REQUEST FOR INFORMATION (RFI)

Health Care Homes

JULY 25, 2016
MINNESOTA DEPARTMENT OF HEALTH
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Purpose & Objective

This document is a request for comments on enhancements to MN’s Health Care Home program and any subsequent changes to Minnesota statutes section 256B.0751 – 256B.0753 and Minnesota administrative rules 4764.000 – 4764.0070.

The goals of the Health Care Homes (HCH) program include:

- Continue building a strong primary care foundation to ensure all Minnesotans have the opportunity to receive team-based, coordinated, patient-centered care.
- Increase care coordination and collaboration between primary care providers and community resources to facilitate the broader goals of improving population health and health equity.
- Improve the quality and the individual experience of care, while lowering health care costs.

The current HCH program has allowed the Minnesota Departments of Health (MDH) and Human Services (DHS) to assist primary care clinics in transforming care delivery by providing a foundation that includes standards, benchmarks, payment for care coordination, evaluation and a Learning Collaborative.

In response to extensive input from certified and non-certified clinics, state and federal policymakers, health care and public health stakeholders, and consumers, MDH is interested in advancing the Health Care Home model so that it is in alignment with evolving best practices and state/federal goals on health equity, social determinants of health, community-centered accountable care, value based payment, and team based care. The principles developed through that input, and potential program enhancements linked to them, are described below. The input obtained through this RFI will help to inform future discussions related to these potential enhancements, opportunities and barriers for implementation, and resource and support considerations to help HCHs meet program goals.

Background

The HCH program is foundational to Minnesota’s efforts to achieve the triple aim of improving the health of Minnesotans, improving the patient experience, and reducing the cost of health care. HCH certification requires a fundamental redesign in the practice of primary care towards prevention and management of chronic disease. Authorized by Minnesota’s 2008 health reform law, the HCH initiative is jointly administered by the Minnesota Department of Health and the Minnesota Department of Human Services. Additional information on the background of the HCH program is located at MDH’s Health Care Homes Background Information & Reports webpage.

Since its launch the HCH program has certified over half of the primary care clinics in MN. A recent evaluation reported $1 billion in savings through high-quality coordinated care in the first five years of implementation, and improved performance on a range of clinical quality metrics for certified HCHs compared to non-certified clinics.

Process for Gathering Input on Future Programming

In developing a set of principles for an updated HCH program for the future, MDH has relied on input and guidance from a wide range of stakeholders as well as reviewing how it aligns with other programs such as Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Comprehensive Primary Care Plus (CPC+), Next Generation Accountable Care Organization (ACO), etc. Throughout this process, our discussions have been guided by a desire to promote consistency of approach across payers and alignment with evolving federal and state models for value-based purchasing and
accountable care, advancing health equity, and encouraging meaningful clinic/community partnerships to improve individual and community health.

In 2014 the Minnesota Legislature directed the Commissioners of Health and Human Services to establish a Health Care Homes Advisory Committee to advise the Commissioners on the ongoing statewide implementation of the Health Care Homes program. The HCH Advisory Committee formed four work groups to guide communication and evaluation, practice transformation, financial sustainability and learning. The committee and work groups, which include representatives from a wide range of care systems as well as consumer and payer representatives, have been working with MDH and DHS staff to identify potential opportunities for improvement to the HCH program since the fall of 2015, including developing the guiding principles outlined below.

In 2015, the Minnesota Legislature established the Minnesota Health Care Financing Task Force, whose Governor-appointed members were charged with advancing strategies to increase access and improve the quality of health care for all Minnesotans. The Minnesota Health Care Financing Task Force made a number of recommendations to increase support for care coordination and for HCHs by:

- Ensuring that financial support for care coordination is sufficiently robust and aligned across payers
- Developing program requirements that include a focus on improving health equity and reducing disparities
- Improving health care providers’ ability to identify and address social determinants that can influence health outcomes through the HCH program
- Promoting broader and more meaningful partnerships with a wide range of community organizations and populations


As a result of this combined input, MDH has identified the following principles as critical for enhancing the ability of the HCH program to meet statewide goals in the future for cost, quality, patient experience and health equity:

- Strengthening meaningful partnerships between HCH clinics and county social service agencies, community organizations, and local public health, to identify and address social determinants of health through formal partnerships/referrals/data collection
- Aligning with emerging federal models for value-based or alternative payment, such as MACRA or CPC+, state-level value-based purchasing models such as the Integrated Health Partnerships program, and payment approaches across payers.
- Supporting the long-term financial sustainability of HCH clinics by moving towards value-based payment for HCHs, and providing support for community/clinic partnerships and other necessary investments.
- Establishing health disparity reduction and health equity goals.
- Supporting the secure exchange of clinical information with a wide range of partners to support care coordination.
- Simplifying administrative processes for certification and recertification, and requirements for learning collaborative participation.
HCH Program Examples and Considerations

To begin addressing the opportunities for improvement referenced in the RFI, the Minnesota Department of Health (MDH) has identified potential enhancements that could become the basis for future certification requirements, or for multiple Health Care Home (HCH) tracks or levels that are tied to performance expectations and reimbursement. The enhancements presented here are provided for the purpose of facilitating feedback and are not the only options open for consideration. Input that we receive through this RFI and other mechanisms will inform decisions related to potential future program changes and support that may needed for clinics and partners to implement changes to their work.

Many of the enhancements discussed in this document are similar to NCQA’s Patient Centered Medical Home model, CMS’ Comprehensive Primary Care Plus (CPC+) program and CMS criteria for Advanced Alternative Payment Medical Home Models under MACRA. This alignment is intentional, so that providers who are currently, or are considering, participating in these programs have some level of consistency in care delivery and payment criteria.

Assumptions

In developing the following example program changes, MDH made several assumptions:

- Participation in the HCH program remains voluntary. If the program, in the future, includes multiple tracks or levels, an organization could choose to enter the program in any track, if it can demonstrate it meets certification criteria, and could choose to remain in their current track as long as the criteria continue to be met.
- Participation in any given track or level would be for a three year period per current statutory requirements on frequency of certification. However, HCHs could elect to change tracks within a given certification period if the higher-level requirements are met.
- We understand that many questions about HCHs’ ability to implement such changes will depend on whether financial support is available, across payers that is sufficient to cover costs. This RFI does include some questions about HCHs’ current mix of payment from public and commercial payers. However, this document primarily focuses on potential changes or enhancements to the care delivery requirements for HCHs rather than payment mechanisms, with an understanding that additional information about costs may need to be collected via other mechanisms.
# Health Care Homes - Possible Program Enhancements

<table>
<thead>
<tr>
<th>Model Component</th>
<th>Current</th>
<th>Examples of Future HCH Enhancements</th>
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</thead>
<tbody>
<tr>
<td>Delivery System Characteristics</td>
<td>Current standards:</td>
<td>• Adopt community care coordination model to improve population health</td>
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<tr>
<td></td>
<td>• Access/Communication</td>
<td>• Expand relationships with community partners, such as local public health, social service agencies, behavioral/mental health centers, schools, faith based organizations, food shelves, and/or housing, to improve care coordination.</td>
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<tr>
<td></td>
<td>• Patient tracking and registry</td>
<td>• Share referral information and data with community partners to improve care coordination.</td>
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<td></td>
<td>• Care coordination</td>
<td>• Employ findings from Community Health Assessments in improving care for the population served.</td>
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<td></td>
<td>• Care plans</td>
<td>• Develop a system to identify or assess patients’ risk for social determinants of health (e.g. transportation, housing, food insecurity, social support) and an approach to support care coordination and self-management based on assessment.</td>
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<td></td>
<td>Performance reporting and quality improvement (Includes participation in Learning Collaborative activities)</td>
<td>• Provide targeted, proactive, relationship-based care management and self-management support to all patients identified as at increased risk due to physical or social health needs.</td>
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<td>• Collect race, ethnicity, and primary language information using standard formats and use this information in providing care delivery or services.</td>
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<td>• Systematically assess the patient/client population for care coordination needs using data or screening tools, such as a population based registry or community, regional or payer data on a regular basis</td>
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<td>• Include a mechanism that proactively engages clinic populations experiencing disparities in clinic strategies.</td>
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<td>• Track ER visits, transitions of care, and/or social services/community/regional referrals electronically.</td>
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<td>• Form community advisory panels/advisory council to develop and guide community health improvement activities involving clinic and community partners.</td>
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<td>• Strengthen patient and community partners’ involvement in use of care plan.</td>
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<td>• Develop and implement improvement projects to reduce health disparities and advance health equity.</td>
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<td>• Use behavioral health and social determinant of health information for population/panel management.</td>
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<tr>
<td>Model Component</td>
<td>Current</td>
<td>Examples of Future HCH Enhancements</td>
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| HIE and Health Information      | • Adopt and use an ONC Certified Electronic Health Record Technology  
• Conduct a security risk assessment and a privacy gap analysis to ensure compliance with state and federal laws to reduce the risk of an impermissible use or disclosure of protected health information (PHI).  
• Establish privacy and security policies and procedures in compliance with state and federal laws  
• Implement consent and authorization procedures and develop release of information forms that are compliant with all state and federal requirements to release PHI and health records.  
• Provide e-prescribing capabilities.                                                                 | • Participate in a State-Certified Health Information Organization to enable directed and query-based exchange with external exchange partners.  
• Enable Direct Secure Messaging capabilities using a State-Certified HIE Service Provider.  
• Capture social determinants of health data in the Electronic Health Record  
• Develop capability to provide bi-directional communication with patients.  
• Implement closed loop referral capability  
• Develop ability to send / receive information necessary for transitions of care (e.g., C-CDA, alerts)  
• Develop capability for electronic access to shared care management plans                                                                 | • Implement capability to monitor cohorts and attributed populations (e.g., capability to identify and monitor cohorts and share trends with care coordinators; ability to normalize and integrate data, including social determinants of health)  
• Implement capability to manage population health (e.g., access to information for health assessment of entire population; access and ability to share population health analysis). |
Financial Sustainability

A payment mechanism that is aligned across payers, sufficient to cover required activities, and focused in a way that incents achievement of program goals is a critical part of ensuring that HCHs can succeed. The HCH financial sustainability workgroup developed the following guiding principles for HCH payment to guide future considerations for payment.

1. The HCH payment mechanisms should reflect whole person orientation and compensate providers who provide team-based care related to prevention activities, chronic disease management, and care coordination.

2. The HCH payment mechanisms should promote quality improvement activities around care coordination that lead to the achievement of benchmarking standards (around infrastructure, process, and outcomes) as evidenced in the five year evaluation report or new benchmarks as they are developed. Payment mechanisms for the HCH model of care should also take into consideration improvement in performance.

To support the adoption and sustainability of the Health Care Home model, financial compensation is needed to support integrated, coordinated and collaborative care efforts inside and outside of the clinic walls including:

- Enhanced communications across the spectrum of care.
- Enhanced registry work to identify and manage the health of the population served.
- Implementation of clinical and operational best practices to ensure patients receive evidence based care.
- Transition work contained in referrals, hospital discharges, and follow up.
- Care plan formulation.
- Community Partnerships to improve health equity.

3. Health Care Home reimbursement should take into account time to manage medical, non-medical and social complexity.

4. The financial sustainability payment framework should support the adoption, use, and sharing of information via an electronic health record.

5. Compensation for Health Care Homes should be consistent and aligned across all payers to reduce burden on providers.

6. The HCH financial sustainability model should include compensation mechanisms to support infrastructure and whole practice redesign as primary care clinics move from volume-based payment to value-based payment.

7. Health Care Homes are not equal in their capacity to develop and sustain care coordination infrastructure. Some Health Care Homes may require technical assistance for readiness to enter value-based purchasing and other alternative payment models (e.g. Integrated Health Partnership (IHP), ACO, bundled payments, capitation), or identifying care delivery resources.
Response Content

MDH is seeking detailed, specific, targeted, and actionable feedback on the following topics:

**Social Determinants of Health and Health Equity**

The health care delivery system can only address approximately 20 percent of what creates health; the rest is largely influenced by social determinants, such as income, education, housing, and safe communities, that lie outside the care delivery system. The current HCH model builds a strong primary care foundation, but needs to further expand care partnerships to the community in order to fully address the health needs of individuals and communities. We are interested in learning about what you would need to better understand the characteristics of your clinic populations and improve the health of these populations by connecting to community partners.

1. Social Determinants of Health
   a. For which social determinants of health elements are you currently collecting data (race/ethnicity/language, housing, income, food insecurity, etc.)?
   b. How are you currently obtaining social determinants of health data (from patients, from another organization, etc.)? Are data collected on paper or in the Electronic Health Record (EHR)?
   c. To what extent are you currently using data on social determinants of health to assess whether patients require care coordination?
   d. If it becomes a requirement to assess for social determinants of health, how hard would it be to introduce such a process to your practice or organization, or to obtain that information through other partners?
   e. How could the HCH program support your efforts at assessing for social determinants of health as well as exchanging this information with other community partners?

2. Health Inequity
   a. To what extent are you currently using data to assess whether there are distinct populations that your organization serves for which there are health inequities?
   b. What do you think the HCH program should do differently to address health inequities within the certification process?
   c. If we require HCHs to conduct health inequity analyses or to assess progress towards reducing disparities, how hard would it be for you to introduce such an assessment into your processes?
   d. Has your practice/organization defined culturally appropriate care? If so, how do you ensure that definition is implemented or measured in your organization? If not, what support would you need to make this part of your approach to care?
   e. What barriers to health care access exist for your patients? Does your clinic use technology such as telehealth or other technological applications to address access and health inequity?
3. Risk Stratification
   a. What are you currently doing to identify patients with high and low risk factors associated with a medical condition or need for intervention?
   b. Are you using a registry from your electronic medical record based on one disease? Or whole person using multiple diseases? Health plan attribution lists? Other?
   c. Are you including socio-economic factors in your risk stratification?
   d. If you are risk stratifying patients, why, and what are you doing with the information?
   e. How might the HCH program help you with risk stratifying your patients?

Partnerships and Data Exchange

Once a clinic understands its population and the medical and non-medical issues that they face, an important step is to identify community partners to help improve the health of that population. Understanding the types of data that each organization holds related to individual patient or community characteristics, and having the ability to share information with partners in a secure way, is a critical step in coordinating care for complex patients. The following questions will help us to understand more about what is already being done around community partnerships and health information exchange, as well as what the priorities should be in the future in these areas to ensure that programmatic and health goals can be met.

4. Community Partnerships
   a. To what extent are you involved in community assessment plans completed by hospitals and/or local public health departments? How are you using the information from these assessments along with information from your risk stratification information in order to determine priorities?
   b. Should HCHs be required to formally partner with non-primary care providers, such as behavioral health, chemical dependency, or disability service providers? How should these partnerships be structured? Under what circumstances should these partnerships be required? How would a HCH demonstrate that these partnerships are in place and adequate to fulfill requirements?
   c. Should HCH’s be required to formally partner with non-medical, social service providers, such as housing services, food banks, job placement services, county social service agencies, or other community programs? If so, how should those partnerships be structured? Who are the highest-priority partners for a HCH to meet ‘enhanced’ program goals described in this RFI? How would a HCH demonstrate that these partnerships are in place and adequate to fulfill any such requirements?
   d. For HCH’s, to what extent are you currently working with non-medical, social service or community organizations such as those described above? What form do those partnerships take? What challenges do you face in establishing or maintaining those relationships?
   e. What support would HCHs need from the State in order to enter into a wider range of partnerships to support care coordination and develop new strategies to address social determinants of health?

5. E-health and Data Exchange
   a. With what clinical and community partners are you currently exchanging data about high-risk patients who are receiving care coordination? What types of data are you currently exchanging with these partners? How are you exchanging information? What works, and what barriers to exchange do you currently experience?
b. To meet the goals of the program related to coordinating care for high-risk patients, reducing total cost of care, expanding community partnerships, and advancing health equity, what are the most important types of data that would need to be collected, used, and/or exchanged from your perspective? For what types of data are additional analytic capabilities needed?
c. What e-health infrastructure and supports would be needed for HCHs and their partners to effectively engage in meeting the program goals? (For example: collection, use and exchange of social determinants of health; effective use of registry information to manage high-risk patients, bi-directional referrals, etc.)

Financial Sustainability

The HCH payment model currently consists of a tiered per member per month care coordination payment based on the patient’s medical complexity. However, the payment landscape is rapidly evolving on both the state and federal levels with a number of programs and payers moving towards value-based payment or Accountable Care Organizations (ACO) type models. With the announcement of proposed Medicare Access & CHIP Reauthorization Act (MACRA) rules, along with other current or pending changes, clinics in Minnesota increasingly need to manage a complex portfolio of payment strategies that are linked to cost and quality outcomes rather than volume. Understanding how HCHs are currently reimbursed for work associated with care coordination and other certification standards, and how these evolving payment approaches may impact them, is an important part of developing a sustainable method of supporting HCHs and other models going forward.

Questions for Clinics:

6. Reimbursement for care coordination and other HCH activities
   a. Are you billing for HCH payments under the current monthly, tiered payment model? If so, are there patients that you are providing care coordination for but not billing under the current model? Why not?
   b. If you are currently not billing for any HCH payments under the current methodology, why not?
   c. Do you currently receive payment for care coordination and/or chronic disease management activities from commercial health plans or other payers using an alternative methodology? Please describe these alternate arrangements.
   d. How much and what kind of variation exists between different commercial payers and between commercial and public payers when it comes to reimbursement for care coordination for HCHs?
   e. To what degree are your patients enrolled in commercial plans being assessed copays for care coordination?
   f. What steps could the State take to ensure that payment for care coordination for HCHs is consistent across payers?
   g. What kind of technical assistance would be valuable to you in order to build and/or maintain a financially sustainable HCH program at your clinic?

7. Are you thinking about moving towards a national accrediting body such as National Committee for Quality Assurance (NCQA) for Patient Centered Medical Home (PCMH) certification? Why?
8. For certified HCHs, what kind of support do you need to sustain the work of implementing and maintaining your Health Care Home certification?
   a. What kind of up-front costs did you incur in order to implement a HCH care delivery model?
   b. What ongoing costs do you incur in order to maintain a HCH care delivery model?
   c. Do you anticipate facing resource or capacity constraints related to meeting MACRA requirements while still maintaining HCH certification?
   d. Have you added any emerging professions (community health workers, community paramedics, dental therapists/advanced dental therapists) to your team? How are these professions being used in your clinic setting?

9. What might the arrangements look like for shared risk and shared reward in partnerships between clinics and community agencies, local public health, and other “non-traditional” service providers?

10. Are you participating, or considering participating, in alternative payment programs, such as Medicaid’s Integrated Health Partnerships (IHPs), CMS’s Comprehensive Primary Care Plus (CPC+), Next Generation ACO, CMS’s Medicare Shared Savings Program (MSSP), etc.? If so, do you view participation in these types of alternate payment models as a necessary support mechanism for your care coordination and/or chronic disease management activities? Do you consider participation in alternate payment models as an alternative to a dedicated care coordination and/or disease management service payment? If you are not involved in any alternate payment models, why not?

**Questions for Health Plans:**

11. Are your members charged copays for care coordination services provided by HCHs?

12. Do you work directly with health care systems and clinics to create alternative payment models that contain HCH certification criteria?

13. Will you work with national organizations that accredit clinics as patient centered medical homes to form Alternative Payment Models (APMs) and Advanced APMs? If so, will you align these efforts with Minnesota’s HCH program?

**Learning Collaborative**

*Health care transformation requires a workforce with knowledge, skills and abilities that go beyond the traditional training that many health care professionals receive. HCH seeks to support development of a learning culture, infrastructure and delivery system designed to strategically meet the needs of health professionals and others engaged in health care transformation. Learning will be delivered through a variety of modalities with an emphasis on easy access, resources for hands on skill-building, and peer based learning.*

14. How can the HCH Learning Collaborative support clinics and partners in building and sustaining a learning culture based on continuous quality improvement?
15. How do you assess a HCH team member’s knowledge, skills and abilities to determine whether he/she can meet the demands of HCH certification/recertification? Would it be helpful to have an assessment tool for this purpose?

16. Creating and sustaining a learning culture requires strong leadership. What is needed to engage organizational leaders to champion a learning environment to support practice transformation both inside the clinic and in partnership with the community.

Communication & Evaluation

Part of the challenge of health care transformation is getting patients and consumers to recognize it as a pathway to receiving better care and improved health outcomes, and ensuring that robust evaluation approaches are in place to assess progress towards program goals.

17. How are you currently communicating with stakeholders about your efforts to transform health care? If you are a HCH provider, do your stakeholders recognize and value how certification impacts the care and services you provide?

18. How can MDH better communicate the value of health care transformation and certification? How can MDH better support HCH certified clinics in communicating this value to your stakeholders?

19. As you think about the programmatic goals and enhancements described here, what types of metrics would be most useful in evaluating success? What data currently exists for this?

Patient Engagement

Patient engagement is a foundational component of practice transformation and Minnesota’s HCH delivery model. Collaboration between primary care clinicians, health care teams, patients and their families and community partners form the basis for improving the cost, quality and experience of care. As we move into shared care through community partnerships, it will be important to continue including patients and consumers in designing and improving care across the continuum.

Questions for Clinics and Community Partners:

20. What efforts have you made to promote patient engagement? What has worked? What has been challenging?

21. How can clinics and community partners engage patients and consumers to design and implement a community care model? What kinds of support would be helpful in facilitating patient engagement?

22. Patient self-management is another important component in successful care outcomes. How are you engaging patients in self-management? What successes have you had? What barriers do you face? What kinds of support would be helpful in improving outcomes through patient self-management?
Questions for Patients/Consumers:

23. What do you need to be healthy? What is most important to you for optimal health?

24. How could your clinic and community care providers be more effective in helping you be as healthy as possible?

25. How do you give feedback to your clinic and community care providers? What method works best? What are the barriers for you?

26. What should clinics and community providers do to encourage more engagement from patients whose voices aren’t often heard?

27. How could social media be used to facilitate more feedback from patients and consumers?

28. How can we ensure patient voices are being heard from ethnic and non-English speaking communities?

29. Does your provider help you understand your health, the plan for your care, and who is responsible for different aspects of your care?

30. What could your clinic do to improve your experience of care?

Longer-term vision

The practice standards of a certified HCH clinic are an important foundation to transforming primary care delivery and improving health. HCH certification and comprehensive primary care continue to be an important strategy to improving health, however, evidence indicates only about 20% of health can be impacted in the clinician’s office. Communities impact health and much of what makes a person healthy depends on where they live, work, and play.

Using HCH’s strong foundation and building upon the work of the 2011 Community Care Teams and the recent Accountable Communities for Health (ACH) model, the future vision for the HCH program incorporates a focus on social needs and clinical care integration for a population or community through patient centered, coordinated care across a range of medical and non-medical providers, guided by local leaders, with support of an accountable care organization (ACO). ACH teams include a wide range of community partners (ex. education, transportation, housing, nutrition, etc.) and use formal business agreements to integrate services through enhanced referrals, transitions management, and implementation of new practice guidelines. In order to address population-specific needs, each ACH features a unique mix of partner organizations and a focus on prevailing health and social conditions; all include an Accountable Care Organization as a partner.

While nearly every ACH includes a HCH as a critical partner for providing care, the HCH is not always at the center of the partnership or in the position of a fiscal agent. In some cases, local public health, social service, or community organizations serve as the organizing hub of an ACH and the ‘entry point’ for community care coordination efforts. ACH’s also work closely with local public health agencies to develop and implement population health improvement projects that are based on local, community-identified needs.
More information about Community Care teams can be found at:
http://www.health.state.mn.us/healthreform/homes/legreport/docs/2013hchlegreport.pdf

More information about Accountable Communities for health can be found at:

The intentional partnerships of the ACH model are designed to bring healthcare systems and community resources together, with financial accountability for results, to lessen fragmentation of care and services. Many of the proposed changes to the HCH program that are included in this RFI, including enhanced requirements related to community partnerships, exchange of data, and health equity/health disparities, describe capabilities that clinics will need to master in order to successfully participate in this type of model. As such, the enhancements proposed here lay the groundwork for building a statewide network of community-based accountable health partnerships in the longer run, but a number of questions remain related to how to make these collaborations financially sustainable and to hold them accountable for results.

31. Would your organization consider participating in a community-based accountable health partnership model? Why or why not?

32. What would this model need to look like for your organization to participate, in terms of expectations/requirements and financial support?

33. Do you think that a model like this offers opportunities to make progress towards triple aim goals and advance health equity? What concerns would you have about it?

34. Are there other models that MDH should be looking at, beyond the SIM-funded ACH model, as we explore how to move towards more of a community-based ‘accountable health’ model?

35. What avenues should the State explore for financial sustainability of ACH-like models?

36. As you look at the expectations for becoming an accountable community for health, what do you see as the barriers/challenges to participation in a model like this?

Procedure & Instructions

This RFI can be accessed on the HCH website News and Announcements Page. Public comment to the RFI is invited through two online surveys, via e-mail and at three public meetings. Responses will be accepted through September 9, 2016. An informational webinar will be held on August 8.

Online Surveys

- Online Provider Survey: For representatives from health care homes and partnering institutions
- Online Patient and Consumer Survey: An abbreviated survey designed for patients and consumers
E-Mail Responses
Additional responses to the HCH program recommendations or the RFI process may also be submitted via e-mail to Health.HealthCareHomes@state.mn.us using the subject line HCH RFI Response. Please include your name, organization, title, telephone number, and e-mail address in your response.

Additional Opportunities for Learning and Input
MDH will host three two-hour stakeholder meetings to review the RFI, clarify any questions, and solicit feedback. The meetings are open to the public. Attendance at these meetings is not required to submit a response to this RFI.

Stakeholder Meetings

**Southern Minnesota Public Meeting**
August 10, 9:00 AM- 11:00 AM
Children’s Health Center – Mankato Clinic
1421 Premier Drive
Mankato, MN 56001

**Metro Public Meeting**
August 16, 1:00 PM- 3:00 PM
Wilder Center 2510
451 Lexington Parkway North
Saint Paul, MN 55104

**Northern Minnesota Public Meeting**
August 11, 10:00 AM - Noon
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56001

Webinar

**Envisioning the Future of Health Care Homes: A Request for Information**
August 8, 12:00 PM- 1:00 PM

To register, go to: https://health-state-mn-ustraining.webex.com/health-state-mn-ustraining/k2/j.php?MTID=t8490e53ce97409d34d22d3a397429daf

Audio only option:
1-888-742-5095 Call-in toll-free number
Conference Code: 3160477076
About the Request for Information

Response to this RFI is completely voluntary. Responders are invited to address as many or as few of the questions as they are able. The State is seeking information that it may use for future planning and program improvement, policy development, and/or competitive contracting for services. This RFI, and responses to it, do not in any way obligate the State, nor will it provide any advantage to respondents in potential future Requests for Proposals for competitive procurement. Respondents are responsible for all costs associated with the preparation and submission of responses to this RFI.

All responses to this RFI are considered public, according to the Minnesota Statutes, section 13.03 unless otherwise defined by Minnesota Statutes, section 13.37 as “Trade Secrets.” If the Responder submits information that it believes to be trade secret/confidential materials, and the Responder does not want such data used or disclosed for any purpose other than the evaluation of this Response, the Responder must clearly mark every page of trade secret materials in its Response at the time the Response is submitted with the words “Trade Secret” or “Confidential,” and must justify the trade secret designation for each item in its Response. If the State should decide to issue an RFP and award a contract based on any information received from responses to this RFI, all public information, including the identity of the responders, will be disclosed upon request.

Thank you for taking the time to respond to this RFI. Your input is appreciated and important to the continued success of the HCH program.