Medicaid Payment and Delivery System Innovation: Minnesota’s Experience

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MN SIM: What are we testing?

Can we improve health and lower costs if more people are covered by Accountable Care Organizations (ACO) models?

If we invest in data analytics, health information technology, practice facilitation, and quality improvement, can we accelerate adoption of ACO models and remove barriers to integration of care (including behavioral health, social services, public health and long-term services and supports), especially among smaller, rural and safety net providers?

How are health outcomes and costs improved when ACOs adopt Community Care Team and Accountable Communities for Health models to support integration of health care with non-medical services, compared to those who do not adopt these models?
SIM Strategy: How will MN achieve targets?

- Build on existing reforms
- **Accelerate adoption of ACOs, specifically expanding Minnesota's Medicaid IHP demonstration**
- Invest in e-Health (health information technology and exchange), data analytics, workforce and practice transformation
- Create up to 15 Accountable Communities for Health
Health Reform Building Blocks: Foundation

- Medicaid ACOs
- Health Care Homes
- SHIP
- Strong Collaborative Partnerships
- Standardized Quality Measurement
- E-health Initiative
- Community Care Teams
The SIM Accelerant

Due to the high concentration of SIM funded programs in the metro area, total projects are indicated in place of multiple markers.
What is MN’s approach to Medicaid ACO development?

- Integrated Health Partnership (IHP) demonstration - Authorized in 2010 by Minnesota Statutes, 256B.0755
- Define the “what” (better care, lower costs), rather than the “how”
- Allow for **broad flexibility and innovation** under a common framework of accountability

**Framework of accountability** includes:

- Models based on, and with accountability for, **total cost of care (TCOC)**
- Robust and consistent **quality measurement**
- Models that drive rapidly **away from the incentive “to do more”** and **towards increasing levels of integration**
IHP providers must:

- Deliver the full scope of **primary care** services.
- **Coordinate** with specialty providers and hospitals.
- Demonstrate how they will **partner** with community organizations and social service agencies and integrate their services into care delivery.

- Model allows **flexibility** in governance structure and care models to encourage innovation and local solutions.
How are IHPs Accountable?

Total Cost of Care (TCOC)

- Providers contract with DHS under one of two models: Virtual IHP or Integrated IHP.
- The models include the same framework but have different financial arrangements.
- Flexibility within models to accommodate provider make up and risk tolerance: goal to ensure broadest possible participation and available options.
- The agreements are 1-year contracts that renew annually for the 3-year demo period.
How are IHPs Accountable?

Total Cost of Care (TCOC)

- Existing provider payment persists during the Demo.

- **Gain-/loss-sharing payments made annually** based on risk-adjusted TCOC performance, **contingent on quality performance** (clinical and patient experience measures; in year 3 of IHP contact, 50% of savings are based on quality performance).

- Performance compares each IHP’s base year TCOC (year prior to start of demo) to subsequent years.
How do we calculate TCOC shared savings?

- Total Cost of Care (TCOC) target (risk adjusted, trended) is measured against actual experience to determine the level of claim cost savings (excess cost) for risk share distribution.

**GAIN:**
Savings achieved beyond the minimum threshold are shared between the payer and delivery system at pre-negotiated levels.

**LOSS:**
Delivery system pays back a pre-negotiated portion of spending above the minimum threshold.
How else are IHPs Accountable?

Quality Measurement

- Performance on quality measures impacts the amount of shared savings an IHP can receive; phased in over 3-year demo
  - Year 1 – 25% of shared savings based on reporting only
  - Year 2 – 25% of shared savings based on performance
  - Year 3 – 50% of shared savings based on performance

- Core set of measures based on existing state reporting requirements – Minnesota’s *Statewide Quality Reporting and Measurement System*

- Core includes **7 clinical measures** and **2 patient experience measures**, totaling 32 individual measure components – across both **clinic** and **hospital** settings
  - IHPs have flexibility to propose alternative measures and methods

- Each individual measure is scored based on either **achievement** or **year-to-year improvement**
How do we help the IHPs succeed?

Reporting and Data Feedback

- IHP Partner Portal
- Performance Dashboard
- Cost Reports (inside vs. outside the IHP and included vs. excluded from TCOC) by category of service
- Comprehensive Care Management – Patient level lists of ACG Clinical Profile includes predictive risk and risk stratification tools, chronic condition and coordination of care indices
- Attributes population change analysis
- Utilization Reports – services over time, compared to benchmark, option to breakdown by participation clinic location
- Quality – performance on selected HEDIS measures, and SQRMS
- Monthly Claim and Pharmacy Utilization files
- Line level detail (1 yr. of history) for attributed recipients of Facility, Professional, and Pharmacy encounters
- Excludes service level paid amounts and CD treatment data

SIM supported contract with analytics vendor for technical assistance, consultation
Managed care organizations (MCOs) participate in IHPs through their contract with DHS.

- DHS provides MCOs with a list of IHPs, including the attributed population enrolled with MCO, TCOC of attributed enrollees, and interim/final settlement amounts due to IHP.
- MCOs are required to provide timely, accurate, and complete encounter and payment data to DHS.

DHS contracts with the IHP/provider, performs all calculations, requires each MCO to pay its share of the payment to each IHP (within 30 days of notice).

MCOs submit encounter data to DHS, which is used to develop TCOC.

MCOs still maintain their contracts with providers.
What does the IHP demo look like right now?

MN Integrated Health Partnerships Growth

- 2013: ACOs = 6, Providers = 2,739, Enrollees = 99,107
- 2014: ACOs = 9, Providers = 4,792, Enrollees = 145,869
- 2015: ACOs = 16, Providers = 7,328, Enrollees = 204,119
<table>
<thead>
<tr>
<th>IHP</th>
<th>Geographic area</th>
<th>Size (# Attributed)</th>
<th>Round</th>
<th>Integrated vs. Virtual</th>
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</thead>
<tbody>
<tr>
<td>CentraCare</td>
<td>Central MN</td>
<td>19,213</td>
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<td>Duluth/NE MN</td>
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<td>Minneapolis/St. Paul</td>
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<td>North Memorial</td>
<td>Minneapolis/St. Paul</td>
<td>4,556</td>
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<td>Integrated</td>
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<td>Northwest Health Alliance (Allina/HealthPartners)</td>
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<td>Mayo Clinic</td>
<td>Rochester/SE MN</td>
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<td>&gt;1,000</td>
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<td>Lakewood Health System</td>
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<td>3</td>
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How are the IHPs doing?

- In **2013** providers saved **$14.8 million** compared to their trended targets.
- **2014 interim** TCOC savings estimated at **$61.5 million**
  - For 2013, all beat their targets and met quality requirements; 5 received shared savings payments ($6 million total ranging from $570,000 to $2.4 million)
  - In 2014, all 9 providers received shared savings settlements ($22.7 million in total)
IHP Feedback Themes

- Value flexibility in model components and need for multiple “tracks” so providers at varying places in their ability and appetite for risk arrangements can participate.

- Desire to make continued improvements in attribution to capture those not accessing primary care, interest in prospective or enrollment models.

- Stabilize payment support for care coordination and data analytic infrastructure (for example through a consolidated prospective payment).
What are some lessons learned so far?

- New partnerships take a long time to become operational, and require resources to develop necessary governance, infrastructure.

- Work on foundational elements needed for providers to effectively manage care and take on greater risk (upfront infrastructure, information/data sharing).

- Risk adjustment methods need further development and enhancement to effectively capture medically and socially complex populations served.
What’s Next?

- Incorporate IHP feedback to develop advanced model track
- Explore Medicare/Medicaid Integrated ACO model for under 65 duals
- Emphasis on integration of acute care and other care settings, behavioral health, and home and community based services/social services
- Support IHP strategies toward more community responsibility for health/accountable communities for health
- Work with new health financing taskforce on state purchasing reform and planning related to waiver options under the ACA to align requirements across affordability programs.