IHP Quality & Performance Measurement 2017 Request for Proposal

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DEPARTMENT OF HUMAN SERVICES

Additional Informational Opportunities

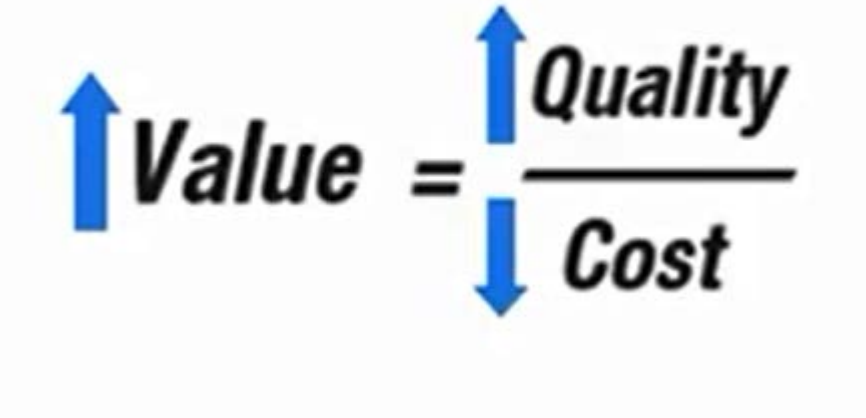
- IHP RFP **website** - http://www.dhs.state.mn.us/DHS-293927
- **Webinars**
  - Overview of RFP process and new IHP model
    Slides available at http://www.dhs.state.mn.us/DHS-293927
  - Payment and risk arrangements
    July 20, 9:00 am to 10:30 am (Central)
  - Registration link available at http://www.dhs.state.mn.us/DHS-293927

- Optional individual **Q&A session** – contact mathew.spaan@state.mn.us by July 18th to request
- **Written questions** – submit to dhs.ihp@state.mn.us by July 25th, responses published ~August 1st
- DHS's IHP **listserv** - Subscribe here

Today's Agenda

- Overview of core principles of Integrated Health Partnerships (IHP) value based payment and the IHP 2.0 model
- Overview of the quality methodology in the Population-Based Payment (PBP) model
  - Medicaid and social determinants of health research
  - Quality Measures in the PBP model
  - Population-based quality score: awarding points and impact in the PBP model
- Overview of the quality methodology in the Shared Risk model
  - Proposed measures for the quality core set in the Shared Risk model
  - Overall quality score: awarding points
  - Overall quality score: impact on shared savings
- Questions?

Principles of Value Based Payments



Impact of Quality on Payment in the 2018 IHP Model

Population-Based Payment	Total Costs of Care Risk Model
IHP will be evaluated on quality, health equity, and utilization measures to determine eligibility to continue participation after the conclusion of each three-year cycle.	Quality results affect the IHP portion of the shared savings amount but do not influence losses.

Quality and Population-Based Payment

Quality and Population-Based Payment

- **Population-based payment** is tied to an IHP's ability to evaluate, intervene, and improve the health of Medicaid beneficiaries.
- **Clinical quality, health equity, and utilization measures** showing improvement in health outcomes.
  - Determined through mutual agreement between IHP and DHS
- **Population-based quality score** - eligibility to continue participation in the program after the conclusion of each three-year cycle.
  - Will not impact the per member per month (PMPM) payment amount during the initial three-year cycle.

Principles: Social Determinants of Health Research

Figure 1: Social Determinants of Health, *Healthy People 2020*, *Office of Disease Prevention and Health Promotion*. (https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health)

Principles: Social Determinants of Health Research

- More resources on social determinants of health:
  - Minnesota Department of Health about Social Determinants of Health (SDOH): http://www.health.state.mn.us/divs/chs/healthequity/guide/additional.html
  - Health Affairs Policy Brief, The Relative Contribution of Multiple Determinants of Health http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=123
  - Office of Disease Prevention and Health Promotion; HealthyPeople.gov https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
  - Kaiser Family Foundation, Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity: http://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

MN Medicaid and Social Determinants of Health

- In 2015, the Minnesota Legislature mandated that DHS study **health disparities among Medicaid enrollees**.
- MN DHS compiled **administrative social risk data** for Medical Assistance and MinnesotaCare enrollees and **health outcomes** and performance measure data.
- The results showed greatest **health disparities** among Medicaid enrollees **when social risk indicators were present**.

Quality Methodology in the PBP Model

- During contract discussions, the IHP attributed population will be examined to determine its **predominant health disparities** using DHS data as well as information provided by the IHP.
- The IHP will be required to propose **at least one quality measure** tied to interventions that are intended to reduce health disparities among the IHP's population.

Example

- MN DHS research showed that among MHCP adults, those who are **homeless** are 17% more likely to have ‘potentially preventable hospitalizations’ and 65% more likely to have preventable emergency department visits.
- MN DHS research showed that the most effective strategy for **improving the health of homeless enrollees** is to offer a combination of housing first with intensive case management. The IHP may choose to work closely with their county partners to secure this combined response for homeless patients.
- MN DHS research showed that another promising practice is ‘medical respite’ when a homeless person is offered shelter or another place to stay so they can recover during medical or chemical health treatment. **Working with a non-medical partner to offer this kind of housing may improve the chemical health of the population**.

Population-based Quality Score

- DHS will calculate a **population-based quality score** based on performance on quality measures.
- The IHP and DHS we will agree on a methodology to award points for performance on quality measures.
- A lack of improvement or an insufficient quality performance could result in discontinuation of the population-based payment after the conclusion of an IHP's three-year contract cycle.

Quality and Total Cost of Care Risk Model

Quality and Total Cost of Care Risk Model

The **Total Cost of Care Risk Model** is available in **Track 2 only**.

This is a **two-sided risk model** with potential for additional revenue through shared savings.

Fifty percent (50%) of an IHP's shared savings will be contingent on overall quality measurement results.

Core Set: Proposed Measures

Category	Key Elements
Care Quality	Prevention & Screening
	Effectiveness of Care for at Risk Populations
	Behavioral Health
	Access to Care
	Patient-centered Care
	Patient Safety
Health Information Technology	Meaningful Use of Electronic Health Records (EHR)
Pilot Measures	For example: Patient Engagement, Care Coordination, Opioid Use, Specialty Measures

Changes to the Minnesota Statues, Section 62U.02

- No more than **six statewide measures** shall be required for single-specialty physician practices and no more than **ten statewide measures** shall be required for multi-specialty physician practices.
- Measures must be selected from **the Medicare Merit-based Incentive Payment System (MIPS)** measure set unless the stakeholders determine that a diagnosis, procedure, condition or service are not reflected among any available MIPS measures.
- MDH will work with a number of stakeholders to develop a new measurement framework by **June 30, 2018**.
- **The IHP core set of measures will remain in alignment with SQRMS.**

More information about Minnesota Statues, section 62U.02 available here: https://www.revisor.mn.gov/statutes/?id=62U.02

Care Quality Category: Prevention and Screening

Measure Title	Measure Steward Organization	Method of Data Submission	MIPS
Pediatric Preventive Care: Overweight Counseling	MNCM	DDS to MNCM	No
Colorectal Cancer Screening	MNCM	DDS to MNCM	Yes (NCQA)
Breast Cancer Screening	NCQA/HEDIS	MN DHS Claims	Yes
Cervical Cancer Screening	NCQA/HEDIS	MN DHS Claims	Yes
Chlamydia Screening in Women	NCQA/HEDIS	MN DHS Claims	Yes
Childhood Immunization Status	NCQA/HEDIS	MN DHS Claims	Yes
Immunization for Adolescent	NCQA/HEDIS	MN DHS Claims	Yes
Adult Body Mass Index Assessment	NCQA/HEDIS	MN DHS Claims	No
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	NCQA/HEDIS	MN DHS Claims	Yes

Care Quality Category: Effectiveness of Care

Measure Title	Measure Steward Organization	Method of Data Submission	MIPS
Optimal Asthma Control	MNCM	DDS to MNCM	Yes
Asthma Education & Self-Management	MNCM	DDS to MNCM	No
Optimal Vascular Care	MNCM	DDS to MNCM	No
Optimal Diabetes Care	MNCM	DDS to MNCM	No
Maternity Care: Cesarean Section Rate	MNCM	DDS to MNCM	No

Care Quality Category: Behavioral Health Measures

Measure Title	Measure Steward Organization	Method of Data Submission	MIPS
Depression Care: Remission at Six Months	MNCM	DDS to MNCM	Yes
Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening	MNCM	DDS to MNCM	No
Antidepressant Medication Management: Acute and Continuous	NCQA/HEDIS	MN DHS Claims	Yes
Follow-Up After Hospitalization for Mental Illness	NCQA/HEDIS	MN DHS Claims	Yes
Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA/HEDIS	MN DHS Claims	Yes
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	NCQA/HEDIS	MN DHS Claims	Yes

Care Quality Category: Access to Care Measures

Measure Title	Measure Steward Organization	Method of Data Submission	MIPS
Annual Dental Visit: Adults and Children	NCQA/HEDIS	MN DHS Claims	No
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA/HEDIS	MN DHS Claims	Yes
Prenatal and Postpartum Care: Postpartum Care Only	NCQA/HEDIS	MN DHS Claims	No

Care Quality Category: Patient-centered Care Measures

Measure Title	Measure Steward Organization	Method of Data Submission	MIPS
CG-CAHPS Timely Appointments, Care and Information	AHRQ	Survey Results to MNCM	Yes
CG-CAHPS How Well Providers Communicate with Patients	AHRQ	Survey Results to MNCM	Yes
CG-CAHPS Helpful Respectful and Courteous Office Staff	AHRQ	Survey Results to MNCM	Yes
CG-CAHPS Patient Rating or Provider as 9 or 10	AHRQ	Survey Results to MNCM	Yes
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)	CMS	Survey Results to CMS	Not MIPS but Hospitals VBP

Care Quality Category: Patient Safety

Measure Title	Measure Steward Organization	Method of Data Submission
Patient Safety Indicator (PSI -90)	AHRQ	MN DHS Claims

Care Quality Category: Alternative Measures

- Must utilize a state or nationally recognized quality measure specification.
- The data must be able to be collected by a third-party using an existing data collection mechanism.
- The data must be validated and audited by a third-party.
- Must not be a measure that is impacted by high variability due to coding changes.
- Must assess health care processes and/or outcomes desirable for the IHP population of patients.

Health Information Technology Category

Measure Title	Measure Steward Organization	Method of Data Submission	MIPS
Coordination of care - Use the functions of CEHRT to engage with patients about their care. Providers must attest to all three measures and meet thresholds for at least two measures.	CMS	MEIP portal	Yes (Advancing Care Information)
Health Information Exchange Use the functions of CEHRT to transfer/receive a summary of care information. Providers must attest to all three measures and must meet the threshold for at least two measures.	CMS	MEIP portal	Yes (Advancing Care Information)

Pilot Measures Category

- Opportunity to test **new and innovative measures**
- **Reporting only**
- Respondents must propose at least **one pilot measure**
- Examples include measures of **patient engagement, care coordination, opioid use, and specialty measures**

Overall Quality Score: Awarding Points

- Performance is based on **improvement** or **achievement**
- MNCM measures will be assessed relative to statewide benchmarks and relative to the IHP rates from the previous performance year
- HEDIS measures will be assessed relative to Medicaid Aggregate Rate
- HIT measures will be assessed based on the percent of clinicians who achieved the Meaningful Use objectives
- Pilot measures will be credited for reporting only

Overall Quality Score: Weights and Shared Savings

Category	Key Elements	Weights
Care Quality	Prevention & Screening	70%
	Effectiveness of Care for at Risk Populations	
	Behavioral Health	
	Access to Care	
	Patient-centered Care	
	Patient Safety	
Health Information Technology	Meaningful Use of Electronic Health Records (EHR)	20%
Pilot Measures	For example: Patient Engagement, Care Coordination, Opioid Use, Specialty Measures	10%

Webinar Overview

Webinar Overview

In this webinar you have learned:

- How DHS plans to evaluate quality performance in **population-based payment model**:
  - DHS and IHP will analyze the prevalence of social risk factors
  - Both parties will agree on quality measures and benchmarks to calculate population-based quality score
  - Eligibility to continue participation in the IHP program depends on IHP's performance on quality measures after the completion of a three-year cycle. The population-based quality score will not affect the actual amount of the PMPM payment.
- How DHS plans to evaluate quality performance in the **total cost of care risk model**:
  - DHS will use quality measures organized in to three categories: care quality, health information technology, and pilot measures
  - DHS will assess performance relative to benchmarks or improvement
  - Fifty percent of an IHP's portion of shared savings will be contingent on overall quality score. The higher the score, the greater the share of the savings the IHP receives

IHP RFP Process | How to Respond

- Letter of Intent (Appendix A-1)
  - Due August 18th, 4:30 pm (Central), via e-mail to Mathew.Spaan@state.mn.us
    1. Organizational information and primary contact
    2. Past experience in value-based purchasing (ex. IHP, MSSP, other ACO or VBP programs)
    3. Certifications at the participating clinics or system level (ex. HCH, NCQA ACO, PCMH)
    4. Intended track
    5. Why interested in participating in IHP program
- Application (Appendix A)
  - Hard copies must be received by DHS by September 1st, 4:30 pm (Central).

Attention: Mathew Spaan
Health Care Administration
Department of Human Services
444 Lafayette Road N.
St. Paul, MN 55155

IHP RFP Process | Key RFP and Contracting Dates

ACTIVITY	DATE
Letter of Intent Due	August 18th, 2017
Proposal Responses Due	September 1st, 2017
RFP Review/Evaluation	~September 15th, 2017
Notice of Intent to Contract	~September 21st, 2017
Potential IHP Plenary Sessions	~Sept. 18th – Sept. 30th, 2017
Individual IHP Contract Negotiations Begin	~September 25th, 2017
Individual Reports to Potential IHPs	~September 29th, 2017
2018 IHP Contracts Executed	~December 15th, 2017
Performance period begins	**January 1, 2018**

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