An overview of community feedback gathered to help build the next generation of Integrated Health Partnerships

The Department of Human Services (DHS) recently introduced the next phase of its Integrated Health Partnership (IHP) initiative, designed to purchase better health — rather than tests or procedures — for Medicaid and MinnesotaCare enrollees. The department shared a proposed framework for growing this work in order to gather feedback from the community, refine the direction and plan next steps.

Through a series of community meetings and a formal request for comment, DHS has engaged in a conversation with Minnesotans on ways to create more patient-focused, flexible financing, community-driven care and continued tax-payer savings. Health care providers have been instrumental in building and improving this model, since its inception. Read earlier IHP request for information and summary of community responses from 2016. This framework was built from those previous responses and feedback over the life of the IHP program.

This next-phase framework is built on the successes of the IHP program, including close collaboration with the community and proven ways to build partnerships with health care providers. The state will continue existing IHP programming, while introducing a new option for providers to have a more direct relationship with the state under an enhanced financial arrangement to ensure many different provider types, sizes and collaboration can participate in the program. Finally, this work aligns the state's purchasing goals and strategies toward a focus on better health across the Medicaid and MinnesotaCare programs.

Progress of Integrated Health Partnerships (IHPs) to date

DHS received overwhelming public input from 74 different organizations or individuals. This brief summarizes the feedback received, the recommendations DHS has put forward in response and the timeline for planned next steps.

Timeline for responding to feedback

1) The Department of Human Services will **continue information gathering and community conversations on the Next Generation IHP model through the summer of 2018.**

2) DHS will lay the groundwork for the Next Generation IHP approach by introducing a **preferred drug list, to unify enrollee's medication experiences across coverage types and plans, in July, 2019.**

3) **Procurement for the Families and Children contracts will be conducted separately for the seven-county metro area and for the non-metro area.** Staging and timing of those procurements will be informed by the continuing conversation, however, the earliest a procurement will be conducted would be for contract year 2020.

What we heard

Community responses focused on:

- **Support for:**
  - Enhancing the patient/provider relationship and putting a primary provider at the center of a patient's care
  - Introducing uniform preferred drug list across the Medicaid and MinnesotaCare program, not limited to the proposed demonstration
  - Rewarding strategies and interventions that lead to improved health outcomes, reduced cost, and that address social determinants of health
  - Phasing in, over a period of time, the impact of outcome and performance measures on payment

- **Calls for additional:**
  - Education and information to engage enrollees in their health care choices including help with selecting providers and plans
  - Options to better integrate dental care into the model
  - Technical assistance and further financial modeling to support provider organizations as they assess the feasibility of participating the Next Generation IHP model
  - Ways to create transparency of payment and accountability for desired outcomes (other than network exclusivity)

Key goals and principles for the demonstration project

- Improve health outcomes and member experience;
- Strengthen the relationship between the enrollee and provider;
- Improve provider satisfaction;

- Incent investment in activities that are demonstrated to improve health outcomes and lower cost;
- Create a more level playing field between providers, plans and other organizations that contribute to the health, service delivery and cost of the program that allows access to the same type of financial reward and investment;
- Reduce and slow the growth in cost of the Medicaid and MinnesotaCare program, making it more financially sustainable over time; and
- Reform financial arrangements and payments across purchasing models to reward all of the above.

To make meaningful change and meet the key goals described above, the following principles should shape further model development. This does not speak to *how* one should incorporate these principles, just that the policies developed should achieve these principles. This includes:

- Enrollees who have better information on the value of developing an ongoing relationship with a primary care provider and who have decision tools and support in selecting their provider, will improve engagement in their own health care and the health care system overall.
- Program and administrative simplification will reduce costs for the program and reduce confusion for enrollees and providers; this cannot be achieved by reforming payment for services alone.
- Outcome and performance measurement must reflect enrollee health risk and meaningfully measure change by taking into account relevant factors that impact an enrollee's health.
- State health care purchasing contracts that provide equitable access to investment and financial rewards for improved health, improved enrollee and provider experience, and cost reductions, will result in greater investment in activities that are local, meet the specific needs of populations and make the overall program more sustainable.
- Transparency in contracting requirements, data, and payment for services will result in greater public awareness and program understanding.
- Payment should be based on significant and meaningful innovation and ability to meet outcomes and reduce cost, where price alone cannot achieve cost reduction and financial sustainability.
- Financial arrangements through contracts and payments to providers (whether directly in FFS, through a contract, or subcontract via a managed care organization) need significant restructuring to transform the system and put health care dollars closer to the point of care. These arrangements should place a greater emphasis on achieving outcomes, and allow for taxpayers and providers to share in any financial reward, which in turn promotes greater investment in activities that benefit enrollees' health. This change will not occur under the status quo, which is a fully-insured/capitated arrangement with underlying fee-for-service payment and a limited number of available vendors to provide services.

Continued progress on the principles initiated with the implementation of the IHP program in 2013, will lead to both broader system transformation and savings to the program that provides the platform for fiscal sustainability. Significant and continued evolvement of the financial incentives and the structure of the financial arrangement with providers and with any contractor is required to achieve further Medicaid savings and to shift greater return on investment based on outcomes. This means the enrollees, the overall program and the taxpayers benefit from the savings achieved by the system.

Further public discussion and work on the model is needed to achieve these objectives, to develop an iterative process that incorporates updates and improvement and to develop a strong process for evaluation and review. This is described below under each domain.

A summary of community feedback received, broken down by project area follows

Primary care choice & network / beneficiary experience

Overview of discussion

DHS called for feedback on new ways to support enrollees in choosing primary care providers and making those choices exclusive within Next Generation IHP and managed care networks. Based on feedback, the department has opted to advance methods that can support enrollee choice in primary care but not network exclusivity. In other words, Next Generation IHP primary care clinics will not be made available exclusively within an overall contract and network choice at this time.

In the short term DHS will establish methods that allow enrollees to have more choice and power in selecting their primary provider and strengthening this relationship. The majority of commenters support the idea of an increasingly engaged provider, at the center of an enrollee's care. People suggested this as a strong way to encourage enrollee participation, strong primary care relationships and better service integration and coordination.

Further discussion can help inform how to align the financial structure and delivery model to promote provider accountability and focus on patient outcomes.

Enrollee provider choice principles

Encourage enrollee choice, supported by information and guidance

- **Integrate and coordinate services**, leaving behind the current fragmentation of health care services
- **Address high rates of "default" enrollment** by which Medicaid enrollees miss the opportunity to make an active choice in their plan selection and are simply assigned to a managed care organization available their area

Primary Care Network principles

Under the proposed framework in the RFC, DHS proposed primary care exclusivity as a tool to address both historical challenges of overlaps between the IHP and MCO contracts as well as to meet or achieve certain goals under the new model. *DHS is not proposing primary care exclusivity as a goal in itself* and we are open to other mechanisms to address these historical issues and make the model functional and viable. This includes:

- **Allow accountability and desired outcomes** to be tracked and evaluated for different financial models and contracts
- **Achieve the level of volume and economies of scale needed to** calculate outcomes and rates and ensure there is a critical mass of enrollment and aligned financial incentives for providers to transform how they delivery care

- **Create clear attachments and accountability for providers and patients,** ensuring they understand which enrollees they are accountable for and are assured that enrollment is sufficient in size to produce reliable financial results, establish rates and execute risk adjustment
- **Ensure transparency of payment and reducing duplication of care management and other service**
- **Promote choice and attribution that more closely ties the provider-patient relationship** of enrollees across the market place, reducing adverse selection and uneven market forces.

Response detail

People who commented expressed support for a more engaged primary care provider who is at the center of an enrollee's care. They saw positives in terms of enrollee participation in strong primary care relationships and better service integration. Commenters used varied definitions of primary care.

Some community members, organizations, providers and provider health systems offered appreciation for these ideas but raised concerns relating to how members are attributed and the definitions used for primary care providers or clinics. Many of these commenters recommended allowing specialty providers and mental health providers to serve as an accountable provider under the Next Generation IHP model.

Many provider health systems and managed care organizations raised questions and concerns about enrollee fidelity to one particular health system, and the model's impact on contracting and networks. Provider health systems were concerned about effects on broader payer contracting and were worried that their networks could look less competitive given the perception of limitations on choice. Managed care organizations expressed concern that their networks would not be sufficient should provider health systems exclusively participate in Next Generation IHPs as primary care clinics. Several commenters recommended requirements related to network adequacy and contractual relationships between entities and providers.

Commenters expressed concern about a current lack of enrollee focus on primary care relationships. Many recommended an extensive educational effort and the development of materials for enrollees to assist with patient choice and health literacy. Topic suggestions for such campaigns include, the importance of receiving annual physicals, the benefits of developing a relationship with a health care provider and continuity of care, the benefits of coordinated and integrated care, information about the health care system and how to navigate their benefits.

Recommendations to carry forward and/or items needing additional input

DHS recommends more work to identify additional approaches that can be leveraged to increase enrollee choice, create clear lines of accountability, stronger service integration and sufficient patient populations.

Provider input

DHS recommends that targeted outreach be conducted with impacted stakeholders and potential Next Generation IHPs to gain additional insights and options for primary care networks and to discuss the definitions of primary care provider/clinic.

Next, we recommend that for 2019 we implement primary care clinic selection as a component of enrollment into a managed care organization. This would allow the department to phase in some benefits of this model component, most notably emphasizing the importance of primary care, encouraging the development of an ongoing relationship between an enrollee and a primary care provider/clinic, and improved continuity of care for more enrollees. Moving forward with this recommendation may lead to greater enrollee-provider relationships, ultimately driving the system toward better care integration and coordination. To support this objective, methods will be established to give enrollees tools which will help them understand their choice of providers, understand what health plan options are available to support their primary clinic choice, and provide information on options to make changes to their primary care provider if necessary. These methods can be built upon over time and adjusted to best support the Next Generation IHP model as it continues its evolution.

Enrollee input

DHS recommends further community discussion and direct enrollee engagement efforts that allow the department and community to gain insights on what tools would be most helpful to enrollees and what is most important to them when accessing health care through a primary care model. DHS will work with consumer groups and other stakeholders on the best way to gain this input and make it part of the ongoing development process. DHS may consider focus groups or working with a contractor to complete this work.

Benefit administration (e.g., Preferred Drug List [PDL], dental, NEMT)

Overview of discussion, benefit administration

The innovation DHS is striving for in this new model will not occur without considering every aspect of the health care system and looking for new innovations across the board. This will require us to consider changing the status quo, a fully-insured/capitated arrangement with underlying fee-for-service payment and a limited number of available vendors to provide services. The following examples demonstrate the changes DHS expects to see through benefit administration reform.

Uniform Preferred Drug List

The department asked for feedback on a uniform Preferred Drug List, or an agreed upon list of medicines, across all state health care purchasing. The department already administers a Preferred Drug List for a uniform drug class, hepatitis C medications, and this initiative would expand the department's current processes to additional drug classes listed on the Preferred Drug List. This possibility was discussed alongside a pharmacy benefit carve out option. There is strong support among responders for a uniform statewide Preferred Drug List, which is DHS' recommendation.

Toward a Preferred Drug List

Improved patient experience

- **Provides a consistent Preferred Drug List** for all enrollees across all plans and minimizes disruptions in therapy if an enrollee moves or changes Managed Care Organizations.
- **Minimizes the need for enrollees to get new prescriptions** or authorizations when changing managed care organizations.
- **Simplifies the enrollment process** as members will know they have a similar pharmacy benefit across all of the Managed Care plans.

Improved provider experience

- **Simplifies administrative processes** at the clinic/provider level by applying one Preferred Drug List to all Medicaid beneficiaries.
- **Minimizes the need to issue new prescriptions** when enrollees change managed care organizations.

Reduced costs

- **Streamlines the administration of the Medicaid Preferred Drug List** and allows DHS to leverage cost effective therapies across all of the Managed Care plans.
- **Allows DHS to collect supplemental drug rebates on Managed Care claims, when applicable**

Response detail

There were no comments in support of limiting the uniform Preferred Drug List to the seven-county metro. There were also no comments in support of a pharmacy benefit carve out. Four commenters opposed both the uniform Preferred Drug List and the pharmacy benefit carve out, citing concerns around increased costs and administrative burden. Several commenters, representing both favorable and oppositional responses to the question, said that the process for the establishment of the uniform Preferred Drug List should include public participation and be transparent.

Recommendations to carry forward and/or items needing additional input

DHS recommends implementing a uniform statewide **Preferred Drug List** for all of the Managed Care Organizations (MCOs) and fee-for-service (FFS) enrollees effective July 1, 2019. This change has community support and would continue the direction the department has already undertaken through the uniform Preferred Drug List for Hepatitis C medications. Phasing in this provision for July 1, 2019, will allow more time to gather public input, allow planning for MCOs, and reduce confusion for enrollees during annual health plan selection.

DHS recommends continued consultation with the Drug Formulary Committee to determine the uniform Preferred Drug List. For transparency, DHS recommends posting a draft Preferred Drug List for public comment by April 1, 2019, to implement by July 1, 2019.

While the primary focus of this work is improving the patient and provider experience, preliminary analysis by DHS staff, the department's pharmacy rebate vendor and contracted actuaries indicates this initiative would result in a net cost savings to the state.

DHS recommends that the department maintain control of the creation and maintenance of the Preferred Drug List to ensure drugs are placed on it in accordance with the department's evaluation of the drugs' safety, efficacy, utilization and cost.

Because this initiative is intended to be statewide, specific outreach and engagement to the rural county based purchasers will be needed.

Dental and non-emergency medical transportation

In the proposed Next Generation IHP model, the department outlined a new approach in which DHS or a contracted vendor would administer some benefits instead of the Next Generation IHP. The benefits to be delivered in this way are dental and non-emergency medical transportation. These services have been historically difficult for MCOs to administer effectively alongside the many other health care benefits. Provider systems may be similarly ill positioned to administer these benefits. The majority of the commenters expressed some concern about how these benefits would be coordinated. DHS plans additional conversations on the topic and continues to see possibility in the consolidation of some administrative services.

DHS recommends moving forward to consolidate the administration of certain benefits (for example, dental care and non-emergency transportation services) for enrollees in a Next Generation IHP. DHS recommends further stakeholder discussion on how dental can be better coordinated with Next Generation IHP and meet the goal of improved outcomes for enrollees.

It is important to clarify that the following dental payment arrangements that are payments above the base rate for certain providers would continue to be maintained in the Next Generation IHP model:

- Critical access dental add-on for all designated providers (MA -37.5 percent, MinnesotaCare 20percent)
- Community clinic add-on (20 percent - and is multiplicative with the CAD add-on)
- Supplemental payments for dental clinics owned and operated by public providers (i.e. county, city), that provide payment for difference between Medicaid and commercial rates
- Cost-based encounter rates for dental services provided by Federally Qualified Health Centers and Indian Health Service facilities (these payments are already carved out of managed care and would continue to be under a new model)

Although the Next Generation IHP model will not impact these payment arrangements, none of the current payment arrangements above are dependent on quality and are not available to the majority of dental providers in the system. DHS recommends options be explored to establish financial incentive models for dental providers serving Next Generation IHP enrollees that rewards providers for achieving better outcomes for enrollees, maintains or improves access, and reduces unnecessary and more costly visits such as emergency room visits. Similarly, measures related to dental access, quality and improving coordination across medical and dental services would be incorporated into Next Generation IHP quality metrics. DHS recommends establishing this outreach in the near future to ensure model components are well developed and in coordination with IHPs prior to Next Generation IHP implementation.

Contractual/financial arrangements

Overview of discussion

Shared risk and reward is central to the model proposed by DHS. Respondents asked for more detail before giving feedback on the overall level of risk and specifics of the risk arrangement. Much of the feedback supported the concept of investments targeted to improve outcomes. DHS recommends more conversation and development of the financial modeling for the new approach.

Next Generation Integrated Health Partnerships principle for financing

1. **Include both up and down-side risk.** The level of risk for Next Generation IHP participation should align with requirements for Medicare MACRA Advanced Alternative Payment Model (AAPM) requirements that allows physicians to get paid an incentive under Medicare if their other payer contracts, like Medicaid, qualify as an AAPM.
2. **Prioritize risk-mitigation strategies for Next Generation IHPs** as appropriate, based on the final financial model.
3. **Create consistency in financial reporting requirements across all participating entities**, where practical and appropriate. There is also a recommendation to enhance existing reporting around activities and expenditures not reported on a claim and non-covered services (i.e. social determinants of health).
4. **Consider the entire population in risk adjusted rate setting,** moving beyond entity-specific population to a uniform payment method

Response detail

Commenters expressed support for moving toward risk-adjusted, partial capitation payments that incorporate costs related to addressing social determinants of health. DHS recommends having more targeted conversations with potential responders, including providing financial modeling and other supportive data to entities about the payment model construct.

Recommendations to carry forward and/or items needing additional input

DHS recommends an initial application and letter of intent for entities interested in the Next Generation IHP model to allow time for financial modeling and further development of the financial model and risk arrangement. This is a similar process DHS conducted during the initial implementation of the IHP program. DHS would intend to provide the transparency and details of the financial model in advance of the formal RFP for both Next Generation IHP and MCO contracts proposing to serve the seven-county metro area.

Outcomes/quality measures

Overview of discussion

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

DHS will want to better understand which measures are most meaningful and actionable for providers during the request for proposal process.

Feedback confirmed the understanding that health care professionals are uniquely positioned to work with one another and their patients to treat illness *and* address barriers to health, such as a lack of healthy food, substance use disorders or medication issues.

Input was solicited on the best existing and new ways to measure such barriers to health, and appropriately balance the cost and improved health outcomes. People expressed support for increased flexibility for providers in choosing solutions that work for their communities. Similarly they encouraged a greater focus on tackling broad barriers to health. The feedback suggests to DHS that the related approaches proposed will work for the community and should be carried forward.

Advancing quality measures

- **Build on the success of a generation of health care innovation**, culminating in our Integrated Health Partnership program, the foundation for this program
- **Respond to uncertainty around federal funding** and work with providers to build a more efficient approach
- **Continue DHS' long-standing investment in reforms that deliver better health to our enrollees at lower costs**
- Develop better strategies to **address public health crises such as the opioid epidemic**

Summary responses

Responders expressed support for continued efforts to include social determinants of health in the quality and payment framework, as well as for the need for effective infrastructure to collect, report and share information among clinical and social service providers. Respondents were in favor of giving providers flexibility to address social determinants in a way that would be most appropriate for their patient, using input from community-based organizations. However, there was a tension among responders regarding provider accountability for social determinants, with some expressing that risk should not extend beyond health care delivery outcomes and the need to be careful to avoid adverse patient selection.

Many responders noted that appropriate risk adjustment methods and more standardized collection and sharing of assessment data are needed to both measure and achieve desired outcomes. Respondents encouraged the inclusion of community members and stakeholders in the measure development, vetting and selection and the inclusion of providers to develop methods for measuring population health and prevention. Respondents also encouraged the inclusion of:

- Functional status measures
- Patient- and family-reported outcome measures
- Longer term health outcomes
- Ways to measure and evaluate resources in place to address health inequities.

Regarding measure alignment, most responders acknowledged the importance of reducing provider burden and confusion through use of standard state and federal measure sets, but there was also

recognition of the importance of measure relevancy and the need to recognize populations with special health needs including behavioral health and substance use disorder.

Recommendations to carry forward and/or items needing additional input

The feedback on the quality measure questions was generally consistent with the proposed approach. DHS should choose core measures that align with state and federal requirements, but allow for some level of flexibility in methodology to allow providers and community partners to focus on measures most relevant for their patients, which is similar to the existing IHP quality methodology.

Going forward, it is recommended that we specify which measures would be used for which model components, and that we develop and put more clarifying detail on how the model will incent longer term wellness and prevention (not just measures of process and appropriate treatment of chronic disease).

DHS will need to use lessons from implementing the population-based payments under IHP 2.0, which includes applying a risk adjustment methodology that accounts for some social risk factors.

Many responders highlighted the lack of an integrated interoperable health record across the continuum of care and the current Minnesota Health Records Act as obstacles to effective care coordination. Continued support of provider participation in the Medicaid Encounter Alerting Service will help accelerate the interoperability of transition of care information among providers.

An evaluation plan and consistent mechanisms to track interventions and ensure that model objectives are being met must be established.

Additional work is needed to put clarifying detail around how entities will be held accountable for infusing equity and cultural competence in service delivery.

Additional discussion and work is needed to identify options for incentivizing eligible members to be engaged in their health.

Financial measures

When health professionals and care providers across specialties and settings coordinate care to deliver health — not just procedures — costs go down and quality goes up.

Leveraging financial measures

Refocusing the incentives on health

- Today we pay health care providers based on the number of procedures they deliver. This system leaves them without the time they need to personalize care or work with patients toward long-term health.
- Too little of every dollar spent on health care is devoted to patient care, making it burdensome for people to consistently get the care they need, understand their options and make informed decisions.

Increased providers accountability

- Providers will be responsible in part for how well their patients do. They will be encouraged to devote resources to address their patients' unique needs. They will then share in the savings they help create when they keep people healthier. They will pay back innovation funding when health goals are not met.

Summary responses

Respondents expressed some concerns about linking financial rewards to social determinant-related health outcomes and interventions that are outside a traditional scope of practice. Additionally, many provider systems emphasized the importance of ensuring sufficient financial support for infrastructure and operationalization of quality measurement that is above and beyond what is typically covered in medical FFS payments. There was strong preference for phasing in the impact of measures on payment, and support for risk and performance measures to be flexible over time. Responders noted the importance of monitoring the financial health of Next Generation IHPs as part of the minimum expectations of participants.

Recommendations to carry forward and/or items needing additional input

DHS should develop financial modeling and information with greater detail to allow potential responders to understand the possible impacts of outcomes-based payment adjustments on their performance.

Support for addressing social risk factors will result in improved health outcomes and lower costs to which providers are accountable, but results may not be immediate. In further developing the measures and payment model details, DHS will support providers' efforts to address social determinants of health and continue working with stakeholders on risk adjustment methods. Furthermore, DHS recommends down-side risk on performance be limited to health outcome measures.

DHS will need to consider enhanced financial reporting to track investments made by Next Generation IHPs and health plans in social determinants of health and community partnerships.

DHS systems modernization efforts for creating an integrated service delivery business model will help support the improved collection and sharing of information of needs assessments and which members are connected to needed supports. Where possible, DHS should coordinate and align implementation of the Next Generation model with applicable components of this systems modernization work.