December 20, 2017

Mat Spaan
Minnesota Department of Human Services
540 Cedar Street
Saint Paul, MN 55155

Re: DHS Request for Comment: Outcomes-Based Purchasing Redesign and Next Generation IHP

Dear Mr. Spaan:

In response to the above-referenced solicitation from the Minnesota Department of Human Services (DHS), the Minnesota Association of Community Health Centers (MNACHC) submits the following comments contained in this correspondence. We appreciate the opportunity to provide you with feedback on DHS’ transformative health care delivery and payment program.

The Minnesota Association of Community Health Centers (MNACHC) represents the interests of the state’s 17 Federally Qualified Health Centers (FQHCs). These FQHCs (hereinafter interchangeably referred to as “Health Centers” or “CHCs”) serve approximately 175,000 low-income Minnesotans. Nearly 50% of the FQHC patients are enrolled in a Minnesota Health Care Program (MHCP) -- Medical Assistance (MA) or MinnesotaCare.

FQHCs are participating in Minnesota’s delivery and payment reform efforts. 11 of MNACHC’s 17 member FQHCs are currently participating in an IHP demonstration authorized under Minnesota Statutes, Section 256B.0755:

- 10 Twin Cities FQHCs as members of the FQHC Urban Health Network (FUHN); and

- Open Door Health Center in Mankato is part of the Southern Prairie Community Care project.

It is also important to note that NorthPoint Health & Wellness, a member of MNACHC, is part of the Hennepin Health demonstration project authorized under Minnesota Statutes, Section 256B.0756.
Collectively, nearly 36,000 FQHC MA patients are part of the IHP program – this is 21% of our total patient base and 41% of our MHCP patient base.

MNACHC’s comments in response to DHS’ RFI will be broken into three areas:

1. Global Observations on the proposal;
2. Specific responses to questions posed by DHS; and
3. FQHC-specific comments on the proposal.

Section #1 - Global Observations on Next Generation IHP

Safety net providers such as FQHCs are unique participants in the state’s current IHP demonstration program for two primary reasons: 1] relatively speaking, they do not have significant financial resources; and 2] they operate as independent primary care organizations, not part of any health care system or plan.

In 2015, roughly 30% of FQHC patients did not have health insurance – nearly 6 times the rate of the general population. FQHCs provide care to 1 out of every 6 uninsured Minnesotan through the use of a sliding fee discount program at each FQHC.

The level of poverty our patients experience is nearly six times the rate of the general Minnesota population – 89% of FQHC patients have incomes below 200% of poverty compared to 25% of the state’s general population.

With such patient demographics, FQHCs tailor their services to remove barriers to primary care services for low-income Minnesotans. These “enabling services” include transportation, case management, patient education/outreach, interpretation services, eligibility assistance legal services, advocacy to reduce domestic violence and rape and human trafficking, and diabetic medical protocols tailored to Muslims during Ramadan. The combination of a low-income, uninsured patient base along with unique services targeted to communities of need, translates to Community Health Centers that operate on very tenuous financial operating margins.
Additionally, most FQHCs in Minnesota are independent, non-profit organization governed by actual patients of the Community Health Center.\(^1\) This independence poses a unique challenge for FQHCs as they do not have unlimited access to or control of specialty and inpatient hospital services.

**OBSERVATION #1 |** Participation in the Next Generation IHP requires significant operational investment ranging from information technology, data analytics and care coordination staff. As non-profit providers serving a low-income patient population, FQHCs may not have the internal financial resources to make the level of investment necessary to participate in the Next Generation IHP.

MNACHC recommends that the Next Generation IHP program upfront investments to safety net and independent organizations to support further FQHC/safety net participation. Furthermore, the administrative requirements of the Next Generation IHPs are significant also require appropriate funding.

As providers of primary medical, dental and behavioral health services, MNACHC commends DHS’ efforts to redesign and reform DHS’s purchasing and delivery strategy. The Next Generation IHP is the natural evolution of the past IHP and IHP 2.0 efforts. MNACHC welcomes this shift toward funding providers to best serve the state’s low-income populations.

**OBSERVATION #2 |** The Next Generation IHP model contains elements that are commonly part of a MCO-driven purchasing strategy. For example, the “network adequacy” standards are critical, however, safety net providers such as FQHCs may not have the financial resources to establish comparable networks.

MNACHC recommends that the Next Generation IHP program should provide flexibility for provider-based organizations and view the model from a population health perspective.

“Gain sharing” in the Next Generation IHP model is contingent upon participants meeting both financial and quality benchmarks. MNACHC is a strong supporter of transforming health care reimbursement methodologies away from volume to value based on the quality of care provided. To date, measurement efforts have been problematic for FQHCs, however, we appreciate the recognition in the Next Generation IHP model of the social determinants of health.

\(^1\) Section 330(k)(3)(H) of the PHS Act and 42 CFR 51c.304
At the core of the FQHC delivery model and mission are features that attract a patient base that is significantly different from the state’s general population. Some of these features of the FQHC model include:

- FQHCs cannot “pick and choose” which patients they serve as they serve all regardless of their ability to pay for those services.²

- Community Health Centers are governed by patient-controlled Boards of Directors that provide Health Center leadership with insight to the needs of the communities.

- FQHCs are located in Medically Underserved Areas where health disparities are significant for most the population.

Given the core pieces of the model, FQHC patients are drawn from communities that are overwhelmingly impacted by socio-economic factors that impact their health. Research strongly suggests a link between a particular patient’s health and their socio-economic factors. These socio-economic factors are referred to as the social determinants of health and include (but are not limited to) poverty, race/ethnicity, country of origin, education level, housing status and geography.

Clinical care – the work that occurs within the four walls of any healthcare setting – contributes roughly 20% to a patient’s outcome. 80% of the outcome is determined by genetics, behavior, environment and the socio-economic factors. Socio-economic factors alone account for 40% of a patient’s health and clinical outcomes.

Over the past two years, MNACHC has worked closely with the Minnesota Safety Net Coalition (SNC) to develop the Quality Measurement Enhancement Project (QMEP). The project was in response to the state’s reluctance to incorporate the social determinants of health (SDH) into quality measurement reports. Consequently, the SNC is in the process of developing a quantitative and qualitative adjustor to incorporate the SDH into any measurement mechanism. Consequently, the Next Generation IHP payment model should incorporate the QMEP tool as part of the risk-adjustment and payment methodology.

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² Section 330(k)(3)(G) of the PHS Act, 42 CFR Part 51c.303(f), and 42 CFR Part 51c.303(u)
**OBSERVATION #3** | The Next Generation IHP measurement proposal does not fully account for the social determinants of health. DHS is making significant progress on this issue, however, MNACHC does not understand the alignment of DHS efforts relative to other state efforts. Nearly all FQHC patients experience socio-economic circumstances that adversely impact their health.

MNACHC recommends that the Next Generation IHP program:
- Adopt the Quality Measurement Enhancement Project (QMEP) tool;
- Use risk-adjusted quality measures in evaluating IHP participant quality outcomes;
- Use individual risk-adjusted measures rather than composite measures; and
- Seek other quality metrics to evaluate provider performance.

An essential component of any value-based purchasing strategy is effective care coordination to promote effective use of health care and other services. Effective care coordination services rely heavily on timely and actionable data exchange between providers in the health care system at a minimum. In addition, data exchange with social services providers would give care coordinators insight into the socio-economic challenges of the patient.

Minnesota does not have a centralized, common platform to support robust and meaningful data exchange between providers. Without this infrastructure, Minnesota is foregoing an opportunity to enhance care coordination services that reduces health care spending on preventable events such as inappropriate emergency room use.

**OBSERVATION #4** | Minnesota’s decentralized and fragmented data exchange infrastructure results in limited data exchange between health care providers. Without actionable and timely data, the true benefits of care coordination are not realized.

MNACHC recommends that the Next Generation IHP program:
- Advocate for a single, statewide platform for data exchange; and
- Advocate for data exchange between health care providers and other social service providers.
Section #2 – MNAHC Responses to Questions in RFC

#1 - DHS has described an idea of “primary care exclusivity,” where a primary care clinic may only be included as a selection choice for one Next Generation IHP or one or more MCOs (other than as network extenders for urgent care, etc.). The goal is to create more clear lines of accountability. Is “primary care exclusivity” the best way to drive toward these goals? Are there exceptions to this to consider? What other options could DHS consider and why?

MNAHC appreciates DHS’ elevation of primary care as a vital component of health care purchasing reform. Community Health Centers in the Twin Cities are the health care home for 118,000 low-income residents — regardless of their insurance status (i.e., both insured and uninsured patients).

MNAHC’s concern under this “attribution” model, however, are two-fold:

1. **Patient Perspective** — Under current models, MHCP enrollees are not required to select a primary care provider (PCP). Rather, the patient’s choice is largely driven by which health carrier (managed care organization, MCO) includes their primary care clinic within the carrier’s network. DHS’ proposal enhances this emphasis on primary care. **MNAHC recommends that DHS: a] provide clear communication to IHP Next Generation enrollees as to their network and benefits; and b] monitor the number of patients that change monthly.**

2. **Health Center Capacity** — As Health Centers offer care to all regardless of their ability to pay, the demand for services can be significant. One prime example is access to dental services. Health Centers are dental access points for both uninsured and MCHIP enrollees since other, non-safety net dental providers are reluctant to provide care to this population. **MNAHC recommends that DHS consider the unique role of safety net providers in the “attribution” methodology. FQHCs cannot deny care to any patient — regardless of their enrollment in an MCO or Next Generation IHP.**

MNAHC recommends that DHS define “primary care exclusivity” as a combination of patient choice and historic utilization data based on where most the primary care services were experienced by the patient.
#2 - DHS would have a mix of contracts with both Next Generation IHPs and MCOs in the Metro area. Is there a minimum beneficiary population size needed to ensure Next Generation IHPs and/or MCOs are sustainable and can achieve economies of scale? Please provide sufficient detail and calculations to support your response.

MNACHC does not have any specific recommendation as to the beneficiary population size needed for Next Generation IHPs. It should be noted that the FQHC Urban Health Network (FUHN) has an attributed population of between 31,000-32,000 individuals. Moreover, the twelve (12) FQHCs in Minneapolis-St. Paul area serve 68,900 MHCP enrollees. Many of these patients come from out-side of the seven-county metropolitan area.

Lastly, the Medicare Shared Savings Program (MSSP) and Pioneer ACOs operated by the federal government have minimum thresholds of 5,000 and 15,000 enrollees respectively.

#3 - What kinds of criteria should be included in a Request For Proposal for Next Generation IHPs and MCOs to ensure that an entity has sufficient and effective provider and benefit network structure (e.g., behavioral health integration with primary care) to ensure enrollees' needs are met? Are there additional services or requirements beyond behavioral health that should be a primary consideration (e.g., criteria related to cultural competency, disparities, equity, etc.)? Please be specific in your response for Next Generation IHP or MCO.

For Next Generation IHPs, MNACHC recommends that the “enabling services” offered by FQHCs serve as a model to inform the benefit structure. Health Center patients face a variety of socio-economic obstacles to access primary care services. Consequently, Health Centers invest in these “enabling services,” even though many of these services are not reimbursed by payers.

Enabling services are defined as “non-clinical services that aim to increase access to healthcare and improve health outcomes,” and include services such as health education, interpretation, and case management. Enabling services are integral to the services that health centers provide, and their patients often rely on these services to access health care. Studies have shown that health centers provide high quality primary care for their patients, with higher rates of screening and health promotion counseling. Enabling services contribute to effective and efficient primary and preventive care at health centers which results in improved health outcomes.

In addition, MNACHC is concerned about the Health Care Services required under the model. As independent clinics providing primary care services, many of the proposed services are beyond the traditional Health Center scope. Examples include,
rehabilitative services, home health services, and prosthetics and orthotics. **MNACHC recommends providing flexibility for safety-net primary care clinics that are not legally part of any large health care system.**

Effective care coordination relies upon real-time, “actionable” data to inform clinical decision-making. Minnesota has made great progress in providing participants in the IHP with relevant data, however, it is not in real-time. MNACHC commented earlier this year (October 31, 2017) on the Minnesota Department of Health’s Request for Information related to “data interoperability.”

One of the salient points in MNACHC’s response addressed this need for robust data interoperability:

> “Aligning the Minnesota Health Records Act with HIPAA will significantly reduce the administrative burden required to manage patient consent requirements. Because FQHCs rely heavily on external specialty and social service providers, they are currently managing and tracking high volumes of authorizations. Allowing the exchange of health information for treatment, payment, and operations without patient consent will save valuable resources and allow patients to receive more timely care.”

**MNACHC recommends that the state of Minnesota align the Minnesota Health Records Act with HIPAA prior to the start of the Next Generation IHP.**

The Next Generation IHP represents a significant shift in DHS’ approach to purchasing health care. MNACHC strongly supports this shift toward quality and cost containment by working directly with providers. However, to accomplish this shift, many of the “MCO-based” metrics are not applicable to provider-based organizations. For example, developing networks is an expensive undertaking. Another example is requiring similar budget reserves of Next Generation IHPs like MCOs. **MNACHC recommends that the evaluation of Next Generation IHPs rely less on traditional MCO**
evaluation tools and more on population health with an emphasis on primary care services. Moreover, MNACHC is unclear on the need for counties to evaluate any proposal.

#6 - DHS is proposing to administer a single Preferred Drug List (PDL) across the Fee-For-Service, Managed Care and Next Generation IHP models. Would administering a single PDL across all the models be preferable to carving out the pharmacy benefit from the Managed Care or Next Generation IHP models? Would expanding the single PDL or pharmacy carve out beyond the seven county metro area be preferable to applying the changes to only the metro county contracts?

MNACHC appreciates the intent of a single Preferred Drug List (PDL) for across the various purchasing mechanisms. MNACHC’s concern relates to what specific criteria DHS will use to accept drugs on to the PDL. **MNACHC recommends that the development of this criteria includes significant stakeholder input.** Additionally, MNACHC recommends that DHS establish an evaluation of the PDL that incorporates patient, provider and quality of care metrics.

#7 - How can this model appropriately balance the level of risk that providers can take on under this demonstration while ensuring incentives are adequate to drive changes in care delivery and overall costs?

Health Centers operate of extraordinarily narrow financial margins. This is no surprise given the patient population that Health Centers serve – 95% below 200% of poverty and at least 85% of patients either uninsured, underinsured or on a public program such as Medicaid. Naturally, the appetite for risk is limited for Health Centers and other safety net providers. In addition, and most importantly, Health Centers are unable to place their federal “Section 330” grants at risk. On average, this represents 25% of a Health Center’s overall revenue and are used (per federal law) to partially offset the cost of care to the 52,000 uninsured Minnesotans served by Health Centers.

FUHN’s results are testimony to the fact that DHS provided an incentive for Health Centers, while at the same time protecting them from risk. Under the IHP “virtual” model, FUHN did not take any downside risk. The potential for gain sharing was a clear incentive for FUHN to invest and partner with other organizations to achieve $18 million in savings over three years.

The very core of Health Center’s mission is to improve population health. This mission, coupled with key tools such as data analytics and quality improvement,
provided enough of an incentive without any sort of meaningful risk undertaken by FUHN.

MNACHC recommends DHS maintain this no-risk option for Health Centers and other safety net, mission-driven organizations. Additionally, MNACHC recommends that DHS incorporate “stop-loss” mechanisms and/or certain risk-thresholds for safety net providers.

#8 - What are appropriate measures and methods to evaluate paying for non-medical, non-covered services that are designed and aimed at addressing social determinants of health, reducing disparities and improving health outcomes?

One of the core competencies of Health Centers are the provision of “enabling services.” As identified in the response to Question #3 above, enabling services are integral to the services that health centers provide, and patients rely on these services to access health care.

At Health Centers, these services respond to the specific socio-economic needs of our patients. In order to identify these needs, Health Centers in Minnesota are adopting the Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences (PRAPARE) tool. This is a national effort to help health centers and other providers collect the data needed to better understand and act on their patients’ social determinants of health.

MNACHC recommends that DHS adopt the PRAPARE tool or similar tool to support payment methods to address socio-economic needs of Medicaid populations. Furthermore, MNACHC recommends that DHS explore the use of the Quality Measurement Enhancement Project (QMEP) tool to properly adjust for patient risk.

#9 - How much of the entities’ payment should be subject to performance on quality and health outcome measures? Please explain your answer.

As payment evolves from volume to value, the quality of care is a critical element for provider reimbursement. Without fully incorporating the social determinants of health (SDH) into quality measures, MNACHC is concerned about the potential financial harm to FQHCs and other safety-net providers, and the resultant loss of access for low-income Minnesotans to primary care services.

If adequate multi-factorial “risk-adjustment” is part of the quality measurement system, a greater share of the payment can rely on health outcomes measures. Under

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3 To learn more about the PRAPARE tool visit https://www.nachc.org/research-and-data/prapare/
the current IHP model, the quality component provides an incentive to maximize the amount of any “gain sharing.” As the Next Generation IHP model moves from a fee-for-service model to a capitation model, quality incentives should be part of this methodology.

**MNACHC recommends that DHS incorporate “risk-adjusted” quality measures into both the per-member, per-month (PMPM) payment and as additional payments beyond the cost-sharing amounts from meeting total cost of care (TCOC) benchmarks.** In other words, a Next Generation’s IHP PMPM can be increased by meeting quality metrics and “bonus” payments can also be made after meeting TCOC goals. Again, **MNACHC strongly recommends that any quality measure should include a multifactorial “risk adjustment” to account for differing patient populations.**

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#10 - **One of DHS’ priorities is to align quality requirements across federal and state quality programs. Which quality programs (e.g. Merit Based Incentive Payment System, MN Statewide Quality Reporting and Measurement System) are important to align with?**

The 2017 Legislature adopted provisions that directs the alignment of the various federal and state quality measures. The intent of the proposal was to address the very question raised as part of this RFC. The legislation also requires that a stakeholder workgroup develop a list of measures for quality purposes.

One of MNACHC’s concerns with quality measurement has been the emphasis on the measurement of care for persons with chronic diseases. From the FQHC perspective, measures should expand to include the prevention of disease and population health measures. **MNACHC recommends greater priority on measuring population health as opposed to the current emphasis on chronic disease measures.**

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#11 - **Success in the new purchasing and delivery model will depend on the ability to improve health outcomes for a population of enrollees served by an IHP or MCO. In order to improve health outcomes, providers may need to address risk factors that contribute to poor health (e.g. social determinants of health, racial disparities and behavioral health). Does the new payment policy give enough flexibility and incentive to improve population health? If not, what change if any would you recommend? What proposed changes as described in this RFC for the IHP and managed care organizations might result in an eligible entity from otherwise participating in the demonstration? Which of these changes might be problematic from a consumer or provider perspective over time, if not in this initial demonstration as proposed for the Metro area?**
Like our response in Question 8, MNACHC welcomes any policy change that incentives and rewards efforts to increase access to primary care. Furthermore, the new payment policy must ensure quality measures are “risk-adjusted” so that safety net providers like Health Centers are not dis-incented from participating in these new models of care. **MNACHC recommends DHS establish a flexible payment related to Next Generation IHPs providing non-clinical services that improve population health. Examples of these types of services include, but are not limited to: community health workers, care coordination and patient outreach/education.**

With regard to the consumer/patient perspective, **MNACHC strongly recommends that DHS provide adequate education to patients and providers so that understand the importance of the primary care clinic.** Medicaid beneficiaries are accustomed to selecting a health plan as opposed to a primary care clinic. Moreover, for families with children enrolled in Medicaid and other family members on products offered through MNsure (Qualified Health Plans), the potential for confusion surrounding the selection process is likely.

**Section #3 – FQHC-Specific Issues**

**FQHC Payment & Federal Law**

FQHCs (and Rural Health Clinics – RHCs) receive a federally-mandated⁴ Prospective Payment System (PPS) or alternative payment mechanism (APM) for qualifying MA encounters. This payment mechanism remains in place for the FUHN IHP, along with a Total Cost of Care (TCOC) savings payment or gain share.

It is MNACHC’s understanding that under the Next Generation IHP, DHS will continue to follow federal law and provide FQHCs with the PPS/APM for qualifying encounters. The PPS rate is a bundled payment that Congress implemented to recognize the patient base of FQHCs and value of Health Centers as an access point for Medicaid beneficiaries.

Without question, FQHCs would not be able to financially sustain operations without this payment rate. Moreover, FUHN’s success – and the $9 million that accrued to the state’s budget due to FUHN – is built upon the Medicaid PPS/APM payment mechanism. **Modifications to the PPS/APM payment mechanism would simply eliminate the savings for the state. More importantly, it would jeopardize access to care for thousands of low-income Minnesotans to primary care services.**

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⁴ 42 U.S.C. §1396a(bb)(1)-(5)
Primary Care Exclusivity

As patients “self-select” into either a Next Generation IHP or MCO, this may present a dilemma for Health Center patients as a particular Health Center may not be part of both simultaneously. A patient may prefer a Health Center for their primary care services, but choose a specialty provider who is part of an MCO’s network. If the Health Center is part of a Next Generation IHP and did not have a contract with that specialty provider, the patient may lose access to the Health Center.

An example highlights the need to understand the primary care exclusivity concept and the unintended consequences that may arise. One of the unique services of some Health Centers is the availability of psychiatry services to public program enrollees. Health Centers are often the only access point for this population. If a MHCP patient seeks psychiatric care at a Health Center, yet that patient is not part of the Health Center’s Next Generation IHP, MNACHC is concerned that this will be uncompensated care for the Health Center. Additionally, the savings because of the Health Center will accrue to whichever MCO/Next Generation IHP that has “exclusivity” to that patient.

The concept of “primary care exclusivity” needs to account for the fact that patients will seek care that is accessible to them, regardless of their enrollment into an MCO or Next Generation IHP. This has the potential to harm Health Centers as they cannot deny care to any patient. Specifically, enrollees seeking care at a Health Center who are not part of the FQHC’s “network” may result in uncompensated care for the Health Center if the Medicaid patient continues to use the Health Center, yet is a part of another Next Generation IHP or ACO.

Applicability of MCO Requirements to Next Generation IHPS

MNACHC is seeking clarification if specific requirements of MCOs will be applicable to Next Generation IHPS. Specifically, the two major areas are related to: 1] the state’s Essential Community Provider (ECP) law; and 2] the amount of budget reserves required.

Summary and Conclusions

Minnesota’s purchasing strategy -- IHP and competitive bidding -- has successful in reduced the cost of care, increased the quality of care provided and improved the patient experience. As DHS seeks to enroll a greater share of MA enrollees in Minnesota into value-based arrangements, the three necessary investments from the Health Center perspective include:
1. Enhancing the IHP’s **quality metrics to include the social determinants of health** (i.e., “risk adjustment);

2. Providing **“up-front” and continuing for safety net providers such as FQHCs** to support data analytics of attributed patients and care coordination efforts; and

3. Fostering an environment to achieve **true data interoperability** between medical and non-medical providers in Minnesota.

On a high-level, MNACHC is concerned about the following issues and would kindly request a discussion on these issues:

1. **DHS’ compliance with federal statute related to FQHC payments**;

2. **Health Centers’ financial and legal ability to take “risk;”**

3. **The definition/criteria related to “primary care exclusivity;”**

4. **Health Centers as “out-of-network” providers relative to federal requirements that do not allow them to deny patients access to services; and**

5. **Beneficiary and provider education.**

Minnesota DHS should be applauded for efforts to improve the care for Medicaid beneficiaries over the last decade. We appreciate the opportunity to comment through this Request for Comment (RFC) process. As you consider our comments, please do not hesitate to contact me at jonathan.watson@mnachc.org or at 612-253-4715 if you have any questions about the content of this correspondence or FQHCs in general.

Respectfully submitted,

Jonathan Watson
Chief Executive Officer