Workgroup #1 Preliminary Recommendations Package

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# Enhancements to Data Sharing

The goal of health information exchange (HIE) is to help make health information available when and where it is needed, to improve the quality and safety of health care while honoring each patient’s decision on how – or if - they want their data to be shared. In Minnesota, while many efforts are underway to help achieve the secure electronic exchange of clinical information between organizations in alignment with patient preferences, many providers and patients continue to report barriers to this process happening as envisioned.

## Recommendations for immediate action:

* Make technical updates and clarifications to Minnesota’s Health Records Act to leave a patient’s ability to specify how their information can be shared intact but allow patient consent preferences to be more easily operationalized at the provider level.
* Provide ongoing education and technical assistance to health and health care providers and patients, about state and federal laws that govern how clinical health information can be stored, used, and shared, and about best practices for appropriately securing information and preventing inappropriate use.
* Conduct a study that will make recommendations on the appropriate future structure for HIE in Minnesota. The study will build on lessons learned in Minnesota as well as other states and countries. Study questions will include, but not be limited to:
	+ Whether Minnesota should continue to use a market-based approach to HIE, or develop a single statewide HIE entity;
	+ Whether additional ‘shared services,’ such as consent management, should be developed;
	+ The appropriate funding source(s), and needed level of funding, to support core HIE transactions and shared services for all health and health care providers statewide; and
	+ Whether Minnesota’s current legal/regulatory framework for HIE supports or hinders secure HIE that is aligned with patient preferences.

## Longer-term recommendations and considerations:

* Dependent on results of HIE study, consider other modifications to Minnesota’s Health Records Act, to align with federal HIPAA standards or to update opt-in or opt-out requirements.
* Support expanded health information technology capabilities (ex. EHRs) in a broad range of care settings, to enable smaller and specialty providers to participate in HIE.
* Consider developing a funding mechanism for core HIE transactions, such as admission/discharge/transfer alerts, care summaries, or care plans, to ensure basic information can be exchanged statewide.
* Support the establishment of robust, sustainable HIE “shared services,” such as consent management, which would be available statewide through a central vendor.

# Enhancements that Support Integrated Care Delivery

The goal of the following recommendations are to decrease barriers and catalyze care delivery reform in a way that effectively coordinates care across the continuum, tying care together more effectively, particularly for those with the most significant disparities. Recommendations are designed to achieve Triple Aim outcomes by creating a policy and funding framework that fosters cross-continuum integration in a way that reduces fragmentation and supports the seamless delivery of care in support of the whole person. There are several value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs currently taking place within Minnesota; the workgroup’s recommendations identify several immediate enhancements that should be applied across these programs. The workgroup also identified several longer-term recommendations that are necessary to stabilize and enhance the care delivery system in Minnesota.

## High-level, cross-cutting recommendations

* Ongoing evaluation of current value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs for effectiveness in meeting Triple Aim goals. Programs and pilots will not be significantly expanded until an evaluation on cost-benefits is conducted. At a minimum, the evaluation should address the following domains:
	+ *Health disparities* - Does the model worsen or improve health disparities? If so, by what mechanism or mechanisms? Does the model sufficiently account for variation in the complexity of patients across providers?
	+ *Financial stability and cost of health care system* – What is the impact of the model on costs across the system, all payers? What costs are associated with the model at the provider level? What is the ROI of the program?
	+ *Patient choice and provider attachment* - How is the patient attached to the provider for purpose of service delivery, care coordination, and payment (prospective or otherwise)? How does the model incorporate patient choice of provider?
	+ *Multi-payer alignment* – What are the areas of alignment across payers under the model? What additional areas could be aligned?
	+ *Quality of patient care* – How has the model impacted the quality of patient care?
	+ *Population health* – How does the model address population health?
	+ *Social determinants of health* – How does the model address the determinants of health beyond medical care (e.g. flexible payment options that enable payment for non-medical services)?
	+ *Impact on provider work force* - What impact has the model had on the provider work force? If it has an impact, what mechanism caused the impact?
* Enhancements identified below will be incorporated, as appropriate, into existing demonstrations, pilots, and programs, such as Integrated Health Partnerships, Health Care Homes, Behavioral Health Homes, and other value-based purchasing and accountable care arrangements across Medicaid and commercial beneficiaries. Any new arrangements should be considered pilots or demonstrations, with significant expansion across the full population only following robust evaluation of program’s impact on Triple Aim (as described above).
* To the extent possible, Minnesota should seek alignment of approaches across public and private payers, including, but not limited to, consistent measurement and payment methodologies, attribution models, and definitions.

## Immediate enhancements to pilots, demonstrations, and existing programs:

### Community partnerships

* Encourage or incentivize partnerships and care coordination activities with broad range of community organizations within care coordination models.
* Fund innovation grants and contracts to collaboratives that include providers and community groups, to meet specific goals related to community care coordination tied to social determinants of health, population health improvement, or other priorities.

### Health disparities and health equity

* Encourage or incentivize participation of diverse patients in provider or provider/community collaborative leadership or advisory teams.

### Measurement (for public reporting or payment)

* Measurement (quality and cost) should be based on the following principles:
	+ Measures include risk adjustment methodology that reflects medical and social complexity.
	+ Existing pilots, demonstrations, and programs that tie a portion of a provider’s payment to costs and/or quality performance should reward providers for both performance or improvement vs. provider’s previous year and performance or improvement vs. peer group, to incentivize both lower and higher performing, efficient providers.
* Incorporate system wide utilization measures to assess impact of care coordination (such as preventable ED visits, admissions, or readmissions, plus appropriate use of preventive services and outpatient management of chronic conditions and risk factors) into performance measurement models; for use in evaluation of pilots, programs, and demonstrations; or as part of certification processes.

### Payment

* For participants not attributed to an ACO (such as IHP program), provide a prospective, flexible payment for care coordination, non-medical services and infrastructure development that is sufficient to cover costs for enrolled patients with complex medical and non-medical needs.
* For participants attributed to an ACO (including risk-taking IHP program), provide a prospective “pre-payment” of a portion of their anticipated TCOC savings.
* Establish consistency of payment approach for care coordination and alternate payment arrangements across all payers. Areas for consistency include (1) level of payments for care coordination activities, (2) identification of complexity tiers, (3) policies for copayments for care coordination services, and (4) billing processes.
* Ensure care coordination payments are sufficient to cover costs for the patients with the most intensive needs; the State (MDH and DHS) shall make modifications to the current HCH tiering process to incorporate social/non-medical complexity, and enhance payment rates to incorporate costs associated with care coordination for patients experiencing these conditions. Modifications may include enhancing the payment tiers to include an additional, higher tier payment for patients with intense needs and social complexity.

### Attribution and patient selection of provider

* Patients will choose a provider during the enrollment process and if they choose to change their primary provider outside of enrollment. Providers will be given data about who enrolled with them and have the opportunity to proactively engage with those enrollees. Method should be consistent across payers.
* When patients are attributed or assigned to a primary care provider or care network for the purposes of payment (not for care delivery), attribution should be prospective, with back-end reconciliation.

## Immediate recommendations with longer-term impact

* Conduct a study that examines various long-term payment options for health care delivery. Study will evaluate impact on cost and quality of health care system, stability and sustainability of system, and data/informational needs to design and implement the system. Study to include, at a minimum, comparison of the following approaches:
	1. Maintenance of current financing mechanism, without expansion of value-based purchasing beyond existing levels
	2. Expansion of value-based purchasing within current system
	3. Publicly-financed, privately-delivered universal health care system.

## Additional long-term concerns

* Identify ways of enhancing existing payment models to more comprehensively include the dual eligible population.
* Identify methods to report on the costs and savings associated with non-medical services, with potential integration into TCOC calculations.
* Prescription drug costs outpacing medical inflation, and potentially hindering overall savings efforts
* Growth of long-term care costs; how do we manage these costs and make them sustainable as population grows older?
* Workforce shortages, particularly in the areas of primary care and mental health practitioners
* Identify ways to capture the savings from care delivery and payment modifications back into the health care system.