



MINNESOTA
HEALTH CARE
FINANCING
TASK FORCE

Health Care Financing Task Force Vision: Sustainable, quality health care for all Minnesotans

Health Care Delivery Design and Sustainability Workgroup

Recommendations Package

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DRAFT

Health Care Financing Task Force

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Minnesota Department of **Human Services**

A. Enhancements to Data Sharing

Sharing data among providers on a patient's care team is critical for effective coordination and to improve the quality and safety of health care, while ensuring patient privacy is essential for building trust between patients and providers. Restrictions on health information sharing must strike a balance between promoting coordination and protecting privacy. Minnesota's Health Records Act provides considerable privacy protections, including requiring that patients consent to having their information shared for treatment, and that they be given an opportunity to opt-out of having their information included in certain exchange mechanisms, such as Record Locator Services. These protections may, at times, limit coordination across providers, which most strongly impacts the care received by patients with multiple physical and behavioral comorbidities or other complex conditions. The Workgroup considered ways to improve data sharing to enable more effective care coordination, while maintaining the strong privacy protections Minnesotans expect.

Recommendation 1:

Make technical updates and clarifications to Minnesota Health Records Act to leave a patient's ability to specify how their information can be shared intact but allow patient consent preferences to be more easily operationalized at the provider level.

JUSTIFICATION: Under the Minnesota Health Records Act, a patient may specify how their information may be shared among providers. But some language contained in the act has created barriers for providers seeking to operationalize patient consent preferences. In other words, even when a patient would permit a provider to share information with another provider on his or her care team, technical challenges with the law limit the ability of providers to share data. By recommending technical edits and clarifications to the Health Records Act, the Workgroup seeks to maintain Minnesota's high level of patient privacy, while enabling more effective coordination across providers.

COST/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: Changes to the existing Minnesota Health Records Act would require state legislation.

OTHER OPTIONS CONSIDERED: The Workgroup considered recommending more sweeping changes to the Health Records Act to better enable data sharing among providers. However, the Workgroup does not recommend further changes beyond those described above until the more thorough study recommended below is complete. Depending on the results of the study, the Workgroup does recommend that additional changes may be required.

Recommendation 2:

Provide ongoing education and technical assistance to health and health care providers and patients, about state and federal laws that govern how clinical health information can be stored, used, and shared, and about best practices for appropriately securing information and preventing inappropriate use.

JUSTIFICATION: Because of the complexity of federal and state patient privacy laws, providers are often wary of sharing health information—even in situations where such sharing is legally permissible. The Workgroup recommends establishing ongoing educational and technical assistance to providers and patients to clarify how information may be stored, used, and shared. Additionally, the education and technical assistance would highlight best practices for securing information. Armed with knowledge about the legal guardrails, providers on a patient's care team will be better able to share information while maintaining appropriate patient privacy. Patients, too,

will have easy to access resources to help them understand how providers may and may not use their health information.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation; however expanding education and technical assistance to providers would likely generate new State costs.

STATE/FEDERAL AUTHORITY: This recommendation would require appropriations authority to implement.

OTHER OPTIONS CONSIDERED: None.

Recommendation 3:

Conduct a broad study that will make recommendations on the appropriate future structure, legal/regulatory framework, financing, and governance for health information exchange (HIE) in Minnesota, building on lessons learned in Minnesota and from other states and countries.

Study questions will include, but not be limited to:

1. Whether Minnesota should continue to use a market-based approach to HIE, or develop a single statewide HIE entity;
2. Whether additional ‘shared services,’ such as consent management, should be developed;
3. The appropriate funding source(s), and needed level of funding, to support core HIE transactions and shared services for all health and health care provider statewide; and
4. Whether Minnesota’s current legal/regulatory framework for HIE supports or hinders secure HIE that is aligned with patient preferences

JUSTIFICATION: Providers are increasingly adopting electronic medical records to manage patient data. But storing data in an electronic format does not enable dramatic improvements in care coordination and population health management unless the data can be shared readily. Sharing patient data consistently across a wide range of providers in a secure, reliable manner is therefore the next frontier in using data to improve health. Given the complex policy and operational issues that arise when a state seeks to encourage or establish health information exchange, and data sharing barriers encountered by providers that are unique to Minnesota, the Workgroup recommends that the State study a wide range of issues related to health information exchange in Minnesota, and provide concrete recommendations for enhancements.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation; however conducting a broad study of HIE in Minnesota would generate new State costs.

STATE/FEDERAL AUTHORITY: This recommendation would require statutory and appropriations authority to implement.

OTHER OPTIONS CONSIDERED: See the discussion of other options considered in Recommendation 1.

Longer-term recommendations and considerations related to data sharing:

- Dependent on results of health information exchange study, consider other modifications to Minnesota’s Health Records Act, to align with federal HIPAA standards or to update opt-in or opt-out requirements.
- Support expanded health information technology capabilities (ex. EHRs) in a broad range of care settings, to enable smaller and specialty providers to participate in HIE.
- Consider developing a funding mechanism for core HIE transactions, such as admission/discharge/transfer alerts, care summaries, or care plans, to ensure basic information can be exchanged statewide.
- Support the establishment of robust, sustainable HIE “shared services,” such as consent management, which would be available statewide through a central vendor.

B. Enhancements that Support Integrated Care Delivery

Recognizing the need to improve quality, enhance care, and reduce costs in the healthcare system—the so-called “Triple Aim”—providers, payers, and policymakers across the United States have developed a plethora of care models and incentive programs intended to promote provider accountability for the cost and quality of care. By holding providers accountable for the cost and quality of care, payers and policymakers intend to create strong incentives for providers to more closely integrate care across primary care, specialty care, and behavioral health. Further, these programs are intended to encourage stronger linkages with community resources so that the full range of a patient’s needs are addressed.

The following recommendations are intended to decrease barriers and catalyze care delivery reform in a way that effectively coordinates care across the continuum, tying care together more effectively, particularly for those with the most significant disparities. There are several value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs currently taking place within Minnesota; the Workgroup’s recommendations identify several immediate enhancements that should be applied across these programs. The Workgroup also identified several longer-term recommendations that are necessary to stabilize and enhance the care delivery system in Minnesota.

Recommendation 4:

Evaluate, on an ongoing basis, current value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs for effectiveness in meeting Triple Aim goals. Programs and pilots should not be significantly expanded until an evaluation of cost/benefits is conducted. At a minimum, the evaluation should address the following domains:

- Health disparities - Does the model worsen or improve health disparities? If so, by what mechanism or mechanisms? Does the model sufficiently account for variation in the complexity of patients across providers?
- Financial stability and cost of health care system – What is the impact of the model on costs across the system, including all payers? What costs are associated with the model at the provider level? What is the ROI of the program?
- Patient choice and provider attachment - How is the patient attached to the provider for purpose of service delivery, care coordination, and payment (prospective or otherwise)? How does the model incorporate patient choice of provider?
- Multi-payer alignment – What are the areas of alignment across payers under the model? What additional areas could be aligned?
- Quality of patient care – How has the model impacted the quality of patient care?
- Population health – How does the model address population health?
- Social determinants of health – How does the model address the determinants of health beyond medical care (e.g. flexible payment options that enable payment for non-medical services)?
- Impact on provider work force - What impact has the model had on the provider work force? If it has an impact, what mechanism caused the impact?

JUSTIFICATION: Health Care Homes, health homes, accountable care organizations, integrated health partnerships, and bundled payment programs, among many others, have grown in the past decade. Although each model and program is promising in concept, and several have shown lower costs and improved quality of care in early results, the findings in larger scale or national evaluations have so far been mixed. Rather than immediately expanding these programs and investing increasing amounts of resources in care models or incentive programs, the Workgroup recommends that the State evaluate on an on-going basis each of these demonstrations, pilots, and

programs for effectiveness in furthering the Triple Aim. Once the State has identified models proven to work for Minnesotans, the State may consider additional expansion of such programs.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation; however including a robust evaluation within existing programs would likely generate new State costs.

STATE/FEDERAL AUTHORITY: This recommendation would require appropriations authority to implement, tied to each specific demonstration.

OTHER OPTIONS CONSIDERED: None

Recommendation 5:

To the extent possible, seek alignment of approaches across public and private payers, including, but not limited to, consistent measurement and payment methodologies, attribution models, and definitions.

JUSTIFICATION: With myriad value-based purchasing programs emerging in Minnesota, there is a risk that each program differs in terms of quality measures, payment methodologies, and attribution models. Providers participating in multiple value-based purchasing programs are less able to develop a single, evidence-based, patient-centered model for delivering care; instead, they may need to tweak their care model to account for the unique features of the value-based purchasing arrangement under which the patient falls. By contrast, alignment of measures and methodologies across payers amplifies the ability of each value-based purchasing program to drive delivery system reform.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: Depending on how this recommendation is implemented, it could require legislative authority to ensure compliance. If implemented through existing stakeholder or advisory bodies, it may not require any additional authority.

OTHER OPTIONS CONSIDERED: The Workgroup considered requiring payers to have a certain percentage of provider payments linked to value or quality. Similarly, the Workgroup considered requiring that providers have a certain percentage of revenue tied to quality or value. In both cases, the Workgroup rejected imposing requirements on providers and payers; instead favoring a more flexible approach that encourages providers and payers to adopt alternative payment models, as appropriate. The Workgroup also considered whether to establish requirements for care coordination payments, attribution, and quality measures. Again, the Workgroup opted to afford providers and payers more flexibility to design their alternative payment arrangements.

Recommendation 6:

Conduct a study that examines various long-term payment options for health care delivery. Study will do a comparative cost/benefit analysis of the health care system under the following approaches:

1. Maintenance of current financing mechanism, without expansion of value-based purchasing beyond existing levels;
2. Expansion of value-based purchasing within current system;
3. Publicly-financed, privately-delivered universal health care system.

The study would additionally examine the stability and sustainability of health care system under the approach and identify any data or information needed to design and implement the system.

JUSTIFICATION: Although there was consensus among the Workgroup that Minnesota (and the United States, generally) must improve quality and reduce cost in order to get its health care system on sustainable footing, there is less consensus on how to achieve this. Some Workgroup members favored an expansion of value-based

purchasing while maintaining the current patchwork of public and private programs; some Workgroup members favored further analysis to evaluate whether additional value-based purchasing would be necessary or effective to drive improved outcomes. Finally, some suggested that expanding value-based purchasing alone would be unable to improve the health care system, favoring wholesale shift to a publicly financed, privately delivered universal health care system. Given the widespread impact of each of these options, the Workgroup recommends further study of each of these three options.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation, however conducting a study examining various long-term health care delivery payment options would likely generate new State costs.

STATE/FEDERAL AUTHORITY: This recommendation would require appropriations authority to implement.

OTHER OPTIONS Considered: None.

Recommendation 7:

Incorporate enhancements, as appropriate, into existing demonstrations, pilots, and programs, such as Integrated Health Partnerships, Health Care Homes, Behavioral Health Homes, and other value-based purchasing and accountable care arrangements across Medicaid and commercial beneficiaries. Consider any new arrangements as pilots or demonstrations, with significant expansion across the full population only following robust evaluation (as described above).

JUSTIFICATION: Minnesota has several on-going demonstrations, pilots, and programs that have shown promise in achieving the Triple Aim. The Workgroup recommends that the State enhance and expand these existing programs, where appropriate, to build on their current success and to correct course, where needed. Because many of these models remain unproven, the Workgroup recommends that any new arrangements begin as pilots or demonstrations and be expanded to the full population only after a robust evaluation.

COSTS/SAVINGS: Milliman modeled the annual savings to the State and Federal government if several enhancements were made to existing programs, including Integrated Health Partnership demonstration and Health Care Homes. The specific enhancements included a prospective “pre-payment” tied to retrospective savings measurement under an ACO arrangement, and for the population not in this ACO arrangement (such as certified Health Care Homes), a monthly prospective care management payments without retrospective shared savings that is modeled on the existing HCH tiering/payment structure but adds a ‘tier zero’ for patients without chronic diseases.

The modeling assumed that the enhancements would make the programs more attractive to providers, resulting in a net increase in participation. Additionally, the modeling assumed the programs would apply across Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), and the on-exchange individual market plans (QHP). Broadly, the modeling assumed approximately 45% of the population would be attributed to the ACO arrangement, 40%-45% would be enrolled in the monthly prospective payment program, and 10% to 15% of the population would fall outside of either arrangement.

Based on these assumptions, Milliman identified a net single-year savings of approximately \$48.1 million, with \$17.8 million of that accruing to the State.

STATE/FEDERAL AUTHORITY: Implementation will be dependent on the status of the active demonstrations, pilots, and programs currently in place. Each agency responsible for the active demonstration or program will need to evaluate on a case-by-case basis which enhancements are relevant to their demonstration or program, and determine if the enhancement will require additional authorization or funding. For example, several of the enhancements to Integrated Health Partnerships (IHP) will require changes to the State’s current State Plan Amendment. Changes to the HCH program may require changes to either statute or administrative rule.

OTHER OPTIONS CONSIDERED: The Workgroup considered recommending more aggressive expansion of existing value-based purchasing models across the state, but determined that expansion would be premature until additional evidence of their impact was gathered through a robust evaluation (see above). The Workgroup also considered recommending a “Primary Care Case Management” model, where the State would contract directly with providers to provide care management and medical services to patients. However, Workgroup members generally agreed that many of the core concepts of this model would be captured in the existing demonstrations, and therefore ultimately included in their evaluation.

C. Immediate Enhancements to Pilots, Demonstrations and Existing Programs

Minnesota currently has several pilots, demonstrations and programs in place that have generating promising preliminary results. For example, the Integrated Health Partnership (IHP) Medicaid ACO demonstration over its first two years exhibited a savings of approximately \$75 million, while enhancing the care of over 200,000 Minnesotans. The Workgroup evaluated immediate steps that the State could take to strengthen and expand these programs, with an eye toward achieving the Triple Aim and reducing health disparities.

Recommendation 8:

Enhance community partnerships by:

- Encouraging or incentivizing partnerships and care coordination activities with broad range of community organizations within care coordination models, and
- Funding innovation grants and contracts to collaboratives that include providers and community groups, to meet specific goals related to community care coordination tied to social determinants of health, population health improvement, or other priorities.

JUSTIFICATION: Medical care alone is not sufficient to ensure the lasting health of communities. Instead, medical care must be coupled with community resources to address a patient’s full range of needs. Some findings attribute as much as 40% of health outcomes to social and economic factors, such as access to food and shelter. The needs of each community vary, making it challenging to develop a single initiative to tackle social determinants of health across the entire State. Further, it is members of that community—not health care professionals—who are best positioned to identify ongoing and emerging needs. The Workgroup therefore recommends that Minnesota more actively engage communities in identifying and prioritizing their needs. Specifically, the Workgroup recommends that the State encourage community groups to participate actively in care coordination activities and fund innovative community – provider collaboratives.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation, however funding innovation grants within existing programs such as IHP or HCH would generate new State costs.

STATE/FEDERAL AUTHORITY: Depending on the type and nature of incentive, encouraging partnerships within existing care delivery demonstrations and programs may not require any additional authorization. Providing innovation grants to participating collaboratives would likely require statutory and appropriations authority to implement.

OTHER OPTIONS CONSIDERED: None.

Recommendation 9:

Improve disparities and health equity by encouraging or incentivizing participation of diverse patients in provider or provider/community collaborative leadership or advisory teams.

JUSTIFICATION: Although Minnesota is a national leader in many aspects of its health care system, it consistently lags behind other states on measures related to health disparities. Despite the State's low rate of uninsurance and its world class network of providers, Minnesota too often falls short in ensuring the health of its most vulnerable residents. To meet the medical and social needs of these vulnerable populations, the State should ensure that the provider – community collaborations or advisory teams reflect the diverse perspectives of the vulnerable populations.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: Depending on the type and nature of incentive, encouraging partnerships within existing care delivery demonstrations and programs may not require any additional authorization. However, if additional funds are tied to the incentive, additional appropriations authority may be needed.

OTHER OPTIONS CONSIDERED: The Workgroup also considered whether to recommend establishing incentive payments tied directly to reducing health care disparities, but the Workgroup ultimately rejected this based on concerns about the limits of providers to address health disparities and the potential to create disincentives to caring for high-need populations.

Recommendation 10:

Base measurement on the following principles: (1) Measures include risk adjustment methodology that reflects medical and social complexity; and (2) Existing pilots, demonstrations, and programs that tie a portion of a provider's payment to costs and/or quality performance should reward providers for both performance or improvement vs. provider's previous year and performance or improvement vs. peer group, to incentivize both lower and higher performing, efficient providers.

JUSTIFICATION: Increasingly linking provider evaluations and payments to quality and value has the potential to drive delivery system reform. But it also could increase health disparities if providers are incented to avoid caring for high-need populations. Providers may face greater challenges managing diabetes, for example, in patients with complex social needs. Rather than risk reduced quality scores, providers may seek to avoid caring for these complex patients. To ensure that measures linked to quality and value promote the Triple Aim without increasing inequity, the Workgroup recommends that the State adjust any quality or value measures to reflect both the medical and social complexity of the population.

Similarly, the Workgroup members acknowledge that some providers have long-standing experience improving quality and promoting value, while other providers have just begun to do so. Additionally, providers vary in the complexity of their patient populations and the financial and other resources available. Recognizing the need to ensure that a wide-range of providers can be successful under quality or value measurement, the Workgroup recommends that measures targets account for both a provider's year-over-year improvement, as well as a provider's performance relative to his or her peer group. By measuring performance on both these fronts, Minnesota will ensure that lagging, but improving, providers are rewarded, as well as consistently stand-out providers.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: The recommendation would likely not require additional legislative authority; however, depending on the demonstration or program may require additional authority from CMS through a State Plan Amendment or other mechanism, or changes to administrative rules.

OTHER OPTIONS CONSIDERED: The Workgroup considered eliminating the approach of tying a portion of a provider's payment to costs and/or quality performance under any model, due to concern that it might discourage providers from caring for patients with the most complex social and medical needs. However, most members agreed that current models within the State did not seem to encourage this type of patient avoidance, and that enhancement of the current models, coupled with sufficient evaluation, was preferable.

The Workgroup also considered whether to recommend including the costs of non-medical services in total-cost-of-care measurements, but the Workgroup rejected this option as premature. Members did agree that understanding the scope and scale of these costs was an important component of managing the overall costs and care of Minnesotans.

Recommendation 11:

Incorporate system wide utilization measures to assess impact of care coordination (such as preventable ED visits, admissions, or readmissions; appropriate use of preventive services and outpatient management of chronic conditions and risk factors) into performance measurement models; for use in evaluation of pilots, programs, and demonstrations; or as part of certification processes.

JUSTIFICATION: Statewide trends provide useful context for understanding the performance of both individual providers and care models. Accordingly, the Workgroup recommends that system-wide utilization measures are incorporated into individual provider performance measures. For example, the ED usage rates statewide should inform the evaluation of the ED usage rates for an individual provider's attributed population. Similarly, when aggregating measures across providers to evaluate the overall success of an incentive program or care model, statewide measures and trends are essential context for interpreting results.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: The recommendation would likely not require additional legislative authority; however, depending on the demonstration or program may require additional authority from CMS through a State Plan Amendment or other mechanism, or changes to administrative rules.

OTHER OPTIONS CONSIDERED: The Workgroup discussed potentially including a broader set of population health measures in the quality measurement methodologies of existing demonstrations and programs. However, members were concerned with a provider's ability to meaningfully impact these population-wide measures and the additional burden this might pose to providers. The Workgroup members did agree that population-wide health quality measurement was an important area for the State to explore for public reporting and analysis purposes, but should not be tied to individual provider performance metrics.

Recommendation 12:

For participants not attributed to an ACO (such as certified Health Care Homes), provide a prospective, flexible payment for care coordination, non-medical services and infrastructure development that is sufficient to cover costs for enrolled patients with complex medical and non-medical needs.

JUSTIFICATION: Accountable care organizations (like the integrated health partnership program) are investing heavily on the infrastructure and staff needed to coordinate care effectively. Providers not affiliated with an ACO, by contrast, may lack the resources needed to invest in care coordination. Patients not served by an ACO, therefore, may miss the benefits of increased care coordination. To ensure that all patients receive coordinated care, the Workgroup recommends that the State develop a prospective payment system for providers that are providing team-based, patient-centered coordinated care, such as certified HCHs, for care coordination that includes non-medical services, and for infrastructure development to support team-based, coordinated care.

COSTS/SAVINGS: Savings under this enhancement were included in the modeling discussed above.

STATE/FEDERAL AUTHORITY: Enhanced, prospective payments would likely require statutory and appropriations authority to implement.

OTHER OPTIONS CONSIDERED: None

Recommendation 13:

For participants attributed to an ACO (including risk-taking IHP program), provide a prospective “pre-payment” of a portion of their anticipated TCOC savings.

JUSTIFICATION: Building a robust program to coordinate care effectively requires considerable investment. Providers must hire care managers, redesign workflows, and strengthen IT capabilities. Some hospitals and large physician groups may have sufficient cash to make investments upfront, recouping them at the end of the year through payments tied to quality and value. Smaller providers, however, lack the cash flow necessary to make these prospective investments. To enable providers large and small to invest in care coordination infrastructure, the Workgroup recommends that the State advance providers a portion of their anticipated total-cost-of-care savings.

COSTS/SAVINGS: Savings under this enhancement were included in the modeling discussed above.

STATE/FEDERAL AUTHORITY: Providing a “pre-payment” of shared savings would likely require State statutory and appropriations authority, as well as CMS authorization through a State Plan Amendment or other mechanism, to implement.

OTHER OPTIONS CONSIDERED: None

Recommendation 14:

Establish consistency of payment approach for care coordination and alternate payment arrangements across all payers. Areas for consistency include (1) level of payments for care coordination activities, (2) identification of complexity tiers, (3) policies for copayments for care coordination services, and (4) billing processes.

JUSTIFICATION: Many payers have recognized the need to pay for care coordination, but payers have differed considerably in how they have designed those payments. Specifically, payers vary in the following respects: (1) how much they pay for care coordination activities; (2) whether and how they scale payments for care coordination based on the complexity of the patient; (3) whether care coordination services are subject to copayments; and (4) how providers bill for care coordination activities. Promoting consistency across payers in these key areas will streamline administration for providers and reduce patient confusion.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: Depending on how this recommendation is implemented, it could require legislative authority and regulation.

OTHER OPTIONS CONSIDERED: None.

Recommendation 15:

Ensure care coordination payments are sufficient to cover costs for the patients with the most intensive needs; the State (MDH and DHS) shall make modifications to the current HCH tiering process to incorporate social and non-medical complexity, and enhance payment rates to incorporate costs

associated with care coordination for patients experiencing these conditions. Modifications may include enhancing the payment tiers to include an additional, higher tier payment for patients with intense needs and social complexity.

JUSTIFICATION: Care coordination requires a significant investment both in terms of staff time and infrastructure costs. Payers should ensure that providers are rewarded for coordinating care for the most complex patients by appropriately tiering care coordination payments. The Workgroup recommends that payments be sufficient to cover the costs of coordinating care for even the most complex patients.

COSTS/SAVINGS: Costs/savings were not separately estimated for this recommendation, although a move to prospective payment is assumed to reduce provider administrative costs are thus incorporated indirectly into the modeling discussed above.

Depending on their level, and the impact on health outcomes and spending, increased payments to providers for patients with complex medical and non-medical needs and for needed infrastructure and workforce changes could add new State net costs.

STATE/FEDERAL AUTHORITY: Depending on how this recommendation is implemented, it might require statutory and appropriations authority to implement.

OTHER OPTIONS CONSIDERED: None.

Recommendation 16:

Strengthen the patient attribution and provider selection process by:

- Allowing patients to choose a provider during the enrollment process and change their primary provider outside of enrollment;
- Giving providers data about who enrolled with them so they have the opportunity to proactively engage with those enrollees;
- Using consistent methods for attaching patients to providers across payers;
- Attributing or assigning patients prospectively to a primary care provider or care network for the purposes of payment (not for care delivery) under an ACO or similar model, with back-end reconciliation.

JUSTIFICATION: Primary care providers are at the center of their patients' care team, coordinating with specialists and supporting linkages with community resources. Given the crucial role of primary care providers, patients should have flexibility to choose their provider both at enrollment and throughout the year. Further, providers are increasingly being held accountable for the quality and cost of care for attributed patients, and thus they are eager to receive a patient roster prospectively so that they may identify and engage high-risk patients. Finally, the Workgroup recommends that when patients are attributed or assigned to primary care providers or a care network for payment purposes, such as advances of a portion of the expected total cost-of-care savings, it should be done prospectively to minimize burden on the provider's side, while ensuring that this prospective assignment or attribution does not constrain patients' choice of providers.

COSTS/SAVINGS: Costs/savings were not separately estimated for this recommendation. Depending on how they are implemented, recommendations may lead to new State costs.

STATE/FEDERAL AUTHORITY: Enabling patients to choose a provider during the enrollment process may require legislative authority and changes to existing enrollment systems. Adjustments to attribution of patients within existing ACO-type models likely would not require additional state authority, but may require additional CMS authorization.

OTHER OPTIONS CONSIDERED: None.

Longer Term Recommendations Related to Supporting Integrated Care Delivery:

- Identify ways of enhancing existing payment models to more comprehensively include the dual eligible population.
- Identify methods to report on the costs and savings associated with non-medical services, with potential integration into TCOC calculations.
- Address increasing costs of prescription drug costs in excess medical inflation.
- Develop an approach to managing the growth of long-term care costs, especially in light of the aging population.
- Address workforce shortages, particularly in the areas of primary care and mental health practitioners.
- Identify ways to capture the savings from care delivery and payment modifications back into the health care system.

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