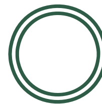
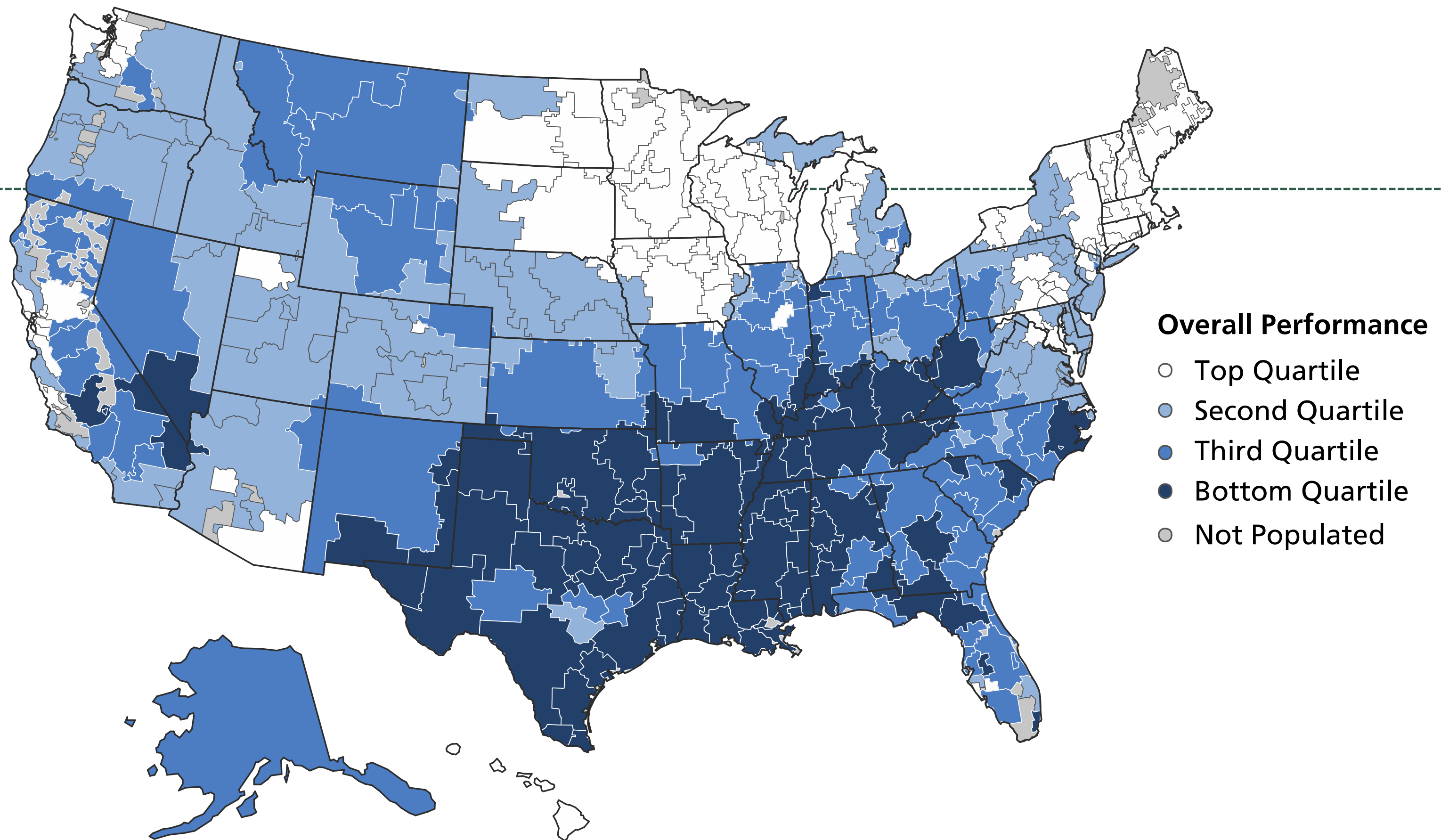
Medicaid Payment and Delivery System Innovation: Minnesota's Experience



MARIE ZIMMERMAN, MEDICAID DIRECTOR
MINNESOTA DEPARTMENT OF HUMAN SERVICES
MILBANK RSG 2015

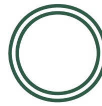
health reform
MINNESOTA
A Better State of Health

Overall Health System Performance



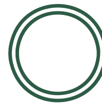
Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.

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)

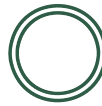
Results of Reform Efforts



- 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 200,00 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

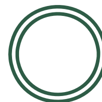
Strong Collaborative Partnerships

Standardized Quality Measurement

E-health Initiative

Community Care Teams

MN SIM: What are we testing?

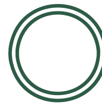


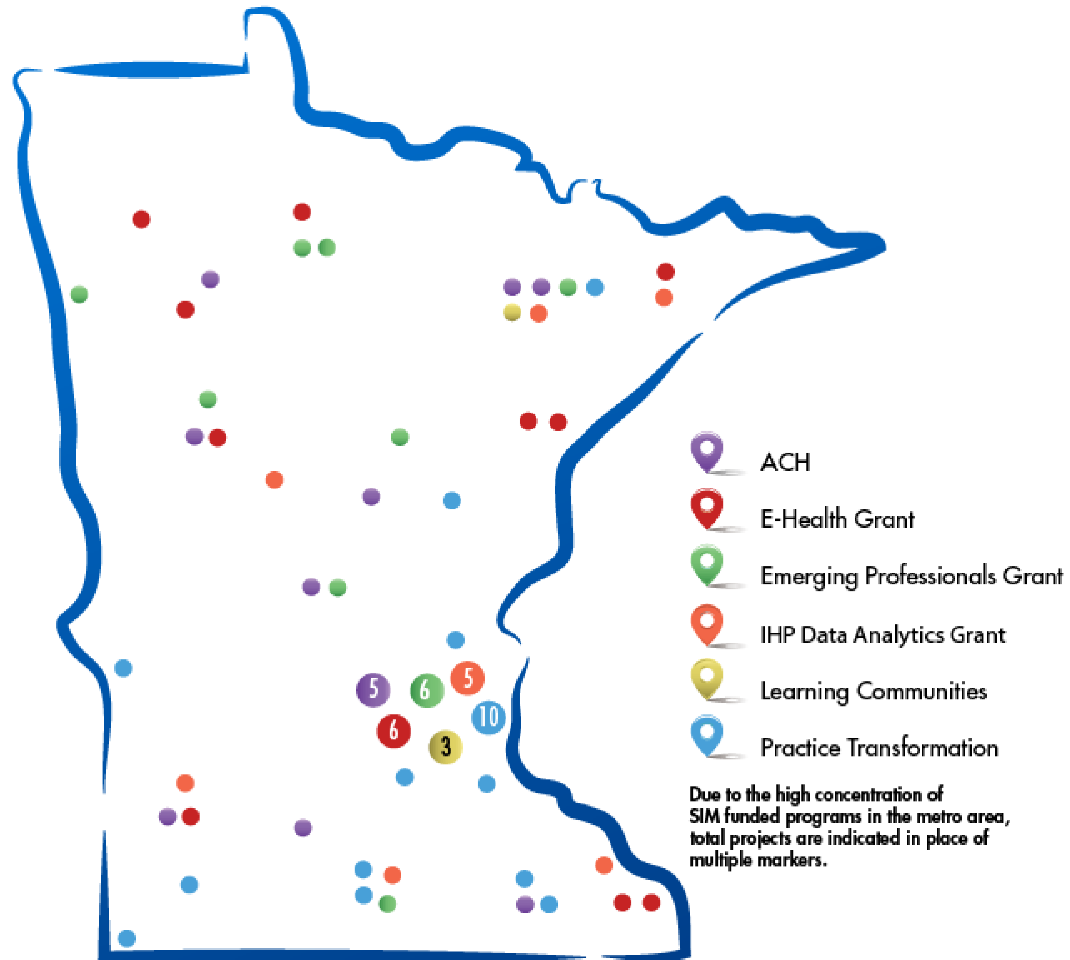
Can we improve health and lower costs if more people are covered by Accountable Care Organizations (ACO) models?

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

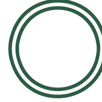




What is MN's approach to Medicaid ACO development?

- **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)

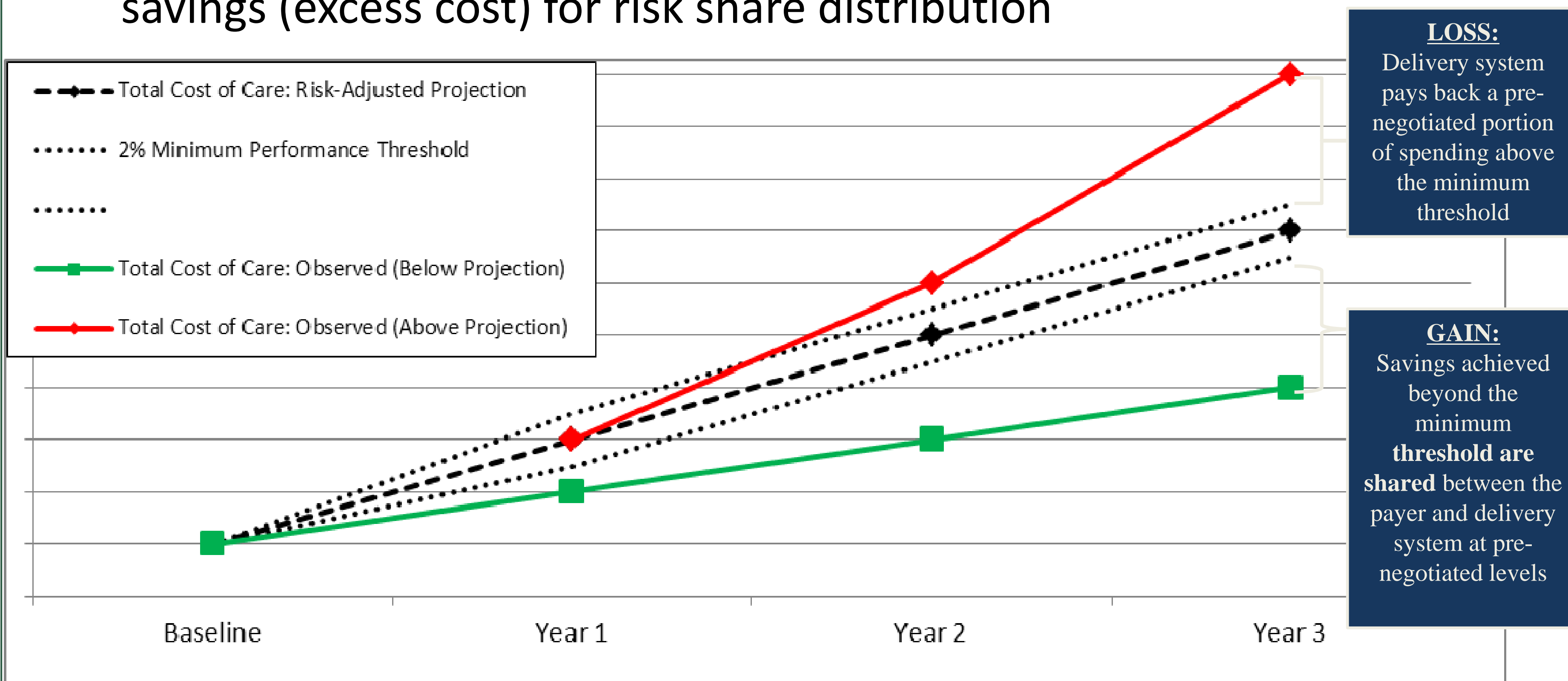
- Providers contract with DHS under one of two models: **Virtual IHP** or **Integrated IHP**.
- The models include the **same framework** but have **different financial arrangements**.
- **Flexibility** within models to accommodate provider make up and risk tolerance: goal to ensure broadest possible 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



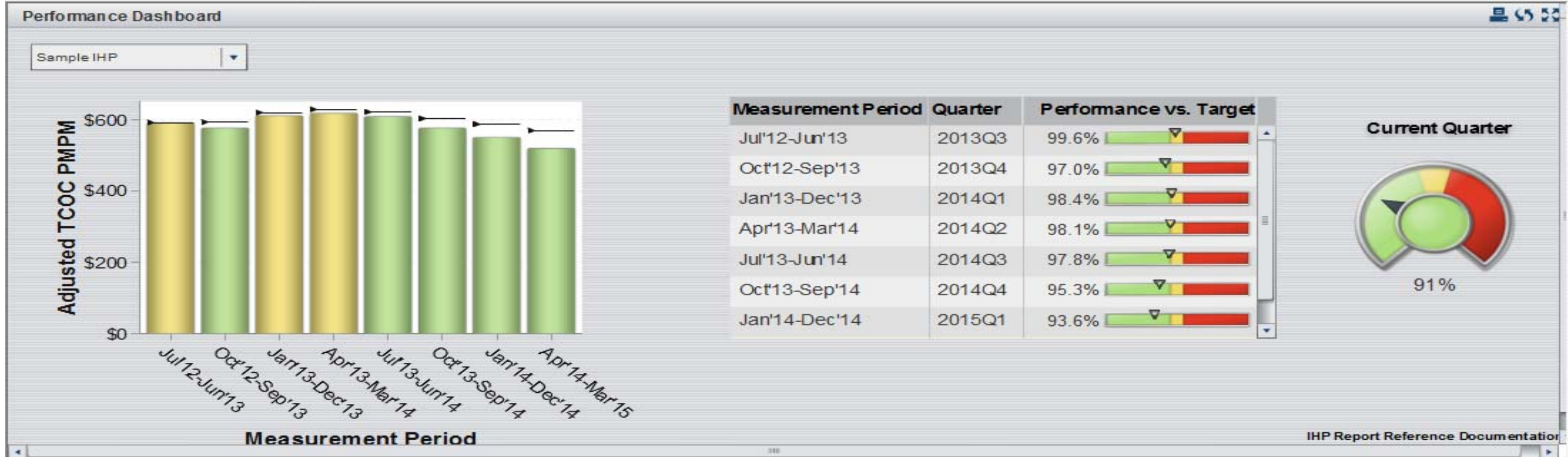
- Performance on quality measures impacts the amount of shared savings an IHP can receive; phased in over 3-year demo
  - Year 1 – 25% of shared savings based on *reporting* only
  - Year 2 – 25% of shared savings based on *performance*
  - Year 3 – 50% of shared savings based on *performance*
- Core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

State of MN DHS - IHP Performance Summary



Measurement Period	Quarter	Performance vs. Target
Jul'12-Jun'13	2013Q3	99.6%
Oct'12-Sep'13	2013Q4	97.0%
Jan'13-Dec'13	2014Q1	98.4%
Apr'13-Mar'14	2014Q2	98.1%
Jul'13-Jun'14	2014Q3	97.8%
Oct'13-Sep'14	2014Q4	95.3%
Jan'14-Dec'14	2015Q1	93.6%

TCOC — *Shared: Integrated Health Partnerships*

Click here to refresh collection.

- Major Category of Service Cost Trend.srx
- I. TCOC Summary.srx
- II. Cost by Detailed Category of Service.srx
- III. Inside vs. Outside Summary.srx
- Included vs. Excluded Drilldown.srx
- IV. Claim Cap Cost Distribution.srx
- V. TCOC by Member Program.srx
- TCOC by Member Category Drilldown.srx
- Included TCOC Breakdown by Provider.srx

Care Coordination

Click here to refresh collection.

- Care Management Report.srx
- Provider Alert Report.srx
- Monthly Attribution Trend.srx
- Chronic Condition Profile.srx
- Provider Roster Gaps.srx
- Attribution Change Analysis.srx

Utilization — *Shared: Integrated Health Partnerships*

Click here to refresh collection.

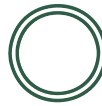
- Inpatient and ED Trends by IHP.srx
- Inpatient and ED Trends by Clinic.srx
- Pharmacy Summary - Utilization.srx
- Pharmacy Summary - Spend.srx

Quality

Click here to refresh collection.

- IHP HEDIS Measures.srx
- IHP Summary of Quality and Patient Experience Measures.srx
- Physician Clinic Clinical Quality Measures, by Clinic.srx
- Physician Clinic Clinical Quality Components, by Clinic.srx
- Physician Clinic Patient Experience Measures, by Clinic.srx
- Hospital Quality and Patient Experience Measures.srx

What is the role of MCOs in IHP?



- Managed care organizations (MCOs) participate in IHPs through their contract with DHS
  - DHS provides MCOs w/ list of IHPs, include 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 (w/in 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

250,000
200,000
150,000
100,000
50,000
0

ACOs = 6
Providers = 2,739

99,107

ACOs = 9
Providers = 4,792

145,869

ACOs = 16
Providers = 7,328

204,119

2013
2014
2015

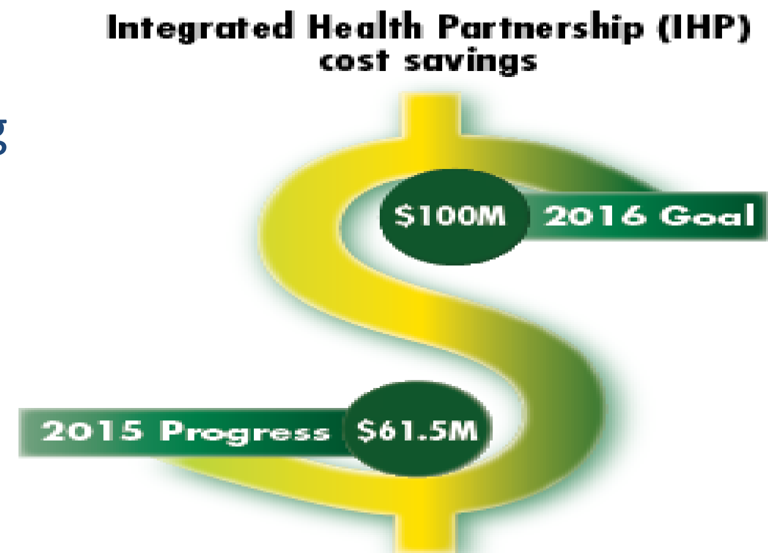
Enrollees

health reform MINNESOTA
A Better State of Health

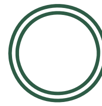
IHP	Geographic area	Size (# Attributed)	Round	Integrated vs. Virtual
CentraCare	Central MN	19,213	1	Integrated
Children's Hospital	Minneapolis/St. Paul	18,298	1	Integrated
Essentia Health	Duluth/NE MN	28,491	1	Integrated
FQHC Urban Health Network	Minneapolis/St. Paul	27,169	1	Virtual
North Memorial	Minneapolis/St. Paul	4,556	1	Integrated
Northwest Health Alliance (Allina/HealthPartners)	Minneapolis/St. Paul	15,538	1	Integrated
Hennepin Healthcare System/HCMC	Minneapolis/St. Paul	29,567	2	Integrated
Mayo Clinic	Rochester/SE MN	6,468	2	Integrated
Southern Prairie Community Care	Marshall/SW MN	23,602	2	Virtual
Bluestone Physician Services	Minneapolis/St. Paul	>1,000	3	Virtual
Courage Kenny, part of Allina Health	Minneapolis/St. Paul	1,691	3	Virtual
Lake Region Healthcare	West Central MN	3,749	3	Integrated
Lakewood Health System	Central MN	3,886	3	Integrated*
Mankato Clinic	Mankato	8,536	3	Virtual
Wilderness Health	NE MN	10,517	3	Virtual
Winona Health	Winona/SE MN	4,331	3	Integrated

How are the IHPs doing?

- In **2013** providers saved **<u>$14.8 million</u>** compared to their trended targets.
- **2014 interim** TCOC savings estimated at **<u>$61.5 million</u>**
    - 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)

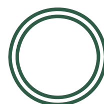


IHP Feedback Themes



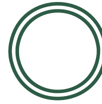
- Value flexibility in model components and need for multiple "tracks" so providers at varying places in their ability and appetite for risk arrangements can participate.
- Desire to make continued improvements in patient attribution/assignment to capture those not accessing primary care, interest in 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?



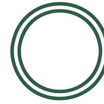
- New partnerships take a long time to become operational, and require resources to develop necessary governance, infrastructure
- Work on foundational elements needed for providers to effectively manage care and take on greater risk (upfront infrastructure, information/data sharing)
- Risk adjustment methods need further development and enhancement to effectively capture medically and socially complex populations served

Other ACO Demos



Hennepin Health: A Safety-Net ACO

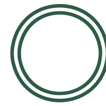
Hennepin Health:
integration with social services and behavioral health



- “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

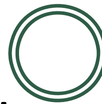
Hennepin county: Minnesota’s largest county (Minneapolis)

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.