Medicaid Payment and Delivery System Innovation: Minnesota’s Experience

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MILBANK RSG 2015

health reform
MINNESOTA
A Better State of Health
Overall Health System Performance

Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.
Health Reforms in Minnesota

- MNSure (state exchange, enrollment and expansion)
- All Payer Claims Data Base (including Medicaid encounters and prices)
- Statewide Health Improvement Initiatives
- Statewide E-Health Plan and Initiative
- Statewide Quality Reporting and Measurement System (SQRMS)
- Health Care Homes
- Medicaid Managed Care Reforms/competitive bidding
- Behavioral Health Home (in process)
- Integrated Health Partnerships (IHPs-Medicaid ACOs for both managed care and FFS)
- State Innovation Model and Grant (SIM) - $45 mil
- Dual Demo (Seniors in MSHO, D-SNP based, not FAD)
Results of Reform Efforts

- **MNSure**: Enrolled about 400,000 since 10/13
  - Medicaid (about 1/3 of total)
  - MinnesotaCare (1115 in 2014; BHP in 2015)
  - QHPs

- **HCHs**: 374 certified clinics, 50% of all primary care clinics, serving over 3 million people including Medicaid patients

- **Medicaid MCOs**: Competitive bidding since 2011 + other reforms = 1.65 billion savings

- **Medicaid ACOs**: 17 participating ACOs covering over 200,000 enrollees = $76 million in savings for first 2 years
Minnesota Medicaid Overview

- 900,000 enrollees, approx. $9 billion annual expenditures Mature Medicaid Manage Care Program
  - Contracts with only non profit plans
  - 8 local non profit plans participating, includes 4 sponsored by counties
  - Mandatory managed care for all except for people with disabilities (opt out)
  - Fee-for-service program primarily people with disabilities opt outs
- Families and Children and Adults without children: 800,000
  - Medicaid and MinnesotaCare
- Seniors 65+ with MLTSS: 50,000 enrollees
  - MSHO (voluntary-integrated with Medicare D-SNPs)
  - MSC+ (mandatory default)
- People with Disabilities 18-65: 50,000 enrollees
  - Special Needs Basic Care (opt out, does not include LTSS)
Health Reform Building Blocks: Foundation

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

Due to the high concentration of SIM-funded programs in the metro area, several 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 Legislature
- Define the “what” (better care, lower costs), rather then 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**
Who can be an IHP?
Provider Characteristics/Requirements

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.

**LOSS:**
Delivery system pays back a pre-negotiated portion of spending above the minimum threshold.

**GAIN:**
Savings achieved beyond the minimum threshold are shared between the payer and delivery system at pre-negotiated levels.
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 Portal Analytical Reports (SAS BI Reports)**
  - Utilization
    - Risk adjusted ED and Inpatient trends
    - Pharmacy – broken down by drug class, highlights specialty drugs
  - Quality
    - HEDIS measures
    - Clinical and hospital SQRMS measures
  - Care Coordination
    - Monthly recipient – level reports including comprehensive care management - ACG© Clinical Profile includes risk stratification, chronic condition and coordination of care indices
    - Attribution reports – track global changes in attributed population
  - Total Cost of Care
    - Population risk change and comparison to interim targets
    - Aggregated Costs (inside vs. outside the IHP and included vs excluded from TCOC) by category of service
- **MN-ITS Mailbox (“Raw” File Distribution System)**
  - 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
  - Monthly Recipient Demographic file
How do we help the IHPs succeed?

Reporting and Data Feedback
What is the role of MCOs in IHP?

- Managed care organizations (MCOs) participate in IHPs through their contract with DHS
  - DHS provides MCOs with a list of IHPs, including attributed population enrolled with MCO, TCOC of attributed enrollees and interim/final settlement amounts due to IHP
  - MCO is 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

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<thead>
<tr>
<th>Year</th>
<th>ACOs</th>
<th>Providers</th>
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</thead>
<tbody>
<tr>
<td>2013</td>
<td>6</td>
<td>2,739</td>
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<tr>
<td>2014</td>
<td>9</td>
<td>4,792</td>
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<tr>
<td>2015</td>
<td>16</td>
<td>7,328</td>
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- Enrollees
- ACOs = 16
  Providers = 7,328
<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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<tbody>
<tr>
<td>CentraCare</td>
<td>Central MN</td>
<td>19,213</td>
<td>1</td>
<td>Integrated</td>
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<tr>
<td>Children’s Hospital</td>
<td>Minneapolis/St. Paul</td>
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<tr>
<td>FQHC Urban Health Network</td>
<td>Minneapolis/St. Paul</td>
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<td>Virtual</td>
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<tr>
<td>North Memorial</td>
<td>Minneapolis/St. Paul</td>
<td>4,556</td>
<td>1</td>
<td>Integrated</td>
</tr>
<tr>
<td>Northwest Health Alliance (Allina/HealthPartners)</td>
<td>Minneapolis/St. Paul</td>
<td>15,538</td>
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<tr>
<td>Hennepin Healthcare System/HCMC</td>
<td>Minneapolis/St. Paul</td>
<td>29,567</td>
<td>2</td>
<td>Integrated</td>
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<tr>
<td>Mayo Clinic</td>
<td>Rochester/SE MN</td>
<td>6,468</td>
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<td>Southern Prairie Community Care</td>
<td>Marshall/SW MN</td>
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<tr>
<td>Bluestone Physician Services</td>
<td>Minneapolis/St. Paul</td>
<td>&gt;1,000</td>
<td>3</td>
<td>Virtual</td>
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<tr>
<td>Courage Kenny, part of Allina Health</td>
<td>Minneapolis/St. Paul</td>
<td>1,691</td>
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<td>West Central MN</td>
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<td>Lakewood Health System</td>
<td>Central MN</td>
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<td>Winona Health</td>
<td>Winona/SE MN</td>
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<td>3</td>
<td>Integrated</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 **patient attribution/assignment** 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.
Other ACO Demos

Hennepin Health: A Safety-Net ACO
Hennepin Health:
integration with social services and behavioral health

- “Safety-net ACO”
- Population focus: adults on Medicaid with incomes below 133% FPG = 10,000+
- Hennepin county receives capitation rate roughly equivalent to MCO cap rates
- Opportunity for savings outside the Medicaid program (i.e. corrections and social services)

Hennepin county:
Minnesota’s largest county (Minneapolis)
Hennepin Health “Safety-Net ACO” demonstration

- Care model includes integration of medical care with
  - Behavioral health,
  - Social services
  - Other county services unique to Hennepin
- Focused on high-need populations who are frequent users of county services
- Incentives aligned under county-run safety hospital and clinics, HMO, FQHC, behavioral health, and other traditional county services.
What’s Next?

- Incorporate provider 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 ACO 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.