Health Care Delivery Design & Sustainability

Workgroup Priorities

October 2, 2015

**Highest Workgroup Priorities**

# Eliminating Health Disparities

*Broad lens for all workgroup priorities*

* All recommendations from the workgroup must be viewed through the lens of health disparities; the group will evaluate all recommendations to determine if it eliminates, reinforces or increases barriers that create health disparities.

*Long-Term Goals*

* Identify and eliminate barriers within current care delivery models or payment mechanisms that create health disparities, including affordability (i.e. premiums, co-pays, deductibles, co-insurance), access, and citizenship status.

# Eliminate Barriers to Data Sharing Across Care Continuum

*Immediate Workgroup Focus*

* Identify and eliminate barriers to appropriate data sharingacross providers across the care continuum (inc. medical, social services, and community health partners)to facilitate more seamless care. Potential policy levers may include legislative changes to the Minnesota Health Records Act.

*Long-term Goals*

* Creation of infrastructure and regulatory supports that enhance the ability and requirements to share data across care continuum.
* Identify methods to create industry-wide (i.e. payers and providers) transparency, including meaningful cost and quality data.

*Guiding Questions*

* How is the lack of data sharing inhibiting care model redesign and innovation efforts?
* Minnesota law restricts sharing of info between entities who are working together to reduce the cost of care and improve quality. How can we remove this barrier?
* What privacy concerns are created by this?
* What is the impact on quality improvement efforts?
* How does data sharing and data transparency benefit consumers?
* How can data sharing and transparency impact health disparities in Minnesota?

*Background Information Needed*

* Presentation(s) on HIPAA, Minnesota Health Records Act, and other relevant laws/regulations impacting patient privacy and data sharing.
* Current data sharing practices, barriers, and opportunities foe enhancement.

# Identify Payment System that Supports Integrated Care Delivery, Coordination, MAnagement

*Immediate Workgroup Focus*

* Identify a flexible payment system that enables comprehensive care management, coordination, or “care navigation” services, broadly understood, through the primary care provider. Prospective payment or direct contracts would allow providers the flexibility to deploy the best wrap around tools/services for their population, and allow providers to assist patients in navigating the care system.
* 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.”

*Long-term Goals*

* Work to increase provider availability across Minnesota including primary care and mental health providers to address the current and anticipated shortage.
* Continue to enhance integration and access across the full care continuum – medical, social services, community health, public health, etc. For example, 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? How do we encourage integration for commercially-insured beneficiaries?

*Guiding Questions*

* What is the appropriate payment mechanism to promote immediate focus and long term goals?
* Prospective payment of direct contracts are a reasonable objective, but are we escalating care payments or complicating delivery system structures?
* What could be gained by simplifying the administrative process, making payment prospective and more flexible to meet a greater variety of patient needs, especially in bridging health care to other parts of the HHS continuum?
* How do we determine appropriate payment structure for various populations without further complicating delivery and payment system, while addressing health disparities?

*Background Information Needed*

* Presentation from DHS or MDH on the current programs for care coordination and management, along with the current challenges. Health care homes and In-Reach are two examples.
* Presentation from MDH and DHS on disparities-based payment models.
* Presentation on VT’s experience with development of universal health care system.

# Enhance PAtient Care through AssignMent of Patients to Primary Care Providers

*Immediate Workgroup Focus*

* Deepen patient engagement with primary care providers through prospective assignment. Arenas for prospective assignment could include:
  + Within care delivery reforms and value-based purchasing models, such as the Integrated Health Partnerships (IHP) [Minnesota’s Medicaid ACO] demonstration (i.e. utilize IHP demonstration as a model for assignment-based attribution)
  + Public program enrollment - enrollees select a primary care provider (like they select a MCO) and then allowing the provider some flexibility to engage them is critical.
  + Commercial enrollees

*Long-term Goals*

*Guiding Questions*

* How do we deepen patient engagement with primary care without creating access issues, particularly in light of provider shortages, and variations in availability across the state?
* How do we develop assignment strategies that reduce, rather than enhance, health disparities?

*Background Information Needed*

* Presentation from DHS on what (if any) barriers exist to moving in this direction. For example, are there conflicts or hurdles with CMS? What would be the process steps to accomplishing this change?
* Data or case studies from other states, identifying various options for prospective assignment, and the impact of prospective assignment on a provider’s ability to manage care, cost of care, or other outcomes.

# Identify, Align, and Enhance Direct Provider Contracting Opportunities

*Immediate Workgroup Focus*

* Identify, align, and enhance direct contracting opportunities with providers. This could include, but isn’t limited to, an expansion or extension of the IHP demonstration to cover a wider population and encourage enhanced risk arrangements with providers. Opportunities must align incentives so providers who are already doing well from a quality and cost perspective are rewarded.

*Long-term Goals*

* Enhance payment models to more comprehensively include the **duel eligible population**.

*Guiding Questions*

* 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.
* The strategy question is to what end do we pursue IHPs or other individual care delivery and payment reform models? The state continues to have multiple purchasing strategies and that can actually slow progress in delivery reform.
* Can we ever move to a full risk model at the provider level? Is this where we want to go? If we can’t, we should assess how enhancing direct contracting with providers impacts or corresponds with MCO contracting. If we can move to full risk by the provider, we should assess the path on how this replaces MCO contracting.
* Do the direct contracting models create an incentive for both highly-efficient, high-quality performance providers and less efficient or lower performing providers to participate?

*Background Information Needed*

* Overview of the IHP model, including an examination of successes and challenges to date. What are the outcomes and impact of IHP to date?

**Additional Needs Identified by Group**

# Need for Enhancement and Alignment of Quality Metrics and Analytics

* **Enhance and align quality metrics** utilized within care delivery and payment reform efforts. Prioritize quality metrics and focus attention on the ones that have greatest impact.
* Further develop **risk adjustment/quality metrics for complex populations**. Risk adjustment and appropriate quality metrics are foundational to value-based reimbursement models.

# Research and Forecasting Needs

* **Inventory and evaluation of current state programs** for efficiency, effectiveness and impact on continuum of care, i.e. patients moving between programs.
* 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.