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February 6, 2013

Pamela Parker, Special Needs Purchasing Manager  
Minnesota Department of Human Services  
P.O. Box 0984  
St. Paul, Minnesota 55164-0984

RE: Request for Public Input on the identification of best practices for development of Integrated Care System Partnerships

Dear Ms. Parker,

Thank you for the opportunity to provide input to the development of best practices for the Integrated Care System Partnerships (the Partnerships) for dual eligible populations. Founded in 1957, the HealthPartners family of health care companies serves more than 1.4 million medical and dental health plan members nationwide. It includes a multispecialty group practice of more than 1,700 physicians; five hospitals; 50 primary care clinics; 21 urgent care locations; 21 dental clinics; and numerous specialty practices in Minnesota and Western Wisconsin. HealthPartners is the largest consumer-governed, nonprofit health care organization in the nation providing care, coverage, research and education to improve the health of members, patients and the community. HealthPartners is the top-ranked commercial health plan in Minnesota and is also ranked among the top 30 plans in the nation according to NCQA's Health Insurance Plan Rankings 2012-13 - private. In addition, HealthPartners<sup>®</sup> Freedom Medicare plan received a five-star rating from the Centers for Medicare and Medicaid Services 2013 plan ratings. Minnesota Senior Health Options (MSHO), HealthPartners dual-eligibility plan for Medicare and Medicaid members, received an impressive 4.5 stars.

We believe it is critical to connect our acute care providers and community long term care providers more closely to improve coordination and safety for our frail elders. We also have a long history and experience with the critical role and value of the health plan in this work. HealthPartners is pleased to support the development of such integrated models to improve the overall care of the dual population. We believe that the Partnerships will enhance existing integration efforts. It is an important step for our community in providing Triple Aim level of care. Better coordination and partnership for frail patients will improve care and safety, improve patient and family satisfaction, and result in decreasing avoidable high cost care.

At HealthPartners, we are committed to providing services that support the Triple Aim. The Triple Aim calls for the simultaneous accomplishment of three critical objectives: improvement of the health of the population served; improvement in the experience of each individual; and improved affordability. It is helpful and important to keep the Triple Aim objectives at the forefront as the Partnerships develop.

We appreciate the significant work and resources the Department of Human Services, health plans, providers, community partners, and other stakeholders are investing in this next step of transforming care and payment in serving dual eligibles.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas von Sternberg". The signature is fluid and cursive, with a long horizontal stroke at the end.

Thomas von Sternberg, MD  
Associate Medical Director

(REDACTED)

**Sent:** Friday, February 22, 2013 7:18 PM

**To:** \*DHS\_Dual Demo

**Subject:** input regard symposium

Hello, I participated in the Best Practices Policy Symposium on Monday January 28, 2013.

I am happy to see that there is recognition for the need for change in providing health care to our most vulnerable citizens. I participated because of my experience serving those with persistent mental illness as an occupational therapist. As an occupational therapist I teach people skills for daily living and provide avenues to be as independent as possible. One of the points made at the symposium was to focus on teaching skills and “patient activation”. Occupational therapy at its core teaches skills for those who struggle with injury, pain, loss of function and mental illness, just to name a few. Occupational therapists are person centered and indeed help each person find within themselves the abilities to overcome and cope with whatever issue is at hand (activation). I am hopeful that more leaders that seek to improve health care policy will see the cost savings when individuals are taught by skilled professionals like occupational therapists to be more independent vs. recurring inpatient care through our hospital system. The concept of “Community First Services” can only succeed when the individual has the tools and knowledge to begin to reintegrate into the community. PCA services can serve a support role, however, the teaching, motivating and assessment of needs should come from a skilled professional who can look at the person, the illness and the environment in order to provide the tools necessary for lasting improvements in independence. At present I serve in an outpatient setting which has been instrumental time and time again with individuals who need to learn how to manage their symptoms, their medications and life in general in order to stay out of hospitals and emergency rooms. As health care becomes more expensive, please be aware that there are low cost alternatives that provide avenues for independence, improve quality of life and emphasize care coordination that is so critical with those who suffer from mental illness.

Thank you for your efforts and the opportunity to give input in this very important issue.

Melissa Adamski, OTR/L

Professional Rehabilitation Consultants

Ph. 651-603-8774 x16

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Blue Cross and Blue Shield of Minnesota  
and Blue Plus  
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St. Paul, MN 55164-0560  
651 662-8000  
800 382-2000



February 21, 2013

Dual Demonstration  
Minnesota Department of Human Services  
Health Care Administration  
[Dual.demo@state.mn.us](mailto:Dual.demo@state.mn.us)

Dear Minnesota Department of Human Services

Re: Request for Public Input on the Identification of Best Practices for Development of Integrated Care System Partnerships (ICSPs) Between MCOs and Providers to Improve Care Delivery for People with Dual Eligibility for Medicare and Medicaid.

Serving the health care needs of all seniors is important to the mission of Blue Plus. Blue Plus has been serving seniors across the state in the Minnesota Senior Health Options (MSHO) program since 2005, collaborating with health care providers, care coordinators and counties to create a health care delivery system that meets the needs of MSHO members in our SecureBlue program. One of Blue Plus' most distinguishing features is the reputable and responsive relationships that we have fostered with counties, providers and private organizations in the development and delivery of care coordination services throughout Minnesota. Our guiding principle has been to assist members "aging in place" in their preferred setting, working with programs such as the Elderly Waiver, Case and Disease Management, Money Follows the Person and the engagement of families, caregivers and others significant to the member's holistic care. The success of the SecureBlue model depends on health care providers and care coordinators working collaboratively to provide integrated services for all members. We recognize and value the unique capabilities of all stakeholders within the health care system.

We have welcomed the opportunity over the past year to work with the Minnesota Department of Human Services to evaluate new opportunities in serving our MSHO members with a rejuvenated focus on the member experience, quality outcomes and savings in health care costs.

**Best Practice Opportunities to Increase Value**

An important consideration for success of the ICSP will be the impact of the size of the population to be served in each model. We believe there to be some risk to success if the population size is too small in a risk/gain model. If the population size is too small, there is a limited ability to show reasonable gains in identified quality measures. Both provider and health plan will need to expend a certain amount of resources to build and deliver quality measures as well as risk/gain models. Too few members in a proposed

model may be a barrier to implementation.  
[bluecrossmn.com](http://bluecrossmn.com)

**Specific model of care designs, strategies or elements should be incorporated into ICSPs to address specific needs.**

Blue Plus looks forward to learning from home and community based and/or residential long term care providers about what strategies should be incorporated into these new ICSP relationships.

**Communication Strategies Across Provider and Service Types and Settings**

Blue Plus supports members' right to control the privacy of their health care information. We recognize the challenges associated with sharing medical information across health care settings to support health care decision making for the member and the provider. Short of real time access to electronic records, agreed upon communication protocols will need to be developed that include prompt notification to all parties when a member transitions to the hospital or nursing facility, and ensures follow up visits are scheduled and followed through post-hospitalization. Similar communication needs to occur for preventive and specialty care visits.

**Payment Models**

**Below are the questions from the RFPI along with the associated answers in the payment model section.**

Are there specific payment models that should be considered for greater alignment of public and private payment systems, or for better alignment between Medicare and Medicaid? Risk or gain-share models, coupled with certain process and quality measures, seem to be the best models that provide the proper incentives for providers to accept accountability for a population or member. This multifaceted approach with cost, quality and process (ensuring certain actions are done as part of care coordination) create the right balance of managing the cost of care, ensuring proper protocols are adhered to, and achieves optimal health outcomes.

Are there proposed payment models proposed that should be avoided? What levels of risk and gain sharing are providers interested in considering? Risk share models that require high levels of "stop-loss" coverage can make that model cost prohibitive to manage these populations. Additionally, traditional fee-for-service that pays per unit may not achieve as positive of an outcome for the involved parties.

How does the size of the population to be serviced impact the ability to tie performance to payment? Are there some payment models that would work best for small numbers of enrollees or specific care model approaches? The greater the size of the population, the greater the ability the provider has to take on full risk. For smaller populations, a gain-

share or a risk-share with certain corridors or individual stop-loss (at a low cost or at no charge) may be required to fully protect the providers. The minimum size of the population may vary based on the provider's experience and population mix.

Other? Depending upon the level of risk sharing, any payment model that has provider risk must be evaluated for compliance with applicable physician incentive plan requirements referenced at Section 17.2 of the Seniors Contract as defined in 42 CFR §422.208. This rule applies when providers are at risk for services they do not directly furnish. In general, if providers have 25% or more of payments at risk, there must be reinsurance protection. This protection can be either aggregate or per-patient stop loss. The ability to have more than 25% risk share is restricted by the stop-loss/reinsurance requirement since the stop loss thresholds were established many years ago and are quite low, producing a high cost of reinsuring.

### **Performance Measures**

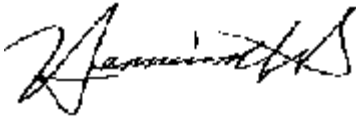
Blue Plus has reviewed and supports the list of quality measures included in Attachment 5 of the RFPI. Blue Plus appreciates the flexibility of choosing from this list those measures that are best suited for the providers we will work with in this demonstration. The proposed measures include sufficient breadth to allow the plan to create an effective partnership with either primary care and/or long term care providers. The administrative burden, however, for the provider and the plan in collecting and reporting data will likely affect which measures are selected and therefore may dictate what improvements the partnership will be contracting for. To reduce the burden of data collection, administrative data or medical record data collected for other contracted incentive plans or other needs, measures that a provider is already submitting for a contracted incentive plan or to Minnesota Community Measurement would more likely to be selected as would administrative data that is easily available to the plan. Healthcare Effectiveness Data and Information Set (HEDIS) data obtained by chart review (done with a sample of records) such as the Care of Older Adults (COA) measures are not provider/member specific enough so these measures would require a different reporting process. That may also be true for some of the SNP Structure and Process measures. Would the cost be a deterrent to selecting these kinds of measurements and are there options for additional funding if the data collection and reporting process requires it?

We would appreciate DHS' analysis or review of how population size impacts the credibility of any given quality measure. There may be some risk in this ICSP demonstration that the population size could be too small for effective evaluation.

Blue Plus appreciates the opportunity to share our thoughts about the Integrated Care System Partnership RFPI and is committed to working with all health care stakeholders to find ways of reducing costs and increasing quality for all Minnesotans. If you have any questions or would like to discuss any of the information included in this letter, please call Frank Fernandez directly at 651-662-9642 or Stacia Cohen at 651-662-1970.

Thank you in advance for your consideration.

Sincerely,



Frank Fernandez  
President and CEO, Blue Plus  
[Frank\\_Fernandez@bluecrossmn.com](mailto:Frank_Fernandez@bluecrossmn.com)



Stacia Cohen  
Director, Program Management  
[Stacia\\_A\\_Cohen@bluecrossmn.com](mailto:Stacia_A_Cohen@bluecrossmn.com)

REDACTED

**Sent:** Friday, February 22, 2013 3:47 PM

**To:** \*DHS\_Dual Demo

**Subject:** CareChoice Comments on ICSP

We are pleased to submit this letter of support and comments regarding DHS's Integrated Care System Partnership (ICSP) changes.

CareChoice, a Cooperative of 22 not for profit senior organizations comprises 38 nursing home facilities and 75 senior communities, consisting of over 10,000 units. The ICSP provides a range of options to work more closely with physician/NP care systems and health plans in improving care and sharing financial risk/reward across various population groups and living arrangements. In the past we have had a number of examples of working with pay for performance/shared savings programs with health plans and select care systems. Broadening the options enables providers, such as nursing homes and senior living communities, greater opportunities to participate in these integrated care systems with the goal of improving care to our residents. These type of plans work well with large systems as well as for care systems/facilities with smaller number of enrollees.

We would like express some areas of concern as the program is being developed, specifically that the number of quality indicators to qualify for pay for performance be manageable and tied to key performance outcomes; that consideration be given to varying the performance weights for ICSP measures based on importance and that there be sufficient financial reward for providers to participate in this type of performance plan. We would suggest no more than four performance outcome measures and that these measures be maintained for more than one year in order to demonstrate success and improvements in care.

Data reporting tools, using the web or other technology platforms, need to be efficient to administer and data needs to be available to the participating partners to assist in managing care in a timely fashion. We have successfully used the secure-web portal to collect data across a large number of facilities as part of the DHS Pay for Performance Program over the past two years.

We encourage that shared savings/risk options type of plans continue to be based on management of total cost of care for the selected group, with tracking on key variables and DHS gives flexibility to partners in determining the financial parameters with the goal of providing quality care for these type of plans. Nursing homes with enrollment over 150 nursing home residents within an ICSP system could share savings /risk within a 20-30% range.

Thank for your opportunity to provide public input on these program changes.

Nellie Johnson, CEO  
CareChoice Cooperative  
1821 University Avenue West, Suite S256  
St. Paul, MN

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February 21, 2013

Department of Human Services  
Dual Demo Request for Public Input  
Mental and Chemical Health Division

To Whom It May Concern,

We are writing as representatives of the Minnesota Society of Clinical Social Work in response to the request for input from the public regarding the strategies to redesign and improve services and improve the coordination and integration of individuals who are dually eligible with Medicaid and Medicare (SNBC and MSHO enrollees).

Effective quality clinical practice with seniors (MSHO) and adults with disabilities (SNBC) who are in need of mental health services are based on the following evidence based practice principles: services need to be culturally sensitive, comprehensive, accessible, flexible, coordinated, multidisciplinary, and continuous in outcome of improvement in wellbeing and quality of life. Successful programs feature accurate clinical assessments, interdisciplinary treatment, education, and collaboration with other agencies including primary care. We agree with these goals.

Clearly controlling costs along with coordination of care is long overdue and in everyone's best interest in providing effective quality treatment. We propose that the risk/benefit question be asked of the health care management companies—rather than individual providers or provider groups—as this is their specialty. The recent law limiting HMO's profit only 1% from state funded enrollees will also help achieve the goal of controlling costs.

Payments negotiated with the insurance companies and not provider groups would also prevent the CCDS system, which severely affected the wellbeing of this population for primary care in the past, and proved to be highly inadequate in meeting the need. The HMO's, many of which already have both the roles successful experience in utilizing already in place, could direct the care navigation portion for clientele as well.

Viewing documents or sending messages through for interdisciplinary communication would allow for many providers in different locations to efficiently collaborate care. We suggest that providers have the capacity to digitally fax notes and updates regarding enrollees to an encrypted site, maintained by DHS. The site would only allow providers to view documents and send messages to other providers and would not be used for completing documentation. This process would eliminate the complications arising from differences between individual providers' or clinics' EHR systems or between the

particular insurance companies covering the enrollees.

The strategies suggested by DHS, although not yet completely defined, have raised concerns related to payment for the skilled service as well as to accessibility. Several reports have indicated a current and predicted increasing gap between the need for services for elderly clients with mental illness and the pool of eligible providers. Contracting only with larger organizations that have the potential to integrate primary and mental health care within the same clinic would limit the number providers for a population that is already underserved and would likely disrupt care for those who are cared for by providers who are not in the “contracted” partnerships.

Finally, we strongly believe that incentives and payment based upon length or duration of treatment for populations that are at risk (seniors being the highest rate and risk for suicide) is not consistent with the quality of care for which Minnesota is known. Such methods will lead to a lack of appropriate care for clients, especially those with the highest needs. In addition it is not fair to providers. Even the most skilled providers have influence on, not control over, treatment outcomes.

Thank you for giving us the opportunity to share our thoughts with you on this very important issue.

Sincerely,

Harriet Kohen, MSW, LICSW President, MSCSW

763.546.5797 x108

harrietskohen@q.com

Beverly Caruso MSW, LICSW, Past President, MSCSW

Tamara L. Kaiser, PhD., LICSW, LMFT, Past President, MSCSW

February 18, 2013

Sarah Anderson  
Psych Recovery, Inc.  
2550 University Ave W Suite 229N  
Minneapolis MN 55114  
651-645-3115  
saraheanderson@mac.com

Department of Human Services  
Duel Demo Request for Public Input  
Mental and Chemical Health Division

To whom it may concern,

I am writing this letter in response to the request for input from the public regarding the strategies to redesign and improve services and improve the coordination and integration of individuals who are dually eligible with Medicaid and Medicare (SNBC and MSHO enrollees).

I have read the information as well as attended the public information session on the topic on January 28th and wish to pass along the following suggestions and statement below as I understand DHS is in the decision making stage for the changes scheduled to occur on July 1, 2013.

Effective quality clinical practice with seniors (MSHO) and adults with disabilities (SNBC) who are in need of mental health services are based on the following evidence based practice principles: services need to be culturally sensitive, comprehensive, accessible, flexible, coordinated, multidisciplinary, and continuous in outcome of improvement in wellbeing and quality of life. Successful programs feature accurate clinical assessments, interdisciplinary treatment, education, and collaboration with other agencies including primary care.

Clearly controlling costs along with coordination of care is long overdue and in everyone's best interest in providing effective quality treatment. I propose that the risk/benefit question be asked of the health care management companies, this is their specialty as well as their experience. The additional benefit to the state of the law passed recently allowing HMO's to profit only 1% from state funded enrollees further indicates an acceptable option.

Payments negotiated with the insurance companies and not provider groups would also prevent the CCDS system, which severely affected the wellbeing of this population for primary care in the past, as well as proved to be inadequate in meeting the need. The HMO's, many of which already have both the roles successful experience in utilizing already in place, would direct the care navigation portion for clientele as well.

The interactive interface of communication could be a simple encrypted site that providers (who have a EMR) could simply digitally fax notes and updates into per patient/consumer chart number could be printed on the back of the enrollees medical card, as well as providers having individual access/login capabilities as well. It would be for viewing documents and sending messages to other providers only, not completing documentation. Therefore which EHR system the clinic/provider uses will not be an additional complicating factor.

Viewing documents or sending messages through for interdisciplinary communication would allow for many providers in different locations to simply collaborate care. This simplified interface could be maintained by DHS for all enrollees as well, therefore decreasing the complications and disruptions in communication/collaborative care if insurance changes or a small lapse in coverage etc. occurs. If each insurance company had their own interactive interface, it would be cumbersome for education as well as compliance with providers, as well as likely limiting the benefits of the collaboration in which it's intended for.

The strategies, although not yet completely defined, has raised concerns related to payment for the skilled service as well as accessibility. The possible options have included specialty contracts with some systems, and contracts offered to some in 2013 to be extended possibility to other providers the following year. I ask that you consider the following:

- The Kaiser Family Foundation offers national and statewide statistics, which includes MN being underserved already on the area of mental health providers. Specifically, 26.7% of MN state population is estimated to be underserved in the area of mental health, in fact MN is reported by Kaiser to be more underserved than the national average (which is 21.1%).
- The John A Hartford Foundation 2011 Annual Report states that “there is a shortage of mental health professionals available to provide services to older adults, and this will become more dire as the number of older adults with mental health conditions steadily rises. Four specialties share most of

the responsibility for managing mental health—psychiatry, psychology, social work, and nursing. There are simply not enough geriatric specialists within these disciplines to meet the growing need.”

- The SAMHSA Center for Mental Health Services (CMHS) completed the survey on MN in 2010, the results in part, recommended the following:
- “The Council identified 17 critical mental health-related issues facing the State. The identified issues include the over-representation of native populations at all levels of the treatment system; high mortality rates among native populations; lack of services for the elderly; a need for more mental health services in schools; the criminalization of persons with mental illness; lack of community-based services; and the need for greater emphasis on prevention and early intervention.”
- I would hope that the improvement in services and programs for seniors and those who are disabled (often also suffering with SPMI) would include policy to follow the recommendations from SAMHSA, therefore increasing the providers and preventative care for those in need.
- MN DHS’s Workforce Work Group Background Reference Material for May 3, 2012  
Conclusions were:
  - Current national shortage of MH professionals at all levels, especially “prescribers”
  - All projections estimate the gap between unmet need and supply will widen substantially over the next 20 years
  - Traditional workforce strategies alone will do little to mitigate this projected gap

Contracting with only larger clinics/companies/agencies who are able to meet the hope for intergration of primary and mental health care within the same clinic would limit the providers for a population which is already underserved would limit access as well as limit the population of skilled providers. Contracting with limited provider groups will likely limit the access to mental health services, would also likely disrupt care for those who are cared for by providers who are not in the “contracted” partnerships.

Incentives and payment based upon length or duration of treatment for populations that are at risk (seniors being the highest rate and risk for suicide) does not appear to be safely consistent with the quality of care MN is known for. Treatment should be based on client needs, not provider benefit. Ethical clinical decisions for

treatment should be the motivation, not dollars. Clinical decisions and treatment should be based upon appropriate need and acuity based upon an individual. Payment incentives or penalty could cause confliction for providers, as well as place an increased risk for inappropriate length of care.

There is a large disparity in Medicare and Medicaid reimbursement between psychiatric care and medical care. Even the most skilled providers only have influence over but cannot have control outcome, therefore the payment incentives or payment penalty does not appear either fair or appropriate to providers or clinics. As a mental health professional myself, I want my clients to get better as soon as possible, and I am motivated to assist with decreasing the symptoms and behaviors to improve their quality of life as soon as possible.

Changing and improving healthcare is well understood to be complicated and complex. Continuing with MN's high standards accompanied with innovative but effective solutions for skilled and appropriate treatment for populations in need is appreciated priority DHS continues to clearly communicate.

Thank you for your continued advocacy for MN's healthcare, as well as the attempts for being on the cutting edge of blazing the trail for assisting and demanding quality of care for its citizens without additional burden on our states financial wellbeing.

Sincerely,

*Sarah Anderson, MSW, LICSW*

Sarah Anderson, MSW, LICSW  
CEO Psych Recovery, Inc  
Program Director of Psych Recovery Senior Services  
MN Society for Clinical Social Workers Past President and Fellow  
Adjunct Instructor at UST/USC for Clinical Practice with Older Adults

*By Electronic Mail*

February 22, 2013

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

RE: Request for Public Input on Best Practices for Development of integrated Care System Partnerships

Dear Commissioner Jesson:

We, as the Minnesota Community Healthcare Network (MCHN<sup>1</sup>), appreciate the opportunity to provide comments in response to the Department's Request for Public Input regarding integrated care system partnerships (ICSPs) for dual eligibles and non-dual Special Needs Basic Care members who have serious mental illness.

MCHN is the collaboration of our six community mental health agencies, formed to create and continuously improve comprehensive treatment and integrated care models that promote wellness and recovery for people who have or are at risk of developing mental illness along with other co-occurring medical conditions, substance abuse or socio-economic barriers to improved health. Together, our organizations represent a breadth and depth of expertise and experience<sup>2</sup> in serving individuals with mental illness who are at risk of high health-related expenditures. Approximately 40% of the clients we serve are dually-eligible for Medical Assistance and Medicare.

\* \* \* \* \*

MCHN applauds the State's efforts to promote care models that integrate mental and behavioral<sup>3</sup> health care with physical health care and other services. We've learned from the RWJ Foundation that co-morbidity between medical and mental health conditions is now considered the rule rather than the exception in high-cost medical cases.

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<sup>1</sup> Pronounced "mission".

<sup>2</sup> Services provided by MCHN members include: Outpatient Services, Psychiatric Services, Integrative Care Services, Care Coordination, Employment Services, Intentional Communities, Adult Rehabilitative Mental Health Services (ARMHS), Chemical Health Services, Case Management, Crisis Services, Community Support Programs, Supportive Housing Programs, Day Treatment, Integrated Dual Diagnosis Treatment (IDDT), Intensive Community Rehabilitation Services (ICRS), Assertive Community Treatment (ACT), Assisted Living Apartments, Foster Care, Intensive Residential Treatment Services (IRTS), and Intensive Case Management.

<sup>3</sup> We noted that the Request for Public Input referred separately to mental health, behavior health, chemical dependency and substance abuse. Please consider our references to "mental health" as including all of these, as appropriate.

There is evidence that having a mental health disorder is a risk factor for developing a chronic medical condition – and, that having a chronic medical condition is a risk factor for developing a mental illness. Moreover, the medical costs for treatment of chronic medical conditions for clients with a co-occurring mental illness are substantially higher than the costs for clients without a mental illness, owing in part to higher pharmacy costs and hospitalization rates. Better integration and coordination of these services holds great potential for reducing medical costs, as well as improving the health of the people we care for.

As DHS proceeds to implement and refine its policy requiring Integrated Care System Partnership care coordination arrangements under certain managed care contracts, we offer the following perspectives for your consideration:

### Behavioral Health Care Homes

MCHN strongly supports the State's efforts toward development of behavioral health care homes (BHH), either through a facilitated referral model or a partnership / co-location model.

Research has consistently shown that successful engagement with clients suffering from mental illness will lead to effective treatment and to reductions in both mental health costs and costs for treatment of other health conditions. While not specific to individuals with a mental health diagnosis, a recent study<sup>4</sup> of Fairview Health Services patients revealed that health care costs are lower among "activated" patients (those who participate in their health care and engage in self-management behaviors) compared to costs for patients with low activation levels. Put simply, patients' ability and willingness to manage their health are key to maximizing outcomes and minimizing costs.

Implementation of a BHH model will ensure that professionals with expertise and experience in engaging and serving clients with mental illness will play a key role in managing these clients' overall care and improving their health. While a primary-care-focused health care home will work well for many clients, certain categories of clients would benefit more from a BHH. Primary care providers who treat chronic medical conditions may be unaware of, or poorly-equipped to deal with, their clients' mental illness or substance abuse. These factors, as well as clinical demands and payment barriers facing primary care providers, can create difficulties in achieving the best possible outcomes for clients with co-morbidities that include mental illness. These difficulties could be overcome through a behavioral health home.

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<sup>4</sup> J. H. Hibbard, J. Greene, and V. Overton, "Patients with Lower Activation Associated with Higher Costs; Delivery Systems Should Know Their Patients' Scores," *Health Affairs*, Feb. 2013 32(2): 216–22. For a synopsis, see <http://www.commonwealthfund.org/Publications/In-the-Literature/2013/Feb/Patients-with-Lower-Activation.aspx>.



In either model, an optimal behavioral health care home will allow and encourage a central role for community mental health agencies. We have a proven ability to engage even the most challenging clients, offer a care model that is focused on what the consumer wants or needs in order to remain in the community, provides services wherever they are needed (going to the client, as needed), and already have many of the connections established with other systems, including social services, necessary to effectively coordinate all facets of care. As the State continues planning around the BHH, we urge you to develop a certification and payment model that allows a central role for community mental health providers.

### Performance Measures

As the State proceeds to implement new payment models, it must necessarily measure the performance of providers, including the quality of care they deliver (patient health outcomes) and patient satisfaction. MCHN, of course, supports robust measurement, but, as DHS expands its health care reform models to include integration of mental health services, we support the Department's intention to incorporate quality measurement standards and methods that are tailored to individuals with mental illness, as the Request for Public Input (Attachment 5) suggests you are planning to do.

In addition to the measures listed in Attachment 5, section 4, we encourage DHS to study and consider using the new mental health-related HEDIS measures designed for those who have mental illness and who are greater risk of adverse outcomes due to lack of medication adherence, lack of preventive care, and gaps in treatment. (see [www.ncqa.org](http://www.ncqa.org))

Also, we believe it is important to measure quality of life from the perspective of the individual served. Quality of life measures include indicators of wellness in life dimensions beyond health care such as financial, vocational, social, spiritual, and others. Such a measure offers a useful perspective on the value of health care, especially for chronically disabling conditions, including chronic mental illness.

Finally, as a related issue, MCHN also recommends that the State work actively toward development of a risk-adjustment methodology so that quality measurements fully reflect the complex and high-risk population served by our community mental health programs. Many of our clients, including dual eligibles, have serious or serious and persistent mental illness as a primary diagnosis, have co-occurring substance abuse disorders, are homeless, and face other socio-economic barriers to improved health. For health care reform to succeed as the State envisions, the quality measurement system will need to take these factors into account.

Access to Data

One of the challenges providers face when evaluating how best to support and engage with the State's health care reform efforts – especially smaller, community-based providers – is a lack of comprehensive, historical data covering a spectrum of services. Whether providers are contemplating an assumption of risk, or pay-for-performance arrangements, it would be helpful to have access to data that would aid in understanding the cohorts of high risk clients and inform the design of service packages, performance benchmarks and so on. While the managed care organization with which a provider might partner in an ICSP arrangement can provide a richer set of data that providers would normally have access to, DHS could do a service by mining the service and cost data it already collects across medical and mental health care services and making it available to all potential health care reform / payment reform project participants.

Also, in order for providers to integrate care effectively, we will require data management solutions and information technology that gives us access to current service and cost data in real time. While our organizations have all implemented electronic medical records systems, our systems may or may not sync well with the systems of the other providers that serve our clients, and we are challenged in finding the resources necessary to fund the on-going costs of acquiring or modifying information technology that might increase our ability to communicate with other providers. As such, a cost effective, statewide data exchange system should be developed so that data could be transferred securely and in a timely way among all the many providers who will be working to align their care and support of clients in a more effective way.

\* \* \* \* \*

MCHN welcomes the opportunity to be part of the work of transforming care delivery and payment methods in Minnesota, whether through ICSP arrangements, delivery system demonstration projects, or through the State's Innovation Model proposal, which we understand CMS has just approved. We will look forward to opportunities that may arise for direct and more detailed discussion of important role that we can play in supporting the Triple Aim, and we thank you for your consideration of this letter.

Sincerely,

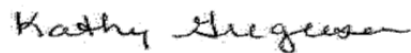


Mark Kuppe, CEO

Canvas Health

7066 Stillwater Blvd North

Oakdale, MN 55128

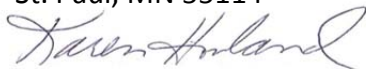


Kathy Gregersen, Executive Director

Mental Health Resources

762 Transfer Road, Suite 21

St. Paul, MN 55114



Karen Hovland, Executive Director

Spectrum Community Mental Health

1825 Chicago Avenue South

Minneapolis, MN 55404

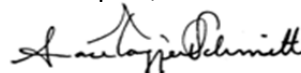


Rosalin Chrest, Executive Director

Family Life Mental Health Center

1930 Coon Rapids Blvd NW

Coon Rapids, MN 55433



Grace Tangjerd Schmitt, President

Guild Incorporated

130 South Wabasha Street, Suite 90

St. Paul, MN 55107



Martha Lantz, Executive Director

Touchstone Mental Health

1925 Nicollet Avenue South

Minneapolis, MN 55403

February 22, 2013

Pamela Parker  
Manager of Special Needs Purchasing  
Minnesota Department of Human Services  
St. Paul, MN

Dear Mrs. Parker:

Thank you for the opportunity to provide feedback on *The Identification of Best Practices for Development of Integrated Care System Partnerships (ICSPs) Between MCOs and Providers to Improve Care Delivery for People with Dual Eligibility for Medicare and Medicaid* initiative. We are excited about the department's interest in evolving the Minnesota Senior Health Options (MSHO) program into a new model that will ensure continued success.

These comments are submitted on behalf of Medica Health Plan, State Public Programs department. Through five different programs administered by Medica's State Public Program department, we meet the health care needs of close to 140,000 Minnesotans. Medica Health Plan manages a little over a fourth of the total senior population enrolled in the MSHO program, which is administered statewide by eight different health plans. It is our mission to make health care affordable, accessible and a means by which our members improve their health.

Medica Health Plan has a long history of partnership with the Department of Human Services (DHS) and is particularly proud to be one of the three health plans DHS partnered with for the conception of MSHO. In 1995, Minnesota was the first state to receive approval from CMS (then known as HCFA) to demonstrate integration of Medicaid and Medicare in order to better serve dually eligible seniors. Since then, Minnesota has continued to be a pioneer of innovative integration to meet the needs of dual eligible's in a cost-effective manner. Our history of partnership is rich as we worked together through the implementation of MSHO in 1997, through a CMS demonstration phase and the eventual move of MSHO into the current Medicare Advantage Special Needs Plan platform, for which ongoing integration for seniors has been possible. It was in 2006 that MSHO went statewide as a result of the great success this program had as a demonstration.

The federal government, along with many state governments, has expressed interest in new service delivery approaches that would incent provider entities to improve the quality and outcomes of services provided while improving the member experience. This notion is not new to Medica Health Plan as we have been engaging in creative contracting to this end with our own provider networks since the inception of MSHO in 1997. Because this has been an existing goal of Medica Health Plan for quite some time now, we are very excited to feel the positive energy at DHS to further our partnership towards this common goal.



A common theme in the emerging provider contracting service delivery model has been around the integration of both social and medical needs as well as the importance of care coordination. Minnesota health plans already focus on a multi-disciplinary team approach to care coordination related to how health plans administering MSHO are responsible for managing the Elderly Waiver (EW) benefits. Currently 92% of EW benefits are managed by health plans, which historically have been able to manage EW benefits in a more cost-effective manner when compared to EW benefit recipients who receive their services in the fee-for-service system<sup>1</sup>.

The multi-disciplinary team approach has become increasingly important to the state (related to the assessment tool/assessment structure needed to determine EW eligibility and needs) and is required by CMS since we are a Medicare Advantage Special Needs Plan. We consider the multi-disciplinary team component of our program a “best practice”. This characteristic makes our integrated program unique as we are unaware of any other direct provider contracting options being considered by Minnesota that require coordination of long term services and supports. Without coordination of these important supports, service delivery models risk furthering fragmentation of systems.

Research supports the need for the integration of Medicare, Medicaid state plan funding and EW services to provide a financial base that allows for care coordination across the continuum<sup>2</sup>. We consider this alignment of coordination efforts across primary care, acute care, home and community-based services, and nursing homes, with no carve outs as another over-arching “best practice” that has resulted in MSHO’s success.

Some additional best practices to consider that are a bit more technical in nature are:

### **Collaboration**

Collaborative work between providers and Managed Care Organizations (MCOs) can help to prioritize interventions that will benefit the member most. One example of this is a MCO sharing member claims information, which can then drive additional interventions by the managing provider. Another example of collaborative work would be the MCO passing along gaps in care to the managing provider that only the MCO would be able to identify through claims analysis. With the robust reporting available through the MCO’s, coupled with effective communication to the managing partner, better coordination of care is possible and brings with it the increased likelihood of more appropriate utilization of procedures/exams/etc.

### **Leveraging Existing Expertise to Maximize the Ability to Meet Needs**

Another opportunity to increase value is to use, and learn from, the expertise of all those already serving elders and people with disabilities in the system. Health and behavioral providers bring their clinical expertise, health insurance organizations have competencies in customer service, quality improvement and data analytics, county staff has expertise in community and waiver services and care coordination agencies are skilled in bringing all of these elements together in an engaging way to serve the complex needs of the people in our programs. Medica believes that leaving any element out results in an incomplete team to serve these clinically complex and often frail members.

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<sup>1</sup> DHS 2012. Minnesota Department of Human Services. Elderly Waiver Fact Sheet (DHS-5357), Dec. 2012.

<sup>2</sup> Malone, Morishita, Paone & Schraeder (2004) Minnesota Senior Health Options Care Coordination Study. Final report submitted to the Minnesota Department of Human Services (June).

### **Innovation within a Regulatory Structure**

We believe that allowing plans and providers to have as much flexibility to innovate within the regulatory structure will produce the best possible outcomes for unique populations. Some key elements of the MSHO program, such as care coordination and partnerships with providers and counties, were developed through collaboration to determine the best way to meet member needs and *were not* required by regulation.

### **Allowing for Delegation of Policies, Procedures and Program Structure**

Medica has demonstrated experience collaborating with care systems to provide care for members. We have policies that govern the work being done through our partnerships. These policies allow for consistencies as well as protection for members in regards to care they receive. Medica has two Clinical Liaisons who are available to work with any providers or Care Coordinators. The role of the Clinical Liaison is to offer consultation, education and resource advocacy to providers and Care Coordinators. Medica has a benefit exception process for Care Coordinators to submit cases for review for possible exceptions of the standard benefit set.

### **Effective Utilization of Population-Specific Assessments and Care Coordinators**

Medica has found that an important strategy in increasing behavioral and physical health integration is employing a health risk assessment that incorporates *both* physical and behavioral health questions. Through the assessment process, the Care Coordinator and the member collaboratively develop a plan of care to meet the member's needs. Medica offers training to all of our Care Coordinators on how to complete this comprehensive assessment and provides resources for our Care Coordinators to follow up if they have questions or concerns. Medica partners with care systems, counties and community agencies to provide care to our membership. Years of experience contracting with a variety of Care Coordination entities has shown Medica the value of assuring we have experts within our network to deliver Care Coordination to our members. We prioritize our effort to match the member with the entity who is able to best meet the identified needs of our Medica membership.

### **Other Best Practices DHS Should Consider Promoting:**

- Medication reviews for all members in all settings of care;
- Depression screenings for all members regardless of setting;
- Physician Orders for Life-Sustaining Treatment (POLST) for nursing home membership and advanced care planning for those in a community setting.

Medica would like to commend the department for the thoughtful development that has gone into creating a list of possible quality measures, from which potential ICSPs will be able to select. We recognize that this list was developed keeping in mind the vast amount of quality measurement already underway for health plan performance and the reality that many measures are ineffective for the aged population. Because health plans have been involved with provider total cost of care arrangement for years, we do hope that the state-developed list of measures will not be an exclusive option for our ICSP partnerships, but rather have the state measures required and additional measures negotiable between health plans and providers. It is only through this arrangement that evolving into ICSPs would not stunt other progress currently underway.

We appreciate DHS's ongoing efforts to evolve in the hope of MN continuing to be ranked the #1 state for long-term services and supports<sup>3</sup> in addition to generally being known as a state that is innovative with health care. It is our opinion that the department's partnership with Minnesota's nonprofit health plans is largely responsible for this success.

Again, Medica Health Plan thanks you for this opportunity to provide comments on this important initiative.

Sincerely,

A handwritten signature in black ink that reads "Julie C. Faulhaber". The signature is written in a cursive, flowing style.

Julie C. Faulhaber  
Senior Director State Public Programs Medica Health Plan



February 21, 2013  
Pam Parker  
Special Needs Purchasing Manager  
540 Cedar Street  
St. Paul, Mn 55155

Dear Ms. Parker,  
Metropolitan Health Plan (MHP) looks forward to working with the Department of Human Services in developing three Integrated Care System Partnerships for our dual eligible elderly and disabled enrollees. We found the Best Practices Symposium helpful and appreciate the opportunity to respond to your Request for Public Input (RFPI).  
MHP offers three key points for discussion by the Minnesota Department of Human Services and the Dual Demo Project Team.

**Timeline**

MHP supports stable multiple-year lifecycles for these partnerships, with some flexibility over time to make adjustments. In the RFPI, MCOs are asked to develop and maintain ICSPs, but little detail about the maintenance component is described. Stronger performance improvement and data-trending is possible if ICSPs are allowed to continue over multiple years, especially with HEDIS as the primary data source for performance measurement. MHP has experienced great success in quality improvement projects with partnering organizations, such as our experience with Hennepin Health, but it can take time to build the effective relationship necessary to see positive outcomes. Stability within the partnership over time also helps identify true baseline data and fits with the quality cycle that, by design, is retrospective.

**Metrics**

MHP would like to echo the concerns put forth by the DHS Dual Demo Clinical Measures Work Group around data limitations. The issue of micro-populations, where one poor patient outcome can devastate a provider’s overall performance, is of particular concern. Conversely, the micro-population focus has the advantage of being flexible and patient-centered. The Kaiser Family Foundation acknowledges the “one size will not fit all” situation for duals. This individual group of people has a large variety of “needs, utilization patterns, and spending habits”<sup>1</sup>. Additionally, ICSPs have little-to-no historical data by which to create benchmarks, baseline measurements, or even appropriate improvement goals. One way to mitigate these data limitations is for MCOs to recognize “collaborative efforts”, such as providers agreeing to participate with an MCO through a performance

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<sup>1</sup> Neuman P, Lyons B, Rentas J, Rowland D. Dx for a careful approach to moving dual-eligible beneficiaries into managed care plans. *Health Affairs* (Millwood). 2012; 31(6): 1186-92.



improvement project or other quality initiative. Such collaboration allows flexibility when determining whether or not a provider meets the desired outcomes of the partnership, as well as truly making efforts between the providers and the MCO's shared.

### **Incentives**

It would be extremely helpful to learn more about other current pay-for-performance arrangements, especially as they relate to how various membership volumes correspond to the incentives needed to achieve meaningful changes. More information would be very useful, such as lessons learned regarding the relationship between partner organizations, how a benchmark or trend was determined, and how often monitoring is done throughout the year to assist providers with staying on track. A recent article in *Health Affairs* found that in order to "integrate care for dual eligible successfully, available data and experiences are shared."<sup>2</sup>

### **Hennepin Health Experience**

MHP has had encouraging experience with the nationally recognized Hennepin Health demonstration project, and the brief Coordinated Care Delivery System preceding the 2011 expansion of Medical Assistance. The opportunity to further that partnership as we develop our ICSPs will build on that foundation. From the Hennepin Health experience, we know that it takes time to build partnerships focused on best practices for improving health outcomes, care quality, and cost-savings. Central to providing strong, consistent, high-quality care is the ability for care systems and payers to collaborate, effectively evaluate results, and sustain the partnership. We look forward to working with you to help Minnesota and its MCOs advance ICSPs from a conceptual idea to the new normal.

The contact person for our ICSP development is:

Veronica Schulz  
Director, Medical Administration  
400 S. 4<sup>th</sup> Street, Suite 201  
Minneapolis, MN 55415

Phone: 612-348-3535

Email: [veronica.l.schulz@co.hennepin.mn.us](mailto:veronica.l.schulz@co.hennepin.mn.us)

Sincerely,  
Karen Sturm, RN, MHA  
CEO, Metropolitan Health Plan

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<sup>2</sup> Gold M, Jacobson G, Garfield R. There is little experience and limited data to support policy making on integrated care for dual eligibles. *Health Affairs* (Millwood). 2012; 31(6): 1176-85.

## **Request for Public Input Response**

### **The Identification of Best Practices for Development of ICSPs Between MCOs and Providers to Improve Care Delivery for People with Dual Eligibility for Medicare and Medicaid**

February 22<sup>nd</sup>, 2013

Responder: Bluestone Physician Services/Bluestone Solutions

Contact: Sarah Keenan, Vice President

651-342-4273

Sarah.Keenan@Bluestonemd.com

#### **BEST PRACTICE OPPORTUNITIES**

There are many best practice opportunities to increase the value provided to the dual eligible population. Value can be defined through the triple aim of improvement in the health of the defined population, enhancement of the patient care experience (including quality, access and reliability), and reduction, or at least control, of the per capita cost of care. Linkages between systems are critical in achieving these goals for duals, both seniors and people with disabilities. Our current system isolates patients by program and payer with little recognition of the quality and cost impact of community based providers. Aligning payment incentives based on quality across payers, providers, and community based LTC partners could be the most impactful action the State could take, which is exceedingly difficult without the integration of Medicare financing. Silos do not exist because primary, acute, LTC, behavioral health and MCO's do not recognize the need for whole person integrated care. Silos exist because there is no financial or systematic incentive to integrate. A seamless beneficiary experience must recognize the crucial role of integration of payment systems. All participants in the care continuum for an individual dually eligible patient must have "skin in the game", tied to quality and cost reduction outcomes, data sharing, and protection from cost and responsibility

shifting. Specific to members in residential care, including nursing facility, assisted living and group homes is the large opportunity to engage the LTC providers through quality and cost incentives. This population includes some of the most frail and highest cost patients in the dual eligible population.

Best practice respects the individual and their caregiver's right to high quality efficient care. The current system results in the need to "tell their story" over and over again. This results in missed information and distrust of the system. This is particularly important for the most vulnerable patients in the system that, for a variety of reasons, may be unable to accurately relay information. The system has the responsibility to collect and relay information to across settings to ensure the best care and outcomes. As an example, Bluestone uses a secure website to include the family, assisted living and group home staff, home care, hospice, care coordinator and primary care team in a dialog regarding care decisions.

Clinic based care system models developed under MSHO are excellent examples of the collaboration among primary care and MCO's. In a few cases LTC providers have been at the table, but not to the extent needed to impact quality, health and cost across the system. For the subset of consumers who are receiving extensive levels of services through the long-term care systems, whether this is residential, HCBS, state plan home care or nursing facility placement the "true decision makers" impacting quality, health and cost are not primary care, acute care, or the payer. The true decision makers are the care givers and service providers closest to the patient. Currently there is little incentive for this decision maker to implement quality improvement and cost reduction strategies. The high number of innovations occurring at the facility level around cost and quality improvements is a testament to the commitment of these providers and an opportunity that should not be lost by the State.

Advancements in transitioning members have been made, and continue to be made, through strategies such as MNChoices, Universal Transfer Forms, etc, but there needs to be continued recognition of the breadth and width of care teams to be included in patient centered care and communication.

Several MCO's have been innovative in alternative payment systems for clinic based care systems in both MSHO and SNBC which has encouraged clinics to create programs that improve quality and reduce cost through more frequent contact and care coordination focused on "pre-acute" care rather than "post-acute" care.

Providers are open and, in fact, welcoming to increased collaboration with the State to shape both clinical and payment policies and to reduce variation.

The impact of the size of the population has much to do with the core principles of population health. Some of the best practices we can learn through the work of Health Care Home in MN is the ability to impact health through patient registries and patient empanelment. Of course, a care system's ability to take full risk will be impacted by the size, frailty and characteristics of the population

#### MODEL OF CARE DESIGN

A strategy for addressing the needs for seniors should include recognition of the social determinates of health. There is a great deal of variation among "seniors". Programs must find a reliable method to risk stratify this population and create appropriate interventions. Far too many resources are spent on the "worried well". Data sharing, predictive modeling, risk stratification and evaluation are all important tools in determining resources needed. Again, there is also great value in determining risk factors based on "life geography". These elements include change in living setting, loss of spouse or caregiver, loss of IADLs, and other life events that often predispose seniors to adverse health events.

Consideration of living setting is crucial across all populations. All parts of the health care system should be prepared to assess and partner with community resources including family, paid and unpaid caregivers, and residential care staff. Technology solutions, such as virtual primary care, MTM, behavioral health visits, remote monitoring, and information exchange must be encouraged overall but have particular benefits to the rural population

A strategy that has demonstrated success in both quality improvement and cost reduction is physician led care coordination. This model is sustainable and scalable in rural settings and results in greater patient engagement as the patient is not asked to change physicians. The system "assures" optimal primary care and an optimized care plan through relational care coordination, collaboration with community primary care and existing supports, and an interdisciplinary physician led team meetings.

As a provider for both primary care in group home settings and care coordination in 27 counties for people with disabilities under SNBC we see the need for integration

with Medicare in this population. Approximately 50% of the community dwelling population is not dual at this time. While this brings its own challenges, the coordination of care is far less confusing for patients and providers. Valuable provider, care coordination and patient advocate time is spent “coordinating” across Medicaid and Medicare systems, which often amounts to jumping through hoops.

## COMMUNICATION

To facilitate communication in related systems, such as Model 1, there must be proactive dialogue between parties. For example, Bluestone employs local care coordinators in rural areas. As part of their job duties they routinely meet with local county agencies, local clinic, and local hospitals.

Communication is improving in more integrated systems. Admission and discharge notifications are increasing and discharge summaries are sent with increasing frequency. There are opportunities for improvement which, again, involve proactive communication and relationship building. Systems should be encouraged to identify and create partnerships with local resources in HCBS, residential care, county, and acute settings. An “inventory” exercise is being proposed for health care homes, which would guide clinics through the identification of resources and relationship building process.

Obvious to communication, is the need for effective use of technology that brings the right parties to the table and encourages relevant response. Relevant response is defined as the right person giving the right information in a timely manner.

## PAYMENT MODELS

DHS should strive to develop payment models that incent performance across the provider continuum. Aligning Medicare and Medicaid is essential to the efficient delivery and engagement of public and private systems. As the healthcare system moves toward total cost of care and quality based payment it is crucial that dual models align. Even more so, lessons learned through MSHO should be promoted as best practice for care for the frail senior in a total cost of care environment. Providers are interested in payment models that allow, incent and demand quality of care. Providers are frustrated by models that remove clinical and quality decision making from physicians and clinics that specialize in the care of frail seniors and people with disabilities. PMPM payment methods are the most adaptable to various size of populations. Incentives based on specific measures such as ED, acute and

pharmacy utilization are also good options to incent practices within the scope of ICSPs.

#### PERFORMANCE MEASURES

Key to acceptance of performance measures for the seniors and people with disabilities is deliberate and purposeful recognition and integration of current requirements. The work done by through Special Needs Purchasing appears to be some of the most comprehensive in crossing the barriers between measures requires by clinics, health care homes, MCO's, and care systems. The use of registries and empanelment allow clinics to tailor the measures to the population served instead of "chasing the numbers" which often is the result of standardized performance measures. The requirement may be the demonstrated use of population based registries and empanelment to identify and meet gaps in care. Open two-way data sharing is essential for the identification in gaps in care. Currently there is great variety in the level of information shared, and the ability of the care systems to impact changed based on delegation status and the coordination of case management at the health plan level. For example an MCO may allow care systems access to pharmacy data as part of the care coordination strategy, which is essential for quality, cost and patient engagement, while another MCO may regard this as "out of scope". As ICSP's are developed there must be open dialogue and trust regarding data sharing and mutually agreed outcomes.

Thank you for the opportunity to respond,

Bluestone Physician Services/Bluestone Solutions

**REQUEST FOR PUBLIC INPUT**  
**Identification of Best Practices for Development of**  
**Integrated Care System Partnerships (ICSPs) Between MCOs and Providers**

Response Comments  
February 22, 2013

**Best Practice Opportunities to Increase Value**

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**How providers and MCO/SNPs can work together:**

Providers can work together and with MCO/SNPs to improve coordination, outcomes, and costs through greater transparency and sharing of information. Specifically, providers and MCOs/SNPs can: 1) share access to electronic medical record information; 2) develop and implement agreed-upon, best practice care protocols; and 3) share performance data.

**Effective policies, strategies, mechanisms and protections needed for consumers:**

DHS can work with CMS to help clarify utilization criteria for Medicare Part A Skilled Nursing Facility (SNF) days. DHS can help clarify PCA determinations and hour allotment, so consumers have a clearer understanding of the qualifying criteria and benefit available.

Additionally, work is needed to remove regulatory barriers to assist elders in receiving vaccinations. Clinics cannot bill payers directly for certain preventive vaccinations covered by Medicare Part D (e.g., Zostavax), leading to billing issues and reluctance of elders to receive the vaccination.

**Best practices that DHS could promote:**

DHS can promote best practices that bring clinical care to the member's place of living, rather than the member travelling to the provider for care. Specific ideas include:

- Greater utilization of nurse practitioners as primary care provider/care coordinator, especially for members residing in institutions.
- Locating on-site providers in LTC/SNF facilities to address needs as they arise.
- Ongoing education to facility staff regarding care that can be performed on-site rather than transferring to emergency rooms (e.g., wound care, congestive heart failure treatment).

**How the size of the population to be served impacts ICSP models and measurement:**

Outliers can have disproportionate impact on smaller population sizes, both in terms of payment model and performance measurement. Exclusion of outliers from performance measures could lead to more realistic performance results, and using a robust method for risk adjusting payment could reduce the risk/impact of outliers on the payment model.

## **Specific model of care designs, strategies or elements to be incorporated into ICSPs**

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### **Strategies for serving seniors in different settings/areas:**

Home and community-based services (HCBS) in rural areas are challenged by a number of factors: 1) lack of providers to provide the services; 2) small number of members needing the services; and 3) transportation costs. Additionally, lower-cost services such as urgent clinical care or assisted living facilities may not be available in rural communities, leading to greater usage of higher-cost care models (e.g., emergency room, nursing facility). Strategies need to account for these challenges.

### **Strategies for serving people with disabilities in different settings/areas:**

DHS can work to adapt policies that make adult day-care more accessible in rural areas, and can encourage providers to make mobile medical visits to enrollees' home, group home or day care.

### **Strategies for increasing Behavioral/Physical Health Integration:**

DHS can help encourage telehealth consultation with behavioral health specialists and telehealth video-based visits by working to amend reimbursement/regulatory barriers that limit these services.

## **Communication Strategies Across Provider and Service Types and Settings**

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### **Strategies to improve or promote more efficient day-to-day communications:**

DHS can assist by describing and auditing communication standard best practices between behavioral health specialists, facility-based providers, and health care delivery systems.

### **Strategies to improve coordination of care and communications during transitions:**

DHS can encourage/expect participating SNF's, assisted living facilities, and home health agencies, to acquire view-only rights and messaging rights to health care delivery's electronic health care record. Additionally, MCOs/SNPs can develop and implement standard communication form templates that can be embedded within a health care system's electronic health record, making the information available to clinical providers.

### **Post-discharge communication strategies:**

DHS could encourage a number of post-discharge strategies, including: 1) describing, then auditing best practices for transitions of care, if deficiencies in current expectations are present; 2) timely notification from hospitals to MCOs/SNPs of initial hospitalizations; and 3) developing standardized communication templates.

### **Utilizing EHR or HIT mechanisms to support and simplify communications:**

To more effectively use EHRs within state programs, concerted efforts should be made to create required program forms that can be: 1) available in electronic formats that can be shared across HIT/EHR platforms; and 2) built/embedded within EHRs.



## **Payment Models**

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### **Models that should be considered:**

Share savings models that include total cost of care (e.g., Medicare, Medicaid, NF, Part D, etc.) should be considered and promoted for ICSPs.

### **Payment models that should be avoided:**

Total risk sharing arrangements should be avoided, due to small population sizes in some parts of the state. Total risk sharing could reduce the interest of care systems to participate in ICSPs.

### **How the size of the population to be served impacts the ability to tie performance to payment:**

Smaller populations can have outlier members who exhibit a disproportionate impact on payment models, especially total risk arrangements. Shared savings provides incentives to align cost and quality while minimizing the financial impact/risk of outlier members to ICSPs.

## **Performance Measures**

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### **The kind of data and analytics needed:**

Greater data and analytics access and abilities are needed to manage program performance. Specific ideas include:

- Ability to received quality measures/financial results on a regular, consistent basis.
- Access to claims and revenue files to conduct analyses related to total cost-of-care.
- Ability to aggregate data by care coordination providers across ICSPs, to better measure overall program results. For example, if Essentia contracts as ICSPs with three separate payors, then the ability to aggregate data to show Essentia's overall results as one ICSP, in addition to the data by contract.

### **Best way to capture several disparate data sources:**

Requiring MCOs/SNPs to adopt common reporting elements and standard definitions would facilitate sharing of information across disparate data sources. Providing claims, revenue, and risk adjustment data files to a data warehouse or reporting database would allow for capture in one area.

### **Sources of data used by providers to analyze performance:**

Currently, providers utilize clinical data related to quality measures to analyze performance. In a total cost-of-care environment, providers should be able to review/analyze electronic claims, risk score, and revenue files to link clinical outcomes and decision with cost and financial information.

### **Comments on preliminary list of performance measures:**

Because of the Catholic Bishops' ongoing concern with the POLST form (<http://www.mncc.org/stewards-of-the-gift-of-life/>), DHS should consider changing the proposed POLST measure to POLST and/or health care directive. Some facilities will not participate in POLST at this time.

# Dennis V Christian, LICSW

1730 Clifton Place, Suite 202  
Minneapolis, MN 55403

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support@dennischristian.com

dennischristian.com

February 5, 2013

Department of Human Services

RE: Medical Assistance for the Working Poor

I have been a psychotherapist for 20 years. Over the years of my practice working with a variety of people in diverse living situations, none has seemed to be more difficult than those with multiple diagnoses, who are on disability and yet can still work. The work is marginal, at best, and undoable, when the disabilities make it life more than difficult. There doesn't seem to be a process for a client to move off of Medical Assistance for the Working Poor, which requires some kind of employment, to straight Medical Assistance.

A short case example. I have seen a 50ish man, morbidly obese due to the medications he takes for several disabling conditions, including AIDS, diabetes, Paranoid Personality Disorder, Major Depression, and back problems. For a while, he "worked" at a video store organizing videos and alphabetizing memberships until he could no longer negotiate the stairs into the basement. As his disability created further limitations, he has had to become reliant on Personal Care Attendants, home health aides, visiting nurses. Getting to medical appointments is his primary activity. He was reminded that he has to "work" at something to continue to qualify for Medical Assistance. The coordinator of the company that manages his PCAs suggested that he report that he is "working" as a pet sitter for the person with whom he lives and that would qualify him to continue getting benefits.

All because there doesn't seem to be a way to transition off of this program.

Should you have any questions, please contact me at 612.940.7033.

Regards,

Dennis V Christian, L.I.C.S.W.