

## Outcomes-Based Purchasing Redesign and Next Generation Integrated Health Partnership (IHP)

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### Request for Comment (RFC) Responses



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(ADA1 [7-16])

# Background

In December, 2017, the Minnesota Department of Human Services (DHS) [requested public comment](#) on the redesign and reform of DHS' purchasing and delivery strategies for Medicaid and MinnesotaCare (BHP). Comments were accepted through Wednesday, December 20, 2017, via an [online survey](#) and via [email](#) submission. A total of seventy-four responses were submitted. The individuals and or organizations providing a response are listed below, and organized in alphabetical order according to the organization.

	Name	Organization	Title
1.	NAN NOVELL	ADOTPIVE SENIOR FAMILY-SELF STARTED	MENTOR AND AIDE
2.	Cultural and Ethnic Communities Leadership Council	Advisory to Commissioner of the Minnesota Department of Human Services	Community Relations Director
3.	Patrick Flesher	Allina Health	Director, Payer Contracting and Next Generation ACO
4.	George Klauser	Altair Accountable Care Organization	Altair Executive Director
5.	Dr. Michael J. Helgeson	Apple Tree Dental	Chief Executive Officer
6.	Kirsten Anderson	AspireMN	Executive Director
7.	Scott Keefer	Blue Cross and Blue Shield of Minnesota	Vice President, Public Affairs
8.	Patti Cullen	Care Providers of Minnesota	President/CEO
9.	Dave Lee, MA, LP, LMFT, LICSW	Carlton County Public Health & Human Services	Director
10.	Kathy Parsons	CentraCare	Executive Director

	<b>Name</b>	<b>Organization</b>	<b>Title</b>
11.	Trevor Sawallish	Children's Minnesota	Chief Operating Officer/Senior Vice President, Clinical Operations
12.	Diana Saenger	City of Minneapolis	
13.	Gretchen Musicant	City of Minneapolis – Health Department	Commissioner of Health
14.	Megan Whittet/ Paula Keller	ClearWay MinnesotaSM	Directors of Cessation Programs
15.	Vacharee Peterson, DDS, CEO	Community Dental Care	Chief Executive Officer
16.	Yi Li You, LSW, E.D.	CSSC	
17.	Deanne Skeens	Dakota County Community Services	Contract and Vendor Manager
18.	Christine Papineau	Essentia Health	Vice President Payer Strategy
19.	James Hereford	Fairview Health Services	President & CEO
20.	Lucas Kunach	Fraser	Strategy analyst
21.	Joseph Petersen, BS, LADC	Freeborn County DHS	R-25 Assessor
22.	Dawn Plested	FUHN	COO
23.	Erin Bailey	Gillette Children's Specialty Healthcare	Director of Executive Initiatives
24.	Buddy Robinson	Greater Minnesota Health Care Coalition	Co-Coordinator
25.	Cindy Robinson	HCAMN	Minnesota citizen
26.	Stephen Janusz	Health Care for All Minnesota (HCAMN)	Board Member
27.	Bonnie LaPlante	Health Care Homes Program	Director
28.	Jennifer DeCubellis	Hennepin Healthcare System, Inc.	Deputy County Administrator
	Jon L. Pryor, MD, MBA		Chief Executive Officer
29.	Brian Rank, MD	Health Partners	Executive Medical Director
	Nancy McClure		Chief Operating Officer
	Donna Zimmerman		Senior Vice President

	<b>Name</b>	<b>Organization</b>	<b>Title</b>
30.	Ellen Roan	Home and Community Based Services	Case Manager
31.	Craig Pierce	Itasca County	
32.	Paul Sobocinski	Land Stewardship Project	Policy Organizer
33.	Jeff Bostic	LeadingAge Minnesota	Director of Data and Financial Policy
34.	Gregory S. Kaupp	Magellan Medicaid Administration, Inc.	Senior Vice President and General Manager
35.	Christine Reiten	Medica Health Plans	Senior Director, State Public Programs
36.	Anne Quincy	Mid-MN Legal Aid	Supervising Attorney
37.	Jonathan Watson	MN Association of Community Health Centers	Associate Director
38.	Jin Lee Palen	Minnesota Association of Community Mental Health Programs	Executive Director
39.	Steve Gottwalt	Minnesota Association of County Health Plans	Executive Director
40.	Susan Voigt	Minnesota Community Healthcare Network	Executive Director
41.	Joan Cleary	MN CHW Alliance	Executive Director
42.	Arnie Anderson, CCAP	MN Community Action Partnership	Executive Director
43.	Julie Sonier	MN Community Measurement	President
44.	Jim Schowalter	Minnesota Council of Health Plans	President & CEO
45.	Michael Scandrett	Minnesota Health Care Safety Net Coalition	Executive Director
46.	Michael Scandrett	Minnesota Oral Health Care Safety Net Coalition	Executive Director
47.	Matthew L. Anderson, J.D.	Minnesota Hospital Association	Senior Vice President of Policy & Chief Strategy Officer
48.	George Schoephoerster, MD	Minnesota Medical Association	President



	Name	Organization	Title
49.	Jon Tollefson	Minnesota Nurses Association	Government Affairs Specialist
50.	Rep. Matt Dean Sen. Michelle Benson Rep. Joe Schomacker	MN Senate & MN House of Representatives	Chair, Health and Human Services Finance Chair, Health and Human Services Finance and Policy Chair, Health and Human Services Reform
51.	Sue Abderholden, MPH	NAMI Minnesota	Executive Director
52.	Thomas H. Berkas	NAMI Minnesota & Augsburg University	Affiliate Coordinator & Adjunct Faculty
53.	Aaron Bloomquist	North Memorial Health	Chief Financial Officer
54.	Diane Thorson, M.S., R.N., P.H.N.	Otter Tail County Public Health Director Partnership4Health	CHB Community Health Administrator
55.	Melodie Shrader	PCMA	Senior Director, State Affairs
56.	Cameo Zehnder, JD	Pediatric Home Service	General Counsel/Chief Operating Officer
57.	Leah Montgomery, MPP	Planned Parenthood Minnesota, North Dakota, South Dakota	Director of Government Affairs and Health Finance
58.	Caroline David	Professional Rehab Consultants	Occupational Therapy
59.	Ellen De la torre Michael Zakula, DDS	Rural Health Advisory Committee Office of Rural Health and Primary Care	Chairs
60.	Rick Varco	SEIU Healthcare Minnesota	Political Director
61.	Senator John Marty	Senate - State of Minnesota	
62.	Dale Dobrin, MD	South Lake Pediatrics	Medical Director
63.	Chris Conry	TakeAction Minnesota	Strategic Campaigns Director
64.	Guthrie Byard	The Arc Minnesota	Advocate
65.	Ellie Skelton	Touchstone Mental Health	Executive Director

	<b>Name</b>	<b>Organization</b>	<b>Title</b>
66.	Stephanie Schwartz	UCare	Vice President/Government Relations
67.	Catherine Anderson	United Healthcare	Senior Vice President, Policy & Strategy
68.	Megan O'Meara	United Way	Senior Project Manager, Community Impact
69.	Randall Seifert, PharmD	University of Minnesota College of Pharmacy	Associate Dean
70.	James Pacala, MD, MS	UMN Family Medicine & Community Health	Head
	Connie Delaney, RN, PhD	UMN School of Nursing	Dean
	Macaran Baird, MD, MS	UMPhysicians and Mhealth	CEO
	Lynda Welage, PharmD	UMN College of Pharmacy	Dean
71.	Dr. Gary Anderson	University of Minnesota School of Dentistry	Interim Dean
72.	Jode Ann Freyholtz-London	Wellness in the Woods	Executive Director
73.	Rep. Diane Loeffler	House of Representatives, District 60A	State Representative District 60a
74.	Dan Schmitt	Accenture	

## Online Response summary

22 respondents completed the online questionnaire, including:

ADOTPIVE SENIOR FAMILY-SELF STARTED

Advisory to Commissioner of the Minnesota  
Department of Human Services

Allina Health

Altair Accountable Care Organization

Apple Tree Dental

Essentia Health

Fraser

FUHN

Gillette Children's Specialty Healthcare

Greater Minnesota Health Care Coalition

HCAMN

Health Care for All Minnesota (HCAMN)

LeadingAge Minnesota

Mid-MN Legal Aid

Minnesota Community Healthcare Network

Minnesota Nurses Association

NAMI Minnesota & Augsburg University

Professional Rehab Consultants

South Lake Pediatrics

The Arc Minnesota

Touchstone Mental Health

Wellness in the Woods

Online respondents indicated the following when asked to indicate where they work and which region they represent.

*Do you work for any of the following? (Please check all that apply.)*

<b>Agency/Organization</b>	<b>Total</b>
Access services providers (e.g. transportation, interpreter)	2
Community and social services organizations	7
Counties	1
Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)	2
Integrated Health Partnerships (IHP)	3
Local Public Health	1
Managed Care Organizations (MCO)	1
Mental Health and Substance Use Disorder Providers	7
No reply	1
Other ancillary health care providers	3
Primary Care, Safety Net & Specialty Providers	5
Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)	3
Tribal Organizations	1
Other: <ul style="list-style-type: none"> <li>• Hospital System</li> <li>• Mental Health Advocacy and Education NAMI Minnesota</li> <li>• Working to provide "Affordable high quality healthcare for every Minnesotan"</li> <li>• LTC Providers (nursing facility, assisted living, adult day and other community services) Non-profit dental organization</li> <li>• Union of Registered Nurses</li> <li>• The CECLC advises the commissioner of human services on reducing disparities and achieving equity Legal services</li> </ul>	9

*What geographic area are you representing? (Please check all that apply.)*

<b>Region</b>	<b>Total</b>
Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)	17
Greater Minnesota: <ul style="list-style-type: none"> <li>• St Louis County and Crow Wing County</li> <li>• Wadena</li> <li>• Rice</li> <li>• Northeast (Arrowhead), East Central, and Central Minnesota (greater St. Cloud) counties</li> <li>• 55 counties throughout the state</li> <li>• All</li> <li>• Statewide</li> <li>• 6 regional programs serve multiple counties</li> <li>• Gillette sees patients from all 87 MN counties and has clinics in 11 counties.</li> <li>• All 87 counties and 11 tribes</li> </ul>	12

## **Outcomes-Based Purchasing Redesign & Next Generation IHP Request for Comment (RFC)**

The Minnesota Department of Human Services (DHS) is requesting public comment on the redesign and reform of DHS' purchasing and delivery strategies for eligible public health care programs.

For administrative efficiency, it is preferred that responses to the specific question outlined in the RFC be collected utilizing this web-based process. This process allows Respondents to provide responses to the specific questions, provide general comments, offer additional perspectives and/or upload entire documents utilizing the web-based process.

**To be assured consideration, comments must be received no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

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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 responses to this Request for Comment.

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 as part of the response.

If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name NAN NOVELL  
Organization ADOTPIVE SENIOR FAMILY-SELF STARTED  
Title MENTOR AND AIDE  
Telephone Number [REDACTED]  
Email [REDACTED]

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

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**Q5** 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.

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**Q6** 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.

DO NOT NEED INTEGRATION NEED APPROPRIATE PROVIDERS WHO KNOW ABOUT AGISM, SENIOR ISSUES AND CAN ALOS PROVIDE SUPPORT GROUPS TO THEM NEED APPROPRIATE COUNSELLORS- NEED COMMUNITY CLINICS WITHIN PRIMARY CLINICS SO WE CAN GET FOOT CARE...IF IF THERE IS A FEE-TOO MUCH RUNNIGN AROUND THE CITY FOR BASIC SERVICES WHY ARE YOU CALLING THIS THE NEXT GENERATION? WE WANT SENIOR/DIS EXPOS THAT PROVIDE MORE THAN GETTING HAIR COUPONS -WE WANT TO KNOW HOW TO ACCESS SERVICES 1. HOW TO FIND ASSISTIVE LIVING IF WE NEEDS IT AND WHAT ARE TH OPTIONS FOR LIVING AS A GROUP SOME WANT TO LIVE TOGETHER AS A GROUP KIND OF HOME AND NOT IN FACILITIES THAT FOCUS ON ILLNESS 2. PEOPLE AT THESE EXPOS THAT ARE NOT GOING TO GLORIFY IT ALL AS THE SENIOR LINKAGE LINE 3. PEOPLE TALKING ABOUT THE VULNERABLE ADULT LAW 4. PEOPLE WHO CAN ACT A SHEALTH ADVOCATES OR FINACIAL ADVOCATES WHEN WE GET RIPPED OFF BY THE MEDICAL AND FINANCIAL PLANNERS-TO DATE-3 OF US-IT TOOK 12 PAGES OF PAPERWORK THROUGH THE AG OFFICE TO ACUTALLY GET HELP WHEN OUR MONEY WAS PLAYED AROUND WITH DO A NEEDS ASSESSMENT ON LINE TO ACTUALL FIND OUT WHAT ARE THE ISSUES OF ALL SENIORS AND DO NOT MAKE IT GENERIC YOU ARE MISSING THE BOAT

**Q7** 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 vs. phased in over time?

TALING OVER OUR HEAD

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**Q8** 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?

SHUT DHS DOWN AND CHANGE TO COMMUNITY WALK INS

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**Q9** **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?

NEED A REAL NEEDS ASSESSMENT DO NOT ASSUME WE KNOW WHAT YOU ARE TALKING ABOUT AND DO NOT ASSUME YOU ACUTALLY KNOW THE NEEDS OUT THERE



**Q10** 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?

C/O TO GOV DAYTON

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**Q11** 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?

**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

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**Q13** **One of DHS's 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?

IT DOES NOT WORK NOW AND WILL NOT WORK WITH TOO MANY BEAUCRACIES

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

A FAILURE

**Q16** Click the icon below if you prefer to upload a file of your responses.

Once file has been successfully attached, a unique ID will appear in the box.

If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Cultural and Ethnic Communities Leadership Council
Organization	Advisory to Commissioner of the Minnesota Department of Human Services
Title	c/o Community Relations Director
Telephone Number	651-431-3301
Email	antonia.wilcoxon@state.mn.us

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
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- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

The CECLC advises the commissioner of human services on reducing disparities and achieving equity

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

All 87 counties and 11 tribes

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

For families and individuals receiving primary care, it is important that they have a "medical home:" a place where the clinic knows the patients' health history, cultural context, what works best for them and support for their maintaining their health and well-being. Is the exclusivity one that is isolated in a silo or Low income people are also mobile? How can technology support their seeing health if they are not near their medical home?

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**Q5** 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.

Each member of populations experiencing inequities expects the state to uphold its constitutional "right to the security, benefit and protection" which the perpetuation of disparities can impose. We'd suggest not only looking at population density thresholds, but also at the prevalence of inequities. A pure population size criterion alone may gloss over the need and impact of supporting that area (e.g. reservation or rural area with concentration of immigrants/refugees, low income whites, etc.)

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**Q6** 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.

Criterion based upon health and human services equity are essential. We strongly recommend requirements around clear cultural and ethnic equity competency and commitment. Proposals should illuminate structural, cultural, and practice based evidence of integrating equity into core functions, leadership structure, and community engagement. Strong applicants need to demonstrate high impact, long range, and policy solutions focused on eliminating health and explicitly (not exclusively) racial inequities. The CECLC members developed a series of recommendations for DHS to consider when sub-contracting with provides to deliver services. They are as follows: 3. Community Health and Health Systems goal: Families are well. They receive collaborative care giving; they trust and are comfortable with their providers. They actively engage in their health care. Providers are capable to provide services that address complex needs, cultural beliefs, and practices are embedded in healing. Patient's concerns do not need a diagnosis to be attended to. a. Modify rules, regulations and incentives b. Increase recognition of foreign trained health care professionals c. Improve understanding of the cultural perspective in understanding complex issues such as a mental health diagnosis in the Western world d. Establish gender-specific fitness programs e. Develop ongoing relationships with cultural communities f. Require managed care organizations to contract with culturally specific providers g. Redefine access to care h. Repeal Child Care Assistance Program statute 4. Culturally and Linguistically Competent Services Goal: Vendor selection is rigorous to meet the needs of the community; there is transparent eligibility determination. Community-based organizations are partners and powerful allies supporting the health of their communities. Utilization of community health workers is the norm. a. Improve interpreter training and add certification as a requirement b. Vendor selection c. Services and eligibility at the county level d. Community Health Workers e. More effective system of health and human services delivery f. Culturally and linguistically appropriate services (CLAS) standards 5. Research and Evaluation Goal: change attitudes about data: data must explain the whole persons. Develop measurement strategies to best obtain most appropriate data with community-defined cultural and ethnic groups' input. Promotion of evidence-based research into practice a. Establish mechanism for obtaining detailed data b. Educate communities about the importance of race/ethnicity and language data collection c. Coordination of data activities d. DHS Equity Dashboard e. Evidence-based practices and research f. Community Based Participatory Research

**Q7** 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 vs. phased in over time?

Back office systems are invisible to enrollees. They are more impacted when they do not work and causes them unnecessary barriers. Staff and leadership personnel need to demonstrate cultural and equity competency and have performance measures applied to all levels of leadership. Additionally, formalized and resourced (staff and money and power) community leadership councils should be established for continuous engagement and equity based leadership developed.

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**Q8** 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?

A rigorous equity dashboard should be developed to track and evaluate equity impact and capacity. This dashboard should be tied to policy and high level leadership oversight to ensure strong accountability and implementation and adaptability of strategies to meet needs of diverse cultural and ethnic communities. Additionally, the Community Relations Division, which engages with cultural and ethnic communities experiencing inequities, staffs the Cultural and Ethnic Communities Leadership Council (CECLC), which was legislatively mandated in 2013 to advise the commissioner of human services on disparities reduction. The policy on equity is the result of a year-long planning process of the Cultural and Ethnic Communities Leadership Council (CECLC) and guided by the Goals of the National Partnership for Action to Eliminate Health Disparities from the Office of Minority Health -- HERE, <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=10> Several other groups (e.g. DHS Leadership Development -- L-4 groups and their action learning projects) and individuals were involved in bringing together the recommendations of the CECLC into this policy. Prior to final approval, the policy has also gone through a number of internal and administrative policy reviews as well as reviews by CECLC and the policy has been carefully aligned with DHS program goals. Several highlights of the policy that I'd like considered include the following:

- DHS is committed to advancing equity, reducing disparities in DHS program outcomes, and improving access to human services for communities experiencing inequities.
- DHS will utilize a collaborative approach to improving the health of all people by institutionalizing efforts to incorporate health considerations into decision-making across sectors and policy area (HIAP)
- There are social, economic, and political factors that result in systemic disadvantages as well as the needs, assets, and challenges of communities experiencing inequities.
- In order to reduce inequities, DHS Department acknowledges and embraces the role it can play in developing policies, investments, and procedures that advance equity.
- Procedures to implement the policy include establishing the following:
  - o Internal equity committees
  - o Equity analysis process
  - o Technical assistance around workforce and leadership development
  - o Contracting and procurement equity criteria
  - o Community engagement and inclusion
  - o A process for piloting enhanced CLAS Standards -- HERE [http://www.hdassoc.org/wp-content/uploads/2013/03/CLAS\\_handout-pdf\\_april-24.pdf](http://www.hdassoc.org/wp-content/uploads/2013/03/CLAS_handout-pdf_april-24.pdf)

An Equity analysis is an examination of how different groups experiencing inequities will likely be impacted by a proposed action or decision. The process allows one to consider resources, decision making, and meaningful community engagement in the process. It requires us to step outside of the 'one size fits all' approach, and hopefully prevent negative disparate impacts before policies are even proposed to decision-makers. It should be applied early and throughout the all phases of the decision making process, from development to implementation and evaluation. It should be used prior to new practice development, making program decisions, hiring, and policy development. The goal is to have the analysis be incorporated into the development of policies, rules, procedures, budget, and legislative proposals, as well as program design and implementation. How To:

1. What groups are impacted by the proposed policy, rule, procedure, budget and legislative proposal, or program design and implementation? (Racial and Ethnic groups, Lesbian, Gay, Bisexual and Transgender groups, Persons with Disabilities and Veterans).
2. What is the nature of the impact? Have representatives from these groups been consulted and collaborated with in order to determine how to address these impacts?
3. Is the project intended to reduce or eliminate any disparities for Racial and Ethnic groups, Lesbian, Gay, Bisexual and Transgender groups, Persons with Disabilities and Veterans? Please explain how implementation of the proposed item(s) will reduce or eliminate these disparities.
4. Are there potential positive or negative impacts on the identified groups? Explain those impacts. If negative, please adjust the project to achieve a more equitable outcome. If there are legal or other barriers to adjusting the project, explain.
5. Can the project be sustainably successful? Discuss the on-going funding, implementation strategies/opportunities, and performance measures/accountability mechanisms.

**Q9** 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?

It depends on the cost and access for the patients/enrollees.

**Q10** 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?

Risk can detract from focusing on the health and well-being of enrollees. Build in a long range ROI model that examines the cost savings of prioritizing and advancing health equity. Avoid short term transactionary risk assessments. What is the risk and cost of not eliminating and committing to inequities?

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**Q11** 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?

Patient and/their families' reported outcomes should guide improvement, quality, and innovation. Attention of the growing demographics in the Twin Cities need to be included in the measures and methods. Measure that gauge Social Isolation, social supports, safety, environmental issues such as food access, gardening, transportation as identified by enrollees. Engagement is critical to learn what works for the enrollees health and well-being. Measure and evaluate the prevalence, experience, and resources in place to address health inequities. Use culturally effective research methods to measure the equitable treatment and care of patients.

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**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

It should be a balanced approach, taking social determinants of health into account as well as patient-reported outcomes. Public health measures are important to incorporate as well. Additionally, are community members involved in measure development, vetting, and selection? If not, they should be. Quality and health outcomes themselves require equity integration into their definitions and measures for progress and payment.

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**Q13** **One of DHS's 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?

Which quality programs (e.g. Merit Based Incentive Payment System; MN Statewide Quality Reporting and Measurement System) are important to align with? Alignment is generally good as it may be cost effective and eases burden. SQRMS alignment helps to keep quality measurements within a Minnesota-based framework, it allows for public input through its annual rule-making process. If equity is not infused with and distinct from "quality", then ensure that it is applied.

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

Success in addressing social determinants of health, racial disparities and behavioral health challenges will significantly impact the advancement of health equity and optimal health for all Minnesotans and those who call Minnesota home. It is essential to incentive health equity progress. Applicants and the system of applicants require clear commitment of resources towards eliminating health inequities for health improvement, cost savings, and the common good.

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

Community input is a cornerstone of equitable, quality and responsive health care. 1. How much of the RFC/RFP have received community members input, were they at the table at the onset of this process? 2. Who will participate in the decision making process in responding to this RFC and issuance of awards of the RFP? 3. How are decisions going to be communicated in plain language so enrollees can also understand? Promote the opportunity and import of this reform to communities experiencing inequities.

**Q16** Click the icon below if you prefer to upload a file of your responses.  
Once file has been successfully attached, a unique ID will appear in the box.



If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Patrick Flesher
Organization	Allina Health
Title	Director, Payer Contracting and Next Generation ACO
Telephone Number	612-262-4865
Email	patrick.flesher@allina.com

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

---

**Q5** 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.

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**Q6** 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.

**Q7** 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 vs. phased in over time?

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**Q8** 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?

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**Q9** **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?

**Q10** 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?

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**Q11** 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?

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**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

---

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Which quality programs (e.g. Merit Based Incentive Payment System; MN Statewide Quality Reporting and Measurement System) are important to align with?

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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 model 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?

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

**Q16** Click the icon below if you prefer to upload a file of your responses.

Once file has been successfully attached, a unique ID will appear in the box.

ref:0000000182:Q16

**Name:** Patrick Flesher  
**Organization:** Allina Health  
**Title:** Director, Payer Contracting & Next Generation ACO  
**Phone #:** 612-262-4865  
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## Questions for the Request for Comment

Allina Health is pleased to provide comments to DHS through this RFC and we are appreciative of the Department's commitment to engaging and collaborating with providers on the development of future payment models. While these questions are extremely complex, they are broadly reflective of themes that have consistently been raised by a wide swath of providers seeking payment models that support the transition to value. Further, Allina Health endorses DHS's continued efforts towards value-based contracting that allows providers to take greater responsibility for the care of their SPP enrollees. Ultimately, we believe that flexible payment models that support care model innovation in a sustainable way, allows providers to address the more complete needs of patients, delivering better outcomes at a lower cost.

We would like to highlight several areas of importance to Allina Health as you consider how to move forward in developing this model. First is placing significant emphasis on ensuring that primary care relationships are maintained. Second, is that the overall funding of the model is appropriate and sustainable for provider systems to viably be able to serve this critically important population. This includes partnering with the state to ensure that independent specialty groups are aligned with the payment model. Third is a shared understanding of the infrastructure investments needed to take on MCO functions, such as network development and care management. Finally, that the pace of the transition be carefully considered to ensure the sustainability of provider capacity into the future.

**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?**

Allina Health appreciates and fully supports DHS's recognition of the importance of creating patient loyalty and responsibility to receive the majority of their care within a health system. Care system assignment is essential in order for us to be financially responsible, effectively manage, and provide the most cost effective care. We also understand the difficult balance DHS is trying to maintain between providing enrollee choice and educating enrollees about the value of receiving care within a designated network.

We feel that maintaining an existing relationship between a patient and their primary care provider is critically important. Our concern with primary care exclusivity is that this relationship may be jeopardized if an enrollee doesn't choose an IHP. Enrollees may be less inclined to sign up with an IHP as they might view their choice of providers as being more limited than an MCO. We would like all of our current SSP population to have the opportunity to choose an Allina Health provider for their care.

Although we support enrollees choosing a clinic, DHS may want to consider performing a secondary review to re-assign enrollees who choose a primary care clinic, but do not receive the majority of their care from that clinic or health system.

It's important to note that two thirds of our current IHP attributed membership spend is outside of the Allina Health care system. In the absence of strict assignment with a reinforcing benefit design, DHS needs to enhance efforts to educate SPP members on the importance of annual physicals and the benefits of receiving the majority of their care with the same primary care provider/clinic/health system. To promote this, we would like DHS to consider what incentives they could put in place for receiving annual physicals and/or the majority of their primary care within a health system. An example of this is CMS's Care Coordination Reward where enrollees receive \$25 when they complete an annual wellness visit with their primary care provider. Fostering a culture of health literacy and partnership with their provider is one of the keys to success in value-based models. Currently there are not enough mechanisms in place to support that alignment between SPP and their provider. A broad toolkit is likely needed to achieve this goal, as being overly reliant on any one tactic (like exclusivity) has the potential for unintended consequences.

Another concern with being out-of-network for enrollees who picked an MCO or another IHP is that it will be difficult for us to determine during the scheduling process. This results in poor patient experience and an increase in our bad debt. We would need the ability to verify whether we are in network for an enrollee on a real-time basis. Additionally, we see the current Minnesota Health Records Act as a sizable barrier to the data sharing that is necessary to ensure that a SPPP is receiving care within their selected provider system and to manage the population risk that this model requires.

**1. 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.**

(Intentionally left blank)

**2. 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.**

We need flexibility in determining network structure and network adequacy criteria no less restrictive than 30 minutes, 30 miles for primary care providers and 60 minutes, 60 miles, for specialists. Our understanding is that all hospitals will be considered in-network if they accept Medicaid FFS patients. Telemedicine services should be allowed as part of meeting network adequacy standards in order to ensure sufficient services are available. The ability to meet these needs should be demonstrated in the respondent's application.

We recommend that IHPs have a great degree of flexibility in meeting the challenges of caring for the whole population and assuming increased risk. It is appropriate for DHS to require IHPs to describe their plans to address behavioral health needs and identify and address disparities, social determinants and equity, and to measure and report their progress. However, it would be better to allow each IHP to develop its own plans than to mandate specific tactics and reporting requirements at this time. Once best practice across IHPs is identified, more directive requirements could be written.

**3. 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?**

Need timely, reliable information on IHP/MCO enrollees at the point of scheduling and service and timely notification of out-of-network care. This would allow follow-up planning designed to help the enrollee receive care in the appropriate network so that coordination of care can be more effective. It is likely that IHPs would work together to help encourage all enrollees to receive care in network if they have a reliable, timely way to do so. Also:

- Care Everywhere functionality enhanced for real-time
- Incentives in place for eligible IHP members to stay in network and accept Care Coordination services and utilize them
- Ability to see care coordination benchmarks
- Again, we are concerned about the implications of the Minnesota Health Records Act as a barrier to being able to seamlessly coordinate care.

**4. 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?**



When applicable, DHS and counties should review a respondent's previous participation as an IHP and their ability to manage the Total Cost of Care (TCOC) as well as performance on quality measures. Minnesota Community Measurement results should be examined, particularly for IHPs that only were scored on reporting quality in 2016. For specific initiatives, DHS could require the submission of an implementation plan with anticipated results. DHS should also consider a respondent's previous and current community partnerships.

**5. 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?**

Allina Health supports a single PDL across the FFS, Managed Care and Next Generation IHP models. Consistency would be easier to manage. We also support having a single PDL or pharmacy carve out state-wide vs. the seven county metro only.

**6. 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?**

The Medical Management PMPM is an incentive of varying significance for IHPs; the variation being related to each IHP's own ability to invest in and support the infrastructure needed to promote services not reimbursed under the standard Medicaid FFS methodology. IHPs should be offered the opportunity to negotiate the value of the PMPM. The model should also support the opportunity for the IHPs and DHS to determine which "non-medical" services, particularly those addressing social determinants of health, would be excluded as expenses in the IHP's performance calculation, or conversely included in Next Generation IHP Payment Model.

We support the current model of allowing IHPs to choose their amount of risk. However, the level of risk needs to meet CMS's Advanced Alternative Payment Model (AAPM) criteria under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). It's important that DHS submits this model to DHS for approval as an AAPM.

Allowing IHPs to transition to more risk over time is essential. This will provide IHPs time to gain experience managing the population, learn which interventions are effective, and invest in resources. MCOs have experienced volatility and recently some have experienced significant losses. IHPs do not have reserves to sustain MCO-like losses.

**7. 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?**

Over time, IHPs should be encouraged to measure functional status of the individuals in its population. It would be best for DHS and IHPs to work together on ideal methods to accomplish that measurement.

IHPs will develop various tactics to address social determinants and health disparities. They should be given the maximum possible flexibility in determining which of those tactics are effective and should be covered services. Measures could include:

1. Global functional status
2. No show rates
3. ED utilization
4. Ambulatory care visits (primary care)
5. TCOC
6. Hospital admissions
7. Pharmacy spend
8. Out of network utilization
9. Functional ability
10. Patient and provider goals completed
11. Total enrollees contacted
12. Total enrollees eligible
13. Connections to internal/external resources (Resources provided to address barriers, types of resources connected to)
14. Episode/intervention details
15. Race, ethnicity, language
16. Care team understanding and ability to respond to enrollee needs
17. Barriers and challenges in completing the activities as planned
18. Availability of inputs and resources
19. External factors that influenced the context in which these services were provided

As providers are learning how to extend care beyond traditional approaches, measures need to be balanced and realistic in what can be achieved within a designated PMPM and with the anticipated amount of churn in this population. Any new model should be cautious to hold providers accountable for things that are not realistically within their span of influence given the resources provided.

**8. How much of the entities' payment should be subject to performance on quality and health outcomes measures? Please explain your answer.**

Allina supports a model similar to Medicare's ACO models where an IHP's shared savings or losses are impacted by their performance on quality. For example, an IHP would receive a larger portion of the shared savings for performing well on quality and a smaller portion for poor

quality. The same would apply to shared losses. It's important that the amount tied to quality meets MACRA's criteria for an AAPM.

**9. One of DHS's 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?**

To reduce future reporting burdens and encourage providers to focus on a limited number of improvement topics using measurement that is evidence-based and generates valuable information for quality improvement, Allina supports alignment with the CMS Quality Payment Program (QPP) specifically in the areas listed below:

- Select quality measures from the list of evidence based measures certified for QPP direct EHR reporting
- Adopt QPP total population measure requirements instead of payer specific measures
- Contract with a 3<sup>rd</sup> party entity such as MNMCM to collect and report using Direct EHR methodology that they already use to report for the MIPS option of the QPP
- Adopt the same electronic record usage definitions that are used in the QPP definitions
- Contract with a 3<sup>rd</sup> part vendor such as MNMCM to collect and aggregate outcomes for electronic records usage
- As with the hospital patient experience measures, accept Ambulatory Patient Satisfaction outcomes posted to Physician Compare website to meet QPP requirements.
- Adopt QPP program scoring methodology to measure performance at the group level instead of clinic level.

**10. 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?**

It appears that the PMPM payment for Medical Management could be less than an IHP is currently receiving on a FFS basis from an MCO. It will be difficult to address services that may not be covered by traditional FFS payments without incurring deterioration in margin. If under the new model IHPs will be providing services that were previously performed by MCOs, the PMPM will need to be paid to the IHPs vs. DHS Administrative fee/margin.

Items that might prevent us from participating include: insufficient funding, onerous network contracting and contract management, too much risk too fast. In order for this type of model to be successful over time, it needs to be a partnership between all parties. It's in the best interest of DHS and IHPs that the model be successful for both. We anticipate the model requiring revisions and need a commitment from DHS to work with us on those revisions in a timely and fair manner.

**11. Do you have any other comments, reactions or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?**

We support DHS's desire to create a model that allows providers to contract directly with DHS and be responsible for a larger portion of a patient's care. We believe the following areas are the most important for this type of model.

- Maintaining Primary Care Relationships - Maintaining PCC relationships is paramount.
- Financial Viability – The model needs to be sustainable over time and funded appropriately. This includes ensuring that positive performance does not result in future performance becoming more difficult to achieve. Recent MCO experience is concerning for us in this regard. Effectively managing this population will require a significant investment in infrastructure. In order to make this investment, we need a commitment from DHS to stay the course. We also will look to DHS for grants or other means to support some of the infrastructure required to manage the population.
- Amount of Risk – We feel it is imperative for providers to have the ability to limit their maximum amount of risk as we do in the current IHP model.
- Membership Caps – DHS should consider allowing IHPs the ability to cap their membership.
- Enrollee Engagement – Enrollees need to be active participants in their health. We understand DHS's desire to ensure provider choice and the ability to switch providers, but DHS also needs to consider the benefits of receiving care within a system and potentially providing incentives to enrollees to do so.
- Network contracting - DHS should consider the challenges with contracting certain specialty groups and consider market-wide contracts or other incentives

We appreciate the opportunity to provide feedback before the model is finalized. However, it is difficult to fully assess the model and provide complete feedback due to the level of detail provided and various interpretations throughout the market. Nonetheless, we look forward to continuing to engage in this conversation with DHS.

If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	George Klauser
Organization	Altair Accountable Care Organization
Title	Altair Executive Director
Telephone Number	651-969-2288
Email	george.klauser@lssmn.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
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Please specify:

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Which county?

55 counties throughout the state

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Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

Altair might need a waiver from network exclusivity to participate as a Next Gen IHP lead. See attached document.

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**Q5** 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.

To serve a lead role, Altair Next Gen IHP might need to start with a smaller population size than a health system IHP. See attached document.

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**Q6** 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.

Allow Next Gen IHP to add HCBS services to their network and integrate through TCOC and quality measures in order for more collaborative groups to participate in the model. Require Next Gen IHPs to include HCBS services to encourage more collaborative groups to take a lead role in IHP Next Gen. See attached document.

**Q7** 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?

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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?

**Q10** 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?

The Altair IHP might need a reduced level of risk sharing (compared to the level of gain sharing), at least for the initial ramp-up years in order to serve in a lead role. See attached document.

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**Q11** 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?

Altair understands this question to be about how DHS evaluates Next Gen applications; if this is correct, then the recommendation is to give the IHP maximum flexibility to invest their care management dollars for the benefit of their unique client population. See attached document.

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**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

The Altair Next Gen IHP might need to phase in performance-based payments much slower in order to serve in a lead role. See attached document.

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**Q13** **One of DHS's 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?

We could consider some HCBS specific programs, such as the regional quality council surveys or the statewide client survey. See attached document.



**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

The most important incentive for Altair's disability population will be including HCBS in the TCOC and quality measures.

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

**Q16** Click the icon below if you prefer to upload a file of your responses.

Once file has been successfully attached, a unique ID will appear in the box.

ref:0000000139:Q16



December 20, 2017

Ms. Marie Zimmerman  
State Medicaid Director  
Minnesota Department of Human Services  
540 Cedar Street  
St. Paul, Minnesota 55115

Dear Ms. Zimmerman:

Thank you for accepting these public comments from the Altair ACO on the Next Gen IHP framework.

As you know, Altair is a disability-focused, social services and health accountable care organization representing 7300+ people with IDD. Our members have come together to put innovation into action and share best practices. We have been a leader in Minnesota, bringing the first shared saving model to the IDD community through the legislative approved HCBS innovation grant. With successful execution of this grant driven by the utilization of a LifePlan, we have addressed unmet health and wellness goals leading to 32 people being successfully placed in community employment and housing supported by a shared innovation award with DHS of \$150,000 in 2017 and an additional award of \$150,000 for 2018 (reference case study on Dave\* below). We have also discovered through this HCBS innovation grant a gold mine of possibilities to support additional people like Dave in some type of integrated model that saves money and provide alignment with IHP goals.

**\*Case study on Dave- Behavioral/Medical Wellness**

Dave is a 24-year-old individual with bi-polar disorder and co-occurring severe explosive disorder with funding through a Development Disability waiver (DD), Straight Medicaid, and Medicare insurances. Over the past year, Dave had been receiving employment services funded through his waiver from an ALTAIR ACO service provider. Dave's job placement was not meaningful to him and he became frustrated with going to work. Dave's medication regimen was also under medical evaluation, as Dave and those close to him noticed increasing agitation, hallucinations, and aggression.

Dave's frustration at work resulted in an explosive episode and immediate termination of employment. In addition to challenges at work, staff at Dave's group home had deficits in training and education pertaining to Dave's mental health diagnosis and medications. Dave's vocational provider recognized the importance of behavioral health wellness defined in his LifePlan as it pertained to his ability to be successful in an employment setting and promptly made a referral within the ALTAIR ACO network to a medical and behavioral health provider.

Dave received a diagnostic assessment through our in-home provider and began to participate in Adult Rehabilitate Mental Health Services (ARHMS) three times a week. Dave and his ARHMS worker identified goals around health/wellness and skills needed to successfully engage in finding and sustaining employment. Dave's guardian worked very closely with his physician to adjust medications to a therapeutic level. In addition to other methods, Dave participated in genomic testing to identify medications which were unnecessary or no longer effective. To assist in the medication reconciliation, behavioral nursing home health care services were ordered and delivered to monitor symptoms and side effects and most importantly, to provide teaching and education group home staff.

Over the course of three months, Dave's medication regimen reached a therapeutic level, his work with his ARHMS worker assisted him in successfully securing and maintaining meaningful employment again, and staff and group home competency in supporting individuals with behavioral health needs increased. Dave has recently received several awards from his employer and he and his guardian have communicated that the supports and services provided through the ALTAIR network has greatly improved his overall quality of life.

This is just one example of utilizing our 'braided funding approach' for individuals with IDD has brought together clinicians from many diverse organizations to discuss best practices and different methods that have been successful in their clinical practice. Altair implemented a health information exchange solution that connects to a State-Certified Health Information Exchange Service Provider. The Altair member organizations, through shared health and health-related information, support a service delivery model that facilitates improved coordination of the '70/30% spend model' to help provide the right services and care at the right time to improve quality of life for individuals with disabilities while helping reduce costs. Altair also connected to pharmacies in the area through Simply Connect, a State-Certified Health Data Intermediary. This connection supports a change in medication notification and ensures that the Altair members always have the most up-to-date version of dispensed medication from the pharmacy.

There are three parts to our strategy implemented to support Dave:

- Advocate to include our clients and services in new demonstration and reform models;
- Partner with health systems and health plans to address the whole health of our clients; and
- Create savings to the system through a focused joint effort on the TCOC (Total Cost of Care).

*Despite our breakthrough progress and accomplishments, Altair along with our demonstrated ability to save money see potentially misaligned incentives overall with the system this IHP- Next Gen RFI.*

**We present these considerations:**

1. Please give RFP applicants flexibility to propose including additional optional populations.
  - Re-categorize dual eligibles and others as optional populations that a Next Gen IHP can elect to serve. This will give more individuals the chance to participate in the demo.
2. Please give RFP applicants flexibility to propose including HCBS services on a pilot basis.
  - Allow HCBS services as optional pilot measures that a Next Gen IHP can include in their outcome or total cost of care calculations. This will help build more evidence of how HCBS services can influence outcomes and cost in the medical system.
3. Please give RFP applicants flexibility to propose phasing in community partnerships.

- Instead of requiring all network arrangements to be in place on the date of application, allow Next Gen IHPs to propose a plan to add partners over the duration of their multi-year demo. This will give IHPs more time to build partnerships with groups like ours.
4. Please incentivize RFP applicants to collaborate with community providers.
    - Similar to the IHP 2.0 model, Next Gen IHPs that propose substantial arrangements with community providers should be rewarded through reduced risk or other mechanisms.
  5. Please expand the IHP Data Portal to include HCBS measures.
    - This will add another dimension to the emerging picture of how HCBS impacts total health care spending and population health outcomes, and it also will complement the data collection that has been started through the HCBS Innovations grant.

**Important Experiential Information:**

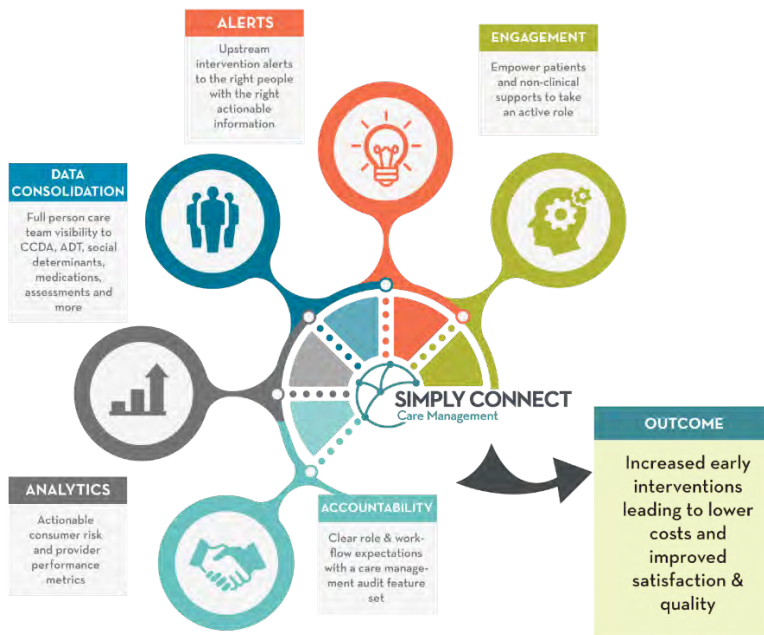
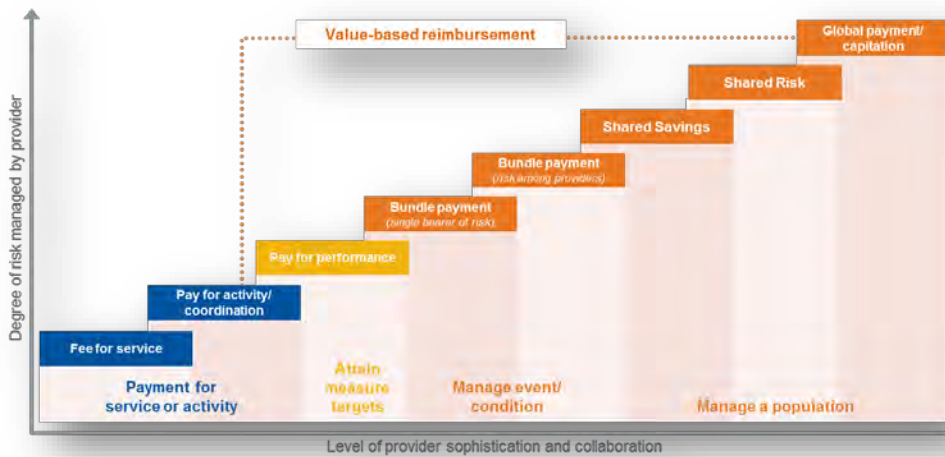
- The IDD population contributes a high cost to the overall DHS budget as we look at the TCOC (Total Cost of Care) acknowledging that on average 70% of the total spend for a person comes from the person’s waiver budget. Recent analysis provided by our lead agency- Lutheran Social Service demonstrates through a focused effort providing people with IDD a shift in supports with attention to community living, working and self-directed services-- they have reduced their average waiver spend by 18.86% another key proof point that we can reduce waiver spending levels.
- The remaining 30% on average funds the health total spend. We refer to this as the ‘70/30% spend model’. This approach introduces new thinking around the true TCOC for a person with IDD.
- Through recent Altair designs for people with IDD that experience intensive needs, we have implemented a ‘braided funding model’ supported by care coordination and in home services providing person focused care plans. Through this approach underpinned by the health determinants of social factors we see this driving the overall savings of ‘70/30% spend model’.

We believe our recommendations should be thoroughly reviewed by DHS before the final RFP is released providing Altair the opportunity to participate with the Next Gen IHPs to implement our ideas for delivering services and creating outcomes differently.

Specifics of two paths that could be implemented:

*Path 1-*

- *Utilize the IHP- Next Gen framework to allow for a managed care carve-in—for people with intellectual and developmental disabilities, 19+ years old, including dual-eligibles.*
- *Identify interested managed care payers/healthcare partners committed to working with us to combine our social capability with their medical and administrative capabilities to improve health, create full lives, and reduce costs in this population.*
- *Develop a relationship where we can share proportionate risk and rewards with identified partners with deliberate attention to the total cost of care for a person that commits specific goals to the ‘70/30% spend model’ distribution of services delivered. i.e.: 70% is the average spend on the social services side vs. 30% average spend on the health side working toward a strong commitment to reduce the total cost of all care within defined quality parameters.*
- *Refer to diagrams of Medical Neighborhood Integration, Value based payment diagrams recently designed with consultation with Optum and Altair’s Care Management model below.*



Path 1A-

- *In addition to Path 1 goals launch a pilot for a targeted population of 1000 people as identified that are supported by Community Neighborhood Centers located in a leading national pharmacy providers. We would assign our community health coordinators to coordinate proactive wellness services such as:*
  - *Access to primary care*
  - *Mental health telehealth services*
  - *Linkage to a trusted pharmacist providing patient centric guidance on medication management*
  - *Identify and manage care advice for chronic conditions such as diabetes, asthma and dementia screening*

I believe these changes could give Altair the opportunity to identify one or more partners, build a Next Gen IHP demo model together, and then launch into a series of pilot demonstration cycles.

In line with our strategy of including our clients and services in new models, Altair is also contemplating asking the legislature to authorize this completely new type of demonstration. We firmly believe that it will be important to test across multiple types of demonstrations in order to unlock as many learnings as possible and determine which models create the best outcomes for people with IDD while strongly addressing the fiscal responsibilities of a cost effective quality based model.

We appreciate your consideration of our Next Gen IHP recommendations and would welcome the opportunity to meet with the department to discuss our suggestions further.

Sincerely,

George J. Klauser, Executive Director  
Altair Accountable Care Organization  
(651) 969-2288 • [george.klauser@lssmn.org](mailto:george.klauser@lssmn.org)

If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Dr. Michael J. Helgeson
Organization	Apple Tree Dental
Title	Chief Executive Officer
Telephone Number	763-754-5780
Email	mhelgeson@appletreedental.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

Non-profit dental organization

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

6 regional programs serve multiple counties

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

See attached comments.

---

**Q5** 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.

See attached comments.

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**Q6** 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.

An adequate network of dental providers who serve sufficient volume of MHCP patients. See attached comments.



**Q7** 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 vs. phased in over time?

See attached comments.

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**Q8** 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?

See attached comments.

---

**Q9** **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?

See attached comments.

**Q10** 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?

See attached comments.

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**Q11** 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?

See attached comments.

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**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

See attached comments.

---

**Q13** **One of DHS's 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?

See attached comments.

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

Inclusion of dental care should be mandatory. See attached comments.

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

Our attached comments include specific suggestions regarding oral health / dental care and its importance to improving health outcomes.

**Q16** Click the icon below if you prefer to upload a file of your responses.

Once file has been successfully attached, a unique ID will appear in the box.

ref:0000000150:Q16



December 20, 2017

Thank you for this opportunity to respond to your Request For Comments (RFC) on the Department of Human Services' Next Generation Integrated Health Partnership model. Apple Tree Dental is a non-profit dental organization providing comprehensive dental care to Minnesota Health Care Program (MHCP) enrollees. Last year, over 25,600 MHCP enrollees received 63,000 dental appointments at our 6 urban and rural regional centers or on-site at Head Start Centers, schools, group homes, long-term care facilities, hospitals, and even on a behavioral health campus. From our establishment in 1985 to serve nursing home residents, we have valued and used an integrated care approach that has improved the health outcomes and individual well-being of our patients.

While there are no specific questions or proposals about dental care within the RFC, we offer the following suggestions in support of the IHP aims of effective care and efficient administration that produces better value and better health outcomes:

1. During the planning and implementation of Next Gen IHP, it is essential that steps are taken to sustain current MHCP dental providers to avoid disruptions in provider-patient relationships, delayed care, and increased Emergency Department use for dental problems. Specifically, the current Critical Access Dental funding levels need to be sustained or increased during the transition.
2. Involve dental stakeholders in structuring new payment models to incentivize dental services that:
  - integrate dental care into IHP's via outreach, bidirectional referrals, co-located services, and care coordination
  - reach the most medically complex, high-need, high-risk enrollees to reduce health disparities
  - prevent and reduce costly mouth infections that negatively affect chronic conditions such as diabetes, coronary artery and cardiovascular diseases\*
  - sustain an adequate network of MHCP dental providers to improve access to care
  - allow evaluation of spending, value and outcomes

A growing body of research shows that appropriate dental care can reduce annual medical and pharmacy expenditures by up to several thousand dollars per person. Minnesota cannot afford a system that does not successfully integrate dental care for MHCP enrollees. Apple Tree would welcome the opportunity to share its experience as you design the Next Generation Integrated Health Partnerships. Please contact me if we can be of service.

Sincerely,

Michael J. Helgeson, DDS  
Chief Executive Officer

\* Additional studies available upon request:

- Nasseh ,K, Vujicic, M & Glick, M, The Relationship Between Periodontal Interventions and Healthcare Costs and Utilization. Evidence from an Integrated Dental, Medical, and Pharmacy Commercial Claims Database. , Health Econ. (2016) Published online in Wiley Online Library ([wileyonlinelibrary.com](http://wileyonlinelibrary.com)). DOI: 10.1002/hec.3316

- Medical Dental Integration Study, March 2013 United Health Care

[https://www.uhc.com/content/dam/uhcdotcom/en/Private%20Label%20Administrators/100-12683%20Bridge2Health\\_Study\\_Dental\\_Final.pdf](https://www.uhc.com/content/dam/uhcdotcom/en/Private%20Label%20Administrators/100-12683%20Bridge2Health_Study_Dental_Final.pdf)

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**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Christine Papineau
Organization	Essentia Health
Title	Vice President Payer Strategy
Telephone Number	218-576-0838
Email	Christine.Papineau@essentiahealth.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

Hospital System

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

St Louis County and Crow Wing County

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

We believe the assignment of PCP's is critical however there appears to be no real incentive for a member to align with any PCP and the program allows a member to change PCP's on a monthly basis. For Care to be effective a member should be aligned to a care team for the measurement period. Geographic assignment is not a method of choice for assignment to a primary care team. Members are unwilling to see the assigned PCP.

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**Q5** 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.

Minimum beneficiary population size for Medicaid members should be 5000 or more. This population has significant medical and mental health needs and smaller populations are not sustainable in value based models.

---

**Q6** 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.

Telehealth and video visits should be an acceptable means of network adequacy in rural areas. Originating site rules should be lifted or less prescriptive as it can be difficult for these beneficiaries to receive care or travel to an originating site. If the care can be given via telehealth means it should be an option and payable service. The program should not be prescriptive regarding how network adequacy is met. It should be outcomes and cost efficiency driven.

**Q7** 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 vs. phased in over time?

Again Telehealth and telehealth video visits with a non-originating site should be an option for rural health care. Prospective Care Coordination fees with nonprescriptive outcomes based models should be considered as systems have already established either centralized care coordination units either in primary care offices or other locations. The system should be based on outcomes driven measures not prescriptive policies.

---

**Q8** 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?

Accepted responders should have a demonstrated ability for value based care. Measures could be NCQA Health Care Home or Minnesota State Certified Health Care Home or proven track record in other public programs.

---

**Q9** **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?

The model should be eligible and expanded beyond the seven county metro area for systems with proven track records of performance. A single statewide formulary would be preferable to maintain a consistent uniformity for practitioners and prescribing.

**Q10** 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?

The current model of payment is not clear as described in this Request for Comment as the calculation of payment is not the same as described in the demonstration of Table 2. It isn't clear if there are outlier limiters, a cap of downside risk, if pharmacy trend is calculated separately from medical costs or even factored in with the appropriate pharmacy trends. These items should be included and clearly outlined.

---

**Q11** 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?

State should not be prescriptive in how care coordination dollars are used. Care coordinators identify the most at-risk beneficiaries and document a care plan for those beneficiaries. The IHP group should have approval rights to the care plans identified for attributed members so that care dollars are being spent appropriately and in agreement with the appropriate care plan.

---

**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

State should not place the entire burden of payment for performance on the IHP Care Group. State and MCO's should have responsibility of assisting in meeting the health and cost outcomes of their assigned population by also using administrative dollars to address the non-medical and social determinates of the populations health.

---

**Q13** **One of DHS's 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?

the current program of quality requirements should not be changed. Medicare requirements do not always align well with the same needs as a Medicaid Population.



**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

The proposed model is difficult to understand with the limited and conflicting information provided. It isn't clear how dollars would be expected to be used or the calculation of how the dollars would be distributed to IHP's and MCO's.

---

**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

The Next Gen IHP model should be expanded outside of the metro area. The health care needs and social determinates are different for a rural population and the lessons learned from a pilot in the metro area may not translate well to a rural population. It is necessary there is a disincentive if enrollees seek non-emergent care outside the Next Gen IHP's network. Maybe treat these enrollees as if they are in a restrictive recipient program.

**Q16** Click the icon below if you prefer to upload a file of your responses.  
Once file has been successfully attached, a unique ID will appear in the box.

If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Lucas Kunach
Organization	Fraser
Title	Strategy analyst
Telephone Number	612-798-8303
Email	lucas@fraser.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

If the definition of "primary care" is broadened to allow community clinics that are not traditional primary care medical clinics to be "primary providers", please provide exceptions to allow those community clinics to participate as primary providers in multiple Next Gen IHPs.

---

**Q5** 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.

---

**Q6** 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.

Please require Next Gen IHPs to follow existing managed care networking standards, including contracting with Essential Community Providers. In reviewing Next Gen IHP applications, please require applicants to include a detailed plan for starting with or phasing in a robust network. In the final RFP, please clarify whether network adequacy will be measured according to the MDH standards for managed care plans, or some other standard. The proposed framework states that Next Generation IHP networks will be supplemented with the current DHS FFS network. Please incorporate this into the final framework. This will ensure that families will be able to continue to access their community provider of choice, even if the Next Gen IHP does not contract with that community provider.

**Q7** 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 vs. phased in over time?

One mechanism that should be in place is an easy way for a community provider to look up whether an individual is enrolled with an IHP (including both existing IHPs and Next Gen IHPs, and also for individuals in managed care and FFS).

---

**Q8** 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?

---

**Q9** **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?

We support the proposal for a single PDL. We believe that this proposal should be broken out of the Next Gen IHP framework and implemented as its own policy across all Minnesota Health Care Programs statewide.

**Q10** 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?

---

**Q11** 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?

We believe that Next Gen IHPs should have maximum flexibility for determining how to invest its care management resources -- including paying for non-medical and non-covered services. We also believe that Next Gen IHPs should be required to invest a minimum percentage of its care management resources in activities tied to improving client outcomes, and they should be required to report on those investments annually.

---

**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

---

**Q13** **One of DHS's 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?

Please consider incorporating the state's C&TC schedule adherence measures, including early childhood screening and follow-up plan standards.

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

Please maintain the current policy for how behavioral health home, CCBHC, and other highly unique care management funding programs interact with existing and Next Gen IHPs. Please use geographic factors to help assign families that do not affirmatively select a managed care choice. Our experience among PMAP families is that travel can be a significant barrier to accessing needed care. Finally, please review the risk adjustment formula to ensure it reflects the fact that the opportunity among children's services is for prevention and future cost avoidance, rather than short-term cost reduction.

**Q16** Click the icon below if you prefer to upload a file of your responses.  
Once file has been successfully attached, a unique ID will appear in the box.

If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Dawn Plested
Organization	FUHN
Title	COO
Telephone Number	651-587-7659
Email	dplested@westsidechs.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

---

**Q5** 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.

---

**Q6** 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.



**Q7** 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 vs. phased in over time?

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**Q8** 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?

---

**Q9** **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?

**Q10** 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?

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**Q11** 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?

---

**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

---

**Q13** **One of DHS's 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?

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

---

**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

**Q16** Click the icon below if you prefer to upload a file of your responses.

Once file has been successfully attached, a unique ID will appear in the box.

ref:0000000197:Q16



Leading your  
community-based health care  
in the Twin Cities

Date: December 20, 2017

To: Mat Spaan, Minnesota Department of Human Services

Fr: Steven J. Knutson, Chair FUHN Board of Directors  
Dawn Plested, COO FUHN

Re: FUHN's Response to DHS Request for Comment Next Generation IHP

On behalf of the FUHN Board of Directors, we thank you for the opportunity, again, to provide comments in response to the Minnesota Department of Human Services' request for information on the Next Generation Integrated Health Partnerships ("Next Gen"). The Federally Qualified Health Center Urban Health Network (FUHN) is a highly collaborative membership organization of 10 Federally Qualified Health Care Centers (FQHC) located in the metro area. Our member clinics serve over 111,000 patients, of those 91% represent diverse populations, 95% have incomes below 200% of the federal poverty level, and 41% are best served in another language than English. Over 55,000 are enrolled in Medicaid or Minnesota Care and currently 32,000+ are attributed to our IHP. FUHN is an important partner to DHS and the IHP program because we are a key safety net for the economically disadvantaged living in the urban core of Minneapolis and St. Paul.

FUHN strongly supports the sustaining focus on realizing the full potential of further reductions in costs, further improvement in care, and a positive patient experience. These are also high priorities for FUHN and all its member clinics as demonstrated by our continued participation the IHP program. As you consider policies that would expand the IHP program, we offer the following overall summary comments followed with more detailed information on specific DHS questions.

### **Overall Comments**

- We believe that the concept of primary care exclusivity is essential to making this program work, but we feel that the IHPs and the MCOs both should be subject to this exclusivity. There may be unintended consequences within the concept of primary care exclusivity and it is critical that this concept is vetted thoroughly and collaboratively.

- There needs to be mechanisms in place to ensure that patients have adequate education and ability to make ethical choices about their care and the ability to continue seeing all of their providers so as not to disrupt care especially for those with significant health conditions and those who lack access to culturally appropriate care.
- Administering Next Gen requires building additional infrastructure both for DHS and FUHN. Explicit in the name of “Next Generation” implies further transformation and this takes money and time. In the past years, DHS and MDH have been instrumental in providing SIM grants for various infrastructure investments, e.g. data analytics. More capital investment is essential for successful expansion of this Next Gen model.
- We believe a central tenet of the Next Gen must include a significant risk adjust payment to providers to address the health disparities experienced by people living in poverty. We all know that most of health and well-being is influenced by social determinants of health and it is time to take action.

### Detailed Comments on Select DHS Questions

#### 1. Primary Care Clinic Exclusivity and Patient Choice

FUHN clearly can support elevating primary care within Next Gen as it is the premise of how we have based our successful IHP activities. **We believe this concept is key to the success of the Next Gen IHP. The MCOs too should also be subject to primary care exclusivity.** With that said, there are a number of unintended consequences that could result from this policy.

To be clear, the FUHN clinics serve patients from a broad geographic area well beyond the 7-county metro area. FUHN clinics will need to maintain contracts with MCOs regardless of Next Gen participation to serve these non-metro patients. That being said, as FUHN understands DHS’s proposed model, primary care clinics are free to join multiple MCOs, but only one IHP for the 7-county metro area. If a clinic joins an IHP, that same clinic is barred from joining a MCO, again within the 7-county metro area. FUHN believes that this creates an untenable advantage in favor of the MCOs. There is little to prevent an MCO from applying pressure on primary care clinics to join the MCO’s network by leveraging participation for commercial and Medicare. There is potential that rather than moving patients towards joining an IHP like FUHN, this model could drive clinics entirely away from the IHP model in order to maintain their MCO contracts for the non-Metro areas, Medicare and commercial arenas. Clearly such an outcome would be unintended.

Additionally, the MCOs have a significantly greater ability to drive enrollment incentives. FUHN cannot compete with the brand awareness and general marketing abilities of the MCOs. The MCOs would be in the position to provide significant incentives to patients, and these factors could also drive patients to select MCOs over IHPs. In the past, our staffs have experienced patients choosing an MCO because of the incentives or “benefits” e.g. gift cards, bus tokens, car seats, or other material offerings by an MCO.

**The Essential Community Provider provision in Next Gen or new requirement for the MCOs model is very unclear. It is also unclear if the MCO's will have the full requirement to serve all MA and MNCare patients similar to a Next Gen IHP.** We are concerned that MCO's will be reluctant to enroll all MA patients due to the possibility that their patient risk profile will be riskier than previous experience with the "excluded categories" of MA patients. In effect, an MCO could manipulate their MA patient risk by carefully choosing primary care providers who likely have a more favorable patient population; limiting their exposure to riskier patients, who may be part of the FUHN IHP.

It is very difficult for FUHN to envision how the "patient choice for a primary care provider" in Next Gen will be communicated to our patients by DHS. Today, most of our clinics have staff who spend an enormous amount of time working with patients to assist them in understanding their coverage choices. Patient's with limited English, limited experience with the American health system, mental health conditions, disabilities, substance abuse concerns, are in violent relationships, all have a really difficult time functioning in this type of restrictive system. We need to make things simpler, not more difficult. Given that patient choice is a critical element to this model functioning correctly, **DHS needs to have a very robust and detailed patient education plan in place to assist with patient choice or deploy plenty of funding throughout the community to assure the community is fully informed to assure ethical choices can be made.** We have excellent examples in the recent past where funding for significant outreach efforts were assured to many diverse groups.

As we have discussed with you in many previous communications, the current attribution process in the current IHP model needs much improvement. **Given that the current IHP attribution may be the proxy for Next Gen in the absence of patient choice, that process needs to be reviewed and collaboratively re-negotiated with transparency.** A key issue includes FUHN's recent past experience with in the current MCO selection. We are quite concerned that patients we are currently treating will be "siphoned away" in the process, such as had been our experience in Hennepin County with Hennepin Health. The "default" to Hennepin Health in certain zip codes was highly problematic for FUHN clinics.

While the concept of care and financial accountability would indicate primary care exclusivity as an important factor, many unanswered questions remain. Financial considerations are central to FUHNs' concerns. As FQHCs, **we cannot turn patients away who present for treatment due to their inability to pay as a requirement of our federal funding.** We cannot afford to provide care without reimbursement. We believe you have indicated that any patient showing up for care will be reimbursed by DHS at MA FFS PPS rates, but we'd like confirmation of that understanding.

We have a concern over the definition of IHPs vs. MCOs. For example, Hennepin Health, Allina/Aetna, and HealthPartners could all qualify as either. Will they be required to select one option? We believe entities should have to choose one or the other.

## 2. Down-Side Risk vs. Shared Savings

As you have already seen, FUHN has saved the State of Minnesota millions of dollars! Our work has proven that an intentional process, informed with data, to engage patients who have had an avoidable emergency department visit or inpatient hospitalization, experience multiple chronic conditions or are at high risk for future hospitalization or adverse outcomes are effective interventions. FUHN embarked on this IHP project with a strong commitment assure that the urban poor in Minneapolis/St. Paul will have accessible, high quality care in the reforming health care market while reducing total cost of care. We have every intention to continue this good work, however, we cannot participate in a Next Gen IHP product that forces downside risk to our PPS reimbursement that would impact our federal grants.

The FQHCs cannot take on down-side risk on their Next Gen IHP medical services payments. Per federal restrictions, FQHCs cannot put at risk any part of the federal funding in participating in this program. We concur that there may be some room for downside risk in the medical management dollars. Regardless, FUHN's outcomes in the IHP process to date has proven that downside risk is unnecessary to achieve the savings that DHS is looking to gain. The opportunity for shared savings has been significant incentive for FUHN. **We highly support continued inclusion of a "shared savings only" model.**

## 3. Building a IHP Network

FUHN understands that one of the goals of the Next Gen IHP is to encourage IHPs to build a larger network to include hospitals, EDs, health systems, labs, etc. outside of our current IHP network. While we agree that all IHPs should work collaboratively with the broader healthcare community to ensure alignment of initiatives, strengthen overall results, and ensure that IHP initiatives are not in conflict or competing with existing system initiatives, **FUHN has demonstrated that creating contracts for gain sharing is not a prerequisite to achieve the savings that DHS is hoping to realize in the IHP model.** FUHN's work over the past several years highlights that significant savings and system improvements are made at the primary care level without such network contractual arrangements.

FUHN further sees an essential component of the Next Gen IHP is to have **complete transparency with the DHS fee schedule in order to pursue additional network relationships if we determine that there is a potential for benefit to our patients or clinics.** Non-FUHN providers should be reimbursed at existing MA FFS rates. If FUHN believes partnerships can further benefit our ability to positively impact TCOC or care improvements, and if, as part of such partnerships, FUHN exchanges funding with such partners in some sort of incentive arrangement, it should be free to pursue such relationships. While network adequacy concerns were raised at the listening sessions, FUHN believes that this does not impact our work, as our network would remain unchanged and at least initially, and has clearly been adequate for the first five years of the IHP Program. Next Gen is not designed to resolve the chronic workforce

shortage issues that exist in our marketplace. As such, the IHP cannot be held responsible for meeting such specialty-specific network adequacy standards.

There is a level of ambiguity in this discussion which would need complete transparency for this model to be successful. The process of setting the per member per month total cost of care calculation must be a completely transparent calculation and it warrants collaboration with FUHN specifically to determine the appropriate amount for the FUHN IHP members. There is current discussion regarding potential modifications to the PPS rate with the Minnesota FQHCs and the outcomes of that discussion need to be accounted for within the PMPM target calculation. Additionally, MCOs may have different (and potentially lower) fee schedules than DHS FFS and therefore the application of the higher DHS rate could also impact the TCOC PMPM target. The basis for target development of the TCOC PMPM rate must be based on the then current service unit payment rate.

#### **4. Sustainability and Infrastructure Needs**

DHS affirmed in the 2.0 IHP model that putting new models of care in the market required practice transformation and funding to support it – thus the inclusion of the care coordination payments. A further transformational effort for Next Gen IHPs will require time and money for infrastructure development. **DHS’s goal to have the Next Gen IHPs take a more active role for more medical management/care coordination for more patients requires investment in 2018 to develop the infrastructure for 2019.** Despite receiving some previous funding to expand our HIT capabilities, it is also likely that additional investment will be necessary for Next Gen to be successful. We remain concerned over the accuracy of the existing DHS claims processing and reporting system and question whether existing infrastructure will be capable of managing the increased volume of claims.

#### **5. Health Inequity and the Social Determinants of Health**

There is abundant scientific evidence to support payment that is risk adjusted based on the patients’ social and economic conditions. Poverty and all the complications of being poor, is a key driver that leads to poor health. Stating the obvious, a starving person needs good healthy food, a homeless person needs safe respectful housing, a child needs a good education. All of these social determinants improve health; and the health care system needs to concern itself with these contributing inequities outside of medical care. **Next Gen presents a rare opportunity to develop a health care system that can address these health disparities.**

**We need to implement a risk adjustment payment that is necessary to incent and/or compensate those providers who are serving patients who experience health disparities.** If this becomes the central tenet to any health reform transformational effort, FUHN is all in.

#### **6. Single PDL Formulary**



FUHN supports this concept. A note of caution however, if there is anything that causes more consternation in the health care system is a third party (e.g. DHS) dictating the care that a provider has the knowledge, training and license to do exclusively. A single PDL formulary would qualify as one of these events. If DHS is serious in moving in this direction, proactive and immediate involvement of the provider community and other renown entities that are experts in the field right here in MN is critical to the acceptance and endorsement of this concept.

We appreciate the opportunity to provide feedback. We are excited about DHS's vision for the future. But we also lack enough information and have many concerns and would welcome the opportunity to continue to participate in shaping care delivery for Minnesota. As you consider our comments, please do not hesitate to contact me at [knutsons@neighborhoodhealthsource.org](mailto:knutsons@neighborhoodhealthsource.org) or our new COO Dawn Plested at [dplested@westsidechs.org](mailto:dplested@westsidechs.org) if you have any questions about the content of this correspondence.

If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Erin Bailey
Organization	Gillette Children's Specialty Healthcare
Title	Director of Executive Initiatives
Telephone Number	55101
Email	erinkbailey@gillettechildrens.com

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

Gillette sees patients from all 87 MN counties and has clinics in 11 counties.

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

There are exceptions that must be considered. It is not reasonable for a specialty care provider, who serves patients from all 87 Minnesota counties, and works closely with and receiving referrals from primary care providers all over the state, to be locked into a primary care exclusivity arrangement. A requirement for primary care exclusivity needs to include a very clear exception process for specialty care providers like Gillette. We continue to support the current IHP model which allows for a specialty provider such as Gillette to be treated the same way as a primary care provider for the purposes of the IHP, as children who have rare or complex conditions will likely see specialty providers like Gillette more often than they see community pediatricians. In these cases, a specialty provider like Gillette provides a child’s primary care, with community pediatricians serving as the “specialty” providers for typical childhood illnesses and conditions. Any exception process needs to preserve the ability for Gillette to receive these referrals and continue to treat these complex patients without any limitations. Our families often treat Gillette as their health care home since the majority of their health care is provided at and/or coordinated through our providers. Some of our patients come to Gillette multiple times a week for treatment and rehabilitation related to their complex condition; and for these families Gillette functions as their “primary” provider and oftentimes works as the care coordinator. This complements their primary care provider in the community.

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**Q5** 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.

There needs to be more years of data to properly evaluate. For Gillette, our population of kids have statistically uncommon conditions and can only be treated and served by providers who understand and have experience with their conditions. For example, in 2017 Gillette treated over 100 Minnesotan children with Rett Syndrome, a disease that affects only one in 10,000 girls nationally. For these statistically uncommon and complex conditions, children need diagnosis, treatment or coordination of care from a highly trained and experienced team of providers across multiple subspecialties. As a result, how you define minimum population size needs to account for this population and be inclusive of those with medically complex conditions. As one of the top volume providers in the United States for many rare conditions, Gillette is willing to assist in this work.

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**Q6** 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.

It is important that any criteria not be too limiting as to exclude specialty care providers who play a vital role in caring for those who have disabilities and medically complex conditions – especially children. For example, the language should not require acute care services or follow requirements that do not fit our patient population in Minnesota. The success of the IHP has resulted from the state’s commitment to flexibility and creativity in best serving Minnesota patients; as a result, we recommend that DHS work collaboratively with providers – including specialty care providers in the drafting of language.

**Q7** 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 vs. phased in over time?

We recommend that the Next Generation IHP utilize measures already collected through existing programs. Gillette utilizes a series of processes (listed below) in our efforts to improve referral management, care coordination and quality measures. For example, we use quality measures (i.e. Supplemental Security Income care improvement and cost, National Surgical Quality Improvement Program, readmissions rates and cost, Gillette's PrePARE program, Minnesota Community Measures- depression, Agency for Healthcare Research and Quality- pressure ulcer rates, National Committee for Quality Assurance- Patient Centered Specialty Practice standards, patient access and appointment timeliness) and patient and family experience measures (NRC Survey and Family Council feedback). Protocol for coordinating with primary care and other referring clinicians Process for workflow for referral management and practice staff responsible Self-referrals and process to connect with PCP Process for timely response to referring clinician and patients Process to identify patients, share information and communicate about transition to PCP Process to identify and document PCP, or process to connect patients with PCP Process to determine patient need and degree of urgency, reserve time for same-day appointments, consults with PCP or referring clinic to determine appropriateness, returning calls, clinical advice, equal access regardless of ability to pay, and help with coverage. Informing patients/families about role of specialist and materials on obtaining care during and after hours, communication with specialist, and coordination of care between specialist and PCP and/or referring provider. \*\*Description of structured clinical team communication about patients, description of training process, and description of staff roles Process for Pre-visit planning, assessing patient need for additional support and services, collaborating with patient on plan of care, sharing care plan with PCP, giving patient written POC, providing education materials for self-management, and assessing and addressing barriers Medication Management Process Procedure for staff on following and documenting test results (includes notifications) Coordinating referrals with secondary specialists Identifying patients who have been hospitalized or had ER visit, and sharing info with hospitals/ER's, and obtaining discharge summaries

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**Q8** 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?

The criteria and evidence must be accessible to diverse populations, allowing flexibility beyond pure metrics to account for how initiatives, contracts, interventions and other efforts may be implemented differently depending on geography, demographics, scope, type of service, etc.

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**Q9** **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?

A single Preferred Drug List (PDL) is preferable but only if it aligns with the Medical Assistance drug formulary.

**Q10** 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?

The model should allow specialty providers like Gillette the opportunity to provide care management, coordinate care delivery and ensure communication across the systems of providers caring for patients. Gillette currently has a care coordination grant from the Minnesota Department of Health and have been working to clearly define the target population, project activities, and outcomes to transition patients from the hospital to home. Models from this program could be helpful in determining how to drive change and costs in healthcare delivery.

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**Q11** 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?

While these measures and methods may be important for evaluating the IHP, the role of providers will be to contribute measures related to health care delivery and relevant clinical outcomes. This is particularly true for certain patient subsets including children who have complex medical conditions and disabilities.

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**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

There is a general trend towards value-based payment. However, in order for any level of payment to be tied to quality and outcomes in an effective way, the measures must be applicable to diverse patient groups and the providers that serve them. For instance, quality and health outcome measures must not be solely primary care focused; they must include measures that appropriately apply to pediatric patients and patients with life-long complex medical conditions. Further there needs to be flexibility in whatever range of measures are set to account for diverse patient needs and abilities across condition complexities.

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**Q13** **One of DHS's 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?

The priorities should align with Minnesota Community Measurement and MN Statewide Quality Reporting and Measurement System where possible, with additional measures for identified sub-populations.

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

Evaluating and improving health outcomes according to social determinants of health, racial disabilities and other related metrics requires collaboration across the social service system. For example, providers do not collect data on housing needs or food insecurity, yet social work teams at providers spend a great deal of time assisting families with these issues regardless of whether there are resources in the community to assist with needs (i.e. food, utilities assistance, insurance gaps and other social issues that often determine the effectiveness of health care interventions). It is not the role of health care to be responsible for these risk factors and this should not be within the model, however, the model could account for provider effort (or lack thereof) to address these risk factors and collaboration within communities to better support the patients.

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

The IHP has specific requirements for gathering patient satisfaction information that can require a special survey. This requires additional time to set up. It would be helpful to integrate the collection with patient satisfaction information with how providers already collect and report on this information.

**Q16** Click the icon below if you prefer to upload a file of your responses.  
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**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Buddy Robinson
Organization	Greater Minnesota Health Care Coalition
Title	Co-Coordinator
Telephone Number	218-727-0207
Email	admin@citizensfed.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
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- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

Northeast (Arrowhead), East Central, and Central Minnesota (greater St. Cloud) counties

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

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**Q5** 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.

---

**Q6** 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.



**Q7** 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 vs. phased in over time?

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**Q8** 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?

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**Q9** **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?

**Q10** 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?

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**Q11** 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?

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**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

---

**Q13** **One of DHS's 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?

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

---

**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

**Q16** Click the icon below if you prefer to upload a file of your responses.

Once file has been successfully attached, a unique ID will appear in the box.

ref:0000000131:Q16

47 Park St. N., Mora, MN 55051

## **Response to MN Dept, of Human Services Request for Comments on: Outcomes-Based Purchasing Redesign and Next Generation IHP**

### **Introductory, general comments:**

Greater MN Health Care Coalition (GMHCC) represents low and middle income health care consumers in the East Central, Central, and Northeast parts of the state. Its member groups have over 40 years of health care public policy involvement at the state level.

GMHCC is glad to see DHS moving further away from HMO middlemen for Medical Assistance and MinnesotaCare, since we have been persistently and strongly advocating for that, for the past ten years. However, we are dismayed to see that DHS wants to impose MCO mechanisms and complex payment systems onto the medical providers that might choose to participate. This is unfortunate, since direct contracting with provider groups can be done much more simply and efficiently, with less administrative expense. DHS' hybrid proposal would require DHS to administer Fee For Service claims while at the same time administering a complicated capitation – for those same medical procedures -- with various adjustments, including risk score measures. It is strange that DHS sees a need to increase its own administrative workload in order to directly contract with medical providers.

A global budgeting process would be better, simpler, and less costly to administer, for both DHS and hospital/clinic groups. A global budget system can vary in how much financial risk is placed on providers. Provisions for smaller risk would enable smaller providers to participate instead of just large integrated medical systems.

While we are glad that the Next Generation Integrated Health Partnerships (IHPs) can result in removal of HMO middlemen for many Medical Assistance and MinnesotaCare enrollees, DHS' proposal, by still incorporating MCOs, fails to seize the opportunity to completely remove the private corporate middlemen, which would involve ceasing to contract at all with private HMOs on a capitated basis. We assert, at the same time, that the publicly-operated County Based Purchasing systems (CBPs) should still be allowed to contract with the state on a capitated basis, since they, having a very different status and motivation than the private Health Plan HMOs, actually perform the Managed Care Organization (MCO) function in the proper, public purpose, economically efficient and financially transparent way that is supposed to happen for all MCOs. The CBPs demonstrate how MCOs ought to operate in relationship to the state, while the private HMOs do not. It is a large mistake to lump the two together. And, depending on how the Next Generation IHP financial incentives work out for hospital/clinic systems, we might or might not end up with a majority of Medical Assistance and MinnesotaCare enrollees still enrolled in private HMOs.

To fully directly contract with hospitals and clinics, another alternative exists apart from global budgets with hospital/clinic systems. It is the managed care method known as Primary Care Case Management (PCCM), which, according to the Kaiser Family Foundation, is used as the only

managed care option in North Carolina, Oklahoma, South Dakota, Vermont, Maine, Alabama, Arkansas, Idaho and Montana. It is also used partially -- along with MCOs -- in Connecticut, Colorado, North Dakota and a few other states. The PCCM method pays fees to primary care medical homes to be care coordinators and gatekeepers, and pays all other medical services to all providers on a Fee For Service basis. Some PCCM systems add on enhanced features such as medication management and disease management programs. A large advantage of PCCM compared to direct-contracting global budgeting (or capitated risk payments for that matter) is that providers are not economically pressured to have to combine into larger and larger groups to shoulder risk. Most important, the PCCM model has proven to reduce cost, while maintaining or improving access and quality of care, compared to MCO contracts with insurance companies. Very large reductions in overall administrative expense, compared to using private MCOs, have taken place. Unfortunately, in some states there has been push-back and reduction in the use of PCCMs, due to pressure by insurance companies who want to get MCO contracts precisely for the purpose of making money off of the states.

Geographic considerations: Direct contracting options including Next Generation IHPs, global budgets with provider groups, or PCCM should be available from the start for provider groups statewide, not just in the Twin Cities. Some of the larger systems in Greater Minnesota would very likely be interested in contracting with the state with the Next Generation IHPs (depending on the risk exposure) or with global budgeting direct-contracting. If a PCCM system is adopted statewide instead, then all sizes of medical providers could readily participate, and enrollees' choice of provider would be maximized. Minnesota has already put a lot of development into Primary Care Medical Homes, which would facilitate widespread PCCM use. Greater Minnesota should not have to wait years for a Twin Cities pilot project to finish.

Specific DHS Questions: In addition to the above general comments, GMHCC offers responses to some of the specific questions posed by DHS. We will respond to questions 5, 6, 7, 9, and 12.

*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?*

A critical component of accountability is to fully verify the medical claims data of the MCOs – despite significant evidence that the private HMOs have repeatedly given inaccurate, inflated numbers to the state. This verification has never been imposed by DHS, the Dept. of Health, the Dept. of Commerce, or the Legislative Auditor, despite statutes and contract provisions requiring and/or allowing it to happen. Those provisions in statute are rendered meaningless if they are never utilized – a cruel joke which makes a mockery of Minnesota's "good government" reputation. GMHCC has found it amazing, in the face of our repeated attempts to see external auditing and verification of paid claims encounter data happen, a steadfast resistance of the part of all state officials to do this. If federal authorities are not interested in enforcing the legal requirements for this accountability, that does not mean the state should put itself off the hook. Basic due diligence dictates that when Minnesota is spending over \$5 billion a year, in the largest contracts by far to any private entities, it is imperative to verify if the money is being spent as intended. Note that the Health Plans collectively invest – by

their own admission to the Minnesota Campaign Finance and Public Disclosure Board – about \$1 million per year to lobby the state legislature. The true amount of financial influence, especially if behind-the-scenes political expenditures were identified, would be much larger.

In its document requesting comments, DHS remarks that its normal MCO rate-setting process includes an allowance for “contribution to reserves,” which for practical purposes equates to a “net income” or “profit” from the managed care contracts. However, DHS has never -- and is not proposing now -- to monitor the level of the reserves, and adjust the allowed contribution to reserves in relationship to how high that level is. DHS should do that. But because it doesn't, that means, as has been the case much more often than not over the years, that the DHS contracts have inappropriately added to financial reserves that are already excessive. If you add up the net income from the state programs – including investment income – that Blue Plus, Medica, HealthPartners and UCare have reported to the state on their MN Supplement Reports, you reach an aggregate total (incorporating both gains and losses) over the last 20 years of over \$1.2 billion dollars. That is an enormous contribution to reserves. If external, forensic auditing were ever to be performed, the number would likely be much higher.

Another problem with accountability is the need for reliable verification for health risk adjustment scores for MCO enrollees, which is a critical aspect of managed care rate setting. It has been shown and proven a number of times that health insurance companies will stoop to inflating their enrollee risk scores if it will bring extra, unjustified payment to them. Hospital/clinic groups which contract with the state on a capitated basis would be subject to the same temptation. In general, it is difficult to achieve meaningful risk adjustment anyway, and to do so accurately would greatly increase the expense of the analysis. The leeway to manipulate reported risk scores is huge. Furthermore, MCO and provider payments based on risk scores leads to rampant “up-coding” at the provider level (either insisted on by insurance payors or self-motivated to get better reimbursements). We have a national Medicare Advantage scandal of some \$15 billion per year stolen by insurance companies inflating their enrollee risk scores -- *and never submitting reduced scores when they have the evidence for that* – which speaks to a need for extensive, expensive regulatory monitoring if cheating is to be kept in check. Accurate health risk scores, without cheating, is a very costly proposition.

*6. Would administering a single Preferred Drug List (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?*

A carve-out of the pharmacy benefit, if administered properly, would be preferable to administering a single Preferred Drug List (PDL). Whichever of the two methods is used, it would be best for it to apply statewide, instead of just in the metro counties. Greater Minnesota needs better formulary choices, and savings in pharmacy costs, as much or more as does the Twin Cities metro area.

A carve-out is preferable because it would allow for efficient, consolidated, lower-cost administrative expense, and because it would eliminate secret rebates that go to HMOs that drive formulary decisions which are often not the most efficacious and cost-effective choices. To realize these benefits, however, the carve-out would have to be administered by, or under the direct and detailed supervision of, the state. If the state were merely to pick and hire a Health Plan or a Pharmacy Benefit Manager to manage the carve-out, even with a competitive bidding process, the result would

likely be unnecessary costs, excess profit to the contractor, hidden costs and profits, and a formulary designed to secretly financially benefit the contractor, rather than provide the most cost-effective drugs at the best prices.

The alternative method of a single PDL used by all the MCOs and Next Generation IHPs would be much less efficient, but it raises both the question and opportunity for coordinated purchasing – by the provider groups as well as the MCOs -- from drug manufacturers of the chosen formulary medications and items. This would work best if the state was negotiating with the drug manufacturers on behalf of these purchasers as one pool. That might be the only feasible way for it to work.

Whether a carve-out or a PDL is used, the state has very good resources to deliberate and decide on the best evidence-based choices for a formulary, with DHS' own Drug Formulary Committee, plus important experts such as Cody Wiberg at the MN Board of Pharmacy, and Prof. Steve Schondelmeyer at the University of Minnesota College of Pharmacy.

*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?*

The question of the appropriate level of risk is very critical, and the state must acknowledge these considerations: (1) It would be a huge mistake to burden medical providers with more financial risk than they can readily handle; (2) The determination of this has to be very individualized to each provider system's particulars; and (3) The determination, to be accurate, has to access detailed financial and operational data for each participating provider system.

Adding too much financial risk can incentivize providers to start acting like an insurer, or even cause them to join forces with an insurer to help manage the risk. It also encourages consolidation of providers into ever-larger groups which can diminish competition that could help hold down prices. Any risk that the state makes providers take on needs to be carefully calibrated with the providers' strategies of holding down or reducing unnecessary costs while providing the full appropriate measures of medical treatments to patients.

The question of financial risk also raises the question of how long a medical provider can count on a particular patient to be with them for the long term. In general, they can't, and this is especially true of patients enrolled in Medical Assistance or MinnesotaCare. The risk models that depend on attributing patients to a particular provider group creates a huge disincentive, which is: Providers would be naturally reluctant to spend increased resources on more prevention, primary care and disease management because the "return on investment" – savings down the road in reduced expensive specialized care – take decades to fully materialize. A provider could spend the extra money for this on their patients, who years later switch to a different provider – who realizes the financial savings caused by the previous provider's investment. Very large integrated systems with tens of thousands of patients would maybe make the investments, but the only way to really solve the problem is to have a unified, universal payment system which shoulders the investment expense for all providers at the same time. To date, the investments that have been generally made by accountable care organization models have been very limited to the "low hanging fruit" of certain types of disease management that can prevent, in a short period of time, reduced hospitalization expense. It does not address our overriding problem of far too little preventive and primary care,

which results in more specialized and expensive care than need happen otherwise, and an unnecessarily high medical expenditure overall.

The vastly problematic issue of provider risk heavily points to the desirability of the PCCM model discussed above. PCCM addresses DHS' goal of reducing spending that is not actual medical care, by very directly and clearing slashing administrative expense. Medical providers don't have to deal with the issues in taking on insurance risk. In PCCM models, utilization is kept in check with the primary care gatekeeper and coordination roles. The old (and very questionable) fear of "blank check" runaway costs with Fee For Service payments has not materialized in the PCCM experience. The huge administrative savings from PCCM could even enable better reimbursements to medical providers above the current DHS Fee For Service rates.

*9. How much of the entities' payment should be subject to performance on quality and health outcome measures? Please explain your answer.*

The concept of pay for performance (P4P) might sound plausible in theory, but it is not a good method to use, and should not be used at all, or at least not for the components that measure patient health outcomes. The chief reason is because the P4P theory depends on accurate and fair measurements which are either extremely expensive and/or impossible to obtain, and because P4P can easily lead to negative consequences. A very real danger is that physicians and clinics would become motivated to not want to see patients who "bring down" their performance scores, which can result in patients who need care the most having the most difficulty receiving it. As mentioned previously, risk adjustment is such an inadequate science that it cannot do a good job of factoring into P4P determinations.

Trying to attribute patient health outcomes to the performance of the physician, when so many factors including patient compliance with instructions, patient ability to afford out of pocket costs for medications and other expenses; and social determinants affecting the patient are all outside of the physician's control. It is useful that the DHS proposal, and other trends, are seeking medical providers' involvement in addressing social determinants, but that does not alleviate or negate the issue of these factors affecting outcomes and physician "performance." P4P adjustments are very likely to lead to financial punishments for providers who treat low income and disadvantaged patients, and reduced care for those patients. That contributes to worse health outcomes, not better ones, and worsens health disparities instead of improving them. Social determinants of health such as housing, environmental factors, education, nutrition, and income are such basic societal realities – and fundamentally a result of our country's vastly unequal distribution of income and wealth -- that it does not make any sense to make medical providers responsible for them. As for personal behaviors, medical providers can influence some of those to some degree, but still have no real control over them.

*12. Other:*

In its request for comments, DHS states that "More than \$212 million of this savings has occurred in the last three years with the state's successful IHP program." GMHCC has repeatedly asked DHS for a breakdown of the calculations to arrive at this number, with no response other than silence. It is important for DHS to provide the detailed calculations to the legislature and the public, so we can properly evaluate the claim.



An important question is: Just what shared savings has DHS actually realized from the IHPs (Medicaid ACOs) to date? When savings occur by beating spending targets, two different processes take place in regard to Fee For Service enrollees, versus MCO enrollees in the PMAP program:

1) For Fee For Service (FFS) enrollees, DHS calculates and pays the ACO provider its share of the savings. DHS has already realized its share of the savings, by virtue of paying out less in FFS reimbursements than it would have otherwise.

2) For managed care (PMAP) enrollees, the process starts with DHS paying the MCO its normal monthly capitation for all of the MCO's enrollees. The MCO pays the ACO provider its normal reimbursement for specific services. After the year is up, DHS calculates the total savings that the ACO accomplished. DHS then orders the MCOs to pay, on behalf of each MCO's enrollees who are patients of the ACO, the appropriate portion of the savings to the ACO.

*The big question is then:* How does DHS receive its portion of the shared savings, out of the money that it already gave to the MCOs? This is apparently accomplished through some sort of adjustments in the capitated rate setting for each MCO, for the next year or perhaps only starting with the year after that. There are also negotiations between DHS and the MCOs. The bottom line is that is unknown and unclear if DHS actually gets the full amount of its shared savings, or whether the MCOs keep some of that, which they should not be retaining.

If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name Cindy Robinson

Organization HCAMN

Title Minnesota citizen

Telephone Number

Email

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

Rice

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

I disagree with the basic premise that adding another level of bureaucratic management is going to reduce spending on health care. The problem is the PRICE, not the amount of care that is accessed. More of our health care dollars need to be going directly to providers, not IHP or MCOs.

---

**Q5** 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.

The premise is faulty.

---

**Q6** 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.

The premise is faulty.

**Q7** 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 vs. phased in over time?

Care coordination should be done by the patient's primary care physician, not some organization not involved in providing patient care.

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**Q8** 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?

The premise is faulty.

---

**Q9** **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?

I support Lori Swanson's proposal to utilize the cost savings of the Minnesota Multistate Contracting Alliance for Pharmacy for all Minnesota residents. Government has a responsibility to do something to reduce the out of control costs of prescription medications.

**Q10** 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?

Please do not proceed with adding yet more paperwork and red tape to our health care providers.

---

**Q11** 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?

no response

---

**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

no response

---

**Q13** **One of DHS's 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?

no response

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

no response

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

As stated above, there is no reason to believe that adding more managed care to our health care system will result in decreasing health care expenditures. Underuse of medical care is a far larger problem in our society than overuse. Our government needs to be able to negotiate for uniform, reasonable payments for prescription drugs, medical procedures, exams, etc. Our current system is shrouded in secrecy and promotes wildly exorbitant prices for health care. Health care is treated like a commodity but has none of the market controls that any other commodity has.

**Q16** Click the icon below if you prefer to upload a file of your responses.

Once file has been successfully attached, a unique ID will appear in the box.

If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name Stephen Janusz  
Organization Health Care for All Minnesota (HCAMN)  
Title Board Member  
Telephone Number [REDACTED]  
Email [REDACTED]

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
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- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

Working to provide "Affordable high quality healthcare for every Minnesotan"

**Q3** What geographic area are you representing? (please check all that apply):

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Rice

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Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

Very concerned with the bureaucracy this creates. MCOs are creating large organizations that limit the freedom to care for the patient.

---

**Q5** 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.

How can someone accurately determine this size?

---

**Q6** 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.

Please see Sen. John Marty's attached letter



**Q7** 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 vs. phased in over time?

Don't believe we can measure this accurately.

---

**Q8** 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?

Don't see where this can easily and accurately be determined.

---

**Q9** **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?

A single Preferred Drug List for the entire state makes sense. Should be available to all people who live in Minnesota.

**Q10** 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?

The element of risk should not be borne by providers. All of us Minnesotans can contribute as our income determines in a risk pool managed by the state.

---

**Q11** 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?

This should be addressed has a separate issue from how we pay for our healthcare.

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**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

Performance must be left to local control within the clinic or peers.

---

**Q13** **One of DHS's 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?

Have grave concerns how we can evaluate quality programs. We are creating a "teaching to the test" approach to healthcare.

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

Don't believe this new payment policy improves population health. There are existing reports that raise serious concerns that IHP an MCO approaches in fact do more harm than good with patient health.

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

Please read Sen. John Marty's letter. I do not believe the continued DHS approach to MCOs and IHPs work to improved quality and reduced costs to Minnesotans.

**Q16** Click the icon below if you prefer to upload a file of your responses.

Once file has been successfully attached, a unique ID will appear in the box.

ref:0000000129:Q16

Senator  
John Marty

**Senate**  
State of Minnesota

Minnesota Department of Human Services  
Elmer L. Andersen Human Services Building  
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December 12, 2017

**Comments from Senator John Marty in response to the Minnesota Department of Human Services Request for Comment on *Outcomes-Based Purchasing Redesign and Next Generation IHP* on November 15, 2017**

**Summary:**

The Minnesota Department of Human Services plans to significantly expand the payment “reforms” for Minnesota’s programs to provide health care for low income people. However, evidence shows that those reforms lead to more bureaucratic, *more expensive* health care that *reduces* the quality of care. My comments are intended to challenge the entire reform, not to fine-tune the proposals for expansion.

**Synopsis of DHS Request for Comment:**

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).<sup>1</sup>

In this request, you are planning to “redesign and reform” the payment system for the public programs through what you call “Integrated Health Partnerships” (IHPs). Here is your explanation of the IHP concept:

Participating health care providers work together across specialties and service settings to meet patient needs. These providers share in savings they help create and in losses when goals are not met. They look for innovations to improve the health of their communities. This work shows Minnesota’s commitment to pay for value and good health outcomes instead of the number of visits or procedures people receive.<sup>2</sup>

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<sup>1</sup> [https://mn.gov/dhs/assets/request-for-comment-outcomes-based-purchasing-redesign\\_tcm1053-318160.pdf](https://mn.gov/dhs/assets/request-for-comment-outcomes-based-purchasing-redesign_tcm1053-318160.pdf)

<sup>2</sup> <https://mn.gov/dhs/integrated-health-partnerships/>

You intend the IHP model to produce the following benefits:

- To improve health outcomes for enrollees and their families
- To improve and standardize the enrollee experience
- To increase savings by reducing overall costs
- To reduce administrative costs and improve efficiency in the system<sup>3</sup>

You highlight one specific problem that you want to see addressed:

**Currently too little of every dollar spent on health care is devoted to patient care.** This makes it makes it burdensome for people to consistently get the care they need, understand their options and make informed decisions.<sup>4</sup>

### Comments from Senator John Marty:

I recognize that the Department of Human Services is hoping that your efforts to redesign and reform DHS' purchasing and delivery strategies for Medicaid and MinnesotaCare might result in lower costs and better health, and I appreciate your request for public comment.

However, these “reforms” are based on some false assumptions and I need to challenge the entire direction that Minnesota is headed with these current and proposed “purchasing and delivery strategies.”

A key problem that you highlight on the DHS webpage announcing the request for comment, is that *too little of every dollar spent on health care is devoted to patient care*. I strongly agree. It is because of that shared concern about the diversion of health care dollars away from patient care that I challenge the direction of both the current “Integrated Health Partnership” (IHP) model and the proposed next step. To explain this direct, head-on challenge, it is important to back up and start at the conceptual level:

If the problem is that too little of the health care dollar is spent on patient care, the response should be to eliminate bureaucratic administrative expenses. Instead, the IHP model proposes additional complications, which require *more* administrative time and money, presumably in the expectation that this will lead to better efficiency at the provider level.

Healthcare dollars spent on patient care are delivered by providers – nurses, doctors, physical therapists, and countless other medical professionals working in clinics or hospitals. The simplest, most efficient means of getting care to those patients is to direct those providers to deliver the care needed, and pay them for doing so.

Using an efficient system of paying medical providers directly to deliver care is analogous to the way the rest of our economy works. Businesses provide a product or service, and we pay them for it. This could be described as “fee-for-service” or “price-per-product.” It is not a perfect system, but it works relatively efficiently. It *is* the way our economy works.

However, in the healthcare sector of the United States economy, the concept of “fee-for-service” (FFS) has been vilified as wasteful and inefficient and numerous reforms have

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<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

claimed to replace it with a better system.<sup>5</sup> For several decades, the “Health Maintenance Organization” (HMO) or “Managed Care” model has claimed to replace FFS with “managed care.”

Essentially “Managed Care Organizations” (MCOs) are a **middleman** between the payer and the provider: they accept a capitation payment from the payer, and then “manage care” that is to be delivered by the provider. By adding a new administrative layer, this model adds additional administrative costs, which presumably will be paid for by greater efficiency in the actual delivery of patient care.<sup>6</sup>

However, it is inaccurate to claim that Managed Care Organizations have ended fee-for-service in health care delivery. MCOs receive *capitation* payments, but they pay providers with fee-for-service payments for performing procedures, for diagnosing, testing, and treating patients. Some of the individuals delivering care are paid FFS and others are paid a salary or hourly wage by their clinic, but that clinic is paid FFS. That payment may include incentives or bonuses, but it is still a FFS payment.

In the last few years, the newer payment reforms have introduced an **additional middleman** to the system. Under various models, these additional middlemen are named “Accountable Care Organizations” (ACOs) or Integrated Health Partnerships (IHPs). In other models, these new administrative middlemen are called “Health Systems” (Allina, Mayo, Sanford, Fairview, Essentia, etc.). Regardless of the name for the new middleman, they are also described as “provider networks,” which is appropriate since they are business organizations that own, buy up, or affiliate with numerous individual providers, clinics, hospitals, and nursing homes.

Even if these new administrative businesses are networks or conglomerations of providers, it is misleading to describe them as medical “providers,” because those corporations provide no care beyond what is being delivered to the patient by the individual providers that they own or affiliate with. The providers are the clinics or hospitals or medical professionals who *provide* care, while the business network or conglomerate is simply an administrative entity that owns or controls those providers.

These administrative entities were created in large part, so that new payment ideas, ostensibly to improve quality and efficiency, such as “Total Cost of Care” (TCOC), “Value-Based Purchasing” (VBP), or “Pay-for-Performance” (P4P) can be implemented. The theory behind the reform is that if a provider gets economic rewards when their patients do better, they will have the incentive to deliver optimum care which will keep the patient healthier, and ultimately save money.

**Note:** This should raise the question whether a “good” medical provider is one who cares more about the patient’s health and well-being *because* they are compensated better as a result. Proponents of the reforms don’t want us

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<sup>5</sup> If requested, I would be pleased to expand on why this ubiquitous vilification of “fee-for-service” among health policymakers is misguided, and offer comments on how to fix problems with our current fee-for-service system that would improve our health care financing system rather than make it worse.

<sup>6</sup> Note that adding administrative expenses with the assumption that it will deliver more or better patient care, is the cause of the problem: “*Currently too little of every dollar spent on health care is devoted to patient care*” that the Request for Comment says the IHP model is intended to address.

to focus on that; they only want us to acknowledge that financial rewards provide behavioral incentives. I certainly acknowledge that financial payments provide incentives, but proponents err in failing to recognize that medical providers have other motivations<sup>7</sup> to provide quality care for their patients beyond financial bonuses.

Not only do proponents of P4P fail to recognize that there are other non-financial motivations, but they do not understand that those P4P financial incentives may actually *undercut* the power of those intrinsic motivations.<sup>8</sup>

The common illustration of how this “Total Cost of Care” (TCOC) incentive system should work comes from hospital readmissions: If a hospital discharges a recovering patient too soon or without appropriate follow-up care, the patient is more likely to be readmitted to the hospital as a result. If we financially penalize the hospital for patients needing readmission, the hospital will have a financial incentive to ensure that the patient’s needs are better met. The hospital is responsible for the patient’s overall costs, and if they short-change the patient, they will be penalized later. This illustration is a logical one, and under our current health care financing system, one could see how it *might* make sense.

However, for a physical therapy clinic, or mental health clinic, or medical clinic, one cannot hold the provider responsible for the overall patient outcome, because these providers deliver only a small portion of the patient’s care. Even if the concept did work for hospitals in relation to readmission rates, it simply doesn’t work for an individual provider. As a result, small provider clinics are pushed to affiliate, or merge with, a big provider network – the administrative middleman. That large administrative entity is paid on a capitated basis, and is then responsible for the TCOC of the patient. In this case, the actual providers are responsible for only a portion (often a small portion) of a patient’s care, and the concept of making the provider responsible for the TCOC makes no sense.

Consequently, it is inaccurate to suggest that the provider is responsible for the TCOC. Instead, it is the “provider network” or “health system” or “managed care organization” that is paid for and responsible for the “total cost of care.” To restate the obvious, we now have two middlemen who “share the risk,” which effectively doubles the administrative cost of these entities that provide no patient care.

There are a number of problems with this entire scheme.

Despite the intent of improving the quality of care, there is significant evidence that these practices actually *harm* the patients they are supposed to help. Earlier, I mentioned the one illustration commonly used by proponents of these “quality” measures, the Hospital Readmission Reduction Program (HRRP). It is not being overly dramatic to say, “Lives are at stake here,”<sup>9</sup> since “Research at the University of Michigan suggests the HRRP program is

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<sup>7</sup> Motivations such as: an ethical commitment to provide the best care possible (for physicians, the Hippocratic Oath), personal & professional concern about the well-being of the patient, pride in one’s work and the desire to get good results, gratitude from patients who have better outcomes, and praise from colleagues for professionalism. These motivations matter.

<sup>8</sup> “Pay-For-Performance: Toxic to Quality? Insights from Behavioral Economics,” International Journal of Health Services, Himmelstein, David U., et. al., April, 2014 <http://journals.sagepub.com/doi/10.2190/HS.44.2.a>

<sup>9</sup> “Practicing Medicine While Black”, Sullivan, Kip, November 9, 2017

killing up to 5,000 [chronic heart failure] Medicare patients annually,” according to Kip Sullivan.<sup>10</sup>

U.S. hospitals have recently shown a consistent and disturbing disconnect between reductions in their heart failure hospital readmission rates and heart failure mortality... “The most concerning question we can ask is whether inappropriate discharges from emergency rooms and observation units” is a driving factor behind the mortality rise despite a readmissions drop, said Dr. Abdul-Aziz, a cardiologist at the University of Michigan in Ann Arbor.... On the basis of [CMS] numbers<sup>11</sup>, as many as 5,200 additional deaths to U.S. heart failure patients in 2014 “may be related to the Hospital Readmission Reduction Program’ of CMS,” according to Gregg C. Fonarow, MD.<sup>12</sup>

If these so-called “quality” reforms are reducing the quality of care and **actually killing people**, that is sufficient reason, on its own, to immediately stop implementing the reform. Period.

There are further problems as well:

First, small medical practices are often forced to merge with large hospital/healthcare systems to implement the risk-sharing payment system that ACOs are designed to deliver.<sup>13</sup>

Forcing small medical clinics to join big provider systems could potentially make medical care better, but it could potentially make it worse, and certainly less personal. The angry public outcry in both Fairmont and Albert Lea, Minnesota over the losses in local care after Mayo Health System took over their local hospitals shows how patients and their local communities view the cutbacks in care.<sup>14</sup>

To be clear, the point of these mergers under ACOs or other payment reforms is not to improve care, but to explore whether they might save money. The risk is that when this experiment is finished, it is possible that these mergers will actually *reduce* the quality of care and cost *more*.

Unfortunately, there is evidence that these mergers are driving costs higher. A December 2015 study from Yale University, “*The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured*,” found that the large hospital/health care systems created by mergers to form Accountable Care Organizations, were actually driving up prices, thus increasing health

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<http://thehealthcareblog.com/blog/2017/11/09/practicing-medicine-while-black/>

<sup>10</sup> Ibid.

<sup>11</sup> <https://jamanetwork.com/journals/jama/article-abstract/2643762?redirect=true>

<sup>12</sup> “While U.S. heart failure readmissions fall, deaths rise,” Internal Medicine News, Mitchel L. Zoler, September 20, 2017 <http://www.mdedge.com/internalmedicineneeds/article/147553/heart-failure/while-us-heart-failure-readmissions-fall-deaths>

<sup>13</sup> Elizabeth Stawicki, “Independent Medical Practices Find It Harder to Stay that Way,” *MPR News*, May 16, 2011, <http://www.mprnews.org/story/2011/05/14/independent-medical-practice>.

<sup>14</sup> “Albert Lea Albert Lea rises up against Mayo’s plan to trim hospital services,” Matt McKinney, Star Tribune, September 2, 2017, <http://www.startribune.com/albert-lea-rises-up-against-mayo-s-plan-to-trim-hospital-services/442553123/> “Fairmont Hospital Struggles after Mayo Takeover,” Star Tribune, November 8, 2014, Jeremy Olson, <http://www.startribune.com/lifestyle/health/282039841.html>.



spending.<sup>15</sup>

Second, conceptually, the *health system* or *provider network*, is playing the same role that we were told HMOs were needed for in the past. Instead of paying the medical provider directly, the provider network serves as a middleman, collecting capitation payments for patients, and then paying providers (again, paying them with some form of fee-for-service). Simply because we are paying these large “provider networks” with capitated payments, does not mean that we have ended fee-for-service in health care delivery. As mentioned earlier, the individual providers are paid fee-for-service by the new provider network middleman. We already had one middleman adding administrative expense. Now we have two middlemen, playing the same role.

It should be obvious that both administrative middlemen (who are simply an administrative payment mechanism, and are not providing care) are diverting money from patient care – the opposite of what is needed to address the problem spelled out by the Department of Human Services, namely, “*too little of every dollar spent on health care is devoted to patient care.*”

Third, because the individual provider clinics may have little choice but to participate in these payment methodologies, they are at a big disadvantage in getting fair compensation. A primary care clinic providing services to high-need, low-income patients has a difficult enough task without trying to track whether their patients are using other providers, especially if the provider network is not transparent about hospitalization or other expenses of *that clinic’s* patient. In other words, the clinic may have no knowledge what other care the patient chooses to get, and the clinic might not even be able to find out about that other care from the IHP or provider network. They cannot even know if they are getting appropriate compensation.

Fourth, the *risk adjustment* necessary for the payment systems to work is both administratively costly, and not very accurate. If the payer is inaccurate in the risk adjustment for some patients in the direction that would benefit the IHP (or provider network or MCO), the IHP is eager to accept the overpayment – and there is little chance that they will tell the payer “you were too generous with us.” If the risk adjustment is too low, the IHP will do whatever necessary to collect a higher reimbursement so that they don’t lose money on the patient.

So, unless DHS was miraculously able to be perfectly accurate in the costly risk adjustment process, they will end up overpaying for some patients as well as wasting money on the risk adjustment bureaucracy.

Fifth, because of the inaccuracy of risk adjustment, payment schemes that are based on these quality measures lead to increased health disparities. A 2014 report commissioned by the Obama administration and convened by the National Quality Forum said that providers who serve low income people and communities, “are more likely to be identified as ‘poor performers’ and... more likely to face financial penalties in pay-for-performance programs.”

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<sup>15</sup> Zack Cooper, et al., “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured,” *Health Care Pricing Project*, December 2015, [http://www.healthcarepricingproject.org/sites/default/files/pricing\\_variation\\_manuscript\\_0.pdf](http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf). See also Kevin Quealy and Sanger-Katz, Margot, “The Experts Were Wrong About the Best Places for Better and Cheaper Health Care,” *New York Times*, December 15, 2015, [http://www.nytimes.com/interactive/2015/12/15/upshot/the-best-places-for-better-cheaper-health-care-arent-what-experts-thought.html?\\_r=4](http://www.nytimes.com/interactive/2015/12/15/upshot/the-best-places-for-better-cheaper-health-care-arent-what-experts-thought.html?_r=4).

This can lead to “a series of adverse feedback loops that result in a ‘downward spiral’ of access and quality for those [socially and economically disadvantaged] populations. The net effect could *worsen* rather than ameliorate healthcare disparities.”<sup>16</sup>

The theories behind some of these payment reforms *sound* good, but they require more administrative bureaucracy, taking resources away from patient care.

## **Coordination of Care**

I am a proponent of increasing care coordination, especially for high-risk, complex patients. However, doing so in an efficient manner means that 100% of the care coordination expenditures go directly to the providers who coordinate the care instead of channeling the payments through MCOs, Provider Networks, IHPs or some other administrative middleman. Paying for care coordination through a third party reduces the amount available for the actual service.

While most care coordination might be funded based on individual patient needs, DHS could also provide direct grants to Minnesota’s Community Health Clinics and other clinics that work with homeless people and other high-need populations. With such grants, the low-income clinics could hire nurses, social workers, or other patient advocates to go to homeless shelters and other places with underserved people, people who use hospitals or emergency rooms for routine care.

Instead of wasting care coordination dollars on IHPs or other third-party administrators, I urge DHS to move all Medical Assistance, MinnesotaCare, and other public program participants into a less costly direct contracting system such as the Primary Care Case Management (PCCM) system as proposed in [Senate File 1299](#).

## **A commonsense alternative: Primary Care Case Management (PCCM)**

If Minnesota moved the delivery and payment system for public health programs to a “**Primary Care Case Management**” (PCCM) system, the Department of Human Services would no longer contract with HMOs or MCOs to pay providers for health care.

Instead, DHS would contract directly with providers (clinics, doctors, hospitals) for care. This is a simpler, more transparent, and less expensive system. This improved efficiency would immediately affect the \$5 billion per year that Minnesota currently spends for managed care in Medical Assistance.

Under the current system, the state pays a “managed care organization” to pay the providers, with the hope that, somehow, the patient’s care will be “managed” or coordinated. However, despite the name “managed care,” the MCOs are essentially managing claims, not managing the patient’s care.

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<sup>16</sup> National Quality Forum, “Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors,” August 15, 2014, p16, [http://www.qualityforum.org/Publications/2014/08/Risk\\_Adjustment\\_for\\_Socioeconomic\\_Status\\_or\\_Other\\_Sociodemographic\\_Factors.aspx](http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx).

As mentioned earlier, those who believe fee-for-service payments are a problem, should *not* see “managed care” as a solution, because it isn’t moving away from FFS payments to providers; it is simply paying a middleman to *make* those FFS payments, instead of making them directly. By contracting directly with providers for the services performed, the PCCM model eliminates the inefficiencies exposed by the debate over whether to have “prospective attribution” or “retrospective attribution” of patients. It also avoids the unintended consequence of harming providers who treat poorer, sicker patients.

For coordination of care, under the PCCM model, the state pays providers directly, with the primary provider coordinating the care, receiving compensation for that service as well.

Medical Assistance and MinnesotaCare patients, especially those with chronic or complex conditions or disabilities, and those with socio-economic challenges that lead to health disparities, would have better health outcomes if they had a care coordinator.

One of the immediate savings that would result from the change would come from elimination of the need to pay “navigators” to help people shop for an insurance plan. Instead, these navigators could be repurposed for the task of coordinating care, helping people navigate the *care* they need.

Under the PCCM model, patients would be encouraged to choose a primary care provider where they would receive help navigating the health care system. Both the patient and the clinic would understand the relationship, unlike the current situation where patients can be “attributed” to a clinic, without their knowledge. The care coordination payments would go to that clinic, with higher care coordination payments for patients with chronic or complex conditions or disabilities. The PCCM provider would provide overall oversight of the patient's health and coordinate with the patient’s other providers to ensure that patients get appropriate care.

The PCCM, or primary care case manager, would typically be a primary care clinic, but in some cases where the patient has a chronic condition or specific needs, such as mental health, a specialist or specialty clinic that regularly works with the patient might fill that role. Minnesota’s community health clinics would be well prepared to provide care coordination because of their extensive experience with low income patients, but whichever clinic a patient is using for care could provide the coordination.

Under the PCCM proposal, the Commissioner of Human Services would collaborate with community clinics and social service providers to do outreach to low income people who need care but are unlikely to access it due to homelessness, mental illness, or other challenges.

The commissioner would also work with medical and social service providers to reduce hospital admissions and readmissions by providing transitional care and other help to people that would help them stay out of inpatient facilities and emergency rooms. Unlike the increased mortality caused by the Centers for Medicare and Medicaid Services (CMS) Hospital Readmission Reduction Program (mentioned previously), this initiative would reduce readmissions by providing care that keeps people healthier, not by incentivizing hospitals to keep them out.

The benefits of the PCCM model are the same types of benefits that the IHP model is supposed

to provide. However, instead of hoping that an extremely complex and costly payment model *might* provide incentives that would result in better coordination of care, the PCCM model would simply and directly pay for the care coordination that we want. It would significantly reduce the administrative burden on doctors and clinics, and consequently, reduce costs. Unlike the IHPs or other alternative payment models the PCCM system would be understandable, transparent, and fair.

PCCM's have been used elsewhere. According to a policy brief of the Kaiser Commission on Medicaid and the Uninsured, in 2012, 31 states operated a Primary Care Case Management (PCCM) program.

“In PCCM programs, states contract directly with primary care providers (PCPs) to provide, manage, and monitor the primary care of beneficiaries who select or are assigned to them.”<sup>17</sup>

The Kaiser brief says that states have chosen to use PCCM “in rural areas with insufficient population to attract MCOs, or because they prefer contracting directly with providers, rather than with insurers, and have the administrative capacity to do so. Oklahoma, and more recently Connecticut, have both dropped earlier MCO contracting programs in favor of PCCM, *citing issues including higher costs associated with MCO contracting, plan turnover, and comparable or better performance by PCCM on measures of quality and enrollee satisfaction.*”<sup>18</sup>

## Quality

Many healthcare reform efforts to improve quality attempt to do so by creating a new “quality measurement” system, along with a bureaucratic formula for paying incentives or bonuses in a financial reward and punishment system. In addition to the *enormous* administrative expense and hassle of setting up that complicated system, those “quality” payments systems create numerous additional problems, including:

- Penalizing providers who care for low-income and high-need patients
- Enabling providers to game the system by devoting more effort into documenting patient problems (to increase compensation) rather than treating patients for their conditions, and
- Diverting provider time from patient care by requiring them to spend more time on administrative reporting of quality measures

Calling those administrative costs “enormous” is not an exaggeration. The title of a March 2016 study published in *Health Affairs*, summarized the scope of the costs: “US Physician Practices Spend More Than \$15.4 Billion Annually to Report Quality Measures.”<sup>19</sup> The report estimated that “the average physician spent 2.6 hours per week (enough time to care for approximately nine additional patients) dealing with quality measures; staff other than physicians spent 12.5 hours per physician per week dealing with quality measures.” That’s a total of over 15 hours required for every physician every week, just for the medical providers

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<sup>17</sup> <https://kaiserfamilyfoundation.files.wordpress.com/2012/02/8046-02.pdf>

<sup>18</sup> Ibid.

<sup>19</sup> Lawrence P. Casalino, et al., “US Physician Practices Spend More Than \$15.4 Billion Annually To Report Quality Measures,” *Health Affairs* 35 (March 2016), pp. 3401-3406, <http://content.healthaffairs.org/content/35/3/401.abstract>.

to report quality measures on which they are to be graded and paid.<sup>20</sup>

Requiring a medical student to repeatedly perform and document any specific quality measure during their training may teach and reinforce best practices. However, requiring a doctor to document the same things over and over, year after year, in order to be paid for better quality care is counterproductive and serves no purpose while wasting time and causing physician burnout.

Not only are states and the federal government pursuing costly, misguided “quality” payment schemes, but in doing so, we *fool ourselves* into believing that we are improving healthcare quality, even as we ignore the most outrageous violations of basic quality standards. This failure to address the most serious violations of quality was illustrated in recent exposés on nursing home care in Minnesota and other states. The Minneapolis Star Tribune reported that there was not even an *investigation* of improper care in 97% of the cases, including criminal assaults on seniors.<sup>21</sup>

If Minnesota is serious about improving the quality of care we should stop wasting time on counterproductive payment schemes and start by investigating reports of the most serious failures to deliver quality care.

### **What about the Cost Savings Claimed by DHS?**

My challenge to these healthcare “payment reforms” explains why the reforms are driving up costs, *not* reducing them. But how can I say these payment reforms cost more when the Department of Human Services (DHS) claims Minnesota Integrated Health Partnerships (IHPs) have saved \$213 million<sup>22</sup> in the first four years?

The reality is that we have such a convoluted health care financing system that it is difficult to measure the full impacts of changes in the system. DHS makes an estimate of savings from reductions in rehospitalizations and ER use that *they attribute to* the IHP model – they claim a 14 percent reduction in inpatient admission and 7 percent reduction in ER visits<sup>23</sup> – however with the inaccuracy of risk adjustment, accurate attribution of these reductions is difficult. In addition, some of those reductions in hospital admissions may well be inappropriate and harmful to patients, as mentioned previously.

On top of that, the savings DHS claims have been achieved by IHPs ignores the spending by the providers and by the administrative middlemen – to set up the administrative infrastructure, to hire the bookkeepers and accountants, and to train medical providers on the data and procedures they need to document in order to maximize reimbursement.

The large amount of provider time needed for documentation and data reporting, along with the huge administrative costs likely outweigh the savings. Unfortunately, *the biggest harm is that done to patients*<sup>24</sup> *as well as the reduction in time devoted to patient care*, and shifted to

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<sup>20</sup> Ibid.

<sup>21</sup> <http://www.startribune.com/senior-home-residents-are-abused-and-ignored-across-minnesota/450623913/>

<sup>22</sup> <https://mn.gov/dhs/media/news/#/detail/appId/1/id/318197>

<sup>23</sup> pg 20, [https://www.chcs.org/media/MedicaidACOPProgramsWebinar\\_01.17.17.pdf](https://www.chcs.org/media/MedicaidACOPProgramsWebinar_01.17.17.pdf)

<sup>24</sup> “While U.S. heart failure readmissions fall, deaths rise,” Internal Medicine News, Mitchel L. Zoler, September

this “quality” and billing-related documentation.

Calculating savings from reductions in the use of some forms of health care, while ignoring the very real increases in administrative expenses is not unique to the IHP initiatives. Over the years, DHS has frequently made claims of big savings. In fact, a couple years ago DHS claimed a cumulative total of \$1.65 billion in savings from health reforms.<sup>25</sup> If we really *are* saving billions on these reforms, one might wonder why health care costs for the public programs continue to rise so much faster than other sectors of the economy.

### **The Solution We Need**

Minnesota has some of the best medical care available in the world. We have some of the best doctors, nurses, and other medical providers. We have some of the best hospitals and clinics, some of the best medical researchers and facilities, some of the best medical technology inventors and manufacturers.

But we squander those incredible assets on a dysfunctional system for accessing care. The US is unique in our high costs – spending twice as much as other industrialized countries, while delivering worse health outcomes. We are also unique in being the only industrialized country that doesn’t provide health care for all of our people.

I have been consistent in calling for comprehensive reform that would provide healthcare to every Minnesota, for all their medical needs, *including* dental, vision, hearing, mental health, prescriptions, long-term care, alcohol & drug treatment. I have been consistent in calling for a system which is driven by patients, who get to choose their own providers; a system where medical decisions are made by patients and their providers, not by government, insurance companies, or employers. We can have such a system, which focuses on keeping people healthy and getting them care when they need it, saving money for families, businesses, and government.

That comprehensive reform is proposed in the Minnesota Health Plan, [Senate File 219](#).

However, this letter is *not* focused on that comprehensive reform. This letter is responding to the DHS request for comments on the IHP model. This letter is merely proposing some immediate next steps for Minnesota:

- An immediate halt to further implementation of payment reforms that are adding to our healthcare administrative bureaucracy
- An immediate end to costly administrative middlemen to pay for healthcare in MinnesotaCare and Medical Assistance
- Using savings from elimination of the administrative middlemen in our public programs, and delivering care along with care coordination through a proposed Primary Care Case Management (PCCM) system, as proposed in [Senate File 1299](#).

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20, 2017 <http://www.mdedge.com/internalmedicineneews/article/147553/heart-failure/while-us-heart-failure-readmissions-fall-deaths>

<sup>25</sup> <http://www.startribune.com/counterpoint-minnesotans-benefit-from-competitive-bidding-on-health-insurance/324527421/>

## Conclusion

I challenge the entire direction of the DHS health payment reforms, which are doing the opposite of what the agency intends. These reforms are *increasing* costs, while *decreasing* the quality of care provided.

It is unwise to push ahead with administratively complex “reforms” that are based on flawed assumptions. I urge DHS to step back and question the assumptions behind their proposed reforms. Recognize that this complexity is moving backwards on the problem highlighted on the DHS Integrated Health Partnerships webpage, namely that, “too little of every dollar spent on health care is devoted to patient care.”

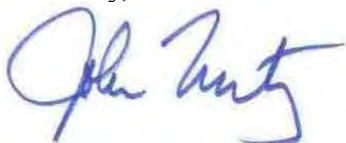
Rather than continuing to build a second costly layer of administrative middlemen, we should be eliminating both layers. We can deliver healthcare in an efficient manner and work directly with providers to improve quality.

For the DHS goal of improving care coordination, I urge you to avoid further administrative waste and deliver it in the most direct, efficient manner – by paying for care coordination and navigation directly to the providers who perform the task.

I am pleased to provide more information and more details on proposed alternatives if the agency is interested.

We are headed in the wrong direction. I urge a halt to further implementation, and a complete rethinking of how we pay for healthcare. Minnesota can provide a model for the world in health care.

Sincerely,



John Marty

cc: Emily Piper, DHS Commissioner  
Ed Ehlinger, MDH Commissioner  
Jessica Looman, Commerce Commissioner  
Dan Pollock, MDH Deputy Commissioner  
Marie Zimmerman, State Medicaid Director  
Nathan Moracco, DHS Assistant Commissioner for Health Care  
Santo Cruz, DHS Deputy Commissioner for External Relations  
Diane Rydrych, MDH Health Policy Director



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**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Jeff Bostic
Organization	LeadingAge Minnesota
Title	Director of Data and Financial Policy
Telephone Number	651-603-3509
Email	jbostic@leadingagemn.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

LTC Providers (nursing facility, assisted living, adult day and other community services)

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

All



**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

Since we do not work with primary care providers we don't have comments here

---

**Q5** 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.

Since we do not work with primary care providers we don't have comments here

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**Q6** 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.

Since we do not work with primary care providers we don't have comments here

**Q7** 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 vs. phased in over time?

Since we do not work with primary care providers we don't have comments here

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**Q8** 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?

Since we do not work with primary care providers we don't have comments here

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**Q9** **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?

Since we do not work with primary care providers we don't have comments here

**Q10** 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?

Since we do not work with primary care providers we don't have comments here

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**Q11** 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?

We feel that this is a very important aspect of the demonstration and that it needs to be flexible enough to encourage innovation in these areas. We believe it is often the case that interventions other than traditional medical services can significantly contribute to improved outcomes and providers should be incented to try these approaches.

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**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

Since we do not work with primary care providers we don't have comments here

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**Q13** **One of DHS's 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?

Since we do not work with primary care providers we don't have comments here

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

Since we do not work with primary care providers we don't have comments here

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

As a LTC provider association, we are supportive of reforms to Medicaid payment to make the system more efficient and to improve client outcomes. We also believe that provider led approaches like what you are proposing in this procurement, as long as they are voluntary and flexible (as this appears to be), are a great way to use provider experience and ingenuity to improve results for clients. We would like to suggest that DHS consider a similar approach to LTSS for seniors and people with disabilities. A pilot project with similar design and incentives seems like an excellent way to test new approaches and find ways to both improve outcomes and potentially slow the growth of spending on LTSS. We acknowledge that such an approach comes with its own complications (for example, how to integrate with primary and acute care benefits through Medicare) but we feel it holds enough promise that it is worth pursuing.

**Q16** Click the icon below if you prefer to upload a file of your responses.

Once file has been successfully attached, a unique ID will appear in the box.

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**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Anne Quincy
Organization	Mid-MN Legal Aid
Title	Supervising Attorney
Telephone Number	612-746-3745
Email	aquincy@mylegalaid.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
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- Tribal Organizations
- Other

Please specify:

Legal services

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Which county?

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What other options could DHS consider and why?

---

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Please be specific in your response for Next Generation IHP or MCO.

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Once file has been successfully attached, a unique ID will appear in the box.

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**LEGAL AID - MINNEAPOLIS**  
Anne S. Quincy • (612) 746-3745 • [aquincy@mylegalaid.org](mailto:aquincy@mylegalaid.org)

December 20, 2017

## **Response to Request for Comments on Outcomes-Based Purchasing Redesign and Next Generation IHP**

Legal Aid - Minneapolis provides civil legal representation to low income individuals in Hennepin County. Our clients include families with children and persons with disabilities, including many individuals who have limited English proficiency. One of the critical needs of our clients is access to quality health care. Part of the mission of our organization is to protect the legal rights of low-income and underserved people to this critical need.

We are offering limited feedback on the Department's Request for Comments (RFC), and write primarily to support and highlight the comments of other consumer representative groups such as Take Action MN calling upon the Department to focus more attention on consumer engagement in the implementation of Next Generation Integrated Health Partnerships (IHP) and other innovations to our public health care programs. In addition to driving reforms among providers in the areas of purchasing and delivering health care which save tax dollars, the promise of innovation is to improve the health and lives of the children, parents, and other adults enrolled in our public health care programs. But we know too little about the actual impact on the lives of patients of the reforms implemented thus far.

The current RFC marks only the second request for public input since the first iteration of IHP's outcomes-based purchasing in 2013. Meaningful consumer education and community engagement has been lacking in the intervening years, while the Department has focused its attention on providers. We echo the comments of Take Action MN to this RFC, that "patients and representative organizations need long term meaningful engagement to develop the expertise and language to translate on-the-ground needs and experiences into relevant measures, feedback and policy language." And "[g]oing forward it is critical that patients be more involved in the design, implementation and oversight of the state's redesign and reform of the purchasing and delivery strategies for the public health care programs. Patients must be involved at all levels."

Proposals from providers seeking to participate in Next Generation IHP must include specific, meaningful ways in which the provider will engage patients and their families in all aspects of providing their health care, from decisions about treatment to how to reinvest the moneys saved by payment reforms. The Department then needs to engage IHP enrollees and representative organizations in the process of measuring outcomes for individuals and impacts on their communities. This can be accomplished by, among other methods, ensuring greater enrollee and enrollee advocate representation on advisory committees such as Minnesota's Medicaid Advisory Committee and/or the creation of a subcommittee of the MAC focused specifically on ACOs and MCOs.

**430 First Avenue North, Suite 300 Minneapolis, MN 55401-1780**

Telephone: (612) 332-1441 Client Intake: (612) 334-5970 Facsimile: (612) 746-3745 [www.midmnlegal.org](http://www.midmnlegal.org)

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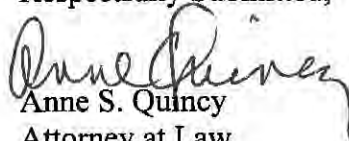
December 20, 2017

Page 2

In addition to calling for greater consumer education and enrollee engagement, Legal Aid also wants to voice support for the Department's stated intention to focus on the enrollee experience with care and, along with that, their proposal to administer a single Preferred Drug List (PDL). Specifically, we support a single PDL being used across all payment models *and* across the state. In addition to pharmacy, we think the Department taking over management of medical services including dental, PCA, DME, vision and hearing aids, and non-medical transportation will enhance the enrollees experience of care by bringing stability and reliability to these key, though ancillary, health services. We often hear from clients that their most anxiety-producing health care experience is a disruption in their prescriptions, their PCA, or the medical transportation they have painstakingly arranged. This can happen when people are disenrolled from their managed care plan due to technical issues beyond their control. Having the Department administer these services through its fee-for-service payment system will ensure enrollees maintain much-needed services without disruption - one key to a good health care experience.

Finally, Legal Aid supports the proposal to permit IHPs and MCOs to use partially-capitated and fully-capitated rate funds to pay for innovative community partnerships like the medical-legal partnerships in which Legal Aid and other legal services in the 7 metro counties are engaged. Embedding legal services attorneys in health care clinics is an effective way to address social determinants of health such as substandard housing, homelessness, access to healthy food and food assistance. We would also support requiring providers to fund such partnerships with health care savings they reinvest.

Respectfully Submitted,



Anne S. Quincy  
Attorney at Law

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**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Susan Voigt
Organization	Minnesota Community Healthcare Network
Title	Executive Director
Telephone Number	612-201-1159
Email	svoigt@mchnforhealth.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
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- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

**Q3** What geographic area are you representing? (please check all that apply):

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Which county?

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Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

MCHN serves a population of individuals with serious and persistent mental illness that require intensive case management and care coordination services. We are assuming that DHS is considering including behavioral health organizations within the definition of a clinic that would qualify for “primary care inclusivity” within the model. We have concerns with the lack of access to behavioral health services within the seven-county metropolitan area and we feel DHS should maintain open access to behavioral health providers for IHP enrollees. We also believe that the most viable model for behavioral health providers to take accountability and have the resources to meet the needs of MHCP recipients is the continued development of attribution models that are inclusive of behavioral health organizations and services that would allow for IHP inclusion as a Track 1 or Track 2 IHP, or an alternate demonstration project.

---

**Q5** 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.

No response.

---

**Q6** 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.

Given the constraints on access to behavioral health services Next Generation IHP applicants should demonstrate ability to meet benchmarking related to availability of appointments for behavioral health providers, and a capacity to manage the targeted case management and care management for individuals with severe and persistent mental illness. This would also include the ability to engage county services, ACT Teams, etc. that are needed to support individuals with mental illness. Formal relationship with community-based providers to meet this level of service expectation would be an example of an IHP demonstrating their ability to meet population needs.

**Q7** 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 vs. phased in over time?

It is critical with the initiation of the Next Generation IHP Model that IT adequacy standards include the Next Generation IHPs ability to provide data and information exchange to providers and community based organizations within the network, and demonstrate the IHPs ability to support population based analytics and reporting. DHS should also consider direct services to network participants as part of the DHS administration function that would include DHS providing options for data sharing directly to providers and community-based organizations within the IHP network. There should be a minimum baseline of reporting provided to network participants (provider and community based organizations).

---

**Q8** 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?

No response.

---

**Q9** **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?

The Preferred Drug List should include all behavioral health medications or have an exceptions process that allows clients to obtain needed medications in a timely and cost-effective manner.



**Q10** 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?

Related to behavioral health services, current research demonstrates that there is an inequity between FFS payments for medical care reimbursement and reimbursement for behavioral health services within Minnesota. Resources and the intensive interventions needed to manage individuals with serious and persistent mental illness far exceeds what can be provided under a FFS model. These individuals also represent high cost populations where investments in innovations and integrations with systems of care have an opportunity to substantially impact the rising costs for their care and produce sustainable health outcomes. As an incentive to make investments into these needed interventions we would proposed that a portion of the PMPM Medical Management and Service Delivery payments based on outcomes, provide for a guaranteed withhold return, or gain share return providing the Next Generation IHP can demonstrate a formal relationship with a financial transaction (investment) targeted at interventions/innovation contributing to patient and population health. These incentives could include a symmetrical or non-symmetrical investment formula.

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**Q11** What are appropriate measures and methods to evaluate paying for non-medical, non-outcome measures?

covered services that are designed and aimed at addressing social determinants of health, reducing disparities and improving health outcomes?

The Next Generation IHP should be required to demonstrate through data analytics and community-based organization input the development of innovation/interventions programs that target populations with proposed outcomes and cost saving opportunity within the population(s). Measurements of population size and opportunity should include claim based data collection and non-validated direct or third-party data collection that is repeatable and can be validated over time. Data collection should track population engagement, improvement and potentially lead to policy change to meet a broader population of MHCP recipients. The investment and risk of the IHP should be equivalent to the resources needed to engage the innovation initiative. Following the Core Principles of the IHP model, IHPs should demonstrate additional risk investments in order to participate in the incentives provided in the contract.

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**Q12** How much of the entities' payment should be subject to performance on quality and health

Please explain your answer.

No response.

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**Q13** **One of DHS's 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?

In 2010, the Patient Protection and Affordable Care Act (ACA) charged the U.S. Department of Human Services with developing a National Quality Strategy (NQS), the purpose of which to better meet access to health care that is safe, effective and affordable. Using NQS as a model, the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a National Behavioral Health Quality Framework (NBHQF). With the NBHQF, SAMHSA proposed a set of core measures to be used in a variety of settings and programs, as well as in evaluation and quality assurance efforts. These recommended and future measures address NBHQF goals related to: evidence based practices; person-centered care; coordinated care; health living for communities; reduction in adverse events, and; affordable/accessible care. These goals are inclusive of NQF measures, and other reporting entities related to national behavioral health quality framework, and due to the high prevalence of mental illness within Medical Assistance and MinnesotaCare public program recipients, we feel aligning measures such as these would benefit populations included in the Next Generation IHP model.

**Q14 Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

MCHN organizations provide extensive case management and care coordination services for its clients often at a cost that well exceeds claim based reimbursement. MCHN interventions, such as the ED in-reach programs, that have been developed are demonstrating improvement in health outcomes and in some cases significant reductions in the total costs of care for the target population. This type of programming often requires sponsors or additional third-party add-on payments in order to achieve the level of programming necessary to sustain such a service. Addressing advancements in value based network development needs to include the realization that additional funding is needed in targeted areas for improvements. Currently with Managed Care Organizations options for additional funding is limited, or unapproachable. Allowing Next Generation IHPs some flexibility with investments required to establish sustainable programs focused on population health would benefit the consumer of health care and provide incentives for network providers/community based organizations to invest in needed infrastructure/ resources knowing that a revenue stream was available to assist with covering costs. Some considerations:

- Providers often rely on grants and foundations, including health plan foundations, to provide for startup and sustainability of programs with objectives to improving health outcomes and reducing medical/community costs in relation to the recipient. This level of innovations requires collaboration, expertise, and the ability to implement methods of PDSA or like methodologies. Providing incentives to Next Generation IHP to lead network performance improvement initiatives and invest in targeted outcomes would elevate the ability to implement and sustain best practices. The IHP payment model could include a construct that would provide for a return of a withhold, or provide an incentive that would be based upon a level of matching the investment made by the IHP considering the impact to the enrollee population (size and scope) and commitment of investment and additional risk taken to incorporate non-medical community partnership or targeted population improvement initiatives across the network.
- Flexibility to allow IHPs to provide additional reimbursements to network providers that exceed performance standards, implement capitative payment models, or FFS add on payments for non-claim based interventions. If DHS will administer the FFS payments to network providers, what is the flexibility and mechanisms to adjust FFS payments or provide additional provider payments based upon contracted engagements? Would these types of payments be allowed? How would they be accounted for: off-book from DHS, or; reportable to DHS as an IHP? Will IHP's have the ability to fund innovation/interventions as part of the claim based payment model, or will there be separate classification to track this type of programming away from administrative fees? Are there limitations? More clarity on flexibility and reporting would be beneficial.
- Requiring the collection of social determinant data within the Next Generation IHP network that can be used to inform and improve future payment models. This could include the use of Z-Codes or other tools for data collection at the identified recipient level. An incentive would be an improvement of the overall risk score of the population based upon data collection with validated tools - assuming risk score adjustments will be provided within the model based upon social determinants present within the IHP attributed population. Accountability related to the data collection would include the Next Generation IHPs ability to track the data and engage community partners and network providers to address gaps in care, or access to services. As payment models graduate to a deeper capitative payment model, so should the level of risk to the IHP related to populations underserved based on social determinants and access needs and rewards for higher performance in this area.
- DHS should provide oversight to provide a level uniformity across IHPs, so IHP's will meet a minimum standard of expectation when addressing social determinant needs for the attributed population. This would provide equity across IHPs and generate a culture of accountability and transformation. DHS's ability to identify high risk sub-populations within the Next Generation IHP Network that would support the additional planning and interventions by the IHP would create engagement and accountability. DHS could consider a contractual obligation during future performance periods related to identified at-risk populations with matching incentives for demonstrated execution and improvement. This could include the intensive needs of behavioral health services, housing coordination, food insecurity etc. Formal relationships with community based organizations and county services would be an example of how an IHP could



demonstrate adequate resourcing and distribution of services to meet population needs. Long term – payment models allow for adjustments based upon social determinant needs of the population and IHPs would benefit by improved outcomes in the population with experienced gains in the IHP performance. • Expansion of undefined claim codes to track initiatives implemented to improve population health. This could include care coordination touches, uncompensated care services, etc. Claim based tracking across IHPs could provide DHS with necessary data to evaluate and measure the level of additional resources being provided to MHCP recipients within the IHP demonstrations and assist with adjusting PMPM payment model to align with resource needs of populations.

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

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**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Jon Tollefson
Organization	Minnesota Nurses Association
Title	Government Affairs Specialist
Telephone Number	651-414-2858
Email	Jon.Tollefson@mnnurses.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
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- Other ancillary health care providers
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- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

Union of Registered Nurses

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

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Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

---

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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.

---

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Please be specific in your response for Next Generation IHP or MCO.

**Q7** 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 vs. phased in over time?

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How should DHS hold entities accountable for their proposal?

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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?

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**Q11** 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?

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**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

---

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Which quality programs (e.g. Merit Based Incentive Payment System; MN Statewide Quality Reporting and Measurement System) are important to align with?

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model and managed care organizations might result in an eligible entity from otherwise participating in the demonstration?

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ref:0000000184:Q16

In response to the Minnesota Department of Human Services (DHS) request for comments regarding the “next-generation” Integrated Health Partnerships (IHPs), the Minnesota Nurses Association submits the following comments.

Nurses believe that everyone must receive the care they need when they need it without regard to their ability to pay. Minnesota has a strong tradition of providing basic health coverage for our neighbors who are most in need, but nurses know that all too often, patients do not receive necessary care. This is why we work towards the policy solution of a publicly-financed healthcare system that covers all Minnesota residents from birth until death without interruption.

As we work towards a Single Payer healthcare system, we seek to build the pillars of that system in our publicly-managed programs, including Medical Assistance and MinnesotaCare. Those pillars include (1) direct contracting between the State and providers, (2) prioritization of preventive care, care coordination, and proactive management of chronic conditions, (3) full choice of providers, (4) the ability to negotiate prescription drug prices, and (5) global budgeting for hospitals.

The “next-generation” IHP program has some positive advancements, though we remain concerned with the overall direction of IHPs and Managed Care Organizations (MCOs) generally.

We applaud the upfront per-member per-month payments to providers for care coordination. This advancement will allow providers to invest in higher-quality, provider-initiated interactions with patients, as well as allow patients to contact providers with basic questions about their health. Right now, nurse hotlines and patient outreach are not reimbursable and are therefore underutilized.

We are concerned, however, with a number of elements within the IHP and MCO models.

First, all risk in healthcare should be held by the population as a whole, not a business. The opportunity and risk of shared savings should not be part of this public-provider relationship as it creates possible perverse incentives to provide less care or lower-quality care in order to maximize profits. Nurses seek to remove profit incentives from healthcare delivery.

Second, and relatedly, the regular rebasing for Total Cost of Care (TCOC) savings determinations leads to a healthcare system more similar to the Walmart style of business – regularly forcing providers to decrease supply costs and thus reduce quality over time – than to one that delivers a high-quality product or service. When we also consider the difficulty or even impossibility to accurately make risk adjustments, the TCOC determinations are largely arbitrary. This is particularly detrimental financially to small clinics that serve high-need patients.

Lastly, no public healthcare dollars should go to insurance companies or any healthcare system that assumes risk for a pool of patients. Insurance companies and hospital system billing agents do not provide any care to patients. Payments should only be made for direct patient care and care coordination.

Instead of expanding on the IHP model, given our aforementioned concerns, we recommend the following to DHS for management of its Medical Assistance and MinnesotaCare programs.

First, that DHS fully invest in preventive care and care coordination by paying clinics a small but reasonable capitated payment for care coordination. DHS should pay higher rates for patients with certain diagnoses and chronic conditions.

Second, that DHS pay set fees for any service or procedure provided beyond general appointments and care coordination. As those services would be included in the capitated payment, reimbursement for other services and procedures would allow providers to use capitated payments exclusively for maintaining regular contact with patients, ensuring they are taking prescribed medication and receiving the care they need when they need it.

Third, that no capitated payment go to a hospital system: only independent clinics and providers. This would remove possible perverse incentives that could include providers from hospital-owned clinics sending patients into hospital systems for unnecessary procedures simply to meet quotas, for example.

Fourth, that DHS work with each hospital in Minnesota to create global budgets and begin making annual per-hospital payments based on the number of public patients each hospital serves. These budgets would include infrastructure improvements, maintenance, and investment in new technology, among other needs. It is important that these global budgets concern individual hospitals and that hospital systems not be allowed to transfer this money between hospitals within their system.

Fifth, that patients have a full choice of providers. Patients should be able to choose any primary care provider, as well as any hospital system for other procedures and services. DHS should rescind current network restrictions that prohibit this.

Sixth, that DHS seek necessary approval to begin negotiating prescription drug prices for patients on public programs.

Finally, that all payments be made directly from DHS to providers for all services. Again, we have no need for insurance companies, and this would also help reduce the rapidly-increasing number of billing agents providers are required to hire.

In summary, nurses work towards a system that guarantees every patient receive the healthcare they need when they need it without regard to their ability to pay. We look to DHS to help construct the pillars of a publicly-financed healthcare system that meets all Minnesotans' healthcare needs within its current public programs. Direct contracting with providers, investments in preventive care and care coordination, full patient choice, negotiated drug prices, and global hospital budgeting are all among those pillars.

If we move in this direction through DHS public programs, Minnesotans can finally begin to take control of our broken healthcare system.



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**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Thomas H. Berkas
Organization	NAMI Minnesota & Augsburg University
Title	Affiliate Coordinator & Adjunct Faculty
Telephone Number	651-35-5014
Email	tberkas@namimn.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
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- Other

Please specify:

NAMI Minnesota

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Please provide sufficient detail and calculations to support your response.

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For all people on Medical Assistance, I would urge DHS to issue a statewide formulary. This would not just be for people who qualify for IHP. This because when Medicaid plans change people have to cope with new formularies.

**Q10** 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?

---

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**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Caroline David
Organization	Professional Rehab Consultants
Title	Occupational Therapy
Telephone Number	██████████
Email	████████████████████

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
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- Tribal Organizations
- Other

Please specify:

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Are there exceptions to this to consider?

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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.

Professional Rehab Consultants is an outpatient Occupational Therapy clinic that specializes in treating adults with mental illness diagnoses. The majority of our clients have SNBC or PMAP health plans and would be directly impacted by this program. As OT practitioners, one of our many skills is to address the barriers our clients face to increase their functional independence in the community. As such, we have a unique perspective on additional services that would increase an individual’s success in the community. When our clients are busy and engaged in the community they tend to be more successful with managing their mental and physical health. Unfortunately, transportation and lack of safe and appropriate programming are barriers to their success. While many of our clients receive covered rides to their medical appointments, they have limited or no accessible transportation to other programs. Non-medical ride transportation should be a primary consideration for IHPs and MCOs. Many of our clients struggle with isolative tendencies (which can be addressed in occupational therapy), therefore, access to safe and appropriate community support programs and drop in centers is important. Use of these supports are not without challenges. Part of the challenge stems from transportation (as stated above) however a lack of suitable programming within the client’s community can lead to a lack of community involvement, isolation and often an exacerbation of mental health symptoms. The current trend toward improved overall wellness could greatly benefit people with mental illness. Unfortunately, the majority of our clients have limited incomes and are often unable to purchase healthy meals or have access to exercise opportunities due to financial constraints. Access to adequate healthy food and exercise facilities along with education and support from trained personnel would increase healthy habits and improve overall health.

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**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Dale Dobrin, MD
Organization	South Lake Pediatrics
Title	Medical Director
Telephone Number	9524018396
Email	ddobrin@slpeds.com

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
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Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

this is a complicated question. health plans, including those managing dhs patients, operate at their own pace. this means that they may not fully up to speed on the nuances of next gen. accordingly, a health plan or product within a health plan may not include a participant's current clinic or provider or may have an exclusive arrangement of its own which would conflict with next gen's exclusivity feature. in general, I am opposed to exclusivity, either by provider or payer, since it limits patients' choice. since the issue here is accountability, why not use another criterion, preferably one already in place and validated, such as Health Care Home certification as the criterion for inclusion by a clinic or provider group? further, re "fidelity to the model", why not agree on a package of "accountables" within HCH, rather than this exclusivity clause.

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**Q5** 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.

ACO uses a minimum population size of 5000. i would look to data from the smaller ACO's to help answer the sustainability and economies of scales questions. another option would be to allow independent provider clinics to join with each other to accomplish sustainability and economies goals for the next gen purpose

---

**Q6** 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.

1. Health Care Home certification 2.demonstrated primary care and behavioral health partnerships 3. alignment with other community agencies, such as schools, social service agencies, etc

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registry tracking is necessary at the provider level to assure that a patient referred actually has care initiated by the service provider referred to; and that once care is initiated that it is a) integrated with other care being provided by the primary care provider, and 2) that the service being referred to is continued to completion. in the absence of such tracking, CC will not be effective; and studies show that patients, left to their own devices, for various reasons, initiate referred care only 50% of the time. These are the elements of continuous coordinated care. Integrating these elements for care delivery with payer processes has proven near impossible. "dummy codes" could be used for initiated and continuing care service elements.

---

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How should DHS hold entities accountable for their proposal?

health care home certification, in both instances

---

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Statewide Might this potentially shifting costs to patients who cannot afford to pay??

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phase in as with IHP 1.0 also, some dollars to providers to ramp up their infrastructure to be able to execute on next gen; then the following year to require risk taking

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designate some money to each NGIHP provider group for this purpose and observe for the more effective initiatives; and have learning /sharing sessions between these provider groups to maximize efficiency and effectiveness.

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Please explain your answer.

phase in: start with 10% for quality (MNCM) and 20% for outcome measures.

---

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Which quality programs (e.g. Merit Based Incentive Payment System; MN Statewide Quality Reporting and Measurement System) are important to align with?

All that are, or soon will be, required.

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see response to questions 10 and 11 need not interpose disruptions to care, such as the ill fated and unwise elimination of U Care from most of the metro area

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

I am VERY concerned about strategies and policies leading to further consolidation in health care delivery. studies show that costs are less and quality as good or better when delivered by independent practices, in particular those with Health Care Home certification, than in hospital-clinic based systems. the NGIHP, as i read it, requires clinics/providers to be either system based or a "provider network". One provider network which would allow for the advantages of independent practice and not continue to force independents into systems and networks, would be a "Health Care Home Network of Independent providers". Certified clinics group already are serviced by the HCH program which provides innovation and other learning/sharing opportunities. Why reinvent wheels?

**Q16** Click the icon below if you prefer to upload a file of your responses.

Once file has been successfully attached, a unique ID will appear in the box.

If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Guthrie Byard
Organization	The Arc Minnesota
Title	Advocate
Telephone Number	952-915-3663
Email	guthrie@arcgreatertwincities.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

Statewide



**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

---

**Q5** 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.

---

**Q6** 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.

**Q7** 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 vs. phased in over time?

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**Q8** 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?

---

**Q9** **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?

**Q10** 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?

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**Q11** 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?

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**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

---

**Q13** **One of DHS's 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?

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

**Q16** Click the icon below if you prefer to upload a file of your responses.

Once file has been successfully attached, a unique ID will appear in the box.

ref:0000000169:Q16

## **The Arc Minnesota**

### **Integrated Health Partnerships 2.0 and Next Generation Integrated Health Partnerships Request for Comments**

Thank you for allowing The Arc Minnesota to comment on the Department of Human Services' (DHS) proposed plan to expand the Integrated Health Partnerships (IHP) model. The Arc Minnesota is a nonprofit community-based disability rights advocacy organization with regional offices throughout Minnesota. The Arc Minnesota promotes and protects the human rights of people with intellectual and developmental disabilities and their families in a lifetime of full inclusion and participation in their communities.

The Arc Minnesota favors a more efficient and effective healthcare delivery system, as individuals with disabilities have historically been disadvantaged and limited the healthcare choices. However, The Arc Minnesota would like to provide several comments and suggestions on the proposed redesign in order to ensure that the resulting public healthcare delivery model holistically addresses the health and wellbeing of people with developmental disabilities.

#### **Incentivize Providers to Partner with Non-medical, Non-provider Advocacy Agencies**

As a non-medical, non-provider advocacy agency, The Arc Minnesota supports hundreds of individuals with developmental disabilities each year in accessing and utilizing health, financial, habilitative, social, and educational programs and services that promote independence, health, and well being. In 2017, The Arc Minnesota will provide health care information and assistance to 400 individuals. This includes first time applications for programs like MA, explaining disability certification processes, renewing and using their coverage and how MA works with private insurance. Without our support, providers would be providing primary care to fewer individuals with developmental disabilities because they would either not have health insurance or know how to utilize that insurance.

The Arc Minnesota offers safety net advocacy support by helping families with limited income obtain public health care and disability-specific programs and services. These advocacy services help keep individuals living in their communities and contributing to the economy.

Accordingly, The Arc Minnesota recommends incentivizing the inclusion of non-medical, non-provider agencies like ours as a component of new partnerships formed either under the IHP 2.0 or the Next Generation IHP. This could be a component of the partial-cap or capitated funds that could be allowed for non-covered social determinants of health initiatives.

## **Utilize National Core Indicators to Address Advocacy Impact on Healthcare and Cost**

Admittedly, data showing that coordinated care that includes partnerships with advocacy organizations addresses the social determinants of health is limited. Much of this is due to the lack of formal partnerships in existence. Many provider organizations are unaware of how individuals gained access to the programs and services they are enrolled in. Inherently, providers often lack knowledge of the role of community-based advocacy organizations like The Arc Minnesota.

Given the data gap, The Arc Minnesota recommends that a key component of measuring the success of the healthcare delivery model include utilization of [National Core Indicators](#) measurements. The National Core Indicators are standard measures used across states to assess the outcomes of services provided to individuals and families. Indicators address key areas of concern including health and safety, as well as other areas that healthcare providers are increasingly referring out for support or including in their treatment care plans.

## **Ensure a Robust Single Preferred Drug List**

While The Arc Minnesota supports efforts to avoid disrupting medication access for those on MA who may be switching MA types or provider networks, We urge DHS to consider prospective unintended consequences of a Single Preferred Drug list if that Preferred Drug List or formulary is not sufficiently robust. If DHS is considering a reduction in covered medications, MA providers and patients should be made aware of and included in the vetting and exception process to ensure necessary medications are not removed unnecessarily.

## **Limit the Role of DHS in Administrative Functions**

The Arc Minnesota is concerned that the proposed IHP will allow providers to contract with DHS or one of their subcontractors on certain administrative duties that current Managed Care Organizations are responsible for. Specifically of concern are the customer service system, grievance and appeals processes, and initial enrollee screening and health risk assessments. Removing administrative duties from the primary care providers will reduce the quality of that administration and level of communication available to enrollees. It may also increase confusion on the part of the enrollee when attempting to seek support formerly offered by their provider. Clarification on why and which administrative duties are being taken over by DHS would be helpful in understanding the impact of this change.

Additionally, we request more thorough clarification regarding the subcontracting option in the Request for Proposal or Request for Comments. The

Arc Minnesota requests that transparencies be established to ensure that not only providers but enrollees know which contracts are being provided in which areas of administrative support.

### **Ensure Meaningful Quality Performance Measures**

The Arc Minnesota would like to recommend a more robust set of categories to effectively measure the health and well-being needs of those with developmental disabilities. Many individuals with disabilities have secondary health conditions like obesity or diabetes which impact their quality of life beyond their primary disability.

Since a one-size fits all approach to healthcare is not sufficient to address unique healthcare needs across populations, how are these measurements adapted to those with disabilities who historically have lower health and financial literacy levels? For instance, in residential settings where healthcare is being offered, how is patient safety assessed and outcomes measured when individuals are under the care of numerous providers throughout a day? What does the medical model do to ensure accountability and support of a coordinated care model that may include nurse practitioner or physician, Personal Care Attendants, Independent Living Skills workers, case managers, support planners, and others? Performance measures that evaluate expanded care coordination for complex care populations is needed to truly understand the efficacy of unique care models that expand beyond the traditional medical model.

Furthermore, The Arc Minnesota has questions about how the measurement weighing process will work for providers and partners providing care for enrollees with disabilities. Will patient-centered care and safety outweigh appropriate treatment, or will there be a greater focus on access to care those with developmental disabilities? We recommend that any providers who seek IHP contracts conduct needs assessment of their patient population that also engages community organizations supporting that enrollee as well as DHS when determining assigned weight to measurement categories.

Also from our understanding, measurements will primarily be calculated from claims data, survey responses, and electronic submission of clinical info. The Arc Minnesota agrees that electronic data submission will lessen administrative burden and cost, but is concerned that this will only tell part of the story. If partnerships with a broader spectrum of providers and community agencies are to occur, a wider collection of both quantitative and qualitative data outside of the medical field will be needed.

## **Address the Effects of Additional Medicaid Enrollees Excluded from Managed Care**

If additional Medicaid enrollees excluded from mandatory participation in managed care are allowed to enroll with an IHP provider, this means that more individuals with certified disabilities—either by Social Security of Minnesota’s State Medical Review Team—will enroll. Consideration should be given to medical needs, cost, and quality of care as the measurements are decided upon and weighed by providers. Data collected should highlight enrollee populations that have certified disabilities with an emphasis on rates of referrals to non-medical providers or partnering agencies to assess quality and complexity of coordinated care.

## **Expand the Definition of Population Health and Social Determinants of Health**

For individuals with disabilities, poverty and lack of healthcare are not the sole source of poor health; rather, it’s often the result of a misaligned medical model that does not prioritize the proactive health education of the community. Healthcare providers and physicians should employ plain language in their field to address low health literacy, reduce isolation and increase access to care for those who most need it. The Arc Minnesota works to address this through supporting the development of an individuals’ person-centered plan, which increases assertiveness, self-determination and direction within the individual.

Many with developmental disabilities are removed from the decision-making process across all aspects of their life, not just in healthcare. Person-centered planning is a core component of our work and support the individual with a disability by putting their wishes and desires ahead of anyone else’s regardless of intentions. This means that they better understand the options they have in improving their healthcare and actively make decisions that impact their life with their network of support as they have created.

DHS should ensure that a component of an IHP provider’s measurement of success include whether the person has an established person-centered plan and that the provider is following that plan along with their medical treatment plan. A person-centered plan acts as a coordinated care plan of services and supports for a person, so it would fit naturally with and properly inform any coordinated care plan.

## **Expand Future IHP Models Beyond Metro**

The Arc Minnesota represents much of the state, not just the seven-county metro area, and we understand that many people with developmental disabilities experience barriers to well being that are unique to their region. Transportation,



for instance—which impacts an individual’s access to timely and appropriate healthcare—is more burdensome and less prevalent in Stearns County than in Hennepin County. Expanding the care coordination model and related performance measures to include transportation is strongly encouraged when scaling future health partnership models beyond the metro.

It is imperative that a coordinated care model like IHP be expanded beyond the metro area with a structure that is unique to the healthcare and wellbeing of MA enrollees across the state. The Arc Minnesota requests that a request for comments on expanding this model to improve healthcare for Medicaid enrollees across the state. Additionally, if rural health clinic services are being considered for inclusion in the next generation IHP healthcare services, reviewing this service and its impact on outcomes should be considered while planning the expansion of this model beyond the metro.

Thank you for this opportunity to provide comments in response to the IHP 2.0 and Next Generation IHP proposals. Leadership, staff, and stakeholders of The Arc Minnesota welcome any request for clarification or more information regarding our comments included here, and look forward to partnering with DHS in ensuring that individuals with developmental disabilities and their families statewide have access to the highest quality healthcare models which meet their diverse needs.

Thank you,

Guthrie Byard

Advocate, The Arc Minnesota

If (at any point) you wish to save your entry and return to complete the survey at a later time, click SAVE at the bottom of the screen. You will be provided with a URL to return to your work in progress. If you wish to upload a document with your responses, you may do so in the final step prior to submission. You will have the opportunity to print your feedback in its entirety before submitting.

**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Ellie Skelton
Organization	Touchstone Mental Health
Title	Executive Director
Telephone Number	612-767-2160
Email	eskelton@touchstonemh.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

**Q3** What geographic area are you representing? (please check all that apply):

- Seven county metro area (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and/or Washington)
- Greater Minnesota

Which county?

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

The population we work with, individuals with serious mental illness, often don't have a primary care provider. In many of our programs, one of our goals is to establish a primary care provider, PCP and we have seen an increase in this metric. If we are providing care coordination, case management or housing services, we are seeing these individuals with far more frequency than their PCP. An exception to consider is if someone receives a monthly billable mental health service versus an annual PCP billing.

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**Q5** 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.

---

**Q6** 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.

**Q7** 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 vs. phased in over time?

Can we move toward an Epic Care Everywhere pilot that allows community based mental health programs to access Epic and enter notes, coordinate care and assist with ease of referrals?

---

**Q8** 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?

What is the teeth for coordinating with housing and residential treatment providers who provide lots of cost savings and don't see any gain sharing? We operate on extremely slim margins and are able to reduce an individual's cost of care which an IHP can see financial benefit for and the community provider may not even be recognized for their work. Substance abuse and residential treatment are still left out of the current IHP models and yet can really drive down costs. How can these partnerships be built into an IHP as a requirement?

---

**Q9** **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?

**Q10** 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?

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**Q11** 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?

Setting population specific goals and providing funding to ensure that the behavior change can be adequately measured. Short pilots, 18 month grants require so much infrastructure investment and don't allow larger population change to happen. A five year grant that is targeted on specific populations to improve health outcomes with funds to hire an outside evaluation firm would be ideal.

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**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

Depends on complexity of population, housing needs, and other social determinants of health.

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**Q13** **One of DHS's 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?

**Q14** Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of patients 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 model 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?

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**Q15** Do you have any other comments, reactions, or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

I'd like to find a way for smaller substance abuse treatment, mental health and housing providers to be at the table. The current model and IHP 2.0 doesn't work for organizations under \$15 million. Also organizations without outpatient mental health or primary care don't fit well even though we are in the field and homes of many of the high cost, high complex folks.

**Q16** Click the icon below if you prefer to upload a file of your responses.  
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**Please submit no later than 5:00 p.m. Central Time on Friday, December 15, 2017.**

**BEGIN HERE**

**Q1** Please provide your contact information.

Name	Jode Ann Freyholtz-London
Organization	Wellness in the Woods
Title	Executive Director
Telephone Number	56481
Email	jode@mnwitw.org

**Q2** Do you work for any of the following? (please check all that apply):

- Access services providers (e.g. transportation, interpreter)
- Community and social services organizations
- Counties
- Individuals receiving their health care benefits through a state purchased program (Medical Assistance & MinnesotaCare)
- Integrated Health Partnerships (IHP)
- Local Public Health
- Managed Care Organizations (MCO)
- Mental Health and Substance Use Disorder Providers
- Other ancillary health care providers
- Primary Care, Safety Net & Specialty Providers
- Providers of Home Care and PCA services (excludes contract for senior and people with disabilities)
- Tribal Organizations
- Other

Please specify:

Mental Health Advocacy and Education

**Q3** What geographic area are you representing? (please check all that apply):

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- Greater Minnesota

Which county?

Wadena

**Q4** 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 clearer lines of accountability.

Is “primary care exclusivity” the best way to drive towards these goals?

Are there exceptions to this to consider?

What other options could DHS consider and why?

In Greater Mn choices are already limited and transportation issues add to the barriers for accessing care. I would consider mandating the providers to offer what needs to be part of services to be included in the primary care exclusivity.

---

**Q5** 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.

---

**Q6** 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.

IHP and MCO should include peer specialists and have consumer representation on their boards.



**Q7** 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 vs. phased in over time?

Continual feedback from patients, family members and community. Frequent focus groups with non employee facilitators.

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**Q8** 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?

Communication and evaluation from and with consumers of services. How will they gather the information and utilize it along with distributing how the information gathered impacted change within the services.

---

**Q9** **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?

What works in metro may not work in rural areas. Keep in mind the unique challenges of both areas

**Q10** 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?

Continued feedback on waste management and quality of care by employees through anonymous evaluation and patient evaluation

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**Q11** 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?

Offer enough flexible funds to AMHI and counties to determine the need in their local areas

---

**Q12** How much of the entities' payment should be subject to performance on quality and health outcome measures?

Please explain your answer.

50%

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**Q13** One of DHS's 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?

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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 model 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?

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**Q16** Click the icon below if you prefer to upload a file of your responses.  
Once file has been successfully attached, a unique ID will appear in the box.

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's payment and care delivery model.

To be assured consideration, comments must be received no later than 5:00 p.m. Central Time on Friday, December 15, 2017.

Please click [submit](#) below.

## Email Response summary

51 respondents (includes duplicates) submitted comments via email including:

Blue Cross and Blue Shield of Minnesota	Minnesota Association of County Health Plans
Care Providers of Minnesota	Minnesota Council of Health Plans
Children's Minnesota	Minnesota Health Care Safety Net Coalition & Minnesota Oral Health Care Safety Net Coalition
Health Care Homes Program	MN Community Action Partnership
Hennepin Healthcare System, Inc.	MN Community Measurement
Medica Health Plans	NAMI Minnesota
Minnesota Association of Community Mental Health Programs	North Memorial Health
Minnesota Hospital Association	Otter Tail County Public Health Director Partnership4Health
Minnesota Medical Association	PCMA
MN Association of Community Health Centers	Planned Parenthood Minnesota, North Dakota, South Dakota
MN CHW Alliance	Rural Health Advisory Committee & Office of Rural Health and Primary Care
Pediatric Home Service	SEIU Healthcare Minnesota
TakeAction Minnesota	United Way
UCare	University of Minnesota Academic Health Center
United Healthcare	University of Minnesota School of Dentistry
University of Minnesota College of Pharmacy	MN Senate & MN House of Representatives
AspireMN	Land Stewardship Project
Carlton County Public Health & Human Services CentraCare	Itasca County
City of Minneapolis	Senate - State of Minnesota
City of Minneapolis – Health Department	Altair Accountable Care Organization
ClearWay MinnesotaSM	Accenture
Community Dental Care	
CSSC	
Dakota County Community Services	
Fairview Health Services	
Freeborn County DHS	
Health Partners	
Home and Community Based Services	
Magellan Medicaid Administration, Inc.	

December 20, 2017

Submitted electronically via email to [DHS.PSD.Procurement@state.mn.us](mailto:DHS.PSD.Procurement@state.mn.us)

Re: Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP

Dear Commissioner Piper:

Thank you for the opportunity to provide comment regarding proposed redesign and reform of the Minnesota Department of Human Services' (DHS') purchasing and delivery strategies for the Prepaid Medical Assistance Program (PMAP) and MinnesotaCare (MNCare). As the leading non-profit health plan serving nearly 360,000 individuals enrolled in these two programs in all regions of the state, Blue Plus appreciates its history of partnering with DHS and looks forward to continuing to collaborate to best serve Minnesota's public health care enrollees.

Like you, we believe innovation is critical to Minnesota's continued recognition as a national leader in delivery of public health care programs. This means finding new and holistic ways to provide the most appropriate, highest quality services to enrollees in the right place and at the right time. And, importantly, delivering care in a way that is accessible and understandable for the patient. We know many enrollees have complex needs and that many face challenges navigating eligibility, care, and service systems. Many have also experienced significant change in the last three years and we value the work DHS has done together with the state's managed care organizations (MCOs) to ensure seamless transitions. Yet there is more work to be done, such as identifying cost-effective approaches to address related social determinants, and we appreciate that improving enrollee experience is one of DHS' top goals. We also take very seriously our responsibility to provide the greatest value for the taxpayer and continue to look for ways to improve health outcomes without increasing costs.

As the state considers how to best move forward into the next generation of purchasing and delivery, Blue Plus urges DHS to 1) build on the strength of the existing managed care model to deliver value and stability to enrollees, 2) ensure thorough vetting and discussion of financial and operational approaches to avoid unintended consequences to enrollees and to the broader delivery system, and 3) ensure that any adjustments enhance the consumer experience for Minnesotans.

### **Leverage and Transform Existing MCO Infrastructure**

#### **Build Upon Established MCO Medical and Care Management Strategies**

Blue Plus prioritizes the Triple Aim of cost, quality, and patient experience in all our programs. MCOs play a critical role in medical management and care coordination for public program

enrollees, and we believe this role should be enhanced rather than duplicated or diminished. MCOs are positioned to be particularly effective in managing care because we can analyze real-time administrative data to understand the needs of our enrollee populations and solve quickly for key trends. Barriers to effective care management – such as limits on convenient, text-based communications – need to be removed so that the role of MCOs can be fully leveraged.

MCOs provide strategic value to our members by using what we have learned over time about delivering efficient and effective care through enrollee-centered medical homes and other coordinated care models. We are actively putting into play risk-based arrangements with providers and moving to person-centered assessments that drive improved health outcomes and enhance value, aligning with state expectations. We further support DHS' goals by providing incentives for high quality, coordinated primary care, providing usable data to primary care clinic (PCC) partners, and identifying and communicating barriers to care, among many other activities. MCOs also provide significant support toward addressing the social determinants of health and connecting enrollees to community resources that extend beyond health care. Food, housing, financial assistance, referrals for county assessments for waived services, and transportation are just some examples.

One specific example of an innovative approach to care management is tracking of high cost claims with an aim to deepen engagement between the enrollee and health care team to ensure coordinated and quality care, while reducing cost and improving the patient experience. The positive performance of Blue Cross' high cost claims unit (HCCU) includes 40% fewer inpatient readmissions across all lines of business. The data also demonstrates shorter lengths of stay, decreased emergency room visits, and fewer inpatient admissions for those managed in the HCCU program as compared to standard health coaching.

### **Ensure A Stable Enrollee Experience**

We appreciate DHS' goal of ensuring all enrollees understand their provider options. Many Medicaid enrollees have low health literacy, language barriers, unstable living conditions, and/or other social determinants that influence their ability to seek appropriate care and manage their health. We are concerned, however, that the up-front provider selection model described in the RFC will not solve for the issues DHS is trying to cure, such as a high default rate.

In 1997, as DHS began to move managed care statewide, great investment of both time and resources was made in educating enrollees about managed care and the benefits of selecting a PCC. A large percentage of enrollees did not select a PCC, so one needed to be assigned. Even with concentrated enrollee education on the concept of a primary care model, including partnership with counties and community-based agencies and scripting of enrollee benefits and expectations, the intended result did not completely materialize. Over time, many of the large MCOs adopted more of an open access model with additional resources dedicated to care management to target enrollees with special needs or health conditions. Most current enrollees in the metro area operate in this model.

Given the disruption caused by moving significant numbers of enrollees among MCOs in 2012, 2014, 2016 and May of 2017, this proposal has the potential to again disrupt enrollees' care by

requiring them to switch administrators and specialists because of a new selection process. Blue Plus urges that providing a more stable enrollee experience is what's most needed at this time.

### **Prioritize Program Sustainability and Beneficiary Protection**

As we strive to enhance both experience and outcomes for public program enrollees, we are concerned that DHS' proposal for Outcomes-Based Purchasing Redesign and Next Generation IHPs will have several unintended financial and operational consequences. To avoid unintended harms to the enrollee and the market, we think it is critical that:

- All responders compete on a level playing field;
- There is clear choice and benefit to the enrollee including improved outcomes;
- Duplication is avoided or, at the very least, minimized;
- Measurement is transparent; and
- The overall model is sustainable, measurable, and actuarially sound.

Below are some areas of the RFC that need further, collaborative review to ensure enrollees, taxpayers, and stakeholders are not harmed in unanticipated ways.

#### **Avoid Exclusive Primary Care Arrangements to Ensure Beneficiary Choice** (addresses RFC Question #1)

Locking PCCs into a single Next Generation IHP, so the PCC is excluded from MCO networks, is one of the most concerning features of this proposal. A number of practical, operational, and regulatory issues, among others, would likely result in serious unintended consequences.

MCOs are uniquely positioned to enable enrollee access to a range of high value providers. Primary care exclusivity would limit enrollee choice by narrowing the number of possible provider-payor relationships and minimizing MCO leverage to secure robust networks. This could force MCOs to contract with less efficient providers. It may also mean MCOs do not have a critical mass of PCCs in certain geographic areas or for certain provider types. DHS has acknowledged that often an enrollee's specialist might be their principal physician, and in that case could be considered their primary care provider. If so, access to such providers could grow difficult for enrollees.

DHS has said that provider choice and formulary are the top factors driving enrollees when they choose an MCO. However, there are other considerations that enrollees weigh when selecting an MCO or network, such as past relationships or customer service. Primary care exclusivity would limit choice if an enrollee wants to maintain his or her care management/administration with an MCO, or ensure access to certain ancillary providers, but is unable to do so due to primary care preference.

The exclusivity model will impact current revenue-based contracting models that are intended to drive provider performance across markets, and for which networks are designed across population-level measures. It may influence negotiated rates with IHP health systems that could impact other government and commercial products. There is also a very real risk that the current proposal will produce adverse selection against MCOs both due to the possible elimination of efficient providers



from MCO networks and because Next Generation IHP providers may have an incentive to encourage high risk patients to seek an alternative primary care provider.

DHS is proposing this model so providers can take meaningful risk for total cost of care and patient outcomes. However, for the last several years, MCOs have been required to move toward value-based payment arrangements. Therefore, Blue Plus has 42% of metro area Medicaid enrollees attributed in value-based contracts. We have invested significant resources in development of these arrangements and in developing reporting packages for providers. Our arrangements contain similar levers as the IHP program, including shared profit/loss and quality measures. This proposal will make it difficult to achieve the state's goal of 60% of membership tied to a value-based contract if key care systems choose to work through an IHP that operates under primary care exclusivity.

Adding IHPs as a care management option would be a much more reasonable pilot if providers weren't locked into IHPs through exclusivity. Blue Plus recommends that even if primary care selection is the most important upfront decision, choice of payor/administrator should be preserved by allowing the member to select an IHP or MCO that contracts with their PCC. This would simultaneously ensure beneficiary satisfaction and provider access. Historically, DHS has not provided clear expectations for the roles of MCOs and providers in an IHP relationship. Providing this guidance in the future could additionally help to support a primary care emphasis within the existing MCO model.

#### **Develop A Transparent and Accountable Financial and Program Model** (addresses RFC Question #7)

It is difficult to fully assess the Next Generation IHP financial model with so many unknown elements. For example, Next Generation IHP payment will be adjusted based on cost and quality performance, but DHS does not provide detail as to how these adjustments will be made. As well, the RFC states MCOs will be expected to demonstrate administrative efficiency on par with DHS or the state can take back those administrative functions. The range and parameters of this requirement are unclear, as is the timing or method by which DHS would transition program administration.

As outlined in the RFC, Next Generation IHPs generally would have increased responsibility for enrollee care and outcomes, but without the same financial risk or program accountability as MCOs. MCOs are required to meet significant financial and reserve requirements to ensure solvency and ability to meet program commitments. Under the current proposal, Next Generation IHPs are not accountable for losses unless losses exceed 2%. Individual MCOs have recently reported annual losses in excess of \$100 million. The lack of common financial and reserve requirements places IHP enrollees at risk. Blue Plus recommends that Next Generation IHPs meet financial requirements that ensure continuation of beneficiary care and available services if the IHP provider sustains shared losses.

MCOs are required to meet significant regulatory requirements, as well, including triennial quality audits conducted by the Minnesota Department of Health. The RFC is unclear as to how Next Generation IHPs will be subject to the same regulatory requirements as MCOs, especially in critical areas such as quality assurance, handling of grievances and appeals, and utilization management.

Program and reporting requirements should be the same across the board to ensure quality care and a positive enrollee experience.

Finally, under current contract arrangements between MCOs and DHS, limited information is available with respect to the IHP calculation methodology and assumptions for shared savings, even in those instances where MCOs are required to make significant payments to IHPs based on the results. Going forward, it will be necessary for DHS to be transparent and robust in how it assesses both clinical and financial outcomes and viability for all IHPs, ensuring they are quantifiable, measurable, and reasonably attainable. Currently, differences in methodology and assumptions used to develop MCO rates and IHP shared savings make the results of these programs inconsistent and difficult to compare. Blue Plus urges consistency in all models including use of the same risk adjustment methodology, normalizing the risk score across all programs, and rebasing the calculation for all programs annually.

#### **Allow for Flexibility and Cost Savings in Drug Administration** (addresses RFC Question #6)

Blue Plus cautions against using a single preferred drug list (PDL) across programs or carving out the prescription drug benefit from managed care as either would increase costs and decrease quality.

According to a report published by the Menges Group in April 2015 entitled “Comparison of Medicaid Pharmacy Costs and Usage in Carve-In Versus Carve-Out States,” between 2011 and 2014 six states switched from a pharmacy carve-out approach to a carve-in approach. These states experienced only a 1% increase in net (post-rebate) prescription drug costs from 2011 to 2014, while seven states that maintained a carve-out approach experienced a 20% increase in net prescription drug costs. This difference translates to an overall savings of \$1.2 billion in the carve-in states in FY2014.

States that carve-in the prescription drug benefit but maintain a statewide PDL miss out on large savings opportunities. The Menges Group published another analysis in February 2016 entitled “Assessment of Medicaid MCO Preferred Drug List Management Impacts,” which estimated that Texas could achieve significant prescription drug savings by allowing its MCOs the flexibility to manage drugs cost-effectively through their own PDLs. Specifically, it concluded that by allowing MCOs flexibility with their own PDLs the state would realize annual Medicaid savings of more than \$230 million and annual general revenue savings of nearly \$100 million. It further estimated that the use of the state mandated PDL cost taxpayers \$1 million every four days due to its use of higher cost brands (even after rebates) and low generic use. Maximizing rebates at the expense of choosing lower cost prescriptions did not prove to be an effective strategy. It was found that even after rebates were accounted for, the cost of name brand drugs was five times higher than lower cost generic alternatives.

A single statewide formulary also adds complexity for prescribers and pharmacies that are accustomed to prescribing and stocking lower cost brands and generic alternatives. An MCO, with expertise in managing care, can respond quickly to market changes and can communicate with prescribing providers, with whom they already have a direct relationship. Furthermore, carving out the prescription drug benefit would jeopardize all other aspects of care integration that the state

hopes to achieve. With a mandated PDL it may be impossible to coordinate clinical programs across all aspects of a member's benefit. Quality programs rely on complete integration across providers, care settings, and benefits.

### **Minimize Fragmentation in Care Delivery, Data Exchange and Evaluation**

The proposed model does not leverage MCO medical management and care coordination practices or consider the broad networks and functions we have built in supporting behavioral health, specialty care, and other needs within the full spectrum of services. Rather, counter to DHS' goals, the Next Generation IHP approach is likely to fragment member care and treatment. Care coordination often requires interoperability with a claims system and communication with specialists that might be outside of the PCC's care system. Having DHS pay claims while Next Generation IHPs perform care coordination fragments the ability to coordinate appropriately. As well, layering multiple IHP models on top of one another – in different regions of the state – stands to make the system more complex and administratively disjointed. It will be very challenging for DHS to measure success under these circumstances.

Data sharing restrictions under the Minnesota Health Records Act may inhibit critical information exchange to support Next Generation IHPs in delivering the safest, most effective care, and are likely to lead to additional fragmentation. There is further risk for fragmentation in quality measurement (addresses RFC Question #10). Blue Plus supports measurement alignment to reduce burden of data collection and reporting for both health plans and providers, allowing for a focus on improving health outcomes. Ideally, measures selected would align across national and local measurement requirements, meaning that measures selected would satisfy quality reporting across multiple programs, such as Healthcare Effectiveness Data Information Set (HEDIS), the Minnesota Statewide Quality Reporting and Measurement System (SQRMS), and the Merit Based Incentive Payment System (MIPS) to limit variability in measurement selection. In addition, quality results need to be standardized in a way that provides for transparent and impartial comparison.

Thank you for your partnership and for the opportunity to comment. We hope this is the start of a dialogue that will dig much deeper into the goals behind DHS' reform vision and the role MCOs can play in achieving them. Please reach out with any questions.

Sincerely,



Scott Keefer  
Vice President, Public Affairs



TO: Minnesota Department of Human Services  
FROM: Patti Cullen, President/CEO, Care Providers of Minnesota  
DATE: December 20, 2017  
RE: Public Comment on the Redesign and Reform of DHS' Purchasing and Delivery Strategies for Medicaid and Minnesotacare

Care Providers of Minnesota is a non-profit membership association with the mission to Empower Members to Performance Excellence. Our 900+ members across Minnesota represent non-profit and for-profit organizations providing services along the full spectrum of post-acute care and long-term services and support. We are responding to three specific questions in your November 15, 2017 Request for Comment.

4. Q: 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?

A: Two critical areas of improvement in care coordination, especially for the frail senior population with multiple co-morbidities is effective transitions of care and streamlining the care coordination experience. Due to the lack of an integrated interoperable health care record across the continuum of care, including post-acute care and long-term services and supports, errors in patient care occur at the transition point or soon after transitions from one point of service to the next. Patient records at point of transfer do not always reflect the latest medications, lab work and/or therapy needs resulting in less than desired outcomes. In addition, for seniors enrolled in Medicaid managed care, they could easily experience three or more different post-discharge care coordinator contacts, each asking different questions on the same topics: outreach from health plan, hospital, primary care, return to community coordinators, and, if applicable, nursing facility/home care. This is confusing for seniors and their families as the contacts can be intrusive and the care coordinators do not work together to get needed information.

8. Q: 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?

A: For the senior population, there is a state-researched analysis on long term care services and supports, and gaps in communities (<https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/gaps-analysis/current-study/>) This research identifies where communities believe services are missing/needed. We suggest the state look at these areas of need in determining which services to add to the list of covered services.

10. Q: 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?

A: For the senior populations receiving long term services and supports (LTSS) there are currently limited quality measures that are applicable even though NQF and other organizations have approved some measures for some services (such as CoreQ for Assisted Living settings). In addition, some of the federal measures for acute and post-acute care such as re-hospitalization rates have different definitions and metrics, depending upon service/payor, making it difficult to apply the measure across the continuum of care. We would recommend whatever quality programs are adopted have metrics that could be applicable through the entire continuum of care, so all providers are working in the same direction. Suggested quality metrics for LTSS could include customer satisfaction (Core Q), re-hospitalization rates, falls, and/or non-standard use of anti-psychotic medications.

For further information contact Patti Cullen at [pcullen@careproviders.org](mailto:pcullen@careproviders.org) or 952-851-2487.

December 20, 2017

Minnesota Department of Human Services  
540 Cedar Street  
St. Paul, MN 55101

**Delivered via email**

To Whom it May Concern:

On behalf of Children's Hospitals and Clinics of Minnesota (Children's), we offer the following comments in response to the "Request for Comments: Outcomes-Based Purchasing Redesign and Next Generation IHP" (RFC). As a long-time partner to the state and one of the first Integrated Healthcare Partnership participants, we appreciate the Department of Human Services' continued interest in pursuing new delivery and payment methods and the opportunity to comment on the Next Generation proposal.

Working with IHPs across the state, DHS has created a solid foundation on which to continue building. Children's participation in the health care home model and the IHP have afforded us important insight into how we can evolve these models moving forward. There are three critical principles we urge the department to consider as you move forward:

- Allow for flexibility in individual IHP model design and approach. We recognize the importance of standardizing where possible, but believe that one-size fits all approaches will not only limit creativity in model design but, more importantly, risk mis-alignment of approaches to the targeted patient population. This is particularly significant for Children's as a pediatric provider. As we often say, children are not small adults.
- Access to timely data that allows providers to better understand patient patterns and behaviors so we can design actionable and meaningful interventions to better serve our patient population.
- Break down the barriers to effective cross-sector collaboration. We agree with the move toward models that are more inclusive of the service providers who interact with our families and yet current policies, regulations and reimbursement methods will limit the willingness/ability of social service organizations, schools and other community organizations to partner.

We also want to acknowledge the ways in which the Next Generation IHP appears to address concerns from the health care community. The emphasis on proactive enrollment/attribution, removing duplication between provider and health plan wrap-around services, such as care coordination and recognizing the value of the primary care setting are all important elements of the Next Generation model.

Children's looks forward to ongoing discussion about the prospects for this new model. We offer the following comments in response to the specific questions outlined in the RFC.

### **Responses to specific questions**

#### **Question #1:**

We appreciate the goal of accountability offered through a centralized point of care and management. However, it is important to achieve this goal while also maintaining a family's ability to choose a primary care clinic that can best manage their care. This is more important than limiting clinics to only one payer method of access. As an exclusively pediatric focused health system, the model is also challenging as families seek to find optimal care for their children and the adults. Children's has always been a resource for families regardless of adult coverage or primary care. We would be concerned if this model limits access to the pediatric-specific services families rely on in this marketplace.

We would offer that you strive for clearly defined primary care with the possibility of exceptions for some who are managed by specialists. This would help ensure that by forced network selection, we are not unintentionally blocking access to necessary specialty services that may be outside of a clinic's network.

It will also be important to carefully account for concerns about how exclusivity could impact current patients who are covered by a different MCO.

#### **Question #2:**

Determining the appropriate beneficiary size for each IHP is dependent on how the state will establish risk. Determining sustainability of the risk pool is dependent on which services are included in the risk, if those services can be managed within a particular network and the acuity of the patient population. With these factors better understood, IHPs can assess the potential attributed populations from an actuarial perspective to determine longer-term risk threshold.

#### **Question #3:**

We would encourage DHS to clearly define network adequacy standard beyond geography to include types of services and other critical factors for managing the Medicaid population. A patient-centered set of requirements that ensure appropriate access to services and support structures that are most relevant for the identified patient population. In order to effectively manage the care of the designated population, IHPs and MCOs must build a network that has a breadth of services and enough capacity to ensure access to those services. An enhanced set of requirements, such as outlined in CMS' Medicaid and CHIP Managed Care Final Rule from 2016 that takes effect in July 2018, should be considered. The nine elements outlined in that rule address network expectations on breadth, depth, specialization, access and culturally-appropriate services. As a health system focused exclusively on children, we would encourage RFP expectations that recognize the need for access to specialized care for a pediatric population.

Accessibility to services in a timely manner is a key lever for managing populations, particularly pediatric populations. We would also encourage careful consideration of how issues of access disproportionately impact communities of color and socio-economically disadvantaged communities, and how network requirements align with those communities.

#### **Question #4:**

We need systems, processes and supports that allow enrollees to make informed decisions and equip health systems with actionable information to actively partner with families as they navigate their network. Immediate needs include an enrollee-focused directory of providers in their selected care systems, continued

implementation of the all-participant EAS system and development of a state-run HIE. Ultimately, policies and tools that allow for EMR integration and data sharing across systems and providers will facilitate coordination as well as policy levers that allow health systems to direct and manage how other systems interact with the IHPs attributed population (e.g. counties, schools, social service agencies, etc.). Specifically:

1. Performance measures aimed at developing and integrating protocols to identify what should be referred to specialists versus which can be handled in primary care would drive more cost-effective care overall.
2. Support IHP autonomy in directing referrals to home-based services that are owned or contracted and meet cost and quality requirements in order to manage cost and quality.
3. Enhance the ability to exchange data in a timely and efficient manner to more actively manage and perform against quality outcomes. Advancing the state-sponsored HIE requires alignment of the Minnesota Health Records Act to the Health Information Portability and Accountability Act (HIPAA). This statutory change would be essential to the success of HIE and value-based care in Minnesota as it would reduce the current burden of data exchange and managing patient consent across different health systems and multiple EMRs

**Question #5:**

Ultimate accountability will be facilitated through the financial elements of the contract. As with current IHP arrangements, continued focus on quality, outcome and utilization metrics and commensurate scoring along with enhanced payment opportunities will facilitate evaluation. In addition, evaluation could be based on an IHPs ability to define the current infrastructure in place to meet the initiative, contract or intervention or being able to identify and demonstrate previous success in implementing similar approaches.

**Question #6:**

Having a single preferred drug list is helpful. It will create a more level playing field in an important area of health care spending. However, it is important to account for the impact on 340B eligible providers and to ensure that the preferred drug list has the appropriate medications for a pediatric patient population. For example, liquid options, ADHD or other pediatric-specific condition medications that allow for appropriate management of pediatric patients.

**Question #7:**

The models should have incentives to increase reimbursement based on successful quality or care delivery enhancements. Next Generation IHP providers are not insurance plans and, therefore, do not have the financial reserves of MCOs to protect them from unanticipated acuity risk associated with adverse selection. It will also take additional financial investment to build the infrastructure needed to analyze the data and provide meaningful direction to manage the population of patients effectively and this is a front-end investment not something that can be postponed until after a network meets a claim target. The model must have adequate upside potential and allow the IHP the autonomy to change how care is delivered and patients are managed. Specific protections like affordable stop-loss coverage/reinsurance are also important.

**Question #8:**

While it is well understood that social determinants have a greater impact on health than medical care, the causal impact of social-determinant related interventions is less clear. Certain pediatric conditions and quality elements may provide greater opportunity to demonstrate direct impact (e.g. well child visits, asthma, diabetes). Over time, it would be appropriate to look at health outcomes such as well-controlled asthma and



reductions in disparities; utilization measures such as emergency utilization and well child visits; and patient experience measures specific to people of color/American Indian families.

Ideal measures to evaluate this would be process measures for addressing social determinants of health. Outcome measures lag in relationship to interventions made in this arena. In addition, interventions undertaken by an IHP and partners are not/will not be the only influencing factors on social determinants and attendant outcomes over time. Accountability measures need to account for these considerations.

From a payment model perspective, the inclusion of social risk factors in the PMPM payment calculation is important.

**Question #9:**

The journey to improved quality and health outcomes is continuous and progress can take time. Providers treat many patients who have many different types of insurance, not all who are paying for quality and outcomes. IHP providers need to have a relevant amount of reimbursement related to this but there still needs to be a base payment to cover costs until all payment systems are better aligned.

**Question #10:**

Quality alignment is important. This is particularly important for Children's as we explore the most relevant measures to drive overall health improvement in children. We would again offer that it is critically important to ensure that quality metrics and accountability is well-aligned with the patient population. Adult measures rarely translate well into a pediatric population. The pediatric community (through the national Children's Hospital Association) has been working on CHA-sanctioned set of measures for hospitals and clinics. We need to continue to evaluate whether MIPS or SQRMS are more aligned with and appropriate for a child/adolescent population.

**Question #11:**

In order to enhance the management of care, we need to better align the various systems that serve families beyond health care, including social services, counties, and schools. To do this, we need greater visibility into the overall spend for families and the opportunities to align the most relevant services for an attributed population. Right now, the system is designed to maintain separate processes and payments. In addition to the lack of visibility into spend, privacy regulations limit the ability to partner with those agencies around shared health-improvement objectives. The performance-based-payment in IHP 2.0 is a good start toward the financial element of what it takes to effectively support patients.

**Question #12:**

As mentioned in previous answers, effective execution of these models goes beyond the contracting relationships between the state and providers. We need to address the policy and regulatory barriers that limit collaboration and opportunities to reduce overall system costs.

We would encourage DHS to give autonomy to the IHPs on authorization. There are certain necessary services that currently require an immense amount of time to obtain administrative approval by DHS and MCOs. In a model that needs to think about work effort and how that contributes to the TCOC, these authorization hurdles represent significant time and money.

NextGen IHP...  
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As it relates to enrollment, we need clear rules about default selection. Once we are to the point of enrollment, it is important that the state implement a robust communication plan and outreach to ensure beneficiaries are as well informed as possible.

We appreciate the opportunity to comment on this opportunity and applaud the department's continued efforts to evolve Minnesota's health care system to focus on value for patients and the system as a whole.

Sincerely,

Trevor Sawallish  
Chief Operating Officer/Senior Vice President, Clinical Operations  
Children's Minnesota  
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# The Minnesota Health Care Homes Advisory Committee Coordinated Response to the Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP

December xx, 2017

## Introduction

### Minnesota Health Care Homes Advisory Committee

The Minnesota Health Care Homes Advisory Committee is a legislatively authorized committee appointed by the Commissioners of Health and Human Services to contribute to planning for ongoing statewide implementation of the Health Care Homes (HCH) program. MN's Health Care Home (Medical Home) Model takes into consideration management of prevention, acute care, and chronic disease for patients. The Committee is comprised of a diverse set of key Minnesota stakeholders, including: consumers, providers, care coordinators, payers, quality improvement professionals, researchers, and state agency personnel.

The HCH program provides certification for clinics and clinicians providing comprehensive primary care. Standards include:

- Access/Communication
- Patient tracking and registry
- Care coordination
- Care plans
- Performance reporting and quality improvement (Includes participation in Learning Collaborative activities)

### Workgroups

The HCH Advisory Committee has five workgroups (Program Innovation, Financial Sustainability, Partnerships and Communication, Evaluation and Measurement, and the Learning Collaborative). The committee and workgroups are the primary vehicle for receiving public input and investigating specific HCH topics through discussion and consensus building. Charters are used to declare the purpose, schedule, and deliverables that guide the process. Statewide members contribute subject matter expertise in discussions, research, and analyses through volunteer time. All meetings are open to the public. MDH HCH staff facilitate, analyze and interpret data, and summarize findings that will contribute to HCH policy development

### Statewide Coordinated Response Approach

This statewide coordinated response to the request for public comment represents multiple stakeholders, including the HCH Advisory Committee and workgroups, from the Minnesota health and health care system to submit written comments. MDH's Health Care Homes program coordinated the work.

The HCH program and the HCH Advisory Committee and associated workgroups recognize the value in providing response to the Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP. We identified areas needing more clarity or action in the comments and recommendations below. We strongly encourage consideration of these comments and recommendations.

## Comments and Recommendations on Specific Provisions of the Request for Comments.

Topic	MN Comments and Recommendations
<b>Question 1</b>  DHS has described an idea of “primary care exclusivity,” where a primary care clinic may only be included as a selection choice for one	The HCH program supports primary care exclusivity. Primary care is the foundation of the health care system. It encompasses an individual's first contact with providers for a variety of reasons. Primary care providers, the frontline of care, serve patients with a wide range of health needs. They

<p><b>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?</b></p>	<p>provide routine preventive or follow-up care; at other times they serve as a gateway for patients needing specialist services or hospital care. The efficacy of primary care impacts health expenditures system wide, as effective preventive care and care coordination can minimize downstream utilization of more expensive services delivered by specialists or in hospitals.</p> <p>Since 2010, when the first Health Care Homes (HCH) became certified the functions of primary care providers and practices have expanded to address the growing burden of disease prevalence and chronic conditions. When primary care works well, as it does in HCH, it initiates and prioritizes care coordination and management; ensures that interventions continue across delivery settings; improves quality, outcomes, and patient experiences; and contains costs by helping patients use services efficiently.</p>
<p><b><u>Question 3</u></b></p> <p><b>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.</b></p>	<p>We recommend HCH certification be specifically outlined as a requirement for all IHPs, and MCOs encourage providers to become HCH certified, since the aims of Outcomes Based Purchasing and HCH are clearly aligned to improve quality, patient experience and continuity and cost of care</p> <p>The Health Care Home approach shifts Minnesota providers from a purely medical model of health care to a focus on linking primary care with wellness, prevention, self-management, shared decision-making and community services. It is best described as a model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, focused on quality and safety, and is a widely accepted model for how primary care should be organized and delivered. HCH model is a philosophy of health care delivery that encourages providers and care teams to provide the right care, at the right time, and in the right manner for each patient from the simplest to the most complex conditions.</p> <p>Requiring certification offers a way for clinics to demonstrate they have put these principles into practice and prevents DHS from creating a new and duplicative way to assess whether they’ve been met. These practices are a community standard in MN, we know that they are effective in improving quality, cost, patient experience of care and provider satisfaction.</p> <p>The goals of the HCH model are to:</p> <ul style="list-style-type: none"> <li>• Continue building a strong primary care foundation to ensure all Minnesotans have the opportunity to receive team-based, coordinated, patient-centered care.</li> <li>• Increase care coordination and collaboration between primary care providers and community</li> </ul>

resources to facilitate the broader goals of improving population health and health equity.

- Improve the quality and the individual experience of care, while lowering health care costs.

The Minnesota Department of Health (MDH) HCH program, known nationally as a Patient Centered Medical Home, is key to improving the quality of health care services delivered at primary care clinics.

MDH's eight years of experience working with clinics to transform how they deliver care – and the results from independent evaluations of the program – demonstrate that the HCH model of care delivery forms a strong foundation for improving quality of patient outcomes and positioning clinics for value based payment. It has proved to be an adaptable and successful model that continues to support Minnesota's primary care clinics as they strive for better care and better health in the midst of an ever-changing landscape of health care payment and delivery reform.

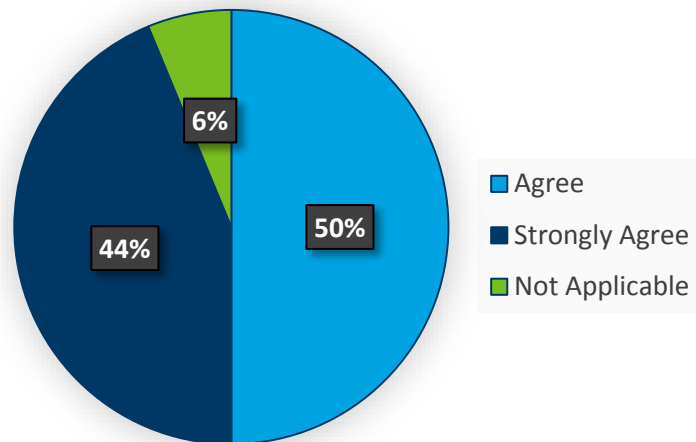
How the HCH model supports the Next Generation:

1. More than half of MN's primary care clinics are certified HCHs from many medical organizations in the state representing about 3,871 dedicated certified HCH primary care clinicians. Their teams and community partners have strengthened the primary care foundation and serve 3.9 million Minnesotans. (Two-thirds of the primary care clinics in the 7 county metro area are currently certified as a HCH.) The HCH focus on partnership creates the foundation needed for IHP to address total cost of care or move to value based payment.
2. The HCH program provides technical assistance to other states on the success of Minnesota's model and reports regularly to CMMI staff on our progress in using HCH to advance other innovative models such as Accountable Communities for Health.
3. The five-year evaluation shows MN's Health Care Home contributes to cost savings and improvement in patient experience and patient outcomes. [http://www.health.umn.edu/sites/default/files/HCH%20Evaluation\\_summary.pdf](http://www.health.umn.edu/sites/default/files/HCH%20Evaluation_summary.pdf)
4. The HCH standards of access, use of a patient registry and data for tracking clinical care and outcomes, care plan development, quality improvement, and care

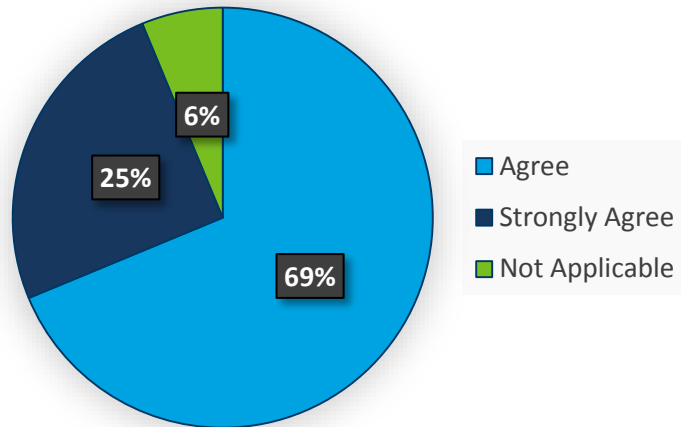
coordination directly address elements in the Medical Management and Care Coordination model component of Next Generation IHP as well as overall cost, quality and patient experience of care expectations.

5. Implementation of BHH was in collaboration with HCH, with a mutual commitment towards behavioral health/primary care integration efforts. HCH nurse planners participate alongside BHH staff at site visits, bringing primary care expertise and community perspectives.
6. A major focus of the HCH program is to address the quadruple aim of healthcare reform, which includes providers and clinic staff satisfaction in a HCH setting. Recent survey results from 104 clinics comprising 1,202 clinicians, from large and small healthcare entities, as well as independent and solo practitioners throughout the state overwhelmingly agreed ( no one disagreed)that the HCH program increased provider and care team satisfaction in their clinical work.

*Since adopting the HCH model of care delivery other members of the care team at my organization have communicated greater satisfaction.*



*Since adopting the HCH model of care delivery clinic providers have communicated greater satisfaction in their work and practice.*



**Benefits of a Health Care Home**

- Care focused on the patient as a whole person
- Coordinated care that meets the patient’s individualized needs
- A care plan personalized for patients
- Help finding specialty care or community services
- Open communication with the health care team
- Information to help the patient learn more about their health and treatment choices
- Provide patients continuous access
- Effective use of data for closing gaps in care and managing patient’s preventive and chronic health needs

**Question 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?**

Adding the requirement of HCH certification at the beginning of the model ensures IHP enrollees have access to a stronger care coordination model with support for their whole person care needs in the clinic and in the community. As noted above, when primary care works well, as it does in HCH, it initiates and prioritizes care coordination and management; ensures interventions continue across delivery settings; improves quality, outcomes, and patient experiences; and contains costs by helping patients use services efficiently. HCH certification also signifies that a primary care clinic is vested in improving care for patients and aligned with the aims of Outcomes Based Purchasing to improve quality, patient experience and continuity and cost of care

	<p>In addition, available utilization and risk data on the provider's attributed populations will be an important tool to being successful in outcomes-based payment arrangements and these data should be consistently available at the start of the model.</p>
<p><b>Question 5</b></p> <p><b>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?</b></p>	<p>We agree with the Request for Comment's language reflecting the need for ongoing collaboration and alignment between state and federal sponsored efforts in order to reduce duplicative measurement efforts and burden for health care providers. We recommend collaboration with MDH program in HCH certification for primary care clinics to ensure Minnesota providers and patients benefit from a strong care coordination model and continue collaborative work toward the aims of improving quality, patient experience and continuity and cost of care.</p>



# HENNEPIN COUNTY

## MINNESOTA

12/20/2017

Minnesota Department of Human Services (DHS)  
Health Care Administration  
PO Box 64983  
St. Paul, MN 55164-0983

RE: Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP

Dear DHS Leaders,

Hennepin County and Hennepin Healthcare System, Inc. (Hennepin County Medical Center [HCMC]) jointly applaud DHS for the vision set out in this request for comment. Our full support and offer of partnership as the largest safety-net provider and most populous County in Minnesota toward the implementation of that vision is rooted in a fundamental understanding that our Medicaid-funded system of safety-net health care delivery and financing is flawed and unsustainable in its current form. Evidence shows that the most effective ways to coordinate care and recognize social determinants of health are based in communities and in clinics, not large payer systems. The population-level tools of surveillance, data analytics, predictive risk scoring, and performance measurement are fragmented and duplicated among multiple layers of payers and purchasers, and poorly connected to providers and health systems doing work on the ground. And we present a false choice between managed care options based on an upper-middle class employer-based insurance system to populations impacted by the toxic stress of intergenerational poverty and trauma without education or tools to empower them. In a year in which the fundamental structure of Medicaid has been preserved by the narrowest of margins at the national level, it is clear that now is the time for bold fundamental change.

Such change will only be possible with a pragmatic and realistic approach to development and implementation that recognizes the funding and operational capabilities and limitations of DHS, Counties, and other stakeholders. Our systems have gained valuable experience through payment and delivery

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system reform efforts based in the provider space (IHP) and the managed care space (Hennepin Health). Together we have the components to connect these functions even more deeply to our human services, corrections, and other County systems to drive further improvement. There is a lot of challenging work ahead, and we look forward to partnering with DHS.

Specific comments on the questions posed are listed below.

- 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?**

Recent shifts in Medicaid managed care across Hennepin County and greater Minnesota has resulted in persistently high rates (over 85% in Hennepin) of default enrollment. This suggests that the current mechanism of presenting a choice of a managed care entity to enrollees is not working. Enrollee choice is an important component to preserve in the safety-net system, and the choice of clinic or provider is more meaningful and likely to drive better outcomes than the choice of a managed care organization.

We understand the importance of primary care exclusivity in the context of ensuring a defined population and network. We also have an appreciation for the important role primary care plays in improving overall health and lowering long-term costs to the system. However, many enrollees who use significant resources do not utilize primary care when accessing the system, and cannot be ignored in the design of this effort. For example, our system includes the Hennepin County Mental Health Center, the “Red Door” Clinic, and Health Care for the Homeless – all crucial points of entry into the health care system that are not capable of, nor envisioned to, provide the full suite of primary care and care coordination. We aim for everyone to have a primary care medical home. New models should not create additional barriers to any Medicaid recipient wanting to establish primary care at any point in their Medicaid coverage.

Primary care exclusivity for consumers may also have downstream impacts on payer and provider relationships that need to be considered and discussed as transparently as possible. It may also result in unintended consequences for enrollees who may not fully understand the implications of choosing a primary care clinic or provider in this new model. This choice should not disrupt their ability to access meaningful care and services. Therefore, it is critical that DHS develop a process for choosing a primary care clinic or provider that fully engages the consumer in this process with accessible and understandable information.

As we move forward, we welcome the opportunity to continue a dialogue with DHS on the operational and policy implications of a primary care approach that is crucial to the future success of this effort. This includes the details of how choice in primary care settings would be offered to enrollees and how primary care exclusivity would be incented or enforced by the State or Next Generation IHPs. A well-functioning system would sync up eligibility determination and renewal with primary care/health plan selection seamlessly – greatly reducing administrative burden on the State and Counties.

- 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.**

Through our experience with Hennepin Health, our systems have experience successfully running capitated models at levels of enrollment as low as 8,000 – 10,000 members, with the appropriate reserves and stop loss policies in place. However, there are clear trade-offs and economies of scale to be gained with administering larger populations. The question of the “right size” of the risk pool will become less important if DHS transitions to providing “back office” administrative services to Next Gen IHPs. Under such an arrangement, as an extension of fee-for-service, DHS could use actuarial tools to offer appropriate risk incentives at different levels of population rather than creating firm entry barriers.

In addition, it would be helpful for providers to understand whether there may be a minimum size necessary to ensure a successful implementation from a state operational and systems perspective.

- 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.**

Since we operate solely in Hennepin County, regulatory minimum requirements around access and accessibility are not particularly useful in such a small geography. We believe that networks should be based on broad access to specialty services, with referral-based accountability wherever possible. Certain services are in short supply and should not be restricted by network (e.g. mental health, addiction medicine, and psychiatry). Mutually exclusive primary care networks are crucial to the success of the model described, and cultural competency and social services integration are the most important factors that should be considered in both managed care and Next Generation IHP models. The most competitive IHPs and MCOs would be able to demonstrate both linkages/referrals to outside community resources addressing social needs, as well as services they provide directly aimed at addressing social determinants.

- 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?**

Our experience suggests that linked electronic health records that allow real-time care integration are crucial to performance in risk-based models. Ideally, these records are linked to community and human services partners so that care can be coordinated across programmatic and funding silos. Absent a single integrated Epic record like Hennepin’s, DHS’ ability to feed all-payer data to risk-based entities in the market is critical to the success of these models. Until health information exchange between health

systems' EHRs is ubiquitous, DHS plays a crucial role as purchaser in feeding data to entities coordinating care and bearing risk.

As DHS considers taking administrative responsibility for the management of pharmacy benefits, personal care assistance (PCA), dental, and non-emergency transportation services on behalf of IHPs, there is tremendous opportunity for administrative efficiency to be gained. This should be done while carefully considering downstream impacts on Counties, such as requirements to conduct assessments.

We also believe that, with better access to necessary information over time, comes a greater responsibility on the entities participating in the Next Generation IHP to show in a transparent manner how they are using the data to improve health outcomes and quality. These models should always evolve toward overall health and comprehensive well-being outcomes as opposed to process measures or disease-specific markers.

**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?**

DHS and Counties should clearly distinguish between work that has already been demonstrated and shown to be successful and work that entities propose to do in the future under this new demonstration or model. Both are important. As DHS incents the creation of Next Generation IHPs, it should require that they have dedicated leadership structures in place rather than combinations of existing organizational leadership. We have found that collaborative governance is useful and has its place, but there is no substitute for a clear top-down strategic leadership approach. Entities seeking to participate in the Next Generation IHPs should also be required to identify their proposed measurement models in addition to the initiatives and interventions they plan to use to improve overall health and quality.

**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?**

A single PDL is desirable for Hennepin's providers in that it reduces administrative time spent on prior authorizations and minimizes disruptions for patients. It would also be a benefit to our pharmacies in managing inventory. As complex patients churn through coverage, a single PDL would minimize coverage changes and disruptions of treatment. We ask that DHS continue to be transparent with stakeholders in managing the pharmacy benefit at the state level, as all agree it is a key driver of the total cost of care.

**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?**

The level of risk needs to be significant enough to drive fundamental organizational investment and change. The health systems with the highest proportion of Medicaid patients are likely least equipped to make up-front investments or assume risk. This dynamic of approaching operational break-even is fundamentally different from commercial and Medicare ACO models aimed at maximizing profit margin. Calculation of risk should incorporate social risk factors that drive health spending, and administrative costs and financial risks placed on Counties should be considered as well as those placed on health systems and MCOs. Measures used as indicators of success should be many and varied, as this is complex systems work. Linear improvement year on year indefinitely is not realistic; rather, the assumption of risk and measurement of impact should shift and broaden over time.

**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?**

The measurement of social needs and utilization of social services is important, yet efforts are hampered by the fact that there are not national or state standards to measure most of these domains. Hennepin has been involved in national work around screening for social needs in clinical settings as well as the integration of cross sector data. DHS' proposed models present opportunities to further this work through the standardized use of ICD-10 codes as markers of social need, validated markers in administrative data, and uniform screening instruments. We encourage the interdisciplinary use of measures across policy sectors: for example, looking at housing placements alongside health indicators and vice versa.

**9. How much of the entities' payment should be subject to performance on quality and health outcome measures? Please explain your answer.**

The answer is dependent on the measures used, risk adjustment methodology employed, and whether the new model will appropriately be able to recognize differences in medical complexity within certain Medicaid populations. In the foreseeable future no more than 50% of payment should be subject to quality in order to ensure up-front investment in infrastructure and care management activities. Over time, it will be important to smooth out the flow of payments so that performance contingencies are not delayed unnecessarily.

Being able to realize actual improvements in quality and health outcomes is critical to the success of these models. Otherwise, the focus will be purely on financial rewards versus losses to the system. Therefore, DHS should reward Next Generation IHPs for improvement in quality and the sustainability of higher levels of quality without solely considering overall financial performance. This should be recognized early in the model with the opportunity for Next Generation IHPs to receive quality payments for improvements, even in the event that total cost of care savings are not achieved or positive performance doesn't exceed the payout threshold.

**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?**

Measurement of quality performance should be at the level of the care system or clinic (versus payer) whenever possible. It is crucial for reporting to be at the level of Medicaid and public program patients, particularly for patient experience, not blended with commercial and other populations. Measurement approaches should incorporate stratification and/or adjustment for social factors that impact outcomes.

Current measurement programs that could be built on include:

- FQHC Universal Data Systems (UDS) reporting
- MN Statewide Quality Reporting System
- Quality Rating System from CMS 2390-F Medicaid and CHIP Managed Care Final Rule

**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?**

The model appears to provide significant flexibility to address social factors, but it is unclear how strong the incentives would be. Participants in either model would have stronger incentives if payment structures incorporate measurements of social need and adjust payment accordingly. County services (such as child care, cash assistance, SNAP benefits, and housing) are often called for in addressing social determinants. It is important that those actors, as partners, have the appropriate tools and incentives to engage with model participants. It will be important and necessary to set up measurement approaches and incentives that incorporate both short-term returns through impacts on utilization and longer-term investments in community health and prevention that will play out over much longer timeframes.

**12. Do you have any other comments, reactions or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?**

We appreciate the opportunity to comment on this proposal and are eager to continue the dialogue with DHS and other stakeholders on this effort. We also strongly believe that DHS and Next Generation IHPs should operate in partnership and expect unanticipated surprises. DHS should avoid rigidity and approach the work as a partnership with Next Generation IHPs. Evaluation of the models should be iterative and not subcontracted to an external evaluator that lacks context.

We also would welcome a fuller conversation around the proposed timeline for this effort, recognizing a phased-in approach may be necessary to set the model up for success and engage in the necessary planning and implementation work. We support the release of an RFP in 2018, but believe there could be room for further policy development through 2019 with a goal of full implementation in 2020.

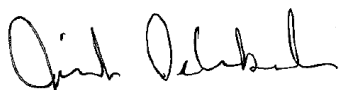
As a system rooted in County government, we will be particularly concerned with possible cost shifts and impacts on Counties that could accompany the carve-out of benefit categories, changes to the enrollment and plan selection process, etc.

Other considerations or suggestions to the model that we have include the following:

- DHS should also consider alignment across SNBC and seniors products as well, and offer similar administrative opportunities across those programs. The unfortunate artificial separation of dually-eligible enrollees from payment models like this, while understandable, is something we would like to work with DHS on better aligning in the future.
- It will be important to anticipate risk selection when populations are “sorted” into groups based on their relationships with care systems. We want to avoid overly favorable or unfavorable risk populations by program or organization.
- As part of this discussion, it is important that we do not lose the voice of the enrollee or patient. This is a huge opportunity to begin to understand what enrollees want, need and value when it comes to their health. For any new approaches to work, the patient must be at the center of the discussion and fully engaged and participating in the process with the opportunity to provide meaningful feedback and direction.
- DHS should consider using medical and social complexity to adjust payments for essential services such as dental care.
- If the model results in more fee-for-service reimbursement, safety net hospitals and DHS will want to understand the impact on upper payment limit (UPL) and other financial interdependencies.
- Providers participating in Next Generation IHP will need to be able to inform enrollees of this new option of choosing a clinic for primary care without any risk of violating any federal and/or state restrictions on choice counseling for enrolling beneficiaries in Medicaid. For example, a provider would need to be able to inform a patient that if they want to keep the provider for primary care that they can only enroll in the provider’s Next Generation IHP.

Thank you again for the opportunity to comment on these models. We look forward to the work ahead.

Sincerely,



Jennifer DeCubellis  
Deputy County Administrator



Jon L. Pryor, MD, MBA  
Chief Executive Officer  
Hennepin Healthcare System, Inc.

Cc: Kareem Murphy, Amy Harris-Overby, Ross Owen, Stacie Weeks

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## **SUBMITTED COMMENTS**

**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?**

- A.** In general, primary care exclusivity is not the best way to drive towards accountability. While Medica supports enrollees having a designated primary care clinic, having one should not limit enrollee choice to the extent contemplated under the Next Generation IHP model. To ensure overall access to care and the avoidance of a fragmented system, the Minnesota Department of Human Services (DHS) should consider a broader delivery system that incorporates primary care clinics, specialty clinics, behavioral health, and ancillary services into one value based care system. The concept of exclusivity at such a granular level could negatively impact continuity of care, access and availability and cause enrollee disruption.
- B.** Transparency, a level-playing field, and encouraging enrollee choice in a broader value based care system are better solutions to fostering lines of accountability. Primary care exclusivity as described in the *Minnesota Department of Human Services Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP* document (RFC) could potentially have significant unintended consequences for the entire health care market in Minnesota. The RFC and DHS input at the public meetings indicate that a primary care clinic may only be included as a choice for one Next Generation IHP or one or more MCOs. This will reduce patient choice, and increase costs through adverse selection due to higher risk members seeking broader provider networks outside of the Next Generation IHPs. We recommend that the access and availability requirements be consistent for the Next Generation IHPs and MCOs.

Additionally, DHS will be supplementing the network for the Next Generation IHP networks if the IHPs cannot meet the access and availability requirements. How will this work? Does this supplementation disincentivize IHPs from managing care and



expanding their networks, which would be counter to the goal of a comprehensive care model?

- C. Since the 7 county metro area is a Metropolitan Statistical Area, federal regulations on enrollee choice are in play. Additionally, enrollees are allowed to make a change to their plan if they choose. How many participating entities will be selected per county? How does the model ensure enrollee choice of provider? In accordance with 42 CFR 438.52, if DHS requires Medicaid beneficiaries to enroll in an MCO, DHS must give those beneficiaries a choice of at least two MCOs.
  - D. What does the network look like for a Next Generation IHP? Is an enrollee bound to only receive services within the Next Generation IHP network? How are specialty services and transplant services made available and how will out of network coverage be handled?
  - E. Given that a primary care clinic may be the sole selection choice under the Next Generation IHP model, there will likely be network disruption, concerns with access and availability, and potentially fragmented care. How will access to services that DHS intends to carve out be handled?
  - F. The Next Generation IHPs will require positive enrollment for the providers with a PCP clinic printed on each enrollee's card. We have found that printing the PCP Clinic on the enrollee's ID card is sufficient in this market due to the significance of "group practice" within the provider systems. It is important to note that the assignment portion of the enrollment process is extremely critical since enrollees who are assigned and not attributed to the Next Generation IHPs would be typically low or non-using enrollees who are presumably healthy. If a particular system is over "assigned" healthy enrollees during the process, there could be significant unintended consequences due to the extremely low MLR of these enrollees, i.e., risk would be spread inequitably across the various health care delivery systems. Can DHS clarify how assignment will be done for new enrollees?
- 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.**
- A. The concept of a minimum beneficiary population is inconsistent with historical processes and generates numerous questions. What entity determines the minimum beneficiary population size and what happens if the minimum is not achieved? Has DHS considered placing a cap on the number of contracts awarded within a specific service

area? As certain administrative expenses are fixed, these costs are better served spread across a larger membership base. The minimum beneficiary population size would depend on DHS' target loss ratio. Of concern is whether the administrative allowance would be inadequate for the MCO/IHP/DHS to realistically achieve the target loss ratio.

- B. As important as is a minimum population threshold in risk based payment systems, how does DHS prevent the attributed population from exceeding the capacity of the Next Generation IHP? How does DHS prevent adverse selection of enrollees out of an IHP? The Medicaid Managed Care Final Rule and Basic Health Program (BHP) requirements clearly emphasize enrollee choice, so we believe multiple options are required for enrollees to experience choice.
- C. If an enrollee is enrolled in a Next Generation IHP based on a primary care clinic and decides to change to a new clinic (every 30 days) that is not part of the IHP, can the enrollee then enroll in an MCO?
- D. Does DHS have the capacity, technology flexibility and core system infrastructure to accomplish the work required for successfully implementing the Next Generation IHP model? Is a minimum beneficiary population size required for DHS administration of an IHP?

**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.**

- A. Any network adequacy standards that apply to Medicaid MCOs under the Medicaid Managed Care Final Rule should also apply to Next Generation IHPs. DHS will need to ensure that there is a comprehensive provider network and benefit structure to meet the needs of the enrollees and ensure continuity of care.
- B. Medica recommends a level playing field. Requirements of the Medicaid Managed Care Final Rule and other state and federal requirements should be applied to Next Generation IHPs to the same extent they apply to MCOs. For example, the Next Generation IHPs should be accountable to provide a person-centered care plan that includes coordination for social services, medication therapy management, disease management, as well as an emphasis on public health and community health considerations.

- 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?**
  - A. Upon commencement of the model, Next Generation IHPs need to be subject to the same requirements as Medicaid MCOs, including requirements for care coordination, disease management, population health, the annual technical report, prompt and appropriate access to care, beneficiary support, and consumer protections. Although the Next Generation IHPs should be required to develop a comprehensive model for care coordination and health management much like the model used by MCOs, there seems to be an inherent conflict of interest in their doing so. Next Generation IHPs would be making coverage determinations for the care they would then be providing.
  - B. How will services rendered by DHS FFS to support Next Generation IHPs be implemented, such as transportation, interpreter and PCA services to name a few? How will IHPs account for overall coordination with public health agencies, homeless shelters and numerous other agencies to ensure that the enrollees' holistic needs are met? How will services be reimbursed?
  - C. How will the Next Generation IHP program allow for better data sharing among providers? DHS should formalize data transfer protocols to limit disruption and ensure continuity of care.
  
- 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?**
  - A. All responders should be required to fulfill their promised bid obligations, and successfully complete a comprehensive readiness audit conducted by DHS.
  - B. DHS must use the same, consistent criteria and evidence for both Next Generation IHPs and MCOs. Proposals should be reviewed and scored consistent with criteria used for previous RFPs, while taking into consideration innovation and the overall value of services. There should be multiple evaluators, including stakeholders across the industry. To avoid a conflict of interest for those IHPs affiliated with a county, that county agency should recuse itself from the evaluation process.
  - C. When scoring a responder's attributes for participation, DHS should focus on how well a responder integrates care taking into consideration the whole spectrum of Medicaid

covered benefits, including an emphasis on social determinants of health, value and the seamless delivery of services.

D. For consistency, DHS must make Next Generation IHP contracts publically available to ensure transparency and accountability.

**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 NextGeneration 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?**

A. A single PDL will be cumbersome and administratively burdensome for PBMs and MCOs, as well as prevent an MCO from providing the best customer experience and ability to innovate. MCOs develop custom relationships with their pharmacy benefit manager (PBM) in order to develop and administer formularies that best balance DHS requirements and enrollee needs while mitigating the effects of increasing drug costs. An alignment to the DHS PDL will disrupt these strategic MCO relationships, which could adversely impact the cost of care. Requiring MCOs to administer a single PDL will not mitigate variations in enrollee experience because of technological differences among MCOs. If the MCO retains prior authorization and appeals responsibility, then DHS must include MCOs in the data, forms, prior authorization criteria, and representation at the P&T committee. The prior authorization criteria would be essential to ensure that decisions are made consistently across MCOs and with the intent of the P&T decisions that formed the shared PDL.

B. Of concern is which entity would be responsible for utilization management and benefit exceptions. A single PDL may increase costs for DHS and potentially increase costs for MCOs. More detail is needed regarding the administration of a single PDL and how DHS would leverage its negotiating power. It is unclear whether this model would be successful for a variety of reasons or whether it would have the expected impact. Furthermore, having a single PDL solely in the 7 county metro area may create concerns regarding consistent coverage for MHCP enrollees across various delivery systems across the state, i.e., MCOs, IHPs, and county based purchasing organization.

**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?**

- A.** Medica supports a model that balances the level of risk that a provider and an MCO take under this demonstration to ensure that incentives adequately drive change, value, outcomes and cost. Next Generation IHPs should be subject to down-side financial risk as a condition of participation in the program. The IHP program has been intended to encourage providers to participate in the financial and quality performance of serving Minnesota MHCP enrollees. Moving forward will require a greater commitment from all partners. A financial commitment through the application of down-side risk will generate greater motivation for all partners to find efficiencies in care delivery.
- B.** DHS has been successful in encouraging a number of providers to participate in performance based measurement for serving MHCP enrollees in a gain sharing model. The ability of providers to participate in the IHP program where they do not need to assume large financial risk for participation has, in some instances, hindered the ability of MCOs to engage providers in value based arrangements where providers are at financial risk for serving MHCP enrollees. By requiring providers to take down-side risk we believe we can expand the ability of providers, MCOs and DHS to work together.
- C.** The requirements for Next Generation IHPs must be equitable with those of MCOs. Next Generation IHPs must be subject to the same withholds, reserve requirements, cost-shifts and, as noted above, down-side risk requirements of Medicaid MCOs.
- D.** Will DHS' reimbursement policy for IHPs match Medicaid FFS or MCO capitation rates or something else? Quality methodology aside, how does DHS intend to reimburse primary care in this model in a manner that expands access?
- E.** It is noted in the RFC that entities participating in outcome-based purchasing should have increased financial accountability over time with a proportional level of risk to their responsibility for services provided. Currently, the only unique characteristic stated about this model is the primary care exclusivity. MCOs need to better understand how the payment mechanism works? MCOs take an unrestricted amount of risk and IHPs should be required to take the same amount of risk. Can DHS define "proportional level of risk"? How will this be measured?
- F.** In the Next Generation IHP payment model, we would anticipate the integrity of the data could conceivably decrease without quality encounter data. Has DHS considered the reliability of the Medicaid data moving forward? Next Generation IHP providers could find encounter data collection challenging in the event those entities have not previously been tasked with providing or developing a comprehensive data set. Additionally, it is not clear what paid data could be provided. We are concerned future rate settings could be severely compromised as a result of substandard data

reporting. How will the full claims administration reconciliation process work for next generation IHPs for service rendered by a specialist?

- G. How does DHS anticipate the total cost of care will be developed? Will total cost of care targets be established based on the results currently observed in the MCO program? Or, will the targets vary from the overall aggregate experience of the MCO's currently in place? If so, how will they vary? When will the targets be available? What proportion of the IHP capitation payment will be subject to the comparison between the target and actual results?
  - H. Does DHS anticipate any fundamental differences in how the MCO payment model capitation payments will be developed? Does DHS anticipate IHP experience will be included in the development of rates in future contract periods?
  - I. How does DHS anticipate developing risk adjustment factors in the future? If the Next Generation IHPs are required to provide comprehensive encounter data, does DHS assume the MCO experience and IHP experience will be collapsed on a regional basis and capitation payments will be modified for all entities accordingly?
  - J. To further encourage partnership and innovation, DHS should include MCOs as a direct party to the Next Generation IHP agreements, in contrast to the current process whereby MCOs are indirectly bound by the DHS program contracts with IHPs. DHS and Next Generation IHPs should consider direct contracting relationships with MCOs that have proven records with success managing the MHCP population, including the development of strong operational infrastructures.
  - K. We request that DHS explain the margin for adverse claims experience. How will DHS handle this for Next Generation IHPs?
- 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?**
- A. It is critical to the success of managing the MHCP population to institute consistent and appropriate measures and methods designed and aimed at addressing social determinants of health, reducing disparities and improving health outcomes. MCOs have comprehensive care models that improve outcomes and address all aspects of an enrollee's needs. To address these needs, MCOs have agreements with providers and other partners that address the above noted enrollee needs. Historically, hospitals rely on MCOs to actively participate in the discharge planning process for enrollees with a special focus on social determinants such as homelessness. Next Generation IHPs will

need to do the same and ensure they have agreements with a variety of agencies and partners to address enrollee needs and ensure continuity of care.

- B. Care coordination and initial needs assessments are essential to provide a person-centered care plan that addresses socio-economic factors, and should be considered in the Next Generation IHP framework.

**9. How much of the entities' payment should be subject to performance on quality and health outcome measures? Please explain your answer.**

- A. Next Generation IHPs should work collaboratively with MCOs and DHS to develop a set of consistent initiatives and measures to improve patient outcomes. These initiatives and measures should be based on the overall needs of the population. Alignment of the initiatives and measures will strengthen overall results, and ensure consistent enrollee outcomes. It will also avoid duplication of efforts across the health care system.
- B. Any new MCO or Next Generation IHP will need time to implement cost saving measures and gain a better understanding of the inefficiencies that currently reside in the program. All entities will need to have an understanding of the current and target metrics before being able to ascertain whether or not these targets are achievable. DHS should consider phasing in any performance metrics across all contracts. To ensure accuracy in measurement, DHS should apply a consistent methodology for IHPs and MCOs.

**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?**

- A. Thank you for considering alignment of quality requirements across federal and state quality programs. In order to maximize the federal money Minnesota receives for its health care programs, DHS should transition all public program quality measurement initiatives to the CMS Star Quality Measures. Minnesota has been a leader in health care quality improvement, transparency, and innovation in its public programs and commercial lines of business for decades. Minnesota's efforts have improved the lives of Minnesotans and demonstrated that pay-for-performance works. The federal government is catching up with Minnesota's innovations, as CMS is placing more emphasis on pay-for-performance initiatives. It is imperative that Minnesota refocus its efforts on measurements that will leverage more federal support for the Minnesota health care system.
- B. Medica recommends that Next Generation IHPs: (i) align with existing MCO and network provider requirements to electronically submit data via MN Community Measurement

for MN SQRMS; and (ii) align with HEDIS (standardized across nation) and consistent with CMS Stars.

- C. DHS indicates that it will set the same quality standards for MCOs as for Next Generation IHPS. Will all entities have an opportunity to receive higher payments for a higher quality of care? Medica supports consistent categories and weights for MCOs and Next Generation IHPS.
- D. The RFC indicates that MCOs would be required to have at least 30% tied to different types of value based payments and quality. The metric should be consistent for MCOs and Next Generation IHPS. Regardless of the level at risk, MCOs need to be recognized for the value they bring and their successful performance.

**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?**

- A. In response to the question of whether the new payment policy gives enough flexibility and incentive to improve population health, more information is needed about the new payment policy. How will DHS finance all of the administrative services? Will there be a fiscal note tied to any of the work supporting the new model?
- B. Eligibility for participation should be determined based on how well an entity can effectively meet all of the MHCP requirements, provide for comprehensive access and availability, integrate social determinants of health, enhance value and drive outcomes.

**12. Do you have any other comments, reactions or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?**

- A. Greater transparency is needed in the performance of each Next Generation IHP in order to understand the successes and challenges. It is important to understand how performance is measured consistently between MCOs and Next Generation IHPS, what and how quality is being measured, the targets for each measurement, how savings are achieved. Without transparency, it is difficult for the public, policymakers, and health



care system innovators to understand how these innovations work and the detail driving the high-level results released by DHS.

- B.** DHS must incorporate greater transparency related to targets and results of the Next Generation IHPs. DHS applies rigorous reporting requirements and transparency to similar contractual arrangements for health care administration and delivery. The public can access a wide range of MCO information through the DHS website regarding vendors that serve the state’s MHCP population, including financial information, membership, quality measures, quality improvement activities, and results. This information offers the public insight into how Minnesota’s vulnerable populations are being managed and holds the state’s vendors accountable. A similar amount of rigor and accountability should be applied to Next Generation IHPs.
- C.** The RFC indicates DHS interest in better aligning the purchasing strategies of managed care with the “advanced track” IHPs that have increased capacity from their participation in the early stages of this program. Can DHS better define “advanced track” and provide a list of IHPs that have identified interest in participating in this new framework? The RFC indicates that MCOs will be required to demonstrate efficiencies. Can DHS provide additional information? How will a Next Generation IHP demonstrate its capabilities and efficiencies? Is DHS planning to develop any additional “core” operational functionality or system changes to onboard or support Next generation IHPs? The RFC document indicates that the Next Generation IHP will be responsible for certain administrative and provider contracting functions. Please explain how this will work and the expectations?
- D.** DHS should allow MCO’s to partner with Next Generation IHPs. This would promote collaboration, consistency and efficiency.
- E.** What is the outcome of the responses to the RFC? Will DHS share comments as CMS does?



# Minnesota Association of Community Mental Health Programs

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December 20, 2017

**To:** Marie Zimmerman, Medicaid Director, Minnesota Department of Human Services  
**From:** Minnesota Association of Community Mental Health Programs  
**Date:** December 20, 2017  
**RE:** Outcomes-Based Purchasing Redesign & Next Generation IHP Request for Comment

Dear Ms. Zimmerman

The Minnesota Association of Community Mental Health Programs is submitting the following responses to the Department of Human Services' Request for Comment. In the comments below, the Association speaks to three key themes:

- Community Mental Health's perspective in this proposed framework and system
- Safety Net Providers' perspective on value-based purchasing systems
- Requests for more clarity and questions for consideration

## **Community Mental Health Programs' Perspective**

The Minnesota Association of Community Mental Health Programs (MACMHP) is the state's leading association for Community Mental Health Programs, representing 32 community-based mental health programs across the state and serving over 100,000 Minnesota families, children and adults. Our mission is to serve *all* who come to us seeking mental and behavioral health services, regardless of their insurance status, ability to pay or where they live. As Essential Community Providers, we are critical to the behavioral health safety net. We serve culturally diverse, low-income, uninsured and public healthcare program Minnesotans, who cannot access services elsewhere. Community Mental Health Programs provide wrap-around and community-based services to very complex and vulnerable patients, with love and coordinated care.

## **Essential Community Providers' (Safety Net Providers) Perspective**

As safety net providers, MACMHP and our members strongly believe safety net services are critical to ensuring services are accessible to all Minnesotans. This is both a position in philosophy and economic



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efficiency. Community-based services keep clients out of emergency departments and hospitals, which are the most expensive forms of treatment. Community-based programs strengthen communities' economies and are more responsive to the needs of our members. The majority of our community mental health programs were built out of communities responding to their local needs.

Safety net providers/ community mental health programs play a key role to maintaining local systems integrity and underserved communities accessing services as the health care industry, systems and policies continue moving toward value-based purchasing. We are invested in seeing industry and policy standards ensure safety net providers and communities can participate and succeed in value-based purchasing models. We recommend the Next Generation IHP and managed care redesign follow the recent **National Qualify Forum (NQF) Health Equity Roadmap** for improving health equity under value-based purchasing:

- *Collect social risk factor data*
- *Prioritize health equity outcome measures*
- *Invest in preventive and primary services for populations with social risk factors*
- *Redesign payment models to support health equity*
- *Support services with additional payment for clients with social risk factors*
- *Ensure organizations disproportionately serving individuals with social risk can compete in value-based purchasing programs*

## **Responses to RFC and questions for considerations**

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?*

**In regards to the idea of "primary care exclusivity," many clients of community mental health programs (CMHP) do not identify a primary medical care clinic. In these cases the CMHP is the "primary" provider, providing the mental health services and coordinating care across medical and social services for the client. MACMHP stresses the option for "primary provider exclusivity" to include the CMHP. We recommend the state use the definition of "primary provider" in Minnesota Statute. This will allow the provider with whom the client most closely aligns with to remain the client's primary point of care.**

**At the very least, an identified CMHP must be assured to being a within the network (or a direct contractor) with the primary medical provider triggering the entity to "manage" the**



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care of the client/ MA enrollee. We are concerned larger systems will take the approach to bring all care internal to their own systems, removing clients' option to stay connected with their existing CMHP.

In the scenario the Next Generation IHP model framework will likely add administrative complexity in the MA market, MACMHP urges DHS to develop a process to streamline the system and provide clear communications of how the process will rollout.

**Potential for Stronger Provider Negotiating with Increased Competition – MACMHP sees opportunity for (community mental health) providers to leverage market competition with the addition of IHPs into the managed care procurement process. We see the new payment structure (FFS base) as a potentially strong basis for negotiating. However, we are looking for confirmation of which services and payments are built into the IHP payment model's fee-for-service (FFS) base and how the risk-sharing/ gain-sharing and administrative capitation portions of the payment will build on top of the FFS base. We also wonder how, or if, an IHP or MCO will guarantee enough enrollees sustain a network of providers.**

**Throughout all this conversation on "primary provider exclusivity," MACMHP's comments are particularly true for ensuring CMHPs inclusion in the default assigning of enrollees.**

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.

**MACMHP urges DHS to balance a minimum population size with the minimum PMPM calculated for the provider. There is a two-fold reason for this: the PMPM must show the provider a reasonable return on investment, and in a population-based model, the population size must be large enough to demonstrate impact. Safety net providers, disproportionately serving more socially and medically complex clients with more intense, comprehensive service arrays, find ourselves investing more costs into the services. However, if there is not a critical mass of enrollees "attributed," we cannot make up the gap between actual costs to population.**

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.



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MACMHP recommends/ urges criteria for the RFP for Next Generation IHPs and MCOs should follow existing mandate that any entity to receive a managed care contract must contract with designated Essential Community Providers (ECP). *The requirement should consider the changes the ACA mandates for ECP contracting compared to the Minnesota state statute and implement the more comprehensive of the two.* Requiring contacts with ECPs, takes steps to insure community partnerships are developed, expanded and strengthened. Contracting with existing community-based agencies utilizes resources already in the community and system, adding a level efficiency. This also helps deter (further) market consolidation and maintains community systems' infrastructure.

MACMHP needs to underline the likely possibility the larger provider networks and systems will try to duplicate the work of the CMHPs internally and will, frankly, add additional cost without the expertise within the populations or responsiveness to health equity.

The RFP should include criteria and requirements for a detailed work plan for providing "enabling" or ancillary services – i.e. housing, language translation, transportation, food access, community outreach, first episode care.

Related to ensuring medical management and care coordination, what additional guarantees or assurances (safeguards) would be put in place to ensure coordination with community and social services? What safeguards would be put into MCO contracts to ensure coordination with community and social services. Essential Community Provider designation entails a robust certification process by the Minnesota Department of Health, including site visits. Would DHS implement a process similar to the ECP designation process?

MACMHP is interested in seeing robust coordination with mental health peer specialist services, crisis services and community supports/ community-based programming services by both MCOs and IHPs.

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?*

MACMHP strongly recommends a streamlined health information exchange system providing consistent PHI exchange and access across *all* partners with both Next Generation IHPs and their contracted providers networks. We recognize the amount of time and work building this HIE system takes, but we see it as a key component to effective care coordination.



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Additionally, this RFP should include some start-up funding for community mental health programs and other safety net providers to connect into existing or new IHPs to have better access to the data to do population health and/or interface with provider networks.

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?*

**The criteria and evaluation needs to consider populations served. The evaluation could look at previous IHP safety net pilot projects or ICSP projects and compare to them other community benchmarks.**

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?*

**MACMHP encourages DHS to pursue either a single preferred drug list or carving out the pharmacy benefit from managed care with the following considerations:**

- **Ensure there is continuity or consistency of access for clients to their prescription drugs**
- **Include feedback and recommendations from prescribers – medical and mental/chemical health**
- **Ensure the benefit be fully inclusive of all prescription drugs or have a process for exceptions that still allows clients/ enrollees and their providers to obtain the drugs in a cost effective and time sensitive manner. (Often the administrative burden falls on the provider network to complete burdensome prior authorizations.)**

**MACMHP recommends *expanding a single preferred drug list or pharmacy benefit carve out statewide, beyond the seven-county Metro.* This will streamline the benefit across the state, bringing consistency and removing confusion.**

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?*



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MACMHP believes the balance of risk to providers must balance with their entire payer mix, or population insurance mix. This speaks to a provider's ability to supplement/ support this model with commercial payments or other revenue streams. Safety Net Providers (ECPs), whose client/ patient mix is primarily public programs, cannot take on *any risk*, as opposed to the larger health systems. The base (FFS) payments, beneath the risk-sharing portion, should be higher than other larger health systems, based on complexity of patients served and their intensive mix of services provided.

The benefit to the system, or MA program, of allowing different risk levels for ECPs is assurance that all MA beneficiaries have access to care, mental health, substance use disorder services and medical care. Unlike other providers, ECPs do not refuse treatment to any client based on ability to pay or health insurance coverage. Maintaining ECPs' space in this new system ensures treatment access to all Minnesotans.

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?*

MACMHP recommends using metrics for race, ethnicity, language and country of origin, poverty level of client populations, tobacco cessation efforts compared to use. We also recommend collecting data on social determinants of health using a combination of client-specific data in the electronic health record and population-wide profiles of the agencies' sites using geocoding and neighborhood deprivation index methodologies under the Quality Measurement Enhancement Project (QMEP). Several national programs are implementing measures of non-medical risk factors and services: PRAPARE (National Association of Community Health Centers), Enabling Services Data Collection (Association of Asian and Pacific Community Health Organizations) and a tool the University of Minnesota is using.

MACMHP strongly recommends any methodology for measuring services in this model be based on relative improvement from one measurement point in time to the next, plus *measures to demonstrate sustaining levels of care/ services*. This is opposed to ranking providers against other providers who are not their peers or setting the threshold at the state average. We also strongly encourage any measurement methodology be appropriately risk-adjusted for the populations' socioeconomic risk factors. A preferred method is *observed: expected*, comparing the actual to the expected outcome, which is calculated specifically to that provider.

9. *How much of the entities' payment should be subject to performance on quality and health outcome measures? Please explain your answer.*

How would the total-cost-of-care (TCOC) target be calculated and using which data? Which





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services across the full health care system will be included in the TCOC target? Mental health service codes have historically not been included in calculations. How will this framework change this?

MACMHP refers to our earlier comments that DHS should consider the provider's entire payer mix and the methodology used to evaluate quality and health outcomes. Regarding the methodology, MACMHP strongly recommends any methodology for measuring services in this model be based on relative improvement from one measurement point in time to the next, and measures to show sustained care levels, as opposed to ranking providers against other providers who are not peers or setting the threshold at the state average.

We also strongly encourage any measurement methodology be appropriately risk-adjusted for the populations' socioeconomic risk factors. A preferred method is observed: expected, comparing the actual to the expected outcome, which is calculated specifically to that provider. In addition, the state should assign a social determinant of health risk index to each organization using data collected with the *QMEP Tool*.

We strongly recommend the same methods, risk-adjustment be used in considering performance of provider networks under any MCO's outcomes-contingent payments. This recommendation is consistent with the 2017 Session law:

- **Alternative Quality Measures for Safety Net Providers.** Chapter 6, SS SF 2. (Article 4, Section 39) - Alternative measures for serving safety net populations in value-based payment arrangements like IHPs, HCH, and other demonstration projects.
- **State Health Care Program Managed Care Quality Measures.** Chapter 6, SS SF 2. (Article 15, Section 6). DHS to implement a written quality strategy for assessing and improving quality services provided by managed care organizations under contract with the state.

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?*

Minnesota 2017 legislation is already aligning the MN Statewide Quality Reporting and Measurement System (SQRMS) with the Merit Based Incentive Payment System (MIPS). Would DHS intend to follow these changes to SQRMS if it decides to align with the state system, or would it choose to incorporate a different set of metrics and methods under SQRMS?

Per 2017 Minnesota Session Law –





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- **Statewide Quality Measurement Framework. Chapter 6, SS SF 2. (Article 4, Section 3).** SQRMS measures be aligned with federal measures in the Merit-based Incentive Payment System (MIPS).
  - Six (6) or ten (10) measures may be mandated
  - Ensure safety net representation during the stakeholder process of developing the new measurement framework and selecting MIPS measures.
- **Alternative Quality Measures for Safety Net Providers. Chapter 6, SS SF 2. (Article 4, Section 39) -** Alternative measures for serving safety net populations in value-based payment arrangements like IHPs, HCH, and other demonstration projects.
- **State Health Care Program Managed Care Quality Measures. Chapter 6, SS SF 2. (Article 15, Section 6).** DHS to implement a written quality strategy for assessing and improving quality services provided by managed care organizations under contract with the state.
  - A plan to identify, evaluate, and reduce health disparities based on an enrollee's age, race, ethnicity, sex, primary language, or disability status

*Additionally, both the MIPS and MN SQRMS systems are focused on primary medical care. MACMHP is concerned about their lack of appropriate mental and substance use disorder health metrics. Any measurement system needs to include more robust measures specifically designed for mental health and substance use disorder. The Substance Abuse Mental Health Services Administration (SAMHSA) has developed tools to measure services in these fields. The creation/ implementation of measures in mental health and substance use disorder needs to be in consultation with providers, consumer advocates and CMHPs.*

**Lastly, the MN SQRMS and any resulting payment mechanisms must be appropriately risk-adjusted to recognize different populations' baseline outcomes compared to the majority population. If DHS decides to align with the state system, it must ensure the SQRMS system is appropriately modified to ensure accuracy and complete analyses.**

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?*



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MACMHP urges DHS to consider the gaps in the current system. These include gaps to coordinate and incorporate mental health, substance use disorder and social services (social determinants of health) into value-based purchasing. They also include gaps the availability of services currently. We need to consider the availability of services before assigning portions of them to risk-sharing. The state released a report on *2015-16 Gaps Regional Data Profile* (<https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7302K-ENG>). Mental health and home-community based services were identified with many service gaps.

Additionally, we urge DHS to focus on the entire family of clients as the client. This is particularly true with children and children's services. Parents and guardians' health and wellbeing are critical to children's. We will not see improvements in children's health if we do not include the family's in the treatment planning and service delivery.

Regarding focusing on social determinants of health, where is the portion of payment that covers ancillary (enabling) services? The model describes payment for coordination for services. We would like more detail on paying for actual services themselves. Will this be an upfront investment? Will the state pay for this investment as opposed to requiring the provider to invest the resources upfront with payments calculated retroactively?

We have concerns the lack of a system-wide measurement program and historic evidence to demonstrate capacity in the same way as medical care providers, which could put our providers at a disadvantage in this new model if not recognized.

There are also less-developed methods for measuring population health and prevention being used in the current state system. *We encourage DHS to consider and engage providers to address this.*

12. *Do you have any other comments, reactions or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?*

In this past year we experienced a lot of turbulence and frustration with current managed care. Most notably:

- Carriers' internal system errors to the detriment of providers
- Poor communication from carriers,
- No transparency of managed care rates,
- A sharp cut in mental health payment rates,
- Inconsistency of carriers coming in and dropping out of the MA market – causing burdens and confusion to clients
- Lack of parity across managed care between mental health and medical care



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MACMHP urges DHS to account for these issues and solutions to them as you develop this framework.

MACMHP is partnering with DHS on the Certified Community Behavioral Health Clinics (CCBHC) pilot. We are seeing many promising practices emerging as result. These include new intake processes for clients, decreased time delays to receiving treatment, streamlining of administrative tasks, enhanced comprehensive services to clients and a sustainable payment mechanism. We recommend DHS consider and use these practices in the new framework as the Department looks to integrate mental health and substance use disorder services in the model. We ask DHS to design this framework to complement these existing models and their payment structures and not disrupt them while they are being built and established. How will DHS integrate the CCBHC model into this framework?

Related to the new payment mechanism of CCBHCs, the pilot is implementing a prospective payment system (PPS) rate, similar to the Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). How will providers paid on this system be incorporated into this framework? Will the incorporation of a PPS rate not be to the detriment of the providers being paid under it?

Overall, MACMHP believes it is necessary to recognize services in mental health and substance use disorder as health care. We believe in systemic integration with medical care. We also see the industry's movement toward value-based purchasing, and we want to ensure our clients and their needs are a key consideration as the system moves farther down this path. In that, we want to ensure the community-based (safety net providers are included in the design of such systems. MACMHP thanks DHS for this opportunity to comment on the framework for the Outcomes-Based Purchasing Redesign and Next Generation IHP. **We strongly urge the Department to *continue engaging providers and stakeholders, particularly Safety Net Providers, in consult for key areas as this framework continues to develop.***

Thank you for this opportunity to submit our response on this Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP. We look forward to collaborating with you as the state moves this model forward. Please do not hesitate to contact MACMHP with any questions related to these comments or information on Community Mental Health Programs.

Sincerely

Jin Lee Palen

Executive Director

Minnesota Association of Community Mental Health Programs | MACMHP



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December 20, 2017

Marie Zimmerman  
State Medicaid Director, Health Care Administrator  
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St. Paul, MN 55164-0997

**Submitted electronically to [DHS.PSD.Procurement@state.mn.us](mailto:DHS.PSD.Procurement@state.mn.us)**

Dear Ms. Zimmerman:

On behalf of the Minnesota Hospital Association (MHA), which represents 142 hospitals and health systems serving communities throughout the state, including our members who sponsor and lead 15 of the 21 Integrated Healthcare Partnership (IHP) demonstration projects underway, we offer the following comments in response to the “Request for Comments: Outcomes-Based Purchasing Redesign and Next Generation IHP” (RFC).

Since the drafting of its enabling legislation and offering suggestions for the first request for proposals (RFP), to the success this one-of-a-kind program has demonstrated over the past several years, MHA has been a strong proponent of the IHP demonstration projects. Several key elements of the IHP program’s structure and implementation are the reason for MHA’s support, for its uniqueness during so many health reform efforts across the country, and for the measurable, year-over-year success of the program. As the Minnesota Department of Human Services (DHS) looks ahead to offering a new option for IHPs to consider, MHA encourages the department to retain these crucial elements of the IHP demonstration projects:

- Participation is voluntary for providers rather than a regulatory mandate;
- Providers have flexibility to design, propose and negotiate the scope and feature of their respective IHP demonstrations, rather than a one-size-fits-all approach;
- Participating providers are afforded access to relevant, near-real-time, health care data in a manner that allows them to analyze individual utilization along the continuum of care as well as aggregate trends across their enrollee population, rather than relying on providers to coordinate care for quality and cost improvements but without allowing providers to have the information they need for care coordination; and
- Results are publicly available and transparent; rather than a proprietary process in which providers and the public are unable to see and compare the performance of those contracting with the State.

MHA is pleased that the Next Generation IHP (Next Gen IHP) framework outlined in the RFC appears to adhere to these standards and principles.

Because of changes in other aspects of the health care system since the inception of the IHP demonstration projects, MHA encourages DHS to take into account another important objective when designing the Next Gen IHP model and creating or modifying other IHP models: to align with other government mandates and payment reform demonstrations, including but not limited to Medicare's Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs), as well as Minnesota's Statewide Quality Measurement and Reporting System (SQRMS), when greater alignment will not decrease the quality of care enrollees receive, produce unnecessary barriers to accessing care for enrollees or result in significant increases in the total cost of care for state public programs.

#### **MHA's Support for the Next Generation IHP Framework**

As noted earlier, MHA has supported the IHP demonstration projects from the beginning. MHA represents a broad and diverse membership and, naturally, individual members may differ on their level of support for the Next Gen IHP proposal and, for those in the Twin Cities area, their level of eagerness to submit a Next Gen IHP proposal during the procurement process. A large part of the reason for this variation is due to the lack of important details about the actual terms and conditions of the Next Gen IHP model when it is implemented.

While it is too soon to assess whether MHA's members will pursue establishing a Next Gen IHP for 2019 or whether the Next Gen IHP model will be successful in the midst of all the other changes underway in our health care system, MHA supports DHS' efforts to create new options and payment models in the IHP program. When overseeing a successful new initiative, like the IHP program, it can be tempting to refrain from making any changes or innovating further. This temptation eventually results in stagnation. Accordingly, MHA is grateful that new models are being developed, that current and future IHPs will have options that provide incentives for them to deliver even better outcomes for patients and cost savings for state public programs.

#### More IHP Models are or will soon be Necessary for Ongoing Success

The tracks available for organizations choosing to participate in the IHP demonstration projects are limited to models based on fee-for-service payments with shared savings opportunities. These models are appropriate, well-designed starting points for payment and delivery reform experimentation. When developing the IHP approaches, however, DHS acknowledged that these methodologies carry an inherent time limit and, eventually, the IHP program's ongoing success will require transitioning to other payment models that create greater incentives and flexibility for providers to continue redesigning how they care for their state public program populations.

In the fee-for-service-with-shared-savings approach that IHPs operate under today, provider organizations focus on improving patient care and reducing unnecessary, duplicative or low-value services to reduce the total-costs-of-care (TCOC). Because the savings generated in one year make it more difficult for the organization to generate additional savings the following year, at some point the costs and effort to create additional marginal savings outweigh the benefits reasonably expected from a future shared savings incentive payment.

Therefore, to ensure that IHPs have sufficient incentives to address the more costly and difficult care redesign necessary to generate quality and cost of care improvements, the payment model needs to change substantially giving providers both more up- and down-side gainsharing incentives. Often, these arrangements are less reliant on fee-for-service payments as the principal measure of performance and, instead, adopt a global budget, per member/per month capitated rate, or other metrics based on a population-based TCOC.

As many stakeholders have expressed to DHS, there are many details that need to be decided to determine whether this new model offers a manageable and practical bridge from today's shared savings IHPs to a new population-based payment methodology that offers providers the necessary incentives. Meanwhile, the framework for the Next Generation IHP clearly aims for creating an avenue for willing providers to make this transition.

The IHP program is uniquely suited to allow for this kind of experimentation. Because the Next Generation IHP will be available on a voluntary basis, only those provider organizations who have the capacity and interest in trying to make this transition will be the first trailblazers. This prevents putting the entire care delivery system under greater risk or requiring providers to take on costs or risks before they are ready.

The IHP program has a proven track record of success which allows interested organizations to understand their historical performance and, therefore, make a better judgment about the best timing for making this transition given their unique capacity and the needs of the communities they serve. The Next Generation IHP model can include guardrails to prevent putting a provider organization at existential risk over the term of the contract.

#### Next Gen IHP Addresses Limitations of Existing IHP Models

MHA members participating in existing IHP demonstration projects offer strikingly similar suggestions for improving their ability to coordinate care better and reduce costs even more.

The single most frequent and emphatic suggestion is to develop a system in which an IHP knows which enrollees will be attributed to it at the beginning of the coverage year, so the IHP can connect with those enrollees and more actively coordinate their care throughout the year, rather than retrospective attribution that leaves providers accountable for the care of certain enrollees after the care has already been delivered. In other words, it is easier to coordinate care when you know which people you are accountable for than it is to find out in hindsight.

The Next Generation IHP framework offers a practical remedy to allow IHP organizations to know which enrollees they are expected to work with to coordinate care. By requiring enrollees to select a primary care provider (PCP) at the time they enroll in a state public program, the State will be able to inform Next Gen IHPs who is in their patient population shortly after enrollment. This will enable Next Gen IHPs to connect with their respective enrollees at the beginning of the enrollment year, begin to develop a relationship with the enrollee and better understand his/her health care needs and goals, and work deliberately with those enrollees throughout the year.

Another common concern with today's IHP models results from IHPs and managed care organizations (MCOs or PMAPs) duplicating care coordination efforts. Because most enrollees within the scope of the IHP demonstration project select a MCO, both the MCO and the IHP entity have incentives to attempt to track and manage enrollees' care. This duplication of effort creates confusion and mixed messages for enrollees and results in unnecessary waste of already limited resources.

The Next Gen IHP model is designed to address these concerns by attributing enrollees to either a Next Gen IHP or a MCO, but not both. When the enrollee selects a PCP, that selection will determine whether the Next Gen IHP or the MCO is accountable for his/her quality and cost of care. This clear, prospective allocation of accountability should result in less confusion and better care coordination for state public program enrollees, and more effective and efficient use of providers' and MCOs' care coordination or disease management resources.

Having enrollees select a PCP at the time of enrollment also addresses another concern with the current IHP models. In today's IHP models, the IHP begins establishing a relationship with an enrollee only after the enrollee has a need for health care services and comes to the IHP-participating provider. Often, this occurs after an otherwise-preventable or -treatable condition has progressed requiring more substantial and costly treatment.

Under the Next Gen IHP approach, the Next Gen IHP will be able to begin forging a relationship with the enrollee, educating him/her about services available and the best ways to obtain those services, and learning about his/her health care needs earlier and, in some cases, when an illness or injury can be treated more effectively. Whether the enrollee selects a Next Gen IHP-participating PCP or a PCP in a MCO's network, this proposed reform will enable earlier, more proactive interactions with enrollees. Accordingly, MHA strongly supports this element of the Next Gen IHP proposal and we encourage DHS to make it a component of coverage for 2019 for all enrollees, regardless of whether they are enrolled in a MCO, enrolled in or attributed to a Next Gen or other model IHP, or covered through Medical Assistance's fee-for-service program.

#### Remaining Questions and Suggestions Expressed by MHA Members and IHP Participants

Through MHA's discussions with our members, feedback from current IHP participants, and attending the public meetings held after release of the RFC, several questions or requests for additional information have been raised. As DHS moves forward with designing the Next Gen IHP option, MHA respectfully requests that it consider, account for, clarify or address the following topics:

- Not unexpectedly, MHA members seek more information about several details concerning (a) the per member/per month capitation rates that will be set for Next Gen IHPs and MCOs, (b) the amount DHS will charge Next Gen IHPs for the administrative services it provides, (c) how Next Gen IHPs will receive or coordinate those services with DHS, and (d) whether DHS would allow a Next Gen IHP to provide some of the administrative services on its own or through a vendor and decrease the administrative fee to DHS proportionately.

- Consider offering the Next Gen IHP option to provider organizations outside of the seven-county Twin Cities metropolitan area through their respective procurements. Evaluations of proposals from potential Next Gen IHPs could examine the feasibility of such a demonstration in the respective communities based on the Next Gen IHPs' capacity, expected enrollee population, and other market dynamics.
- Explain how the Next Gen IHP payment methodology will impact, if at all, other financing in the Medical Assistance and MinnesotaCare programs, such as upper payment limit (UPL) calculations, disproportionate share hospital (DSH) payment formula, Medical Education and Research Cost grants, etc.?
- Allow health systems to define the scope of their Next Gen IHP based on certain geographic areas or communities that represent a defined portion of their overall service area. Doing so would allow potential Next Gen IHPs to continue operating IHPs in other tracks that serve a distinctly different population (e.g., only children or enrollees who reside in a defined geographic area) and/or conduct their own internal comparisons in performance between their Next Gen IHP providers and their other providers. The intent of this suggestion is not to divide PCPs within the same clinic location between Next Gen IHP and IHP 2.0, for example. Instead, the suggestion is to allow health systems with primary care clinics in many different geographic areas to identify a subset of those clinics, such as those within a particular county, as participants in the health system's Next Gen IHP, and clinics that serve different communities that do not overlap with the Next Gen IHP service area as participants in a different IHP model or as participating in none of the IHP models.

DHS allows these kinds of designations in the current IHP models, and doing so within the Next Gen IHP approach might make it more attractive to health systems that want to participate but are wary of disrupting successful IHP programs already underway, overextending themselves, or overlooking the different needs and capacity in different communities.

- Further define which social services or supports that are otherwise not covered services under Medical Assistance or MinnesotaCare, such as food security or sustainable housing, might be eligible to be included in a Next Gen IHP's service offerings for enrollees. Likewise, clarify how payment for these services will occur – for example, will there be a fee-for-service rate set like other traditional medical services or, instead, will providers recoup their costs through their quality and cost incentive payments?
- What marketing restrictions will apply to Next Gen IHPs – those applicable to Medicaid MCOs, to Medicaid-enrolled providers, or both?
- DHS has described its expectations that Next Gen IHPs would receive smaller and smaller fee-for-service reimbursement rates over time to place a greater portion of their total payments in the outcomes- or value-based component of the per member/per month capitation rate. Will the timing and scale of such reduced payments be defined in the upcoming procurement process or does DHS expect that any such reductions to fee-for-service rates for Next Gen IHPs would be elements or conditions in subsequent procurements?



- Given the importance of PCP selection for enrollees' care and available provider network, success of the Next Gen IHP model will depend heavily on DHS' ability to ensure that enrollees make well-informed and deliberate decisions at the time of enrollment. DHS has reported that the number of people who do not make an active selection of a MCO in today's enrollment process indicates that accomplishing this level of education will be a significant undertaking. It will be helpful to MHA members to better understand DHS' plans for educating enrollees and ensuring that they make knowledgeable decisions when selecting a PCP.
- MHA members have asked for clarification of the parameters for enrollees' ability to change their designated PCP, and potentially their placement in a Next Gen IHP or MCO, during an enrollment year.

#### Concerns Raised by Other Stakeholders

Again, DHS has heard many stakeholders explain how they need more details about the model before making a final assessment about its likelihood of success. MHA doubts that this feedback in our comments and those the department receives from other stakeholders will come as a surprise.

However, even in the absence of these details and in the context of the Next Generation IHP as a proposed framework, MHA believes that some individuals and interest groups intend to contest the merits of even entertaining this kind of demonstration project and to request that DHS move forward with next year's procurement without a Next Gen IHP option. Because we are unsure whether there will be future opportunities to provide additional comments or respond to arguments submitted by these individuals or interest groups, MHA offers the following feedback regarding the arguments that might be submitted and would otherwise go unaddressed.

Shortly after releasing the RFC, MHA began hearing the Next Gen IHP approach attacked with a commonly used label in discussions of new health policy innovations: it will move health care to a government-controlled single-payer system. At the outset, it is important to note that Medical Assistance and MinnesotaCare, the programs involved in the IHP demonstrations, have always been government-controlled with the State as the sole purchaser of the coverage and services provided to enrollees. The State pays for the coverage and services through direct payments to providers in the fee-for-service system or through its contracts with MCOs or county-based purchasing organizations. But in all of these arrangements, Medical Assistance and MinnesotaCare are government-run programs with the State as the single payer ultimately responsible for the costs of enrollees' coverage and health care.

Moreover, the Next Gen IHP proposal does not move Minnesota any closer to a single-payer system. According to the Next Gen IHP framework described in the RFC, it is unequivocally clear that Next Gen IHPs are intended to compete with MCOs and one another. They will compete for enrollees, they will compete on the quality of care their enrollees receive, and they will compete to ensure that their respective enrollees receive their covered benefits in the most cost-effective manner possible.

Quite simply, the Next Gen IHP model is deeply rooted in and heavily relies on free-market-style competition to drive better customer service, higher quality care, and greater efficiencies.

Another refrain MHA has heard from potential opponents of the notion that provider organizations might be measurably more successful in coordinating enrollees' care than previous fee-for-service or managed care models, is that the Next Gen IHP framework is "too complicated." This criticism is difficult to support in light of the complexity and administrative burdens that exist in the State's Prepaid Medical Assistance Plan demonstration project.

Today, the State already calculates the actuarially expected costs of care for various enrollee populations, the expected administrative costs MCOs will incur, and the projected margins they might generate for themselves if they operate efficiently. The State already collects and evaluates measures of the quality of care enrollees receive. The State already tracks and evaluates the actual costs of care incurred after MCOs' capitated payment rates are set. Under the Next Gen IHP proposal, the State will undertake these same steps and those calculations will serve as the basis for both MCOs' and Next Gen IHPs' maximum capitated payment rates. In short, the Next Gen IHP model as outlined by DHS appears to be no more complex than the calculations, data collection and analysis, and monitoring of the program that the State already performs for the populations of enrollees assigned to MCOs.

Another foothold opponents have attempted to leverage is based on the argument that the playing field will not be level for competing MCOs and Next Gen IHPs. MHA agrees that the playing field is not configured identically, but this does not mean that the model necessarily favors one care coordination structure over another.

In essence, the Next Gen IHP model will provide qualitative and quantitative data from market-based competition to enable DHS and policy makers to discern which model of enrollee care coordination performs best and results in the greatest improvement from the existing state of Medical Assistance and MinnesotaCare. In this corner, a managed care model that has dominated Minnesota's state public program design for decades; and in this corner, a new provider-led care model in which there is not a third party attempting to influence patient-provider decision making. Minnesota's state public programs should not cling to a legacy fee-for-service model or a managed care model if new models or innovations might deliver better, more cost-effective care for enrollees.

Furthermore, any claim that an element of the Next Gen IHP framework will lead to a playing field that slopes in one direction or another the unlevel, has examples of other elements of the framework that appear to lean in the opposite direction. In other words, the proposed framework includes components that might appear to advantage MCOs and others that could advantage Next Gen IHPs.

For example, MCOs will have a substantial competitive advantage when it comes to designing provider networks. At the outset, they already have provider networks in place and will spend less time and resources to establish their networks for the next procurement process. And, unlike Next Gen IHPs, MCOs will not have to convince PCPs to agree to an exclusive network, as proposed in the DHS framework.

On the other hand, MCOs will incur expenses to provide their own billing and claims capacity, grievance and appeals processes, and other administrative functions. Note that, regardless of implementing the Next Gen IHP model, MCOs must provide these same functions for their other insurance business lines, so these are incremental costs. For Next Gen IHPs, the State will provide those administrative functions

for a fee. This will avoid the need for provider organizations to divert resources from care delivery to building an administrative infrastructure that will be used for only a small portion of their patient population.

Who gains a competitive advantage from this difference? One could argue that it will benefit Next Gen IHPs because they will have less responsibility and functions to perform compared with their MCO competitors. Yet, the cost to Next Gen IHPs to have DHS provide these administrative services remains unknown. It is possible that this arrangement will benefit MCOs if they can perform these administrative functions for less incremental cost than the amount charged to Next Gen IHPs. Thus, it is too early for anyone to support a claim that the allocation of administrative functions benefits one competitor over another.

Similar to the “unlevel playing field” argument, is the claim that Next Gen IHPs’ financial reserves will be insufficient for prudently managing downside risk in state public programs. The Next Gen IHP proposal accounts for the need to examine potential Next Gen IHPs’ financial capacity and risk exposure. As part of the procurement process, DHS will assess a Next Gen IHP’s financial capacity to assume different degrees of risk. The amount of downside risk that a Next Gen IHP will assume can then be designed to avoid putting the provider organization’s community at risk of losing access to essential services. This concern, therefore, is not one of whether the Next Gen IHP proposal should be further developed and explored, but rather an example of the need for DHS and provider organizations to have flexibility when defining and tailoring the scope and degree of risk each IHP can assume under any IHP model.

#### **Responses to Specific Questions from the RFC**

- 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?**

MHA supports the proposal to have state public program enrollees select a primary care clinic at the time of enrollment. Regardless of the status of that clinic’s participation in a Next Gen IHP, another IHP track and/or a MCO’s network, the ability to proactively connect with enrollees and begin care coordination activities earlier and more confidently will benefit enrollees’ health, and ultimately improve the quality and cost of care they receive.

With respect to primary care exclusivity, MHA would like greater assurance that enrollees will have sufficient choice of providers. If DHS determines that this exclusivity is a necessary and unavoidable component for creating the Next Gen IHP option, MHA suggests that DHS remain flexible and practical when it comes to providing exceptions that are in enrollees’ best interests.

Possible exceptions for DHS to consider at the outset of the Next Gen IHP pertain to specialists who can also serve as an enrollee’s designated PCP, such as OB/GYN, mental health, certain pediatric specialties, etc. Generally, MHA supports including these kinds of specialties in the Next Gen IHP

model's definition of "primary care provider" to better reflect enrollees' interests in selecting these clinics as their PCP at the time of enrollment. For example, while it would make sense to include mental health providers as an option for enrollees to select as their PCP because many people rely on those providers to coordinate their overall health care needs.

However, because our communities already face significant access issues for some of these services, such as mental health care, MHA is concerned about limiting their availability to only a portion of state public program enrollees if these providers cannot participate in both Next Gen IHPs' and a MCOs' networks. MHA suggests that DHS consider allowing certain specialties to be available for enrollees to select as their PCP clinic and then assigning those enrollees to that clinic's corresponding Next Gen IHP or MCO while also allowing those clinics to provide in-network care and treatment as a non-PCP for enrollees in other Next Gen IHPs and MCOs.

MHA respectfully suggests that DHS provide an analysis of the expected impact, if any, on enrollees' access to care, particularly for services that are already difficult for enrollees to obtain. Because it is impossible to anticipate every scenario in such a prospective analysis, MHA anticipates that DHS will make exceptions or modifications based on the experience of enrollees, IHPs and MCOs as the model is implemented.

- 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.**

MHA understands that smaller populations make models like the proposed Next Gen IHP difficult or unwieldy to implement. MHA is reluctant, however, to support establishing a hard-and-fast minimum number of beneficiaries for the Next Gen IHP option to be available. It is likely that populations in the Twin Cities area will be sufficient, but it is important to anticipate the possibility that this new model will be available in other areas of the state where an inflexible standard might preclude innovation and improvement in care delivery.

IHP demonstrations in place today demonstrate the value of flexibility for DHS and provider organizations to determine what criteria are most appropriate and practical based on their unique circumstances. MHA suggests that DHS establish a "presumptive minimum beneficiary population" while retaining flexibility to approve Next Gen IHP proposals that offer other approaches for adequately meeting a smaller population's needs and managing financial risk.

- 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.**

Before or at the beginning of the procurement process, MHA requests that DHS clarify the scope of providers required to be in a Next Gen IHP's network. More specifically, MHA encourages DHS to allow Next Gen IHPs to identify their network of participating providers and then, for covered non-

primary care services for which the Next Gen IHP's network might be insufficient, to supplement or gap-fill the network with providers in DHS' fee-for-service system at fee-for-service reimbursement rates.

MHA expects that other provider network development issues will need to be resolved to ensure that enrollees have meaningful access to their covered benefits while avoiding unnecessary burden or insurmountable cost of entry during the Next Gen IHP start-up phase.

- 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?**

MHA does not have recommendations at this time, but we are willing to work with DHS and other stakeholders to identify appropriate mechanisms.

- 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?**

MHA does not have recommendations at this time, but we are willing to work with DHS, counties and other stakeholders to identify appropriate criteria and accountability standards to the extent permissible or prudent in light of any restrictions associated with procurement process.

- 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?**

At this time, MHA does not have sufficient information to assess or predict the impact of a single PDL on enrollees' care or the state public programs' total costs. Generally, MHA supports the proposal's underlying motivation to provide enrollees with access to medically needed prescriptions, eliminate a confusing variation in coverage when enrollees move from one MCO to another, and increase the State's leverage to reduce total health care spending. However, MHA does not have access to data or projections to substantiate these expected benefits.

As one MHA member noted, the more carve outs or different coverage for different services that exist in an enrollee's coverage design, the more challenging it can be to coordinate care and manage the enrollee's health holistically. Therefore, it is important for DHS to evaluate the expected benefits vis-à-vis potential impacts on care coordination in its decision making on the question of carving out pharmacy benefits.

In whatever direction DHS decides to take, MHA members will seek assurances that enrollees will be allowed to receive medically necessary medications even if they are not included on the PDL. In other words, specialty drugs or brand-name medications that are not on the PDL but are needed by an individual with a rare clinical condition, allergy or other medical need should continue to be available to enrollees in state public programs when those situations occur.

**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?**

MHA suggests that DHS negotiate with each Next Gen IHP to determine the appropriate balance of up- and down-side risk based on its capacity to assume risk, its care coordination and data analytics abilities, its financial status and patient mix, and the number of beneficiaries expected to enroll in its Next Gen IHP. MHA doubts that a one-size-fits-all, uniform incentive system will produce as much uptake in the Next Gen IHP model and, therefore, as much improvement in quality and costs for our state public programs.

Also, MHA encourages DHS to seek as much alignment with Medicare's Advanced Alternative Payment (Advanced APM) requirements so the standards used in the Next Gen IHP model support providers' efforts to qualify as an Advanced APM.

**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?**

MHA and our members have supported adoption of risk adjustment methodologies that account for social determinants of health, for example in Medicare's hospital readmissions program. Our support for including such factors in risk adjustment rests on data-driven studies documenting the variation in likelihood of various health outcomes when social determinants of health are taken into account.

MHA is eager to support initiatives designed to improve individuals' health status by addressing underlying social determinants of health. Intuitively, the Medical Assistance and MinnesotaCare enrollees seem like logical populations to begin integrating social determinants interventions and health care delivery.

At the same time, MHA encourages DHS to proceed in a data-driven fashion. Some of our members have expressed concerns that already limited state public program resources will be diverted from health care to social services or other activities without corresponding evidence of health improvement for enrollees or reductions in the total costs of care. In other words, MHA suggests that selecting social determinants of health-focused activities to be financed in part with state public program resources should place a high priority on existing evidence that those activities measurably improve health status and/or reduce costs of care.

For obvious reasons, MHA members have fewer concerns about initiatives aimed at reducing health disparities or improving health outcomes because those activities are, by definition, designed to deliver higher quality of care and achieve better health outcomes with less likelihood that health care resources are used in ways that do not improve health care for enrollees.

**9. How much of the entities' payment should be subject to performance on quality and health outcome measures? Please explain your answer.**

Without more information about per member/per month payment rates and the amount of costs paid to DHS for administrative functions, it is not possible to estimate the remaining amount of funding available to divide between fee-for-service payments, up-front care coordination or infrastructure development, quality and health outcome achievements, or cost savings. With this caveat, MHA suggests that a Next Gen IHP should have a portion of its total payments based on quality and outcome measures and it should be able to receive payments for achieving benchmarks on those measures even if its enrollees' total costs of care did not generate savings for the State.

**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?**

Ideally, all of these programs will align with one another. To the extent that there are discrepancies, MHA encourages DHS to select SQRMS measures that are also measures in Medicare's MIPS catalog. Because state law requires reporting SQRMS measures, MHA strongly urges DHS to select measures that are not part of SQRMS because it will increase overall costs of care, collection and reporting burdens, and confusion among providers.

**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?**

MHA encourages DHS to include socio-economic determinants of health in its risk adjustment calculations when establishing per member/per month capitation rates.

MHA encourages DHS to consider adopting or creating measures of efficiency or total costs of care that span more than a 12-month period so that IHPs and MCOs have greater incentive to provide earlier, low-cost interventions that generate savings in future coverage years.

MHA expects that the element of the Next Gen IHP proposal that is most likely to result in an eligible entity choosing not to participate is the primary care exclusivity policy and providers' concern about losing portions of their current patient population or even being blocked from MCOs' networks across their entire books of business – Medical Assistance, MinnesotaCare, commercial, Medicare Advantage, etc.

Ms. Marie Zimmerman

December 20, 2017

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**12. Do you have any other comments, reactions or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?**

As noted earlier, DHS should develop and share a communications and enrollee education plan detailing how it will provide enrollees with the information necessary to make thoughtful PCP clinic selections at the time of enrollment and with the information necessary to better understand provider networks and where to access care based on their enrollment.

Sincerely,

A handwritten signature in black ink, appearing to read 'Matthew L. Anderson', with a long horizontal flourish extending to the right.

Matthew L. Anderson, J.D.  
Senior Vice President of Policy &  
Chief Strategy Officer





## SENT ELECTRONICALLY

December 20, 2017

RE: Minnesota Department of Human Services, Request for Comment on Outcomes-Based Purchasing Redesign and Next Generation IHP

To Whom It May Concern:

The Minnesota Medical Association (MMA) appreciates the opportunity to submit comments on the proposed redesign and reform of the state of Minnesota's purchasing and delivery strategies for Medicaid and MinnesotaCare.

Overall, the MMA supports the department's core objectives and proposal to conduct a new procurement in the seven county metropolitan area in 2018, for contracts beginning in 2019. The MMA also supports efforts to further refine options for the Integrated Health Partnership (IHP) demonstration model consistent with efforts to further test alternative payment and delivery models that can improve care, efficiency, and patient experience.

As outlined, the new proposal appears to move away from recent competitive bidding approaches and, instead, would rely on a rate-setting process for Next Generation IHPs and MCOs. The proposal does not appear to delineate how Next Generation IHPs or MCOs would be selected by the state for participation, however; further clarity on this is critical in order to provide guidance to physician practices looking to determine their options with respect to affiliating with one or more Next Generation IHPs and/or participating in an MCO network. Currently, many (if not all) commercial health plan contracts currently link physicians' network participation for the commercial products to their network participation for public program products. These contracting provisions, as well as Rule 101, may warrant further state consideration to ensure that physician practices are afforded the flexibility needed to realize the Next Generation IHP goals.

The MMA is not in a position to provide specific comment on some of the design features, but offers the following comments on some questions posed by the department:

1. Next Generation IHP Primary Care Exclusivity

The MMA has long supported a medical home for every Minnesotan and recognizes the value that a usual source of care offers patients in terms of prevention, chronic disease management, care coordination, and appropriate utilization. A requirement for the Next Generation IHP models to be

built around an exclusive primary care clinic /network is similar to the requirement for the Medicare Shared Savings Program. Further clarity on the contract selection/participation items noted above are critical to determine the reasonableness of this proposal, however. In addition, greater clarity on the definition of “primary care clinic” is needed. In general, the MMA is supportive of shifting toward a definition and focus of enrollee participation based around a primary care relationship, rather than around a particular MCO selection or assignment.

6. Single Preferred Drug List

The MMA strongly supports the department’s proposal to require a single preferred drug list across fee-for-service, managed care and Next Generation IHP models. The MMA has long argued that the current variation in drug coverage and policies is disruptive to enrollees and administratively burdensome to physicians. The MMA generally opposes carve out models and instead supports management of all health care costs and utilization in aggregate, rather than in isolation. The MMA strongly urges the department to implement the single preferred drug list on a statewide basis, rather than just for the metropolitan area.

8. Addressing Social Determinants of Health

The MMA applauds the department for acknowledging the need to develop payment policies that support interventions aimed at addressing social and economic factors that contribute to poor health and reduced access to care.

10. Quality Measure Alignment

The current quality measurement environment is burdensome to physicians, lacking in focus and priority, of questionable value to individuals and purchasers, and unsustainable for many organizations. The MMA worked during the 2017 legislative session to improve alignment between state and federal measurement by limiting the number of Statewide Quality Reporting and Measurement System (SQRMS) measures required of physician practices, and requiring (with some limited exceptions) selection of SQRMS measures from the roster of measures available for the Merit-Based Incentive Payment System. The MMA urges the department to align its quality measurement requirements consistent with this approach.

The MMA looks forward to continuing to work with the department on the development of this new model and appreciates your consideration of these comments. Please feel free to contact me or staff at the MMA with any questions or concerns.

Sincerely,



George Schoephoerster, MD  
President



December 20, 2017

Mat Spaan  
Minnesota Department of Human Services  
540 Cedar Street  
Saint Paul, MN 55155

Re: DHS Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP

Dear Mr. Spaan:

In response to the above-referenced solicitation from the Minnesota Department of Human Services (DHS), the Minnesota Association of Community Health Centers (MNACHC) submits the following comments contained in this correspondence. We appreciate the opportunity to provide you with feedback on DHS' transformative health care delivery and payment program.

The Minnesota Association of Community Health Centers (MNACHC) represents the interests of the state's 17 Federally Qualified Health Centers (FQHCs). These FQHCs (hereinafter interchangeably referred to as "Health Centers" or "CHCs") serve approximately 175,000 low-income Minnesotans. Nearly 50% of the FQHC patients are enrolled in a Minnesota Health Care Program (MHCP) -- Medical Assistance (MA) or MinnesotaCare.

FQHCs are participating in Minnesota's delivery and payment reform efforts. **11 of MNACHC's 17 member FQHCs are currently participating in an IHP demonstration** authorized under Minnesota Statutes, Section 256B.0755:

- 10 Twin Cities FQHCs as members of the **FQHC Urban Health Network (FUHN)**; and
- **Open Door Health Center** in Mankato is part of the Southern Prairie Community Care project.

It is also important to note that **NorthPoint Health & Wellness**, a member of MNACHC, is part of the Hennepin Health demonstration project authorized under Minnesota Statutes, Section 256B.0756.

**Collectively, nearly 36,000 FQHC MA patients are part of the IHP program – this is 21% of our total patient base and 41% of our MHCP patient base.**

MNACHC's comments in response to DHS' RFI will be broken into three areas:

1. Global Observations on the proposal;
2. Specific responses to questions posed by DHS; and
3. FQHC-specific comments on the proposal.

### Section #1 - Global Observations on Next Generation IHP

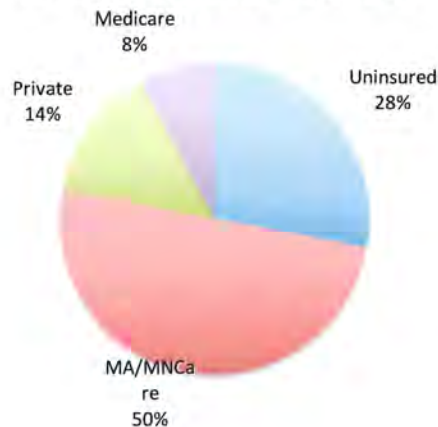
Safety net providers such as FQHCs are unique participants in the state's current IHP demonstration program for two primary reasons: **1] relatively speaking, they do not have significant financial resources; and 2] they operate as independent primary care organizations, not part of any health care system or plan.**

In 2015, roughly 30% of FQHC patients **did not have health insurance** – nearly 6 times the rate of the general population. FQHCs provide care to 1 out of every 6 uninsured Minnesotan through the use of a sliding fee discount program at each FQHC.

The **level of poverty** our patients experience is nearly six times the rate of the general Minnesota population – 89% of FQHC patients have incomes below 200% of poverty compared to 25% of the state's general population.

With such patient demographics, FQHCs tailor their services to remove barriers to primary care services for low-income Minnesotans. These "enabling services" include transportation, case management, patient education/outreach, interpretation services, eligibility assistance legal services, advocacy to reduce domestic violence and rape and human trafficking, and diabetic medical protocols tailored to Muslims during Ramadan. The combination of a low-income, uninsured patient base along with unique services targeted to communities of need, translates to **Community Health Centers that operate on very tenuous financial operating margins.**

**FQHC Patient Insurance, 2017**





Additionally, most FQHCs in Minnesota are **independent**, non-profit organization **governed by actual patients of the Community Health Center**.<sup>1</sup> This independence poses a unique challenge for FQHCs as they do not have unlimited access to or control of specialty and inpatient hospital services.

**OBSERVATION #1 | Participation in the Next Generation IHP requires significant operational investment ranging from information technology, data analytics and care coordination staff. As non-profit providers serving a low-income patient population, FQHCs may not have the internal financial resources to make the level of investment necessary to participate in the Next Generation IHP.**

**MNACHC recommends that the Next Generation IHP program upfront investments to safety net and independent organizations to support further FQHC/safety net participation. Furthermore, the administrative requirements of the Next Generation IHPs are significant also require appropriate funding.**

As providers of primary medical, dental and behavioral health services, MNACHC commends DHS' efforts to redesign and reform DHS's purchasing and delivery strategy. The Next Generation IHP is the natural evolution of the past IHP and IHP 2.0 efforts. MNACHC welcomes this shift toward funding providers to best serve the state's low-income populations.

**OBSERVATION #2 | The Next Generation IHP model contains elements that are commonly part of a MCO-driven purchasing strategy. For example, the "network adequacy" standards are critical, however, safety net providers such as FQHCs may not have the financial resources to establish comparable networks.**

**MNACHC recommends that the Next Generation IHP program should provide flexibility for provider-based organizations and view the model from a population health perspective.**

"Gain sharing" in the Next Generation IHP model is contingent upon participants meeting both financial and quality benchmarks. MNACHC is a strong supporter of transforming health care reimbursement methodologies away from volume to value based on the quality of care provided. **To date, measurement efforts have been problematic for FQHCs, however, we appreciate the recognition in the Next Generation IHP model of the social determinants of health.**

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<sup>1</sup> Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304

At the core of the FQHC delivery model and mission are features that attract a patient base that is significantly different from the state's general population. Some of these features of the FQHC model include:

- FQHCs cannot “pick and choose” which patients they serve as **they serve all regardless of their ability to pay for those services.**<sup>2</sup>
- Community Health Centers are **governed by patient-controlled Boards of Directors** that provide Health Center leadership with insight to the needs of the communities.
- FQHCs are located in **Medically Underserved Areas** where health disparities are significant for most the population.

Given the core pieces of the model, FQHC patients are drawn from communities that are overwhelmingly impacted by socio-economic factors that impact their health. Research strongly suggests a link between a particular patient's health and their socio-economic factors. These socio-economic factors are referred to as the **social determinants of health** and include (but are not limited to) poverty, race/ethnicity, country of origin, education level, housing status and geography.

Clinical care – the work that occurs within the four walls of any healthcare setting – contributes roughly 20% to a patient's outcome. 80% of the outcome is determined by genetics, behavior, environment and the socio-economic factors. **Socio-economic factors alone account for 40% of a patient's health and clinical outcomes.**

Over the past two years, MNACHC has worked closely with the Minnesota Safety Net Coalition (SNC) to develop the Quality Measurement Enhancement Project (QMEP). The project was in response to the state's reluctance to incorporate the social determinants of health (SDH) into quality measurement reports. Consequently, the SNC is in the process of developing a quantitative and qualitative adjustor to incorporate the SDH into any measurement mechanism. Consequently, the Next Generation IHP payment model should incorporate the QMEP tool as part of the risk-adjustment and payment methodology.

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<sup>2</sup> Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f)), and 42 CFR Part 51c.303(u))



**OBSERVATION #3** | The Next Generation IHP measurement proposal does not fully account for the social determinants of health. **DHS is making significant progress on this issue, however, MNACHC does not understand the alignment of DHS efforts relative to other state efforts.** Nearly all FQHC patients experience socio-economic circumstances that adversely impact their health.

**MNACHC recommends that the Next Generation IHP program:**

- **Adopt the Quality Measurement Enhancement Project (QMEP) tool;**
- **Use risk-adjusted quality measures in evaluating IHP participant quality outcomes;**
- **Use individual risk-adjusted measures rather than composite measures; and**
- **Seek other quality metrics to evaluate provider performance.**

An essential component of any value-based purchasing strategy is effective **care coordination** to promote effective use of health care and other services. Effective care coordination services rely heavily on **timely and actionable data exchange between providers in the health care system at a minimum.** In addition, data exchange with social services providers would give care coordinators insight into the socio-economic challenges of the patient.

Minnesota does not have a centralized, common platform to support robust and meaningful data exchange between providers. Without this infrastructure, Minnesota is foregoing an opportunity to enhance care coordination services that reduces health care spending on preventable events such as inappropriate emergency room use.

**OBSERVATION #4** | Minnesota's decentralized and fragmented data exchange infrastructure results in limited data exchange between health care providers. Without actionable and timely data, the true benefits of care coordination are not realized.

**MNACHC recommends that the Next Generation IHP program:**

- **Advocate for a single, statewide platform for data exchange; and**
- **Advocate for data exchange between health care providers and other social service providers.**

## Section #2 – MNAHC Responses to Questions in RFC

*#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?*

MNACHC appreciates DHS’ elevation of primary care as a vital component of health care purchasing reform. Community Health Centers in the Twin Cities are the health care home for 118,000 low-income residents – regardless of their insurance status (i.e., both insured and uninsured patients).

MNACHC’s concern under this “attribution” model, however, are two-fold:

1. **Patient Perspective** – Under current models, MHCP enrollees are not required to select a primary care provider (PCP). Rather, the patient’s choice is largely driven by which health carrier (managed care organization, MCO) includes their primary care clinic within the carrier’s network. DHS’ proposal enhances this emphasis on primary care. **MNACHC recommends that DHS: a) provide clear communication to IHP Next Generation enrollees as to their network and benefits; and b) monitor the number of patients that change monthly.**
2. **Health Center Capacity** – As Health Centers offer care to all regardless of their ability to pay, the demand for services can be significant. One prime example is access to dental services. Health Centers are dental access points for both uninsured and MCHP enrollees since other, non-safety net dental providers are reluctant to provide care to this population. **MNACHC recommends that DHS consider the unique role of safety net providers in the “attribution” methodology. FQHCs cannot deny care to any patient – regardless of their enrollment in an MCO or Next Generation IHP.**

**MNACHC recommends that DHS define “primary care exclusivity” as a combination of patient choice and historic utilization data based on where most the primary care services were experienced by the patient.**



**#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.**

**MNACHC does not have any specific recommendation as to the beneficiary population size needed for Next Generation IHPs.** It should be noted that the FQHC Urban Health Network (FUHN) has an attributed population of between 31,000-32,000 individuals. Moreover, the twelve (12) FQHCs in Minneapolis-St. Paul area serve 68,900 MHCP enrollees. Many of these patients come from out-side of the seven-county metropolitan area.

Lastly, the Medicare Shared Savings Program (MSSP) and Pioneer ACOs operated by the federal government have minimum thresholds of 5,000 and 15,000 enrollees respectively.

**#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.**

For Next Generation IHPs, **MNACHC recommends that the “enabling services” offered by FQHCs serve as a model to inform the benefit structure.** Health Center patients face a variety of socio-economic obstacles to access primary care services. Consequently, Health Centers invest in these “enabling services,” even though many of these services are not reimbursed by payers.

Enabling services are defined as “non-clinical services that aim to increase access to healthcare and improve health outcomes,” and include services such as health education, interpretation, and case management. Enabling services are integral to the services that health centers provide, and their patients often rely on these services to access health care. Studies have shown that health centers provide high quality primary care for their patients, with higher rates of screening and health promotion counseling. Enabling services contribute to effective and efficient primary and preventive care at health centers which results in improved health outcomes.

In addition, MNACHC is concerned about the Health Care Services required under the model. As independent clinics providing primary care services, many of the proposed services are beyond the traditional Health Center scope. Examples include,



rehabilitative services, home health services, and prosthetics and orthotics. **MNACHC recommends providing flexibility for safety-net primary care clinics that are not legally part of any large health care system.**

**#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**

Effective care coordination relies upon real-time, “actionable” data to inform clinical decision-making. Minnesota has made great progress in providing participants in the IHP with relevant data, however, it is not in real-time. MNACHC commented earlier this year (October 31, 2017) on the Minnesota Department of Health’s Request for Information related to “data interoperability.”

One of the salient points in MNACHC’s response addressed this need for robust data interoperability:

*“Aligning the Minnesota Health Records Act with HIPAA will significantly reduce the administrative burden required to manage patient consent requirements. Because FQHCs rely heavily on external specialty and social service providers, they are currently managing and tracking high volumes of authorizations. Allowing the exchange of health information for treatment, payment, and operations without patient consent will save valuable resources and allow patients to receive more timely care.”*

**MNACHC recommends that the state of Minnesota align the Minnesota Health Records Act with HIPAA prior to the start of the Next Generation IHP.**

**#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?**

The Next Generation IHP represents a significant shift in DHS’ approach to purchasing health care. MNACHC strongly supports this shift toward quality and cost containment by working directly with providers. However, to accomplish this shift, many of the “MCO-based” metrics are not applicable to provider-based organizations. For example, developing networks is an expensive undertaking. Another example is requiring similar budget reserves of Next Generation IHPs like MCOs. **MNACHC recommends that the evaluation of Next Generation IHPs rely less on traditional MCO**



**evaluation tools and more on population health with an emphasis on primary care services. Moreover, MNACHC is unclear on the need for counties to evaluate any 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?**

MNACHC appreciates the intent of a single Preferred Drug List (PDL) for across the various purchasing mechanisms. MNACHC's concern relates to what specific criteria DHS will use to accept drugs on to the PDL. **MNACHC recommends that the development of this criteria includes significant stakeholder input.** Additionally, **MNACHC recommends that DHS establish an evaluation of the PDL that incorporates patient, provider and quality of care metrics.**

**#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?**

Health Centers operate of extraordinarily narrow financial margins. This is no surprise given the patient population that Health Centers serve – 95% below 200% of poverty and at least 85% of patients either uninsured, underinsured or on a public program such as Medicaid. Naturally, the appetite for risk is limited for Health Centers and other safety net providers. In addition, and most importantly, Health Centers are unable to place their federal "Section 330" grants at risk. On average, this represents 25% of a Health Center's overall revenue and are used (per federal law) to partially offset the cost of care to the 52,000 uninsured Minnesotans served by Health Centers.

FUHN's results are testimony to the fact that DHS provided an incentive for Health Centers, while at the same time protecting them from risk. Under the IHP "virtual" model, FUHN did not take any downside risk. The potential for gain sharing was a clear incentive for FUHN to invest and partner with other organizations to achieve \$18 million in savings over three years.

The very core of Health Center's mission is to improve population health. This mission, coupled with key tools such as data analytics and quality improvement,



provided enough of an incentive without any sort of meaningful risk undertaken by FUHN.

**MNACHC recommends DHS maintain this no-risk option for Health Centers and other safety net, mission-driven organizations. Additionally, MNACHC recommends that DHS incorporate “stop-loss” mechanisms and/or certain risk-thresholds for safety net providers.**

**#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?**

One of the core competencies of Health Centers are the provision of “enabling services.” As identified in the response to Question #3 above, enabling services are integral to the services that health centers provide, and patients rely on these services to access health care.

At Health Centers, these services respond to the specific socio-economic needs of our patients. In order to identify these needs, Health Centers in Minnesota are adopting the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) tool.<sup>3</sup> This is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients’ social determinants of health.

**MNACHC recommends that DHS adopt the PRAPARE tool or similar tool to support payment methods to address socio-economic needs of Medicaid populations. Furthermore, MNACHC recommends that DHS explore the use of the Quality Measurement Enhancement Project (QMEP) tool to properly adjust for patient risk.**

**#9 - How much of the entities’ payment should be subject to performance on quality and health outcome measures? Please explain your answer.**

As payment evolves from volume to value, the quality of care is a critical element for provider reimbursement. Without **fully** incorporating the social determinants of health (SDH) into quality measures, MNACHC is concerned about the potential financial harm to FQHCs and other safety-net providers, and the resultant loss of access for low-income Minnesotans to primary care services.

If adequate multi-factorial “risk-adjustment” is part of the quality measurement system, a greater share of the payment can rely on health outcomes measures. Under

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<sup>3</sup> To learn more about the PRAPARE tool visit <https://www.nachc.org/research-and-data/prapare/>



the current IHP model, the quality component provides an incentive to maximize the amount of any “gain sharing.” As the Next Generation IHP model moves from a fee-for-service model to a capitation model, quality incentives should be part of this methodology.

**MNACHC recommends that DHS incorporate “risk-adjusted” quality measures into both the per-member, per-month (PMPM) payment and as additional payments beyond the cost-sharing amounts from meeting total cost of care (TCOC) benchmarks.** In other words, a Next Generation’s IHP PMPM can be increased by meeting quality metrics and “bonus” payments can also be made after meeting TCOC goals. Again, **MNACHC strongly recommends that any quality measure should include a multi-factorial “risk adjustment” to account for differing patient populations.**

**#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?**

The 2017 Legislature adopted provisions that directs the alignment of the various federal and state quality measures. The intent of the proposal was to address the very question raised as part of this RFC. The legislation also requires that a stakeholder workgroup develop a list of measures for quality purposes.

One of MNACHC’s concerns with quality measurement has been the emphasis on the measurement of care for persons with chronic diseases. From the FQHC perspective, measures should expand to include the prevention of disease and population health measures. **MNACHC recommends greater priority on measuring population health as opposed to the current emphasis on chronic disease measures.**

**#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?**

Like our response in Question 8, MNACHC welcomes any policy change that incentivizes and rewards efforts to increase access to primary care. Furthermore, the new payment policy must ensure quality measures are “risk-adjusted” so that safety net providers like Health Centers are not disincented from participating in these new models of care. **MNACHC recommends DHS establish a flexible payment related to Next Generation IHPs providing non-clinical services that improve population health. Examples of these types of services include, but are not limited to: community health workers, care coordination and patient outreach/education.**

With regard to the consumer/patient perspective, **MNACHC strongly recommends that DHS provide adequate education to patients and providers so that understand the importance of the primary care clinic.** Medicaid beneficiaries are accustomed to selecting a health plan as opposed to a primary care clinic. Moreover, for families with children enrolled in Medicaid and other family members on products offered through MNsure (Qualified Health Plans), the potential for confusion surrounding the selection process is likely.

### Section #3 – FQHC-Specific Issues

#### FQHC Payment & Federal Law

FQHCs (and Rural Health Clinics – RHCs) receive a federally-mandated<sup>4</sup> Prospective Payment System (PPS) or alternative payment mechanism (APM) for qualifying MA encounters. This payment mechanism remains in place for the FUHN IHP, along with a Total Cost of Care (TCOC) savings payment or gain share.

It is MNACHC’s understanding that under the Next Generation IHP, DHS will continue to follow federal law and provide FQHCs with the PPS/APM for qualifying encounters. The PPS rate is a bundled payment that Congress implemented to recognize the patient base of FQHCs and value of Health Centers as an access point for Medicaid beneficiaries.

Without question, FQHCs would not be able to financially sustain operations without this payment rate. Moreover, FUHN’s success – and the \$9 million that accrued to the state’s budget due to FUHN – is built upon the Medicaid PPS/APM payment mechanism. **Modifications to the PPS/APM payment mechanism would simply eliminate the savings for the state. More importantly, it would jeopardize access to care for thousands of low-income Minnesotans to primary care services.**

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<sup>4</sup> 42 U.S.C. §1396a(bb)(1)-(5)



### **Primary Care Exclusivity**

As patients “self-select” into either a Next Generation IHP or MCO, this may present a dilemma for Health Center patients as a particular Health Center may not be part of both simultaneously. A patient may prefer a Health Center for their primary care services, but choose a specialty provider who is part of an MCO’s network. If the Health Center is part of a Next Generation IHP and did not have a contract with that specialty provider, the patient may lose access to the Health Center.

An example highlights the need to understand the primary care exclusivity concept and the unintended consequences that may arise. One of the unique services of some Health Centers is the availability of psychiatry services to public program enrollees. Health Centers are often the only access point for this population. If a MHCP patient seeks psychiatric care at a Health Center, yet that patient is not part of the Health Center’s Next Generation IHP, MNACHC is concerned that this will be uncompensated care for the Health Center. Additionally, the savings because of the Health Center will accrue to whichever MCO/Next Generation IHP that has “exclusivity” to that patient.

**The concept of “primary care exclusivity” needs to account for the fact that patients will seek care that is accessible to them, regardless of their enrollment into an MCO or Next Generation IHP. This has the potential to harm Health Centers as they cannot deny care to any patient. Specifically, enrollees seeking care at a Health Center who are not part of the FQHC’s “network” may result in uncompensated care for the Health Center if the Medicaid patient continues to use the Health Center, yet is a part of another Next Generation IHP or ACO.**

### **Applicability of MCO Requirements to Next Generation IHPs**

MNACHC is seeking clarification if specific requirements of MCOs will be applicable to Next Generation IHPs. Specifically, the two major areas are related to: 1] the state’s Essential Community Provider (ECP) law; and 2] the amount of budget reserves required.

### **Summary and Conclusions**

Minnesota’s purchasing strategy -- IHP and competitive bidding -- has successfully reduced the cost of care, increased the quality of care provided and improved the patient experience. As DHS seeks to enroll a greater share of MA enrollees in Minnesota into value-based arrangements, **the three necessary investments from the Health Center perspective** include:

1. Enhancing the IHP's **quality metrics to include the social determinants of health** (i.e., "risk adjustment);
2. Providing "**up-front**" and **continuing for safety net providers such as FQHCs** to support data analytics of attributed patients and care coordination efforts; and
3. Fostering an environment to achieve **true data interoperability** between medical and non-medical providers in Minnesota.

On a high-level, MNACHC is concerned about the following issues and would kindly request a discussion on these issues:

1. DHS' compliance with federal statute related to FQHC payments;
2. Health Centers' financial and legal ability to take "risk;"
3. The definition/criteria related to "primary care exclusivity;"
4. Health Centers as "out-of-network" providers relative to federal requirements that do not allow them to deny patients access to services; and
5. Beneficiary and provider education.

Minnesota DHS should be applauded for efforts to improve the care for Medicaid beneficiaries over the last decade. We appreciate the opportunity to comment through this Request for Comment (RFC) process. As you consider our comments, please do not hesitate to contact me at [jonathan.watson@mnachc.org](mailto:jonathan.watson@mnachc.org) or at 612-253-4715 if you have any questions about the content of this correspondence or FQHCs in general.

Respectfully submitted,



Jonathan Watson  
Chief Executive Officer



## PATHWAYS COMMUNITY HUB

### Introduction

The Pathways Community HUB model is designed to identify the most at-risk individuals within a community, connect them to evidence-based interventions, and measure the results. This “Find-Treat-Measure” approach emphasizes the importance of tracking health and social service interventions at the individual, agency and regional level using common metrics or “Pathways.” As an infrastructure for community-based care coordination that utilizes braided funding, the HUB tracks pathways across agencies, eliminates duplication, streamlines referrals, and provides an invoicing system using standard Medicaid billing codes.

The model has been endorsed by the federal Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention, CMS Innovation Center, HRSA, Institute for Healthcare Improvement, National Institute of Health, National Science Foundation, Ohio Department of Health and Ohio Department of Medicaid.

The AHRQ Innovations Exchange provides the following summary:

“The Community Health Access Project (CHAP) implemented the Pathways Model, which employs community health workers who connect at-risk individuals to evidence-based care through the use of individualized care Pathways designed to produce healthy outcomes. This model promotes timely, efficient care coordination through incentives and prevents service duplication through use of a Community Hub, a regional point of patient registration and quality assurance supporting a network of agencies involved in providing care to the target population.”  
<http://www.innovations.ahrq.gov/content.aspx?id=2040>

### History

As co-founders of CHAP, Drs. Mark and Sarah Redding developed and piloted Pathways in Richland County, OH with an initial focus on preventing low birth weight babies, drawing on their successful experience working with Alaska CHWs, known as community health aides. Pathways—basically a measurement tool focused on achievable outcomes—can address education, depression, prenatal care, housing, and other needs. A patient may have many Pathways. A Pathway is only complete when an identified problem is solved. Key to the model’s success is the CHW role as a community care coordinator who navigates care and advocates for patients.

Over the past 16 years, CHAP has designed, tested and implemented 20 core pathways and created the community HUB infrastructure. AHRQ brought 16 communities across the US under a learning collaborative to further develop the HUB model. More recently, with support from the Kresge Foundation, there is now a certification process for community HUBs with projects underway in MI, OH, OR and NM, some with a *chronic disease focus*. Tools and technology in support of the HUB model are available through Care Coordination Systems, Inc., headed up by Dr. Sarah Redding. For more info, see: <http://carecoordinationsystems.com/>

## Evidence

The following published studies highlight the HUB model's maternal and child health outcomes. Dr. Redding reported an ROI of \$5.59 long term for every dollar spent.

*Innovation Profile: Program Uses "Pathways" To Confirm Those At-Risk Connect to Community Based Health and Social Services, Leading to Improved Outcomes at <http://www.innovations.ahrq.gov/node/4433>*

*S. Redding et al. Pathways Community Care Coordination in Low Birth Weight Prevention. Maternal Child Health Journal. Published online 20 Aug 2014 published with open access at <http://link.springer.com/article/10.1007/s10995-014-1554-4>*

## Benefits of Pathways Community HUB for Minnesota

implementation of this evidence-based model supports health reform trends at the state and federal level; advances the Minnesota Accountable Health Model Continuum for Accountability; introduces a sustainable CHW care coordination approach with multiple benefits for multiple providers, health plans and community agencies and those they serve; and holds exciting promise to reduce persistent and preventable health inequities in Minnesota, with strong results for patient populations facing a disproportionate burden of poverty, illness and death.

Addressing limitations and gaps found in many care coordination approaches now in use across the state, the HUB model:

- Removes silos and fragmentation
- Uses existing community resources efficiently and effectively
- Focuses on common metrics to identify and track risks
- Provides holistic care coordination—one care coordinator who can potentially serve the entire household
- Targets resources to those most at risk and often the most difficult to find and serve, recognizing that 50% of health costs are associated with only 5% of the population
- Ensures that patients' health and social service needs are met in a timely, coordinated, and culturally-competent way using trained CHWs, reflecting the impact of social determinants on health status and CHW effectiveness
- Pays for performance based on measurable outcomes, rather than for inputs, consistent with payment reform measures underway
- Allows for local innovation and community ownership which Minnesotans favor.

Prepared by the Minnesota Community Health Worker Alliance

**From:** Cameo Zehnder  
**To:** [MN\\_DHS\\_DHS PSD Procurement](#)  
**Subject:** Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP  
**Date:** Wednesday, December 20, 2017 10:25:17 AM

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Pediatric Home Service response to the MN Department of Human Services “Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP (November 15, 2017)”

**Date:** December 15, 2017

**Contact:**

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Pediatric Home Service (PHS) would like to thank the Department of Human Services (DHS) for the opportunity to provide input on the redesign of outcomes-based purchasing and the evolution of the IHP model to the Next Generation IHP. We appreciate the collaborative approach DHS is taking.

Before directly answering the questions provided in the RFC document, PHS would like to discuss positive aspects of the proposed model and areas where this model and the overall outcomes based purchasing redesign has opportunities for improvement. PHS is a provider of homecare services for children with medical complexity. The patients and families that we serve are some of the most complex patients in the system. They are frequent users of the healthcare system and rely greatly on their providers, various care coordinators and community supports to achieve their individualized goals of health and healthy living.

**The timeframe laid out in this RFC is aggressive:** The model proposed is a large change to the way that Medical Assistance providers and MCOs interact. Essentially, providers who create a Next Generation IHP would be in competition for membership with MCOs. On the other hand, those same providers will need to contract with MCOs in either the Next Generation MCO model or the traditional PMAP model. This will likely create unanticipated market dynamics such as smaller networks, restricted access, and patient confusion. We suggested a longer timeframe to allow for further refinement and input on the Next Generation model.

**Recognition of the value of care coordination is positive:** Considering the patient population that PHS services, the recognition of and payment for care coordination at the provider level is a positive aspect of this model. PHS considers coordination of care a central aspect of our service. This includes coordination among services we provide and services provided by other healthcare entities. By coordinating among the various service providers needed by a patient, we are able to provide a safer environment for our patients and relieve some of the stress associated with being a parent or caregiver for these patients. Through the development of this model, it will be essential to get the quality measurement for Care Coordination correct. We suggest measurement frameworks in our response to question #10.

**Primary Care model is not appropriate for some populations:** Most importantly, the model proposed focuses on the one-size-fits-all primary care model by requiring a patient to select their primary care provider upon enrollment. The model does not take into consideration the reality that many patients with medical complexity do not have a traditional primary care relationship. These patients represent a large portion of the state's overall healthcare spend and should be accounted for in any sweeping model change enacted by DHS.

Patients with medical complexity, many times, consider one of their specialists their primary care provider. The specialist will direct ongoing care, outpatient engagement and interaction with the post-acute system. For the patients PHS serves and the specialists with whom we work the most closely, this coordination is handed to PHS as the provider that is interacting with the patient most frequently through some form of home visit.

An updated model must take into consideration these children with medical complexity. We suggest the following changes to benefit this critical population:

- Create a separate model with less focus on primary care recognizing primary care is delivered differently for complex populations.
- Allow for outcomes based payments on all segments of care including those designated to FFS on page 5 of the RFC such as home health, DME, and PCA services.
- Allow for more time developing appropriate quality metrics for complicated populations like children with medical complexity.

Questions from RFC Document Pages 14, 15:

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?

*Primary care exclusivity does not seem like the best way to drive toward these goals. We support the concept that increased visibility around accountability for care is essential to improving value based models. However, it is important to consider complex patients who are high users of healthcare and how they interact with the system. These patients do not always work with a typical primary care practitioner rather they may use a specialist, a social worker or someone else to play that role. Forcing primary care on these patients would not be a benefit.*

*Additionally, as mentioned above, we think that the concept of primary care exclusivity will create unintended consequences by creating competition between health systems and MCOs resulting in a reduction in access for patients.*

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.

*No comment.*

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.

*No comment.*

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?

*Health Information Exchange enables care coordination. Alerts, Admit / Discharge / Transfer summaries, and other common exchange structures provide information that is critical to the coordination of healthcare and services for a patient. DHS should put in place or require that participants have Health Information Exchange in place and in action to gain the full 'shared savings' payment.*

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?

*No comment.*

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?

*No comment.*

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?

*No comment.*

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?

*No comment.*

9. How much of the entities' payment should be subject to performance on quality and health outcome measures? Please explain your answer.

*No comment.*

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?

*The National Quality Foundation has endorsed a set of Care Coordination quality measures called the "Family Experiences with Coordination of Care (FECC)" measures. These measures were developed with Children with Medical Complexity in mind across a group of stakeholders and intended for use by Medicaid agencies.*

*These measures should be considered when evaluating the effectiveness of care coordination services implemented by providers in these models.*

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?

*The health services that are carved out to be paid under Fee For Service by DHS can each be leveraged by an MCO or Next Gen IHP to improve health outcomes. The new model should allow for groups to negotiate with all service providers and allocate funding as appropriate to achieve the healthiest outcomes.*

*In particular, home health and DME are two areas that are able reduce healthcare cost by providing the appropriate care in the lowest cost setting. Additionally, service providers in these areas are able to provide education, training, and emergency preparedness recommendations for patients and families increasing adherence to prescribed therapies and avoiding costly ER visits or readmissions.*

*Finally, home health and DME are, many times, the most frequent touchpoint with the patient. Next Generation IHP participants should have the opportunity to differentiate pay for providers who are able to deliver high quality outcomes.*

12. Do you have any other comments, reactions or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?

*Above*

## **Cameo Zehnder, JD**

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December 20, 2017

To: Department of Human Services Health Care Purchasing

Re: Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP

Thank you for the opportunity to comment on the next phase of redesigning Department of Human Services' (DHS) purchasing and delivery strategies for Medicaid and MinnesotaCare enrollees. TakeAction Minnesota is a grassroots network of over 14,000 individual members and 23 member organizations working for economic and racial justice, including access to quality, affordable health care. TakeAction Minnesota has provided input to DHS since 2011 on the redesign of purchasing.

While we have questions about the Next Generation Integrated Health Partnership (IHP) model, we believe DHS is moving in the right direction. TakeAction Minnesota supports DHS emphasizing the importance of the enrollee experience and social determinants of health. The greatest potential value of IHPs to individual enrollees is in the promise of better health through care coordination, and reducing acute care costs to allow for reinvestment in prevention and in integrated social services (i.e. "moving upstream"). A 2015 report from the Yale Global Health Leadership Institute, *Leveraging the Social Determinants of Health*, collates a number of studies showing the potential health and financial benefits of providing these services and concludes that "there is strong evidence that increased investment in selected social services as well as various models of partnership between health care and social services can confer substantial health benefits and reduce health care costs for targeted populations."

The development of IHPs also represents an understanding that after decades of trying, Minnesota has not succeeded in incentivizing Managed Care Organizations (MCOs) to invest in care coordination and integrative care in an effective and significant way. The better incentives and tools for health improvement via care integration exist at the state level where budgets for social services and health care are in relationship with each other. We support a universal publicly funded health care system in part because it would provide a better framework for leveraging significant payment and delivery reform to achieve better health at lower cost. We want IHPs to have the best chance at achieving those goals, making sure we can evaluate their performance, and protecting enrollees in the process.

The following recommendations offer observations based on our experience in grass roots organizing, outreach for enrollment, and health care policy, and then respond directly to some questions in the RFC.

### **Enrollee and Community Engagement**



Going forward, it is critical that enrollees be more involved in the design, implementation and oversight of the state’s redesign and reform of the purchasing and delivery strategies for our public health care programs. Enrollees must be involved at the clinical, IHP, and state levels.

### *Clinical Level*

The RFC states on page 2 that one of the domains DHS plans to evaluate the model on is the “enrollee experiences with care.” There are a variety of tools being used across the country at the clinical level to support enrollee engagement. If the “enrollee experience with care” is one of the key evaluation criteria, DHS must, as part of the RFP, require the Next Generation IHPs to specify the tools that they will use improve enrollee experiences with care, such as:

- A shared decision-making tool;
- Enrollee engagement measures, such as the patient activation measure or a health confidence measure<sup>1</sup>;
- Actively engaging enrollees and caregivers in the updating of required individual care plans;
- Developing a plan to involve enrollees in care transitions to improve the continuity and quality of care across settings (for example, Oregon measures the “quality of enrollee readiness for transitions”<sup>2</sup>); and
- Tools similar to the Stanford Chronic Disease Self-Management Program.

### *Next Generation IHP level*

Next Generation IHPs should be required to have enrollee and family advisory councils informing policy and evaluating the success of individual IHPs. This could mean leveraging existing enrollee advisory councils or developing ones specific to IHPs. IHP managers should be required to regularly consult with these councils. The state should require reporting on the level and diversity of participation, and basic efforts to make participation accessible such as providing meals, bus fare, childcare, etc. to participants, and including seats for organizations that can provide support to individual enrollee representatives so that they are not at as steep a power differential from other participants. The IHP should be required to engage with enrollees using a variety methods such as focus groups, member meetings, advisory councils and surveys.

### *State Level*

As DHS moves to the Next Generation model, it must develop a process for meaningful enrollee and community engagement as the state develops new policies and implements the Next Generation model. To date, there has been limited input by enrollees or community organizations. Public input has been limited to opportunities to respond to Requests for Information or Requests for Comments. Enrollees and representative organizations need long term meaningful engagement to develop the expertise and language to translate on-the-ground needs and experiences into relevant measures, feedback, and policy language. At a minimum, the state should establish an oversight committee that includes enrollees and consumer groups. Enrollees and community organizations also need a learning collaborative much like

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<sup>1</sup> <http://www.insigniahealth.com/products/pam-survey>

<sup>2</sup> <https://oregonenrolleesafety.org/blog/safety-culture/cco-accountability-for-transitions-in-care/664>

what DHS has developed with providers. We would like to continue to explore what infrastructure would make it possible to develop this needed expertise and meaningful feedback in a way that is sustainable for resource strapped families and organizations.

### **Health Equity**

Health equity should be considered and embedded in all stages of the development of new payment and care delivery models, including provider network requirements, payment, data collection, and quality.

The state should absolutely monitor the Next Generation IHPs' and MCOs' impact on health disparities faced by their enrollee populations. Given Minnesota's health disparities, the Next Generation IHPs and MCOs should be required to articulate which disparities they seek to reduce, the strategies they intend to use, and the timeframe for results. The state should also specify some goals that each IHP and MCO must achieve over the next three years.

Race, ethnicity, and language data is key to risk adjustment to ensure appropriate expectations of Next Generation IHPs or of MCOs for positive impacts on population health, and to ensure that they are not penalized for serving populations with disproportionate barriers to health.

We also encourage the state to find ways to stratify reported quality measurement data by race, ethnicity, primary language, gender identity, sexual orientation, and disability status to bring disparities to light. We think it is important that the state share quality measurement data publicly.

### **Social Determinants of Health**

It is important that screening measures related to social determinants of health (SDOH) be included in this program, such as the Accountable Health Communities Screening tool recommended by the Social Interventions Research and Evaluation Network (SIREN).<sup>3</sup> This tool was developed by CMS and is recommended by the National Academy of Medicine.

While DHS should leave flexibility for Next Generation IHPs and MCOs to innovate, there should be some specific risk factors that DHS evaluates all Next Generation IHPs and MCOs on. The success of the new purchasing and delivery model on population health will depend on successful upstream investments and interventions in foundational needs like housing and food.

Next Generation IHPs and MCOs must also be active in pushing for greater investment in upstream resources at the state level. There are clear links, for example, between income and housing and disparate health outcomes. Therefore, Next Generation IHPs and MCOs must be more active in promoting policy changes that increase affordable housing and the income available to poor families as a strategy to improve the health of the family.

The remainder of our comments respond to specific questions in the Request for Comments:

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<sup>3</sup> <https://sirenetwork.ucsf.edu/tools-resources/mmi/accountable-health-communities-screening-tool>

**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?**

The emphasis on “primary care exclusivity” raises the question of the definition of primary care. In Minnesota’s Access Review Monitoring Program submitted to CMS in September 2016, DHS defined primary care to include general practice, family medicine, internal medicine, pediatrics, and obstetric/gynecology. This definition excludes behavioral health and other specialty providers (including addiction specialists). Given the prevalence of behavioral health issues, an emphasis on primary care exclusivity that continues to exclude behavioral health would not create more accountability. Thus, member attachment should take into consideration a broad range of services, not just where someone sees a primary care provider, because in many cases, the potential benefits of care coordination through an IHP are greatest for people who are not seeing a primary care provider.

We support the objectives of this new IHP strategy to include meaningful enrollee choice and understanding about their different provider network options. With regard to implementing enrollee choice, enrollees need to be able to search by provider system (e.g. Allina), by clinic location (e.g. by zip code search), and/or by the name of their doctor or other primary provider. DHS should also ensure that additional information given to enrollees when they choose a provider is culturally and linguistically appropriate, provides clinical data on provider quality, and includes other information important to enrollees such as the language(s) spoken at the primary care clinic.

On pages 7-8 (Member enrollment and selection processes), it states that members get locked into a certain IHP or MCO unless they request a change within the first 60 days of determination, within the first year or program, or for a “cause”. We are concerned that enrollees will not be aware that they are becoming a part of a Next Generation IHP or MCO. Affirmative choice of a primary care provider is not the same as affirmative choice of a Next Generation IHP or MCO, especially if you do not have flexibility to change your IHP or MCO. DHS has indicated that data currently shows that Minnesota Health Care program enrollees are frequently being assigned to MCOs rather than affirmatively picking an MCO. As the IHP model has developed, it has not been transparent to the enrollee that they have been attributed to an IHP. As risk shifts down to the provider level, it is even more critical that enrollees understand the importance of the choice of a Next Generation IHP and a primary care provider or clinic. We also believe that no enrollees should ever be assigned to a for-profit MCO.

We think that the rollout of this new model should include a robust consumer education program that would include the state contracting with community based organizations to do some of the education work. In addition, the State, Next Generation IHPs, MCOs, enrollees and community based organizations should work together to develop new enrollee materials and notices. Materials must address health literacy, be accessible in multiple languages, and be offered in alternative formats for blind and visually impaired members.

**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.**

We agree that behavioral health should be one of the primary considerations. Within the context of behavioral health, we would support criteria that also ensure that Next Generation IHPs and MCOs are investing in building networks that can adequately address the behavioral health needs of Minnesota's children and young adults. With the growing evidence of the impact of adverse childhood experiences and the impact of trauma on the development of children, it is important that DHS recognize that it purchases for thousands of children who have experienced trauma and who are in need of services. We also believe that DHS must pay particular attention to addiction specialists and other specialists providing services to enrollees. Next Generation IHPs and MCOs should be required to formally partner with non-primary care providers and non-medical social service providers. Assessment of those partnerships should include the opportunity for those organizations to provide feedback on the adequacy of integration and compensation, and for providers within those organizations to provide feedback on the outcomes for their clients.

**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?**

As indicated above, evaluation of the responders' ability to implement should emphasize the responders plans to address the enrollee care experience and address health disparities. The Next Generation IHPs and MCOs should be required to articulate their plans to address the enrollee care experience and which disparities they seek to reduce, the strategies they would use, and the timeframe for results. The state should also specify some goals that each IHP and MCO must achieve over the next three years.

The state should also encourage the implementation of best practices, not just innovation. In the RFC, the emphasis is on the change in the payment model and not on the changes DHS wants to see in the delivery model. Now that IHPs have been in existence for multiple years and cycles, we encourage DHS to incentivize IHPs to scale up innovations that have worked so far. DHS wants improved population health but there is little guidance other than references to improved care. Communities and enrollees cannot afford to be the subject of endless experiments, nor to give input over and over to dozens of different entities, without seeing their input brought to scale.

**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?**

From an enrollee standpoint, we believe that DHS should administer a PDL across all of the models. Currently, all MCO enrollees are initially enrolled in Fee-For-Service for one to two months (or longer). For the enrollee, having one PDL would mean that your prescriptions would not change based on the payment model (FFS or MCO- capitation payment). We think this would lead to better enrollee experiences and outcomes.

Reducing health care costs to the system and program is one of the evaluation domains. A recent 2017 MDH report documented that the costs of medical services decreased in Minnesota but overall medical costs did not go down because of pharmacy costs. If there was one PDL, there may be strategies that the state could implement to reduce pharmacy costs while also improving the enrollee experience as noted above. It would be preferable to make the PDL statewide since the eligibility/enrollment system is the same across the state. Enrollees across the state are frequently required to change drugs as they move from Fee-For-Service to a Managed Care Organization.

**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?**

As we are changing payment models, it is important to articulate the positive changes in care delivery that DHS wants to achieve under this new model. The risk level should not create incentives for providers to deny care to enrollees. Instead, incentives should be created to continue to encourage innovative pilots and best practices to address the unique needs of the DHS populations.

In the RFC, DHS does not address changes to the risk adjustment process that might be needed given the new payment model. We are concerned that changes might be needed to better reflect the risk that providers are now taking on with the Medical Management and Service Delivery payment. It is also critical that Next Generation IHPs and MCOs not be penalized for serving populations with complex needs or other disproportionate barriers to health.

While we understand that DHS is actively working on accounting for SDOH in their quality improvement policies, it is unclear how DHS plans to change the risk adjustment payment calculation or the payment methodology to account for SDOH. The Health Care Administration issued Phase I Initial Findings in April 2016 on Accounting for Social Risk Factors in Minnesota Health Care Program Payments<sup>4</sup>, and we encourage DHS to incorporate the full findings of this methodology development process, as well as any relevant results of Minnesota's State Innovation Models grant, into the risk adjustment process for Next Generation IHPs and for MCOs.

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<sup>4</sup> <https://www.leg.state.mn.us/docs/2016/mandated/160992.pdf>

For example, Massachusetts has developed an enhanced risk adjustment model that tries to account for the impact of SDOH.<sup>5</sup> Aligning the risk of the population with the payment amount will help balance the risk/incentive equation that is necessary to drive changes in care delivery and overall costs.

It is critical that the model allow shared savings to be reinvested by the Next Generation IHPs in new interventions and partnerships that promote better population health. The IHPs must have the flexibility to invest in community resources, such as community health workers or community paramedics, and to actively partner with community partners such as schools, employment service providers, food banks, homeless shelters, detox centers and law enforcement to produce better health outcomes.

The experience of Hennepin Health provides useful examples of the kind of risk identification, community partnerships, and reinvestment of shared savings that Next Generation IHPs and MCOs need to be capable of undertaking:

- Hennepin Health has a proactive risk identification system. They use a “lifestyle assessment”<sup>6</sup> to identify social needs and then care coordinators and community health workers help connect enrollees to services.
- Hennepin is also considered a leader in partnering with local groups. This Commonwealth Fund brief<sup>7</sup> describes their efforts to contract with housing organizations, substance use disorder providers, and vocational counselors such as Rise, Inc.
- Hennepin Health is using their shared savings from the state to reinvest in the community by hiring additional community health workers and community paramedics that work in homeless shelters.

## **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?**

As noted above, the state could require that Next Generation IHPs reinvest a portion of their savings toward community needs. One of New Jersey’s Medicaid ACOs lists community partners (including medical and non-medical) that will share if it has savings.<sup>8</sup> Another New Jersey Medicaid ACO has established a “shared savings reinvestment process” with community input in decision-making on how to use savings that accrue to the ACO.<sup>9</sup>

Next Generation IHPs and MCOs should be encouraged to work with the hospital systems and public health boards in its area to conduct comprehensive community health needs assessments. In Oregon, each

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<sup>5</sup> [http://www.chcs.org/media/12.13.16\\_WebinarSlides.pdf](http://www.chcs.org/media/12.13.16_WebinarSlides.pdf)

<sup>6</sup> <http://www.commonwealthfund.org/publications/case-studies/2016/oct/hennepin-health>

<sup>7</sup> Ibid.

<sup>8</sup> <http://trentonhealthteam.org/wp-content/uploads/THT-ACO-Gainsharing-Plan-Final-June-30-2016-with-attachments.pdf>: page 8.

<sup>9</sup> [http://www.nj.gov/humanservices/dmahs/info/Camden\\_Coalition\\_of\\_Healthcare\\_Providers\\_Gainsharing\\_Plan.pdf](http://www.nj.gov/humanservices/dmahs/info/Camden_Coalition_of_Healthcare_Providers_Gainsharing_Plan.pdf): pp. 7-8.

ACO has a consumer advisory board that oversees the process and provides guidance on how resources can be used to address the needs that surface via the assessment.<sup>10</sup>

**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?**

Currently, Minnesota's quality measures are focused on processes rather than outcomes. We strongly urge DHS to adopt quality measurements that focus on health outcomes for the enrollee population. For example, a measure that tracks obesity prevalence is better than one that asks if a provider measured BMI.

We also encourage DHS to adopt measures focused on quality of life and patient-reported outcomes. For example, survey questions that include an option for enrollee narrative are a positive step towards enrollee-centered quality measurement. An example of this is the CAHPS Patient Narrative Elicitation Protocol<sup>11</sup>, which can be included as part of the CAHPS standard survey.

Special attention must also be paid to reducing health disparities. We encourage the state to find ways to stratify reported quality measurement data by race, ethnicity, primary language, gender identity, sexual orientation, and disability status if possible, in order to bring to light disparities. Along a similar vein, we think it is important that the state share quality measurement data publicly.

If you have further questions, please contact Chris Conry, Strategic Campaigns Director at TakeAction Minnesota, at 651-641-6199 or [chris@takeactionminnesota.org](mailto:chris@takeactionminnesota.org).

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<sup>10</sup> <https://www.communitycatalyst.org/resources/publications/document/ConsumerEngagementMedicaidACOs.pdf>

<sup>11</sup> <https://www.ahrq.gov/cahps/surveys-guidance/item-sets/elicitation/index.html>

December 20, 2017

**UCARE RESPONSES TO OUTCOMES-BASED PURCHASING REDESIGN AND NEXT GENERATION IHP –  
DHS REQUEST FOR COMMENT**

UCare appreciates the opportunity to provide comments on the Minnesota Department of Human Services' November 15, 2017 Outcomes-Based Purchasing Redesign and Next Generation IHP Request for Comment (RFC).

As the following comments will detail, given the longstanding efforts to continue to improve the current managed care approach and the significant questions and risks about the proposed model outlined in the RFC, UCare urges the Department of Human Services (the Department) before reprocurring PMAP/MinnesotaCare to: (1) conduct a robust evaluation of the current IHP and managed care model and the risks of the proposed changes to beneficiaries and the stability of state public programs; and (2) work with all stakeholders to realize further enhancements to the current IHP and managed care model, including how to strengthen primary care connections with beneficiaries, support greater accountability for costs and results and explore innovative ways to address social determinants of health.

In its RFC, the Department lays out a series of objectives it hopes to achieve. UCare steadfastly supports the Department's commitment to continuing to improve the care delivered to state public programs beneficiaries, with a heightened emphasis on improved value and population health. The objectives defined by the Department, such as consistent beneficiary experiences and beneficiary education, are aligned with those of UCare, and, in fact, reflect the work UCare has accomplished serving Medical Assistance and MinnesotaCare enrollees through our "enrollee first," cost-effective, quality-enhancing managed care model.

Our response will demonstrate that the overarching goals and objectives laid out by the Department in its RFC are ones we not only share, but also ones that the managed care model has successfully delivered over time and is poised to continue to advance with ongoing improvements in today's evolving health care delivery environment. A continued focus on strengthening the current model – rather than disrupting the program and potentially the entire Minnesota health care marketplace under the proposed model described in the RFC – will better serve families and children after two years of tumultuous change.

Minnesota's health plans have developed significant critical infrastructure over the past 30 years serving state public programs enrollees. We strongly believe that managed care, with health plan partners working with quality provider systems (particularly when delivered through UCare's enrollee-focused model), continues to be the best method for the Department to achieve these important objectives. We also appreciate the Department's acknowledgement regarding health plan innovation in the recent discussions related to the RFC. UCare's unique and long history of unwavering commitment to Minnesota's state public programs beneficiaries, close collaboration with our provider and community partners and success in ensuring cost-effective, positive health outcomes for Minnesotans demonstrates the value of the managed care approach, which DHS confirmed in an independent evaluation by PCG Health reported to the legislature as recently as 2013.

UCare has a strong record of working on the goals highlighted in the RFC: accepting clear accountability for cost and outcomes through full capitation for all services; providing enrollees meaningful choice of providers through our high-quality and efficient provider networks; adopting early the use of health home models for state public programs enrollees to ensure coordinated care; and collaborating with the Department to continually ease and streamline administrative processes for both our providers and



enrollees. And, critically, UCare was an early and committed pioneer in structuring a care delivery model dedicated to meeting the needs of the diverse Medicaid and, later, MinnesotaCare populations, with a focus on reducing disparities in health outcomes and addressing social determinants of health, oftentimes in the context of individual enrollees' unique needs and situations.

Among the major changes proposed in the RFC is shifting significant financial risk directly to providers while growing DHS' fee-for-service role. Although endorsing the Department's emphasis on greater use of value-based purchasing to incent improvement in health outcomes through new payment strategies, we are very concerned that fragmentation of Minnesota's Medicaid Program between health plan and IHP coverage stands to dilute and lose the decades of experience, refined service models and administrative efficiencies health plans like UCare have developed. The Department can build on this experience and expertise by instead encouraging value-based arrangements within managed care, which could include more than financial-based risk, and support quality and improved outcomes without potentially risking and disrupting care delivery for beneficiaries. In addition to total cost of care collaborations like those UCare successfully operates with providers in our Medicare Advantage and dual eligibles products, the Department could encourage health plans and providers to jointly develop other value-based models tailored to provider competency, panel size, capabilities and risk tolerance levels. One example is pay-for-performance outcomes, which UCare has implemented in improving HEDIS performance in state public programs.

In addition to the fragmentation of care and payment while unduly focusing on one risk-based payment methodology, we are concerned the proposed model will create increased complexity and confusion that will adversely impact beneficiaries' ability to navigate the system and realize the proposed model's promised value. We also foresee the potential for increased administrative costs, particularly where providers and the Department would need to develop new disease management, utilization review, call center and other beneficiary and provider support capabilities that would require coordinating across many organizations. In contrast, health plans have significant experience in offering many programs and services within strict regulatory requirements in a cost-effective and coordinated manner. Finally, we are concerned that to the extent the Department is seeking to evaluate the Next Generation IHP model as compared to the current managed care approach, the Department is undermining the value of any comparative evaluation by exempting Next Generation IHPs from certain service delivery and operating requirements.

We look forward to working with the Department and provider organizations to continue to find collaborative and sustainable approaches that encourage the adoption of value-based payment arrangements and innovative coverage and delivery approaches to improve the health of the families and children we all serve.

**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?**

As a health plan serving state public programs enrollees since 1984, UCare has supported and promoted the importance of individuals having a "medical home" where the needs of the whole person are understood and addressed. However, we believe the Department's Next Generation IHP proposal to drive all aspects of the coverage and care delivery system exclusively based on a beneficiary's selection of a primary care clinic (PCC) is misguided.

We understand the proposed model (i.e., having beneficiaries in either an IHP or a health plan model) seeks to create “clear lines of accountability,” which may support the Department’s evaluation of outcome and costs. However, the accountability the Department is seeking exists today through the Department’s capitated payments to health plans in exchange for all-inclusive coverage of Medical Assistance and MinnesotaCare benefits – everything from primary care visits to inpatient hospitalization to pharmacy to transportation services. The Department also creates accountability through performance-based withholds, which can be used to support performance improvements in identified areas of need. We note here that it is unclear how inconsistent performance targets and requirements between Next Generation IHPs and health plans would advance the Department’s goals of consistency and outcomes while supporting any meaningful evaluation. The current IHP model creates some level of accountability for provider systems, which could be enhanced through new value-based arrangements with health plans.

The troubling trade-offs associated with the proposed exclusivity, which would reconfigure how all services, other than those delivered within a primary care system, are delivered for a large number of beneficiaries and would result in two separate delivery systems (managed care with health plans and Next Generation IHPs) outweigh the benefits of making such a dramatic and disruptive change. We also believe that this is potentially the most disruptive aspect with the proposal and would compound the disruptions experienced by beneficiaries over the past two years of reprocurement changes.

As an alternative to the proposed exclusivity, the Department could consider encouraging collaborations between health plans and particular IHPs, so that a health plan could offer both an IHP plan and a more typical broader network plan in a service area. This approach would still create greater accountability, incent innovation, and support choices for beneficiaries, without the issues created by the proposed exclusivity.

We have additional concerns about the proposed exclusivity relating to beneficiary and administrative impacts, detailed below. As we have noted above, UCare is interested in working with the Department and providers in increasing value-based arrangements without the need for exclusivity and other aspects of the Next Generation IHP model.

#### Beneficiary Impact

Another UCare concern of the PCC exclusivity model is the unintentional restricting of beneficiary choice of providers. An approach that structurally limits beneficiaries to a particular PCC ties all aspects of their care delivery to selection of the PCC and could interfere with beneficiaries exercising “meaningful choice in providers,” one of the goals included in the proposed Next Generation IHP model.

The Department also mentions, and we agree, that beneficiaries should understand the differences between the various provider networks, but this may be setting expectation higher than is reasonable knowing that few consumers, whether or not enrolled in public programs, understand the differences in the care systems they access or are available to them. Compounding the lack of ability to understand differences in care systems is that the metro area contains a population that historically has had difficulty accessing providers due to limited English proficiency and/or non-Western cultural backgrounds. The stakes of picking, or being assigned to, a PCC would be higher under the proposed exclusivity, and assignment could be difficult to implement if beneficiaries do not understand what is being asked of them and why, the process for picking a PCC, or the impact of their choices.

We suggest that before adding another IHP model to the mix that the Department work in concert with health plans and counties on steps to take to ensure beneficiaries understand their choices and make

informed decisions. Examples include moving away from a paper enrollment process (the counties' telephone enrollment and improving MMIS are great starts) and determining how to decrease the high default enrollment rate through greater support for beneficiaries such as a Beneficiary Support System.

In addition, based on UCare's previous experience with a medical home model in state public programs, individual choice must be aligned with special programs and services alongside the primary care network. Family members should be allowed to stay within the same system, but also have assurance that age/sex/cultural needs will be met within the overall care system. Due to the social determinants of health and at times transient living situation of state public program beneficiaries, there is significant value in the access and support programs offered by health plans such as UCare's transportation program (Health Ride), which could be undermined under primary care exclusivity as described in the RFC.

We also question whether the proposed model will have the unintended consequence of causing PCCs to potentially manage access to beneficiaries if the numbers of beneficiaries, particularly those with complex needs, creates significant financial risk.

The relationship between primary care practitioner and patient is of paramount importance in the delivery of health care. While primary care is the cornerstone of our system, evidence from ACOs and from Medicaid enrollment data indicate that there is significant "churn" in the beneficiary population that is attributed to primary care physicians (PCPs). In Medicare, a significant portion of ACO beneficiaries are attributed to specialists, and high numbers of Medicaid patients change PCPs throughout the year. This strongly suggests that many beneficiaries do not choose to align their care to a PCC, but seek a PCP or a suitable specialist *at the time care is needed*. Therefore, despite the best of intentions, a "primary care exclusivity" policy that requires a PCC to be exclusive to a single Next Generation IHP may have numerous negative impacts to beneficiaries, as well as create administrative complexity.

In addition, based on UCare's experience, health plans are well-situated to identify and work with the important population of individuals who are not accessing care. Health plans have responsibility for the full panel of identified membership. As such, they are responsible for outreach and outcomes for all membership and are positioned to find and connect these individuals to a medical home. Gap analysis programs help identify individuals, and outreach programs work to assure that preventive services, tests and targeted outcomes are met for individuals with chronic conditions. Exclusivity would sever the health plans from the process of helping beneficiaries get access to primary care.

Our most significant area of concern is that in the proposed model, current Medical Assistance and MinnesotaCare managed care enrollees would be required to disenroll from their health plan to retain their PCC if it were only offered through a Next Generation IHP. This would cause enrollees to lose the many benefits, including those offered over and above the standard benefits, which managed care plans "bring to the table." Examples are:

- customer service phone lines answered by people (vs. use of IVR systems)
- after-hours nurse lines
- representatives in enrollee-facing departments (e.g., customer services and clinical services/disease management) able to speak enrollees' languages
- provision/coordination of key access services such as transportation and interpreter services that are often "richer" than the same service in fee-for-service (example – UCare provides MinnesotaCare enrollees transportation to chemotherapy services and other cancer treatments)

- evidence-based disease management programs
- multiple, ongoing quality improvement programs
- dental care coordination for enrollees facing difficulty accessing dental services
- unique to UCare, a mobile dental clinic providing services at both metro and Greater Minnesota locations in recognition of statewide dental access issues
- additional benefits such as waiver of the family deductible cost sharing (a heretofore overlooked additional benefit)
- health promotion/incentive programs such as rewards for staying up-to-date on Child & Teen Check-Ups
- fitness kits for enrollees aged under 18
- discounted fitness club fees (with attendance thresholds) for enrollees 18 and older
- preventive services such as free car seats/car seat installation training (UCare was the first health plan to offer)
- free quit smoking programs

### Administrative Impact

We also have serious questions regarding the proposed realignment of administrative services to IHPs and to the Department. If the Department assumes responsibility for claims processing, customer service, enrollment, utilization review, initial screening, grievance and appeals, there will be extensive need for additional information interfacing with the IHP networks. The design, technology, implementation, and staffing of these interfaces will require careful analysis and planning to properly assess the overall costs for centralizing these administrative functions. The centralization of these functions also puts pressure on the health plan efficiencies because it will reduce enrollment and impact overall economies of scale for health plans that already have the necessary administrative infrastructure.

Given the complexities described above that arise from a “primary care exclusivity” policy, the Department should consider models that allow for provider organizations to assume greater financial accountability, while allowing partnerships with one or more health plans to support coordinated administration and beneficiary choice.

**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.**

It must be noted here that Minnesota health plans currently have value-based arrangements in other product areas that allow for the appropriate level of risk based on the population, from full risk to pay-for-performance arrangements. Utilizing a health plan’s full scope of value-based arrangements tailored to the care systems would satisfy the Department’s concern about economies of scale. The current state public programs health plan model is successful in adequately sharing risk and ensuring sustainability by way of health plan investments.

Within any system, a minimum number of beneficiaries, coupled with responsibility for the full array of covered services that can impact outcomes, are needed to credibly determine accountability for outcomes, as well as to ensure sustainability and economies of scale. Dividing enrollment between more entities – without the reserves of a health plan – will erode the economies of scale that have produced

significant administrative efficiency through managed care, generate new administrative costs and inefficiencies within new entities and pose new levels of financial risk for provider organizations. Overall, we agree that a minimum level of enrollment is necessary, which will be challenging to develop in light of the varying size, patient populations and scope of services of the provider systems. Of course, one of the key value propositions of health plans is that a health plan could assume the insurance risk even when a provider assumes a greater level of financial accountability for the care the provider delivers.

**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 primary consideration (e.g., criteria related to cultural competency, disparities, equity, etc.)? Please be specific in your response for Next Generation IHP or MCO.**

UCare has a robust provider network and meets all contract requirements for network adequacy and provision of Medical Assistance and MinnesotaCare services. With our clinical and behavioral staff co-located in our office, we coordinate and support the holistic, comprehensive needs of our enrollees across the continuum of services and related providers including behavioral health, primary and acute care needs, medication management – plus consideration of social determinants of health when appropriate.

Current managed care provider networks include extensive networks of behavioral health/substance use disorder providers. These managed care networks support the ability of enrollees in need of such services to choose from nearly all providers. This broad range of beneficiary choice should be maintained in any model, and the Department should ensure all entities are held to the same network standards and requirements in order to meet the objective of fair and equitable access and care for all beneficiaries.

Entities responding to this RFC and an expected future RFP must ensure they have the same capability to leverage the flexibility of providing additional services under the Department's current purchasing strategy. UCare takes advantage of this flexibility to go above and beyond the required Medical Assistance and MinnesotaCare services and requirements to meet the needs of our enrollees by providing the services listed above on pages 4-5, some in partnership with our county social services and public health partners.

Based on the background of the population enrolled in state public programs managed care, the Department should prioritize an organization's experience working toward improving the cultural competency within the organization and by its business partners. Any organization participating in a reprourement must:

- Demonstrate knowledge of the diverse ethnic and cultural background of Minnesota's public program membership, and current/future strategies for improving the ability to meet their needs/improve health outcomes. For example, UCare has partnered with [Stratis Health](#) to offer providers and PCCS valuable cultural information at [Culture Care Connection](#). We also have bilingual, in-house employees answering calls in our Customer Services Department.
- Demonstrate an understanding of Minnesota's documented health disparities, a track record of taking specific steps toward eliminating them, and future plans for continuing to address them.

- Have the experience and ability to support beneficiary use of access services to all Medicaid and MinnesotaCare covered services, for example, use of various kinds of transportation and interpreter services.
- Have resources to work with beneficiaries, providers, counties and/or the Department on issues related to social determinants of health, like food insecurity (addressed in part by UCare’s partnership with Wilder’s Mobile Market) and lack of transportation (addressed by UCare’s flexible transportation program structure).

**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?**

Three obvious items necessary for effective care coordination are: (1) an organization’s information technology infrastructure; (2) diverse staff (see Question #3 response); and (3) analytics and clinical/behavioral staff to monitor utilization and cost of services for all Medical Assistance and MinnesotaCare covered services, as well as the ability to focus on utilization of services known to have costs and insurance risk. These are highly developed capabilities and expertise that exist within UCare and other health plans today.

In the short term, Next Generation IHPs would need to use claims-based data to identify opportunities for improvement and then eventually to integrate clinical data with claims to manage and achieve quality and cost targets. Developing such capabilities would require significant capital investments.

Lastly, we are unclear how the Next Generation IHP model encourages IHP outreach to “unseen” beneficiaries; that is, beneficiaries who do not routinely visit a PCC or access health care. Health plans have the full continuum of care responsibility and so engage beneficiaries not accessing care to ensure preventive services and quality care. It is unclear how the Next Generation IHP model will support this important outreach.

Regarding performance measures, UCare welcomes the opportunity to work with the Department and providers in developing meaningful and aligned performance measures to support effective care coordination.

**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?**

A good indicator of how responders will be able to implement a proposed initiative is their track record on implementation. In this area, UCare has demonstrated our ability to put in place programs and initiatives that address defined needs of enrollees. For instance, UCare was the first health plan to offer car seats and car seat education, as well as a mobile dental clinic that provides services in areas with low dental access. Each initiative had targeted goals, timelines and proposed outcomes that were evaluated initially every six months and ongoing on a yearly basis.

We also believe that evaluation of proposed RFP responses must ensure a level playing field. As such, at a minimum, all respondents must be required to demonstrate their ability to meet state and federal regulatory and service and network delivery requirements (e.g., Minnesota Department of Commerce risk-based capital requirements and financial reserves requirements; pass Department of Health quality

assurance/Department of Human Services Triennial Compliance Assessment audits; and, for new managed care organizations, the Department of Health's comprehensive network requirements). The ability for an organization to be successful could be based, at least in part, on a responder's past success in meeting Medical Assistance and MinnesotaCare managed care requirements.

Under current laws and contract requirements applicable to health plans, the Department has authority to audit or review compliance with a multitude of requirements, and health plans have been subject to a variety of oversight audits and reviews in recent years. We would expect the same level of oversight to ensure performance for any respondent in a future reprocurement process.

**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?**

UCare has concerns about both approaches, but appreciates the interest in more formulary consistency for practitioners and beneficiaries. As the Department continues to evaluate this policy, we wanted to provide the following thoughts about potential impacts of a single Preferred Drug List.

#### Beneficiary Impact

Although the Department has confirmed it would handle all appeals related to pharmacy in the Next Generation IHP proposal, we suggest that this would be confusing for beneficiaries, who would have two tracks for appeals, dependent upon the benefit in dispute.

#### Increased Cost

A single PDL will likely impact a health plan's ability to influence any pharmacy utilization and pharmacy spend. A 2016 study prepared for the Texas Health and Human Services Commission, a state agency the Minnesota Department of Human Services has spoken with, found that the overall cost would be \$40 million less per year if there was not a PDL. See: <https://hhs.texas.gov/sites/default/files/formulary-control-state-vs-mco.pdf>. An April 2016 study concluded that a change to a uniform, state-administered PDL would be costly for Louisiana and that the programmatic advantages would be modest at best. See: [https://www.themengesgroup.com/upload\\_file/louisiana\\_pdl\\_report\\_april\\_2016.pdf](https://www.themengesgroup.com/upload_file/louisiana_pdl_report_april_2016.pdf).

States allow health plans varied level of control over PDLs. In 2014:

- 10 states had no Medicaid health plan contracting, and another six states used a pharmacy carve-out model within their capitated health plan managed care program.
- 30 states (plus the District of Columbia) with Medicaid health plan involvement allowed health plans to develop independent PDLs, although some states retained control over PDLs for some drug classes.
- Four states required Medicaid health plans to utilize uniform PDLs.

States that control PDLs entirely are not performing well in terms of net cost per prescription. An analysis of prescription drug costs for each state's Medicaid population in 2014 revealed the following information:

- States with no health plan involvement in Medicaid drug purchasing collectively experienced higher net costs per prescription than the national average and states with MCO involvement.
- States with Medicaid health plan involvement that allow health plans to have PDL latitude collectively experienced lower net costs per prescription than the national average.
- The four states requiring Medicaid health plans to utilize uniform PDLs were collectively above the national average in net cost per prescription.
- In 2014, Minnesota ranked 16th in terms of net post-rebate cost per prescription.

**Medicaid Prescription Drug Cost Management Outcomes, FFY 2014**

State Group	Net Post Rebate Cost Per Prescription	Initial Cost Per Prescription	Rebates Per Prescription	Generics as % of Total Prescriptions	% of Medicaid Prescriptions Paid by MCOs
USA Total	\$37.37	\$72.38	\$35.00	80.7%	55.3%
Minnesota	\$33.67	\$71.43	\$37.77	83.3%	72.0%
16 States With No MCO Paid Drugs	\$45.80	\$87.42	\$41.62	77.0%	0.0%
30 States (plus District of Columbia) with MCO Paid Drugs and where PDL Latitude Exists	\$35.53	\$68.39	\$32.87	81.8%	65.1%
4 States Requiring Uniform PDL of Medicaid MCOs	\$39.26	\$79.70	\$40.44	78.5%	65.8%

Administering a single PDL across all models (fee-for-service, managed care and Next Generation IHP) also has implications from a rebates and clinical outcomes perspective because it would be hard for health plans and Next Generation IHPs to have value-based contracts with providers if providers are forced to use the fee-for-service PDL. It is unlikely providers will adhere to value-based contracting if one of the key drivers of health (pharmaceuticals) requires them to use a "vanilla" PDL – providers will want options that include biosimilars, orphan drugs or others that may not be covered by a fee-for-service PDL.

Formulary Experience

Health plans and their pharmacy benefits managers have had experience with formularies for years. Through this experience with formulary management, health plans have driven generic utilization and cost savings through utilization management as outlined in the section above.

Although some may believe that having multiple health plan formularies today creates confusion, the reality is that providers today deal with multiple formularies in the commercial world. The key argument typically made in favor of a uniform PDL is ease of administration for prescribing physicians and pharmacists. However, Medicaid pays only approximately 15-20% of population-wide prescriptions, and creating “uniformity” with the Medical Assistance/MinnesotaCare PDL does not change the number of PDLs that are in use for other managed health care plans (i.e., for Medicare or the individual market), which pay for 80-85% of all prescriptions. Thus, the prescriber and pharmacy community will need to work with several dozen PDLs regardless of a single PDL.



Then too, a single PDL will hamstring health plans that are in the final stages of 2018 formulary changes – changes that may align a health plan’s drug coverage across all its lines of business – that would not match a state single PDL and, in 2019, cause additional enrollee confusion and disruption.

We also have some additional questions about a single PDL for the Department’s consideration:

- Will health plans have access to federal Medicaid rebates in this model?
- If only in the seven county metropolitan area, will the Department expect health plans to administer one formulary in the seven counties and a different formulary in the remaining 80 counties?
- Will health plans have representation on the P&T Committee that determines the PDL?
- What ability will health plans have to influence pharmacy utilization and thereby manage costs?
- Would a PDL also apply to the medical benefit drugs?

**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?**

While we do not have specific suggestions about striking the appropriate balance described in the question, UCare and health plans are well situated to collaborate with providers so that providers can take an appropriate level of risk. UCare has a long history of innovative risk and quality models with our provider network. While some of our most flexible models have been in our Medicare and dual eligibles products, we have been able to utilize more innovative value-based financial models in state public programs. Our models vary by product and populations within the products. The risk level requires review of the financial position of the provider along with the provider's specific skills and service competency for the population targeted. Systems with larger panel size have more financial model flexibility, but programs that build on pay-for-performance support providers regardless of their panel size. An enhanced “front-end” primary care selection model will improve the ability to attribute a patient base and track quality outcome measurement during the year. Many quality improvement outcomes are not tied to short-term financial improvement and must be recognized as long term investments for population health.

We appreciate the Department’s goal to align health plan and Next Generation IHP measurement. We believe there should be identical or, at a minimum, similar measures for all respondents. When delivering Medical Assistance and MinnesotaCare managed care services, all entities must be held to the same standards in order to achieve the same – or better – results and provide a way to measure agreed-upon criteria.

**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?**

We fully support the Department's desire to allow payments for non-medical, non-covered services to address beneficiary needs that are outside those typically addressed through the health care system. UCare provides non-medical, non-covered services, including some, like our mobile dental clinic and provision of car seats and car seat training, related to social determinants of health; see pages 4-5.

UCare’s longtime commitment to addressing social determinants of health also includes support models such as our partnership with [WellShare International](#), built to work with families who have a higher than expected use of emergency services. This model utilizes culturally competent Community Health Workers for outreach, which enhances outcomes for the specific outreach effort. Other examples

include hiring a Community Health Worker as part of a PCC care team to work specifically with the PCC's diverse populations. This type of program enhances the clinic's ability to serve the population and creates an extension to the bricks and mortar traditional clinic model. Another example includes community education programs with trusted individuals from the local community to educate and empower enrollees on how to appropriately use their health care services. These programs also build local resources to support the community over time. UCare also sponsors a mobile market to address our enrollees' food insecurity and transportation barriers in some communities.

Any evaluation of non-medical, non-covered services must consider the total cost of care along with improved education and quality measures. Recognition must be given to the importance of efforts that have longer term outcome improvement as well as short turn-around documentation. Measures must be tailored to align the specific community health risks and disparities with defined metrics focused on key quality and cost measures, e.g. preventive screenings, emergency room visits, emergency room admissions, etc. Other measures could be the numbers of beneficiaries served who are impacted by social determinants of health and how an increase in race, ethnicity and language information coming on the Department's enrollment files translates into increased access to all services.

Longitudinal analysis of interventions and costs across systems is needed to fully assess and ultimately understand the value and impact of initiatives that try to address social determinants of health. Because this work involves many stakeholders and systems, we would like to be involved in collaborative work in this area to make our work in this area even more valuable.

UCare stands ready to support development and implementation of new practices that improve these connections, and, ultimately, enrollee outcomes. In particular, we would like to discuss the possibility of partial capitation or other payment methodologies that provide flexibility in paying for efforts to address social determinants of health with providers and other community partners.

**9. How much of the entities' payment should be subject to performance on quality and health outcome measures? Please explain your answer.**

All health plans have portions of their capitation based on performance on metrics, and UCare welcomes that continued accountability and discussions for continued progress in aligning payment with outcomes. If the Department proceeds with Next Generation IHPs, we agree that it is appropriate to also tie Next Generation IHP payment to performance on selected metrics, so that all entities are held to the same standards. As we have described earlier in our comments, we believe that providers could work with health plans under the current IHP and health plan model to structure additional financial incentives that make sense for the particular provider in question.

Any payment amount must be meaningful enough to drive the expected action over time, in collaboration with providers. The amount subject to performance should be based on the relative difficulty of achieving the outcome and the social complexity of the beneficiaries at the focus of the activity (e.g., if an entity's non-compliant beneficiaries are all LEP, which creates a demand for more services and likely additional expenditures to ensure appropriate services).

**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?**

We appreciate the Department identifying and acknowledging the importance of alignment of quality requirements and recognize many other states are working toward aligning measures across programs.

The need to choose one measurement system and hold all contracted entities (health plans and Next Generation IHPs) to the same standard, while also accounting for risk, cultural and socio-demographic factors or barriers to care is critical. Consistent measures are needed across all participating entities to evaluate effectiveness of models and compare the performance of entities participating in the Medical Assistance and MinnesotaCare service delivery space. Standard HEDIS metrics should be considered for the initial measurement model, as HEDIS is currently in use and has the support mechanisms in place for standards and comparisons. Previous comments about the PCC selection and beneficiary movement in the Next Generation IHP model versus the health plan model raises some concerns related to the known need for continuous enrollment to ensure credible measurement of impact on outcomes.

**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?**

Addressing social determinants of health is an emerging and evolving field, which will be highly reliant on a collaborative process, with input from counties, beneficiaries, social service providers, health plans and others.

The Department should build on the work of UCare and other health plans – and potentially of IHPs – in their work on social determinants of health, racial disparities and behavioral/substance use disorder services. The flexibility to apply partial cap or capitated funds to pay for social determinant-related services is a good initial step toward meeting beneficiaries where they are in life. A Department-led collaborative planning process around coordination across service sectors will be important to reduce risk and confusion for all eligible entities and beneficiaries.

New models for beneficiary outreach will be required. Proven initiatives such as the growing use of Community Health Workers and programs that operate outside the bricks and mortar walls of the clinic systems will be required. A detailed community assessment of local and regional resources as a tool would be a valuable way to engage and not duplicate required services.

In closing, UCare appreciates the opportunity to provide comments. The Department has outlined important goals in the RFC that are focused on improving the care delivered to Medical Assistance and MinnesotaCare beneficiaries. We support the Department's goals, as they align with UCare's mission. While we have concerns about the proposed model and urge the Department to evaluate the current IHP model and reevaluate the proposed timeline for a RFP, in the meantime we hope to be at the table working with stakeholders to further enhance the current managed care model.

Meeting the needs of families and children is central to UCare, and we look forward to working with the Department and others to find collaborative, equitable and sustainable approaches that increase the adoption of value-based payment arrangements and improve cost-effective, quality outcomes in Minnesota's Medical Assistance and MinnesotaCare programs.

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December 20, 2017

Minnesota Department of Human Services  
Submitted to: DHS.PSD.Procurement@state.mn.us

**RE - Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP, UnitedHealthcare Community & State Comments**

UnitedHealthcare Community & State appreciates the opportunity offered by the Minnesota Department of Human Services (DHS) to provide feedback on the state's Outcomes-Based Purchasing Redesign and Next Generation IHP through this Request for Comment (RFC).

We support the state's mission to redesign and reform DHS' purchasing and delivery strategies for public health care programs with the goal of improving health outcomes at reasonable cost.

As an experienced, national Managed Care Organization (MCO), UnitedHealthcare Community & State is honored to serve 6.4 million Medicaid consumers across 26 states, including 14 managed long term services and supports programs, two Financial Alignment Demonstrations, Duals Special Needs Plans (DSNP) in 27 markets, and the Basic Health Plan in New York, we have actively partnered with states in implementing transformational health care system program design. In serving our state partners, we are not merely a program administrator; we establish long-term, innovative partnerships and invest in the communities we serve. We welcome the opportunity to respond to this RFC and begin establishing a strong relationship with DHS and Minnesota, our enterprise's home state.

We have reviewed the RFC application through the lens of our experience and offer the following comments for DHS's consideration.

If any additional information or insights would be helpful, please contact me.

A handwritten signature in blue ink, appearing to read 'Catherine Anderson', written in a cursive style.

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## **NEXT GENERATION PROGRAM DESIGN RECOMMENDATIONS**

We are supportive of Minnesota’s intentions to leverage creative, market-based strategies to advance system transformation, improve health outcomes of Minnesotans, and lower the overall cost of care. Investing in innovative partnerships across the delivery system as proposed in the Request for Comments document (RFC) will support the state’s continued evolution toward an accountable system of care that leads to better health outcomes and higher enrollee satisfaction. However, we believe that the program design as conceived presents opportunities to further improve the enrollee experience of new health system and leveraging contractors, such as managed care organizations (MCOs), to further advance the system’s ability to take on risk for the total cost of care.

### ***Improving Enrollee Experience***

The Next Generation design proposes that qualifying Integrated Health Plans (IHPs) and MCOs operate side-by-side, serving individuals in the seven-county metro region, supported by an attribution model driven by “primary care exclusivity.” However, the proposed design includes several inherent differences in program administration across the IHPs and MCOs that will likely drive different beneficiary experience and create complexity in navigating the system. These differences are proposed across the program design, but several are specifically enrollee-facing: state versus MCO-contracted wrap around services, member support services, and in-network providers. Any enrollee that moves from an MCO to an IHP, or vice versa, will be subjected to changes in their primary care provider, the vendor for their wrap around service such as transportation, and new processes for their member services such as asking a question about their coverage. These inherent differences will likely cause confusion for the individual seeking their and providers contracted with disparate managed care entities attempting to help them navigate their services. DHS should consider how these types of differences create challenges for members trying to navigate the health care system. Smoothing out these gaps inherent in the system design will be critical in achieving enrollee satisfaction.

To that end, DHS should consider leveraging a contractor, such as an MCO, to lie on top of the IHPs to even out these differences.

### ***Leveraging MCOs to Support IHPs to Take on Risk***

The model should ideally incentivize practices – to the extent appropriate – across the entire delivery system at a total cost of care threshold to encourage an integrated approach to care management and whole-health population management. Total cost of care management and/or risk is difficult to manage and there may be a limited number of practices that have the experience or the readiness to enter in to a risk-based partnership, placing both taxpayers and enrollees at risk. While Minnesota is further along the continuum in standing up provider-led organizations in their ability to accept risk than most states, not all practices or systems in the region will be equal in their sophistication level, readiness to accept risk, availability of technology solutions, etc., to participate as a Next Generation IHP.

We believe there is strong opportunity for DHS to rely on MCOs to serve in a critical role as the backbone of the program to support provider groups transform and move along the continuum toward being able to accept full risk. History demonstrates that provider groups that have failed



because they were not ready to take on full-risk cause disruption of care, confusion to the community, and reduced delivery system capacity, placing taxpayer dollars at risk.

The type of technical assistance providers need will depend on the individual practice's capabilities and existing infrastructure. MCOs bring the capability to work with providers that are not currently aligned with IHPs to prepare them for value-based purchasing methodologies and taking on accountability for quality and outcomes at a pace that aligns with their capacity and infrastructure, advancing the state's goals for a broadly accountable system of care.

To that end, we recommend that Minnesota and DHS modify the proposed Next Generation IHP strategy to instead leverage the experience, capabilities, and risk management tactics of a contractor, such as an MCO, to support IHPs to serve as the backbone of the Next Generation program. In this arrangement, the Next Generation IHPs would be supported administratively to move along the continuum to eventually accept a full risk reimbursement model, which is critical to driving the state's desired system transformation.

MCOs with deep experience in transformative practice strategies and value-based contracting can elevate efforts to drive toward value-based care, align alternative payment models within Medicaid, and ensure effective, sustainable delivery system transformation. Modifying the program design such that IHPs are required to enter into robust partnerships with an experienced MCO can assist state purchasers as they evaluate the efficacy of alternative payment models and benefit the state and IHPs by providing:

- The opportunity to aggregate smaller, value-based contracting provider practices through MCO contracting strategies;
- Centralized accountability and ability to controls for performance variability at the practice by holding a smaller number of MCOs accountable for outcomes;
- Robust strategies to assess participation in advanced payment models and include a disciplined, data-driven approach to practice assessments, tools to monitor system performance, and methods to sequentially progress practices across value based initiatives;
- Customizable supports at the practice level across the continuum of value based payment programs that advance the system as a whole toward transformation. This approach begins to prepare physicians who are less prepared for transformation and ensures the continuous growth of practices that can take on more accountable partnerships, up to and including risk;
- The ability to align system performance within the goals of the Medicaid program and create greater accountability for alignment across all other Minnesota Medicaid MCOs and other public and private systems within the state.
- Strategic, targeted, and disciplined approach to infrastructure investments that supports practice evolution;
- Development of effective methods of provider engagement to identify the optimal balance of accountability, integrated delivery systems, and practice activation to provide the most complete and effective patient care; and
- Administrative streamlining and simplicity due to the reduction in the number of contracts, data sharing agreements and other "back end" processes and procedures.

***If DHS is committed to its program design as proposed, the state needs to guarantee an even playing field between MCOs and Next Generation IHPs in the procurement***

If the state chooses to design the program such that MCOs and Next Generation IHPs compete head-to-head as managed care entities in the seven-county metro region, we strongly encourage DHS to ensure that contract and procurement requirements for each entity guarantees an “even playing field” of regulatory neutrality<sup>[1]</sup> between MCOs and Next Generation IHPs. Specifically, DHS should address the following:

- Apply insurance regulations (including licensure), antitrust policies, and governance requirements consistently across all organizations that administer the program;
- Hold Next Generation IHPs and MCOs to uniform requirements for equitable beneficiary protections (e.g., adhering to requirements for member complaints and appeals, quality oversight, provider credentialing and licensure standards, marketing and network adequacy). Applying consistent requirements ensures product quality across plan offerings;
- Hold Next Generation IHPs and MCOs to the same solvency requirements including financial viability, minimum reserve requirements to cover claims costs, operating cash flow, and financial statement reviews. Next Generation IHPs assuming any level of risk should be continuously monitored for financial health. With these requirements in-place, DHS will protect the state’s general fund, which would serve as the stop-loss in the case a catastrophic event (such as an emergent event for an attributed member that requires a month-long acute inpatient stay out of state) that financially dissolves a Next Generation IHP.
- Next Generation IHPs should be held accountable for the same coordination expectations of MCOs and other risk-bearing entities. This ensures a minimum standard of quality and access for beneficiaries in Next Generation IHPs and across all risk bearing systems.

There are specific aspects included in Table 1. Model Components and in the Rate Setting Process section of the RFC that we recommend DHS address to ensure an even competitive playing field (additional comments on these areas are addressed in our responses to the questions posed by the state):

- **Populations Included:** DHS would allow additional MA and MinnesotaCare populations, including those exempt from mandatory managed care to enroll in a Next Generation IHP but this same flexibility is not afforded to those who may want to enroll in an MCO. We recommend expanding this option to allow additional individuals to enroll in either an IHP or MCO to expand beneficiary choice and provide fair opportunity across participating IHPs and MCOs to maximize enrollment.

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<sup>[1]</sup> Health Affairs speaks to the essential nature of establishing an even playing field for Accountable Care Organizations competing as insurers in a 2013 article available here: <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2012.0360>



- **Network Requirements:** The RFC indicates that MCOs are to be held to current network adequacy standards but Next Generation IHPs are to be held to standards for a core set of services, relying on the DHS fee-for-service network to fill gaps. This design creates an unfair advantage for Next Generation IHPs in their ability to meet baseline requirements to participate in the program. Additionally this exacerbates usage of a volume-based fee-for-service system and does not align total cost of care accountability to the IHPs.  
Next Generation IHPs and MCOs should be held to the same set of rigorous network adequacy standards to participate in the program. In addition the state should eliminate the exclusivity provision (primary care clinic exclusive relationship with an IHP or MCO) as this will likely create challenges to build sufficient networks and therefore limit the state's ability to attract bidders.
- **Healthcare Services:** The RFC proposes that Next Generation IHPs rely on DHS for several wraparound services including non-emergent transportation and durable medical equipment while MCOs are held to current MCO health care service offerings. Fragmenting service management between Next Generation IHP and DHS creates challenges in managing an individual's health care needs holistically. MCOs are experienced at integrating wrap around services in their suite of benefits provided to members. Next Generation IHPs and MCOs should be responsible for the same set of benefits to ensure an even playing field in meeting network adequacy requirements and ability to offer consistent member experience.
- **Administrative Services:** The RFC indicates that Next Generation IHPs will contract with DHS to provide a subset of administrative services including claims processing, customer service, provider enrollment, integrity, appeals & grievances, providing data on cost and quality, among others. The document also indicates that MCOs are required to offer these same services and meet certain efficiency requirements but if are unable to do so, DHS will provide them. These types of administrative functions are core to managed care entities' ability to identify gaps in care, conduct targeted care management strategies, and design value-based purchasing strategies. Imbedding these functions in the managed care entity is critical to driving toward an outcomes-based, accountable system of care. We recommend that DHS apply aligned requirements across MCOs and Next Generation IHPs to support core administrative functions to support these goals, particularly claims processing, member-facing services, and provider-facing functions. If the preference is to maintain the administrative functions at DHS for the Next Generation IHPs the administrative payments and/or partial capitation should be adjusted accordingly to reflect the amount of administrative accountability for those services.
- **Member Enrollment and Selection Process:** The RFC indicates that enrollees may change their primary care clinic (driving selection) as often as once per month. This design favors Next Generation IHPs based on their face-to-face interactions with members, a lever MCOs are not afforded by nature of their structure. As a result Next Generations IHPs may influence plan selection up to and including the potential for adverse selection based on Next Generation IHPs influencing members with complex or

difficult to treat conditions to select MCOs. Additionally, allowing members to change their plan selection each month will create challenges in maintaining continuity of care. Therefore, we recommend the state ensure sufficient protections against this practice and lock in member plan elections for a minimum of 12 months to minimize the challenges described and ensure enrollment for a sufficient amount of time to warrant investment by health plans.

- **Data Provided by DHS:** Based on the language in Table 1, it appears that DHS intends to provide robust utilization and risk data to Next Generation IHPs upon member enrollment but is not committed to providing the same level of historical data to MCOs upon initial member enrollment. If this type of historical information is available across the region, we recommend that DHS provide it to the same level to both Next Generation IHPs and MCOs to ensure even footing upon member enrollment to support risk stratification, care management strategies, etc. Particularly if the state chooses to move to a single PDL outside of the managed care system, DHS should provide analogous pharmacy utilization data to both the MCOs and IHPs on a regular basis to support appropriate care coordination.
- **The Next Generation IHP Rate Setting Process:** At its core, the strategy to bifurcate the reimbursement strategy across MCOs and Next Generation IHPs inherently creates differing levels of financial accountability for administration of the Medicaid program. The ability to manage risk and coordinate care under full-risk capitation requires capabilities, experience, and infrastructure not necessary to succeed under a partial-risk capitation. However, the ability for MCOs to holistically manage a person's health care under a full-risk contract is significantly more robust than an entity managing care under a partially-capitated payment. If DHS does not believe that Next Generation IHPs are prepared to adopt a full-risk payment structure at this stage, we recommend that Minnesota contract with MCOs for management of the Next Generation program, with the requirement to contract with the IHPs under a value-based purchasing model to advance the state's system accountability goals and advance practice transformation (as described above).

## RESPONSES TO QUESTIONS POSED

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?**

“Primary care exclusivity” as the driver for determination of the primary care clinic's (PCCs) participation in the Next Generation IHP or the MCO program creates an anticompetitive environment with power dynamics in favor of the PCCs. This likely will create challenges in MCOs' ability to create sufficient provider networks which could limit the state's ability to attract qualified contractors who may be unable to fulfill network adequacy requirements because of

the exclusivity requirement. From a beneficiary's stand-point because of the financial and administrative requirements to participate in the Next Generation IHP, PCCs may have limited patient panel capacity which could result in inconsistent and/or disruptive beneficiary experience. As opposed to the exclusivity requirement we would recommend the following design alternatives:

- Allow PCCs to participate in both Next Generation IHP and MCO systems. Members that do not choose a program upon enrollment we would recommend auto assignment to a health plan through a round robin approach – distributing membership equally to all Next Generation IHPs and MCOs. This supports achieving sufficient enrollment mass to support contractor sustainability and does not favor any one system over the other.
- If the state elects to maintain exclusivity, we would recommend elimination of network adequacy requirements or appropriate weighting of network build in the procurement to reflect the market dynamics. This allows the state to judge potential contractors on the merits of their managed care capabilities and network dynamics can be addressed post procurement.
- We would also encourage the state to consider establishing floor reimbursement rates for Medicaid services received outside of the managed care system (either Next Generation IHPs or MCOs). This will eliminate any incentives for providers to increase reimbursement rates for Medicaid beneficiaries based on refusal of providers to participate in the managed care system.

**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.**

Practice capacity and/or size should be a primary factor for attribution to ensure an optimal volume and critical mass of patients to spread risk. We recommend DHS assess the Next Generation IHPs' ability to manage a critical mass of patients at procurement as a gating factor as to whether a group meets the standards to participate in the program. Ensuring capacity increases will increase the IHP's to obtain practically meaningful results on cost and quality of impacts and incentivizes providers to invest in meaningful practice transformation.

Overall, for the purposes of ensuring proper spreading of risk and population mix, we recommend that DHS limit the number of IHP contractors in the Next Generation program to ensure appropriate balance between the two programs to achieve sufficient membership mass in the seven-county metro region. Limiting the number of contractors to three will limit the level of administrative costs built into the overhead for management of the program.

Reaching a critical mass of enrollees will be critical for the sustainability of the program. Leveraging an auto assignment process, as discussed in question 1 above, will facilitate appropriate enrollee distribution across the program. In year 1 of the program we would encourage DHS to focus the auto assignment methodology to achieve critical mass. Quality and/or performance should be factored in to auto assignment in years 2 and beyond.

Because of their structure, IHPs will likely reach critical capacity before the MCOs; therefore, the auto assignment process should facilitate turning assignment to IHPs "off" when that capacity is reached and "on" when membership falls below capacity.. The on/off process during year 1 should allow the IHP to enter or leave the round robin assignment process. More sophisticated enrollment assignment methodologies that factor in performance should be considered in post

implementation years. Because of the nature and capacity of MCOs, they will not reach a critical mass of enrollees as early or often as IHPs. The “round robin” approach for members who do not actively choose an IHP or MCO will facilitate appropriate, fair distribution of membership for each entity to reach critical mass of enrollment.

**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.**

To ensure a bidding entity has a sufficient network structure, the Request for Proposal (RFP) must provide an even playing field for both IHPs and MCOs in its requirements. Requirements should focus on ability to meet core care management capabilities, network adequacy and aligned to DHS reform goals.

As discussed above, because the proposed “primary care exclusivity” model creates inherent challenges related to member attribution and network build, we encourage the state to re-think that approach. However, if DHS is committed to “primary care exclusivity”, the RFP scoring should include weighting adjustments that considers the fact that limiting primary care clinics in contracting with either an IHP or an MCO will create challenges, particularly for MCOs, to meet network adequacy standards (as referenced above). Limiting primary care clinics in their ability to contract with more than one entity will likely create scarcity of available primary care clinics with which to contract in the market, creating barriers to meeting minimum contracting standards, therefore potentially preventing MCOs from bidding. RFP scoring should assess tactics such as clinical approaches, experience, care management, valued based contracting tactics and innovation to drive improved health outcomes, influence utilization and control costs.

Additionally, through the requirements of the RFP, we recommend that Minnesota advance a system of integrated physical and behavioral health care under the manage care umbrella. Doing so would provide significant benefit to the State and its consumers by reducing expense and administrative complexity, improving both beneficiary and provider experience, and increasing system capacity for behavioral health innovations. DHS should consider requirements that align with the following three pillars to advance an effective behavioral integration strategy:

- Integrated care model: An approach that incorporates person-centered, trauma-informed care management for physical health, behavioral health, and social services and supports a single clinical model under the MCOs.
- Network curation strategy that reflects integrating the physical and behavioral networks and demonstrates use of value-based, pay-for-performance contracts to reward and drive integration at the provider level.
- Integrated technology: A holistic clinical approach and integrated approach can only be achieved if there is an underlying technology infrastructure that supports comprehensive data exchange and clinical integration.

**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?**

As discussed above, administrative services including claims processing, customer service, provider enrollment, integrity, appeals & grievances, providing data on cost and quality, among others, are critical to a managed care entity's ability to engage with members, deliver care management strategies, close gaps in care, and pursue value-based purchasing models. As such, these types of administrative services should be required of both MCOs and IHPs at the launch of the program.

DHS should phase in and incrementally increase the percentage of reimbursement that is at-risk for quality and outcome metrics over time. MCOs that are entering the market through this procurement will not have the experience with the population required to take-on significant risk within the first year. We recommend that DHS put a small percentage of payment (1% or less) at-risk in the first year, tied to achieving process and reporting goals to ensure infrastructure is being put in-place to achieve quality and outcomes goals, to provide managed care entities the experience with the population necessary to advance strategies that will improve quality and outcomes going forward. Over time, as those strategies grow more sophisticated, the state can incrementally increase the portion of the payment at-risk.

**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?**

It is important to ensure that all bidders, regardless of whether they are MCOs or IHPs, be held accountable to the same standards, regulations, and requirements. Such an approach maintains equitable beneficiary rights and protections regardless of what type of plan an individual enrolls in, ensures consistent product quality across the program, and reduces administrative burden for DHS as it defines program requirements and monitors plan performance.

Through the competitive procurement process, DHS should look to bidders that show a track record of success, references from other states that offer descriptions of the entity's successful and innovative management of populations and services that are evidence-based and patient-centric. Awardees should be assessed for their readiness to execute on contract terms prior to the implementation deadline. Ongoing oversight will be also be necessary for contractors to demonstrate compliance with the terms of the contract in addition to performance monitoring to ensure contractors continue to meet their obligations.

As with any type of procurement, ensuring that awarded contractors have experience in the topic at hand is critical. At a minimum, DHS should look to the following qualifications to evaluate a responder's ability to implement the state's proposed program:

- Working knowledge and demonstrated history with Medicaid regulations and low-income populations;



- Internal managed care culture and robust systems that can integrate across finance, operations, and medical management;
- Sufficient financial capital; and,
- Robust data analytic capabilities.

**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?**

We encourage DHS to reconsider its transition to a single PDL. Studies have shown that leveraging a single PDL actually leads to increases in overall drug spending rather than containing cost. When managed care entities are provided the latitude to administer the PDL, they can leverage their clinical data and analytical tools to promote the use of the least expensive, clinically effective medication. Drugs placed on the PDL can be prescribed without authorization by the plan and non-preferred drugs can be accessed by plan members through prior authorization.

Retaining administration of the PDL with the managed care entities will allow the state to control pharmacy costs, optimize the drug mix to achieve programmatic cost savings, and ensure member access to appropriate, cost-effective medications.

Through their clinical and analytical capabilities, MCOs have access to the data and tools to understand the most clinically-effective drugs across the wide price spectrum prescribed to their members. As true drug prices are not transparent to prescribers or members, under a broad and uniform statewide PDL there is no mechanism to prevent the prescription of a high cost medication even in the case when a cheaper generic option may be available. Ensuring the appropriate mix, balanced among generic and brand name drugs, is the most effective tool states have to control pharmacy costs. Statewide PDLs are intended to drive administrative, and therefore cost, efficiencies in the system, but are actually more likely to be overly inclusive of high-cost, brand name prescriptions that increase overall cost.

**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?**

Through ensuring consistency in membership (by locking members into a particular plan model for longer than one month at a time) and incentivizing primary care, the state can help IHPs balance risk and work toward quality incentives. However, taking on risk with the appropriate reserves, administrative functions, and beneficiary protections in-place necessary to succeed in this model, the challenges for providers to sustain the model financially may prove a disincentive for providers to participate.

At its core, the partial risk financing structure for IHPs will create challenges for DHS in achieving system change through the provider-led model. Full-risk capitation financing is preferred to effectively align incentives and accountability throughout the delivery system and drive system transformation that will improve care delivery and control costs. A partial risk

model that relies on fee-for-service reimbursement for certain services creates inherent roadblocks in aligning incentives across the entire system.

To drive the greatest level of success for this model, DHS should work with a contractor such as an MCO to drive accountability through the entire system while effectively managing risk. As discussed above, contractors with deep experience in transformative practice strategies and value-based contracting efforts will help Minnesota drive toward value-based care, align alternative payment models within the program, and ensure effective, sustainable delivery system transformation.

**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?**

Numerous states are leveraging their Medicaid health plan partners to implement programs that interact with social services and community-based providers to create a more holistic care model. A critical first step in these efforts is identifying the specific social determinant of health (SDOH) drivers in a state or local community to ensure the most effective use of funding. Tackling a large number of SDOH factors concurrently in either system (MCO or Next Generation IHP) would generate considerable burden for DHS (and providers participating in these pilots, both healthcare and social) and create less impactful program design and outcomes. Thus, we encourage DHS to invest strategically in “need” areas identified through an initial and comprehensive review of SDOH data. For example, DHS could consider pathways to provide IHPs and MCOs with early access to community and SDOH data to allow contractors to couple social experiences with healthcare experiences, allowing the identification of effective interventions to be driven organically. The health risk assessment (HRA) process also could be leveraged to collect additional information on individuals such as vulnerability for food insecurity or housing status. Additionally, given IHP and MCOs’ role in coordinated care and prevention they can serve as a front-line partner to facilitate SDOH efforts in the Medicaid program once the key SDOH issue areas have been isolated.

Data sharing across the various partners engaged in integrated healthcare/social services programs (such as community-based programs) can be challenging, as these entities’ systems typically do not interface or “communicate” with one another. In some cases, providers may have extremely limited or no health information technology infrastructure to facilitate communication with other providers. Furthermore, there are no standardized approaches or measures for successful outcomes across these various provider types, and the regulations governing each of these entities will differ, particularly regarding data sharing. In light of these challenges, we encourage DHS to consider the following strategies to enhance the use of alternative provider types to support this work:

- Reimburse for community health workers and peer support specialists, at a minimum, as a viable and critical component of community-based care team
- Ensure data infrastructure but allow choice of hardware/software to provide IHPs/MCOs the ability to innovate how data and systems are used to address SDOH “hot spots”
- Leverage a telehealth and mobile health policy that is flexible
- Align and connect with state and local public housing agencies
  - Develop a strategy to engage with additional community partners to address:
    - Individuals coming in and out of criminal justice system
    - Programs/providers that focus on reunification of families/family stability



- Deinstitutionalization
- Increased access to healthcare services

DHS can also create sufficient flexibility for IHPs/MCOs to use “in lieu of services” to provide an array of services that assist individuals and families with complex and acute health conditions with state flexibility and approval to consider accounting for the cost of these services (outside to those identified above). Example services could include vocational placement assistance, housing search assistance, advocacy with landlords to rent units, and eviction prevention. We also encourage DHS to ensure that “in-lieu-of” services are encounterable services and counted toward the MLR numerator calculation.

It is important to note that using “in-lieu-of” services to deliver care should be a short-term strategy. DHS should monitor and trend the use of in-lieu of coverage requests to determine if the collective needs of Medicaid beneficiaries and the anticipated cost savings achieved for providing coverage warrant defining specific services as Medicaid covered benefit (either as an entitlement or for a subset of the Medicaid population). This approach also maximizes funding opportunities for the State. In addition, we encourage DHS to consider defining a subset of vital housing and employment support services for vulnerable populations, similar to Virginia and Washington, through 1115 waiver authority as permitted under CMS guidance.

**9. How much of the entities’ payment should be subject to performance on quality and health outcome measures? Please explain your answer.**

The level of the entities’ payment at-risk for quality and health outcomes should be a percentage that is actuarially sound based on the health risk of the population, should not exceed the entities’ profit, and should be based upon metrics that are challenging but ultimately realistically attained in the timeframe allotted.

In the first year of the program, metrics tied to performance should be focused on reporting and process, ensuring that the proper infrastructure is established to support success in achieving improved health outcomes. In subsequent years, metrics should transition to outcomes as the system matures with achieving reporting and process-related measures becoming table stakes.

**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?**

In addition to those cited, we recommend aligning quality requirements with the Medicaid Adult and Child Core Measures and the National Committee for Quality Assurance (NCQA) Medicaid Accreditation Measures with the program. The Accreditation and Medicaid Core Measure sets address the most critical aspects of the delivery system that touch the broad Medicaid population, including prevention, clinical management, and health plan efficiency and management. The holistic nature of these measure sets will help states reduce overlap and administrative inefficiency in the collection and reporting of data among both MCOs and providers.

Additionally, per the requirements of the Medicaid Managed Care Final Rule published in 2016, CMS is in the process of designing a Medicaid Quality Ratings System (QRS); beginning in 2021 states will be required to issue annual quality ratings for each managed care plan leveraging the QRS or a federally-approved, state-based alternative framework. We recommend





that DHS align quality requirements with the proposed federal QRS once available for state review.

**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?**

For DHS, success in this program is defined by the long-term sustainability of an accountable delivery system. To that end, integrating social determinants of health as a part of the scope of the health care delivery system is paramount to break down siloes, leverage true whole-person health care strategies, and reduce overall costs.

Long term sustainability requires a purchasing and reimbursement structure that does not place undue financial burden on the managed care entities driving the delivery model. Requiring a portion of the managed care reimbursement to be used for non-covered services to directly address social determinants will place an undue financial burden on managed care entities and is currently in conflict with actuarial soundness requirements.

In our experience, populations in need of integrated social determinants of health solutions have considerably higher medical and behavioral need than the average population. Therefore, to ensure financial viability of the program, we recommend that DHS provide an enhanced payment, either through a risk adjustment methodology (presuming availability social data to inform risk adjustment) or a prospective high cost risk mitigation strategy, to the managed care entities in order to address social determinants of health. As an alternative approach the state could provide sufficient flexibility to cover non Medicaid benefits through in-lieu of services as described in the answer to question 8.

An enhanced approach to develop actuarially-sound payment will allow the managed care entities to provide the highest levels of wrap around services to those in the greatest level of need without putting the program at undue financial risk. It is likely that a more coordinated approach to addressing the social determinants of health will increase demand for services and stress the social service delivery system's capacity. We encourage DHS to consider these dynamics when developing IHP and MCO requirements.

To address both the clinical and social determinant needs for the full population, and for targeted, high cost populations, DHS should work with MCOs in engaging other state and local governments in data sharing. Access to behavioral health / substance abuse disorder medical records and information held in other parts of the system, including corrections, will serve as critical resources to engage these members in the community in a timely manner. Enhanced administrative allowances in the managed care reimbursement structure would also help incentivize coordination in this area.

**12. Do you have any other comments, reactions or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?**

MCOs and IHPs should have sufficient flexibility to develop strategic partnerships and subcontractor relationships to support administrative functions. For example, IHPs should be allowed to contract with third parties to take on end to end administrative support to ease the burden with DHS to provide those services and allow for competitive bidding of those services by IHPs to drive system value.

Experienced MCOs can provide an array of services that assist individuals and families with complex and acute health conditions, inclusive of social determinants of health. Minnesota should create sufficient flexibility for MCOs to create strategic partnerships to drive these types of innovative strategies either within the Next Generation IHP program or through a separate contracting arrangement.

Among the services that could be covered include, but are not limited to: coordination with primary care and health homes, coordination with substance use treatment providers, housing search assistance, motivational interviewing, and coordination with hospitals/emergency departments, advocacy with landlords to rent units, eviction prevention, and more.

*Developing Housing Partnerships*

MCOs can develop partnerships and provide services and supports to connect individuals and families with complex health needs and histories of housing instability and/or homelessness. Among the partnerships that should be explored are:

- **Local public housing agencies (PHAs):** Health plans can develop collaborations with local public housing agencies to help identify residents and connect them to the healthcare they need. Health plans could place outreach workers at public housing developments, develop protocols with PHAs to connect residents to healthcare via PHA case management staff, etc. In particular, health plans can engage with PHAs that are “moving to work” PHAs, such as the Minneapolis PHA, which provides additional flexibility to create these types of partnerships.
- **Local Continuum of Care (COC):** Health plans can create partnerships with local COCs and partner with them to identify and conduct outreach to homeless plan members. Health plans can also do data matches with Homeless Management Information System (HMIS) data to identify plan members, and can also contract with service providers in the COC to connect people to housing.
- **Affordable and Supportive Housing Providers:** Health plans can develop relationships and networks with local affordable and supportive housing providers to improve chances of locating housing for homeless and housing unable individual and families. Health plans can provide these owners with connections to health care for their members. Key housing owners including Project for Pride and Living, Common Bond, Aeon, and Community Development Housing Corporation should be engaged.

*Additionally, MCOs can provide services that support two specific populations:*

- **Individuals exiting (or being diverted from) jail or prison:** In addition to the services above, health plans could use “in lieu of services” to coordinate with county jails and state prisons to more seamlessly and effectively transition individuals from incarceration into the community, with connections to healthcare and supports they need. They could also develop partnerships with problem-solving courts, such as mental health court, to ensure there is a “diversion to where and what?” plan. Health plans could provide “in-reach services” so they could connect with individuals and build relationships trust before the individual is released. Health plans could also cultivate a network of non-medical partners to improve support for individuals, including landlord networks for housing, peer support and mentoring programs, etc.
- **Families involved in the child welfare system:** Health plans could develop partnerships with state and county child welfare agencies to identify and better serve families in the child welfare system – and keep them together rather than the kids going to foster care when there is not abuse/violence etc. Health plans could provide parenting programs and family support groups and mentoring programs. Health plans could also partner to provide programming on healthy living and more for children.

Based on a strong evidence base, MCOs could expect to see a reduction in health care utilization and costs if they provide these in lieu of services to populations that with acute and complex needs and histories of extensive involvement in crisis systems of care, including jails, hospitals, prisons, detox, etc.

**From:** Randall Seifert  
**To:** [MN\\_DHS\\_DHS PSD Procurement](#)  
**Cc:** [Todd Sorensen](#); [Joel Farley](#); [Steve Schondelmeyer](#)  
**Subject:** Comments  
**Date:** Tuesday, December 19, 2017 10:13:45 AM

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Randall Seifert, PharmD  
University of Minnesota College of Pharmacy  
Associate Dean  
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Comments:

Question 3:

We would suggest consideration of adding a high performance pharmacist comprehensive medication management network. This network could be contracted to manage and support patients who have complex medications and/or have special needs requiring additional support for adherence etc. There are models for value-based performance pharmacist networks. These networks have demonstrated a high ROI but require effective data and communication links. In addition, this would open up access and support the primary care initiatives.

Question 6

We support the concept of a single Preferred Drug List (PDL), however there will need to be a process for making decisions. A PDL offers a strong opportunity to manage costs, increase leverage and improve system efficiency but requires a well defined process for managing the formulary.

We would like to add one additional comment to encourage IHP mental health providers to integrate comprehensive pharmacist services into the mental healthcare team. There are several organizations with pharmacist integrated care models that are proving successful in addressing some or all of the four key domains for evaluating the impact and quality of care outlined in the Next Generation IHP proposal.

Thank you for the opportunity to provide comment.

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An association of resources and advocacy for children, youth and families  
[www.aspiremn.org](http://www.aspiremn.org)

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December 20, 2017

Response to Request For Comment – Next Generation Integrated Health Partnerships

Submitted by: Kirsten Anderson, Executive Director, AspireMN  
651-290-6272, [kanderson@aspiremn.org](mailto:kanderson@aspiremn.org)

To: [DHS.PSD.Procurement@state.mn.us](mailto:DHS.PSD.Procurement@state.mn.us).

Delivering quality services to children and youth in need of mental health and other supports to assure their wellbeing and the health of their families is representative of the mission and interest of the diverse membership of AspireMN. Key members from the association have developed the following comments to further inform the process within the Minnesota Department of Human Services and assure designs for the Next Generation Integrated Health Partnerships (IHP) include children's mental health, and wrap around services to support health outcomes for Minnesota's children, youth and families.

**We are heartened to see the following elements in the IHP design:**

- Identifying the published Medicaid rate as the payment floor for service providers.
- Orienting the health care system around the client, and measuring success based on health outcomes of clients while taking into account social determinants of health and wider community (population) health.
- The Preferred Drug List - drug formulary that guarantees medications will be made available consistently to all accessing care – regardless of the payer within the system. *Knowing medication management and maintenance is a critical part of treatment, we encourage DHS to extend the drug formulary as a standard made available to all – including those who are presently not part of the IHP focus population.*

As IHP design is further developed, we encourage the following considerations:

**Contracting:** Essential core services must include the full continuum of mental health services and interventions for children and families. Due to the nature of our mental health and overall health care system, most of the children's mental health continuum is provided by organizations whose core business function falls within behavioral health and not traditional physical health care. We anticipate our members will be in a position to contract with IHPs and bring value

**AspireMN improves the lives of children, youth and families served by member organizations through support for quality service delivery, leadership development and policy advocacy.**

based on present areas of expertise with children, youth and families. It is critical that the IHP design assure contractors are:

- Welcome to hold contracts with multiple IHPs.
- Are able to exchange data on unique clients served – to share in the IHP learning process based on the experience of serving their unique client population.
- Clients should be able to come into the IHP by designating their mental health service provider as their path to designating their IHP, and select their Primary Care Provider to determine their IHP based on their interest in maintaining their relationship with their children’s mental health or other critical relationship with a contracted service provider.
- As valued contractors providing a core service, contracting should be designed recognizing the potential to mutually define and share in performance payment.
- The proposed framework states that Next Generation IHP networks will be supplemented with the current DHS FFS network. Please incorporate this into the final framework. This will ensure that children and families will be able to continue to access their community provider of choice, even if the IHP does not contract with that community provider.
- IHPs should be required to demonstrate and be incentivized to contract with a broad provider network that allows for client choice in provider access and responsiveness to changing needs (outside of their primary IHP entity).
- IHPs should have accountability to markers of success that go beyond geographical counts of providers.
- IHP entities should be required to demonstrate how consumer choice of providers is respected.
- A clause for no financial “take backs” for services previously authorized and provided should be included in contracts.

**Population health:** Innovative approaches to service delivery are being achieved on a daily basis as mental health service providers provide quality treatment to children and youth, psychotherapy and education to families, and wrap-around services. With extensive background in responding to population health as an integrated part of service delivery, the children’s mental health continuum of service providers need to be in continuous consultation in the process of population health approaches, measures, and evaluation. A component of the deep-level collaboration and learning related to enhancing population health should include the ability to access and creatively deploy designated funds within the IHP by this group of expert contractors.

- Children’s mental health delivery standards should take into account reliance on active parent/caregiver involvement (rather than based on an adult mental health model).
- IHPs should demonstrate an ability to have an impact on client’s environmental context and its impact on mental health functioning (e.g. housing, childcare for other children in the family, violence in the neighborhood, access to transportation).
- This IHP system should demonstrate an awareness of the unique health care approach needed to effectively serve children.

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### **Residential Treatment, Day Treatment and Foster Care:**

- Residential treatment providers are compensated based on a formula set between DHS and County payers. IHP design needs to accommodate this current standard of compensation and bring expert provider partners to the table to determine how a new payment concept and mechanism would apply to this critical service.
- Choice of service provider is a valuable part of a healthy system. Today, the notion of making a clear choice in residential treatment is clouded by county placement decisions and very practical access issues. We anticipate wait lists to access residential treatment that may result in a child or youth waiting months to access needed services. IHP design must acknowledge this challenge, and, ideally support the children's mental health continuum to further build capacity to care for children, youth and their families.
- High prevalence of trauma that is experienced by children who are in residential, day treatment and foster care should be reflected in the service delivery models developed.

### **Performance measures:**

- A health care system that compensates all parts of the system for the right things is a universal goal. When applied to children's mental health, performance measures must take into account social determinants of health, (a noted and important part of this approach) **and be designed in collaboration with the provider community.**
- Medical necessity for ongoing services should be made in a manner that accounts for environmental factors in children's lives (e.g. parent's ability to provide a safe and nurturing environment that supports improved mental health functioning).

The opportunity to submit comment on the Next Generation Integrated Health Partnerships design is most appreciated. We look forward to providing supportive contributions to this process going forward.

**From:** Dave Lee  
**To:** [MN\\_DHS\\_DHS PSD Procurement](#)  
**Subject:** Feedback  
**Date:** Monday, November 27, 2017 9:39:27 AM  
**Attachments:** [Cost benefit of integrating behavioral health.docx](#)  
[Economics of Integrated Behavioral Healthcare.docx](#)  
[us-social-determinants-and-collaborative-health-care.pdf](#)  
[Lexicon\\_ExecSummary.pdf](#)

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Good Morning, I appreciate the effort to move Minnesota's purchasing of healthcare from a "volume" base to a "value" base. Considerations:

- \* One of the largest cost drivers of healthcare is untreated behavioral health services
  - o Over utilization on the physical medicine side
  - o Depression/anxiety is the highest representation in comprehensive claims data for chronic conditions
  - o Other systems also see increased costs
- \* Corrections
- \* Educational settings
- \* Loss of productivity in commerce/business sector
- \* Lack of access for behavioral health services
  - o Stigma
  - o Lack of treating professionals
  - o Treated in silos – segmented care
  - o Funding
- \* Promising solutions exist
  - o Integrated behavioral healthcare is well researched with significant positive outcomes
  - \* Better health for patients
  - \* Higher satisfaction for both patients and providers
  - \* Lower costs
  - o Fairview, Mayo, FQHCs across MN are early adopters
  - o Range of integration exists – Lexicon for the range of options  
<https://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>
- \* Current barriers
  - o Fee for service funding creates many roadblocks to make it work financially
  - o "Value" purchasing incents providers to rethink how they provide services
  - o Both medical providers and behavioral health providers need to change their paradigm to treat holistically
  - \* One patient, treated by one Team (above and below the neck) in one location/exam room, on one visit, paying one bill
- \* Technology can help
  - o Use of a single, interoperable, telehealth platform can allow for all providers to collaborate and integrate care for patients
  - \* Any primary or specialty care provider can provide integrated care with a telebehavioral health provider via internet-based telecare
  - \* Minnesota MNITs is providing leadership to develop a public/private, single platform telepresence network (Vidyo)that could be leveraged for this purpose

Thank you for soliciting feedback!

Dave Lee

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Publications Newsletters Quality Matters August/September 2014 In Focus: Integrating Beh...

## Quality Matters

*Quality Matters* offers reports on emerging models and trends in health care quality improvement and interviews with leaders in the field.

- August 28, 2014 Issue

### **In Focus: Integrating Behavioral Health and Primary Care**

By Sarah Klein and Martha Hostetter

**Summary:** *New payment models that reward providers for simultaneously improving health outcomes and reducing health care spending may provide an impetus for integrating behavioral health and primary care services. Such integration has long been recommended but has been difficult to achieve because restrictive payment methods and practice patterns have impeded collaboration.*

Behavioral health conditions are extremely common, affecting nearly one of five Americans and leading to health care costs of \$57 billion a year, on par with cancer. Conditions such as depression can be very disruptive, occurring among younger as well as older Americans and leading to significant disability and lost income.<sup>1</sup> In spite of this, behavioral health care is mostly separated from the primary care system—a practice that the Institute of Medicine concluded nearly 20 years ago was leading to inferior care.<sup>2</sup> In the intervening years, evidence has continued to mount that having two, mostly independent systems of care leads to worse health outcomes and higher total spending, particularly for patients with comorbid physical and behavioral health conditions ranging from depression and anxiety, which often accompany physical health conditions, to substance abuse and more serious and persistent mental illnesses.

Part of the problem is that the majority of patients with behavioral health problems—as many as 80 percent—present in emergency departments and primary care clinics, where providers often lack the time, training, and staff resources to recognize and treat behavioral health conditions.<sup>3</sup> By some estimates, 60 percent to 70 percent of these patients leave medical settings without receiving treatment for behavioral health conditions, even though this increases the odds that they will have difficulty recovering from their medical conditions.<sup>4</sup> Some patients do enter the behavioral health system, where the vast majority of clinical social workers, psychologists, and psychiatrists work—either in independent practice or in clinics and hospitals that treat mental

health and substance abuse problems exclusively.<sup>5</sup> But many patients referred for behavioral health treatment do not follow through, adding to the cohort of patients who receive no care.<sup>6</sup>

*If we are going to look to develop a high-performing health care system that deals with the totality of medical costs—ignoring mental health and substance use as drivers of costs and human suffering will not work. These illnesses are too big to ignore and too important.*

*—Paul Summergrad, M.D., American Psychiatric Association president*

Failure to recognize and appropriately treat behavioral health conditions has a significant impact on health outcomes and costs: patients with these diagnoses use more medical resources, are more likely to be hospitalized for medical conditions, and are readmitted to the hospital more frequently.<sup>7</sup> Some of these patterns are reflected in an analysis commissioned by the American Psychiatric Association (APA) that found **spending for patients with comorbid mental health or substance abuse problems is 2.5 to 3.5 times higher than for those without such problems—with the vast majority of spending going to general medical services, not behavioral health.**<sup>8</sup> For example, almost half of those who die from tobacco-related illnesses also have a serious mental illness, according to Paul Summergrad, M.D., the APA’s president, though those with serious mental illnesses make up only 6 percent of the U.S. population.<sup>9</sup>

## **Barriers to Integration**

This evidence—combined with the growing recognition that physical, mental, and social challenges are interrelated—has led to calls to integrate behavioral health care into primary care services.

Some of the most well-tested models for integrating behavioral health services into primary care focus on training primary care providers to use evidence-based practices in screening for and treating depression, anxiety, and other conditions that can be effectively managed in primary care settings. These models often also include a care manager or behavioral health specialist who follows up with patients and monitors their response and adherence to treatment. The main goal of most of the integrated care programs is to improve communication between behavioral health and primary care providers and thereby improve care coordination.

Two of the best-known approaches—the Collaborative Care and TEAMcare models—were developed at the University of Washington. A key aspect of the Collaborative Care model is the strategic use of psychiatrists, who are in limited supply, to provide consultations to primary care providers, with a focus on patients who don’t make progress or who have more serious mental illnesses. A 2012 review of 79 research trials documented that this model significantly improves depression and anxiety outcomes, compared with standard primary care.<sup>10</sup> The TEAMcare approach encourages the simultaneous treatment of mental conditions such as depression and medical conditions such as diabetes and/or cardiovascular disease using teams of behavioral health and primary care providers. The model is designed to prevent situations in which one poorly controlled chronic condition lessens the effectiveness of the treatment of another. (See the accompanying **profiles** to see how different health care organizations are using these and other approaches to integrate behavioral health into primary and other care settings.)

Behavioral health integration is still rare, and the integration of substance abuse services even rarer, in part because there's been little or no financial incentive or administrative advantage to bringing what are now standalone medical and behavioral health operations together. Payers use separate provider networks, billing and coding practices, accreditation metrics, and record-keeping requirements. This makes a team-based approach to care difficult to finance and structure—whether it's achieved by including behavioral health professionals in primary care settings or medical practitioners in behavioral health settings. Primary care practices that seek to enhance behavioral health services face restrictions on the types of services they can bill for and reimbursement rates are often low. And sometimes there are pre-approval requirements or other restrictions that make it difficult for behavioral health care providers to work side by side with primary care clinicians. "Payment is the heart of the problem," says Roger Kathol, M.D., president of Cartesian Solutions Inc., a Burnsville, Minn.-based consulting firm that advises health systems, health plans, and other purchasers on sustainable strategies for integrating behavioral health and physical health services.

*Health care as a system has not evolved to align financial mechanisms, practice delivery, training, and education, and even our community expectation, to support a model of care that integrates behavioral health.*

*—Benjamin Miller, Psy.D., director of the Eugene S. Farley, Jr. Health Policy Center, University of Colorado School of Medicine*

Medical training that bifurcates physical and behavioral health care also impedes collaboration, as do privacy regulations that prevent providers from sharing information about mental health and substance abuse. There is also an enduring stigma attached to mental health problems, which discourages some patients from seeking help and some providers and other caregivers from getting involved. Education and firsthand experience can help lessen the stigma. A national program, [Mental Health First Aid](#), is training providers, schools, clergy, first responders, and laypeople how to respond when someone has a panic attack, psychotic episode, or appears depressed or suicidal.

In addition, integration requires both primary care and behavioral health providers to change the way they work. Primary care providers—pressed for time and burdened with multiple priorities—often prefer to refer patients with mental or substance abuse problems to specialists, while behavioral health providers may be hesitant to practice in primary care settings in part because it requires a new skill set, according to Michael Hogan, Ph.D., former commissioner of mental health for New York State and former chair of George W. Bush's President's Commission on Mental Health. "As part of a team, behavioral health providers have to deal not only with depression and anxiety but also heart failure and diabetes," he says. In similar fashion, primary care providers must be comfortable talking about behavioral health issues, particularly substance abuse.

Many of the health care organizations that have made progress in integrating behavioral and primary care have either funded the initiatives themselves or relied on grants. (According to a 2011 survey, 78 percent of primary care providers who have integrated behavioral health services into their practices said they pay for them with the help of grants.<sup>11</sup>) Others have taken advantage of Medicare and Medicaid demonstration programs and waivers that enable them to

accept global payments for delivering both types of services. And some health systems have been willing—at least in the short run—to absorb the costs of adding behavioral health services to primary care. For example, Boston Medical Center, an academic medical center and safety-net provider, is covering the cost of adding social workers, psychiatric nurse practitioners, and patient navigators into its family medicine practices on a trial basis. Part of the rationale is that the investment may help the medical center succeed in future value-based contracts, or as an accountable care organization, by allowing it to share in any savings that accrue from improving outcomes and reducing costs.

Indeed, behavioral health integration is likely to grow as purchasers increasingly move away from fee-for-service payment models and providers are given responsibility for the overall health of patient populations.

### **Global Payment Initiatives**

The Colorado-based Rocky Mountain Health Plans—in partnership with the family medicine department at the University of Colorado–Denver and the Collaborative Family Healthcare Association, a nonprofit that promotes collaborative models of primary care—is testing whether a global payment model can support the provision of behavioral services in local primary care practices. Under the SHAPE pilot (Sustaining Healthcare Across integrated Primary care Efforts), which was launched in 2012, three practices in Western Colorado that have already integrated behavioral health care are receiving global payments to pay for team-based care, with three integrated practices that earn fee-for-service payments serving as the controls.

Instead of offering supplementary per-member/per-month payments to reimburse practices for delivering behavioral health care, as some insurers have done, SHAPE's leaders opted for a global payment approach in order to reimburse practices for the full costs of providing behavioral health care—taking into account staffing resources as well as the number and complexity of the patients served. The global payment also provides practices with flexibility to determine which services will produce the best results, and to dedicate time to panel management, care coordination, and other "in-between-visit" activities that may lead to big health gains.

"We don't want behavioral health providers to be trapped by requirements to demonstrate productivity by the volume of traditional mental health services they render or to earn their 'keep' through a fee-for-service revenue model," says Patrick Gordon, associate vice president at Rocky Mountain Health Plans. "We think that pulls them away from the care team, pulls them away from activity that might add value but can't easily be coded."

Participating practices are held accountable for patients' total costs of care: they stand to lose part of their payment if they do not meet certain budgetary and quality benchmarks, and can also earn incentive payments for demonstrating improvement in health outcomes.

The long-term goal of this effort is "to show what's possible when you can actually create a global budget," Gordon says. "You can allocate resources to create value, and set up aligned

gain-sharing mechanisms (for example, with community mental health centers and primary care providers). It's accountability and gain-sharing mechanisms that pull people together."

## Roles of Medicaid and Medicare

Medicaid is a major purchaser of behavioral health services—accounting for more than a quarter of all behavioral health spending nationally—and its beneficiaries who have behavioral health conditions on top of chronic medical conditions are much more expensive than those without such conditions.<sup>12</sup> (According to the Kaiser Family Foundation, more than one-third of Medicaid beneficiaries have a mental illness, and of those 61 percent have a comorbid medical condition.<sup>13</sup>)

As detailed in a Commonwealth Fund [report](#), state Medicaid agencies across the country are seeking to make administrative, purchasing, and regulatory reforms in order to promote integrated care for Medicaid beneficiaries with comorbid physical and behavioral health needs. These efforts take on greater urgency in states that are expanding Medicaid under the Affordable Care Act, since many of these newly insured are at high risk for having behavioral health problems.<sup>14</sup>

Massachusetts' Medicaid program (MassHealth) is seeking to promote integrated care through payment reform. Under its Primary Care Payment Reform Initiative, primary care providers are offered a risk-adjusted capitated payment for primary care services, including behavioral care, with an annual incentive payment for meeting quality benchmarks and an opportunity to share in savings for reductions in non-primary care services, such as hospitalizations. The initiative aims to enhance coordination across providers, increase accountability for the total cost of care, and integrate behavioral health services.

Through its One Care program, Massachusetts is seeking to improve care for those under age 65 who are dually eligible for Medicaid and Medicare, including by integrating behavioral and primary care (49 percent of dual eligibles have a behavioral health diagnosis in a given year.)<sup>15</sup>

Peggy Johnson, M.D., chief of psychiatry at Commonwealth Care Alliance (CCA), a nonprofit health plan and delivery network and one of the providers contracted by the state under One Care, notes that those with a serious and persistent mental illness tend to die 25 years earlier than the general population—not because more of them commit suicide but because more of them suffer from conditions like cardiovascular disease. "There is a compelling need for a primary care presence to be actively engaged with these patients," Johnson says. In CCA's model, social workers and psychologists conduct behavioral health assessments and provide consultation, education, and support to primary care teams regarding behavioral health treatment, resulting in individualized care plans. Care coordinators also work with hospitals to help oversee care for patients who have been admitted for mental health or substance abuse treatment.

There are also efforts being made to improve behavioral health care for Medicare beneficiaries. The Centers for Medicare and Medicaid Services has awarded a consortium of health care systems and health plans, including Kaiser Permanente Southern California and the Mayo Clinic Health System, \$18 million to test another model, Care of Mental, Physical, and Substance-Use

Syndromes (COMPASS).<sup>16</sup> In the COMPASS model, which incorporates aspects of the University of Washington's Collaborative Care model of behavioral health integration and others, a primary care practice-based care manager meets weekly with a consulting psychiatrist and a consulting internist (or family practice physician) to review the care of patients with depression and diabetes and/or coronary artery disease. Together, the team makes sure it is moving toward medical as well as patient-identified goals. One-third of Medicare patients have diabetes and another 30 percent have coronary artery disease. When depression accompanies these conditions—which it does about 15 percent of the time—health care costs are about 65 percent higher.<sup>17</sup>

The care managers, who are registered nurses, social workers, psychologists, and in some case specially trained medical assistants, also address life stressors that may interfere with treatment. "We're finding that for a lot of folks who have been disengaged in care, social challenges are a real problem," says Claire Neely, M.D., medical director at the Institute for Clinical Systems Improvement, which is leading the COMPASS demonstration. The program's impact on cost and utilization, including emergency department and hospital use, is still under evaluation, but very preliminary results based on a small number of patients suggest it is having a positive impact on outcomes. Among diabetic patients who have been in the program for more than four months, the percentage of patients with hemoglobin A1c levels below 8 percent increased from 28 percent at baseline to 51 percent. More than half (53%) of patients who entered the program with uncontrolled blood pressure and remained in it for at least four months have the condition under control. And among those with depression, 39 percent are in remission. The program has also been well received by doctors. "Primary care physicians say, 'Oh, my gosh. Those are my patients who I couldn't get to move, ever. Now they are heading in the right direction,'" Neely says.

### "Perfect Storm" Encouraging Integration

While there are still significant barriers to integrating behavioral health and primary care, there are also several forces encouraging it, among them: new payment policies, including models that begin to hold providers accountable for controlling overall costs, and demonstration programs led by Medicaid and Medicare. Mental health parity laws that prevent insurers from placing greater financial requirements (e.g., copayments) or treatment restrictions on mental health or substance abuse care than they do on medical care also help, as does the fact that private health plans sold through the Affordable Care Act's health marketplaces must now include behavioral health benefits.<sup>18</sup> Convenience for patients and their desire to avoid the stigma still attached to separate psychiatric care are also factors. "All of this," says Hogan, "is creating a perfect storm to encourage integration."

### Notes

<sup>1</sup> A. Soni, "The Five Most Costly Conditions, 1996 and 2006: Estimates for the U.S. Civilian Noninstitutionalized Population," Statistical Brief #248 (Rockville, Md.: Agency for Healthcare Research and Quality, July 2009). Note that this estimate does not include those with substance abuse disorders. Also see National Institute of Mental Health, [http://www.nimh.nih.gov/statistics/1ANYDIS\\_ADULT.shtml](http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml).



<sup>2</sup> Institute of Medicine, *Primary Care: America's Health in a New Era* (Washington, D.C.: The National Academies Press, 1996.)

<sup>3</sup> R. G. Kathol, S. Melek, and S. Sargent, "Mental Health and Substance Use Disorder Services and Professionals as a Core Part of Health in Clinically Integrated Networks." In *Clinical Integration: Accountable Care & Population Health*, third edition, eds. K. Yale, J. Bohn, C. Korschak et al. (Virginia Beach, Va.: Convurgent Publishing, forthcoming).

<sup>4</sup> Kathol, Melek, and Sargent, forthcoming.

<sup>5</sup> Kathol, Melek, and Sargent, forthcoming.

<sup>6</sup> Institute of Medicine, 1996.

<sup>7</sup> Kathol, Melek, and Sargent, forthcoming.

<sup>8</sup> S. P. Melek, D. T. Norris, and J. Paulus, *Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry* (Denver, Colo.: Milliman Inc., April 2014.)

<sup>9</sup> National Alliance for the Mentally Ill, "Mental Health Facts and Numbers," [http://www.nami.org/factsheets/mentalillness\\_factsheet.pdf](http://www.nami.org/factsheets/mentalillness_factsheet.pdf).

<sup>10</sup> J. Archer, P. Bower, S. Gilbody et al., "Collaborative Care for Depression and Anxiety Problems," *Cochrane Database of Systematic Reviews*, 2012, Issue 10.

<sup>11</sup> *The Colorado Blueprint for Promoting Integrated Care Sustainability* (Denver, Colo.: Colorado Health Foundation, March 2012).

<sup>12</sup> Truven Health Analytics, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009*, No. SMA-13-4740 (Rockville, Md.: Substance Abuse and Mental Health Services Administration, April 2013) and C. Boyd, B. Leff, C. Weiss et al., *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations* (Hamilton, N.J.: Center for Health Care Strategies, December 2010).

<sup>13</sup> See: [http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383\\_bhc.pdf](http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_bhc.pdf).

<sup>14</sup> D. Bachrach, S. Anthony, and A. Detty, *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment* (New York, N.Y.: The Commonwealth Fund, August 2014).

<sup>15</sup> One Care is part of a demonstration program funded through the Affordable Care Act that aims to develop new care models for those covered by both the Medicare and Medicaid programs. Information on dual eligibles comes from: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, The CBHSQ Report:



Behavioral Health Conditions and Health Care Expenditures of Adults Aged 18 to 64 Dually Eligible for Medicaid and Medicare (Rockville, Md., July 2014).

<sup>16</sup>The COMPASS project was made possible by Grant Number 1C1CMS331048-01-00 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services.

<sup>17</sup>See G. S. Adler, "Diabetes in the Medicare Aged Population, 2004," *Health Care Finance Review*, Winter 2007 29(2):91–101; J. Unutzer, M. Schoenbaum, W. J. Katon et al., "Health Care Costs Associated with Depression in Medically Ill Fee-for-Service Medicare Participants," *Journal of the American Geriatric Society*, March 2009 57(3):506–10; and K. Z. Bambauer, D. G. Safran, D. Ross-Degnan et al., "Depression and Cost-Related Medication Non-Adherence in Medicare Beneficiaries," *Archives of General Psychiatry*, May 2007 64(5):602–08.

<sup>18</sup>By one estimate, the Affordable Care Act's requirement that all non-grandfathered health plans sold through the exchanges provide mental health and substance abuse treatment as one of 10 essential health benefits will benefit some 62 million Americans. See K. Beronio, R. Po, L. Skopec et al., *Affordable Care Act Expands Mental Health and Substance Use Disorder Benefits and Federal Parity Protections for 62 Million Americans* (Washington, D.C.: Office of the Assistant Secretary for Planning and Evaluation, 2013).



### **The doctor will analyze you now**

A health center for native Alaskans brought mental and physical care under one roof, with impressive results. Why isn't it more popular?

By JOANNE SILBERNER

08/09/2017 05:05 AM EDT

As a child growing up in rural Alaska, Vera Starbard was diagnosed with major depression. She'd been sexually abused by her uncle and was plagued by thoughts of suicide. By the age of 10, she'd already spent time as an inpatient in a psychiatric hospital. "It was a really dark time," she says. "And I didn't feel like it was ever going to get better."

But when she was 11, things changed. Her family moved to Anchorage, and they joined the [Southcentral Foundation](#), a health care provider for native Alaskans. The foundation was launching a new approach to health care—one that wove mental health into the rest of its primary care.

For Vera, that meant every checkup included a mental health evaluation. Her primary care team included a psychologist or social worker who offered care on-site. There were a variety of group counseling programs to choose from. Every person she saw had her health record, there were no outside charges, and there was never a wait to make an appointment.

Perhaps most important, accessing mental health treatment was as easy as going to her regular doctor, and there was no stigma attached: Her mental health services were provided at the same time and in the same place as other medical care, just like heading down the hall for an X-ray or blood test.

In Anchorage, she still had a lot to work through, and difficult times ahead. But today, at age 35, she says that Southcentral's approach to mental health care saved her life. "There's a higher than not probability that I would have committed suicide without the resources at my disposal," she says.



Vera Starbard at home in Anchorage, Alaska. A victim of sexual abuse as a child, she credits the easy access to behavioral health care at Southcentral Foundation with helping her overcome profound depression. | Ash Adams for POLITICO

It's a truism that the mind and the body are connected, but the U.S. health care system has long treated them as separate—with separate doctors, separate hospitals, separate payment systems. That's a major reason people with acute mental illnesses don't get help. Ditto for chronic conditions like depression and anxiety. People may not seek help because of stigma. They may not find it because there are too few providers and they are too hard to locate. Or people don't have health insurance, or can't afford the co-pays, or lose interest when faced with a long wait. The result is that many people who need mental health care aren't getting it. According to a [recent article](#) published in the Journal of the American Medical Association, nearly 18 percent of adults surveyed in 2015 reported having a mental, behavioral or emotional disorder. And 20 percent of respondents said either they or a family member had needed mental health care but didn't get it, either because they couldn't afford it, their insurance wouldn't cover it, they were afraid or embarrassed, or they had no idea where to go.

At the patient level, this means people with mental health issues suffer when they don't need to. And at the policy level, there are huge reasons to fix this, primarily the high long-term cost of untreated mental illness. Mental health plays a big role in chronic conditions like hypertension, obesity and diabetes. "You can go ahead and give all the insulin you want," says Donald Berwick, former head of the Centers for Medicare and Medicaid Services, founder of the Institute for Healthcare Improvement and a big proponent of behavioral health integration. "If you're not addressing the attendant behavioral health issues, you're not just missing the chance to reduce suffering, you're reducing the chance to save a lot of money."

In part because of their Alaska Native heritage, which puts a high value on spiritual health, the leaders of Southcentral recognized decades ago that behavioral health is tightly linked with bodily health. So they became one of the early adopters of integrated care. They embedded treatment for mental and emotional ills in their primary care practices, and found that patient satisfaction rates skyrocketed and usage of medical care went down, saving millions of dollars while improving patient outcomes.

In the nearly 30 years since Southcentral hired its first psychologist, pretty much every study has shown that integrating mental health care into medical care results in better patient outcomes and lower costs. A few years ago, analysts at actuarial firm Milliman estimated that integrating medical and behavior health care could shave \$26 billion to \$48 billion each year from the nation's health care costs.

But adoption has been slow, in part because of the way much health insurance is structured. Mental health is often a separate benefit, if insurance pays anything at all. Doctors are paid more for procedures on sick people. They get less if they keep their patients healthy and out of the hospital.

Of all the structural problems in the U.S. health care system, the segregation of mental health care from the rest of medical care is arguably the most costly, both financially and in terms of patient health. With new pressure to find ways to bend the curve of health care costs, and the

bang for the buck as finally integrating mental and physical health care.

**IN THE MIDDLE** of the 20th century, mental illnesses weren't considered illnesses per se; fully debilitating illnesses were seen as "insanities" and their sufferers often confined against their will in special mental hospitals. Illnesses that were less debilitating—milder depressions, say, or anxiety or substance abuse—were viewed as weaknesses of will, often ignored by medical professionals. Payment followed suit; for mental health providers it was low, for primary care providers it was essentially nonexistent.

People had to either figure out a way to live with their conditions, or suffer as their illnesses got more acute. The arrival of more effective medications for mental illnesses opened things up a bit—doctors could write a prescription, and patients could feel better without months or years of talk therapy. Still, several studies in the 1980s showed that many patients didn't get treatment, with as many as one-half of patients saying no when their doctors suggested they get mental health care.

The search was on for something better. In the early 1990s, private foundations and the federal government, through the Substance Abuse and Mental Health Services Administration, began funding clinical studies around the country. Could primary care providers be trained to recognize depression, and get their patients treated? Would that make a difference? The studies showed the answers were yes and yes. In 1996, the Institute of Medicine published a suggestion—integrate primary and behavioral health care so that patients would get diagnosed and treated by their doctors or via direct referral to a behavioral health specialist as part of their routine medical care. Big health care systems like Kaiser Permanente and the Veterans Administration began experimenting with integrating behavioral health care in some locations.



Physician's assistant Ingrid Carlson examines 6-month-old Milo Rebne. Southcentral Foundation's exam rooms have comfortable chairs and minimal equipment – the idea is to encourage conversation between health providers and patients, or in this case Milo's mom, Heather Lee Rebne. | Ash Adams for POLITICO

Southcentral Foundation was ahead of the trend, having started thinking about integrating its care in 1985. CEO Katherine Gottlieb, an Alaska Native who won a MacArthur “genius” grant award for her work at Southcentral, says there was a simple reason: “We did a survey of our community.”

Southcentral asked community members to rank their health care priorities among choices like cancer care, diabetes, obesity and behavioral health. The top five priorities, says Gottlieb, were all related to behavioral health—child sexual abuse, child neglect, domestic violence, behavioral health counseling and addictions.

So Southcentral forged forward with its goal of making patients with behavioral health issues feel welcome. It built an airy new primary care center that looks as much like a mountain lodge as it does a place to get medical care. Huge windows frame the snowcapped peaks of the nearby Chugach Mountains, and the halls are filled with Alaska Native art—beadwork, blankets, dolls, carvings and paintings of totem animals such as ravens, orcas and eagles. There's an expansive lobby designed to host community gatherings. Foundation planners say the setting sends the message that the health of the community directly relates to the health of each of its members. Today, a patient with a history of mental illness, like Vera, gets evaluated by her doctor whenever she comes in for a medical appointment. If Vera seems anxious or depressed, the doctor might talk to her about it, or call in the behavioral health consultant. But the same goes for

patients without a history of behavioral problems. A diabetes patient who has stopped taking his pills, for instance, might find himself in a 20- or 30-minute discussion with his primary care doctor about ways to deal with anxiety or depression. The primary care doctor or the behaviorist on the team might suggest more formal counseling, or the request might come from the patient. When hospital care is needed, patients are sent by their care team, and they return to that care team when they get out.

The system puts mental illnesses into the realm of routine health care. “We know that for tons and tons of people, stigma is a really big deal in behavioral health,” says Douglas Eby, vice president of medical services at Southcentral and one of the many staffers who’ve been there since the beginning. “But getting behavioral health during your visit with your primary care provider, or by the guy down the hall, at the same place and maybe during the same visit—then it’s nothing different, and not likely to be stigmatized.” Your employer won’t find out, and your buddies won’t see your truck parked outside a mental health office. Integrating behavioral health care into a medical setting normalizes it, he says.

Southcentral takes things a step further, with several innovative group therapy programs, some of them building on Native American culture—“learning circles” where people talk about how they dealt with internal conflict and about how to resolve their feelings. Vera attended an intensive one-week group therapy session where people shared memories of domestic violence, abuse and neglect. “That was the week I figured out I could be happy,” she says. Family, faith and friends also helped, but what she learned at Southcentral was instrumental. “That was the start of not being a victim anymore, of seeing that there was light at the end of the tunnel and I wouldn’t always be depressed.”

Southcentral’s administrators credit integration for lowering hospital admissions and visits to the emergency room by more than a third between 2000 and 2015. In a recent survey, 97 percent of patients said they were satisfied with the care. In 2011, the foundation was awarded a [Malcolm Baldrige National Quality Award](#) for delivering top-quality care for less cost than the vast majority of U.S. providers.

**THE BIGGEST CHALLENGE** all along, says CEO Gottlieb, has been money.

Southcentral gets by on a combination of private insurers and government programs including Medicare, Medicaid and the Indian Health Service. But most of them don’t pay much for mental health care, and they don’t pay anything at all for some of the counseling and group sessions the foundation offers. So Southcentral subsidizes behavioral health care with savings from the medical side, and it gets grants as well.



TOP: A mask in the lobby of the primary care building at the Alaska Native Medical Center. Beadwork, sculpture, and paintings are intended to make the foundation’s 65,000 patients feel connected to their native Alaskan heritage. BOTTOM: Behavioral health consultant Emily Degroot speaks with patient Elizabeth Pawluk. | Ash Adams for POLITICO



Payment is a challenge across the country.

A landmark study of 113,452 patients in 102 group practices within the Intermountain Healthcare system in Utah and Idaho showed how much can be saved by integrating mental health care. Some practices included mental health care in a “medical home.” In other practices, patients were referred to outside therapists. Annual medical costs were \$515 higher per year for patients who did not get mental health services through their primary providers.

While the benefit to patients was clear, the study had a second conclusion—that providers lost money by integrating mental health. As physician Thomas Schwenk noted in an [accompanying editorial](#), during the 2010-13 study period the integrated practices received \$115 *less* per patient per year than the traditional practices, because payment was based on procedures and office visits. Since patients in the integrated practices needed less medical care, the doctors made less money.

Such payment practices are common, and Schwenk wrote that it’s going to take “a profound change in the fundamental structure of the U.S. health care delivery system” to integrate behavioral health care into the primary care environment. That would take heavier reliance of payments going to groups of doctors caring for groups of patients, not piecemeal payments for individual services.

There’s broad support for behavioral health integration within the health care community and in Congress; there are few critics on record, and no one is lobbying against it. The trade association for companies that provide health care services to people in insurance plans, the Association for Behavioral Health and Wellness, is a big booster. Patient groups love it for the access it gives, and for the destigmatization. Supporting health care reform that favors behavioral health care is a major legislative priority for the National Alliance for Mental Illness, which represents people with mental illnesses and their family members.

Andrew Sperling, a lobbyist for NAMI, echoes the conclusion that the chief challenge is money. According to a [SAMHSA estimate](#), Medicare spent \$29 billion on mental health care in 2016, and the Medicaid bill was \$67 billion. Sperling would like to see more for various demonstration programs. And if funds for Medicaid are cut, “a lot of the innovation we’ve seen with primary behavioral health integration would be stifled,” he says.

Still, some doctors and other providers are not totally on board. Many psychiatrists today don’t accept Medicare or other insurance, making access still a problem. And primary care practitioners and behavioral health workers may need training in how to work in an integrated system. “People who become cardiologists and rheumatologists and all the other ‘-ologists’ get minimal instruction in behavioral health,” says Berwick.

Psychologists and social workers may also have to be retrained, says Berwick’s IHI colleague Mara Laderman. Mental health consultants in integrated care systems work differently. “They’re focused on action-oriented problem solving over one session or a couple of 20-minute sessions, as opposed to having a more longitudinal therapeutic relationship,” she says. “You know, that 50-minute, hour appointment.” Southcentral’s Eby confirms that—he says they have to look long and hard for people willing to give care outside of those 50-minute boxes.



LEFT: A garden with Alaska Native traditional healing plants outside Southcentral Foundation’s primary care facility. Patients, including those with behavioral health issues, can ask for a referral to one of the traditional healers employed by the foundation. RIGHT: Health care providers use a bulletin board to send the message that patients are in charge. | Ash Adams for POLITICO

**SOLVING THESE PROBLEMS** will take more than money; it will require changing the culture of medicine. Many groups are moving in that direction; the American Medical Association, the American College of Physicians, the American Psychiatric Association, the American Psychological Association and other groups have policies promoting integrated care and offer information to their members on how to adopt it.

The federal government supports a multitude of initiatives designed to promote behavioral health care integration. The Affordable Care Act set aside money for model projects. Close to a billion dollars has been granted for programs that will promote behavioral health care, like setting up patient-centered medical homes within Medicaid. And starting last January, Medicare has been paying physicians for behavioral health care management and consultation. There are new billing codes that allow physicians to charge for helping their patients get behavioral health treatment, managing their patients’ care, and working with psychiatrists.

Authors of [an article](#) in the New England Journal of Medicine say it’s a “major step forward” and predict millions of beneficiaries will benefit and that there will be millions of dollars in savings. There could be a ripple effect: Medicare often serves as an example to other insurers. Southcentral Foundation leaders are often invited to speak at conferences or to health care organizations in the Washington, D.C., area, and when they do, they usually stop by Capitol Hill or federal agencies to talk about the benefits of providing mental health care in a primary care setting. Douglas Eby’s trips have led him to believe that there will be more support in the future for fully integrated systems.

“We are popular with the whole political spectrum,” he says. “We cut costs like crazy and emphasize self, and family, so Republicans love us. Democrats love us because we’re all about community and social factors and reforming the pillars of society so that everyone has improved access to care. When we walk into different political offices, we emphasize different parts of the system so that they can hear our story in their words and values, but it is all very true and the truth is the same truth.”



Conversations are a key part of the relationship between providers and patients -- called "customer-owners" -- at Southcentral Foundation. Physician's Assistant Ingrid Carlson speaks with customer-owner Taylir Kueter, 20. | Ash Adams for POLITICO

Berwick, with plenty of experience on Capitol Hill when he was head of CMS, is concerned about protecting funding for some of the demonstration projects in the current chaos of health care funding. But in the long run, he says, integrating behavioral health into primary health care is inevitable. "Look, we've got to solve the health care cost problem," he says.

In Anchorage, Vera Starbard is watching with interest. Until recently, she figured that all health systems offered mental health care right along with primary care. "That's literally what I had grown up knowing as health care."

But recently, she's seen several friends who are not part of Southcentral struggle to get mental health services. One friend, who, like Starbard, had been sexually abused, struggled for months to get approval from her health insurance company. Then her friend's intended counselor stopped taking new patients. "I'm only now seeing how good integrated care is," says Starbard. "We definitely took it for granted."

*Joanne Silberner is a freelance health writer based in Seattle.*



## **Social determinants and collaborative health care: Improved outcomes, reduced costs**

Implications and opportunities  
for health plans and states



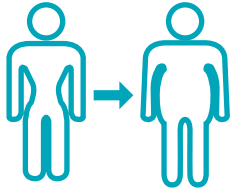
### **Overview**

Three factors can dramatically influence a person's health status and associated health care costs: physical health, behavioral health, and social determinants. Research has shown that collaborative care models which address behavioral and physical health or programs which address social determinants have independently generated improved patient outcomes. However, these three factors are inextricably linked; combining social determinants with collaborative care models may further improve individual and overall outcomes, and provide the cost savings that health plans and states are looking for. This paper reviews some of the individual and collective impacts that physical health, behavioral health, and social determinants have on individuals and the US health system; examines how collaborative care models can help to improve outcomes and lower costs; discusses challenges to implementing integrated care; and suggests implications and opportunities for health plans and states.

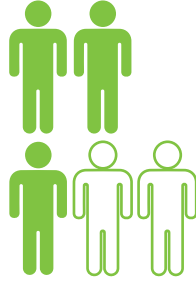
### **Introduction**

Traditionally, physical health has been the primary clinical and financial focus of US health care stakeholders: providers, payers, life sciences companies, employers, people receiving services, and US federal and state governments. Yet, even though the US spends the most on health care across all countries – 16.9 percent of GDP in 2012, the highest share among Organization for Economic Cooperation and Development (OECD) countries and far above the OECD average of 9.3 percent<sup>1</sup>— and leads the world in medical research and medical care,<sup>2</sup> the US health care system is fragmented, complex, costly, and the country lags other high-income nations in life expectancy and many other health outcome measures.<sup>3</sup>

Recent statistics illustrate that the US population's physical health is, frankly, unhealthy:

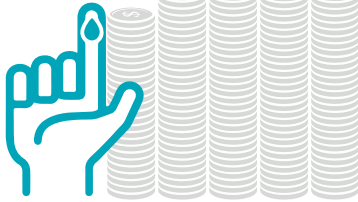


Obesity rates among US adults have increased greatly, from 30.9 percent in 2000 to reach 35.3 percent in 2012. This is the highest rate among OECD countries.<sup>4</sup>

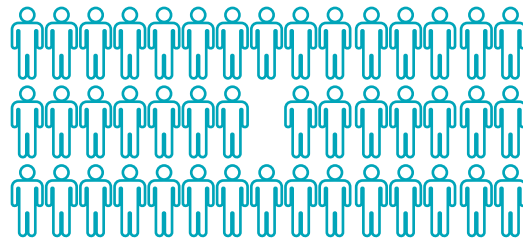


Complex patients with two or more chronic illnesses are primary drivers of health care costs. According to estimates, the top five percent of patients in complexity account for over 50 percent of costs.<sup>5</sup>

**\$245 billion**



29.1 million US residents have diabetes and comprise \$245 billion in direct and indirect costs.<sup>6</sup>



About

**610,000**

Americans die from heart disease every year. It is the leading cause of death for most racial/ethnic groups in the United States.<sup>7</sup>



About

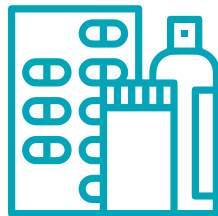
**595,690**

Americans are expected to die of cancer in 2016.<sup>8</sup>

Still, achieving and maintaining good health depends, in part, on people making conscious decisions to engage in positive behaviors – eating healthy foods and exercising are obvious choices – and to avoid risky behaviors such as smoking and heavy drinking. Some less recognized and/or acknowledged behavioral health risks – among them mental health conditions, substance abuse, and stress management – can have a disproportionately detrimental impact on physical health and health care costs, especially when they are not properly treated. Consider:

**18%** 

About 42.5 million American adults (18 percent of the total US adult population) suffer from some mental illness.<sup>9</sup>



Individuals with mental health and substance abuse disorders are often underdiagnosed and undertreated in primary care settings.<sup>12</sup> Depression and anxiety, in particular, are common in primary care settings but are often underidentified and undertreated.<sup>13</sup>



Health care costs associated with untreated mental disorders are estimated at \$70 billion annually.<sup>10</sup>

Depression alone will be one of the three leading causes of disability in the developed world by 2030.<sup>14</sup>



**67%**

Sixty-seven percent of individuals with a behavioral health disorder do not get behavioral health treatment.<sup>11</sup>



Approximately eight million deaths each year are attributable to mental illness.<sup>15</sup>



Medicaid is the single largest payer in the United States for behavioral health services. In 2011, the one-in-five beneficiaries with a behavioral health diagnosis accounted for almost half of Medicaid expenditures.<sup>16</sup>

## Physical, behavioral health linked

Despite US health care’s history of treating physical health conditions independently from behavioral health, the two are inseparably linked.<sup>17</sup> Up to 70 percent of physician office visits are for issues with a behavioral health component.<sup>18</sup> A similar percentage of adults with behavioral health conditions also have one or more physical health issues.<sup>19</sup> Having a chronic condition puts people at risk for a behavioral health condition and vice versa.<sup>20</sup>

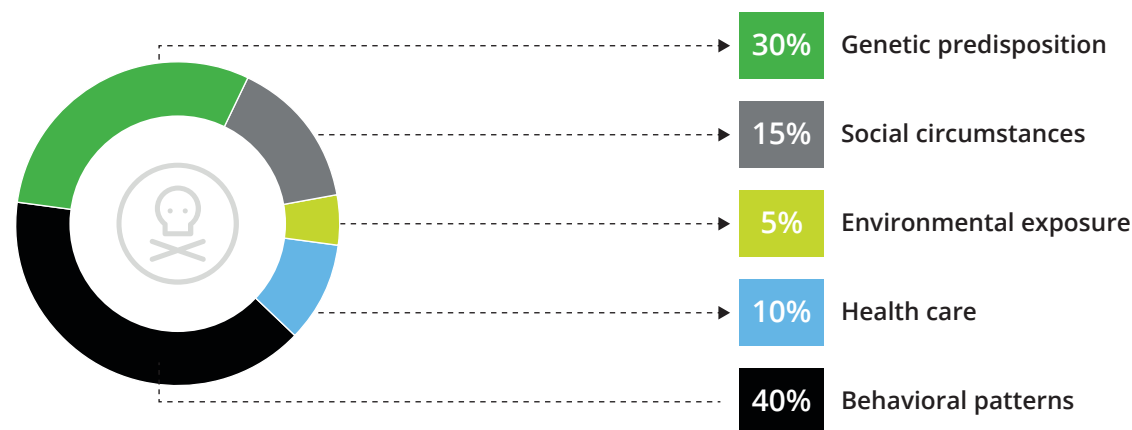
People with combined chronic medical and behavioral health conditions cost the health care system significantly more than those with only a chronic medical condition.<sup>21</sup> For example, annual health care costs are much greater for adults who have diabetes or heart disease and depression.<sup>22</sup> Unfortunately, the current fragmented state of mental health, substance use, and medical services results in inadequate care for those with mental illness.<sup>23</sup> People with mental disorders are frequently seen in primary care but are often underdiagnosed and undertreated.<sup>24</sup> Similarly, individuals with serious mental illness and substance use disorders seen in mental health settings lack adequate general medical care.<sup>25</sup>

## Social determinants directly, indirectly shape health

Scientists have found that the conditions in which we live and work have an enormous impact on our health.<sup>26</sup> Social determinants, some of which individuals can do little or nothing to control, can directly and indirectly shape physical and behavioral health.<sup>27</sup> Among these influencers are income, education, living and working conditions, transportation availability, and environmental factors (e.g., lead paint, polluted air and water, dangerous neighborhoods, and the lack of outlets for physical activity). Case in point: While research suggests that chronic stress can have direct physiological effects on health, it also may affect health-related behaviors. For example, children who experience stressful circumstances, especially on a daily basis, are more likely later in life to adopt—and less likely to discontinue—risky health behaviors like smoking and drug or alcohol abuse<sup>28</sup> that may function as coping mechanisms.<sup>29</sup>

Studies show that social factors and behavioral patterns outside the control of the health care system account for more of a patient’s health care outcome – including premature death – than do clinical services (Figure 1).

**Figure 1: Factors contributing to premature death<sup>30</sup>**



Adapted from McGinnis et al.

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“The environments in which people live, work and play support healthier choices. Efforts focused solely on informing or encouraging individuals to modify behaviors, without taking into account their physical and social environments, often fail to reduce health inequalities.”



**Paula Braveman and Susan Egerter, *Overcoming Obstacles to Health: Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America, Washington (DC): RWJF Commission to Build a Healthier America, February 2008***

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“For decades, policymakers and providers have seen worse health outcomes for people with behavioral health disorders compared to those without them. Some of the reasons for this include the lack of understanding of the relationship between mental and physical disorders and siloed behavioral and physical health care systems.”<sup>31</sup>



**Martha Gerrity, MD, MPH, PhD, Milbank Memorial Fund**

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“Health starts where we live, learn, work and play.”<sup>32</sup>



**Robert Wood Johnson Foundation**

In general, people with lower socioeconomic status have greater exposure to health-compromising conditions.<sup>33</sup> Both Medicaid and some commercially insured patients (e.g., people buying coverage on health insurance exchanges (HIX) who are below the median income but don't qualify for Medicaid) report problems with social determinant issues. Addressing these challenges within the health care system usually consists of linking patients with social and educational services to meet their needs (e.g., housing via Social Services or support from community-based services and groups that patients could attend or participate in online, such as Alcoholics Anonymous, Alzheimer's Support Group, and Weight Watchers<sup>34</sup>). However, communication and collaboration among service agencies, primary care and behavioral health care providers is often limited, disjointed, or non-existent; situations that can impede care quality and drive up costs.

## Lexicon: Behavioral health and primary care integration<sup>35</sup>

**Behavioral health care:** Umbrella term for care that addresses behavioral problems bearing on health, including patient activation and health behaviors, mental health conditions, substance use, and other health behaviors, including smoking, poor diet and a sedentary lifestyle.

**Collaborative care:** Linking patients with primary care and behavioral health providers in a joint management effort, often coordinated by a care or case manager.

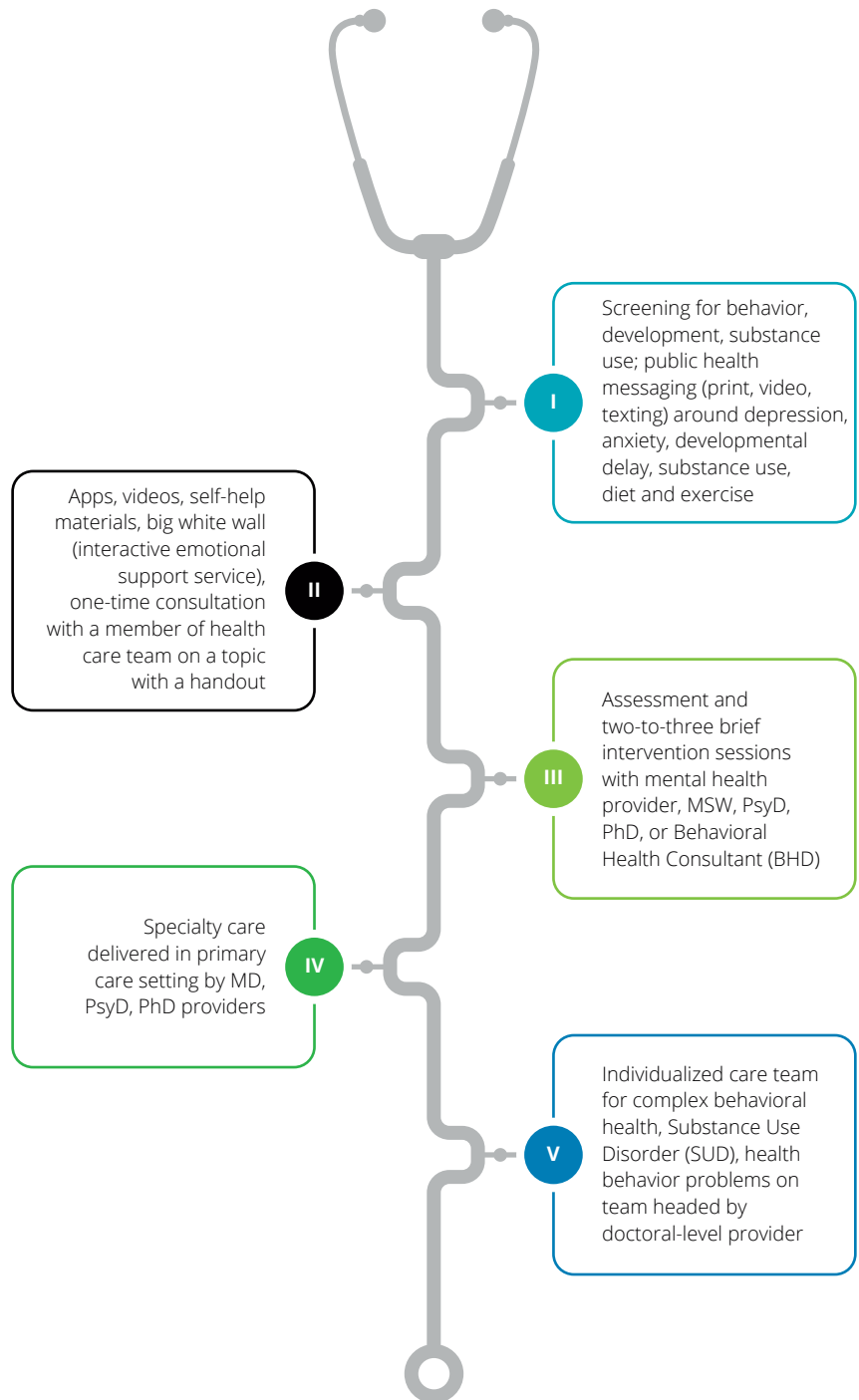
**Coordinated care:** Providers work within their own systems of care and the main contact among providers is through a referral, often with formal structured communication via treatment plans or discharge plans.

**Care management:** More robust integration of services. Providers may be co located, usually target specific diseases or problem areas. Care managers provide assessment, intervention, care facilitation, and follow up services.

**Integrated care:** Tightly integrated, collaborative teamwork with a unified care plan as a standard approach to care for designated populations. Also connotes organizational integration, often involving social and other community services.

**Integrated behavioral health and primary care:** The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost effective approach to provide patient centered care for a defined population. This care combines medical and behavioral health services, and may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress related physical symptoms, and ineffective patterns of health care utilization.

## Primary care behavioral health levels



## Integration improves outcomes

The Institute for Clinical and Economic Review (ICER) recently identified 36 models of integrated care that showed significant improvements in one or more outcomes areas.<sup>36</sup> In addition:

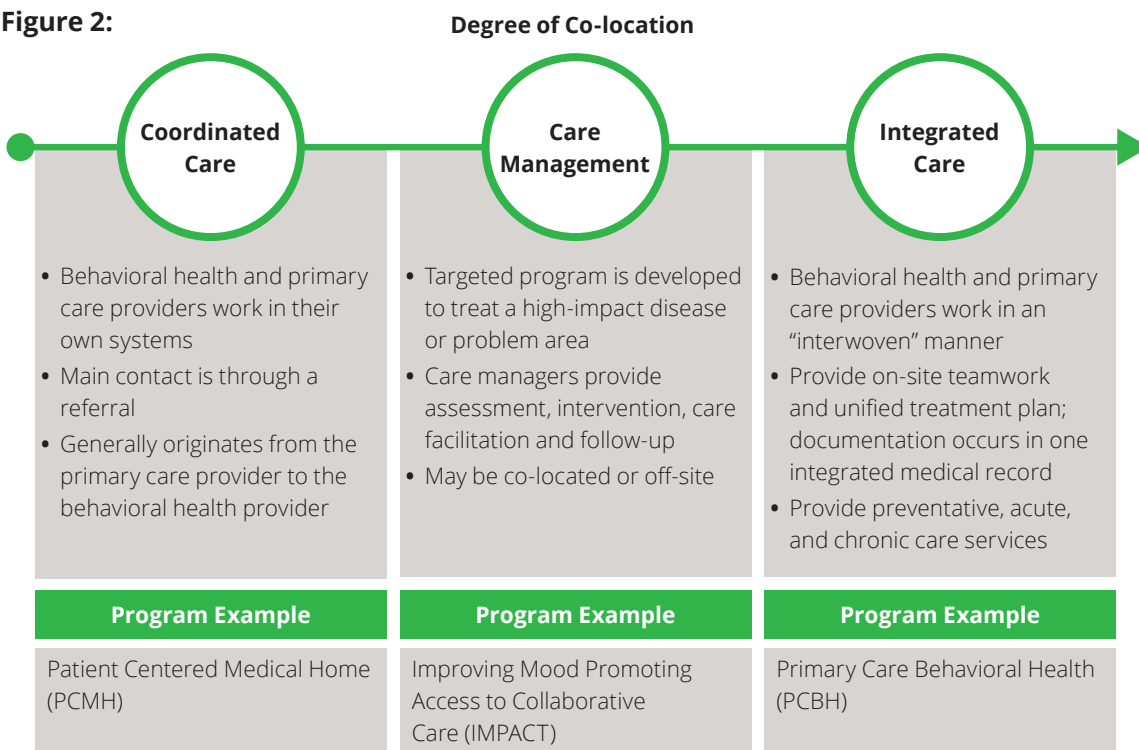
- High-quality evidence from more than 90 studies involving over 25,000 individuals corroborates that the Collaborative Care Model (CCM) improves symptoms specifically from mood disorders and mental health-related quality of life.<sup>37</sup>
- The Behavioral Health Consultant model addresses not only mood disorders but the full range of behavioral concerns. The model has been implemented effectively in large health care systems including Cherokee, Intermountain, and the US Department of Veterans Affairs (VA).<sup>38</sup>
- Components in both models that appear to be most strongly associated with improved outcomes are well-defined care plans, education, well-supervised care managers who provide systematic monitoring and follow-up, use of standard screening tools, communication with primary care providers (PCP), and psychological interventions.<sup>39</sup>

Many policymakers, program administrators, clinicians, and advocates have suggested that coupling behavioral and physical health services through collaborative care models would not only improve health outcomes for Medicaid beneficiaries, it would also help to reduce costs.<sup>40</sup>

### Models of collaborative care

Collaborative care has been defined as linking people with primary care and behavioral health providers in a joint management effort. Often, this joint effort is coordinated by a care or case manager.<sup>41</sup> The core features of collaborative care are: 1) communication between primary care and behavioral health care providers; and 2) an ongoing relationship among providers over time. Collaborative care falls across a spectrum defined by the degree of provider co-location and services integration. It leverages the benefits of multiple disciplines working together to address the challenges faced by people needing both medical and behavioral health care. Figure 2 illustrates three models of collaborative care.

Figure 2:



Source: Deloitte Consulting LLP, 2015 Webinar on Integrated Health Care Physical and Behavioral Care Delivery Models

**Coordinated Care** is the least-integrated of the three models. Providers work within their own systems of care and the primary contact among providers is through a referral, often with formal structured communication via treatment plans or discharge plans. An example of Coordinated Care is a Patient Centered Medical Home (PCMH). The concept of the medical home has been around since the 1970s, when pediatrics began considering a central source for children’s medical records—the medical home of the record. Additionally, during this time, psychologists would partner with physicians as a primary referral source. This relationship offered ease of access for the patient as well as improved communication among providers. The providers were rarely co-located and continued to practice in a largely independent system of care. A study of multi-condition PCMH coordinated care for depression and diabetes reported significant improvement in patients’ diabetes, blood pressure, and cholesterol; improved patient satisfaction after 12 months of care;<sup>43</sup> and savings of \$594 per person over 24 months.<sup>44</sup>

The second form of collaborative care is **Care Management**, which features more robust integration of services. Providers may be co-located but they are not always. Like a medical home, programs are developed which usually target specific diseases such as diabetes, cardiac disease, and depression, or problem areas such as compliance to a treatment regimen or preventative practices. Care managers provide assessment, intervention, care facilitation, and follow-up services. Communication among primary care providers and care managers may fall along a spectrum from structured referral and discharge plans to integrated record sharing and treatment teams. Improving Mood—Promoting Access to Collaborative Treatment, or IMPACT, is an example of the Care Management model. This program from the AIMS Center (Advancing Integrated Mental Health Solutions)<sup>45</sup> provides an intervention for adults with a diagnosis of major depression or dysthymia, often with a co-morbidity such as diabetes. The IMPACT model includes a stepped-care approach in which a trained depression care manager (DCM)—usually a nurse, social worker, or psychologist—works with the patient, their primary care provider, and a psychiatrist to develop and administer a course of treatment. Follow-up is provided by the depression care manager after the treatment has been successfully implemented.

“The health care system must acknowledge and systematically address those realities of patients’ lives that directly impact health outcomes and costs. Specifically, the goals of value-based care—improving quality while reducing costs—cannot be achieved without meeting patients’ social needs.”<sup>46</sup>



**Commission to Build a Healthier America,  
Robert Wood Johnson Foundation**

“Access to a usual provider is associated with increased receipt of needed mental health services. Patients who have access to usual providers with PCMH qualities are more likely to receive mental health counseling.”



**Audrey L. Jones, Ph.D.<sup>1</sup>, Susan D. Cochran, Ph.D., M.S., Arleen Leibowitz, Ph.D., Kenneth B. Wells, M.D., M.P.H., Gerald Kominski, Ph.D., and Vickie M. Mays, Ph.D., M.S.P.H. (May, 2015)**  
**Usual Primary Care Provider Characteristics of a Patient-Centered Medical Home and Mental Health Services Use. UCLA**



**Integrated Care** is the most interwoven of the three collaborative care models. Behavioral health and primary care providers are co-located and share infrastructure including records and staff. Integrated care offers a full spectrum of services (preventative, acute and chronic care), features on-site teamwork and unified treatment planning and documentation. Integrated care has been shown to improve satisfaction and chronic physical health<sup>47</sup> and to reduce treatment costs. For example:

- The Department of Veterans Affairs (VA) augmented its existing infrastructure to implement a national strategy for behavioral health integration that focuses exclusively on serious mental illness (SMI) and depression. The program involves several individual projects that are coordinated but are individualized to each site's unique needs. Under this system, PCPs provide universal screening of depression and post-traumatic stress disorder (PTSD). Patients with positive screens are assessed for behavioral health needs using structured protocols performed by care managers. Depression care managers are included on the primary care team and make recommendations to the PCP about treatment, provide proactive patient follow-up, and communicate with consultant psychiatric specialists when problems arise. EHRs are used to facilitate provider communication, report data, and provide point-of-care decision support.<sup>48</sup>
- The VA's Patient Care Aligned Teams (PACT) are comprised of PCMH services designed to provide comprehensive primary care. Behavioral health services are deemed essential and all PACT programs have on-site behavioral health consultants who provide screening, consultation, and brief therapy services. A recent review of the PACT program showed an 8.6 percent reduction in hospitalizations, 7.5 percent reduction in specialty care referrals, and in veterans over 65, an 18.4 percent reduction in urgent care visits.<sup>48</sup>
- Cherokee Health Systems in Tennessee takes a population-based approach to integrated care management in which every patient is screened for behavioral health conditions and triaged to the appropriate level of support. Generalist Behavioral Health Consultants (BHCs) are fully embedded on the care team and work collaboratively with PCPs to develop treatment plans and co-manage patient care. BHCs are available to provide rapid access to behavioral services – often during the same patient visit. Psychiatric consults are available to provide guidance and support for more complex cases. Team members are connected through a system of EHRs and use standard measures to track patient outcomes.<sup>49</sup> This hybrid model of behavioral health psychologists working closely with psychiatrists resulted in an overall reduction of 22 percent in costs compared to other clinicians in Cherokee's region over a three-year period (2009-2012).<sup>50</sup>

- Intermountain Healthcare's Mental Health Integration Program uses its existing institutional structures for coordinated care to integrate primary care and behavioral health services. Features of this model are being applied to health systems nationally. At Intermountain, all patients receive a comprehensive mental health assessment and are screened for depression, anxiety, and other behavioral health concerns using validated screening tools. PCPs and other behavioral health team members collaborate to develop shared treatment plans and provide for seamless patient transition across providers. A secure, central health information exchange is available to all team members to track and upload patient data, using a standard set of measure.<sup>51</sup> Intermountain showed an average decreased cost of \$115 per member per year.<sup>52</sup>
- The Agency for Healthcare Research and Quality (AHRQ) provides an interactive map with an overview of behavioral health and physical health integration efforts that are occurring at the clinical level across the country.<sup>53</sup>

While there is no "one-size-fits-all" approach to collaborative care, most models are complementary – utilizing one or more could help clinicians address many population health needs. The most common program component across successful models in ICER's review was inclusion of a standardized care coordination plan that involved regular patient-physician interaction (86 percent), followed by formal education (69 percent).<sup>54</sup>

Combining social determinants with collaborative health care models may further improve individual and overall outcomes, and lower costs. For example, social conditions affect people's choices, so improving them should create more opportunities for people to choose healthy behaviors.<sup>55</sup>

## Integrated care implementation challenges

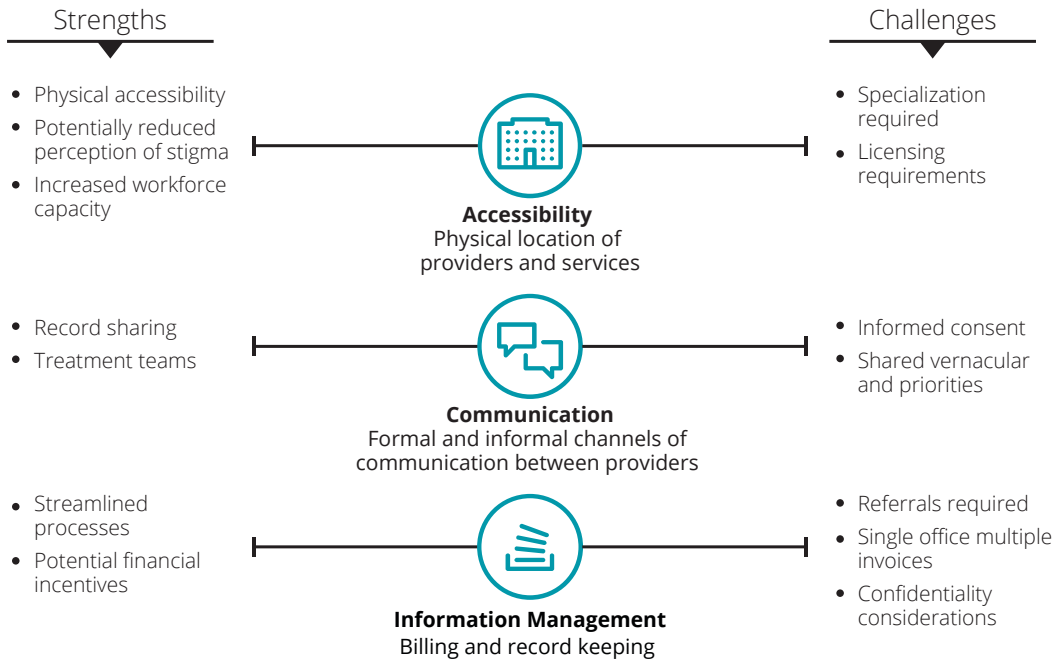
Payers and providers looking to implement sustainable integrated care programs face both financial and organizational barriers.<sup>56</sup> In addition to a lack of financial incentives for addressing social determinants, certain activities associated with integrated care, such as consultations between providers, and visits conducted outside of a physician's office (including online and phone consultations), may not be reimbursed under traditional fee-for-service (FFS) payment models. Sometimes there are pre-approval requirements or other restrictions that make it difficult for behavioral health care providers to work side by side with primary care clinicians.<sup>57</sup> Certain state Medicaid plans link physical and behavioral health components, but silo social determinants. Plus, there are ownership issues that may impact reimbursement – some state-level behavioral care programs are reimbursed through non-Medicaid programs. Finally, reduced funding negatively impacts all Medicaid programs, including integrated care.

Government and private payers are undertaking a number of strategies to overcome these and other financial impediments, such as moving from FFS to value-based-care (VBC) payment models, having health plans credential providers, and instituting creative employment and contract structures for care managers.<sup>58</sup> Still, financial disconnects remain, and are often exacerbated by the structure of contemporary primary care, wherein physician practices typically deal with numerous insurance plans. Inconsistent payment policies across the plans may make providers reluctant to invest in the clinical, technology, and process changes needed to implement integrated care.<sup>59</sup>

Organizational challenges around implementing a collaborative care model are likely to be both cultural and structural. For both providers and payers, it can be difficult to overcome employees' resistance to new roles and procedures without strong leaders who are committed to integrated care and champion the program.<sup>60</sup> In addition, state health agencies may show resistance to a single care model, especially for behavioral health.

Structural, communication, and information management issues also may impact the effectiveness of an integrated care model (Figure 4). For example, two-thirds of primary care physicians report not being able to access outpatient behavioral health for their patients<sup>61</sup> due to shortages of mental health care, health plan barriers, and inadequate or lack of coverage. Some states require a separate office structure and billing process for behavioral health clinicians co-located with primary care physicians. Finally, the complexity of care collaboration may be magnified by the number and different types of community organizations that health systems typically partner with; these could include local health departments, substance abuse and mental health organizations, and faith-based organizations.<sup>71</sup>

**Figure 4: Integrated care model strengths & challenges**



Source: Deloitte Consulting LLP, 2015 Webinar on Integrated Health Care Physical and Behavioral Care Delivery Models

“Payment is the heart of the problem.”<sup>62</sup>

**Roger Kathol, M.D., president, Cartesian Solutions Inc.**



“We must break down silos that separate improving health from the work of education, business, transportation, community development, and other historically 'non-health' sectors that form an integral piece of the health puzzle.”<sup>64</sup>



“The delayed returns from investments in social services and population health—years for early childhood interventions—require a longer time frame than many revenue-strapped governments believe they can afford.”<sup>63</sup>

**Christopher F. Koller  
President, Milbank Memorial Fund**



**From Vision to Action: Measures to Mobilize a Culture of Health  
Robert Wood Johnson Foundation, 2015**

Improved health information technology (HIT) can foster care integration<sup>65</sup> but getting providers on board can be problematic – currently, less than 40 percent of physicians link electronic health information with other providers with the goal of encouraging integration, collaboration, and communication (Figure 5).<sup>66</sup> Improved education and reimbursement incentives may improve adoption rates and usage. Public policies also can play a key role in encouraging and maintaining collaboration across sectors, as well as creating incentives for different sectors to contribute what they can to the cause of improving the nation's health.<sup>67</sup>

### The reimbursement conundrum

Certain health care models – coordinated care, care management, and integrated care – do a better job of addressing the interplay of social determinants, physical health, and behavioral health, but the current FFS provider payment mechanisms that incentivize volume over quality are not properly aligned to reimburse these models of care.<sup>68</sup>

The US health care system is moving away from payment models based on volume and services delivered to those based on value and outcomes. VBC is a concept that has existed for years, but has not been widely implemented to date. However, key legislation at the federal level is driving change. The US Department of Health and Human Services (HHS) has set a goal of tying 30 percent of FFS Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements, by the end of 2016, and tying 50 percent of payments to these models by the end of 2018.<sup>69</sup> The Health Care Transformation Task Force, consisting of providers, health plans, and employers, has committed to shift 75 percent of its members' business into contracts with incentives for health outcomes, quality, and cost management by January 2020.<sup>70</sup>

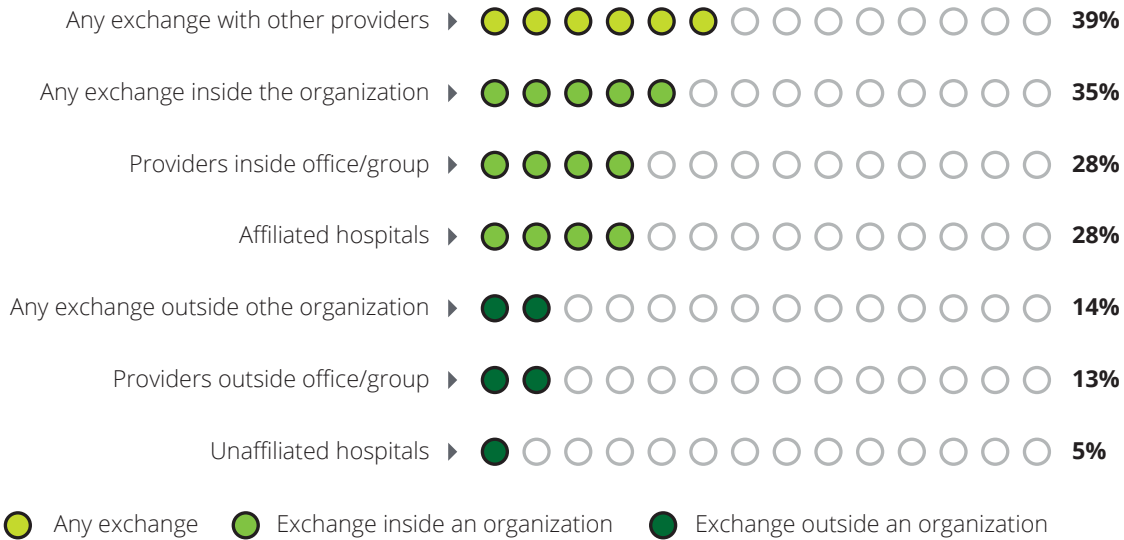
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is poised to drive payment and delivery system reform for clinicians, health systems, Medicare, and other government and commercial payers. MACRA overhauls Medicare's payments to clinicians by creating strong incentives for them to participate in alternative payment models that require financial risk-sharing for a broad set of health services. Over time, resource use performance – measuring the costs associated with clinicians' practice and referral patterns – will grow to 30 percent of the performance formula. Together, these policies will encourage much stronger focus on quality and total cost of care.<sup>71</sup> MACRA's financial incentives for clinicians to enter risk-bearing, coordinated care models could create opportunities for health systems and health plans to enter into new arrangements with clinicians under Medicare; this may set the stage for similar initiatives in other government programs, as well as with employers and commercial health plans.<sup>72</sup>

Most VBC models emphasize outcomes related to medical care/physical health, even though that accounts for only about 10 percent of the variance in outcomes and is eclipsed by social determinants at 40 percent and behavioral health at 30 percent.<sup>73</sup> For example, MACRA does not address the importance of social determinants, although it reflects the impact a large payer can have on the marketplace. So where do programs to address social determinants fit into new, value-based reimbursement models? Many are taking place at the state level; among them are Accountable Communities for Health (ACH), a strategy to transform and align health care delivery with community-based social services in an effort to promote state health. ACHs bring together various stakeholders with a target of addressing multiple contributors to poor health.<sup>74</sup> The Center for Medicare & Medicaid Innovation (CMMI) administers the ACH initiatives and is working with four states (CA, MN, VT, and WA) to develop and implement statewide models. While the models vary in their approach to care, certain elements such as governance, reimbursement, geography and targeted populations span these initiatives.

The long-term goal of implementing social determinants programs and generating an ROI to attain financial stability will involve addressing the key equations of where savings accrue and how they become dedicated to the community.

**Figure 5: Provider electronic health information exchange**

**Office-based physicians' electronic health information exchange with other providers, by organizational affiliation**



**Data source:** National Electronic Health Records Survey, 2013

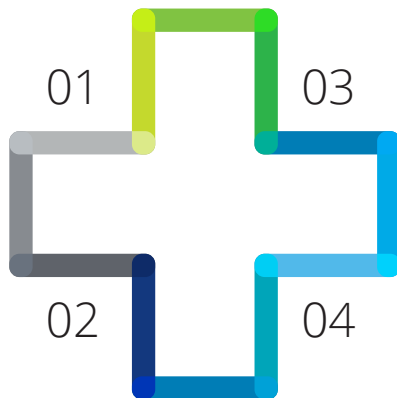
**Implications and potential opportunities for health plans**

Educate the entire organization (clinical, operational, and administrative) on the challenges, requirements, and benefits of integrating social determinants with physical and behavioral health care.

From a financial perspective, confirm the costs of serving different member populations and quantify how different integrated care models can generate a positive impact on the bottom line.

From a clinical perspective, validate how integrated care improves members' lives. For example, health plans could start by identifying a subset of people (usually chronically ill patients) who have high behavioral health needs, provide appropriate support services, and track clinical progress and costs.

As the largest payer of mental health services in the United States, state Medicaid agencies are key players, often influencing how mental health care is delivered. Policymakers and health care planners can benefit from information that helps them understand and implement effective interventions.<sup>75</sup>



## Many questions, no easy answers

Studies have verified the efficacy and value of integrated care. Unfortunately, there are many, many questions and no easy answers.

- How can health plans work with providers and policymakers to expand Americans' views about what it means to be healthy to include not just where health ends but also where it starts?<sup>77</sup>
- What role can health plans play to foster policies, partnerships, and investments that support cross-sector collaboration to improve physical and behavioral health?
- How do we better align reimbursement and care models to encourage provider and payer adoption of integrated care? Should the industry consider an integrated eligibility approach, in which participants receive insurance coverage assistance and service integration as part of their care coordination?
- How can stakeholders strengthen integration of social and health services across patient populations?
- What technology tools are needed to support organizational process changes?
- Is CMS willing to modify reimbursement policy to include non-medical services that are proven to be cost-effective and improve care?
- Will states be able to align and integrate siloed agencies that need to work together in a collaborative model?
- Can financing and financial incentives be developed to enable implementation of leading practice models?

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“To achieve lasting change, our nation cannot continue doing more of the same. We must embrace a more integrated, comprehensive approach to health—one that places well-being at the center of every aspect of American life. This approach must focus largely on what happens outside the health and health care systems, recognizing the key influences of factors found in communities, business and corporate practices, schools, and the many other spheres of everyday life.”



**From Vision to Action: Measures to Mobilize a Culture of Health<sup>76</sup>**  
**Robert Wood Johnson Foundation, 2015**

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## Endnotes

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# *Executive Summary*

# Lexicon for Behavioral Health and Primary Care Integration

Concepts and Definitions Developed by  
Expert Consensus



**Agency for Healthcare Research and Quality**  
Advancing Excellence in Health Care • [www.ahrq.gov](http://www.ahrq.gov)

## *Executive Summary*

# **Lexicon for Behavioral Health and Primary Care Integration**

## ***Concepts and Definitions Developed by Expert Consensus***

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The information in this report is intended to help clinicians, employers, policymakers, and others make informed decisions about the provision of health care services. This report is intended as a reference and not as a substitute for clinical judgment.

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# Foreword

*The Lexicon for Behavioral Health and Primary Care Integration* was funded by AHRQ through the Center for Primary Care, Prevention, and Clinical Partnerships (CP3) as part of a programmatic focus on developing and promoting the field of integrating behavioral health primary care. The original version of the Lexicon was developed through an AHRQ small conference grant to the University of Colorado in 2009. Throughout the planning process for that meeting, it became clear that the experts involved were struggling to find common language and concepts related to integration that would allow them to communicate effectively. After the pilot work at the meeting to develop a shared understanding, all participants agreed that the Lexicon was an important, even critical, advancement for the field that needed further refinement.

To date, the *Lexicon* has been used with another important effort underway with funding by AHRQ – the *Atlas of Integrated Behavioral Health Care Quality Measures (IQM)* (expected to be released in 2013). The *Lexicon* will continue to be part of ongoing efforts of AHRQ’s Academy for Integrating Behavioral Health and Primary Care (<http://integrationacademy.ahrq.gov>).

AHRQ expects the *Lexicon* will inform stakeholders such as providers, practices, health plans, purchasers, governments, researchers and others, by providing a common definitional framework for building behavioral health integration as one important way to improve health care quality. For example, implementers could use the lexicon to describe basic functions to put in place, differences in options for fulfilling those functions, and milestones for reaching full functionality.

Others have also recognized the need for shared language, e.g., the SAMHSA-HRSA Center for Integrated Health Solutions (2013), University of Washington AIMS Center, Milbank Memorial Fund (2010), and others. The creators hope that stakeholders will use the lexicon in their own ways in their own work as they converse with others who are developing this field as a whole.

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## About the Academy for Integrating Behavioral Health in Primary Care

This Lexicon was developed under the auspices of AHRQ’s **Academy for Integrating Behavioral Health in Primary Care** (the Academy; <http://integrationacademy.ahrq.gov>). AHRQ created the Academy to advance the field of integration by serving as a national resource and coordinating center for those interested in behavioral health and primary care integration. The Academy’s vision is to support the collection, analysis, synthesis, and dissemination of actionable information that is useful to providers, policymakers, investigators, and consumers.

The National Integration Academy Council (<http://integrationacademy.ahrq.gov/bios>) advises the Academy operational team on strategic issues, helping to improve the sharing of knowledge, experience, and ideas as the field moves forward. The NIAC comprised most of the expert panel that created this Lexicon. By reflecting the diversity in the field and providing a forum for outstanding leaders to share perspectives and tools, the NIAC will also help to expand the common ground and enrich the discussion about what methods work in which contexts.

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# Executive Summary

This lexicon is a set of concepts and definitions developed by expert consensus for what we mean by behavioral health and primary care integration—a functional definition—what things look like in practice. A consensus lexicon enables effective communication and concerted action among clinicians, care systems, health plans, payers, researchers, policymakers, business modelers and patients working for effective, widespread implementation on a meaningful scale.

## The Problem

The field of behavioral health integration is only beginning to develop a standardized vocabulary, with different vocabularies emerging from different intellectual, geographical, organizational, or disciplinary traditions. Definitions in the field have emphasized values, principles, and goals rather than functional specifics required for a particular implementation to count as “the genuine article. Definitions have not supplied a vocabulary for acceptable alternatives—to prevent behavioral health integration from being seen as a field in which “anything goes.”

## Benefits of a Shared Lexicon

**For patients and families.** “What should I expect from integrated behavioral health?”

**For purchasers.** “What exactly am I buying if I add integrated behavioral health care to the benefits?”

**For health plans.** “What specifically do I require clinic systems to provide to health plan members?”

**For clinicians and medical groups.** “What exactly do I need to implement—to count as genuine behavioral health integrated in primary care?”

**For policymakers and business modelers.** “If I am being asked to change the rules or business models to support integrated behavioral health, exactly what functions need to be supported?”

**For researchers.** “What functions need to be the subject of research questions on effectiveness? What functions need to be measured? What terms will I use to ask research questions?”

## Methods for Creating a Consensus Lexicon

Methods exist for defining complex subject matters (Ossorio, 2006). These methods led to:

1. Six paradigm case *defining clauses* that map similarities and differences in genuine integrated behavioral health.
2. Twelve *parameters*, a vocabulary for how one instance of integrated behavioral health might differ from another one across town.

### Requirements for a Method

- Be consensual but analytic (a disciplined transparent process).
- Involve actual implementers and users—“native speakers”.
- Bring out functionalities in practice (not only principles, values, or ‘anatomical’ features).
- Specify acceptable variations on the required pattern—not a rigid prescription.
- Be amenable to gathering an expanding circle of contributors.

## Lexicon Overview

The outline on the next five pages helps the reader quickly see the basic lexicon structure and content. However, the full lexicon contains denser clarifying detail that the creators found necessary to resolve ambiguities and get beyond, “What do you mean by that?” The full lexicon backs up the summary.

# Lexicon for Behavioral Health and Primary Care Integration

## *At a Glance*

<p><b>What</b></p> <p>The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.</p>	
<p><b>Defining Clauses</b></p> <p><i>What integrated behavioral health needs to look like in action</i></p>	<p><b>Corresponding Parameters</b></p> <p><i>Calibrated acceptable differences between practices</i></p>
<p><b>Parameter numbering at right does not correspond to clause numbering below.</b></p>	
<p><b>How</b></p> <ol style="list-style-type: none"> <li>1. A practice team tailored to the needs of each patient and situation               <ol style="list-style-type: none"> <li>A. With a suitable range of behavioral health and primary care expertise and role functions available to draw from</li> <li>B. With shared operations, workflows and practice culture</li> <li>C. Having had formal or on-the-job training</li> </ol> </li> <li>2. With a shared population and mission               <ol style="list-style-type: none"> <li>A. A panel of patients in common for total health outcomes</li> </ol> </li> <li>3. Using a systematic clinical approach (and a system that enables the clinical approach to function)               <ol style="list-style-type: none"> <li>A. Employing methods to identify those members of the population who need or may benefit</li> <li>B. Engaging patients and families in identifying their needs for care and the particular clinicians to provide it</li> <li>C. Involving both patients and clinicians in decision-making</li> <li>D. Using an explicit, unified, and shared care plan</li> <li>E. With the unified care plan and manner of support to patient and family in a shared electronic health record</li> <li>F. With systematic follow-up and adjustment of treatment plans if patients are not improving as expected</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>1. Range of care team function and expertise that can be mobilized</li> <li>2. Type of spatial arrangement employed for behavioral health and primary care clinicians</li> <li>3. Type of collaboration employed</li> <li>4. Method for identifying individuals who need integrated behavioral health and primary care</li> <li>5. Protocols               <ol style="list-style-type: none"> <li>A. Whether protocols are in place or not for engaging patients in integrated care</li> <li>B. Level that protocols are followed for initiating integrated care</li> </ol> </li> <li>6. Care plans               <ol style="list-style-type: none"> <li>A. Proportion of patients in target groups with shared care plans</li> <li>B. Degree to which care plans are implemented and followed</li> </ol> </li> <li>7. Level of systematic follow-up</li> </ol>
<p><b>Supported by</b></p> <ol style="list-style-type: none"> <li>4. A community, population, or individuals expecting that behavioral health and primary care will be integrated as a standard of care.</li> <li>5. Supported by office practice, leadership alignment, and business model               <ol style="list-style-type: none"> <li>A. Clinic operational systems and processes</li> <li>B. Alignment of purposes, incentives, leadership</li> <li>C. A sustainable business model</li> </ol> </li> <li>6. And continuous quality improvement and measurement of effectiveness               <ol style="list-style-type: none"> <li>A. Routinely collecting and using practice-based data</li> <li>B. Periodically examining and reporting outcomes</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>8. Level of community expectation for integrated behavioral health as a standard of care</li> <li>9. Level of office practice reliability and consistency</li> <li>10. Level of leadership/administrative alignment and priorities</li> <li>11. Level of business model support for integrated behavioral health</li> <li>12. Extent that practice data is collected and used to improve the practice</li> </ol>

Three auxiliary parameters appear on page 8 of this Executive Summary.

## “How” Defining Clauses (1-3)

*(Those functions that define what integrated behavioral health care looks like in action)*

### 1. A practice team tailored to the needs of each patient and situation

Goal: To create a patient-centered care experience and a broad range of outcomes (clinical, functional, quality of life, and fiscal), patient-by-patient, that no one provider and patient are likely to achieve on their own.

A. *With a suitable range of behavioral health and primary care expertise and role functions available to draw from*—so team can be defined at the level of each patient, and in general for targeted populations. Patients and families are considered part of the team with specific roles.

B. *With shared operations, workflows, and practice culture* that support behavioral health and medical clinicians and staff in providing patient-centered care

- Shared physical space—co-location

**Alternative (what could change):** Change “shared physical space—co-location” to “a set of working relationships and workflows between clinicians in separate spaces that achieves communication, collaboration, patient-centered operations, and practice culture requirements.”

- Shared workflows, protocols, and office processes that enable and ensure collaboration—including one accessible shared treatment plan for each patient.
- A shared practice culture rather than separate and conflicting behavioral health and medical practice cultures.

C. *Having had formal or on-the-job training* for the clinical roles and relationships of integrated behavioral health care, including culture and team-building (for both medical and behavioral clinicians).

### 2. With a shared population and mission

*With a panel of clinic patients in common*, behavioral health and medical team members together take responsibility for the same shared mission and accountability for total health outcomes.

**Alternative:** Change “a panel of clinic patients in common” to “any identifiable subset of the panel of clinic patients for whom collaborative, integrated behavioral health is made available, e.g., age group, disease cluster, gender, culture, ethnicity, or other population.”

### 3. Using a systematic clinical approach (and system that enables it to function)

A. *Employing methods to identify those members of a population who need or may benefit* from integrated behavioral/medical care, at what level of severity or priority.

B. *Engaging patients and families in identifying their needs for care*, the kinds of services or clinicians to provide it, and a specific group of health care professionals that will work together to deliver those services.

C. *Involving both patients and clinicians in decision-making* to create an integrated care plan appropriate to patient needs, values, and preferences.

D. *Caring for patients using an explicit, unified, and shared care plan* that contains assessments and plans for biological/physical, psychological, cultural, social, and organization of care aspects of the patient’s health and health care. Scope includes prevention, acute, and chronic/complex care. (See full lexicon for elements of care plans and markers for their implementation.)

- E. *With the unified care plan, treatment, referral activity, and manner of support to patient and family contained in a shared electronic health record or registry, with regular ongoing communication among team members.*

**Alternatives:** *Change “unified care plan in shared medical record” to problem list and shared plans are contained in provider notes or other records in the same organization medical record which everyone reads and acts upon.”*

*Delete “electronic” in “shared electronic medical record” (interim, not desired final state).*

- F. *With systematic follow-up and adjustment of treatment plans if patients are not improving as expected. This is the “back-end” management of patients from “front-end” identification. (See full lexicon for specific markers of such follow-up and care plan adjustment.)*

## **The “Supported by” Defining Clauses (4-6)**

*(Functions necessary for the “how” clauses to become sustainable on a meaningful scale)*

- 4. A community, population, or individuals expecting that behavioral health and primary care will be integrated as a standard of care** so that clinicians, staff, and their patients achieve patient-centered, effective care.

### **5. Supported by office practice, leadership alignment, and a business model**

- A. *Clinic operational systems, office processes, and office management* that consistently and reliably support communication, collaboration, tracking of an identified population, a shared care plan, making joint follow-up appointments or other collaborative care functions.

**Alternative:** *Delete “consistently and reliably” (an interim state, not a desired final state).*

- B. *Alignment of purposes, incentives, leadership, and program supervision* within the practice.

**Alternative:** *Substitute “Intention and process underway to align...” for “alignment of.”*

- C. *A sustainable business model* (financial model) that supports the consistent delivery of collaborative, coordinated behavioral and medical services in a single setting or practice relationship.

**Alternative:** *Substitute “working toward sustainable business model” for “sustainable business model.”*

### **6. And continuous quality improvement and measurement of effectiveness**

- A. *Routinely collecting and using measured practice-based data* to improve patient outcomes—to change what the practice is doing and quickly learn from experience. Include clinical, operational, demographic and financial/cost data.

- B. *Periodically examining and internally reporting outcomes*—at the provider and program level—for care, patient experience, and affordability (The “Triple Aim”) and engaging the practice in making program design changes accordingly.

# Parameters 1-7 Related to the “How” Defining Clauses

*How one genuine integrated practice might differ from another*

<b>1. Range of care team function and expertise that can be mobilized to address needs of particular patients and target populations</b>	<b>Foundational functions for target population</b> <ul style="list-style-type: none"> <li>• Triage/identification</li> <li>• Behavioral activation/self management</li> <li>• Psychological support/crisis intervention</li> <li>• Straightforward community resource connection</li> <li>• Straightforward mental health/substance abuse psychological interventions</li> <li>• Straightforward mental health pharmaceutical interventions</li> <li>• Common chronic/complex illness care</li> <li>• Follow-up, outcome monitoring for timely adjustment of care and coordination</li> <li>• Cultural and linguistic competency</li> </ul>	<b>Foundational plus others for population</b> <ul style="list-style-type: none"> <li>• Triage/identification with registry and tracking/coordinating functions</li> <li>• Complex or specialized mental health therapies needed for population</li> <li>• Complex or more specialized pharmacologic interventions</li> </ul>	<b>Extended functions, add</b> <ul style="list-style-type: none"> <li>• Specialized disease experts</li> <li>• Specialized population experts</li> <li>• Experts from cultural, school, vocational, spiritual, corrections, other areas of intersection with health care or specialized care managers</li> </ul>
<b>2. Type of spatial arrangement employed</b>	<b>Mostly separate space</b> <ul style="list-style-type: none"> <li>• Behavioral, health and medical clinicians spend little time with each other practicing in same clinic space.</li> <li>• Patient has to see providers in at least two buildings</li> </ul>	<b>Co-located space</b> <ul style="list-style-type: none"> <li>• Behavioral health and medical clinicians in different parts of the same building, spending some but not all their time in same medical clinic space.</li> <li>• Patient typically has to move from primary care to behavioral health space</li> </ul>	<b>Fully shared space</b> <ul style="list-style-type: none"> <li>• Behavioral health and medical clinicians share the same provider rooms, spending all or most of their time seeing patients in that shared space.</li> <li>• Typically, the clinicians see the patient in same exam room.</li> </ul>
<b>3. Type of collaboration employed</b>	<b>Referral-triggered periodic exchange</b> Information exchanged periodically with minimally shared care plans or workflows	<b>Regular communication/coordination</b> Regular communication and coordination, usually via separate systems and workflows, but with care plans coordinated to a significant extent	<b>Full collaboration/integration</b> Fully shared treatment plans and documentation, regular communication facilitated and/or clinical workflows that ensure effective communication and coordination.
<b>4. Method for identifying individuals (who need integrated behavioral health and medical care)</b>	<b>Patient or clinician</b> Patient or clinician identification done in a non-systematic fashion	<b>Health system indicators</b> <i>(Other than patient screening)</i> Demographic, registry, claims, or other system data, at risk for complex needs or special needs	<b>Universal screening or identification processes</b> All or most patients or members of clinic panel are screened or otherwise identified for being part of a target population
<b>5A. Protocols in place or not for engaging patients in integrated care</b>	<b>Protocols not in place</b> <i>(Not acceptable—described here only for context)</i> Undefined or informal: Up to individual clinician and patient whether or not and how to initiate/engage with integrated behavioral health care, e.g., whose care should be integrated, goals, appropriate team and roles, main contact person		<b>Protocols in place</b> Protocols and workflows for initiation and engagement in collaborative care are built into clinical system as a standard part of care process
<b>5B. Level that protocols are followed for initiating integrated care</b>	<b>Protocols followed less than 50%</b> <i>(Not acceptable)</i>	<b>Protocols followed more than 50% but less than 100%</b> <i>(an interim state)</i> Protocols for initiating integrated behavioral health care are followed for 75% to 100% of patients identified in priority group.	<b>Protocols followed nearly 100%</b> Protocols for initiating integrated behavioral health care are followed for nearly 100% of patients identified in priority group. Goal is 100%--as in “standard work”.



<b>6A. Proportion of patients in target groups with shared care plans</b>	<b>Less than 40%</b> <i>(Not acceptable)</i> Most patients in targeted groups for integrated behavioral health without written care plans	<b>40% to nearly 100%</b> A meaningful proportion but less than full-scale integrated behavioral health care plans for targeted groups—an interim state—not a desired final state	<b>Nearly 100%</b> Nearly 100% of patients in targeted groups with care plans—as “standard work”
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<b>6B. Degree that care plans are implemented and followed</b>	<b>Less than 50%.</b> <i>(Not acceptable)</i> Care plans implemented and followed for less than 50% of patients.	<b>More than 50%, less than 100%</b> <i>(An interim state, not final state)</i> Significant but incomplete implementation of care plans	<b>Care plans followed nearly 100%</b> Care plans implemented and followed for nearly 100% of patients in priority group. Goal is 100%--as in “standard work”.
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<b>7. Level of systematic follow up*</b> (Percent of patients in the practice population or target sub-population)	<b>Less than 40 %</b> <i>(Not acceptable—shown here only for context)</i>	<b>40% to 75%</b> Significant but incomplete follow-up being done	<b>76% to 100%</b> Goal is 100%--“standard work”
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\*Follow up elements that may be tracked in parameter 7 include: A) Patients with at least one follow-up (those engaged in care); B) Patients with at least one follow-up in initial 4 weeks of care; C) Patients who have their cases reviewed for progress on a regular basis (e.g., every 6-12 weeks); D) Patients who receive treatment adjustments if not improving.

## Parameters 8-12 Related to the “Supported by” Defining Clauses

*Calibrated conditions needed for success of clinical action in the real world on a meaningful scale*

<p><b>8. Level of community expectation for integrated behavioral health as a standard of care</b></p>	<p><b>Little or no understanding and expectation</b> <i>(Not acceptable—shown here for context)</i> Insufficient reach of understanding and expectation to enable integrated behavioral health programming to start and function in this community or practice</p>	<p><b>Expected as standard of care only in pockets</b> Partial but substantially incomplete community understanding and expectation for integrated behavioral health as a standard of care; need for continuing education, consciousness-raising, clarification</p>	<p><b>Widely expected as standard of care</b> Almost universal community understanding and expectation for integrated behavioral health as a standard of care</p>
<p><b>9. Level of office practice reliability and consistency</b></p>	<p><b>Non-systematic</b> <i>(Not acceptable—shown here only for context)</i> Referral, communication, and other processes are non-standard and vary with clinician and clinical situation</p>	<p><b>Substantially routinized</b> Standards set for most processes, but unwarranted variability and clinician preference still operate—not yet standard work</p>	<p><b>Standard work</b> Whole team operates each part of the system in a standard expected way that improves reliability and prevents errors.</p>
<p><b>10. Level of leadership/administrative alignment and priorities</b></p> <p><i>Inspired by Schein (2004), Collins (1996)</i></p>	<p><b>Misaligned</b> <i>(Not acceptable—shown here only for context)</i> Integrated behavioral health care is one among several strategic initiatives, but practical conflicts with other organizational priorities, resource allocations, incentives, and habits are apparent. Such tensions may or may not be articulated openly</p>	<p><b>Partially aligned</b> Some alignment achieved but with constructive ongoing work to bring to the surface and resolve unresolved tensions between purposes, incentives, habits, and standards.</p>	<p><b>Fully aligned</b> Constructive balance achieved between priorities, incentives, and standards. Integrated behavioral health functions are fully designed into priorities and incentives. Emerging conflicts are routinely addressed and respected as part of what the organization does to improve</p>
<p><b>11. Level of business model support for integrated behavioral health</b></p>	<p><b>Behavior health integration not fully supported</b> The business model has not yet found ways to fully support the integrated behavioral health functions selected and built for this practice. If these functions are maintained, it is by diverting resources not designated for these purposes or through unsustainable sources of funding such as grants or gifts.</p>	<p><b>Behavioral health integration fully supported</b> The business model has found ways to fully support the integrated behavioral health functions selected and built for this practice. No diversion of funds marked for other purposes nor unsustainable sources of funding are required.</p>	
<p><b>12. Scale of practice data collected and used on at least the integrated medical/behavioral health aspect of the practice</b></p>	<p><b>Minimum: (less than 40% of patients)</b> <i>(A startup state only—not a desired final state)</i> A system for collecting and using practice data from a limited number of patients or situations—to improve quality and effectiveness (of integrated behavioral health), especially at the individual patient level</p>	<p><b>Partial: (40%-75% of patients)</b> <i>(An interim state, not a desired final state)</i> Significant but less than full collection and use of practice-based data for decision-making—to improve quality and effectiveness and reporting at the system or unit level</p>	<p><b>Full/standard work: 76% -100% of patients</b> Routine data collection on most patients with integrated behavioral health—with internal reporting of “triple aim” outcomes and their use in decision-making to improve effectiveness at the system, unit, or community/population level</p>

## Auxiliary Parameters

*These may be useful for specific purposes, though not considered central to the full lexicon.*

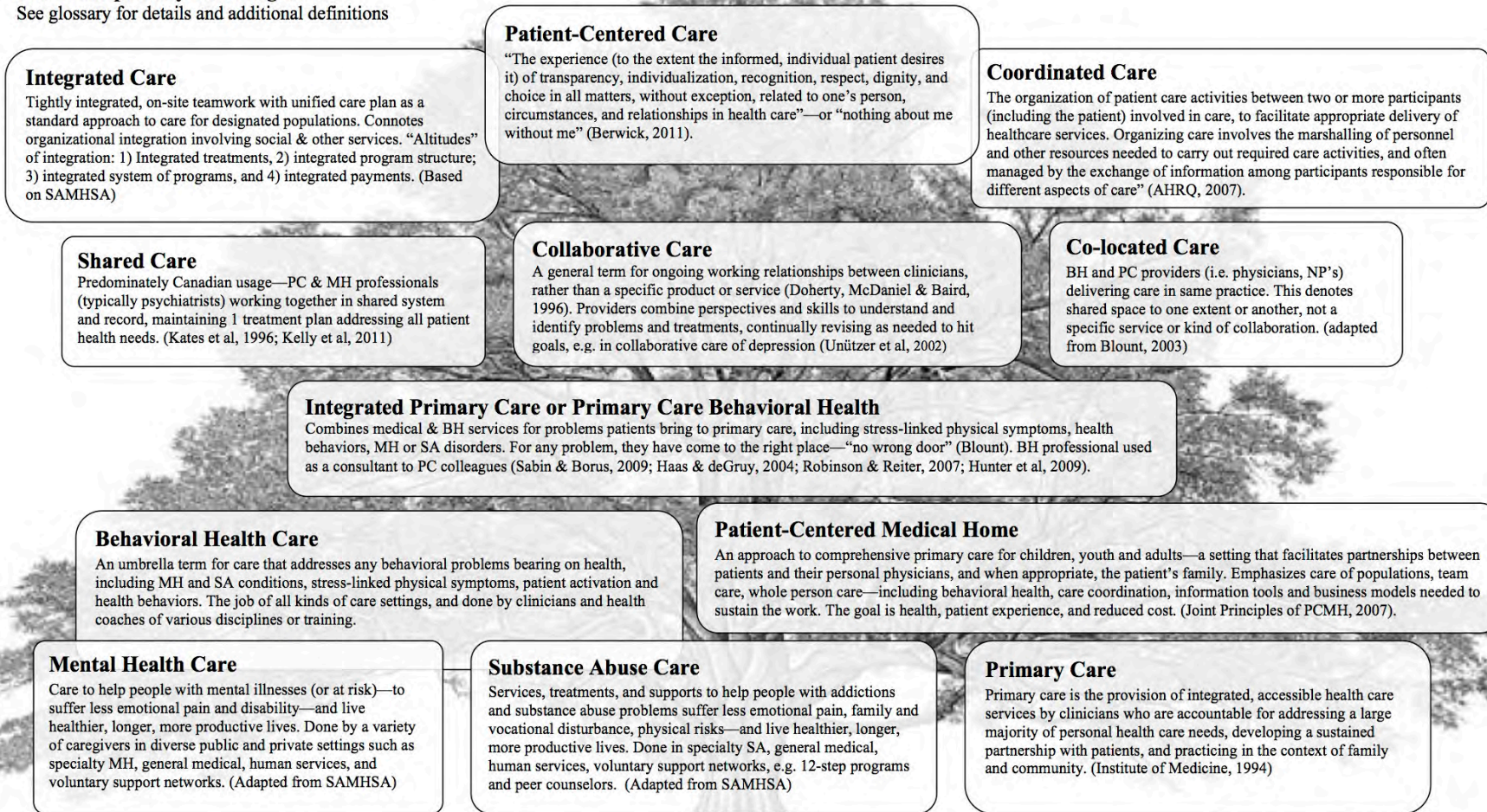
<b>Target sub-population for integrated behavioral health</b>	<b>A. Locus of care</b>	<b>Primary medical care</b>		<b>Specialty medical care</b>		<b>Specialty mental health care</b>		
	<b>B. Life stage</b>	<b>Children</b>	<b>Adolescents</b>	<b>Adults/young adults</b>	<b>Geriatrics</b>	<b>End of life</b>		
	<b>C. Type of symptoms targeted</b>	<b>Severe mental illness</b> High risk and often high stress for clinics	<b>Mental health or substance abuse conditions</b> Patients with one or more typical mental health or substance abuse conditions; family, partner, and relationship problems affecting health	<b>Stress-linked physical symptoms</b> Patients with stress-linked or “psycho-physiological” symptoms, e.g., headache, fatigue, insomnia, other	<b>Medical conditions</b> Patients with one or more medical diseases or conditions, e.g., diabetes, asthma, cardiovascular disease, lung disease	<b>Complex cases</b> Complex blend of symptoms, problems, conditions, diseases or personal situations, social determinants of health		
	<b>D. Type of situations targeted</b>	<b>No contact</b> Patients with no presenting problems or no contact with health system, even for prevention	<b>Diseases, conditions</b>	<b>Prevention, wellness</b>	<b>Acute life stress</b> Unsafe environment, social risks, isolation, financial, other	<b>Culture, race, ethnicity and language or other special populations linked to disparities</b>	<b>High risk and/or high cost cases</b>	

<b>Degree that program is targeted to specific population or situation</b> <i>(Blount, 2003)</i>	<b>Targeted</b> Integrated behavioral health program designed for specific populations such as disease, prevention, at-risk, age, racial and ethnic minorities, social complexity, pregnancy or other specific situation.	<b>Non-targeted</b> Integrated behavioral health program designed generically for any patient deemed to need collaborative care for any reason—“all comers”
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<b>Breadth of outcomes expected depending on program scale or maturity</b> <i>(From Davis, 2001)</i>	<b>Pilot scale</b> Limited expectations for a limited set of outcomes for a limited group of patients: A “pilot” is a demonstration of feasibility or starter “test of change” with limited number of patients or clinical scope	<b>Project scale</b> Significant, but not full-scale outcomes expected: Multiple promising pilots gathered together with a larger, but still not full scale population, but led visibly as a project aiming toward the mainstream.	<b>Full-scale</b> Full-scale and broad-based outcomes expected: Full scale way of life in the organization for the entire population of patients—the way things are done, no longer a project attached to the mainstream that hasn’t changed
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**Illustration: A family tree of related terms used in behavioral health and primary care integration**

See glossary for details and additional definitions



Thanks to Benjamin Miller and Jürgen Unützer for advice on organizing this illustration

From: Peek CJ and the National Integration Academy Council. *Lexicon for Behavioral Health and Primary Care Integration*: AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. 2013. Available at <http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>

# MEMO

DATE: December 22, 2017

TO: Department of Human Services

FROM: Kathy Parsons, CentraCare Health

RE: Next Gen IHP Comments

I appreciate the opportunity to provide comments, albeit late, regarding the proposed IHP Next Gen program. While I am certain there have been many comments, I wanted cover a couple of critical items as well as add a couple that are specifically impactful in the outstate arena.

**Primary Care exclusivity** is generally a good thing and can be very beneficial. However, in the outstate where there are rural areas with a single primary care clinic that services two different, broad ranging geographic areas in different directions, this may be difficult. I think there will need to be exceptions in some rural areas. I would not want to abandon the idea in the rural areas, but find those areas of the venn diagram that overlap and consider exceptions.

**Provider Network and Structure** will be a significant issue in the outstate areas. It is difficult for the larger communities to have enough primary care and/or behavioral medicine. There will be communities where coverage is not possible and provider IHPs will not be in a position to somehow take that on. It will be important to allow provider sponsored IHPs to lay out their area of coverage and not require it to be for entire counties.

**Care Coordination** is important to success. I don't believe claim edits bring any value except barriers. I don't think an IHP will be successful without Care Coordination and to mandate the "How" is overreach from my perspective. I would say that for managed care plans that are active in a county vs. and IHP, the managed care plan should have to work with the providers to determine what is best from a care coordination standpoint. Some of the plans think they do care coordination and providers would disagree as to the effectiveness of that. A care coordinated embedded in the clinics would be fine, but care coordination from afar is not helpful.

**Appropriate Risk** will be very difficult to set broadly. There may be IHPs that can take a great deal and some that cannot bear as much so I think flexibility will be important. I also think that if a provider system has an insurance license as a provider run plan, they should be able to take on risk more similar to the managed care plans, with some concessions (sufficiency) making it more similar to an IHP.

**A Single PDL** may be helpful. However, I prefer to keep the pharmacy benefit carve out. I think it would be good to include more than the seven county metro – patients often drive up I-94 looking for something they cannot get in the metro for whatever reason.

**Quality programs** – For the outstate I believe the MN Statewide reporting and measurement system is the better one to follow. The MIPS program has limited impact on rural health clinics and thus those organizations are not nearly as in tune with that program.

**From:** [MN\\_DHS\\_DHS PSD Procurement](#)  
**To:** [REDACTED]  
**Subject:** FW: One more comment  
**Date:** Friday, December 22, 2017 3:52:39 PM

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**From:** Spaan, Mathew N (DHS)  
**Sent:** Friday, December 22, 2017 2:59 PM  
**To:** MN\_DHS\_DHS PSD Procurement <DHS.PSD.Procurement@state.mn.us>  
**Subject:** FW: One more comment

**From:** Parsons, Kathy [<mailto:Parsons@centracare.com>]  
**Sent:** Friday, December 22, 2017 2:50 PM  
**To:** Spaan, Mathew N (DHS) <[mathew.spaan@state.mn.us](mailto:mathew.spaan@state.mn.us)>  
**Subject:** One more comment

Hi Mat – I forgot to put one more comment regarding the Next Gen IHP. My understanding is that IHPs would be responsible for the network of specialty providers needed (burns etc). I do not think the outstate (and likely even the metro) IHPs will have the capacity to do this work. It would also be a more costly way to have to do this. We do not have entire staffs devoted to contract negotiations with specialists and it may well be a deal breaker.

Thanks,

Kathy Parsons  
Executive Director, Central MN ACO/CIN and CC Rev Cycle  
(320) 656-7060  
[parsons@centracare.com](mailto:parsons@centracare.com)

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**From:** [MN\\_DHS\\_DHS PSD Procurement](#)  
**To:** [REDACTED]  
**Subject:** FW: Comment  
**Date:** Wednesday, December 20, 2017 11:13:45 AM

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From the Procurement Mailbox

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**From:** Saenger, Diana L. [mailto:Diana.Saenger@minneapolismn.gov]  
**Sent:** Friday, November 17, 2017 3:43 PM  
**To:** MN\_DHS\_DHS PSD Procurement <DHS.PSD.Procurement@state.mn.us>  
**Subject:** Comment

It would be great if there were day programs funded at a level to allow successful environments with innovative technologies that could assist in the continued progress, provide dignity, and staff at a level that is needed for many who have complex needs within their person centered care plan.

It seems that programs are great while the person with needs is a minor. Then all seems to drop off when they become an adult

Diana Saenger  
612-802-6603

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**From:** Gretchen Musicant  
**To:** [MN\\_DHS\\_DHS PSD Procurement](#)  
**Subject:** Outcomes Based Purchasing Redesign - contat person please  
**Date:** Monday, December 18, 2017 9:52:36 AM  
**Attachments:** [image001.png](#)  
[image002.png](#)  
[image003.png](#)

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To whom it may concern,

I am the incoming chair of the Metro Local Public Health Association, an organization of all the city and county Public Health Directors in the 7 County metro area. In reviewing the proposed Outcomes Based Purchasing Redesign and Next Generation IHP, it is clear to me that there will likely be an impact on both the public's health and possibly the local public health system. I would like the opportunity to facilitate a two way conversation about these changes with the metro public health directors. Is there a person who I can speak with? We meet in the morning of the second Friday of every Month. I would like to invite a representative from DHS to one of our meetings early in 2018 to talk about the changes and identify ways that we can work together and possibly align our efforts to improve the health of the metro population.

I look forward to your response with the name of an individual that I can speak with or correspond with via e mail.

Thank you,

Gretchen Musicant  
Commissioner of Health

City of Minneapolis – Health Department  
250 S. Fourth St. – Room # 510, Minneapolis, MN 55415

Office: 612-673-3955| Cell: 612-919-3855

[gretchen.musicant@minneapolismn.gov](mailto:gretchen.musicant@minneapolismn.gov)

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Member of the Big Cities Health Coalition, a forum for the leaders of America's largest metropolitan health departments. [www.bigcitieshealth.org](http://www.bigcitieshealth.org)

The philosophy behind public health is social justice. William Foege



December 15, 2017

Subject: Department of Human Services' Request for Information: Outcomes-Based Purchasing Redesign and Next Generation IHP

Dear Commissioner Piper:

ClearWay Minnesota<sup>SM</sup> respectfully submits this comment in response to the Department of Human Services' Request for Information: Outcomes-Based Purchasing Redesign and Next Generation IHP. ClearWay Minnesota is an independent nonprofit organization funded with 3 percent of Minnesota's tobacco settlement. Our mission is to enhance life for all Minnesotans by reducing tobacco use and exposure to secondhand smoke through research, action and collaboration.

Tobacco use is the single most preventable cause of death and disease in the United States. Each year in Minnesota, tobacco use is responsible for 6,312 deaths. Additionally, the annual cost of smoking in Minnesota is estimated to be over \$7 billion: \$3.19 billion in direct health care costs and \$4.3 billion in lost productivity.<sup>i</sup> Medicaid enrollees, in particular, smoke at approximately twice the rate of the general population, costing the state of Minnesota more than \$563 million annually in smoking-related health care costs.<sup>ii</sup> Fortunately, there is a demonstrated positive return on investment<sup>iii</sup> for systematically addressing tobacco use within programs that serve this population. The Centers for Medicare & Medicaid Services states:

*Cigarette smoking is one of the greatest drivers of adverse health outcomes and costs for state Medicaid programs. . . . Tobacco treatment is one of the most cost-effective preventive services with as much as a \$2-\$3 return on every dollar invested.<sup>iv</sup>*

By elevating tobacco dependence treatment as a priority within the Integrated Health Partnership (IHP) program, the state has the unique opportunity to curb one of the main drivers of health care costs, saving money and improving health outcomes in the state's most vulnerable populations in both the short and long term.

Tobacco use is unique in that it is a chronic relapsing condition itself and is also a significant contributor to higher incidence, complexity, costs and adverse outcomes for other costly chronic diseases including diabetes, asthma, vascular disease and cancer. Additionally, tobacco use screening and interventions are among the top three preventive services in terms of cost savings and the potential to improve overall population health.<sup>v</sup> Because of this, it is crucial that IHPs place a high priority on systematically identifying and treating tobacco dependence.

Generally, the IHP program can prioritize tobacco dependence treatment in the following ways:

- 1. Require IHPs to implement health systems changes to ensure that patients' tobacco use is addressed consistently.** Seventy-five percent of current smokers report visiting a health care provider in the past 12 months.<sup>vi</sup> The majority of smokers want to quit and want their health care provider to address their smoking.<sup>vii</sup> Patients also report greater satisfaction with their care when their health care provider addresses their tobacco use.<sup>viii</sup>

Health systems change – a sustainable, integrated solution implemented at the organizational level to support clinicians and health systems to address tobacco use consistently and effectively – is effective in reducing rates of office visits for smoking-related disease as well as smoking prevalence. The reduction in smoking prevalence is 40 percent greater among clinics that achieve health systems change compared to those that do not. Moreover, each clinical intervention with a smoker increases their likelihood of quitting by 2.4 percent.<sup>ix</sup>

Health systems change strategies for addressing tobacco use focus on improving care delivery processes and include:

- Identifying all tobacco users at every visit using a system-wide identification system;
- Providing education, resources and feedback to promote provider intervention and referrals for tobacco cessation;
- Dedicating staff to provide tobacco dependence treatment and assess its delivery in staff performance evaluations; and
- Promoting hospital policies that support and provide inpatient tobacco dependence services.<sup>x</sup>

The strategies outlined above represent opportunities for health care provider organizations to make sustainable changes in how they are addressing tobacco use in ways that will ultimately lower health care costs and improve population health. The IHP program would be strengthened by requiring implementation of health systems changes to improve tobacco dependence treatment delivery. By requiring IHPs to implement health systems changes to systematically address tobacco use, DHS is demonstrating the importance of addressing a factor that directly contributes to four of the five leading causes of death in Minnesota<sup>xi</sup> and costs the state \$3.19 billion in direct health care costs.<sup>xii</sup> This requirement also directly benefits patients – by systematically addressing tobacco use, more patients who use tobacco will ultimately quit, thus improving their health and reducing the toll of tobacco-related illness and death on the state.

ClearWay Minnesota has experience supporting health systems change. We have funded multiple rounds of health systems change grants and developed case studies to share key strategies and lessons learned.<sup>xiii</sup> Health care provider organizations that participated in these grants committed to making the delivery of tobacco use a standard practice of care, such as implementing workflow and electronic health record changes to assess a patient's tobacco use and assisting them in the quitting process by implementing internal and/or external referral options. For example, Essentia Health implemented an internal referral process to onsite tobacco treatment specialists throughout their entire health system. They also made modifications to their electronic health record and workflow to track these changes and follow-up with patients.<sup>xiv</sup>

We also understand that for some health systems, an incremental, step-by-step approach is more appropriate to make progress towards fully integrating tobacco dependence treatment into routine health care delivery. For example, a health system may be ready to identify gaps for assessing tobacco use within an existing workflow or share tools and information with providers to build capacity around talking with their patients about tobacco use.

In response to this need, ClearWay Minnesota is working with the Institute for Clinical Systems Improvement (ICSI) on a health systems change capacity building project. This project focuses on providing resources and tools to improve health system performance on assessing and addressing tobacco use and developing capacity within health systems to implement tobacco-related systems change that can be sustained. We welcome continued and new IHP program participation in the capacity building project. IHPs can visit the Health Systems Change website to view upcoming activities, subscribe to the electronic newsletter, *Connections*, and access updated tools and resources.<sup>xv</sup>

- 2. Establish a strong tobacco use and treatment quality measure with adequate risk adjustment methodology.** Advice to patients from health care providers increases use of evidence-based cessation treatments, improves outcomes,<sup>xvi</sup> and increases patient satisfaction with their care.<sup>xvii</sup> However, research shows that tobacco dependence treatment is not consistently provided.<sup>xviii</sup> Data from the 2014 Minnesota Adult Tobacco Survey shows that while about 78.9 percent of current smokers are advised by health care providers not to smoke, only half (52.6 percent) received referrals for assistance in quitting smoking.<sup>xix</sup> Routinely measuring and reporting health care provider organization performance on assessing tobacco use and delivering evidence-based tobacco dependence treatment would enhance the state's ability to achieve the Triple Aim of improving the population's health, improving the experience of care and reducing the total cost of health care.

The IHP program would be significantly improved if it included a robust tobacco use and treatment measure with adequate risk adjustment methodology. Please see our response to question #10 with our specific recommendations about such a measure.

- 3. Include barrier-free tobacco cessation benefits in Minnesota Health Care Programs (MHCP).** DHS should include best practice tobacco dependence treatment as defined by the United States Preventive Services Task Force as a core health care service that IHPs and Managed Care Organizations must provide. Based on the Clinical Practice Guideline,<sup>xx</sup> the U.S. Preventive Services Task Force<sup>xxi</sup> has outlined best practice tobacco dependence treatment as including barrier-free access to all forms of counseling (individual, group and phone) and all FDA-approved cessation medications. Currently, MHCP enrollees do not have consistent access to phone counseling through their Managed Care Organization and there are inconsistencies in coverage for cessation medications. In order to support IHP program partners in helping their patients quit, it is important that MHCP enrollees have barrier-free access to a comprehensive tobacco cessation benefit that includes all best practice treatments. Including a barrier-free, comprehensive cessation benefit is a way to lower health care costs and support providers and health systems in helping their patients quit.

We would also like to respond to specific, relevant questions posed within this Request for Comment:

*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?*

Currently, all FDA-approved tobacco cessation medications are required to be covered without cost-sharing under Minnesota Health Care Programs. However, the amount and formulation of these medications varies by MCO, which is problematic for enrollees wanting to quit and providers wanting to help their patients by prescribing medications based on individual needs. Given this, it would be beneficial to have a single PDL that is implemented across all DHS-administered programs and includes all FDA-approved cessation medications without any barriers, such as quantity limits and prior authorization requirements. We also support implementation of a single PDL statewide, rather than just in the seven-county metro area contracts. A single statewide PDL with barrier-free coverage for all cessation medications has the potential to ensure consistency in covered medications across payers, MCOs and products. This represents an opportunity to reduce confusion among providers who are seeing patients across multiple payers and MCOs, and can also make it easier for patients to understand pharmacy coverage and make a quit attempt.

*10. One of DHS's 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?*

Advice to patients from health care providers increases use of evidence-based cessation treatments, improves outcomes<sup>xxii</sup> and increases patient satisfaction with their care.<sup>xxiii</sup> However, research shows that tobacco dependence treatment is not consistently provided.<sup>xxiv</sup> Data from the 2014 Minnesota Adult Tobacco Survey shows that while about 78.9 percent of current smokers are advised by health care providers not to smoke, only half (52.6 percent) received referrals for assistance in quitting smoking.<sup>xxv</sup> Routinely measuring and reporting health care provider organization performance on assessing tobacco use and delivering evidence-based tobacco dependence treatment would enhance the state's ability to achieve the Triple Aim of improving the population's health, improving the experience of care and reducing the total cost of health care.

First, it is important to acknowledge that the Statewide Quality Reporting and Measurement System (SQRMS) is currently going through drastic changes at the direction of the 2017 Legislature. We know that future SQRMS measures must be aligned with the Centers for Medicare and Medicaid Services' (CMS) Merit Based Incentive Payment System (MIPS) measures and have encouraged MDH to prioritize a strong tobacco use and treatment measure as they consider the future of SQRMS and quality measurement in Minnesota. We would encourage DHS and the IHP program to take a similar approach.

While tobacco use is currently minimally reported within composite measures in the Statewide Quality Measurement and Reporting System, there is a need for a separate, more robust tobacco use and treatment measure that includes identifying tobacco users and documenting treatment, referral and follow-up care. Because the current state-mandated SQRMS measures and other statewide quality measures that are used for public reporting and payment do not emphasize getting further upstream to prevent chronic disease, providers are not recognized, rewarded or paid adequately for improving their patient's health. Tobacco use is a prime example of the lost opportunity this represents. Even though the return on investment of tobacco cessation treatment is high, best practices are known, and tobacco has widespread consequences across all regions and patient populations, providers are incented instead to focus on improving treatment for people that already have serious tobacco-related conditions. A tobacco use and treatment measure would allow better understanding of trends of tobacco use, especially within priority populations – populations that experience disproportionate harm from tobacco – and treatment trends to better identify variation and areas for improvement.

The IHP program would be significantly improved if it included a tobacco use and treatment measure with the following well-established components:

- Tobacco Use Assessment
  - o Percentage of patients who were queried about tobacco use at every clinical encounter<sup>xxvi</sup>
- Tobacco Cessation Intervention
  - o Percentage of patients who received advice to quit using tobacco<sup>xxvii</sup>
  - o Percentage of patients whose practitioner recommended or discussed

- o tobacco cessation methods or strategies (including provision of referrals) <sup>xxviii</sup>
- o Percentage of patients whose practitioner recommended or discussed tobacco cessation medication <sup>xxix</sup>
- o Percentage of tobacco-using patients who are contacted after a clinical visit for follow-up about tobacco use status <sup>xxx</sup>
- Tobacco Use Outcomes (for later implementation after refinement of measures)
  - o Percentage of patients who are documented tobacco-free

Tobacco use and treatment measures exist. The CMS MIPS includes a strong tobacco use screening and cessation intervention measure, National Quality Forum (NQF #0028) in its preventive care and screening measure set. Additionally, the Minnesota Department of Health has successfully developed and piloted the Community Transformation Grant (CTG) Healthy Lifestyle/Risk Reduction measure, which includes strong tobacco use and treatment components that have been endorsed by the National Quality Forum (NQF #0028). NQF #0028 is part of Meaningful Use and is a CMS core measure, thus it is familiar to providers and therefore limits burden. This measure could be included in all IHPs with minimal provider reporting burden and could provide the necessary information about tobacco use and treatment to develop strategies to address tobacco use within health care systems.

It is also critical that all measures used within the IHP program adequately account for socio-demographic factors (e.g., income, race and ethnicity, language, education) that profoundly impact a patient’s health, access, quality of care and treatment outcomes. Just as these factors contribute to wide variations in health, access, quality and outcomes, they also contribute to variations in rates of tobacco use. The same individuals who are impacted by these socio-demographic factors bear a disproportionate burden from tobacco.<sup>xxx</sup> Tobacco use and its correlate burden of disease are not evenly distributed across the population.<sup>xxxii</sup> Collecting additional data on these non-clinical factors and providing patient-centered cessation strategies is essential, especially within a program such as IHP that is testing new payment structures based on performance on quality measures and health outcomes.

Thank you for considering our recommendations.

Sincerely,



David J. Willoughby, M.A.  
 Chief Executive Officer  
 ClearWay Minnesota<sup>SM</sup>



**Primary Contact:**

Paula Keller, M.P.H.

Director of Cessation Programs

ClearWay Minnesota<sup>SM</sup>

952-767-1410

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<sup>i</sup> Blue Cross and Blue Shield of Minnesota. 2017 Lost Productivity: How smoking costs business. April 2017 <https://www.centerforpreventionmn.com/-/media/sites/cfp/files/factsheets/lost-productivity.ashx?la=en>

<sup>ii</sup> Campaign for Tobacco-Free Kids. The Toll of Tobacco in Minnesota. 2013; [http://www.tobaccofreekids.org/facts\\_issues/toll\\_us/minnesota](http://www.tobaccofreekids.org/facts_issues/toll_us/minnesota). Accessed September 1, 2013.

<sup>iii</sup> ClearWay Minnesota<sup>SM</sup>. Return on Investment for Tobacco Cessation Factsheet: <http://clearwaymn.org/wp-content/uploads/2017/08/FINAL-ROI-Fact-Sheet-2017-Update.pdf>

<sup>iv</sup> Centers for Medicare and Medicaid Services- <https://www.medicaid.gov/medicaid/quality-of-care/improvement-initiatives/tobacco/index.html>

<sup>v</sup> Maciosek, M. V., A. B. LaFrance, S. P. Dehmer, D. A. McGree, T. J. Flottemesch, Z. Xu & L. I. Solberg (2017a) Updated Priorities Among Effective Clinical Preventive Services. *Ann Fam Med*, 15, 14-22.

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<sup>vii</sup> Halladay, J. R., M. Vu, C. Ripley-Moffitt, S. K. Gupta, C. O'Meara & A. O. Goldstein (2015) Patient perspectives on tobacco use treatment in primary care. *Prev Chronic Dis*, 12, E14.

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<sup>ix</sup> Land, T. G., N. A. Rigotti, D. E. Levy, T. Schilling, D. Warner & W. Li (2012) The effect of systematic clinical interventions with cigarette smokers on quit status and the rates of smoking-related primary care office visits. *PLoS One*, 7, e41649.

<sup>x</sup> Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008.

<sup>xi</sup> Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/pressroom/states/minnesota.htm>

<sup>xii</sup> Blue Cross and Blue Shield of Minnesota. 2017 Lost Productivity: How smoking costs business. April 2017 <https://www.centerforpreventionmn.com/-/media/sites/cfp/files/factsheets/lost-productivity.ashx?la=en>

<sup>xiii</sup> ClearWay Minnesota<sup>SM</sup>. Health Systems Change Grants – Case Studies: <http://clearwaymn.org/policy/cessation-policy/>

<sup>xiv</sup> Health Systems Change Case Study, Essentia Health- <http://clearwaymn.org/wp-content/uploads/2017/11/FINAL-Essentia-Case-Study.pdf>

<sup>xv</sup> Tobacco Health Systems Change Website- <https://www.centerforpreventionmn.com/-/media/sites/cfp/files/factsheets/lost-productivity.ashx?la=en>

<sup>xvi</sup> Centers for Disease Control and Prevention. A Practical Guide to Working with Health-Care Systems on Tobacco Use Treatment. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion Office on Smoking and Health; 2006.

<sup>xvii</sup> Quinn, V. P., V. J. Stevens, J. F. Hollis, N. A. Rigotti, L. I. Solberg, N. Gordon, D. Ritzwoller, K. S. Smith, W. Hu & J. Zapka (2005) Tobacco-cessation services and patient satisfaction in nine nonprofit HMOs. *Am J Prev Med*, 29, 77-84.

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- <sup>xxi</sup> U.S. Preventive Services Task Force: Tobacco Smoking Cessation in Adults, Including Pregnant Women Recommendation Summary  
<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1>
- <sup>xxii</sup> Centers for Disease Control and Prevention. A Practical Guide to Working with Health-Care Systems on Tobacco-Use Treatment. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion Office on Smoking and Health; 2006.
- <sup>xxiii</sup> Quinn, V. P., V. J. Stevens, J. F. Hollis, N. A. Rigotti, L. I. Solberg, N. Gordon, D. Ritzwoller, K. S. Smith, W. Hu & J. Zapka (2005) Tobacco-cessation services and patient satisfaction in nine nonprofit HMOs. *Am J Prev Med*, 29, 77-84.
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- <sup>xxv</sup> ClearWay Minnesota, Minnesota Department of Health. *Minnesota Adult Tobacco Survey: Tobacco Use in Minnesota: 2014 Update*. February 2015
- <sup>xxvi</sup> Adapted from the National Quality Forum
- <sup>xxvii</sup> Adapted from the National Committee on Quality Assurance and the National Quality Forum
- <sup>xxviii</sup> Adapted from the National Committee on Quality Assurance and the National Quality Forum
- <sup>xxix</sup> Adapted from the National Committee on Quality Assurance and the National Quality Forum
- <sup>xxx</sup> Adapted from The Joint Commission
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## Community Dental Care

Quality Dental Care and Preventive Education for All  
www.cdentc.org

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Nicholas Weinand, DC  
Megan Welborn, DDS

December 14, 2017

Dear Sir or Madame at Minnesota Department of Human Services,

We would like to thank the Department of Human Services (DHS) for the opportunity to provide feedback on the proposed Outcomes-Based Purchasing Redesign and Next Generation IHP. We are very much aligned with your objectives to improve access to high quality cost effective health care for our most vulnerable populations, as that is in fact our very mission.

Community Dental Care is a nonprofit organization and a Minnesota Health Care Programs dental clinic that has provided culturally sensitive dental care, preventive education, professional training, and advocacy for access for over 35 years. As one of the largest providers of community-based oral health services in the state, we are recognized by the Minnesota Department of Health as one of six successful models statewide that provide dental services for underserved communities.

The reason for this letter is to alert you of our concern that changes resulting in payment reductions to dental safety net providers could put our ability to serve these populations at risk. Ideally, this project would increase the fiscal health and capabilities of the existing dental safety net, as we have proven to be cost effective, experienced and willing providers for this population for many years.

### Community Dental Care Provides Culturally Sensitive Access for the Underserved

In 2016, our four clinics provided 134,274 patient encounters to 46,868 unique patients. Of these, 91% were low-income, with 83% enrolled in public programs and 8% uninsured. Approximately 69% of patients served were a racial or ethnic minority, and 47% were children.

For the past 35 years, eliminating barriers to access to oral health care has been our mission. To accomplish this, we locate clinics in areas of poverty and those with diverse populations. We do not turn away anyone who cannot pay. We offer early morning and evening appointments to accommodate work and school hours. We hire diverse dental providers and health educators who collectively speak 24 languages and tailor all handouts to the populations we serve. We distribute thousands of oral health care kits annually to families that cannot afford them. Also, through our clinical training program for dental professionals and student nurses, we train and encourage minority students to consider careers in public health dentistry.

Community Dental Care underwrites between 3-4% of its budget in uncompensated care annually. The amount of charges foregone in 2016, based on established rates, was approximately \$1,064,400. This includes emergency care for patients unable to pay. In 2016, Community Dental





## Community Dental Care

Quality Dental Care and Preventive Education for All  
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Care covered an additional \$2,620 in preventive and restorative care for 38 children in our school-based program. We also provided \$33,909 worth of charity care for 259 children through our school-based program. All of our services are available on a sliding fee scale of 10-50% for low-income patients not eligible for public programs.

Besides offering preventive and restorative dental services, the clinic makes urgent care a high priority, dedicating time daily for emergency patients. In 2016, Community Dental Care dentists treated over 14,100 emergency patients, thus saving the state millions of dollars annually by avoiding hospitalization for dental procedures.

### Financial Concerns

Our primary source of income—public program reimbursements, including Critical Access funding—is only 47% of what is paid for standard dental rates. To make operating expenses, our clinic pays staff below market for their roles. Consequently, we sometimes find it difficult to recruit and retain staff. Because of already low reimbursement, Community Dental Care relies on charitable contributions to support delivering on our mission, though these are never a guarantee.

We ask that whatever changes are made to the IHP and MCO programs, these changes do not result in lower reimbursement for dental safety net providers. Ideally, this project would increase the fiscal health and capabilities of these providers.

Thank you for this opportunity to provide feedback. We would be glad to discuss potential changes specific to dental care as you refine your model.

Sincerely,

Dr. Vacharee Peterson, CEO  
Community Dental Care

**From:** Yi Li You  
**To:** [MN\\_DHS\\_DHS PSD Procurement](#)  
**Subject:** request for comments  
**Date:** Wednesday, December 20, 2017 9:20:38 AM

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Hi,

I glanced at the DHS purchase plan, "Outcomes-Based Purchasing Redesign and Next Generation IHP " . seems very confusing to public.

I am E.D. of the nonprofit org: Chinese Social Service center. We are MNsure navigator, before MNsure, we contracted with MNCAA, help community members to apply MA, MNcare.

MA, MNcare, esp MNcare are very unique programs for Minnesotans' low income people. It helped so much of these low income working population.

All we know, is that: consumers if immigration eligible, apply MNcare/MA through MNsure web. based on their income level, they are categorized into MA, or MNcare.

What is funding sources for MA and MNcare? DHS? or Managed care dept? Is latter under DHS's leadership? each county also under DHS?

What do you mean by saying: DHS purchase and redesign and the IHP? Who DHS purchase from?

Is the organization chart should be like this:

DHS guide MNcare office: approve consumers to be on MNcare.

Managed care dept send health plan infor: plan enrollment and health plan cards to consumers.

Each insurance manage the daily services for consumers, and send claims to DHS for reimbursement.

That is why each consumer get one state white card and an insurance card.

For the past years, DHS, counties, MNcare's computer systems not match. cause lot of confusion for cconsumers. Why not streamline the computer system at each office: DHS, managed care, MNcare, counties.

Who purchase from whom? it is like to take money from one pocket and put in another pocket, right?

The most important thing is: how to balance the budget: help low income and don't let state fund run out.

now I see: MNcare increase the office copy: \$15, etc which is good. I think: MNcare, and even MA can also charge copay for some procedures and treatments: e.g. \$200 for each of these treatments: deep cleaning, root canal, denture and hearing aid  
\$3, \$6 for each prescription. \$15 and \$25 copay for glasses for all MA, MNcare recipients respectively to reduce state cost to some extent.

Above is my suggestions,

Thanks,

Yi Li You, LSW, E.D.  
CSSC

**Dakota County's Comments for Submission to DHS (Due: 12/20/17)**

- 1) Would counties be required to contract with IHPs, or would the State hold the contracts?
- 2) How are we establishing performance criteria for patient-centered care? Is there the availability to align with other contributing services, such as Public Health, Social Services, etc.?
- 3) What is the impact on the customer? What is the message and who is delivering it?
- 4) Would Public Health incentives be included in the IHP package, such as car seats?
- 5) Currently, counties are able to advocate directly with MCO's on behalf of customers. How do you envision counties will be able to advocate for customers with the IHPs in this Model, e.g., care coordination for social services needs, county advocates for services and payment provisions, etc.?
- 6) Please clarify roles between county staff and DHS's new role, including the hiring of navigators, and how will the roles and responsibilities currently in place change?
- 7) The Preferred Drug List is a potential positive, but clarification is needed on how appeals, advocacy, and exceptions would be handled.
- 8) Respectively, what plans does DHS have in place to accommodate this significant change to a person-centered system when current DHS systems and operations appear to be inflexible?
- 9) Some of the success of county-based purchasing is due to the relationships built between counties and the local IHPs. How can DHS replicate that success when they have not established those relationships?
- 10) Dakota County is pleased to see the Social Determinants of Health outlined in the Model, albeit minimally. How deep does the role of the Care Coordinator delve into the specific needs of the customer related to the Social Determinants of Health?
- 11) The IHP documents appear to be silent on culturally appropriate and specific care needs around inclusion and diversity. Please provide assurance that future documents will address these important areas.
- 12) Is Primary Care Exclusivity actually necessary? Currently, clients can be identified and tracked through IHPs and/or MCOs easily for fair comparison.
- 13) How will the customer base be managed so IHPs and/or MCOs cannot choose specific customers who lead to more positive outcomes?

- 14) We continue to see changes in the market (mergers). How will this Model be responsive to those changes?
- 15) How will default plans be determined? Specifically, will there be one plan, a rotation, IHP's vs MCO's?
- 16) Dental services and related issues are paramount. The MCOs have requirements built in to their contracts to access those services. This Model doesn't appear to address dental services. Can this requirement be built into the IHP Model as well?
- 17) Clarification is needed on whether the IHPs include specialty care, such as mental health services, chemical dependency treatment, etc.
- 18) A Spring 2018 solicitation in preparation for 2019 involves partnership between the metro counties and DHS. A timeline with expectations and role delineation would be appreciated as soon as this information is available.



December 22, 2017

Commissioner Emily Johnson Piper  
Deputy Commissioner Charles Johnson  
Minnesota Department of Human Services  
540 Cedar Street  
St. Paul, MN 55101

Commissioner Johnson Piper and Deputy Commissioner Johnson,

On behalf of Fairview Health Services, I offer the following response to the Minnesota Department of Human Services' (DHS) request for public comment on Outcome-Based Purchasing Redesign and Next Generation Integrated Health Partnership (IHP).

Fairview Health Services, joined by HealthEast Care System in June 2017, is the largest provider of Medicaid services in the state of Minnesota. We are committed to serving Minnesota's Medicaid population with high quality, efficient care. Fairview, through Fairview Physician Associates Network, and HealthEast, through Community Health Network, are already participating in the IHP demonstration project.

Fairview believes strongly in orienting our care on the triple aim—quality, experience and cost—and that relationships between patients and providers are key to influencing the triple aim. We are committed to continuing to serve Minnesota's Medicaid population in partnership with DHS through Next Generation IHP or other models.

While we are open to exploring opportunities to redesign and reform purchasing and delivery strategies for public health care programs, we remain cautious about the implementation of the redesign. The current redesign proposal to allow provider organizations to hold a contract with DHS would require provider organizations to assume new risk and add new core services. We offer the following comments related to DHS's request.

- Fairview supports the belief that lasting relationships between a patient and a provider lead to better health outcomes. To that end, primary care exclusivity has the potential to strengthen the relationships between the patient and the integrated provider network.
- The Next Generation IHP model would require providers to accept more insurance risk. A transition period would need to be established to enable providers to accept increasing amounts of risk. Even so, we question whether provider entities would have a large enough enrollment base to handle the insurance risk required by the model.
- Capping losses that a Next Generation IHP is required to accept either through individual or aggregate stop-loss provisions or a risk corridor would be critical for providers to be able to

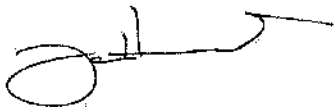
accept risk for the Medicaid population, and we encourage DHS to consider such coverage to reduce the risks held by the provider organization or IHP.

- Rather than developing requirements for network adequacy specific to Next Generation IHP, we believe there are existing network adequacy requirements that could be used as a starting point. We would support flexibility in network adequacy requirements based on the specific needs of the population being served.
- We have generally found that access restrictions or incentives are the most effective approach to ensure that enrollees receive their care consistently through their integrated provider network. We support such restrictions or incentives, within reason, as a means to improve the ability to manage the health of the population. Consistency in receiving patient care through in-network providers also aides care coordination initiatives, which in turn brings down the total cost of care.
- We believe the sharing of information between IHPs and Managed Care Organizations (MCO) regarding the effectiveness of measures aimed at addressing social determinants of health would be beneficial. Because IHPs or MCOs would have risk associated with total cost of care for their enrolled population, there would be a natural incentive to manage that risk through both covered and non-covered services.
- We must have metrics in place to measure success. While total cost of care metrics are naturally visible, more development is needed to measure patient satisfaction, quality and efficiency to ensure the triple aim is being met.

Fairview believes that keeping the Next Generation IHP model relatively open ended and flexible is the best way to ensure that IHPs and MCOs are appropriately incented to improve health outcomes for their enrolled populations.

Fairview continues to work with all providers and payers—commercial plans, the individual market and public health care programs—to realign incentives on the triple aim. Fairview is committed to partnering with DHS to improve the health of all Minnesotans.

Regards,



James Hereford  
President & CEO  
Fairview Health Services

**From:** Joseph Petersen  
**To:** [MN DHS DHS PSD Procurement](#)  
**Cc:** [Mark Kossman](#)  
**Subject:** RE: CCDTF e-Memo: We want to hear from you: comment period extended to Dec. 20  
**Date:** Tuesday, December 12, 2017 10:10:09 AM

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Comment Subject: Comprehensive assessment reimbursement to counties.

One question I presented during the video conference was the dollar amount that would be reimbursed to counties for doing an assessment. At the time the answer was approximately the same dollar amount as two hours of individual therapy or about \$150.00. However during the 30 hour Rule 25 training mandated by the state for social workers to do an assessment, the information provided at that time suggested the total time involved from prep to completion and referral was closer to four hours.

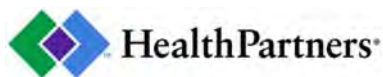
There are a large number of private businesses that do CD assessments and charge a minimum of anywhere from \$250 (ex: Fountain Centers-Mayo Clinic's facility in Albert Lea) and up to \$500.00 in the Metro area. Freeborn County currently uses a sliding fee scale based on income to determine the cost of an assessment for a client exceeding income guidelines. The maximum charged is \$250.00.

I would suggest a standard fee paid to a county should be closer to \$300.00 per assessment. The states thoughts on this?

Joseph Petersen, BS, LADC  
Freeborn County DHS, R-25 Assessor  
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December 20, 2017

Commissioner Emily Piper  
Minnesota Department of Human Services  
Sent electronically to: DHS.PSD.Procurement@state.mn.us

RE: Minnesota Department of Human Services Request for Comment dated November 15, 2017

Dear Commissioner Piper:

Thank you for the opportunity to review the proposed model as outlined in the Outcomes-Based Purchasing Redesign and Next Generation Integrated Health Partnership (IHP) Request for Comment. We greatly appreciate that DHS is actively pursuing best practices to improve the health outcomes, patient experience and affordability for Minnesotans with Medicaid coverage.

HealthPartners was started 60 years ago by Minnesotans seeking solutions to achieve quality and affordability. We are able to provide a unique perspective on this proposal given our long history of participation as an integrated system in the Medicare and Medicaid programs, as an Integrated Health Partnership with the Northwest Alliance, and as one of only four hospitals to volunteer to serve the former General Assistance Medical Care population as a Coordinated Care Delivery System in 2010.

Our key areas for comment include: Primary care exclusivity and enrollee default, impacts on care integration, coordination and quality, payment considerations, and infrastructure needs.

We also look forward to further dialogue with DHS on the following topics in order to fully evaluate the impact of the proposal.

**Primary Care Exclusivity** – How will a care system’s ability to achieve best patient outcomes be impacted by low rates of patient primary care choice? How will patients be impacted by disaggregating medical, dental, pharmacy and mental health services? How will parity and consumer protections for beneficiaries be applied to new models?

**Payment Considerations** – Will the State be providing additional protections to IHPs in the case of federal cuts? What savings are anticipated and how will they be invested in the program? DHS supports the state budget by making delayed payments to health plans every year. If enrollees move under Next Generation IHPs, which will not have delayed payment, what will be the budget impact?

**Infrastructure needs** - How will community organizations, navigators, brokers and stakeholders be supported to offer the intensive education needed for enrollees? What type of phone- and web-based applications be developed?

## Detailed Comments

Our comments in detail on these topics are as follows.

**Primary care exclusivity.** We appreciate that the DHS model encourages a strong connection to a primary care provider. However, DHS should examine the value of primary care exclusivity in the context of how primary care is organized in our state. The ideas presented are a departure from other programs, including Medicare Accountable Care organizations and commercial designs, and could create undue barriers in how we support our Medicaid patients. We participate today in multiple plans and as an IHP with health plans, and have a very strong primary care coordination model. The model envisioned by DHS will restrict patients on Medicaid to a much greater extent than other patients. In addition, there will be inevitable confusion and patients will likely go to different IHPs for primary care or to a clinic in a health plan network. There could be specific challenges for community clinics in our network, as patients may use our care system as well as a Federally Qualified Health Center. These clinics play an important role and exclusivity may prevent the ability for them to participate with us. We are also concerned that this exclusivity will unintentionally decrease access to front door mental health. In addition, primary care in many cases also includes urgent care, and the proposed model does not address how these services for members and patients could be impacted.

The model envisions that patients can change their primary care clinic monthly. We don't know if this means patients will be issued a new enrollee ID card with the name of their primary care clinic on it each time they change. We have experienced similar processes which assign a primary care clinic up front and put the name of the primary care clinic on the ID card and it can be burdensome for us as a care group since patients do not consistently come to the specific clinic to which they are assigned.

**Enrollee default:** DHS should address the reality that there could be a high rate of patients not likely to choose a clinic and how they will be assigned to the Next Generation IHP. Members who are defaulted will have less understanding of our care group network and the DHS wraparound providers. Currently there is a very high default rate (75 – 80%) and the success of the Next Generation IHP model appears to require a very low default rate. The infrastructure to reduce the default rate, particularly when it will include clinic selection, is not current in place, and we would like more information on how DHS will have that ready by 2019.

The infrastructure DHS will need to invest in to successfully serve patients on Medicaid (high mobility and address challenges) will need to be multi-lingual and provide new modes of education, meeting participants effectively across a broad geography. We appreciate that DHS is looking into using phones more broadly for enrollment purposes, but believe that a telephonic option will be only a partial solution for the infrastructure investment. If primary care clinic assignment is a fundamental part of the model, DHS will want to make assurances that the infrastructure for enrollee education, choice and understanding is fully activated and tested prior to fall 2018 open enrollment.

**Care integration:** HealthPartners has significant experience in integrating care and co-locating care, such as medical, behavioral health, pharmacy and dental care, provided in coordination with important health plan services such as medication therapy management, necessary medical and behavioral health disease and case management support, health promotion, member navigation and support, and access to online services. The Next Generation IHPs model could disaggregate these services for patients so that some services are handled by the IHP and others are handled by DHS, and in addition various subcontractors. Many of our primary care clinic sites have dental clinics co-located. Our dental clinics also recently adopted the same electronic medical record as our medical clinics which further enhances coordinated care, communication and medical/dental referrals. We also are expanding our behavioral health clinics, having just added two more behavioral health clinics this month. We often co-locate behavioral health within our clinics.

Health plans currently are held accountable to integrate medical, behavioral health, pharmacy and dental care. Our outcomes demonstrate that integration works, is in place, and we continue to improve upon it. Please describe the specific plan to develop new, additional resources and systems at our Next Generation IHPs and at DHS and at the DHS subcontractors to manage and integrate these services efficiently and without duplication of existing structures.

**Care coordination:** As a group of multi-specialty clinics and hospitals, we know the value that our care teams bring and the barriers they face to improve patient health and outcomes. We appreciate that the DHS model understands the importance of the care team-patient connection and care coordination. The DHS model raises questions for us as the Next Generation IHPs are given all responsibility for care coordination, case management, disease management and medication management. We have a comprehensive set of expertise to bring to high risk patient identification and management, high and medium risk patient care coordination and population health. As a care group we also rely upon and coordinate with health plans to provide additional disease and case management and programs. Based on our experience as a care group, IHP and health plan, we believe the best outcomes are when we are able to combine the care coordination at the clinic and clinic system level with the health plan wrap around supports, particularly for patients on Medicaid with specialized health care needs.

**Quality and health outcomes:** We anticipate that both for the Next Generation IHPs and for the health plans, DHS will be setting measurable and realistic targets to support improved outcomes. Yet it is unclear how DHS will be measuring and reflecting social determinants of health. We note that DHS is proposing to use a subset of existing quality measures (which currently don't measure social determinants of health) to avoid provider burden. We are interested to learn more about addressing the need to address provider burden and also introducing new measures for social determinants of health and innovation.

**Pharmacy:** We appreciate that DHS is exploring having a single preferred drug list in this proposal. We caution that several other states have used this approach and found overall costs to the state are greater. For example, the State of Texas commissioned a study to compare the overall cost difference to the State if the health plans were to manage their own formulary rather than continue to use the Texas mandated formulary, preferred drug list and prior authorization along with state management of federal and supplemental rebates. The study report is dated January 9, 2017 and used actuaries to assess actual claims and actual rebates. The key finding of the state-commissioned study was that the State would save 1.8% in State funds and the generic dispensing rate would increase if the health plans managed their own formulary.

A pharmacy carve-out could have further adverse impact on the total cost of care due to the loss of the proven value of integrated management of costs and utilization across pharmacy, medical, and behavioral health. HealthPartners, along with several other national health plans, have shown significant reductions in total cost of care when care management includes pharmacy. When services are integrated across medical and pharmacy, there is early identification of at-risk members using claims data, earlier identification for high cost cases and medication optimization is a critical component of many quality initiatives.

**Centralized help for persons enrolled in state public programs:** As a health plan, we offer an integrated and comprehensive set of services and programs to our Medicaid members to support access to care, health outcomes, healthy equity, member satisfaction and affordability. From a practical, member-centered perspective, it is important to understand how DHS, its subcontractors and the IHP will share program, service and claim information so that an enrollee has one place to call for help and questions.

It appears there will be administrative costs to build these programs and this integration infrastructure for Next Generation IHPs, both at the IHP and at DHS. It's important to note that these capabilities, core to any health plan's administrative capabilities, are a feature of the existing IHP-health plan model. We believe DHS will need to frame out these infrastructure costs and deliverables in the RFP in order to support a freestanding IHP model.

**Consumer protections:** In the proposed model, both DHS and the Next Generation IHPs take on more financial risk for patients enrolled in Medical Assistance. There have been many changes for these high risk patients in Minnesota and federal uncertainty creates an environment where more change and risk is likely. For the Next Generation IHPs taking on more financial risk, it is helpful to understand the legal requirements for IHPs, how the State will regulate them, and which consumer protections apply. Given the lack of current statute for Next Generation IHPs, we expect that there will be a level-playing field of consumer protection for enrollees in health plans and Next Generation IHPs, including solvency protection and risk.

We appreciate that DHS would like to expand Minnesota's benefit coverage under Medicaid to include services considered to address social determinants of health. It will be helpful for DHS to describe how the federal government and state budget for Medicaid will support the expanded benefits in the context of a constrained fiscal environment and how these benefits could be available to all enrollees in the Medicaid program.

**Payment:** The State has created a complex three-part payment and risk model for the Next Generation IHPs, based on the DHS Medicaid fee schedule. The methodology for IHP payment and rate development isn't fully clear and we appreciate DHS will share those details in the actual Request for Proposals. Several scenarios, however, would be helpful. We are trying to keep our costs down as a care group and this model's complexity seems to add administrative costs without value to the IHP. The model also proposes more administrative responsibility for an IHP than our care group currently has. This is not an area we would prioritize for investment as a care group, given the uncertainty of federal funding in the five year horizon.

In order to be successful, the Next Generation will need significant support and administrative infrastructure from DHS, currently performed by health plans. For example, DHS will need to administer multiple Next Generation IHP networks and fee schedules for multiple types of services in addition to the DHS fee-for-service structure. We would like more information on DHS current or planned capability to administer networks and fee schedules that will vary from IHP to IHP.

**Risk Adjustment:** Under the proposed model, DHS is dividing the population into smaller groups and this increases the importance of accurate and timely risk adjustment. A one-month snapshot will no longer be sufficient to drive payments for 6 or 12 months. We urge DHS to consider using a methodology that more closely resembles the Medicare risk adjustment payment methodology. Members would have a prospective risk score based on historical diagnoses and members without a history would have a new member score of some kind. Also, payments to IHPs and plans need to be based on actual enrollment for the payment month rather than using October enrollment for January through June payments

We support the State of Minnesota's goal to improve the Medicaid program and manage the challenges of the rising costs of health care. We hope there will be much more opportunity to meet with the Department and state leaders about this model and other ideas to serve this population and provide the best care and service outcomes. We encourage DHS to make sure all specifications are in writing, and there is adequate time to invest in, plan for and implement the new infrastructures and arrangements. This is best done with health care providers and health plans working together in collaboration with the State of Minnesota to design the program. The program has experienced a great deal of disruption over the past two years and we need to ensure that there is stability in coverage and care for persons who need it the most.

We are very committed to supporting the triple aim for Minnesotans with Medicaid coverage. We welcome the opportunity to work with, and support DHS efforts to continue to make improvements.


With best regards,



Brian Rank, MD  
Executive Medical Director  
HealthPartners Care Group



Nancy McClure  
Chief Operating Officer  
HealthPartners Care Group



Donna Zimmerman  
Senior Vice President  
HealthPartners



**From:** Ellen Roan  
**To:** [MN DHS DHS PSD Procurement](#)  
**Subject:** DHS calls for feedback on next generation of health care reform to improve health, lower costs  
**Date:** Monday, November 20, 2017 3:45:01 PM

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Well I would like to let you know you may be lowering costs but several of my cadic clients do not have near enough PCA services to meet their needs. I have one client who is calling me about once a week saying she is forced to sleep in her wheelchair (3 times now in a week) because staff no show or the company calls to say they have no one. That means a woman who should have staff get her up in the am and put her to bed in the evening sleeps in her chair. She has use of one arm. No use of her legs. She is at high risk. Refuses (person centered) to live in assisted living. She has gone several days (not I a row) with no staff whatsoever. She is 71 and sometimes her 78 year old sister comes to assist but she cannot lift her. She has no other family to help her. I can see where money is saved. But it is not right.

The work is difficult and the pay is poor. Can't keep staff in the jobs.

Ellen Roan, Case Manager  
Home and Community Based Services  
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MAGELLAN MEDICAID  
ADMINISTRATION

December 20, 2017

Minnesota Department of Human Services  
St. Paul, MN

RE: Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP -  
November 15, 2017

Magellan Medicaid Administration, Inc. (MMA) commends the State for their healthcare purchasing reform that will build upon the Integrated Health Partnerships program. We are supportive of a “common prescription drug formulary” (Preferred Drug List (PDL)) for the Medicaid Assistance (MA) population administered by the Department of Human Services (DHS). The common PDL program, among other benefits to the State, eliminates confusion over available drug choices and results in the lowest net pharmacy spend for the State while allowing providers to continue to deliver the best clinical care to Medicaid recipients.

A study conducted by the American Medical Association found that there is a direct relationship between multiple formularies and a prescriber’s negative view of a program due to the complexity of dealing with multiple coverage arrangements. The situation is further aggravated by patient churn as they move in and out of Medicaid eligibility, and between MCOs, forcing doctors to check if the patient’s current therapy matches the formulary and clinical policy of their new plan.<sup>i</sup> The inefficiencies of multiple formularies adversely impact patient care, provider practice and State economics. Having a common PDL administered by DHS would allow prescribers to adhere to one formulary.

By aggregating the prescription volume of an entire Medicaid program, states can capture lower net prices from drug manufacturers as opposed to an individual health plan due to advantages of best price protection via fee-for-service (FFS) reimbursement. Additionally, many states form drug purchasing pools combining their volumes for even greater purchasing power. These lower net prices are only available on prescriptions under the state’s FFS PDL. Splitting the drug benefit across the separate FFS PDL and MCO formularies causes states to reduce utilization subject to FFS discounts and dilute their purchasing power on the remaining FFS prescriptions. Drug utilization subject to the MCO formularies is not eligible for State supplemental rebates and cannot be leveraged in negotiation.

Federal rebate optimization has significant impact on pharmacy expenditures, as well. Brand products are frequently less expensive than their generic equivalents for months or years beyond their patent expirations. This is due to Federal rebates that increase over time as loss-of-exclusivity draws near; significant factors consist of price increases by the manufacturer and best price discounts in commercial business. As many states have observed due to these dynamics, favoring brands over their generics often save millions of dollars. In addition, Federal rebate dynamics need to be accounted for when considering pharmacy management turnover to MCOs. MCOs drive utilization toward generics at a

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higher rate than States due to differences in reimbursement models. This action drives MCOs to a lower net reimbursement of pharmacies, but States need to recognize that higher generic utilization results in lower brand utilization and therefore lower Federal rebate totals. Capitation rate calculations must be adjusted when accounting for this potential utilization change.

One example of Minnesota's use of a common PDL is found in the Hepatitis C class. MMA has worked closely with DHS and its actuarial firm to evaluate the benefits of a common PDL for the Hepatitis C class. The common Hepatitis C PDL was approved by CMS as of January 1, 2017. This initiative allows the State to include utilization from the MCOs when invoicing supplemental rebates. This lowers the net cost of products in this expensive drug class beyond the ability of commercial pharmacy benefit managers (PBMs). DHS currently has the ability to extend the common PDL to additional classes or the entire PDL. This presents the State with an opportunity to increase cost effectiveness, optimize use of healthcare dollars, and reduce prescriber frustrations dealing with multiple formularies.

Regardless of the State's ultimate decision, MMA stands ready to support Minnesota efforts to deliver the best patient care to its Medicaid population. As part of the State's history of healthcare innovation, we are eager to continue the development of ideas that keep patient interests at the forefront while delivering value that helps State budgets optimize use of healthcare expenditures. On behalf of Magellan Medicaid Administration, Inc. we appreciate the opportunity to offer these comments as DHS considers matters.

Respectfully Submitted,



Gregory S. Kaupp  
Senior Vice President and General Manager  
Magellan Medicaid Administration, Inc.  
[gaskaupp@magellanhealth.com](mailto:gaskaupp@magellanhealth.com)

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<sup>i</sup> Churning Under the ACA and State Policy Options for Mitigation: Timely Analysis of Immediate Health Policy Issues. Buettgens, M; Nichols, A; Dorn, S. The Urban Institute June 2012.



1753 Cottonwood Circle • Saint Cloud, MN 56303 • [www.machp.org](http://www.machp.org)

December 19, 2017

VIA E-MAIL

**Response to DHS Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP**

The Minnesota Association of County Health Plans (MACHP) appreciates the Minnesota Department of Human Services' (DHS's) recognition and affirmation of what rural counties utilizing county-based purchasing (CBP) are already accomplishing for more than 90,000 Minnesotan Health Care Programs (MHCP) participants across 25 rural counties of our state. CBP's unique, rural-focused model is locally accountable and proven effective in integrating the full continuum of health care, wellness and human services around the needs of rural Minnesotans participating in MHCP.

Although many questions remain as to how the proposed "Next Generation IHP" demonstration would deliver similar results in the seven-county Twin Cities metropolitan area, MACHP applauds the stated goals of this initiative. We also appreciate DHS's recognition that, while such an IHP procurement model might work in the Twin Cities metro area, it should not be extended to rural areas where residents and the State are already well-served by CBP.

CBP effectively delivers MHCP products and covered services to rural beneficiaries in ways private HMOs and health care reform models like accountable care organizations (ACOs) alone cannot. Because county health plans are owned by counties, they are organizationally integrated with county social services, public health, and behavioral health services. This uniquely positions county health plans to better integrate these services with local and regional medical services to facilitate the delivery of coordinated, cost-effective quality care. County health plans provide the State and counties an alternative to HMOs, ACOs and Integrated Health Partnerships (IHPs).

County health plans' integrated care delivery, accountability and risk-sharing approaches are actually achieving the goals envisioned for accountable care reforms. Instead of a corporate health care system being solely accountable for addressing health care quality, population health and cost, the entire community accepts and shares responsibility, financial risk, and accountability. This facilitates integrated care across the entire continuum of health care and human services providers. Through this community-based fusion of managed care and accountable care, county health plans effectively:

- Control health care costs and reduce preventable health care service utilization
- Improve access to wellness, medical, dental, mental health and social services
- Improve local health care system capacity to meet local MHCP participants' health care needs
- Assure consistent participation in MHCP in rural counties, providing stability to residents in public programs through the mission-driven commitment of county boards
- Maintain equitable provider reimbursement rates between metro and rural providers to support fragile rural health care infrastructures



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- Refocus savings into the communities we serve to improve access and quality of care for rural MCHP participants
- Bring health care reform such as accountable care and value-based reimbursement to rural areas
- Respond to the specific needs of the rural counties we serve through the development of unique programs and services
- Provide transparent operations so that our members, providers, the State, and legislators can readily assess cost vs. benefit for MHCP beneficiaries.

Thank you for this opportunity to provide comment, and please contact me with any questions or concerns.

Sincerely yours,

Steve Gottwalt  
Executive Director  
[steve@machp.org](mailto:steve@machp.org)  
952.923.5265

cc: MACHP Board of Directors



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December 20, 2017

Commissioner Emily Piper  
Minnesota Department of Human Services  
540 Cedar Street  
Mail Stop 0998  
St. Paul, MN 55155

VIA EMAIL

RE: RFC on Outcomes-Based Purchasing Redesign and Next Generation IHP Proposal

Dear Commissioner Piper:

On behalf of the Minnesota Council of Health Plans, representing Minnesota's nonprofit health insurers, thank you for the opportunity to provide feedback to your November 15, 2017 Request for Comment (RFC) on the Outcomes-Based Purchasing Redesign and Next Generation Integrated Health Partnership (IHP) proposal. We appreciate the Department of Human Services' (DHS) willingness to continue to explore ways to improve how the government pays for, and delivers care for Minnesotans enrolled in Medical Assistance (MA) and MinnesotaCare.

The Council's managed care organizations (MCOs) want to work with the state to continually improve outcomes for patients. We share the desire to better serve enrollees and encourage shoring up the program's foundation as a first step. Getting the basics right—like capturing complete contact information during enrollment, linking individuals to a clinic, and improving communication—is essential before adding even more complexity. We know that even today the basic enrollment processes need improvement. What we do not know, yet must prepare for together, are more Medicaid changes coming from the federal government.

Moving away from paying for volume to implementing value-based provider contracts is important. Council members have years of experience developing outcomes-based contracts, and the state can take advantage of this expertise by modifying existing or developing new models in partnership with plans. My members also have specific ideas of how to advance key concepts included in the RFC as part of a broader framework that would improve care for all of the Minnesotans we serve. Ultimately, creating a clear and equitable set of expectations and contract terms is in the state's best interest to encourage competition and improve care for all Minnesotans. The Council supports a level playing field for all entities serving people in MA or MinnesotaCare. Detailed comments from individual health insurers will be delivered separately.

I do have three comments specific to the Request for Comment.

- Develop the framework specifics and communicate changes. A new round of contracting could create additional disruption for enrollees who may have gone through multiple transitions in the last eight years. We know from experience that it takes time to develop and operationalize new contracts and implement major changes to IT systems. Expectations for enrollee responsibility, accountability and network use are promising ideas but people will need time and clear instructions to move from today's reality where three out of four enrollees do not actively choose their health plan. First steps include getting more reliable contact information for enrollees, comprehensive communication strategies, and full assessment of system capacity to support clearly connecting enrollees to primary care.

Page 2  
Commissioner Emily Piper  
December 20, 2017

- Create a comprehensive care system. All organizations participating in Minnesota Health Care Programs should have contracts and networks necessary to deliver care. One benefit MCOs bring to enrollees is the ability to coordinate and integrate needed medical services, particularly in those areas that are difficult to manage such as personal care assistance, non-emergency medical transportation, dental access, and securing medical supplies and medical equipment such as eyeglasses and hearing aids. In many cases, MCOs are able to do this by leveraging their market-wide work and existing partnerships with DHS and other care providers. Future models should retain this design feature of comprehensive, integrated management of all covered benefits for enrollees. In addition to promoting health care coordination, MCOs provide the state value through budget predictability and stability.
- Strive for consistency for all Minnesotans. Success is not just defined by how reforms work for the state, but how they work for all Minnesotans. We encourage DHS to ensure its reform vision is consistent with partnerships within state public programs, in the private sector and federal Medicare program so that we create consistent, non-duplicative practices for all provider groups. This approach avoids building duplicative administrative capacity at the state and for provider groups and MCOs. It also ensures consistency for individuals as they move from state public programs to other insurance.

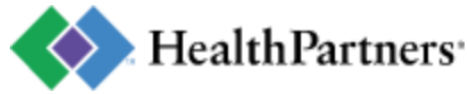
Minnesota's nonprofit health insurers have decades of experience in working together with the state and federal agencies as well as local employers to solve complicated health care problems. Collaboration on everything—from the launch of Medicaid in the 1960s, development of MinnesotaCare in the 1990s, creation of programs for Minnesotans who are elderly or disabled in the 2000s, expanding Medicaid in 2011 to ensuring MNsure enrollees received coverage in 2014—has been a point of pride for Minnesotans. It is in this spirit of collaborative success that I encourage DHS to work with us and others who care about the well-being of low-income Minnesotans.

Again, thank you for the opportunity to provide comments. Please let me know if you have any further questions regarding this feedback or if there is additional information I can provide.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Schowalter". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Jim Schowalter  
President & CEO  
Minnesota Council of Health Plans



December 20, 2017

Minnesota Department of Human Services  
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Saint Paul, MN 55155  
Email to: [DHS.PSD.Procurement@state.mn.us](mailto:DHS.PSD.Procurement@state.mn.us)

**Response to DHS Request for Comment:  
Outcomes-Based Purchasing Redesign and Next Generation IHP**

We would like to thank the Department of Human Services (DHS) for the opportunity to provide comments in response to the Request for Comment (“RFC”) on the proposed Outcomes-Based Purchasing Redesign and Next Generation IHP project. We are writing on behalf of Minnesota’s safety net oral health community. Comments were prepared by those individuals and organizations listed at the end of this document, but our work was also guided by the consensus policy principles developed by the Minnesota Oral Health Coalition, which is a statewide coalition of most of Minnesota’s dental organizations and leaders – beyond just safety net providers – and also includes other non-dental organizations with a strong interest in oral health, including nonprofit organizations, governmental agencies, public health and social service organizations and others.

We recognize, and are aligned with, your objectives to improve access to high quality cost effective health care for our most vulnerable populations. That is, in fact, the mission of dental safety net



providers. Dental safety net providers are essentially specialists in serving populations with the greatest disparities. Safety net clinics are located in areas of poverty and limited dental access, and those with diverse populations. We offer early morning and evening appointments to accommodate our patients' schedules. We hire diverse dental providers and health educators who speak the languages of our patients, utilize interpreters as needed, and tailor all handouts to the populations we serve. We encourage minority students to consider careers in public health dentistry and train them to be successful. We cost effectively improve the oral health of vulnerable populations through preventive education and comprehensive dental services, including dental emergency care, thus saving the State millions of dollars annually by avoiding emergency room visits and hospitalization for dental procedures. Many safety net providers also devote substantial staff and resources to providing additional support and wraparound services to address social determinants of health that affect health and access for low-income and diverse patients such as housing instability; lack of transportation; racial, cultural and language barriers; and mental illness or substance abuse.

The seven organizations who authored this letter provide a significant portion of the public program dental care for the entire State of Minnesota as noted in detail below. Minnesota's health care education institutions also serve as vital parts of the state's safety net. A significant portion of the training for Minnesota's dentists, dental hygienists and dental therapists happens in safety net clinics that serve a highly diverse population with complex dental, medical, and socioeconomic challenges with a high percentage of patients who are enrolled in state health care programs. The seven organizations serve a total of **221,600 low-income and underserved Minnesotans**:

- **Children's Dental Care:** 31,000 Medical Assistance and 4,000 uninsured patients, children ages birth to 26 and pregnant women in 45 Minnesota counties
- **Community Dental Care:** 44,500 patients in the Twin Cities metropolitan area and southern Minnesota
- **HealthPartners Dental Clinics:** 30,000 Medical Assistance patients, primarily in the seven-county metro area
- **Minnesota Association of Community Health Centers:** Minnesota's Community Health Centers served 62,100 dental patients in 2017. Ninety percent of these patients are either enrolled in a state program or uninsured. About 33,000 are MA or MinnesotaCare beneficiaries.
- **Northern Dental Access:** 10,000 patients across 20 counties in northwest Minnesota.
- **University of Minnesota School of Dentistry Clinics:** 20,000 Medical Assistance and 9,000 uninsured patients across the Seven County metro area and training sites in across Minnesota
- **Minnesota State Colleges and University System:** 20,000 patients, the vast majority of which are uninsured, across the entire state.

The Request for Comment document and information provided at public meetings still do not provide adequate detail about the new system for us to provide complete comments or offer specific and relevant suggestions in response to the questions posed in the document. For this reason, we request a follow-up meeting of Minnesota's safety net oral health providers with DHS so that we can learn more about what is planned for oral health services and, based on this, provide more specific comments and suggestions.

This is a major, transformational change that is being implemented with serious lack of detail and information, and according to an aggressive timeline that will leave little time for health care organizations to plan and prepare. As a result, it is very likely that the uncertainty, disruption and financial consequences will cause unintended harm to the most vulnerable and disadvantaged patients and the safety net providers who have developed unique services and programs to serve them. We strongly urge you to slow down the timeline, provide more details about the planned changes, and give sufficient advance notice. We do not think it is possible to do this with an implementation date of January 1, 2019.

Our bottom line request to DHS is that you do no harm to the most vulnerable and disadvantaged low-income Minnesotans who have the greatest disparities today and the safety net providers who serve them. As noted in the RFC, significant strides have been made in developing new accountable health models, with over \$1 billion in savings through existing programs. Many of us have been an important part of this effort and any future changes should not negatively impact the existing oral health safety net. The changes should improve access and oral health outcomes for low-income Minnesotans and improve the fiscal health and capabilities of the dental safety net as we have proven to be cost effective, experienced and willing providers for this population for many years.

This comment letter includes a combination of questions for DHS and recommendations for ways in which the oral health components of the new model can be improved.

1. **Critical Access Dental (CAD) and Community Clinic (CC) Payments.** In order to assess the potential impact of this system on the oral health safety net, we need more clarity from DHS about the impact of the new system on existing state laws and policies that have been enacted to preserve Minnesota's safety net and ensure that patients with higher levels of racial, cultural and socio-economic complexity receive the specialized services and supports that they need. Specifically, will MCOs be accountable for continuing to make CAD payments as they are today and will the DHS fee-for-service payments that will be made by DHS on behalf of IHP enrollees continue to be made in compliance with state laws requiring CAD, CC and other add-on payments? Unless all oral health care payments made under the new system honor the core health equity principle that some patients need more time and services than others to achieve optimal health, the new system will lead to even greater disparities. If DHS intends to discontinue these payments under the new system, what alternative payment systems will be put in place to fulfill DHS' stated intent behind the new system to address social determinants of health and reduce disparities? Finally, what safeguards will be in place to prevent unintended harm to safety net providers and services? Many important parts of the safety net system are fragile and financially vulnerable. Even short-term damage that occurs before actions can be taken to correct problems may cause irreparable harm to patients and essential providers.
2. **Dental Program Underfunding.** Our perspectives and comments on the new system are deeply affected by the fact that the current public program dental program is chronically underfunded. No amount of reform will make up for the fact that there is not enough money to pay adequately to achieve good access, good outcomes, and fewer oral health disparities. Establishing oral health performance requirements that are tied to payment incentives will not be effective if the payment levels are not adequate to enable providers to devote the additional time and resources that are needed to improve performance and achieve the desired outcomes. Any payment incentives or risk-based reimbursements should be

linked to the opportunity to obtain additional payments for high performance over and above current reimbursement levels rather than withholding payment conditional on achieving performance goals. Reducing base level payments for safety net services will not only decrease providers' ability to improve performance but actually reduce their capacity to continue to provide even the existing level of access and service which will negatively impact patients and exacerbate existing disparities.

3. **Dental Benefit Set.** Not only are current reimbursement rates and overall funding for dental services inadequate, past dental benefit cuts have deprived many patients of oral health services that are important for their oral health and treatment of dental disease. For long term, outcome-based reimbursement, it will be important that the MA dental benefit set not be in continual flux if we are to achieve positive and measurable progress on improved oral health. A specific example is that just under 50% of our new patients present with some level of periodontal disease. Reinstating, and maintaining, effective and consistent periodontal disease services such as planing and scaling are still critical to reducing disease.
4. **Social Determinants of Health.** We agree that addressing the social determinants of health is a key factor in improving the overall health outcomes of this population, especially those who experience more serious oral health disparities. We have long and extensive experience in this area. Identifying and addressing social determinants that negatively impact our patients requires additional staff, programs and services beyond just providing dental treatment. This is why higher payments for clinics serving patients with greater socio-economic complexity are necessary and appropriate. We appreciate DHS interest in seeking ideas for how to address social determinants under the new system. This can be accomplished through mechanisms such as Critical Access Dental and Community Clinic add-on payments. However, we also believe these current payment methods could be improved or replaced so that dental dollars are better targeted to meet the varying needs and socio-economic complexity of patient populations. We have spent a considerable amount of time reviewing different options and are willing to work with DHS to develop alternative payment strategies for preserving access and giving patients the level of services and programs they need for better health. Regardless of the mechanism chosen, the outcome should be to ensure that people who need more time, services and support to achieve optimal health receive it.
5. **Service Integration and Coordination.** The State has made it clear that one of the paramount goals for health reform is integration of all health care services, interdisciplinary team-based care models, and accountability for total costs of care. Additionally, the State is seeking additional coordination of health care services with non-health care services that are needed to address patients' social determinants of health. For these reasons, we see the separation of oral health care from other medical care under this project to be problematic and contrary to the direction of Minnesota's health care reforms. We fail to see why the proposed new system does not include incentives for both IHPs and MCOs to coordinate and integrate all services rather than segmenting dental care from other services to be paid for under a different system and without incentives or accountability of IHPs to improve oral health along with medical and behavioral health. We also offer, for consideration, the option of providing an Oral Health Home payment to cover the added cost to providers of patient education, health promotion and prevention, and coordination of care that will improve oral health, reduce the incidence of serious dental disease, and reduce future total costs of dental care.

6. **Performance Measurement and Incentives.** The description of the measurement categories for IHP and MCO performance requirements and the mechanisms for quality and performance adjustments to payments are general in nature and do not include specifics on oral health services. They do not provide enough detailed clarity for us to do an analysis of their potential impact on the oral health safety net and provide meaningful comments on whether the planned performance measures and incentives will be effective in achieving the desired outcomes. We request that DHS provide greater detail on this so that we are able to evaluate the metrics upon which our performance and reimbursements will be based. Unlike other areas of health care, there are no accepted statewide quality and performance indicators for oral health services. Any new measures will need to be carefully developed and tested before they are used for quality improvement, reporting or payment incentives. All quality and performance measures should be risk-adjusted by socio-economic complexity so that providers serving the highest risk, most socio-economically complex patient populations are not penalized because of serving these high priority patients.
7. **Payment Transparency.** We believe a major flaw in the current system is the lack of transparency of payment rates currently paid by MCOs. Without knowing what payments are made for different services, providers and geographic regions, it is not possible to know whether limited dental dollars are being spent where they are most needed and will produce the best results. In recent years, the disparities in payments have become increasingly visible. We now understand that some safety net providers who serve primarily higher risk, low-income patients impacted by disparities may be receiving lower payment rates than some providers who serve lower need, lower complexity patients. We recommend that the new system include transparency of payment rates and financial incentives.
8. **Implementation Process and Timeline.** Also, in order for the new system to be effective and to prevent unintended harm to patients and providers, detailed performance requirements and payment methods should be provided well in advance of implementation so that there is adequate time for providers to analyze their impact and provide feedback to DHS on the likely impact and outcomes to be expected, including possible adverse impact on patient health, access and quality of care. Then, after DHS refines the system based on analysis and modeling from providers, IHPs and MCOs, oral health providers will need adequate time to implement the changes in personnel, clinical systems and care models that will be needed to achieve positive results. In addition to these pre-launch steps that are needed, it will be important that DHS have a system in place for continuous monitoring and evaluation of the new system so that mid-course corrections can be made quickly to avert harm to patients and providers and to implement changes if the system is not achieving the desired results or is causing problems.
9. **Patient-Centered Care and Authentic Community Engagement.** Last, but perhaps most importantly, it is unclear from the Request for Comment document how this new system will be patient-centered and lead to an improved patient experience with the health care system, especially for patients and communities experiencing the greatest health disparities. We request more information on whether and how patients and communities most impacted by health disparities have been consulted in the design of the new system to ensure that it is effective in addressing disparities. This was a requirement of Governor Dayton for all departments preparing proposals for new programs and policy changes. It is also unclear how the state patients and consumers will be engaged as partners with the state, IHPs, MCOs

and providers on an ongoing basis under the new system to ensure that the system is responsive to their needs and is leading to better health and a better patient experience. One important element of patient-centered care and an improved patient experience is the ability of patients to seek care from the clinics and providers who are best matched to their needs and preferences. It is not evident from the RFC document how DHS will ensure that all state program enrollees will have adequate choice of and access to the dental providers.

Minnesota DHS should be applauded for efforts to improve the oral health care for Medicaid beneficiaries over the last decade. We appreciate the opportunity to comment through this Request for Comment (RFC) process. As you consider our comments, please do not hesitate to contact Michael Scandrett at [msscandrett@msstrat.com](mailto:msscandrett@msstrat.com) or at 612-790-0442 if you have any questions about the content of this correspondence.

Respectfully submitted,

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## **DHS Request for Comments on the Outcomes-based Purchasing Redesign and Next Generation IHP/MCO Model**

### **Comments of the Minnesota Health Care Safety Net Coalition**

December 20, 2017

The Safety Net Coalition (SNC) represents Minnesota’s nonprofit health care providers who serve primarily low-income, disadvantaged and uninsured Minnesotans. These patients have complex personal, social, economic and cultural challenges and needs that affect their health and their access to health care services compared to Minnesota’s general population. These are the patients experiencing the greatest health disparities today. The Coalition’s mission is to improve the health and health care of safety net patients by uniting and strengthening the safety net community that serves them. The Coalition brings together all sectors of health care including primary care, mental health, substance abuse, dental, hospital and specialty care. The Coalition also partners with consumer and community organizations who represent the patients served by the safety net.

#### **Summary of Comments**

- The Coalition’s comments focus on improve health equity for Minnesota patients and populations who experience the greatest health disparities through changes to quality measurement and payment.
- The proposed reformed purchasing system offers great potential to improve health and reduce costs, but also poses serious risks of unintended consequences that will make disparities worse and do irreparable harm to Minnesota’s fragile safety net system
- The potential opportunity the new system offers for achieving the state’s goals of reducing disparities is by addressing flaws in the current system:
  1. Current quality measures for clinics do not adjust for social determinants of health (“SDOH”) that impact quality scores.
  2. Current payment methods do not adequately account for the higher costs of the additional time and services needed to address SDOH needs of patients affected by disparities.
  3. Current clinic quality measures and payment methods do not prioritize wellness and prevention of serious, preventable chronic diseases, which are especially important for populations with serious SDOH that increase their health risks.
  4. Minnesota’s safety net system is chronically underfunded due to these flaws, which contributes to greater disparities for the high-risk and socio-economically complex Minnesotans and poses a serious risk that safety net providers will not have the financial resources needed to compete and succeed under a risk-based system.
- Fortunately, strategies and tools are available for addressing these flaws and calibrating the system to diminish risks that it will make disparities worse rather than better. The Coalition

recommends that the State follow the recommendations made in the recent National Quality Forum Health Equity Roadmap for value-based purchasing, including:

1. Collect social risk factor data.
  2. Use and priorities health equity outcome measures
  3. Invest in preventive and primary care for patients with social risk factors
  4. Redesign payment models to support health equity
  5. Support services with additional payment for patients with social risk factors
  6. Ensure organizations disproportionately serving individuals with social risk can compete in value-based purchasing programs
- In order for the State to achieve its goals of improving equity, achieving a patient-centered system, and improving the patient experience *for patients and communities affected by disparities*, these patients and communities must be fully engaged as partners at every level of the system and at every stage of the process from initial planning and design through implementation and continuing with monitoring the impact and outcomes of the new system.
  - The expedited process and aggressive timeline for implementing the new purchasing system poses even greater risks that the new system will exacerbate disparities and harm the safety net system. We strongly urge the State to slow down the timeline to give the state and all stakeholders more time to further develop the details for the new system, assess the potential risks and impacts before implementation, take the steps needed to prepare for the new system, and establish safeguards that will enable the state to take quick action to avert unintended harm to patients and providers.
  - The Safety Net Coalition and the many partners participating in the Quality Measurement Enhancement Project have developed expertise, tactics and tools that can be used to implement all recommendations of the Health Equity Roadmap. We look forward to working with the state and with IHPs, MCOs, providers and communities to take the steps needed to ensure that the new system achieves its goal of better health outcomes, lower costs and greater health equity for people enrolled in Minnesota's state health care programs.

## Safety Net Coalition Comments

The Safety Net Coalition's comments will focus primarily on how to achieve better health outcomes and lower costs for people who experience the greatest health disparities today. This is a subset of the total population of people enrolled in state health care programs and primarily affects only a subset of providers who have the greatest proportion of these types of high-risk patients. Our comment proposes specific, evidence-based tactics that will help ensure that the new Next Generation model is successful in reducing disparities for these particular individuals and communities. Even so, some of our proposed tactics may be valuable for improving population health and reducing future costs for *all* people, not just those with the greatest health disparities. This comment also focuses primarily on measurement and payment as it affects the health systems effectiveness in addressing social determinants of health and reducing health disparities. Other safety net providers and organizations are submitting more detailed comments separately.

We appreciate DHS' statements in the Request for Comments that reducing health disparities is a high priority for the State and acknowledging that social determinants of health ("SDOH") are major drivers of both overall population health and health disparities for some populations. The new system has the *potential* to reduce disparities if performance measures and payment methods are designed and implemented with this specific goal in mind and with adequate planning and preparation. However, the new system also raises a serious risk that the new system will perpetuate or exacerbate health disparities and lead to poorer health, less access, lower quality and higher costs for patients already experiencing health disparities today.

Warning bells have been sounded more and more frequently about the potential adverse impact of value-based purchasing systems on safety net providers and the serious risk that new payment models will exacerbate rather than reduce disparities. Examples of include:

- "In every type of care setting examined, providers that disproportionately served beneficiaries with social risk factors tended to have worse performance on quality measures. . . . As a result, safety net providers were more likely to face financial penalties in most of the value-based purchasing programs in which penalties are currently assessed." *Should Medicare Value-Based Purchasing Take Social Risk into Account?* New England Journal of Medicine (2017)
- "VBP schemes shift greater financial risk to providers. Because current VBP programs do not account for social risk factors for poor health outcomes, these programs may underestimate the quality of care provided by providers disproportionately serving socially at-risk populations. Consequently, these providers may be more likely to fare poorly on quality rankings." "When payment is tied to quality rankings under VBP, these providers may also be more likely to receive penalties and less likely to receive incentive payments. Moreover, these providers have historically been less well reimbursed than providers serving more advantaged patients and have fewer resources." *Accounting for Social Risk Factors in Medicare Payment*. National Academies of Science (2016).
- "Basic questions remain about whether value-based purchasing will improve quality and efficiency for Medicare. At the same time, there are concerns that such programs could



exacerbate disparities in care associated with race and socioeconomic status.” “Results show that hospitals caring for more disadvantaged patients did in fact fare worse in the first year of HVBP. . . . . Over time, resource reductions from the additive effects of these programs may cause quality of care to deteriorate among hospitals caring for more disadvantaged patients.” *Will Value-Based Purchasing Increase Disparities in Health Care?* New England Journal of Medicine (2013).

- “The impact of ACOs on racial disparities in quality will not be known for several years. Nevertheless, our findings are consistent with concerns that quality improvements achieved by Medicare ACO programs may not be associated with substantial reductions in health disparities, and may even be associated with larger disparities nationally if these programs disproportionately engage physicians and hospitals serving fewer minority patients. Additional incentives and novel payment arrangements may be required for ACOs to promote greater equity in care.” *Quality of Care and Racial Disparities in Medicare Among Potential ACOs.* Journal of General Internal Medicine (2014).

The Minnesota Health Care Safety Net Coalition – in partnership with a large coalition of organizations representing racial and ethnic communities, consumer and advocacy organizations, providers and health systems, researchers and educational institutions, and state agencies – has been working for several years to develop and test improvements to quality measurement and payment systems. This coalition is called the Quality Measurement Enhancement Project (QMEP). Through this work, QMEP has developed specific, actionable recommendations for components that can be incorporated into the new state purchasing model to increase the likelihood that health disparities will be reduced and reduce the risk that the changes will lead to worsening disparities.

Minnesota’s health disparities will get worse under this new system if the payments and incentives of the system do not adjust for several important factors:

- (1) SDOH affecting patients served by a clinic can have a negative impact on the clinic’s clinical quality scores that is not attributable to the clinical competence and effectiveness of the provider and clinic. The use of quality measures that do not adjust for the impact of SDOH penalizes safety net providers under standardized quality measures that do not adjust for socio-economic complexity.
- (2) Patients and communities with high disparities and SDOH complexity need more provider and staff time and special additional services to achieve better health outcomes. This means the providers who serve them need higher payments and funding compared to other providers serving patients who do not have these needs and barriers. If the new system ties provider payment levels to both quality scores and costs of services, safety net providers will receive less money under value-based payment because they will be categorized as higher-cost, lower-quality providers unless adjustments are made for SDOH complexity.
- (3) Current clinic quality and performance measures do not prioritize or reward providers for devoting time and resources to prevention and wellness. Current quality measures reward cost-effective treatment and management of *existing* chronic disease rather than preventing disease

from occurring. The current “preventive” measures are for immunizations and screening for existing disease. While this can produce short-term savings, it will not solve the larger problem of more and more people developing preventable chronic diseases due in part to lack of prioritization of wellness and prevention in the current system. To truly improve population health, the system must include performance measures and payment methods that reward providers for identifying and addressing health risks of their patients in order to improve their health, reduce the incidence of costly chronic disease, and reduce future health care costs in the long-term. For patients with the added complexity of social determinants of health, additional resources and services are needed for them to achieve optimal health.

- (4) The safety net system of providers who serve primarily low-income, high SDOH, high disparities populations has been chronically underfunded due to the inequities of the current payment and measurement system. This means that the providers that are most experienced and skilled at serving the most socio-economically complex populations with the greatest disparities do not have the substantial resources, reserves, technology and infrastructure that is needed to participate successfully in a complex, risk-based purchasing system.

These are examples of the systems and institutional structures that perpetuate and accelerate health disparities. The outcome of the current system is that patients and communities with the greatest needs receive far less than they need to realize better health outcomes and the safety net providers who serve them are chronically underfunded and disadvantaged under quality measures and payment models, compared to providers who serve patient populations with fewer disparities and SDOH complexities.

To prevent this system from making health disparities worse and doing serious and potentially irreparable harm to Minnesota’s safety net system, the new purchasing system must be intentionally and carefully designed to recalibrate provider quality measures and payment methods to reward health improvement and greater equity for populations with health disparities. Fortunately, we now have tactics and tools that can be used to accomplish this goal. We will provide general descriptions of these tactics and tools in this letter, but more specific and actionable information will be provided to DHS in follow up meetings and subsequent documents.

We recommend that the State follow the **National Quality Forum’s Health Equity Roadmap for Value-Based Purchasing** that is described in the report, *A Roadmap for Promoting Health Equity and Eliminating Disparities: the Four I’s for Health Equity*. This ground-breaking report provides specific, well-researched, evidence-based recommendations for implementing value-based purchasing models in a way that improves equity and prevents harm to the safety net system that serves those with the greatest health disparities.

The most important recommendations in the Roadmap are.

1. **Collect social risk factor data (NQF 1).** Data on SDOH is needed in order for providers to be able to identify and address patients’ SDOH risk factors and for the state and other purchasers to carefully calibrate quality measures and payment methods to take into account the varying levels of SDOH risk and complexity of different communities and patient populations. QMEP has identified specific strategies for implementing this recommendation. The Coalition recommends using a combination of patient-specific data recorded at the clinic level in the EHR system and population-specific data showing the SDOH risk profile of each clinic’s patient population using

geocoding methodologies that use various data sources to identify the SDOH risk factors that are prevalent in the neighborhoods in which patients live. Such data can be used to develop a SDOH risk profile for clinics that can be used to adjust quality measures and payment rates to the specific SDOH risk factors of the clinic's patients. A QMEP pilot project undertaken at the University of Minnesota has developed and tested this methodology. The Coalition will provide more detailed information on SDOH data collection tactics and tools.

2. **Use and prioritize health equity outcome measures (NQF 2).** Health equity is not a high priority in the current statewide quality measures or in the existing Minnesota Health Care Programs performance measures for providers and health plans. The new system is an opportunity to change this. The NQF report lays out specific strategies and options for measurement of progress toward health equity that are divided into five domains: (i) a culture of equity, (ii) structures that support equity, (iii) equitable access to care, (iv) quality of care that continuously reduces disparities, and (v) collaboration across organizations and programs to influence health by addressing SDOH. The new system should not be implemented until health equity measures have been incorporated at all levels of the health care system. Again, the Coalition is prepared to offer specific suggestions for development and implementation of health equity measures under the new purchasing system. Later in this comment letter we provide more detailed suggestions on the importance of health equity domains (i) and (ii).
3. **Invest in preventive and primary care for patients with social risk factors (NQF 4).** Lack of prioritization of prevention and wellness is a problem for the entire health care system but the problem is especially acute for populations with disparities and serious SDOH risk factors. The majority of Minnesota's existing clinical quality measures relate to screening or treatment of *existing* chronic diseases. Most of the chronic diseases that are driving health care costs are preventable and related to individual lifestyle choices and the impact of external SDOH factors. Yet, the only standardized statewide "prevention" measures in Minnesota are for immunizations – most of which do not prevent most of the diseases that are most costly and prevalent today. If the State wants better population health and lower future costs, the new purchasing system must include prevention and wellness quality measures in addition to measures of treatment quality. QMEP, the Minnesota Department of Health, and the Minnesota Association of Community Health Centers have been testing a clinic quality measure that could be deployed in the new system. The measure is based on evidence-based practices for prevention and wellness developed by Minnesota's Institute for Clinical Systems Improvement. Because prevention and wellness efforts are not adequately paid for or prioritized in the current system, new measures will need to be made a higher priority under payment models and financial incentives instituted so that providers have the resources necessary to improve their patients' health and prevent chronic disease.
4. **Redesign payment models to support health equity (NQF 5).** Minnesota's serious health disparities are caused in part by the fact that current payment and funding methods for state programs have produced chronic underfunding of services needed to improve health and treatment outcomes for the patients and populations with the most severe and complex SDOH risks and barriers. The NQF Roadmap identifies strategies for addressing this through up-front

payments, pay-for-performance models tied to addressing SDOH and reducing disparities, and quality measures that are appropriate for high SDOH-risk populations. The Coalition does not believe it is necessary to establish special SDOH related performance measures and payments for all Minnesota providers serving people on public programs. This may add unnecessary costs and burdens on providers who do not serve significant numbers of the patients with disparities and SDOH complexity. Instead, we propose that special performance measures and payment methods be used for a subset of clinics with the highest proportion of patients with the greatest disparities. The relative SDOH complexity of a clinic can be determined using the SDOH data collection methods recommended by the Coalition in number 1 above and and/or using other methods. We hope that DHS is now prepared to move ahead with alternative payment models to address SDOH risks because of the work that has been done in response to the Safety Net Coalition's legislative proposal that were enacted in 2015, requiring to DHS to develop alternative payment methods to address SDOH risk, and the subsequent legislation enacted in 2017 requiring DHS to consider and implement as appropriate alternative quality measures for safety net providers.

5. **Support services with additional payment for patients with social risk factors (NQF 7).** The NQF roadmap recognizes that some patients and populations need more time, resources and services for optimal health outcomes compared to others. Minnesota already has some special payment mechanisms that are intended to account for higher SDOH complexity of some providers' patient populations, such as the special FQHC payment methods, special rates for community clinics, and add-on dental payments for Critical Access Providers. We applaud DHS statements about the importance of SDOH and its request for specific suggestions on how to address SDOH under the new system. We appreciate the work that has already been done by DHS in response to the 2015 legislation requiring DHS to develop alternative payment methods that will address the higher costs of services provided by safety net providers to address social determinants of health in populations impacted by disparities. In addition to paying different tiers of PMPM and fee-for-services rates that are adjusted based on the SDOH needs of the patient population served, we recommend that the State consider implementing a "Pathways and Hub" outcomes-based payment model that uses a structured process for paying for specific steps taken and outcomes achieved in eliminating each SDOH barrier affecting a patient such as homelessness, health illiteracy, or language or cultural barriers. This nationally recognized, evidence-based model was brought to our attention by the Greater Twin Cities United Way through its work with the Healthy Communities Task Force funded in part by a grant from Medtronic. The Pathways and Hub outcomes-based payment system is described in greater detail in a comment letter they have submitted. We will later provide specific proposals for how to incorporate appropriate SDOH-focused payment methods into the new system. As we stated in relation to quality measures under number 4 above, we do not think it is necessary to establish special payment methods for all providers, but instead they can implemented for the subset of providers who serve populations with the greatest disparities.
6. **Ensure organizations disproportionately serving individuals with social risk can compete in value-based purchasing programs (NQF 8).** The NQF roadmap warns that value-based purchasing poses a risk of unfairly penalizing providers who serve the patient populations with

the greatest disparities and the most severe SDOH risk factors. The roadmap and this comment letter present a number of strategies and tools for reducing this risk. Further comments about how to prevent unintended harm to safety net patients and providers is provided later in this comment letter.

Fortunately, as a result of many years of work of many different state and national organizations and the past activities and projects of QMEP undertaken in partnership with DHS and MDH, we have already taken many steps to develop the tactics and tools needed to follow the NQF Health Equity Roadmap and achieve the health equity goals set forth in the Request for Comment. The new purchasing system proposed by DHS creates a unique opportunity for Minnesota to once again be a national leader in health care and a first implementer of the recommendations set forth in Health Equity Road Map.

### **A Patient-Centered System for People and Communities Impacted by Health Disparities.**

Before concluding our comments, we would like to take additional time to respond to the RFC's requests for comments on how to achieve patient-centered care and improve the patient experience with care. It is unclear from the Request for Comment document how this new system will be designed to be patient-centered and lead to an improved patient experience with the health care system specifically for patients and communities experiencing the greatest health disparities. Accomplishing these goals and achieving the overall goal of improving equity requires authentic partnerships with patients and communities, especially those who are most impacted by disparities. This speaks to the importance of establishing health equity measures and accountability in *all* of the NQF domains of health equity, including the expectation that all parts of the health care system adopt a culture of equity and implement structures that will authentically support equity, including engagement of patients and communities served in planning and implementing strategies to reduce disparities. This accountability should extend to all levels of the system: the State, IHPS, MCOs and health care providers.

We believe that an important component within the NQF health equity domains is evaluating how the consumers, patients and communities who are most affected by disparities are engaged, respected and treated as leaders and partners in designing and implementing the systems and changes that are intended to benefit them.

- On this point, we request more information on how the patients and communities most impacted by health disparities were consulted in the design of the new purchasing system to ensure that it is effective in reducing disparities and that members of these communities will receive truly patient-centered care and a better experience with the health care system. We also request information on the results of the department's assessment of the impact of both the existing IHP system and the proposed system on the state's serious health disparities. This kind of state agency community engagement and impact assessment has been a requirement of Governor Dayton for all departments preparing proposals for new policies, programs, legislation and funding requests.
- In addition to better understanding of how communities impacted by disparities participated in the development of the new system and how the potential impact on them was assessed, we request more information on how, in the future, patients and communities impacted by

disparities will be engaged as partners and continuously consulted by the state, IHPs, MCOs and health care providers as the new system is further developed and implemented at every level of the system.

The Coalition and QMEP have been engaging and consulting consumers and communities impacted by disparities in the development of our proposals and recommendations for quality measurement and payment. QMEP was initially initiated by racial, ethnic and immigrant community leaders seeking to improve health care data systems so that they make visible the health disparities experienced by each community so that the community could take action to address them.

QMEP recently completed a Community Based Participatory Action Research project through which community leaders from seven Minnesota racial, ethnic and cultural communities most impacted by disparities were engaged in answering the question of how to define “quality health care” from the perspective of those who are most impacted by SDOH forces and barriers. A few of the priorities heard from these communities were: (1) respectful, trusting relationships; (2) health equity structures and processes; (3) addressing structural and unconscious bias and discrimination; and (3) patient-centered care that is culturally responsive and maximizes health promotion. QMEP also completed a qualitative research study to obtain the perspectives of physicians and providers who serve high-SDOH-complexity populations about the relevance and impact of the state’s current statewide quality measures as applied to these high-risk populations. This type of data from consumers impacted by disparities and the providers who serve them is vitally important to achieve the State’s goal of improving health equity. We will provide more information on these activities and the findings of our research so that it can be used in further defining the new IHP/MCO purchasing system.

### **Process and Timeline for Implementation.**

We conclude our comments with our view that, if DHS proceeds with implementing this major change according to the process and aggressive timeline set forth in the Request for Comment, it is highly likely that serious unintended consequences will result. We expect that access and quality of care will decline, especially for the vulnerable and disadvantaged populations. Health disparities will worsen. Potentially, irreparable harm will be done to the safety net system.

The description of the new purchasing system is notably lacking in details. Without knowing specifically what performance measures and payment methods will be used and how other aspects of the system will be implemented, no one can adequately assess or model the potential impacts to determine if it is likely to work as intended and whether it may cause unintended harm to patients and providers. Because of the lack of details, no one is able to start now to prepare to respond to the coming RFP or make the changes that will be needed to be successful under the new system.

Additionally, a few months over the holiday season are not sufficient time for DHS to review all comments received and use them to more fully define the details of the new system to the extent that will be necessary to issue an RFP. After the RFP is issued, IHPs and MCOs will have only a few months to assess the RFP requirements, build provider networks, define their core health care benefits, establish new partnerships, identify what technology and staffing infrastructure is needed and how much it will cost, assess their ability to meet performance requirements and quality measures, and do complex financial modeling to determine the net impact of all of the different costs and payments. We urge DHS to slow down the timeline and do this right. This model has tremendous potential for improving the

health care system, reducing disparities and reducing future health care costs. But this potential will not be realized if this system is implemented without adequate time for careful planning and preparation and without full transparency of the details of performance measures and payments to enable advance modeling of impacts before implementation. Additionally, to anticipate potential problems and prevent them from occurring, we recommend developing “Use Case” case study examples of particular patients and circumstances posing the greatest risk of unintended adverse consequences and the greatest opportunities for health improvement and equity for patients experiencing disparities.

Because we expect that serious problems are likely to occur and that safety net patients and providers are likely to be the ones most harmed, we request that the State establish a quick response system that will enable the State to identify emerging problems early before it is too late and step in to take whatever actions are needed to avert disastrous consequences. This will likely require setting aside reserve funds that can be deployed on short notice. In addition to the quick response system, we recommend that the entire system be continuously monitored and evaluated to determine if it is achieving the desired outcomes so that mid-course corrections can be made to keep the system on track to a successful outcome.

In conclusion, Minnesota’s safety net community has both high hopes and great fears about the new state purchasing system. We greatly appreciate the high level of cooperation and support that we have received from DHS and the Minnesotan Department of Health in our long-standing efforts to address flaws and shortcomings in our existing measurement and payment systems. Our high hopes are that these changes will improve the health and outcomes for the most disadvantaged and vulnerable Minnesotans and reduce Minnesota’s health disparities that are among the worst in the nation. Our fears are that the new system will not work as intended and will make things worse rather than better for these Minnesotans.

The Safety Net Coalition intends to provide additional information with more detailed recommendations for how the proposed new purchasing system can be designed to achieve greater health equity based on the National Quality Forum Roadmap and the quality measurement and payment lessons, tools and tactics developed under the QMEP project. We also request an opportunity to meet with DHS to learn more about DHS’ intentions for the new system and go through our recommendations for addressing health equity. For more information and to schedule a follow-up meeting, please contact Michael Scandrett at [miscandrett@msstrat.com](mailto:miscandrett@msstrat.com) or 612-790-2547.

### Selected Sources:

1. *A Roadmap for Promoting Health Equity and Eliminating Disparities* (National Quality Forum, September 2017). [National Quality Forum Health Equity Roadmap](#)
2. *Pathways Community Hub Manual: A Guide to Identify and Address Risk Factors, Reduce Costs and Improve Outcomes*. (Agency for Healthcare Research and Quality, January 2016). [Pathways Community Hub Manual](#).
3. *Advancing Health Equity in Minnesota*. (Minnesota Department of Health, February 2015). [MDH Advancing Health Equity Report](#).
4. *Accounting for Social Risk Factors in Medicare Payment* (National Academies of Science, January 2017). [National Academies - Accounting for Social Risk Factors](#)
5. *Quality Measurement Enhancement Project (QMEP): Accounting for Social Determinants of Health*. (Minnesota Physician, October 2016). [Minnesota Physician - QMEP](#)
6. *Review of Social Determinants of Health used in Electronic Health Records and Related Semantic Standards*. (Office of Health Information Technology, Minnesota Department of Health, October 2015). [Social Determinants in Electronic Health Records - Minnesota Office of Health Information](#)
7. *Should Medicare Value-Based Purchasing Take Social Risk into Account?* (New England Journal of Medicine, February 2017). [NEJM - Value-based Purchasing and Social Risk](#)
8. *Will Value-Based Purchasing Increase Disparities in Health Care?* (New England Journal of Medicine, 2013). [NEJM Value-Based Purchasing - Will It Increase Disparities](#)
9. *Quality of Care and Racial Disparities in Medicare Among Potential ACOs*. (Journal of General Internal Medicine, 2014). [Quality and Racial Disparities in ACOs](#)
10. *Report to Congress on Social Risk Factors and Performance under Medicare's Value-based Purchasing Programs* (US Department of Health and Human Services, December 2016). [HHS Report - Social Risk Factors in Value-based Purchasing](#)
11. *Authentic Community Engagement: A Key to Racial Equity* (Voices for Racial Justice). [VRJ - Equity through Authentic Community Engagement](#)
12. *Institute for Clinical Systems Improvement: Healthy Lifestyles Guideline Summary*. (ICSI, January 2016). [ICSI Wellness and Healthy Lifestyle Best Practice Guidelines](#)
13. *Integrating Social Determinants of Health with Treatment and Prevention: A New Tool to Assess Local Area Deprivation* (Centers for Disease Control and Prevention, September 2016). [Geocoding Tools for Assessing Social Risk Factors](#)
14. *Health Equity of Care Report*. (Minnesota Community Measurement, 2015). [MNCM Health Equity](#).



**From:** Arnie Anderson  
**To:** [MN DHS DHS PSD Procurement](#)  
**Subject:** public comments -- Outcomes-Based Purchasing Redesign and Next Generation IHP  
**Date:** Tuesday, December 19, 2017 12:14:25 PM

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To Whom it May Concern,

Thank you for this opportunity to comment.

We strongly support and encourage your inclusion of social determinants of health as a core health care cost containment and health outcome strategy. Thank you.

In that regard, we encourage future efforts to:

1. Require external evaluation to better understand the degree to which prescribed health care therapies are, or are not, implemented and maintained at therapeutic levels in the Medicaid population.
2. Support systems that collect social service data that is sufficiently granular so as to allow meaningful cost benefit calculations vis a vis the cost of health care interventions. For example, a personal health care record might collect the drug, the dosage, the frequency and the cost per unit. If that same individual receives housing services, those services need to be similarly tracked with sufficient granularity for meaningful cost/benefit analysis to be performed.
3. Support data system design that facilitates client data sharing, as directed by the individual, across the full range of service partners by connecting privacy permissions to individual data elements rather than globally to an individual's entire record.

Thank you for your consideration,

Arnie

Arnie Anderson, CCAP  
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Community Action: Helping People. Changing Lives.



Broadway Place East | Suite 455 | 3433 Broadway Street NE | Minneapolis, MN 55413

December 15, 2017

Ms. Julie Marquardt  
Director, Purchasing and Service Delivery Division  
Minnesota Department of Human Services  
540 Cedar Street  
Saint Paul, MN

Dear Ms. Marquardt:

Thank you for the opportunity to comment on the Minnesota Department of Human Services (DHS) proposed redesign of health care purchasing through Integrated Health Partnerships (IHPs) and Managed Care Organizations (MCOs).

MN Community Measurement's (MNCM's) comments focus on two key areas that we believe are critical to the success of value-based purchasing initiatives: quality measurement and data sharing with provider organizations. In addition, we offer some suggestions related to Medicaid enrollees' prospectively choosing primary care clinics.

### **Quality Measurement**

With increasing focus by state, federal, and private payers on value-based purchasing, it is important that quality measures be aligned across payers to the degree possible. Minnesota has led the nation in implementing a Statewide Quality Reporting and Measurement System (SQRMS) that focuses on meaningful quality measures, many of which are outcome measures. Through a consensus-based multi-stakeholder process, Minnesota has built a robust quality measurement and reporting system that produces comparable, transparent results across health care providers on a set of measures that are responsible for significant chronic disease burden and cost – especially for diabetes, vascular disease, asthma, and depression. These measures are currently used extensively by payers and health care providers in quality improvement efforts, as well as by consumers and employers. Having a common set of measures enables stakeholders to focus on a common set of priorities, rather than multiple payers each sending different – and possibly conflicting -- messages to providers about priorities for quality improvement.

The implementation of Medicare's Merit-Based Incentive Payment System (MIPS) beginning in 2017 has created a new set of challenges for Minnesota with respect to the goal of aligning

quality measures across payers. From MNMCM's perspective, two key points are important to keep in mind. First, because of the large number of measures in MIPS it is highly likely that providers will make different choices about which measures to submit to CMS, making it difficult for DHS to align its quality measures for IHPs and MCOs to MIPS in a way that does not increase reporting burden for at least some, if not all, providers (assuming that DHS intends to use a core set of quality measures that are comparable across providers). Second, the Centers for Medicare and Medicaid Services (CMS) have indicated a strong preference for MIPS to move toward outcome measures, and especially patient-reported outcomes, over time. Many measures that are currently included in Minnesota's SQRMS are either already in MIPS or under consideration by CMS to be added to MIPS through rulemaking in 2018.

Page 13 of the Request for Comment notes that "To 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." Measurement burden is an important consideration, and we offer a few comments on this topic:

- First, it will be important not to sacrifice meaningful measurement in the process of seeking to reduce reporting burden; many claims-based indicators measure processes rather than outcomes and thus provide less valuable and meaningful information about the quality of care.
- Second, we were glad to see that DHS is interested in supporting efforts to use electronic clinical data for quality measurement. MNMCM currently has an initiative under way to lessen the burden of reporting by streamlining the ways in which providers can submit clinical information, which will reduce the level of effort required to extract, submit, and validate data. The primary goal of this effort is to achieve a better balance between the value and the burden of measurement.
- Third, clinical data currently collected by MNMCM offer potential opportunities for DHS to incentivize and measure progress toward reducing disparities that claims data do not. This is because MNMCM's clinical measures include information on patients' race, ethnicity, language, and country of origin that could be used to measure progress toward reducing disparities, a key goal of DHS's health care programs.

With regard to future uses of clinical data for quality measurement, as you know MNMCM is a nationally regarded developer of quality measures, with several measures that have been endorsed by the National Quality Forum and/or included in CMS payment programs. To the degree that existing quality measures do not meet DHS's needs, we would be willing to discuss a potential collaboration on development of new measures in the future.

Finally, we wish to note that the Minnesota Department of Health's SQRMS no longer includes a requirement for providers to report patient experience survey data. As such, MNMCM will not be collecting these measures for public reporting purposes. However, we still have the infrastructure required to collect and analyze these measures on behalf of DHS, if desired.

## **Data Sharing With Provider Organizations**

For providers that choose to participate in value-based purchasing arrangements, the availability of timely, actionable information that helps them to manage their patients' care is critically important. DHS's commitment to making data available to providers for this purpose is to be commended.

As with quality measurement, differences across payers in how they approach data feedback to providers have the potential to increase burden and frustration, with results that are less than optimal compared to what would be possible if providers had access to data and feedback reporting that is streamlined across payers. MNMCM is in the beginning stages of an effort to determine the best ways to streamline provider data feedback across payers, and we welcome DHS's participation and input. With our history of multi-stakeholder collaboration and strong data collection and reporting capabilities, MNMCM is well positioned to facilitate this cooperative effort that has the potential to help all payers, including Medicaid, make more progress toward their goals through collaboration than they could alone.

## **Prospective Choice of Primary Care Clinic**

The Request for Comment outlines a system in which enrollees will select a primary care clinic upon initial enrollment and annually during open enrollment. Among other things, having enrollees assigned to primary care clinics will facilitate more proactive management of individual patients, since providers will know in advance which enrollees they are responsible for. To assist enrollees in selecting a clinic, it may be beneficial for DHS to make available user-friendly information on relative cost and quality of care, such as the clinic-level quality data currently published by MNMCM, to enrollees at the time they are selecting a clinic. For enrollees who do not select a clinic on their own, DHS envisions assigning them to clinics based on historical utilization or geography; MNMCM suggests that DHS may wish to consider also incorporating provider cost and/or quality into the assignment method, in order to reward high-value providers and reinforce progress toward DHS's goal of improved value in the Medicaid program.

I look forward to seeing the next iteration of DHS's proposal and would be happy to provide additional information as needed.

Sincerely,



Julie J. Sonier  
President, MN Community Measurement  
612 454-4812  
[sonier@mncm.org](mailto:sonier@mncm.org)

Sue Abderholden, MPH  
NAMI Minnesota  
Executive Director  
(651) 645-2948 ext. 105  
[sabderholden@namimn.org](mailto:sabderholden@namimn.org)

I am submitting comments on behalf of NAMI Minnesota concerning the Department of Human Services pilot program on Integrated Health Partnerships (IHPs)

In their first four years, IHPs across the state have served 460,000 Minnesotans, improved health care access for outcomes for those served, reduced hospital admissions by 14% and saved the state nearly \$213 million. The new developments for the IHP program are promising and will lead to more choices for Minnesotans who qualify for coverage through an IHP. However, additional attention will be required to ensure that people living with a mental illness are able to benefit equally from Minnesota's IHP program. NAMI would like to highlight 4 key issues for DHS to consider:

- 1. Issue a Statewide Drug Formulary for All People on Medical Assistance.** People living with a mental illness faced many challenges when Medicaid plans changed through the competitive bidding process and people had to work with a new formulary. In many cases, people had to switch medications or go through a step-therapy protocol in order to receive the prescription drugs that had already been proven to effectively treat their mental illness. A statewide formulary for all Medicaid recipients, and not just those served through the IHP program, will decrease confusion and remove administrative hurdles for people with a mental illness to get the treatment they need.
- 2. Allow people to choose their mental health provider as the point of contact and not primary care.** For many people with a mental illness, the most important medical relationship that they have is with their mental health provider. This is especially important for young people who are unlikely to have a primary care provider they see routinely. The new IHP pilot program should give people with a mental illness the flexibility to designate their mental health provider as the point of contact.
- 3. Ensure that there is an adequate mental health network.** NAMI strongly supports the efforts made by the IHP pilot project to increase consumer choice in their health care provider. Unfortunately, people living with a mental illness consistently face inadequate networks when it comes to seeking their mental health or substance use disorder treatment. We encourage DHS to continue their efforts on network adequacy for mental health care so that people with a mental illness can access mental health treatment.
- 4. Ensure IHPs share their per-capita dollars to support non-billable supports.** One of the most innovative parts of the IHP pilot project is the way it incentivizes a transition from a fee-for-service payment model to payments based on the overall health of the covered group through per-capita payments. It is important that the per-capita benefits are distributed equally across the health care system and include peer support specialists, community support programs, and support the expansion of other non-billable services that support recovery.

**Conclusion**

The IHP pilot project is a promising and innovative model for delivering efficient, consumer driven health care. NAMI urges DHS to consider the unique challenges and persistent inequities that people with a mental illness face when seeking coverage for mental health and substance use disorder treatment.

Thank you for your time and attention.

Sincerely,

Sue Abderhodlen, MPH  
Executive Director



Commissioner Emily Piper  
Attn: Health Care Administration  
Minnesota Department of Human Services  
P.O. Box 64983  
St. Paul, MN 55164-0983

December 20, 2017

Submitted electronically to [DHS.PSD.Procurement@state.mn.us](mailto:DHS.PSD.Procurement@state.mn.us)

**RE: North Memorial Health's Response to the Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP**

Thank you for the opportunity to provide comments on the state's proposed purchasing strategy for Medical Assistance and MinnesotaCare families and children enrolled in the metropolitan area.

North Memorial Health (NMH) is a health system with 2 hospitals, North Memorial Health Hospital and Maple Grove Hospital, 26 clinics including primary, specialty, and urgent care across the Northwest metro area and some rural locations. NMH operates an expansive emergency response with 9 helicopters serving 6 air bases and 126 ambulances serving 9 ground regions. NMH employs over 5,000 team members, including nearly 500 care providers, serving over 55,000 customers per month. While North Memorial Health strives to customize services for a diverse population, a large portion of our population relies on government sponsored insurance for coverage, overall, NMH sees around 40% Medicare and 20% Medical Assistance with the remainder commercial and self-pay.

North Memorial Health has participated in the Integrated Health Partnership (IHP) program since its inception and our IHP has been successful in reducing the total cost of care for our attributed members each year. Starting in 2016, NMH partnered with additional, independent primary care providers to develop a more robust network for MA enrollees in our IHP model. At that time, we grew from around 5,000 to 30,000 attributed members, additional partners include: Stellis Health, North Clinic, MultiCare Associates, Northwest Family Clinics and Broadway Family Medicine. We expect our 2017 performance to be in line with previous years, showing success in reducing the total cost of care.

North Memorial Health, along with other legacy IHPs, has started to realize the challenges in the IHP model to continue to achieve incentive payments based on improved total cost of care benchmarks with multiple years of success and welcome the evolution of this model to incent providers, align stakeholders, and ultimately save money within the health care system. While we look forward to continuing a partnership with the state in exploring purchasing strategies for Medical Assistance and MinnesotaCare enrollees, we recognize the healthcare portion of the overall Health and Human Services budget is very small. We look forward to seeing

additional creative ideas from the department and industry on reducing the total cost of care in other areas including long term care and disability and waived services.

We appreciate the state exploring creative strategies to purchasing health care for Medical Assistance and MinnesotaCare enrollees and will be interested to see the final Request for Proposal as we consider responding. We have a number of questions and concerns with the framework outlined in the Request for Comment, including:

### **Member Enrollment**

We agree a provider-patient relationship is very important and should be a significant factor in the enrollment process, however, we have concerns with the level of disruption this model could have within this population. With high default rates in the current managed care model, there will need to be significant education to enrollees on the choice they are making and the consequences of that choice. We hope to partner with DHS and other stakeholders in the education of enrollees for any significant disruption in the public program enrollment process. At the same time, for those who do not choose, the criteria for default will be very important and have significant consequences on those participating as Next Generation IHPs.

It is unclear how the options will be presented at the county level (options of IHPs and MCOs), and each county is very unique with a wide range of provider systems dominating different geographic areas. While this will all be within the seven-county metro area, we hope DHS will be thoughtful in mapping options for enrollees. Our fear is being accountable for the cost and care for enrollees who have chosen NMH but do not reside in the geographic area, have transportation barriers, and have not typically been a patron of our system. When we participated in the Coordinated Care Delivery System an enrollee in Duluth chose NMH to be their care provider which caused significant strain on that model.

As this model moves forward, we look forward to partnering with DHS and other stakeholders in developing the details of enrollee education and outreach strategies, the default methodology, and operations of enrollee choice to ensure Next Generation IHPs have sufficient enrollment to be successful.

### **Primary Care Exclusivity**

#### *Primary Care Exclusivity*

The details in which the primary care exclusivity is implemented will have tremendous impact on the enrollment and success of the Next Generation IHP model. NMH believes the provider choice would be most effective at the clinic level, rather than the individual provider or system. There will still be many challenges within this model, especially with super utilizers of the health care system, but identification at the clinic level will allow for some movement of enrollees to see additional providers within the clinic and providers to move between clinics without significant disruption. We believe it will be necessary to be able to communicate directly with

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enrollees during the selection and enrollment process to ensure they are familiar with NMH primary care, the clinic they are choosing, and the choice they are making.

#### *Administrative Complexities*

We appreciate this framework intends to align accountability for cost and care with the primary care provider, however, this model adds another layer of complexity to the administration and contracting with the managed care organizations and the state. It will reduce the number of contracts we have for the population that is enrolled in a Next Generation IHP for those primary care clinics only, but for the remainder of our system— urgent care, hospital services, specialty care, etc.— we will continue to operate under multiple contracts with plans and the state. While this simplifies the administration in one area of our service model, this would ultimately add to the complexity of our overall contracting strategy and potentially effect contracts for care delivery in other populations.

North Memorial Health does not currently have the resources to administer all of the outlined administrative services that would be a Next Generation IHP's responsibility and would have to analyze and determine whether to build capacity internally or contract with another entity that has the necessary expertise. With that, it may be more economical and efficient to have one relationship for all administration services, rather than dividing responsibilities among entities.

#### **Network Design and Adequacy**

##### *Narrow Network Design*

We, along with many other providers, have been advocating for a stronger attribution model within the IHP and recognize the Next Generation IHP enrollment moves in that direction. We have concerns with the implementation and consequences when Next Generation IHP enrollees seek care outside of the preferred network, aside from emergency services. While we understand there have been administrative challenges with claim denials and maintaining preferred networks historically within the managed care model, it will be important to have some requirements and an approval process to ensure Next Generation IHP enrollees remain within the preferred network, as often as possible, to control cost and quality.

While NMH is interested in learning more about the details of the model, including the network design and enforcement within the Medical Assistance and MinnesotaCare populations, we hope DHS will think creatively about the options that may be available to providers to enforce or incent enrollees to remain in network. Without copays, deductibles, and other tools managed care uses in other lines of business, enrollee incentives may be a good solution to maintaining care within the preferred network. We look forward to continuing to work with DHS and other stakeholders on developing a feasible system for preferred and narrow networks for enrollees.

### *Network Adequacy*

In order for this model to be successful, the state will need to think creatively about determining and approving preferred networks. With shared responsibilities between the state and providers and the use of technology in health care, there is a unique opportunity to implement creative network adequacy requirements. Even though many systems, including NMH, are operationalizing and evolving telehealth capabilities and other unique care models, alternative consumer access points should be considered in determining network adequacy. Alternative consumer access points allow providers to meet customers where it is convenient for clients and utilizes technology that has been underutilized in the health care industry, to ultimately deliver the right level of care at the right time to those who choose to engage in their health care in this way.

Since a Next Generation IHP would still be responsible for the cost and quality for those additional or wrap around services that DHS intends to administer, it would be necessary for a Next Generation IHP, in partnership with the administration organization, to outline a preferred provider network. We hope to explore the possibility of preferred networks within the services that are managed by DHS in order to work with partners and have some control over cost and quality.

### **Metro vs Greater MN**

We have around 30,000 attributed members in our current IHP and around 19,000 of our attributed members reside in the metro counties. Because we serve a mix of metro and rural enrollees, we will be in a unique situation in determining how to divide our network if we were to participate in the Next Generation IHP framework. While there are many benefits to starting this in the metro area, this is a significant concern with the limited scope and we hope to work with the department in determining how to best address this unique challenge.

### **Payment Model and Reserves**

In a shared responsibility model, as outlined in the RFC, we understand there will be some risk-based reserves a Next Generation IHP is required to have. Without significantly more detail on the amount of risk, fee-for-service fee schedule, projected enrollment, and amount of reserves necessary, it is difficult to determine our capacity or ability to participate in the Next Generation IHP model.

### **Other Considerations**

#### *Minimum and Maximum Enrollment*

Without additional details on the size of enrollment, risk of the population, capitation amounts, and more, it is challenging to estimate what the minimal beneficiary amount would need to be for NMH to be successful in this model. NMH would be interested in additional information from DHS around enrollment estimates and the minimum and maximum enrolled beneficiaries

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Next Generation IHP

and health system participation in the Next Generation IHP model in order for the model to be successful.

*Social Determinants of Health*

For a health system that has historically served a significant proportion of low income individuals with government sponsored insurance, it is increasingly more important to better understand the challenges our customers have beyond just health care challenges, but also the barriers to receiving care. Through its evolution, the IHP model has been the first to provide upfront, flexible funding for care coordination and addressing some of the social determinants of health our customers face, but there has not been the research necessary to understand the additional time and resources needed to serve individuals that experience multiple barriers to receiving care and maintaining good health.

Again, on behalf of North Memorial Health, we sincerely thank the Department, including the Health Care Administration and other divisions within the department, as well as other partners involved in outlining this framework and allowing stakeholders to comment on the framework before releasing a Request for Proposal.

Sincerely,

A handwritten signature in black ink, appearing to read 'Aaron Bloomquist', with a stylized flourish at the end.

Aaron Bloomquist  
Chief Financial Officer

**From:** Diane Thorson  
**To:** [MN\\_DHS\\_DHS PSD Procurement](#)  
**Subject:** Integrated Health Partnerships  
**Date:** Monday, December 11, 2017 3:24:32 PM

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The concept is good.

In smaller rural communities, there are multiple independent providers of service. It would be more challenging for a local clinic/hospital system to manage the cost of care for providers that are not a part of their system. Partnership development should come first, then application to incorporate services such as dental, chiropractic, and vision into the IHP contract with a clinic/hospital system.

I am fearful that due to the lower reimbursement rates that more providers will decide not to serve that population. We have seen this occur in the dental provider community. We already have chiropractors not contracting with health plans. So far I have not heard of an issue with vision-however persons are limited to a smaller selection of eyewear products at the provider offices.

Diane Thorson, M.S., R.N., P.H.N.  
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December 15, 2017

Minnesota Department of Human Services  
Delivered via email: [DHS.PSD.Procurement@state.mn.us](mailto:DHS.PSD.Procurement@state.mn.us)

**Re: Request for Comment on Outcomes-Based Purchasing Redesign  
& Next Generation IHP**

To Whom It May Concern:

On behalf of the Pharmaceutical Care Management Association I am respectfully submitting comments at the Department for Human Services open request in your recent Request for Comments on Outcomes-Based Purchasing Redesign & Next Generation IHP. PCMA is the national trade association representing pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided through large employers, health insurance plans, labor unions, state-funded health programs, and Medicare Part D.

Both brand and generic drug manufacturers are raising drug prices, sometimes to excessive degrees. There are few tools that payers can use to help drive down net costs of providing a pharmacy benefit. Among those tools is the ability to negotiate rebates from manufacturers. Rebates are a form of discount that reduces the net costs of drugs retrospectively (typically on a quarterly basis after drugs have been dispensed to patients). In Medicaid, those rebates that are collected on behalf of the Medicaid program by private MCOs are transferred to the state and federal government to help offset costs in the Medicaid program.

The Request for Comments document poses the following questions:

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 NextGeneration 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?

PCMA proposes the Department take into consideration the following information.

**States That Have Limited MCOs' Ability to Manage the Medicaid Pharmacy Benefit Have Experienced Higher Overall Drug Costs and Lower Generic Dispensing Rates.**

PCMA understands that the state's goal is to reduce drug costs and maximize supplemental rebates from drug manufacturers. However, the restriction on the MCOs' ability to manage Medicaid drug costs in other states has shown to actually increase overall costs.

Florida enacted a single PDL in 2011 at the same time it moved to a statewide Medicaid managed care program. Early data showed that Medicaid MCOs were suffering monetary

losses, which appeared to be related to higher than expected prescription drug utilization. One analysis found that “[o]verall, drug, generic, and non-formulary brand drug utilization declined by 9%, 13% and 97%, respectively, while formulary brand drug utilization increased by 50% among Florida Medicaid members” after the policy was implemented.” Also, “overall plan costs and formulary brand drug costs increased by 45% and 49% respectively, while generic plan cost declined by 13%. On a per member basis, formulary brand drug costs went up from \$21.54 pre-policy to \$55.75 post-policy.” These findings “highlight the unintended consequences of decreased drug utilization and increased plan costs that may result from state-mandated PDLs.”<sup>1</sup>

In addition, Texas limits the ability of MCOs to manage the pharmacy benefit for Medicaid beneficiaries. The Texas Association of Health Plans in 2016 retained the Menges Group to review Medicaid drug costs in the state.<sup>2</sup> There were several important findings:

- The Menges Group concluded that “[s]ecuring relatively large rebates was not an effective strategy in achieving optimal net costs.” Despite obtaining average rebates of \$43.55 per prescription, which were 24.4% above the USA average (\$35.00), the average net cost per prescription across the 17 states that had highest rebates (\$43.09) was 15.3% above the national average (\$37.37). The 17 states with the highest generic dispensing rate and the 17 states with the largest rebates per prescription are entirely separate groups of states. **Maximizing rebates and optimally managing drug mix are two separate strategies that are in conflict with each other, with managing drug mix producing lower overall prescription drug spending for state Medicaid programs.** Net costs in the top third of states with regard to generic mix are 24.1% below the net costs per prescription in the top third of states with regard to rebates per prescription.
- **Use of generics was strongly correlated with achieving relatively low net costs.** The states in the “top third” with regard to generic dispensing rate (generics as a percentage of all Medicaid prescriptions) consistently achieved highly favorable net costs per prescription. This group of 17 states collectively had a net cost of \$32.72 per prescription (post-rebate) during FFY2014, which was 12.5 percent lower than the national average and 9.6% lower than Texas. Of the 17 states in the top third with regard to generic dispensing rate, 13 were also in the top third of states in terms of lowest net costs per prescription; 10 were among the top third in terms of the degree to which Medicaid prescriptions were paid by MCOs.
- TAHP reported that the Menges Group found that:<sup>3</sup>
  - Twenty-one other states outperform Texas on lower Medicaid net (after rebate) costs per prescription drug, and Texas ranks 45<sup>th</sup> in the country on the use of generics.

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<sup>1</sup> *Does Florida Medicaid’s State-Mandated Formulary Provision Influence Prescription Drug Utilization and Costs?*, Express Scripts, 2015.

<sup>2</sup> Menges Group, *Assessment of Medicaid MCO Preferred Drug List Management Impacts*, Prepared for Texas Association of Health Plans, February 2016.

<sup>3</sup> Texas Association of Health Plans, Fact Sheet: Prescription for Medicaid Rx Savings, 2016.



- The top third of high performing states, which focus more on lowering drug costs rather than maximizing rebates, have Medicaid net per-prescription drug costs that are 21% lower than the national average and 19% lower than Texas.
- The use of generics in Texas is 4.6% below the national average and that Texas' approach favors more expensive brand name drugs. Texas has "achieved a relatively low net cost per prescription for brand name drugs," but because brand name drugs are still 5 times higher than generic drugs in Texas (6.5 times nationally), greater use of brand name drugs over generics is not offset by the increased rebate revenue. As a result, Texas ranks 9<sup>th</sup> in rebate revenue, but only 22<sup>nd</sup> in overall net cost per prescription after rebates.
- The states that focused more on managing drug costs rather than maximizing rebates spent 21% less than the national average on net per drug costs.

These two states demonstrate how limiting MCOs' ability to manage prescription drug benefits can be shortsighted and ultimately cost the program even more.

Again, PCMA understands and agrees that manufacturer list prices for drugs are unreasonable and need to be reined in, especially in public programs. However, PCMA believes that restrictions on the formulary management tools that payers have to reduce net costs could prove costly for Minnesota. If you have any questions about our position, please contact me at 270-454-1773.

Sincerely,

Melodie Shrader  
Senior Director, State Affairs



**To:** Mathew Spaan, Health Care Policy Specialist  
Health Care Administration – Office of the Assistant Commissioner  
Department of Human Services

**From:** Leah Montgomery, Director of Government Affairs and Health Finance  
Planned Parenthood Minnesota, North Dakota, South Dakota

**Date:** 12/19/17

**Re:** Request for Comments, Next Generation Integrated Health Partnerships (IHP)

Thank you for the opportunity to comment on the redesign of DHS' Medicaid and MinnesotaCare purchasing and delivery strategies proposed through the Next Generation IHP model. Planned Parenthood Minnesota, North Dakota, South Dakota (Planned Parenthood) applauds DHS' continued efforts to improve health outcomes for public program enrollees, coordinate care across provider settings and pay for value over volume.

Planned Parenthood has been providing high-quality, affordable reproductive health care services in Minnesota since 1928. Today, our statewide network of 18 clinics provide necessary preventive health care services – including family planning services, STD testing and treatment and cancer screenings - to more than 66,000 Minnesotans every year. Most of our patients are women, ages 20-29. Three-quarters have incomes below 200% of the Federal Poverty Level and one-third are of diverse racial or ethnic backgrounds. Nearly 40% of our patients consider us their main source of health care, with one-third of patients saying that they have no other health care provider.

While Planned Parenthood does not fit the parameters of a Next Generation IHP envisioned in the request for comment (RFC), we respectfully request that DHS consider future reforms that bolster preventive services, recognize the distinct health care needs of women and appropriately value the services provided by reproductive health providers.

**Overview of Planned Parenthood and our Services**

Planned Parenthood is an essential part of Minnesota's health care landscape. We care for over 66,000 Minnesotans each year through our Online Health Services and our statewide network of 18 clinics (10 in greater Minnesota, five in suburban communities and three in Minneapolis/St. Paul). Fifty five percent of our Minnesota clinics are located in rural or medically underserved areas, making us a vital source of preventive and primary care in areas of the state where access to health care may be sparse.

Planned Parenthood provides comprehensive reproductive and sexual health services including well-woman visits, contraception counseling and access, STI testing and treatment, blood pressure screening,



BMI screening, depression screening, and breast and cervical cancer screening. In 2016, Planned Parenthood performed 56% of abortions in Minnesota.<sup>1</sup> Additionally, Planned Parenthood meets our patients' specific care coordination needs by referring to specialty providers for mental health services, prenatal and pregnancy services, mammography, and cancer diagnosis or treatment. We also create rigorous follow-up plans for patients who require additional care or treatment.

## **Distinct Health Care Needs of Women and the Role of Preventive Services**

The health care needs of women are intimately tied to their reproductive health care needs. Indeed, for most young and healthy women, reproductive health care is their primary health care need. Therefore, to account for the needs of all covered beneficiaries, we encourage designing a payment methodology that better accounts for prevention's role—and especially the role of family planning services—in averting costs to the health care system in Minnesota.

Excellent primary and preventive care for women integrates reproductive health care into the constellation of traditional primary care services. Primary care and preventive care for women must go beyond controlling high blood pressure, maintaining a health weight, limiting tobacco use and preventing other chronic conditions. In addition to those critical services, pregnancy intention, effective contraception use and sexually transmitted infection (STI) prevention are critical pieces to ensuring that women can maintain or improve their health status and avoid more costly conditions in the future.

Many of the preventive services Planned Parenthood provides avert future Medicaid costs, including contraception services, blood pressure screening, BMI screening, depression screening, and breast and cervical cancer screening. Family planning services, in particular, are shown to achieve a significant return on investment; for every \$1 invested in family planning, \$7 in future Medicaid costs are averted.<sup>2</sup> Additionally, because Planned Parenthood patients are primarily young, we help them set a foundation for avoiding unintended pregnancies and for establishing sound health care habits, thereby improving health outcomes and lowering costs into the future.

Thus, Planned Parenthood and other prevention-oriented providers add value to the health care system and control costs by identifying issues that our patients face early in their lives. We ask that DHS consider future payment reforms that recognize the value of averting future costs to the system. We would be happy to partner with DHS in exploring payment strategies that can capture and appropriately reward providers for focusing on preventive care services that achieve the triple aim of higher quality, improved population health and reduced costs in Minnesota.

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<sup>1</sup> Induced Abortions in Minnesota, January –December 2016: Report to the Legislature (July 2017). Retrieved from <http://www.health.state.mn.us/divs/chs/abrpt/2015abrpt.pdf>

<sup>2</sup> Frost, J.J., Sonfield, A., Zolna M.R., and Finer, L.B. (2014). Return on Investment: A Fuller Assessment of the Benefits and Cost Savings of the US Publicly Funded Family Planning Program, *Millbank Quarterly*, December; 92(4); 667-710. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4266172/>

## **Primary Care vs. Primary Source of Care vs. “Primary Care Exclusivity”**

Nearly 40% of Planned Parenthood patients consider us their main source of health care, with one-third of patients saying that they have no other health care provider. For a substantial number of our patients, reproductive health care is their primary health care need and we are their primary *source* of care. In addition to our reproductive health care services, Planned Parenthood also provides primary care services, including blood pressure screening, BMI screening, depression screening and tobacco cessation services.

However, the definition or extent of primary care services required to participate in the Next Generation IHP model (and earlier IHP iterations) remains unclear. Moving forward, it would be helpful to distinguish between primary care and primary *sources* of care. This distinction would better enable smaller and/or specialty providers to evaluate whether they could meaningfully participate in an IHP model.

The differentiation between primary care and primary source of care is also particularly important for patients served by reproductive health care providers. Because many of our patients rely on us exclusively for their care, patients can easily become “lost” in the larger health care system if they receive care elsewhere. It is these “lost” patients whom would most benefit from attribution to an IHP. Differentiating between primary care and primary source of care can help more specialty providers like Planned Parenthood enter into IHP arrangements, therefore better positioning those providers to track, coordinate and/or incentivize care across entities for those patients who rely on us exclusively for care.

Lastly, we urge caution around the phrase “primary care exclusivity” as referenced on page 14 of the RFC. As laid out in the RFC, “primary care exclusivity” implies that Next Generation IHP enrollees must receive care at a primary care clinic. Given the uncertainty around what “primary care” means in this context, requiring “primary care exclusivity” may inadvertently create barriers for enrollees who want to receive certain elements of their primary or preventive care elsewhere or whom require services outside the traditional scope primary care services (ex. chemical and mental health services). While Planned Parenthood agrees with the spirit of a robust approach to primary care and care coordination as part of achieving the Triple Aim, enrollees must also be guaranteed their free choice of provider, regardless of their attribution to an IHP.

## **Conclusion**

With modest adjustments to who is involved and what is being measured, the IHP program will better serve as the foundation for lowering costs and increasing health outcomes for Minnesotans. Planned Parenthood is committed to partnering with DHS to explore reforms designed with reproductive health providers and young populations, particularly women of color and women with incomes below 100% of the federal poverty level, in mind.

Thank you for the opportunity to provide feedback. We look forward to partnering in the future to expand the IHP program, reduce health care costs, and improve health outcomes for Minnesotans.

# Oral Health in Rural Minnesota

## KEY FINDINGS AND RECOMMENDATIONS FROM THE RURAL HEALTH ADVISORY COMMITTEE

### Background

As rural Minnesota begins experiencing the full effects of a population that is both aging and diversifying rapidly, many questions arise regarding the sustainability and sufficiency of the state's current oral health delivery system.

The Rural Health Advisory Committee (RHAC), a 15-member group appointed by the governor to advise the commissioner of health and other policymakers on rural health issues, convened a workgroup of key stakeholders to explore this increasingly important issue and develop recommendations.

Over approximately one year, the workgroup studied the current landscape of Minnesota's rural oral health system and needs, including:

- The oral health status of rural Minnesotans
- Utilization and access trends
- The oral health workforce
- Emerging models

The following is a summary of the workgroup's final recommendations and key findings.

A full report will be published in late 2017 on the [Rural Health Advisory Committee website](http://www.health.state.mn.us/divs/orhpc/rhac/index.html) (<http://www.health.state.mn.us/divs/orhpc/rhac/index.html>).

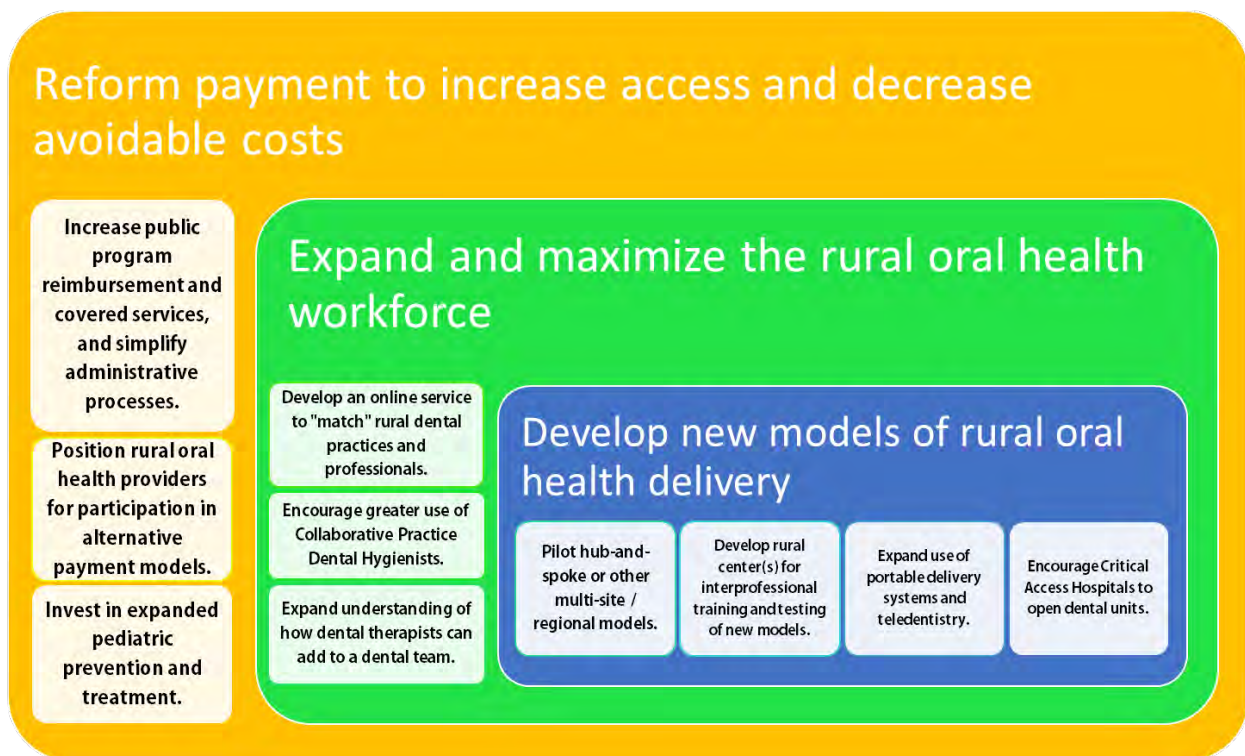
### Key Findings

- Rural Minnesotans face a variety of **barriers** to accessing dental care, including geographic isolation, lack of transportation, higher poverty rates, and difficulty finding providers willing to treat publicly insured patients.
- Residents of rural Minnesota **visit emergency rooms for oral health conditions** at disproportionate rates: Between 2007 and 2010, over one third of patients visiting hospitals with traumatic oral health emergencies were from rural areas.
- Compared to their urban counterparts, rural Minnesotans have **lower rates of dental insurance** and slightly higher rates of foregone care, with the worst rates of both in isolated rural areas.
- Minnesota has some of the lowest Medicaid dental **reimbursement rates** in the U.S.
- Minnesota's **oral health workforce**, with the exception of dental therapists, is disproportionately urban.
- Nearly half of rural Minnesota's dentists **plan to stop practicing** in the next 10 years, yet 56 percent of the state's rural counties have no dentists aged 35 or younger to replace them.
- **Dental hygienists and dental therapists** could provide more preventive and basic restorative care in community settings, but are underutilized outside traditional dental clinics.
- **New models** of rural oral health practice are needed, including those able to provide more extended geographic reach, integration with medical services, and more emphasis on prevention and addressing social and cultural barriers to good oral health.

# Recommendations

1. Increase public program **reimbursement rates** and covered services, and simplify program processes.
2. Develop a central online service to facilitate **recruitment and retention** for the rural Minnesota oral health workforce.
3. Pilot regional **Center(s) for Rural Oral Health** that would provide both oral health training and service clinics in underserved rural areas of the state.
4. Pilot hub-and-spoke or other regional model(s) for **multi-site dental practices**.
5. Encourage greater use of **Collaborative Practice Dental Hygienists**.
6. Expand awareness and understanding of how **dental therapists** can be incorporated into rural practice.
7. Invest in expanded **pediatric prevention** and treatment.
8. Facilitate use and expansion of **portable delivery systems and teledentistry**.
9. Encourage **Critical Access Hospitals** to open dental units.
10. Position rural oral health providers for participation in **alternative payment models** (developmental recommendation).
11. Add an oral health professional representative to the **Rural Health Advisory Committee**.

Figure 1. Overview of proposed recommendations



Minnesota Department of Health  
Office of Rural Health & Primary Care  
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St. Paul, MN 55164-0882  
651-201-3838  
[health.orhpc@state.mn.us](mailto:health.orhpc@state.mn.us)  
[www.health.state.mn.us](http://www.health.state.mn.us)

09/15/2017

To obtain this information in a different format, call: 651-201-3838. Printed on recycled paper.

# RURAL HEALTH ADVISORY COMMITTEE

December 19, 2017

Minnesota Department of Human Services  
Elmer L. Andersen Human Services Building  
540 Cedar St  
St Paul, MN 55101

RE: Outcomes-Based Purchasing Redesign & Next Generation IHP Request for Comment

Dear Colleagues:

The Rural Health Advisory Committee is pleased to submit our recent recommendations for improving oral health in rural Minnesota for your consideration as you plan for Outcomes-Based Purchasing Redesign & Next Generation IHPs.

The Rural Health Advisory Committee (RHAC) is a Governor-appointed statewide body that advises the commissioner of health and other state agencies on rural health issues, pursuant to Minnesota Statutes section 144.1481. Our membership comes entirely from Greater Minnesota and includes House and Senate members of each party, health care providers and consumers.

We recently completed a major project to study oral health needs in rural Minnesota and develop recommendations to improve oral health and access for rural Minnesotans. Of the 10 recommendations, three related to reforming payment for oral health services both to increase access and decrease avoidable costs. One of these payment reform recommendations is of particular note for the current Request for Comment: **We recommend that the State work to position rural oral health providers for participation in alternative payment models such as IHPs.**

. Specific elements of this recommendation are as follows:

1. We recommend that such models -- based on purchasing value (vs. paying for volume) and incorporating quality measurement -- include risk adjustment for rural patient-population characteristics that may independently affect results of a given measure and are not equally distributed across all providers.
2. We recommend adding dental services to the Total Cost of Care formulations used in the IHPs, and hope you will include dental services in the next generation of IHPs.
3. We recommend that because such financial models represent a significant departure from how rural dental providers have long operated, state policy should prioritize helping dental practices develop the capabilities needed to participate effectively in an IHP or similar models. Building blocks rural dental practices may need support developing include:

#### **Rural Health Advisory Committee**

Daron Gersch, MD • John Baerg • Ann Bussey • Ray Christensen, MD • Thomas Crowley • Ellen De la torre  
Rep. Clark Johnson • Margaret Kalina, RN • Sen. Mary Kiffmeyer • Sen. Tony Lourey • Andy Johnson, CRNA  
Rep. Joe Schomacker • Nancy Stratman • Thomas Vanderwal • Michael Zakula, DDS

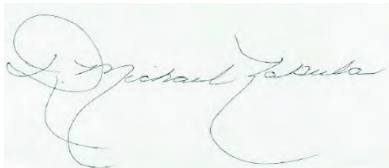
- Prevention/disease management as the main focus (vs restorative/acute care as primary focus).
- Risk-adjusted quality goals/metrics.
- Team-based care.
- Population health management.
- Whole-person, continuous care through coordination or even integration with health and other services (vs episodic, fragmented care).

A summary of our recommendations is attached, and our full report is forthcoming. For further details, please contact Darcy Dungan Seaver, our committee policy analyst at MDH, at [darcy.dungan-seaver@state.mn.us](mailto:darcy.dungan-seaver@state.mn.us), 651.201.3855.

Sincerely,



Ellen De la torre, Chair



Michael Zakula, DDS, Rural Oral Health Work Group Chair

**Rural Health Advisory Committee**

Daron Gersch, MD • John Baerg • Ann Bussey • Ray Christensen, MD • Thomas Crowley • Ellen De la torre  
Rep. Clark Johnson • Margaret Kalina, RN • Sen. Mary Kiffmeyer • Sen. Tony Lourey • Andy Johnson, CRNA  
Rep. Joe Schomacker • Nancy Stratman • Thomas Vanderwal • Michael Zakula, DDS

***Comment Letter  
DHS Request for Comment on Outcomes-based Purchasing Redesign and Next  
Generation IHP***

**Submitted by the Greater Twin Cities United Way  
on behalf of the Minnesota Pathways to Health (MPATH) Workgroup**

Greater Twin Cities United Way (United Way) believes that communities will only reach their full potential when everyone participates. Serving individuals and families in the nine-county Twin Cities metropolitan area, United Way and its partners seek to uproot the causes of our communities' most vital needs and challenges. Greater Twin Cities United Way is the largest non-governmental investor in health and human services in Minnesota – supporting 270 programs across the Twin Cities.

Healthy Communities is a health equity initiative, funded by Medtronic Philanthropy and brought to life by Greater Twin Cities United Way. Healthy Communities works to improve the health of low-income people by mobilizing Community Health Workers to address the social determinants of health and build a strong and sustainable Community Health Worker field in Minnesota. Healthy Communities supports the Minnesota Pathways to Health Workgroup, a coalition of stakeholders advocating for an evidence-based, community focused model that addresses a patients' social determinants of health (“SDOH”) resulting in better health outcomes, lower costs and better delivery of care.

This comment letter responds specifically to the following statements in the DHS Request for Comment:

*Page 13: “Social risk factors...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.”*

*Page 14, question 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?”*

GTCUW launched the Healthy Communities in 2014, and even before that, for decades we have devoted extensive attention and resources to identifying and promoting evidence-based, outcomes oriented strategies for improving the effectiveness of safety net nonprofits in meeting the needs of their clients and communities.

We are writing to recommend the use of a proven, evidence-based model to provide outcomes-based payments for services provided to high-risk individuals to address non-clinical risk factors – social determinants of health (“SDOH”) – that directly affect patient's health and treatment outcomes and, as a result, drive up health care costs. We have given



this the working title of Minnesota Pathways to Health (“M-PATH”). M-PATH will both reduce total costs of care and improve health and treatment outcomes for high-risk individuals impacted by serious SDOH risk factors such as homelessness, poverty, mental illness, substance abuse, etc. The components of the proposed M-PATH model are described in greater detail in documents produced by the Agency for Healthcare Research and Quality (AHRQ), including *Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes*, initially published in 2010. This Minnesota model description is based upon and uses the descriptions provided in the AHRQ documents.

M-PATH is designed for those individuals who are at greatest risk of poor health, chronic disease and suboptimal outcomes due to serious SDOH factors. M-PATH would pay for progress made and outcomes achieved in addressing each SDOH factor that is directly affecting the individual. M-PATH would rely on community care coordinators (CCCs)—community health workers, nurses, social workers, and others—who reach out to at-risk individuals through home visits and community-based work that is undertaken in coordination with clinical services and community resources such as housing and social services. Once an at-risk individual is engaged, the CCC completes a comprehensive assessment of health, social, behavioral health, economic, and other issues that place the individual at increased risk. Each identified risk factor is tracked as a standardized Pathway that confirms the risk is addressed through connection to evidence-based and best practice interventions.

The Pathway is a tool for confirming that the intervention has been received and that the risk factor has been successfully addressed. The Pathway also serves as the quality assurance and payment tool, and it is used by the CCC to ensure that each risk factor is addressed and that outcomes have improved.

When this model is deployed across multiple agencies within a “community”<sup>1</sup> a centralized HUB would help and CCCs communicate, coordinate and avoid duplication of effort. The HUB serves as a community-wide networking strategy that helps isolated (“siloed”) programs become a quality-focused team to identify those at risk and connect them to care. The HUB connects all community resources and agencies serving a community including health care providers, governmental agencies, nonprofits and community-based organizations. The HUB model was first developed by the Community Health Access Project (CHAP) in Mansfield, Ohio, with leadership from Drs. Sarah and Mark Redding. The model involves working across organizational silos within a community (CHAP worked with multiple stakeholders in three counties) to reach at-risk individuals and connect them to health and social services that yield positive health outcomes. The model is now part of a national network of community-based initiatives working under a common set of national standards and certification developed by the Pathways Community HUB Institute.

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<sup>1</sup> A community could be a geographic neighborhood or it could be a racial, ethnic or cultural group that shares common characteristics and risk factors



## Greater Twin Cities United Way

404 South Eighth Street  
Minneapolis, MN 55404-1084



We recommend that the State of Minnesota establish the M-PATH model as part of the state's new outcomes-based purchasing strategy to be implemented in the Twin Cities metropolitan area in 2019, as described in the Request for Comments. It is recommended that the established AHRQ criteria for eligibility certification, accountability and payment be used. It is recommended that M-PATH services be paid for directly by DHS under its fee-for-service system, separately from payments to providers, IHPs and health plans. Additionally, we recommend that IHPs and health plans be required to collaborate with community-based M-PATH agencies, exchange health and service information, and coordinate other services and payments provided for high-risk individuals participating in the M-PATH program to address non-clinical SDOH risk factors and barriers.

Minnesota DHS should be applauded for efforts to improve the overall health care for Medicaid beneficiaries over the last decade. We appreciate the opportunity to comment through this Request for Comment (RFC) process. As you consider our comments or if you would like more information, please do not hesitate to contact either of us below.

Olivia Jefferson  
Director, Safety Net  
Greater Twin Cities United Way  
[olivia.jefferson@gtcuw.org](mailto:olivia.jefferson@gtcuw.org)  
612-340-7521

Megan O'Meara  
Senior Project Manager, Community Impact  
Greater Twin Cities United Way  
[megan.omeara@gtcuw.org](mailto:megan.omeara@gtcuw.org)  
612-340-7529

**From:** [MN\\_DHS\\_DHS PSD Procurement](#)  
**To:** [REDACTED]  
[REDACTED] Outcomes-Based Purchasing Redesign and Next Generation IHP  
**Date:** Thursday, December 28, 2017 1:26:18 PM  
**Attachments:** [Comment Letter - DHS IHP System 12-20-17.pdf](#)

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Please see the email as requested. Thanks!

**From:** Susan Jackson [mailto:sjackson@umn.edu]  
**Sent:** Wednesday, December 20, 2017 3:15 PM  
**To:** MN\_DHS\_DHS PSD Procurement <DHS.PSD.Procurement@state.mn.us>  
**Subject:** Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP

Attached and following please find comments regarding the Outcomes-Based Purchasing Redesign and Next Generation IHP from Drs. Jim Pacala, Connie Delaney, Macaran Baird and Lynda Welage.

Feel free to contact me if you have any questions or need additional information.

Thank you.

Sue Jackson

--  
Susan Jackson  
Assistant to James Pacala, MD, MS  
Head, Dept. of Family Medicine & Community Health  
University of Minnesota Medical School  
6-240 Phillips Wangensteen Bldg, MMC 381  
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**University of Minnesota Academic Health Center**  
**Comment on DHS Outcomes-Based Purchasing Redesign and Next Generation IHP Model**  
December 20, 2017

We support the goals of the new Outcomes-based Purchasing Redesign and Next Generation IHP model. As the largest source of Minnesota's future health care professionals, we believe that their training should embrace these concepts. The University of Minnesota (UMN) family medicine residency clinics, the Community University Health Care Clinic, and the Interdisciplinary Nurse practitioner clinic, are all engaged in realizing the primary vision of the Next Generation IHP initiative. These sites include co-located dentistry, pharmacy, and behavioral health services dedicated to improving health care quality and equity. They are also important training sites for

the Minnesota health care workforce across many health professions. In addition to primary care services, improving the delivery of complex care across various sites will be essential. We recognize that the involvement of trainees at clinics participating in the Next Generation IHP model may introduce some complexities but we are eager to take on that challenge.

**We offer to partner with DHS in helping to design the Next Generation system in ways that will ensure that its goals of improving patient experience, improving health outcomes, reducing total costs of care, and increasing provider satisfaction will be achieved while promoting health equity.** We would like an opportunity to meet with you at your earliest convenience to determine what the next steps might be. We are currently undertaking additional internal analysis of the Request for Comment and will be prepared to meet with DHS in January to:

- offer specific comments and possible answers to the 12 questions listed in the Request for Comment;
- explore possible roles the University can play in partnering with DHS in the development and successful implementation of the Next Generation IHP Model;
- discuss the implications of the new model for the University, including those that might impact the University's mission of workforce training and community outreach. For example, we would like to assess whether the "primary care exclusivity" requirement could potentially reduce access to our primary care sites and impair our missions of workforce training and outreach to vulnerable populations and explore solutions to safeguard against such an unintended consequence.

Thank you for the opportunity to provide preliminary remarks. We look forward to following up with additional meetings, conversations and comments.

Respectfully submitted,

James Pacala, MD, MS  
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[delaney@umn.edu](mailto:delaney@umn.edu)

Macaran Baird, MD, MS; CEO, UMPHysicians and Co-President of M Health, 612-525-2841 or [baird005@umn.edu](mailto:baird005@umn.edu)

Lynda Welage, PharmD; Dean, UMN College of Pharmacy, 612-624-4137 or  
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# Minnesota Senate



# Minnesota House of Representatives

December 20, 2017

Commissioner Emily Johnson Piper  
Deputy Commissioner Charles Johnson  
Minnesota Department of Human Services  
540 Cedar Street  
St. Paul, MN 55101

Commissioner Johnson Piper and Deputy Commissioner Johnson,

This letter is in response to the Request for Comment (RFC) issued by the Minnesota Department of Human Services (DHS) on November 15, 2017. While Minnesota has a rich history of novel and innovative approaches to health care purchasing and delivery, the Next Generation Integrated Health Partnership (Next Gen IHP) RFC lacks details about how DHS will ensure adequate protection of consumers' rights and access to care.

Existing Managed Care Organizations (MCOs) must meet specific financial reserve and capital requirements outlined in statute or rule. *e.g.*, *Minn. Stat. 60A, 62D.05, 256B.692*. Access to care is jeopardized if an entity lacks reserves sufficient to cover risk. However, the RFC does not describe how or to what level Next Gen IHPs must maintain adequate financial reserves. Reserves are necessary to ensure, for instance, a payer can handle an unexpectedly high volume of expensive medical claims.

Given the unique demands outlined in the RFC, it is imperative that DHS provide specific details about the financial reserves an entity must maintain in order to qualify as a Next Gen IHP. In August 2016, the Departments of Health and Commerce issued a joint Request for Proposals for new qualified health plan options in the individual market. The RFP suggested the departments would consider waiving reserve requirements. This alarmed many in the health care community in light of significant individual market volatility. Allowing Next Gen IHPs a lower standard for reserves relative to MCOs could create a competitive balance and risk the solvency of participating entities that are central to community care.

Throughout the life of the MNsure system, DHS, MNsure and MN.IT have struggled to integrate it with existing DHS technology systems. Problems with enrollment and eligibility determinations, as well as MinnesotaCare premium invoicing are well-documented. Many are ongoing. Outside partners, such as counties and health plans, incurred significant additional administrative costs just to keep private and public enrollment partially functional. The scope of services outlined in the RFC, enhances the importance of timely and accurate invoicing and payment for both MA and MinnesotaCare.

DHS should provide additional information about how Next Gen IHPs can seamlessly be incorporated into existing systems and how the agencies can ensure the data integrity of IHP enrollees. Potential respondents should know the extent of manual work that may be necessary to manage enrollment, both in the state and respondent systems. DHS should also disclose expected effort or costs which may be incurred by outside parties as DHS's "Integrated Service Delivery System" replaces existing technology in coming years.





The RFC indicates DHS could create significant financial liability for taxpayers by DHS bearing the upfront cost of and responsibility for a nearly a dozen administrative and care services. It is unclear how MCOs or Next Gen IHPs should account for the cost of these services, or what would happen to an MCO and its enrollees if DHS determines the MCO is not meeting DHS's standards for the service. DHS should provide potential respondents and the public more detail of how it will minimize risk to taxpayers, handle billing and disputes related to these services, and how it will enforce these service contracts.

DHS has indicated that the Department can implement the Next Gen IHP program without legislative approval during their public presentations on the RFC. DHS should provide the statutory authority to implement the Next Gen IHP program without this legislative approval. Direct provider contracting legislation was introduced during the 2017 Session and DHS raised a number of concerns about that legislation. DHS should provide an explanation of why they now support direct provider contracting through the Next Gen IHP.

The RFC will result in significant changes for MA and MinnesotaCare enrollees, counties, health plans, and providers in how they receive, provide and are reimbursed for health care. Due to the complexity of the proposed changes and the lack of details provided by DHS in the RFC, DHS should immediately announce if DHS plans to issue the RFP in 2018 for implementation January 1, 2019 as well as a detailed timeline.

The House and Senate intend to hold hearings during the 2018 Legislative Session on DHS's RFC on the Next Gen IHPs and procurement for the seven county metro area. We would like to work with DHS, stakeholders, and enrollees to ensure that any changes to MA and MinnesotaCare will not result in disruptions to care for low-income families or increased financial liability for taxpayers.

Sincerely,



Rep. Matt Dean  
Chair, Health and Human Services Finance



Sen. Michelle Benson  
Chair, Health and Human Services Finance and Policy



Rep. Joe Schomacker  
Chair, Health and Human Services Reform

**University of Minnesota Academic Health Center**  
**Comment on DHS Outcomes-Based Purchasing Redesign and Next Generation IHP Model**  
December 20, 2017

We support the goals of the new Outcomes-based Purchasing Redesign and Next Generation IHP model. As the largest source of Minnesota's future health care professionals, we believe that their training should embrace these concepts. The University of Minnesota (UMN) family medicine residency clinics, the Community University Health Care Clinic, and the Interdisciplinary Nurse practitioner clinic, are all engaged in realizing the primary vision of the Next Generation IHP initiative. These sites include co-located dentistry, pharmacy, and behavioral health services dedicated to improving health care quality and equity. They are also important training sites for the Minnesota health care workforce across many health professions. In addition to primary care services, improving the delivery of complex care across various sites will be essential. We recognize that the involvement of trainees at clinics participating in the Next Generation IHP model may introduce some complexities but we are eager to take on that challenge.

**We offer to partner with DHS in helping to design the Next Generation system in ways that will ensure that its goals of improving patient experience, improving health outcomes, reducing total costs of care, and increasing provider satisfaction will be achieved while promoting health equity.** We would like an opportunity to meet with you at your earliest convenience to determine what the next steps might be. We are currently undertaking additional internal analysis of the Request for Comment and will be prepared to meet with DHS in January to:

- offer specific comments and possible answers to the 12 questions listed in the Request for Comment;
- explore possible roles the University can play in partnering with DHS in the development and successful implementation of the Next Generation IHP Model;
- discuss the implications of the new model for the University, including those that might impact the University's mission of workforce training and community outreach. For example, we would like to assess whether the "primary care exclusivity" requirement could potentially reduce access to our primary care sites and impair our missions of workforce training and outreach to vulnerable populations and explore solutions to safeguard against such an unintended consequence.

Thank you for the opportunity to provide preliminary remarks. We look forward to following up with additional meetings, conversations and comments.

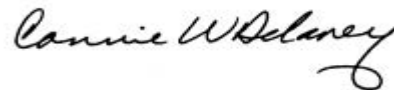
Respectfully submitted,



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December 20, 2017

Minnesota Department of Human Services  
540 Cedar Street  
Saint Paul, MN 55155

Thank you for the opportunity to provide feedback on the proposed Outcomes-Based Purchasing Redesign and Next Generation IHP Project.

As the state's only dental school, we are responsible for educating the next generation of oral health professionals who are committed to providing quality oral health care for all Minnesota citizens. More and more, this goal is fraught with practical and logistical barriers and we struggle to balance social responsibility with financial reality. Some of the provisions of the Minnesota Forward report suggest additional challenges to our mission.

For well over the past decade, the University Of Minnesota School Of Dentistry has been both strategic and pragmatic in its efforts to partner with the State to enhance access to care. We have increased class sizes and started new education programs to expedite the transition of dentists into the workforce and enhance the capacity of the existing network of dentists to treat more patients. We've adopted new admissions and recruiting initiatives to increase the workforce in underserved communities. We contribute to and staff 5 brick and mortar clinics and support 5 Mobile Dental Clinic sites in the seven-county metropolitan area, including two special needs clinics for children and adults, and a geriatric clinic. We treat public program patients at all of these sites, as well as at our dental school-based clinic (377 dental chairs).

In 2016, our School of Dentistry faculty and staff treated 21,000 Minnesotans on public programs, primarily in our on-campus clinics and across the seven-county metro area and Minnesota training sites to be used in the next generation ACO pilot. This mission of patient care is a critical part of our dental education program as a means for developing both clinical and cultural competence. Indeed, accreditation standards require that we educate students to be both clinically and culturally competent. Separate accreditation standards require inclusion of interprofessional education experiences as part of the required curriculum.

It is in these two areas that the Outcomes-Based Purchasing Redesign and Next Generation IHP Project may create additional changes.

First, our ability to educate dental, dental hygiene and dental therapy students is dependent upon the partnership we have with the Department of Human Services and managed care organizations to fund the treatment of our Medicaid and MNCare patients with dollars above the base rate. Public program patients often present with deferred oral health care needs and complex care requirements. The loss of the critical access provider reimbursement for dental



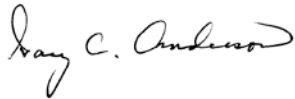
services provided to public program patients would affect our ability to care for the underserved and provide students with these critical educational experiences.

Too, as evidence continues to grow in support of systemic health, health care providers across the professions are moving to increase collaboration in support of patient-centered care and improved health care outcomes. Collaborative care is especially important when providing complex care needed for an aging population and for patients with chronic diseases. The exclusion of dental services from IHP provided service requirement poses a threat to our ability to educate our students in interprofessional work teams and prepare them for their role as member of the health care team of the future.

It is our hope that additional consideration will be given to these concerns as you move forward with a final draft of the report.

Please feel free to contact me if you have questions. I am happy to help in any way that I can.

Sincerely,

A handwritten signature in black ink that reads "Gary C. Anderson". The signature is written in a cursive style with a large initial "G" and "A".

Gary C. Anderson  
Interim Dean, School of Dentistry  
Associate Professor

Cc:

Dr. Jakub Tolar

Dr. Jim Pacala

Dr. Sheila Riggs

Dr. Paul Schulz

Ms. Genevieve Plumadore

Ms. Christine Kiel

**From:** [MN\\_DHS\\_DHS PSD Procurement](#)  
**To:** [REDACTED]  
**Subject:** FW: Requests For Comments, Next Generation Integrated Health Partnership(IHP)  
**Date:** Thursday, December 28, 2017 1:25:49 PM

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Hi Cat,

Please see this email as requested.

PJ

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**From:** Paul Sobocinski [mailto:sobopaul@redred.com]  
**Sent:** Wednesday, December 20, 2017 3:16 PM  
**To:** MN\_DHS\_DHS PSD Procurement <DHS.PSD.Procurement@state.mn.us>  
**Subject:** Requests For Comments, Next Generation Integrated Health Partnership(IHP)

To: Mathew Spaan, Health Care Policy Specialist  
Health Care Administration – Office of the Assistant Commissioner  
Department of Human Services

From: Paul Sobocinski, Policy Organizer  
Land Stewardship Project

Date: 12/20/17

Re: Request for Comments, Next Generation Integrated Health Partnerships (IHP)

Thank you for the opportunity to comment on the redesign of DHS's Medicaid and MinneostaCare purchasing and delivery strategies proposed through the Next Generation IHP model. Land Stewardship Project supports DHS' effort to improve health outcomes for public program enrollees in general even though we have questions about the process.

Land Stewardship Project has about 5000 household memberships in Minnesota with about 2/3's of those members are farm families or are families that reside in our rural part of the state. We have been strong advocates for MinnesotaCare and a number of our members make use of Minnesota's public programs for healthcare. This is especially true for beginning farmers and for farm families in financial stress due to three years of extremely low farm prices.

Our comments will be brief. In general we support the recommendation that our ally, TakeAction Minnesota has already submitted. In particular we strongly support enrollee and community engagement in the design, implementation, oversight of the state's reform and delivery strategy for public health care programs. We believe that Land Stewardship Project and organizations like TakeAction Minnesota should be included as part of community engagement upfront.

Finally, we think it is long overdue to recognize that Managed Care Organizations are not the best way to deliver care. We believe in a universal publically funded health care system because it would be better for delivering significant payment and delivery reform to achieve better healthcare outcomes at lower costs.

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**From:** Craig Pierce  
**To:** [MN DHS DHS PSD Procurement](#)  
**Subject:** Care Cost and improved patient out comes comment  
**Date:** Thursday, November 30, 2017 2:21:50 PM

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I would like to see DHS have some requirement of using or offering psychiatric health care directives. It can be denied by the consumer, but this could potentially help with less court time, cost of legal fees, cost at CBHH's and bed wait times. It would give the consumer more choice in their treatment when they are unable to make their own decisions.

Craig Pierce

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Senator  
John Marty

**Senate**  
State of Minnesota

Minnesota Department of Human Services  
Elmer L. Andersen Human Services Building  
540 Cedar Street  
St Paul, MN 55101  
[DHS.PSD.Procurement@state.mn.us](mailto:DHS.PSD.Procurement@state.mn.us)

December 12, 2017

**Comments from Senator John Marty in response to the Minnesota Department of Human Services Request for Comment on *Outcomes-Based Purchasing Redesign and Next Generation IHP* on November 15, 2017**

**Summary:**

The Minnesota Department of Human Services plans to significantly expand the payment “reforms” for Minnesota’s programs to provide health care for low income people. However, evidence shows that those reforms lead to more bureaucratic, *more expensive* health care that *reduces* the quality of care. My comments are intended to challenge the entire reform, not to fine-tune the proposals for expansion.

**Synopsis of DHS Request for Comment:**

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).<sup>1</sup>

In this request, you are planning to “redesign and reform” the payment system for the public programs through what you call “Integrated Health Partnerships” (IHPs). Here is your explanation of the IHP concept:

Participating health care providers work together across specialties and service settings to meet patient needs. These providers share in savings they help create and in losses when goals are not met. They look for innovations to improve the health of their communities. This work shows Minnesota’s commitment to pay for value and good health outcomes instead of the number of visits or procedures people receive.<sup>2</sup>

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<sup>1</sup> [https://mn.gov/dhs/assets/request-for-comment-outcomes-based-purchasing-redesign\\_tcm1053-318160.pdf](https://mn.gov/dhs/assets/request-for-comment-outcomes-based-purchasing-redesign_tcm1053-318160.pdf)

<sup>2</sup> <https://mn.gov/dhs/integrated-health-partnerships/>

You intend the IHP model to produce the following benefits:

- To improve health outcomes for enrollees and their families
- To improve and standardize the enrollee experience
- To increase savings by reducing overall costs
- To reduce administrative costs and improve efficiency in the system<sup>3</sup>

You highlight one specific problem that you want to see addressed:

**Currently too little of every dollar spent on health care is devoted to patient care.** This makes it makes it burdensome for people to consistently get the care they need, understand their options and make informed decisions.<sup>4</sup>

### Comments from Senator John Marty:

I recognize that the Department of Human Services is hoping that your efforts to redesign and reform DHS' purchasing and delivery strategies for Medicaid and MinnesotaCare might result in lower costs and better health, and I appreciate your request for public comment.

However, these “reforms” are based on some false assumptions and I need to challenge the entire direction that Minnesota is headed with these current and proposed “purchasing and delivery strategies.”

A key problem that you highlight on the DHS webpage announcing the request for comment, is that *too little of every dollar spent on health care is devoted to patient care*. I strongly agree. It is because of that shared concern about the diversion of health care dollars away from patient care that I challenge the direction of both the current “Integrated Health Partnership” (IHP) model and the proposed next step. To explain this direct, head-on challenge, it is important to back up and start at the conceptual level:

If the problem is that too little of the health care dollar is spent on patient care, the response should be to eliminate bureaucratic administrative expenses. Instead, the IHP model proposes additional complications, which require *more* administrative time and money, presumably in the expectation that this will lead to better efficiency at the provider level.

Healthcare dollars spent on patient care are delivered by providers – nurses, doctors, physical therapists, and countless other medical professionals working in clinics or hospitals. The simplest, most efficient means of getting care to those patients is to direct those providers to deliver the care needed, and pay them for doing so.

Using an efficient system of paying medical providers directly to deliver care is analogous to the way the rest of our economy works. Businesses provide a product or service, and we pay them for it. This could be described as “fee-for-service” or “price-per-product.” It is not a perfect system, but it works relatively efficiently. It *is* the way our economy works.

However, in the healthcare sector of the United States economy, the concept of “fee-for-service” (FFS) has been vilified as wasteful and inefficient and numerous reforms have

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<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

claimed to replace it with a better system.<sup>5</sup> For several decades, the “Health Maintenance Organization” (HMO) or “Managed Care” model has claimed to replace FFS with “managed care.”

Essentially “Managed Care Organizations” (MCOs) are a **middleman** between the payer and the provider: they accept a capitation payment from the payer, and then “manage care” that is to be delivered by the provider. By adding a new administrative layer, this model adds additional administrative costs, which presumably will be paid for by greater efficiency in the actual delivery of patient care.<sup>6</sup>

However, it is inaccurate to claim that Managed Care Organizations have ended fee-for-service in health care delivery. MCOs receive *capitation* payments, but they pay providers with fee-for-service payments for performing procedures, for diagnosing, testing, and treating patients. Some of the individuals delivering care are paid FFS and others are paid a salary or hourly wage by their clinic, but that clinic is paid FFS. That payment may include incentives or bonuses, but it is still a FFS payment.

In the last few years, the newer payment reforms have introduced an **additional middleman** to the system. Under various models, these additional middlemen are named “Accountable Care Organizations” (ACOs) or Integrated Health Partnerships (IHPs). In other models, these new administrative middlemen are called “Health Systems” (Allina, Mayo, Sanford, Fairview, Essentia, etc.). Regardless of the name for the new middleman, they are also described as “provider networks,” which is appropriate since they are business organizations that own, buy up, or affiliate with numerous individual providers, clinics, hospitals, and nursing homes.

Even if these new administrative businesses are networks or conglomerations of providers, it is misleading to describe them as medical “providers,” because those corporations provide no care beyond what is being delivered to the patient by the individual providers that they own or affiliate with. The providers are the clinics or hospitals or medical professionals who *provide* care, while the business network or conglomerate is simply an administrative entity that owns or controls those providers.

These administrative entities were created in large part, so that new payment ideas, ostensibly to improve quality and efficiency, such as “Total Cost of Care” (TCOC), “Value-Based Purchasing” (VBP), or “Pay-for-Performance” (P4P) can be implemented. The theory behind the reform is that if a provider gets economic rewards when their patients do better, they will have the incentive to deliver optimum care which will keep the patient healthier, and ultimately save money.

**Note:** This should raise the question whether a “good” medical provider is one who cares more about the patient’s health and well-being *because* they are compensated better as a result. Proponents of the reforms don’t want us

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<sup>5</sup> If requested, I would be pleased to expand on why this ubiquitous vilification of “fee-for-service” among health policymakers is misguided, and offer comments on how to fix problems with our current fee-for-service system that would improve our health care financing system rather than make it worse.

<sup>6</sup> Note that adding administrative expenses with the assumption that it will deliver more or better patient care, is the cause of the problem: “*Currently too little of every dollar spent on health care is devoted to patient care*” that the Request for Comment says the IHP model is intended to address.

to focus on that; they only want us to acknowledge that financial rewards provide behavioral incentives. I certainly acknowledge that financial payments provide incentives, but proponents err in failing to recognize that medical providers have other motivations<sup>7</sup> to provide quality care for their patients beyond financial bonuses.

Not only do proponents of P4P fail to recognize that there are other non-financial motivations, but they do not understand that those P4P financial incentives may actually *undercut* the power of those intrinsic motivations.<sup>8</sup>

The common illustration of how this “Total Cost of Care” (TCOC) incentive system should work comes from hospital readmissions: If a hospital discharges a recovering patient too soon or without appropriate follow-up care, the patient is more likely to be readmitted to the hospital as a result. If we financially penalize the hospital for patients needing readmission, the hospital will have a financial incentive to ensure that the patient’s needs are better met. The hospital is responsible for the patient’s overall costs, and if they short-change the patient, they will be penalized later. This illustration is a logical one, and under our current health care financing system, one could see how it *might* make sense.

However, for a physical therapy clinic, or mental health clinic, or medical clinic, one cannot hold the provider responsible for the overall patient outcome, because these providers deliver only a small portion of the patient’s care. Even if the concept did work for hospitals in relation to readmission rates, it simply doesn’t work for an individual provider. As a result, small provider clinics are pushed to affiliate, or merge with, a big provider network – the administrative middleman. That large administrative entity is paid on a capitated basis, and is then responsible for the TCOC of the patient. In this case, the actual providers are responsible for only a portion (often a small portion) of a patient’s care, and the concept of making the provider responsible for the TCOC makes no sense.

Consequently, it is inaccurate to suggest that the provider is responsible for the TCOC. Instead, it is the “provider network” or “health system” or “managed care organization” that is paid for and responsible for the “total cost of care.” To restate the obvious, we now have two middlemen who “share the risk,” which effectively doubles the administrative cost of these entities that provide no patient care.

There are a number of problems with this entire scheme.

Despite the intent of improving the quality of care, there is significant evidence that these practices actually *harm* the patients they are supposed to help. Earlier, I mentioned the one illustration commonly used by proponents of these “quality” measures, the Hospital Readmission Reduction Program (HRRP). It is not being overly dramatic to say, “Lives are at stake here,”<sup>9</sup> since “Research at the University of Michigan suggests the HRRP program is

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<sup>7</sup> Motivations such as: an ethical commitment to provide the best care possible (for physicians, the Hippocratic Oath), personal & professional concern about the well-being of the patient, pride in one’s work and the desire to get good results, gratitude from patients who have better outcomes, and praise from colleagues for professionalism. These motivations matter.

<sup>8</sup> “Pay-For-Performance: Toxic to Quality? Insights from Behavioral Economics,” International Journal of Health Services, Himmelstein, David U., et. al., April, 2014 <http://journals.sagepub.com/doi/10.2190/HS.44.2.a>

<sup>9</sup> “Practicing Medicine While Black”, Sullivan, Kip, November 9, 2017



killing up to 5,000 [chronic heart failure] Medicare patients annually,” according to Kip Sullivan.<sup>10</sup>

U.S. hospitals have recently shown a consistent and disturbing disconnect between reductions in their heart failure hospital readmission rates and heart failure mortality... “The most concerning question we can ask is whether inappropriate discharges from emergency rooms and observation units” is a driving factor behind the mortality rise despite a readmissions drop, said Dr. Abdul-Aziz, a cardiologist at the University of Michigan in Ann Arbor.... On the basis of [CMS] numbers<sup>11</sup>, as many as 5,200 additional deaths to U.S. heart failure patients in 2014 “may be related to the Hospital Readmission Reduction Program’ of CMS,” according to Gregg C. Fonarow, MD.<sup>12</sup>

If these so-called “quality” reforms are reducing the quality of care and *actually killing people*, that is sufficient reason, on its own, to immediately stop implementing the reform. Period.

There are further problems as well:

First, small medical practices are often forced to merge with large hospital/healthcare systems to implement the risk-sharing payment system that ACOs are designed to deliver.<sup>13</sup>

Forcing small medical clinics to join big provider systems could potentially make medical care better, but it could potentially make it worse, and certainly less personal. The angry public outcry in both Fairmont and Albert Lea, Minnesota over the losses in local care after Mayo Health System took over their local hospitals shows how patients and their local communities view the cutbacks in care.<sup>14</sup>

To be clear, the point of these mergers under ACOs or other payment reforms is not to improve care, but to explore whether they might save money. The risk is that when this experiment is finished, it is possible that these mergers will actually *reduce* the quality of care and cost *more*.

Unfortunately, there is evidence that these mergers are driving costs higher. A December 2015 study from Yale University, “*The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured*,” found that the large hospital/health care systems created by mergers to form Accountable Care Organizations, were actually driving up prices, thus increasing health

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<http://thehealthcareblog.com/blog/2017/11/09/practicing-medicine-while-black/>

<sup>10</sup> Ibid.

<sup>11</sup> <https://jamanetwork.com/journals/jama/article-abstract/2643762?redirect=true>

<sup>12</sup> “While U.S. heart failure readmissions fall, deaths rise,” Internal Medicine News, Mitchel L. Zoler, September 20, 2017 <http://www.mdedge.com/internalmedicineneeds/article/147553/heart-failure/while-us-heart-failure-readmissions-fall-deaths>

<sup>13</sup> Elizabeth Stawicki, “Independent Medical Practices Find It Harder to Stay that Way,” *MPR News*, May 16, 2011, <http://www.mprnews.org/story/2011/05/14/independent-medical-practice>.

<sup>14</sup> “Albert Lea Albert Lea rises up against Mayo’s plan to trim hospital services,” Matt McKinney, Star Tribune, September 2, 2017, <http://www.startribune.com/albert-lea-rises-up-against-mayo-s-plan-to-trim-hospital-services/442553123/> “Fairmont Hospital Struggles after Mayo Takeover,” Star Tribune, November 8, 2014, Jeremy Olson, <http://www.startribune.com/lifestyle/health/282039841.html>.

spending.<sup>15</sup>

Second, conceptually, the *health system* or *provider network*, is playing the same role that we were told HMOs were needed for in the past. Instead of paying the medical provider directly, the provider network serves as a middleman, collecting capitation payments for patients, and then paying providers (again, paying them with some form of fee-for-service). Simply because we are paying these large “provider networks” with capitated payments, does not mean that we have ended fee-for-service in health care delivery. As mentioned earlier, the individual providers are paid fee-for-service by the new provider network middleman. We already had one middleman adding administrative expense. Now we have two middlemen, playing the same role.

It should be obvious that both administrative middlemen (who are simply an administrative payment mechanism, and are not providing care) are diverting money from patient care – the opposite of what is needed to address the problem spelled out by the Department of Human Services, namely, “*too little of every dollar spent on health care is devoted to patient care.*”

Third, because the individual provider clinics may have little choice but to participate in these payment methodologies, they are at a big disadvantage in getting fair compensation. A primary care clinic providing services to high-need, low-income patients has a difficult enough task without trying to track whether their patients are using other providers, especially if the provider network is not transparent about hospitalization or other expenses of *that clinic’s* patient. In other words, the clinic may have no knowledge what other care the patient chooses to get, and the clinic might not even be able to find out about that other care from the IHP or provider network. They cannot even know if they are getting appropriate compensation.

Fourth, the *risk adjustment* necessary for the payment systems to work is both administratively costly, and not very accurate. If the payer is inaccurate in the risk adjustment for some patients in the direction that would benefit the IHP (or provider network or MCO), the IHP is eager to accept the overpayment – and there is little chance that they will tell the payer “you were too generous with us.” If the risk adjustment is too low, the IHP will do whatever necessary to collect a higher reimbursement so that they don’t lose money on the patient.

So, unless DHS was miraculously able to be perfectly accurate in the costly risk adjustment process, they will end up overpaying for some patients as well as wasting money on the risk adjustment bureaucracy.

Fifth, because of the inaccuracy of risk adjustment, payment schemes that are based on these quality measures lead to increased health disparities. A 2014 report commissioned by the Obama administration and convened by the National Quality Forum said that providers who serve low income people and communities, “are more likely to be identified as ‘poor performers’ and... more likely to face financial penalties in pay-for-performance programs.”

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<sup>15</sup> Zack Cooper, et al., “The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured,” *Health Care Pricing Project*, December 2015, [http://www.healthcarepricingproject.org/sites/default/files/pricing\\_variation\\_manuscript\\_0.pdf](http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf). See also Kevin Quealy and Sanger-Katz, Margot, “The Experts Were Wrong About the Best Places for Better and Cheaper Health Care,” *New York Times*, December 15, 2015, [http://www.nytimes.com/interactive/2015/12/15/upshot/the-best-places-for-better-cheaper-health-care-arent-what-experts-thought.html?\\_r=4](http://www.nytimes.com/interactive/2015/12/15/upshot/the-best-places-for-better-cheaper-health-care-arent-what-experts-thought.html?_r=4).

This can lead to “a series of adverse feedback loops that result in a ‘downward spiral’ of access and quality for those [socially and economically disadvantaged] populations. The net effect could *worsen* rather than ameliorate healthcare disparities.”<sup>16</sup>

The theories behind some of these payment reforms *sound* good, but they require more administrative bureaucracy, taking resources away from patient care.

### **Coordination of Care**

I am a proponent of increasing care coordination, especially for high-risk, complex patients. However, doing so in an efficient manner means that 100% of the care coordination expenditures go directly to the providers who coordinate the care instead of channeling the payments through MCOs, Provider Networks, IHPs or some other administrative middleman. Paying for care coordination through a third party reduces the amount available for the actual service.

While most care coordination might be funded based on individual patient needs, DHS could also provide direct grants to Minnesota’s Community Health Clinics and other clinics that work with homeless people and other high-need populations. With such grants, the low-income clinics could hire nurses, social workers, or other patient advocates to go to homeless shelters and other places with underserved people, people who use hospitals or emergency rooms for routine care.

Instead of wasting care coordination dollars on IHPs or other third-party administrators, I urge DHS to move all Medical Assistance, MinnesotaCare, and other public program participants into a less costly direct contracting system such as the Primary Care Case Management (PCCM) system as proposed in [Senate File 1299](#).

### **A commonsense alternative: Primary Care Case Management (PCCM)**

If Minnesota moved the delivery and payment system for public health programs to a “**Primary Care Case Management**” (PCCM) system, the Department of Human Services would no longer contract with HMOs or MCOs to pay providers for health care.

Instead, DHS would contract directly with providers (clinics, doctors, hospitals) for care. This is a simpler, more transparent, and less expensive system. This improved efficiency would immediately affect the \$5 billion per year that Minnesota currently spends for managed care in Medical Assistance.

Under the current system, the state pays a “managed care organization” to pay the providers, with the hope that, somehow, the patient’s care will be “managed” or coordinated. However, despite the name “managed care,” the MCOs are essentially managing claims, not managing the patient’s care.

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<sup>16</sup> National Quality Forum, “Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors,” August 15, 2014, p16, [http://www.qualityforum.org/Publications/2014/08/Risk\\_Adjustment\\_for\\_Socioeconomic\\_Status\\_or\\_Other\\_Sociodemographic\\_Factors.aspx](http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx).

As mentioned earlier, those who believe fee-for-service payments are a problem, should *not* see “managed care” as a solution, because it isn’t moving away from FFS payments to providers; it is simply paying a middleman to *make* those FFS payments, instead of making them directly. By contracting directly with providers for the services performed, the PCCM model eliminates the inefficiencies exposed by the debate over whether to have “prospective attribution” or “retrospective attribution” of patients. It also avoids the unintended consequence of harming providers who treat poorer, sicker patients.

For coordination of care, under the PCCM model, the state pays providers directly, with the primary provider coordinating the care, receiving compensation for that service as well.

Medical Assistance and MinnesotaCare patients, especially those with chronic or complex conditions or disabilities, and those with socio-economic challenges that lead to health disparities, would have better health outcomes if they had a care coordinator.

One of the immediate savings that would result from the change would come from elimination of the need to pay “navigators” to help people shop for an insurance plan. Instead, these navigators could be repurposed for the task of coordinating care, helping people navigate the *care* they need.

Under the PCCM model, patients would be encouraged to choose a primary care provider where they would receive help navigating the health care system. Both the patient and the clinic would understand the relationship, unlike the current situation where patients can be “attributed” to a clinic, without their knowledge. The care coordination payments would go to that clinic, with higher care coordination payments for patients with chronic or complex conditions or disabilities. The PCCM provider would provide overall oversight of the patient's health and coordinate with the patient’s other providers to ensure that patients get appropriate care.

The PCCM, or primary care case manager, would typically be a primary care clinic, but in some cases where the patient has a chronic condition or specific needs, such as mental health, a specialist or specialty clinic that regularly works with the patient might fill that role. Minnesota’s community health clinics would be well prepared to provide care coordination because of their extensive experience with low income patients, but whichever clinic a patient is using for care could provide the coordination.

Under the PCCM proposal, the Commissioner of Human Services would collaborate with community clinics and social service providers to do outreach to low income people who need care but are unlikely to access it due to homelessness, mental illness, or other challenges.

The commissioner would also work with medical and social service providers to reduce hospital admissions and readmissions by providing transitional care and other help to people that would help them stay out of inpatient facilities and emergency rooms. Unlike the increased mortality caused by the Centers for Medicare and Medicaid Services (CMS) Hospital Readmission Reduction Program (mentioned previously), this initiative would reduce readmissions by providing care that keeps people healthier, not by incentivizing hospitals to keep them out.

The benefits of the PCCM model are the same types of benefits that the IHP model is supposed

to provide. However, instead of hoping that an extremely complex and costly payment model *might* provide incentives that would result in better coordination of care, the PCCM model would simply and directly pay for the care coordination that we want. It would significantly reduce the administrative burden on doctors and clinics, and consequently, reduce costs. Unlike the IHPs or other alternative payment models the PCCM system would be understandable, transparent, and fair.

PCCM's have been used elsewhere. According to a policy brief of the Kaiser Commission on Medicaid and the Uninsured, in 2012, 31 states operated a Primary Care Case Management (PCCM) program.

“In PCCM programs, states contract directly with primary care providers (PCPs) to provide, manage, and monitor the primary care of beneficiaries who select or are assigned to them.”<sup>17</sup>

The Kaiser brief says that states have chosen to use PCCM “in rural areas with insufficient population to attract MCOs, or because they prefer contracting directly with providers, rather than with insurers, and have the administrative capacity to do so. Oklahoma, and more recently Connecticut, have both dropped earlier MCO contracting programs in favor of PCCM, *citing issues including higher costs associated with MCO contracting, plan turnover, and comparable or better performance by PCCM on measures of quality and enrollee satisfaction.*”<sup>18</sup>

## Quality

Many healthcare reform efforts to improve quality attempt to do so by creating a new “quality measurement” system, along with a bureaucratic formula for paying incentives or bonuses in a financial reward and punishment system. In addition to the *enormous* administrative expense and hassle of setting up that complicated system, those “quality” payments systems create numerous additional problems, including:

- Penalizing providers who care for low-income and high-need patients
- Enabling providers to game the system by devoting more effort into documenting patient problems (to increase compensation) rather than treating patients for their conditions, and
- Diverting provider time from patient care by requiring them to spend more time on administrative reporting of quality measures

Calling those administrative costs “enormous” is not an exaggeration. The title of a March 2016 study published in *Health Affairs*, summarized the scope of the costs: “US Physician Practices Spend More Than \$15.4 Billion Annually to Report Quality Measures.”<sup>19</sup> The report estimated that “the average physician spent 2.6 hours per week (enough time to care for approximately nine additional patients) dealing with quality measures; staff other than physicians spent 12.5 hours per physician per week dealing with quality measures.” That’s a total of over 15 hours required for every physician every week, just for the medical providers

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<sup>17</sup> <https://kaiserfamilyfoundation.files.wordpress.com/2012/02/8046-02.pdf>

<sup>18</sup> Ibid.

<sup>19</sup> Lawrence P. Casalino, et al., “US Physician Practices Spend More Than \$15.4 Billion Annually To Report Quality Measures,” *Health Affairs* 35 (March 2016), pp. 3401-3406, <http://content.healthaffairs.org/content/35/3/401.abstract>.

to report quality measures on which they are to be graded and paid.<sup>20</sup>

Requiring a medical student to repeatedly perform and document any specific quality measure during their training may teach and reinforce best practices. However, requiring a doctor to document the same things over and over, year after year, in order to be paid for better quality care is counterproductive and serves no purpose while wasting time and causing physician burnout.

Not only are states and the federal government pursuing costly, misguided “quality” payment schemes, but in doing so, we *fool ourselves* into believing that we are improving healthcare quality, even as we ignore the most outrageous violations of basic quality standards. This failure to address the most serious violations of quality was illustrated in recent exposés on nursing home care in Minnesota and other states. The Minneapolis Star Tribune reported that there was not even an *investigation* of improper care in 97% of the cases, including criminal assaults on seniors.<sup>21</sup>

If Minnesota is serious about improving the quality of care we should stop wasting time on counterproductive payment schemes and start by investigating reports of the most serious failures to deliver quality care.

### **What about the Cost Savings Claimed by DHS?**

My challenge to these healthcare “payment reforms” explains why the reforms are driving up costs, *not* reducing them. But how can I say these payment reforms cost more when the Department of Human Services (DHS) claims Minnesota Integrated Health Partnerships (IHPs) have saved \$213 million<sup>22</sup> in the first four years?

The reality is that we have such a convoluted health care financing system that it is difficult to measure the full impacts of changes in the system. DHS makes an estimate of savings from reductions in rehospitalizations and ER use that *they attribute to* the IHP model – they claim a 14 percent reduction in inpatient admission and 7 percent reduction in ER visits<sup>23</sup> – however with the inaccuracy of risk adjustment, accurate attribution of these reductions is difficult. In addition, some of those reductions in hospital admissions may well be inappropriate and harmful to patients, as mentioned previously.

On top of that, the savings DHS claims have been achieved by IHPs ignores the spending by the providers and by the administrative middlemen – to set up the administrative infrastructure, to hire the bookkeepers and accountants, and to train medical providers on the data and procedures they need to document in order to maximize reimbursement.

The large amount of provider time needed for documentation and data reporting, along with the huge administrative costs likely outweigh the savings. Unfortunately, *the biggest harm is that done to patients*<sup>24</sup> *as well as the reduction in time devoted to patient care*, and shifted to

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<sup>20</sup> Ibid.

<sup>21</sup> <http://www.startribune.com/senior-home-residents-are-abused-and-ignored-across-minnesota/450623913/>

<sup>22</sup> <https://mn.gov/dhs/media/news/#/detail/appId/1/id/318197>

<sup>23</sup> pg 20, [https://www.chcs.org/media/MedicaidACOPProgramsWebinar\\_01.17.17.pdf](https://www.chcs.org/media/MedicaidACOPProgramsWebinar_01.17.17.pdf)

<sup>24</sup> “While U.S. heart failure readmissions fall, deaths rise,” Internal Medicine News, Mitchel L. Zoler, September



this “quality” and billing-related documentation.

Calculating savings from reductions in the use of some forms of health care, while ignoring the very real increases in administrative expenses is not unique to the IHP initiatives. Over the years, DHS has frequently made claims of big savings. In fact, a couple years ago DHS claimed a cumulative total of \$1.65 billion in savings from health reforms.<sup>25</sup> If we really *are* saving billions on these reforms, one might wonder why health care costs for the public programs continue to rise so much faster than other sectors of the economy.

### **The Solution We Need**

Minnesota has some of the best medical care available in the world. We have some of the best doctors, nurses, and other medical providers. We have some of the best hospitals and clinics, some of the best medical researchers and facilities, some of the best medical technology inventors and manufacturers.

But we squander those incredible assets on a dysfunctional system for accessing care. The US is unique in our high costs – spending twice as much as other industrialized countries, while delivering worse health outcomes. We are also unique in being the only industrialized country that doesn’t provide health care for all of our people.

I have been consistent in calling for comprehensive reform that would provide healthcare to every Minnesota, for all their medical needs, *including* dental, vision, hearing, mental health, prescriptions, long-term care, alcohol & drug treatment. I have been consistent in calling for a system which is driven by patients, who get to choose their own providers; a system where medical decisions are made by patients and their providers, not by government, insurance companies, or employers. We can have such a system, which focuses on keeping people healthy and getting them care when they need it, saving money for families, businesses, and government.

That comprehensive reform is proposed in the Minnesota Health Plan, [Senate File 219](#).

However, this letter is *not* focused on that comprehensive reform. This letter is responding to the DHS request for comments on the IHP model. This letter is merely proposing some immediate next steps for Minnesota:

- An immediate halt to further implementation of payment reforms that are adding to our healthcare administrative bureaucracy
- An immediate end to costly administrative middlemen to pay for healthcare in MinnesotaCare and Medical Assistance
- Using savings from elimination of the administrative middlemen in our public programs, and delivering care along with care coordination through a proposed Primary Care Case Management (PCCM) system, as proposed in [Senate File 1299](#).

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20, 2017 <http://www.mdedge.com/internalmedicineneews/article/147553/heart-failure/while-us-heart-failure-readmissions-fall-deaths>

<sup>25</sup> <http://www.startribune.com/counterpoint-minnesotans-benefit-from-competitive-bidding-on-health-insurance/324527421/>

## Conclusion

I challenge the entire direction of the DHS health payment reforms, which are doing the opposite of what the agency intends. These reforms are *increasing* costs, while *decreasing* the quality of care provided.

It is unwise to push ahead with administratively complex “reforms” that are based on flawed assumptions. I urge DHS to step back and question the assumptions behind their proposed reforms. Recognize that this complexity is moving backwards on the problem highlighted on the DHS Integrated Health Partnerships webpage, namely that, “too little of every dollar spent on health care is devoted to patient care.”

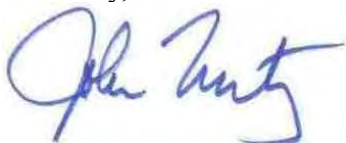
Rather than continuing to build a second costly layer of administrative middlemen, we should be eliminating both layers. We can deliver healthcare in an efficient manner and work directly with providers to improve quality.

For the DHS goal of improving care coordination, I urge you to avoid further administrative waste and deliver it in the most direct, efficient manner – by paying for care coordination and navigation directly to the providers who perform the task.

I am pleased to provide more information and more details on proposed alternatives if the agency is interested.

We are headed in the wrong direction. I urge a halt to further implementation, and a complete rethinking of how we pay for healthcare. Minnesota can provide a model for the world in health care.

Sincerely,



John Marty

cc: Emily Piper, DHS Commissioner  
Ed Ehlinger, MDH Commissioner  
Jessica Looman, Commerce Commissioner  
Dan Pollock, MDH Deputy Commissioner  
Marie Zimmerman, State Medicaid Director  
Nathan Moracco, DHS Assistant Commissioner for Health Care  
Santo Cruz, DHS Deputy Commissioner for External Relations  
Diane Rydrych, MDH Health Policy Director





December 20, 2017

Ms. Marie Zimmerman  
State Medicaid Director  
Minnesota Department of Human Services  
540 Cedar Street  
St. Paul, Minnesota 55115

Dear Ms. Zimmerman:

Thank you for accepting these public comments from the Altair ACO on the Next Gen IHP framework.

As you know, Altair is a disability-focused, social services and health accountable care organization representing 7300+ people with IDD. Our members have come together to put innovation into action and share best practices. We have been a leader in Minnesota, bringing the first shared saving model to the IDD community through the legislative approved HCBS innovation grant. With successful execution of this grant driven by the utilization of a LifePlan, we have addressed unmet health and wellness goals leading to 32 people being successfully placed in community employment and housing supported by a shared innovation award with DHS of \$150,000 in 2017 and an additional award of \$150,000 for 2018 (reference case study on Dave\* below). We have also discovered through this HCBS innovation grant a gold mine of possibilities to support additional people like Dave in some type of integrated model that saves money and provide alignment with IHP goals.

**\*Case study on Dave- Behavioral/Medical Wellness**

Dave is a 24-year-old individual with bi-polar disorder and co-occurring severe explosive disorder with funding through a Development Disability waiver (DD), Straight Medicaid, and Medicare insurances. Over the past year, Dave had been receiving employment services funded through his waiver from an ALTAIR ACO service provider. Dave's job placement was not meaningful to him and he became frustrated with going to work. Dave's medication regimen was also under medical evaluation, as Dave and those close to him noticed increasing agitation, hallucinations, and aggression.

Dave's frustration at work resulted in an explosive episode and immediate termination of employment. In addition to challenges at work, staff at Dave's group home had deficits in training and education pertaining to Dave's mental health diagnosis and medications. Dave's vocational provider recognized the importance of behavioral health wellness defined in his LifePlan as it pertained to his ability to be successful in an employment setting and promptly made a referral within the ALTAIR ACO network to a medical and behavioral health provider.

Dave received a diagnostic assessment through our in-home provider and began to participate in Adult Rehabilitate Mental Health Services (ARHMS) three times a week. Dave and his ARHMS worker identified goals around health/wellness and skills needed to successfully engage in finding and sustaining employment. Dave's guardian worked very closely with his physician to adjust medications to a therapeutic level. In addition to other methods, Dave participated in genomic testing to identify medications which were unnecessary or no longer effective. To assist in the medication reconciliation, behavioral nursing home health care services were ordered and delivered to monitor symptoms and side effects and most importantly, to provide teaching and education group home staff.

Over the course of three months, Dave's medication regimen reached a therapeutic level, his work with his ARHMS worker assisted him in successfully securing and maintaining meaningful employment again, and staff and group home competency in supporting individuals with behavioral health needs increased. Dave has recently received several awards from his employer and he and his guardian have communicated that the supports and services provided through the ALTAIR network has greatly improved his overall quality of life.

This is just one example of utilizing our 'braided funding approach' for individuals with IDD has brought together clinicians from many diverse organizations to discuss best practices and different methods that have been successful in their clinical practice. Altair implemented a health information exchange solution that connects to a State-Certified Health Information Exchange Service Provider. The Altair member organizations, through shared health and health-related information, support a service delivery model that facilitates improved coordination of the '70/30% spend model' to help provide the right services and care at the right time to improve quality of life for individuals with disabilities while helping reduce costs. Altair also connected to pharmacies in the area through Simply Connect, a State-Certified Health Data Intermediary. This connection supports a change in medication notification and ensures that the Altair members always have the most up-to-date version of dispensed medication from the pharmacy.

There are three parts to our strategy implemented to support Dave:

- Advocate to include our clients and services in new demonstration and reform models;
- Partner with health systems and health plans to address the whole health of our clients; and
- Create savings to the system through a focused joint effort on the TCOC (Total Cost of Care).

*Despite our breakthrough progress and accomplishments, Altair along with our demonstrated ability to save money see potentially misaligned incentives overall with the system this IHP- Next Gen RFI.*

**We present these considerations:**

1. Please give RFP applicants flexibility to propose including additional optional populations.
  - Re-categorize dual eligibles and others as optional populations that a Next Gen IHP can elect to serve. This will give more individuals the chance to participate in the demo.
2. Please give RFP applicants flexibility to propose including HCBS services on a pilot basis.
  - Allow HCBS services as optional pilot measures that a Next Gen IHP can include in their outcome or total cost of care calculations. This will help build more evidence of how HCBS services can influence outcomes and cost in the medical system.
3. Please give RFP applicants flexibility to propose phasing in community partnerships.

- Instead of requiring all network arrangements to be in place on the date of application, allow Next Gen IHPs to propose a plan to add partners over the duration of their multi-year demo. This will give IHPs more time to build partnerships with groups like ours.
4. Please incentivize RFP applicants to collaborate with community providers.
    - Similar to the IHP 2.0 model, Next Gen IHPs that propose substantial arrangements with community providers should be rewarded through reduced risk or other mechanisms.
  5. Please expand the IHP Data Portal to include HCBS measures.
    - This will add another dimension to the emerging picture of how HCBS impacts total health care spending and population health outcomes, and it also will complement the data collection that has been started through the HCBS Innovations grant.

**Important Experiential Information:**

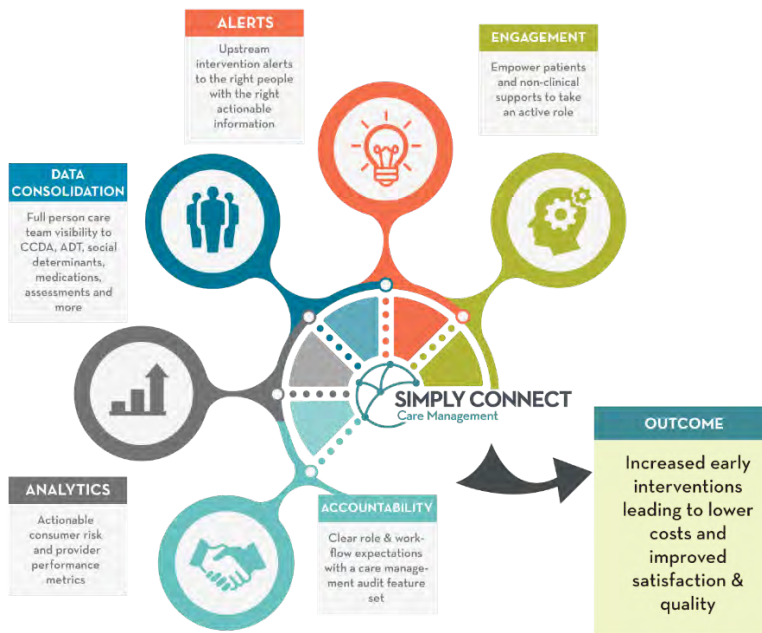
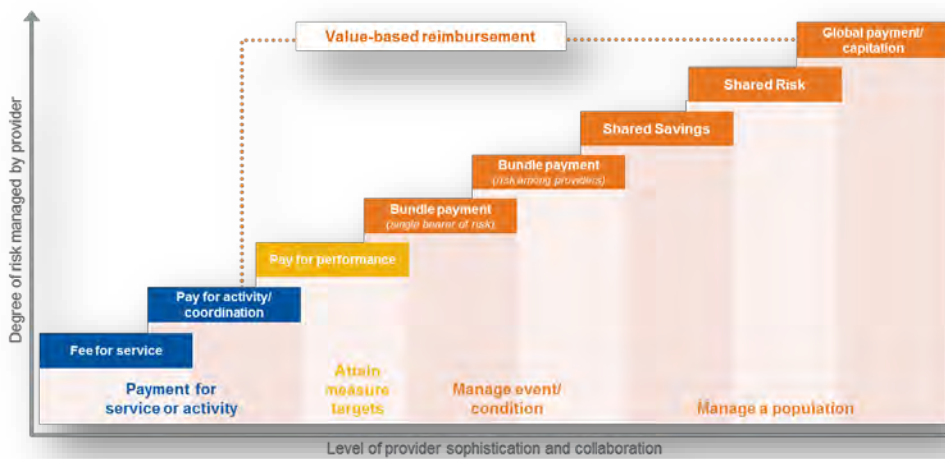
- The IDD population contributes a high cost to the overall DHS budget as we look at the TCOC (Total Cost of Care) acknowledging that on average 70% of the total spend for a person comes from the person’s waiver budget. Recent analysis provided by our lead agency- Lutheran Social Service demonstrates through a focused effort providing people with IDD a shift in supports with attention to community living, working and self-directed services-- they have reduced their average waiver spend by 18.86% another key proof point that we can reduce waiver spending levels.
- The remaining 30% on average funds the health total spend. We refer to this as the ‘70/30% spend model’. This approach introduces new thinking around the true TCOC for a person with IDD.
- Through recent Altair designs for people with IDD that experience intensive needs, we have implemented a ‘braided funding model’ supported by care coordination and in home services providing person focused care plans. Through this approach underpinned by the health determinants of social factors we see this driving the overall savings of ‘70/30% spend model’.

We believe our recommendations should be thoroughly reviewed by DHS before the final RFP is released providing Altair the opportunity to participate with the Next Gen IHPs to implement our ideas for delivering services and creating outcomes differently.

Specifics of two paths that could be implemented:

*Path 1-*

- *Utilize the IHP- Next Gen framework to allow for a managed care carve-in—for people with intellectual and developmental disabilities, 19+ years old, including dual-eligibles.*
- *Identify interested managed care payers/healthcare partners committed to working with us to combine our social capability with their medical and administrative capabilities to improve health, create full lives, and reduce costs in this population.*
- *Develop a relationship where we can share proportionate risk and rewards with identified partners with deliberate attention to the total cost of care for a person that commits specific goals to the ‘70/30% spend model’ distribution of services delivered. i.e.: 70% is the average spend on the social services side vs. 30% average spend on the health side working toward a strong commitment to reduce the total cost of all care within defined quality parameters.*
- *Refer to diagrams of Medical Neighborhood Integration, Value based payment diagrams recently designed with consultation with Optum and Altair’s Care Management model below.*



Path 1A-

- *In addition to Path 1 goals launch a pilot for a targeted population of 1000 people as identified that are supported by Community Neighborhood Centers located in a leading national pharmacy providers. We would assign our community health coordinators to coordinate proactive wellness services such as:*
  - *Access to primary care*
  - *Mental health telehealth services*
  - *Linkage to a trusted pharmacist providing patient centric guidance on medication management*
  - *Identify and manage care advice for chronic conditions such as diabetes, asthma and dementia screening*

I believe these changes could give Altair the opportunity to identify one or more partners, build a Next Gen IHP demo model together, and then launch into a series of pilot demonstration cycles.

In line with our strategy of including our clients and services in new models, Altair is also contemplating asking the legislature to authorize this completely new type of demonstration. We firmly believe that it will be important to test across multiple types of demonstrations in order to unlock as many learnings as possible and determine which models create the best outcomes for people with IDD while strongly addressing the fiscal responsibilities of a cost effective quality based model.

We appreciate your consideration of our Next Gen IHP recommendations and would welcome the opportunity to meet with the department to discuss our suggestions further.

Sincerely,

George J. Klauser, Executive Director  
Altair Accountable Care Organization  
(651) 969-2288 • [george.klauser@lssmn.org](mailto:george.klauser@lssmn.org)

**Altair ACO Response to Questions  
IHP Next Gen**

<b>Question</b>	<b>Altair option 1: Moderate changes allow Altair to participate as a Next Gen IHP partner</b>	<b>Altair option 2: Substantial changes allow Altair to participate as a Next Gen IHP lead</b>
1. Network exclusivity	* No change needed	* The Altair Next Gen IHP might need a waiver from network exclusivity
2. Minimum population size	* No change needed	* The Altair Next Gen IHP might need to start with a smaller population size than a health system IHP
3. Network adequacy for IHP and MCO	* Allow Next Gen IHP to add HCBS services to their network and integrate through TCOC and quality measures	* Require Next Gen IHPs to include HCBS services
4. Care coordination systems	* Integrate information from the waiver case management system	* Same
5. RFP evaluation criteria		
6. Single preferred drug list		
7. Balancing risk for providers	* No change needed	* The Altair IHP might need a reduced level of risk sharing (compared to the level of gain sharing), at least for the initial ramp-up years
8. How to evaluate paying for non-medical, non-covered services	* I understand this question to be about how DHS evaluates Next Gen applications; if this is correct, then the recommendation is to give the IHP maximum flexibility to invest their care management dollars for the benefit of their unique client population	* Same
9. Amount of payment tied to performance	* No change needed	* The Altair Next Gen IHP might need to phase in performance-based payments much slower
10. Which quality programs to align with	* We could consider some HCBS specific programs,	* Same

	such as the regional quality council surveys or the statewide client survey	
11. Flexibilities and incentives for population health	* The most important incentive for our population will be including HCBS in the TCOC and quality measures	* Same
12. Other comments		

**From:** [MN\\_DHS\\_DHS PSD Procurement](#)  
[REDACTED]  
[REDACTED]  
**Subject:** FW: Next Gen IHP Comments from SEIU Healthcare Minnesota  
**Date:** Friday, December 29, 2017 10:57:43 AM

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[REDACTED]  
[REDACTED]  
[REDACTED]

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**From:** Rick Varco [mailto:Rick.Varco@seiuhcmn.org]  
**Sent:** Wednesday, December 20, 2017 4:53 PM  
**To:** MN\_DHS\_DHS PSD Procurement <DHS.PSD.Procurement@state.mn.us>  
**Subject:** Next Gen IHP Comments from SEIU Healthcare Minnesota

Rick Varco  
Political Director  
SEIU Healthcare Minnesota  
651-294-8130  
Rick.Varco@seiuhcmn.org

Re: Request for Comments, Next Generation Integrated Health Partnerships (IHP)

Thank you for the opportunity to comment on the next phase of redesigning the Department of Human Services' (DHS) purchasing and delivery strategies for Medicaid and MinnesotaCare enrollees. SEIU Healthcare Minnesota represents more than 35,000 healthcare and long-term care workers in hospitals, clinics, nursing homes, and self-directed home care throughout the state of Minnesota. Our employers include Allina, HealthPartners, and other major metro area providers.

In general, we strongly support this proposal and believe that it elaborates on success DHS has had in reforming our public healthcare programs. Under the Dayton administration, DHS has taken several steps to get the best value for our public dollars and we think this proposal is the next step towards that goal. Directly contracting with providers gives DHS an important tool that will allow you to improve care coordination, to better address racial disparities, and to address the social determinants of health. To better serve Minnesotans, we encourage DHS to structure the Next Generation IHP in a way that guarantees money saved through better care will be reinvested in expanded care and services throughout the program. Initiatives to improve quality can only become self-sustaining when stakeholders are confident that the savings will be re-invested.

We are concerned that in the proposed Next Generation IHP, an individual patient's primary care medical home will not necessarily be aligned and/or coordinated with their dental care. In the proposed model, general medical services appear to rest with the new Next Generation IHP, but other services, specifically dental, appear to be administered by the State. In order to provide the best care, SEIU supports allowing models that provide integrated care.



## **Representative Diane Loeffler**

### **District 60A - The fifteen neighborhoods of Northeast and northern Southeast Minneapolis**

#### **Feedback to DHS re: Outcomes Based Purchasing and IHP2 Proposal**

In general, I appreciate the continued desire to look for innovative approaches that can improve the health outcomes of the very low income persons served. We should be in a process of continuous improvement and know that many are not well served given their own personal barriers and delivery and management system challenges. That these approaches may often (but not always) prove more cost effective is a plus, but not an end in itself. The best outcomes will come from a long term perspective, not short term annual results.

Incentives that promote a short term orientation in less mission focused organizations, more focused on managed finances than improved outcomes, can actually lead to underperformance in prevention measures, establishing good health habits, and stabilizing households. The constant churn of much of this population lends itself well to that – focusing on the “lifers” and “frequent flyers” where the cost savings are most available while ignoring those who may only have affordable, quality health coverage during the short time on TANF before returning to a benefit-less position that will leave them and their family inadequately covered until Medicare eligible (and usually without paid sick time so they are unable to access business hour focused providers to keep them and their children up to date).

#### **Process and timing concerns**

I feel compelled to first criticize the overall process and timing. It has become almost standard practice for DHS to seek stakeholder input on extremely short notice and generally in the most popular times for vacations in MN (July and Thanksgiving to Christmas with its extra burden of year end obligations and budget setting). Who can adequately analyze these options when understaffed with very short timeframes? Having the first overview scheduled 2 days after the release and the next a week later – rude and totally disrespectful of the many demands on partners and their need for advanced notice and planning. There seems to be no serious attempt to engage policy partners in the legislature or the impacted public or smaller providers.

The “DHS system to large provider systems bias” leaves critical gaps in practical knowledge of potential impacts and obstacles. Counties were to be equal partners in purchasing, a process that has been reduced by DHS leadership over the years with inadequate attention to the spillover effects, especially now that there is an interest in better coordinating health and human services. The public has consistently turned to county staff to remedy problems, explain confusing processes and options, and solve immediate needs when the paperwork gets lost and critical needs have to be met.

#### **Test first, then implement**

I’ve talked to a large number of current and retired leaders in health and human services from different parts of the metro. No one can remember a major DHS system change implementation that has gone well in initial implementation during the past 10-15 years. The policy goals and plans are admirable, but the practical execution has been disastrous too often and resulted in tremendous frustration by all involved, bad publicity that casts further doubts on a generally good service system at all levels, increased private sector dissatisfaction, and often resulted in increased property tax costs to counties. From automatic income withholding of child support, to the MAARS system, MNchoices, and much more there is a legacy of bad launches.

Often the bad launch is a result of overeager DHS leaders to give inadequate time for preparation and problem solving by all involved. It seems those responsible for implementation are asked to do the impossible on short timeframes. Too often those with practical, on the ground experience in implementation, IT systems and operations are only brought in as serious advisors once the implementation is a major problem, not in the formation and roll out planning. (MNsure is a recent example of that, MNchoices too).

While this proposal builds on small IHP pilots, the roll out to over half of the population seems to also risk unanticipated problems. DHS proposes to become a purchaser of specific services in areas that more experienced health systems have had significant difficulty. Much of health care delivery is local (even in the metro area where my constituents prefer, and often need, local as bus service is inadequate and they too want to support our local small businesses for service). But they'd prefer a distant provider on their bus line than a closer one that requires a trip downtown and then transferring back on limited service bus routes. That's city resident planning – not geographic distance, distance in time via fixed schedule buses.

Small vendors are worried that the ease of major contracts vs many small ones will result in their being squeezed, if not eliminated from this client base, while their clients get inadequate services and administrative costs associated with centralized efforts take needed funds.

Almost no one likes dealing with complex health coverage choices and this population has been inadequately supported in their current decision making (85% don't choose and go to a default assignment). This will only increase the complexity and confusion for new enrollees and those having to change doctors or clinics as new network combinations are offered.

I don't believe this approach will be ready for implementation until the year 2020, more likely 2021 with current resources. This outlined proposal has too little meat, especially in the difficult yet key areas of data management, risk adjustment based on social determinants, financial models, etc. There is no reason to fast track this. Do it right

#### **Needs more input from those most impacted - the people served- and direct service staff at the local level**

While the state is engaged (under the leadership of the Olmstead Plan) in person centered planning, there seems little of that in this proposal. In fact the clients served and their experiences are almost not mentioned in the draft proposal. There is no indication of their involvement or focus groups to get the reaction of those served to proposals that may disrupt their care system and options.

My sense is DHS staff never really understood the negative impacts of their shifting hundreds of enrollees back and forth twice between health systems within a year when it discontinued UCare as a provider, then Medica left and people had to choose again and UCare was asked to remobilize. The proposed model of coordinated care is based it seems on a primary care relationship and continuity of care to yield the results from improved case management and coordination. None of that continuity of care and relationship honoring was part of the last market transitions. As a result, I still hear complaints from the people who had major disruptions in their health care twice.

DHS is too theoretical and too removed from the people served and their life challenges. This population is less well equipped due to extreme poverty (many families trying to live on less than \$500 a month, some singles with \$203 a month), along with often limited literacy and language skills and the burdens of poor health, nutrition and energy and little patience for system complexity. Many, if not most, lack solid social support systems to help them navigate this. DHS needs to be more fully engaged with enrollees and those who directly serve them. Increased use of agency staff placed in other settings for professional development should be considered along with similar opportunities for local agency and direct care staff to join DHS as temporary staff. As the sign in Gov. Dayton's office says "None of us is as smart as all of us" (paraphrase, not sure of the exact wording).

I would suggest that this be piloted in several counties, not just in the metro with the participating counties volunteering to participate. That is how managed care began in the state with Hennepin, Dakota and Isanti leading the way and problem solving before the major roll outs. The small pilot IHPs do not reflect many of the complicated provisions of this proposal (plan selection criteria, primary care exclusivity, state takeover of some portions of the care model,

tremendous reliant on state data systems for feedback, evaluation and risk adjustment more demanding and sophisticated than that tried to date).

DHS experience in measuring and influencing social determinants of health is almost nonexistent. The county and nonprofit service system is not prepared to step up to new demands for services and partnership where the financial rewards sit with others and there is no proposal for meeting their increased needs (they are to be contracted vendors? Is that in their long range plans? Are they willing to ramp up and add personnel and services? I've heard there's been little serious engagement and joint planning.

### **Inadequate analysis of the population to be served**

The proposal will have major impacts on the lives of people, many with major health issues and chronic illnesses. The population has many different components:

- People on short term (generally younger families) who have major unmet preventative care needs, undiagnosed mental health challenges due to the stress of their lives or other underlying causes, and often get almost no service from the care system
- Longterm users who often juggle homelessness, depression or other mental health challenges, and a resulting risky lifestyle. They have disproportionately been the focus of some IHP pilots.
- Persons with ongoing chronic health issues (some on the TANF exception provisions) whose ability to cope with family needs and their own safety is sometimes limited by extreme poverty, historic trauma, major mental health and physical health challenges, and a care system that often is designed for stable, middle class expectations.
- And other subgroups.

Each of these populations needs further definition, analysis of their past utilization history, reasonable goal setting for improvement, and incorporation of their risk factors into the risk adjustment model.

### **Specifics related to the questions DHS has posed:**

#### **1. Primary care provider exclusivity**

For those with one or more complex health diagnosis, their access to a preferred specialist is more important than their primary care provider – their continuity of care is more important. Assignment should be on the provider most utilized, not necessarily their primary care clinic. ALL enrollees should be asked about key care providers they wish to retain in the application or renewal. They should also be able to request the network with the greatest amount of native speakers of their language. No one prefers telephone translation or another stranger in the exam room translating. This shows respect for them and their needs.

Continuity of care and selection of clinic is also very important for recipients who are on, find jobs and then pick a health plan/options through employer. Many know their enrollment is temporary. Their desire to be served in clinics accepting a wide range of insurance taken needs to be considered.

Also, I suspect many safety net providers or providers in areas with large public program enrollees may not survive financially if they cannot accept MA or MNCare enrollees from various plans, especially if there is low take up on the IHP2. I looked at the websites of several in my district and they all take enrollees from various health plans. I haven't had time to contact those clinics directly.

There is a often a misconception that people develop a longterm relationship with a primary care provider and that is the best and most common model. My experience is that that is only true for people in very stable lives, served by a stable clinic and who are older and have major health challenges that result in a relationship being built. I have been in the same clinic system my entire adult life and have never had a primary care provider that I've been able to stay with more than 5 years. They are routinely transferred, laid off when a major employer contract is lost or move

just as others change jobs to get closer to home or a better situation. The metro area is very different from Greater MN where practitioners tend to build a longterm practice in one clinic is my impression. To be successful does this model assume longterm supportive relationships?

I don't see how an IHP2 can manage its risk if it is required to use the entire fee for service (FFS) network as well. Some in the FFS system are very specialized and all in the state should have access to while others choose to be in FFS because they won't accept system oversight and direction and prefer to operate independently. Another option would be care management added within the FFS model as another model to be tested.

### **3. Network and service performance adequacy**

DHS has almost no experience in researching or leading change in social determinants of health, racial disparities, reducing the impacts of historic or secondary trauma, and improving enrollee attitudes and approaches to improved health. The proposal reflects no partnership at either the state or local level with public health. That is a MAJOR shortcoming. MDH has worked hard over the last years to develop expertise in these areas and partners in the affected communities. They and local health should be heavily involved in setting the measures and outcome goals in this area.

Along with the new focus on better service and coordination, there needs to be new measures of network adequacy. This would include:

- Measures of sufficient hours of access for employed persons who don't have paid sick time. This should be a measure of length to open appointment for various services on nights and weekends. Coverage means little if you can't get to it or preventative care.
- Access adequacy in the metro area has to be measured in bus time provisions unless all qualify for non-bus NEMT. I represent 15 neighborhoods (like small towns within the city) and 20-25% of my residents don't own one car in the household (mostly due to poverty, not age). Taking a bus less than 8 miles can take over an hour each way with a transfer (sometimes longer - some buses only run every half hour or hour) during most times of the day, sometimes more. So while miles may be an ok measure in Greater MN, it is not in the metro. Many suburban specialty clinics are impossible to access during mid day. Another approach would be to assure all access to door to door transportation if the trip will take over 45 minutes, require more than one transfer, or take place in winter conditions for people with mobility challenges or numerous small children.
- Minimum levels of onsite help for people speaking the most common non-English languages should be expected.
- Length of wait time to appointment should be the consistent measure for adequacy of all networks for both primary care and specialty care services. Financial penalties should be imposed for not meeting those.
- Using past utilization data and projecting higher utilization in a more intense care management model should guide requirements for adequacy of initial networks of dentists, behavior health specialists, and other high demand areas of care. As the model develops, the measures should transfer to lag time to appointment.
- In geographic sub areas with large populations of cultural and language subpopulations, adequacy must be measured by the cultural diversity and language abilities of the providers, with specific measures in obstetrics, hospice care, dietitians, mental health and substance abuse.
- Cultural experience, native speaking providers by specialty, translators on site where volume reaches certain levels, and proof of training in trauma informed care should all be required components not only of judging adequacy but in advertising clinic capabilities as enrollees select care.
- All complaints, denial of care, and enrollee satisfaction surveys must separately report based on subpopulation served on public programs.

There needs to be a priority given for local providers to continue serving this population in all aspects and to assure continuity of care in the DHS proposed purchasing of some services.

#### **4. Systems needed for care coordination and performance measures at the start**

All these must be defined at the start. May modify over time but the expectations and measures need to be clear and specific. A challenge with this proposal is that the end goals and outcomes are not very clear or articulated. Failure to define them will result in an emphasis on managed finances, not managed care. Specific outcome measures by subpopulation should be established.

To emphasize care coordination and positive relationship building, and to identify and address unmet preventative and early diagnosis needs, a IHP2 and MCO should be paid an enrollment fee but not receive full capitation for an individual until the provider completes an initial in person health assessment with the enrollee. We are spending too much for people with un or undermet health needs who don't get those addressed while the state is paying capitation payments. For many families and individuals, their time on MA or MNcare is the only chance for this care before they transfer to high deductible policies that on modest incomes discourage care. If the focus is improved population health and reduced disparities, this is the time to step up and deliver good outcomes.

Clear definition and criteria needs to be established and communicated about when a persons needs go beyond care coordination and requires serious levels of case management.

The obligations of the IHP2 or MCO regarding paying for needed social supports, housing assistance, county services, and other support services critical to stabilizing lives so consistent health care and nutrition can become a priority needs to be spelled out. Medical vs social service budgets need to be separated.

#### **5. Criteria for selection and accountability**

From the start, robust goals and clear measures of baseline by subpopulation need to be established. (That that gets measured gets done.) The subpopulations should be by subgeographic area (zip codes have been proven to be strong measures of health in our MN metro), racial and ethnic minority, gender, length of time on the public program, involvement with other key systems (social services, criminal justice, adult or child protection, etc.), and life stability (homeless, socially isolated, two or more chronic diseases, etc).

Separate out and use public programs recipients data only for quality (should not include commercial data) and include all enrollees, not just those enrolled for a certain period of time. Performance data for evaluation and communication to the public should be done at the individual clinic and hospital level, not a clinic network summary. We ask enrollees to pick a specific clinic – this data should guide them in that selection and be based on the experience with other public program enrollees.

Provide counties and other non-health care system partners at least a month and half feedback time and participation in the establishment and review of this and other key features to balance work.

For the initial pilots, only those with strong evidence of working with public program enrollees, an effective history of tackling social determinants of health directly through their clinic processes (not in grants from their foundations), and an adequate network in areas of concentrated poverty should be accepted.

#### **6. Single preferred drug list.**

Should be a consistent approach within MN – the people served are very mobile. Clear criteria for acceptance and inclusion need to be established in advance. Initial list should be based to incorporate most based on utilization info. This must be made public to enrollees and providers for at least two months for input prior to final adoption.

This may reduce costs but may create problems with individuals with special needs and may have negative effects when they are forced to switch drugs thus need a plan for transition and a special need exceptions process.

The model must incorporate the social determinants – prescription may need to change based on the living arrangement of the individual (lack of housing or access to refrigeration, no volunteer to help, etc)

## **7. Risk/reward**

All accountability needs to be transparent and be based on all public enrollees serviced, not mixed populations with commercial products.

Measurable goals in reducing disparity measures, improving trauma informed care, and reducing gaps in prevention and early diagnosis milestones need to be part of the initial measures. The U of M and SHADAC should be consulted along with MDH and other experts.

There should be clinic based (not foundation based) measures of addressing health and social disparities.) Maximizing the impact of public health promotion efforts (like SHIP) by incorporating it into health care practices without creating new burdens on public health should be measured. Similarly Reach Out and Read and similar programs which supports physicians promoting early literacy interactions and brain development and providing books to families.

Evaluation needs to take in to account the risk on county services and administrative costs and local non-profits.

Risk adjustment must go beyond diagnosis related measures to incorporate social factors that influence outcomes (homelessness, social isolation, dual or more diagnosis that make outcomes more difficult, self management levels, etc.)

Short and longterm outcome goals should be measured and continuity of care encouraged.

DHS has indicated benefits would be shared with IHP2s, taxpayers and enrollees. How do we design this so that savings are re-invested to improve care and outcomes, not just go to changed forecasts?

## **8. Appropriate measures**

MCOs and IHPs must report out programs and where the money is being used. Other measure advise is reflected in other answers.

## **9. How much of payment should be on performance and outcome measures**

This should be the majority and it needs to have an appropriate risk adjustment based on social determinants of health (not on diagnosis). Otherwise this is just another way of organizing current care practices with a little window dressing.

## **10. Alligning quality reporting and measurements**

If you want to change the system, you have to change the measures. If you use the same old measures, you won't change the focus to short and longterm improvements in improved health, reduced disparities, and stable and healthier lives. This is key to the whole effort and requires major involvement of outside, academic researchers on the cutting edge of these issues.

Most measures used now are very basic and designed to make all look generically "good". They don't challenge or inspire change. I find them generally not useful in making my decisions re: my own care providers. And I don't have the intense challenges of many on MA.

Some measures of prevention and early diagnosis are essential for a population where that is a major disparity. Report at specific clinic level (not a network of clinics) and it should be based only on public health care recipients (NOT commercial), all enrollees, not just those in for longer periods of time.

#### **11. Improved measures of population health of the enrollees. Key criteria that would reject otherwise qualified applicants.**

MDH has worked hard over the last years to develop expertise in these areas and with partners in the affected communities and in the research community. They should be heavily involved in setting the measures and outcome goals in this area.

Both system design and health plan network proposals and operational policies must be carefully evaluated so redlining will be avoided in less than initially obvious ways. Or targeting only the most likely to be "profitable" populations – the frequent users vs the basic care of the bulk of the enrollees where change is harder to achieve quickly.

Applicants should not be selected that are not recommended by the county they wish to serve. Proposers should be rejected that do not have a history of going above and beyond basic health care for enrollees (and foundation grants don't count), and that can prove a positive set of outcomes with at risk populations. How can they demonstrate a person centered approach to care and adequate flexibility in their policies to enable that?

A limited number of choices per county is desirable along with better client input into selection and/or assignment. Most people are overwhelmed choosing between two plans at work, to expect stressed, often educationally limited and long term uninsured populations to easily confront complex choices is difficult. Testing approaches to this should be part of the initial pilots (and again it shouldn't go metro wide to start). The current system is a fail as to assuring good choices and continuity of care.

#### **12. Other comments**

##### **See my introductory comments**

DHS has historically tried to implement large system changes with too little time for working out the details or recognition of client/county impacts and thus fall short on the outcomes. This has repeated over and over and this seems likely to fall to that fate as well given the current lack of detail and agreed on focus.

The proposal doesn't pull all of the goals together and use research to work together to have better outcomes. The proposal has very little details, no clear outcomes defined, tested modeling of finance and risk adjustment components that applicants can put their own data into, and is not ready for prime time. The DHS history with

new reimbursement systems is equally error prone (think of the disability waiver system that still has lots of issues and work arounds).

We need to take the time to make this a major step forward and that to me is 2020 at the earliest, more likely 2021 with some more targeted pilots before. I'm not sure DHS or its health and county partners, let alone MDH and our research community will have sufficient time and resources to engage fully and do this right. I'd be open to supporting a legislative proposal on this. After so many failed starts, waiting 'til 2021 to do it right would be worth a good nation leading outcome. That would be my goal. For sure, starting and putting at risk the care system and enrollees of half the state is too big a step. This should scale to pilot counties, then go bigger. There's no reason not to also include regional centers as potential applicants.

Consider not doing this with 50% of the population on public health care in the state of MN – potentially pilot in one county. County must volunteer to participate.

This should not be the only opportunity for input and broad feedback. That should be a regular part of the design of each major component and be done individually for each with lots of lead time, analysis and development considerations shared, and true listening and adjustment to the feedback received.

I appreciate your consideration. I do support innovation and look forward to a more vetted and developed proposal arising out of strong partnerships in its development that includes advocates for the people served (county staff, underserved community representatives, small community based providers, etc.) and input from the people to be served. What do they want and would they prioritize? You need a strong set of professionally facilitated focus groups.

You can see by the length of this that I have taken it seriously and it reflects my listening carefully over the years to many voices in health care, my constituents and the problems they have encountered, my years in serving the people who are on MA and MNCare, and my career as a policy analyst and planner. I've seen too many good ideas go awry with inadequate planning and lead time. Health care and improving our disparities among our growing minority populations is too important to our state's future to take this lightly. Done well this can transform lives, done poorly it will feed the all to present cynicism.

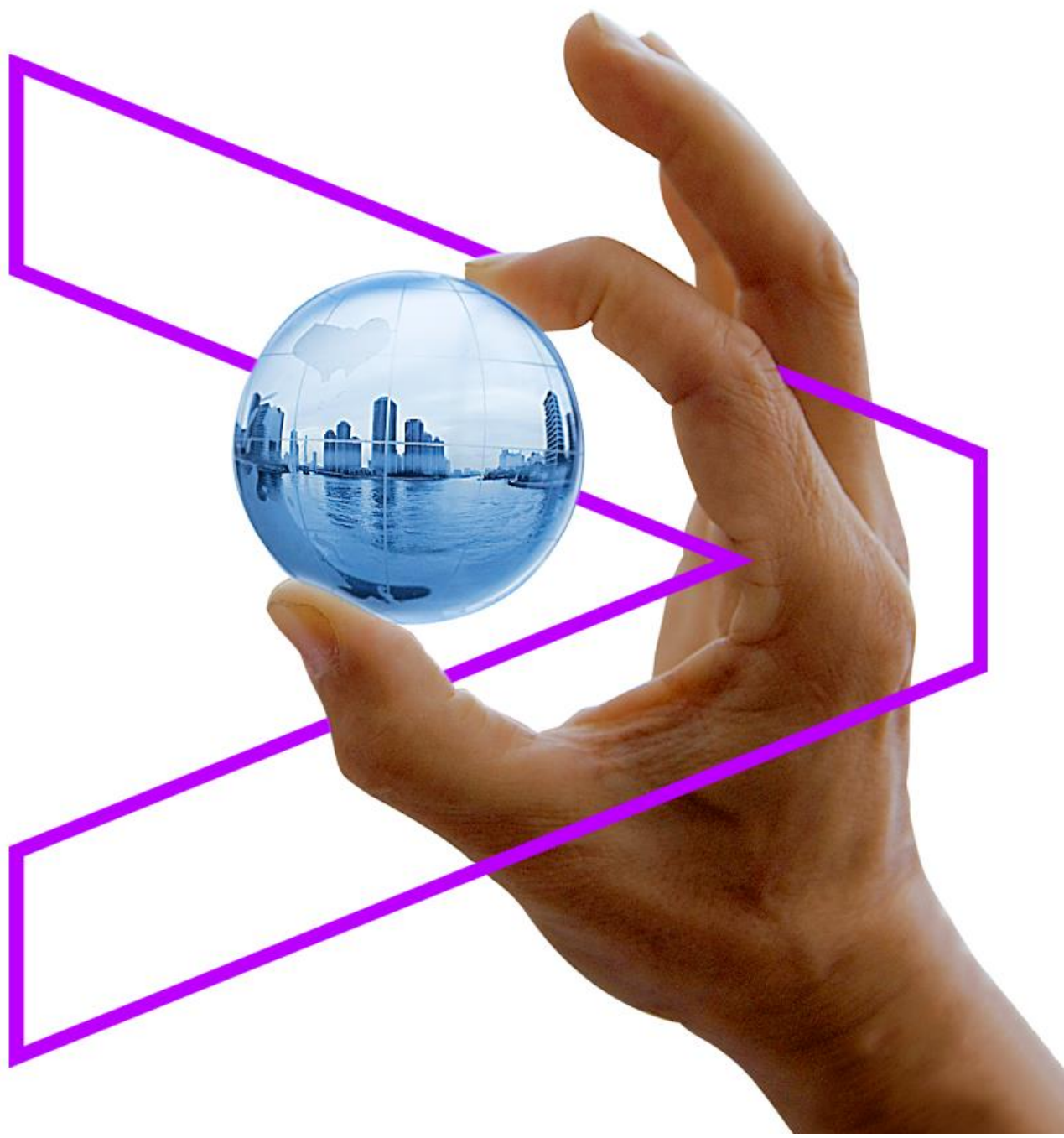
I wish this great outcomes and patience in the development.

Diane Loeffler  
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# **RESPONSE TO DHS REQUEST FOR COMMENT JANUARY 2018**



# INTRODUCTION

Thank you for inviting Accenture to contribute to The Minnesota Department of Human Services (DHS) redesign and reform of DHS' purchasing and delivery strategies for Medicaid and MinnesotaCare.

## **Why are you submitting the RFC after the deadline?**

While meeting with DHS Leadership on Dec 6<sup>th</sup>, 2017 Commissioner Piper requested Accenture to participate in the “*Outcomes-Based Purchasing Redesign and Next Generation IHP*” RFC that had been released on Nov 15<sup>th</sup> and due the following week on Dec 15<sup>th</sup>. Our initial review revealed that Accenture would need a reasonable amount of time to meaningfully respond. Accenture notified Nathan Moracco, DHS Leadership on Dec 15<sup>th</sup> that we would reply after the holidays.

Please let us know if you would like to discuss and/or explore our responses further.

Sincerely,

Dan Schmitt

## **ASSUMPTIONS AND CAVEATS**

This document was written from the perspective of a large, international consulting firm with ties to every industry. These ties enable Accenture to identify best practices used by those industries and adopt them to solving complex healthcare solutions. The following caveats apply:

This document is written with the perspective of a state Medicaid entity in mind. This means that considerations that may apply in the commercial payer space or within the context of large commercial health systems - may not apply to the comments here.

A variety of subject matter experts contributed to this document. Writing tone and style may vary between responses. For ease of reference, the contributing writer is listed with each response. Brief contributor biographies can be found on pages 38-40.

# RESPONSES

*Question 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?*

**Accenture has chosen not to respond to this question.**

*Question 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.*

**Accenture has chosen not to respond to this question.**

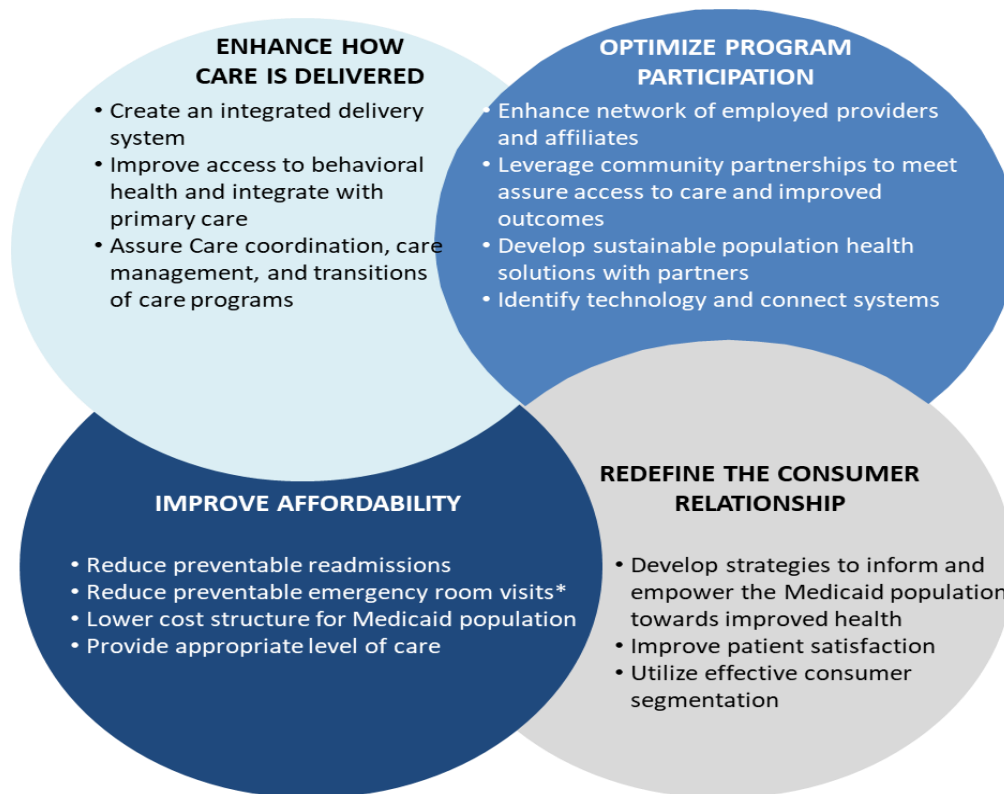
*Question 3: What kinds of criteria should be included in a Request for Proposal for Next Generation IHPs and MCOs to ensure that an entity has sufficient and effective provider and benefit network structure (e.g., behavioral health integration with primary care) to ensure enrollees’ needs are met? Are there additional services or requirements beyond behavioral health that should be a primary consideration (e.g., criteria related to cultural competency, disparities, equity, etc.)?*

## **Question 3 Response: AnnMarie Merta**

The purpose of these two sections of Accenture’s response is to frame-up network structure to ensure it is sufficient and effective. While the state of Minnesota should have a floor for network adequacy to assure enrollees have “real” access to care, this section is designed to give Minnesota a framework to help meet Minnesota’s own goals for an effective network and greater beneficiary satisfaction with healthcare delivery. The relationship with your network providers should be a relationship in which you are working toward aligned goals.

**Section 1: Criteria to be included in a Request for Proposal for Net Generation IHP’s and MCO’s to insure an entity has sufficient and effective provider and benefit network structure.**

## Key Objectives for Network Partnership Beyond Adequacy



Current specific adequacy standards should demonstrate to the state the appropriate levels of primary care, preventative health and specialty services to provide care for the anticipated number of enrollees in the service area. Network adequacy requirements need to be consistently enforced and networks should regularly monitor compliance. Reports should include location, number, specialty and capacity of providers. Reports should recognize areas of concern and specifically provide corrective action plans for any identified inadequacies.

Minnesota should look to MCOs and IHPs to provide concrete opportunities to exceed adequacy standards and performance. In addition, MCOs and IHPs reporting capabilities should include the following required metrics on quality, cost, outcomes, satisfaction, network utilization in addition to access.

- Improved time and distance standards
  - A minimum number of PCP and specialists for all designated specialties to assure access to covered benefits; for example, 2 primary care options within 30 minutes; specialists requiring frequent visits should be within 30 minutes for urban areas. Rural areas 60 minutes for specialists.
  - Travel time should include public transportation where available. For areas without public transportation, other options using community resource relationships should be identified.
  - Use of telehealth or virtual visits should be an option especially in rural areas.
  - All hospital, pharmacy services should be within 30 minutes or 30 miles
- Provider types
  - Network should include all required provider types
  - RFP should encourage participation of specific specialty types to meet the needs of benefit plan design but also the populations needs. Examples include adolescent medicine, obstetrics and gynecology, women's reproductive services, psychiatrists, cardiologists, endocrinologists, dermatologists. Provider ratios of specialist to populations they service should be set.
- Assured and timely access
  - RFP should request attestation to assure the providers "in-network" have an open panel, will accept attributed patients and will see them within required time frame, for example: urgent acute within same day, and chronic episode within 48 hours.
  - Extended hours
    - Primary care/ Behavioral Health offer extended hours
    - Formal relationship with retail clinics, urgent cares or call groups
    - Telehealth
  - Appointment availability
    - Same day availability for acute conditions
    - Emergent/Urgent options (12 hours)
    - Chronic condition episode within 48 hours
    - Preventative and routine visits within (10-14 days)
  - Accessibility for disabilities, low literacy, limited English proficiency must be addressed
  - Appoint reminders and education; follow-up on missed appointments and rescheduling. Address barriers to complying with appointments
- Out-of-Network
  - Plans should provide access to all covered services in an adequate and timely manner which may include access to out-of-network providers; if no provider either exists or is accessible to enrollee.
    - Information on use of out-of-network providers should be communicated to MCO network to identify opportunity to contract provider
    - MCO's should demonstrate plan to assure referrals are made to "in-network" providers and communication channels are in place.

- Assure access to medically necessary specialists who are specialized for the treatment of children, cancer, cardiac, etc
- Identification of IT platforms and interface to provide communication of not only clinical care plans but social determinants and barriers.
- Out Reach / Programs
  - RFP should inquire and require outreach programs specifically to identify and address social determinants of health, risks, disabilities, chronic care and preventive care programs. These programs and efforts should produce measurable results. Below are a few examples:
    - PCP – Behavioral Health combined clinics and programs
    - Medication adherence programs
    - Emergency room diversion
    - Chronic care management programs
    - Dual diagnosis programs (both mental health and medical)
    - Care coordination (clinical, mental health and community based resources); Whole Patient Care Journey
      - Integrated care plans (Health Roadmap)
    - Reduction of re-admissions
    - Wellness and preventative care outreach
    - Community and clinical support groups

## **Section 2: Additional requirements beyond behavioral health to be considered.**

MCOs and IPHs should demonstrate their ability to identify existing community short-falls and barriers to improving health for the population and plan to address these factors. There is a growing recognition that improving poor health is not just about high-quality medical care but also addressing the social determinants. The Kaiser Family Foundation graphic on the next page outlines determinants. A risk assessment tool to screen patients for social determinants of health, risk factors and barriers should be required to obtain the next-level. Partnerships with community based organizations should be outlined. Public health agencies, social service organizations, can enable MCOs and IHPs to provide non-clinical support for beneficiaries to include services like transportation, housing support, meals, job placement. Network partners should further demonstrate integration and communication channels with their community based organizations, including use of Health Roadmap and evidence of “Whole Patient Care Journey model”



Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social Integration	Health Coverage
Income	Transportation	Language	Access to Healthy Options	Support Systems	Provider Availability
Expenses	Safety	Early Childhood Education		Community Engagement	Provider Linguistic and Cultural Competency
Debt	Parks	Vocational Training		Discrimination	
Medical Bills	Playgrounds	Higher Education			Quality of Care
Support	Walkability				

**Health Outcomes**

- Substance Abuse
  - Demonstrate program integration with behavioral health, self-care tools, housing support, job placement, family reintegration.
  - 24-hour access for crisis
- Structural Barriers
  - Demonstrate partnerships to address transportations issues, specifically those who do not have public transportation access.
- Getting Care
  - Demonstrate access efforts and performance, publicizing provider office hours and extended hours. Provide clear direction and education on what patients should do after-hours to get needed support or care and avoid emergency department.
  - Identify processes and tools to assure appoints are kept, follow-up on adherence to medications and post visit instructions takes place.
- Physician Communication
  - Identification of the tools and systems used for physicians, community based organizations, patients and families to communicate.
  - Use of survey tools to assure patient understands diagnosis, treatment, medications and their responsibility.
- Cultural Competency
  - Demonstrate options for patients who have race, ethnicity, social dynamics, for example Tribal Health Clinics
  - Provide tools for providers to be educated on the specific race and ethnicity cultural dynamics for their attributed patient panel demographics.
- Linguistic Competence

- Demonstrate ability to communicate effectively with those patients who demonstrate low literacy, limited English proficiency or where the race, ethnicity, and social adaptation is a barrier.

*Question 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?*

#### **Question 4 Response: Rick Stewart**

To properly address this question, there are two foundational principles that need to serve as the basis for the Care Coordination functions of any organization:

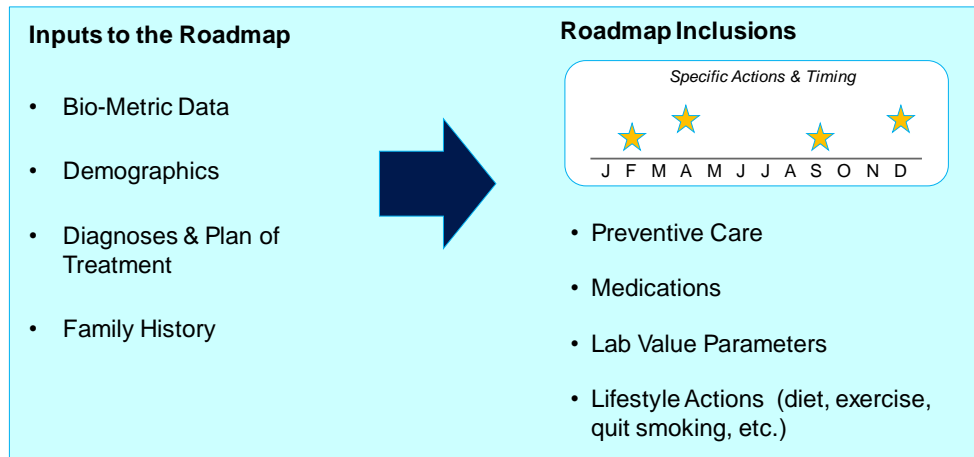
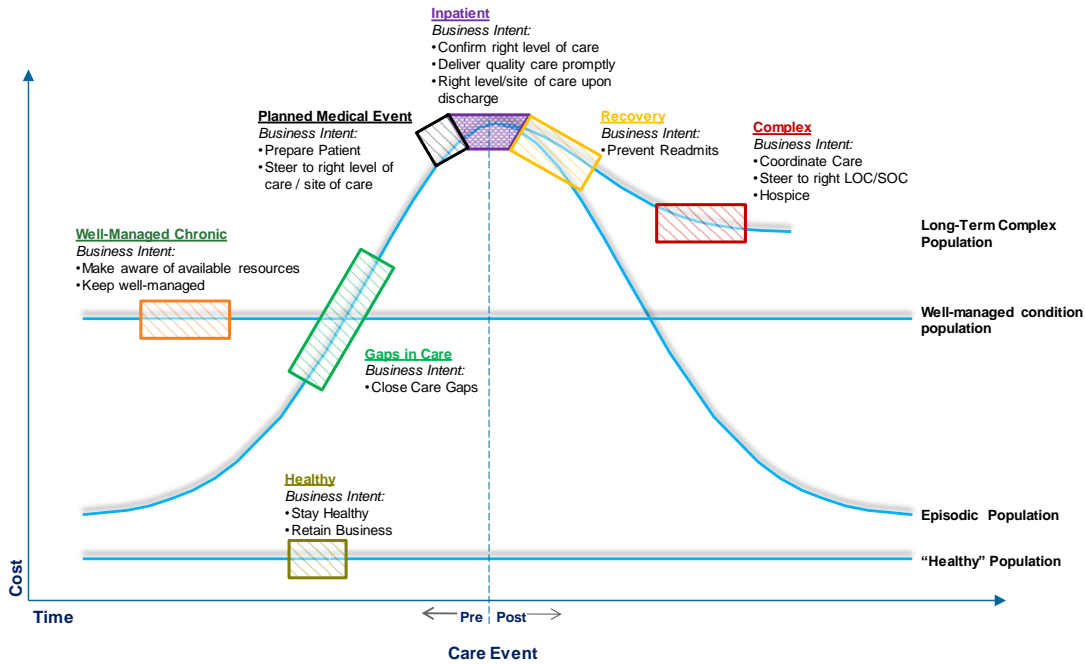
#### **Principle 1: Coordinating care requires different actions with different clinical and business intentions depending on the patient's needs at a given point in time**

Too often, we see health organizations attempt to apply the same care coordination processes and approaches to people with very divergent care needs. This leads to three unfavorable results:

1. Patients with needs who are missed because the analytics used to identify and prioritize those who need care coordination are too broadly defined, for example a patient who has congestive heart failure who has failed to refill a prescription for their ace inhibitor. This care gap alone may not trigger identification for a care manager to get involved. However, if left as an open gap, the patient will probably have a near term need for an emergency room visit and/or hospital admission.
2. Actions that fail to align with the patient's needs. Many Care Coordination actions are designed assuming high acuity and are often miscast when applied to people with low acuity. An example of this is a high risk maternity program. Often, the trigger to activate the program is a general diagnosis of pregnancy, and the first step is an assessment to determine if the patient has potential to have a high risk pregnancy. Fortunately, the great majority of pregnancies are low risk. Looking through the lens of "high risk pregnancy" alone, many programs stop once the patient is determined to be low risk, and miss the opportunity to shift focus from avoiding NICU admission to ensuring a positive experience for the patient and retaining her business.
3. Lower than expected Return on Investment caused by applying cost to patients who lack the need for care coordination, or by applying approaches that fail to meet the patient's needs.



The following Exhibit A is a framework we use to demonstrate the alignment of care coordination actions with clinical and business intent based on the patient's need at that time:



**Principle 2: Each individual has a single physician-defined Health Roadmap based on their demographics, conditions, health history, bio-metric values, and health habits.**

What occurs all too commonly in today's health ecosystem is that as individuals, we often have multiple Health Roadmaps in motion simultaneously. These health roadmaps are created by multiple physicians we are seeing, a care manager from a payer, and our own views as to our health needs which can be influenced by a variety of sources.

The Next Generation IHP needs to have the ability to forge and communicate a single Health

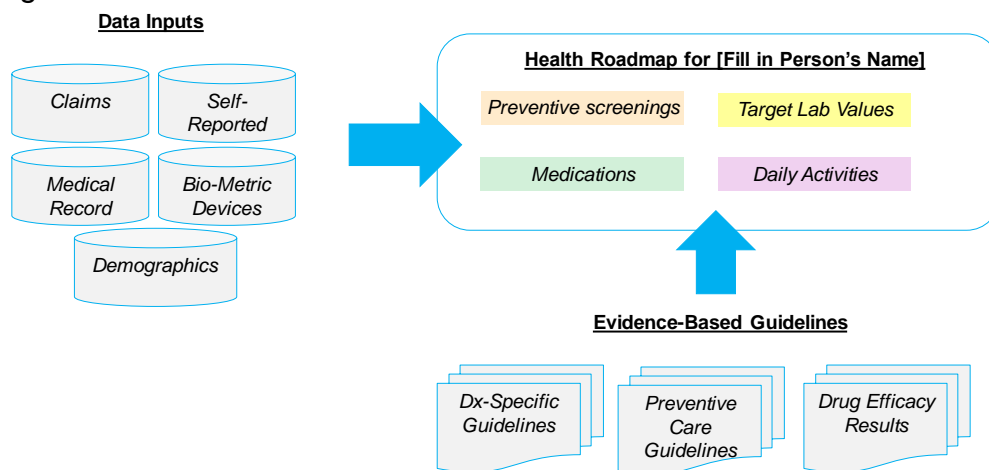
Roadmap, that is created as a collaborative effort between the patient and their primary physician, and to enable the Health Roadmap to be viewed (and modified as needed) by treating physicians, care managers, or other health stakeholders who are providing, directing, or influencing care for that patient.

The Next Generation IHP will possess mechanisms to manage presence of, deviations from, and changes to an individual's Health Roadmap.



1. Managing Presence of a Health Roadmap:

Ideally, the Health Roadmap for an individual is defined as a collaborative process between the patient and her/his Primary Care Physician. In the absence of that, a Health Roadmap can be constructed using best available data.



Mechanisms a Next Generation IHP needs to possess to confirm the presence of an individualized Health Roadmap include:

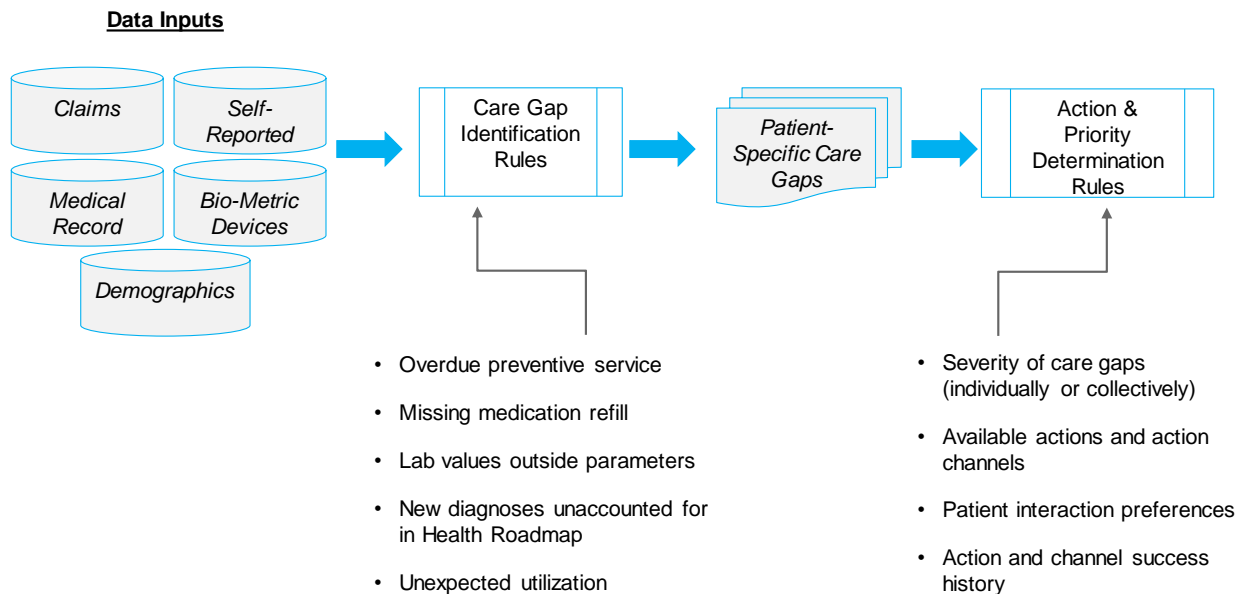
- a) Ability to capture and store individual Health Roadmaps, and make them accessible to treating physicians, care managers and other care providers (who are likely working from different workflow systems)
- b) Ability to capture raw data needed to construct/supplement an individual Health Roadmap. These data can come from clinical systems, claims/encounters, demographics, patient surveys, and bio-metric devices.
- c) Analytics that forge or enhance an individual's Health Roadmap based on existing roadmaps, other available data, and applicable evidence based guidelines.

## 2. Managing Deviations from or Changes to Health Roadmaps

Next Generation IHPs will need to have two categories of mechanisms to manage deviations from Health Roadmaps:

- a) Ability to Identify when Deviations Occur**
- b) Actions that Effectively Resolve Deviations**

Identifying when deviations occur involves mechanisms to constantly monitor key data sources and apply identification rules that flag when a deviation (or care gap) occurs and determine if/what action is necessary to close the care gap.

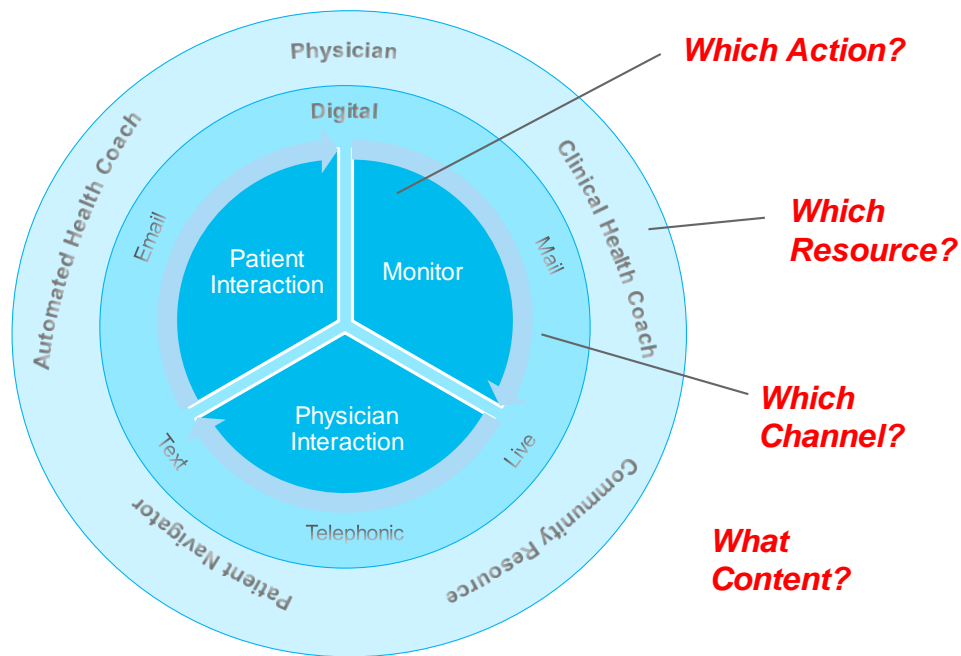


Important to note is that a Deviation, or Care Gap, can indicate two different things:

- The patient is failing to comply with their Health Roadmap. This can include missing preventive care services, failing to fill needed medications, seeking care from sub-optimal providers, or failing to apply proper health habits in daily life (e.g., smoking, failure to achieve activity targets, diet mismanagement, etc.)
- Something has occurred that indicates a needed change to the Health Roadmap. This can include a new diagnosis, unexpected utilization, a significant change in bio-metric values, or a demographic change that drives changes to the Health Roadmap.

Once deviations from the Health Roadmap are identified, Next Generation IHPs will need a variety of mechanisms to select and execute actions that either update the Health Roadmap and/or close any outstanding care gaps.

Healthcare as an industry is beginning to apply learnings from other industries which have been more focused on influencing individual consumer actions. Proliferation of new payment models, new consumer choice options, new technologies, and consumer expectations have all had a hand in driving this change. Our view is that payers and providers are still in the early stages of applying these capabilities, but are moving beyond “pilot” and into “scale across the population” mode. Specific to Care Coordination, a Next Generation IHP’s gap closure actions will need to represent the combination of “which action”, “which channel”, and “which resource” using “what content” that will most successfully resolve the care gap for that individual patient.



Going back to Principle 1: Alignment of analytics and actions with specific clinical or business intent; it will be critical for Next Generation IHPs to demonstrate this alignment and apply it to their approach for managing deviations from Health Roadmaps.

For situations where the patient is failing to comply with their health roadmap, potential remediating actions can include:

- Static electronic or mail-based notifications to patients
- Static electronic or mail-based notifications to providers
- Dynamic interactions with patients via phone, electronic channels, or in-person

These actions require mechanisms that include the following:

- “Campaign Management” capabilities that learn which channels and interactions are most effective with specific individuals, and individuals “like them” (based on segmentation)
- Inbound and out-bound call center capabilities
- Digital interaction capabilities; including text, mobile app, electronic chat, etc.
- In-office and in-home live interaction capabilities using both clinicians and non-clinical community care resources

For situations where a health event has occurred that indicates a change to the patient's Health Roadmap, actions you should expect from Next Generation IHPs include support that:

- Helps patients (and referring physicians) to find the “right” provider to meet their needs. “Right” defined as optimal choice across key variables such as quality, cost, location, and other patient preferences (e.g., gender, languages, etc.)
- Coordinates when patients have a health event that causes a significant change to their Health Roadmap and/or requires more active coordination across providers (e.g., hospitalizations, other events that require multiple providers). Note that this support should span both patient clinical needs (e.g., understanding/adherence to doctor's plan of care, engaging right providers, etc.) and administrative needs (e.g., understanding financial implications/options, understanding/adherence to administrative procedures, etc.)

*Question 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?*

## **Question 5 Response: Gerry Meklaus**


### **Section 1: Introduction and Approach**

Minnesota's Integrated Health Partnership (IHP) program is perceived as having achieved considerable success to date<sup>1</sup>. With 21 ACO-like organizations encompassing ~460,000 members, \$212M of savings has been attributed to this effort. With the State's continued commitment to redesign and reform of purchasing strategies for public health care programs, Minnesota is embarking upon a next generation program (IHP 2.0) to build upon the gains initially realized within this structure, further improve health outcomes (without increasing costs) and address risk factors traditionally considered outside the purview of health system providers. Those factors include social determinants of health, racial disparities and behavioral health risk factors.

Using this Next Generation model, providers are expected to coordinate care across a continuum of services that include both medical and social services. One of the goals of the program is working with the community to improve outcomes in a deeper, more collaborative form than is available today. Providers participating in outcome-based purchasing are expected to have accountability for cost and quality while maintaining flexibility in their organizational structure, contracts, partnerships and

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<sup>1</sup> Request for Comment: Outcomes Based Purchasing Redesign and Next Generation UHP, November 15, 2017, Minnesota Department of Human Services, p.1



management of provider activities<sup>2</sup>. In short, while the program goals would be somewhat proscribed and incentivized, how providers get to “success” will largely be left up to them to define. The structure of this initiative is thus similar to that of Accountable Care Organizations (ACO’s). Given the aims of IHP 2.0, one could also draw some analogies to the emergence of Performing Provider Systems within the New York State Delivery System Reform Incentive Program (DSRIP).

Accenture has considerable experience assisting clients pursuing initiatives in both of those frameworks. As a global consulting firm, we have assisted clients in the US pursuing goals associated with value-based purchasing initiatives, both on the payer and provider sides of this effort. In addition, we are preparing to respond to initiatives emerging within the United Kingdom, as the National Health Service is proposing a similar approach of Accountable Care Systems that would engage widely on a population’s health initiatives, encompassing both medical and social needs.

With the exception of the NHS initiative, which is still in planning phases, it is fair to surmise that results of Accountable Care efforts in the US to date have generally proven to be uneven in distribution.<sup>3</sup> Only about one-third of Medicare ACO’s have achieved shared savings to date in any given distribution year. Such unevenness of results have led to considerable efforts to develop frameworks for the success factors that would catalyze a more consistent level of success. Advocates of ACO’s generally believe that the competencies of success are widely known but highly concentrated in specific organizations.

## **Section 2: Assessing ACO’s capabilities using a Logical Operating Model (LOM) framework**

Accenture realized early on in working with clients developing ACO-like entities that the “roadmap” or “guidebook” on how to do this was not developed. In that vein, we developed a Logical Operating Model structure that defines the major components of effort that would need to be undertaken to create a successful ACO.

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<sup>2</sup> Ibid, p.2

<sup>3</sup> Blackstone, EA and Fuhr, JP. The Economics of Medicare Accountable Care Organizations. American Health Drug Benefits. 2016 Feb; 9(1): 11-19.

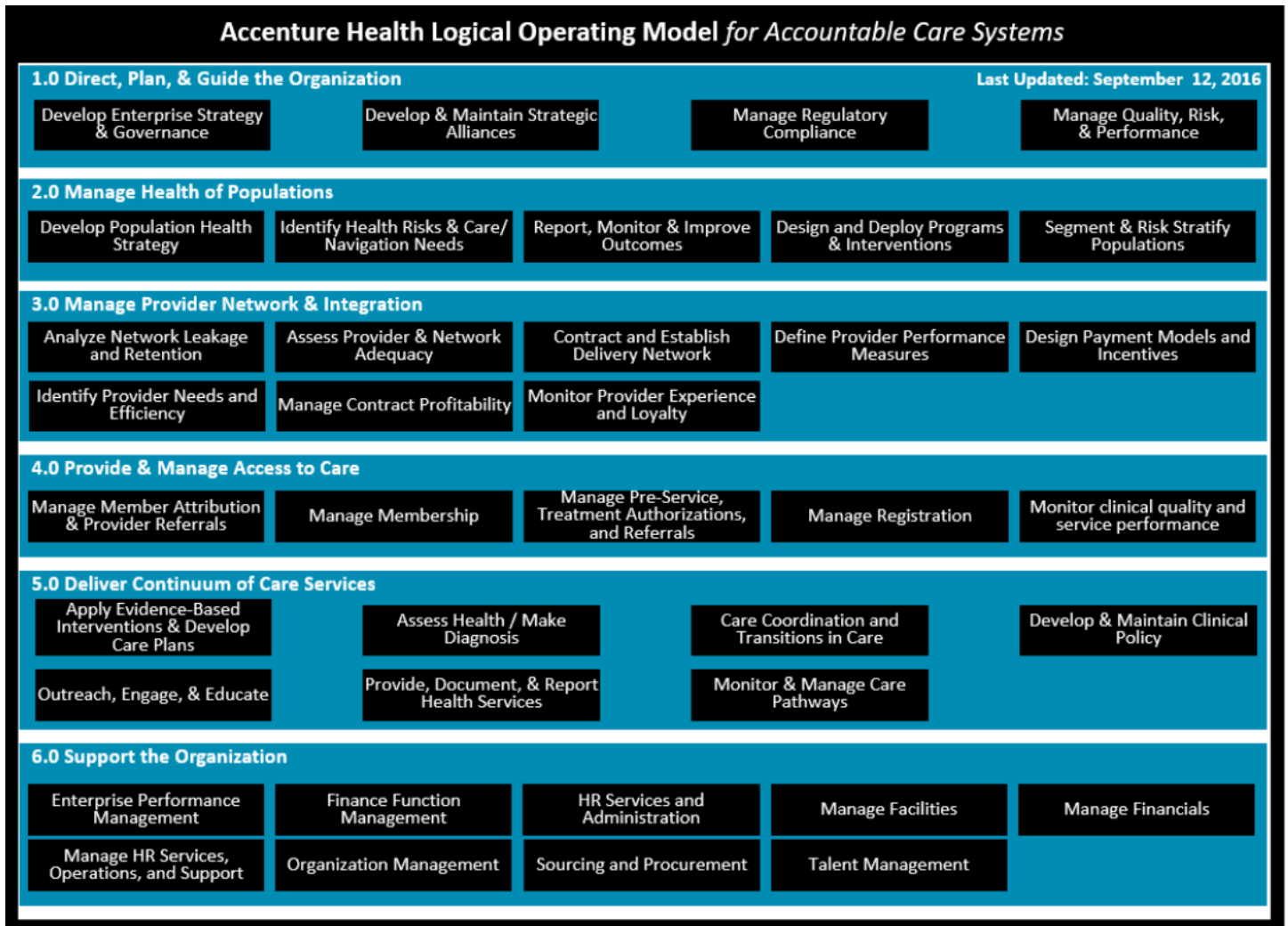



Figure 1: Accenture Logical Operating Model for ACO's, Level One

The Logical Operating Model (LOM) is a structure that Accenture utilizes to assess organizational readiness for a given set of missions (patent pending). The LOM extends to 4 levels of actions, with each level driving down to a greater level of specificity and detail. This tool became the foundation of a Capability Assessment Model (CAM) which is a proprietary analytical tool to assess the readiness of organizations to take on risk in an accountable care setting.

Subsequently, organizations have emerged to develop public-source collaborative efforts toward a similar set of detailed competencies. The Accountable Care Learning Collaborative (ACLC), under the direction of Western Governor's University and Leavitt Partners, has developed an Accountable Care Atlas with detailed competencies enabling self-assessment by ACO's in more nascent stages of development (see <https://www.accountablecarelc.org/atlas>).

Accenture has been a strong supporter of the ACLC and similar efforts to codify ACO competencies





and develop assessment tools that can assist organizations in moving more rapidly to a platform of consistent success. We believe that Minnesota DHS should build upon these efforts and help to create a common platform of understanding of key competencies for Next Generation IHP's. These evaluations could then be used to help identify the capabilities that would be needed by any given IHP in implementing the specific initiatives they are undertaking.

We would like to stress that an effort like a capability assessment tool based on competencies could be utilized in two ways: one the one hand, organizations would have to score over a certain level in each domain in order to take on population risk; or conversely, these tools could be offered as informative in nature, assisting organizations in developing a unified set of operating principles and exchanging information on leading practices while developing the shared competencies. While both approaches could be valid, we would suggest beginning with the latter approach and developing a consensus-driven approach to competency standardization. This would enable organizations to co-create the solution. Since IHP's have already created value, there are likely many lessons to be learned that can be shared across organizations.

### **Section 3: Developing a LOM/CAM specific to Next-Gen IHP models, incorporating Social Determinants of Health (SDoH)**

While the ACLC and others have developed detailed competency based operating models (ACLC's is termed an "Accountable Care Atlas"), most of these tools are not specifically directed at the Medicaid beneficiary and do not explicitly include competencies related to integration with social services providers. This is due to the fact that most ACO's are Medicare-driven currently, with perhaps some commercial contracts for managed lives. Given that most of these entities are still in nascent stages, they have not yet reached out to social service agencies or community based organizations in a comprehensive way to achieve true integration across a continuum of care.

For lessons on how to truly integrate across the continuum, one could look to the experiences of the New York State DSRIP program. Achieving integration across the continuum is an explicit goal of that program. To launch that effort, New York State invested developing "personas" encompassing a profile of certain Medicaid beneficiaries achieving care in a coordinated system, as opposed to the currently fragmented structure. In a collective fashion, New York attempted to build consensus around the goals of an integrated approach by developing examples of how care can be better coordinated. These personas then acted as examples of the integration that should be pursued by Performing Provider Systems.

Achieving this level of integration remains a work in progress, even several years into this effort. We have learned that integrating community based organizations and providers is subject to a number of barriers related to mission, resources and lack of centralized information technology infrastructure. Across the country, organizations like Parkland Memorial Hospital's Parkland Center for Clinical Innovation are working to develop coordinated information sharing networks that use advanced technology to create the continuum of care "systemness" that can be used to derive a new ecosystem



of care.<sup>4</sup> But financial, mission, and cultural barriers remain and require extraordinary committed local leadership to overcome.

At Accenture, we believe that local success stories can overcome the significant barriers to comprehensive coordination of care, aided by the appropriate data convergence strategies (see response to question 12). Our consulting approach utilizes Design Thinking perfected by our subsidiary, Fjord Consulting. As an example, Fjord worked with a large social service organization to team to explore how technology could eliminate fragmentation and strengthen care coordination within the care network that the client and other state social service organizations belong to. To better understand social service delivery from the client’s perspective, Fjord developed an understanding of its integrated healthcare approach. Fjord designed the Whole Patient Care Journey, a tool that helps case managers better visualize and coordinate the care of their clients. The tool also provides a way to gather analytics on the health of the network, get an idea of which services are working best for clients, within a system where measuring return on investment is difficult to measure. Fjord demonstrated the value of the tool by seeing how elements of the design would work across programs via a low-fidelity digital prototype. The design team worked closely with caseworkers to refine the Whole Patient Care Journey throughout the demonstration period.

Fjord found that the best way to build on the strength of the client’s work was to use an empathetic approach to design that relied heavily on designers and decision-makers forming a close working relationship. The design team was able to infuse more empathy into the process by designing and demonstrating the integrated healthcare approach in real-time with case managers who had first-hand knowledge of what it is like to work in this arena. In this way, Fjord was able to bring design into a space, and to people, who generally are not its focus, putting service design and innovation at the heart of social services.

Accenture (and Fjord’s) approach to Design Thinking overcomes barriers with a high degree of engagement of participants.

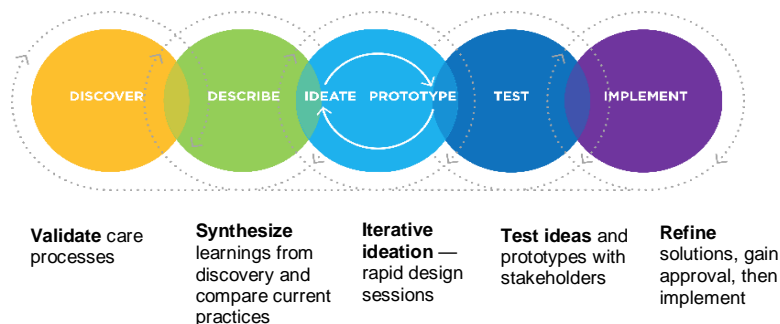


Figure 2: Accenture’s Approach to Collaborative Design Thinking

<sup>4</sup> Allen, A. The ‘Frequent Flyer’ Program that Grounded a Hospital’s Soaring Costs. Politico Magazine, December 18, 2017.

## Section 4: Conclusion

DHS and counties evaluating potential responders' ability to implement proposed initiatives, especially in the context of care coordination across the new ecosystem of care that includes providers, community based organizations, social service organizations, and the like, will require a comprehensive assessment template derived from a Logical Operating Model or similar instrument. Distinct and specific competencies underlie such a template, and organizations participating in IHP 2.0 should participate in forming this rich asset. Accenture has participated in creating such an asset in a collaborative environment which energized the participants, so we know this instrument and more importantly, the dialogue that emerges, can improve the chances of success in this complex endeavor.

*Question 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?*

**Accenture has chosen not to respond to this question.**

*Question 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?*

**Accenture has chosen not to respond to this question.**

*Question 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?*

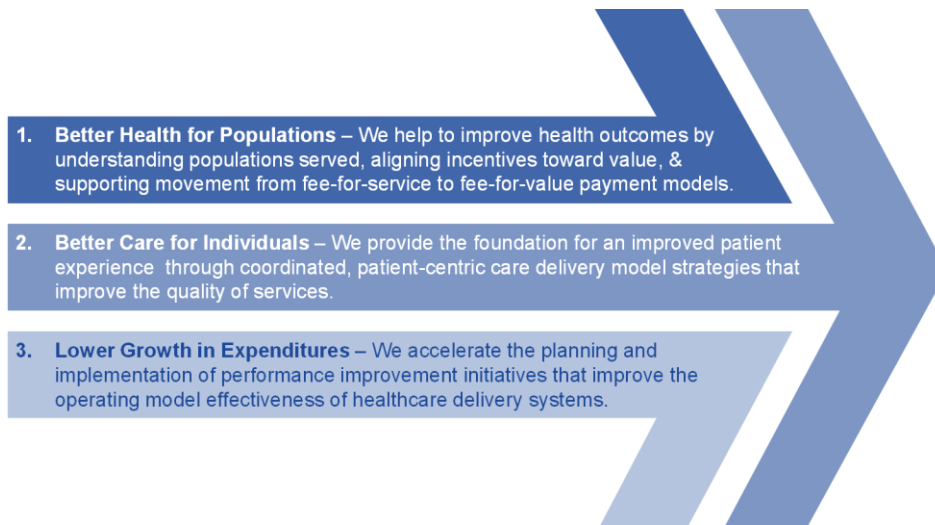
**Question 8 Response: Felix Bradbury**

### **Section 1: Appropriate measures for evaluating services to reduce health care disparities and improve outcomes**

The purpose of this section of Accenture's response is to frame-up the key performance measures, and the questions and processes required to evaluate the measures from the perspective of the State

of Minnesota. This section is designed to give Minnesota a framework to help meet Minnesota's own goals of better outcomes, more cost-effective care delivery, lower per capita costs, and greater beneficiary satisfaction with healthcare delivery.

Organizations like Minnesota are seeking to move toward, and achieve, the goals of the "Triple AIM"



Because the goal is to transform an enterprise at the state level – as opposed to an individual group of doctors, the performance measurement must be comprised of both macro-components and micro components as outlined below:


- **Micro-Level Performance:** Typically measure clinicians, teams, and departments. Micro-level measures are typically used for:
  - Assessing individual or small group-level performance against best practices or key organizational objectives,
  - Evaluating the impact of local process innovations and/or guidelines,
  - Locally organizing and displaying information to improve knowledge access,
  - Improving the management of patients presenting for care,
  - Improving communication among providers, and
  - Reducing variability in clinical care.
- **Macro-Level Performance:** Macro-level measures reflect either whole- system or major system unit performance (e.g., hospitals) and serve somewhat different purposes than “micro-level” (e.g., individual clinician or small group) measures. They are typically used by either health plan leaders or external purchasers for:
  - Assessing organizational performance against key strategic objectives;
  - Determining executive and management incentive compensation;
  - Making decisions about capital allocation;
  - Setting strategic planning goals and direction;

- Interacting with regulatory and accreditation agencies or bond rating agencies;
- Comparing performance of similar operating units (e.g., hospitals or nursing homes) within large systems;
- Aligning operating unit goals and priorities with overall system goals and priorities;
- Aligning system priorities with purchaser priorities;
- Setting system-wide priorities for QI and CQI initiatives.
- Macro-measures of performance typically are not used for:
  - Assessing effectiveness of individual clinical and administrative performance initiatives;
  - Calculating incentive compensation for individual clinicians or first-line managers (part of the incentive may be linked to overall system or large operating unit performance, but individual “line workers” are too far removed from overall system performance to have incentives pay calculated completely at that level.)
  - Assessing impact of local technology enhancements or other types of capital improvements;
  - Interacting with small local purchasers, community groups, or other stakeholder groups;
  - Evaluating impact of local innovations, demonstration projects, or community-level initiatives where the system is only one of several health care organizations in the community.

In contrast to their macro-performance counterparts, micro-performance measures tend to be *fluid, frequently reported measures oriented around specific clinical contexts*. Change in these measures is to be expected, since their *raison d'être* is *to invite, encourage and support ongoing improvement at the work- unit level*.

Because “macro” performance measures are most often used by management oversight groups to oversee contracts they represent stable aspects of system performance. Actually, purchasers who use comparative performance measures to make decisions about future contracting relationships are not well served if they either track measures that change frequently or shift the thresholds that they are using to measure performance too often. For example, if Clinic A is going to be chosen over Clinic B as a preferred provider, it is essential that the better performance of Clinic A over Clinic B this year be repeated next year. If the key performance measures are changing rapidly, it is unlikely that they will be a good basis for long-term purchasing decisions. Financial performance measures are an exception, where monthly or quarterly analyses are necessary to monitor potentially significant fluctuations.

Other exceptions include efficiency or quality measures may represent other exceptions to the pattern of annual reporting. As an example, an annual rate of nosocomial infections would miss a sudden outbreak of infections in a single unit related to a new source of infection. Likewise, an annual analysis of staffing levels per discharge would not allow for careful management of staffing to reflect seasonal variations or even weekly variations in patient volumes in different units.



Reporting frequency for performance measures depends on the needs of the information stakeholders to act, and the extent to which the underlying phenomena are stable vs. variable. Accenture understands the drivers of health outcomes includes the dynamic interrelationship of socioeconomic status, lifestyle choices, and health-related behavior. When one considers these macro-determinants, there are a number of potential measures to consider. The following is intended to be illustrative of the typical measures Accenture uses to help evaluate the performance against reducing health disparities and improving health outcomes.

### Quality of Care

- Hospital-level mortality, complication, and infection rates
- Rates of specific medical errors or other patient safety issues
- Unexpected return to surgery
- HEDIS Effectiveness of Care Measures (for health plans or defined “member” populations)
  - Mammography Rates
  - Childhood Immunization Rates
  - Influenza Vaccination Rates
  - Rates of Glycosylated Hemoglobin Testing for Diabetics
  - Adequacy of Follow-up for Antidepressant Treatment
  - Beta Blocker after Acute MI
  - Prenatal Care in First Trimester
- Low Birthweight or Pre-term Birth Rate
- Five-year survival rates for specific cancers

### Access and Availability

- Source of Care
  - % of persons who have a specific source of ongoing care
  - % of persons in fair or poor health who have a specific source of ongoing care
  - % of persons with hospital outpatient department as usual source of care
  - % of persons with hospital emergency department as usual source of care because of no usual source of healthcare
  - % of persons with a usual primary care provider
  - % of persons with community health center as usual source of care
  - % of persons with very little or no choice in source of care
  - Time with regular doctor (years)
  - Time since last PCP visit (months)
- Unmet Need
  - % of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members
  - % of families in which a family member did not receive doctor's care or prescription medications because the family needed the money
- Mental Health / Substance Abuse
  - % of adults with 2 or more chronic conditions who have not been screened for depressions

- % of adults with serious mental illness who received treatment
- % of adults with substance abuse treatment need who received treatment
- % of adults with DSM major depression criteria who received treatment
- % of adults with DSM generalized anxiety disorder criteria who received treatment
- % of adults with DSM substance use disorder criteria who received treatment
- Structural Barriers
  - Transportation
  - % of person who usually use public transportation to get to provider
- Getting Care
  - Does provider have office hours at night or on weekends?
  - How difficult is it to get appointment with provider on short notice?
  - How difficult is it to contact provider over the telephone about a health problem?
  - How much of a problem was it to get a referral to a specialist that you need to see?
  - How satisfied with professional staff?
- Waiting Times
  - About how long do they usually have to wait before seeing usual source of care?
  - ED: Waiting time to see physician
  - ED: % of people where disposition = "Left before being seen"
  - ALOS in hospice (reflects delays in getting hospice care)
- Physician Communication
  - Does provider generally listen?
  - Does provider usually ask about prescription medications and treatments other doctors may give?
  - Does provider listen carefully?
  - Does provider explain things?
  - Does provider show respect for what you had to say?
  - Poor communication during last visit
- Cultural Competency
  - Would have gotten better care if different race/ethnicity?
  - Felt treated with disrespect because of race/ethnicity
  - Doctor understands background and values
  - Health Information
    - Very easy to understand prescription bottle
    - Very easy to understand information from doctor's office
    - Health information resources
- Linguistic Competence
  - Availability of foreign-language written materials
  - Availability and ease of use of translation services
  - Number and scope of cultural competence training program
  - Provider mix reflective of communities served
  - Governing board and management staff reflective of communities served

- Inpatient days per 1,000 or admissions per 1,000 for defined populations (e.g., managed care plan members);
- Total acute admissions and acute admits/1,000
- Readmission rate/1,000
- Total admissions by service line and total admissions by service line/1,000
- Total bed days and bed days/1,000
- Length of stay which is calculated as the quotient of (bed days/1000)/(acute admissions/1,000);
- Cost or charge per admission (or all-payer refined DRG, i.e., APR-adjusted admission);
- Cost per member per month;
- ER admissions/1,000
- ER visit rate/1,000.
- Revenue/FTE
- RVU/FTE
- Cost per adjusted discharge
- FTEs per bed or per discharge

#### Operational Performance Satisfaction / Reports of Care

- Patient-Reported Satisfaction
- Technical Quality of Care
- Communication/Information
- Caring/Compassion
- Wait Times
- Ease of Access
- Appearance of Facilities
- Parking/Food/Other Services
- Control of Pain or Other Symptoms
- Expected Results Achieved

#### Reports of Care

- Wait Times
- Problems in Communication
- Consistent Messages from Multiple Providers
- Coordination of Care
- Involvement of Family and Friends
- Respect for Values and Preferences

#### Community Benefit

- Uncompensated Care
- Care Provided in Public Programs (e.g., Medicaid)
- Numbers Served in Free Clinical Service Programs (e.g., blood pressure screening, immunizations)



The above collection of domains, and measures within domains is intended to be illustrative of a macro-level system performance measure set. It might constitute a reasonable set of performance measures for many systems. However, no such stock set of measures should be adopted directly; rather, measurement sets are better when they are *carefully tailored to important system goals, mission, or priorities, or intentionally integrated with performance measures at smaller units in the system.*

## Section 2: Methodology for performance evaluation

Accenture’s approach to evaluating the impact of healthcare interventions and initiatives is grounded in event history analytics and the use of a combination of generalized structural equation modeling (GSEM) and panel data, i.e., cross-sectional time series (*xt*-regression models), i.e., longitudinal data analyses. This approach, grounded in economic modeling, and survival analyses, uses analytic methods to leverage historical data and glean insights that are not otherwise possible with more traditional regression-based approaches. A summary of the pros and cons of event history analytics are outlined below:

*The pros and cons of the typical pre-post analyses done by NCQA and other quality organizations are outlined below. The intervention “event” is the dividing line between “pre” and “post”. Accenture’s approach is a compliment to the existing pre-post approach.*

Pros	Cons
<ul style="list-style-type: none"> <li>Shows that statistically significant change has occurred; “Something happened”.</li> <li>Indicates directionality of change.</li> <li>Analytically inexpensive and easy to implement from count data.</li> <li>Well-established industry norm.</li> </ul>	<ul style="list-style-type: none"> <li>Omits large amounts of valuable historical information prior to and after an “event”</li> <li>Assumes the “event” or intervention caused the outcome.</li> <li>Cannot show whether X caused Y or Y caused X.</li> <li>Cannot control for confounders, analytic “noise”, or unobservables.</li> <li>Cannot show the determinants of the results.</li> </ul>

Property or Characteristic	Regression	Time-series	Panel data
Subjects observed over time		X	X
Many (n>=30) subjects observed	X		X
Able to simultaneously study effects of time on other variables			X
Able to control for effects of time (as an interaction effect)			X
Able to determine causality, E.g., Did x cause y or did y cause x?			X




*Question 9: How much of the entities' payment should be subject to performance on quality and health outcome measures? Please explain your answer.*

**Question 9 Response: Felix Bradbury**

Accenture believes that to drive sustainable improvement in the healthcare system and to support a transition from fee-for-service to value-based care, most of payment over what is usual and customary for covering primary care providers' fixed costs, should be aligned to driving improvements in quality of care and quality of service. Accenture has many years of experience in servicing commercial, Medicare, and Medicaid payers as well as national health systems. Our experience

P4V Design	Description	Pros	Cons
Percentage of total contract value incentive pool	In this design the incentive pool reflects a predetermined, fixed percentage of the total value of all of the contracts. The performance against clearly defined metrics is measured and percentages of withhold dollars are paid out based on performance	Because 100% performance is rarely achieved, the full 100% value for the contract is rarely paid out and the payer saves money relative to their total contract payout	May be difficult to sell to the physician community as many expect the base payment, which physicians may have already discounted, to be paid out as per the contract. Under this design, contract amendments or renegotiations may be required. As such, there is no new money to incentivize performance and is very much a "stick" approach
Separate Bonus Pool	Under this design, a separate pool of "new" money is set aside to be used to reward top performers	Easier to sell to the provider community because it reflects new money and not withholds	The new money is new money and while money will be saved by reducing avoidable utilization and costs, these savings occur over a longer term horizon and are not realized until after the bonuses are paid out. As a result, this approach may be difficult for the CFO to reconcile.
Bonus Pool Tied to Measurable Reductions in Avoidable Utilization and Costs	This design attempts to address the deficits of the two previous designs by creating a clear-line between costs, utilization, and bonus payouts. Under this design, bonus money is paid out – typically on a quarterly basis – based on a percentage of the savings realized from the difference between expected costs and utilization and actual costs	Payout is aligned to measurable improvements in pre-defined outcome metrics, e.g., reductions in acute ER utilization for ambulatory care sensitive conditions, and reductions in unplanned rehospitalization.	This design is more difficult to implement because it requires a comparison of what happened (actual) to what may have happened (expected); it is difficult to sell what "might have happened"




indicates that the optimal mix of incentive to fee-for-service is roughly 15%-20% for incentives and 80%-85% FFS. Additional thoughts on this topic are delineated below.

Neither FFS nor capitation are a recipe for improving clinical outcomes or lowering healthcare costs trends. The fundamental problem is a misalignment and a mismatch between how clinicians are paid - based on volume - and the value that patients want. Transforming health care delivery in the United States and around the world requires paying differently. The current fee-for-service payment model results in high volume, high cost, and inadequate outcome. There is a fundamental mismatch in that providers are incented to produce more volume while patients want greater value.

Accenture has been at the forefront of helping health systems, providers, and payers make the transition from fee-for-service (FFS) to pay-for-value (P4V). Our staff have lead engagements involving national health system clients as well as national payer accounts with commercial, Medicare, and Medicaid lines of business.

Accenture has experience developing and implementing successful P4V solutions for some of the largest health systems in the US and Europe; during the course of these partnerships, we learned a great deal about what works and what doesn't. In summary, here's what we've learned are the key components for success under value-based contracting and P4P:

1. Recognize the keys to success are through partnering with the provider community and empowering physicians do what they do best: provide care. Some plans use P4P but are careful to treat their providers as partners and collaborators and not as vendors.
2. Create transparency of information around cost of care and quality of care – and the ability to be able to identify actionable variations in performance. See Figures 3-4 for examples of transparency of information around cost of care and quality of care.
3. Build effective, robust Care Management: Case Management, Concurrent Review, Prior Authorizations, and Disease Management – provide input into benefit design.
4. Develop high touch concierge member services that really supports the beneficiary and helps overcome barriers to care up to and including providing transportation to the PCP, lab, or pharmacy – transportation will always be cheaper than an ER visit and an acute inpatient admission.
5. Use predictive analytics to identify and stratify well-at-risk, chronically-ill and catastrophically ill patients and a bottom up approach to identifying and resolving barriers to care.
6. Elicit support for quality - Support for quality comes from the CEO: Quality is viewed as a core competency across the entire organization and not only the QI dept.
7. Implement data governance and provenance strategies that results in timely, accurate and complete data.


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8. Publish regular performance reports to every provider that gives them clear line of sight between their performance and their pay.
  9. Develop metrics specific to the program; the metrics used in the program were always EBM-based and relevant, measurable, actionable, and timely.
  10. Facilitate regular opportunities for physicians to discuss issues and for the organization to address programmatic improvements
  11. Implement executive information system dashboards to enable physician leaders to identify opportunities to reduce variations in performance and move the bar up in terms of quality and effectiveness

Accenture staff worked with the health systems to develop a value-based contracting frameworks that gave physicians a significant financial incentive to perform well. This framework is flexible, scalable and grounded in the following key components:

1. Strong ties with the provider community and a mutual willingness to share risks and rewards.
2. Evidenced-based metrics for the domains of wellness, preventive services, chronic disease management, and reduction in unplanned hospitalizations.
3. Transparency of information around the quality and cost of care.
4. An understanding that physicians are, by nature, competitive.
5. Regular performance feedback that provides clinicians with actionable information to close gaps and improve performance.
6. Significant financial rewards for moving the bar upward on quality of care and quality of service

Accenture notes that “incentive pools” are tools for helping align physician behavior to the payer’s desired clinical and financial outcomes. As such, incentive pools, come in three distinct variations which may be characterized as “carrot vs. stick vs. some combination of carrot and stick”. Below are the pros, cons, and key characteristics of each approach:

1. Percentage of total contract value incentive pool: In this design the incentive pool reflects a predetermined, fixed percentage of the total value of all of the contracts. The performance against clearly defined metrics is measured and percentages of withhold dollars are paid out based on performance. Performance reconciliation and payouts typically occur on a quarterly basis and a 90- day claims lag is assumed. Technically, this is a pay-for-value but not a performance bonus program because the participating physicians are only incentivized to get the pay they contracted for anyway.



Pros: Because 100% performance is rarely achieved, the full 100% value for the contract is rarely paid out and the payer saves money relative to their total contract payout.

Cons: May be difficult to sell to the physician community as many expect the base payment, which physicians may have already discounted, to be paid out as per the contract. Under this design, contract amendments or renegotiations may be required. As such, there is no new money to incentivize performance and is very much a “stick” approach.

2. **Separate Bonus Pool:** Under this design, a separate pool of “new” money is set aside to be used to reward top performers. Typically, the new money is paid out on a quarterly basis.

Pros: Easier to implement; easier to sell to the provider community because it reflects new money and not withholds.

Cons: The new money is new money and while money will be saved by reducing avoidable utilization and costs, these savings occur over a longer-term horizon and are not realized until after the bonuses are paid out. As a result, this approach may be difficult for the CFO to reconcile.

3. **Bonus Pool Tied to Measurable Reductions in Avoidable Utilization and Costs:** This design attempts to address the deficits of the two previous designs by creating a clear-line between costs, utilization, and bonus payouts. Under this design, bonus money is paid out – typically on a quarterly basis – based on a percentage of the savings realized from the difference between expected costs and utilization and actual costs and utilization.

Pros: Payout is aligned to measurable improvements in pre-defined outcome metrics, e.g., reductions in acute ER utilization for ambulatory care sensitive conditions, and reductions in unplanned rehospitalization.

Cons: This design is more difficult to implement because it requires a comparison of what happened (actual) to what may have happened (expected); it is difficult to sell what “might have happened”.

The above designs can easily incorporate administrative measures as well as clinical measures. Administrative measures are classified as “quality of service” and clinical measures are classified as “quality of care”. Both quality of care, and quality of service measures may be further subdivided into Structure, Process, or Outcome measures. As examples. Structural measures ask if policies and procedures are in place. Process measures include services such as giving a flu shot or breast cancer screenings. Outcome measures focus on the end-state results; examples include, reductions in Acute inpatient admits/1,000 or reduction in length of stay for COPD, asthma, or orthopedic surgeries. Much of the history of NCQA and HEDIS are based on structure and process measures and only recently, have started to grow the drive for outcomes. Accenture recommends focusing on the specific outcome measures important to Minnesota.

*Question 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?*

**Question 10 Response: Felix Bradbury**

Accenture believes that both the Merit-based Incentive Payment System (MIPS) and the Minnesota Statewide Quality Reporting and Measurement System are importance quality frameworks to align to. Our rationale is based on many years of experience with helping organizations over from FFS to P4V as well as build systems that deliver value while creating a line-of-sight between the desired outcomes and financial remuneration. Our rationale is grounded in the following:

- Both MIPS and the Minnesota Statewide Quality Reporting and Measurement System are grounded in the well-established structure-process-outcome model of continuous quality improvement. As such, they are easily defensible and represent common knowledge in the provider community.
- The measures used in MIPS and the Minnesota Statewide Quality Reporting and Measurement System are derived from roughly 93 different organizations including for example, the Agency for Healthcare Research and Quality (AHRQ), the National Council for Quality Assurance (NCQA), the American Diabetes Association, et al. These measures are well-established and standardized.

*Question 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. 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?*

### **Question 11 Response: Felix Bradbury & Gerry Meklaus**

Accenture recognizes that it has become increasingly important to address barriers to accessing healthcare, particularly for underserved populations, as uninsured populations are rising and health care reform regulations are pressing organizations to address these issues through programs such as, accountable care organizations (ACOs). The proposed payment policy appears to contain both the flexibility and financial incentive to meet the goals of improved clinical outcomes, reduced per capita healthcare costs, improved patient and physician experience with the healthcare delivery system. Several caveats apply; these caveats should be part of the program policy and procedure documentation:

- The shared saving and PMPM payment adjustments for performance, should reflect outcomes and metrics that are actionable by providers, i.e., the proposed performance model needs to align directly to factors within the clinicians' control and not hold providers accountable for determinants such as medication non-compliance, that are outside of their control
- There needs to be clear acknowledgment that operational effectiveness of the model is predicated upon the following:
  - a. Identify the right people at the right time in their disease progression – at a time when they are ready to change – to proactively avoid acute events
  - b. Reduce avoidable utilization of ER and acute inpatient care. This is accomplished through by identifying and removing barriers to access to primary care preventive services
  - c. Avoid duplication of diagnostic effort
  - d. Use of analytics to identify over- and underutilization and reduce practice variation through the use of evidence based medicine.
- For programs that improve medication and treatment compliance and/or access to primary care, one should expect the health care costs to go up. What should go down are the numbers of ER visits, acute admissions, readmissions and their concomitant costs.
- Costs cannot decline faster or more significantly than event avoidance and quality-related measures improve.



- One cannot use a non-chronically ill population as a control group for costs and utilization of a chronically-ill population; they are two separate and distinct populations. The control group and the case group should be similar homogeneous groups. In addition, using a non-disease group as a control will tend to overstate cost savings because some people with chronic illnesses do not generate claims and get lumped into the control group. When their condition exacerbates, their costs will increase and exaggerate cost trends.
- Costs can never decline by more than 100%.
- ROI is not the right metric for tracking event reduction savings: If one spends \$1.00 and then gets \$10, it's a net gain of \$9 but a 10:1 ROI; if a person spends \$25 dollars and gets \$100, they gain \$75 but have an ROI of only 4:1.

While significant reductions in avoidable utilization - and the concomitant costs associated with that utilization - have been demonstrated, there are several additional benefits that are realized such as improved stakeholder satisfaction and increased community involvement.

*Question 12: Do you have any other comments, reactions or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?*

### **Question 12 Response: Erik Pupo**


Traditionally, the healthcare industry has lagged behind other industries in data convergence. Part of the problem stems from resistance to change—providers are accustomed to making treatment decisions independently, using their own clinical judgment, rather than relying on aggregated data from a wide range of sources. Other obstacles are more structural in nature and are observed by

Accenture at its payer and provider clients almost every day. Many healthcare stakeholders have underinvested in information technology because of uncertain returns—although their older systems are functional, they have a limited ability to standardize and consolidate data. The nature of the healthcare industry itself also creates challenges: while there are many players, there is no way to easily share data among different providers or facilities, partly because of privacy concerns.

A goal of modern value-based healthcare models is to provide optimal health care driven by meaningful data convergence in order to:

- Improve healthcare quality and coordination, so that outcomes are consistent
- Reduce healthcare costs; reduce avoidable overuse
- Provide support for reformed payment structures

The need for a comprehensive data platform in accountable care environments is becoming more critical as high utilization and lack of comprehensive data integration threaten to overwhelm providers and payers in their shift to value-based models. The accountable care model (referred to in this paper as a value-based model) is an opportunity for practices, hospitals, and payers to take advantage of



today's advances in technology and data to help their patients navigate the whole health care system without needing to vertically integrate multiple technology investments

But these value-based models continue to struggle in an environment of disparate data, technologies, and metrics. Accenture increasingly sees the market moving in the direction of what we call a “data convergence platform”. Many of the key components of this data convergence platform are enabled by what Accenture calls the “Architecture of the New” – emerging technology capabilities such as Artificial Intelligence (AI), the cloud, predictive and retrospective analytics, all coordinated and combined in a flexible approach.

### **Section 1: What is driving Data Convergence?**

The shift to fee-for-value is directly changing how payers measure and pay for care, and has led to the creation of increasing variations of alternative payment models and value-based programs of varying complexity and with differing requirements. For providers to adjust their technology and data to align to all these potential models and programs is a daunting task, so many newer approaches rely on what is called “provider-payer convergence models” to align to these value-based health market incentives. Provider-payer convergence requires collaboration among payers and providers across contracting, risk management, population and care management, direct services, and consumer engagement.

As providers and payers converge, they need to collaborate efficiently and accurately, particularly as they align on reimbursement strategies and population health management (PHM) programs. **Many organizations lack the technical platform, infrastructure, and know-how to integrate data from different sources, such as EMRs, claims data, and HIEs.** Many programs also lack the infrastructure to consult multiple data sources during the provision of health care or social services leading to poor coordination. Without this data convergence, the structural and business collaboration they have established will not come to fruition.

### **Section 2: Why Data Convergence as a Platform?**


By thinking of data as a network, organizations can envision how to most effectively treat a patient across the entire care continuum. As data is made available about a patient beyond their interactions with inpatient and outpatient facilities, such as with social services, behavioral health specialists, or fitness classes, this data enriches the opportunities that states and payers have to coordinate care. Organizations are using data to reveal where opportunities exist and then bringing discipline and focus around these opportunities to execute.

Below, we discuss the advantages of data convergence and data sharing driven by a singular platform approach:

### **Section 3: Analytics as a Network**

The concept of Analytics as a Network relies on the assumption that data is constantly being analyzed and used as it is being shared. Providers can use both descriptive and retroactive reporting for care managers and creating predictive models and a “heat map” that predicts the risk of a patient being readmitted have an advantage in newer value-based approaches.





This type of opportunity analysis is focused on finding the right mix of measures, such as using hospital utilization measures (e.g., emergency department use, preventable hospital admissions and readmissions, excess hospital stays) to assess program performance. Data convergence also involves smaller organizations using other measures, such as prescription drug use and high-cost imaging, as well as organizations incorporating patient outcomes and population-level indicators.

A successful data convergence platform can help clinicians better understand length-of-stay and expected length-of-stay in the post-acute space, while also helping to support decisions about who should be in the network by looking at quality and other metrics. Using analytics can allow an organization to look at who is leaving an accountable care network and how the network can best support patients in that post-acute area. Organizations can also create clinic “no-show” models that helps providers see the risk of a potential no-show to an appointment so that they better understand the individuals they are working with and what issues they are facing as patients who might need to be better supported.

### *Takeaways*

- A key piece of any overall solution is that it needs to work across the care continuum. Care managers want a data convergence platform that integrates into their workflow, and want to use it in ambulatory settings as well, and also in post-acute settings. This usage needs to lead to reductions in avoidable readmissions and costs.

## **Section 4: Cloud-driven workflow**

Value-based approaches that leverage a cloud model are increasingly being seen as the most efficient way to drive super alternative payment model performance. The concept of an enterprise health cloud is gaining traction as a way to aggregate, mashup, and analyze data, and to provide actionable alerts and clinical decision support (CDS). These newer cloud platforms enable smarter workflow to improve the coordination of patient care and the efficiency of member practices. Automated worklists help ACO members track and coordinate outreach to patients for annual wellness visits, emergency department follow-ups, and transitional care-management appointments.

Cloud-based solutions also are providing greater integration to provider management solutions that connect to your patient schedule to provide real-time information on upcoming patient visits. For patients with chronic conditions, care management “clouds” allows members to create customized intervention plans and collaborate across a practice care team to close gaps in care.

### *Takeaways*

- Cloud-driven models for value-based approaches should be considered higher-priority by states to further enhance data liquidity and sharing across multiple organizations associated with a patient’s health.

## Section 5: Data Liquidity

The premise of data liquidity on a data convergence platform is to enable members to easily refer people discharged from an emergency room to shelters, behavioral health facilities, and other social services, and to let staff at those places see what their clients were doing: whether they were filling their prescriptions, or getting healthy food, or had a place to sleep, or money for the bus. By focusing on liquidity of data across all potential touch points for care, members can meet the needs of those outside the medical system rather than to pay for the consequences inside it.

One example of where data liquidity becomes important is the concept of the “frequent flier” in healthcare. The ability to proactively notify providers as events occur outside the scope of an inpatient or outpatient visit is driving adoption of data convergence platforms. These types of platforms allow for inter-organizational notification and data sharing. The State of New York is using an approach called the Strategic Health Information Exchange Collaborative (SHIEC) that adopts this approach, and relies on existing HIEs to drive it under a model they call the Patient Centered Data Home (PCDH)

### *Takeaways*

- States should explore and encourage models that move away from closed systems of data to more open systems.
- Incentives and metrics should be aligned to these goals to allow for greater expansion of data liquidity across all entities involved in value-based programs
- Grant programs should reward vendors and initiatives that focus on the movement and sharing of data as a key component in their proposals.


## Section 6: Flexibility and Modularity

Providers and payers are specifically looking for the ability to establish customizable, specific, and unique access and/or views to drive one of the main success criteria of value-based care and population health – collaboration. With a flexible data access architecture, providers and payers can customize and revise decisions about what to share, with whom and when. The ability to reuse existing networks to share data is a reason why more providers and payers are looking at technologies such as blockchain.

Modularity expands on this concept by giving vendors who cannot make large investments in a single platform the ability to match components from best-of-breed vendors. The aim, again, is (or ought to be) to create an ecosystem—one strong enough, and independent enough, to write its own rules. And if those rules ultimately benefit patients, providing more value at less cost, then the system will thrive.

### *Takeaways*

- States should evaluate the flexibility and modularity of technology investments made by initiatives and programs to ensure that data liquidity, open architectures, and flexibility in implementation are being



considered. Make sure the platform approach being adopted is open and allows for an ecosystem of technology and cultural change to flourish.

## **Section 7: Governance and Data Management**

There is no one stakeholder that will hold the silver bullet for scaling new models of value-based care - this will have to be a collaborative effort. From start-ups to regional provider systems to non-health industry players there is a potential role to be played in order to provide different facets of care and support. A strong governance model can help health systems focus priorities and efforts on driving value from analytics-enabled insights.

### *Takeaways*

- Engage and develop committed leaders across the enterprise who are committed to understanding and leveraging analytics to deliver superior results.
- Implement a structured data governance model and enterprise-wide analytics strategy.
- Manage analytics capabilities and investments to drive innovation and tangible value for functional business units and programs.
- Emphasize data and technology standards to promote interoperability and more efficient use of analytics resources.
- Recognize the cultural aspects of leveraging analytics to accelerate insight-driven results

## **Section 8: Self-Aggregation – Consumer at the Center**

A key driver for accountable care consideration is the role of the patient in these initiatives. Patients are taking their care into their own hands in a self-service mantra. Accenture believes in the concept of the Patient Centered Data Home (PCDH) as championed by SHIEC. This concept relies on patient's data being self-aggregating over time no matter where a healthcare event occurs.

The question is whether healthcare can be wrenched free from its rigid, decades-old payment and provider constructs and be re-formed into new self-contained, efficiently run ecosystems that put the consumer at the center. Accenture believes the answer is yes—and that we'll start seeing business models (both for-profit and not-for-profit) emerge and evolve around this idea. These business models specifically will exist to provide data aggregation and sharing at the center of the model. The technological foundation for accomplishing data aggregation (stored in one place, stored in the cloud, etc...) often trips up the PCDH approach. Accenture believes that states should encourage new innovations and technologies that don't specifically prescribe the technology but get the job done.

### *Takeaways*

- In the health ecosystems to come, a substantial number of new access points are likely to lead to care that bypasses traditional medical centers altogether. At the same time, better homecare options—largely made possible by digital health innovations, telemedicine, and new payment structures—will keep many patients out of the hospital to begin with. States should consider this shift in how they approach value-based model development and evaluation.

## Section 9: Serving the Underserved

An increasing focus within value-based models has been population health and how to measure large data sets to determine population-specific outcomes. Underserved and unserved populations represent a performance factor in value-based models that is often not measured or considered. Health data has traditionally proliferated from health encounters at inpatient facilities, doctor offices, clinical labs, and retail pharmacies. Each of these touch points may not encounter underserved populations who lack access to these facilities.

### *Takeaways*

- States should incentivize initiatives and programs that are targeting underserved populations through additional technology investment. This type of spending, which it may not exhibit an initial ROI comparable to other investments, can pay off with strong improvements in measurements associated with social determinants of health (SDOH).

## Section 10: Socially Determined

The increased importance of social determinants of health (or SDOH) for value-based programs cannot be understated. Social determinants of data could support evaluations of populations to better understand depression rates correlated to SDOH like financial stability or community context. Social determinants can also be correlated to events such as frequent ER use or no-show rates. With this knowledge, addressing SDOH that drive these events could help providers design strategies to reduce no-show rates and unnecessary ER use.

When augmenting their risk and care management programs with socioeconomic data, organizations have to ensure that SDOH have been clinically validated against actual healthcare outcomes. This is vital for the success of predictive analytics because not all determinants correlate strongly to health outcomes. Organizations should use the most up-to-date, complete and longitudinal data that has been proven to be consistently linked to specific patient populations. For example, Accenture Insights Platform works with partners to derive attributes from public records data such as education, income, proximity to relatives, bankruptcy, addresses and criminal convictions.

### *Takeaways*

- States should evaluate inclusion of both attributes and scores to measure SDOH performance in all value-based programs. They can incorporate SDOH attributes, such as education or income, into existing predictive models and care management based on medical data to better assess and predict risk for individuals. Moreover, SDOH provide critical insights in the absence of medical data. Another way of utilizing SDOH is through predictive health scores that score a patient's health risk. Scores are based on hundreds of relevant socioeconomic attributes to paint a full picture of the individual's future risk.



## **Conclusions**

As providers and payers align on value-based models, they need to collaborate efficiently and accurately, particularly as they align on reimbursement strategies and population health management (PHM) programs. This is where data convergence comes in - the ability to establish customizable, specific, and unique access and/or views of health data is critical to collaboration that drives new value-based models. With a flexible data convergence platform, providers and payers can customize and revise decisions about what to share, with whom and when.

# CONTRIBUTORS

## Felix Bradbury

Dr. Felix Bradbury, FACHE is a Principal Director of data science with Accenture in global Health Analytics; he is based in Houston, Texas. Dr. Bradbury has had a diverse career in health and analytics that spans 35 years. He established a Medical Management Reporting Department for a national commercial payer, led medical economics division for a Medicaid and Medicare Advantage payer and served as VP of Analytics, Risk Management, and Reporting for a national disease management company. He has served on product advisory boards for McKesson Payer Solutions, IHCIS, and Symmetry and successfully implemented predictive models and P4P programs for commercial and Medicare payers. He has published research in the areas of predictive modeling, program monitoring and evaluation for care management initiatives, human reliability techniques, and operations research such as the use of discrete event simulation in medical management operations.


Dr. Bradbury is an oncology RN by training and holds a Masters in Health Administration with an emphasis in biostatistics and a Doctor of Science, *cum laude*, in Health Systems Management and Cost-Effectiveness Research from Tulane University Medical Center, School of Public Health and Tropical Medicine in New Orleans where he completed an administrative residency through the Louisiana Center for Health Statistics and a doctoral fellowship in medical informatics through the Ochsner Health Plan and Clinic in New Orleans.

Dr. Bradbury is board certified in executive healthcare management as well as a Fellow and board member of the American College of Health Care Executives and the American Nurses Association; he currently serves on the editorial review board for the *Journal of Healthcare Management* and hosts a blog on healthcare analytics for Accenture. His most recent projects include the development of an analytics strategy for NC Medicaid and a pay-for-value framework for the US Department of Defense.

## Gerry Meklaus

Gerry Meklaus has nearly 20 years of experience consulting to over 100 health systems, payers and healthcare companies. His experience includes both strategic and operational consulting. His clients include academic medical centers, community hospitals and large integrated delivery networks. He brings hands-on experience in all aspects of Physician Enterprise, Risk Based Entity operations and Managed Care contracting. He is a frequent speaker and author on Physician-Hospital affiliation approaches and the transition to Value Based Care.

Prior to consulting, Gerry was a COO for a large multispecialty practice, Executive Director of an large IPA, Vice President for Revenue Management & Contracting for a national provider of rehabilitation services, and a Senior Product Manager for a global medical equipment manufacturer. Gerry is also a Registered Respiratory Therapist who once led Respiratory Care clinical services at



Massachusetts General Hospital while researching and publishing on topics in critical care and mechanical ventilation.

Gerry holds a B.A in Philosophy from Binghamton University, B.S. in Cardiorespiratory Sciences from Stony Brook University and a Master of Health Services Administration from the University of Michigan.

### AnnMarie Merta

AnnMarie is a Principal Director in Accenture's Value Based Care Practice. She has over 20 years of experience leading health systems, ambulatory care networks and physician practice organizations in strategy and operations. AnnMarie's experience spans into the payer realm providing a unique skill to lead organizations through integration of providers and payers focused on achieving value based care. Her most recent work centered on the improvement of existing CINs and ACOs within large health systems to align the efforts of hospitals, CINs, ACOs and employed physician practices with provider sponsored health plans and other payer value based contracts in effort to build strong provider networks.

AnnMarie was National Vice President, Provider Integration and Performance for large non-profit Health System and Health Plan prior to joining Accenture. Her experience also includes Vice President of Product Management for a large provider system owned by a major Payer and multiple years of senior leadership roles in strategy and operations for national health systems both not-for-profit and for-profit.

AnnMarie holds a BS in Medical Technology from Saint Bonaventure University and a Masters of Business Administration from University of Louisville. She is as a Fellow of the American College of Health Care Executives.

### Erik Pupo

Erik Pupo is a Senior Executive in Accenture's Health & Public Service (H&PS) practice based out of the Miami office. Erik has more than 20 years of experience in healthcare, including vendor, industry and advisory roles. Prior to Accenture, Erik was a senior manager at Deloitte where he worked with federal and commercial healthcare clients and was a leader in the broad healthcare IT practice, serving payers, PBMs, providers, life sciences, government, and healthcare IT vendors.

Erik has worked to help clients create new operating strategies, supported the design and implementation of products and solutions, and is recognized as an industry thought leader in numerous fields pertaining to healthcare, including enterprise and data architecture, healthcare policy development and analysis, health information security, electronic health information exchange, and healthcare analytics

Erik currently serves as the lead for Accenture's Healthcare Technology Consulting practice in North





America, as well as Accenture's Healthcare Blockchain lead and a key advisor and leader within Accenture's Value Based Care practice.

Erik holds his MBA from Lynn University and Undergraduate Degrees in Finance and History from Florida Atlantic University.

### Rick Stewart

Rick Stewart is a managing director in Accenture's Health & Public Service practice, and is a leader in Accenture's Clinical & Health Management solution group. Since joining Accenture in 1993, Rick has worked with large for-profit and not-for-profit payers, providers, and government health organizations to improve the quality, effectiveness and efficiency with which health care is delivered in North America. Rick has architected many of Accenture's Health Management methods and points of view, has published multiple white papers, and co-holds a US Patent for a Payer High Performance Capability Assessment.

As a leader within Accenture's Clinical & Health Management solution group, Rick Stewart oversees Accenture's end-to-end portfolio of strategy, management consulting, information technology, analytics and business operations services that Accenture provides to its clients in support of improving their quality outcomes and Star Ratings, improving efficiency of clinical operations, and reducing wasted medical spend that comes from overuse, misuse and underuse of the medical delivery system.

Rick holds a B.S. in Industrial & Systems Engineering from The Ohio State University.

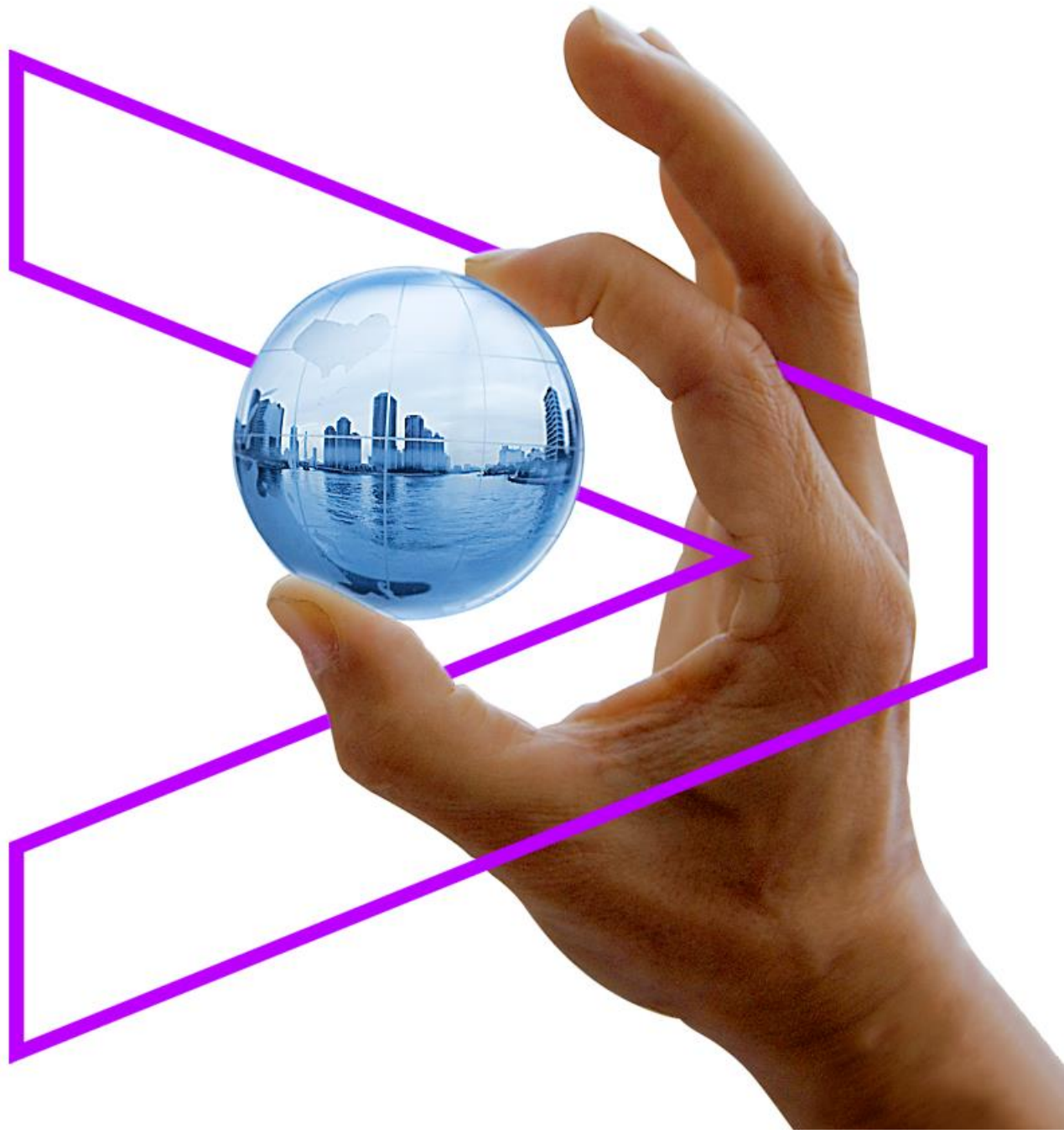


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# **RESPONSE TO DHS REQUEST FOR COMMENT JANUARY 2018**



# INTRODUCTION

Thank you for inviting Accenture to contribute to The Minnesota Department of Human Services (DHS) redesign and reform of DHS' purchasing and delivery strategies for Medicaid and MinnesotaCare.

## **Why are you submitting the RFC after the deadline?**

While meeting with DHS Leadership on Dec 6<sup>th</sup>, 2017 Commissioner Piper requested Accenture to participate in the “*Outcomes-Based Purchasing Redesign and Next Generation IHP*” RFC that had been released on Nov 15<sup>th</sup> and due the following week on Dec 15<sup>th</sup>. Our initial review revealed that Accenture would need a reasonable amount of time to meaningfully respond. Accenture notified Nathan Moracco, DHS Leadership on Dec 15<sup>th</sup> that we would reply after the holidays.

Please let us know if you would like to discuss and/or explore our responses further.

Sincerely,

Dan Schmitt

## **ASSUMPTIONS AND CAVEATS**

This document was written from the perspective of a large, international consulting firm with ties to every industry. These ties enable Accenture to identify best practices used by those industries and adopt them to solving complex healthcare solutions. The following caveats apply:

This document is written with the perspective of a state Medicaid entity in mind. This means that considerations that may apply in the commercial payer space or within the context of large commercial health systems - may not apply to the comments here.

A variety of subject matter experts contributed to this document. Writing tone and style may vary between responses. For ease of reference, the contributing writer is listed with each response. Brief contributor biographies can be found on pages 38-40.

# RESPONSES

*Question 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?*

**Accenture has chosen not to respond to this question.**

*Question 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.*

**Accenture has chosen not to respond to this question.**

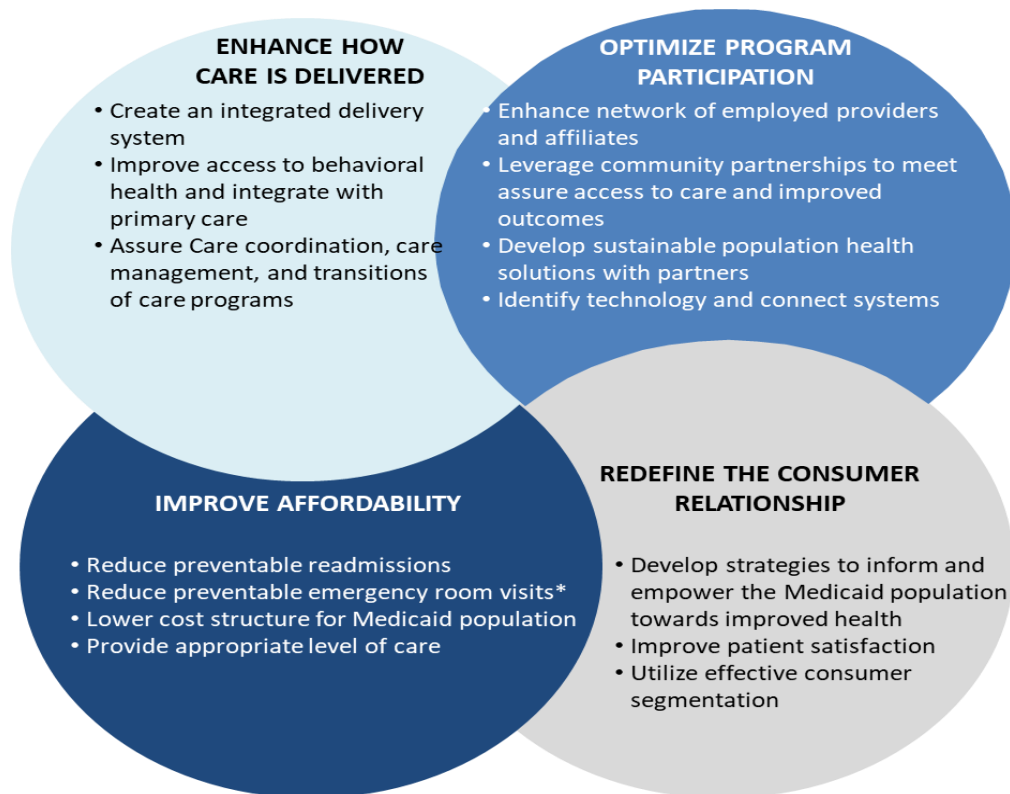
*Question 3: What kinds of criteria should be included in a Request for Proposal for Next Generation IHPs and MCOs to ensure that an entity has sufficient and effective provider and benefit network structure (e.g., behavioral health integration with primary care) to ensure enrollees’ needs are met? Are there additional services or requirements beyond behavioral health that should be a primary consideration (e.g., criteria related to cultural competency, disparities, equity, etc.)?*

## **Question 3 Response: AnnMarie Merta**

The purpose of these two sections of Accenture’s response is to frame-up network structure to ensure it is sufficient and effective. While the state of Minnesota should have a floor for network adequacy to assure enrollees have “real” access to care, this section is designed to give Minnesota a framework to help meet Minnesota’s own goals for an effective network and greater beneficiary satisfaction with healthcare delivery. The relationship with your network providers should be a relationship in which you are working toward aligned goals.

**Section 1: Criteria to be included in a Request for Proposal for Net Generation IHP’s and MCO’s to insure an entity has sufficient and effective provider and benefit network structure.**

## Key Objectives for Network Partnership Beyond Adequacy



Current specific adequacy standards should demonstrate to the state the appropriate levels of primary care, preventative health and specialty services to provide care for the anticipated number of enrollees in the service area. Network adequacy requirements need to be consistently enforced and networks should regularly monitor compliance. Reports should include location, number, specialty and capacity of providers. Reports should recognize areas of concern and specifically provide corrective action plans for any identified inadequacies.

Minnesota should look to MCOs and IHPs to provide concrete opportunities to exceed adequacy standards and performance. In addition, MCOs and IHPs reporting capabilities should include the following required metrics on quality, cost, outcomes, satisfaction, network utilization in addition to access.

- Improved time and distance standards
  - A minimum number of PCP and specialists for all designated specialties to assure access to covered benefits; for example, 2 primary care options within 30 minutes; specialists requiring frequent visits should be within 30 minutes for urban areas. Rural areas 60 minutes for specialists.
  - Travel time should include public transportation where available. For areas without public transportation, other options using community resource relationships should be identified.
  - Use of telehealth or virtual visits should be an option especially in rural areas.
  - All hospital, pharmacy services should be within 30 minutes or 30 miles
- Provider types
  - Network should include all required provider types
  - RFP should encourage participation of specific specialty types to meet the needs of benefit plan design but also the populations needs. Examples include adolescent medicine, obstetrics and gynecology, women’s reproductive services, psychiatrists, cardiologists, endocrinologists, dermatologists. Provider ratios of specialist to populations they service should be set.
- Assured and timely access
  - RFP should request attestation to assure the providers “in-network” have an open panel, will accept attributed patients and will see them within required time frame, for example: urgent acute within same day, and chronic episode within 48 hours.
  - Extended hours
    - Primary care/ Behavioral Health offer extended hours
    - Formal relationship with retail clinics, urgent cares or call groups
    - Telehealth
  - Appointment availability
    - Same day availability for acute conditions
    - Emergent/Urgent options (12 hours)
    - Chronic condition episode within 48 hours
    - Preventative and routine visits within (10-14 days)
  - Accessibility for disabilities, low literacy, limited English proficiency must be addressed
  - Appoint reminders and education; follow-up on missed appointments and rescheduling. Address barriers to complying with appointments
- Out-of-Network
  - Plans should provide access to all covered services in an adequate and timely manner which may include access to out-of-network providers; if no provider either exists or is accessible to enrollee.
    - Information on use of out-of-network providers should be communicated to MCO network to identify opportunity to contract provider
    - MCO’s should demonstrate plan to assure referrals are made to “in-network” providers and communication channels are in place.

- Assure access to medically necessary specialists who are specialized for the treatment of children, cancer, cardiac, etc
- Identification of IT platforms and interface to provide communication of not only clinical care plans but social determinants and barriers.
- Out Reach / Programs
  - RFP should inquire and require outreach programs specifically to identify and address social determinants of health, risks, disabilities, chronic care and preventive care programs. These programs and efforts should produce measurable results. Below are a few examples:
    - PCP – Behavioral Health combined clinics and programs
    - Medication adherence programs
    - Emergency room diversion
    - Chronic care management programs
    - Dual diagnosis programs (both mental health and medical)
    - Care coordination (clinical, mental health and community based resources); Whole Patient Care Journey
      - Integrated care plans (Health Roadmap)
    - Reduction of re-admissions
    - Wellness and preventative care outreach
    - Community and clinical support groups

## **Section 2: Additional requirements beyond behavioral health to be considered.**

MCOs and IPHs should demonstrate their ability to identify existing community short-falls and barriers to improving health for the population and plan to address these factors. There is a growing recognition that improving poor health is not just about high-quality medical care but also addressing the social determinants. The Kaiser Family Foundation graphic on the next page outlines determinants. A risk assessment tool to screen patients for social determinants of health, risk factors and barriers should be required to obtain the next-level. Partnerships with community based organizations should be outlined. Public health agencies, social service organizations, can enable MCOs and IHPs to provide non-clinical support for beneficiaries to include services like transportation, housing support, meals, job placement. Network partners should further demonstrate integration and communication channels with their community based organizations, including use of Health Roadmap and evidence of “Whole Patient Care Journey model”



Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social Integration	Health Coverage
Income	Transportation	Language	Access to Healthy Options	Support Systems	Provider Availability
Expenses	Safety	Early Childhood Education		Community Engagement	Provider Linguistic and Cultural Competency
Debt	Parks	Vocational Training		Discrimination	
Medical Bills	Playgrounds	Higher Education			Quality of Care
Support	Walkability				

## Health Outcomes

- Substance Abuse
  - Demonstrate program integration with behavioral health, self-care tools, housing support, job placement, family reintegration.
  - 24-hour access for crisis
- Structural Barriers
  - Demonstrate partnerships to address transportation issues, specifically those who do not have public transportation access.
- Getting Care
  - Demonstrate access efforts and performance, publicizing provider office hours and extended hours. Provide clear direction and education on what patients should do after-hours to get needed support or care and avoid emergency department.
  - Identify processes and tools to assure appointments are kept, follow-up on adherence to medications and post visit instructions takes place.
- Physician Communication
  - Identification of the tools and systems used for physicians, community based organizations, patients and families to communicate.
  - Use of survey tools to assure patient understands diagnosis, treatment, medications and their responsibility.
- Cultural Competency
  - Demonstrate options for patients who have race, ethnicity, social dynamics, for example Tribal Health Clinics
  - Provide tools for providers to be educated on the specific race and ethnicity cultural dynamics for their attributed patient panel demographics.
- Linguistic Competence



- Demonstrate ability to communicate effectively with those patients who demonstrate low literacy, limited English proficiency or where the race, ethnicity, and social adaptation is a barrier.

*Question 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?*

#### **Question 4 Response: Rick Stewart**

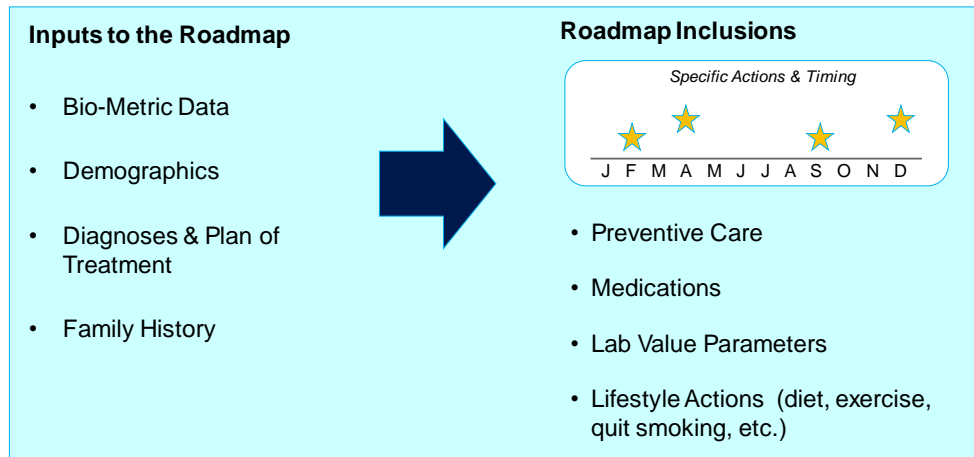
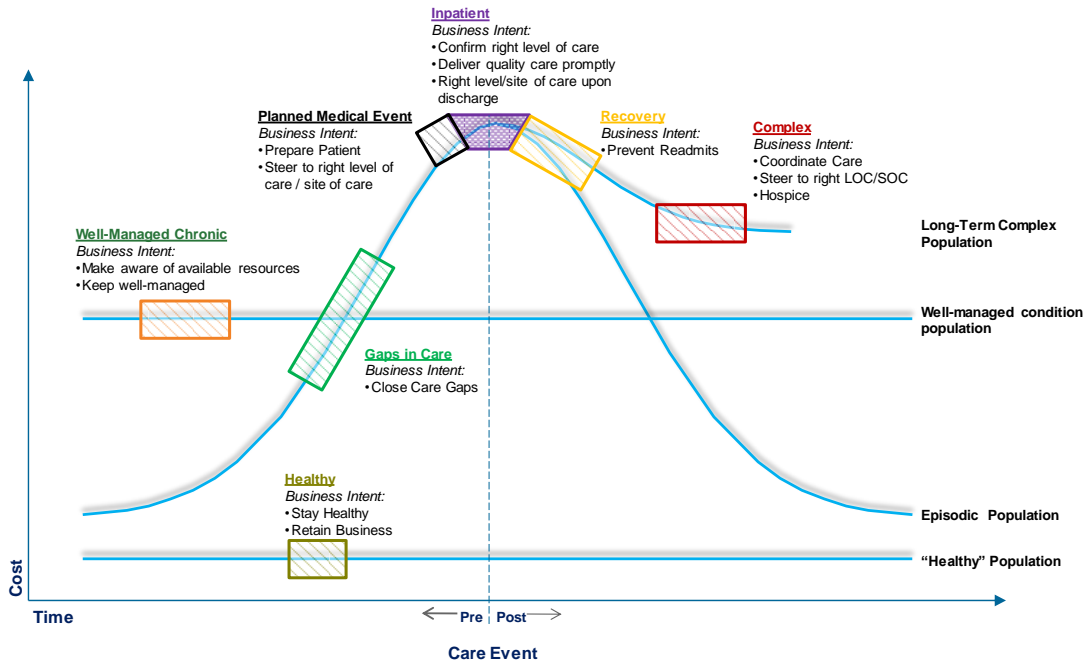
To properly address this question, there are two foundational principles that need to serve as the basis for the Care Coordination functions of any organization:

#### **Principle 1: Coordinating care requires different actions with different clinical and business intentions depending on the patient's needs at a given point in time**

Too often, we see health organizations attempt to apply the same care coordination processes and approaches to people with very divergent care needs. This leads to three unfavorable results:

1. Patients with needs who are missed because the analytics used to identify and prioritize those who need care coordination are too broadly defined, for example a patient who has congestive heart failure who has failed to refill a prescription for their ace inhibitor. This care gap alone may not trigger identification for a care manager to get involved. However, if left as an open gap, the patient will probably have a near term need for an emergency room visit and/or hospital admission.
2. Actions that fail to align with the patient's needs. Many Care Coordination actions are designed assuming high acuity and are often miscast when applied to people with low acuity. An example of this is a high risk maternity program. Often, the trigger to activate the program is a general diagnosis of pregnancy, and the first step is an assessment to determine if the patient has potential to have a high risk pregnancy. Fortunately, the great majority of pregnancies are low risk. Looking through the lens of "high risk pregnancy" alone, many programs stop once the patient is determined to be low risk, and miss the opportunity to shift focus from avoiding NICU admission to ensuring a positive experience for the patient and retaining her business.
3. Lower than expected Return on Investment caused by applying cost to patients who lack the need for care coordination, or by applying approaches that fail to meet the patient's needs.

The following Exhibit A is a framework we use to demonstrate the alignment of care coordination actions with clinical and business intent based on the patient's need at that time:



**Principle 2: Each individual has a single physician-defined Health Roadmap based on their demographics, conditions, health history, bio-metric values, and health habits.**

What occurs all too commonly in today's health ecosystem is that as individuals, we often have multiple Health Roadmaps in motion simultaneously. These health roadmaps are created by multiple physicians we are seeing, a care manager from a payer, and our own views as to our health needs which can be influenced by a variety of sources.

The Next Generation IHP needs to have the ability to forge and communicate a single Health

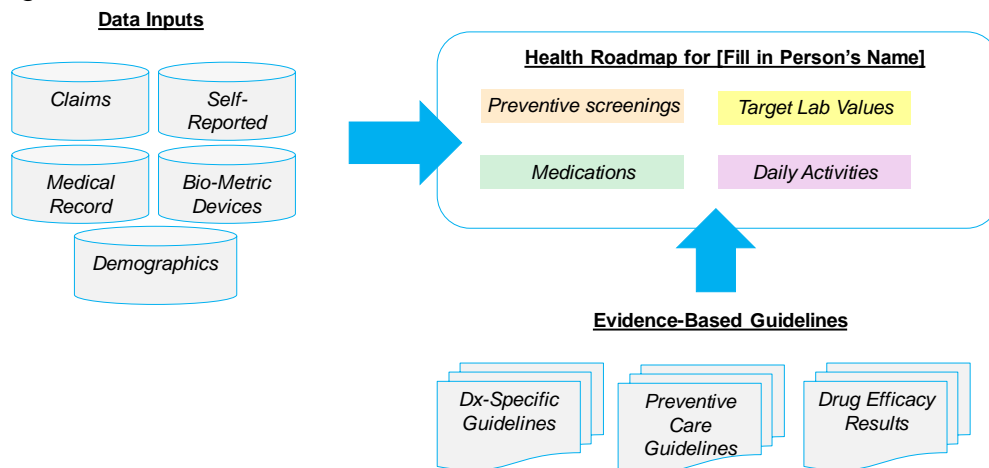
Roadmap, that is created as a collaborative effort between the patient and their primary physician, and to enable the Health Roadmap to be viewed (and modified as needed) by treating physicians, care managers, or other health stakeholders who are providing, directing, or influencing care for that patient.

The Next Generation IHP will possess mechanisms to manage presence of, deviations from, and changes to an individual's Health Roadmap.



1. Managing Presence of a Health Roadmap:

Ideally, the Health Roadmap for an individual is defined as a collaborative process between the patient and her/his Primary Care Physician. In the absence of that, a Health Roadmap can be constructed using best available data.



Mechanisms a Next Generation IHP needs to possess to confirm the presence of an individualized Health Roadmap include:

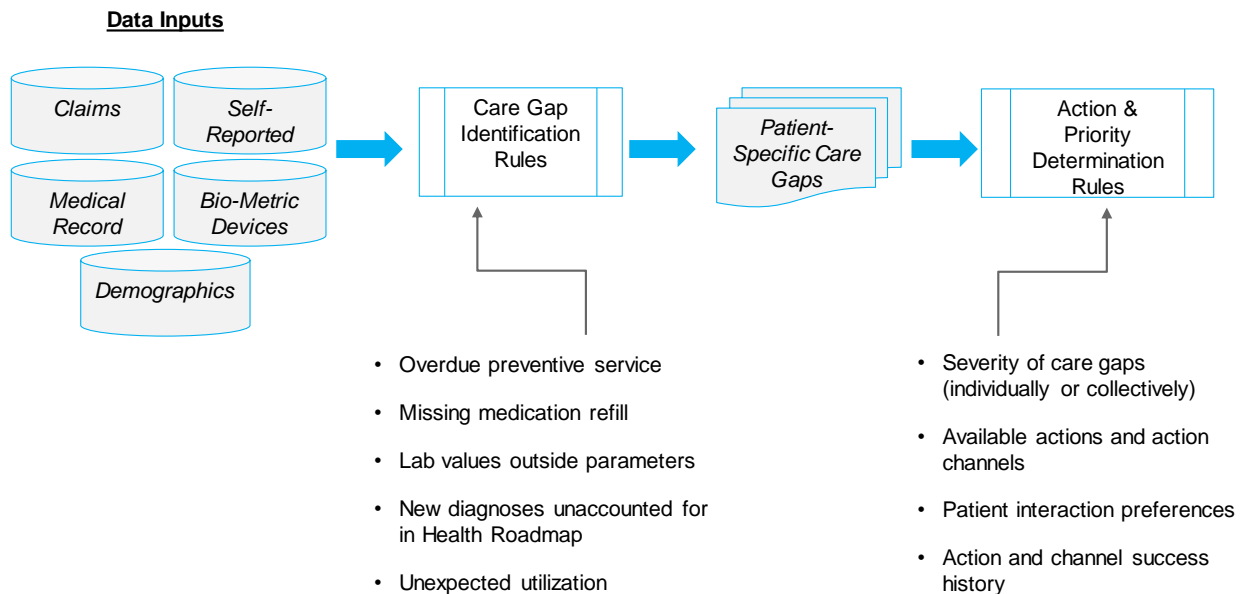
- a) Ability to capture and store individual Health Roadmaps, and make them accessible to treating physicians, care managers and other care providers (who are likely working from different workflow systems)
- b) Ability to capture raw data needed to construct/supplement an individual Health Roadmap. These data can come from clinical systems, claims/encounters, demographics, patient surveys, and bio-metric devices.
- c) Analytics that forge or enhance an individual's Health Roadmap based on existing roadmaps, other available data, and applicable evidence based guidelines.

## 2. Managing Deviations from or Changes to Health Roadmaps

Next Generation IHPs will need to have two categories of mechanisms to manage deviations from Health Roadmaps:

- a) Ability to Identify when Deviations Occur**
- b) Actions that Effectively Resolve Deviations**

Identifying when deviations occur involves mechanisms to constantly monitor key data sources and apply identification rules that flag when a deviation (or care gap) occurs and determine if/what action is necessary to close the care gap.

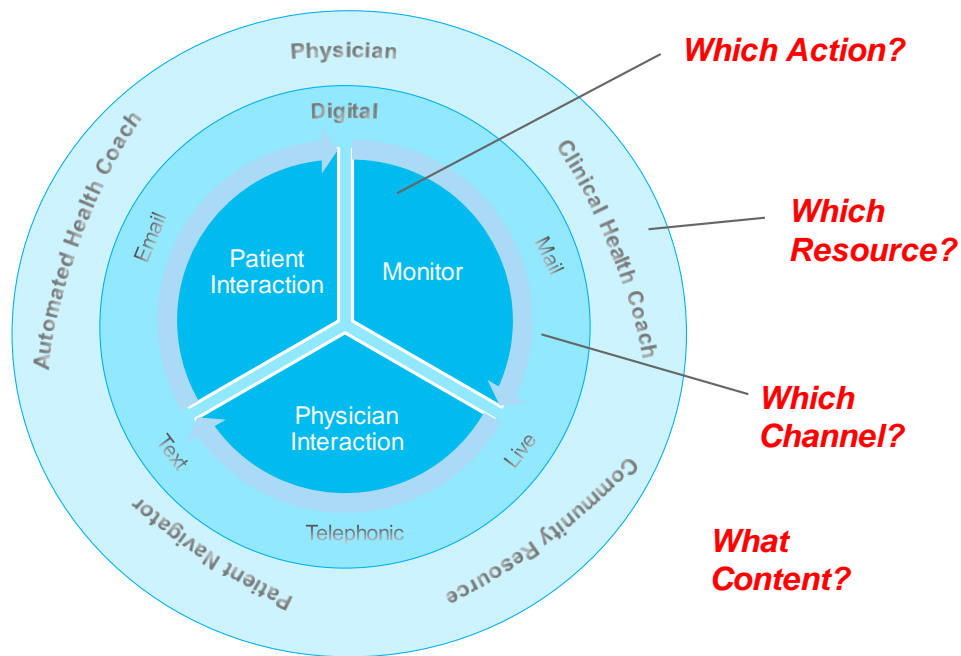


Important to note is that a Deviation, or Care Gap, can indicate two different things:

- The patient is failing to comply with their Health Roadmap. This can include missing preventive care services, failing to fill needed medications, seeking care from sub-optimal providers, or failing to apply proper health habits in daily life (e.g., smoking, failure to achieve activity targets, diet mismanagement, etc.)
- Something has occurred that indicates a needed change to the Health Roadmap. This can include a new diagnosis, unexpected utilization, a significant change in bio-metric values, or a demographic change that drives changes to the Health Roadmap.

Once deviations from the Health Roadmap are identified, Next Generation IHPs will need a variety of mechanisms to select and execute actions that either update the Health Roadmap and/or close any outstanding care gaps.

Healthcare as an industry is beginning to apply learnings from other industries which have been more focused on influencing individual consumer actions. Proliferation of new payment models, new consumer choice options, new technologies, and consumer expectations have all had a hand in driving this change. Our view is that payers and providers are still in the early stages of applying these capabilities, but are moving beyond “pilot” and into “scale across the population” mode. Specific to Care Coordination, a Next Generation IHP’s gap closure actions will need to represent the combination of “which action”, “which channel”, and “which resource” using “what content” that will most successfully resolve the care gap for that individual patient.



Going back to Principle 1: Alignment of analytics and actions with specific clinical or business intent; it will be critical for Next Generation IHPs to demonstrate this alignment and apply it to their approach for managing deviations from Health Roadmaps.

For situations where the patient is failing to comply with their health roadmap, potential remediating actions can include:

- Static electronic or mail-based notifications to patients
- Static electronic or mail-based notifications to providers
- Dynamic interactions with patients via phone, electronic channels, or in-person

These actions require mechanisms that include the following:

- “Campaign Management” capabilities that learn which channels and interactions are most effective with specific individuals, and individuals “like them” (based on segmentation)
- Inbound and out-bound call center capabilities
- Digital interaction capabilities; including text, mobile app, electronic chat, etc.
- In-office and in-home live interaction capabilities using both clinicians and non-clinical community care resources

For situations where a health event has occurred that indicates a change to the patient's Health Roadmap, actions you should expect from Next Generation IHPs include support that:

- Helps patients (and referring physicians) to find the “right” provider to meet their needs. “Right” defined as optimal choice across key variables such as quality, cost, location, and other patient preferences (e.g., gender, languages, etc.)
- Coordinates when patients have a health event that causes a significant change to their Health Roadmap and/or requires more active coordination across providers (e.g., hospitalizations, other events that require multiple providers). Note that this support should span both patient clinical needs (e.g., understanding/adherence to doctor's plan of care, engaging right providers, etc.) and administrative needs (e.g., understanding financial implications/options, understanding/adherence to administrative procedures, etc.)

*Question 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?*

## **Question 5 Response: Gerry Meklaus**


### **Section 1: Introduction and Approach**

Minnesota's Integrated Health Partnership (IHP) program is perceived as having achieved considerable success to date<sup>1</sup>. With 21 ACO-like organizations encompassing ~460,000 members, \$212M of savings has been attributed to this effort. With the State's continued commitment to redesign and reform of purchasing strategies for public health care programs, Minnesota is embarking upon a next generation program (IHP 2.0) to build upon the gains initially realized within this structure, further improve health outcomes (without increasing costs) and address risk factors traditionally considered outside the purview of health system providers. Those factors include social determinants of health, racial disparities and behavioral health risk factors.

Using this Next Generation model, providers are expected to coordinate care across a continuum of services that include both medical and social services. One of the goals of the program is working with the community to improve outcomes in a deeper, more collaborative form than is available today. Providers participating in outcome-based purchasing are expected to have accountability for cost and quality while maintaining flexibility in their organizational structure, contracts, partnerships and

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<sup>1</sup> Request for Comment: Outcomes Based Purchasing Redesign and Next Generation UHP, November 15, 2017, Minnesota Department of Human Services, p.1



management of provider activities<sup>2</sup>. In short, while the program goals would be somewhat proscribed and incentivized, how providers get to “success” will largely be left up to them to define. The structure of this initiative is thus similar to that of Accountable Care Organizations (ACO’s). Given the aims of IHP 2.0, one could also draw some analogies to the emergence of Performing Provider Systems within the New York State Delivery System Reform Incentive Program (DSRIP).

Accenture has considerable experience assisting clients pursuing initiatives in both of those frameworks. As a global consulting firm, we have assisted clients in the US pursuing goals associated with value-based purchasing initiatives, both on the payer and provider sides of this effort. In addition, we are preparing to respond to initiatives emerging within the United Kingdom, as the National Health Service is proposing a similar approach of Accountable Care Systems that would engage widely on a population’s health initiatives, encompassing both medical and social needs.

With the exception of the NHS initiative, which is still in planning phases, it is fair to surmise that results of Accountable Care efforts in the US to date have generally proven to be uneven in distribution.<sup>3</sup> Only about one-third of Medicare ACO’s have achieved shared savings to date in any given distribution year. Such unevenness of results have led to considerable efforts to develop frameworks for the success factors that would catalyze a more consistent level of success. Advocates of ACO’s generally believe that the competencies of success are widely known but highly concentrated in specific organizations.

## **Section 2: Assessing ACO’s capabilities using a Logical Operating Model (LOM) framework**

Accenture realized early on in working with clients developing ACO-like entities that the “roadmap” or “guidebook” on how to do this was not developed. In that vein, we developed a Logical Operating Model structure that defines the major components of effort that would need to be undertaken to create a successful ACO.

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<sup>2</sup> Ibid, p.2

<sup>3</sup> Blackstone, EA and Fuhr, JP. The Economics of Medicare Accountable Care Organizations. American Health Drug Benefits. 2016 Feb; 9(1): 11-19.



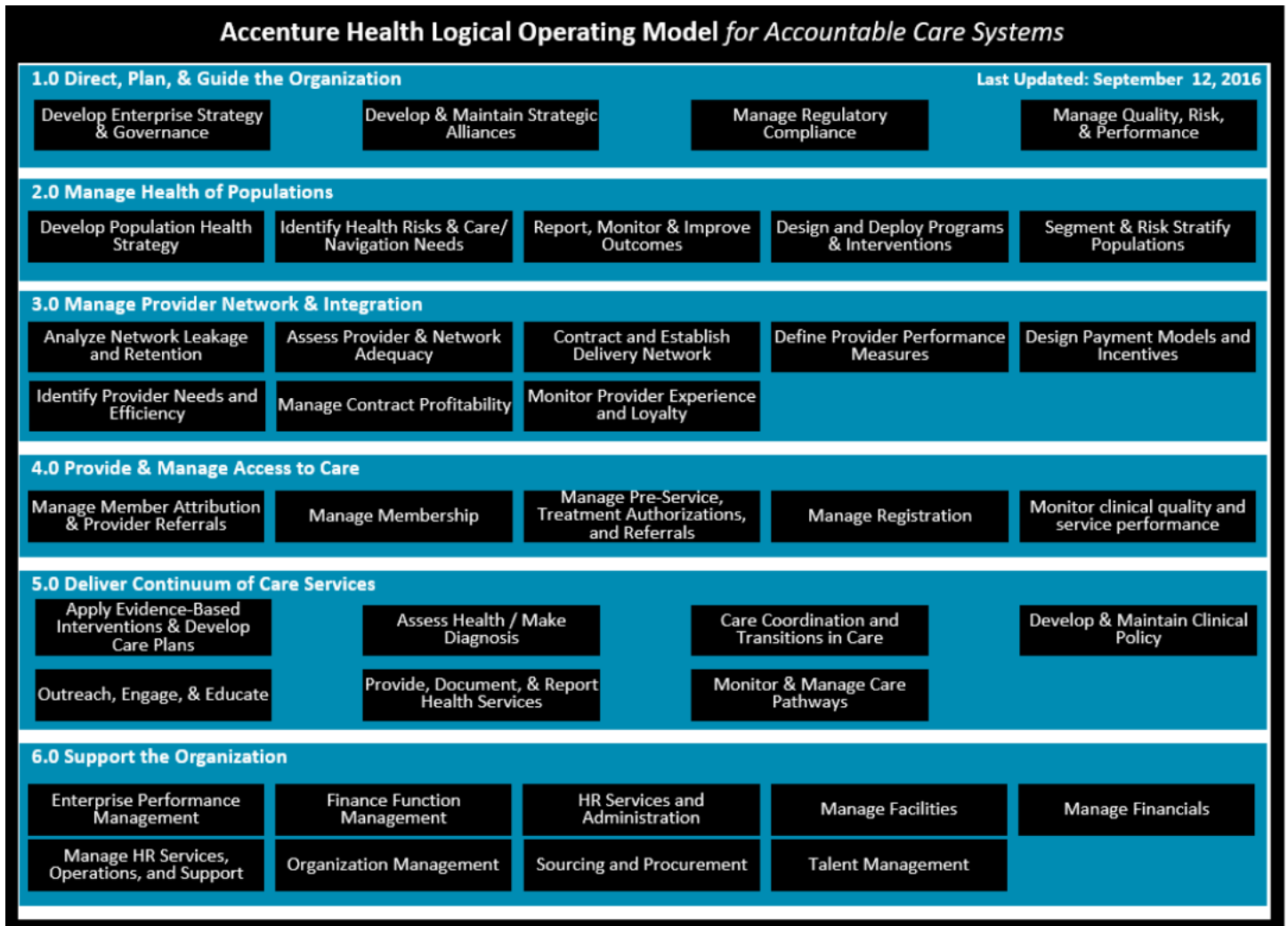



Figure 1: Accenture Logical Operating Model for ACO's, Level One

The Logical Operating Model (LOM) is a structure that Accenture utilizes to assess organizational readiness for a given set of missions (patent pending). The LOM extends to 4 levels of actions, with each level driving down to a greater level of specificity and detail. This tool became the foundation of a Capability Assessment Model (CAM) which is a proprietary analytical tool to assess the readiness of organizations to take on risk in an accountable care setting.

Subsequently, organizations have emerged to develop public-source collaborative efforts toward a similar set of detailed competencies. The Accountable Care Learning Collaborative (ACLC), under the direction of Western Governor's University and Leavitt Partners, has developed an Accountable Care Atlas with detailed competencies enabling self-assessment by ACO's in more nascent stages of development (see <https://www.accountablecarelc.org/atlas>).

Accenture has been a strong supporter of the ACLC and similar efforts to codify ACO competencies





and develop assessment tools that can assist organizations in moving more rapidly to a platform of consistent success. We believe that Minnesota DHS should build upon these efforts and help to create a common platform of understanding of key competencies for Next Generation IHP's. These evaluations could then be used to help identify the capabilities that would be needed by any given IHP in implementing the specific initiatives they are undertaking.

We would like to stress that an effort like a capability assessment tool based on competencies could be utilized in two ways: one the one hand, organizations would have to score over a certain level in each domain in order to take on population risk; or conversely, these tools could be offered as informative in nature, assisting organizations in developing a unified set of operating principles and exchanging information on leading practices while developing the shared competencies. While both approaches could be valid, we would suggest beginning with the latter approach and developing a consensus-driven approach to competency standardization. This would enable organizations to co-create the solution. Since IHP's have already created value, there are likely many lessons to be learned that can be shared across organizations.

### **Section 3: Developing a LOM/CAM specific to Next-Gen IHP models, incorporating Social Determinants of Health (SDoH)**

While the ACLC and others have developed detailed competency based operating models (ACLC's is termed an "Accountable Care Atlas"), most of these tools are not specifically directed at the Medicaid beneficiary and do not explicitly include competencies related to integration with social services providers. This is due to the fact that most ACO's are Medicare-driven currently, with perhaps some commercial contracts for managed lives. Given that most of these entities are still in nascent stages, they have not yet reached out to social service agencies or community based organizations in a comprehensive way to achieve true integration across a continuum of care.

For lessons on how to truly integrate across the continuum, one could look to the experiences of the New York State DSRIP program. Achieving integration across the continuum is an explicit goal of that program. To launch that effort, New York State invested developing "personas" encompassing a profile of certain Medicaid beneficiaries achieving care in a coordinated system, as opposed to the currently fragmented structure. In a collective fashion, New York attempted to build consensus around the goals of an integrated approach by developing examples of how care can be better coordinated. These personas then acted as examples of the integration that should be pursued by Performing Provider Systems.

Achieving this level of integration remains a work in progress, even several years into this effort. We have learned that integrating community based organizations and providers is subject to a number of barriers related to mission, resources and lack of centralized information technology infrastructure. Across the country, organizations like Parkland Memorial Hospital's Parkland Center for Clinical Innovation are working to develop coordinated information sharing networks that use advanced technology to create the continuum of care "systemness" that can be used to derive a new ecosystem

of care.<sup>4</sup> But financial, mission, and cultural barriers remain and require extraordinary committed local leadership to overcome.

At Accenture, we believe that local success stories can overcome the significant barriers to comprehensive coordination of care, aided by the appropriate data convergence strategies (see response to question 12). Our consulting approach utilizes Design Thinking perfected by our subsidiary, Fjord Consulting. As an example, Fjord worked with a large social service organization to team to explore how technology could eliminate fragmentation and strengthen care coordination within the care network that the client and other state social service organizations belong to. To better understand social service delivery from the client’s perspective, Fjord developed an understanding of its integrated healthcare approach. Fjord designed the Whole Patient Care Journey, a tool that helps case managers better visualize and coordinate the care of their clients. The tool also provides a way to gather analytics on the health of the network, get an idea of which services are working best for clients, within a system where measuring return on investment is difficult to measure. Fjord demonstrated the value of the tool by seeing how elements of the design would work across programs via a low-fidelity digital prototype. The design team worked closely with caseworkers to refine the Whole Patient Care Journey throughout the demonstration period.

Fjord found that the best way to build on the strength of the client’s work was to use an empathetic approach to design that relied heavily on designers and decision-makers forming a close working relationship. The design team was able to infuse more empathy into the process by designing and demonstrating the integrated healthcare approach in real-time with case managers who had first-hand knowledge of what it is like to work in this arena. In this way, Fjord was able to bring design into a space, and to people, who generally are not its focus, putting service design and innovation at the heart of social services.

Accenture (and Fjord’s) approach to Design Thinking overcomes barriers with a high degree of engagement of participants.

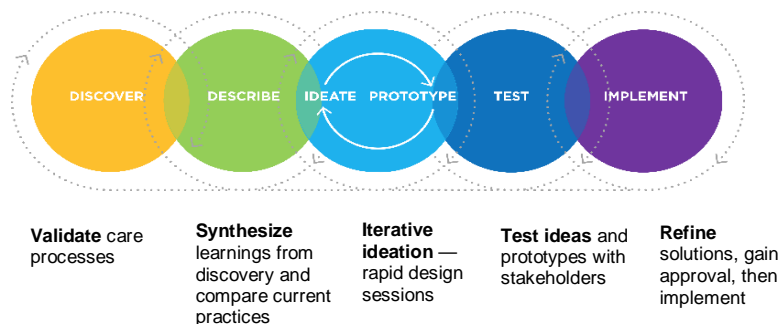


Figure 2: Accenture’s Approach to Collaborative Design Thinking

<sup>4</sup> Allen, A. The ‘Frequent Flyer’ Program that Grounded a Hospital’s Soaring Costs. Politico Magazine, December 18, 2017.

## Section 4: Conclusion

DHS and counties evaluating potential responders' ability to implement proposed initiatives, especially in the context of care coordination across the new ecosystem of care that includes providers, community based organizations, social service organizations, and the like, will require a comprehensive assessment template derived from a Logical Operating Model or similar instrument. Distinct and specific competencies underlie such a template, and organizations participating in IHP 2.0 should participate in forming this rich asset. Accenture has participated in creating such an asset in a collaborative environment which energized the participants, so we know this instrument and more importantly, the dialogue that emerges, can improve the chances of success in this complex endeavor.

*Question 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?*

**Accenture has chosen not to respond to this question.**

*Question 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?*

**Accenture has chosen not to respond to this question.**

*Question 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?*

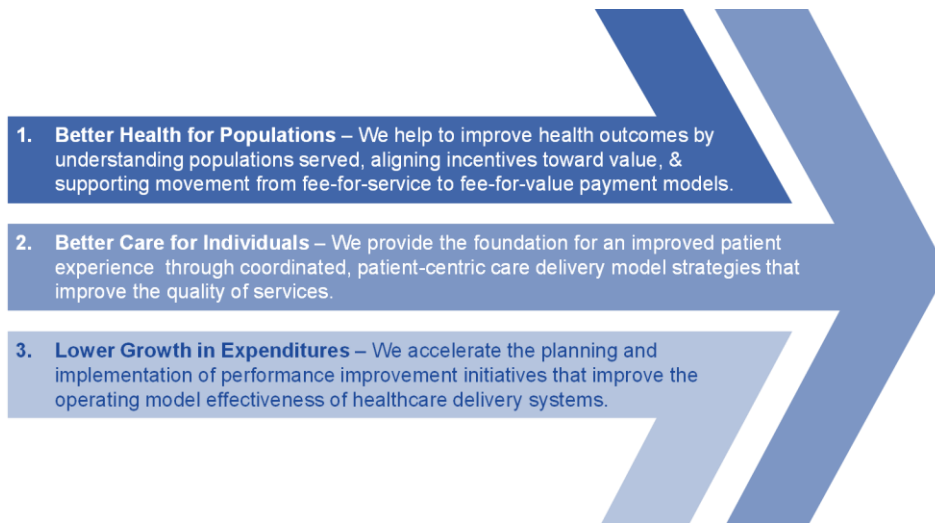
**Question 8 Response: Felix Bradbury**

### **Section 1: Appropriate measures for evaluating services to reduce health care disparities and improve outcomes**

The purpose of this section of Accenture's response is to frame-up the key performance measures, and the questions and processes required to evaluate the measures from the perspective of the State

of Minnesota. This section is designed to give Minnesota a framework to help meet Minnesota's own goals of better outcomes, more cost-effective care delivery, lower per capita costs, and greater beneficiary satisfaction with healthcare delivery.

Organizations like Minnesota are seeking to move toward, and achieve, the goals of the "Triple AIM"



Because the goal is to transform an enterprise at the state level – as opposed to an individual group of doctors, the performance measurement must be comprised of both macro-components and micro components as outlined below:


- **Micro-Level Performance:** Typically measure clinicians, teams, and departments. Micro-level measures are typically used for:
  - Assessing individual or small group-level performance against best practices or key organizational objectives,
  - Evaluating the impact of local process innovations and/or guidelines,
  - Locally organizing and displaying information to improve knowledge access,
  - Improving the management of patients presenting for care,
  - Improving communication among providers, and
  - Reducing variability in clinical care.
- **Macro-Level Performance:** Macro-level measures reflect either whole- system or major system unit performance (e.g., hospitals) and serve somewhat different purposes than “micro-level” (e.g., individual clinician or small group) measures. They are typically used by either health plan leaders or external purchasers for:
  - Assessing organizational performance against key strategic objectives;
  - Determining executive and management incentive compensation;
  - Making decisions about capital allocation;
  - Setting strategic planning goals and direction;

- Interacting with regulatory and accreditation agencies or bond rating agencies;
- Comparing performance of similar operating units (e.g., hospitals or nursing homes) within large systems;
- Aligning operating unit goals and priorities with overall system goals and priorities;
- Aligning system priorities with purchaser priorities;
- Setting system-wide priorities for QI and CQI initiatives.
- Macro-measures of performance typically are not used for:
  - Assessing effectiveness of individual clinical and administrative performance initiatives;
  - Calculating incentive compensation for individual clinicians or first-line managers (part of the incentive may be linked to overall system or large operating unit performance, but individual “line workers” are too far removed from overall system performance to have incentives pay calculated completely at that level.)
  - Assessing impact of local technology enhancements or other types of capital improvements;
  - Interacting with small local purchasers, community groups, or other stakeholder groups;
  - Evaluating impact of local innovations, demonstration projects, or community-level initiatives where the system is only one of several health care organizations in the community.

In contrast to their macro-performance counterparts, micro-performance measures tend to be *fluid, frequently reported measures oriented around specific clinical contexts*. Change in these measures is to be expected, since their *raison d'être* is *to invite, encourage and support ongoing improvement at the work- unit level*.

Because “macro” performance measures are most often used by management oversight groups to oversee contracts they represent stable aspects of system performance. Actually, purchasers who use comparative performance measures to make decisions about future contracting relationships are not well served if they either track measures that change frequently or shift the thresholds that they are using to measure performance too often. For example, if Clinic A is going to be chosen over Clinic B as a preferred provider, it is essential that the better performance of Clinic A over Clinic B this year be repeated next year. If the key performance measures are changing rapidly, it is unlikely that they will be a good basis for long-term purchasing decisions. Financial performance measures are an exception, where monthly or quarterly analyses are necessary to monitor potentially significant fluctuations.

Other exceptions include efficiency or quality measures may represent other exceptions to the pattern of annual reporting. As an example, an annual rate of nosocomial infections would miss a sudden outbreak of infections in a single unit related to a new source of infection. Likewise, an annual analysis of staffing levels per discharge would not allow for careful management of staffing to reflect seasonal variations or even weekly variations in patient volumes in different units.



Reporting frequency for performance measures depends on the needs of the information stakeholders to act, and the extent to which the underlying phenomena are stable vs. variable. Accenture understands the drivers of health outcomes includes the dynamic interrelationship of socioeconomic status, lifestyle choices, and health-related behavior. When one considers these macro-determinants, there are a number of potential measures to consider. The following is intended to be illustrative of the typical measures Accenture uses to help evaluate the performance against reducing health disparities and improving health outcomes.

### Quality of Care

- Hospital-level mortality, complication, and infection rates
- Rates of specific medical errors or other patient safety issues
- Unexpected return to surgery
- HEDIS Effectiveness of Care Measures (for health plans or defined “member” populations)
  - Mammography Rates
  - Childhood Immunization Rates
  - Influenza Vaccination Rates
  - Rates of Glycosylated Hemoglobin Testing for Diabetics
  - Adequacy of Follow-up for Antidepressant Treatment
  - Beta Blocker after Acute MI
  - Prenatal Care in First Trimester
- Low Birthweight or Pre-term Birth Rate
- Five-year survival rates for specific cancers

### Access and Availability

- Source of Care
  - % of persons who have a specific source of ongoing care
  - % of persons in fair or poor health who have a specific source of ongoing care
  - % of persons with hospital outpatient department as usual source of care
  - % of persons with hospital emergency department as usual source of care because of no usual source of healthcare
  - % of persons with a usual primary care provider
  - % of persons with community health center as usual source of care
  - % of persons with very little or no choice in source of care
  - Time with regular doctor (years)
  - Time since last PCP visit (months)
- Unmet Need
  - % of families that experience difficulties or delays in obtaining health care or do not receive needed care for one or more family members
  - % of families in which a family member did not receive doctor's care or prescription medications because the family needed the money
- Mental Health / Substance Abuse
  - % of adults with 2 or more chronic conditions who have not been screened for depressions



- % of adults with serious mental illness who received treatment
- % of adults with substance abuse treatment need who received treatment
- % of adults with DSM major depression criteria who received treatment
- % of adults with DSM generalized anxiety disorder criteria who received treatment
- % of adults with DSM substance use disorder criteria who received treatment
- Structural Barriers
  - Transportation
  - % of person who usually use public transportation to get to provider
- Getting Care
  - Does provider have office hours at night or on weekends?
  - How difficult is it to get appointment with provider on short notice?
  - How difficult is it to contact provider over the telephone about a health problem?
  - How much of a problem was it to get a referral to a specialist that you need to see?
  - How satisfied with professional staff?
- Waiting Times
  - About how long do they usually have to wait before seeing usual source of care?
  - ED: Waiting time to see physician
  - ED: % of people where disposition = "Left before being seen"
  - ALOS in hospice (reflects delays in getting hospice care)
- Physician Communication
  - Does provider generally listen?
  - Does provider usually ask about prescription medications and treatments other doctors may give?
  - Does provider listen carefully?
  - Does provider explain things?
  - Does provider show respect for what you had to say?
  - Poor communication during last visit
- Cultural Competency
  - Would have gotten better care if different race/ethnicity?
  - Felt treated with disrespect because of race/ethnicity
  - Doctor understands background and values
  - Health Information
    - Very easy to understand prescription bottle
    - Very easy to understand information from doctor's office
    - Health information resources
- Linguistic Competence
  - Availability of foreign-language written materials
  - Availability and ease of use of translation services
  - Number and scope of cultural competence training program
  - Provider mix reflective of communities served
  - Governing board and management staff reflective of communities served

- Inpatient days per 1,000 or admissions per 1,000 for defined populations (e.g., managed care plan members);
- Total acute admissions and acute admits/1,000
- Readmission rate/1,000
- Total admissions by service line and total admissions by service line/1,000
- Total bed days and bed days/1,000
- Length of stay which is calculated as the quotient of (bed days/1000)/(acute admissions/1,000);
- Cost or charge per admission (or all-payer refined DRG, i.e., APR-adjusted admission);
- Cost per member per month;
- ER admissions/1,000
- ER visit rate/1,000.
- Revenue/FTE
- RVU/FTE
- Cost per adjusted discharge
- FTEs per bed or per discharge

#### Operational Performance Satisfaction / Reports of Care

- Patient-Reported Satisfaction
- Technical Quality of Care
- Communication/Information
- Caring/Compassion
- Wait Times
- Ease of Access
- Appearance of Facilities
- Parking/Food/Other Services
- Control of Pain or Other Symptoms
- Expected Results Achieved

#### Reports of Care

- Wait Times
- Problems in Communication
- Consistent Messages from Multiple Providers
- Coordination of Care
- Involvement of Family and Friends
- Respect for Values and Preferences

#### Community Benefit

- Uncompensated Care
- Care Provided in Public Programs (e.g., Medicaid)
- Numbers Served in Free Clinical Service Programs (e.g., blood pressure screening, immunizations)



The above collection of domains, and measures within domains is intended to be illustrative of a macro-level system performance measure set. It might constitute a reasonable set of performance measures for many systems. However, no such stock set of measures should be adopted directly; rather, measurement sets are better when they are *carefully tailored to important system goals, mission, or priorities, or intentionally integrated with performance measures at smaller units in the system.*

## Section 2: Methodology for performance evaluation

Accenture’s approach to evaluating the impact of healthcare interventions and initiatives is grounded in event history analytics and the use of a combination of generalized structural equation modeling (GSEM) and panel data, i.e., cross-sectional time series (*xt*-regression models), i.e., longitudinal data analyses. This approach, grounded in economic modeling, and survival analyses, uses analytic methods to leverage historical data and glean insights that are not otherwise possible with more traditional regression-based approaches. A summary of the pros and cons of event history analytics are outlined below:

*The pros and cons of the typical pre-post analyses done by NCQA and other quality organizations are outlined below. The intervention “event” is the dividing line between “pre” and “post”. Accenture’s approach is a compliment to the existing pre-post approach.*

Pros	Cons
<ul style="list-style-type: none"> <li>Shows that statistically significant change has occurred; “Something happened”.</li> <li>Indicates directionality of change.</li> <li>Analytically inexpensive and easy to implement from count data.</li> <li>Well-established industry norm.</li> </ul>	<ul style="list-style-type: none"> <li>Omits large amounts of valuable historical information prior to and after an “event”</li> <li>Assumes the “event” or intervention caused the outcome.</li> <li>Cannot show whether X caused Y or Y caused X.</li> <li>Cannot control for confounders, analytic “noise”, or unobservables.</li> <li>Cannot show the determinants of the results.</li> </ul>


Property or Characteristic	Regression	Time-series	Panel data
Subjects observed over time		X	X
Many (n>=30) subjects observed	X		X
Able to simultaneously study effects of time on other variables			X
Able to control for effects of time (as an interaction effect)			X
Able to determine causality, E.g., Did x cause y or did y cause x?			X

*Question 9: How much of the entities' payment should be subject to performance on quality and health outcome measures? Please explain your answer.*

**Question 9 Response: Felix Bradbury**

Accenture believes that to drive sustainable improvement in the healthcare system and to support a transition from fee-for-service to value-based care, most of payment over what is usual and customary for covering primary care providers' fixed costs, should be aligned to driving improvements in quality of care and quality of service. Accenture has many years of experience in servicing commercial, Medicare, and Medicaid payers as well as national health systems. Our experience

P4V Design	Description	Pros	Cons
Percentage of total contract value incentive pool	In this design the incentive pool reflects a predetermined, fixed percentage of the total value of all of the contracts. The performance against clearly defined metrics is measured and percentages of withhold dollars are paid out based on performance	Because 100% performance is rarely achieved, the full 100% value for the contract is rarely paid out and the payer saves money relative to their total contract payout	May be difficult to sell to the physician community as many expect the base payment, which physicians may have already discounted, to be paid out as per the contract. Under this design, contract amendments or renegotiations may be required. As such, there is no new money to incentivize performance and is very much a "stick" approach
Separate Bonus Pool	Under this design, a separate pool of "new" money is set aside to be used to reward top performers	Easier to sell to the provider community because it reflects new money and not withholds	The new money is new money and while money will be saved by reducing avoidable utilization and costs, these savings occur over a longer term horizon and are not realized until after the bonuses are paid out. As a result, this approach may be difficult for the CFO to reconcile.
Bonus Pool Tied to Measurable Reductions in Avoidable Utilization and Costs	This design attempts to address the deficits of the two previous designs by creating a clear-line between costs, utilization, and bonus payouts. Under this design, bonus money is paid out – typically on a quarterly basis – based on a percentage of the savings realized from the difference between expected costs and utilization and actual costs	Payout is aligned to measurable improvements in pre-defined outcome metrics, e.g., reductions in acute ER utilization for ambulatory care sensitive conditions, and reductions in unplanned rehospitalization.	This design is more difficult to implement because it requires a comparison of what happened (actual) to what may have happened (expected); it is difficult to sell what "might have happened"




indicates that the optimal mix of incentive to fee-for-service is roughly 15%-20% for incentives and 80%-85% FFS. Additional thoughts on this topic are delineated below.

Neither FFS nor capitation are a recipe for improving clinical outcomes or lowering healthcare costs trends. The fundamental problem is a misalignment and a mismatch between how clinicians are paid - based on volume - and the value that patients want. Transforming health care delivery in the United States and around the world requires paying differently. The current fee-for-service payment model results in high volume, high cost, and inadequate outcome. There is a fundamental mismatch in that providers are incented to produce more volume while patients want greater value.

Accenture has been at the forefront of helping health systems, providers, and payers make the transition from fee-for-service (FFS) to pay-for-value (P4V). Our staff have lead engagements involving national health system clients as well as national payer accounts with commercial, Medicare, and Medicaid lines of business.

Accenture has experience developing and implementing successful P4V solutions for some of the largest health systems in the US and Europe; during the course of these partnerships, we learned a great deal about what works and what doesn't. In summary, here's what we've learned are the key components for success under value-based contracting and P4P:

1. Recognize the keys to success are through partnering with the provider community and empowering physicians do what they do best: provide care. Some plans use P4P but are careful to treat their providers as partners and collaborators and not as vendors.
2. Create transparency of information around cost of care and quality of care – and the ability to be able to identify actionable variations in performance. See Figures 3-4 for examples of transparency of information around cost of care and quality of care.
3. Build effective, robust Care Management: Case Management, Concurrent Review, Prior Authorizations, and Disease Management – provide input into benefit design.
4. Develop high touch concierge member services that really supports the beneficiary and helps overcome barriers to care up to and including providing transportation to the PCP, lab, or pharmacy – transportation will always be cheaper than an ER visit and an acute inpatient admission.
5. Use predictive analytics to identify and stratify well-at-risk, chronically-ill and catastrophically ill patients and a bottom up approach to identifying and resolving barriers to care.
6. Elicit support for quality - Support for quality comes from the CEO: Quality is viewed as a core competency across the entire organization and not only the QI dept.
7. Implement data governance and provenance strategies that results in timely, accurate and complete data.


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8. Publish regular performance reports to every provider that gives them clear line of sight between their performance and their pay.
  9. Develop metrics specific to the program; the metrics used in the program were always EBM-based and relevant, measurable, actionable, and timely.
  10. Facilitate regular opportunities for physicians to discuss issues and for the organization to address programmatic improvements
  11. Implement executive information system dashboards to enable physician leaders to identify opportunities to reduce variations in performance and move the bar up in terms of quality and effectiveness

Accenture staff worked with the health systems to develop a value-based contracting frameworks that gave physicians a significant financial incentive to perform well. This framework is flexible, scalable and grounded in the following key components:

1. Strong ties with the provider community and a mutual willingness to share risks and rewards.
2. Evidenced-based metrics for the domains of wellness, preventive services, chronic disease management, and reduction in unplanned hospitalizations.
3. Transparency of information around the quality and cost of care.
4. An understanding that physicians are, by nature, competitive.
5. Regular performance feedback that provides clinicians with actionable information to close gaps and improve performance.
6. Significant financial rewards for moving the bar upward on quality of care and quality of service

Accenture notes that “incentive pools” are tools for helping align physician behavior to the payer’s desired clinical and financial outcomes. As such, incentive pools, come in three distinct variations which may be characterized as “carrot vs. stick vs. some combination of carrot and stick”. Below are the pros, cons, and key characteristics of each approach:

1. Percentage of total contract value incentive pool: In this design the incentive pool reflects a predetermined, fixed percentage of the total value of all of the contracts. The performance against clearly defined metrics is measured and percentages of withhold dollars are paid out based on performance. Performance reconciliation and payouts typically occur on a quarterly basis and a 90- day claims lag is assumed. Technically, this is a pay-for-value but not a performance bonus program because the participating physicians are only incentivized to get the pay they contracted for anyway.



Pros: Because 100% performance is rarely achieved, the full 100% value for the contract is rarely paid out and the payer saves money relative to their total contract payout.

Cons: May be difficult to sell to the physician community as many expect the base payment, which physicians may have already discounted, to be paid out as per the contract. Under this design, contract amendments or renegotiations may be required. As such, there is no new money to incentivize performance and is very much a “stick” approach.

2. **Separate Bonus Pool:** Under this design, a separate pool of “new” money is set aside to be used to reward top performers. Typically, the new money is paid out on a quarterly basis.

Pros: Easier to implement; easier to sell to the provider community because it reflects new money and not withholds.

Cons: The new money is new money and while money will be saved by reducing avoidable utilization and costs, these savings occur over a longer-term horizon and are not realized until after the bonuses are paid out. As a result, this approach may be difficult for the CFO to reconcile.

3. **Bonus Pool Tied to Measurable Reductions in Avoidable Utilization and Costs:** This design attempts to address the deficits of the two previous designs by creating a clear-line between costs, utilization, and bonus payouts. Under this design, bonus money is paid out – typically on a quarterly basis – based on a percentage of the savings realized from the difference between expected costs and utilization and actual costs and utilization.

Pros: Payout is aligned to measurable improvements in pre-defined outcome metrics, e.g., reductions in acute ER utilization for ambulatory care sensitive conditions, and reductions in unplanned rehospitalization.

Cons: This design is more difficult to implement because it requires a comparison of what happened (actual) to what may have happened (expected); it is difficult to sell what “might have happened”.

The above designs can easily incorporate administrative measures as well as clinical measures. Administrative measures are classified as “quality of service” and clinical measures are classified as “quality of care”. Both quality of care, and quality of service measures may be further subdivided into Structure, Process, or Outcome measures. As examples. Structural measures ask if policies and procedures are in place. Process measures include services such as giving a flu shot or breast cancer screenings. Outcome measures focus on the end-state results; examples include, reductions in Acute inpatient admits/1,000 or reduction in length of stay for COPD, asthma, or orthopedic surgeries. Much of the history of NCQA and HEDIS are based on structure and process measures and only recently, have started to grow the drive for outcomes. Accenture recommends focusing on the specific outcome measures important to Minnesota.

*Question 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?*

**Question 10 Response: Felix Bradbury**

Accenture believes that both the Merit-based Incentive Payment System (MIPS) and the Minnesota Statewide Quality Reporting and Measurement System are importance quality frameworks to align to. Our rationale is based on many years of experience with helping organizations over from FFS to P4V as well as build systems that deliver value while creating a line-of-sight between the desired outcomes and financial remuneration. Our rationale is grounded in the following:

- Both MIPS and the Minnesota Statewide Quality Reporting and Measurement System are grounded in the well-established structure-process-outcome model of continuous quality improvement. As such, they are easily defensible and represent common knowledge in the provider community.
- The measures used in MIPS and the Minnesota Statewide Quality Reporting and Measurement System are derived from roughly 93 different organizations including for example, the Agency for Healthcare Research and Quality (AHRQ), the National Council for Quality Assurance (NCQA), the American Diabetes Association, et al. These measures are well-established and standardized.



*Question 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. 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?*

### **Question 11 Response: Felix Bradbury & Gerry Meklaus**

Accenture recognizes that it has become increasingly important to address barriers to accessing healthcare, particularly for underserved populations, as uninsured populations are rising and health care reform regulations are pressing organizations to address these issues through programs such as, accountable care organizations (ACOs). The proposed payment policy appears to contain both the flexibility and financial incentive to meet the goals of improved clinical outcomes, reduced per capita healthcare costs, improved patient and physician experience with the healthcare delivery system. Several caveats apply; these caveats should be part of the program policy and procedure documentation:

- The shared saving and PMPM payment adjustments for performance, should reflect outcomes and metrics that are actionable by providers, i.e., the proposed performance model needs to align directly to factors within the clinicians' control and not hold providers accountable for determinants such as medication non-compliance, that are outside of their control
- There needs to be clear acknowledgment that operational effectiveness of the model is predicated upon the following:
  - a. Identify the right people at the right time in their disease progression – at a time when they are ready to change – to proactively avoid acute events
  - b. Reduce avoidable utilization of ER and acute inpatient care. This is accomplished through by identifying and removing barriers to access to primary care preventive services
  - c. Avoid duplication of diagnostic effort
  - d. Use of analytics to identify over- and underutilization and reduce practice variation through the use of evidence based medicine.
- For programs that improve medication and treatment compliance and/or access to primary care, one should expect the health care costs to go up. What should go down are the numbers of ER visits, acute admissions, readmissions and their concomitant costs.
- Costs cannot decline faster or more significantly than event avoidance and quality-related measures improve.

- One cannot use a non-chronically ill population as a control group for costs and utilization of a chronically-ill population; they are two separate and distinct populations. The control group and the case group should be similar homogeneous groups. In addition, using a non-disease group as a control will tend to overstate cost savings because some people with chronic illnesses do not generate claims and get lumped into the control group. When their condition exacerbates, their costs will increase and exaggerate cost trends.
- Costs can never decline by more than 100%.
- ROI is not the right metric for tracking event reduction savings: If one spends \$1.00 and then gets \$10, it's a net gain of \$9 but a 10:1 ROI; if a person spends \$25 dollars and gets \$100, they gain \$75 but have an ROI of only 4:1.

While significant reductions in avoidable utilization - and the concomitant costs associated with that utilization - have been demonstrated, there are several additional benefits that are realized such as improved stakeholder satisfaction and increased community involvement.

*Question 12: Do you have any other comments, reactions or suggestions to the Next Generation IHP Model or proposed managed care contract modifications?*

### **Question 12 Response: Erik Pupo**

Traditionally, the healthcare industry has lagged behind other industries in data convergence. Part of the problem stems from resistance to change—providers are accustomed to making treatment decisions independently, using their own clinical judgment, rather than relying on aggregated data from a wide range of sources. Other obstacles are more structural in nature and are observed by


Accenture at its payer and provider clients almost every day. Many healthcare stakeholders have underinvested in information technology because of uncertain returns—although their older systems are functional, they have a limited ability to standardize and consolidate data. The nature of the healthcare industry itself also creates challenges: while there are many players, there is no way to easily share data among different providers or facilities, partly because of privacy concerns.

A goal of modern value-based healthcare models is to provide optimal health care driven by meaningful data convergence in order to:

- Improve healthcare quality and coordination, so that outcomes are consistent
- Reduce healthcare costs; reduce avoidable overuse
- Provide support for reformed payment structures

The need for a comprehensive data platform in accountable care environments is becoming more critical as high utilization and lack of comprehensive data integration threaten to overwhelm providers and payers in their shift to value-based models. The accountable care model (referred to in this paper as a value-based model) is an opportunity for practices, hospitals, and payers to take advantage of





today's advances in technology and data to help their patients navigate the whole health care system without needing to vertically integrate multiple technology investments

But these value-based models continue to struggle in an environment of disparate data, technologies, and metrics. Accenture increasingly sees the market moving in the direction of what we call a “data convergence platform”. Many of the key components of this data convergence platform are enabled by what Accenture calls the “Architecture of the New” – emerging technology capabilities such as Artificial Intelligence (AI), the cloud, predictive and retrospective analytics, all coordinated and combined in a flexible approach.

### **Section 1: What is driving Data Convergence?**

The shift to fee-for-value is directly changing how payers measure and pay for care, and has led to the creation of increasing variations of alternative payment models and value-based programs of varying complexity and with differing requirements. For providers to adjust their technology and data to align to all these potential models and programs is a daunting task, so many newer approaches rely on what is called “provider-payer convergence models” to align to these value-based health market incentives. Provider-payer convergence requires collaboration among payers and providers across contracting, risk management, population and care management, direct services, and consumer engagement.

As providers and payers converge, they need to collaborate efficiently and accurately, particularly as they align on reimbursement strategies and population health management (PHM) programs. **Many organizations lack the technical platform, infrastructure, and know-how to integrate data from different sources, such as EMRs, claims data, and HIEs.** Many programs also lack the infrastructure to consult multiple data sources during the provision of health care or social services leading to poor coordination. Without this data convergence, the structural and business collaboration they have established will not come to fruition.


### **Section 2: Why Data Convergence as a Platform?**

By thinking of data as a network, organizations can envision how to most effectively treat a patient across the entire care continuum. As data is made available about a patient beyond their interactions with inpatient and outpatient facilities, such as with social services, behavioral health specialists, or fitness classes, this data enriches the opportunities that states and payers have to coordinate care. Organizations are using data to reveal where opportunities exist and then bringing discipline and focus around these opportunities to execute.

Below, we discuss the advantages of data convergence and data sharing driven by a singular platform approach:

### **Section 3: Analytics as a Network**

The concept of Analytics as a Network relies on the assumption that data is constantly being analyzed and used as it is being shared. Providers can use both descriptive and retroactive reporting for care managers and creating predictive models and a “heat map” that predicts the risk of a patient being readmitted have an advantage in newer value-based approaches.



This type of opportunity analysis is focused on finding the right mix of measures, such as using hospital utilization measures (e.g., emergency department use, preventable hospital admissions and readmissions, excess hospital stays) to assess program performance. Data convergence also involves smaller organizations using other measures, such as prescription drug use and high-cost imaging, as well as organizations incorporating patient outcomes and population-level indicators.

A successful data convergence platform can help clinicians better understand length-of-stay and expected length-of-stay in the post-acute space, while also helping to support decisions about who should be in the network by looking at quality and other metrics. Using analytics can allow an organization to look at who is leaving an accountable care network and how the network can best support patients in that post-acute area. Organizations can also create clinic “no-show” models that helps providers see the risk of a potential no-show to an appointment so that they better understand the individuals they are working with and what issues they are facing as patients who might need to be better supported.

### *Takeaways*

- A key piece of any overall solution is that it needs to work across the care continuum. Care managers want a data convergence platform that integrates into their workflow, and want to use it in ambulatory settings as well, and also in post-acute settings. This usage needs to lead to reductions in avoidable readmissions and costs.

## **Section 4: Cloud-driven workflow**

Value-based approaches that leverage a cloud model are increasingly being seen as the most efficient way to drive super alternative payment model performance. The concept of an enterprise health cloud is gaining traction as a way to aggregate, mashup, and analyze data, and to provide actionable alerts and clinical decision support (CDS). These newer cloud platforms enable smarter workflow to improve the coordination of patient care and the efficiency of member practices. Automated worklists help ACO members track and coordinate outreach to patients for annual wellness visits, emergency department follow-ups, and transitional care-management appointments.

Cloud-based solutions also are providing greater integration to provider management solutions that connect to your patient schedule to provide real-time information on upcoming patient visits. For patients with chronic conditions, care management “clouds” allows members to create customized intervention plans and collaborate across a practice care team to close gaps in care.

### *Takeaways*

- Cloud-driven models for value-based approaches should be considered higher-priority by states to further enhance data liquidity and sharing across multiple organizations associated with a patient’s health.

## Section 5: Data Liquidity

The premise of data liquidity on a data convergence platform is to enable members to easily refer people discharged from an emergency room to shelters, behavioral health facilities, and other social services, and to let staff at those places see what their clients were doing: whether they were filling their prescriptions, or getting healthy food, or had a place to sleep, or money for the bus. By focusing on liquidity of data across all potential touch points for care, members can meet the needs of those outside the medical system rather than to pay for the consequences inside it.

One example of where data liquidity becomes important is the concept of the “frequent flier” in healthcare. The ability to proactively notify providers as events occur outside the scope of an inpatient or outpatient visit is driving adoption of data convergence platforms. These types of platforms allow for inter-organizational notification and data sharing. The State of New York is using an approach called the Strategic Health Information Exchange Collaborative (SHIEC) that adopts this approach, and relies on existing HIEs to drive it under a model they call the Patient Centered Data Home (PCDH)

### *Takeaways*

- States should explore and encourage models that move away from closed systems of data to more open systems.
- Incentives and metrics should be aligned to these goals to allow for greater expansion of data liquidity across all entities involved in value-based programs
- Grant programs should reward vendors and initiatives that focus on the movement and sharing of data as a key component in their proposals.


## Section 6: Flexibility and Modularity

Providers and payers are specifically looking for the ability to establish customizable, specific, and unique access and/or views to drive one of the main success criteria of value-based care and population health – collaboration. With a flexible data access architecture, providers and payers can customize and revise decisions about what to share, with whom and when. The ability to reuse existing networks to share data is a reason why more providers and payers are looking at technologies such as blockchain.

Modularity expands on this concept by giving vendors who cannot make large investments in a single platform the ability to match components from best-of-breed vendors. The aim, again, is (or ought to be) to create an ecosystem—one strong enough, and independent enough, to write its own rules. And if those rules ultimately benefit patients, providing more value at less cost, then the system will thrive.

### *Takeaways*

- States should evaluate the flexibility and modularity of technology investments made by initiatives and programs to ensure that data liquidity, open architectures, and flexibility in implementation are being



considered. Make sure the platform approach being adopted is open and allows for an ecosystem of technology and cultural change to flourish.

## **Section 7: Governance and Data Management**

There is no one stakeholder that will hold the silver bullet for scaling new models of value-based care - this will have to be a collaborative effort. From start-ups to regional provider systems to non-health industry players there is a potential role to be played in order to provide different facets of care and support. A strong governance model can help health systems focus priorities and efforts on driving value from analytics-enabled insights.

### *Takeaways*

- Engage and develop committed leaders across the enterprise who are committed to understanding and leveraging analytics to deliver superior results.
- Implement a structured data governance model and enterprise-wide analytics strategy.
- Manage analytics capabilities and investments to drive innovation and tangible value for functional business units and programs.
- Emphasize data and technology standards to promote interoperability and more efficient use of analytics resources.
- Recognize the cultural aspects of leveraging analytics to accelerate insight-driven results

## **Section 8: Self-Aggregation – Consumer at the Center**

A key driver for accountable care consideration is the role of the patient in these initiatives. Patients are taking their care into their own hands in a self-service mantra. Accenture believes in the concept of the Patient Centered Data Home (PCDH) as championed by SHIEC. This concept relies on patient's data being self-aggregating over time no matter where a healthcare event occurs.

The question is whether healthcare can be wrenched free from its rigid, decades-old payment and provider constructs and be re-formed into new self-contained, efficiently run ecosystems that put the consumer at the center. Accenture believes the answer is yes—and that we'll start seeing business models (both for-profit and not-for-profit) emerge and evolve around this idea. These business models specifically will exist to provide data aggregation and sharing at the center of the model. The technological foundation for accomplishing data aggregation (stored in one place, stored in the cloud, etc...) often trips up the PCDH approach. Accenture believes that states should encourage new innovations and technologies that don't specifically prescribe the technology but get the job done.

### *Takeaways*

- In the health ecosystems to come, a substantial number of new access points are likely to lead to care that bypasses traditional medical centers altogether. At the same time, better homecare options—largely made possible by digital health innovations, telemedicine, and new payment structures—will keep many patients out of the hospital to begin with. States should consider this shift in how they approach value-based model development and evaluation.

## Section 9: Serving the Underserved

An increasing focus within value-based models has been population health and how to measure large data sets to determine population-specific outcomes. Underserved and unserved populations represent a performance factor in value-based models that is often not measured or considered. Health data has traditionally proliferated from health encounters at inpatient facilities, doctor offices, clinical labs, and retail pharmacies. Each of these touch points may not encounter underserved populations who lack access to these facilities.

### *Takeaways*

- States should incentivize initiatives and programs that are targeting underserved populations through additional technology investment. This type of spending, which it may not exhibit an initial ROI comparable to other investments, can pay off with strong improvements in measurements associated with social determinants of health (SDOH).

## Section 10: Socially Determined

The increased importance of social determinants of health (or SDOH) for value-based programs cannot be understated. Social determinants of data could support evaluations of populations to better understand depression rates correlated to SDOH like financial stability or community context. Social determinants can also be correlated to events such as frequent ER use or no-show rates. With this knowledge, addressing SDOH that drive these events could help providers design strategies to reduce no-show rates and unnecessary ER use.

When augmenting their risk and care management programs with socioeconomic data, organizations have to ensure that SDOH have been clinically validated against actual healthcare outcomes. This is vital for the success of predictive analytics because not all determinants correlate strongly to health outcomes. Organizations should use the most up-to-date, complete and longitudinal data that has been proven to be consistently linked to specific patient populations. For example, Accenture Insights Platform works with partners to derive attributes from public records data such as education, income, proximity to relatives, bankruptcy, addresses and criminal convictions.

### *Takeaways*

- States should evaluate inclusion of both attributes and scores to measure SDOH performance in all value-based programs. They can incorporate SDOH attributes, such as education or income, into existing predictive models and care management based on medical data to better assess and predict risk for individuals. Moreover, SDOH provide critical insights in the absence of medical data. Another way of utilizing SDOH is through predictive health scores that score a patient's health risk. Scores are based on hundreds of relevant socioeconomic attributes to paint a full picture of the individual's future risk.



## **Conclusions**

As providers and payers align on value-based models, they need to collaborate efficiently and accurately, particularly as they align on reimbursement strategies and population health management (PHM) programs. This is where data convergence comes in - the ability to establish customizable, specific, and unique access and/or views of health data is critical to collaboration that drives new value-based models. With a flexible data convergence platform, providers and payers can customize and revise decisions about what to share, with whom and when.

# CONTRIBUTORS

## Felix Bradbury

Dr. Felix Bradbury, FACHE is a Principal Director of data science with Accenture in global Health Analytics; he is based in Houston, Texas. Dr. Bradbury has had a diverse career in health and analytics that spans 35 years. He established a Medical Management Reporting Department for a national commercial payer, led medical economics division for a Medicaid and Medicare Advantage payer and served as VP of Analytics, Risk Management, and Reporting for a national disease management company. He has served on product advisory boards for McKesson Payer Solutions, IHCIS, and Symmetry and successfully implemented predictive models and P4P programs for commercial and Medicare payers. He has published research in the areas of predictive modeling, program monitoring and evaluation for care management initiatives, human reliability techniques, and operations research such as the use of discrete event simulation in medical management operations.

Dr. Bradbury is an oncology RN by training and holds a Masters in Health Administration with an emphasis in biostatistics and a Doctor of Science, *cum laude*, in Health Systems Management and Cost-Effectiveness Research from Tulane University Medical Center, School of Public Health and Tropical Medicine in New Orleans where he completed an administrative residency through the Louisiana Center for Health Statistics and a doctoral fellowship in medical informatics through the Ochsner Health Plan and Clinic in New Orleans.


Dr. Bradbury is board certified in executive healthcare management as well as a Fellow and board member of the American College of Health Care Executives and the American Nurses Association; he currently serves on the editorial review board for the *Journal of Healthcare Management* and hosts a blog on healthcare analytics for Accenture. His most recent projects include the development of an analytics strategy for NC Medicaid and a pay-for-value framework for the US Department of Defense.

## Gerry Meklaus

Gerry Meklaus has nearly 20 years of experience consulting to over 100 health systems, payers and healthcare companies. His experience includes both strategic and operational consulting. His clients include academic medical centers, community hospitals and large integrated delivery networks. He brings hands-on experience in all aspects of Physician Enterprise, Risk Based Entity operations and Managed Care contracting. He is a frequent speaker and author on Physician-Hospital affiliation approaches and the transition to Value Based Care.

Prior to consulting, Gerry was a COO for a large multispecialty practice, Executive Director of an large IPA, Vice President for Revenue Management & Contracting for a national provider of rehabilitation services, and a Senior Product Manager for a global medical equipment manufacturer. Gerry is also a Registered Respiratory Therapist who once led Respiratory Care clinical services at





Massachusetts General Hospital while researching and publishing on topics in critical care and mechanical ventilation.

Gerry holds a B.A in Philosophy from Binghamton University, B.S. in Cardiorespiratory Sciences from Stony Brook University and a Master of Health Services Administration from the University of Michigan.

### AnnMarie Merta

AnnMarie is a Principal Director in Accenture's Value Based Care Practice. She has over 20 years of experience leading health systems, ambulatory care networks and physician practice organizations in strategy and operations. AnnMarie's experience spans into the payer realm providing a unique skill to lead organizations through integration of providers and payers focused on achieving value based care. Her most recent work centered on the improvement of existing CINs and ACOs within large health systems to align the efforts of hospitals, CINs, ACOs and employed physician practices with provider sponsored health plans and other payer value based contracts in effort to build strong provider networks.

AnnMarie was National Vice President, Provider Integration and Performance for large non-profit Health System and Health Plan prior to joining Accenture. Her experience also includes Vice President of Product Management for a large provider system owned by a major Payer and multiple years of senior leadership roles in strategy and operations for national health systems both not-for-profit and for-profit.

AnnMarie holds a BS in Medical Technology from Saint Bonaventure University and a Masters of Business Administration from University of Louisville. She is as a Fellow of the American College of Health Care Executives.

### Erik Pupo

Erik Pupo is a Senior Executive in Accenture's Health & Public Service (H&PS) practice based out of the Miami office. Erik has more than 20 years of experience in healthcare, including vendor, industry and advisory roles. Prior to Accenture, Erik was a senior manager at Deloitte where he worked with federal and commercial healthcare clients and was a leader in the broad healthcare IT practice, serving payers, PBMs, providers, life sciences, government, and healthcare IT vendors.

Erik has worked to help clients create new operating strategies, supported the design and implementation of products and solutions, and is recognized as an industry thought leader in numerous fields pertaining to healthcare, including enterprise and data architecture, healthcare policy development and analysis, health information security, electronic health information exchange, and healthcare analytics

Erik currently serves as the lead for Accenture's Healthcare Technology Consulting practice in North





America, as well as Accenture's Healthcare Blockchain lead and a key advisor and leader within Accenture's Value Based Care practice.

Erik holds his MBA from Lynn University and Undergraduate Degrees in Finance and History from Florida Atlantic University.

### Rick Stewart

Rick Stewart is a managing director in Accenture's Health & Public Service practice, and is a leader in Accenture's Clinical & Health Management solution group. Since joining Accenture in 1993, Rick has worked with large for-profit and not-for-profit payers, providers, and government health organizations to improve the quality, effectiveness and efficiency with which health care is delivered in North America. Rick has architected many of Accenture's Health Management methods and points of view, has published multiple white papers, and co-holds a US Patent for a Payer High Performance Capability Assessment.

As a leader within Accenture's Clinical & Health Management solution group, Rick Stewart oversees Accenture's end-to-end portfolio of strategy, management consulting, information technology, analytics and business operations services that Accenture provides to its clients in support of improving their quality outcomes and Star Ratings, improving efficiency of clinical operations, and reducing wasted medical spend that comes from overuse, misuse and underuse of the medical delivery system.

Rick holds a B.S. in Industrial & Systems Engineering from The Ohio State University.

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