



Health Care Financing Task Force Vision: Sustainable, quality health care for all Minnesotans

Delivery Design Recommendations Executive Summary

Enhancements to Data Sharing

Recommendation 1: Make technical updates and clarifications to Minnesota 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.

Recommendation 2: 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.

Recommendation 3: Conduct a broad study that will make recommendations on the appropriate future structure, legal/regulatory framework, financing, and governance for health information exchange (HIE) in Minnesota, building on lessons learned in Minnesota and from other states and countries.

Long-Term Recommendations:

- Dependent on results of HIE study (recommendation 3), 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

Recommendation 4: Evaluate, on an ongoing basis, current value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs for effectiveness in meeting Triple Aim goals. Programs and pilots should not be significantly expanded until an evaluation of cost/benefits is conducted.

Recommendation 5: To the extent possible, seek alignment of approaches across public and private payers, including, but not limited to, consistent measurement and payment methodologies, attribution models, and definitions.

Recommendation 6: Conduct a study that examines various long-term payment options for health care delivery.

Recommendation 7: Incorporate enhancements, **as described in recommendations 8 through 16 below**, as appropriate, into existing demonstrations, pilots, and programs, such as Integrated Health Partnerships, Health

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Care Homes, Behavioral Health Homes, and other value-based purchasing and accountable care arrangements across Medicaid and commercial beneficiaries. Consider any new arrangements as pilots or demonstrations, with significant expansion across the full population only following robust evaluation (as described in recommendation 4 above).

Cost/Savings: *Net single-year savings of approximately \$48.1 million, with \$17.8 million of that accruing to the State.*

Recommendation 8: Enhance community partnerships by:

- Encouraging or incentivizing partnerships and care coordination activities with broad range of community organizations within care coordination models, and
- Funding 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.

Recommendation 9: Improve disparities and health equity by encouraging or incentivizing participation of diverse patients in provider or provider/community collaborative leadership or advisory teams.

Recommendation 10: Base measurement on the following principles: (1) Measures include risk adjustment methodology that reflects medical and social complexity; and (2) 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

Recommendation 11: Incorporate system wide utilization measures to assess impact of care coordination (such as preventable ED visits, admissions, or readmissions; 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.

Recommendation 12: For participants not attributed to an ACO (such as certified Health Care Homes), 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.

Recommendation 13: For participants attributed to an ACO (including risk-taking IHP program), provide a prospective "pre-payment" of a portion of their anticipated TCOC savings.

Recommendation 14: 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.

Recommendation 15: 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 and 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.

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Recommendation 16: Strengthen the patient attribution and provider selection process by:

- Allowing patients to choose a provider during the enrollment process and change their primary provider outside of enrollment;
- Giving providers data about who enrolled with them so they have the opportunity to proactively engage with those enrollees;
- Using consistent methods for attaching patients to providers across payers;
- Attributing or assigning patients prospectively to a primary care provider or care network for the purposes of payment (not for care delivery) under an ACO or similar model, with back-end reconciliation.

Long-Term Recommendations:

- 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.

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