HC Delivery Design & Sustainability – Suggested Priorities

# Continuum of Care/Care Delivery Reform

*Immediate*

1. Deepen patient engagement with providers – **assignment, as opposed to retrospective attribution**, to primary care for public program enrollees; short of full prospective assignment of state public program enrollees to a care provider, having enrollees select a primary care provider (like they select a MCO) and then allowing the provider some flexibility to engage them is critical.
2. **Prospective payment to providers for care management** (broadly defined) services; currently the reimbursement for care management services does not exist, is inadequate or too burdensome. Creating a prospective payment for providers, who can then have the flexibility to deploy the best wrap around tool/service would unlock a big area of innovation. This would help small and large providers alike to care for the highest utilizers with personalized tools. Using data to target these resources would create a large impact. This approach would also help to bridge medical care with social services to address the social determinants of health.
3. Replace our delivery and payment system with a “**Primary Care Case Management” (PCCM) system** in which DHS would contract directly with providers, and the role of navigators would change to helping people navigate the ***care*** they need, not the ***coverage*** they get.
4. Promote consumer understanding of **how to best** **access care** once they are enrolled into coverage.
5. **Inventory and evaluation of current state programs** for efficiency, effectiveness and impact on continuum of care, i.e. patients moving between programs.
6. Network requirements and adequacy standards.

*Mid- to Long-term*

1. Figure out how to **proactively attribute** consumers to IHP model.
2. Move Minnesota to a **publicly-financed, privately-delivered** health care system.
3. Minnesota should take advantage of the Affordable Care Act’s Section 1332 Waivers by designing and proposing a **universal health care system**, where there are no seams in coverage. This includes no seams in who is covered (all Minnesotans) or in what is covered (all medical needs, including dental, mental health, long term care, chemical dependency treatment, prescription drugs, etc.). The entire focus should be on creating a health care system that keeps people healthy, and gives them access to the care they need, when they need it.
4. **Reduce silos** between the parts of the care continuum. How do we change the way that DHS is organized and we budget for programs to promote a seamless care continuum that goes from prevention/public health all the way through Home and Community based services?
5. Incentivize providers who proactively work with **Public Health**; Partnership for Health
6. Work to increase **provider availability** across Minnesota including **primary care** and **mental health** providers to address the current and anticipated shortage.

# Value-based Direct PRovider Contracting

*Immediate*

1. Expand/extend **Integrated Health Partnerships (IHP)** [Minnesota’s Medicaid ACO] demonstration.
2. **Align incentives** so providers who are already doing well from a quality and cost perspective are rewarded.
3. **Direct contracting** with providers (health care professionals and facilities that provide direct care to patients).

*Mid- to Long-term*

1. Develop payment models for **duel eligible population**. This is an expensive population and it will only continue to grow as the population ages.

# Data Sharing

*Immediate*

1. Clear barriers to appropriate **data sharing** to facilitate more seamless care (HIPAA conformity is the most pressing issue, but not the only issue). Improved data sharing is the critical infrastructure needed to help bridge the care continuum, social services, and community health partners. This is also important for providers to be able to take more financial risk. Good examples include: EMS and homecare – it is easy for gaps to form in a person’s care because data is not accessible to the providers. This can be accomplished with a legislative change to the Minnesota Health Records Act.

*Mid- to Long-term*

1. Require all **payers to share data**.
2. Health information **exchange**.

# Quality Metrics and Analytics

*Immediate*

1. **Prioritize quality metrics** and focus attention on the ones that have greatest impact and then incentivize.
2. For any payment designs proposed that would rely on measurements and data related to quality and outcomes, we need to thoroughly **examine the design, the measurement systems and the data to ensure that the payment design is not counterproductive**, and that it decreases, not increases, disparities. Michael Scandrett made this point to the Task Force recently, describing how low income clinics are financially punished because of quality measures that show they are doing worse with diabetes care simply because a higher percentage of their patients smoke or due to other factors over which the clinic has no control.

*Mid- to Long-term*

1. Further develop **risk adjustment/quality metrics for complex populations**. Risk adjustment and appropriate quality metrics are foundational to value-based reimbursement models. Currently, we do not have good risk adjusters for the most complex populations even though that is where the biggest opportunity exists. It is a barrier to moving forward.

# Research and Forecasting

*Immediate*

1. Create a **scoping study** to determine what information would be needed to design and assess a **universal health care system** that will eliminate the “seams” or “cliffs” in our Minnesota system. It is also the way in which we will truly accomplish the working group’s charge of reforming our health care delivery system in a manner that will “reduce costs and improve health outcomes.” Preparing for design of a Minnesota-specific system is a necessary first step in applying for a 1332 waiver.
2. Commission a **financing study** to determine the most efficient and effective way to deliver and finance health care long term.
3. **Mental Health/Substance Abuse population services forecast**. This type of report and on-going forecast would help providers appropriately scale their services and would provide a level of transparency and accountability that does not exist today.

*Mid/Long-term*

1. Access claims data by markets/programs – for example, individual market, small group, public programs, employer coverage – to understand **utilization patterns and care access by consumers** covered in these markets and how those patterns may shift as consumers move between coverage programs/markets.

# Transparency

*Immediate*

1. Create **industry (insurance, hospital/clinic, pharmaceutical) transparency** for all entities receiving tax dollars to provide health insurance or medical care to patients, including **meaningful cost and quality data**.

# Policy/Regulation Simplification

*Immediate*

1. Policy housekeeping – **eliminating pre-ACA requirements** that are now barriers to innovation.
2. **Regulatory simplification** and streamlining.

# Health Disparities

*Immediate*

1. **Elimination of barriers that create health disparities**, including affordability (total cost i.e. premiums, co-pays, deductibles, co-insurance), access to mental health services, and citizenship status.

# Additional Mid- to Long-term priorities

1. Allow communities to form their own **Accountable Communities of Health** and form ACO-like organization
2. Statewide **drug formularies**.
3. Develop new ways of **tracking savings/ROI in the state budget process**. As of now, when we save the system money (IHP, competitive bid, etc.), it does not get scored in a way that it can be reinvested into HHS. It falls to the general fund. This capture of the savings will be increasingly important as budget pressures grow. It also would provide incentive for providers to accelerate reform.