott counties, and for the state’s families and children’s population in Medicaid and MinnesotaCare. DHS plans to use existing claims data regarding the history of the costs of the population as a baseline for setting rates for the Next Generation IHPs and traditional MCOs seeking to participate in the demonstration. Any payments to a Next Generation IHP under this model will be adjusted by cost and quality performance. The state anticipates the initial rate setting process for the Next Generation IHPs will be accomplished in a similar manner as the current process for the MCOs and populations served.

Any proposed rates for the Next Generation IHP model and managed care organizations will be included and published as part of a formal RFP process.

Rate Setting Process

Currently, the capitation rates in managed care for each program are developed by projecting anticipated costs with respect to future medical claims that are based on the cost of prior claims and the expected utilization of services for Medicaid and MinnesotaCare enrollees. The process for developing the monthly capitation rates requires collection of base year data from the MCOs. The MCOs submit financial information and claims data (called “encounter claims”) to DHS. Typically, the base period data is a full years worth of claims and financial data from two or more years prior to the contract year. Projected claims and administrative costs are then divided by projected member months for the covered population to produce a medical and administrative cost rate per member per month (PMPM).

From the base period medical costs from all MCOs are pooled and projected forward to the contract period by category of service (e.g., inpatient hospital services, mental health services, prescription drugs, physician and professional services, etc.) based on known changes in benefits and anticipated impacts of changes to state and federal laws. Medical costs are projected forward based on a trend which is assumed to be inflated by cost for each category of service. Trend is also applied to utilization in anticipation of any changes in utilization. The assumptions related to trend are based on economic and market information about health care costs obtained from national, state and local sources of data and information. Categories of service trends are then blended to produce an overall trend rate. Once future medical costs have been projected an allowance for administrative costs is added to the rate. Then, a margin for adverse experience and profit is added to produce the final statewide capitation rate for the program.

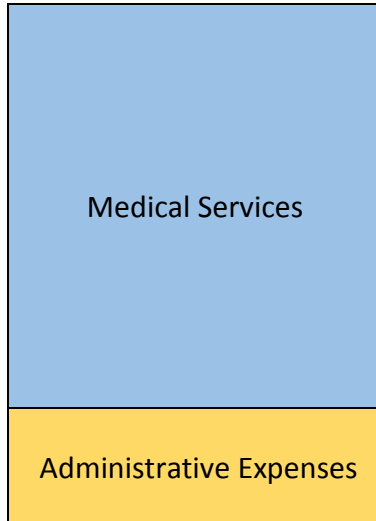
The final step in determining capitation rates paid to MCOs is the risk adjustment process. This process calculates MCO specific factors applied to capitation rates which adjust the rates to reflect variation in the relative health risk burden between MCOs. In other words, if an MCO in a specific region has a historically sicker population, the risk adjustment factor for that region will provide a higher payment to that MCO relative to other MCOs for that same region. This process is budget neutral to the state.

Current Managed Care Payment Model

Currently, monthly capitation payments, much like health insurance premiums, are paid to MCOs by DHS for each month that an individual is enrolled in managed care. The monthly capitation payment paid to the MCO is for the provision of medical goods and services for each enrollee covered under the managed care contract between DHS and the MCO and includes an allowance for administrative expenses and a margin for adverse claims experience and contribution to an MCO's reserve. MCOs are at full risk for the majority of Medicaid and MinnesotaCare covered services for an enrollee, meaning the MCO must pay for all covered services in its contract even if the services received by an enrollee cost more than the payment made by DHS, and conversely the MCO may retain the funding if the costs come in less than expected.

For informational purposes only, the weighted average rate across all eligible Medical Assistance populations, in the seven-county metro area, for calendar year 2018, is \$468.55 PMPM. The weighted average rate across all eligible MinnesotaCare populations in the seven-county metro area is \$428.55 PMPM.

Figure 1. Current Managed Care Payment Model



Proposed Next Generation IHP Payment Model

Using the same overall rate established for current managed care, Next Generation IHPs will receive payments that are a combination of a partial MCO capitation and FFS payments. For any enrollees who select a primary care provider in a Next Generation IHP, that IHP will receive a FFS rate for any direct health care services received. The capitated portion of the payment will be made up of the difference in what is paid under the MCO capitation rate and consist of distinct portions for administrative services, medical management and service delivery outcomes. Because the Next Generation payment model is a

type of outcome-based payment, where the outcome is understood as an equation of cost and quality, payments to a Next Generation IHP will be adjusted based on performance on cost and quality metrics.

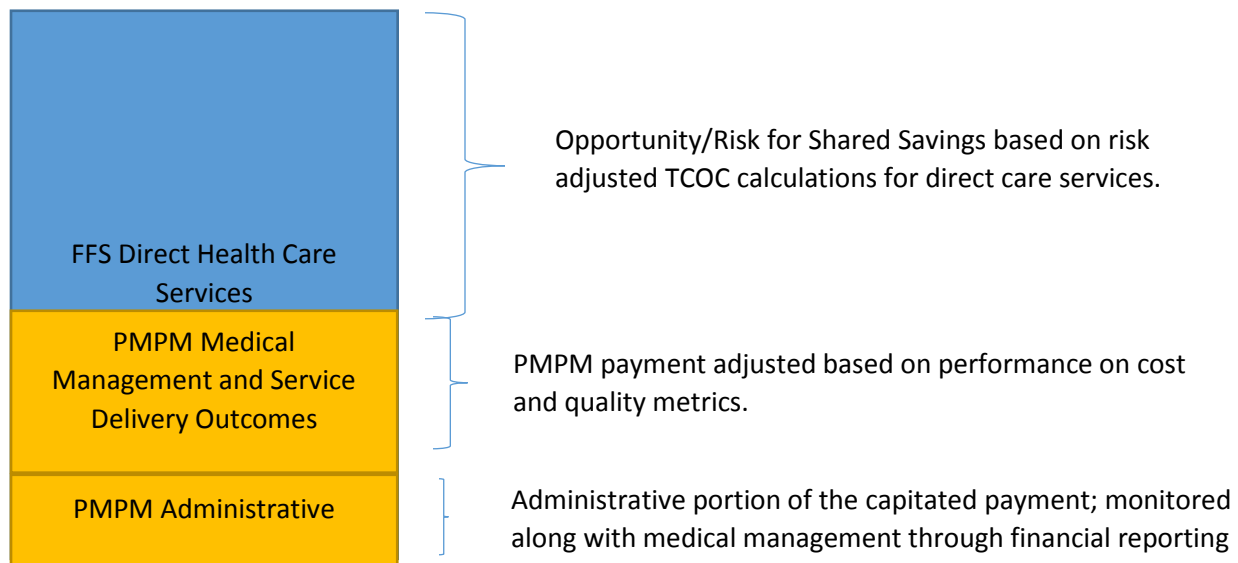
Cost (shared savings) adjustment

A Next Generation IHP will have an opportunity to share in savings if the total costs of care (TCOC) for direct health care services are lower than the target. The shared savings TCOC will be risk adjusted and calculated based on FFS rates for direct health care services provided to the enrollee (including care provided outside of the Next Generation IHP). DHS is considering applying achieved savings or losses through a mix of adjustments to the medical management and service delivery PMPM and through a settlement process.

Quality adjustment

A Next Generation IHP will have an opportunity to receive higher payments for a higher quality care of. The medical management and service delivery PMPM will be at risk for performance adjustment. The amount of the performance adjustment will consist of a percent of the overall total costs of care (FFS portion and a capitated portion). DHS is proposing that the 2019 performance adjustment be calculated based on entity’s historical performance on a set of core measures.

Figure 2. Proposed Next Generation IHP Payment Model



Evolution of the Next Generation IHP Payment Model

Over time, the proportion of the partial capitated payment will increase as the amount in the FFS base payment decreases because savings occurring from reductions in unnecessary or inappropriate utilization will result in a combination of shared savings settlements as well positive adjustments to the PMPM available for Medical Management and Service Delivery outcomes. This gradual shift away from a dependency on the fee-for-service payments allows providers the needed flexibility to address enrollee needs and moves that flexible payment closer to the point of care and enrollee/provider relationship. Although the fee-for-service payments to providers will be reduced over time, providers will still submit service and cost information through encounter or other financial reporting to DHS to allow accurate total costs of care (TCOC) calculations.

The value of the PMPM for Medical Management and Service Delivery Outcomes is made up of the difference between what is paid in direct payments by managed care organizations, the portion of the MCO capitation that is paid for medical management services, and a portion of dollars paid for administrative services (remaining administrative dollars would support administrative function procured through DHS). The shared savings opportunity under the fee-for-service direct payments would be similar to the current IHP TCOC arrangement. The PMPM would be significantly larger than the current Population-Based Payment under the IHP 2.0 model, but would also represent an increased responsibility and financial risk.

Measuring Cost Performance

Services Included in Total Cost of Care

All Medicaid covered services will be included in a Next Generation IHP's Total Cost of Care for purposes of measuring performance. All of the Next Generation IHP's enrollee's care, as provided in the total cost of care definition, will be attributed to the Next Generation IHP, regardless of whether the Next Generation IHP delivered the services.

Calculation of Total Cost of Care

The risk-adjusted Total Cost of Care (TCOC) target will be calculated by DHS for all MA and MinnesotaCare recipients that select the Next Generation IHP for the performance period, based on the services included in the Total Cost of Care. Next Generation IHP performance assessment will be based on a comparison of the observed TCOC for each performance period to a TCOC Target. The TCOC Target will be based on a base period TCOC after adjusting for expected trend and changes in population size and relative risk from the base period to the performance periods. At the end of each performance period, DHS will calculate the Performance Period TCOC, based on the claims incurred by the population during the performance period. The Adjusted Target TCOC will be compared to the Performance TCOC for purposes of determining the performance results and the basis for the calculation of shared savings and losses.

Measuring Quality Performance

In selecting measures for the core set, DHS sought measures that would be meaningful and actionable for the participating entities and their enrollees as well as aligned across federal and state quality programs. In addition to the alignment across federal and state quality programs, DHS sought alignment between MCO and Next Generation IHP quality requirements and, consequently, DHS will set the same quality standards for MCOs as for Next Generation IHP entities.

Measuring Next Generation IHPs Performance for Payment Adjustment

The quality adjustment to the Next Generation IHP payment will be evaluated based on Next Generation IHPs' performance on a core set of measures organized into six categories: prevention and screening, appropriate treatment for at risk populations, behavioral health, access to care, patient-centered care and care coordination/patient safety. The Next Generation IHPs' performance in each category will be weighted to calculate the overall quality score.

Table 2. Measurement categories for the performance adjustment to the Next Generation IHPs' payment.

Measure Category	Purpose
Prevention & Screening	To promote use of preventive services, reduce health disparities between Medicaid enrollees and commercial enrollees and improve population health
Effectiveness of Care/Appropriate Treatment for at Risk Populations	To improve health outcomes and promote optimal chronic disease management for at risk populations
Behavioral Health	To improve integration of physical and behavioral health and improve access to behavioral health services
Access to Care	To improve access to health care
Patient-Centered Care	To monitor and improve enrollee satisfaction with care in the face of changing incentives
Care Coordination/Patient Safety	To monitor and improve care coordination and enrollee safety

Selecting Meaningful Measures

Providers have offered feedback to DHS that they are not able to focus on many quality improvement efforts at the same time. DHS understands the burden of multiple quality measurements and proposes that the weight assigned for each category should be agreed upon between the Next Generation IHP entity, MCO network providers and DHS to help focus quality improvement efforts in a meaningful way. DHS will want to better understand which measures are most meaningful and actionable for providers during the request for proposal process.

To further reduce measurement burden for clinicians and other providers, the majority of Next Generation IHP and MCO network providers measures will be calculated from claims data, although a few of the measures may be survey-based or may require electronic submission of clinical information. DHS believes that the electronic submission of clinical data will eventually drive high-value care and further reduce the administrative burden of data submission and DHS would like to support efforts to use electronic data for quality measurement.

To minimize measurement burden, DHS will try to use measures that Next Generation IHPs and MCO network providers are already required to report for other state or federal quality programs. DHS solicits feedback to better understand which quality programs Next Generation IHPs and MCO network providers are potentially already participating in.

Population Health and Social Determinants of Health

In the Next Generation IHP and the MCO contracts, the goal is to create payment policy that rewards high-value care for all Medicaid and MinnesotaCare enrollees and help providers address nonclinical factors that contribute to poor health outcomes and disparities. Recent DHS research shows that social risk factors e.g. homelessness, family and neighborhood poverty, mental illness and chemical dependency are correlated with health disparities and poor health. DHS is seeking public comments on how Next Generation IHP providers and MCOs can address social determinants of health to improve population health.

Questions for the Request for Comment

Below, please find the 12 questions for which DHS is specifically requesting comments. For administrative efficiency, it is preferred that responses to these specific question be collected utilizing the web-based process explained below. Feedback is not limited to these questions.

1. DHS has described an idea of “primary care exclusivity,” where a primary care clinic may only be included as a selection choice for one Next Generation IHP or one or more MCOs (other than as network extenders for urgent care, etc.). The goal is to create more clear lines of accountability. Is “primary care exclusivity” the best way to drive toward these goals? Are there exceptions to this to consider? What other options could DHS consider and why?
2. DHS would have a mix of contracts with both Next Generation IHPs and MCOs in the Metro area. Is there a minimum beneficiary population size needed to ensure Next Generation IHPs and/or MCOs are sustainable and can achieve economies of scale? Please provide sufficient detail and calculations to support your response.
3. What kinds of criteria should be included in a Request For Proposal for Next Generation IHPs and MCOs to ensure that an entity has sufficient and effective provider and benefit network structure (e.g., behavioral health integration with primary care) to ensure enrollees’ needs are met? Are there additional services or requirements beyond behavioral health that should be a primary consideration (e.g., criteria related to cultural competency, disparities, equity, etc.)? Please be specific in your response for Next Generation IHP or MCO.
4. To make care coordination most effective, what system (claims edits, etc.) or non-system (performance measures, etc.) mechanisms should DHS and Next Generation IHPs have in place to ensure and support enrollees accessing care consistently through their selected care system networks? Which mechanisms are critical to have in place at the start of the model as opposed to phased in over time?
5. What criteria and evidence should DHS and counties use to evaluate any potential responder's ability to implement any proposed initiative, contract, intervention, etc.? How should DHS hold entities accountable for their proposal?
6. DHS is proposing to administer a single Preferred Drug List (PDL) across the Fee-For-Service, Managed Care and Next Generation IHP models. Would administering a single PDL across all the models be preferable to carving out the pharmacy benefit from the Managed Care or Next Generation IHP models? Would expanding the single PDL or pharmacy carve out beyond the seven county metro area be preferable to applying the changes to only the metro county contracts?
7. How can this model appropriately balance the level of risk that providers can take on under this demonstration while ensuring incentives are adequate to drive changes in care delivery and overall costs?
8. What are appropriate measures and methods to evaluate paying for non-medical, non-covered services that are designed and aimed at addressing social determinants of health, reducing disparities and improving health outcomes?

9. How much of the entities' payment should be subject to performance on quality and health outcome measures? Please explain your answer.
10. One of DHS' priorities is to align quality requirements across federal and state quality programs. Which quality programs (e.g. Merit Based Incentive Payment System, MN Statewide Quality Reporting and Measurement System) are important to align with?
11. Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of enrollees served by an IHP or MCO. In order to improve health outcomes, providers may need to address risk factors that contribute to poor health (e.g. social determinants of health, racial disparities and behavioral health). Does the new payment policy give enough flexibility and incentive to improve population health? If not, what change if any would you recommend? What proposed changes as described in this RFC for the IHP and managed care organizations might result in an eligible entity from otherwise participating in the demonstration? Which of these changes might be problematic from a consumer or provider perspective over time, if not in this initial demonstration as proposed for the Metro area?
12. Do you have any other comments, reactions or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

Procedure and Instruction

While this Request for Comment is open to any individual or organization that chooses to respond, the target audience includes:

- Integrated Health Partnerships (IHP)
- Managed Care Organizations (MCO)
- Primary care, safety net and specialty providers
- Mental health and substance use disorder providers
- Providers of home care and personal care assistant (PCA) services (excludes contract for senior and people with disabilities)
- Other ancillary health care providers
- Access services providers (e.g. transportation, interpreter)
- Local public health
- Counties
- Tribal organizations
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Community and social services organizations
- Other

TO BE ASSURED CONSIDERATION, COMMENTS MUST BE RECEIVED NO LATER THAN 5:00 P.M. CENTRAL TIME ON WEDNESDAY, DECEMBER 20, 2017.

Responding to this Request for Comment is completely voluntary. Responders are invited to address as many or as few of the questions as they chose. The Department of Human Services is seeking information that it may use for future planning and program improvement, policy development and/or contracting for services. This Request for Comment, and responses to it, do not in any way obligate the

state, nor will it provide any advantage to respondents in potential future Requests for Proposals for competitive procurement. Respondents are responsible for all costs associated with the preparation and submission of feedback.

All responses to this Request for Comment are considered public, according to Minnesota Statutes §13.03. Responders should not anticipate a response to their submission or answers to any questions submitted.

Respondents may answer specific questions, provide general comments, offer additional perspectives and/or upload entire documents utilizing the web-based process.

Your web-based submission will require the following information:

- Name
- Organization
- Title
- Telephone number
- Email address
- Submitted comments

Click [HERE](#) to access the online submission form.

Responses may also be submitted via email at DHS.PSD.Procurement@state.mn.us. Emailed submissions are required to contain the following information:

- Name
- Organization
- Title
- Telephone number
- Email address
- Submitted comments

If you have any questions regarding the process to submit comments, please contact DHS.PSD.Procurement@state.mn.us.

In-Person Stakeholder Meetings

DHS will host two 90-minute stakeholder meetings to review the Request for Comment, address questions and solicit feedback. The meetings are open to the public. Attendance at these meetings is not required in order to submit a response to this Request for Comment.

Monday, Nov. 20, 2017

9:30 a.m. – 11:00 a.m.

Elmer Andersen Building, Room 2380

540 Cedar Street, St. Paul, MN 55155

Thursday, Dec. 7, 2017

1:00 p.m. – 2:30 p.m.

Wellstone Center

Anna Heilmaier Meeting Room

179 Robie Street East, St. Paul, MN 55107

Thank you for taking the time to respond to this Request for Comment. Your input is appreciated and important to the continued evolution of DHS' payment and care delivery model.