Integrated Health Partnerships

Request for Information (RFI) Summary and Highlights

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# Table of Contents

- Purpose and Objective ..................................................................................................................................... 3
- Background...................................................................................................................................................... 4
- Sustainability and Infrastructure Needs ........................................................................................................... 5
- Payment and Performance on Cost .................................................................................................................. 8
- Member Attachment ....................................................................................................................................... 9
- Integration of Services ................................................................................................................................... 11
- Quality and Patient Outcomes Measurement.................................................................................................. 13
  - Measurement Alignment ................................................................................................................................. 13
  - Social Determinants of Health ....................................................................................................................... 13
- Other ............................................................................................................................................................. 16
Purpose and Objective

In April 2016, the Department of Human Services released a Request for Information (RFI) soliciting comments on enhancements to the Integrated Health Partnerships (IHP) program to support innovative health care delivery systems serving Minnesota Health Care Programs (MHCP) populations authorized under Minnesota Statutes, §256B.0755.

The IHP program has allowed the Minnesota Department of Human Services (DHS) to engage in alternative payment arrangements directly with provider organizations that serve an attributed population, in an agreed-upon Total Cost of Care (TCOC) and risk and gain sharing payment arrangement. Quality of care and patient experience are measured and incorporated into the payment models alongside cost of care.

DHS is interested in advancing this accountable care model to continue to improve the quality of and reduce the cost of care provided to individuals in the state’s public programs, such as Medical Assistance (Minnesota’s Medicaid program) and MinnesotaCare.

DHS received 27 responses to the RFI and synthesized the feedback with the goal of preparing revisions to the IHP model for the 2018 IHP contracting cycle. Respondents ranged widely; DHS received responses from smaller, specialty health care providers to large mature health systems, nonprofit interest groups, coalitions, health plans, behavioral health and disability providers, and current and potential IHPs.

A full list of the respondents can be found below:

South Lake Pediatrics
Medicity
MNACHC (Minnesota Association of Community Health Centers)
People Incorporated
Blue Cross Blue Shield Minnesota
Zumbro Valley Health Center
Minnesota Hospital Association
Gillette Children’s Specialty Healthcare
Planned Parenthood Minnesota
ClearWay Minnesota
Minnesota Community Healthcare Network
Medica
Mayo Clinic

HealthPartners Allina Health
FUHN (FQHC Urban Health Network)
UCare
MN Health Care Safety Net Coalition
Hennepin County Medical Center & Hennepin County
Northwest Metro Alliance
PrimeWest Health
Minnesota Council of Health Plans
Lakewood Health System
Bluestone Physician Services Altair
ACO - Disability Services
TakeAction Minnesota
Southern Prairie Community Care
The IHP program was designed to reduce the total cost of care for Medicaid patients while maintaining or improving the quality of care. Combined, Minnesota’s now nineteen IHPs provide care to over 340,000 Minnesotans enrolled in MHCPs, and have achieved an estimated savings of $76 million dollars. A portion of these savings are used by provider systems to support expanding use of care coordinators, extending available hours for primary care clinics, and developing partnerships with community supports that impact the health of members. Additional background on the current IHP program and methodologies can be located at DHS’ Integrated Health Partnerships (IHP) Overview webpage.

The IHP program was designed to be flexible, in order to allow for a wide variety of member and provider participants, and to integrate different potential care management strategies and operating models.

For example:

- The IHP program builds off existing care and delivery systems but does not require specific or prescribed care models. This gives providers flexibility to develop innovative methods for coordinating and delivering care to improve patient health and experience with few new requirements.

- Systems with smaller regional footprints and provider groups that may not have direct affiliation with a hospital system are able to participate. Many of the payment model components (risk-share percentages, maximum per-member expenses, trend targets, etc.) allow for customization to reflect the specific circumstances or preferences of the provider participants.

- Attribution of MHCP enrollees and their TCOC calculations are done across Minnesota’s Health Care Programs (MHCPs). This includes Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Special Needs Basic Care (SNBC), and members enrolled under DHS fee-for-service or in any of Minnesota’s Medicaid managed care organizations (MCOs). Incentives are aligned across the MHCP population segments, and providers who may have small numbers of enrollees with any single MCO can participate based on the size of their aggregate Medicaid population across programs and MCOs.

- The IHP program allows for wide flexibility in the structure and governance of any participating provider organizations. Current participants range from large integrated medical groups, to collaboratives made up of independent physician groups and hospitals and rural independent physician groups.
Sustainability and Infrastructure Needs

The current IHP total cost of care model incentivizes effective care delivery across a wide spectrum of health care system models and provider settings, and is a transition step away from fee-for-service payments. However, potential shared savings alone is not a sustainable source of operating revenue.

1. **What percentage of revenue would need to be at risk or tied to care coordination services for your organization to drive meaningful changes to care delivery across your organization? What factors influence the proportion of revenue that your organization would need to receive through a reliable, consistent source, versus being contingent on your performance? Please provide sufficient details to fully understand your response.**

2. **DHS is considering a base, consolidated, care coordination payment to IHPs. If there was a single IHP prospective payment for care management (i.e. consolidating current care management payments received through Health Care Homes, Behavioral Health Homes, in-reach services, Targeted Case Management), what level of per patient payment would be required to cover the costs of enhanced care coordination activities. Would some portion of that payment need to be outside of any risk arrangement (i.e. not tied to cost and/or quality performance)? Please provide sufficient details to fully understand your response.**

Respondents had difficulty quantifying the percent of revenue that would need to be at risk. Many respondents cautioned tying revenue to risk without further research into various unknown factors, for example, the ability to incorporate risk adjustment for patient complexity, and the effect of reimbursement rates among different types of providers on ability to take on risk. Responding health plans encouraged DHS to implement downside risk across all IHPs at a minimum of 50%.

Health system respondents were strongly in support of some type of an upfront care coordination payment, of which at least a portion (and possibly all) is outside of the risk arrangement. Options included adjusting the payment over time, or adding “enhanced” care coordination payments to the base payment. DHS was cautioned to recognize potential duplication of care management services from MCOs, SNBC, and Minnesota Senior Care Plus (MSC+) non-dual members, and to factor in certain costs that are included in care coordination and management, such as transportation, staffing, training, complex patients that require more intensive care coordination, and behavioral health. At least six respondents noted the inadequacy of the current Health Care Home (HCH) care coordination payment, and others recommended consolidation of the HCH, behavioral health home (BHH), in-reach services, and target case management payments. A few respondents mentioned alignment with other payment structures such as Comprehensive Primary Care Plus (CPC+) in terms of utilization of a per-member per-month payment based on patient complexity, and Advanced Alternative Payment models under the Medicare Access & CHIP Reauthorization Act (MACRA) prospective payment systems methodology. Health plans voiced concern regarding the ability to incorporate administrative costs incurred by MCOs in the payment, and discouraged DHS from adding payments, unless these payments mirror the financial structure of MCOs payments and were explicitly included in an IHP’s total cost of care calculations.
3. **What infrastructure and supports need to be in place for a wider variety of providers to participate in total cost of care models?**

Ability to share, strengthen, and act upon health care data and technology emerged as the top recommendations for infrastructure and support needed to be in place for a wider variety of providers to participate in total cost of care models. Recommended mechanisms to do so included the following:

- Addressing the barriers present in the Minnesota Health Records Act
- Providing funding to implement a Health Information Exchange (HIE) in health systems (particularly independent or smaller systems with limited resources)
- Pursuing 90/10 funding through the CMS Medicaid Meaningful Use program to build out technical infrastructure for MN Health Insurance Network (HIN) to facilitate exchange with Health Information Organizations (HIOs)
- Support of data analytics expertise that can apply data analysis of IHP reports
- Facilitating sharing data on outside-network encounters
- Enabling action on total cost of care through tools such as real-time event notifications in the Electronic Health Record (EHR)
- Support for population health such as identifying patients needing care coordination
- Incorporation of social services data and contacts into the HER

Other comments included various improvements to the existing IHP model: ensuring that members are assigned to one IHP at a time (as is currently in place), greater safeguards for outliers or catastrophic events, making IHP Portal reports ready-to-use for providers, and improving patient engagement activities. A few respondents also mentioned variations of an IHP program on-ramps, with lower risk in the beginning stages that progressively increases over time and experience, which would be conducive to providers for complex or disabled populations. One respondent recommended overall alignment with the State Innovation Model (SIM) Multi-Payer Alignment Task Force.

4. **Under a population-based payment structure, where a provider system takes on greater levels of risk and responsibility tied directly to the care and health outcomes of their patient population, what responsibilities would provider systems be able to take on (e.g. care management, utilization management, etc.)? Under this type of a population-based payment structure, how would the additional provider responsibilities integrate with the responsibilities of the managed care organizations, and what role would MCOs need to play to support the provider system?**

Responsibilities between MCOs & Providers: All respondents were interested in clearly delineating the responsibilities of providers versus MCOs, and ensuring no duplication of services, which would cause confusion for patients and systems waste. Some respondents stated that these conversations should be between the provider and the MCO, but supported by IHP, and to exercise caution before transferring responsibilities from MCOs to providers or vice versa. Responses were mixed regarding quality measurement and improvement.
activities between IHPs and MCOs, but two respondents stated that the two parties should have mutual cost and quality incentives.

Role of the Provider: Health systems expressed interest in taking on a range of care management responsibilities. For example, some respondents wanted providers to take on facilitation of communication with the physician and immediate intervention, patient satisfaction, population health improvement, and even utilization management. MCOs generally encouraged the idea that providers could take on more care management, but not utilization management.

Role of the MCOs: MCOs made the distinction between care management (provider responsibility) and utilization management (MCO responsibility), and strongly suggested that these conversations remain between MCOs and providers. For health systems, the role played by MCOs centered around data: from the provision of timely utilization data and existing population-based data, reporting and analytics, consistency and coordination with other MCOs. One respondent suggested the establishment of a “community benefit” requirement that MCOs support activities related to data analytics, care coordination, and data exchange.

5. What mechanisms could the state use to ensure the necessary infrastructure is in place and used appropriately by entities participating in either total cost of care or population-based payment arrangements?

Several respondents, both providers and health plans, suggested that instead of evaluating infrastructure supports, the state should focus on health outcome metrics and the ability to report on these metrics. Additionally, several respondents identified the health care homes certification process as an important tool for ensuring a provider has the proper infrastructure in place.

Respondents also highlighted the state’s role in helping providers maintain the proper infrastructure, echoing many of the points identified under question 3.

6. As multiple payers move towards value-based payment (VBP) models providers report that maintaining multiple VBP contracts across their patient population can lead to challenges and complexity. How could the IHP program be structured, either contractually or operationally, to enable it to more effectively align with other payer’s value-based payment programs? What opportunities are there to enable broad alignment across multiple payers moving towards value-based payment models?

Respondents urged DHS to align IHP with other federal value-based payment contracts and national standards, including MACRA and Health Care Payment Learning and Action Network (HCP LAN) models. For example, regarding quality, Federally Qualified Health Centers (FQHCs) suggested that DHS accept existing reporting metrics that FQHCs currently report to the Health Resources and Services Administration (HRSA). MCOs suggested further use of CMS Star Quality Measures.

MCOs also suggested that DHS take into consideration the provider, member, and MCO activities and market fluctuations that could drive higher or lower claim costs, and reiterated the need to incorporate downside risk into all IHP arrangements.
Respondents also urged DHS to align IHP with other state and local standards. Examples included coordinating data efforts through the Administrative Uniformity Committee (AUC) at the Minnesota Department of Health (MDH); developing a state risk pool similar to the Worker’s Comp program; and continued alignment with Health Care Homes, behavioral health homes, and MCO care coordination arrangements. One respondent suggested that DHS’s Integrated Care System Partnership (ICSP) could be an example of working collaboratively across payers.

**Payment and Performance on Cost**

Unlike insurance risk, where an entity must have sufficient reserves to guarantee solvency in catastrophic events, providers in total cost of care arrangements, like IHP, take on limited risk for their performance.

7. **What factors might indicate whether a provider system has reached its maximum efficiency and can no longer expect to achieve savings compared to their own historically benchmarked targets?**

Many respondents were skeptical about setting a standard of maximum efficiency for the IHP program as it is still very new. However, suggestions to measure maximum IHP efficiency included: comparison to a fair best practice benchmark using risk adjustment; benchmarking nationally, regionally and locally; looking at the stability of attributed population, having a combined benchmark measuring providers against themselves, between peers and other objective standards; comparison to an IHP’s base year; comparison to a fair best practice benchmark; and improvement in health outcomes metrics.

8. **To what extent should an IHP’s TCOC targets be based on market performance rather than against their own performance over multiple years?**

   i. **Should an IHP be eligible for potential savings based on either performance against a target or improvement from prior performance? Why?**

   ii. **If savings or losses are based on market performance, how should the groups of providers or geographic areas be defined?**

   iii. **Should performance be weighted in a way that emphasizes or de-emphasizes the impact of certain types of care or the systems’ performance on specified populations? For example, should we allow for an IHP to take on more risk for a core set of services and less risk on long-term care services? Why?**

The majority of respondents suggested that flexibility and choice for IHPs was very important: a mix of market performance or improvement from the IHP’s own prior performance would be ideal for IHP performance measurement. A few respondents were hesitant to encourage basing savings on market performance, until IHPs can achieve a fairly stable performance level.

Market performance was favored by respondents if the market performance measures were able to take into account specific populations and tiers of cost. Suggested methods to resolve this issue included:
• Allowing providers to select comparable peers based on their estimated cost of care, case mix, or level of patient complexity (especially high risk population groups by age, condition, etc.)
• Geographic comparisons (metro vs. rural)
• IHP type
• Provider specialties and availability of ancillary services
• Rewarding performance excellence for those leading the market

One respondent suggested blending historical costs with benchmark measures, and pairing improvement incentives with benchmark achievement incentives. Another respondent requested that the base period not be reset at the end of the three-year contract period. Of the nine respondents that favored weighting of some kind, the top suggested factors to weight were social determinants of health and socioeconomic complexity, IHPs taking on a fuller scope of population management and the degree of influence or impact that an IHP has on the utilization of a service, and level of inclusion of other programs and initiatives who could contribute to IHP savings.

Member Attachment

The retrospective use of a member’s prior evaluation and management visits to determine association to a provider group is a common method of attribution that reflects the member’s choice. However, many members are not included with this approach because they have not sought this type of care in the recent past, or their care is predominately provided by specialists.

9. What additional types of care or services should be considered when determining a member’s principal provider for purposes of attribution? Why?

While a small portion of respondents suggested that primary care services should be the only care or services considered when determining a member’s attribution, the majority of respondents had a range of suggestions for additional care and services that should be considered. A few respondents stated that primary care and multi-specialty delivery systems should be considered for attribution. One respondent specified that specialty care for chronic conditions should be considered. Three respondents suggested that attribution occur at the provider group (clinic) level as opposed to the individual provider (currently, attribution is at the IHP level), and another respondent suggested that services provided by other professionals such as physicians and nurse practitioners should be considered eligible for attribution. One respondent suggested adding emergency care, and performing proactive outreach to individuals with disabilities or chronic conditions who only seek care in the Emergency Department. One respondent said that IHPs could be allowed to define the services that quality a member for attribution, and another mentioned attribution by geography. In terms of specific services, respondents suggested adding behavioral health services and outpatient mental health, as well as substance use disorder assessment, treatment, and detox, as well as homeless outreach, residential treatment, and case management.
10. Should members be able to designate a principal provider system during enrollment; and if so, what criteria would determine which provider systems would be available for selection by a potential member?

The majority of respondents suggested that prospective attribution should be used to determine a patient’s principal provider. However, most respondents were additionally unsure if the IHP program would be able to accommodate such a change while ensuring that a patient’s choice of provider remained paramount. Some of the suggestions and caveats to prospective attribution were that there should be a product or benefit design that limits or, more preferred, incentivizes members to receive care from their designated principal provider. A few IHPs stated that ensuring that providers that can be designated as a principal provider meet certain criteria would be an important step in prospective attribution. One respondent recommended that DHS start with a prospective attribution “pilot” before rolling out prospective attribution to all IHPs.

The remaining three respondents who expressed doubts about prospective attribution were concerned that it could decrease access or create barriers for care, particularly for patients that have less stable provider relationships, and suggested that attribution be based on actual utilization by the patient.

In the case that prospective attribution is not possible, one respondent offered up the suggestions in HCP LAN white paper, which include using a claims and encounter based approach, defining eligible providers at the beginning of the performance period, providing information to patients regarding their attribution, and prioritizing primary care in claims-based attribution.

11. How do we determine that a specialist is acting as a patient’s principal provider, particularly for those patients with unique or complex conditions?

The majority of were in support of certain specialists acting as a patient’s principal provider, with various perspectives towards how this should be implemented. Some of the suggestions for criteria for determination of specialists as the principal provider included:

- Principal providers must demonstrate the ability to coordinate care through methods such as comprehensive care plan (similar to HCH), or through behavioral health providers (BHH Designation).
- Principal providers must also be able to realistically coordinate local care for the patient (e.g. patients with chronic conditions in rural areas may need regular care from providers in the metro area).
- DHS should set the scope of specialists’ duties: Some respondents suggested only the demonstration of connection to primary care, while others wanted to limit the specific situations in which a specialist would be principal provider (e.g. oncology, neurosurgery, OT, PT, speech and pharmacy patients with brain tumors).
- Be designated as principal provider by diagnosis code or by frequency of visit.

Several respondents strongly suggested that designating a specialist as a principal provider would not be appropriate, and could weaken or diffuse the overall role of primary care physicians. They agreed that specialists should be included in accountable care arrangements, but in the form of formal partnership agreements and possible risk sharing as opposed to acting as the principal provider. They also stated that specialists should not necessarily be assumed to be providing primary care and coordinating patients’ needs. One respondent thought
about implications on trends, stating that it is too difficult to segment the trend into subpopulations by specialty, and this could further complicate trends for primary care providers being measured in the model.

Integration of Services

Our health outcomes are significantly impacted by factors beyond simply the medical care we receive, including socio-economic and environmental factors. Therefore, effective health care coordination requires relationships across a broad spectrum of medical, behavioral health, and social service supports. These relationships between providers, whether medical, behavioral health, social service, or other type of provider, may be formal or informal in nature, and may or may not be embedded in the risk arrangements of an IHP.

12. **How could non-primary care providers, such as behavioral health, chemical dependency, or disability service providers, participate in a risk bearing IHP-type of arrangement? What level of risk would these provider types be able to take?**

13. **Should IHPs be required to formally partner with non-primary care providers, such as behavioral health, chemical dependency, or disability service providers? How should these partnerships be structured? Under what circumstances would these partnerships be required (for example, in order to receive enhanced prospective payments or a population-based payment)? How would an IHP demonstrate that these partnerships are in place and adequate to fulfill any such requirements?**

Most respondents considered it premature to consider non-primary care providers to be full partners in risk-bearing arrangements, with many stating that IHPs should be incentivized, but not required, to formally partner with non-primary care providers. These respondents agreed that IHPs should be encouraged to align with non-primary care providers, but to require formal partnerships could result in less than optimal partnerships, with terms negotiated by the partners. Some larger systems stated that they already contain non-primary care services within their current programs and services, and that the addition of these services must not negatively influence targets.

However, many expressed a desire to move toward the goal of non-primary care providers taking on risk in partnerships and offered suggestions on how to implement this. At least three respondents recommended introducing a gradual on-ramp whereby partners can phase-in the amount of risk they would take on according to time or experience, such as an activities-based payment arrangement (where the IHP pays the partner for specific activities) that eventually ramps up to an outcomes-based arrangement, or beginning as partners and then determining level of risk as value and performance is determined. Another respondent recommended a regional model where non-medical specialists and providers receive support payments or targeted grants from DHS in exchange for partnering with one or more IHPs in their region.

Many respondents offered suggestions on the regulation and management of these partnerships. A few respondents stated that the terms of any partnerships should be managed between the IHP and the non-primary care partner, not regulated by DHS through the design of the overall IHP program. DHS was encouraged to remain flexible in terms of risk arrangements, such as incentivizing non-primary care providers with upside risk only and limiting the risk to specific quality measures tied more closely to the non-primary care provider’s direct area of influence.
14. How could non-medical social service providers, such as housing services, food banks, job placement services, or other community programs, participate in a risk bearing IHP-type of arrangement? What level of risk would these provider types be able to take?

15. Should IHPs be required to formally partner with non-medical, social service providers, such as housing services, food banks, job placement services or other community programs? How should these partnerships be structured? How would an IHP demonstrate that these partnerships are in place and adequate to fulfill any such requirements?

The responses to this question were divided, mostly due to the uncertainty around the value of non-medical social service providers in health care cost-reducing partnerships, and ability for them to impact costs and absorb risk given their financial structure. The majority of respondents agreed that IHPs should not be required to partner with non-medical providers, but should rather be incentivized and encouraged to partner. Some suggestions for next steps in this direction that respondents made were to first focus on understanding the impact of partnerships on cost, for example, by introducing survey instruments for social determinants of health that are aligned with national efforts (for example, CMMI’s Accountable Health Communities). This would also allow DHS to assess the value of the partnerships, give organizations opportunity to provide feedback on integration, compensation and feedback, and give patients opportunities to provide feedback on care coordination received.

DHS could also create risk and payment arrangements that would incentivize IHPs to partner with non-medical social service providers such as upside only risk, sharing of PMPM payments, or testing “enhanced” capitation payments. One respondent suggested creating an informal list of potential activities that could eventually qualify as a “community partnership” with IHPs. Two respondents mentioned the need to coordinate with HCH, BHH, and county social service agencies for payment alignment, and to be wary of duplication with other care coordination efforts.

16. In order to capture the full costs of a member’s health care, should non-medical, social service costs be integrated into a cost of care model and financial arrangement? If so, how? What non-medical services should be considered for inclusion?

Respondents agreed with the underlying premise of this question – that Minnesota does not currently have a comprehensive model of the full cost of members’ healthcare. Respondents cautioned DHS to understand the costs of additional coordination efforts and services before fully incorporating them into the model, or giving IHPs flexibility and incentives but not requirements to include non-medical services. MCOs cautioned that services should be added only if the costs actually have direct impact on medical costs and quality outcomes. Other requests for inclusion in DHS’s model included acute, post-acute, medical, and all social services. Two respondents also wanted to include waiver-covered residential housing costs, vocational and day programs, care coordination costs, and multiple respondents mentioned covering the full Medicaid benefit set (e-visits, telephone visits, nurse visits, virtual visits, and home visits).
Quality and Patient Outcomes Measurement

One of the overt goals of the IHP program is to increase the overall quality of care that patients’ receive. Currently, the IHP program ties a portion of an IHP’s shared savings to performance on a sub-set of measures found in Minnesota’s Statewide Quality Reporting and Measurement System.

Measurement Alignment

Outside of specific questions, many respondents emphasized the need to align quality measures across state and federal quality programs, such as Medicare’s Merit-based Incentive Payment System (MIPS), Physician Quality Reporting System (PQRS), Value-based Payment Modifier, clinical practice improvement measures, the Minnesota Statewide Quality Reporting and Measurement System (SQRMS), and various Accountable Care Organization-related measures. Measurement alignment would minimize burdensome reporting requirements and allow providers to focus on quality improvement.

Two respondents recommended aligning IHP measures with specific measure sets. For example, measures collected for the Federally Qualified Health Centers (FQHC) and measures used by the MN Department of Human Services (DHS) to measure quality performance of managed care organizations (MCOs). Finally, one respondent recommended that provider systems should have the ability to select metrics from a broad core IHP measure set to ensure that metrics are tailored to the specific population of patients they serve.

Social Determinants of Health

In addition to the need for measurement alignment, many respondents also emphasized the need for inclusion of social determinates of health in any payment methodology that incorporates quality metrics. Social determinants of health have been shown to have a significant impact on population health. Several respondents suggested that measures used in the IHP demonstration should be risk adjusted for socio-economic complexities of the attributed patients.

17. Are there additional quality metrics outside of Minnesota’s Statewide Quality Reporting and Measurement System that should be considered for inclusion across all IHPs?

Respondents recommended several quality metrics for inclusion across all IHPs, including:

- Measures that reflect the patient’s perception of their health and their perception of their role in the management of their health. Specifically, CDC’s “Healthy Days” measure, Patient Activation Measure (PAM), and the National Core Indicators to assess the outcomes of provided services.
- A tobacco use and treatment quality measure with adequate risk adjustment methodology, e.g. the Preventive Care and Screening Tobacco Use measure that has been endorsed by the National Quality Forum (NQF #0028).
- The Contraceptive Use Performance Measures that were developed by the Office of Population Affairs (OPA) and the Centers of Disease Control and Prevention (CDC) and are currently under review for the NQF’s endorsement.
• Outcome measures such as increased emergency department utilization, levels of hospital readmission, rates of hospitalization and length of stay, use of crisis services, rate of institutionalization and length of stay, as well as non-refill of medications.
• Dental visits, annual well-care exams, cancer screening, and medication management measures related to chronic conditions and behavioral health.
• Two respondents recommended moving away from the SQRMS slate of measures and instead using claims-based performance metrics as well as measures reported by IHPs or the Centers for Medicare and Medicaid Services (CMS) Five-Star Quality Rating System.

18. What process, access or health outcomes measures related to the use of non-primary care services, such as behavioral health, chemical dependency, or disability services, could demonstrate that a patient population’s health needs in those areas are being addressed or met? How can these be measured?

Most respondents agreed that capturing the quality of these services and health outcomes was critical, but that metrics are not always available or reported, and so inclusion in the payment model should only be done cautiously. Several respondents suggested that DHS evaluate the degree to which non-medical outcomes were being achieved, possibly using the standard measures developed under the National Core Indicators project. This evaluation could be at a patient or population level.

Many respondents further suggested that SQRMS does not include appropriate behavioral health measures, in particular. IHPs that serve populations with complex behavioral health problems should have the option to operate under measures that are better suited to their clients. IHPs could choose from already existing National Quality Forum (NQF) measures, Health Effectiveness Data and Information Set (HEDIS) measures or subscale measures from the Level of Care Utilization System for Psychiatric and Addition Services (LOCUS) instrument, the World Health Organization Disability Assessment Schedule (WHODAS) or the Adverse Childhood Experiences (ACEs) questionnaires. One respondent suggested exploring the CDC’s Behavioral Risk Factor Surveillance System (BRFSS) annual survey. Two respondents recommended the inclusion of social determinants of mental health into the SQRMS, electronic health records, and any other IHP performance measures. Other respondents also recommended using the CMS Five-Star Quality Rating System to assess behavioral health and chemical dependency outcomes; increasing use of early intervention programs for mental health and chemical dependency; and aligning IHP quality measures with the Medicaid Behavioral Health Homes quality measures set.

19. What process, access or health outcomes measures related to the use of non-medical services, such as housing services, food banks, job placement services, or other community programs, in interventions could demonstrate that a patient population’s health needs are being addressed or met? How can these be measured?

Respondents generally stated that DHS should incorporate non-medical enabling services fully into the IHP demonstration, but include them for reporting purposes only (i.e. not have a direct impact on payment). Non-medical enabling services include but are not limited to transportation, care coordination, language translation, housing, food supports, and financial assistance. Several respondents suggested that the data on the impact of these services on a patient’s health, and the ability for a physician to impact these services, is still in its infancy.
Respondents suggested that community partnerships should be evaluated with process measures rather than outcome measures. Another respondent suggested that DHS should aggregate a complete list of county social services and require counties to contribute additional data that would allow for the evaluation of the IHP demonstration on non-primary care services. Finally, one respondent suggested that DHS, together with the Minnesota Department of Health (MDH), could evaluate the added value of community-based providers who address socio-economic barriers such as homelessness, language, as well as racial or cultural barriers.

20. Should a state monitor an IHP’s impact on the health disparities faced by their patient population? If so, how?

Most respondents agreed that this is a critical area that the state should monitor, but current methods would make it very difficult to attribute any impacts directly to an IHP. This effort would require better collection of race, ethnicity, and language (REL) data across the health care system – not just across IHPs. Additionally, respondents agreed that REL data is key to ensure that providers are not penalized for serving populations with disproportionate barriers to health.

Respondents also agreed that DHS should monitor progress IHPs are making to reduce health disparities, where possible. One respondent suggested that DHS should provide opportunities for IHPs to share best practices and lessons learned to maximize impact and improve outcomes. New measures should be considered to evaluate the effectiveness of efforts to address health disparities and DHS should provide additional incentives to IHPs that demonstrate improvement in health disparities. One respondents, however, expressed a concern that health disparities should be measured across the entire IHP population, not at the individual IHP level.

Another respondent suggested that outside of the IHP contract, DHS should consider funding provider systems that develop innovative models to address health disparities. These rewards could last three to five years to allow for the model to be developed, studied, improved upon, and sustained over time.

21. Currently, an IHP’s quality measurement results could lower the percentage of shared savings that the IHP earned through lower costs. Should quality measurement results additionally mitigate some of an IHP’s responsibility for any shared losses they may end up owing? Should IHPs be able to earn above their shared savings if quality is exceptionally high?

Respondents disagreed on whether to allow quality performance to impact both shared savings and losses. Arguments for allowing quality to mitigate losses were that quality and cost should have equal weighting in impacting payments, and that particularly high quality IHPs should be eligible for bonuses. On the other hand, opponents of this approach indicated that quality could undermine the Triple Aim goals, allowing for payments in lieu of cost containment.

Many respondents added that if quality impacts an IHP’s payments in any way, DHS should use risk- adjusted measures and align its quality methodology with what providers are already doing for other programs like MIPS. One respondent said that quality should not factor into IHPs payments when those payments are passed through MCOs because MCOs’ capitation payments from the state do not include any quality payments.
Other

22. It’s possible that some proposed enhancements will require more time to authorize and implement, for example, if they require a federal waiver. Should the state consider making incremental changes as components are authorized, or should the state wait until all components are authorized and introduce a single cohesive package?

Respondents were evenly divided on this question as to whether changes should be implemented incrementally or all at once, without any particular pattern related to specialty versus primary, large versus small provider system, or type of respondent. One respondent requested to wait until changes could be aligned with BHHs (behavioral health homes) or CCBHCs (certified community behavioral health clinics), and another requested that changes be implemented incrementally in order to evaluate the change components separately over time, while another requested implementation all at once to ease administrative burden and ensure a more complete package.